

Coping Mechanisms for Managing Stressful Situations among Healthcare Professionals: A Comparison between Psychiatric Hospitals and Psychiatric Departments of General Hospitals

Μηχανισμοί Διαχείρισης
Στρεσογόνων Καταστάσεων των
Επαγγελματιών Υγείας: Σύγκριση
Ψυχιατρικών Νοσοκομείων και
Ψυχιατρικών Τμημάτων Γενικών
Νοσοκομείων

Abstract at the end of the article

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Origin of the Study:

This study was conducted as part of a doctoral dissertation at Faculty of Nursing, National and Kapodistrian University of Athens, and includes data collected from Psychiatric Hospitals and Psychiatric Departments of General Hospitals in Greece.

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Introduction: Healthcare professionals, particularly those working in mental health settings, are frequently exposed to stressful conditions that affect their psychological well-being and professional performance. Coping mechanisms play a crucial role in stress management and are influenced by the work environment.

Aim: The aim of the study was to comparatively investigate coping strategies for stressful situations among healthcare professionals working in psychiatric hospitals and in psychiatric departments of general hospitals, considering differences in the organizational and clinical context. The study hypotheses were that there are statistically significant differences in coping strategies between these healthcare professionals and that demographic and professional characteristics are associated with stress coping mechanisms.

Material and Methods: A quantitative cross-sectional study was conducted on a sample of 369 healthcare professionals (physicians and nursing staff), including 235 working in psychiatric hospitals and 134 in psychiatric departments of general hospitals in Greece. Data were collected between August 2023 and May 2024 using anonymous questionnaires, including an informed consent form, demographic and professional characteristics and the Brief-COPE scale. Statistical analysis was performed using IBM SPSS Statistics v28, with a significance level of $\alpha=0,05$.

Results: Healthcare professionals working in psychiatric departments of general hospitals showed higher mean scores in active coping [5,28 (SD=0,931) vs. 3,95 (SD=1,126), $p<0,001$], denial [5,60 (SD=0,951) vs. 4,40 (SD=1,203), $p<0,001$], substance use [5,37 (SD=0,930) vs. 4,36 (SD=1,148), $p<0,001$], seeking emotional support [5,10 (SD=1,089) vs. 4,69 (SD=1,117), $p<0,001$], behavioral disengagement [5,40 (SD=1,111) vs. 4,29 (SD=1,076),

$p < 0,001$], and self-blame [5,28 (SD=1,127) vs. 4,91 (SD=1,134), $p = 0,004$]. Conversely, healthcare professionals working in psychiatric hospitals showed higher scores in planning [5,20 (SD=1,261) vs. 4,38 (SD=1,032), $p < 0,001$], acceptance [5,81 (SD=1,230) vs. 5,17 (SD=1,199), $p < 0,001$], and religion/religious coping [5,13 (SD=1,138) vs. 4,79 (SD=1,048), $p < 0,001$].

Conclusions: Coping mechanisms differ significantly between the two types of healthcare settings, highlighting the influence of organizational context and individual characteristics. Strengthening adaptive coping strategies through psychoeducation, supervision, and organizational support is essential for enhancing staff resilience. Future research should focus on longitudinal and multicenter studies, as well as on evaluating interventions aimed at reducing burnout.

Keywords: Brief-COPE, coping mechanisms, healthcare professionals, hospitals, psychiatric hospitals, stressful situations

Introduction

Healthcare professionals are exposed to demanding and stressful working conditions that may influence their mental health and the quality of care provided.¹⁻³ Stress in healthcare settings has been associated with psychological burden, burnout, reduced job satisfaction, and adverse effects on patient safety.⁴⁻⁶ In mental health services, work demands are particularly high, as medical and nursing staff are frequently required to manage acute psychiatric conditions, unpredictable patient behaviors, and the need for continuous vigilance.⁷⁻⁹

According to Carver, coping mechanisms are the cognitive and behavioral efforts individuals use to manage demands perceived as stressful or exceeding their available resources.¹⁰ They are dynamic processes shaped by individual characteristics, professional experience, stressors, and organizational environment.^{10,11} Coping mechanisms are commonly classified as adaptive and maladaptive.^{10,13} Adaptive mechanisms generally reflect active engagement with the stressor and include problem-focused strategies, such as active coping, planning, and instrumental support seeking, as well as emotion-focused strategies, such as emotional support seeking, positive reframing, acceptance, humor, and religion. In contrast, maladaptive mechanisms mainly reflect avoidance or disengagement and include denial, substance use, behavioural disengagement, self-blame, self-distraction, and venting.^{10,13,14} Their use is associated with psychological resilience, professional functioning, and burnout among healthcare professionals.^{3,5,15}

International evidence indicates that work environ-

ment, clinical setting, professional role, workload, and organizational support influence stress and coping strategy selection.^{4-6,15,16} Perveen et al reported differences in occupational stressors and coping mechanisms among nurses working in different hospital settings,¹⁶ while other studies show that unit characteristics and working conditions affect how healthcare professionals manage stress.^{4,6,17}

Mental health environments are important considering the operational, organizational, staffing, case severity, and daily work experience differences between psychiatric hospitals and the psychiatric departments of general hospitals.^{7,8,17} These factors may influence the severity of stressful events and the coping strategies employed by physicians and nurses.^{7,8,18} Demographic and professional characteristics, including age, years of service, and educational level, have also been associated with differences in coping strategies.^{15,21}

Greek studies have shown considerable psychological burden, burnout, and varied coping mechanisms among mental healthcare professionals.¹⁹⁻²¹ Mangoulia et al reported high secondary traumatic stress among psychiatric nurses in Greece,¹⁹ Tsaras et al linked coping strategies with psychiatric nurses' mental health,²⁰ and Dimitriadou et al showed associations between occupational stress, coping strategies, and demographic and professional factors.²¹ These findings highlight the need for further investigation of coping mechanisms in Greek mental health settings.

