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SUMARIO / SUMMARY / RESUMO

Editorial

At finish the year with the following edition of Psychology Research magazine. The first article of the current issue is a scientific contribution with the aim of identifying the predominant style of conflict resolution in the Spanish State Security Forces and Corps. Likewise, it intends to describe the relationship between conflict resolution and emotional intelligence, as well as verify the relationship between conflict resolution and psychological well-being. For this, a large sample is used in which emotional well-being, emotional intelligence and conflict resolution styles have been measured with different questionnaires. In view of the results obtained, the study stresses the benefits of training workers in mediation techniques and conflict resolution.

The purpose of the following contribution is to analyze self-awareness and self-control in a comparative study between students trained in emotional competencies from the perspective of emotional intelligence and students without training in said competencies. The results seem to indicate that many of the respondents have little ability to cope with emotions adequately, so it is concluded that greater awareness and involvement is necessary on the part of fathers and mothers, as well as those responsible for education regarding stimulation of emotional components.

The third article investigates the relationship between parental educational styles, family structure and the perception of family functionality in the appearance of criminal behavior in adolescents. The results show significant relationships between criminal behaviors and a low perception of family functionality based on low family cohesion, one-way communication, assertions of power, rigid and inflexible rules, and little affective involvement, typical of authoritarian and negligent parenting styles. These results allowed us to conclude that the family factor that significantly affects the adoption of criminal behaviors in adolescents is the perception that they have about family functioning and support factors, conflict resolution, participation in decision making, establishment of limits and tolerance to the crisis that they find present in the family environment.

The following article explores the psychosocial impact that COVID-19 has had among university students in Uruguay. Its objectives were to describe the impact in detail, identify the relationships between the different dimensions, and highlight the determinants of mental health. Students indicated an increase in signs of anxiety, depression, or sleep disturbances, in addition to other related factors, such as increased substance use, deterioration in social relationships, the negative impact of school closures, and concerns personal finances. The findings are discussed in terms of their public health implications and future directions for research on the effects of the pandemic on mental health.

The fifth proposal consisted of evaluating the sociodemographic characteristics and the psychopathological symptoms of the patients attended by clinical psychology in primary care. Information was collected through a clinical interview, a questionnaire for sociodemographic variables and ad hoc clinical aspects, and the GHQ-28 general health questionnaire. The most frequent reasons for attention, the presence of psychopharmacological treatment and the processes of psychological intervention were evaluated. In view of the results, it was concluded that the psychological intervention provides a better psychological adjustment and avoids the chronification of psychopathology.

We close the current issue with an article that reviews attitudes towards death in health professionals, with the aim of delving into the practical implications of these attitudes. The absence of interventions based on promoting resilience, coping strategies and other factors involved in the attitude towards death in this group was verified and a program aimed at prevention and promotion of skills was presented to provide greater well-being and better handling these situations. Among its objectives: to develop coping strategies to manage adverse situations that arise when facing death on a daily basis, facilitate good emotional management and be able to recover from the impact caused by such situations through compassion, self-pity, gratitude and management of the blame.

Dr. Juan Luís Martín Ayala
Editor Jefe / Editor in chief / Editor Chefe

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BIENESTAR PSICOLÓGICO, INTELIGENCIA EMOCIONAL Y RESOLUCIÓN DE CONFLICTOS EN MIEMBROS DE LOS CUERPOS Y FUERZAS DE SEGURIDAD DEL ESTADO ESPAÑOL: UN ESTUDIO CORRELACIONAL

Celia Antuña Camblor
Universidad Europea del Atlántico (Spain)
ccelia.a.camblor@gmail.com ·https://orcid.org/0000-0002-0555-6441

Resumen. Introducción: La resolución de conflictos y el bienestar emocional son cruciales ante situaciones de estrés agudo como puede ser el trabajo policial. Es por ello que los objetivos de este trabajo son: (1) identificar el estilo de resolución de conflictos predominante en las Fuerzas y Cuerpos de Seguridad del Estado español, (2) describir la relación entre resolución de conflictos e inteligencia emocional y, (3) describir la relación entre resolución de conflictos y bienestar psicológico. Método: se ha utilizado una muestra de 434 participantes pertenecientes de los Cuerpos y Fuerzas de Seguridad del Estado y se ha medido con distintos cuestionarios el bienestar emocional, la inteligencia emocional y los estilos de resolución de conflictos. Resultados: el estilo predominante era el evitativo en más de la mitad de la muestra. Las variables asertividad y bienestar psicológico pueden explicar el 78.1% de la varianza del estilo integrador. Se han encontrado correlaciones estadísticamente significativas entre la inteligencia emocional y estilos de resolución de conflicto. Discusión: En base a los resultados, podría ser beneficioso instruir a los trabajadores en técnicas de mediación y resolución de conflictos tal y como se ha realizado en algunas ocasiones (ej. Medipol). A diferencia de otros estudios anteriores, se han encontrado correlatos significativos entre algunas variables de inteligencia emocional y los estilos de resolución de conflictos. Sin embargo, el estudio presenta limitaciones a tener en cuenta como el hecho de no incluir variables de personalidad.

Palabras clave: Resolución de Conflictos; Bienestar psicológico; Inteligencia emocional; Fuerzas y Cuerpos de Seguridad

PSYCHOLOGICAL WELL-BEING, EMOTIONAL INTELLIGENCE, AND CONFLICT RESOLUTION IN MEMBERS OF THE SPANISH STATE SECURITY FORCES AND CORPS: A CORRELATIONAL STUDY

Abstract. Introduction: Conflict resolution and emotional well-being are crucial in acute stress situations such as police work. That is why the objectives of this work are: (1) to identify the predominant conflict resolution style in the Spanish State Security Forces and Corps, (2) to describe the relationship between conflict resolution and emotional intelligence and, (3) describe the relationship between conflict resolution and psychological well-being. Method: a sample of 434 participants belonging to the State Security Forces and Corps has been used and emotional well-being, emotional intelligence and conflict resolution styles have been measured with different questionnaires. Results: the predominant style was avoidance in more than half of the sample. The assertiveness and psychological well-being variables can explain 78.1% of the variance of the integrative style. Statistically significant correlations have been found between emotional intelligence and conflict resolution styles. Discussion: Based on the results, it could be beneficial to instruct workers in mediation and conflict resolution techniques, as has been done on some occasions (e.g. Medipol). Unlike other previous studies, significant correlates have been found between some variables of emotional intelligence and conflict resolution styles. However, the study has limitations to consider, such as the fact that it does not include personality variables.

Keywords: Conflict Resolution; Psychological Well-being; Emotional Intelligence; Security Forces and Corps.

Introduction

Emotional intelligence affects our daily life in different areas such as physical and mental health or education. (Baudry et al., 2018; Li et al., 2021; Martins et al., 2010; Schutte et al., 2007). Despite the importance of our emotions in so many areas, only a few authors had been interested in the emotional field, and it was not until the 1990s when Mayer and Salovey decided to investigate it. Thus, they discovered a construct that they called emotional intelligence and defined it as a set of skills that contribute to the evaluation and expression, regulation, and use of feelings. (Salovey & Mayer, 1990, pg. 189). A few years later, Goleman popularized the term and listed three main components: empathy, assertiveness, and prosocial relationships. (Goleman, 1995; Goleman & Cherniss, 2005).

Today, this concept continues to develop and increase the scientific corpus, demonstrating in a clear way that emotional intelligence affects health and specifically mental health, so it has an impact on our well-being. The concept of well-being is a very important term in health and especially in mental health, and it has been recognized by the World Health Organization (WHO) as a primary objective. (World Health Organization (WHO), 2013). However, there is no consensus among authors to delimit the meaning of the term and there are two perspectives when talking about well-being: the hedonic perspective and the eudemonic perspective. The first is known as subjective well-being and fits in with the affective aspect, according to which the important thing is the pursuit of happiness. The second is more cognitively oriented and is known as psychological well-being. In this current, wellbeing and happiness are no longer synonymous, but rather wellbeing is the development of skills necessary for personal growth.

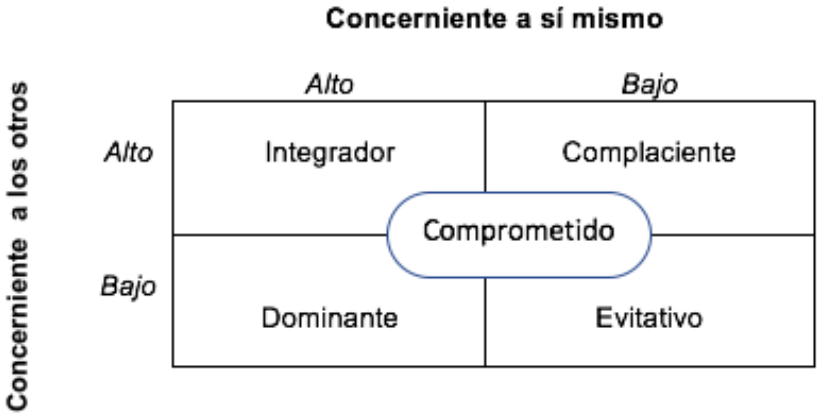
Within the eudemonic perspective or psychological well-being, Ryff stands out (1989, 2014); he developed a multidimensional model and a scale to measure

psychological well-being. In the scale, he distinguished six dimensions (self-acceptance, positive relationships, mastery of the environment, autonomy, purpose in life, and personal growth). Subsequent studies using confirmatory factor analysis have confirmed the existence of these six factors. (e.g., Gallardo Cuadra & Moyano-Díaz, 2011).

Another aspect closely related to emotional well-being is the person's own handling of conflicts since each individual in the organization handles interpersonal conflicts differently, depending on his or her conflict resolution style (Afzalur Rahim, 2000; Afzalur Rahim et al., 2000; M. A. Rahim & Katz, 2019). Conflict management styles can be defined as the ways in which individuals approach the other party in a conflict situation. (Abas, 2010). According to Rahim and Bonoma's model (1979), conflict management styles are defined along two dimensions: with respect to "self" (i.e., the degree to which one tries to satisfy one's own concerns) and with respect to "others" (or the extent to which one tends to satisfy the concerns of others). This structure, which has been confirmed in different decades (Rahim & Katz, 2019), proposes a two-dimensional structure that gives rise to five conflict resolution styles (see *Figure 1*): integrative, compliant, dominant, avoidant, and compromising.

Figure 1

Conflict resolution styles according to Rahim



These styles are described as follows. (Rahim, 2000; Rahim & Bonoma, 1979; Rahim & Katz, 2019):

1. The integrative or problem-solving style (win-win). There is collaboration between the parties as they exchange information and examine differences to find a solution for those involved. There are two distinctive elements in this style: confrontation and problem solving. Through the former, open communication is established that leads to understanding and analysis of the causes. It is therefore a prerequisite for the second element which involves an identification and solution of the problem taking into account the interests of both parties.
2. Complacent or accommodative style (lose-win). The person does not pay attention to existing differences and tends to satisfy others. The person sacrifices him/herself for the other, so it tends to be used by unfriendly people with close bonds of friendship.

3. Dominant or competitive style (win-lose). The orientation of the problem is to win, the objective is to win the conflict for their own benefit, totally ignoring others. It is used by dominant people. If they do not have a position of command or power, they will tend to lie or manipulate to impose themselves on others.
4. Avoidant style (lose-lose). This style tries to postpone or avoid conflict. These people do not satisfy their own needs or those of others, nor are they capable of recognizing the existence of a conflict.
5. Compromised style (neither winning nor losing). It is an intermediate style where the person takes into account his benefits and those of the rest. In this style there is less pressure than in the dominant style but not as much as in the complacent style, and it is more direct than the avoidant style but does not explore as much as the integrative style.

Some authors have tried to relate emotional intelligence to conflict resolution styles. In this line, Morrinson (2008) showed that all dimensions of emotional intelligence (self-awareness, self-management, social awareness, and relationship management) correlated positively with the integrative mode, while only two dimensions correlated negatively with the compliant (self-management and relationship management). The avoidant style had no correlates in any dimension of emotional intelligence, while the compromising one was negatively correlated with self-awareness.

Both emotional well-being and conflict resolution are crucial in the face of high stress events. An example of work under high levels of acute stress is that of the police (Miller, 2007), where high levels of physiological and emotional arousal are experienced (Garcia-Castro, 2015). If we add to this the fact that, "the better a person's job requirements and competencies match, the better the person's job performance and job satisfaction will be" (Spencer y Spencer, 1993, cited in Goleman & Cherniss, 2005, pg. 241), we understand the importance of emotional competencies within the police work environment.

In a study at the European level for more than three years, conducted by the research group of the University of Maastricht and led by Fred Ziljstra, the impact of stress on absenteeism was analyzed. The findings suggest that members of law enforcement agencies are the most stressed professionals at work. (García-Castro, 2015). Therefore, it seems that the effective management and use of emotions is of vital importance. However, very little research has been aimed at this. Along these lines, López-Curbelo and his collaborators (2006) examined emotional intelligence in a sample of local police officers in the Canary Islands. The results of the study show that, although they possessed adequate skills to know, understand, regulate, and control their emotions, most of them needed to improve their competencies to perceive emotions. Another relevant fact that was extracted from this work is that police officers who had the ability to recognize their feelings were more sensitive to what others thought and could give rise to a variety of emotions such as embarrassment or sense of inferiority. On the other hand, those who had good emotional regulation experienced fewer of these negative emotions. The results of this study show that an adequate emotional intelligence within the police environment will improve both their psychological well-being and their mental health, which will result in an improvement in the work tasks of the personnel. All this situation could be the one that leads to a really important number of suicides within the security forces.

The objectives of this paper are (1) to identify the predominant conflict resolution style in the Spanish State Security Forces, (2) to describe the relationship between conflict resolution and emotional intelligence, and (3) to describe the relationship between conflict resolution and psychological well-being.

Method

Participants

The sample was composed of 434 participants with age range between 18 and 45 years (M = 28.41, SD = 11.89) that belonged to the State Security Forces and Corps; 54.15% (n = 235) were from the Civil Guard; 23.27% (n = 101) were workers assigned to the National Police; 11.52% (n = 50) belonged to the Local Police; 8.06% (n = 35) worked within the Police of the Autonomous Communities; 1.84% (n = 8) worked as Port Police; and 1.15% (n = 5) were forest agents. Of the respondents, 64.75% (n = 281) were men, and the remaining 35.25% (n = 153) were women.

Instruments

Adaptation of the Ryff Psychological Well-Being Scale. (Rivera et al., 2016). The instrument consists of 29 items assessing 6 dimensions: self-acceptance (α=.82) (4 items; e.g., "in general, I feel confident and positive about myself"); autonomy (α =.77) (6 items; e.g., "I tend to be influenced by people with strong convictions"); positive relationships with other people (α =.86) (5 items; e.g.., "I feel that my friendships bring me many things"); personal growth (α =.79) (4 items; e.g., "I have the feeling that over time I have developed a lot as a person"); mastery of the environment (α =.83) (5 items; e.g., "in general, I feel that I am responsible for the situation in which I live"); and purpose in life (α =.87) (6 items; e.g., "I am clear about the direction and purpose of my life").

Assertiveness subscale of the Inventory of Social-Emotional Competencies for Adults (ICSE). (Mikulic et al., 2015). It consists of 11 items (α =.73) (e.g., "It makes me uncomfortable to say that something bothers me") that measure behaviors that allow adequately expressing opposition, expressing disagreements, making and receiving criticism, defending rights, and generally expressing negative feelings.

Empathy subscale of the Inventory of Social-Emotional Competencies for Adults (ICSE). (Mikulic et al., 2015). Consisting of 5 items (e.g., "It is difficult for me to see things from the other's point of view") (α =.80), it assesses the emotional reaction produced by and congruent with the emotional state of the other (Mikulic et al.,2015).

Prosocial subscale of the Inventory of Social-Emotional Competencies for Adults (ICSE). (Mikulic et al., 2015). It consists of 6 items (e.g., "I find it hard to accept that other thinks differently") (α =.72) that assess voluntary actions performed for the benefit of others (Caprara and Pastorelli, 1993).

Rahim's Conflict Management Styles Inventory (*Rahim Organizational Conflict Inventory II, form C; ROCI-II form C*; Rahim 1983). This instrument reports the frequency with which participants perceive themselves to use each of the conflict styles of Rahim's model (1983, 2001). In this study, we used the Spanish version of the

instrument validated by Munduate et al.(1993), which measures five conflict resolution styles: (1) integrative (α = .91); (2) dominant (α = .70); (3) avoidant (α = .82); (4) compliant (α = .83); and compromising (α = .82) (Munduate et al., 1993).

Regarding the application of the scales, a seven-point Likert-type scale was used since it has been shown that, although it was believed that the higher the number of points on the Likert scale, the greater the reliability, there are no significant differences after seven points. (Lozano et al., 2008).

Procedure

The application of the scales took place in computerized form using the recommendations (Elosua, 2020). Participation in the study was previously informed and voluntary by all participants. The choice of the computerized format was due to several reasons. (Eiroá- Orosa et al., 2018). Firstly, access to the police sample meant greater ease in terms of their levels of participation. On the other hand, the fact that no face-to-face attendance was required made it possible for the questionnaires to be applied to people who were not physically located in the same Autonomous Community as the study, thus allowing greater flexibility. In addition, in the review

Once the data were collected, they were analyzed with the IBM SPSS Statistics software.

Results

Regarding the results obtained when analyzing the conflict resolution styles in the sample of State Security Forces and Corps, 55.07% (*n=239*) of the participants presented an avoidant conflict resolution style; 23.27% (*n=101*) an integrative style; 9.68% (*n=42*) obtained a score referring to a complacent conflict resolution style; 8.53% (*n=37*) a dominant style; and 3.46% (*n=15*) a compromising style.

The correlations between conflict resolution styles and emotional intelligence variables, also psychological well-being, can be observed in Table 1. As can be seen, there is only a statistically significant relationship with the variables analyzed in the integrative, compliant, and compromising conflict resolution styles.

Table 1

Correlations between variables

	Psychological well-being	Assertiveness	Empathy	Prosocial	Years of service
Integrator	**.686***	**-.809***	-.198	-.118	-. 055
Complacent	-.080	-.200	**.416***	-.130	.039
Dominant	-.190	.060	.166	-.092	-.034

Avoidant	-.011	-.151	.093	-.024	-.076
Committed	.221	**-.549***	.124	-.115	-.058

In the integrative conflict resolution style, there is a statistically significant relationship with the levels of this way of handling problems and those of psychological well-being and assertiveness. However, while the higher the level of psychological well-being, the higher the scores in this solution strategy, the relationship between the integrative style and assertiveness takes the opposite path, so that the higher the assertiveness, the lower the levels of this conflict resolution style.

Continuing with agreeableness, this is only directly related to empathy so that the higher the level of empathy, the higher the score in the agreeableness mode.

As for the engaged conflict resolution style, it is only related at least significantly with assertiveness. Moreover, the relationship with assertiveness is again inverse in this conflict resolution style.

After that, the last objective of the present work is the creation of an equation capable of predicting conflict resolution modes. As it has been seen that the relationships between variables were statistically significant only for three conflict resolution styles (integrative, compliant, and compromising), only these three variables will be used as dependent variables. Before proceeding with the linear regression, the necessary assumptions (normality and independence) were checked.

Finally, the integrative style is the only one that can be predicted with the variables studied. Specifically, using assertiveness and psychological well-being we would be explaining 78.1% of the differences in the results obtained for this dependent variable (see Table 2). Furthermore, the regression equation for predicting the subject's score would be represented as follows:

Integrator = .8.836 + .321 (Assertiveness) + .047 (Psychological Well-Being)

Table 2

Determination coefficient in integrative style

	R	R squared
Assertiveness	.809	.655
Assertiveness and psychological well-being	.884	.781

Discussion and conclusions

As seen, and this study being a pioneering one, the conflict resolution styles in the State Security Forces and Corps are quite poor. Specifically, the most predominant was avoidant (55.07%). This means that most of them do not confront their problems, but they try to postpone or avoid the conflict without satisfying their own or others' needs or recognizing the existence of such conflict. (M. A. Rahim & Katz, 2019). The fact that avoidance is a predominant strategy is of particular importance because it has been shown to have an impact on mental health (Goodman et al., 2018), and it may increase sick leave and may be related to some of the news published about these workers, including suicide.

With respect to the relationship between conflict resolution styles and emotional intelligence, the results of this study only support the null relationship between the two constructs suggested by Gambill (2008) in the avoidant and dominant styles. In contrast to the aforementioned work, the following results were found:

- The integrative conflict resolution style shows a negative relationship with assertiveness so that the higher the assertiveness, the lower the levels of integrative conflict resolution.

- Complacent conflict resolution style shows a positive relationship with empathy levels (the higher the levels of the empathy variable, the higher the levels of complacent conflict resolution style).

- The engaged conflict resolution style shows a negative relationship with the levels of assertiveness so that the higher the levels of assertiveness, the lower the levels of engaged conflict resolution style.

The relationship of assertiveness with conflict resolution is noteworthy. While previous research has shown that the correlation is positive. (e.g., Abd El-Rahman et al., 2019). Moreover, it would seem logical that skills that allow one to adequately express opposition, disagreements, make and receive criticism, defend rights, and generally express negative feelings would have a relationship with better conflict resolution skills. Nevertheless, this study shows a negative relationship with all conflict resolution styles, where it was significant (integrative and compromising). The integrative style involves an exchange of information and an examination of differences to find the best solution. The fact that it involves communication could imply, as seen in previous studies, an emphasis on the appropriate way of expressing oneself, i.e., assertiveness. However, this could be due to cultural or even professional differences since no work has been done in this area to date.

On the other hand, the relationship between coping and empathy remains in the same position with respect to previous research (e.g., Luna-Bernal & de Gante-Casas, 2017). In this sense, assessing the emotional reaction in oneself produced by and congruent with the emotional state of the other is of great relevance in the compliant style. For putting oneself in the other's point of view is relevant to the primacy of the other's point of view.

As for the relationship between levels of psychological well-being and conflict resolution styles, this is a fairly new topic that has not previously appeared in the literature. The results obtained highlight that psychological well-being is only related to

the integrative style, with no statistically significant relationship appearing in the rest of the conflict resolution styles.

Since so few correlations were obtained, it was only possible to establish interesting empirical evidence for one conflict resolution style, namely the integrative style, by means of a multiple regression analysis. The 78.1% of the variance for the integrative style can be obtained by measuring assertiveness and psychological well-being.

The results obtained open a line of research: police mediation. That is, the need to take into account the figure of the police mediator who, in addition to the task of intermediary, would teach conflict resolution courses in an autonomous and proactive way. Within this work, it is worth mentioning the figure of Medipol. (Torrens Ibarguren, 2013). The Medipol program was developed in the Guardia Civil but was later extrapolated to the National Police Corps and the Autonomous Police. The program adapts Social Mediation to the police context and makes it possible to distinguish between: mediation between agents called Intra-Corps Mediation or MIC, mediation between an agent and a citizen (Extra-Corps Mediation or MEC), and Public Service Mediation (MSP), which will be carried out between citizens representing a community, where the agent will be the one who intercedes. This program has not been able to be maintained to date due to lack of resources. However, according to the results obtained, it would be very useful and of great interest. Likewise, if in addition to intervening in the context of mediation, we carry out an intervention in emotional intelligence, it could be beneficial for the health of workers both physically and psychologically (Martins et al., 2010). In view of the results obtained by López-Curbelo and his collaborators (2006), it would be necessary a training in emotional intelligence and, specifically, in the subcomponent of emotional perception and emotional regulation.

Despite its contributions, this study is not free of limitations. One of them is related to the sample. Although participants from several State Security Forces and Corps have been obtained, it would be convenient to analyze each corps separately since the working conditions are different. Therefore, it leaves aside environmental factors that could influence and be of special relevance. Neither have personality variables such as the Big Five or specific personality traits like Social Dominance or Authoritarianism been taken into account, which could provide a clearer answer to this question. Furthermore, this is a correlational study that would not indicate causality, only a mere relationship between the variables, and another type of analysis might be necessary to provide more clarity but due to the correlations found it cannot be carried out. It would also be necessary to compare it with workers in other fields who are in equally stressful situations, such as firefighters or health personnel working in the emergency department.

