REVISTA DE PSIHOLOGIE

Vol. 67 ***2021*** ***Nr. 3***

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INTIMACY AND COUPLE SATISFACTION IN EMERGING ADULTHOOD. THE MEDIATING ROLE OF SUPPORTIVE DYADIC COPING

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Abstract

Intimacy and couple satisfaction are some of the main factors related to relationship quality. Likewise, intimacy has long been associated with couple satisfaction as it is one of its most important predictors. Another meaningful correlation of couple satisfaction is supportive dyadic coping, which correlates with the satisfaction in marital and non-marital couples. This present study is aimed to investigate the associations of intimacy and couple satisfaction and to explore the mediating role of supportive dyadic coping. The sample is composed of 105 emerging adults involved in a romantic relationship, who filled up three self-reporting scales. The results indicate that intimacy predicts both couple satisfaction and supportive dyadic coping. Moreover, supportive dyadic coping fully mediates the relationship between overall intimacy / intimate commitment and couple satisfaction. Also, supportive dyadic coping partially mediates the relationship between intimate openness / affection and couple satisfaction. The possible explanations and implications for therapeutical interventions are discussed.

Cuvinte-cheie: intimitate, satisfacție în cuplu, coping diadic suportiv, mediere, adulți tineri.

Keywords: intimacy, couple satisfaction, supportive dyadic coping, mediation, emerging adults.

1. INTRODUCTION

In the last four to five decades, intimacy has become an important construct when it comes to understanding the dynamics within couples. Together with couple satisfaction it is one of the main factors of relationship quality. Focusing on emerging adults, the present study aims to test the relationships between overall intimacy / specific dimensions of intimacy and couple satisfaction, considering their theoretical and empirical interconnection (Ubando, 2016; Yoo *et al.*, 2013). Moreover, we investigated the mediating role of dyadic coping in the relationships between intimacy and couple satisfaction. Intimacy is positively related with supportive dyadic coping (Traa *et al.*, 2014). Also, previous empirical cross-sectional studies suggest that dyadic coping is an important predictor of couple satisfaction (Levesque *et al.*, 2014; Traa *et al.*, 2014). More specifically, supportive dyadic coping seems to be one of the strongest predictors of couple satisfaction, compared

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to other forms of coping (Bodenmann *et al.*, 2019). To our knowledge, there is presently scarce research allowing us to understand how dyadic coping mediates the interaction between intimacy and couple satisfaction. More studies are needed to investigate the relations between these variables during emerging adulthood in order for one to build a better understanding of how close relationships initiate and develop, throughout a timespan when achieving intimacy is the main developmental task for individuals (Shulman & Connoly, 2013). Therefore, in this present study we will focus on a sample of emerging adults.

2. LITERATURE REVIEW

2.1. INTIMACY AND COUPLE SATISFACTION IN EMERGING ADULTS

Researchers have long struggled, without much success, to develop and agree upon the definition of intimacy. But some of its main components have been underlined by theoretical and empirical approaches: involvement, emotion, sexuality, interdependency, fulfillment of needs and emotional attachment (Dandeneau & Johnson, 1994; Greeff & Malherbe, 2001; Perndorfer *et al.*, 2018; Robinson & Blanton, 1993; Schaefer & Olson, 1981). Several approaches have investigated the development of intimacy in close relationships. On the one hand, part of the empirical research available advances the idea that intimacy is developed primarily through self-disclosure (Derlega *et al.*, 1993; Perlman & Fehr, 1987). On the other hand, there are studies suggesting that a partner's level of responsiveness contributes significantly to the advancement of intimacy (Berg, 1987; Davis, 1982; Laurenceau *et al.*, 2005;). Reis & Shaver (1988) blend both alternatives in their interpersonal model of intimacy, in which self-disclosure, followed by a positive and supportive dyadic response, contributes to the creation of intimacy between partners (Reis, 2017).

Emerging adulthood has achieved considerable attention in dyadic relationship research, as being one of the most important life transitions in terms of couple formations and development (Baggio *et al.*, 2016). Defined as the age period between 18 and 25, it is characterized by an increase in independence, without the full responsibilities and commitment of adulthood (Whitton & Kuryluk, 2012). According to Erikson's developmental theory (Erikson, 1968) and to Arnett's emerging adulthood studies (Arnett, 2000), intimacy may be one of the key issues defining young adults (Weisskirch, 2018). Emerging adulthood is a timeframe where young adults have the opportunity to explore romantic relationships, in the absence of pressure to engage in a committed and enduring relationship. Considering the widespread acceptance of premarital sex, increased premarital cohabitation and a rise in the age of the first marriage (Arnett, 2007), it is likely that emerging adulthood allows rare opportunities for the advancement of psychosocial intimacy and its correlations.

Cross-sectional studies associate poor psychosocial intimacy development, mostly for females from 16 to 22 years old, with Cluster B symptoms from the

DSM-5. The cluster of personality disorders is manifested through dramatic, overly emotional or unpredictable thinking or behavior and interactions with others (Crawford *et al.* 2004). In contrast, in longitudinal studies, the development of psychosocial intimacy during college predicts midlife satisfaction (Sneed *et al.* 2012). Moreover, intimacy in emerging adulthood predicted greater marital adjustment 25 years later (Boden *et al.* 2010). This is consistent with other studies, which indicate a positive link between emotional intimacy and couple satisfaction. Higher levels of one's emotional intimacy were also related with higher levels of one's marital satisfaction (Dandurand & LaFontaine, 2013; Greeff and Malherbe, 2001). Furthermore, low levels of intimacy are reported as one of the most frequent causes of decreased couple satisfaction, distress and dissolution in couples. Decreased levels of intimacy between romantic partners are one of the most frequently invoked motives for attending couple therapy (Yoo *et al.*, 2013) or crumbling relationships (Waring, 1981). Cross-sectional dyadic studies have shown that all components of intimacy were positively correlated with women's and men's own relationship and sexual satisfaction as well as with their partners' relationship satisfaction (Rubin & Campbell, 2012; MacNeil & Byers, 2005).

Whether or not the same patterns of associations between intimacy and couple satisfaction are present in emerging adults and have not been largely explored in empirical studies. Also, there is a lack of studies conducted on non-US samples or non-western countries, such as samples from Eastern Europe. Despite being considered less stable and committed than adult marriages, emerging adulthood relationships account for individual well-being. Moreover, couple satisfaction is similarly important to other age groups (Whisman, 2001). For women, it is especially relevant at the beginning of their romantic relationship (Whitton & Kurlyuk, 2012). In this context, for a further investigation of the link between intimacy and couple satisfaction, this present study examines the association among these variables in the case of a sample of emerging adults from Romania.

2.2. DYADIC COPING AS MEDIATOR

Dyadic coping (DC) is a multidimensional process that consists of mutual communication of stress among partners but also in their responses when dealing with stress (Falconier *et al.*, 2015). Supportive dyadic coping (SDC) is especially important, as it is strongly linked to the quality of couple relationship through two mechanisms. First of all, it reduces the negative influence of stress on relationships, hence having a moderating effect. Secondly, through supportive dyadic coping, partners perceive their relationship as being a support for them, thus enhancing intimacy, trust and solidarity (Bodenmann, 2005).

The research investigating the relationship between intimacy and DC/ SDC is scarce. DC increases mutual intimacy in romantic relationships (Bodenmann, 1995; Cutrona, 1996). For couples facing breast cancer, lower levels of partner support and communication (essential parts of dyadic coping), are related to lower levels of each partner's own reports of average daily intimacy and relationship functioning (Pasipanodya *et al.*, 2012).

Numerous studies have found significant positive associations between DC and couple satisfaction (Bodenmann *et al.*, 2006; Herzberg, 2013; Papp & Witt, 2010;), psychological well-being of the partners (Bodenmann *et al.*, 2011) and reduced effects of chronic illness (Berg & Upchurch, 2007; Hagedoorn *et al.*, 2008; Revenson, 2003). More specifically, positive dyadic coping was linked to couple satisfaction, whereas negative dyadic coping was associated with couple distress (Bodenmann *et al.*, 2006; Falconier *et al.*, 2015; Rusu *et al.*, 2018). A meta-analysis conducted by Falconier and her collaborators (2015), which included 72 independent samples (N= 17,856 participants), found positive association regardless of gender, age, nationality, education level or length of relationship between dyadic coping and couple satisfaction ($r = 0.45$, $p < 0.001$, 95% CI [0. 41, 0.48]). Positive DC was found to be a stronger predictor for relationship satisfaction than negative DC (Falconier *et al.*, 2015; Sim *et al.*, 2017).

However, studies have primary focused on adult couples. Much less is known about how couples of emerging adults cope with outside and inside stressors dyadically, considering the particularities of relationships during their age. Previous studies on DC in emerging adulthood have found a strong association between interindividual differences and couple satisfaction of young, emerging adult couples (Breitenstein *et al*., 2018). In addition, Bodenmann (2000) reports significant correlations from .32 to .63 between dyadic coping and couple satisfaction in young emerging adults. The strongest correlations reported were between supportive dyadic coping and couple satisfaction ($r = .62$).

Furthermore, in their study of college attending couples, Papp and Witt (2010) found DC to be a stronger predictor of relationship satisfaction compared to individual coping. Other studies with late adolescent / young adults samples found associations between the partners' support and relationship satisfaction (Cramer, 2006; Pinquart & Fabel, 2009). These findings suggest that DC may be of high relevance during emerging adulthood, considering it performs a similar function to the same type of coping in adulthood (Furman, 2002). Based on this evidence, we aim to investigate the mediating role of SDC in the relationship between intimacy and couple satisfaction in emerging adults.

3. METHODOLOGY

3.1. CURRENT STUDY – AIMS AND HYPOTHESIS

Considering the theoretical highlights and empirical evidence described above, regarding the role of intimacy and supportive dyadic coping in shaping couple satisfaction, we aim to understand how these variables develop in emerging adult couples. Drawing from existing research and previous theoretical contributions, it was hypothesized that: *H1 Intimacy and couple satisfaction positively correlate. H2 The link between intimacy and couple satisfaction is mediated by supportive dyadic coping.*

3.2. PROCEDURE AND SAMPLE

The protocol for this study was approved by the Ethical Committee of the University. Students enrolled in graduate and post-graduate courses and their partners were recruited to take part in the study. All attendants consented to the study protocol and were given course credit for participation, as at least one of the partners was enrolled in university/post-university studies. The participants were aware that their data would be anonymized and kept confidential and that they could discontinue the study at any time. To ensure confidentiality and privacy of each dyad member's report, the couples were instructed to complete the questionnaires independently, without consulting each other.

The sample consisted of 105 participants, 31 men (29.5%) and 74 women (70.5%), with ages between 18 and 55, with a mostly urban background (74.3% urban *vs* 25.7% rural). Most couples (63%) were consensual and not married. 72.4% of the sample had graduate studies and 21.9% were undergraduates. The participants living in consensual couple relationships had a mean duration of their relationship of 3.14 years (± 2.28 years). For the married couples, the length of the relationship ranged from 2 to 25 years with a mean of 10.58 years (± 6.11 years), significantly higher than that of the consensual couples (p=0.001).

3.3. MEASURES

We used the following instruments to assess the main variables of the study.

The Dyadic Adjustment Scale (DAS, Spanier, 1976), a well-known instrument to measure the quality of couple relationships, was used to assess couple satisfaction. It comprises 32 items spread across four subscales: (a) Consensus, (b) Marital Satisfaction, (c) Couple cohesion, (d) Affective expression. We used the mean scores for the subscale measuring couple satisfaction, having an Alpha Cronbach coefficient of 0.726.

The Marital Intimacy Questionnaire (Van den Broucke, 1995) is a scale meant to measure marital intimacy, with 56 items, ranging from 1 to 5 on a Likert type scale. The instrument contains 5 subscales: authenticity, consensus, intimacy problems, affective status and commitment. The Alpha Cronbach coefficient for the entire scale is 0.954 and it has the following values for the subscales: Consensus- 0.944 Openness- 0.921; Affection- 0.968; Commitment- 0.829; Intimacy problems- 0.871.

The Dyadic Coping Inventory (Bodenmann, 2008; Ledermann *et al.*, 2010) is a 37 items scale, meant to measure perceived communication and dyadic coping (supportive, delegate, negative). We chose the supportive coping scale, composed of 5 items, to assess how partners offer support to each other in a problem-focused or emotion-focused approach. The Alpha Cronbach coefficient for our sample is 0.896.

4. RESULTS

4.1. DESCRIPTIVE RESULTS

The total scores for intimacy ranged from 117 to 243, with an overall mean level of 184.90 ± 19.60, suggesting a moderate level of intimacy. There were no significant differences based on gender (182.28 *vs* 185.92; p=0.434), age (186.90; 182.82; 184.60; p=0.655), area of living (185.56 *vs* 183.20; p=0.612), marital status (182.13 *vs* 186.36; p=0.343), educational level (169.90; 187.24; 181.48; p=0.104) and income (182.0 *vs* 188.14; p=0.141). *The total scores for couple satisfaction* ranged from 75 to 138 with an overall mean level of 110.02 ± 13.51, suggesting a moderate level of satisfaction. There were no significant differences based on gender (110.43 *vs* 109.85; p=0.843), age (109.44; 110.18 and 111.58; p=0.885), area of living (110.74 *vs* 108.54; p=0.376), marital status (110.36 *vs* 109.83; p=0.852), educational level (107.33; 109.55 and 112.32; p=0.622) and income (109.08 *vs* 111.02; p=0.473). *The total scores for supportive dyadic coping* ranged from 9 to 25, with an overall mean level of 19.75 ± 3.50. The results did not differ significantly according to gender (19.16 vs 20.0; p=0.265), age groups (20.51; 18.87; 20.17; p=0.069), living areas (19.62 vs 20.15; p=0.498), marital status (19.0 vs 20.12; p=0.115) or family income (19.73 vs 19.78; p=0.939), but the score was significantly lower for the participants with high-school studies (15.83; 19.96; 20.09; p=0.017).

4.2. TESTING OF OUR FIRST HYPOTHESIS

Couple satisfaction positively and moderately correlated with intimacy (r= 0.39; p ≤ 0,001), thus confirming our first hypothesis (H1). Furthermore, there is a positive strong correlation between intimacy and SDC (r= 0.52; p = 0.001). All the subscales of intimacy correlate positively both with couple satisfaction and SDC, except for intimacy problems (which negatively correlates with couple satisfaction, but not with supportive dyadic coping). SDC also correlates with couple satisfaction in a moderate, positive way (r= 0.46; p= 0.001). Table no. 1 shows the means, standard deviations and Pearson correlation coefficients among all the variables of the study.

Table no. 1

Means, Standard deviations and correlations among the study's variables

Variable	M	SD	Pearson Correlation Coefficient							
			1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
1	110.02	13.50	____							
2	19.75	3.49	.46**	___						
3	175.06	45.86	.39**	.52**	___					
4	45.05	12.53	.56**	.59**	.92 **	___				
5	32.44	9.11	.53**	.61**	.92**	.92**	___			

Table no. 1 (continued)

Variable	M	SD	Pearson Correlation Coefficient							
6	30.02	8.13	.34**	.44**	.94**	.81**	.82**	___		
7	42.21	11.46	.46**	.59**	.95**	.94**	.94**	.83**		
8	26.92	11.04	-.23*	-0.04	.53**	.18	.187	.54**	.27**	___

Note: 1. *Couple satisfaction; 2. Supportive dyadic coping; 3. Overall intimacy; 4. Intimacy – Consensus; 5. Intimacy – Affection; 6. Intimacy – Commitment; 7. Intimacy – Openness; 8. Intimacy – Problems; ** p < .01; * p < .05*

4.3. MEDIATION ANALYSIS

The Process extension for SPSS provided us with the tools necessary to analyze the mediation effects with some models suggested by the above-mentioned correlations, examining the degree to which an intervening set of variables accounts for an association between an independent and dependent variable (Baron & Kenny, 1986; Preacher & Hayes, 2008).

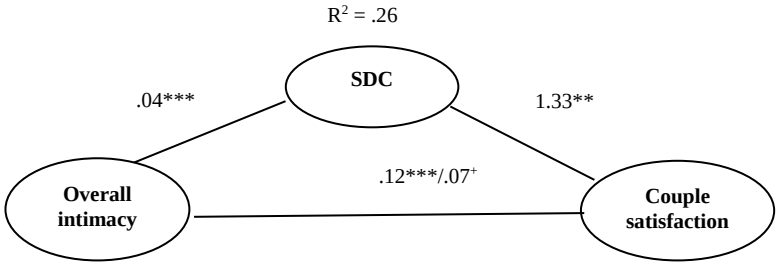


Figure no. 1. Mediation analysis Overall Intimacy – Couple Satisfaction with Supportive Dyadic Coping as a mediator

The total effect of overall intimacy on couple satisfaction is positive and significant (b = .12, p < .001). The participants with higher levels of intimacy also report higher satisfaction levels. After introducing SDC as a mediator in our analysis the effect remains positive, yet on the border of significance (b = .07, p = .056). Intimacy is linked to SDC (b = .04, p < .001). SDC has a positive and significant effect on satisfaction (b = 1.33, p = .01). The indirect effect of intimacy on satisfaction, through SDC, is significant (b = .06, LCI = .011, UCI = .16).

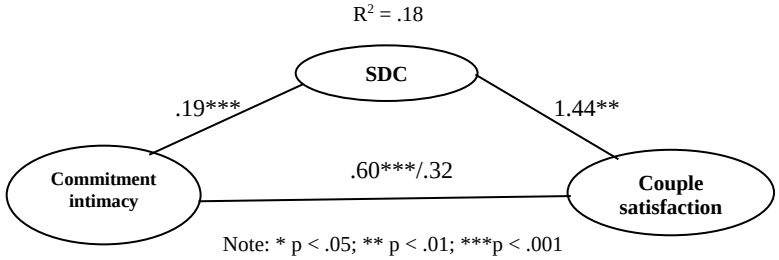
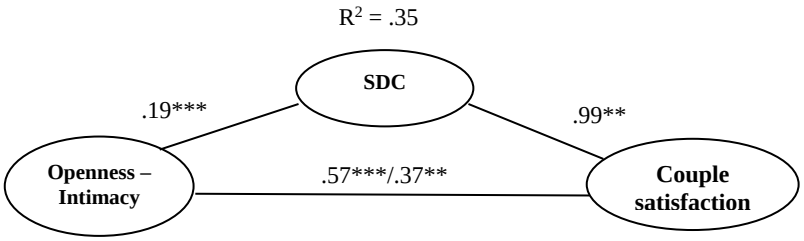


Figure no. 2. Mediation analysis Commitment (Intimacy) – Couple Satisfaction with Supportive Dyadic Coping as a mediator

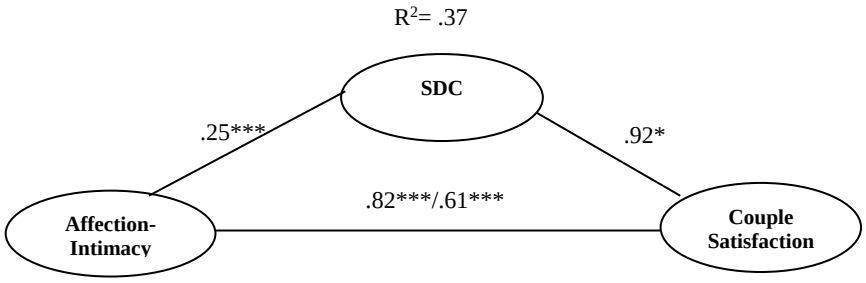
The total effect of the Commitment subscale of intimacy on satisfaction is positive and significant (b = .60, p < .001), as participants with a higher level of commitment also report a higher level of relationship satisfaction. After introducing SDC as a mediator, the effect remains positive but not significant (b = .32, p = .067). The commitment subscale of intimacy predicts SDC (b = .19, p < .001). SDC has a positive and significant effect on satisfaction (b = 1.44, p < .001). The indirect effect of the commitment subscale of intimacy on satisfaction through SDC, is significant (b = .28, LCI = .09, UCI = .51).



Note: * p < .05; ** p < .01; ***p < .001

Figure no. 3. Mediation analysis Openness (Intimacy) – Couple Satisfaction with Supportive Dyadic Coping as a mediator

The Openness subscale of intimacy is associated with couple satisfaction (b = .57, p < .001), thus the participants with a higher level of intimacy also have higher satisfaction levels. When SDC is introduced in the model, the link remains significant (b = .37, p < .001). The Openness subscale of intimacy is associated with supportive dyadic coping (b = .19, p < .001). Furthermore, there is a positive and significant association between SDC and couple satisfaction (b = .99, p = .02). Yet, the indirect effect of openness on couple satisfaction, through SDC, is not significant (b = 0.19, LCI = -.01, UCI = .44).