Although occupational stress and coping mechanisms among healthcare professionals have been widely stud-

Table 1. Percentages of categorical variables of the questionnaire

Demographic and professional characteristics	N	(%)
Sex		
Male	152	41,2
Female	217	58,8
Marital status		
Single	64	17,3
Married or living with a partner	262	71,0
Other	43	11,7
Income		
≤25.000	130	35,2
25.001–35.000	176	47,7
35.001–50.000	56	15,2
>50.000)	7	1,9
Educational level		
Non-university education	256	69,4
University education	113	30,6
Job position		
Assistant nurses	225	61
Nurses	35	9,5
Physicians	109	29,5
Position of responsibility		
No	333	90,2
Yes (Head Nurse, Sector Head, Director)	36	9,8
Collaboration with colleagues		
Very good	17	4,7
Good	171	46,3
Neutral	172	46,6
Poor	9	2,4
Very poor	0	0
Have you experienced a threat/traumatic event?		
No	231	62,6
Yes	138	37,4
Have you experienced the death of a loved one?		
No	193	52,3
Yes	176	47,7
Do you have a person with a chronic disease at home?		
No	223	60,4
Yes	146	39,6
Do you have a chronic disease yourself?		
No	271	73,4
Yes	98	26,6
Do you receive systematic medication for a health problem?		
No	275	74,5
Yes	94	25,5
Do you have a hobby?		
No	143	38,8
Yes	226	61,2

Do you exercise?		
No	145	39,3
Yes	224	60,7
Do you smoke?		
Former smoker	20	5,4
No	186	50,4
Yes	163	44,2
How often do you consume at least one alcoholic drink?		
Never or up to 3 days per week	115	31,2
Up to 3 times per month	178	48,2
More often	76	20,6

Note: Percentages may not sum to 100.0 due to rounding.

ied, an important research gap remains regarding comparative evidence across different psychiatric care settings. Addressing this gap is essential, as psychiatric hospitals and psychiatric departments of general hospitals may differ in organization, operation, work demands, and staff experience, potentially influencing the coping mechanisms used by healthcare professionals and have not been sufficiently compared.

The **aim** of the present study was to compare coping mechanisms for stressful situations among healthcare professionals working in psychiatric hospitals and psychiatric departments of general hospitals. The specific objectives were to investigate differences in coping mechanisms between the two settings and examine their associations with demographic and professional characteristics. The research hypotheses were that coping mechanisms for managing stressful situations differ significantly between healthcare professionals working in psychiatric hospitals and those working in psychiatric departments of general hospitals and that demographic and professional characteristics are associated with coping mechanisms.

Method

Study design

A quantitative cross-sectional study was conducted using a convenience sample of physicians and nursing staff working in two public psychiatric hospitals and six psychiatric departments of general hospitals in Greece. The study was conducted from August 2023 to May 2024. This design was considered appropriate, as it enabled the assessment of the study variables within a defined study period.

Study sample

A total of 369 healthcare professionals participated in the study, of whom 235 were employed in psychiatric hospitals and 134 in psychiatric departments of general hospitals. An effort was made to distribute the questionnaires to physicians and nursing staff working in the participating settings. All completed questionnaires were considered suitable for analysis.

The inclusion criteria were medical or nursing professional status, permanent or auxiliary employment status, active employment in the participating psychiatric settings during the data collection period, and adequate understanding of the Greek language. The exclusion criteria were other healthcare professionals, administrative or auxiliary staff, and students.

Data collection

Anonymous printed questionnaires were used for data collection and were completed independently by participants in the presence of a researcher to prevent interaction during completion. They included an informed consent form, a demographic and professional characteristics questionnaire, and the Brief Coping Orientation to Problems Experienced scale (Brief-COPE).

The Brief-COPE, the short form of the original COPE inventory, was developed to assess a broad range of coping mechanisms in research and clinical settings.^{10,12} It includes 28 items forming 14 subscales, with two items per subscale: self-distraction, active coping, denial, substance use, use of emotional support, behavioral disengagement, venting, use of instrumental support, positive reframing, self-blame, planning, humor, acceptance, and religion.¹⁰ Responses are rated on a four-point Likert scale, from 1 ("I have not been doing this at all") to 4 ("I

Table 2. Mean values and standard deviations of quantitative variables of the questionnaire

Demographic and professional characteristics	Mean	SD
Age (years)	41,71	8,249
Number of children	1,36	,874
Service in the psychiatric sector (years)	14,15	9,315
Percentage of problems attributed to work	27,72	3,626
Percentage of problems attributed to family	27,52	3,833
Percentage of problems attributed to financial issues	26,94	3,682
Percentage of problems attributed to another cause	17,79	6,711

Table 3. Results of the comparison of demographic and professional characteristics between employees in PHs and PDGHs using the *Independent Mann–Whitney U-test and **X²-test

Demographic and professional characteristics	p
Sex (Male, Female)	0,742**
Age (years)	0,828*
Marital status (Single, married/living with partner, other)	0,128**
Number of children	0,024*
Years of service in the psychiatric sector	<0,001*
University education (Yes, No)	<0,001**
Job position (Assistant nurses, Nurses, Physicians)	<0,001**
Position of responsibility [No, Yes (Head Nurse, Sector Head, Director)]	0,099**
Collaboration with colleagues (Very good, Good, Neutral, Poor, Very poor)	0,047**
Income (≤25.000, 25,001–35,000, 35,001–50,000 >50,000)	0,023**
Has experienced a threat/traumatic event? (Yes, No)	<0,001**
Has experienced the death of a loved one? (Yes, No)	0,009**
Has a person with a chronic disease at home? (Yes, No)	0,509**
Has a chronic disease himself/herself? (Yes, No)	<0,001**
Receives systematic medication? (Yes, No)	<0,001**
Has a hobby (Yes, No)	0,317**
Exercises (Yes, No)	0,097**
Smoking status (Yes, No, Former smoker)	0,029**
Frequency of alcohol consumption (Never or up to 3 days per week, up to 3 times per month, more often)	<0,001**
Percentage of problems attributed to work	0,053*
Percentage of problems attributed to family	0,135*
Percentage of problems attributed to financial issues	0,020*
Percentage of problems attributed to another cause	0,417*

Table 4. Results of the comparison of demographic and professional characteristics categorized as binary variables in PHs and PDGHs using the χ^2 -test

Demographic and professional characteristics	Variables	p
Age	Age ≤ 42 or Age > 42	0,451
Marital status	Lives with partner/spouse or Other	0,096
Children	No or Yes	0,055
Educational level	Non-university education or University education	0,828
Years of service in the psychiatric sector	≤ 13 or > 13	<0,001
Job positions 1	Assistant nurses or Nurses	0,040
Job positions 2	Nurses or Physicians	0,027
Job positions 3	Assistant nurses or Physicians	0,623
Collaboration with colleagues	Good–very good or Neutral–poor	0,023
Annual family income (€)	$\leq 25,000$ or $> 25,000$	0,498
Smoking	No or Yes	0,009
Alcohol consumption	Never to up to 3 days per month or More often	<0,001
Percentage of problems attributed to work	≤ 25 or > 25	0,127
Percentage of problems attributed to family	≤ 25 or > 25	0,329
Percentage of problems attributed to financial issues	≤ 25 or > 25	0,129
Percentage of problems attributed to another cause	≤ 10 or > 10	0,581

Note. PH: psychiatric hospitals; PDGH: psychiatric departments of general hospitals

have been doing this a lot”), and each subscale score is calculated by summing the two corresponding items.¹⁰ For interpretation, subscales are grouped into adaptive and maladaptive coping mechanisms, according to the theoretical and research framework.^{10,13} The Greek version has demonstrated satisfactory validity and reliability in Greek-speaking populations (Cronbach’s $\alpha = 0,714$).¹¹