References

Abas, N. A. H. (2010). *Emotional intelligence and conflict management styles . Recuperado de http://www2.uwstout.edu/content/lib/thesis/2010/2010abasn.pdf* [University of Wisconsin-Stout]. http://www2.uwstout.edu/content/lib/thesis/2010/2010abasn.pdf

Abd El-Rahman, R. M., Abd El Hazem Hosny, W., & Abdeldayem Ata, A. (2019). Conflict Management Styles, Assertiveness and Stress among Nursing Students. *IOSR Journal of Nursing and Health Science (IOSR-JNHS)*, *7*(2), 49–59.

Afzalur Rahim, M. (2000). Empirical studies on managing conflict. *International Journal of Conflict Management*, *11*(1), 5–8. https://doi.org/10.1108/eb022832

Afzalur Rahim, M., Magner, N. R., & Shapiro, D. L. (2000). Do justice perceptions influence styles of handling conflict with supervisors?: What justice perceptions, precisely? *International Journal of Conflict Management*, *11*(1), 9–31. https://doi.org/10.1108/eb022833

Baudry, A.-S., Grynberg, D., Dassonneville, C., Lelorain, S., & Christophe, V. (2018). Sub-dimensions of trait emotional intelligence and health: A critical and systematic review of the literature. *Scandinavian Journal of Psychology*, *59*(2), 206–222. https://doi.org/10.1111/sjop.12424

Eiroá- Orosa, J., Fernández-Pinto, I., & Pérez Sales, P. (2018). Cuestionarios psicológicos e investigación en Internet : una revisión de la literatura. *Anales de Psicología*, *24*(1), 150–157. Recuperado de a partir de https://revistas.um.es/analesps/article/view/32871

Elosua, P. (2020). Aplicación remota de test: riesgos y recomendaciones. *Papeles Del Psicólogo - Psychologist Papers*, *41*(2). https://doi.org/10.23923/pap.psicol2021.2952

Gallardo Cuadra, I., & Moyano-Díaz, E. (2011). Análisis psicométrico de las escalas Ryff (versión española) en una muestra de adolescentes chilenos. *Universitas Psychologica*, *11*(3), 940. https://doi.org/10.11144/Javeriana.upsy11-3.aper

Gambill, C. R. (2008). *Emotional intelligence and conflict management style among Christian clergy* . Capella University.

García-Castro, T. (2015). El estrés policial. *Seguridad y Salud*, *84*, 15–26. http://www.insht.es/InshtWeb/Contenidos/Documentacion/PUBLICACIONES%20PERIOD

Goleman, D. (1995). *Emotional Intelligence*. Bantam.

Goleman, D., & Cherniss, C. (2005). *Inteligencia emocional en el trabajo: Cómo seleccionar, medir y mejorar la inteligencia emocional en individuos, grupos y organizaciones*. Editorial Kairós. Recuperado a partir de https://revistas.um.es/analesps/article/view/32871

Goodman, F. R., Larrazabal, M. A., West, J. T., & Kashdan, T. B. (2018). Experiential Avoidance. In *The Cambridge Handbook of Anxiety and Related Disorders* (pp. 255–281). Cambridge University Press. https://doi.org/10.1017/9781108140416.010

Li, N., Li, S., & Fan, L. (2021). Risk Factors of Psychological Disorders After the COVID-19 Outbreak: The Mediating Role of Social Support and Emotional Intelligence. *Journal of Adolescent Health*, *69*(5), 696–704. https://doi.org/10.1016/j.jadohealth.2021.07.018

López- Curbelo, M., Acosta, I., García- García, L., & Fumero, A. (2006). Inteligencia emocional en polícias locales. *Ansiedad y Estrés*, *12*(2), 467–477. https://core.ac.uk/download/pdf/80533350.pdf

Lozano, L. M., García-Cueto, E., & Muñiz, J. (2008). Effect of the Number of Response Categories on the Reliability and Validity of Rating Scales. *Methodology*, *4*(2), 73–79. https://doi.org/10.1027/1614-2241.4.2.73

Luna-Bernal, A. C. A. , & de Gante-Casas, A. (2017). Empatía y gestión de conflictos en estudiantes de secundaria y bachillerato. *Revista de Educación y Desarrollo*, *40*, 27–37.

Martins, A., Ramalho, N., & Morin, E. (2010). A comprehensive meta-analysis of the relationship between Emotional Intelligence and health. *Personality and Individual Differences*, *49*(6), 554–564. https://doi.org/10.1016/j.paid.2010.05.029

Mikulic, I. M., Crespi, M., & Radusky, P. (2015). Construcción y validación del Inventario de Competencias Socioemocionales para adultos (ICSE). *Interdisciplinaria: Revista de Psicología y Ciencias Afines*, *32*(2). https://doi.org/10.16888/interd.2015.32.2.7

Miller, L. (2007). Police Families: Stresses, Syndromes, and Solutions. *The American Journal of Family Therapy*, *35*(1), 21–40. https://doi.org/10.1080/01926180600698541

MORRISON, J. (2008). The relationship between emotional intelligence competencies and preferred conflict-handling styles. *Journal of Nursing Management*, *16*(8), 974–983. https://doi.org/10.1111/j.1365-2834.2008.00876.x

Munduate, L., Ganaza, J., & Alcaide, M. (1993). Estilos de gestión del conflicto interpersonal en las organizaciones. *Revista de Psicología Social*, *8*(1), 47–68. https://doi.org/10.1080/02134748.1993.10821669

Organización Mundial de la Salud (OMS). (2013). *The European Health Report 2012: charting the way to wellbeing. The European Health Report 2012: charting the way to well-being. .* http://www.euro.who.int/__data/assets/pdf_file/0004/197113/EHR2012-Eng.pdf

Rahim, A., & Bonoma, T. v. (1979). Managing Organizational Conflict: A Model for Diagnosis and Intervention. *Psychological Reports*, *44*(3_suppl), 1323–1344. https://doi.org/10.2466/pr0.1979.44.3c.1323

Rahim, M. A., & Katz, J. P. (2019). Forty years of conflict: the effects of gender and generation on conflict-management strategies. *International Journal of Conflict Management*, *31*(1), 1–16. https://doi.org/10.1108/IJCMA-03-2019-0045

Rivera, J. A. G., Veray-Alicea, J., & Rosario-Rodríguez, A. (2016). Adaptación y Validación de la Escala de Bienestar Psicológico de Ryff en una Muestra de Adultos Puertorriqueños. , . *Salud y Conducta Humana*, *3*(1), 1–14.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*(6), 1069–1081. https://doi.org/10.1037/0022-3514.57.6.1069

Ryff, C. D. (2014). Psychological Well-Being Revisited: Advances in the Science and Practice of Eudaimonia. *Psychotherapy and Psychosomatics*, *83*(1), 10–28. https://doi.org/10.1159/000353263

Salovey, P., & Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cognition and Personality*, *9*(3), 185–211. https://doi.org/10.2190/DUGG-P24E-52WK-6CDG

Schutte, N. S., Malouff, J. M., Thorsteinsson, E. B., Bhullar, N., & Rooke, S. E. (2007). A meta-analytic investigation of the relationship between emotional intelligence and health. *Personality and Individual Differences*, *42*(6), 921–933. https://doi.org/10.1016/j.paid.2006.09.003

Torrens Ibarguren, J. G. (2013). *Mediación: aplicación al entorno de la Guardia Civil* [Universidad de Cádiz]. https://dialnet.unirioja.es/aervlet/tesis?codigo=51386

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ANÁLISE DAS COMPETÊNCIAS INTERPESSOAIS AUTOCONTROLE E AUTOCONSCIÊNCIA DE ALUNOS DO 8º E 9º ANOS DO ENSINO FUNDAMENTAL

María Verónica Santana Sales
Universidad Internacional Iberoamericana (Brazil)
projetecmv@gmail.com ·https://orcid.org/0000-0003-1340-471X

Maria Aparecida Santos e Campos
Universidad Internacional Iberoamericana (Brazil)
maria.santos@unini.edu.mx · http://orcid.org/0000-0001-7190-5438

Resumo. Estudo qualitativo descritivo busca investigar o domínio da autoconsciência e do autocontrole dos alunos de duas instituições de Ensino Fundamental de Sergipe: a privada tem programa de desenvolvimento da inteligência emocional e a pública não dispõe deste benefício. O objetivo: analisar a autoconsciência e o autocontrole em alunos alfabetizados sob a perspectiva da inteligência emocional e alunos não alfabetizados emocionalmente. Método quali-quantitativo descritivo e correlacional enfocando a inteligência emocional e gerenciamento das emoções. A amostra não probabilística compôs-se de 104 estudantes. Instrumentos pesquisa e análise de dados**:** utilizou-se o questionário (Medida de Inteligência Emocional - MIE). Os dados foram tabulados e apresentados em análise descritiva. Resultados: Constatou-se que nas duas competências emocionais os inquiridos da Escola Tancredo Neves apresentam ligeiro resultado positivo comparado ao Colégio Atena. Entretanto, observa-se, no panorama geral, tanto no domínio da autoconsciência quanto no autocontrole, que os resultados em ambas instituições, em vários aspectos apontam muitos dos questionados com pouca capacidade para lidar bem com as emoções. **Conclui**-se que quanto ao grupo que se beneficiam do programa de desenvolvimento emocional se faz necessário um olhar mais criterioso no que se refere as suas respostas emocionais, visto que tais resultados tendem a se manifestarem na forma de padrões de pensamentos, sentimentos, comportamentos e influências, ou seja, não se pode ignorar o que interfere tais comportamentos, o que exige uma maior conscientização e envolvência por parte dos pais e gestores da educação das componentes emocionais.

Palavras-chave: Inteligência emocional; emoções; autoconsciência; autocontrole

ANALYSIS OF INTERPERSONAL SKILLS SELF-CONTROL AND SELF-AWARENESS OF STUDENTS IN THE 8TH AND 9TH YEARS OF ELEMENTARY SCHOOL

Abstract. A descriptive study seeks to investigate the mastery of self-awareness and self-control in students at two elementary school institutions in Sergipe: the private one has an emotional intelligence development program, and the public one does not have this benefit. The objective: to analyze self-consciousness and self-control in student's literate from the perspective of emotional intelligence and students not emotionally literate. Qualitative-quantitative descriptive and correlational method focusing on emotional intelligence and emotion management. The non-probability sample consisted of 104 students. Research instruments and data analysis: we used the questionnaire (Emotional Intelligence Measure - EIM). The data were tabulated and presented in descriptive analysis. Results: It was found that in the two emotional competencies the respondents of Tancredo Neves School present slight positive result compared to Atena College. However, it is observed, in the general panorama, both in the domain of self-awareness and self-control, that the results in both institutions, in several aspects, point many of the respondents with little capacity to deal well with emotions. We conclude that regarding the group that benefits from the emotional development program, it is necessary to have a more careful look at their emotional responses, such results tend to manifest themselves in the form of patterns of thoughts, feelings, behaviors, and influences, that is, we cannot ignore what interferes with such behaviors, which requires a greater awareness and involvement on the part of parents and managers in the education of emotional components.

Keywords: Emotional intelligence; emotions; self-awareness; self-control

Introduction

Emotional issues seem to be intrinsically linked to the academic and professional performance of individuals and, in this process, all actions held in the school environment tend to influence the improvement or not of students' behavior. The school curriculum is supposedly developed in a planned and intentional way; however, it seems that practices related to the development of emotional intelligence (EI) are not reflected or prioritized; they do not seem to be important in the formation of the individual.

It is evident the diversity of behavioral profiles in individuals, in schools, with learning difficulties and lack of emotional control, and there is little evidence of programs aimed at the development of emotional intelligence in schools, especially in public institutions. It seems urgent to become aware of the need to include in the school curriculum programs that contemplate and prioritize the training and emotional development of students.

It is understood that cognitive and emotional processes are not opposites; they are linked to academic development. Thus, emotional learning goes beyond the cognitive dimension that requires individuals to have the ability to identify and regulate their own emotions. In this aspect, Machado (2020) points out that:

> Emotions, as part of the echoes that resonate in what, for centuries, has been tried to fix as a form of individualizing identity, are configured and expressed through a constant dynamic between biological and physiological factors and mimics, gestures, attitudes, and cadences typical of a space that, if seen as universal,

prevent us from perceiving that immense multiplicity that is often untranslatable between distant territories.

The influence of emotions was strongly addressed by Goleman (2012) and classified into interpersonal (self-control, self-awareness, and self-motivation) and intrapersonal (empathy and sociability), which involves the self and the other. Thus, it is understood that being emotionally intelligent is not only about being more skilled in identifying, understanding, and regulating one's own emotions but also those of others. Therefore, emotional intelligence is fundamental to establish and maintain quality interpersonal and intrapersonal relationships.

Given its scope, it is understood that the exaltation in the development of emotions should therefore be part of the school curriculum from early childhood, yet in the early stages of schooling, the child's development is what underpins its future and emotional issues must be taken into account because, according to Santana Sales and Campos (2021, pg. 164), "although it may seem that emotions are part of our genetic heritage, it is developable and moldable, so it is a matter of choice, one can manage them and take turns." They are therefore essential for life and constitute the basis or necessary condition for their progress in the different dimensions of their development.

Given this vehemence, the objective of this study was to analyze self-awareness and self-control in emotionally literate students from the perspective of emotional intelligence and non-emotionally literate students from the 8th and 9th grades of the Atena School and Tancredo Neves School; the former being a private institution, contemplated by the emotional intelligence development program; and the latter a public school and not part of the programs that contemplate emotional growth.

Given the breadth of the dimensions associated with the concepts of emotional intelligence and emotional competencies, self-control and self-awareness are integral to this research. And in these domains are the focus of the research that directly addresses the question of student behavior in the two educational institutions.

Emotional intelligence (EI) is distinguished as a competence that allows individuals to recognize and regulate their own emotions, to be self-motivated, empathetic, and sociable. The perception of emotions is considered an important skill and the basis for the development of other skills related to emotional intelligence (Mayer and Salovey, 1997). However, according to Mayer et al. (2002), it is not developed if the individual does not learn to respect feelings and does not possess the ability to pay attention, register, and decipher emotional messages, including through facial expressions.

They are associated with significant events, which establish the responses and reactions to the situations faced by the individual, and depending on how he/she faces them, these responses can be positive or negative. They can be identified from facial expressions (Carocho, 2018). When emotional intelligence is well developed, it favors and facilitates development in all areas of the individual's experience, whether with oneself, in the family, at school, and in society as a whole, above all, the fullness of emotional and cognitive competences, which as has been said

Mayer, Salovey, and Caruso (2000, pg. 267) emphasized that Emotional Intelligence (EI) represents "the ability to perceive emotions, assimilate them from

feelings, evaluate, and manage them." In this line, Siqueira and Santillo (2019, pg. 12) state that emotional intelligence consists of "the ability of the human being to identify emotions and feelings in oneself and in others and, when it comes to oneself, to be able to control them and manage to maintain an emotional balance and coherent with reality." For Modolon and Vitor (2020, pg. 14), emotional intelligence is

> the ability to face and successfully resolve emotionally uncertain situations, such as conflicts. It is to assimilate the control and management of emotions, putting them to work in our favor. Not letting them command our actions and thoughts, making us make inadequate or irrational decisions. Emotional intelligence is nothing more than the ability to know our neighbor through our feelings and to know ourselves.

In this context, Le Breton (2019, pg. 146) states that "emotions translate the affective resonance of the event in a way that is comprehensible to the eyes of others," without individualized origin, it is an inference resulting from personal learning and identification. For the author, "emotion is the sensitive definition of the event as experienced by the individual, the immediate and intimate existential translation of a value confronted with the world."

Therefore, it is understood that to be emotionally intelligent is to be able to recognize one's own emotions and understand how they influence thoughts and behavior as well as to have the ability to control one's own feelings and impulses, understand the emotions of others, and be sociable.

According to Santana Sales and Campos (2021, pg. 163), "emotional intelligence is framed in the primacy of facing uncertain situations, such as conflicts, frustrations, losses, and even successes, assimilating, regulating, and managing emotions on one's own account in making rational and appropriate decisions." Therefore, having self-awareness and self-control over one's feelings consists of taking control of emotions, "by not letting them rule our actions and thoughts, making us make inadequate or irrational decisions." Emotional intelligence is nothing more than the ability to know the other through feelings and to know oneself (Modolon and Vitor, 2020, pg. 14).

When considering emotional intelligence through the bias of the domains consisting of knowing oneself, controlling oneself, motivating oneself, recognizing emotions in others, managing relationships. Amestoy (2020, pg. 4) reiterates that:

> The understanding of emotional intelligence is related to the knowledge of the pillars that constitute it: self-awareness, self-management, self-motivation, empathy, and relationship management. This capacity is associated with intrapersonal relationships, corresponding to the individual and interpersonal relationships, which are established with the group.

As already mentioned, this study is limited to the analysis of self-awareness and self-control, domains inherent to intrapersonal intelligence.

The interpersonal intelligence of which Goleman (2012) speaks, consists of the individual's capacity to enter into his own emotions, which is produced through the ability to discriminate and name feelings "translate them through symbolic concepts; to achieve, through this understanding, to guide and conduct his own behavior; to understand his own fears and desires as well as his own history, to symbolize and understand complex feelings" Bridges, (2020, pg. 20). Intrapersonal intelligence encompasses the dimensions of self-awareness, self-motivation, and self-control.

Damasio (2010) states that self-awareness refers to an intuitive process, to being aware of something; therefore, the most approximate and general definition is the mental state in which a person recognizes his own existence (feels himself) and what exists in his environment. Therefore, this study focuses on self-awareness, self-motivation, and self-control in 8th and 9th grade students from two schools in Sergipe, Brazil.

Self-awareness is the ability to know oneself and, consequently, the effects that one's emotions can cause in others, being the attention paid to what one feels. In this sense, it is possible to be aware of feelings at the exact moment they occur (Goleman, 2012) and, not being subject to the dominance of emotions, supports self-reflection. However, the author considers that "in this self-reflective awareness, the mind observes and investigates what is being experienced, including emotions" (pg. 70). However, by having the competence of self-awareness well developed, the individual better recognizes and designates his or her own emotions as well as has a greater capacity to understand what he or she feels and its cause.

In this characteristic, Amestoy (2020) highlights self-awareness as the basis of emotional intelligence and according to him, it is through self-awareness that the individual exercises the ability to set aside negativity, neutralizing it and maintaining self-reflection in the face of tribulations.

In this sense, it is reflected that the individual endowed with full self-awareness is able to deeply understand his own emotions, strengths and weaknesses, has firmness, recognizes reality and possibility, does not have floating dreams, in short, knows himself, evaluates himself, does not betray himself.

Hansen et al. (2018, pg. 6) state that "self-awareness is the first component of emotional intelligence. Self-awareness means a deep understanding of one's emotions, strengths, weaknesses, needs, and drives. Self-awareness is neither overly critical nor truly hopeful."

According to Santana Sales and Campos (2021, p. 164), "self-awareness encompasses the person's capacity to be aware of his own consciousness and thus be able to recognize himself, read his emotions at the exact moment they occur or later through self-reflection"; thus, it is understood that self-awareness is produced through the mastery of thought management in the observation and investigation of one's own experiences, especially emotional ones.

As for self-control, according to Goleman (2015, pg. 16), "it is an ongoing inner conversation, it is the component of emotional intelligence that frees us from being prisoners of our feelings."

Discussing theories and studies of self-control, Batista and Tourinho (2012, pg. 257-258) state that:

> Emotional self-control has been discussed mainly in the form of cognitive theoretical orientations, but it can be interpreted with the concepts of Behavior Analysis, resulting in an elaboration that places it in the same terrain (that of behavioral relations) in which societies find themselves.

In this perspective, regarding self-control, Oliveira et al. (2020) consider that it is still urgent for individuals to achieve, on a daily basis, learning that favors the control of

emotions, peaceful, calm, balanced, and judicious resolution of conflicts for a good coexistence at work and in the social environment.

Thus, according to (Goleman 2015, pg. 16), self-control consists of self-management, self-regulation, thought management, among other attributes, "self-control is a continuous inner conversation, it is the component of emotional intelligence that frees us from being prisoners of our feelings."

In this context, Santana Sales and Campos (2021, p. 165) argue that "self-control or management of emotions refers to the subject's ability to control his or her emotions and inherent manifestations, consists of thinking before acting, and consists of self-management, self-regulation." Thus, it can be stated that the exercise of self-control consists of the ability to regulate emotions, resolve conflicts, maintain balance, among others.

Methodology

Design

Descriptive and correlational quali-quantitative study focused on emotional intelligence and emotion management. As for the approach, it is a quali-quantitative research characterized by the use of quantification, both in the collection of information and in its treatment by statistical means, it emphasizes objectivity, and mathematical language is used to expose the causes of the facts.

Sample

This non-probabilistic study was composed of 8th and 9th grade students from two educational institutions, being 57 from the Atena School and 47 from the Tancredo Neves School, in the municipality of Sergipe, Brazil. The criteria for selecting the educational institutions and the population were based on the availability of students at the desired school level, the welcome, the willingness of the students to participate in the research, and the difference in the school curriculum with respect to the emotional development programs.

Inclusion criteria

It was decided that the student should be enrolled and attending school, should not suffer from any disease that could compromise the research, have the informed consent signed by the parents or guardians through the free consent form allowing their participation in the study, and the approval of the schools to conduct the study.

Research *instrument*

The MIE (Measured Emotional Intelligence) questionnaire by Siqueira, Barbosa, and Alves (1999) was used. The MIE instrument was prioritized because it is a validated measure for use in human research, it contemplates the interests raised by the problem, is appropriate for the research population, and consists of 59 scalar items, with four points each (1- never; 2- sometimes; 3- many times; 4- always), evaluating five factorial dimensions. However, in this study, only the 10 items that measure self-control were used, that is, the ease or difficulty to manage one's feelings, handle and regulate emotions, thoughts, and behaviors is investigated. We applied questionnaires composed of 10

questions, 6 of positive connotation and 4 of negative connotation in scales (always, many times, sometimes, and never), for a universe of 104 students from the Elementary School of Tancredo Neves School and Atena School. The data were tabulated and subjected to a simple statistical analysis. At the time of data collection, the researcher went to the schools, as previously agreed, at class time, in the presence of the regular teacher, each student was given a questionnaire, the informed consent form in an envelope with a pen.

Data analysis

The data were tabulated and analyzed in descriptive statistics and the quantitative rip if it stipulated numbers and percentages to quantify the variables studied. Regarding the nature of the methodological objectives, this research is considered descriptive since it seeks to describe the characteristics of a certain population or a certain event, being used in this study (GIL, 2008). Furthermore, for this purpose, it takes into account what Santos (2012, pg. 4) states, "In the data interpretation phase, the researcher needs to return to the theoretical referent, seeking to substantiate the analysis, giving meaning to the interpretation." Thus, the analysis of the quali-quantitative aspects of the research, as well as the results, will be presented in descriptive statistical data and presented in graphs and tables.

The research was approved by the Ethics Committee of Plataforma Brasil and by the Ethics Committee of the Universidad Internacional Iberoamericana - UNINI.

Results and discussions

As for the sociodemographic data, the question referring to data on the gender of the participants can be seen in Table 1.

Table 1

Sociodemographic data of the students of the two participating schools (gender).

Participants of Atena College	**NO. %**	**Participants of Tancredo Neves School**	**NO. %**
Male	43,9	Male	51,1
Female	56,1	Female	48,9
Total number of participants in the study 104			

Regarding the gender factor (male, female), there was a greater presence of females at Atenea College, although the values show that this prevalence is small, presenting almost parity between the sexes. This result shows a significant balance with respect to gender, which denotes austerity with respect to this variable.

Table 2

Sociodemographic data of the students of the two participating centers (age).

Sample distribution age	12 years	13 years	14 years	15 years	16 years	17 years
Tancredo Neves School	0	2	29	3	12	1
Atena College	24	7	24	0	0	2

In the analysis of Table 2, referring to the distribution of the sample by age, the largest number of respondents is found in the interval corresponding to the age range between (12 and 14) years in both centers. In addition, it should be noted that the (17) age group is the smallest since it constitutes only 2.9% of the total sample.

There is parity between the ages of the students in the two schools, which shows that most of the students are within the expected age range for these grades, but there is a notable deviation from the norm in the Tancredo Neves school, represented by students between 16 and 17 years of age.

Once the general data (age, sex) of the sample have been characterized, the following results of the questionnaire will be addressed.