Note: * p < .05; ** p < .01; ***p < .001

Figure no. 4. Mediation analysis Affection (Intimacy) – Couple Satisfaction with Supportive Dyadic Coping as a mediator

The Affection subscale of intimacy is linked to couple satisfaction (b = .82, p < .001), as the participants with a higher level of intimacy also have higher levels of couple satisfaction. When considering SDC as mediator, the effect is still statistically significant (b = .61, p < .001). Affection is associated with SDC (b = .25, p < .001). This constellation of variables shows a positive and statistically significant association between SDC and couple satisfaction (b = .92, p = .02). However, the indirect effect of intimacy on satisfaction, through SDC, is not significant (b = 0.23, LCI = -.05, UCI = .55).

Yet, not all forms of intimacy are mediated by SDC when associated with relationship satisfaction, such as in the case of consensus and intimacy problems.

5. DISCUSSION

The focal point of our study was to test the association between intimacy and couple satisfaction, by identifying an explanatory mechanism for this relation. Therefore, we explored the role of SDC in emerging adults couples. The main contribution of the current research is the recognition of SDC as a mediator variable in a timeframe when intimate relationships are initiated and developed.

First, results indicate a direct, positive association between intimacy (overall score and three of its dimensions) and SDC. In line with previous research, even though scarce, intimacy promotes connectiveness on an emotional level to one's partner and builds supportive responses of partners to the stressful events the other partner or the couple as a unit face (Bodenmann, 1995; Cutrona, 1996). We can thus underline the central role intimacy plays in developing and maintaining romantic couples, starting with emerging adulthood and throughout the adult life (Laurenceau *et al.*, 2005; Dandurand & LaFontaine, 2013; Greeff & Malherbe, 2001).

Second, SDC has a significant effect on couple satisfaction, in agreement with previous studies which consistently underlined that DC is a very strong predictor of couple satisfaction, compared to other forms of coping (Bodenmann *et al.*, 2006; Falconier *et al.*, 2015; Rusu *et al.*, 2018), beyond cultural and gender differences (Hilpert *et al.*, 2016). This robust association is present, not only in adult couples, but also in emerging adulthood (Cramer, 2006).

Third, SDC mediates the relationship between intimacy and couple satisfaction. Mediation is total for overall intimacy and for commitment and partial for openness and affection, as dimensions of intimacy. The results are consistent with previous research results, where DC has been empirically shown to be a mediator for couple satisfaction (Levesque *et al.*, 2014). Furthermore, overall intimacy builds an interpersonal framework of support and communication. The main aspects of SDC, in turn, influence the couple satisfaction level. Being supportive and perceived as supportive by one's partner will ingrain a positive perspective of the couple's relationship, thus leading to couple satisfaction (Bodenmann & Cina, 2005).

More than that, when commitment is considered, the mediation of SDC is in line with the long-established empirical link between commitment and couple satisfaction (Le & Agnew, 2003; Rusbult & Buunk, 1993). Other consistent

findings in past research indicate that affection and expressing affection promote couple satisfaction, a result the present study also endorses, through the mediational effect of SDC (Dainton *et al.*, 1994; Floyd *et al.*, 2005; Gulledge *et al.*, 2003). Nonetheless SDC does not mediate the relation between all dimensions of intimacy and couple satisfaction, results which could also be explained by variables other than SDC. For instance, other individual and relationship-level variables have been associated both with couple satisfaction and intimacy, including patterns of dyadic interactions and attachment style (Gottman & Notarius, 2000; Guerrero, 1996; Keelan *et al.*, 1998).

All things considered, our research points out that intimacy influences couple satisfaction through the mediation of SDC, hence underlying how relevant feeling connected to one's partner is for the outcome of the relationship (Greeff & Malherbe, 2001; Schaefer & Olson, 1981). The present study contributes to comprehension on intimacy and its link to SDC and couple satisfaction.

From a therapeutic standpoint, the findings of the present study suggest working directly on tangible variables in order to improve one's own couple satisfaction, respectively intimacy and supportive dyadic coping. Couple therapy approaches have become increasingly focused on such variables to gain insight into how coping and intimacy impact the quality and stability of romantic relationships (Péloquin *et al.*, 2011). Schema therapy proves to be particularly effective in increasing both couple intimacy and relationship satisfaction (Forouzandeh *et al*., 2016; Yousefi, 2011; Zolfaghari *et al*., 2008), an encouraging result which may be explained by the basic underlying mechanism of this therapeutic intervention: modifying maladaptive schemas, or coping styles, into adaptive coping (Roedinger *et al*., 2018; Simeone-Difrancesco *et al*., 2015). Our own results endorse the focus on dyadic coping, a mediator for positive relationship outcomes, in line with clinical trials and longitudinal studies of schema therapy interventions (Baucom *et al*., 2013).

6. CONCLUSIONS

Some limitations need to be noted regarding the methodological and procedural aspects of the study. First, the use of cross-sectional data limits the understanding of the psychological processes on the within-person level and limits the causal interpretation of the mediation results. Secondly, the scales used throughout the study are self-reporting scales, which prevent us from observing the real manifestation of the processes we analyze. Third, our analysis is constraint to an individual level, which prevents us from identifying partner inter-dependencies and effects at the dyadic level. Future research may seek to implement more advanced procedural methods to verify the robustness of mediation effects, as self-reporting scales have a series of limitations. In conclusion, our findings highlight the complex associations between intimacy, SDC and couple satisfaction within a mediational model.

Received: 5.03.2021

BIBLIOGRAFIE

1. ALVES, S., FONSECA, A., CANAVARRO, M.C., PEREIRA, M., *Dyadic coping and dyadic adjustment in couples with women with high depressive symptoms during pregnancy*, Journal of Reproductive and Infant Psychology, **36**, *5*, 2018, p. 504–518.
2. ARNETT, J.J., *Emerging adulthood: A theory of development from the late teens through the twenties*. American Psychologist, **55**, *5*, 2000, p. 469–480.
3. ARNETT, J.J., *Emerging adulthood: What is it, and what is it good for?* Child Development Perspectives, **1**, *2*, 2007, p. 68–73.
4. BADR, H., HERBERT, K., BONNEN, M.D., ASPER, J.A., WAGNER, T., *Dyadic coping in patients undergoing radiotherapy for head and neck cancer and their spouses*, Frontiers in Psychology, **9**, 2018, p. 1780.
5. BAGGIO, S., STUDER, J., IGLESIAS, K., DAEPPEN, J.B., GMEL, G., *Emerging Adulthood: A Time of Changes*, Psychosocial Well-Being. Evaluation & the Health Professions, **40**, *4*, 2016, p. 383–400.
6. BARON, R.M., KENNY, D.A., *The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations*, Journal of Personality and Social Psychology, **51**, *6*, 1986.
7. BAUCOM, B.R., ATKINS, D.C., SIMPSON, L.E., & CHRISTENSEN, A., *Prediction of response to treatment in a randomized clinical trial of couple therapy: A 2-year follow-up*, Journal of Consulting and Clinical Psychology, **77**, 2013, p. 160–173.
8. BERG, J.H., *Responsiveness and self-disclosure* în DERLEGA, V.J. & BERG, J.H. (Eds), *Self-Disclosure. Perspectives in Social Psychology*, Boston, MA, Springer, 1987, p. 101–130.
9. BERG, C.A., UPCHURCH, R., *A developmental-contextual model of couples coping with chronic illness across the adult life span*, Psychological Bulletin, **133**, *6*, 2007, p. 920–954.
10. BERSCHEID, E., *Emotion* în KELLEY, H.H., BERSCHEID, E., CHRISTENSEN, A., HARVEY, J., HUSTON T.L., LEVINGER, G., MCLINTOCK, E., REPTAN, I.A., PETERSON, R.A. (Eds.), *Close relationships*, New York, Freeman, 1983, p. 110–168.
11. BODEN, J., FISCHER, J., NIEHUIS, S., *Predicting Marital Adjustment from Young Adults' Initial Levels and Changes in Emotional Intimacy over Time: A 25-Year Longitudinal Study*, Journal of Adult Development, **17**, 2010, p. 121–134.
12. BODENMANN, G., *A systemic-transactional conceptualization of stress and coping in couples*, Swiss Journal of Psychology, **54**, 1995, p. 34–49.
13. BODENMANN, G., *Stress und Coping bei Paaren* (Stress and Coping in Couples), Göttingen, Hogrefe, 2000.
14. BODENMANN, G., *Dyadic coping and its significance for marital functioning*, Couples coping with stress: Emerging perspectives on dyadic coping, **33**, *49*, 2005.
15. BODENMANN G., CINA A., *Stress and coping among stable-satisfied, stable-distressed and separated/divorced Swiss couples: a 5-year prospective longitudinal study*, Journal of Divorce & Remarriage, **44**, 2005, p. 71–89.
16. BODENMANN, G., PIHET, S., KAYSER, K., *The relationship between dyadic coping and marital quality: A 2-year longitudinal study*, Journal of Family Psychology, **20**, *3*, 2006, p. 485–493.
17. BODENMANN, G. *Dyadic coping and the significance of this concept for prevention and therapy*, Zeitschrift für Gesundheitspsychologie, **16**, *3*, 2008, p. 108–111.
18. BODENMANN, G., FALCONIER, M.K., RANDALL, A.K., *Systemic-transactional model of dyadic coping* în LEBOW, J., CHAMBERS, A., BREUNLIN, D. (Eds.), *Encyclopedia of Couple and Family Therapy*, Boston, Springer, 2009, p. 2888–2894.
19. BODENMANN, GUY, FALCONIER, MARIANA K., RANDALL, ASHLEY K., *Editorial: Dyadic Coping*, Frontiers in Psychology, **10**, 2019.
20. BRADBURY, T.N., FINCHAM, F.D., BEACH, S.R.H., *Research on the nature and determinants of marital satisfaction: A decade in review*, Journal of Marriage and Family, **62**, *4*, 2000, p. 964–980.

21. BREITENSTEIN, C.J., MILEK, A., NUSSBECK, F.W., DAVILA, J., BODENMANN, G., *Stress, dyadic coping, and couple satisfaction in late adolescent couples*, Journal of Social and Personal Relationships, **35**, *5*, 2018, p. 770–790.
22. CLARK, M.S., REIS, H.T, *Interpersonal processes in close relationships*, Annual Review of Psychology, **39**, *1*, 1988, p. 609–672.
23. CONNOLLY, J., JOHNSON, A., *Adolescents' romantic relationships and the structure and quality of their close interpersonal ties*, Personal Relationships, **3**, *2*, 1996, p. 185–195.
24. CRAMER, D., *How a supportive partner may increase relationship satisfaction*, British Journal of Guidance & Counselling. **34**, *1*, 2006, p. 117–131.
25. CRAWFORD, T.N., COHEN, P., JOHNSON, J.G., *The Course and Psychosocial Correlates of Personality Disorder Symptoms in Adolescence: Erikson's Developmental Theory Revisited*, Journal of Youth and Adolescence **33**, *5*, 2004, p. 373–387.
26. CUTRONA, C.E., *Social support in couples: Marriage as a resource in times of stress*, Sage Publications, Inc., 1996.
27. DAINTON, M., STAFFORD, L., CANARY, D., *Maintenance Strategies and Physical Affection as Predictors of Love, Liking, and Satisfaction in Marriage*, Communication Reports, **7**, *2*, 1994, p. 88–98.
28. DANDENEAU, M.L., JOHNSON, S.M., *Facilitating intimacy: Interventions and effects*, Journal of Marital and Family Therapy, **20**, *1*, 1994, 17–33.
29. DANDURAND, C., LAFONTAINE, M., *Intimacy and couple satisfaction: The moderating role of romantic attachment*, International Journal of Psychological Studies, **5**, *1*, 2013.
30. DAVIS, D., *Determinants of responsiveness in dyadic interaction* în WILLIAM, I., ERIC, S.K., (Eds.), *Personality, roles, and social behavior*, NY, Springer-Verlag, 1982, p. 85–139.
31. DERLEGA, V.J., METTS, S., PETRONIO, S., MARGULIS, S.T., *SAGE series on close relationships, Self-disclosure*, California, Sage Publications, 1993.
32. DONATO, S., PARISE, M., IAFRATE, R., BERTONI, A., FINKENAUER, C., BODENMANN, G., *Dyadic coping responses and partners' perceptions for couple satisfaction*, Journal of Social and Personal Relationships, **32**, *5*, 2014, p. 580–600.
33. ERIKSON, E.H., *Identity: youth and crisis*, Behavioral Science, **14**, *2*, 1968, p. 154–159.
34. FALCONIER, M.K., JACKSON, J.B., HILPERT, P., BODENMANN, G., *Dyadic coping and relationship satisfaction: A meta-analysis*, Clinical Psychology Review, **42**, 2015, p. 28–46.
35. FOROUZANDEH, E., KHATAMSAZ, B., & GHADERI, D., *Effectiveness of schema therapy on marital satisfaction and marital relationship quality in married women*, International Journal of Educational and Psychological Researches, 2016.
36. FURMAN W., *The Emerging Field of Adolescent Romantic Relationships*, Current Directions in Psychological Science, **11**, *5*, 2002, p. 177–180.
37. FURMAN, W., SHAFFER, L., *The role of romantic relationships in adolescent development*, Adolescent romantic relations and sexual behavior: Theory, research, and practical implications, 2003, p. 3–22.
38. FLOYD, K., HESS, J.A., MICZO, L.A., HALONE, K.K., MIKKELSON, A.C., TUSING, K.J., *Human affection exchange: VIII. Further evidence of the benefits of expressed affection*, Communication Quarterly, **53**, *3*, 2005, p. 285–303.
39. GREEFF, A.P., MALHERBE, H.L, *Intimacy and marital satisfaction in spouses*, Journal of Sex & Marital Therapy, **27**, *3*, 2001, p. 247–257.
40. GMELCH S., BODENMANN G., *Dyadisches Coping in Selbst- und Fremdwahrnehmung als Prädiktor für Partnerschaftsqualität und Befinden (Dyadic coping in self- and partner perception as predictor for relationship quality and well-being)*, Zeitschrift fur Gesundheitspsychologie, **15**, *4*, 2007, p. 177–186.
41. GOTTMAN, J.M., NOTARIUS, C.I., *Decade review: Observing marital interaction*, Journal of Marriage and Family, **62**, *4*, 2000, p. 927–947.
42. GUERRERO, L.K, *Attachment-style differences in intimacy and involvement: A test of the four-category model*, Communication Monographs, **63**, *4*, 1996, p. 269–292.

43. GULLEDGE, A., GULLEDGE, M., STAHMANNN, R., *Romantic Physical Affection Types and Relationship Satisfaction*, American Journal of Family Therapy, **31**, *4*, 2003, p. 233–242.
44. HAGEDOORN, M., SANDERMAN, R., BOLKS, H.N., TUINSTRA, J, COYNE, J.C., *Distress in couples coping with cancer: a meta-analysis and critical review of role and gender effects*, Psychological Bulletin, **134**, *1*, 2008, p. 1–30.
45. HERZBERG, P.Y., *Coping in relationships: the interplay between individual and dyadic coping and their effects on relationship satisfaction*, Anxiety Stress Coping, **26**, *2*, 2013, p. 136–53.
46. HILPERT P., RANDALL A.K., SOROKOWSKI P., ATKINS D.D., SOROKOWSKA A., AHMADI K, *The associations of dyadic coping and couple satisfaction vary between and within nations: A 35-nation study*, Frontiers in Psychology, **7**, *1106*, 2016.
47. KEELAN, J.P., DION, K.K., DION, K.L., *Attachment style and couple satisfaction: Test of a self-disclosure explanation*, Canadian Journal of Behavioural Science, **30,** *1*, 1998, p. 24–35.
48. KELLEY, H.H., *Personal relationships: their structures and processes*, Hillsdale, N.J, L.E. Associates, 1979.
49. LAURENCEAU, J.P., BARRETT, L.F, ROVINE, M.J., *The interpersonal process model of intimacy in marriage: a daily-diary and multilevel modeling approach*, Journal of Family Psychology, **19**, *2*, 2005, p. 314–23.
50. LE, B., AGNEW, C.R., *Commitment and its theorized determinants: A meta-analysis of the investment model*, Personal Relationships, **10**, *1*, 2003, p. 37–57.
51. LEDERMANN, T., BODENMANN, G., GAGLIARDI, S., CHARVOZ, L., VERARDI, S., ROSSIER, J., BERTONI, A., IAFRATE, R., *Psychometrics of the dyadic coping inventory in three language groups*, Swiss Journal of Psychology, **69**, *4*, 2010, p. 201–212.
52. LEVESQUE, C., LAFONTAINE, M., CARON, A., FLESCH, J.L., BJORNSON, S., *Dyadic empathy, dyadic coping, and couple satisfaction: A dyadic model*, Europe's Journal of Psychology, **10**, *1*, 2014, p. 118–134.
53. MACNEIL, S., BYERS, E.S., *Dyadic assessment of sexual self-disclosure and sexual satisfaction in heterosexual dating couples*, Journal of Social and Personal Relationships, **22**, *2*, 2005, p. 169–181.
54. MOLGORA, S., FENAROLI, V., ACQUATI, C., DE DONNO, A., BALDINI, M.P., SAITA, E., *Examining the role of dyadic coping on the marital adjustment of couples undergoing assisted reproductive technology (ART)*, Frontiers in Psychology, **10**, 2019, p. 415.
55. NIEDER, T. SEIFFGE-KRENKE, I., *Coping with stress in different phases of romantic development*, Journal of adolescence, **24**, *3*, 2001, p. 297–311.
56. OTTO, A.K., LAURENCEAU, J.-P., SIEGEL, S.D., BELCHER, A.J., *Capitalizing on everyday positive events uniquely predicts daily intimacy and well-being in couples coping with breast cancer*, Journal of Family Psychology, **29**, *1*, 2015, p. 69–79.
57. PAPP, L.M., WITT, N.L., *Romantic partners' individual coping strategies and dyadic coping: Implications for relationship functioning*, Journal of Family Psychology, **24**, *5*, 2010, p. 551–559.
58. PASIPANODYA, E.C., PARRISH, B.P., LAURENCEAU, J.P., COHEN, L.H, SIEGEL, S.D., GRABER, E.C., BELCHER, A.J., *Social constraints on disclosure predict daily well-being in couples coping with early-stage breast cancer*, Journal of Family Psychology, **26**, *4*, 2012, p. 661–670.
59. PÉLOQUIN, K., LAFONTAINE, M., BRASSARD, A., *A dyadic approach to the study of romantic attachment, dyadic empathy, and psychological partner aggression*, Journal of Social and Personal Relationships, **28**, *7*, 2011, p. 915–942.
60. PERLMAN, D., FEHR, B., *The development of intimate relationship*s, în PERLMAN, D. & DUCK, S. (Eds.), *Intimate relationships: Development, dynamics, and deterioration*, California, Sage Publications, 1987, p. 13–42.
61. PERNDORFER, C., SORIANO, E.C., SIEGEL, S.D., LAURENCEAU, J.P., *Everyday protective buffering predicts intimacy and fear of cancer recurrence in couples coping with early-stage breast cancer*, Psycho-oncology, **28**, *2*, 2019, p. 317–323.
62. PINQUART, M., FABEL, K., *Social change demands, coping and intimate relationship development among German adolescents and adults*, Journal of Social and Personal Relationships, **26**, *6–7*, 2009, p. 793–810.