Ethics Approval and Consent to Participate

The study was conducted in accordance with the Declaration of Helsinki, and data were collected and managed exclusively for research purposes, ensuring participants’ anonymity and confidentiality in compliance with the General Data Protection Regulation [Regulation (EU) 2016/679 – GDPR].^{22,23} The Ethics and Deontology Com-

mittee of the Faculty of Nursing, National and Kapodistrian University of Athens approved the study (decision no. 447/09-06-2023). Approvals for the psychiatric hospitals were granted by the Board of Directors (protocol no. 31997/17-10-2023 and protocol no. 913/14-12-2023) for each hospital, and a positive opinion from the Ethics Committee and Scientific Council. For the psychiatric departments of general hospitals, approvals were obtained under protocol numbers 453/25-10-2023, 28209/06-11-2023, 11410/10-04-2024, Board decision no. 1753/05-01-2024 following the Board meeting of 06-12-2023, 684/11-01-2024, and 15408/09-04-2024 (ref. 56485). Permission to use the Brief-COPE scale was also obtained. Participation was voluntary and based on written informed consent; participants were informed about the study purpose, data collection procedures,

Table 5. Results of the comparison of mean values of the Brief-COPE subscales using the Independent Samples Mann-Whitney U-test

Brief-COPE subscales	PH, PDGH	N	Mean	Standard deviation	p
Self-distraction	PH PDGH	235 134	5,35 5,29	1,205 1,188	0,659
Active coping	PH PDGH	235 134	3,95 5,28	1,126 0,931	<0,001
Denial	PH PDGH	235 134	4,40 5,60	1,203 0,951	<0,001
Substance use	PH PDGH	235 134	4,36 5,37	1,148 0,930	<0,001
Use of emotional support	PH PDGH	235 134	4,69 5,10	1,117 1,089	<0,001
Behavioral disengagement	PH PDGH	235 134	4,29 5,40	1,076 1,111	<0,001
Venting	PH PDGH	235 134	5,02 4,96	0,934 1,123	0,589
Use of instrumental support	PH PDGH	235 134	4,47 4,72	1,055 1,072	0,035
Positive reframing	PH PDGH	235 134	4,85 4,97	1,117 1,026	0,488
Self-blame	PH PDGH	235 134	4,91 5,28	1,134 1,127	0,004
Planning	PH PDGH	235 134	5,20 4,38	1,261 1,032	<0,001
Humor	PH PDGH	235 134	5,21 5,14	1,135 1,012	0,553
Acceptance	PH PDGH	235 134	5,81 5,17	1,230 1,199	<0,001
Religion / religious coping	PH PDGH	235 134	5,13 4,79	1,138 1,048	<0,001

confidentiality, and their right to withdraw at any time without consequences.

Statistical Analysis

Each statistical test was performed at a significance level of $\alpha=0,05$. Statistical analysis was conducted using IBM SPSS Statistics v28. For each quantitative variable, normality was assessed using the Kolmogorov-Smirnov test, which showed that none of the variables followed a normal distribution. Subsequently, equality of mean values of the 14 Brief-COPE subscales was examined

between employees, according to whether they worked in psychiatric hospitals or psychiatric departments of general hospitals, using the Independent Samples Mann-Whitney U-test.

For each individual, demographic, and professional characteristic included in the questionnaire, it was examined whether there was a statistically significant difference between the two groups, depending on the type of variable, using either the Independent Samples Mann-Whitney U-test or the X^2 -test.

For each employee characteristic with more than two

Table 6. Results of the comparison of mean values of adaptive coping mechanisms found statistically significant across binary variables using the Independent Mann–Whitney U-test

Adaptive coping mechanisms of the Brief-COPE scale	Variables	N	Mean	Standard deviation	p
A. Problem-focused adaptive coping mechanisms					
Active coping	Good–very good collaboration	188	4,60	1,208	0,019
	Neutral–poor collaboration	181	4,27	1,246	
	Years of service in psychiatric sector ≤13	181	4,62	1,248	0,003
	Years of service in psychiatric sector >13	188	4,26	1,201	
	Alcohol: never to up to 3 days per month	254	4,56	1,280	0,004
	Alcohol: more often	115	4,17	1,092	
	Has experienced a life-threatening event	138	4,73	1,212	<0,001
	Has not experienced a life-threatening event	231	4,26	1,220	
	Has experienced death of a loved one	176	4,59	1,206	0,024
	Has not experienced death of a loved one	193	4,30	1,250	
	Has a chronic disease himself/herself	98	4,74	1,115	0,003
	Does not have a chronic disease himself/herself	271	4,32	1,261	
	Receives systematic medication	94	4,72	1,121	0,009
	Does not receive systematic medication	275	4,34	1,261	
	Planning	Good–very good collaboration	181	4,71	1,297
Neutral–poor collaboration		188	5,10	1,162	
Has experienced a life-threatening event		138	4,63	1,233	0,001
Has not experienced a life-threatening event		231	5,07	1,228	
Has a chronic disease himself/herself		98	4,52	1,105	0,001
Does not have a chronic disease himself/herself		271	5,04	1,267	
Receives systematic medication		94	4,51	1,105	0,001
Does not receive systematic medication		275	5,04	1,265	
B. Emotion-focused adaptive coping mechanisms					

Use of emotional support	Male	152	4,59	1,107	0,008
	Female	217	4,93	1,128	
	Has experienced a life-threatening event	138	4,92	1,121	0,043
	Has not experienced a life-threatening event	231	4,71	1,131	
	Has experienced death of a loved one	176	4,97	1,103	0,002
	Has not experienced death of a loved one	193	4,62	1,031	
	Has a person with chronic disease at home	146	5,00	1,114	0,002
	Does not have a person with chronic disease at home	223	4,65	1,121	
	Has a chronic disease himself/herself	98	5,07	1,028	0,003
	Does not have a chronic disease himself/herself	271	4,68	1,149	
	Receives systematic medication	94	5,06	1,025	0,004
	Does not receive systematic medication	275	4,69	1,151	
Acceptance	Years of service in psychiatric sector ≤ 13	181	5,38	1,266	0,005
	Years of service in psychiatric sector > 13	188	5,77	1,217	
	Has a position of responsibility	36	5,19	1,167	0,038
	Does not have a position of responsibility	333	5,62	1,259	
	Has experienced a life-threatening event	138	5,30	1,240	0,001
	Has not experienced a life-threatening event	231	5,75	1,236	
	Has a chronic disease himself/herself	98	5,31	1,296	0,010
	Does not have a chronic disease himself/herself	271	5,68	1,228	
	Receives systematic medication	94	5,27	1,297	0,004
	Does not receive systematic medication	275	5,69	1,225	
	Has a hobby	226	5,71	1,348	0,008
	Does not have a hobby	143	5,38	1,067	
	Lives with partner/spouse	262	5,66	1,297	0,048
	Other	107	5,39	1,131	
Religion / religious coping	Years of service in psychiatric sector ≤ 13	181	4,87	1,101	0,016
	Years of service in psychiatric sector > 13	188	5,14	1,120	