As already highlighted, in this study, it is important to analyze self-control, being the ability mentioned by Goleman (2015), which consists of self-management and is an intimate and constant dialogue that gives freedom to the individual not to be imprisoned to feelings and self-awareness, taken as the person's ability to be aware of his own feelings and thus be able to recognize himself, read his emotions, and self-reflect them. Thus, Goleman (2012, pg. 70) considers that, "In this self-reflective awareness, the mind observes and investigates what is being experienced, including emotions."

When dealing with self-control, Tamayo (2006) presents three behaviors that the individual can use and that reflect self-control or the absence thereof; passive, which represents inhibited, introverted, frustrated, and anxious behavior; aggressive, behavior in which the subject humiliates, is explosive, harasses the other, is authoritarian; and assertive, which according to the author, is viable in which the individual has his own choice, understands, recognizes and defends his rights, respects the emotions of the other.

Table 3

Results of the Atena School and Tancredo Neves School self-control competition.

Self-control	Atena College		E.E. Tancredo Neves	
	Often and always	Sometimes	Often and always	Sometimes
Control of disturbing feelings	47,4%	52,6%	55,3%	44,7%

Curbs impulses in a conflict situation	28,1%	71,9%	65,9%	34,1%
Speak your mind	36,8%	63,2%	36,2%	63,8%
Reacts to aggression	43,9%	56,1%	34%	66%
Makes decisions based on impulses	50,9%	49,1%	36,2%	63,8%

It is observed that of the 57 respondents from Atena School, in the items that inquire about the control of disturbing feelings and the restraint of impulses, items with positive connotations, less than half present a good performance in this competence, calling attention to the lack of impulsive control, that is, only 28.1% control their impulses. As for talking about what occurs to them and reacting to aggression, an item with a negative connotation, these students present more than 50% of self-controlled aggressive reactions and 49.1% in impulsive decision making. As can be seen, 50.9% act impulsively. Of the 47 students surveyed at the Tancredo Neves School, in the items investigating the control of disturbing feelings and restraint of impulses, it is observed that more than half present themselves as self-controlled. As for speaking what comes to mind, reacting to aggression, and making decisions based on impulses as can be observed, they also appear balanced since, in these items, the alternatives, never and seldom, are favorable.

Given these results, it can be observed that respondents need to learn to develop emotions since, according to Cury (2012 pg. 41), "when we are offended, assaulted, pressured, coerced, or rejected. Otherwise, emotion will always abort reason. The immediate consequence of this lack of emotional defense is that we react irrationally and unifocal, and not multifocal."

It is observed that the mastery of the participants in the research, here, is not very high; however, the individuals of the Tancredo Neves School show better self-control capacity, compared to those of the Atena School. Given this scenario, it is corroborated with what Sousa (2021) says when mentioning the need for the individual to have control and emotional mastery so that coherent actions that favor relationships flow.

There is a perceived absence of emotion regulation and management. It is known that emotions are moldable and, according to Berra (2018), it is necessary for the individual to make emotionally intelligent decisions, which is a virtue. In this thinking, self-criticism is fundamental because, according to Cury (2015, pg. 107), "the code of self-criticism is the code of one who self-evaluates, weighs his actions, judges his behaviors, adjusts, self-corrects, reflects on his reactions, conjectures with himself."

From the bias of the act impulsively approach, Cury (2019, pg. 62) states that the individual does not allow himself to be contradicted.

> We are addicted to reacting when someone contradicts us. Action and reaction are great for physics but terrible for human relationships. Those who are impulsive or react without thinking, in addition to failing to protect their own emotions, will turn their memory into a social wastebasket and destroy their best relationships.

In the fact that the individual does not manage thoughts, for Cury (2015, pg. 115), "Whoever prides himself on saying everything he thinks, hurts the one who should be loved the most. He has not deciphered the language of self-control." It is inferred that the control of emotions does not come from genetic inheritance nor is it negotiable, its acquisition is through training and development of mastery, management, and regulation.

In this perspective, according to Santana Sales and Campos (2021, pg. 175), focus that "emotional intelligence can be worked on and developed, and it is by choosing to learn to manage emotions that the improvement and refinement of self-control occurs."

From this perspective, Cury (2019, pg. 41) warns that, "Whoever gravitates around problems and does not learn to make an introspective stop to think before reacting makes of small barriers insurmountable obstacles, of small difficulties, of unsolvable problems, of small disappointments, a sea of suffering."

It is perceived that the instinctive trigger of reaction is always armed, ready to fire in conflictive situations, which can trigger suffering; however, as already mentioned, emotions can be molded, character can be changed, reformulated. Berra (2018, pg. 11) highlights that:

> The formation of character is constituted when the constancy of the practice of good habits that must be in harmony with reasoning is carried out. These habits, when correctly acquired, constitute virtue and, therefore, allow the subject to act with wisdom, acting well when facing actions or relating to pleasure and suffering.

Reacting to insults in an aggressive manner is characteristic of a lack of emotional intelligence. Managing and regulating emotions is the solid basis for controlling impulsive reactions. It is wise to exercise silence and tolerance.

In this sense, regarding self-control, corroborating with other authors, de Oliveira, de Figueiredo, & Dutra (2020) warn that self-control is a developable skill and, according to Santana Sales and Campos (2021), the emotionally self-controlled individual gets around situations, reverses bad feelings, resinify feelings, builds himself, perfects his own character.

Table 4

Results of the self-awareness competition at Atena School and Tancredo Neves School

Self-awareness				
Schools	**Atena**		**Tancredo Neves**	
Response options:	Often and always	Sometimes and never	Often and always	Sometimes and never
Evaluates their own feelings	77,2 %	22,8 %	80,9 %	19,1 %
Cares about how you feel	59,6 %	40,4 %	68,1 %	31,9 %
Recognizes conflicting feelings	40,3 %	59,7 %	51 %	49 %

Identifies feelings	42,1 %	57,9 %	57,4 %	42,6 %
Avoids reflecting on what he/she thinks	31,6 %	68,4 %	42,6 %	57,4 %

In this emotional competence, it can be observed that of the 57 respondents in the Atena School, in the items that inquire about self-knowledge, how the respondents evaluate and understand their feelings, how they recognize and interpret themselves, a good number of the respondents are competent in this competence as can be observed in a 77.2%. In terms of caring about how they feel, the figure is lower. As for recognizing feelings and identifying them, less than half of the respondents scored well in this competency. As for avoiding reflecting on what they think, 31.6% of these students do so, which does not look good. Of the 47 students surveyed at the Tancredo Neves School in the items that investigate the evaluation of one's own feelings and concern for them, a large percentage is perceived as exercising this ability. Regarding the items of recognition of contradictory feelings and identification of them, it is observed that slightly more than 50% affirm that often and always. As for the avoidance of reflecting on what one thinks, 42.6% affirm that they always or often do this reflection.

Therefore, it does not seem interesting to avoid reflection on what one thinks. The reflection of thought is the vigilance of acts. And since thoughts are ours, if we take care to reflect on them, "with greater or lesser difficulty, we can nourish them, direct them, expand them, reduce them, or reject them."

In the competence of self-knowledge, it can be concluded from the survey results that in the evaluation of their own feelings, both educational institutions showed results above 50% in the final sum. When observing the items by individual educational institution, the respondents of the Tancredo Neves School present a significantly positive disparity compared to the Atena School scenario.

It is well known that the evaluation and understanding of feelings requires interest in self-knowledge, self-interpretation, care for one's own emotions, so to explain the importance of emotions Gardenswartz (2012, pg. 27) states:

> Emotional intelligence is the ability to assess and understand feelings and use their energy productively. In addition to understanding, it involves specific actions to recognize feelings, understand them, express them verbally, and then apply their energy effectively. Emotions are not so tame to deal with.

It is understood that worrying about the "I" is a way to lead one's own vital itinerary. Taking care of feelings, avoiding the rescue of frustrations is the step to manage emotions. Convergent, Cury (2019, pg. 72) states:

> To manage emotion, we must quickly doubt our disturbing thoughts, doubt the unhealthy content of our emotions. We must question the reasons for our reaction, criticize our anxiety, demand to be free at that moment. Finally, we must use the tool of silence, internalize ourselves and rescue the leadership of the "I." If the "I" does not doubt and criticize the sick theatrical plays that are staged in the mind, it will become a victim of its own emotional disturbances.

Conclusions

The competencies of emotional intelligence direct the individual's behavior and involve aspects of awareness of feelings, the ability to control them, to motivate oneself positively, to be empathetic, altruistic, and sociable, encompassing intrapersonal and interpersonal relationships.

The research, now argued, was concerned with analyzing **the** interpersonal skills: self-control and self-awareness of 8th and 9th grade students at Tancredo Neves School and Atena College and, finally, comparing possible differences through data analysis between students at Tancredo Neves School not emotionally literate; and those at the public school, Atena College, who are enrolled in emotional development programs in terms of the domains of these emotional skills.

Through the analysis of the data, it was verified the proximity in terms of the gender factor, with a slight prevalence of the feminine; as for the age distribution, the percentage is higher between (13 and 14 years) since the schooling, in both institutions, was given to students in the eighth and ninth year of Basic Education.

In the analysis of self-control, an ability that reflects the capacity that the individual has to control his emotions and related manifestations, involving impulses, reactions as well as the mastery of his own feelings. In the general scenario, it can be observed that both institutions show a large number of respondents lacking self-control; however, the participants of the Tancredo Neves School showed a slight advantage in this emotional component in comparison with the respondents of the Atenea School, reflecting a better emotional balance.

Regarding self-awareness, a competence marked by self-reflection, and which acts as an investigator of our experiences, including emotional ones, considered by Amistoy (2020) as the foundation of emotional intelligence, it is concluded, in what presents the results of the research, that in the evaluation and understanding of one's own feelings and in the self-dialogue about what one feels, the two educational institutions show a very close coincidence in the final result.

Self-awareness, in both schools, is the competency that, in general terms, gives the best results. Thus, they demonstrate maturity in caring about themselves, having control over themselves, self-evaluating, being aware of different aspects of the self, including traits, behaviors, and feelings. However, the number of students who do not perform well in their emotional competencies is considerably high. This well-developed skill has knowledge about what one feels and how these emotions positively or negatively affect one's performance in the individual's professional and personal context. It is also evident that the Tancredo Neves School population reflects, albeit subtly, better emotional development.

Although a considerable number of the subjects investigated showed difficulties in exercising self-control and being self-aware, the results indicated that many of them had learned and developed emotional competencies in their lives, yet the school that presented the best result did not include emotional development programs. However, this result does not affirm that these methods are ineffective or unnecessary, for the research did not refer to the factors influencing the results. In this sense, the continuity of the study becomes relevant to investigate other aspects derived from the emotional behavior of these individuals.

Therefore, the reasons for human behavior cannot be ignored; on the contrary, greater awareness and involvement on the part of parents and educational managers is necessary to apply emotional components in the school curriculum.

References

Amestoy, S. C. (2020). Inteligência emocional: habilidade relacional para o enfermeiro-líder na linha de frente contra o novo Coronavírus/Emotional intelligence: relationship skill for the nurse-leader on the front line against the new Coronavirus. Journal of Nursing and Health, 10(4). https://periodicos.ufpel.edu.br/ojs2/index.php/enfermagem/article/view/18993

da Fonseca, J. J. S. (2002). Apostila de metodologia da pesquisa científica. João José Saraiva da Fonseca. https://books.google.es/books?hl=es&lr=&id=oB5x2SChpSEC&oi=fnd&pg=PA6&dq=da+Fonseca,+J.+J.+S.+(2002).+Apostila+de+metodologia+da+pesquisa+cient%C3%ADfica.+Jo%C3%A3o+Jos%C3%A9+Saraiva+da+Fonseca.&ots=ORS-3u7kj4&sig=EyCLAoFVgu0xLCOMfC3qNul1ZDE#v=onepage&q&f=false

de Oliveira, G. A., de Figueiredo, T. B., & Dutra, J. A. A. (2020). Inteligência Emocional e o Capital Psicológico nas Organizações e em suas Lideranças/Emotional Intelligence and Psychological Capital in Organizations and their Leadership. ID on line. Revista de psicologia, 14(52), 185-201. https://idonline.emnuvens.com.br/ id/article/view/2649

Batista, J. R., & Tourinho, E. Z. (2012). Interpretação analítico-comportamental do autocontrole emocional. Interação em Psicologia, 16(2), 249-259. http://dx.doi.org/10.5380/psi.v16i2.16884

Berra, E. A. (2018). A educação das emoções, do desejo e do prazer na Ética a Nicômacos de Aristóteles. [Dissertação de Mestrado, Universidade de Passo Fundo]. http://tede.upf.br/jspui/handle/tede/1688

Cury, A. (2012a). Mentes brilhantes, mentes treinadas. Leya.

Cury, A. (2015). O código da inteligência. Sextante.

Cury, A. J. (2017). Ansiedade-Como enfrentar o mal do século para filhos e alunos. Saraiva Educação SA.

Cury, A. (2019a). Inteligência socioemocional. Sextante.

Damásio, A. R. (2011) E o cérebro criou o homem. (L. T. Motta, trad.). Companhia das Letras.

Gardenswartz, L., Cherbosque, J., & Rowe, A. (2012). Inteligência emocional na gestão de resultados. (H.A.R. Monteiro, trad.). Clio Editora.

Gil, A. C. (2008). Métodos e técnicas de pesquisa social. 6. ed. Editora Atlas SA.

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ASOCIACIÓN DE LOS ESTILOS PARENTALES, ESTRUCTURA Y PERCEPCIÓN FAMILIAR EN LA APARICIÓN DE CONDUCTAS DELICTIVAS EN ADOLESCENTES.

Maria Angelica Vivas Dominguez
Corporación Universitaria del Caribe (Colombia)
maria.vivas@cecar.edu.co · http://orcid.org/0000-0002-6766-5010
Robinson Martinez
Corporación Universitaria del Caribe (Colombia)
robin27martinez@gmail.com · http://orcid.org/0000-0002-2251-2731
Laura Vivas
Corporación Universitaria del Caribe (Colombia)
laura.vivas@cecar.edu.co · https://orcid.org/0000-0001-8808-201X

Resumen. El objetivo principal del presente estudio fue establecer la relación entre los estilos parentales, la estructura familiar y la percepción de la funcionalidad familiar en la aparición de conductas delictivas de los adolescentes pertenecientes al servicio social de la ciudad de Sincelejo. Para ello, se realizó un estudio de tipo cuantitativo, de nivel correlacional y de corte transversal, con una muestra de 181 adolescentes a quienes se les aplicó un cuestionario de caracterización Ad hoc y se les aplicaron los cuestionarios A-D de Seisdedos, el apego familiar y la escala de estilos parentales. Los resultados muestran relaciones significativas entre las conductas delictivas y una baja percepción de la funcionalidad familiar basada en la poca cohesión familiar, comunicación unidireccional, afirmaciones de poder, normas rígidas e inflexibles y poca implicación afectiva, propios de estilos de crianza autoritarios y negligentes. Estos resultados permitieron concluir que el factor familiar que incide de manera significativa en la adopción de conductas delictivas en los adolescentes es la percepción que estos tienen acerca del funcionamiento familiar y de los factores de apoyo, resolución de conflictos, participación en la toma de decisiones, establecimiento de límites y tolerancia a la crisis que encuentren presentes en el entorno familiar.

Palabras clave: Conductas delictivas; delincuencia juvenil; estilos parentales; estructura familiar; funcionalidad familiar

ASSOCIATION OF PARENTAL STYLES, STRUCTURE AND FAMILY PERCEPTION IN THE EMERGENCE OF CRIMINAL BEHAVIOR IN ADOLESCENTS.

Abstract. The main objective of this study was to establish the relationship between parental styles, family structure and the perception of family functionality in the appearance of criminal behaviors of adolescents belonging to the social service of the city of Sincelejo. To do this, a quantitative, correlational, cross-sectional study was carried out with a sample of 181 adolescents to whom an Ad hoc characterization questionnaire was applied and the AD questionnaires of Seisdedos, the family apgar and the parental style scale. The results show significant relationships between criminal behaviors and a low perception of family functionality based on poor family cohesion, one-way communication, assertions of power, rigid and inflexible norms and little affective involvement, typical of authoritarian and negligent parenting styles. These results allowed to conclude that the family factor that has a significant influence on the adoption of criminal behaviors in adolescents is the perception that they have about family functioning and support factors, conflict resolution, participation in decision-making, establishment of limits and tolerance to the crisis that are present in the family environment.

Keywords: Criminal behavior; juvenile delinquency; parenting styles; family structure; family functionality

Introduction

Adolescence is the stage of the life cycle in which the individual goes through a series of biological and psychological changes that lead him/her to face the feeling of misunderstanding by adults and constant changes in his/her character, resulting in a constant search for identity and social acceptance (Robles, 2008). In view of this, authors such as Gaete (2015) and Tur, et al. (2004) highlight the importance of the role of parents at this stage of development through parental supervision, support, communication, and respect, as they consider them to be protective factors in the appearance of disruptive behaviors in adolescents.

Other authors such as Muris and collaborators (2004), Jiménez and Rosser (2013), and Aguilar (2012) mention parenting styles as a risk factor linked to the commission of criminal acts, highlighting coercive or authoritarian, permissive and negligent parenting styles. However, Sanabria and Rodriguez (2009) highlight to a greater extent authoritarian parenting styles, characterized by poor communication, inflexible rules, and little independence, resulting in fearful, irritable, rebellious, and aggressive children.

A study conducted by Ruiz et al. (2014) shows that homes in which individual interests and achievements, little affective support, and little interaction among family members predominate are factors that promote the linkage of adolescents with conflictive peer groups. This is supported by the study conducted by Frachia (2015) on the three factors of dysfunctional interaction present in families of adolescents with delinquent behaviors, where he identifies denial, symmetrical schismogenesis, and rigidity. The first responds to the non-resolution of internal conflicts in the family system, the second refers to the distancing of the members of a system for any personal or behavioral reason, and the last refers to the lack of flexibility in the imposition of rules and distribution of roles in the family group. However, there are other studies that present other family factors associated with the appearance of these behaviors in adolescents, including child abuse, early parenthood and/or motherhood, and the presence of dysfunctions in the family (Antolín, 2009) as well as the constitution of the household.

Regarding this last factor, some authors, such as Torrente and Rodríguez (2004), affirm that family disintegration added to stress factors, and family conflicts are factors that trigger behaviors outside the law, while other authors, such as Estrada et al. (2015), point to single-parent and extended families as contributors to their development. This argument is based on the typification of families presented by Cohen and Peluso (2010), cited by Frachia (2015), in which they identify five types of families: nuclear family, single-parent family, extended family, blended family, and de facto family. The nuclear family corresponds to the traditional system made up of parents and children; the single-parent family is delimited by the absence of one of the parents, either by death, abandonment, divorce, temporary, or intermittent separation; in the extended family there is a group of subjects to which belong uncles/uncles, grandparents, cousins, grandchildren, and other members belonging to nuclear families such as sons-in-law, sisters-in-law, etc. The blended family, on the other hand, refers to the breakup of the couple that formed a nuclear family and both parties decide to form a new nucleus, and the de facto family refers to that family structure which is not composed under any legal union, that is to say, the free union.

However, despite the fact that juvenile delinquency is a social phenomenon that is on the rise in Colombia, in the figures reported by the National Police (Ramirez and Arroyo, 2014; Goleman, 2002), which amounted to 60,186 in 2020 in the period between January and August, in the Caribbean region there have been few studies about juvenile offenders that attempt to find some kind of association between family variables and the appearance of delinquent behaviors. In this sense, the studies that are found in this regard involve some variable, as is the case of Castillo et al. (2015), and Ramírez and Arroyo (2014), but there are no antecedents to date that allow delving into the incident factors in adolescent criminal behavior from the family area, which shows the scarce research approach to this subject not only at the regional level but specifically in the city of Sincelejo, despite the increase in criminal situations presented in this sector of the country, possibly related to the aftermath left by the armed conflict in the department of Sucre. The latter is due to the fact that Sucre has been a department heavily hit by violence since the 1980s, and today, forty years later, the security director of the National Police reports that more and more young people are on the base line of illegal groups, in structures such as the Gulf clan, the ELN and the dissidents of the FARC (Revolutionary Armed Forces of Colombia).

In this regard, the director of the Observatorio Javeriano de la Juventud, Marta Lucía Gutierrez Bonilla, points out that due to precarious living conditions young people are recruited by illegal groups, offering them job opportunities; but for psychiatrist Rodrigo Córdoba, it is due more to a phenomenon based on upbringing that may be having failures in the establishment of limits of social construction (El Tiempo, 2020).

In this sense, the present study is carried out taking into account the definition of family dynamics given by Minuchin (2004), cited in Frachia (2015), in which he mentions the role system, bonds of belonging, affection relationships, communication systems, and conflict resolution methods as component factors of family functionality and in the classification of parenting styles, presented by Craig (1997), cited by Aroca and Paz-Cánovas (2013), which is detailed in Table 1.

Table 1

Parenting styles.

Parenting styles	Features
Authoritative	Parents who instill autonomy in their children. Open communication, flexible rules, children with greater personal confidence, self-control, high self-esteem, better school performance.
Authoritarian	Poor communication, inflexible rules, little independence; fearful, irritable, rebellious, and aggressive boys; passive and dependent girls in their adolescence.
Permissive	Non-existent restriction, unconditional love, lots of freedom, little driving, no limits. Aggressive and rebellious children, self-understanding, impulsive, in some cases active, social, and creative.
Negligent/Indifferent	No boundaries and lack of affection. Parents focus on their own lives, sometimes neglectful. Children with delinquent behaviors and destructive impulses.

Retrieved from: Aroca and Paz-Cánovas (2013).

Finally, the above demonstrates the importance of studying this phenomenon with emphasis on the family factor and on aspects related not only to parental styles, but also to the family structure and the adolescents' perception of its functionality, in an attempt to approach an answer that could explain the genesis of this social phenomenon.

Method

Design

The study was conducted under a quantitative, observational, correlational, and cross-sectional approach. Probabilistic cluster sampling was used to select the sample, where the sample is given by a unit of analysis, whose characteristics are encapsulated in a specific sampling unit (Hernández et al. 2010).

Participants

For this research, students from different educational institutions in the city of Sincelejo in grades 8, 9, 10, and 11, who were doing their mandatory social service[1] participated in the study. Thus, the sample consisted of 181 students between 13 and 18 years of age, which was relatively homogeneous with a prevalence of the female sex (see Table 1 of results).

Instrument

Among the instruments used, an Ad Hoc questionnaire was used for sociodemographic characterization, which inquired about gender, age, level of schooling,

[1] Social service is a formative mechanism whose main purpose is to integrate students into community life in order to contribute to their social and cultural formation (Law 115, 1994).

socioeconomic level, marital status, and family structure, that is, with whom they lived at the time of the application of the instruments; in addition, information was obtained about belonging to the population that was a victim of the armed conflict or had suffered a victimizing event.

To assess the perception of family functionality, the Family APGAR was used (Smilkstein, 1978, cited by Suarez, M, and Alcalá in 2014), which measures family dimensions such as Adaptation, Participation, Gradient of personal resources, affection, and Resources from the adolescents' perception. This questionnaire consists of 5 questions that are rated on a Likert scale ranging from 0 – 3, taking into account that 0 represents the total absence or never, 1 represents the option almost never, 2 represents the option of sometimes, and 3 corresponds to the option of almost always. The interpretation of these results will depend on the sum of your answers: Normal (7 - 10 points), Moderate Dysfunctional (4 - 6 points), and Severe Dysfunction (0 - 3 points).

The Parenting Practices Scale for Children (Lempers, Clark-Lempers, & Simons, 1989), a self-report test in which participants evaluate the parenting style imparted by their parents from their own perception, was used to evaluate the parenting style imparted by their parents. It is a list of statements in which the answers are Likert-type with values ranging from 1 (Never) to 5 (Very frequently), which evaluate 5 dimensions of parental practice: Support, Induction, Supervision, Guarantee autonomy, Punishment, and Withdrawal of affection, with a Cronbach's alpha of 0.79 and 0.76 for paternal and maternal dimensions for Support, 0.86 and 0.86 for positive induction, 0.89 and 0.83 supervision, 0.82 and 0.65 for guarantee of autonomy, 0.80 and 0.79 for punishment, and 0.71 and 0.63 for withdrawal of affection (Rodríguez and Cortés; 2017).

