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## **The relationship between personality traits and dysfunctional attitudes of medical staff in the pandemic period**

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**Abstract.** In recent years, the study of medical employees' mental health has become an important debated topic in the literature around the world, but little information is available on the extent to which social, psychological, and organizational factors affect the degree of exhaustion, leading to behavioral changes. The pandemic period that has affected (negatively impacted) the whole world in the last year, represented even more a degree of stress for the medical staff, who imminently and directly confronted the biological enemy. Medical employees are frequently exposed to both physical and mental risks. Shocking events and the likelihood of failure encountered during the work schedule can cause mental changes and an emotional imbalance.

**Keywords:** personality traits, dysfunctional attitudes, medical staff, pandemic period

### **Introduction**

The relationship between the doctor's personality and diagnosis has been approached by many specialists, who have shown that certain personality traits can distort the diagnosis and lead to diagnostic errors.

The doctor's personality can be a wide area with unsuspected implications in misdiagnosis and can start with one's vanity and pride, fear of not making mistakes and responding with a lack of self-criticism, to the point of refusing the help they can receive from other specialists. "All this can be accompanied by a tendency to constantly contradict, the impossibility of accepting that others can reach a correct diagnosis, uncontrolled and excessive optimism, but also exaggerated and unmotivated pessimism. But learning from mistakes is a success, and can become an additional source of instruction if retouched with time and experience". (Ețco & Cernițanu, 2012, p. 220-221)

There is a close connection between a doctor's personality and the way they practice their profession. The existence of the relationship between the two dimensions of the person, its nature and importance, depend on the various moments and situations in which they are involved, and its impact is also different. "These connections can be beneficial if they foster

empathy with the patient and help the physician find a fair or detrimental relationship with the patient, if it prevents an objective judgment, or a diagnosis". (Eţco & Cerniţanu, 2012, p. 212)

The image of the physician has changed over the centuries, but has left its mark on the perception of this profession. Thus, in most primitive religions, the healer is God's representative. Like the priest, the doctor fulfils his duties by observing some "rituals", some "canons", his language being, like that of religion, hermetic (Eţco & Cerniţanu, 2012, p. 213).

Hippocrates asked doctors for vocation, education, time and love of work. He believed that therapeutic success depended first on the word, and then on the plant used in healing. Although the doctor is more criticized than honored, the role of life saver is assigned to each doctor through the studies he follows and the professional qualification he obtains. The personality of the patient is an important factor, but just as significant is the personality of the doctor who treats the patient. The meeting between the doctor and the patient is the meeting between two personalities who fulfill different roles". (Eţco & Cerniţanu, 2012, p. 214).

The status of the doctor is often associated with values such as: power, knowledge, devotion, heroism and the power of sacrifice. Well-known French psychiatrists, Delay and Pichot, compiled a list of the main qualities required of the French public by doctors. These qualities, in order of priority, would be the following: professional conscience (100%), devotion (75-95%), accuracy of diagnosis (51-66%), scientific knowledge (33%), frankness (12%), material disinterest 11%), authority. Psychologist Donn W. Parson points out that in front of the sick person the doctor can adopt 5 types of attitudes: technical competence, universal attitude, functional specificity, affective neutrality, altruistic attitude (Eţco & Cerniţanu, 2012, p. 218-219).

Aggression is defined as "destructive and violent behavior toward people, objects, or oneself. It involves negative denial and produces damage or just transformations." (Popescu-Neveanu, 1978, p. 34-35)

Taken in a narrow sense, this term refers to the belligerent character of a person. In a broader sense, the term characterizes the dynamism of a subject that asserts itself, that escapes neither difficulties nor struggle on an even more general level, it characterizes that fundamental disposition due to which the living being can obtain the satisfaction of his vital needs, mainly food and sexual. For many psychologists, aggression is closely linked to frustration: a child prevented from playing snorts or trots with anger (Sillamy N., 1998, p. 19)

Behavior can derive from two broad categories: biological or social.

Social psychologists rely primarily on the social factors of aggression, thus building theories based on learning this behavior. However, biological theories cannot be ignored either, as violence is basically a reaction that is more about the body than the psyche (Boncu, p. 1-2).