Table 7. Results of the comparison of mean values of maladaptive coping mechanisms found statistically significant across binary variables using the Independent Mann–Whitney U-test

Maladaptive coping mechanisms of the Brief-COPE scale	Variables	N	Mean	Standard deviation	p
Denial	Good–very good collaboration	188	5,06	1,195	0,001
	Neutral–poor collaboration	181	4,60	1,277	
	Without children	71	5,20	1,214	0,003
	With children	298	4,75	1,252	
	Years of service in psychiatric sector ≤13	181	5,15	1,263	<0,001
	Years of service in psychiatric sector >13	188	4,54	1,176	
	Alcohol: never to up to 3 days per month	254	5,01	1,240	<0,001
	Alcohol: more often	115	4,45	1,208	
	Has experienced a life-threatening event	138	5,01	1,168	0,038
	Has not experienced a life-threatening event	231	4,74	1,297	
	Has a person with chronic disease at home	146	4,68	1,161	0,034
	Does not have a person with chronic disease at home	223	4,94	1,307	
	Has a chronic disease himself/herself	98	5,07	1,186	0,028
	Does not have a chronic disease himself/herself	271	4,75	1,271	
	Receives systematic medication	94	5,10	1,146	0,020
	Does not receive systematic medication	275	4,75	1,281	
	Lives with partner/spouse	262	4,77	1,245	0,049
	Other	107	5,01	1,270	
Substance use	Good–very good collaboration	188	4,90	1,126	0,002
	Neutral–poor collaboration	181	4,55	1,204	
	Without children	71	4,99	1,076	0,035
	With children	298	4,66	1,193	

Substance use	Years of service in psychiatric sector ≤ 13	181	4,90	1,146	0,007
	Years of service in psychiatric sector > 13	188	4,56	1,184	
	Alcohol: never to up to 3 days per month	254	4,89	1,126	$< 0,001$
	Alcohol: more often	115	4,37	1,209	
	Male	152	4,89	1,099	0,035
	Female	217	4,61	1,217	
	Has experienced a life-threatening event	138	4,99	1,220	$< 0,001$
	Has not experienced a life-threatening event	231	4,57	1,124	
	Has a chronic disease himself/herself	98	5,17	1,046	$< 0,001$
	Does not have a chronic disease himself/herself	271	4,56	1,181	
	Receives systematic medication	94	5,15	1,057	$< 0,001$
	Does not receive systematic medication	275	4,58	1,182	
Behavioral disengagement	Good-very good collaboration	188	4,93	1,166	$< 0,001$
	Neutral-poor collaboration	181	4,34	1,221	
	Without children	71	4,93	1,087	0,009
	With children	298	4,57	1,251	
	Nurses	35	4,97	1,043	0,032
	Physicians	109	4,52	1,135	
	Years of service in psychiatric sector ≤ 13	181	4,83	1,164	0,001
	Years of service in psychiatric sector > 13	188	4,46	1,264	
	Alcohol: never to up to 3 days per month	254	4,74	1,255	0,024
	Alcohol: more often	115	4,41	1,139	
	Has experienced a life-threatening event	138	4,86	1,251	0,011
	Has not experienced a life-threatening event	231	4,51	1,197	
	Has a chronic disease himself/herself	98	5,14	1,268	$< 0,001$
	Does not have a chronic disease himself/herself	271	4,46	1,163	
	Receives systematic medication	94	5,16	1,289	$< 0,001$
	Does not receive systematic medication	275	4,46	1,156	
	Lives with partner/spouse	261	4,52	1,193	0,004
	Other	107	4,94	1,265	

categories in which a statistically significant difference was found between the two groups, the X^2 -test was used to examine whether pairs of categories differed significantly between psychiatric hospitals and psychiatric departments of general hospitals. These binary variables were created, for quantitative variables, by removing the median or central values, while for qualitative variables they were created by merging categories.

Finally, for the Brief-COPE subscales in which statistically significant differences in mean values were found, equality of mean values was examined for each binary characteristic that had been found to differ significantly between psychiatric hospitals and psychiatric departments of general hospitals, using the Independent Samples Mann-Whitney U-test.

Results

A total of 369 healthcare professionals participated in the study, including physicians and nursing staff; 235 were employed in psychiatric hospitals (PHs) and 134 in psychiatric departments of general hospitals (PDGHs). The response rate of completed questionnaires in relation to those distributed was 87,7%.

Demographic and professional characteristics of the sample

In the total sample, 58,8% were women and 41,2% men. Most participants were married or living with a partner (71,0%), while 17,3% were single and 11,7% belonged to another category. Regarding education, 69,4% had non-university and 30,6% university education. Assistant nurses accounted for 61,0%, nurses for 9,5%, and physicians for 29,5%, while 9,8% held a position of responsibility. Collaboration with colleagues was rated as very good by 4,7%, good by 46,3%, neutral by 46,6%, and poor by 2,4%, with no responses in the "very poor" category (Table 1).

A threat or traumatic event was reported by 37,4%, death of a loved one by 47,7%, having a person with a chronic disease at home by 39,6%, personal chronic disease by 26,6%, and systematic medication use by 25,5%. Moreover, 61,2% reported having a hobby, 60,7% exercising, 44,2% smoking, and 5,4% being former smokers. Alcohol consumption was reported as never or up to 3 days per week by 31,2%, up to 3 times per month by 48,2%, and more frequently by 20,6% (Table 1).

The mean age was 41,71 years ($SD=8,249$), the mean number of children 1,36 ($SD=0,874$), the mean years of service in the psychiatric sector 14,15 ($SD=9,315$), and

the mean annual family income €29.065 ($SD=6.674,8$), with €70.000 considered as the upper income limit. Problems were attributed on average to work by 27,72% ($SD=3,626$), family by 27,52% ($SD=3,833$), financial issues by 26,94% ($SD=3,682$), and another cause by 17,79% ($SD=6,711$) (Table 2).

Comparison of PHs and PDGHs in terms of demographic and professional characteristics

Statistically significant differences between employees in PHs and PDGHs were found in number of children ($p=0,024$), years of service in the psychiatric sector ($p<0,001$), educational level ($p<0,001$), job position ($p<0,001$), collaboration with colleagues ($p=0,047$), income ($p=0,023$), experience of a threat or traumatic event ($p<0,001$), death of a loved one ($p=0,009$), participants' own chronic disease ($p<0,001$), systematic medication use ($p<0,001$), smoking ($p=0,029$), alcohol consumption frequency ($p<0,001$), and percentage of problems attributed to financial issues ($p=0,020$). No significant differences were found in sex, age, marital status, position of responsibility, presence of a person with chronic disease at home, hobby, physical exercise, or percentages of problems attributed to work, family, or another cause (Table 3).