Finally, the A-D test of Seisdedos (1995) was applied to young people and adolescents (11 - 19 years old) for the measurement of antisocial and criminal behaviors present in the participants. It currently consists of 40 items that are divided into two equal parts for the evaluation of the two aspects of behavior with a dichotomous response possibility (Yes - No), taking values of 0 - 1, where the direct score will be taken from the statements answered with "Yes" in each of the evaluated aspects.

Procedure and data analysis.
This study was carried out in three phases:

Phase 1: The sample size was determined for a population of 247 students by means of the Excel 2010 program, which yielded a minimum sample of 151 students for a representative sample, with a confidence level of 95%, an estimated percentage of 50% and a margin of error of 0.05 (5%). After this, authorization was obtained from the Colombian Civil Defense (DCC), which is in charge of the Social Service of the participating institutions to lead us to the facilities where this service is provided and to have a first contact with the participants; then, the purpose of the research, their voluntary participation, and the confidentiality of the data to be collected were explained to the students.

During the first phase, logistical support was obtained from the instructors in charge of the Social Service for the delivery of informed consents and the collection of socio-demographic data, where data such as sex, age, level of schooling, marital status, and socio-economic level were collected. In addition, information was collected about having been a victim of displacement or another victimizing event.

Phase 2: The constructed test battery was applied, which includes the following evaluation instruments: A - D Scale (Seisdedos, 1995), Parental Styles Scale, and the Family APGAR.

The evaluation lasted approximately 30 minutes and was carried out in agreed-upon areas within the school, controlling noise, light, and ventilation conditions as much as possible.

Phase 3: Once the evaluation process was completed, we proceeded to analyze the data. Initially, a database was created in Excel Office 2010, where all the variables of both the descriptive data of the population and the instruments applied were appended.

Subsequently, the SPSS 10.0 program was used for the respective statistical analysis. Frequency statistics, percentages, and measures of central tendency were used for descriptive data and the R-Pearson statistical form for data corresponding to the correlational analysis. In addition, ANOVA was used to compare quantitative variables between groups such as sex and the presence of victimizing events with criminal behavior.

Results

The results of this research are represented in frequency tables, which correspond to the data collected on the study variables: parental styles, family structure, perception of family functionality, and presence of delinquent behaviors in the population studied. These results are initially presented individually and, subsequently, the correlation between the variables studied is shown.

With regard to the socio-demographic variables, the characteristics of the population are shown as follows:

Regarding the sex variable, a relatively homogeneous sample was found between both sexes with a difference of 9.3%, with a prevalence of the female sex; in the same line, regarding the economic level, a predominance of the medium socio-economic level was found (70%), and regarding age, 97.3% of the population is under 18 years of age, with an average of 15 years of age represented in 43% of the population.

On the other hand, with regard to the level of schooling, it can be observed that most of them belonged to the 9th grade (53.6%), with the 8th grade being the least present in the selected sample. In turn, with regard to the marital status of the participants, 92% were single. In addition, it is important to mention that 23% of the participating population stated that they were victims of displacement, and 11% stated that they had been victims of another victimizing event (See Table 1).

Table 1

Socio-demographic data.

Variable	Category	Frequency	Percentage
Sex	Women	96	54.1
	Men	85	44.8
Economic level	High	8	4.4
	Medium	129	70.5
	Low	44	24.0
Age	13	10	5.5
	14	49	26.8
	15	79	43.2

	16	29	15.8
	17	11	6.8
	18	3	1.6
Schooling	8	5	2.7
	9	98	53.6
	10	78	42.6
Marital status	Single	170	92.9
	Married	2	1.1
	Free union	9	4.9
Victim displacement	Yes	42	23.3
	No	138	76.7
Victimizing event			
	Yes	21	11.6
	No	160	88.4

1. Parental styles.

In relation to parental styles, it was found that the most used in the homes of these adolescents were Authoritative and Permissive, with 37% and 32%, respectively. This means that the participants perceive to a greater extent a parental style characterized by parents who instill autonomy in their children, open communication, and flexible rules, which corresponds to the Authoritative parenting style, and which forms individuals with greater personal confidence, self-control, and high self-esteem. On the other hand, another percentage of the population perceives an education based on little normative restriction and non-existence of limits, which characterizes the permissive parenting style and tends to form aggressive and impulsive individuals, although they may present other personality traits, such as creativity and sociability, as shown in Table 2.

Table 2

Parental Styles

Variable	Frequency	Percentage
Parental style		
Authoritarian	40	21.9
Authoritative	69	37.7
Permissive	59	32.2
Negligent	12	6.6

2. Perception of family functionality.

According to the perception of family functionality, it was found that the level of functionality of the evaluated population indicates some degree of family dysfunctionality (39.4%); which translates into little or no capacity to use family resources to resolve conflicts, low participation of family members in decision-making, little family cohesion, and lack of attention to the emotional and physical needs of other family members, as shown in Table 3.

On the other hand, it is pertinent to point out that, in spite of the above, the majority reported adequate visualization of the role systems, parental authority, and differentiated limits, which are characterized by the presence of rules that determine the participation of the members of the subsystem, flexibility, and

precision, generating effective contact, autonomy, and capacity to resolve internal conflicts. However, 12% of the population scored with severe dysfunctionality.

Table 3

Perception of family functionality.

Variable	Frequency	Percentage
Perception of family functionality.		
Severe dysfunction	23	12.6
Moderate dysfunction	49	26.8
Normal	108	59.0

3. Criminal conduct.

As for the criminal behaviors present in the study sample, there is evidence of a greater inclination towards physical transgression of people, expressed in a mean of 4.74, which translates into behaviors that go beyond the violation of the law; therefore, they are considered antisocial rather than criminal, which presented a mean of 1.01. This information can be seen in Table 4.

Table 4

Criminal conduct.

	N	Media	Standard deviation
Antisocial	181	4,74	3,766
Criminal	181	1,01	2,243

4. Family structure.

Regarding the family composition of the participants, the most representative family type in the sample was nuclear (51%), which responds to the traditional family type composed of parents and children, and the least prevalent was the reconstructed family type with a percentage of 4%, which is characterized by the breakup of the couple that formed a nuclear family and both parties decide to form a new nucleus, as shown in Table 5.

Table 5

Family structure.

Variable	Frequency	Percentage
Family structure.		
Nuclear	95	51.9
Single parent	45	24.6
Extensive	33	18.0
Rebuilt	8	4.4

1. ***Association between parenting styles, family function, family structure, and delinquent behavior.***

   Finally, with regard to the correlation of the variables of this research, it was found that the greater the favorable perception of family functionality, the less the presence of illegal behaviors. Likewise, the results show that the favorable perception of the family is related to the presence of parental styles, where good family communication, cohesion among the members, responsibility in attending to the needs of the members of the system, and affective demonstrations, present in authoritative styles, prevail. On the other hand, it is shown that results associated with a poor perception of family dynamics are associated with parental styles, where rigid and inflexible rules, unidirectional communication, little affective involvement on the part of the parents, and scarce motivation prevail, corresponding to negligent and authoritarian parenting styles; therefore, they are more prone to commit antisocial acts, as shown in Table 6.

Table 6

Association between parenting styles, family function, family structure and delinquent behavior.

	Criminal and antisocial behavior		Parenting styles			
	Criminal	Antisocial	Authoritarian	Authoritative	Permissive	Negligent
Family structure	,104	,083	,059	-,059	-,037	,037
APGAR	-,047	**-,308****	**-,448****	**,448****	**,360****	**-,376****

Discussion and conclusions

The present research has made it possible to carry out the main objective of this study, which was focused on determining the existing association of parental styles, family structure, and the perception of family functionality in the appearance of delinquent behaviors of adolescents belonging to the Social Service of the city of Sincelejo.

The results of the study showed significant links between the variables studied, showing, for example, that parental styles that present rigid and meticulous rules, unidirectional communication, little family cohesion, and assertions of power typical of authoritarian parenting styles are related to the presence of delinquent and even antisocial behaviors among the fraternal agents of the system, i.e., the children. In view of this, Minuchin and Fishman (2004) mention that those parenting styles that are under total

control, little communication and peripheral parental roles will result in the appearance of disruptive behaviors. Therefore, as suggested by Frachia (2015), this parenting style would not generate protective factors to the family system, but on the contrary, promotes the risk of juvenile delinquency.

Taking this into account, it could be said that authoritarian and negligent styles would be associated with the development of disruptive behaviors, since it is possible to appreciate the indifference on the part of parents to the behaviors of children in the case of negligent styles and the presence of reiterative punishments, absence of praise, and inflexible rules in authoritarian styles. In this regard, the results of Estrada, Rodríguez, Cerros, and Solano (2017) show affinity with the above, highlighting that the appearance of disruptive behaviors is mostly evidenced in negligent parenting styles, since the indifference expressed in the reinforcement of negative and positive attitudes generates confusion in the child about what is right or wrong, resulting in the failure to differentiate between punishments and reinforcements in behaviors. Similarly, Aguilar (2012) agrees with the above, indicating that disciplinary inconsistency and lack of supervision typical of negligent parental styles as well as constant punishment and coercion among members of the system, typical of authoritarian styles, are risk factors for violent behaviors in adolescents.

Contrary to this, Bravo, Sierra, and Del Valle (2009) indicate that the relationship with parental practices in which the permissive parenting style prevails are those associated with disruptive behaviors, since it is characterized by the non-assertion of authority and the restriction of rules by parents and the tolerance of the child's impulses by agreeing to their impositions.

On the other hand, parenting styles that showed clear rules, manifestations of affection, directed discipline, and assertive communication, where the needs of the minors were attended to, promote the capacity to resolve conflicts effectively, permeating self-control, competencies, and pro-social behaviors that allow the development of better positions in the face of conflicts. In this regard, some authors, such as Tur et al. (2004), affirm that good parenting habits, where autonomy, support, discipline, and satisfaction of adolescents are instilled, promote the emergence of socially accepted behaviors.

Regarding family composition, expressed by Salazar et al. (2011) and Estrada et al. (2017) as an incident factor in the development of delinquent behaviors in adolescents, no significant associations were found that could evidence that the way in which the family is conformed is an influential factor in the commission of criminal acts, since the results of this study show that the highest percentage of subjects are found in nuclear households (51%) and these, in turn, showed the presence of antisocial behaviors (M=4.74), which does not allow establishing with certainty that a structured family is considered a protective factor for the development of this type of behavior. This is supported by Velazco, Galicia, and Ojeda (2018), and Torrente and Ruíz (2005), who state that they have not established a significant relationship between a specific type of family and the appearance of delinquent behaviors, which is why they believe that other types of family factors could be associated with this social problem, such as the family climate under which adolescents develop.

Based on the above, it is conceivable that from the adolescent's perspective, nuclear-type families may present family dysfunctions, bearing in mind that family functionality is not only based on the shared distribution of roles and the establishment of hierarchies in a system but also on factors such as support, emotional support, problem-

solving, decision-making system, maturity of the system's participants, and the attention paid to the needs of other members (Minuchin et al. 2004), which is not guaranteed by belonging to a specific type of family. Therefore, this fact would reflect the need for more research studies on this topic in the department.

On the other hand, the results of this research disagree with Valenzuela et al. (2013), who state that single-parent families are more likely to generate violent behaviors in children since they are characterized by frivolous relationships, insecure attachments, poor parental supervision, and constant parental conflicts, which promote family dysfunction. Likewise, several authors affirm that this type of single-parent families, where the maternal figure prevails, are criminogenic type homes since there is little emotional support, less mother-child interaction, and several father figures at the same time, imposing themselves on the minor such as, for example, grandparents, uncles, cousins, etc., which leads to the mother being repeatedly disavowed by them (Estrada et al. 2017 and Torrente et al. 2004).

Along the same lines, Frachia (2015) outlines that extended and reconstructed families, where there are children from two or more different family nuclei, are a risk factor for adolescents as they generate early unions, teenage pregnancies, bad jobs, and disintegration of family nuclei, which are factors favorable to crime.

Finally, one of the family-type factors most frequently implicated in the development of delinquent behavior is the way in which adolescents perceive their family environment, i.e., how they appreciate the education imparted by their parents and/or other family members within the system. This is considered of great importance since it is common knowledge that there are often discrepancies between the way in which parents believe they act in a corrective manner towards their children and the way in which the latter receive and assume this type of corrections.

Thus, the results of this research show that family systems where greater interest in the needs of the adolescent, fluid communication, clarity of roles and authority, precise limits, conflict resolution capacity, and the active participation of agents in family decision-making, present in 59% of the population, favored to a certain extent the adolescent's view of the education provided by parents; this is in line with Ruiz et al. (2014), who found that greater family cohesion, organization, and autonomy among members promises greater generation of pro-social behaviors in adolescents. This, taking into account that the developmental phase faced by the subject in adolescence is influenced by the need for both family and social recognition, in addition to personal motivations and interests, so that parental supervision, support, and constant communication often play an important role in modeling behaviors in this evolutionary stage.

In this sense, Frachia (2015) mentions that the lack of tolerance to conflict, avoiding responsibility for acts, little family interaction, ignorance of the other within the system in which behaviors are adopted, where only one's own well-being, arguments, shouting, threats, emotional distance, and detachment are important risk factors in the development of not only criminal but also antisocial behaviors. Consequently, other studies suggest that low levels of emotional warmth, coupled with high levels of rejection, control, and inconsistencies in perceived support and family dysfunction are factors that generate hostile behaviors in adolescents (Muris et al. 2004; Salazar et al. 2011).

It should be noted that there are other social factors that could promote the commission of criminal acts and that emerged secondarily in the study, such is the case

of the variables "victims of armed conflict" and "having suffered from some victimizing event," to which 34.9% of the sample belong. Faced with this, Morales (2018) states that the armed conflict in Colombia has left sequelae in the mental health of the victims, ranging from psychological trauma, anguish, and depression to the development of violent behaviors. Considering the number of adolescent victims of the armed conflict in Colombia, it is to be expected that violent and aggressive behaviors will increase in this segment of the population as an expression of negative emotions such as resentment, guilt, and anger. Thus, for Aristizábal and collaborators (2012), the violent behavior of adolescent victims of the conflict arises as compensation for the defenselessness and mistreatment to which they were subjected, assuming a role opposite to that of victim, reflecting in criminal behavior the feelings of resentment, resentment and anger that they vent through aggression, which could explain the high percentage of adolescents with criminal behavior shown in this study, related to the high prevalence of adolescents who have been victims of the armed conflict or of some victimizing event. However, it would be necessary to verify this in future research since it is not conclusive in this study due to lack of data; as a result, this variable was not included as a research objective.

In general terms, it can be concluded that delinquent behavior in adolescents is closely related to the family component, since it is the first system to which the individual belongs and which is responsible for effective development in all areas that make up the human being. This is why the relationship established by parents with their children in terms of the organization of the system is an essential point in their moral development, since a system of clear rules and norms, established limits, levels of support and constant interaction, and the generation of autonomy are usually protective factors against the appearance of disruptive behavior.

Likewise, the way in which the family system is constituted does not reflect a direct relationship with the occurrence of illegal behavior; Thus, nuclear, single-parent, extended, or de facto family structures have the same risk of harboring adolescent children who commit this type of behavior since, although it has been shown that family dynamics are important in the moral development and criminal behavior of adolescents, no type of family structure ensures its good functionality, due to the fact that there are various personal and relational factors that have a significant impact on the construction of the dynamics in the parental-fraternal systems.

Finally, parental style is related both to the way in which the adolescent perceives the functionality of his or her family environment and to the development of disruptive behaviors. Thus, authoritarian and negligent parental styles are conducive to the emergence of violent and antisocial behavior. Therefore, it can be affirmed that the presence of rigid, inflexible rules, the proportion of punishments greater than that of flattery, authority assertions based on power, poor family cohesion, and the absence of communication are usually a risk factor not only for the development of criminal behavior but also of antisocial behavior in adolescents. However, it should be borne in mind that parenting styles where limits are usually flexible and the child has exclusive decision making in aspects such as conflict resolution and global decision making can also be considered risk factors for adolescents.

References

Aguilar, M. (2012). La influencia del contexto familiar en el desarrollo de las conductas violentas durante la adolescencia: factores de riesgo y protección; Universidad de Murcia, Murcia – España, 2012. Disponible en http://www.scielo.org.co/pdf/crim/v54n2/v54n2a03.pdf

Antolín, L., Oliva, A., Arranz, E. (2009). Contexto familiar y conducta antisocial infantil. *Anuario de Psicología, 40* (3); 313-327. Disponible en https://www.redalyc.org/pdf/970/97020869001.pdf

Aristizábal, E., Palacio, J., Madariaga, C., Osman, H., Parra, L. H., Rodríguez, J., & López, G. (2012). Síntomas y traumatismo psíquico en víctimas y victimarios del conflicto armado en el caribe colombiano. Psicología desde el Caribe, 29(1), 123-152. Recuperado de: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=s0123417x2012000100008&lng=en&tlng.

Aroca, M. y Paz-Cánovas, L. (2012) Los estilos educativos parentales desde los modelos interactivos y de construcción conjunta: revisión de las investigaciones. *Biblid 24* (2), 149-176. Disponible en https://dialnet.unirioja.es/servlet/articulo?codigo=4115348

Castillo, S., Carpintero, L., Sibaja, D., y Romero-Acosta, K. (2015). Estilos de crianza y su relación con sintomatología internalizante en estudiantes de 8 a 16 años. *Revista de Psicología GEPU, 6* (2), 53 – 65, ISSN 2145 – 6569. Disponible en https://revistadepsicologiagepu.es.tl/Estilos-de-Crianza-y-su-relaci%F3n-con-Sintomatolog%EDa-Internalizante-en-Estudiantes-de-8-a-16-a%F1os.htm

Estrada, C., Rodríguez, F., Cerros, E., y Solano, C. (2015). Implicaciones parentales en las conductas delictivas de adolescentes: tendencias y narrativas. *Papeles de población, 21* (84); 107 – 132, ISSN: 1405-7425. Disponible en http://www.scielo.org.mx/scielo.php?script=sci_abstract&pid=S1405-74252015000200005&lng=en&nrm=iso&tlng=es

Frachia, P. (2015) *"Análisis de la dinámica familiar en adolescentes en conflicto con la ley desde un enfoque sistémico"* (Trabajo final de grado). Universidad de la República Montevideo – Uruguay. Disponible en https://sifp.psico.edu.uy/sites/default/files/Trabajos%20finales/%20Archivos/trabajo_final_de_grado_analisis_de_la_dinamica._1._version_pdf.pdf

Gaete, V. (2015). Desarrollo psicosocial del adolescente. *Revista chilena de pediatría, 86* (6), 436-443. https://dx.doi.org/10.1016/j.rchipe.2015.07.005

Goleman, D. (48ª edición). (2002). *Inteligencia Emocional.* Editorial Kairós

Jiménez, R., y Rosser, A. (febrero, 2013). Delincuencia juvenil y estilos educativos parentales. *XIV Congreso Virtual de Psiquiatría*, Interpsiquis.

Lempers, J. D., Clark-Lempers, D., & Simons, R. (1989). Economic Hardship, Parenting, and Distress in Adolescence. *Child Development*, 60, 25-39. http://dx.doi.org/10.2307/1131068

Mendez, A. (12 de septiembre de 2020). Cada día se captura, en promedio, 248 jóvenes de entre 19 y 29 años. *El Tiempo.* Recuperado de Delincuencia juvenil | Cada día capturan 248 jóvenes en Colombia - Delitos - Justicia - ELTIEMPO.COM

Minuchin, S. y Fishman, Ch. (2004). *Técnicas de terapia familiar*. Paidós. Buenos Aires, Argentina.

Morales, J. (2018). *Diferencias en los tipos y niveles de agresividad en adolescentes víctimas y no víctimas del conflicto armado en Colombia* (Tesis de pregrado). Institución Universitaria de Envigado, Antioquia. iue_rep_pre_psi_morales_2017_diferencias.pdf

Muris, P., Meesters, C., Morren, M y Moorman, L. (2004). Anger and hostility in adolescents: Relationships with self-reported attachment style and perceived parental rearing styles. *Journal of Psychosomatic Research, 57* (3), 257-264. https://doi.org/10.1016/S0022-3999(03)00616-0

Ramírez, A., y Arroyo-Alvis, K. (2014). Características neuropsicológicas en adolescentes infractores de la ciudad de Sincelejo-Sucre. *Psicogente, 17* (32), 421-430; ISSN 0124-0137. Disponible en http://publicaciones.unisimonbolivar.edu.co/rdigital/psicogente/index.php/psicogente

Ruíz, A., Hernández, M., Mayrén, P., y Vargas, M. (2014). Family functioning of consumers of addictive substances with and without criminal behavior. *Liberabit, 20*(1); 109-117, ISSN 1729-4827. Disponible en http://www.scielo.org.pe/scielo.php?pid=S1729-48272014000100010&script=sci_abstract&tlng=en

Robles, B. (2008). La infancia y la niñez en el sentido de la identidad. Comentarios entorno a las etapas de la vida de Erik Erikson. *Revista Mexicana de Pediatría, 75* (1); 29 – 34. Disponible en https://www.medigraphic.com/pdfs/pediat/sp-2008/sp081g.pdf

Rodríguez, A., y Cortés, M. (2017) Prácticas de crianza y trastornos psicológicos en adolescentes colombianos. *Behavioral Psychology, 25* (3); 599 – 621, ISSN 1132-9483. Disponible en https://pesquisa.bvsalud.org/portal/resource/pt/ibc-169769

Salazar, J., Torres, T., Quinteros, C., Figueroa, N., y Araiza, A. (2011). Factores asociados a la delincuencia en adolescentes de Guadalajara Jalisco. Papeles de población, 17 (68); 103 – 116, ISSN 2448-7147. Disponible en http://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S1405-74252011000200005

Sampieri, R. (5ª edición). (2010). *Metodología de la investigación*. México. Interamericana Editores, S.A. de C.V

Sanabria, A., y Uribe, A. (2009). Conductas antisociales y delictivas en adolescentes infractores y no infractores. *Pensamiento psicológico, 6* (13); 203-218. Disponible en Disponible en: https://www.redalyc.org/articulo.oa?id=80112469014

Suarez, M., y Alcalá, M. (2014). Apgar Familiar: Una Herramienta Para Detectar Disfunción Familiar. *Revista Médica La Paz, 20* (1), 53-57. ISSN 1726-8958. Disponible en http://www.scielo.org.bo/scielo.php?script=sci_arttext&pid=S1726-89582014000100010

Torrente, G., y Rodríguez, A. (2004). Características sociales y familiares vinculadas al desarrollo de la conducta delictiva en pre-adolescentes y adolescentes. *Cuadernos de trabajo social, 17*, 99 – 115. ISSN: 0214-0314. Disponible en https://dialnet.unirioja.es/servlet/articulo?codigo=1155765

Torrente, G., y Ruiz, J. (2005). Procesos familiares relacionados con la conducta antisocial de adolescentes en familias intactas y desestructuradas. *Apuntes de Psicología, 23* (1); 41-52, ISSN 0213-3334. Disponible en https://dialnet.unirioja.es/servlet/articulo?codigo=2217822

Tur, A., Maestre, M., y Del Barrio, V. (2004). Los problemas de conducta exteriorizados e interiorizados en la adolescencia: relaciones con los hábitos de crianza y el temperamento. *Acción psicológica, 3* (3), 207 – 221. Disponible en http://e-spacio.uned.es/fez/eserv.php?pid=bibliuned:AccionPsicologica2004-numero3-0005&dsID=Documento.pdf

Valenzuela, M., Ibarra, A., Tamara, Z., y Correa, M. (2013). Prevención de conductas de riesgo en el Adolescente: rol de familia. *Index de Enfermería, 22* (1-2), 50-54. Disponible en: https://dx.doi.org/10.4321/S1132-12962013000100011

Velazco, A., Galicia, I., y Ojeda, F. (2018). Conductas antisociales – delictivas en adolescentes: relación con el género, la estructura familiar y el rendimiento académico. *Alternativas en psicología, 38*, 80 – 98. Disponible en https://alternativas.me/27-numero-38-agosto-2017-enero-2018/158-conductas-antisociales-delictivas-en-adolescentes-relacion-con-el-genero-la-estructura-familiar-y-el-rendimiento-academico

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PSYCHOSOCIAL IMPACTS OF COVID-19 AMONG UNIVERSITY STUDENTS IN URUGUAY

Alejandro Vásquez-Echevarría
Universidad de la República (Uruguay)
alejandro.vasquez@pedeciba.edu.uy · http://orcid.org/0000-0003-0100-6968
Tianna Loose
Universidad de la República (Uruguay)
loose.tianna@gmail.com · https://orcid.org/0000-0002-1608-2309

Abstract. The new coronavirus has had a catastrophic toll around the world on physical and mental health. In this article, we focus on the psychosocial impact among students in Uruguay, a country relatively protected from the pandemic during 2020. Our study had three main objectives: 1) describe the impact in detail; 2) identify the relationships between the different dimensions and; 3) highlight the determinants of mental health. We designed a multidimensional questionnaire to investigate the perceived impact of students. The questionnaire was administered online to 144 Uruguayan university students while the university was closed. Between 38 and 66% of the students indicated an increase in signs of anxiety, depression or sleep disturbances. Regardless of other related factors, increased substance use, deterioration in social relationships, negative impact of school closings, and personal financial concerns accounted for 41% of the variation in mental health. The findings are discussed in terms of their implications for public health and future directions of research on the effects of the pandemic on mental health.