Biological theories consider aggression an innate tendency. Aggression is an instinct, a predetermined pattern of responses that are genetically controlled. Every instinct has the following characteristics: it is beneficial for the individual and for the species, it is not learned based on individual experiences, it develops as the individual matures, it is present in all members of the species (Boncu, p. 2).

After 1920, Freud developed a conception of human conduct based on two fundamental instincts: the instinct of life, Eros, and the instinct of death, Thanatos. Freud researched the slow process of degradation of the human body over the years. He found that this process is directed by a psychic force, by the instinct of death, directed towards self-destruction. Under certain conditions, this instinct determines behaviors aimed at destroying others, which are called aggressive behaviors. Freud's theory is one-factor: aggression arises naturally from physiological tensions and must manifest itself in order for the individual to relax (Boncu, p. 2).

Social psychologists do not value biological theories too much, preferring theories that emphasize the learning process and the factors in the social context that determine aggression. Even if the idea of instinct is rejected, there are researchers who accept that aggression should be seen as a learned or innate tendency, the manifestation of which is triggered by specific social circumstances. Since such an approach includes a biological element, they are bio-social theories (Boncu, p. 4).

Neuroticism is the individual differences in the negative emotional response to threat, frustration or loss. Although the term neuroticism has its roots in Freudian theory and in the old philosophical and medical traditions on which psychodynamic models were based, the modern conception of neuroticism has nothing to do with such theories of unconscious conflict (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2792076/?ncid=txlnkusaolp00000618>).

Neuroticism, also called emotional instability, is defined by “the interrelationship between the traits of anxiety, low self-esteem depression, shyness. The strong emotional reactions of the unstable interfere with their poor adaptation, leading them to irrational reactions, sometimes rigid. If it is an unstable extrovert, anxiety and sensitivity are at the forefront, it becomes excitable, even aggressive. At the other extreme, emotional reactions are slow and weak, with a tendency to return to their original state very quickly after emotional activation.” (Minulescu, 2004, p. 138)

Neuroticism is the characteristic that reveals negative effects, including anger, anxiety, self-awareness, irritability, emotional instability and depression. People with high levels of neuroticism respond poorly to environmental stress, interpret common situations as threatening, and may experience minor frustrations as overwhelming. Neuroticism is one of the best established and empirically validated areas of personality traits, with a substantial body of research to support heredity, childhood history, lifelong temporal stability, and universal presence.

Neuroticism is comparable to a wide range of physical ailments, such as heart problems, impaired immune function, asthma, atopic eczema, irritable bowel syndrome, and even an increased risk of mortality. The relationship of neuroticism with physical problems is both direct and indirect, in the sense that neuroticism offers a vulnerability to the development of these conditions, as well as a willingness to exaggerate their importance and failure to respond effectively to their treatment (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428182/>).

Neuroticism is also associated with a diminished quality of life, including feelings of excessive worry, professional failure, and marital dissatisfaction.

High levels of neuroticism will contribute to poor work performance due to emotional preoccupation, exhaustion and distraction. Similar to the neurotic effect of mourning on physical condition, high levels of neuroticism will lead to effective impairment of marital relationships, but also to subjective feelings of marital dissatisfaction even when there is no objective basis for such feelings, which in turn can lead to real frustration and withdrawal of the husband. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5428182/>)

Depression is morbid condition, more or less lasting, characterized mainly by sadness and a decrease in tone and energy (Roland Doron & Françoise Parot, 2006, p. 96).

Depression is a vital sadness, characterized by nostalgia and remorse for the past, disgust for the present, anxiety for the future, self-loathing and emotional anesthesia (Daniel Widlöcher apud Sylvie Tenenbaum, 2018, p. 15).

It does not describe the sadness or state of deviation that is normally part of everyday life, but a real mental illness. Depression should not be confused with a transient malaise that does not make life easier but does not last long nor with the term stress, so used lately, and which has changed its meaning: from generalized adaptation syndrome, to synonymous with disorder and malaise (Sylvie Tenenbaum, 2018, p. 15-16).