In the binary analysis, significant differences were found in years of service in the psychiatric sector (≤ 13 or >13 years, $p<0,001$), assistant nurses versus nurses ($p=0,040$), nurses versus physicians ($p=0,027$), collaboration with colleagues (good-very good or neutral-poor, $p=0,023$), smoking ($p=0,009$), and alcohol consumption ($p<0,001$). No significant differences were found in age, marital status, having children, educational level, assistant nurses versus physicians, annual family income, or percentages of problems attributed to work, family, financial issues, or another cause (Table 4).

Comparison of PHs and PDGHs in Brief-COPE subscales

No significant differences were found in self-distraction [PHs: 5,35 ($SD=1,205$), PDGHs: 5,29 ($SD=1,188$), $p=0,659$], venting [5,02 ($SD=0,934$) vs. 4,96 ($SD=1,123$), $p=0,589$], positive reframing [4,85 ($SD=1,117$) vs. 4,97 ($SD=1,026$), $p=0,488$], and humor [5,21 ($SD=1,135$) vs. 5,14 ($SD=1,012$), $p=0,553$] (Table 5).

Significant differences were observed in active coping, denial, substance use, use of emotional support, behavioral disengagement, use of instrumental support, self-blame, planning, acceptance, and religion. Employees in

PDGHs had higher mean scores in active coping [5,28 (SD=0,931) vs. 3,95 (SD=1,126), $p<0,001$], denial [5,60 (SD=0,951) vs. 4,40 (SD=1,203), $p<0,001$], substance use [5,37 (SD=0,930) vs. 4,36 (SD=1,148), $p<0,001$], use of emotional support [5,10 (SD=1,089) vs. 4,69 (SD=1,117), $p<0,001$], behavioral disengagement [5,40 (SD=1,111) vs. 4,29 (SD=1,076), $p<0,001$], use of instrumental support [4,72 (SD=1,072) vs. 4,47 (SD=1,055), $p=0,035$], and self-blame [5,28 (SD=1,127) vs. 4,91 (SD=1,134), $p=0,004$]. Conversely, employees in PHs had higher mean scores in planning [5,20 (SD=1,261) vs. 4,38 (SD=1,032), $p<0,001$], acceptance [5,81 (SD=1,230) vs. 5,17 (SD=1,199), $p<0,001$], and religion [5,13 (SD=1,138) vs. 4,79 (SD=1,048), $p<0,001$] (Table 5).

Adaptive coping mechanisms

Among problem-focused adaptive coping mechanisms, active coping differed significantly by collaboration with colleagues, years of service in the psychiatric sector, alcohol consumption, experience of a life-threatening event, death of a loved one, participants' own chronic disease, and systematic medication use. Higher scores were observed among participants with good-very good collaboration [4,60 (SD=1,208) vs. 4,27 (SD=1,246), $p=0,019$], ≤ 13 years of service [4,62 (SD=1,248) vs. 4,26 (SD=1,201), $p=0,003$], alcohol consumption never to up to 3 days per month [4,56 (SD=1,280) vs. 4,17 (SD=1,092), $p=0,004$], experience of a life-threatening event [4,73 (SD=1,212) vs. 4,26 (SD=1,220), $p<0,001$], death of a loved one [4,59 (SD=1,206) vs. 4,30 (SD=1,250), $p=0,024$], participants' own chronic disease [4,74 (SD=1,115) vs. 4,32 (SD=1,261), $p=0,003$], and systematic medication use [4,72 (SD=1,121) vs. 4,34 (SD=1,261), $p=0,009$] (Table 6).

Planning differed significantly by collaboration with colleagues, experience of a life-threatening event, participants' own chronic disease, and systematic medication use. Higher scores were observed among participants with neutral-poor collaboration [5,10 (SD=1,162) vs. 4,71 (SD=1,297), $p<0,001$], no experience of a life-threatening event [5,07 (SD=1,228) vs. 4,63 (SD=1,233), $p=0,001$], no chronic disease [5,04 (SD=1,267) vs. 4,52 (SD=1,105), $p=0,001$], and no systematic medication use [5,04 (SD=1,265) vs. 4,51 (SD=1,105), $p=0,001$] (Table 6).

Among emotion-focused adaptive coping mechanisms, use of emotional support differed significantly by sex, experience of a life-threatening event, death of a loved one, presence of a person with a chronic disease at home, participants' own chronic disease, and sys-

tematic medication use. Higher scores were observed among women [4,93 (SD=1,128) vs. 4,59 (SD=1,107), $p=0,008$], participants with experience of a life-threatening event [4,92 (SD=1,121) vs. 4,71 (SD=1,131), $p=0,043$], death of a loved one [4,97 (SD=1,103) vs. 4,62 (SD=1,031), $p=0,002$], a person with chronic disease at home [5,00 (SD=1,114) vs. 4,65 (SD=1,121), $p=0,002$], participants' own chronic disease [5,07 (SD=1,028) vs. 4,68 (SD=1,149), $p=0,003$], and systematic medication use [5,06 (SD=1,025) vs. 4,69 (SD=1,151), $p=0,004$] (Table 6).

Acceptance differed significantly by years of service in the psychiatric sector, position of responsibility, experience of a life-threatening event, participants' own chronic disease, systematic medication use, having a hobby, and marital status. Higher scores were observed among participants with >13 years of service [5,77 (SD=1,217) vs. 5,38 (SD=1,266), $p=0,005$], no position of responsibility [5,62 (SD=1,259) vs. 5,19 (SD=1,167), $p=0,038$], no experience of a life-threatening event [5,75 (SD=1,236) vs. 5,30 (SD=1,240), $p=0,001$], no chronic disease [5,68 (SD=1,228) vs. 5,31 (SD=1,296), $p=0,010$], no systematic medication use [5,69 (SD=1,225) vs. 5,27 (SD=1,297), $p=0,004$], having a hobby [5,71 (SD=1,348) vs. 5,38 (SD=1,067), $p=0,008$], and living with a partner or spouse [5,66 (SD=1,297) vs. 5,39 (SD=1,131), $p=0,048$]. Religion differed significantly only by years of service, with higher scores among participants with >13 years [5,14 (SD=1,120) vs. 4,87 (SD=1,101), $p=0,016$] (Table 6).