Keywords: Questionnaire; COVID-19; psychology; mental health; university

IMPACTOS PSICOSOCIALES DEL COVID-19 EN ESTUDIANTES UNIVERSITARIOS DE URUGUAY

Resumen. El nuevo coronavirus ha tenido un costo catastrófico en todo el mundo en la salud física y mental. En este artículo, nos enfocamos en el impacto psicosocial entre los estudiantes de Uruguay, un país relativamente protegido de la pandemia durante 2020. Nuestro estudio tuvo tres objetivos principales: 1) describir en detalle el impacto; 2) identificar las relaciones entre las diferentes dimensiones y; 3) resaltar los factores determinantes de la salud mental. Diseñamos un cuestionario multidimensional para investigar el impacto percibido de los estudiantes. El cuestionario se administró en línea a 144 estudiantes universitarios de Uruguay mientras la universidad estaba cerrada. Entre 38 y 66% de los estudiantes indicaron un aumento en los signos de ansiedad, depresión o alteraciones del sueño. Independientemente de otros factores relacionados, el aumento en el uso de sustancias, el deterioro en las relaciones sociales, el impacto negativo del cierre de las facultades y las preocupaciones económicas personales explicaron el 41% de la variación en la salud mental. Los hallazgos se discuten en términos de sus implicaciones para la salud pública y las direcciones futuras de investigación sobre los efectos de la pandemia en la salud mental.

Palabras clave: Cuestionario; COVID-19; psicología; salud mental; Universidad

Introducción

As of October 21st 2020 when this study was conducted, the novel corona virus (COVID-19) had killed 1,119,431 people worldwide and infected 40,455,651. These tolls continue to climb. In South America, Brazil (154,176), Argentina (26,716) and Peru (33,820) count the highest death tolls, whereas only 51 people had died in Uruguay (World Health Organization, 2020). In response to the outbreak, in March 2020, the Uruguayan government acted swiftly with closures of schools, stores and social gatherings. Citizens were advised to stay home, wear masks, avoid social interactions and wash hands. Unlike many other countries, the government never enforced any recommendations but rather relied on the personal and social responsibility of residents. In April 2020, it was estimated that about 70% of the population respected the stay at home measures but then began re-engaging in social interactions (Herrero, 2020). The country has received widespread praise for its control of the pandemic and low infection rates in 2020. By the end of 2020, most public spaces and businesses were reopened (bars, restaurants, shops, beaches, parks) and social gatherings had resumed (concerts, sports team) or in other words, many of the structures necessary for young people to go about their lives with an air of normalcy. Nonetheless, the University was closed to students and classes were held using online platforms.

In addition to the harm by COVID-19 infections and deaths, the context of the pandemic has caused major disruptions and collateral damage in terms of the psychological, social, physical and economic welfare of populations worldwide (VanderWeele, 2020). For example, a large scale international study found that social activities involving family, friends or entertainment dropped nearly 50% from before to after confinement. Adoption of digital platforms for social connection rose, but life satisfaction fell (Ammar et al., 2020). In terms of physical health, exercise has decreased whereas there was little change in alcohol

consumption (Knell et al., 2020). Alarmingly, mental health problems have increased up to seven fold in general populations. The prevalence of depression is now at 32% and anxiety at 34% (Salari et al., 2020) and higher among young people in comparison to other age groups (Huang & Zhao, 2020). Young people would be bearing the psychosocial brunt of COVID-19 regulations. The American Psychological Association (2020) found this month that young people aged 18-23 (Gen Z adults) were experiencing more anxiety and depression in response to COVID-19 in comparison to any other age groups. 31% reported that their mental health had declined over the last year, 81% reported that the school year was causing them stress and 67% said that planning for the future felt impossible. 31% experienced disrupted sleep patterns, 28% had a less healthy diet and 28% had experienced a change in body weight. In comparison to all other age groups, Gen Z adults were the most likely to agree that they felt "very lonely" (63%) and to report distress in their relationships notably because they felt less close with their family, friends and community. As we can see, the psychosocial impact of switching interactions to virtual platforms does not appear to be curbed by Gen Z being a technological generation. In fact, the group appears to be among the most at risk for pandemic related mental health distress.

The pandemic has caused a mental health crisis and it is critical that researchers investigate the topic immediately (Holmes et al., 2020). Governments, policy makers and researchers need to account for these collateral factors when considering total years of life lost and strategies to implement (VanderWeele, 2020). Only a handful of scattered studies have investigated levels of psychological distress in response to COVID-19 among university students so far, but research on the topic will surely accumulate. In China, a fourth of students had symptoms of generalized anxiety which was related to economic, academic and social stressors (Cao et al., 2020). In India, college students had good knowledge of the disease and followed recommendations (Prasad Singh et al., 2020) as was the case in with undergraduates in the USA. The American undergraduates also reported struggling in their everyday lives and in the academic context specifically. They reported high levels of stress, distress and mental health issues including anxiety and depression. Contributing factors included difficulties concentrating, financial problems due to unemployment, lack of access to hygienic and medical supplies, looking at COVID-19 related information, age (younger) and gender (female) (Kecojevic et al., 2020).

In terms of prevalence and regulations, the COVID-19 situation in Uruguay specifically is not nearly as dire as in most other places around the world (World Health Organization, 2020). Severity of COVID-19 infections and mortality rates increase with age meaning that youth would be the least vulnerable in this regard (Omori et al., 2020). However, youth are the most vulnerable in terms of psychosocial collateral damage which contributes to years of life lost in the long run. We were unable to identify any research conducted on how university students in Uruguay perceived the impact of COVID-19. In fact, research conducted among specific groups (e.g. college students) or among South Americans is beginning to accumulate but lacking. Guidelines in conducting psychosocial research on the pandemic suggest that generalizing results is irreverent. Instead we should conduct contextualized research describing problematic situations and their determinants (Venkatesh, 2020). In this study, our first goal was to highlight the extent to which COVID-19 has impacted various spheres in the lives of Uruguayan University students in a detailed descriptive manner. For example, were students in Uruguay experiencing psychological

distress despite no official lockdown? How was their social and academic life impacted? How has the pandemic impacted their substance use, exercise patterns and healthy eating? Are any students finding benefits or enjoying the experience? In the second part of our study, our goal was to examine how these different spheres were inter-related and determinant of psychological distress.

Methods

Material

Two doctors in clinical psychology with experience in psychometrics designed a questionnaire for the purposes of the study. The questionnaire prompted students to consider how COVID-19 changed aspects of their lives on a scale ranging from (1) *strongly disagree* to (5) *strongly agree*. Spheres included general impact, impact of school closures, social functioning, psychological health, financial issues, socioeconomic worries, health behaviors, and positive benefits. We also assessed adherence to recommendations and the extent to which students enjoyed virtual activities. Vulnerability was assessed with yes/no questions. All items of the questionnaire and reliabilities for scales are presented in the results section.

Population and procedure

144 undergraduate students participated in the study online while in person classes at the University were suspended. We added the COVID-19 questionnaire to another investigation already underway on academic outcomes, motivation, time perspectives and personality. The protocol underwent ethical approval by the board at our university. Professors from various departments put an invitation to the study on the educative online platform associated with their class. Age averaged 22 years old (*SD*=3.90). 101 participants identified as female (70%), 42 as male (29%), and one as other. 98% were born in Uruguay, 85% were white, 11% were mestizo and 3% had another ethnicity. Participants were most often unemployed (76%) and received financial help from their parents (88%) but not from the government (9%). Two students reported that they routinely had trouble meeting basic needs (food, rent), 20% reported that they sometimes had troubles and 79% said they never did. 70% reported having an adequate place to study at home (e.g. desk, quiet), 26% said they somewhat did, and 4% said they did not.

Statistical design

In order to describe the impact of COVID-19 among university students, we provided proportions of students who endorsed single items on the questionnaire. When we described results for the questions using a 5-point Likert type scale, we collapsed the response categories strongly or somewhat agree or disagree into three (*agree*, *neutral* and *disagree*) in order to enhance readability.

After describing the situation, we checked the reliability of regrouping items by domains and created corresponding scale scores. These scales were used in correlation analyses to apprehend inter-relationships between factors. Lastly, all factors that showed a significant correlation with psychological distress were carried over as predictors in a hierarchical regression analysis where psychological distress was figured as an outcome. All tests were two-tailed, $p<0.05$ indicated statistical significance and analyses were run with SPSS 20.

Results

Description of impact

Students generally did not indicate high levels of vulnerabilities. 17% reported they had health vulnerabilities (e.g. pre-existing conditions), 33% lived with someone with health vulnerabilities and 67% were living with someone who was working in a job involving contact with people. Almost all students (90%) reported that they had sufficient access to healthcare services. Most students reported that COVID-19 did not impact their employment status. 17% continued working normally with a job that involved contact with people, 6% said they continued working but with less hours or less pay and 8% had lost their job or couldn't work because of COVID-19. 2% were working in health care (hospital, retirement) and one person had come into direct contact with COVID-19. We then calculated the proportions of students who endorsed each of the five response options for each item of the questionnaire (table 1).

Table 1

COVID-19 questionnaire items in Spanish and English: Percentage of endorsement

	1	2	3	4	5
Impacto					
Impact					
COVID-19 ha tenido un gran impacto en mi vida *COVID-19 has had a big impact in my life*	3.5	4.2	30.6	33.3	28.5
Ahora con el COVID-19, todo es totalmente diferente *Now with COVID everything is totally different*	4.2	6.9	24.3	37.5	27.1
Odio el impacto que COVID-19 ha tenido en mi vida *I hate the impact that COVID-19 has had in my life*	23.6	17.4	32.0	15.3	11.8
Me encanta el impacto que COVID-19 ha tenido en mi vida. *I love the impact that COVID has had in my life*	44.4	13.9	31.3	6.3	4.2
Educación					
Education					
La enseñanza virtual tiene un efecto negativo en mi aprendizaje *Virtual teaching has a negative effect on my learning*	19.4	18.8	22.2	23.6	16.0
Me extraño ir a clase *I miss going to class*	10.4	8.3	14.6	26.4	40.3
Estoy menos motivado para hacer el trabajo del curso *I am less motivated to do classwork*	19.4	13.9	17.4	22.9	26.4
Estoy menos motivado para completar mis estudios universitarios *I am less motivated to complete my university studies*	43.8	18.8	13.9	13.2	10.4
Social					
Social					
Ha tenido un impacto negativo en mi vida social *There has been a negative impact on my social life*	16.7	13.9	18.8	29.2	21.5
Me siento más socialmente aislado *I feel more socially isolated*	13.9	17.4	13.9	33.3	21.5
El contacto virtual es suficientemente bueno para mí *Virtual contact is good enough for me*	20.8	31.9	18.1	19.4	9.7
Me extraño compartir activades con la gente *I miss sharing activities with people*	7.6	6.3	16.7	32.6	36.8
Mundo virtual					
Virtual world					
Me gustan las computadoras y las pantallas *I like computers and screens*	5.6	14.6	29.9	22.9	27.1

Me gustan los videojuegos *I like video games*	33.3	15.3	16.0	14.6	20.8
Disfruto viendo series o películas *I enjoy watching series and movies*	.7	7.6	11.8	32.6	47.2
Disfruto de las actividades virtuales *I enjoy virtual activities*	6.3	19.4	35.4	24.3	14.6
Empleo y finanzas					
Employment and finances					
Estoy más preocupado por mis propias finanzas *I am more worried about my own finances*	22.9	14.6	22.9	22.9	16.7
Estoy más preocupado por el desempleo *I am more worried about unemployment*	21.5	8.3	16.0	31.3	22.9
Estoy más preocupado por mi carrera *I am more worried about my career*	6.3	6.3	17.4	35.4	34.0
Social y Economía					
Social and economy					
Estoy más preocupado por el futuro de la economía *I am more worried about the future of the economy*	2.1	3.5	23.6	40.3	30.6
Estoy más preocupado por la sistema social *I am more worried about the social system*	6.3	3.5	25.7	36.1	28.5
Estoy más preocupado por las industriales y empresas *I am more worried about industries and businesses*	6.3	11.8	35.4	30.6	16.0
Psicología					
Psychology					
Tengo más problemas para concentrarme *I have more problems concentrating*	13.2	12.5	16.0	27.1	31.3
Siento más estrés y ansiedad *I feel more stress and anxiety*	10.4	8.3	15.3	34.0	31.9
Tengo más sentimientos de tristeza *I have more feelings of sadness*	18.8	13.2	23.6	22.2	22.2
Tengo más sentimientos de soledad *I have more feelings of loneliness*	22.2	17.4	22.2	22.2	16.0
Tengo más sentimientos de desesperanza o impotencia *I have more feelings of hopelessness and helplessness*	20.8	17.4	22.2	20.1	19.4
Mis ciclos de sueño han cambiados *My sleep cycles have changed*	20.1	13.2	12.5	22.2	31.9
Comportamientos de salud					
Health behaviors					
Tomo más alcohol *I drink more alcohol*	74.3	9.0	6.3	7.6	2.8
Fumo más marihuana *I smoke more marijuana*	87.5	3.5	4.9	2.1	2.1
Como alimentos más saludables *I eat healthier foods*	20.8	18.1	29.9	16.7	14.6
Hago más actividad física (p. ej., caminar, yoga ...) *I do more physical activity (e.g. walking, yoga)*	47.2	16.0	14.6	13.9	8.3
Siguiendo las recomendaciones					
Following recommendations					
Sigo atentamente todas las recomendaciones de los gobiernos *I carefully follow all of the governments recommendations*	2.1	9.0	19.4	37.5	31.9
Me lavo las manos con frecuencia *I wash my hands frequently*	.7	2.8	16.0	27.1	53.5
Evito salir de mi casa *I avoid leaving my house*	4.9	10.4	16.0	27.1	41.7
Uso una máscara cuando estoy afuera *I use a mask when outside*	4.2	2.1	10.4	25.0	58.3

Beneficios positivos ***Positive benefits***					
Estoy más agradecido por lo que tengo *I am more grateful for what I have*	3.5	4.9	22.2	36.1	33.3
Soy más amable y compasivo con la gente *I am nicer and more compasionate with people*	9.7	16.0	39.6	20.8	13.9
He aprovechado tener más tiempo *I have benefited from having more time*	17.4	16.0	22.2	21.5	22.9
He crecido mucho *I have grown a lot*	14.6	15.3	38.2	17.4	14.6

Note. 1= totalmente en desacuerdo (totally disagree), 2=algo en desacuerdo (somewhat disagree), 3=ni de acuerdo ni en desacuerdo (neither agree nor disagree), 4= algo de acuerdo (somewhat agree), 5= totalmente de acuerdo (totally agree)

Most students reported adhering to government recommendations. 69% agreed that they "carefully followed all of the government recommendations" and 69% said they avoided leaving their house. 80% said they were washing their hands more often (4% disagreed) and 83% reported using a mask outside (6% disagreed). As far as the perceived impact of COVID-19 on their lives, 65% of students endorsed the extreme statement "now with COVID-19, everything is totally different." And only 11% disagreed. About half (52%) of students said that COVID-19 had a big impact on their life (8% disagreed). In terms of the emotional connotation of the impact, 27% of students reported that they "hated it" (41% disagreed) and interestingly, 10% reported that they "loved it" (57% disagreed).

Our indicators of psychological distress in response to the pandemic tapped signs of anxiety, depression and sleep disturbances. We found that 66% of students reported having more stress and anxiety, 58% more trouble concentrating and 54% experienced changes in their sleep cycles. 44% of students reported increased feelings of sadness, 38% feelings of loneliness and 40% feelings of hopelessness or helplessness. Students reported changes in health behaviors in terms of substance use, diet and exercise. 10% of students reported drinking more (83% disagreed) and 4% were consuming more marijuana (91% disagreed). 21% of students reported that they were eating healthier (39% disagreed) and 22% reported that they were exercising more (63% disagreed).

Students' social relations were disrupted. 50% reported a negative impact on their social lives (20% disagreed) and 55% reported feeling more isolated (31% disagreed). 69% reported that they missed sharing activities with people (15% disagreed) and for 52% of students, virtual contact was not sufficient (29% disagreed).

Students conveyed having difficulties because of closures of in person classes. Most students (67%) reported that they missed going to class and only 19% disagreed. 60% reported that virtual teaching had a negative effect on their learning (38% disagreed), 49% reported being less motivated to do classwork (33% disagreed) and 24% reported they were less motivated to finish their study program at the university (62% disagreed).

Not all students enjoyed activities involving a screen. 59% liked computers and screens (20% disagreed), 35% liked video games and 39% enjoyed virtual activities. Watching series and movies was popular, with 80% of students stating it was enjoyable.

Some students did report positive growth, notably 69% of students agreed that they were now more grateful for what they have and only 8% disagreed. 44% said they took advantage of having more time, but 23% disagreed with the statement. 22% said they grew a lot (29% disagreed) and 34% said they were kinder to others (26% disagreed).

Students were worried about the negative impact of COVID-19 on financial and economic matters. 39% were now more worried about their own finances (37% disagreed), 54% were more worried about unemployment (30% disagreed) and 69% were now more worried about their whole career (12% disagreed). 71% were worried about the future of the economy and only 6 % said they disagreed. In terms of sectors, 47% were worried about

industry and business (18% disagreed) and 65% worried about the social system (10% disagreed).

Dimensions and inter-relationships

Categories of items were then checked in terms of reliability in order to create scale scores and investigate inter-relationships between factors. Reliability coefficients were acceptable for mental health (α=0.86; 8 items), positive benefits (α=0.74; 4 items), adherence to recommendations (α=0.73; 4 items), general socioeconomic worries (α=0.76; 3 items) and the impact of school closures (α=0.80; 4 items). For the affinity with screens scale, we deleted the item appraising movies and series because the activity was passive and it improved statistics (α=0.71; 3 items). Reliability fell below 0.7 for the personal worries about finances and employment scale (α=0.62), but was only represented by three items and was conserved in subsequent analyses. Diet and exercise were averaged to create a 2-item scale (inter item correlation r=0.410, p<0.001) as were cannabis and alcohol use (r=0.516, p<0.001) because these two health categories were not correlated. Skew and kurtosis for all scales fell below the absolute value of one, except changes in substance use but acceptable normality was maintained (skew=2.28, kurtosis 5.11). Two-tailed person correlations between the 10 scales were calculated (table 2).

Table 2

Correlations between Scales of the COVID-19 Questionnaire

	1	2	3	4	5	6	7	8	9	10	11	12
1. Mental health	1	0.230**	-0.156	0.425**	0.447**	0.245**	-0.022	-0.149	0.053	-0.018	-0.102	-0.117
2. Substance use	0.230**	1	0.064	0.047	0.096	0.191*	0.102	-0.067	-0.292**	0.053	0.138	0.109
3. Diet and exercise	-0.156	0.064	1	0.091	-0.144	-0.014	-0.066	0.312**	-0.165*	-0.112	0.189*	-0.135
4. Social distress	0.425**	0.047	0.091	1	0.319**	0.111	0.007	-0.096	-0.031	-0.189*	-0.172*	-0.051
5. School closure	0.447**	0.096	-0.144	0.319**	1	0.230**	-0.077	-0.212*	0.154	-0.020	-0.078	-0.040
6. Personal socioeconomic	0.245**	0.191*	-0.014	0.111	0.230**	1	0.290**	0.174*	0.207*	0.147	0.004	-0.036
7. General socioeconomic	-0.022	0.102	-0.066	0.007	-0.077	0.290**	1	0.171*	0.064	-0.024	0.108	0.068
8. Positive benefits	-0.149	-0.067	0.312**	-0.096	-0.212*	0.174*	0.171*	1	0.103	-0.045	0.148	-0.153
9. Recommendations	0.053	-0.292**	-0.165*	-0.031	0.154	0.207*	0.064	0.103	1	0.087	-0.030	-0.176*
10. Virtual appraisal	-0.018	0.053	-0.112	-0.189*	-0.020	0.147	-0.024	-0.045	0.087	1	-0.073	0.344**
11. Age	-0.102	0.138	0.189*	-0.172*	-0.078	0.004	0.108	0.148	-0.030	-0.073	1	-0.029
12. Gender	-0.117	0.109	-0.135	-0.051	-0.040	-0.036	0.068	-0.153	-0.176*	0.344**	-0.029	1

Note. *p<0.05, **p<0.01, ***p<0.001

To highlight some of these results, psychological distress was correlated with worries about personal socioeconomic status as well as increased substance use, social distress and a negative impact of school closures. Those experiencing negative social impacts were also

negatively impacted by the learning environment, tended to negatively appraise virtual activities and be of a younger age. Higher distress because of school closures was also related to worries about personal socioeconomic status and lower endorsement rates of positive benefits. People who endorsed positive benefits adopted a healthier diet and exercise regimes, but were more worried about personal and societal socioeconomic problems. Personal and general socioeconomic worries were inter-related, but personal socioeconomic worries were more often related to other determinants. Note that positive benefits had no relationship with mental health. Those who followed recommendations were less at risk for increased substance use, but tended to disagree that their diet and exercise had improved. Those who followed recommendations were more worried about their own employment and tended to be female.

Regression analysis

A hierarchical multiple regression analysis was run wherein psychological distress was used as an outcome. Correlation analyses revealed four factors that were significantly correlated with psychological distress: substance use, school closure distress, social distress, and personal socioeconomic worries. These were entered in as predictors in the regression. The correlation analyses showed that the other factors were not correlated with psychological distress, but these factors were correlated among themselves and with predictors. For example, age was not correlated with psychological distress, but was correlated with social distress. Therefore after having noticed that factors such as age could act as confounding factors, we decided to enter them in as controls. All four predictors were significant determinants of psychological distress independently of controls. The model explained 41% of variance in psychological distress (R^2). Curiously diet and exercise appeared to be significantly related to mental health but only in the second step of the regression. Note that the first step of the regression which included control variables did not reach statistical significance (table 3).

Table 3
Determinants of Psychological Distress: Hierarchical Multiple Regression

Step		B	SE	β	t	p	*F*(df), *p*
1	Constant	4.532	0.920		4.928	0.000	*F*(7,140)=1.425, *p*=0.200
	Age	-0.014	0.024	-0.051	-0.586	0.559	
	Sex	-0.351	0.222	-0.148	-1.580	0.117	
	General socioeconomic	0.015	0.109	0.012	0.138	0.891	
	Recommendations	0.067	0.127	0.047	0.528	0.598	
	Positive benefits	-0.122	0.109	-0.103	-1.117	0.266	
	Diet and exercise	-0.143	0.088	-0.152	-1.622	0.107	
	Virtual appraisal	-0.030	0.096	-0.029	-0.315	0.753	
2	Constant	1.001	0.862		1.162	0.248	*F*(11,140)=8.293, *p*<0.001
	Age	-0.001	0.020	-0.002	-0.031	0.976	
	Sex	-0.287	0.180	-0.121	-1.597	0.113	
	General socioeconomic	-0.062	0.092	-0.049	-0.674	0.502	
	Recommendations	0.093	0.111	0.066	0.843	0.401	
	Positive benefits	-0.013	0.091	-0.011	-0.140	0.889	
	Diet and exercise	-0.182	0.072	-0.194	-2.515	0.013	
	Virtual appraisal	-0.005	0.080	-0.005	-0.067	0.946	
	School closure	0.242	0.075	0.249	3.225	0.002	
	Personal socioeconomic	0.162	0.083	0.151	1.946	0.054	
	Social distress	0.375	0.084	0.338	4.479	0.000	
	Substance use	0.295	0.101	0.220	2.918	0.004	

Discussion

Distress among University students

As COVID-19 runs rampant around the world, Uruguay is an epidemiological exception with low infection rates and death. Nevertheless we found a high prevalence of psychological distress among young people. 38-66% of students had experienced increased stress, anxiety, difficulty concentrating, sadness, loneliness, hopelessness, helplessness or sleep issues. Unfortunately this downturn in mental health converges with a growing body of extent literature (e.g. Solomou & Constantinidou, 2020). Mental distress in response to the pandemic needs to be normalized and policies need to provide care for the students who are suffering (Holmes et al., 2020). For example, we could be administering screening tests for substance abuse, anxiety and depression to identify at risk students and direct them to available mental health services. COVID-19 focused support or therapy groups can be effective and have the added benefit of fostering social bonds (Marmarosh et al., 2020). With the current regulations in Uruguay, these could be done online or in person and health care providers generally cover psychological care.