Depression is one of the most common mental disorders, from neurotic syndromes in somatic diseases to manic-depressive psychoses and autolytic behaviours. Depression can be found as a nosological entity (bipolar disorder, major depressive episode, recurrent depression), syndrome, symptom in some psychopaths or in drug use or can be depression secondary to a medical condition (Pintea, 2015, p. 15).

“The major depressive episode manifests itself as an intense negative emotional experience, feeling of uselessness, psycho-motor slowness, moral pain, irritability, guilt, bradypsychia, bradylalia, hyporexia, melancholy rape accompanied by impulsive acts of hetero or self-aggression. Many psychopathological symptoms, such as hopelessness, drug addiction, or helplessness, are predictors of suicide risk”. (Pintea, 2015, p. 15)

In the current epidemiological context, an increase in the number of cases of mental disorders in the spectrum of depression or anxiety is expected. Healthcare professionals, whether we are talking about doctors, nurses or nursing staff, are at increased risk for symptoms on this spectrum. Depression and anxiety are two nosological entities with a strong impact on both the patient and the public health systems. Early identification and psychiatric intervention in crisis have the ability to reduce the pressure, both the one felt individually by medical staff and the pressure on the public health system, already required in the context of the pandemic (<https://socola.eu/impactul-covid-19-asupra-simptomatologiei-anxioase-si-depresive-in-randul-cadrelor-medicale/>).

### *1.1. 2. Research objectives*

**The objectives** pursued in this research are the following:

**Objective 1** - Assessment of personality traits and dysfunctional attitudes depending of medical staff on age group (28-45 years / 46-65 years)

**Objective 2** – Assessment of level of correlation between neurotic personality trait and dysfunctional attitudes of medical staff.

### *1.2. 1.2. Research hypotheses*

**Hypothesis 1** - *It is assumed that there are significant differences between people aged 28-45 years and those aged 46-65 years, in terms of aggression - hostility caused by pandemic context and burn-out syndrome.*

**Hypothesis 2** - *It is assumed that there is a positive correlation between neuroticism-anxiety and dysfunctional attitudes caused by pandemic context and burn-out syndrome.*

### *1.3. 2.1 Research methods and techniques*

#### **2.1.1. Sample description**

This study was conducted on a sample of 99 subjects, of which 76 women and 23 men, aged between 28 and 65, from Brăila County. 94 of them have a permanent urban domicile, and the other 5 have a permanent rural domicile. The sample was divided into two age categories; thus, the first category consists of people aged 28-45 years and the second of people aged 46-65 years. From the point of view of the work section, we also have two distinct categories: the staff from the Brăila County Hospital and the staff from the Ambulance Service.

A adulthood encompasses the time interval 26-65 years of age, and it has several phases of evolution. The stage between 26-40 years old is distinguished by the burning desire to improve the qualification, professional stabilization and job. Also in this stage of maturity, individuals create their own family. In this context, they must adapt to the new obstacles caused by the lack of time, determined by household chores, job requirements, the needs of the newborns.

**The independent variable** is represented by the events to which the subjects were subjected. Both positive and negative situations, the cases they faced during this pandemic

period, reveal their representative characteristics, being the perfect opportunity to observe how the stimuli are perceived.

**The dependent variable** highlights the way of interpreting each, through the prism of their own feelings, beliefs, feelings for the described circumstances.

#### 1.4. 2.2. Description of the tools used

For this research were used:

1. The Zuckerman-Kuhlman Personality Questionnaire (ZKPQ), author Marvin Zukerman,
2. Dysfunctional Attitudes Scale, Form A (DAS-A), Aaron Beck.

##### (a) 2.2.1. The ZKPQ questionnaire

Trying to identify the dimensions of this model, M. Zuckerman initially focused on nine factors: sociability, neuroticism, anxiety, hostility, socialization, the search for sensations, impulsivity, activity and social desirability. A series of researches, which he later conducted, using hundreds of subjects, using scales that measured these factors, led to only five dimensions, which he called: Impulsive Search for Sensations, Sociability, Neuroticism-Anxiety, Aggression-Hostility and Activity. These are the dimensions of the five-factor alternative model being evaluated by the scales of the ZKPQ questionnaire.