63. PREACHER, K.J., HAYES, A.F., *Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models*, Behavior Research Methods, **40**, *3*, 2008, p. 879–891.
64. RAFAELI, E., GLEASON, M.E.J., *Skilled support within intimate relationships*, Journal of Family Theory & Review, **1**, *1*, 2009, p. 20–37.
65. RANDALL, A.K., HILPERT, P., JIMENEZ-ARISTA, L.E., WALSH, K.J., BODENMANN, G., *Dyadic coping in the U.S.: Psychometric properties and validity for use of the English version of the dyadic coping inventory*, Current Psychology, **35**, *4*, 2015, p. 570– 582.
66. REGAN, T.W., LAMBERT, S.D., KELLY, B., MCELDUFF, P., GIRGIS, A., KAYSER, K., TURNER, J., *Cross-sectional relationships between dyadic coping and anxiety, depression, and couple satisfaction for patients with prostate cancer and their spouses*, Patient Education and Counseling, **96**, *1*, 2014, p. 120–127.
67. REIS, H.T., SHAVER, P., *Intimacy as an interpersonal process*, în DUCK, S. (Ed.), *Handbook of Personal Relationships: Theory, Research and Interventions*, NY, John Wiley & Sons, 1988, p. 367–389.
68. REIS, H.T., CLARK, M.S., HOLMES, J.G., *Perceived Partner Responsiveness as an Organizing Construct in the Study of Intimacy and Closeness*, în MASHEK, D.J., ARON, A.P. (Eds.), *Handbook of Closeness and Intimacy*, London, L.E. Associates Publishers, 2004, p. 201–225.
69. REIS, H.T., *The interpersonal process model of intimacy: Maintaining intimacy through self-disclosure and responsiveness*, în FITZGERALD, J. (Ed.), *Foundations for couples' therapy: Research for the real world*, Routledge/Taylor & Francis Group, 2017, p. 216–225.
70. REMPEL, J., ROSS, M., HOLMES, J.G., *Trust and communicated attributions in close relationships*, Journal of Personality and Social Psychology, **81**, *1*, 2001, p. 57–64.
71. REVENSON, T.A., *Scenes from a marriage: Examining support, coping and gender within the context of chronic illness*, în SULS, J., WALLSTON, K.A. (EDS.), *Blackwell series in health psychology and behavioral medicine*. *Social psychological foundations of health and illness*, Malden, Blackwell Publishing, 2003, p. 530–559.
72. ROBINSON, L.C., BLANTON, P.W., *Marital strengths in enduring marriages*, Family Relations, **42**, *1*, 1993, p. 38–45.
73. ROEDIGER, E., ZARBOCK, G., FRANK-NOYON, E., HINRICHS, J., & ARNTZ, A., *The effectiveness of imagery work in schema therapy with couples: A clinical experiment comparing the effects of imagery rescripting and cognitive interventions in brief schema couples therapy*, Sexual and Relationship Therapy, **35**, *3*, 2018, p. 320–337.
74. ROTTMANN, N., HANSEN, D.G., LARSEN, P.V., NICOLAISEN, A., FLYGER, H., JOHANSEN, C., HAGEDOORN, M., *Dyadic coping within couples dealing with breast cancer: A longitudinal, population-based study*, Health Psychology, **34**, *5*, 2015, p. 486–495.
75. RUBIN, H., CAMPBELL, L., *Day-to-day changes in intimacy predict heightened relationship passion, sexual occurrence, and sexual satisfaction: A dyadic diary analysis*, Social Psychological and Personality Science, **3**, *2*, 2012, p. 224–231.
76. RUFFIEUX, M., NUSSBECK, F.W., BODENMANN, G., *Long-term prediction of couple satisfaction and stability by stress, coping, communication, and well-being*, Journal of Divorce & Remarriage, **55**, *6*, 2014, p. 485–501.
77. RUSBULT, C.E., BUUNK, B.P., *Commitment processes in close relationships: An interdependence analysis*, Journal of Social and Personal Relationships, **10**, *2*, 1993, p. 175–204.
78. RUSU, P.P., BODENMANN, G., KAYSER, K. *Cognitive emotion regulation and positive dyadic outcomes in married couples*, Journal of Social and Personal Relationships, **36**, *1*, 2018, p. 359–376.
79. SCHAEFER, M.T., OLSON, D.H., *Assessing intimacy: The PAIR Inventory*, Journal of Marital and Family Therapy, **7**, *1*, 1981, p. 47–60.
80. SIM, A., CORDIER, R., VAZ, S., *Relationship Satisfaction and Dyadic Coping in Couples with a Child with Autism Spectrum Disorder*, Journal of Autism and Developmental Disorders, **47**, *11*, 2017, p. 3562–3573.
81. SIMEONE-DIFRANCESCO, C., ROEDIGER, E., STEVENS, B. A., *Schema therapy with couples: A practitioner's guide to healing* relationships, John Wiley & Sons, 2015.

82. SHULMAN, S., CONNOLLY, J., *The Challenge of Romantic Relationships in Emerging Adulthood: Reconceptualization of the Field*, Emerging Adulthood, **1**, *1*, 2013, p. 27–39.
83. SNEED, J. WHITBOURNE, S., SCHWARTZ, S., HUANG, S., *The Relationship Between Identity, Intimacy, and Midlife Well-Being: Findings From the Rochester Adult Longitudinal Study*, Psychology and aging, **27**, 2011, p. 318–323.
84. SPANIER, G.B., *Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads*, Journal of Marriage and the Family, **38**, *1*, 1976, p. 15–28.
85. STONE, E.A., SHACKELFORD, T.K., BUSS, D.M., *Socioeconomic development and shifts in mate preferences*, Evolutionary Psychology**, 6**, *3*, 2008, p. 447–455.
86. SWITZER, A., CALDWELL, W., DA ESTRELA, C., BARKER, E.T., GOUIN, J., *Dyadic coping, respiratory sinus arrhythmia, and depressive symptoms among parents of preschool children*, Frontiers in Psychology, **9**, 2018.
87. THOMPSON, L., WALKER, A.J., *Gender in families: Women and men in marriage, work, and parenthood*, Journal of Marriage and the Family, **51**, *4*, 1989, p. 845–871.
88. TOLSTEDT, B.E., STOKES, J.P., *Relation of verbal, affective, and physical intimacy to marital satisfaction*, Journal of Counseling Psychology, **30**, *4*, 1983, p. 573–580.
89. TRAA, M.J., DE VRIES, J., BODENMANN, G., DEN OUDSTEN, B.L., *Dyadic coping and relationship functioning in couples coping with cancer: A systematic review*, British Journal of Health Psychology, **20**, *1*, 2014, p. 85–114.
90. UBANDO, M., *Gender Differences in Intimacy, Emotional Expressivity, and Relationship Satisfaction*, Pepperdine Journal of Communication Research, **4**, *13*, 2016.
91. VAN DEN BROUCKE, S., VERTOMMEN, H., VANDEREYCKEN, W., *Construction and validation of a marital intimacy questionnaire*, Family Relations, **44**, *3*, 1996, p. 285–290.
92. VILCHINSKY, N., DEKEL, R., *Cardiac disease-induced PTSD: The need for a dyadic Perspective*, în BERTONI, A., DONATO, S., MOLGORA, S. (Eds.), *Psychology research progress. When "we" are stressed: A dyadic approach to coping with stressful events*, Nova Science Publishers, 2018, p. 109–124.
93. WARING, E.M., *Facilitating marital intimacy through self-disclosure*, The American Journal of Family Therapy, Journal of Family Therapy, **9**, *4*, 1981, p. 33–42.
94. WARING, E.M., PATTON, D., *Marital intimacy and depression*, British Journal of Psychiatry, **145**, *6*, 1984, p. 641–644.
95. WEINBERGER, M.I., HOFSTEIN, Y., WHITBOURNE, S.K., *Intimacy in young adulthood as a predictor of divorce in midlife*, Personal Relationships, **15**, *4*, 2008, p. 551– 557.
96. WEISSKIRCH, R.S., *Psychosocial Intimacy, Relationships with Parents, and Well-being among Emerging Adults*, Journal of Child and Family Studies, **27**, 2018, p. 3497–3505.
97. WHISMAN, M.A., *Marital adjustment and outcome following treatments for depression*, Journal of Consulting and Clinical Psychology, **69,** *1*, 2001. p. 125–129.
98. WHITTON, S.W., KURYLUK, A.D., *Relationship satisfaction and depressive symptoms in emerging adults: Cross-sectional associations and moderating effects of relationship characteristics*, Journal of Family Psychology, **26**, *2*, 2012, p. 226–235.
99. YOO, H., BARTLE-HARING, S., DAY, R., GANGAMMA, R., *Couple communication, emotional and sexual intimacy, and couple satisfaction*., Journal of Sex & Marital Therapy, **40**, *4*, 2013, p. 273–293.
100. YOUSEFI, N., *Comparison of the effectiveness of family therapy based on schema therapy and Bowen's emotional system therapy on divorce tendency among divorce applicant clients*, Journal of Clinical Psychology, **3**, 2011, p. 53–64.
101. ZIMMERMANN, T., RAUCH, S.-L., *Dyadic coping in patients with prostate and laryngeal cancer and their partners* în BERTONI, A., DONATO, S., MOLGORA, S. (Eds.), *Psychology research progress. When "we" are stressed: A dyadic approach to coping with stressful events*, Milano, Nova Science Publisher, 2018, p. 125–138.
102. ZOLFAGHARI, M., FATEHI ZADEH, M., ABEDI, R., *Determining relationships between early maladaptive schemas and marital intimacy among Mobarakeh steel complex personnel*, Journal of Family Research, **4**, 2008, p. 247–61.

REZUMAT

Intimitatea și satisfacția în cuplu sunt factori esențiali asociați calității relației. Intimitatea a fost asociată cu satisfacția în cuplu, fiind unul dintre cei mai importanți predictori ai săi. La rândul său, copingul diadic suportiv corelează cu satisfacția în cuplurile maritale și nonmaritale. Prezentul studiul își propune să investigheze asocierile dintre intimitate și satisfacția în cuplu, explorând rolul mediator al copingului diadic suportiv. Participanții la studiu sunt 105 adulți tinerii implicați în relații romantice, care au completat trei scale de autoraportare. Rezultatele indică faptul că intimitatea prezice atât satisfacția în cuplu, cât și copingul diadic suportiv. Mai mult, copingul diadic suportiv mediază total relația dintre intimitatea globală și subscala angajament a intimității și satisfacția în cuplu. De asemenea, copingul diadic suportiv mediază parțial relația dintre subscalele deschidere / afecțiune și satisfacția în cuplu. Posibile explicații și implicații pentru intervenții terapeutice sunt discutate.

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

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Abstract

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

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

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

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[1] Author's Note

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

Danut I. Crasovan contributed to analysis and interpretation of data, and to drafting the article and revising it critically for important intellectual content. Delia N.R. Crasovan contributed to research design and collection of data. In the first stage of research (years 2010–2014) and deployment phase of research in psychiatric clinics from western Romania, Danut I. Crasovan was affiliated with Department of Psychology, University of Bucharest, Romania, respectively during the completion of the study (years 2017–2020) at Babeș-Bolyai University (UBB University Center in Reșița), Romania. Delia N.R. Crașovan was affiliated during the study at Caritas Federation, Catholic Diocese Timişoara, Romania.

Rev. Psih., vol. 67, nr. 3, p. 233–246, București, iulie – septembrie 2021

1. INTRODUCTION

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

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

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

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

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

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

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

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

2. METHOD

2.1. PARTICIPANTS

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

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

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

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

The demographic characteristics of the participants from the general population were: 42,86% men and 57.14% women; an average age of 31.16 years (ranging from 18 to 66); most of them having a university education – college three years; faculty four, five or six years; master or doctoral (53.4%) and 46.6% of the participants did not have a university education.

2.2. INSTRUMENTS AND PROCEDURE

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

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

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

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

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

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

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

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

2.3. DESIGN

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

3. RESULTS

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

Table no. 1

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

	(men + women)				men				women			
coping mechanisms	non-clinical sample		clinical sample		non-clinical sample		clinical sample		non-clinical sample		clinical sample	
	N = 770		N = 103		N = 330		N = 42		N = 440		N = 61	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1) Positive reinterpretation and growth	12.58	2.19	10,90	2,80	12.43	2.11	10.83	3.20	12,69	2.25	10,95	2.53
2) Mental disengagement	9.64	2.69	9.36	2.53	9.24	2.59	9.36	2.51	9.94	2.73	9.36	2.56
3) Focus on and venting of emotions	9.64	2.72	10.91	2.97	9.24	2.61	10.40	2.93	9.94	2.76	11.26	2.97

Table no. 1 (continued)

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

Table no. 2

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

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

Table no. 2 (continued)

coping mechanisms	*source of variation*	sum of squares	df	mean square	F	p
5. Active coping	grup	73.91	1	73.91	12.19	< .01
	gen	0.20	1	0.20	0.03	
	grup*gen	0.73	1	0.73	0.12	
	eroare	5.266.67	869	6.061		
6. Denial	grup	3.60	1	3.60	0.54	
	gen	5.61	1	5.61	0.84	
	grup*gen	0.78	1	0.78	0.11	
	eroare	5.778,59	869	6.65		
7. Religious coping	grup	170.12	1	170.12	13.10	< .01
	gen	153.82	1	153.82	11.85	< .01
	grup*gen	7.40	1	7.40	0.57	
	eroare	11.277,45	869	12.97		
8. Humor	grup	532.68	1	532.68	42.51	< .001
	gen	24.84	1	24.84	1.98	
	grup*gen	12.59	1	12.59	1.01	
	eroare	10.888,56	869	12.53		
9. Behavioral disengagement	grup	236.32	1	236.32	37.04	< .001
	gen	60.70	1	60.70	9.51	< .01
	grup*gen	42.04	1	42.04	6.59	< .01
	eroare	5.544,16	869	6.38		
10. Restraint	grup	11.26	1	11.26	2.04	
	gen	6.18	1	6.18	1.12	
	grup*gen	1.82	1	1.82	0.33	
	eroare	4.794,78	869	5.51		
11. Use of emotional social support	grup	0.46	1	0.46	0.04	
	gen	71.53	1	71.53	7.48	< .01
	grup*gen	0.07	1	0.07	0.01	
	eroare	8.303,18	869	9.55		
12. Substance use	grup	58.61	1	58.61	9.49	< .01
	gen	264.90	1	264.90	42.96	< .001
	grup*gen	143.31	1	143.31	23.22	< .001
	eroare	5362.66	869	6.17		
13. Acceptance	grup	103.41	1	103.41	12.55	< .001
	gen	18,94	1	18.94	2.30	
	grup*gen	4.81	1	4.81	0.58	
	eroare	7.157,06	869	8.23		
14. Suppression of competing activities	grup	5.53	1	5.53	0.83	
	gen	2.08	1	2.08	0.31	
	grup*gen	7.14	1	7.14	1.07	
	eroare	5.756,68	869	6.62		
15. Planning	grup	85.33	1	85.33	12.36	< .001
	gen	0.53	1	0.53	0.07	
	grup*gen	1.61	1	1.61	0.23	
	eroare	5.995,97	869	6.90		

Table no 3

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

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

4. DISCUSSION AND CONCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Received: 28.03.2021

REFERENCES

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

9. CARVER, C.S., SCHEIER, M.F., & WEINTRAUB, J.K., *Assessing coping strategies: A theoretically based approach*, Journal of Personality and Social Psychology, **56**, 1989, p. 267–283, doi:10.1037/0022-3514.56.2.267.
10. CARVER, C.S., *You want to measure coping but your protocol's too long: Consider the Brief COPE*, International Journal of Behavioral Medicine, **4**, 1997, p. 92–100, DOI: 10.1207/s15327558ijbm0401_6.
11. CRAMER, P., *Development of defense mechanisms: Theory, research, and assessment*, New York: Springer-Verlag, 1991.
12. CRAMER, P., *Coping and Defense Mechanisms: What's the Difference*? Journal of Personality, **66**, 1998, p. 919–946, DOI: 10.1111/1467-6494.00037.
13. CRAMER, P., *Protecting the self: Defense mechanisms in action*, New York, NY, The Guilford Press, 2006.
14. COMPAS, B.E., CONNOR-SMITH, J., & JASER, S.S., *Temperament, stress reactivity, and coping: Implications for depression in childhood and adolescence*, Journal of Clinical Child and Adolescent Psychology, **33**, *1*, 2004, p. 21–31, DOI: 10.1207/S15374424JCCP3301_3.
15. CRAȘOVAN, D.I., *Psychological defense mechanisms associated with disfunctional attitudes in non-psychotic major depressive disorder*, Cognition, Brain, Behavior. An Interdisciplinary Journal, **XVIII**, *1*, 2014, p. 39–55, ISSN: 1224–8398.
16. CRAȘOVAN, D.I, TOMICI, D., *Psychological adaptive mechanisms in homeless people – a study carried out on people in the Caritas Federation Night Shelter, Catholic Diocese Timișoara, România* în RAȚĂ, G., and RUNCAN, P.L. (Eds), *Social Issues*, Newcastle upon Tyne, UK: Cambridge Scholars Publishing, ISBN (10): 1-4438-5676-2, ISBN (13): 978-1-4438-5676-8, 2014.
17. CRAȘOVAN, D.I., & SAVA, A.F., *Translation, adaptation and validation on Romanian population of COPE Questionnaire for coping mechanisms analysis*, Cognition, Brain, Behavior, An Interdisciplinary Journal, **XVII**, *1*, 2013, p. 61–76. ISSN: 1224-8398,
18. CUIJPERS, P., *A psychoeducational approach to the treatment of depression: A meta-analysis of lewinsohn's* "*coping with depression*" *course*, Behavior Therapy, **29**, *3*, 1998, p. 521–533, DOI.org/10.1016/S0005-7894(98)80047-6.
19. CUIJPERS, P., VAN STRATEN, A., SMIT, F., MIHALOPOULOS, C., & BEEKMAN, A., *Preventing the onset of depressive disorders: a meta-analytic review of psychological interventions*, American Journal of Psychiatry, **165**, *10*, 2008, p. 1272–1280, DOI: 10.1176/appi.ajp.2008.07091422.
20. D'IUSO, D.A., DOBSON, K.S., BEAULIEU, L., & DRAPEAU, M., *Coping and interpersonal functioning in depression*, Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, **50**, *4*, 2018, p. 248–255, http://dx.doi.org/10.1037/cbs0000112.
21. GARNEFSKI, N., LEGERSTEE, J., KRAAIJ, V., VAN DEN KOMMER, T., & TEERDS, J.A.N., *Cognitive coping strategies and symptoms of depression and anxiety: A comparison between adolescents and adults*, Journal of Adolescence, **25**, *6*, 2002, p. 603–611, http://dx.doi.org/10.1006/jado.2002.0507.
22. HEWITT, P.L., FLETT, G.L., ENDLLER, N.S., *Perfectionism, Coping, and Depression Symptomatology in a Clinical Sample*, Clinical Psychology and Psychotherapy, **2**, *1*, 1995, p. 47–58, DOI: 10.1002/cpp.5640020105.
23. HOLAHAN, C.J., MOOS, R.H., HOLAHAN, C.K., BRENNAN, P.L., & SCHUTTE, K.K., *Stress generation, avoidance coping, and depressive symptoms: A 10-year model*, Journal of Consulting and Clinical Psychology, **73**, *4*, 2005, p. 658, doi.org/10.1037%2F0022-006X.73.4.658.
24. HOWITT, D., & CRAMER, H., *Introducere în SPSS pentru psihologie* [*Introduction to SPSS for Psychology*], 16th version, Iași, Editura Polirom, 2010.
25. IONESCU, Ș., JACQUET, C.-L., & LHOTE C., *Mecanismele de apărare. Teorie și aspecte clinice* [Defense mechanisms. Theory and clinical aspects], Iași, Editura Polirom, 2002.
26. MARICUȚOIU, L.P. AND CRAȘOVAN, D.I., *Coping and defence mechanisms: What are we assessing?* International Journal of Psychology, **51**, 2016, p. 83–92 (Epub 2014 Nov 22), https://doi.org/10.1002/ijop.12113.
27. MCCRAE, R.R., *Age differences in the use of coping mechanisms*, Journal of Gerontology, **37**, 1982, p. 454–460, doi.org/10.1093/geronj/37.4.454.
28. MCCRAE, R.R., *Situational determinants of coping responses: Loss, threat, and challenge*, Journal of Personality and Social psychology, **46**, 1984, p. 919–928, doi.org/10.1037/0022-3514.46.4.919.

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

REZUMAT

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

EMOTIONAL COPING ACCROSS GENDERS DURING THE PANDEMIC TIMES

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Abstract

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

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

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

1. INTRODUCTION

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

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

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

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

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

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

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

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

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

Scientifically documented biological differences between men and women were highlighted. From these, a stronger immune system in women brings survival advantages to their offspring (Wanner, 2020), presence of female estrogen, with a role in the immune system, women carrying two X chromosomes containing genes related to immunity, while men carry only one (Chang, 2020), could have led to higher mortality rates in men in comparison with women. Another investigated area was the modification in women's sexual behaviour, authors concluding that, during the COVID-19 pandemic, there were a significantly increased sexual desire and frequency of intercourse, but the quality of sexual life significantly decreased (Yuksel & Ozgor, 2020).

In a meta-analysis of 697 effect sizes representing 236,304 individual ratings of self-conscious emotions states and traits, Else-Quest *et al.* (2012) state that findings support the inaccuracy about women's greater emotionality, with only small gender differences in relation to shame and guilt and only for the White population investigated and not for embarrassment, authentic pride and hubristic pride where gender similarities where shown. Still, authors are not fully in consensus. A meta-analysis studying the magnitude and variability of sex differences in vocational interests, has shown that men showed stronger Realistic and Investigative interests with more specific measures of engineering, science and mathematics interests whereas women showed stronger Artistic, Social and Conventional interests (Su, Rounds & Armstrong, 2009).

Coming closer to the current study theme, there are some studies discussing about gender differences in organizationally relevant phenomena such as work burnout which link the gender differences to experiencing stress related phenomena and moves us closer to the preferred coping strategies in both men and women. In one of these studies – a meta-analysis conducted by Purvanova and Muros (2010) – it was shown that women are slightly more emotionally exhausted than men, while men are somewhat more depersonalized than women, fighting in this way the prejudiced idea that only women are likely to experience burnout rather than men.