We found that the collateral psychological damage among Uruguayan students mainly resulted from four factors including closures of schools, social distress and personal worries about economic downturn. Increased substance use was the fourth factor associated with psychological distress and at least one in ten students reported consuming more alcohol or cannabis. Research on pandemic related changes in levels of substance use is inconsistent. For example, some found that harmful alcohol use decreased probably because students could not go out to bars or parties (Callinan et al., 2020), but others reported that substance use

increased because people were turning to substances to cope with boredom, loneliness and distress (Vanderbruggen et al., 2020). Even if we might find a net decrease in the prevalence of substance use because of closures, those who are coping with negative affect by means of substance use are the most at risk for abuse (Kuntsche et al., 2005). The other health behavior we measured was diet and exercise which was not correlated with substance use nor with psychological distress. However, when we ran the regression analysis, the diet and exercise scale showed up as a significant predictor in the second step suggesting that the relationship between these factors and psychological distress could be complex or conditional. More research would be merited on these inter-relationships because of the implication they could have for public policy and communication.

Social distress was the factor the most strongly related to psychological distress. Most students reported a downturn in their social lives, feelings of isolation and that they missed doing activities with people. These changes in social dynamics are observed worldwide with decreases in shared activities and increases in feelings of isolation (e.g. Ammar et al., 2020). Technological solutions have become the new "oxygen" in social contact (Venkatesh, 2020) but not all people find this acceptable. For most students, virtual platforms were not sufficient in fulfilling their social needs. Furthermore, one in five students reported they simply did not like computers and screens which in context becomes a real issue. We found that those who enjoyed virtual worlds were more often male and experienced less social distress. As we were the first to our knowledge to investigate distaste for virtual worlds as a predictor for social distress, more research could be conducted on the topic.

In another virtual shift, in person classes at the university were suspended and replaced with online classes. One might think that students prefer learning from the comfort of their own home and wonder if virtual learning is here to stay, but we found that seven out of 10 students wanted to go back to class. Importantly students reported that their learning was negatively impacted by the switch. They were having trouble maintaining motivation and concentration on school work. This converges with findings about the negative impact of the pandemic on learning among undergraduates (Kecojevic et al., 2020). Professors should be aware of the negative impacts and attempt to make classes more engaging. Another interesting line of research could investigate the negative impact of virtual platforms on teachers' levels of motivation or well-being.

Though most students were worried about general socioeconomic welfare (economy, social system, industries), it was only when these issues became personal that they negatively impacted mental health. About 70% of students were now more worried about their entire career and about half were worried about their finances and employment. Studies suggest that young people now feel like it is impossible to plan for the future and many are considering alternative paths in light of current events (American Psychological Association, 2020). Researchers have found that COVID-19 induced financial issues rendered populations vulnerable to psychological distress (e.g. Kecojevic et al., 2020). The negative socio-economic impact of COVID-19 on young peoples' lives needs to be focal when considering the damage done by the pandemic and drafting policy (VanderWeele, 2020).

Sex, age, general economic worries, finding positive benefits, diet and exercise, and the student's appraisal of virtual activities were not correlated with psychological distress but

were correlated together in some instances. This list of factors could point to some dead ends in terms of mental health care or to more complex conditional relationships that merit further investigation. For example, we found no relationship between psychological distresses and benefit finding. Positive psychology suggests that mental health distress should be curbed by feelings of gratitude, positive growth and acts of interpersonal kindness. However in the wake the pandemic, the term "toxic positivity" is gaining popularity and refers to the denial or minimization of understandable responses to real negative events (Chiu, 2020; Kecojevic et al., 2020). We found that positive benefit finding was related to improved diet and exercise as well as less of a negative impact of school closures, but also to more worries about personal and societal economic issues. A study found that gratitude was unrelated to psychological distress but gratitude lessened the negative impact of the pandemic on academic outcomes (Bono et al., 2020). It would be beneficial to conduct more research on effectiveness or potential harm of public communications encouraging positive psychology techniques as coping mechanisms in the context of the pandemic.

On a positive note, a majority of students were adhering to government regulations and recommendations without these being enforced by law. Students did not report a high level of vulnerability in terms of pre-existing conditions or contact with infected people. For some students, COVID-19 had a positive rather than negative impact. In fact, one in ten students "loved" the impact that COVID-19 had on their lives. 38% of students reported no negative effects on their learning, 19% did not want to go back to class, and 29% said virtual contact was sufficient for their social needs. About one in five were eating healthier or exercising more, and one in three endorsed positive personal growth, increased kindness or benefiting from having more free time. We found that an impressive 69% of students were now more grateful for what they had. Students might feel grateful because they realize that Uruguay is doing relatively well or maybe people are feeling more grateful world-wide because of a newfound appreciation for basic activities that were taken for granted beforehand (e.g. sitting outside). Nevertheless, even if some students have experienced benefits or little psychological damage, we mainly need to adjust policy to take care of the large proportions of the students who are hurting on various psychosocial levels in response to the global tragedy.

Limitations

This study was limited by the cross sectional design and self-report measures. We asked students if they followed government regulations but did not assess knowledge of government regulations. The data collection period spanned a time when government regulations were changing which created contextual heterogeneity. We created a questionnaire specifically for the purposes of this study and verified some psychometric properties, but further validation and adjustment would be merited.

Conclusions and implications

Government recommendations and regulations have been effective in lowering the spread COVID-19 and death toll notably among elderly populations. These recommendations can contribute to keeping people safe physically but do come at a cost. We drew focus to collateral damage among university students in terms of social, psychological, economic and academic well-fare. We found that university students were a vulnerable population in these

respects. Researchers should focus immediately on the toll COVID-19 has taken on mental health and policy makers ought to take action to protect student populations with psychosocial vulnerabilities.

Conflict of interest: The authors have no conflict of interest to declare.

References

American Psychological Association. (2020). Stress in AmericaTM 2020: A National Mental Health Crisis. https://www.apa.org/news/press/releases/stress/2020/report-october

Ammar, A., Chtourou, H., Boukhris, O., Trabelsi, K., Masmoudi, L., Brach, M., Bouaziz, B., Bentlage, E., How, D., Ahmed, M., Mueller, P., Mueller, N., Hsouna, H., Aloui, A., Hammouda, O., Paineiras-Domingos, L. L., Braakman-Jansen, A., Wrede, C., Bastoni, S., … on behalf of the ECLB-COVID19 Consortium. (2020). COVID-19 Home Confinement Negatively Impacts Social Participation and Life Satisfaction: A Worldwide Multicenter Study. International Journal of Environmental Research and Public Health, 17(17), 6237. https://doi.org/10.3390/ijerph17176237

Bono, G., Reil, K., & Hescox, J. (2020). Stress and wellbeing in urban college students in the U.S. during the COVID-19 pandemic: Can grit and gratitude help? International Journal of Wellbeing, 10(3), Article 3. https://www.internationaljournalofwellbeing.org/index.php/ijow/article/view/1331

Callinan, S., Smit, K., Mojica-Perez, Y., D'Aquino, S., Moore, D., & Kuntsche, E. (2020). Shifts in alcohol consumption during the COVID-19 pandemic: Early indications from Australia. Addiction. https://doi.org/10.1111/add.15275

Cao, W., Fang, Z., Hou, G., Han, M., Xu, X., Dong, J., & Zheng, J. (2020). The psychological impact of the COVID-19 epidemic on college students in China. Psychiatry Research, 287, 112934. https://doi.org/10.1016/j.psychres.2020.112934

Chiu, A. (2020, August 19). Time to ditch 'toxic positivity,' experts say: 'It's okay not to be okay.' Washington Post. https://www.washingtonpost.com/lifestyle/wellness/toxic-positivity-mental-health-covid/2020/08/19/5dff8d16-e0c8-11ea-8181-606e603bb1c4_story.html

Herrero, A. (2020, April 15). El desafío del gobierno entre el mensaje de quedarse en casa y la gente que empieza a salir. El Observador. https://www.elobservador.com.uy/nota/el-desafio-del-gobierno-entre-el-mensaje-de-quedarse-en-casa-y-la-gente-que-empieza-a-salir-202041421110

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., Ballard, C., Christensen, H., Cohen Silver, R., Everall, I., Ford, T., John, A., Kabir, T., King, K., Madan, I., Michie, S., Przybylski, A. K., Shafran, R., Sweeney, A., … Bullmore, E. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: A call for action for mental health science. The Lancet Psychiatry, 7(6), 547–560. https://doi.org/10.1016/S2215-0366(20)30168-1

Huang, Y., & Zhao, N. (2020). Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 outbreak in China: A web-based cross-sectional survey. Psychiatry Research, 288, 112954. https://doi.org/10.1016/j.psychres.2020.112954

Kecojevic, A., Basch, C. H., Sullivan, M., & Davi, N. K. (2020). The impact of the COVID-19 epidemic on mental health of undergraduate students in New Jersey, cross-sectional study. PLOS ONE, 15(9), e0239696. https://doi.org/10.1371/journal.pone.0239696

Knell, G., Robertson, M. C., Dooley, E. E., Burford, K., & Mendez, K. S. (2020). Health Behavior Changes During COVID-19 Pandemic and Subsequent "Stay-at-Home" Orders. International Journal of Environmental Research and Public Health, 17(17), 6268. https://doi.org/10.3390/ijerph17176268

Kuntsche, E., Knibbe, R., Gmel, G., & Engels, R. (2005). Why do young people drink? A review of drinking motives. Clinical Psychology Review, 25(7), 841–861. https://doi.org/10.1016/j.cpr.2005.06.002

Marmarosh, C., Forsyth, D., Strauss, B., & Burlingame, G. (2020). The Psychology of the COVID-19 Pandemic: A Group-Level Perspective. Group Dynamics: Theory, Research, and Practice, 24(3), 122–138. https://doi.org/10.1037/gdn0000142

Omori, R., Matsuyama, R., & Nakata, Y. (2020). The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age. Scientific Reports, 10(1), 16642. https://doi.org/10.1038/s41598-020-73777-8

Prasad Singh, J., Sewda, A., & Shiv, D. G. (2020). Assessing the Knowledge, Attitude and Practices of Students Regarding the COVID-19 Pandemic. Journal of Health Management, 22(2), 281–290. https://doi.org/10.1177/0972063420935669

Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., Mohammadi, M., Rasoulpoor, S., & Khaledi-Paveh, B. (2020). Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. Globalization and Health, 16(1), 57. https://doi.org/10.1186/s12992-020-00589-w

Solomou, I., & Constantinidou, F. (2020). Prevalence and Predictors of Anxiety and Depression Symptoms during the COVID-19 Pandemic and Compliance with Precautionary Measures: Age and Sex Matter. International Journal of Environmental Research and Public Health, 17(14), 4924. https://doi.org/10.3390/ijerph17144924

Vanderbruggen, N., Matthys, F., Laere, S. V., Zeeuws, D., Santermans, L., Ameele, S. V. den, & Crunelle, C. L. (2020). Self-Reported Alcohol, Tobacco, and Cannabis Use during COVID-19 Lockdown Measures: Results from a Web-Based Survey. European Addiction Research, 26(6), 309–315. https://doi.org/10.1159/000510822

VanderWeele, T. J. (2020). Challenges Estimating Total Lives Lost in COVID-19 Decisions: Consideration of Mortality Related to Unemployment, Social Isolation, and Depression. JAMA, 324(5), 445. https://doi.org/10.1001/jama.2020.12187

Venkatesh, V. (2020). Impacts of COVID-19: A research agenda to support people in their fight. International Journal of Information Management, 55, 102197. https://doi.org/10.1016/j.ijinfomgt.2020.102197

World Health Organization. (2020, October 21). WHO Coronavirus Disease (COVID-19) Dashboard. https://covid19.who.int

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SOCIODEMOGRAPHIC CHARACTERISTICS AND PSYCHOPATHOLOGICAL SYMPTOMS OF PATIENTS SEEN BY CLINICAL PSYCHOLOGY IN PRIMARY CARE: A DESCRIPTIVE STUDY

Ana Isabel Burguillos Peña
Psychology (Spain)
anaisabel.burguillos@gmail.com -https://orcid.org/0000-0002-6532-9048

Summary. The aim of the study is to evaluate the formal aspects of the psychological intervention and the sociodemographic characteristics of the referred patients. Methodology. Descriptive study of patients referred by their primary care physician to Clinical Psychology for the presence of psychopathological symptoms. Information was collected by means of a clinical interview, a questionnaire for sociodemographic variables and ad hoc clinical aspects, and the GHQ-28 general health questionnaire. The population served was 123 patients, with a total of 95 women. Results. The most common reason for referral was life situations that decompensated their psychological state (51.2%). A total of 29.3% of patients attended Clinical Psychology with psychopharmacological treatment prescribed by their primary care physician. The range of sessions ranged from 1 to 12, with a sample mean of two. The intervention by Clinical Psychology favors that during an average of 2.3 sessions, 30.9% of patients were discharged due to improvement and 13.8% are still in follow-up, being relevant that only 8.9% of patients were referred to the second level of specialized care, thus reducing the care burden in this one. 21.1% of the patients showed psychopathological symptoms acutely (last month) and 30.1% chronically. The latter data were statistically significant only in relation to mental health history, the use of psychotropic drugs and evolution during the intervention. Discussion. Psychological intervention in a few sessions provides a better psychological adjustment and avoids the chronification of psychopathology.

Keywords: Clinical Psychology; Primary Care; Mental Health; Mental Health

CARACTERÍSTICAS SOCIODEMOGRÁFICAS Y SÍNTOMAS PSICOPATOLÓGICOS DE PACIENTES ATENDIDOS POR PSICOLOGÍA CLÍNICA EN ATENCIÓN PRIMARIA: UN ESTUDIO DESCRIPTIVO

Resumen. El objetivo del estudio consiste en evaluar los aspectos formales de la intervención psicológica y las características sociodemográficas de los pacientes derivados. Metodología. Estudio descriptivo de pacientes derivados por su médico de atención primaria a Psicología Clínica por considerar la presencia de síntomas psicopatológicos. La recogida de información se llevó a cabo mediante entrevista clínica, un cuestionario para variables sociodemográficas y aspectos clínicos ad hoc, y el cuestionario de salud general GHQ-28. La población atendida fueron 123 pacientes, habiendo un total de 95 mujeres. Resultados. El motivo de derivación más común fueron situaciones vitales que descompensaron su estado psicológico (51,2%). Un total de 29,3% de pacientes acudían a Psicología Clínica con tratamiento psicofarmacológico prescrito por su médico de atención primaria. El rango de sesiones osciló entre 1 y 12, siendo la media de la muestra de dos. La intervención por Psicología Clínica favorece que durante una media de 2,3 sesiones se produjesen un 30,9% de altas por mejoría y un 13,8% siguen en seguimiento, siendo relevante que sólo un 8,9% de pacientes fuese derivado al segundo nivel de atención especializada, reduciendo así la carga asistencial en éste. El 21,1% de los pacientes mostraban síntomas psicopatológicos de forma aguda (último mes) y un 30,1% de manera crónica. Estos últimos datos sólo fueron estadísticamente significativos en relación con los antecedentes en salud mental, a la toma de psicofármacos y a la evolución durante la intervención. Discusión. La intervención psicológica en pocas sesiones proporciona un mejor ajuste psicológico y evita la cronificación de la psicopatología.

Palabras Clave: Psicología Clínica; Atención Primaria; Salud Mental

Introduction

The General Council of Clinical Psychology shows a prevalence of around 25-55% of consultations related to a mental disorder in Primary Care (PC), 80% of which are of mild to moderate severity, in the form of anxiety or depressive states. Around 10% are referred from PC to specialized care, with the remaining percentage falling on primary care physicians (PCPs) (Prado-Abril, 2016).

This situation has led to an approach in which specialized care (SC) has been given preference to patients with moderate to severe mental health pathologies, leaving the rest, a large volume of patients with mild symptomatology, oversaturating primary care staff. This means that, in order to provide a rapid and effective response to the population, in accordance with health criteria and following clinical practice guidelines, the MAPs need to resort to drugs, which means more expense for the health system and chronifies the pathology, without previously offering the possibility of a specialized psychological intervention (WHO, WONCA, 2008).

Mental health units could run the risk of becoming increasingly overcrowded if clear criteria for referral to a second level are not established. The figure of the Clinical Psychologist in Primary Care could reduce this saturation by taking on patients with mild or moderate affective symptomatology that until now has been assumed by the MAP or referred to the second level.

The oversaturation of mental health units has led to the optimization of resources and to consider the inclusion of the clinical psychologist in PC (Consejo General de Psicología Clínica, 2017). Also relevant is the need to maintain coordination between both levels, PC and specialized care, in order to analyze referrals or to strengthen specialized follow-up and thus prevent the patient from returning to PC without resolution of the condition (Gálvez-Llompart et al., 2021). It is worth mentioning that the organizational and functional deficiencies of the National Health System partly hinder

cooperation between the different levels of health care, causing problems in the balance of the health care burden between devices (Moreno and Moriana, 2012).

Internationally and nationally, the implementation of coordination programs between mental health units and PA for intervention with people with a mental disorder is increasingly being carried out. In the UK, the "Improving Access to Psychological Therapies" program was implemented incorporating clinical psychologists in PA services, showing long-term recovery outcomes of 50.9-66.6% (Community & Mental Health team, NHS, 2017).

At the national level, we find the pioneering study by Cano Vindel with the PsiCAP project, which analyzes the implementation of psychological care in PC, showing that psychological treatment is up to three times more effective than the usual treatment in PC (pharmacological, MAP care) for anxiety disorders, depression and somatization (Plataforma APPI. PsiCAP, 2017).

An increasing number of primary care centers, in coordination with mental health units, are establishing a project for the inclusion of clinical psychology in PC, as can be seen in the evidence collected in this section. The projects that have been developed have favored positive results in terms of the effectiveness of early psychological intervention in primary care, thus avoiding the collapse of mental health units, the chronification of disorders, or the overmedicalization of patients with mild or moderate psychopathology (APPI Platform. PsicAP, 2017; Alonso et al., 2019).

PC bears more than 50% of the burden of mental disorders, the most common being those related to anxiety, depression and somatization (49.2%). Two out of three patients are treated by the PC physician, usually with drugs, with a low rate of remission and frequent relapses. In the British initiative, a greater efficacy of the application of cognitive-behavioral interventions performed by the Clinical Psychologist in PA was appreciated, following the recommendations of the NICE guideline (Infocop, 2019).

Psychological intervention in PA using behavioral activation or cognitive-behavioral interventions for depression produced improvements in symptomatology, had longer-lasting effects than with psychotropic drugs, and were better regarded by patients (Cuijpers, Quero, Dowrick, & Arroll, 2019).

The inclusion of specialized psychological care in PC is an act of quaternary prevention, limiting unnecessary or excessive activity of the health system. In this way, not every human suffering is turned into a pathology, with the clinical psychologist having the role of pointing out functional coping strategies or reinforcing certain behaviors (Alonso et al., 2019).

In Retolaza's study, an analysis of the most prevalent psychiatric disorders in PC was carried out using questionnaires such as Goldberg's GHQ-28 General Health Questionnaire and the Current State Examination (PSE) on a sample of about 500 patients, highlighting the diagnostic limitations in PC and concluding the need to establish a set of standardized measures to be used as a way of measuring psychopathology in PC (Retolaza, Márquez and Ballesteros, 1995). There are many studies that highlight the most prevalent disorders treated in PC, one of the most frequent being depression. A

meta-analysis of 41 studies from different countries showed that the prevalence of depression in PA was 19.5% (Retolaza, 1993).

Emotional disorders account for two thirds of the most frequent diagnoses of mental disorders seen in PC and in which there is an association between stress and negative emotionality. The most common treatment is pharmacological, not adequate to the mild symptomatology or adjusted to the criteria of clinical practice guidelines, with greater relapses and a tendency to become chronic (Cano Vindel, 2011a; 2011b). Villalva and Caballero (2006) report that antidepressant treatment in PC is started in 76% of cases, the rest being referred to Mental Health; 32% of patients abandon treatment before recovery, the most cited cause of abandonment (88%) being the patient's perception of not needing to continue with treatment.

It is indicative that patients with depression may become frequent visitors to health centers, suffering from different pathologies, somatizations or a diversity of non-specific symptoms, which, if properly evaluated, would fall into the category of depressive disorder, and therefore would require specialized care (Dowrick, Bellón, & Gómez, 2000; Mitchell, Vaze, & Rao, 2009; Cano-Vindel et al., 2012).

Several experiences are being collected in Spain on the characteristics of the population that is referred to Clinical Psychology in health centers. The most relevant diagnoses were depressive disorders, anxiety disorders, adaptive disorders and Z codes (factors influencing health status and contact with health services). Standardized measures are used to evaluate the effectiveness of the intervention, showing improvements in an average of three sessions, thus appreciating an effectiveness in the comprehensive application of the biopsychosocial model by including the clinical psychologist in PA (Gutiérrez-López, 2020; Sánchez-Reales, 2015).

Primary Care (PC) is the first level of the healthcare system accessed by people with various psychological and/or somatic complaints. It is the staff representing this institution who must respond to this discomfort, either by assuming the care of the person themselves or by knowing the different services to which to refer for more specialized care. It coordinates with specialized care services and other services in order to respond to the problems posed by the population. They exercise a vertebral function in the health institution, being responsible for the supervision and integral continuity of care to the population under the paradigm of the biopsychosocial model.

The present study presents the first results obtained by the author during the rotation at a Primary Care Center during the PIR (Psychologist in Residence) training. The health center where this experience took place employs about twenty doctors and another twenty nurses, a social worker, auxiliary and administrative personnel, orderlies, cleaning and service personnel. During the first month of rotation, the resident contemplated the doctor-patient relationship, learning about the disease process and its approach from the primary care point of view. Once the rotation was completed, psychological care continued during the "continuous care" period of the training, two afternoons a week, attending a total of eight patients a week. Therefore, the data collection period was about 15 months, located between the last quarter of 2019 until December 2021.

The psychological intervention carried out with the patients followed the cognitive-behavioral paradigm, with cognitive techniques as a means of identifying and questioning the most frequent cognitive distortions in the disorders treated, and behavioral techniques to improve coping with symptoms and the ability to adapt to them. In general, the therapeutic process has always started with psychoeducational tools and the reduction of physiological activation, so that with lower levels of anxiety or dysphoria, cognitive or behavioral techniques could be introduced to manage the symptomatology. In all cases, in the first consultation, once the reason for concern was exposed, a functional analysis was returned with hypotheses about the symptomatology and, from there, psychoeducation was connected. The intervention had a limit of about eight sessions, and in specific cases it could be longer.

Method

Objectives

The main objective of the study is to describe the sample of patients referred by primary care physicians to Clinical Psychology, a pioneer study in Huelva capital and province, in order to assess the sociodemographic characteristics, health status and the most prevalent type of mental pathology in Primary Care. The specific objectives proposed in this study are as follows:

- To study the reasons for referral from the primary care physician to clinical psychology at the health center.
- Analyze the number of patients referred to Clinical Psychology.
- To assess the number of patients who are referred to Clinical Psychology and who are previously medicated with psychotropic drugs.
- To study the sociodemographic characteristics of patients referred to Clinical Psychology.
- Check general health status prior to psychological intervention at the health center.
- Analyze the number of psychological intervention sessions needed to successfully complete a treatment.
- To assess the follow-up of referred patients and to study the number of discharges due to clinical improvement and the number of dropouts.