**The Impulsive Sensation Search Scale** contains two groups of items, which measure two constructs:

- ⇒ The Impulsivity construct refers to the lack of planning and the tendency to act quickly, on impulse, without reflecting in advance.
- ⇒ The Sensation Search construct describes the general need for excitement and agitation, the preference for unforeseen situations and friends with unpredictable behavior, as well as the need for change and novelty.

**The Neuroticism - Anxiety Scale** brings together items related to upsets, emotional tensions, worries, difficulty making decisions, lack of self-confidence, and sensitivity to criticism.

**The Aggression - Hostility Scale** measures two constructs:

- ⇒ Items that assess Aggression describe the predisposition to express aggression, especially in verbal form.
- ⇒ Items that measure Hostility refer to rudeness, antisocial behavior, revenge and enmity, to a volcanic temperament and to the impatience manifested in interpersonal relationships.

**The Sociability Scale** contains two groups of items:

- ⇒ The first group measures the Attraction to parties and friends construct. The items refer to the subject's pleasure in taking part in big parties, interacting with others, and having many friends.
- ⇒ The second group of items evaluates the construct Intolerance to social isolation. In the case of introverts, it measures the preference for solitary activities, and in the case of extroverts, intolerance of social isolation.

**The Activity Scale** evaluates two constructs:

- ⇒ The first is the need for activity. It is measured by items related to the need to be always active, to the impatience and anxiety felt when there is nothing to do.
- ⇒ The second construct, the need to make an effort, expresses the preference for a challenging and difficult job and the consumption of a large amount of energy in work and in performing other tasks.

### 2.2.2. The DAS-A questionnaire

The DAS-A questionnaire presents the main topic, namely clinical depression, which is a different condition from the states of sadness that sometimes occur in the life of each of us. People with clinical depression feel sad and hopeless for weeks on end. Most of the time, they lose interest in the things they used to enjoy and have trouble sleeping and eating.

At the same time, they find it difficult to make the effort to find solutions to the problems they have, again sometimes they can't concentrate enough even for daily activities. Usually, depressed people spend many hours thinking about suicide, death, or the fact that they will be fine if they no longer exist. These symptoms are similar to those found in people going through situations of mourning, but in the case of clinical depression either the events of loss are missing or the manifestations last much longer than would be normal in such situations. The mentioned manifestations produce major difficulties of adaptation, the major depressive disorder being one of the important causes of death, in association with the idea of suicide.

The dysfunctional attitude scale (DAS - Weissman, 1979; Weissman and Beck, 1978) is a tool that allows the evaluation of attitudes that may be a predisposition for the onset of depression.

The initial shape of the scale had 100 items, later transformed into two parallel shapes of 40 items each (DAS-A and DAS-B). Using a clinical group with anxiety and affective disorders of 2,023 subjects, Beck, Brown, Steer, and Weissman (1991) showed that the factorial structure of the original form included nine main factors: (1) vulnerability, (2) approval, (3) perfectionism, (4) the need to please others, (5) avoiding weaknesses, (6) controlling emotions, (7) disapproval, (8) absolutist demands, and (9) the need to impress others.

### 1.5. 3.1. Presentation of the data

The research began by assigning the ZKPQ Assessment Questionnaires and the Dysfunctional Attitude Scale, Form A (DAS-A), distributed using the Google Forms platform, being completed 100% by a sample of 99 subjects during the pandemic.

The sample consists of women and men working in the medical system, aged between 28 and 65, being a convenience sampling due to the current restrictions caused by the pandemic context. For the hypotheses from which we started studying the data, the following results were obtained:

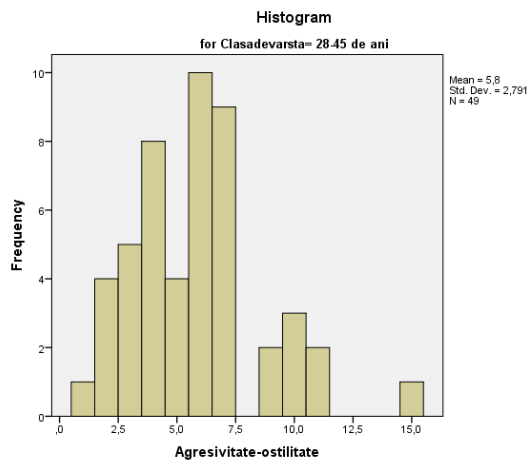
#### (b) 3.1.1. Hypothesis 1

*It is assumed that there are significant differences between people aged 28-45 years and those aged 46-65 years, in terms of aggression - hostility caused by pandemic context and burn-out syndrome.*