In his theory related to the development of gender-typed behaviours, Maccoby (1990) states that gender differences in individual characteristics, such as personality and temperament, are likely to be small. Consistent with this theory, Else-Quest *et al.* (2006) state in their meta-analysis studying the gender differences in temperament of the children, that there were found negligible effect sizes for gender differences in many dimensions of temperament.

Also, building up to two more theories that studied gender differences, namely Brody's (1997, 2000) theory of gender differences in emotional expression and Scarr and McCartney's (1983) theory of evocative interactions, Else-Quest *et al.* (2006) found no gender difference in sociability and small gender differences in activity, favouring boys. In turn, they sustain other studies showing that girls are

more adjusted to the fine details of their environment (including negative emotions displayed by important others in their environment, such as parents, teachers, or peers), therefore may experience more stressors, simply because they notice more negative events around them (Rothbart, Ahadi & Hershey, 1994). And since the boys tend to exert higher incidence of attention and externalizing behavior problems, including attention-deficit/ hyperactivity disorder (Nigg, Goldsmith & Sachek, 2004), we may presume that, later on, the men would be less prone to focusing on the aspects of life that require more patience, such as worrying about the others including about greater aspects of society and political issues.

Finally, we presume that there are gender differences in coping based on emotions, even if, stereotypically, and, in initial studies, one may state that women are more prone to cope in an emotional manner rather than men (Billings & Moos, 1981; Folkman & Lazarus, 1980). This presumption is in line with previous studies that showed that not in all emotional coping areas men are disadvantaged from emotion focused coping (Howerton, 2005). And since women and girls tend to experience different kinds of traumatic events (perhaps more severe or pathogenic events) than do men and boys (Tolin & Foa, 2006), we expect that they are more focused on healing and mentally connected with the idea of trauma and, therefore, interested in how they can, in advance, protect from experience an emotional damage.

2. METHODOLOGY

2.1. OBJECTIVE

The study aims to determine whether the four coping strategies included in the coping focalized on emotions factor, namely positive interpretation and growth, abstention, acceptance and turning to religion differ between men and women.

2.2. RESEARCH QUESTIONS

Building on previous studies on gender differences, but taking into account that behaviours should be interpreted in the special context generated by the SARS-CoV-19 pandemic that affected us globally in 2020, a context whose study only now generates a relevant body of literature, we choose to we formulate the following research questions:

Research Question 1: Is there a variance in the studied coping strategies due a combined effect of gender?

Research Question 2: Is there a variance in the positive interpretation and growth, due to gender?

Research Question 3: Is there a variance in the restraint due to gender?

Research Question 4: Is there a variance in the acceptance due to gender?

Research Question 5: Is there a variance in turning to religion due to gender?

2.3. PARTICIPANTS

The study was conducted on a non-probabilistic, non-clinic, convenience sample of 476 Romanian participants (M_{age} = 37.35, *SD* = 11.76), 75.6% women. The respondents have completed an online survey, using a virtual testing platform, during March – April 2020, after the World Health Organization's Director declared that *the global COVID-19 outbreak can be described as a pandemic* on March 11th, 2020 (Adhanom Ghebreyesus, 2020). The recruitment of the participants and their inclusion were made on a voluntary, snowball basis, with confidentiality assurance.

2.4. MEASURES

Positive interpretation and growth was measured by the homonym 4 items scale in the COPE Questionnaire (Carver, Scheier & Weintraub, 1989). Internal reliability coefficient calculated for the present study was α = 0.66 (0.67 for men and 0.65 for women), the original alpha Cronbach coefficient for this scale was α = 0.62 (Carver *et al.*, 1989) and in the Romanian adaptation study α = 0.58 (Crașovan & Sava, 2013). An item example from this scale was: "I look for something good in what is happening".

Restraint was measured by the homonym 4 items scale in the COPE Questionnaire (Carver *et al.*, 1989). Internal reliability coefficient calculated for the present study was α =0.60 (0.51 for men and 0.62 for women), the original alpha Cronbach coefficient for this scale was α = 0.72 (Carver *et al.*, 1989) and in the Romanian adaptation study α =0.48 (Crașovan & Sava, 2013). An item example from this scale was: "I hold off doing anything about it until the situation permits.".

Acceptance was measured by the homonym 4 items scale in the COPE Questionnaire (Carver *et al.*, 1989). Internal reliability coefficient calculated for the present study was α = 0.73 (0.74 for men and 0.73 for women), the original alpha Cronbach coefficient for this scale was α = 0.65 (Carver *et al.*, 1989) and in the Romanian adaptation study α = 0.74 (Crașovan & Sava, 2013). An item example from this scale was: "I accept that this has happened and that it can't be changed".

Turning to religion /Religious approach was measured by the homonym 4 items scale in the COPE Questionnaire (Carver *et al.*, 1989). For the present study, reliability was α = 0.92 (0.90 for men and 0.92 for women), the original alpha Cronbach coefficient for this scale being α = 0.92 (Carver *et al.*, 1989). An item example from this scale was: "I try to find comfort in my religion".

The respondents were asked to indicate what do they do and feel in this period (lockdown, pandemic), related to the experienced /perceived stressful events. For all the scales included in the present study, the respondents used a 4 point Likert-scale, where 1 – I usually don't do this at all, 2 – I usually do this a little bit, 3 – I usually do this a medium amount to 4 – I usually do this a lot.

2.5. DATA ANALYSIS

The statistical analysis was carried out in SPSS. Multivariate analysis of variance (MANOVA) was used to determine the significance of differences between the coping strategies focused on emotions of men and women. The assumptions for the multivariate analysis of variance were met. A substantial correlation between the dependent variables (Kerlinger & Lee, 2000) was observed. Also, the Box's M value of 16.024 was associated with a *p* value of .105, interpreted as non-significant according to the standard guideline of p <.005 (Huberty & Petoskey, 2000). Also, we used the Box's Test to test for homogeneity of covariance matrices especially because we had unequal sample sizes.

We observed both Pillai–Bartlett trace, the sum of the proportion of explained variance on the discriminant functions, similar to R^2 (Field, 2018, p. 842) and Wilk's Lambda. We choose to report the later, being the product of the unexplained variance on each of the variates (Field, 2018, p. 843). Also, we are interpreting the effect size, considering Cohen's guidelines (1988), where η2 = .01 indicates a small, η2 = .06 a medium and η2 = .14 a large effect size.

3. RESULTS

3.1. CORRELATION ANALYSIS

Prior to conducting the MANOVA, a series of Pearson correlations were performed between all of the dependent variables to test the MANOVA assumption, namely that the dependent variables will be correlated with each other as Meyers, Gampst & Guarino (2006), in the moderate range.

Table no. 1

Descriptive statistics and correlations for the variables in study

Variables	*M*	*SD*	1	2	3	4
Positive interpretation and growth	3.29	.42	-			
Restraint	2.84	.43	**.26**	-		
Acceptance	2.91	.47	**.31**	**.27**	-	
Turning to religion	2.60	.89	**.18**	**.26**	.07	-

Note. N = 476; in bold significant correlation at p < .001

The results shown in Table no. 1 show dependent variables correlating between themselves with one exception, namely the coping strategy based on Acceptance did not significantly correlate with the coping strategy implying Turning to religion (*r.* = .07, *p* =.142).

3.2. MANOVA

The results of the MANOVA analyses are provided in Table no. 2.

Table no. 2

Multivariate tests for the gender groups

Variable	*Value*	*F*	*df*	*Error df*	*p*	Partial Eta Squared
Gender	.969	3.73[a]	4.00	471.00	**.005**	.03

Note. Statistically significant difference in bold: $p < .05$; [a]Exact statistic

There was a significant difference between men and women when considered jointly on the variables positive interpretation and growth, abstention, acceptance and turning to religion, Wilk's $\Lambda = .969$, $F(4, 471) = 3.73$, $p = .005$. These results support positively answering to *Research Question 1*. A low to medium effect size was observed (partial $\eta^2 = .03$) related to the variance in the studied coping strategies due a combined effect of gender.

A separate ANOVA was conducted for each dependent variable (see Table no. 3), with each ANOVA evaluated at an alpha level of .025.

Table no. 3

One-way ANOVA with Emotional Coping Subscales as Dependent Variables and Gender as Independent Variable

Dependent variable	Levene's		ANOVAs		
	$F_{(1,474)}$	*p*	$F_{(1,474)}$	*p*	η^2
Positive interpretation and growth	.33	.566	5.44	**.020**	.011
Restraint	1.52	.218	1.51	.220	.003
Acceptance	2.70	.101	.88	.350	.002
Turning to religion	.02	.893	11.77	**.001**	.024

Note. $N = 476$; ANOVA statistically significant in bold; η^2 = Partial eta squared

Based on a series of Levene's *F* tests, the homogeneity of variance assumption was considered satisfied, since the Levene's *F* tests suggested variances asociated with all four emotional coping strategies were homogenous ($p > .05$). A series of one-way ANOVA's on each of the four dependent variables was conducted as a follow-up tests to the MANOVA. As can be seen in Table no. 3, two of the ANOVA's were statistically significant, with effect sizes (partial η^2) scoring a low of .11 for positive interpretation and growth and a higher score of .024 for turning to religion. The other two of the ANOVA's were statistically not signficant with effect sizes very low of $\eta^2 = .002$, $p = .350$ for acceptance, as coping mechanism and $\eta^2 = .003$, $p = .220$ for restraint. These results show that *Research Questions 2* and *5* were positivelly answered, whereas *Research Questions 3* and *4* were not.

Table no. 4 presents that in two out of the four dependent variables studied there are differences between genders. To ilustrate these differences, we included in Table no. 4, the means and standard deviations for the genders reported for each of the dependent variables.

Also, the effect sizes as estimated by Cohen's d are reported in the Table no. 4. It can be observed that Cohen's *d* values for positive interpretation and growth = -.25 and turning to religion = -.36 are suggestive of a low to medium effect size, according to Cohen (1992).

Table no. 4

Descriptive Statistics for the Dependent Variables in relation to the Genders and Mean Differences in Emotional Coping Strategies Expressed as Cohen's d

Dependent variable	Men (N=116)		Women (N=360)		Mean Difference	Cohen's *d*
	M	*SD*	*M*	*SD*		
Positive interpretation and growth	3.21	.44	3.31	.41	**-.10**	-.25
Restraint	2.80	.39	2.85	.45	-.06	-.13
Acceptance	2.87	.52	2.91	.46	-.05	-.10
Turning to religion	2.36	.87	2.68	.88	**-.32**	-.36

Note. N = 476; significant mean differences in bold

3.3. LIMITATIONS

One limitation of this study could be seen in the transversal design that impair us to draw causal inferences. Also, the results were obtained solely through self-report questionnaires, which increase the possibility of contamination of the reported relationships through common method variance. Also, even if the study had a medium size large sample (N=476), the two gender samples were uneven, women being much more willing to take part in this study announced on a social platform and requiring a voluntary response. Lastly, the novelty of the general context in which this study was run, objectively insufficiently studied constitute both a limitation and also a very important path for future research both for general population as well as for the gender specific studies.

4. DISCUSSIONS AND CONCLUSIONS

The current study aims to explain how different emotional coping strategies were preferred by men and women at the outbreak of the pandemic *global COVID-19* and if those strategies were differently preferred by both genders.

When discussing about the problem solving and emotional coping strategies, it is important to make the distinction between the two, namely that "*the problem focused coping, is aimed at problem solving or doing something to alter the source of the stress*, whereas, *the emotion focused coping, is aimed at reducing or*

managing the emotional distress that is associated with (or cued by) the situation" (Folkman & Lazarus, 1980). Since the pandemic was, at least in its outset, a situation that one cannot solve, emotional coping mechanisms where rather involved when dealing with this kind of stressor. In their seminal article on the development of the COPE measure, Carver *et al.* (1989) explained each of the emotional coping strategies, followed by a deepening of understanding these strategies in a follow-up work (Carver, 1997).

One important point that the results of the current study support is the aspect related to *acceptance* and *restraint*. Both of them could occur in primary appraisal, when a person realize that the stressor is real and are rather spontaneous reactions to the unknown nature of the stressor. Therefore, being characteristic of the human nature to either restrain oneself from doing anything too quickly until one gathers more information to react, or, simply accept the reality of the fact that it happened, both men and women cope in a similar way. Therefore, no significant difference could be seen, as shown by the results, between genders.

When it comes to secondary appraisal in which people need to bring to mind a potential response to the threat (Carver *et al.*, 1989), coping strategies like *positive reinterpretation and growth* (termed also *positive reappraisal*) and *turning to religion*, are carriers of both gender specific responses and understanding of the stressor's nature as well as individual differences. The current study results are aligned with the results obtained by Tamres, Janicki & Helgeson (2002) in a meta-analysis. In 19 studies (N=3315), results have shown that women are more inclined to use much more positive reappraisal than men and in 9 other studies (N=1675) women have shown a higher preference to turn to religion than man. These authors showed also that women tend to adhere much more than men to positive reappraisal when the nature of the stressor is related to personal health (result found in 9 studies, N=1264) and to religion when the nature of the stressor is related to both personal health and others' health (result found in 3 studies, N=398 and, respectively, 2 studies, N=220).

As the authors explained and this current study also support, gender socialization may explain these findings as well as the fact that women tend to look at the stressors trying to grow, learn, or derive some benefit from them and in a more interpersonal, self-disclosing manner, way that may be viewed by men as revealing weaknesses and exposing vulnerabilities (Tamres *et al.*, 2002). Accepting that the pandemic could be distressing, women wanted more to seek comfort in turning to religion rather than men. To fight a prejudice related to women being more emotional than men in all situations, analyses of covariance (ANCOVA) revealed that sex differences in turning to religion remained significant when neuroticism was statistically controlled (Tamres *et al.*, 2002).

It was reported that positive religious coping strategies have consistently been associated with psychological adjustment variables such as self-esteem, life satisfaction, and quality of life, and negative religious coping strategies have consistently been related to more depressive symptoms (Harrison *et al.*, 2001; Ano & Vasconcelles, 2005).

The conclusion of this study is that, in terms of basic, primary appraisal emotion coping mechanisms, both men and women tend to react similarly. Still, when coming to choosing a manner in which the pandemic, as the studied stressor, was approached, women tend to score higher than men in turning to religion to manage the stress and to positively reappraise this situation, finding a way to grow and learn something new, different, out of the pandemic.

Practical implications could be drawn around manners in which men and women may choose to manage their activities in the pandemic crisis, not only in their work environments but also in the family settings, keeping in mind and respecting the differences and similarities.

Received: 1.02.2021

REFERENCES

1. ADHANOM GHEBREYESUS, T., *WHO Director-General's opening remarks at the Mission briefing on COVID-19 on 12 March 2020*, 2020, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---12-march-2020, Accessed Jan 24, 2021.
2. ANO, G.G, VASCONCELLES, E.B., *Religious coping and psychological adjustment to stress: a meta-analysis*, Journal of Clinical Psychology, **61**, *4*, 2005, p. 461–480.
3. BILLINGS, A.G., MOOS, R.H., *The role of coping responses and social resources in attenuating the stress of life events*, Journal of Behavioral Medicine, **4**, *2*, 1981, p. 139–157.
4. BRODY, L.R., *Gender and emotion: Beyond stereotypes.* Journal of Social Issues, **53**, *2*, 1997, p. 369–394.
5. BRODY, L.R., *The socialization of gender differences in emotional expression: Display rules, infant temperament, and differentiation.* In A.H. Fischer (Ed.), *Gender and emotion: Social psychological perspectives*, Cambridge, England, Cambridge University Press, 2000.
6. CARVER, C.S., *You Want to Measure Coping But Your Protocol's Too Long: Consider the Brief COPE*, International Journal of Behavioural Medicine, **4**, *1*, 1997, p. 92–100.
7. CARVER, C.S., SCHEIER, M.F., WEINTRAUB, J.K., *Assessing coping strategies: A theoretically based approach*, Journal of Personality and Social Psychology, **56**, *2*, 1989, p. 267–283.
8. CHANG, W.-H, *Understanding the COVID-19 pandemic from a gender perspective*, Taiwanese Journal of Obstetrics and Gynecology, **59**, *6*, 2020, p. 801–807.
9. CHIABURU, D.S., SAWYER, K., SMITH, T.A., BROWN, N., HARRIS, T.B., *When civic virtue isn't seen as virtuous: The effect of gender stereotyping on civic virtue expectations for* women, Sex Roles, **70**, *5*, 2014, p. 183–194.
10. COHEN, J., *A power primer*, Psychological Bulletin, **112**, *1*, 1992, p. 155–159.
11. COHEN, J., *Statistical power analysis for the behavioral sciences (2nd ed.)*, Hillsdale, NJ, Erlbaum, 1988.
12. CRAȘOVAN, D., SAVA, F. *Translation, adaptation, and validation on Romanian population of COPE questionnaire for coping mechanisms* analysis, Cognition, Brain, Behavior. An Interdisciplinary Journal, **17**, *1*, 2013, p. 61–76.
13. EAGLY, A.H., KARAU, S.J., *Role congruity theory of prejudice toward female* leaders, Psychological Review, **109**, *3*, 2002, p. 573–598.
14. ELSE-QUEST, N., HIGGINS, A., ALLISON, C., MORTON, L., *Gender Differences in Self-Conscious Emotional Experience: A Meta-Analysis*, Psychological bulletin, **138**, *5*, 2012, p. 947–981.
15. ELSE-QUEST, N., HYDE, J., GOLDSMITH, H., VAN HULLE, C., *Gender Differences in Temperament: A Meta*-Analysis, Psychological bulletin, **132**, *1*, 2006, p. 33–72.
16. FIELD, A., *Discovering Statistics Using IBM SPSS Statistics* (5th ed.), London, UK, Sage Publications, 2018.

17. FOLKMAN, S., LAZARUS, R.S., *An analysis of coping in a middle-aged community sample.* Journal of Health and Social Behavior, **21**, *3*, 1980, p. 219–239.
18. HARRISON, M.O., KOENIG, H.G., HAYS, J.C., EME-AKWARI, A.G., PARGAMENT, K.I., *The epidemiology of religious coping: A review of recent literature*, International Review of Psychiatry, **13**, *2*, 2001, p. 86–93.
19. HEILMAN, M.E., CHEN, J.J., *Same behavior, different consequences: Reactions to men's and women's altruistic citizenship behavior*, Journal of Applied Psychology, **90**, *3*, 2005, p. 431–441.
20. HOLTSBERG M., "*Crisis always exacerbates gender inequality*", UN Women AsiaPacific, Available at: https://mobile.twitter.com/un_women/status/ 1238232061007331330, Accessed January 24, 2021.
21. HOWERTON, A., *Gender differences in coping: Implications for depression and crime*, Doctoral Dissertations, **267**, 2005, https://scholars.unh.edu/dissertation/267.
22. HUBERTY, C.J., PETOSKEY, M.D., *Multivariate analysis of variance and* covariance in Tinsley, H., Brown, S. (Eds.) *Handbook of applied multivariate statistics and mathematical modeling*, New York, Academic Press, 2000.
23. KERLINGER, F.N. LEE, H.B., *Foundations of behavioral research (4th Ed.)*, Fort Worth, TX, Harcourt College Publishers, 2000.
24. KIDDER, D.L., MCLEAN PARKS, J.M., *The good soldier: Who is s(he)?* Journal of Organizational Behavior, **22**, *8*, 2001, p. 939–959.
25. KRALJEVIĆ, R., Z. FILIPOVIĆ, *Gender differences and consumer behavior of* Millennials, Acta Economica Et Turistica, **3**, *1*, 2017, p. 5–13.
26. LÄMSÄ, A.-M., VEHKAPERÄ, M., PUTTONEN, T., PESONEN, H.-L, *Effect of business education on women and men students' attitudes on corporate responsibility in society*, Journal of Business Ethics, **82** , *1*, 2008, p. 45–58.
27. MACCOBY, E.E., *Gender and relationships: A developmental account*, American Psychologist, **45**, *4*, 1990, p. 513–520.
28. MEYERS, L.S., GAMST, G., GUARINO, A., *Applied multivariate research: Design and interpretation*, Thousand Oaks, CA, Sage Publishers, 2006.
29. NIGG, J.T., GOLDSMITH, H.H., SACHEK, J., *Temperament and attention-deficit/ hyperactivity disorder: Preliminary convergence across child temperament and adult personality data may aid a multi-pathway model*, Journal of Clinical Child and Adolescent Psychology, **33**, 2004, p. 42–53.
30. PURVANOVA, R., MUROS, J., *Gender differences in burnout: A meta-analysis*, Journal of Vocational Behavior, **77**, *2*, 2010, p. 168–185.
31. ROTHBART, M.K., AHADI, S.A., HERSHEY, K.L., *Temperament and social behavior in childhood*, Merrill-Palmer Quarterly, **40**, 1994, p. 21–39.
32. SCARR, S., MCCARTNEY, K., *How people make their own environments: A theory of genotype-environment effects*, Child Development, **54**, *2*, 1983, p. 424–435.
33. SU, R., ROUNDS, J., ARMSTRONG, P., *Men and Things, Women and People: A Meta-Analysis of Sex Differences in Interests*, Psychological bulletin, **135**, *6*, 2009, p. 859–884.
34. TAMRES, L., JANICKI, D., HELGESON, V., *Sex Differences in Coping Behavior: A Meta-Analytic Review and an Examination of Relative Coping*, Personality and Social Psychology Review, **6**, *1*, 2002, p. 2–30.
35. TIFFERET, S., HERSTEIN, R., *Gender differences in brand commitment, impulse buying, and hedonic consumption*, Journal of Product & Brand Management, **21**, *3*, 2012, p. 176–182.
36. TOLIN, D.F., FOA, E.B., *Sex Differences in Trauma and Posttraumatic Stress Disorder: A Quantitative Review of 25 Years of Research*, Psychological bulletin, **132**, *6*, 2006, p. 959–992.
37. Visual and Data Journalism Team, *Coronavirus pandemic: Tracking the global outbreak*, BBC News, 2020.
38. WANNER, M., *Immune system changes with age differ between men and women*, The Jackson Laboratory, 2020, Available at: https://www.jax.org/news-and-insights/2020/february/immune-system-changes-with-age-differ-between-men-and-women, Accessed January 24, 2021.
39. YUKSEL, B., OZGOR, F., *Effect of the COVID-19 pandemic on female sexual behavior*, International Journal of Gynecology and Obstetrics, **150**, *1*, 2020, p. 98–102.