Maladaptive coping mechanisms

Denial differed significantly by collaboration with colleagues, having children, years of service in the psychiatric sector, alcohol consumption, experience of a life-threatening event, presence of a person with chronic disease at home, participants' own chronic disease, systematic medication use, and marital status. Higher scores were observed among participants with good-very good collaboration [5,06 (SD=1,195) vs. 4,60 (SD=1,277), $p=0,001$], no children [5,20 (SD=1,214) vs. 4,75 (SD=1,252), $p=0,003$], ≤ 13 years of service [5,15 (SD=1,263) vs. 4,54 (SD=1,176), $p<0,001$], alcohol consumption never to up to 3 days per month [5,01 (SD=1,240) vs. 4,45 (SD=1,208), $p<0,001$], experience of a life-threatening event [5,01 (SD=1,168) vs. 4,74 (SD=1,297), $p=0,038$], no person with chronic disease at home [4,94 (SD=1,307) vs. 4,68 (SD=1,161), $p=0,034$], participants' own chronic disease [5,07 (SD=1,186) vs. 4,75 (SD=1,271), $p=0,028$], systematic medication use

[5,10 (SD=1,146) vs. 4,75 (SD=1,281), $p=0,020$], and not living with a partner or spouse [5,01 (SD=1,270) vs. 4,77 (SD=1,245), $p=0,049$] (Table 7).

Substance use differed significantly by collaboration with colleagues, having children, years of service in the psychiatric sector, alcohol consumption, sex, experience of a life-threatening event, participants' own chronic disease, and systematic medication use. Higher scores were observed among participants with good-very good collaboration [4,90 (SD=1,126) vs. 4,55 (SD=1,204), $p=0,002$], no children [4,99 (SD=1,076) vs. 4,66 (SD=1,193), $p=0,035$], ≤ 13 years of service [4,90 (SD=1,146) vs. 4,56 (SD=1,184), $p=0,007$], alcohol consumption never to up to 3 days per month [4,89 (SD=1,126) vs. 4,37 (SD=1,209), $p<0,001$], men [4,89 (SD=1,099) vs. 4,61 (SD=1,217), $p=0,035$], experience of a life-threatening event [4,99 (SD=1,220) vs. 4,57 (SD=1,124), $p<0,001$], participants' own chronic disease [5,17 (SD=1,046) vs. 4,56 (SD=1,181), $p<0,001$], and systematic medication use [5,15 (SD=1,057) vs. 4,58 (SD=1,182), $p<0,001$] (Table 7).

Behavioral disengagement differed significantly by collaboration with colleagues, having children, comparison between nurses and physicians, years of service in the psychiatric sector, alcohol consumption, experience of a life-threatening event, participants' own chronic disease, systematic medication use, and marital status. Higher scores were observed among participants with good-very good collaboration [4,93 (SD=1,166) vs. 4,34 (SD=1,221), $p<0,001$], no children [4,93 (SD=1,087) vs. 4,57 (SD=1,251), $p=0,009$], nurses [4,97 (SD=1,043) vs. physicians 4,52 (SD=1,135), $p=0,032$], ≤ 13 years of service [4,83 (SD=1,164) vs. 4,46 (SD=1,264), $p=0,001$], alcohol consumption never to up to 3 days per month [4,74 (SD=1,255) vs. 4,41 (SD=1,139), $p=0,024$], experience of a life-threatening event [4,86 (SD=1,251) vs. 4,51 (SD=1,197), $p=0,011$], participants' own chronic disease [5,14 (SD=1,268) vs. 4,46 (SD=1,163), $p<0,001$], systematic medication use [5,16 (SD=1,289) vs. 4,46 (SD=1,156), $p<0,001$], and not living with a partner or spouse [4,94 (SD=1,265) vs. 4,52 (SD=1,193), $p=0,004$] (Table 7).

Overall synthesis of findings

Overall, employees in PHs and PDGHs differed in several demographic, professional, and individual characteristics, mainly years of service in the psychiatric sector, job position, collaboration with colleagues, smoking, and alcohol consumption (Tables 3, 4). Statistically significant differences were also observed in several

Brief-COPE subscales, with employees in PDGHs showing higher mean scores in most subscales that differed significantly, whereas employees in PHs showed higher mean scores in planning, acceptance, and religion (Table 5). In addition, adaptive and maladaptive coping mechanisms differed according to specific demographic, professional, and individual characteristics, including years of service, collaboration with colleagues, experience of threat or loss, chronic disease, medication use, and marital status (Tables 6, 7).

Discussion

The present study comparatively investigated coping strategies for stressful situations among physicians and nursing staff working in psychiatric hospitals and psychiatric departments of general hospitals in Greece. The findings demonstrated that the two groups differ in demographic and professional characteristics and in several Brief-COPE subscales, supporting the hypothesis that the work setting is associated with distinct coping strategies. This observation is consistent with the international literature, which indicates that healthcare professionals, particularly those in mental health, are exposed to high levels of occupational stress that significantly influence both psychological well-being and coping behaviors.^{1-8,24-26}

In the total sample, participants were predominantly female and mainly belonged to the nursing workforce, a finding aligned with the composition of healthcare professionals. Additionally, a substantial proportion reported experiences such as traumatic or threatening events, loss of a loved one, chronic illness, or regular medication use. This highlights that occupational burden is not confined to the workplace but is shaped by a broader interplay of personal, familial, and social factors. The multidimensional stress exposure has been widely documented in previous studies, where occupational stress in mental healthcare professionals has been associated with burnout, psychological distress, and diverse coping strategies.^{5,7,8,19,20,25}

The comparison between the two settings revealed that professionals working in psychiatric departments of general hospitals exhibited higher mean scores in active coping, emotional and instrumental support seeking, as well as in maladaptive strategies such as denial, substance use, behavioral disengagement, and self-blame. In contrast, those working in psychiatric hospitals showed higher scores in planning, acceptance, and religion. The coexistence of adaptive and maladaptive

coping mechanisms confirms Carver's theoretical framework, which conceptualizes coping as a dynamic set of cognitive and behavioral responses to stressors.^{10,13}

Higher levels of active coping in general hospital psychiatric departments may reflect the necessity for rapid mobilization of resources within a multidisciplinary and highly demanding clinical environment. These settings often involve complex interactions across specialties, increased workload, and time pressure, necessitating immediate and problem-focused responses. Similar associations between work environment characteristics and coping strategies have been reported in the literature, where workload, organizational support, and structural conditions significantly shape stress management approaches.^{4,6,15,16,27}

However, the simultaneous elevation of maladaptive coping strategies in the same group is particularly significant. Denial, substance use, behavioral disengagement, and self-blame have been consistently associated with poorer mental health outcomes, increased stress, and burnout.^{3,5,7,14,20,28} This pattern suggests that increased coping effort does not necessarily equate to effective psychological adaptation. Instead, it may indicate heightened psychological burden, where individuals employ a mixture of functional and dysfunctional strategies. Similar findings have been documented in studies of psychiatric nurses and mental healthcare professionals, where high-stress environments were linked to both active and avoidant coping responses.^{7,8,20,26}

Conversely, the higher scores in planning, acceptance, and religion among psychiatric hospital staff suggest a different coping profile. Planning represents a problem-focused coping strategy associated with structured and cognitively processed responses to stress.¹⁰ However, acceptance and religious coping are emotion-focused and may be particularly relevant in settings characterized by chronic, complex, and less controllable stressors. This interpretation aligns with findings from previous research, indicating that long-term exposure to psychiatric care environments fosters more stable and internalized coping mechanisms.^{7,8,19,20}

Importantly, the observed differences cannot be attributed solely to the type of healthcare setting. The two groups also differed significantly in years of service in the psychiatric field, educational level, job position, collaboration with colleagues, income, and individual health-related characteristics. The literature consistently highlights that demographic and professional variables, such as age, experience, education, and organizational

support, play a crucial role in shaping coping strategies and their psychological outcomes.^{15,21,24,27,29} Therefore, the work environment should be interpreted within the broader context of workforce composition and individual characteristics.