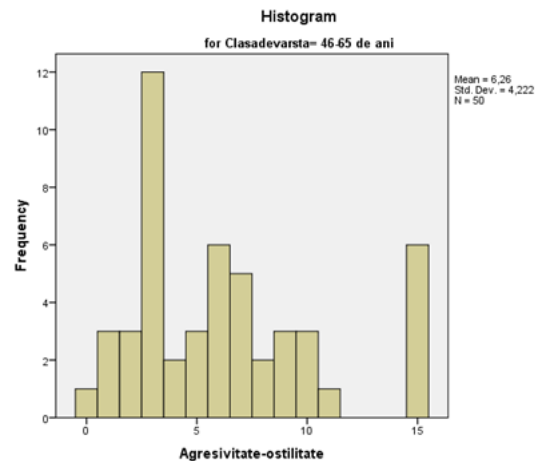
The reason we started from the presumption of this hypothesis is that people aged 28-45 are more prone to upset, emotional tension, worries, rudeness, antisocial behavior, revenge, hostility and impatience in interpersonal relationships, compared to those in the second category aged 46-65 years, because work experience led them to become stronger, even cynical in certain situations, and tolerance towards critical situations is much more developed.

As mentioned above, the adult between the ages of 28-45 has many family and personal responsibilities, while being forced to complete the demands of the current job. He therefore tries to manage his/hers attention and energy in all the directions in which they are asked.

Given the stressors of each group, we set out to identify which of the two have a lower level of aggression and also which of them manage to overcome more easily the obstacles of the stage of life in which they are.



**Fig. 2 - Distribution of scores for aggression in the category 46-65 years**



**Fig. 3 - Distribution of scores for aggression in the category 28-45 years of age**

As we can see in the histograms attached above, the distribution of scores in the age category between 28 and 45 years is asymmetric, because it includes most scores at the extremities, otherwise forming a bimodal curve. For the age category between 46 and 65 years, we can determine its membership in asymmetry. Regarding the first class (28-45 years old) the average obtained is 5.80 and for the second class (46-65 years old) its value is 6.26.

**Table 1 – Calculation 1 of normality for aggression according to age category**  
**Tests of Normality**

|                      | Age class       | Kolmogorov-Smirnov |    |      | Shapiro-Wilk |    |      |
|----------------------|-----------------|--------------------|----|------|--------------|----|------|
|                      |                 | statistical        | Df | Sig. | statistical  | Df | Sig. |
| Aggression-hostility | 28-45 years old | ,170               | 49 | ,001 | ,937         | 49 | ,012 |
|                      | 46-65 years old | ,160               | 50 | ,003 | ,895         | 50 | ,000 |

a. Lilliefors Significance Correction

According to table 1 above, it is observed in the case of column Sig. of the test applied the fact that the sample of the category of 28-45 years, in the case of the examined dependent variable, obtained an asymmetric distribution of scores, but also the sample of the category of 46-65 years, obtained a non-normal distribution of scores. Following the verification of the normality of the data distribution and the identification of the asymmetry in the case of age categories in order to verify the validity of hypothesis 1, we applied a non-parametric test method, namely the Mann-Whitney test:

**Table 2 - Calculation of ranks for aggression by age category**  
**Ranks**

|                      | Age class       | N  | Mean Rank | Sum of Ranks |
|----------------------|-----------------|----|-----------|--------------|
| Aggression-hostility | 28-45 years old | 49 | 50,26     | 2462,50      |
|                      | 46-65 years old | 50 | 49,75     | 2487,50      |
|                      | total           | 99 |           |              |