REZUMAT

Studiul, realizat în primele luni ale pandemiei (martie-aprilie 2020) în rândul populației generale din România (N = 476), a examinat modul în care bărbații și femeile diferă în ceea ce privește apelul la cele patru strategii de coping emoțional descrise de Carver, Scheier și Weintraub (1989) în situația crizei generate de pandemie. Analiza multivariată a variației a arătat că există diferențe semnificative statistic între bărbați și femei atunci când cele patru tipuri de strategii de coping emotional sunt analizate ca un tot unitar. Pe lângă aceasta, s-au evidențiat diferențe semnificative între bărbați și femei în ceea ce privește apelul la două dintre cele patru strategii de coping centrat pe emoții, respectiv apelul la religie și reevaluarea pozitivă cu scoruri medii mai ridicate în favoarea femeilor. În cazul celorlalte două strategii de coping, respectiv reținerea și acceptarea nu au existat diferențe semnificative între grupurile studiate. Rezultatele sunt în concordanță cu literatura actuală referitoare la diferențele individuale dintre băieți și fete, și cele dintre bărbați și femei. Aceste rezultate pot fi valorificate pentru a propune particularizat, și nu bazat pe stereotipii de gen, diferite abordări pentru femei și bărbați, nu numai în organizații, ci și în familie și în gestionarea propriei persoane, în situații de criză medicală.

THE EFFECTS OF SOCIAL ISOLATION ON ROMANIAN YOUNG PEOPLE IN THE CORONAVIRUS PANDEMIC CONTEXT

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Abstract

The quarantine imposed by the COVID-19 virus pandemic has an impact on young people' mental health. This was shown after 1,207 young people across Romania responded to an online survey undertaken by Copaceanu. The subjects were 72.4% female and 27.6% male and their average age is 21.93 years. The results show increased consumption of tobacco, alcohol and food during this period, more worried and anxious young people. Female participants experienced significantly more ($p < 0.001$) anxiety than males. Experiencing anxiety does not differ depending on the number of people living in the same house with the subjects. We found that family income and the size of family did not influence participants 'stress or anxiety. Regarding food, 50.9% said they ate more than usual and 17% gained at least 5 kg, while 13.8% lost weight. Furthermore, young people who used the Internet in excess reported a higher percentage (43.9%) of sleep disorders, compared to people who do not use the Internet excessively (21.2%). However, the participants also showed considerable optimism which indicates an important psychological resource. Data suggest the need for psychological interventions tailored on young people's needs.

Cuvinte-cheie: tineri, coronavirus, izolare socială, anxietate, alcool, tutun.

Keywords: young people, coronavirus, social isolation, anxiety, alcohol, tobacco.

1. INTRODUCTION

In the spring of 2020, Romania, like other countries around the world, underwent changes due to the coronavirus pandemic. All areas of life were affected, medical, educational, business, social and political. The increase of infected cases, the increase of deaths determined that the President of Romania to issue a presidential decree decreeing the state of emergency on March 16, 2020. Almost weekly, after analyzing the epidemiological situation in Romania, the Ministry of Internal Affairs issued military ordinances establishing new restrictions for the population. With some impact on young people was the Military Ordinance no. 3 of 24.03.2020 on measures to prevent the spread of COVID-19 issued by the

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Ministry of Internal Affairs which provided for the prohibition of the movement of all persons outside the home/ household, with a few exceptions. So, the citizens were not allowed to leave their homes for two months, except in the case of necessary situations well-defined by law such as the purchase of food or critical medical care. Young people were forced to stay at home, school classes were suspended, and only some of the pupils and students had access to a form of online education. The coronavirus disease 2019 (COVID-19) pandemic it will cause an extraordinary stressor to patients and health care systems across the globe

Children are likely to be experiencing worry, anxiety and fear (Kontoangelos, Economou and Papageorgiou, 2020). This study is aimed at identifying and analysing the impact of quarantine on young people in terms of emotional status, family and social aspects. The results of the study are relevant to both researchers and local authorities, youth organizations, families, and young people themselves. In Romania this is the first study that analyses the effects of the pandemic on young people.

2. LITERATURE REVIEW

Social isolation has an impact on mental health consisting of the risk for isolated people to experience symptoms of depression, anxiety, feelings of insecurity (Copeland *et al.*, 2018; Lin *et al.*, 2018). Some studies show that different forms of isolation are associated with unhealthy behaviours such as smoking, alcohol and marijuana use among young people (Copeland *et al*., 2017; Copeland *et al.*, 2018).

Some studies reported that social isolation may lead to increase fat accumulation (Nogueira-de-Almeida *et al.,* 2020). Social isolation in the context of the coronavirus epidemic has a psychological impact on people depending on their age and social support (Brooks, 2020). Young people are a category characterized by a high degree of socialization and thus experience more acute feelings of loneliness than the general population and may suffer consequences such as confusion, lack of confidence, increased anxiety during this period. Consequences can extend to neglect and abuse from parents (Green, 2020). Sleeping is another problem among young people, recent and emerging data indicate a key role for sleep in supporting cognitive function and mental well-being in adolescence. The chronic insufficient and poorly timed sleep that is endemic amongst adolescents is of concern (Tarokh *et al.*, 2016). Children's anxiety is linked to parental anxiety. According to Dalton *et al*. exposure to unexplained and unpredictable behaviour is perceived by children as a threat, resulting in a state of anxiety (Dalton *et al.*, 2020). In some countries, during the coronavirus pandemic, alcohol consumption registered significant increase. For instance, in the United Kingdom, alcohol sales

at the supermarket increased by 22% in March 2020 (Ellson, 2020). In Poland alcohol consumption increased by 14% (Chodkiewicz *et al.*, 2020). Regarding emotional state some studies have already investigated emotional impairment due to isolation in the general population not specific among young people. In a recent study conducted in China, 53.8% of respondents rated the psychological impact of the outbreak as moderate or severe; 16.5% reported moderate to severe depressive symptoms; 28.8% reported moderate to severe anxiety symptoms; and 8.1% reported moderate to severe stress levels. Most respondents spent 20–24 h per day at home (84.7%); were worried about their family member contracting COVID-19 (75.2%); and were satisfied with the amount of health information available (75.1%) (Wang *et al.*, 2020).

In February 2021, YoungMinds, the UK's leading charity fighting for children and young people's mental health published the result of a study on the impact of the pandemic on the mental health of young people. According to their results 67% of the participants believed that the pandemic will have a long-term negative effect on their mental health and 58% experienced loneliness or isolation.[1]

Other studies have shown high rates of depression: 27.1% of respondents and 7.7% about 10.1% of respondents suffered from phobia (Liu X, 2020). The prevalence of depressive symptoms, anxiety symptoms, and a combination of depressive and anxiety symptoms was 43.7%, 37.4%, and 31.3%, respectively, among Chinese high school students during the COVID-19 outbreak (Zhou *et al.*, 2020). In Romania, young people consume tobacco and alcohol at a high level that can be risky for their health. An observational study in a sample of Craiova high-school students on the use of substances such as cigarettes, alcohol and drugs, found that 37.4% of students declare to smoking, starting when they were between 12 and 15 (41.3%) and in particular 42.5% are female. Regarding alcohol consumption, 67% make use of it and started drinking when they were 14 or 15 years old (Petrelli *et al*., 2018). The education of young people suffered during the coronavirus pandemic. In a study with a sample of 2029 Romanian students, more than half (62%) reported a lower level of concentration in online courses, as well as a lower level of understanding of materials. Also, half of the respondents rated the possibility of collaborating with colleagues as lower and stated that they participate less in discussions in online courses (Lup and Mitrea, 2020). Other studies found that children and youth also may be engaging in more on-line behaviour in general or due to emotional distress (e.g., loneliness due to social isolation) and be increasing the chance for solicitation from others who prey on their emotional vulnerabilities (Peterman *et al.*, 2020).

[1] Coronavirus: Impact on young people with mental health needs Survey 4: February 2021, p4 (2021, March 25) retrieved from https://youngminds.org.uk/media/4350/coronavirus-report-winter.pdf

3. METHODOLOGY

During the isolation period due to the COVID-19 pandemic, young people would be more likely to experience more feelings of loneliness, a more strained relationship with their family, more anxiety, not enough sleep at night, excessive Internet usage and consumption of more alcohol, tobacco and food. Studies on the direct impact of COVID-19 infection as well as other medical issues or about the impact of using technology in education (e.g., zoom fatigue) have been published, but this study did not aim to analyse these variables.

3.1. RESEARCH OBJECTIVES

The objective of this research is to assess and describe the influence of the pandemic on young people emotionally, socially and family.

3.2. THE RESEARCH QUESTIONS

What is the impact of the pandemic on young people emotionally? Did the young people feel more alone, did they have more tense relationships with the family, did they feel more worried? Did young people consume more internet, alcohol, tobacco, and food? Has sleep quality been affected?

3.3. THE RESEARCH TOOL

In April – May 2020, an online questionnaire was distributed containing 75 questions referring to the impact of the COVID-19 crisis on Romanian young people. The questionnaire, developed by Copaceanu, included the most relevant aspects of the lives of young people who may have been affected by the pandemic crisis. The questionnaire included the following categories. section 1: demographics (sex, education, age, number of family members, income), section 2: emotional issues (isolation, impaired sleep, worries, emotional relationships), section 3: sociability (number of friends) and family relationship (stress, conflicts), section 4: tobacco use, alcohol, food, internet, and section 5: school concern. Of course, the questionnaire has a limitation because it could have contained other variables: such as health damage, covid infection of young people or family members. The questionnaire was distributed on online platforms most used by young people, namely Instagram and Facebook. Participants were informed on the purpose of the study, the methods used, confidentiality and data retention and analysis. Personal data of the participants remained anonymous.

3.4. THE PARTICIPANTS

One thousand two hundred seven young people from across Romania participated in this study. In the end, the analysis of the statistical data was carried out on a sample of 1,201 subjects. The survey included 72.4% (869) girls and 27.6% (332) boys, with an average age of 21.93 years; the predominant age was 18. In terms of education, most of the respondents were upper secondary school

students (48.1%) and university students (40.3%), but there was also a small percentage of postgraduates (7.6%) and lower secondary school students (3.8%). Regarding the number of people living in the same house, 33.6% of the subjects lived with three other people, 29.2% with two other people, 8% with more than four other people, 11.8% lived with one other person and 2.7% lived alone. In terms of family income, 50.3% declared their family had average income, 37.4% above average income, and 4.8% below average income (7.5 participants did not answer this question).

3.5. STATISTICAL ANALYSIS

The statistical analysis was carried out using the SPSS 20 (Statistical Package for the Social Sciences) program. In addition to the descriptive analysis of the variables considering their type and the formulated objectives, were also used the cross-table and the χ^2 (chi-square) test.

3.5.1. Family relationship

During the crisis, 45.2% of respondents said that there was more stress in their lives, 35.6% said the crisis has not brought anything good in their family life, 22% acknowledged that there were more quarrels and misunderstandings than before, and 33.1% showed concern about financial stability and family income. The comparison of the respondents by age showed a higher percentage of secondary education young people who reported that this crisis did not bring anything good in their family life, while a high percentage of those with more years of education said that this statement was false.

Table no. 1

The level of education

		7) The crisis brought nothing good in my family's life	
		True	False
1) Your current level of education	Lower secondary education	24	22
		52.2%	47.8%
	Upper secondary education	238	342
		41.0%	59.0%
	bachelor's degree	145	339
		30.0%	70.0%
	Postgraduates	22	67
		24.7%	75.3%
	No education	0	2
		0.0%	100.0%
Total		429	772
		35.7%	64.3%

$\chi 2$=25,35; df=4; p<0.001; Cramer's V=0.145

Generally speaking, 51.4% said that their parents were more stressed than them, 19.2% believed that someone in their family would need some form of psychological intervention (see table no. 2). The number of parents who were stressed did not differ significantly depending on the family income level. Although 70.9% said that they communicate almost daily with their friends during the crisis, to a later question, 35.7% said that their social life was affected by the crisis.

Table no. 2

Family income and stress

		60) My parents are much more stressed than I am	
		Yes	No
3) Consider your family to be one with income:	Average	313	293
		51,7%	48,3%
	above average	241	206
		53,9%	46,1%
	below average	18	17
		51,4%	48,6%
	$\chi 2$=5.93; df=4; p=0.204		

3.5.2. Feeling of isolation and relationships

Fifty-six percent of the total number of respondents experienced feelings of isolation, of which a higher percentage of secondary education students (58%) felt **isolated** compared to university students (33.7%) ($\chi 2$=32.91; df=4; p<0.001; Cramer's V=0.166). There was a difference in respondents depending on family income. Thus, a significantly higher percentage of young people whose families have low incomes considered that this crisis did not bring anything good in family life (52.2%) (see table no. 1). In comparison, little more than 25% of those with above-average or well-above-average income consider that this crisis did not bring anything good in the life of their family. Although the subjects stating they felt isolated was higher among those with low incomes compared to those with above-average or well-above-average incomes, the statistical analysis showed that the difference was not significant. ($\chi 2$=6.73; df=4; p=0.150). Being in a relationship does not lead to a stronger feeling of isolation, compared to not being involved in a relationship, as seen in the table below (see table no. 3).

Table no. 3

The relationship status

			41) I feel isolated	
			Yes	No
43) I'm involved in a relationship	Yes	Count	362	260
		%	58.2%	41.8%
	No	Count	309	270
		%	53.4%	46.6%
Total		Count	671	530
		%	55.9%	44.1%

$\chi 2=2.83$; df=1; p=0.092

3.5.3. The emotional state

Since the COVID crisis began, 46.9% of participants had felt unhappy, 41.3% felt more tired than usual, 35.1% got angry more easily, 33.2% had experienced anxiety, 29.2% had been worried more than usual, 28.2% had had fears about the future, 22.6% had cried more than usual and 6% had used medication to cope with these conditions. There were no statistically significant differences between secondary school students and university students in reporting anxiety during the crisis. Regardless of the level of family income, the percentage of those who said they began experiencing anxiety during the crisis is close in value, ranging between 31.1% and 40%. Comparing by gender, 22.9% of the girls in the study said they were very scared, even anxious, compared to 7.5% of the boys, the difference being statistically significant ($\chi 2=37.40$; df=1; $p<0.001$; Cramer's V=0.176). Experiencing anxiety does not differ depending on the number of people living in the same house with the subjects ($\chi 2=2.09$; df=4; p=0.718). There are no significant differences depending on the level of education and age in terms of anxiety (17.4% of young people in lower secondary school, 19% of young people in upper secondary school, 19% of young students and 14.6% of higher education graduates). The results show that 20.3% of the young people involved in a relationship consider themselves anxious, while 16.9%. of those not involved in a relationship also consider themselves anxious. The two rates are not significantly different ($\chi 2=2.19$; df=1; p=0.139).

3.5.4. Sleep disorders

Of the total number of participants, almost 40% said they experienced sleep disorders. It seems that the share of girls who could not sleep at night is significantly higher (42.9%) compared to boys (30.1%). The association between gender and the presence of sleep disorders is one of low intensity (Cramer's V = 0.117). The presence of sleep disorders does not differ significantly depending on the level of family income.

Table no. 4

Sleep disorder and family income

		49) I can't sleep at night (I have sleep disorders)	
		Yes	No
3) You consider your family income to be	Average	239	367
		39.4%	60.6%
	Above average	164	283
		36.7%	63.3%
	Well above average, money is not an issue	40	50
		44.4%	556%
	Below average	15	20
		42.9%	57.1%
	Unfortunately, we are short on money	15	8
		65.2%	34.8%
Total		473	728
		39.4%	60.6%

$\chi 2=8.93$; df=4; p=0.063

The presence of sleep disorders does not differ significantly depending on the sociability of the respondents (see table no. 5).

Table no. 5

Sleep disorder and sociability

			49) I can't sleep at night (I have sleep disorders)	
			Yes	No
9) I consider myself an outgoing person, I make friends easily	Yes	Count	348	566
		%	38.1%	61.9%
	No	Count	125	162
		%	43.6%	56.4%
Total		Count	473	728
		%	39.4%	60.6%

$\chi 2=2.74$; df=1; p=0.097

The analysis show that 61.1% of the young people who currently smoke more than they did before the onset of the COVID-19 crisis could not sleep at night as compared to the other categories: young people who do not smoke or smoke just as much. Thus, from the total number of respondents who had sleep disorders 36.1% are not smokers and 47% smokes just like before the crisis (see table no. 6).

Table no. 6

Sleep disorder and smoking

			49) I can't sleep at night (I have sleep disorders)	
			Yes	No
16) Do you smoke more than before the COVID-19 crisis?	Yes	Count	44	28
		%	61.1%	38.9%
	No	Count	162	262
		%	38.2%	61.8%
	I smoke the same	Count	54	61
		%	47.0%	53.0%
	N/A	Count	213	377
		%	36.1%	63.9%
Total		Count	473	728
		%	39.4%	60.6%

$\chi 2$=19.90; df=3; p<0.001; Cramer's V=0.129

The percentage of those who could not sleep at night differ significantly between people who did not consume alcohol (36.3%), those who consumed just as much as before the COVID-19 crisis (40.5%) and those who consumed more alcohol than before the COVID-19 crisis (49.1%) (see table no. 7).

Table no. 7

Sleep disorder and alcohol use

			49) I can't sleep at night (I have sleep disorders)	
			Yes	No
20) Since the COVID-19 began I have drunk more alcohol	Yes	Count	52	54
		%	49.1%	50.9%
	No	Count	225	330
		%	40.5%	59.5%
	N/A	Count	196	344
		%	36.3%	63.7%
Total		Count	473	728
		%	39.4%	60.6%

$\chi 2$=6.62; df=2; p=0.036; Cramer's V=0.074

A higher percentage of people who used the internet excessively during this period (43.9%) accused sleep disorders compared to people who had sleep disorders without using the internet excessively during this period (21.2%).

3.5.5. Internet use

Regarding the excessive use of the Internet, most of the respondents, regardless of education, said that they used it largely for socializing (54%), on a significantly distanced 2nd place being music (11.7%), followed by video games (8.4%) while an extremely low percentage of the subjects used the Internet for gambling (2.3%) (see table no. 8). Regarding the excessive use of the Internet for sexual purposes, 8.1% of the boys answered affirmatively as compared to the significantly low 1.4% of the girls who declared they used the Internet excessively in this purpose. Comparing results of secondary education students with those of university students, the former used the Internet excessively for other purposes such as music and video games, while the latter used the Internet rather for information and documentation. A very high percentage of both the girls (80.4%) and the boys (78.9%) declared that they used the Internet in excess during this period. There is no difference based on gender from this point of view ($\chi 2=0.348$; df=1; p=0.555). Regarding the time spent online, a higher percentage of boys (63.6%) considered that they spent more than 6–8 hours a day on the Internet, compared to a percentage of 55.8% of the girls. Although the difference is statistically significant, the association between gender and spending more than 6–8 hours a day on the Internet has an extremely low intensity. (Cramer's V=0.07).