The hypotheses put forward in this study are as follows:

- The number of referrals of patients with psychopathological symptoms to a second level of specialized care (USMC) will be reduced with the intervention of the Clinical Psychologist in primary care.
- Patients referred by primary care physicians to Clinical Psychology at the health center will have an affective psychopathological diagnosis of mild and/or moderate severity.
- Patients will need an average of eight sessions to be discharged from Clinical Psychology.

Design and Procedure

The Clinical Psychology intervention began with an information session with the medical team, reaching a consensus and establishing the criteria for referral to the PIR. Referrals from professionals were channeled through the rotation's MAP tutor. Even so, in more complex cases, a prior meeting was held between the referring MAP and the PIR to determine whether the referral was appropriate, the type of intervention that could be

provided or whether the patient should be referred to the second level. The criteria for referral from the MAP to the (resident internal psychologist) PIR are reflected in Table 1.

Table 1

Referral and exclusion criteria

Inclusion	Anxiety disorders Mood disorders (mild, moderate) Adaptive disorders
Exclusion	Personality disorders Substance use disorders Current assistance by Mental Health or other specialized services, public or private Recent admissions to Psychiatric Inpatient Unit

The MAP referral was agreed with the patient in his or her consultation. The physician indicated on a printed "Consultation follow-up sheet" the patient's personal data, the most relevant physical data and briefly the reason for referral. The referral was transferred to the PIR who proceeded to assess the physician's request. The analysis of the demand assessed the urgency of the case, whether it met the requirements for care at the Health Center, whether it corresponded to referral to a second level of specialized care or the criteria for urgency. If it did not meet the requirements, the PIR met with the corresponding MAP or provided a report with the result of the demand analysis, the reason for non-compliance and an alternative care for the patient. If the request was accepted, the patient was contacted and an appointment was made (see Table *2*).

Table 2

Intervention conditions

MAP Demand	*Informs the patient of the existence of the Clinical Psychology Unit and shows the need for referral.* *He/she makes a "consultation follow-up sheet" where he/she specifies the contact data, initial diagnosis, brief reason for referral and current pharmacological treatment.*
Previous contact	This was done by telephone where she introduced herself as the Resident Psychologist of the health center, informing her of the receipt of the referral form by her MAP. He was asked if he agreed to make an appointment. The framework was established, informing them of the conditions of the appointments, absences, the form of contact with the center, the day of clinical attention and the schedules.
Inquiries	First consultations: if they did not attend the first consultation, they were discharged for non-appearance, leaving a printed sheet to their MAP for information purposes. Similarly, if the patient was called twice and did not answer, the same procedure was followed. If you would like to return for an appointment in Clinical Psychology, you would have to return to your MAP to request it. Check-ups: if they did not attend two check-ups, they were discharged for non-appearance. If, during the intervention, a patient was referred to the second level, the intervention was stopped, leaving a "consultation follow-up sheet" with the most relevant data of the therapeutic process with his or her MAP.
Number of sessions	A maximum of 8 individual sessions were offered. If there was no clinical improvement, the patient was referred to the second level.

Duration sessions	*of*	First consultations: 1h Revisions: 45 min
Frequency sessions	*of*	Biweekly.

A morning clinical schedule was established, four days a week, with a maximum of five patients per day. Upon completion of the rotation period established in the PIR program, clinical care has been continued in the same manner in the afternoons, two days a week, from October 2019 through December 2021. During this time, the Clinical Psychology Unit attended to a maximum of eight patients per week during two afternoons. During this period of time there has been a critical situation that we have to point out as a possible interference in the beginning of this Unit, which is the pandemic by COVID-19, where this attention has been prioritized, where the consultations were telematic and the requests for referral to Psychology decreased considerably, to later increase again once the face-to-face consultations were resumed.

Population

The study population consists of 123 patients from the same Primary Care Center, seen by a PIR during 2019, 2020 and 2021. These patients were referred by their Primary Care Physicians upon detecting symptoms of origin to receive psychological intervention instead of direct referral to a second level of specialized care (Community Mental Health Unit). Of the 123 patients assigned to a PIR, 30 patients did not attend the first consultation, so 93 patients will be assessed in some of the results.

Variables and Instruments

- *Information and informed consent form*. It is administered by the psychologist at the first consultation.
- *Clinical interview*: an open interview is conducted to collect sociodemographic and autobiographical data, personal and family psychiatric history, the reason for consultation, previous mental health experiences and expectations for the current intervention.
- *Goldberg and Hilier's* (1979)*GHQ-28 general health questionnaire* : is a questionnaire validated and adapted to the Spanish population by Lobo and Echevarría and Artal (1986). It shows high reliability, with a Cronbach's alpha of 0.97 (Godoy-Izquierdo, Godoy, López-Torrecillas and Sánchez-Barrera, 2002). It is self-administered and has 28 items that are answered with a Likert scale from 0 to 3 points. They assess the perception of health as for example in this item "*Have you felt exhausted and without strength at all?*" The questionnaire provides an overall score and a score for each of the four subscales: A (somatic symptoms), B (anxiety and insomnia), C (social dysfunction) and D (severe depression). It is also possible to obtain data on the chronification of symptomatology and to detect cases of acute onset (non-case/case score): 5/6) or chronic (non-case/case score: 12/13).
- *Ad-Hoc questionnaire of sociodemographic variables and clinical aspects*: collects data such as age, gender, marital status, employment status, academic level, reason for referral to clinical psychology, total number of sessions attended, ~~number of sessions of psychological intervention~~, diagnosis and mental health history (including previous and current pharmacological treatment).

Data analysis

An analysis of sociodemographic, clinical and evolution variables of psychological intervention in primary care was carried out using the SPSS version 25.0 statistical package. Descriptive statistical analyses were performed on variables such as: age, gender, marital status, academic level, employment status, reason for referral, mental health history, previous and current pharmacological treatment, number of sessions, type of patient evolution, diagnosis and data from the GHQ-28 questionnaire. Likewise, statistical tests such as *Chi-Square* (X^2) were performed to contrast the data of the variables collected and those of the GHQ-28.

Results

Sociodemographic data

The sample of patients seen in Primary Care during 2019, 2020 and 2021 (123 people) has an average age of 47.29 years, with a range between 15 and 83 years. In relation to gender, the sample consisted of 95 women (77.2%) and 28 men (22.8%). Marital status shows the following variability: 54 people with a partner or married (43.9%), 19 single (15.4%), 13 divorced or separated (10.6%) and 7 widowed (5.7%). There are a total of 30 missing values, which are the people in the entire sample who do not attend the first consultation.

The academic level shows a majority of patients with secondary education (40.7%), followed by those with higher education (25.2%) and finally, those with primary education (9.8%).

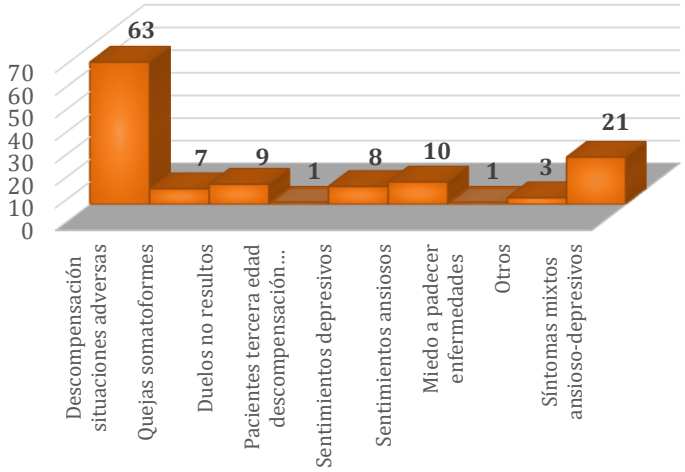
Analysis of employment status indicates that the highest percentage corresponds to patients who are working at the time of clinical care (39%), followed by those who are unemployed (16.3%), retired persons (11.4%), students (8.1%) and, finally, disabled pensioners (0.8%).

Assistance data

The main causes of referral by Primary Care Physicians (PCP) to the Clinical Psychology Unit were collected, categorizing them after data collection into nine categories. *Figure 1* shows the cases or frequency of each of the reasons for referral in the sample of 123 patients, with two of them being the most frequent: "decompensations in the face of stressful life events" with 51.2% and patients with complaints of "mixed anxious-depressive symptoms".

Figure 1

Reasons for referral to Clinical Psychology



This set of data includes both those who have received clinical care and those who did not attend the first consultation, but the reason for referral indicated by their MAP was collected.

As relevant data for the initiation and evolution of the psychological intervention, we considered whether the patients referred by the Primary Care Physicians had previously received psychological care, either privately or publicly, and whether they had been under psychopharmacological treatment or were taking any psychopharmacological treatment at the time of the psychological care. The 30 cases that did not attend the first consultation have been excluded, making a total of 93 cases. Some 33.3% of the patients reported having a history of mental health or having seen a psychologist and/or psychiatrist at some point in their lives. Twenty-six percent of the patients had at some time taken psychopharmacological treatment and 29% attended the first session with a previously prescribed psychopharmacological treatment.

As can be seen, it is revealing that prior to referral to the Clinical Psychology Unit of the Health Center, Primary Care Physicians usually start prescribing antidepressants and/or anxiolytics in a large percentage of cases. Patients presenting with prescribed psychotropic drugs comprised 29.3% (36) of the total 93 cases in psychological treatment. A total of 33.3% (41) of the cases had a public or private mental health background.

This study considers the evolution of patients during psychological intervention, categorizing it into eight possible situations: "discharge due to improvement", "does not go to first consultation", "change of health center or city", "continues in follow-up", "referral to second level USMC", "abandonment", "already goes to USMC", "goes to psychology at private level". This is relevant data for analyzing the therapeutic process and the possible causes of abandonment or successful aspects of the intervention. The 123 cases were taken as a whole, with the highest percentage corresponding to patients who were discharged due to improvement (30.9%), followed by dropouts (21.1%) and those who did not attend the first consultation and therefore did not initiate follow-up in Clinical Psychology (18.7%). 13.8% remain in follow-up. During this period of time, 8.9% of the cases were referred to specialized care (USMC). 4.1% abandoned treatment or did not start because they moved to a different city, Autonomous Community or health center. 1.6% of the patients were attending psychology in a private setting, so the

intervention was completed at the center. And 0.8% were already attending USMC when referred, so the case was not assumed at the center.

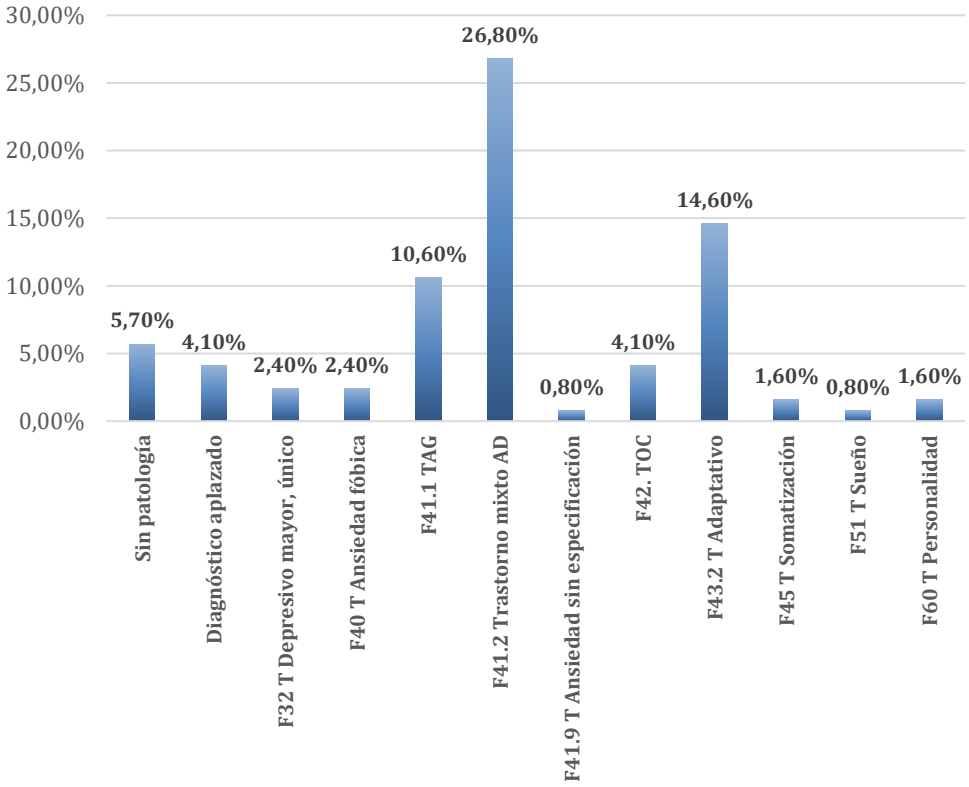
Analysis of the number of sessions in this sample indicates that the most frequent number of sessions was a single session (26.8%), followed by two sessions (22%). There are a total of 5 people who have received between 9 and 12 sessions, for a total of 4%. The average number of sessions is 2.33, with lower and upper limits of 0 and 12, respectively.

The number of sessions is significantly related to patient evolution*(*X^2 = 13.003, *p* = ,043). More patients were discharged for improvement having received less than 5 sessions than those who received more. More cases were also referred in the first sessions and those who dropped out of follow-up did so within the first five sessions.

Finally, one of the most relevant aspects of psychological intervention in primary care is the diagnostic evaluation and application of this type of intervention to emotional disorders of mild to moderate severity. For this purpose, the interventions included the administration of clinical interviews and diagnostic coding according to ICD-10, in addition to assessing affective symptomatology by administering the GHQ-28 questionnaire. The most prevalent disorders in the sample are shown in Figure 2.

Figure 2

Diagnostics



The GHQ-28 questionnaire provides a different score if it is a symptomatology of recent onset or if it is already chronic. Of the 93 patients attended, 90 were taken into account, since three did not answer or stopped attending the sessions and did not provide their answers. The number of acute cases detected by this questionnaire was 64 (52%) while the number of clinical cases of chronic evolution was 53 (43.1%).

The GHQ-28 questionnaire provides an insight into the symptomatology presented by the population seen at the health center during this period of time. The mean of the total scores of the questionnaire is 16.74. The mean of the "somatic symptoms" scores is 6.41, that corresponding to the "anxiety-insomnia" subdimension is 4.74. Finally, the means of the subdimensions "social dysfunction" and "severe depression" are 4.36 and 0.91 respectively.

Contiguity tables were made using the Chi-Square statistic as a contrast criterion for the different sociodemographic and clinical variables and the cases detected by the GHQ-28 (Tables 3 and 4). 21.1% of the patients showed psychopathological symptoms acutely (last month) and 30.1% chronically. The latter data were statistically significant only in relation to mental health history, the use of psychotropic drugs and evolution during the intervention.

Table 3

Chi-Square Chi-Demographic and clinical variables and acute clinical cases detected with the GHQ-28

VARIABLES		VALUES	CHI-SQUARE (SIG.)	*P*
AGE	15-35	14	,664	*p* = ,717
	36-55	28		
	56-90	22		
GENRE	Man	14	,078	*p* = ,781
	Woman	50		
E. CIVIL	Single	13	1,191	*p* = ,755
	Married-Couple	36		
	Divorced	10		
	Widower	4		
EMPLOYMENT STATUS	Unemployed	13	,598	*p* = ,897
	Work	33		
	Retired	11		
	Student	6		
ACADEMIC LEVEL	Primary	8	,766	*p* = ,682
	Secondary	32		
	Superiors	23		
BACKGROUND MENTAL HEALTH	Yes	28	,793	*p* = ,673
	No	36		
PREVIOUS PHARMACOLOGICAL TREATMENT	Yes	24	,680	*p* = ,712
	No	40		
CURRENT PHARMACOLOGICAL TREATMENT	Yes	23	2,4176	*p* = ,337
	No	41		
EVOLUTION	High improvement	33	22,423	*p* = ,001
	Continua	9		
	USMC referral	2		
	Abandonment	18		
	CAP / CAAC change	2		
NUMBER OF SESSIONS	1-5	50	,022	*p* = ,881
	6-14	13		

Table 4

Chi-Square Chi-Demographic and clinical variables and chronic clinical cases detected with the GHQ-28

VARIABLES		VALUES	CHI-SQUARE (SIG.)	*P*
AGE	15-35	16	4,509	*p* = ,105
	36-55	22		
	56-90	15		
GENRE	Man	11	,010	*p* = ,921
	Woman	42		
E. CIVIL	Single	13	3,135	*p* = ,371
	Married-Couple	27		
	Divorced	8		
	Widower	4		
EMPLOYMENT STATUS	Unemployed	9	,976	*p* = ,807
	Work	28		

	Retired	9		
	Student	6		
ACADEMIC LEVEL	Primary	5		
	Secondary	25	4,663	*p* = ,097
	Superiors	22		
BACKGROUND MENTAL HEALTH	Yes	19	6,116	*p* = ,047
	No	34		
PREVIOUS PHARMACOLOGICAL TREATMENT	Yes	17	1,618	*p* = ,445
	No	36		
CURRENT PHARMACOLOGICAL TREATMENT	Yes	15	8,797	*p* = ,012
	No	38		
EVOLUTION	High improvement	32	23,447	*p* = ,001
	Continua	6		
	USMC referral	2		
	Abandonment	11		
	CAP / CAAC change	2		
NUMBER OF SESSIONS	1-5	42	,077	*p* = ,782
	6-14	10		

Discussion and conclusions

This work contemplates an analysis of the project of the inclusion of the Clinical Psychologist in Primary Care in Huelva (capital), as a pilot experience carried out by the figure of the Resident Internal Psychologist and supervised by the superiors of the training and the Primary Care attendants. One of the objectives of the study was to assess the patients referred to Clinical Psychology, to analyze the sociodemographic characteristics of this population and the reasons for referral, as well as the common diagnoses.

In this sense, the population shares characteristics with other ~~populations~~ analyzed in other studies, in terms of sociodemographic or clinical variables such as diagnoses of an affective nature and mild or moderate severity or use of psychopharmacological medication prior to referral to psychology (APPI Platform). PsicAP, 2017; Gutiérrez-López et al., 2020). Analyses on the reasons for referral reflect that the highest percentage of referrals correspond to decompensations and reactions to stressful situations and patients presenting diffuse anxious-depressive symptomatology (WHO WONCA, 2008; Cano-Vindel et al., 2012).

It should be noted that the diagnoses found in this study that appear in the referrals of primary care physicians are, in order of appearance and frequency, those related to anxious-depressive symptomatology, adaptive disorders, anxious disorders and mild depressive disorders, data that are similar to those found in other previous studies; results that are in line with other studies (APPI Platform. PsicAP, 2017, Infocop, 2019).

Likewise, the exploration carried out through the GHQ-28 questionnaire shows symptoms of recent affective character in half of the population studied, being mostly somatic symptoms, anxiety and insomnia and interference in the social sphere, with minimal severe depressive symptoms. These results respond to one of the objectives and hypotheses raised in the present study in relation to the reasons for referral and mild-

moderate affective diagnoses (Cano-Vindel, 2011b; Platafroma APPI. PsicAP, 2017; Sánchez-Reales et al., 2015).

In line with other studies that place women as the population that most demands psychological care and that represents higher percentages of referrals in Primary Care, the present study, in accordance with the objectives of exploring the sociodemographic characteristics, finds a percentage of more than 70% of women attended (APPI Platform). PsicAP, 2017; Sánchez-Reales et al., 2015).

The coordination that occurs when the Clinical Psychologist is included in Primary Care allows the referrals made by the physician to be analyzed and optimized. In relation to the stated objective of assessing whether care at the center would reduce referral to a second level, a reduction in the number of referrals to specialized care has been contemplated, about 8% of the total referred by MAPs coordination with primary care physicians and the subsequent review and analysis of the cases concluded that this minimum percentage had a more severe symptomatology or needed a more extensive treatment by Clinical Psychology to achieve a remission of symptoms (Alonso et al., 2019).

Coordination at the health center itself has allowed a reduction in referrals to specialized care, hence the benefits of incorporating clinical psychology into health centers, assuming the psychological interventions of a large number of patients with mild to moderate symptomatology, and as a consequence, providing a filter function by severity or resources to specialized care, avoiding collapses in the latter. Also, the presence of the Clinical Psychologist in the first link of the health system, in Primary Care, allows the population to reconsider the stigmatization of mental illness and to appreciate psychological interventions as an accessible, necessary and useful tool in their disease process (Gálvez-Llompart et al., 2021; Alonso et al., 2019).

Psychological interventions in primary care have their own characteristics that are different from those of specialized care, both in terms of the techniques used and the time allocated to their administration. Clinical Psychology implements low-intensity psychological interventions aimed at mild or moderate emotional alterations in a limited number of sessions, which in the present study showed an average of 2. The objective of this work was to study the number of sessions required to complete an intervention with clinical improvement, and it is significant that the patients who were discharged due to clinical improvement progressed in less than five sessions, which is congruent with other studies. In addition, discharges due to clinical improvement or remission of the initial symptomatology for which they consulted, comprise the highest percentage in relation to all discharges in the study, being congruent with the efficacy of psychological interventions exposed in previous experiences and studies (Gutiérrez-López et al., 2020; Sánchez-Reales et al., 2015; Infocop, 2019).

One of the objectives of the study was to explore whether patients referred to Clinical Psychology in Primary Care had previous psychopharmacological treatment. A high percentage of patients were found to have already had a first psychopharmacological approach by their MAP, considering the subsequent psychological approach, consistent with previous studies (Sánchez-Reales et al., 2015; Platafroma APPI. PsicAP, 2017; Gutiérrez-López et al., 2020; Villalva and caballero, 2006).

However, more research is needed to overcome the current limitations. For example, there are few studies on the use of a series of instruments that are standardized and can be replicated in clinical psychology studies in primary care (Retolaza et al., 1993). The Goldberg general health questionnaire in its Spanish adaptation has been used in several Spanish clinical samples and in recent years it is being used in samples of patients in health centers (Retolaza et al., 1993). This questionnaire allows to obtain global results of the symptomatology of the patient who is referred to Primary Care, obtaining a screening, to then focus on more specific questionnaires and establish a diagnosis. In the present work it has been possible to detect patients with mild to moderate psychopathology of both acute and chronic onset, being of great utility in the diagnosis and evolution of the patient (Cano-Vindel, 2011a; Retolaza et al., 1993; Mitchell, Vaze and Rao, 2000).

In conclusion, this study highlights some sociodemographic characteristics of patients who are referred by primary care physicians to the Clinical Psychologist, being mostly women, married or in a couple, with secondary education and who are working. The information on the reasons for referral is relevant, with the most important data corresponding to adaptive reactions due to stressful situations or periods of life change. The most frequent diagnoses are mixed anxious-depressive disorders, anxiety disorders and adaptive disorders. On the other hand, it is relevant that the average number of sessions in the whole sample is two, being statistically significant that the discharges due to clinical improvement occur in less than five sessions. The Goldberg general health questionnaire provides data on acute and chronic clinical cases, which are shown to be significantly related to mental health history, pre-intervention psychopharmacological intake or evolution, with the clinical cases detected being those who were taking medication, who had a history and who dropped out more or were under follow-up.

Primary Care, as the first link in the healthcare institution and, therefore, more accessible to the general population, is the one that receives the complaints and demands of the general population. It receives the demand, intervenes, orients, coordinates and refers to other links where specialized care is available. Primary care physicians absorb a large number of psychological problems that sometimes, because of their mild nature or reactive to physical or social circumstances, are not considered to meet the criteria in specialized care. Thus, they take on a large number of psychological problems derived from physical pathologies or that influence the evolution of a pathology treated in the health centers, and therefore provide a comprehensive approach to the patient. However, this high demand for care generates an overcrowding of primary care, an increase in the use of pharmacological resources as a means of alleviating symptoms and a chronification or aggravation of the psychopathological symptomatology.

Therefore, as a result of the general exploration of some variables involved in psychological care in primary care in this study, we may consider that new lines of research are necessary, expanding the number of sociodemographic variables or the type of intervention and the characteristics of the psychological approach, as well as the referral protocols, with the aim of further reducing the number and type of patients referred to a second level. In this way, to further strengthen the criteria for primary care and referral to a second level of specialized care. The improvement of protocols could consider a first psychological approach to patients with mild or moderate symptomatology, prior to the psychopharmacological approach, being able to analyze the economic consequences of a possible reduction in pharmaceutical expenditure.