**Table 3** - Calculation of the statistical test for aggression according to age category

| Test Statistics        |                      |
|------------------------|----------------------|
|                        | Aggression-hostility |
| Mann-Whitney U         | 1212,500             |
| Wilcoxon W             | 2487,500             |
| z                      | -,088                |
| Asymp. Sig. (2-tailed) | ,930                 |

a. Grouping Variable: Age class

***Interpretation of the obtained result:***

From table 3 we observe that Sig. (2-tailed) has the value 0.930. The result obtained is higher than 0.05, which means that there are no significant differences in terms of aggression between the two age categories. As we can see both from the calculations made with the tests and by analyzing the average, in the case of both age categories, no significant differences were noticed that we can examine. We believe that we have achieved the current result for several reasons. As we mentioned, each stage of life, targeted in this research, comes with updated elements, which can be disruptive both for individuals going through this pandemic period, and for people with multiple responsibilities to themselves, but of those around.

***Psychological interpretation of the data:***

In the literature it is argued that both doctors and nurses are subject to significant stressors, which leave their mark on both personality, character, mood, and physical and mental health, productivity, work capacity. They demonstrated minimal score, especially at parameters such as: energy level, concern for one's own life and health, anxiety, emotional instability-lability (Cazacu, 2014).

University professor, Gheorghe Baciu, also conducted a study on aggression in which he claims that it develops only within relational systems by involving some individuals in relation to others. It can be concluded with certainty that aggression has its origins in multiple social, psychological, medical, etc. causes. Often the main reasons are associated with numerous risk factors including stress (Baciu, 2011).

As for the profession, the medical staff is exposed to many strong emotions, such as: the desire to save their patients, frustration in case of failure, helplessness in the face of illness, fear of getting sick, uncertainty in clinical practice or desire to to detach and avoid these feelings. Aggression is a risk factor in this area, they easily lose patience, become recalcitrant, and at some point become unaware of their own actions.

It has also been shown that the expression of aggressive behavior causes major changes during development. For example, research shows that aggression occurs and reaches its peak at the beginning of life and is gradually replaced by verbal aggression as verbal abilities increase. Normative perceptions of aggression in emerging adulthood were examined with a coding scheme that reflects a wide range of aggressive behaviors. These are considered normative perceptions, given the approach of asking emerging adults to describe how most people do when they try to harm others.

A possible explanation for the fact that the hypothesis is not confirmed is due to the fact that we used a relatively small sample of only 99 subjects. In most cases, aggression occurs in

both age groups taking into account the factors that cause stress in the workplace, but also this pandemic period that has amplified the situation.

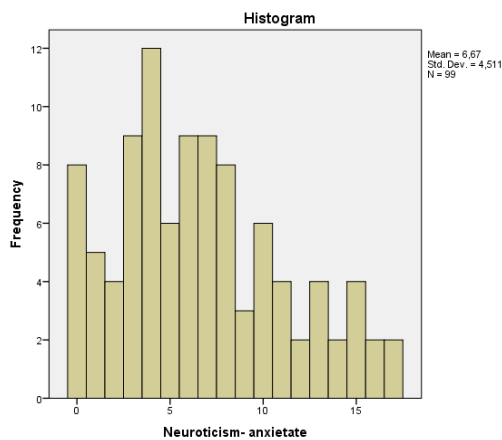
### 3.1.2. Hypothesis 2

*It is assumed that there is a positive correlation between neuroticism-anxiety and dysfunctional attitudes of the medical staff caused by pandemic context and burn-out syndrome.*

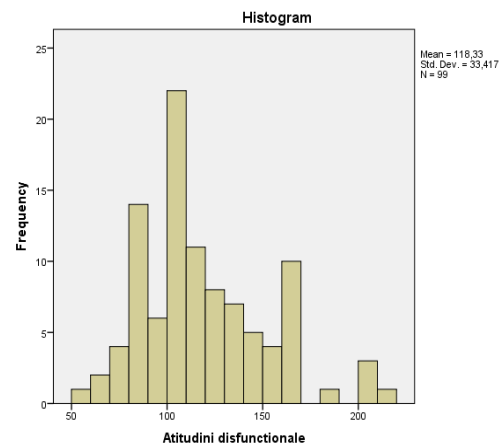
For this hypothesis, we correlated the results obtained by the participants in the neuroticism-anxiety inventory from the ZKPQ questionnaire, with the results obtained at the dysfunctional attitude scale from the DAS-A questionnaire.