A higher percentage of secondary school young people use the Internet in excess (86.2%), compared to people with postgraduate studies (52.8%) ($p<0.001$; Cramer's V=0.220). Regarding the number of hours/days, 27% of postgraduate respondents spent more than 6–8 hours a day on the Internet, compared to 54.3% of the lower secondary education respondents. What is worrying is the high percentage (35.2%) of the subjects who admitted being addicted to the Internet. It is noted that young people with postgraduate studies and those with lower secondary education are those who are considered in a high proportion as severely dependent on the Internet, compared to people with upper secondary education and university education. There is also no difference depending on the family's income, the number of people living in the house when it comes to how they experienced the isolation or the excessive usage of the Internet. For example, the following percentages of respondents overused the Internet: 56.2% of the young people living alone, 81.3% of the young people living with one other person and respectively 81% of the young people living with three or more other persons (p=0.017; Cramer's V=0.100). The percentages of people who spent more than 6–8 hours a day on the Internet is similar, with no statistically significant differences, regardless of the number of people living in the same house.

Table no. 8

The use of internet and the level of education

		33) I overuse the internet for				
		Socialisation	Music	Video games	Get information and document	Others
1) Your current level of education	lower secondary education	18	9	8	2	9
		39.1%	19.6%	17.4%	4.3%	19.6%
	upper secondary education	272	120	73	54	61
		46.9%	20.7%	12.6%	9.3%	10.5%
	undergraduate	215	68	39	79	83
		44.4%	14.0%	8.1%	16.3%	17.1%
	postgraduate	29	6	4	35	15
		32.6%	6.7%	4.5%	39.3%	16.9%
	no education	0	2	0	0	0
		0.0%	100.0%	0.0%	0.0%	0.0%
Total		534	205	124	170	168
		44.5%	17.1%	10.3%	14.2%	14.0%

$\chi 2=100.99$; df=16; $p<0.001$; Cramer's V=0.145

3.5.6. Smoking and alcohol consumption during the crisis

Of the total participants, 32% of respondents were smokers at the time, 12.2% said they smoked more than before the crisis, and 8.4% of them with at least five more cigarettes a day. Only 21% wanted to quit smoking. The percentage of young people smoking more than before the COVID-19 crisis does not differ significantly based on the respondents' gender (6.6% boys and 5.8% girls, $\chi 2=0.61$; df=3; p=0.892) nor in terms of the number of cigarettes smoked daily: 6.9% smoked at least five cigarettes more during the crisis 6.9% boys and 8.9% girls, and at least 10 cigarettes/day – 2.7% boys and 2.5% girls, respectively at least 15 cigarettes/day, 1.8% boys and 1% girls ($\chi 2=6.93$; df=4; p=0.139). Also, 6.9% of the boys and 10.9% of the girls said they had given up smoking since the crisis began (see table no. 9). A higher percentage (12.2%) of the subjects who lived with one other person in the household report they smoked more than before the COVID-19 crisis compared to those who lived alone or with more than one person in the same house.

Table no. 9

Smoking and the number of family members

			16) Do you smoke more than before the COVID-19 crisis?			
			yes	No	Same	n/a
2) How many people live in the house?	1 person	Count	17	52	21	49
		%	12.2%	37.4%	15.1%	35.3%
	2 persons	Count	21	127	34	169
		%	6.0%	36.2%	9.7%	48.1%
	3 persons	Count	17	140	28	219
		%	4.2%	34.7%	6.9%	54.2%
	4 or more persons	Count	15	95	27	138
		%	5.5%	34.5%	9.8%	50.2%
	alone	Count	2	10	5	15
		%	6.2%	31.2%	15.6%	46.9%
Total		Count	72	424	115	590
		%	6.0%	35.3%	9.6%	49.1%

$\chi 2$=28.17; df=12; p=0.005; Cramer's V=0.088

Regarding the number of cigarettes, they smoked extra, the same respondents who lived with only one more person in the house said in a higher percentage (12.9%) that they smoked at least five extra cigarettes compared to the other respondents living alone or with more than one person in the household (6.2%) (see table no. 10).

Table no. 10

Smoking and the number of family members

		17) I estimate I smoke more with:					
		min. 5 cigarettes / day	min 10 cigarettes / day	min 15 cigarettes / day	N/A	Since the crisis started, I've given up cigarettes	
2) How many people live in the house?	1 person		18	4	6	105	6
			12.9%	2.9%	4.3%	75.5%	4.3%
	2 persons		28	9	5	274	35
			8.0%	2.6%	1.4%	78.1%	10.0%
	3 persons		30	8	1	326	39
			7.4%	2.0%	0.2%	80.7%	9.7%
	4 or more persons		22	9	2	206	36
			8.0%	3.3%	0.7%	74.9%	13.1%
	Alone		2	1	1	26	2
			6.2%	3.1%	3.1%	81.2%	6.2%
Total		100	31	15	937		118
		8.3%	2.6%	1.2%	78.0%		9.8%

$\chi 2$=29.25; df=16; p=0.022; Cramer's V=0.078

3.5.7. Alcohol and food

Since the crisis began, only 44.8% said they were abstainers. 4.3% of the young people reported daily alcohol consumption and 18 participants considered that they consumed excessively. **Concerning alcohol consumption, there are statistically significant differences between male and female participants (make this correction throughout the article). Thus, 15.1% of boys had consumed more alcohol since the COVID-19 crisis began, while among girls, only 6.4% say they started consuming more alcohol.** ($\chi 2$=30.27; df=2; p<0.001; Cramer's V=0.159) Study participants living alone, living with another person or living with four or more people stated in slightly higher percentages, between 10.1% and 12.5%, that, since the beginning of the COVID-19 crisis, they had been consuming more alcohol. Respondents living with two or three people in the house stated in slightly lower percentages (8.3% and 6.7%, respectively) that they had consumed more alcohol since the COVID-19 crisis began.

Of the total respondents, 50.9% said they ate more than usual and 17% gained at least 5 kg, while 13.8% lost weight. The percentage of girls who ate more than usual during this period (52.6%) is higher than that of boys (45.5%).

3.5.8. Family income

The analysis was centred on possible differences depending on the income of families. Young people coming from low-income families discovered during this period new, interesting, fascinating and pleasant thing in a significantly lower percentage (43.5%) than young people in other income categories. One can observe the percentage of young people who discovered new, interesting and pleasant things is higher as the income level increases (see table no. 11).

Table no. 11

Family income and pleasant things

			62) During the crisis period, I discovered new, interesting, fascinating and pleasant things	
			Yes	No
3) You consider your family income to be:	Average	Count	372	234
		%	61.4%	38.6%
	Above average	Count	305	142
		%	68.2%	31.8%
	Well above the average, money is not an issue	Count	64	26
		%	71.1%	28.9%
	Below average	Count	21	14
		%	60.0%	40.0%
	Unfortunately, we are short on money	Count	10	13
		%	43.5%	56.5%
Total		Count	772	429
		%	64.3%	35.7%

$\chi 2$=11.69; df=4; p=0.020; Cramer's V=0.099

3.5.9. School

The questionnaire included questions about the school. Only 46.7% said that their school adapted very well to online education, 32.6% acknowledged that education suffered during this period and 25.6% said that "school is a disaster when it comes to managing online education." Girls are also much more concerned about the future of education (53%) than boys (39.8%) ($p<0.001$). High concern about the future of education does not differ significantly depending on the level of family income. Thus, 50% of young people who said that their family had an average income and 47% of young people who said that they had above average income been worried about their educational future.

3.5.10. Optimism and sociability

Regarding the aftermaths of the COVID-19 crisis, 87.7% of the boys are more optimistic about their future, while 80.3% of the girls showed optimism about their future ($p=0.003$; Cramer's $V=0.086$). A high percentage of people (66.1%) who considered themselves sociable discovered new, interesting, fascinating and pleasant things, compared to people who did not consider themselves sociable and who discovered new, pleasant things in a percentage of 58.5%. Optimism about one's own future differs significantly depending on how sociable the person is. Thus, 86.1% of people who consider themselves sociable are optimistic about their own future, while 70.4% of the people who do not consider themselves sociable are optimistic about their own future ($p<0.001$). Optimism about their own future differs significantly depending on family income, which increases as family income is higher (78.9% of those with average incomes are optimistic about their future, 85.9% of those with above average incomes are optimistic and 92.2% of those with far above average incomes are optimistic). Results show that sociability does not influence how one cares about school in the future. Accordingly, 47.8% of sociable people worry about the future while 54.4% of those who do not consider themselves sociable also have worries when it comes to school in the future ($\chi 2=3.75$; $df=2$; $p=0.153$).

4. CONCLUSIONS AND DISCUSSION

As the study suggests, young people appear to have suffered during the pandemic in a few ways: their emotional state, concerns about educational future, family stability, sleep disorders, feelings of anxiety, quarrels with family or excessive consumption of food, the Internet, tobacco, and alcohol. However, they also showed considerable optimism which indicates an important psychological resource. In this study, we found that family income and the size of family did not influence participants 'stress or anxiety. Further research is needed to understand how these young people cope with challenges such as COVID-19. Given that young people use the Internet, mobile applications and social media to a great

extent, largely because they are attractive and easy-to-use, such tools can be used to deliver safety information, offer specialized emotional support (to help cope with stress and anxiety) and reduce risk behaviour (excessive usage of internet, alcohol, tobacco, food). Unfortunately, this kind of help is currently not available in Romania. There is only one application in Romanian for reducing alcohol consumption. There are no applications to help young people get in touch with psychologists. To reduce the risk of problematic consumption behaviour, families should consider substituting sedentary leisure for more active leisure pursuits (Moore *et al*., 2020).

On the other hand, at the national level, the Ministry of Health or the Romanian College of Psychologists does not show much interest for specialized interventions to support young people during the pandemic. On the contrary, the COVID-19 pandemic could be an opportunity to improve mental health services (Morena *et al*., 2020).

There were several NGOs, universities, and psychiatric hospitals in Romania that voluntarily provided psychological assistance but these services were not necessarily focused on young people. Moreover, volunteer psychologists did not receive specific training; for example, psychologists could have been offered a chance to register in volunteer databases. Finally, the pandemic has shown that the pre-university and university education system has major problems and has not been able to adapt quickly or efficiently.

Received: 8.12.2021

REFERENCES

1. BROOKS, S.K., WEBSTER, R.K., SMITH, L.E., WOODLAND, L., WESSLEY, S., GREENBERG, N., & JAMES RUBIN, G., *The psychological impact of quarantine and how to reduce it: Rapid review of the evidence*, Lancet, **395**, 2020, p. 912–920.
2. CHODKIEWICZ, J., TALAROWSKA, M., MINISZEWSKA, J., NAWROCKA, N., BILINSKI, P., *Alcohol Consumption Reported during the COVID-19 Pandemic: The Initial Stage*, Int. J. Environ. Res. Public Health, **17**, *13*, 2020, p 4677.
3. COPELAND, M., FISCHER, J.C., MOODY, J., & Feinberg, M.E., *Different kinds of lonely: Dimensions of isolation and substance use in adolescence*, Journal of Youth and Adolescence **47**, *8*, 2018, p. 1755–1770.
4. COPELAND, M., BARTLET, B, FISCHER, JC. *Dynamic Associations of Network Isolation and Smoking Behavior*, Netw Sci. (Camb. Univ. Press), **5**, *3*, 2017, p. 257–277.
5. DALTON, L., RAPA, E., STEIN, A., *Protecting the psychological health of children through effective communication about COVID-19*, Lancet Child Adolesc. Health. **4**, *5*, 2020, p. 346–347.
6. ELLSON, A., *Coronavirus: bingeing Britons buy 20% more alcohol for lockdown*, Times 2020 Mar 31. https://www.thetimes.co.uk/article/coronavirus-bingeing-britons-buy-20-per-cent-more-alcohol-for-lockdown-njh6jn55.
7. GREEN, P., *Risks to children and young people during covid-19 pandemic*, BMJ **369,** 2020, doi: https://doi.org/10.1136/bmj.m1669 (Published 28 April 2020).
8. KONTOANGELOS, K., ECONOMOU, M., PAPAGEORGIUOU, C., *Mental Health Effects of COVID-19 Pandemia:A Review of Clinical and Psychological Traits*, Psychiatry Investig., **17**, *6*, 2020, p. 491–505, doi: 10.30773/pi.2020.0161.

9. LIN, S., LI, X., CHEN, Y. *et al*., *Social Isolation During Adolescence Induces Anxiety Behaviors and Enhances Firing Activity in BLA Pyramidal Neurons via mGluR5 Upregulation*, Mol. Neurobiol., **55**, 2018, p. 5310–5320, https://doi.org/10.1007/s12035-017-0766-1
10. LIU, X., LUO WT, LI Y *et al*., *Psychological status and behavior changes of the public during the COVID-19 epidemic in China*, Infect Dis. Poverty; **9**, *1*, 58, 2020,. doi:10.1186/s40249-020-00678-3.
11. LUP, O., MITREA, E.C., *Învățământul universitar din România în contextul pandemiei COVID-19: experiențele studenților*, Făgăraș, Editura Institutului de Cercetare Făgăraș, 2020.
12. MORENA, C. *et al*., *How mental health care should change as a consequence of the COVID-19 pandemic*, Lancet Psychiatry; ***7***, 2020, p. 813–24, https://doi.org/10.1016/ S2215-0366(20)30307-2.
13. MOORE C. *et al*., *International Journal of Behavioral Nutrition and Physical Activity*, **17:85**, 2000; https://doi.org/10.1186/s12966-020-00987-8.
14. NOGUEIRA-DE-ALMEIDA, C.A., Del CIAMPO, L.A., FERRAZ, I.S., Del CIAMPO, I.R.L., CONTINI, A.A., UEDC F.V., *COVID-19 and obesity in childhood and adolescence: a clinical review*, J. Pediatr. (Rio J), **96**, *5*, 2020, p. 546–558.
15. PETRELLI, F., SCURI, S., TANZI, E., GUYEN, T., & GRAPPASONNI, I., *Lifestyles and discomfort in a sample of young Romanian students*, Journal of preventive medicine and hygiene, **59**, *3*, 2018, p 230–235, https://doi.org/10.15167/2421-4248/jpmh2018.59.3.985.
16. PETERMAN, A., POTTS, A., O'DONNELL, M., THOMPSON, K., SHAH, N., OERTELT-PRIGIONE, S. *et al.*, *Pandemics and violence against women and children*, Center for Global Development Working Paper, 2020.
17. TAROKH, L., SALETIN, J.M., & CARSKADON, M.A, *Sleep in adolescence: Physiology, cognition and mental health*, Neuroscience and biobehavioral reviews, **70**, 2016, p. 182–188. https://doi.org/10.1016/j.neubiorev.2016.08.008.
18. WANG, C., PAN, R., WAN, X., TAN, Y., XU, L., Ho, C.S., & Ho, R.C. *Immediate Psychological Responses and Associated Factors during the Initial Stage of the 2019 Coronavirus Disease (COVID-19) Epidemic among the General Population in China*, International journal of environmental research and public health, **17**, *5*, 2020, p. 1729. https://doi.org/10.3390/ijerph17051729.
19. ZHOU, S.J., ZHANG, L.G, WANG, L.L *et al.*, *Prevalence and socio-demographic correlates of psychological health problems in Chinese adolescents during the outbreak of COVID-19*, Eur. Child Adolesc. Psychiatry, **29**, *6*, 2020, p. 749–758, doi:10.1007/s00787-020-01541-4.
20. Coronavirus: Impact on young people with mental health needs Survey 4: February 2021, p4 (2021, March 25) retrieved from https://youngminds.org.uk/media/4350/coronavirus-report-winter.pdf

REZUMAT

Carantina impusă de pandemia virusului COVID-19 are un impact asupra sănătății mintale a tinerilor. Acest lucru a fost demonstrat după ce 1.207 de tineri din toată România au răspuns la un sondaj online derulat de Copaceanu. Subiecții au fost 72,4% de sex feminin și 27,6% de sex masculin, iar vârsta lor medie este de 21,93 ani. Rezultatele indică un consum crescut de tutun, alcool și alimente în această perioadă, tinerii fiind mai îngrijorați și mai anxioși. Participanții de sex feminin au prezentat o anxietate semnificativ mai ridicată (p <0,001) comparativ cu băieții. Experimentarea anxietății nu diferă în funcție de numărul de persoane care trăiesc în aceeași casă cu subiecții. Am constatat că venitul familiei și dimensiunea familiei nu au influențat stresul sau anxietatea participanților. În ceea ce privește produsele alimentare, 50,9% au spus că au mâncat mai mult decât de obicei și 17% au îngrășat cel puțin 5 kg, în timp ce 13,8% au slăbit. Mai mult, tinerii care au folosit internetul în exces au raportat un procent mai mare (43,9%) de tulburări de somn, comparativ cu persoanele care nu folosesc internetul în mod excesiv (21,2%). Cu toate acestea, participanții au prezentat, de asemenea, un optimism considerabil, ceea ce indică o resursă psihologică importantă. Datele sugerează necesitatea intervențiilor psihologice adaptate nevoilor tinerilor.

TIME MANAGEMENT AND STUDY SKILLS GUIDE FOR IMPROVING ACADEMIC PERFORMANCE

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Abstract

Managing responsibilities in a limited time and using cognitive resources in an efficient way, to maximize performance, are a set of, not only desirable, but also necessary skills in our current society. The studies that assess these skills for different age groups and educational levels support this need. Thus, we propose, based on the support of scientific studies in the field of educational psychology, a guide of learning and time management. In the case of time management, we focus on defining goals as well as on prioritizing and organizing activities. In terms of learning skills, we first focus on how to write down relevant information, then on organizing said information into meaningful units, and finally, on a method to facilitate its retention in the long-term memory. This approach has the goal to maximize the potential improvement of the subject's academic performance.

Cuvinte-cheie: metoda Cornell, strategii studiu, scopuri SMART, managementul timpului.

Keywords: Cornell method, mind maps, study skills, SMART goals, time management.

1. INTRODUCTION

The importance of studying and improving study and time management skills is justified by the possibility of avoiding certain negative effects, usually brought by ignoring these variables. Starting with study techniques, El Meysarah (2015) proposes that the inabilities to develop a method of memorizing and taking notes effectively are some of the main reasons why students lack the understanding of the necessary class materials.

In the case of time management, the studies declare difficulties in organizing personal time, this being true both in the case of undergraduate and even doctoral students. Wilson and Onquegbuzie (2003, cited in Behnam, Jenani & Ahangari, 2014) show, in the latter case, that the factors that were listed as prevalent in inducing anxiety were the amount of study material, the difficulty of the material, the number of projects related to each course and personal time management. In the

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case of 198 undergraduate students, Sannsgiry and Sail (2006, cited in Behnam *et al.*, 2014) positively correlate student's perception of the amount of work they have to do, and the perceived ability to manage them, with test anxiety and poor academic performance. According to Hatos and Pop (2019), out of a sample of 498 people, extracted from three universities in Romania, the percentage of students thinking of dropping out of the university they were enrolled in is between 9.8% and 25.2%. Analysing the variables that could lead to these results, the authors concluded that the school curriculum and the socio-economic status of students do not explain the obtained results. Some of the proposed variables that could explain these percentages are the social integration of the student in the academic environment, motivation and interest in the chosen field and time management, such as accomplishing academic tasks and maintaining job attendance during the semester. In the study of Stăiculescu and Ramona (2018, p. 1) a "report on the state of higher education in Romania shows that between 2014 and 2015 the average duration of academic attendance was 1.2 years", only a third of the students (35.5%) finishing their undergraduate studies. The authors propose as explanatory variables of this phenomenon, the academic goals, perceived academic and social support and the academic skills of the students.

2. THE COGNITIVE PATTERNS BEHIND LEARNING

To facilitate the process of learning and managing personal responsibilities of students, this paper aims to teach practical methods of study and time management, supported from an empirical point of view. Defining learning is however a problematic issue, due to the wide applicability of the concept. Thus, we consider that it cannot be said that learning has a general definition, but a variety of specific definitions. In the case of academic learning, as an informal definition, we could assume that the focus is on the integration of semantic, theoretical information in the long-term memory of the subject, to use it in a practical manner. Banikowski and Mehring (1999) theorize that memory is not only a basic concept of learning, with a role in storing, organizing, and connecting information, but it is also the only method to attest the presence of semantic information. We further refer to the necessary theoretical basis that we follow in choosing the study techniques. According to the information processing model, "semantic memory is mentally organized in networks interconnected by ideas, called schemes (schemata). Thus, information is processed, interpreted, and stored in a way that can be later updated" (Voss & Wiley, 1995 cited in Banikowski & Mehring, 1999). One of the purposes of study techniques is to facilitate the recall of information. According to the processing level model, the more a study technique "focuses on the details of a stimulus, the more, the information, needs to be processed in depth, thus its chances to be recalled and successfully updated are increasing" (Bower & Karlin, 1974, cited in Banikowski & Mehring, 1999).