Regarding adaptive coping strategies, active coping was associated with collaboration with colleagues, years of service, alcohol consumption, experiences of threat or loss, chronic illness, and medication use. The higher levels of active coping among individuals reporting better collaboration underscore the importance of social and organizational support as protective factors. Similar findings have been reported in studies demonstrating that supportive work environments promote more effective coping and resilience among healthcare professionals.^{4,14,21,27}

Interestingly, active coping was higher among participants with fewer years of psychiatric experience, possibly reflecting a greater tendency among less experienced professionals to engage in immediate problem-solving efforts. In contrast, acceptance and religious coping were more prominent among those with longer professional experience, suggesting that prolonged exposure to psychiatric settings may foster more emotionally regulated and reflective coping styles. The literature indicates that professional experience may have a dual effect, enhancing coping skills while also increasing vulnerability to long-term stress and burnout.^{5,8,25,28}

Emotional support seeking was more prevalent among women and among participants with personal experiences of trauma, loss, or chronic illness. This finding suggests that personal vulnerability may increase the need for emotional support, a coping mechanism widely recognized as beneficial in high-stress professions such as mental healthcare providers.^{14,24,27} Greek studies have similarly shown that healthcare professionals frequently rely on social support, positive reframing, and acceptance to manage occupational stress.²¹

Maladaptive coping strategies were associated with absence of children, fewer years of service, exposure to threatening experiences, chronic illness, and medication use. These findings indicate that individuals with less experience or greater personal burden may be more prone to avoidant coping behaviors. This is consistent with evidence linking avoidance-based strategies to higher psychological distress and burnout risk.^{3,7,20,25,28}

A particularly complex finding was that better collaboration with colleagues was associated with higher active coping and with higher levels of denial, substance

use, and behavioral disengagement. This suggests that coping processes are multifaceted and cannot be interpreted linearly. It is possible that strong team cohesion develops in high-pressure environments, where peer support coexists with maladaptive coping mechanisms. Alternatively, it may reflect cultural or organizational norms that influence coping behaviors within specific work contexts.^{10,13,14,27}

In the Greek context, Mangoulia et al. have highlighted significant levels of secondary traumatic stress among psychiatric nurses,¹⁹ while Tsaras et al. demonstrated strong associations between coping strategies and mental health outcomes.²⁰ The present findings are consistent with this body of research, reinforcing the notion that psychiatric care is a highly demanding field where coping strategies are shaped by both environmental and individual factors. Furthermore, Dimitriadou et al. reported that occupational stress among Greek healthcare professionals is closely linked to diverse coping mechanisms, emphasizing the importance of organizational context.²¹

The present study contributes to existing literature by addressing a notable research gap. While prior studies have examined coping strategies among healthcare professionals or psychiatric nurses, few have directly compared psychiatric hospitals with psychiatric departments of general hospitals.^{7,8,19,20,25,26} This comparison is particularly important, as these settings differ in organizational structure, clinical demands, and workforce composition. The findings suggest that such differences are reflected in distinct coping strategies for managing stressful situations.

In relation to the study objectives, the findings provide clear answers to the research questions. The first hypothesis was confirmed, as significant differences were identified in coping strategies between healthcare professionals working in the two types of psychiatric settings. The second hypothesis was also supported, as demographic, professional, and individual characteristics were associated with variations in both adaptive and maladaptive coping mechanisms. Overall, the study demonstrates that coping strategies among mental healthcare professionals are shaped by a complex interaction of personal, professional, and organizational factors.

Study Limitations

The study has several limitations. Its cross-sectional design does not allow for causal inferences but only for

the identification of associations. The use of self-reported questionnaires may introduce bias due to subjective perception and socially desirable responses. Additionally, the sample was a convenience sample drawn from specific healthcare settings in Greece, limiting the generalizability of the findings. Finally, the dichotomization of certain variables, although useful for comparative analysis, may have resulted in some loss of information.

Conclusions

This study significantly enhances the understanding of coping mechanisms among healthcare professionals by comparing two distinct mental healthcare environments: psychiatric hospitals and psychiatric departments of general hospitals. The results demonstrated significant differences in coping strategies across different settings, highlighting the critical role of the organizational and clinical environment on stress management responses.

Healthcare professionals in psychiatric departments of general hospitals demonstrated greater activation of both adaptive and maladaptive coping strategies, indicating increased psychological burden and the necessity for persistent adjustment. In contrast, healthcare professionals in psychiatric hospitals appeared to rely more on stable and internalized coping strategies, such as planning and acceptance. These differences were similarly correlated with demographic and professional characteristics, including age, years of service, and educational level.

The study emphasizes that managing occupational stress among mental health professionals is a complicated, multifaceted process influenced by the interaction of individual, professional, and organizational factors. Its significance resides in providing comparative data in a relatively under-researched domain, especially within the Greek context, contributing to a better understanding of staff needs and supporting improvements in the quality of care.

Implications for Clinical Practice and Future Research

The findings have important implications for clinical practice, education, and healthcare management, highlighting the need for targeted interventions to strengthen adaptive coping mechanisms and reduce maladaptive strategies, particularly in high-demand settings such as psychiatric departments of general hospitals. Psychoeducational programs, structured clinical super-

vision, enhanced interdisciplinary collaboration, and supportive organizational frameworks may improve staff resilience, while systematic monitoring of psychological burden and coping strategies could help prevent burnout. Future longitudinal and multicenter studies are needed to further explore causal relationships between work environments and coping strategies, investigate the impact of ongoing mental health system reforms, and evaluate interventions aimed at improving healthcare professionals' psychological well-being and professional functioning.

Ethics

The study was conducted in full accordance with the code of human rights and the principles of deontology for research involving human subjects, as outlined by the International Committee of Medical Journal Editors and the Declaration of Helsinki. Anonymity and confidentiality of participants were fully ensured throughout data collection and management. Participation was voluntary and all participants provided written informed consent prior to completing the questionnaires. The study was approved by the competent Ethics Committees, Scientific Councils and Administrative Boards of the Faculty of Nursing, National and Kapodistrian University of Athens and the participating psychiatric hospitals and general hospitals. Permission to use the Brief-COPE questionnaire was also obtained.

Statement of Conflict of Interest

No Conflict of Interest has been declared by the Authors.