The reason we started from the presumption of this hypothesis is that people with upsets, emotional tensions, worries, difficulty making decisions, lack of self-confidence and sensitivity to criticism, which activates in the medical field, can develop a strong relationship with dysfunctional attitudes that become affected by clinical depression, feeling sad, hopeless weeks in a row. Most of the time, they lose interest in the things they used to enjoy and even have trouble sleeping. At the same time, they become difficult to make the effort to find solutions to the problems they have, and sometimes they cannot concentrate enough even for daily activities. Usually, depressed people spend many hours thinking about suicide, death, or whether it would be better if they didn't exist.

I believe that medical staff may be prone to such disorders because the field in which they apply makes them sadder, worried about the cases they face every day, and in cases of failure, they are / can be blamed for reaching such of manifestations.



**Fig. 4 - Distribution of scores for neuroticism-anxiety in medical staff**



**Fig. 5 - Distribution of scores for dysfunctional attitudes in medical staff**

As we can see in the histograms attached above, the distribution of scores in the case of neuroticism-anxiety is asymmetric, because it includes most scores at the extremities, otherwise forming a bimodal curve. For dysfunctional attitudes we can determine its belonging to asymmetry. Regarding the neuroticism-anxiety obtained, the average obtained is 6.67 and for the dysfunctional attitudes its value is 118.33.

**Table 4 - Calculation of normality for neuroticism-anxiety and dysfunctional attitudes**  
**Tests of Normality**

|                      | Kolmogorov-Smirnov |    |      | Shapiro-Wilk |    |      |
|----------------------|--------------------|----|------|--------------|----|------|
|                      | statistical        | Df | Sig. | statistical  | Df | Sig. |
| Neuroticism- Anxiety | ,107               | 99 | ,007 | ,953         | 99 | ,001 |



|                         |      |    |      |      |    |      |
|-------------------------|------|----|------|------|----|------|
| Dysfunctional attitudes | ,109 | 99 | ,006 | ,950 | 99 | ,001 |
|-------------------------|------|----|------|------|----|------|

a. Lilliefors Significance Correction

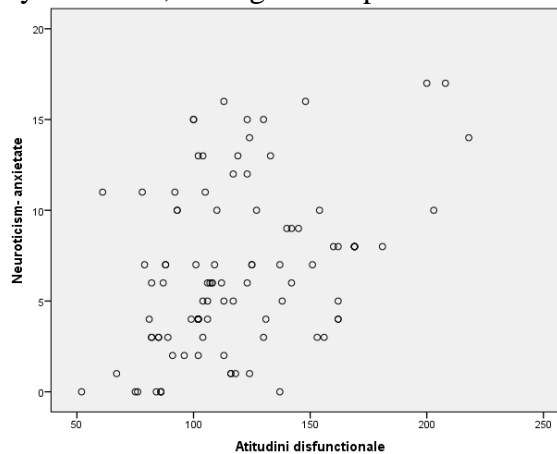
According to the table above, it is observed in the case of the column Sig. of the test applied the fact that neuroticism-anxiety has an asymmetric distribution of scores, as well as dysfunctional attitudes that obtained a non-normal distribution of scores. Following the verification of the normality of the data distribution and the identification of the asymmetry in the case of neuroticism and dysfunctional attitudes in order to verify the validity of hypothesis 2, we applied a nonparametric test method, respectively the nonparametric correlation coefficient Spearman:

**Table 5 - Calculation of the correlation for neuroticism-anxiety and dysfunctional attitudes**  
**Correlations**

|                            |                         | Neuroticism-<br>Anxiety    | Dysfunctiona<br>l attitudes |
|----------------------------|-------------------------|----------------------------|-----------------------------|
| Sperman's rho              | Neuroticism-<br>Anxiety | Correlation<br>Coefficient | 1,000                       |
|                            |                         | Sig. (2-tailed)            | ,389**                      |
|                            |                         | N                          | ,000                        |
| Dysfunctional<br>attitudes |                         | 99                         | 99                          |
|                            |                         | Correlation<br>Coefficient | ,389**                      |
|                            |                         | Sig. (2-tailed)            | 1,000                       |
|                            | N                       | ,000                       | .                           |
|                            |                         | 99                         | 99                          |

\*\* . Correlation is significant at the 0.01 level (2-tailed).