3. HISTORY OF TIME MANAGEMENT

For the first time, the concept of time management was used in business, in "The Principles of Scientific Management" by Frederick Winslow Taylor, published in 1911, which researched the optimal way to implement training and distribution of rewards to employees (Albert, 2018). In the case of academic performance, Macan (1994), Powell (2004) and Sansgiry (2006) (cited in Jinalee & Singh, 2018) included as relevant factors, for the definition of time management, the ability to select goals and establish priorities, the ability to plan, and to follow relevant study techniques. Covering them under the same umbrella, Lay & Schouwenburg (1993) proposed what are referred to as "behavioural clusters" that aim to facilitate productivity and minimize stress. Incorporating multiple principles, in addition to some already mentioned, Classens (2009, cited in Čiarniene & Vienazindiene, 2014) proposes the following. First, is that time requires a goal to be directed at, for example, towards academic performance, and secondly, that there should be a focus on the practical approach, referring to techniques that involve optimal use of time, such as time assessment, planning and monitoring behaviour.

Time assessment measures the temporal resources and the limits within which the subject can perform his tasks. Planning refers to the definition of goals, their prioritization, and their categorization. Monitoring allows keeping track of a trend of activities, as well as analysis of potential errors (Čiarniene & Vienazindiene, 2014).

4. RECOMMENDED METHODS OF LEARNING

The Cornell method of note-taking was developed by Walter Pauk, a professor at Cornell University, in 1940 (Pauk & Owens, 2010). This method consists of dividing a sheet of paper into three segments. On the upper-left side of the sheet, keywords, abbreviations, schemes, drawings can be used, to underline important concepts. On the upper-right side, the student will summarize definitions or other important and relevant information. The benefit of this method is the constraint on the space that can be used to take notes, which guides the process of information selection (Akintunde, 2013). Finally, at the bottom of the page, the student is advised to use a method that tests information retention, for example, a quiz. Some of the positive aspects of the technique are the ability to keep the user focused on important tasks, taking notes in an organized style, requiring significant cognitive resources. At the same time, the structure of those resources offers the possibility to condense and reformulate the information in an easy to manage way, which leaves room for individual autonomy. Regarding the negative aspects, the technique requires a long time of planning and caution on what needs to be included as vital information (Musyawaroh, 2017).

A comparative study (Akintunde, 2013), between the Cornell method, Verbatim (word-for-word writing), and retention by underlining and outlining, concludes that the recommended method (Cornell) is superior in terms of improving task performance. The testing methods for each of the groups were free-recall, recognition, and essay. The most important differences discovered in the experiment are the correlations between the level of malleability of the technique (in terms of information systematization and the level of processing) and the possibility of multi-tasking during the task. In addition to underlining and Verbatim, additional steps in the Cornell method such as adding keywords, creating a summary, or solving questions based on the notes, not only develops critical thinking but also facilitates the internalization of information in the long-term memory in an autonomous way, which helps the understanding of the material in a faster way than simply copying and arranging information (Anjarsit & Adnan, 2017; Akintunde, 2013). Although there are other studies that support the usefulness of the Cornell technique in various contexts (Musyawaroh, 2017; Hayati & Jalilifar, 2009), there are also results that challenge its efficiency (Quintus *et al.*, 2012). In the study conducted on a class of high school students, Quintus (2012) compares the Cornell technique with a method chosen by the students, for most of which was their own note-taking strategies. Following the experiment, no notable results were observed between groups, concluding that a method with which the student is already accustomed can be as effective as an empirically supported technique.

Acronyms refer to abbreviation of certain phrases or words, with the goal of improved recalling of complex information. They are most often found in combination with other variations, such as acrostics – through which a sentence is constructed with the initials of each word to be remembered. Although the subject was the object of many research experiments, their isolated effect on academic performance is still insufficiently documented (Lubin & Polloway, 2016). In any case, compared to other categories of mnemonic techniques, linguistic ones can be used regardless of subject. However, a major limitation is the number of abbreviations that can be made until the information can no longer be efficiently stored in memory. Therefore, it is recommended to use chunking, or "grouping individual information into extensive meaningful units" (Banikowski & Mehring. 1999). Chunks are used in abundance when it is necessary to compress a substantial amount of information. As an example, in the case of a therapeutic system, The ABC of Albert Ellis, the initials gradually symbolize the processes of the therapeutic approach. "A" stands for the Activating event, "B" for the Beliefs about the event, "C" for the Consequences (behaviour) caused by the beliefs. Nemati's (2013) study addresses, in a comparative matter, 7 study strategies, including underlining, use of mental images, grouping and acronyms. Its purpose is to observe the improvement of the retention of linguistic information in various student groups. The experiment shows that although other strategies such as highlighting information help retention in the short term, the use of acronyms is a more effective choice for retaining information

in the long run. At the same time, together with other language strategies, "acronyms are evaluated as effective in the case of students with learning disabilities" (Demirdag, 2014).

The mind map method was created by Tony Buzan, published in "The Mind Map Book" in 1993, and described as a metacognitive tool, which, according to Silver (2013, cited in Sweet *et al.*, 2017), allows reflection on one's own approach to thinking and organizing information, resulting in a deeper processing of information. In terms of design, mind maps involve the construction of interconnected diagrams integrating concepts and images. The method consists in deciding on a central idea or theme and extending it to adjacent topics. Thus, a mental map can comprise an infinity of connections between concepts (Jain, 2015). The method can also be used in conjunction with other techniques, such as flash cards. Concomitant and efficient use of these strategies involves avoiding simple recitation and transcription of targeted information. Instead, it is recommended to transform the notes into meaningful schemes, integrated into a mental map and test retention through questions (Sweet, Blythe, & Carpenter, 2017). The method was validated in terms of pedagogical utility as an individual study technique, both for middle and high school students, as well as for students who studied arts (music), social sciences and medicine (Jain, 2015; Çoban & Selçuk, 2017; Rosciano, 2015).

The method of spaced learning is based on the spacing effect, which was first studied in the 19th century by Hermann Ebbinghaus and included in "Memory: A Contribution to Experimental Psychology", published in 1885. Quoting Ebbinghaus: "A significant number of repetitions, distributed over time, is more advantageous (for memorization) than merging them into a single instance of time" (Ebbinghaus, 1913 quoted in Smolen, Zhang, & Byrne, 2016). The conclusion expressed by the author is based on experiments of memorization of lists of syllables, but current studies extend the results to concepts and word lists (Smolen *et al.*, 2016). The distributed study method is based on 3 theories: The encoding variability theory, the study-phase retrieval theory, and the deficient-processing theory. According to Smolen and collaborators (2016):

- **The encoding variability theory** assumes that memory is influenced by the context in which the encoding is done. Often, when study sessions are spread over a longer period, it is very possible that the environment will be different for each of the sessions. Thus, the chance of recalling information, encoded in a similar environment, increases.
- **The study-phase retrieval theory** shows that presenting stimuli in a spaced way is more efficient than merging them, to consolidate memory, because each study session reactivates the information created and stored by the previous session. Combining the information into a single study session can be the situation where the previous information is still present in the memory. In this situation, reactivation is impossible, because the information is still present in the working memory, and thus long-term memory consolidation has a lower chance of success.

- **The deficient-processing theory** shows that in the case of combined learning, a tendency to get used to stimuli is created. At the same time, the subject's attention decreases, and the chances that the information will be processed in depth and retained in the long-term memory decrease. The method has biological support. The results of conditioning experiments on animals (mice) show that the administration of electrical stimuli, with a spacing of 30 minutes between sessions, produce behaviour changing effects lasting up to 24 hours, with detectable residual effects that last up to 4 days after the mentioned sessions.

We observed that the main interest, so far, was the study of the effects of distributed study sessions over short periods of time, addressing the ability to memorize and recall various lists of words or artificial language concepts. Thus, the time between sessions, in the respective experiments, does not exceed the interval of a couple of minutes, making the generalization of the results impossible, when it comes to more extended periods of time (Khoii & Abed, 2017; Delaney, Verkoeijen, & Spirgel, 2010). However, as will be explained in detail, the method of distributed study has shown promising results when used together with other techniques like self-testing through flashcards.

Self-testing. Self-testing is viewed as one of the best methods for in-depth learning. It involves writing a question and an answer on the front and back of a sheet of paper. Although the method seems simple, most students, according to various studies (Kornell, 2009; Senzaki, Hackathorn, Appleby & Gurung, 2017), use it in a counterproductive way. First, the theory of distributed study is not considered by students when constructing, and using, the sets of flashcards. It should be noted that, in this case, the distributed study focuses on the distance between the cards to be learned and not between the study sessions themselves. In an experiment (Senzaki *et al.*, 2017) two groups are trained according to the following instructions. The first group is assigned to the combined study method and uses four smaller sets of cards while the second experimental group has only one set available and was instructed to use the distributed study method. The result was in favour of the distributed study group. According to the authors, the more time passes between repetitions and the more often the repetition is done, the greater the chances of memorizing the information. In the group that used distributed study, if we have 20 cards, the repetition of an item (card) is dependent on going through the other 19 items, so a larger spacing, whereas, in the case of the combined study group, the cards being divided into significantly smaller sets, one card is separated only by 4 other items. The tendency to create sets comes from the need to separate the items considered memorized by those that have yet to be memorized. The merged learning process creates the idea that the information has been retained so many times, that the student chooses not to repeat the ones he already solved correctly. This habit is detrimental to the retention of information in the long-term memory, but is assessed in a positive way by students, mainly because it requires fewer time resources. Secondly, based on the same principle,

the allocation of temporal resources to the study sessions is made very shortly before an evaluation, and, in this case, the learning process involves mainly cramming. Studies on cramming the information before an evaluation show poorer results in terms of in-depth learning (Kornell, 2009).

Senzaki *et al.* (2017) offers an alternative to this situation by combining the flashcard method with paraphrasing and learning by examples. In a typical situation, the student begins by noting the term and definition, then continues by repeating the information several times to retain the information, but the authors recommend that after memorization, students reformulate the definition in their own terms and create examples to illustrate what they memorized. To adapt the method to technological opportunities, various studies (Dizon & Tang, 2017; Sage, Krebs & Grove, 2019) compared the classical method, in which concepts are written on paper, with the situation in which cards are created in a digital space, for example, on a tablet. The conclusion of the comparisons is that both have similar effects on memory performance.

As we have seen, science-based learning techniques can be applied to a variety of subjects and learning contexts, but it is also useful to keep in mind that all of them are influenced by factors that have been proven to mediate the effect on overall performance. Some of the variables are past learning habits, the compatibility between the addressed subject and the chosen technique, and gender. For example, although studies have shown the effectiveness of mental maps in the medical field (Rosciano, 2015), another technique that is just as effective, and perhaps more effective in biology and medical related subjects, is drawing the information that needs to be retained (Joewono *et al.*, 2018). Regarding the differences between genders, based on Reilly's (2019) comprehensive study on the issue, we can at least suppose that there is a significant difference in verbal and spatial skills between males and females. Women show superior verbal learning skills and abilities, while in terms of visual-spatial skills, the observed results were significantly higher in the case of male subjects (Reilly, 2019).

5. CONCLUSIONS

The concept of academic performance is a multi-factorial one, and is dependent on both the external context, such as time-consuming day-to-day responsibilities or unexpected events, and the individual's particular traits and abilities, such as genetic factors, time management and learning skills. Lastly, although there are a multitude of learning and time management techniques, it is necessary to choose them according to the existing empirical support, as well as to the practical application that best suits the individual and the subject at hand.

What we hope the reader takes out from this paper, no matter the learning techniques he chooses to use, is that the best way to retain information is when it is

structured. As we have seen structure can take many forms, from physically arranging information, with the Cornell note taking method, to chunking information into a manageable form using linguistic techniques like Acronyms. Time management techniques are not an exception from this rule, no matter the granularity of the structuredness of the chosen method. We hope the reader finds these tips and methods helpful on their own or as building blocks for self-made techniques, that better suit the reader's needs.

Received: 12.01.2021

REFERENCES

1. AKINTUNDE, O. O., *Effects of Cornell, verbatim and outline note-taking strategies on students' retrieval of lecture information in Nigeria*, Journal of Education and Practice, **4**, *25*, 2013, p. 67–73.
2. ALBERT, C., *Brief History of Time Management and Why It's Crucial to a Happy Life*, 2018, Articol disponibil pe www.calendar.com.
3. ANJARSIT, Y., & ADNAN, A., *The use of Cornell note taking technique to improve listening comprehension of senior high school students*, Journal of English Language Teaching, **6**, *1*, 2017, p. 9–15.
4. BANIKOWSKI, A.K., & MEHRING, T.A., *Strategies to enhance memory based on brain-research, Focus on Exceptional Children*, **32**, *2*, 1999, p. 1–16.
5. BAST, F., *Crux of time management for students*, Resonance, **21**, *1*, 2016, p. 71–88.
6. ČIARNIENĖ, R., & VIENAŽINDIENĖ, M., *The conceptual model of time management*, In Book of Proceedings, 2014, p. 42–48.
7. ÇOBAN, S., & SELÇUK, E., *The effect of mind mapping technique on students' achievements in music lesson and on their attitudes towards the mind mapping technique*, Egitim ve Bilim, **42**, *190*, 2017, p. 423–435.
8. DELANEY, P.F., VERKOEIJEN, P.P., & SPIRGEL, A., *Spacing and testing effects: A deeply critical, lengthy, and at times discursive review of the literature*, In Psychology of learning and motivation, Academic Press, **53**, 2010, p. 63–147.
9. DEMIRDAG, S., *Effective teaching strategies and student engagement: Students with learning disabilities*, International Journal of Teaching and Education, **2**, *3*, 2014, p. 168–175.
10. DIZON, G., & TANG, D., *Comparing the Efficacy of Digital Flashcards versus Paper Flashcards to Improve Receptive and Productive L2 Vocabulary*, The EuroCALL Review, **25**, *1*, 2017, p. 3–15.
11. EL MEYSARAH, C., *Listening of news through cornell note-taking system in a univeristy critical listening class*, RETAIN, **3**, *1*, 2015, p. 1–6.
12. HATOS, A., & POP, A., *Commitment to the goal of completing studies in higher education: Dropout risk of the students from social science specialization from three Romanian public universities*, Journal of Adult Learning, Knowledge and Innovation, **3**, *1*, 2019, p. 12–19.
13. HAYATI, A.M., & JALILIFAR, A., *The Impact of Note-Taking Strategies on Listening Comprehension of EFL Learners*, English Language Teaching, **2**, *1*, 2009, p. 101–111.
14. JAIN, S., *The comprehensive study of how mind mapping technique helps to understand concepts and ideas in science teaching*, International Journal of Scientific and Research Publications, **5**, *12*, 2015, p. 284–286.
15. JINALEE, N., & SINGH, A.K. *A descriptive study of time management models and theories*, 2018, p. 141–147.
16. JOEWONO, M., KARMAYA, I., WIRATA, G., WIDIANTI, I., & WARDANA, I., *Drawing method can improve musculoskeletal anatomy comprehension in medical faculty student*, Anatomy & cell biology, **51**, *1*, 2018, p. 14–18.

17. KHOII, R., & ABED, K.F., *Effects of equal spacing, expanding spacing, and massed condition on EFL learners' receptive and productive vocabulary retrieval*, Pixel, Proceedings of ICT for language learning (10th Ed.) ICT for language learning, 2017, p. 500–504.
18. KORNELL, N., *Optimising learning using flashcards: Spacing is more effective than cramming*, Applied Cognitive Psychology: The Official Journal of the Society for Applied Research in Memory and Cognition, **23**, *9*, 2009, p. 1297–1317.
19. LUBIN, J., & POLLOWAY, E.A., *Mnemonic instruction in science and social studies for students with learning problems: a review*, Learning disabilities: A contemporary Journal, **14**, *2*, 2016, p. 207–224.
20. MACAN, T.H., *Time management: Test of a process model*, Journal of applied psychology, **79**, *3*, 1994, p. 381–391.
21. MUSYAWAROH, B., *The effectiveness of using cornell note-taking strategy toward students' reading comprehension (an experimental research at the second grade of smpn 1 bojonegara)*, (doctoral dissertation, universitas islam negeri "sultan maulana hasanuddin" banten), 2017, p. 11–29.
22. NEMATI, A., *Vocabulary learning strategies: A short way to long term retention*, Linguistics and Literature Studies, **1**, *1*, 2013, p. 8 –14.
23. PAUK, WALTER & OWENS, ROSS J.Q., *How to Study in College* (10 ed.), Boston, MA: Wadsworth, ISBN 978-1-4390-8446-5, Chapter 10: "The Cornell System: Take Effective Notes", 2010, p. 235 –277.
24. QUINTUS, L., BORR, M., DUFFIELD, S., NAPOLEON, L., & WELCH, A., *The impact of the Cornell note-taking method on students' performance in a high school family and consumer sciences class*, Journal of Family & Consumer Sciences, **30**, *1*, 2012, p. 27–38.
25. REILLY, D.H.,. *Sex and sex-role differences in cognitive abilities*, i, 2019, p. 1–166.
26. ROSCIANO, A., *The effectiveness of mind mapping as an active learning strategy among associate degree nursing students*, Teaching and Learning in Nursing, **10**, *2*, 2015, p. 93–99.
27. SAGE, K., KREBS, B., & GROVE, R., *Flip, slide, or swipe? Learning outcomes from paper, computer, and tablet flashcards*, Technology, Knowledge and Learning, **24**, *3*, 2019, p. 461–482.
28. SANSGIRY, S.S., & SAIL, K., *Effect of students' perceptions of course load on test anxiety*, American journal of pharmaceutical education, **70**, *2*, 2006, p. 1–6.
29. SENZAKI, S., HACKATHORN, J., APPLEBY, D.C., & GURUNG, R.A., *Reinventing flashcards to increase student learning*, Psychology Learning & Teaching, **16**, *3*, 2017, p. 353–368.
30. SMOLEN, P., ZHANG, Y., & BYRNE, J.H., *The right time to learn: mechanisms and optimization of spaced learning*, Nature Reviews Neuroscience, **17**, *2*, 2016, p. 77–88.
31. STĂICULESCU, C., & RAMONA, R.N.E., *University dropout. Causes and solution*, Mental Health: Global Challenges Journal, **1**, *1*, 2018, p. 71–75.
32. SWEET, C., BLYTHE, H., & CARPENTER, R., *Mind Mapping: A Technique for Metacognition*, Teaching with Metacognition, 2017, p. 1–4.

REZUMAT

Gestionarea responsabilităților într-un timp limitat și utilizarea resurselor cognitive într-un mod eficient, pentru a maximiza performanța, reprezintă un set de abilități nu numai de dorit, ci și necesar în societatea actuală. Studiile care evaluează aceste abilități pentru diferite grupe de vârstă și niveluri educaționale susțin această nevoie. Astfel, propunem, pe baza studiilor științifice din domeniul psihologiei educației, un ghid al învățării și al gestionării timpului. În cazul gestionării timpului, ne concentrăm pe definirea obiectivelor. precum și privind prioritizarea și organizarea activităților. În ceea ce privește abilitățile de învățare, ne concentrăm mai întâi pe modul de notare a informațiilor relevante, apoi pe organizarea informațiilor respective în unități semnificative și, în cele din urmă, pe o metodă de facilitare a păstrării acestora în memoria pe termen lung. Această abordare are scopul de a maximiza îmbunătățirea potențială a performanței academice a subiectului.

ELEMENTE DE PSIHOTERAPIE SCURTĂ STRATEGICĂ ÎN CONTEXT ORGANIZAȚIONAL

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Abstract

Organizations are much more interested in increasing the performance of leaders and key people – the context of the pandemic has exposed and exacerbated old problems, with a negative impact on organizational culture and expected results.

Many resources have appeared in the last ten years that organizations have appealed to for leadership and organizational culture improvement, but the results failed to show up or could not be measured - it seems that the focus is on false horizons.

This research paper argues why other types of interventions and programs are needed to increase performance, presents the conscious and unconscious psychic mechanisms involved in leadership, explains the strategic tools and their usefulness in an organizational context and presents a working methodology. Its effectiveness is to be demonstrated in a future paper.

Cuvinte-cheie: dezvoltare de leadership, psihoterapie scurtă strategică, consultanță, organizații, performanță.

Keywords: leadership development, brief strategic psychotherapy, consultancy, organizations, performance.

1. INTRODUCERE

Există foarte puține detalii legate de metodologia de lucru folosită de specialiștii în leadership în sesiunile cu liderii pe care îi sprijină, dar şi despre ce anume se întâmplă efectiv în timpul sesiunilor, precum şi despre randamentul acestor intervenții și impactul lor asupra performanței și profitului. Argumentul principal, așa cum notează unele studii de specialitate, este nivelul înalt de confidențialitate.

„Psihoterapia corporativă" are un grad redus de penetrare în România, în comparație cu alte țări care au înțeles rolul acesteia și necesitatea de a furniza oamenilor resurse profunde de dezvoltare, acordate cu trăsăturile unice ale fiecărui individ în parte, renunțând la soluții cu caracter general. Ne confruntăm încă cu o percepție distorsionată a acestui domeniu – astfel de intervenții durează foarte mult, sunt mult mai costisitoare în comparație cu altele, nu au impact pozitiv în performanță, întrucât se ocupă de traume (abuz, violență domestică etc.) și alte argumente limitative, bazate pe înclinația către etichetare și generalizare.