References

Alonso, R., Lorenzo, L., Flores, I., Martín, J. & García, L. (2019). The clinical psychologist in health centers. A joint work between primary care and mental health. *Primary Care, 51*(5), 310-313. doi: 10.1016/j.aprim.2018.08.012.

Cano-Vindel A. (2011a). Emotional disorders in Primary Care. *Anxiety and Stress, 17,* 73-95.

Cano-Vindel A. (2011b). Theoretical bases and empirical support for psychological intervention on emotional disorders in primary care. An update. *Anxiety and Stress, 17,* 157-184.

Cano-Vindel, A., Salguero, J.M., Mae Wood, C., Dongil, E. & Latorre, J.M. (2012). Depression in primary care: prevalence, diagnosis and treatment. *Papeles del Psicólogo, 33*(1), 2-11.

Community & Mental Health team, NHS Digital. Improving access to psychological therapies (IAPT) (2017). Retrieved from: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports

General Council of Clinical Psychology. More and more Autonomous Communities are joining the demand for psychologists in PC. (2017). Infocop online. Retrieved ~~January 12, 2022~~ from http://www.infocop.es/view article.asp?id= 6563.

Cuijpers, P., Quero, S., Dowrick, C., & Arroll, B. (2019). Psychological Treatment of Depression in Primary Care: Recent Developments. *Current psychiatry reports, 21*(12), 129. doi.org/10.1007/s11920-019-1117-x

Dowrick, C.F., Bellón, J.A. & Gómez, M.J. (2000). GP frequent attendance in Liverpool and Granada: The impact of depressive symptoms. *British Journal of General Practice, 50,* 361-365.

Galvez-Llompart, A.M., Valor Gisbert, M., Perez-Almarcha, M., Ballester-Gracia, I., Canete-Nicolas, C., Reig-Cebria, M.J. & Hernandez-Viadel, M. (2021). Impact on mental health care following collaboration between primary care and mental health, *Family Medicine*. *SEMERGEN*, *47*(6), 385-393. doi.org/10.1016/j.semerg.2021.04.006.

Godoy-Izquierdo, D, Godoy, J.F., López-Torrecillas, F. and Sánchez-Barrera, M.B. (2002). Psychometric properties of the Spanish version of the "Goldberg General Health Questionnaire-28". *Journal of Health Psychology, 14*(1), 49-71.

Gutiérrez López, M.I., López Alonso, N., Alonso Gómez, R. & Veiga Martínez, C. (2020). Clinical Psychology in Primary Care: the experience in Asturias [Psicología Clínica en Atención Primaria: la experiencia en Asturias [Clinical Psychologist in Primary Care: The work carried out in Asturias]. *Semergen, 46*(2), 101-106. doi.org/10.1016/j.semerg.2019.09.002.

Infocop (2019). Proposal to have clinical psychologists in Primary Care in all autonomous communities. Retrieved from https://www.infocop.es/view_article.asp?id=7987

Lobo, A. A., Pérez-Echevarría, J.M. & Artal, J. (1986). "Validity of the scaled version of the General Health Questionnaire (GHQ-28) in a spanish population", *Psychological Medicine, 16,* 135-140.

Mitchell, A.J., Vaze, A. & Rao, S. (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *Lancet, 374,* 609-619.

Moreno, E. & Moriana, J.A. (2012). The treatment of psychological and mental health problems in primary care. *Mental Health, 35,* 315-328.

APPI Platform. PsicAP. Psychological intervention in primary school, more effective than usual treatment. Plata- forma por una Atención Psicológica Pública e Integrada. (2017). Retrieved from: https://plataformaappi.wordpress.com/2017/03/05/psicap- la-intervencion-psicologica-en-primaria-mas-efectiva-que-el- tratamiento-habitual/.

Prado-Abril, J. (2016). Facilitators and barriers of a computer-assisted psychotherapeutic intervention for depression in primary care: a qualitative study (Doctoral dissertation). University of Zaragoza, Zaragoza, Spain. Retrieved from https://zaguan. unizar.es/record/58557/files/TESIS-2017-003.pdf.

Retolaza, A., Mostajo, A., De la Rica, J.R., Días de Garramiola, A., Pérez de Loza, J., Aramberri, I. & Markez, I. (1993). "Validation of the Goldberg General Health Questionnaire (28-item version) in primary care consultations." *Revista de la A.E.N.*, *13*(46), 187-194. Retrieved from http://ww.revistaaen.es/index.php/aen/article/view/15340

Retolaza, A., Márquez, I. & Ballesteros, J. (1995). Prevalence of psychiatric disorders in Primary Care. *Revista Asociación Española de Neuropsiquiatría, 15*(55), 593-608.

Sánchez-Reales, S., Tornero-Gómez, M.J., Martín-Oviedo, P., Redondo-Jiménez, M. & Del-Arco-Jódar, R. (2015). Clinical Psychology in Primary Care: description of one year of attendance. *SEMERGEN - Medicina de Familia*, *41*(5), 254-260. doi.org/10.1016/j.semerg.2014.06.001.

Villalva, E. & Caballero, L. (2006). Study on the use and follow-up of antidepressant treatment by primary care physicians. *SEMERGEN-Medicina de Familia, 32*(9), 427-432. doi.org/10.1016/S1138-3593(06)73310-X

WHO, WONCA. (2008). Integrating mental health into primary care. A global perspective. Retrieved from http://www.who.int/mental health/ resources/mentalhealth PHC 2008.pdf.

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Attitudes towards death in health personnel: intervention proposal

Miguel Basalo de Castro
European University of Madrid (Spain)
miguelrodba@gmail.com - http://orcid.org/0000-0001-5361-5912
Francisco Rivera Rufete
European University of Madrid (Spain)
francisco_rivera_rufete@hotmail.com - http://orcid.org/0000-0001-9372-6502
Jesus Gonzalez Moreno
International University of Valencia (Spain)
jesus.gonzalezm@campusviu.es - http://orcid.org/0000-0002-3968-8864
María Cantero García
International University of Valencia (Spain)
maria.canterogar@gmail.com - http://orcid.org/0000-0002-7716-2257

Summary. This article reviews the attitudes towards death in health professionals. In order to deepen the practical implications of these attitudes, a literature review is carried out. Given the absence of interventions based on promoting resilience, coping strategies and other factors involved in the attitude towards death in this group, we present a program aimed at prevention and promotion of competencies to provide greater well-being and better management of these situations. Among the objectives are: to develop coping strategies to manage the adverse situations that arise when facing death on a daily basis, to facilitate good emotional management and to be able to recover from the impact caused by such situations through compassion, self-compassion, gratitude and guilt management. The program follows an experiential methodology; healthcare professionals are active agents in the process of change, and is accompanied by rigorous implementation and evaluation to analyze the changes that occur as the intervention progresses.

Keywords: Resilience; health care personnel; attitude toward death; coping; compassion; compassion

Actitudes hacia la muerte en el personal sanitario: propuesta de intervención

Resumen. En este artículo se realiza una revisión sobre las actitudes hacia la muerte en el profesional sanitario. Con el objetivo de profundizar en las implicaciones prácticas de dichas actitudes, se realiza un análisis de la literatura. Dada la ausencia de intervenciones basadas en promover la resiliencia, estrategias de afrontamiento y otros factores intervinientes en la actitud hacia la muerte en este colectivo, se presenta un programa destinado a la prevención y la promoción de competencias para proporcionar un mayor bienestar y un mejor manejo de estas situaciones. Entre los objetivos, se proponen: desarrollar estrategias de afrontamiento para gestionar las situaciones adversas que surgen al afrontar la muerte a diario, facilitar una buena gestión emocional y ser capaz de recuperarse del impacto que causan dichas situaciones a través de la compasión, autocompasión, gratitud y manejo de la culpa. El programa sigue una metodología experiencial; los profesionales sanitarios son agentes activos en el proceso de cambio, y se acompaña con una implementación y evaluación rigurosa que permiten analizar los cambios que se producen según se avanza en la intervención.

Palabras Clave: Resiliencia; personal sanitario; actitud hacia la muerte; afrontamiento; compasión

Introduction

The goal of the healthcare provider is to preserve life, care for and accompany the patient, especially those close to death (García-Avendaño et al., 2018) . Thus, death can be seen as a failure, even though it consists of a natural process (Vázquez-García et al., 2019). This highlights that negative attitudes have implications -also negative- in the health care setting(Cara Rodríguez, 2020; Puente-Fernández et al., 2020). These result in avoidance of the patient, delegation of responsibilities and emotional disconnection, and lead to worse care(Puente-Fernandez et al., 2020)this, together with the beliefs of failure, predispose the health worker to suffer compassion fatigue and burnout(Acevedo et al., 2013). Attitudes toward death of the healthcare worker are relevant because they impact their job performance, mental and emotional health (Kagan, 2020). These factors feed back, causing increased anxiety, following Zamora (2018), job dissatisfaction and low mood. However, there are healthcare workers who develop positive attitudes because of protective factors such as beliefs, experience or training (Bayat et al., 2018). These protective factors or coping strategies are related to resilience, this concept being understood as the capacity of human beings to recover from adverse situations and emerge stronger.

The aforementioned aspects motivated the authors to carry out a search on previous interventions on attitudes towards death in health personnel. However, in the literature we found that, although several articles point out the importance of staff training as a preventive factor(Cevik & Kav, 2013), there is a total absence of intervention programs that address the problem we have raised.

This highlights that, although it is known that attitudes towards death can be changed with educational programs, and that such attitudes can translate into better care for patients near death (Chua & Shorey, 2021) greater resilience, self-esteem and lower burnout (Edo-Gual et al., 2015; Guo & Zheng, 2019), no assistance is provided to healthcare personnel to provide them with tools in this direction. Thus, this team considered it important to make up for the absence of current formations. Having reviewed the causes that provoke an unfavorable attitude towards death and towards the last stage in the patient's life, the intervention program would provide a better service

by acting directly with the health personnel and indirectly on the patient. In addition, this program would prevent future difficulties for healthcare personnel in dealing with their palliative patients.

Thus, although the aim of this study was to review the attitudes towards death of health care personnel, as well as their personal and professional implications, and to study the existing interventions in this area, due to the lack of this type of program, it was decided to design an intervention proposal to address them.

Intervention Program on Attitudes Towards Death in Health Care Personnel

This absence, together with the repeated expression of the need for training of healthcare workers, led us to design a model intervention program, called "Intervention Program on Attitudes Towards Death in Healthcare Personnel". In this one, we decided to focus on coping strategies, resilience, compassion and self-compassion, guilt and gratitude, as well as behaviors towards death more explicitly. This is based on the protective factors highlighted in the literature. The program is formulated as a resource that can be accessed both in healthcare and telematically to be able to offer its application in hospitals, health centers, nursing homes or any other center where healthcare tasks are carried out.

Target population

The program is aimed at healthcare professionals who have day-to-day contact with patients in near-death situations and want to improve the way they relate to them, among whom we find prominently physicians from various specialties, such as: palliative care, oncology, geriatrics, internal medicine or primary care, nurses from primary care centers as well as from hospitals and specialty centers, psychologists, etc. These specialties are the target specialties for participation in the intervention program.

Inclusion criteria

1) willing to voluntarily participate in the intervention program,

2) sign consent to participate and perform the pre- and post-intervention evaluation,

3) to work actively in a public or private health center in contact with palliative or chronic patients who are in the last stage of life.

As exclusion criteria, it is established that

1) the participant must be working with completed formal training, excluding those persons who, while undergoing university or vocational training, are in an internship, rotation or performing any academic function in the health center

2) having a score higher than 20 in the items corresponding to the Beck Depression Inventory-II (BDI-II) when considering that the person presents symptoms of moderate or severe depression, and therefore, should be referred to another type of program more suitable to his or her situation.

In this way, it is intended that professionals improve their well-being, self-care and acquire coping tools with which they can relate to death in a healthier way. Ultimately, the aim is to benefit both them directly and the patients they serve indirectly.

Objectives and competencies

During the development of the program, it is intended that the participating health professionals acquire tools to be able to manage stress situations in an adaptive way and work on resilience. Participants will also delve into the concepts of compassion and self-compassion to increase their self-care, as well as manage possible feelings of guilt and coping behaviors towards death in a healthy way. The program will end by working on gratitude both to oneself and to others. In this way, the program not only aims to work on the management of stressful and anxiogenic situations, but also delves into the self-care of the healthcare professional, which influences a better perception of psychological well-being and a better service to the patient.

General objectives

The general objectives of the intervention program are:

- To reduce stress and anxiety in order to increase the well-being of healthcare personnel.
- Increase resilience to adaptively cope with stressful situations.
- Develop compassion and self-compassion for the participant's self-care.
- Manage feelings of guilt in an adaptive way.
- Developing gratitude to foster positive experiences
- Healthy coping with death-related situations.

Specific objectives

The specific objectives covered by the program are:

- To prevent the occurrence of stress and anxiety responses in healthcare personnel exposed to risk factors.
- Identify risk factors and protective factors against stress and anxiety.
- Identify, understand and accept emotions.
- Work on emotional clarity and emotional repair.
- Adaptive coping in threatening and stressful situations, through the qualities of resilient people.
- To know the participant's strengths and areas of development.
- Obtain tools for positive coping, based on emotions and the problem.
- Develop social skills based on assertiveness and emotional social support.
- To increase the participant's self-knowledge in actions of compassion towards other people and self-compassion towards him/herself.
- Be able to identify situations of compassion and self-pity.
- Differentiate compassion and self-pity from other emotions.
- To develop tools that allow the participant to have compassionate and self-compassionate behaviors that optimize his or her perception of psychological well-being.
- Provide the participant with tools to avoid compassion fatigue.
- Differentiate adaptive from maladaptive feelings of guilt.

- Identify factors outside one's control that influence situations about which one feels guilt.
- Learning guilt repair behaviors.
- Identify fears and ideas associated with death and the dying process.
- Acquire adaptive skills to cope with death.
- Develop gratitude behaviors to foster positive experiences, both to the participant and to others on their behalf.

Program content

In order to meet the objectives and achieve the competencies described above, the program is structured in 9 sessions of 90 minutes, which will be carried out weekly, both face-to-face and telematically. In addition, a session zero or initial session will be developed with the objective of promoting the familiarization of the facilitator with the group of professionals, as well as establishing the first rules of the group (confidentiality, respect, etc.) and the initial evaluation. In this same session, the objectives/contents of the program are introduced to the participants, and a brief reflection is made on the importance of working on attitudes towards death. The following is a brief description of each of the sessions.

- *Session 0. Presentation and Evaluation*.
- *Session 1. The importance of emotions*. This session introduces the participant and the facilitator to the intervention program, as well as raising awareness of the emotional risk factors involved in health processions.
- *Session 2. Resilience and coping*. The objective of this session is to learn about the term "resilience", as well as the characteristics of the most resilient people, and to work on the self-knowledge of each of the participants, as well as to learn about coping strategies in stressful situations.
- *Session 3. The problem, assertiveness and social support*. Through this session we will continue to deepen in coping strategies in adverse situations, in addition to learning tools that facilitate assertiveness and social support in the participant.
- *Session 4. Compassion and self-pity*. The objective of this session will be to learn about the feelings of compassion and self-compassion, differentiating them from others, as well as to identify professional situations of compassion towards other people.
- *Session 5. We and our self-care: self-pity and compassion fatigue*. In this session we work on concepts of self-care, focusing on self-compassion and the provision of tools to avoid compassion fatigue.
- *Session 6.- Guilt and reparation.* The objective is to reflect on and work with guilt, in adaptive and maladaptive situations, as well as to identify factors beyond the participant's own control, and to develop reparative tools to deal with guilt.
- *Session 7. Coping behaviors in the face of death*. In this session, the effects of death anxiety are addressed, as well as how to confront the participant with these situations through the situation, with the objective of implementing the tools discussed in previous sessions.
- *Session 8. Gratitude*. This session aims to work on the concept of gratitude, both to others and to oneself.

- *Session 9. Post-intervention measurement.* The objective of this session is to conduct a post-intervention measurement of the program participants for evaluation, in addition to closing the program with the participants themselves.

Methodology

The program uses experiential methodology(Ariza, 2010). The true meaning of the experiential model implies following a process of reflection and analysis of educational practices, involving the participant directly in what is being taught. Thus, psychoeducation will be used -as minimally as possible, for the conceptualization of ideas and clarification of terms- and exercises that allow the participant to experience individually or collaboratively with other participants the topics addressed in the sessions. For this purpose, techniques such as role-playing, meditations, breathing techniques and various group exercises will be used. All the techniques and tools proposed are adapted to the topics covered in each session, the profile of the participants, and the modality of the session (face-to-face, virtual or mixed). Following this methodology, the facilitator's task is to help participants to build their own knowledge and experiences, guiding them and encouraging reflection, and being a support point for the realization of tasks outside the session (voluntary inter-session tasks, in which the participant, with the prior support of the facilitator, will carry out in order to internalize more effectively the contents covered in the different sessions). Likewise, it will also be the facilitator's role to create a motivating and challenging work environment for the participant, guiding him/her throughout the experiential exploration towards the proposed changes.

Program implementation

The implementation of the program is a key point to facilitate the effectiveness of the work with healthcare personnel, and it is for this reason that we have to ensure the principles and methodology of the program, in addition to adapting it to each of the groups of participants, as well as the physical or virtual presence of the participants, in order to optimize the results of the program.

The working group will present the program to the different centers that will be offered, and once the centers have been decided, a communication will be made through management, service/department heads and team leaders, in addition to the use of posters, leaflets or web resources, in order to create a pool of participants and have groups according to the objectives of the program. Once the groups have been formed, an inaugural event will be held at the level of the hospital, health center, or any other organization or institution where the program is carried out, with the objective of informing the entire center of the subject matter and intervention objectives.

At the end of the intervention program with as many groups as deemed appropriate, a communication will be made as a conclusion, addressing the topic again, and where general recommendations on self-care will be given, as a reminder for attendees, and as a way of education for non-attendees. Both the opening and closing speeches, whenever permitted by the center or institution, will be broadcast via streaming to ensure the attendance and participation of

all those attendees, whether or not they are participants in the program, who wish to participate online.

Program evaluation

In order to carry out a rigorous evaluation of the effectiveness of the program, the process will be carried out at different times: 1) initial evaluation, 2) evaluation at the end of the process and 3) post-process evaluation. Table 1 describes the instruments to be used in each of the evaluation phases. In this way, the end of the program does not mean its closure, but rather that four months after the end of the last session of the program, an evaluation will be carried out with the same measures as the initial and final evaluation to determine whether the effects are maintained over time.

Table 1

Program evaluation

Moment	Instrument	Dimensions evaluated	Informants
Session 0	Questionnaire	Sociodemographic data and physiological indicators	Participants
	Bugen's Coping with Death Scale and the Revised Profile of Attitudes Toward Death	Approach acceptance, death avoidance, escape acceptance, fear of death and neutral acceptance.	Participants
Initial / Final with immediate and deferred post-testing	Maslach Burnout Inventory	Frequency and intensity of burnout in three subscales: emotional exhaustion, depersonalization and personal fulfillment	Participants
	Brief Resiliency Scale (BRS)	Global resilience	Participants

	Compassion and Satisfaction Fatigue Test. PALIEX	Compassion fatigue	Participants
	Life Satisfaction Scale (SWLS)	Satisfaction with life	Participants
	State-Trait Anxiety Questionnaire (STAI)	State Anxiety (A/E) and Trait Anxiety (A/R)	Participants
	BDI-II	Evaluation of depressive symptomatology in adolescents and adults	Participants
	WOC-R. (Ways of Coping Inventory)	Assessment of coping modes	Participants
Session 9	Program evaluation questionnaire	Questionnaire for evaluation of the intervention program by the participants	Participants

Final conclusions

As we have seen, the taboo on death has repercussions on how healthcare personnel relate to death, leading to negative attitudes towards it and, subsequently, to poorer patient care and self-care. However, the way of relating to death can be modified through various techniques of intervention in prevention and promotion of competencies.

Based on this premise, and on all the scientific literature that insists on the importance of intervention programs and training for health professionals, we propose the program "Attitudes Towards Death in Health Personnel". This program is in line with what is proposed by relevant authors on the subject such as Cervik &Kav (2013). Thus, starting from the main objective of facilitating the development of more positive coping attitudes towards death on the part of healthcare personnel, we propose working on compassion and self-compassion to relate appropriately to this type of situation, feelings of guilt, resilience, stress and anxiety management, and gratitude. The program uses experiential methodology, putting the participants in an active role, involving them and making the sessions dynamic. In order to reach as many healthcare professionals as possible, the program can be carried out in person, blended learning or online.

References

Acevedo, G. E., Sánchez, J., Farías, M. A., & Fernández, A. R. (2013). Psychosocial Risks in the Health Team of Public Hospitals of the Province of Córdoba, Argentina. *Science & Work*, *15*(48). https://doi.org/10.4067/s0718-24492013000300006. https://doi.org/10.4067/s0718-24492013000300006

Ariza, M. R. (2010). Experiential Learning and New Training Demands. *Journal of Experimental Anthropology*, *8.*

Bayat, Z. S., Borhani, F., Nasiri, M., & Mokhtari, P. (2018). Correlation between Nurses' Attitude toward Death and the Quality of Nursing Care to Patients at the End Stages of Life in the ICU: A Systematic Review. *JOURNAL OF RESEARCH IN MEDICAL AND DENTAL SCIENCE*, *6*(6).

Cara Rodríguez, R. (2020). A phenomenological study about nursing professionals' perceptions of death. *Jan*, *14*(1). https://doi.org/10.4321/s1988-348x2020000100007

Cevik, B., & Kav, S. (2013). Attitudes and experiences of nurses toward death and caring for dying patients in Turkey. *Cancer Nursing*, *36*(6). https://doi.org/10.1097/NCC.0b013e318276924c. https://doi.org/10.1097/NCC.0b013e318276924c

Chua, J. Y. X., & Shorey, S. (2021). Effectiveness of end-of-life educational interventions at improving nurses and nursing students' attitude toward death and care of dying patients: A systematic review and meta-analysis. In *Nurse Education Today* (Vol. 101). https://doi.org/10.1016/j.nedt.2021.104892

Edo-Gual, M., Monforte-Royo, C., Aradilla-Herrero, A., & Tomás-Sábado, J. (2015). Death attitudes and positive coping in Spanish nursing undergraduates: A cross-sectional and correlational study. *Journal of Clinical Nursing*, *24*(17-18). https://doi.org/10.1111/jocn.12813. https://doi.org/10.1111/jocn.12813

García-Avendaño, D. J., Ochoa-Estrada, Ma. C., & Briceño-Rodríguez, I. I. (2018). Attitude of nursing staff to death in the intensive care unit: a quantitative study. *Duazary*, *15*(3). https://doi.org/10.21676/2389783x.2421. https://doi.org/10.21676/2389783x.2421

Guo, Q., & Zheng, R. (2019). Assessing oncology nurses' attitudes towards death and the prevalence of burnout: A cross-sectional study. *European Journal of Oncology Nursing, 42. https://doi*.org/10.1016/j.ejon.2019.08.002

Kagan, M. (2020). Social Support Moderates the Relationship Between Death Anxiety and Psychological Distress Among Israeli Nurses. *Psychological Reports*.https://doi.org/10.1177/0033294120945593

Puente-Fernández, D., Lozano-Romero, M. M., Montoya-Juárez, R., Martí-García, C., Campos-Calderón, C., & Hueso-Montoro, C. (2020). Nursing Professionals' Attitudes, Strategies, and Care Practices Towards Death: A Systematic Review of Qualitative Studies. *Journal of Nursing Scholarship, 52*(3). https://doi.org/10.1111/jnu.12550. https://doi.org/10.1111/jnu.12550

Vázquez-García, D., Rica-Escuín, M. D. la, Germán-Bes, C., & Caballero-Navarro, A. L. (2019). Coping and professional perception in end-of-life care in hospital emergency departments. A qualitative systematic review. *Rev. Public Health, 93*, 0-0.

Zamora Muñoz, M. J., Priego Valladares, M., van-der Hofstadt Román, C. J., Portilla Sogorb, J., & Rodríguez-Marín, J. (2018). Emotional distress of patients and family members in the Palliative Care Unit of a general hospital: a pilot study. *Palliative Medicine, 25*(3). https://doi.org/10.1016/j.medipa.2017.03.006. https://doi.org/10.1016/j.medipa.2017.03.006

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