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Authors' Contributions

All authors contributed substantially to the study and manuscript preparation.

GM: contributed to study conception and design, data collection, interpretation of results, and manuscript writing.

TK: contributed to study conception and design, statistical analysis, interpretation of results, and manuscript writing.

EK: contributed to study design and manuscript writing.

MH: contributed to study design and manuscript writing.

PM: conceived and designed the study, contributed to interpretation of results, manuscript writing, and overall supervision.

All authors critically reviewed and approved the final manuscript.

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ΠΕΡΙΛΗΨΗ

Μηχανισμοί Διαχείρισης Στρεσογόνων Καταστάσεων των Επαγγελματιών Υγείας: Σύγκριση Ψυχιατρικών Νοσοκομείων και Ψυχιατρικών Τμημάτων Γενικών Νοσοκομείων**Γεωργία Μαντά¹, Θεοφάνης Κατοστάρας², Ευμορφία Κούκια Ευμορφία³, Μιχαήλ Χατζούλης⁴, Πολυξένη Μαγγούλια⁵**¹Νοσηλεύτρια RN, MSc, MPA, PhD©, Αναπληρώτρια Προϊσταμένη Παθολογικού Τμήματος, Ψ.Ν.Α. «Δρομοκαΐτειο»²Τέως Καθηγητής Βιοστατιστικής και Ποσοτικής Αξιολόγησης Φροντίδας Υγείας, Τμήμα Νοσηλευτικής, ΕΚΠΑ³Καθηγήτρια Ψυχιατρικής Νοσηλευτικής, Τμήμα Νοσηλευτικής, ΕΚΠΑ⁴Αναπληρωτής Καθηγητής Ψυχιατρικής, Τμήμα Νοσηλευτικής, ΕΚΠΑ⁵Επίκουρη Καθηγήτρια Ψυχιατρικής Νοσηλευτικής και Ψυχοφαρμακολογίας, Τμήμα Νοσηλευτικής, ΕΚΠΑ

Εισαγωγή: Οι επαγγελματίες υγείας, και ιδιαίτερα οι εργαζόμενοι σε δομές ψυχικής υγείας, εκτίθενται καθημερινά σε στρεσογόνες συνθήκες, οι οποίες επηρεάζουν την ψυχική τους υγεία και την επαγγελματική τους λειτουργικότητα. Οι μηχανισμοί διαχείρισης του στρες αποτελούν κρίσιμο παράγοντα προσαρμογής και επηρεάζονται από το εργασιακό περιβάλλον.

Σκοπός: Σκοπός της μελέτης ήταν η συγκριτική διερεύνηση των μηχανισμών διαχείρισης στρεσογόνων καταστάσεων μεταξύ επαγγελματιών υγείας που εργάζονται σε ψυχιατρικά νοσοκομεία και σε ψυχιατρικά τμήματα γενικών νοσοκομείων, λαμβάνοντας υπόψη τις διαφοροποιήσεις του οργανωσιακού και κλινικού πλαισίου. Οι ερευνητικές υποθέσεις της μελέτης ήταν οι πιθανές στατιστικά σημαντικές διαφορές στους μηχανισμούς διαχείρισης στρεσογόνων καταστάσεων αυτών των επαγγελματιών υγείας και η πιθανή συσχέτιση δημογραφικών και επαγγελματικών χαρακτηριστικών με τους μηχανισμούς διαχείρισης του στρες.

Υλικό και Μέθοδος: Πραγματοποιήθηκε ποσοτική συγχρονική μελέτη σε δείγμα 369 επαγγελματιών υγείας (ιατρών και νοσηλευτικού προσωπικού), εκ των οποίων 235 εργάζονταν σε ψυχιατρικά νοσοκομεία και 134 σε ψυχιατρικά τμήματα γενικών νοσοκομείων, στην Ελλάδα. Η συλλογή των δεδομένων πραγματοποιήθηκε από τον Αύγουστο 2023 έως τον Μάιο 2024 με τη χρήση ανώνυμων ερωτηματολογίων, που περιλάμβαναν δημογραφικά και επαγγελματικά χαρακτηριστικά και την κλίμακα Brief-COPE. Η στατιστική ανάλυση πραγματοποιήθηκε με το πρόγραμμα IBM SPSS Statistics v28, με επίπεδο σημαντικότητας $\alpha=0,05$.

Αποτελέσματα: Οι εργαζόμενοι στα ψυχιατρικά τμήματα γενικών νοσοκομείων εμφάνισαν μεγαλύτερες μέσες τιμές στην ενεργητική αντιμετώπιση [5,28 (SD=0,931) έναντι 3,95 (SD=1,126), $p<0,001$], στην άρνηση [5,60 (SD=0,951) έναντι 4,40 (SD=1,203), $p<0,001$], στη χρήση ουσιών [5,37 (SD=0,930) έναντι 4,36 (SD=1,148), $p<0,001$], στην αναζήτηση συναισθηματικής υποστήριξης [5,10 (SD=1,089) έναντι 4,69 (SD=1,117), $p<0,001$], στη συμπεριφορική αποδέσμευση [5,40 (SD=1,111) έναντι 4,29 (SD=1,076), $p<0,001$] και στην αυτομομφή/αυτοκατηγορία [5,28 (SD=1,127) έναντι 4,91 (SD=1,134), $p=0,004$]. Αντίθετα, οι εργαζόμενοι στα ψυχιατρικά νοσοκομεία εμφάνισαν μεγαλύτερες τιμές στον σχεδιασμό [5,20 (SD=1,261) έναντι 4,38 (SD=1,032), $p<0,001$], στην αποδοχή [5,81 (SD=1,230) έναντι 5,17 (SD=1,199), $p<0,001$] και στη θρησκεία/θρησκευτική προσφυγή [5,13 (SD=1,138) έναντι 4,79 (SD=1,048), $p<0,001$].

Συμπεράσματα: Οι μηχανισμοί διαχείρισης του στρες διαφοροποιούνται σημαντικά μεταξύ των δύο τύπων δομών, υποδεικνύοντας την επίδραση του οργανωσιακού πλαισίου και των δημογραφικών χαρακτηριστικών. Η ενίσχυση προσαρμοστικών μηχανισμών μέσω ψυχοεκπαίδευσης, εποπτείας και οργανωσιακής υποστήριξης είναι απαραίτητη για τη βελτίωση της ψυχικής ανθεκτικότητας του προσωπικού. Μελλοντικές έρευνες θα πρέπει να εστιάσουν σε διαχρονικές και πολυκεντρικές μελέτες και στην αξιολόγηση παρεμβάσεων για τη μείωση της επαγγελματικής εξουθένωσης.

Λέξεις-κλειδιά: Brief-COPE, επαγγελματίες υγείας, μηχανισμοί διαχείρισης, νοσοκομεία, στρεσογόνες καταστάσεις, ψυχιατρικά νοσοκομεία

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