From Table 5 we notice that the significance threshold, Sig. (2-tailed) is less than 0.05, and the Spearman correlation coefficient is 0.389 which means that there is a positive correlation, but weak, slightly moderate, having interdependence between the two variable.



**Fig. 6 - Graphic representation of the correlation between neuroticism-anxiety and dysfunctional attitudes**

Following this graph we can see a slight scatter in the upper right, being more numerous in the lower left, which shows that it is a very high correlation, with a very close relationship between variables.

***Psychological interpretation of data:***

Mostafa A F. Abbas et al. (2012) conducted a study on anxiety and depression among medical staff at a hospital in Riyadh, the capital of Saudi Arabia. Regarding anxiety, 53% of the subjects were normal, 27% were classified as a cause for concern, and 20% were clinical cases. In case of depression: 75% were normal, 15% classified as a cause for concern, and 10% of these are possible clinical cases. Most possible clinical cases of anxiety have been reported in the 20-30 age group. In the case of depression, the highest prevalence rate of possible clinical cases has been reported among the 30-40 age group.

Atif K. et al. (2016) also conducted a study on anxiety and depression among doctors at a hospital in Pakistan. A high level of anxiety and depression was therefore reported. There was a strong positive relationship between the scores obtained for anxiety and depression. Regarding depression, doctors who have a longer seniority in work, had a higher level of depression.

We consider that the poor correlation between neuroticism-anxiety and dysfunctional attitudes is due to the use of a weak numerical sample, of only 99 subjects. In most cases, anxiety makes its first appearance, a consequence of it on the way of life, constituting dysfunctional attitudes.

**Conclusions**

Following the questionnaire applied, the sample was balanced from the point of view of the staff working at the Brăila County Hospital and the staff of the Ambulance Service, as well as of the age classes: between 28-45 years and between 46-65 years. Following the analysis, it was possible to find some differences between the present study, compared to those already existing in the literature. The differences could arise from the fact that a convenience sampling was performed, but also due to the small number of subjects who engaged in participating in this research. Another argument could be the way we applied the questionnaires. Considering the current situation, the conditions in which the activities have been carried out lately in absolutely all fields of activity, the pandemic generated by the COVID-19 virus has determined the impossibility of applying the questionnaires in physical format. Thus, the sampling of the subjects was carried out exclusively online, through questionnaires designed on "Google Forms". It would have been preferable for these questionnaires to be applied under the supervision of an objective observer, who would take part physically in the activities aimed at the research objectives, thus being able to analyze the subjects over a longer period of time, thus issuing the most objective and real answers.

From our own observations, we can draw the following conclusions: there is a relationship in terms of neuroticism-anxiety and dysfunctional attitudes, especially in the pandemic period faced by all health professionals. The uncomfortable equipment consisting of coveralls and medical mask, gives the medical staff a rigid allure, which prevents them from smiling at patients, to convey the confidence and empathy they need. Also, the increase in cases of COVID-19 virus disease has degenerated into anxiety and frustration, not having the power to help patients on a regular basis, given the large number of infected in the wards.

Regarding the profession, the medical staff is exposed to shocking situations and strong emotions, such as: the desire to save their patients, frustration in case of failure, fear of getting sick, uncertainty in clinical practice or the desire to detach and avoid the accumulation of feelings. The staff is also exposed to stressors outside the doctor-patient relationship, such as bureaucratic requirements that are increasing. The medical field is in a continuous ascent, so doctors are in a continuous formation and are forced to adapt quickly. Social support is an important factor in moderating the impact of demanding events. People whose work occupies

a large part of individual resources find more problems in family relationships, such as poor communication, less defined roles and less emotional involvement.

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