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Rev. Psih., vol. 67, nr. 3, p. 285–296, București, iulie – septembrie 2021

1.1. LEADERSHIP ȘI INCONȘTIENT

Haslam, Reicher și Platow (2010) afirmă că „leadershipul nu este despre a determina oamenii să facă diverse lucruri, ci este despre a-i determina să dorească să facă acele lucruri". Toate mecanismele implicate în acest proces complex și cu multiple influențe ar putea fi urmărite prin *lentila* eficienței.

Goleman (2014) arată că leadership-ul eficient este legat strâns de inteligența emoțională (EQ). După Goleman (2014), inteligența emoțională conține patru componente – conștiința de sine (înțelegerea profundă a emoțiilor, punctelor tari și slabe, nevoilor și motivației), autocontrolul (înclinația către reflecție și gândire, confort în situații ambigue sau schimbătoare, integritate, capacitatea de a spune „nu" impulsurilor), empatia (luarea în considerare a sentimentelor angajaților) și abilitățile sociale (liderul să fie „prietenos" cu un scop – de a pune oamenii în mișcare). Comparând liderii de top cu cei de nivel mediu, 90% dintre competențele care îi distingeau erau atribuite inteligenței emoționale (Goleman, 2014). Conform observațiilor făcute de autor, oamenii cu potențial de leadership au o dorință profundă de a atinge succesul de dragul acestuia, sunt pasionați de muncă în sine, caută proiecte interesante și sunt mândri când treaba lor e bine făcută.

Dintr-o altă perspectivă, liderii conduc pe baza credințelor pe care le au, care reprezintă modalitatea în care creierul găsește sensul și navighează prin lumea înconjurătoare – sunt pattern-urile la care creierul se așteaptă ca lumea să se conformeze. După Shermer (2011), credințele reprezintă fundația învățării eficiente și a supraviețuirii. O concepție greșită ar fi aceea că sistemul de credințe este unul static și că ține de alegerile pe care fiecare persoană le face (Chaudhuri, 2013).

Credințele sunt legate strâns de emoții – reacționăm agresiv în situații în care credem că cineva ne atacă sistemul de credințe. După Lipton (2016), partea emoțională a creierului nu se mai limitează la locurile clasice ale hipocampului, amigdalei și hipotalamusului, iar când o persoană își schimbă gândurile (automat apar explozii de neurotransmițători), mintea acesteia devine deschisă și receptivă la alte bucăți de informații senzoriale, până atunci blocate de convingeri. Tot Lipton (2016), în cercetările sale, afirmă că toate celulele corpului sunt influențate de gânduri, iar epigenetica demonstrează legăturile între minte și materie. Biologia celulară ne învață că viața e mult mai influențată de mediu decât de gene – credem lucruri și ne organizăm viața în funcție de informațiile pe care le-am înmagazinat în copilărie (Lipton, 2016). Credințele acestea sunt implicate în judecățile morale făcute de persoană și ajută în luarea deciziilor. Lobii frontali joacă un rol deosebit în acest sens. După Young și Saxe (2008), cortexul prefrontal median este implicat în procesarea valențelor credințelor (bine sau rău), iar judecarea sau punerea în balanță a credințelor începe odată cu vârsta de cinci ani.

Conform sociologilor Thomas și Znanieki (1918, 1927), „dacă oamenii definesc situațiile ca fiind reale, ele devin reale prin consecințele lor" (cf. Smith 1995).

1.2. SISTEME DE GÂNDIRE

Liderii au o funcție deosebit de importantă în procesul de luare a deciziilor, proces strâns legat de mecanismele gândirii. Kahneman (2011) indică faptul că gândirea noastră e compusă din două sisteme mari: Sistemul 1, cel rapid, care ia decizii fără efort, care face tot felul de „scurtături", care ne scapă conștient, venind cu răspunsuri de tip „asul din mânecă". Sistemul 1 e mai degrabă interesat să conserve energia și să ne prezinte o imagine coerentă asupra lumii, inteligibilă, însă nicidecum adevărată. Sistemul 2, care este gândirea conștientă, lentă, intervine rar și e mare consumator de energie cognitivă. Se poate spune astfel că Sistemul 2 se ocupă cu „adevărul".

Dacă prezentarea Sistemelor 1 și 2 oferă un cadru general referitor la modul în care mintea noastră ia decizii, putem aminti și patru mari dușmani în luarea deciziilor (Heath și Heath, 2013).

Primul este perspectiva limitată, care este tendința de a ne defini opțiunile prea strict, de a le privi în termeni binari. Distorsiunea de confirmare, al doilea dușman, se referă la faptul că obiceiul nostru în viață este să dezvoltăm rapid o convingere despre o anumită situație, iar apoi să căutăm informații care să o susțină. Emoția de moment este cel de-al treilea dușman – când oamenii au de luat o decizie, sentimentele dau în clocot. În final, ultimul dușman este încrederea exagerată – oamenii tind să fie orbiți de o singură variantă/părere, fără a lua în considerare argumentele venite din partea unor persoane abilitate.

Așadar, pe baza cercetărilor lui Kahneman si Heath, leadership-ul se confruntă cu două sisteme de gândire, unul rapid și altul lent, și cu patru mari dușmani. Din păcate, foarte puțină conștientizare există pe aceste planuri în rândul liderilor. Credințele, cât și distorsiunile cognitive sunt dificil de autodepistat și reglat, din motivele prezentate anterior. Rolul intervențiilor strategice este inclusiv de a aduce în planul conștiinței aceste aspecte, bineînțeles legate de realitatea practică și de universul individual al fiecărui lider.

1.3. OPTICA MODERNĂ ASUPRA LEADERSHIP-ULUI

Senge (2014), după ce a cercetat mai bine de 15 ani modul în care firmele și organizațiile își dezvoltă capacitatea de adaptare, a propus cinci discipline ale „organizațiilor care învață" și tipologia liderului modern, funcțional și care poate aduce performanță. Disciplinele sunt: gândirea sistemică (putem înțelege cu adevărat doar contemplând întregul, nu părțile), măiestria personală (începe cu clarificarea lucrurilor care într-adevăr contează pentru noi; a trăi viața în slujba aspirațiilor cele mai înalte), modele mentale (percepții adânc înrădăcinate, generalizări, imagini care ne influențează lumea și modelul după care acționăm), crearea unei viziuni comune (a pune în evidență imagini despre viitor, fără a impune o viziune) și învățarea în echipă (dialogul, identificarea interacțiunilor care subminează învățarea). „Perspectiva noastră tradițională despre lideri – ca oameni speciali care stabilesc o direcție, iau decizii cheie și dau energie trupelor – este adânc înrădăcinată într-o perspectivă individualistă și nesistematică asupra lumii" (Senge, 2014).

Într-o cercetare realizată de Feser, Mayol și Srinivasan (2015) pe un eșantion de 189.000 de persoane din 81 de organizații din întreaga lume, s-a arătat că pot fi identificate patru tipuri de comportament ale liderilor menite să explice 89% din variația dintre organizațiile cu leadership puternic și slab. Comportamentele găsite sunt: 1) a susține oamenii din jur; 2) centrarea puternică pe rezultate; 3) căutarea/ explorarea de noi perspective asupra activității; 4) rezolvarea eficientă a problemelor.

După Pfeffer (2016), cărțile de management suprasimplifică și oferă rareori un ghidaj în ceea ce privește abilitățile și comportamentele necesare liderilor pentru a duce obiectivele la bun sfârșit. Divizarea liderilor și acțiunilor acestora în „*bune* sau *rele*" continuă să întărească un model foarte discutabil al comportamentului uman, bazat pe trăsăturile de personalitate. Parte a discrepanței – între ce crede majoritatea lumii cu privire la leadership-ul eficient și ce este real –, rezidă din biasul de confirmare: tendința de a vedea și memora acele lucruri în care suntem motivați să credem. De exemplu, dacă o persoană crede că un lider eficient este acela care „controlează cu orice preț activitatea pentru că oamenii nu sunt demni de încredere", din diverse motive, în momentul în care va deține această poziție va acționa în direcția credinței. Deși persoana în cauză consideră că demersul aparține categoriei „comportamentelor bune de leadership", translatând în acest caz adevărul individual într-unul universal, performanța echipelor și climatul de lucru vor avea de suferit.

1.4. ORGANIZAȚII ȘI PSIHOTERAPIE

Russell (2016) a realizat cercetări interesante legate de fenomenul de migrare a experților psihoterapeuți în zona de consultanță de leadership. Plecând de la diverse teorii cu privire la comportamentului uman, ei oferă suport liderilor de business. Creșterile de profitabilitate, ca urmare a intervenției consultanților de leadership, nu au fost demonstrate empiric, în ciuda informațiilor prezentate într-o manieră pozitivă. Foarte puține elemente regăsim în literatura de specialitate despre tehnicile de consultanță în leadership folosite de psihoterapeuții reprofilați în domeniul organizațional. Același autor prezintă modul în care consultanții organizaționali aplică concepte ale teoriilor sistemice cu privire la familie în domeniul leadership-ului, însă fără a arăta în mod clar și specific cum sunt aplicate propriu-zis aceste teorii și tehnici. Datele reale sunt greu de obținut, în parte datorită naturii strict confidențiale a relației dintre organizații și specialiștii contractați.

Într-un articol din *Financial Times* (2019), se precizează că Institutul Internațional pentru Dezvoltarea Managementului din Elveția oferă participanților la MBA sesiuni de psihoterapie pentru autocunoaștere, concluzia fiind aceea că studenții nu realizează existența unor „forțe inconștiente" care le influențează deciziile și viața în manieră semnificativă. Inconștientul este explicat de lectorii instituției prin modelul iceberg și relevat printr-o abordare jungiană care pornește de la interpretarea viselor.

Terapia *corporate* de scurtă durată („*Short Term Corporate Therapy*") este un termen propus de Anna Rowley (2008) și își are bazele în psihoterapiile de

scurtă durată. Diferenţa majoră dintre cele două abordări este aceea că sesiunile se desfăşoară în locația clientului și nu în cabinetul individual de psihologie. Printre rezultatele obţinute cu clienţii săi, menţionăm următoarele: identificarea credințelor de bază care determină comportamentul și motivația, creșterea acceptării de sine, creșterea toleranței în ceea ce privește ambiguitatea și schimbarea, adaptarea deciziilor personale la mediu și la alte persoane, prezicerea comportamentului altor persoane pentru îmbunătățirea managementului, conștientizarea faptului că unele comportamente avute anterior nu se mai potrivesc în contextul nevoii de creștere permanentă, creșterea conștientizării de sine (ca sursă principală de putere și influență pentru atingerea succesului) și construirea unui business care îi determină pe oameni să vină la muncă cu determinare.

1.5. PSIHOTERAPIA SCURTĂ STRATEGICĂ

Pentru a înțelege filosofia psihoterapiei scurte strategice, în acest subcapitol sunt cuprinse elemente-cheie cu privire la sursele și ipotezele care au condus la apariția acestui tip de terapie.

După Piaget (1937), un copil își construiește realitatea sa proprie prin intermediul unor acțiuni exploratorii, concluzia fiind că „acțiuni diferite conduc la construirea unor realități diferite” (Nardone şi Watzlawick, 2005). Christian, Safran și Muran (2012) readuc în discuţie conceptul de „*experiența emoțională corectivă*”. Potrivit acestuia, „*insight*-ul intelectual singur nu este suficient”, clientului fiindu-i necesar să treacă prin experiențe noi. Contrar accepțiunii analiștilor, clientul suferă nu atât din pricina amintirilor sale, cât din incapacitatea sa de a face față problemelor actuale și nu este necesar și nici posibil să aducem în cursul terapiei la suprafață fiecare sentiment reprimat al acestuia, idee utilizată și în psihoterapia scurtă strategică.

Psihoterapia scurtă strategică preia și utilizează concepte inclusiv din hipnoza ericksoniană, potrivit cărora simptomele nu trebuie privite ca aspecte psihopatologice, ci ca mecanisme sau resurse care pot conduce la vindecare, în același mod în care au condus la comportamentul dezadaptativ (Holdevici, 2011).

Steve de Shazer (1985) consideră că o terapie scurtă se caracterizează prin faptul că este limitată în timp și, totodată, rezolvă problema cu care s-a prezentat clientul și nu „macină” aceleași dificultăți, fără a ajunge la vreo concluzie. De aceea, pentru a asigura succesul terapeutic, nu este necesar să avem informații detaliate în legătură cu simptomele și nici măcar nu trebuie să stabilim precis cum anume se mențin respectivele simptome. Observațiile lui Nardone (2005) au arătat că orice alt tip de comportament nou într-o situație problematică poate conduce la găsirea unei soluții – este important ca persoana să realizeze ceva diferit, chiar dacă respectivul comportament pare irațional, bizar, irelevant sau chiar comic. În acest sens, o tehnică cunoscută în psihoterapia scurtă strategică este *prescrierea simptomului* – realizarea comportamentului simptomatic în aceeași direcție duce la însănătoșire.

Terapia centrată pe soluții și viitor este un alt tip de psihoterapie care a reprezentat un izvor important de cunoaștere pentru orientarea scurtă strategică și își are originile în lucrările lui Milton Erickson, în activitatea echipelor terapeutice ale Institutului de Cercetări Mintale (Mental Research Institute – MRI) de la Palo Alto și ale Centrului de Terapie Familială Scurtă (Brief Family Therapy Centre), condus de Steve de Shazer (Dafinoiu, 2005). Una dintre regulile terapiei centrate pe soluții este că „*oamenii au resursele necesare rezolvării problemelor lor*". Erickson spunea de multe ori clienților săi în timpul transei că „*există lucruri pe care le știți, dar nu știți că le știți. Când veți ști ceea ce nu știți că știți, atunci vă veți elibera*". Orientarea terapeutică este centrată pe soluții, terapeutul asigurând doar cadrul producerii acestora de către client – clientul este cel care produce soluțiile. Un alt element deosebit de important este formularea scopurilor într-o manieră pozitivă, clară, să conțină acțiuni, să utilizeze cuvintele clientului etc.

Psihoterapia scurtă strategică sau constructivistă reprezintă un model psihoterapeutic elaborat de Nardone (1996), iar eficiența terapiilor strategice a fost demonstrată, așa cum prezintă autorul (Nardone, 2005), în cercetările lui Weakland (1974), Fisher (1984), Steve de Shazer (1986–1994), Nardone și Watzlawick (1993), DeJoug și Berg (1995), Nardone (1996) și Watzlawick și Nardone (1997).

Psihoterapia scurtă strategică afirmă că soluția eficientă este cea care dirijează subiectul, într-un timp scurt, astfel încât să nu își modifice doar propriile acțiuni, ci și modul în care percepe realitatea, iar pentru a realiza acest lucru este necesară modificarea modalității în care acesta își organizează informațiile. În terapiile propuse de Nardone, regăsim tehnici precum: utilizarea limbajului clientului, reetichetare circulară a problemei, a sistemului percepție-reacție și a soluției, paradoxală, tehnica bazată pe confuzie, comunicare metaforică, prescrieri indirecte.

Terapia scurtă strategică nu presupune utilizarea teoriilor cu privire la natura umană, în consecință nu utilizează nici definiții privind normalitatea sau patologia psihică. Așadar, specialistul care aplică instrumentele terapiei scurte-strategice este interesat să descopere modul în care clientul își construiește realitatea și gradul în care comportamentul este funcțional sau disfuncțional în raport cu obiectivele sau nevoile sale.

Nardone (2005) prezintă și o listă de „erezii" ale demersului terapeutic strategic. Acestea nu fac nicidecum trimitere la aspecte religioase, ci se referă la poziția psihoterapeutului care adoptă stilul strategic față de problemele cu care se confruntă oamenii. Acesta este denumit eretic, strict în sensul de bază, din limba greacă (*hairetikos*), indicând persoana care are capacitatea de a alege și care nu integrează teoriile din domeniul funcționării umane ca pe niște axiome. Din aceste motive, la baza ereziilor stă principiul alegerii probabilității în locul așa-zisului adevăr universal valabil. Cele patru erezii sunt:

– trecerea de la sisteme teoretice închise la unele deschise, adică adaptarea la percepția și realitatea internă a fiecărei persoane;

– focusarea pe „*cum*?" și mai puțin pe „*de ce*?" – contează mai mult procesul decât conținutul. Persoanele trebuie să fie susținute astfel încât să facă față dificultăților prezente. Asumpția fundamentală a terapeuților strategici este că problemele

mintale și de comportament rezidă din modul în care persoana își construiește realitatea și reacționează față de ea cu un comportament disfuncțional – sau așa-numitele psihopatologii. De obicei clientul consideră că un comportament ales este cea mai bună metodă de a face față unei situații specifice. Ideea este ca specialistul să producă o schimbare de perspectivă, care produce o schimbare de percepție a realității, care la rândul ei determină comportamente noi;

– terapeutul este responsabil de influențarea comportamentului și percepției clienților și are inițiativa pe toată durata tratamentului. Dacă terapia funcționează bine, vor apărea mici semnale de îmbunătățire, dacă nu, strategia trebuie schimbată. Terapeutul trebuie să prezinte elasticitate mentală și să adapteze tratamentul la client, și nu invers;

– schimbarea vine înainte de înțelegere (*insight*). Contrar altor abordări terapeutice, în abordarea strategică este necesar ca mai întâi să schimbăm comportamentul clienților și, ulterior, gândirea (punctul de vedere, fereastra de realitate). Prin urmare, experienţa trăită devine foarte importantă.

În terapia strategică, terapeutul se concentrează pe procesele și procedurile terapiei: ce se întâmplă în relațiile de interdependență ale clientului (cu sine, cu alți oameni, cu lumea în general); cum are legătură problema actuală a clientului cu tiparele de relație ale acestuia (cu sine, cu alți oameni, cu lumea); cum a încercat clientul până acum să rezolve problema/ce soluții a încercat (soluția încercată poate fi parte din problemă); cum situația problematică poate fi înlăturată cât de repede cu putință.

În psihoterapia scurtă strategică, eficacitatea terapiei depinde în primul rând de influența personală și charisma terapeutului – sugestia jucând un rol deosebit de important. Prezentată în mod corect, sugestia va duce la cooperare terapeutică și la dorință de schimbare. În această notă, limbajul este deosebit de important, iar terapeutul trebuie să folosească limbajul clientului. De asemenea, recadrarea este un alt instrument eficient folosit în abordarea strategică. Poate varia în complexitate, de la o simplă redefinire cognitivă a unei idei sau unui pattern comportamental, până la metafore, sugestii evocative și recadrări paradoxale. Evitarea formulărilor negative, folosirea paradoxurilor şi prescrierea paradoxală, utilizarea metaforelor, anecdotelor și poveștilor, precum şi prescripţiile comportamentale directe, indirecte şi paradoxale, toate reprezintă proceduri specifice terapiei scurte strategice.

2. METODOLOGIE DE LUCRU

Cercetările prezentate în studiul de față arată, pe lângă instrumentele și filosofia strategică, faptul că există factori inconștienți care influențează semnificativ leadership-ul, procesul decizional, comportamentele – implicit, performanța.

În general, psihoterapiile de lungă durată au o forță de penetrare redusă în mediul organizațional – stigma, percepția distorsionată, timpul îndelungat de implementare, resurse semnificative necesare, cultura organizațională care nu acceptă astfel de demersuri, nevoia de rezultate rapide, dinamismul economiei și al

pieţelor şi lipsa unor modele de aplicare concrete, toate sunt doar câteva dintre argumente.

În acest context, filosofia şi tehnicile psihoterapiei scurte-strategice par a fi cele mai potrivite pentru a veni în sprijinul organizaţiilor, în demersul de a îmbunătăţi performanţele oamenilor. Iată câteva argumente în favoarea aplicării acestui demers terapeutic: lipsa teoriilor despre funcţionarea umană, evitarea folosirii psihopatologiilor, adaptarea la realitatea fiecărei persoane, centrarea pe dificultăţile din prezent şi pe soluţii, responsabilizarea specialistului şi nu doar a clientului şi determinarea unor comportamente noi (nu doar a unor noi moduri de gândire).

Elementele de bază care asigură fundaţia solidă pentru orice fel de proces de dezvoltare individuală sunt: crearea şi consolidarea relaţiei de lucru; definirea exactă a problemei, identificarea soluţiilor deja utilizate şi acordul asupra obiectivelor; concentrarea pe proces şi nu pe conţinut – crearea de experienţe noi prin intermediul unor acţiuni concrete.

1. Crearea şi consolidarea relaţiei de lucru

Obiectivul principal este crearea unei atmosfere pozitive, de încredere, care să faciliteze procesul de rezolvare a problemelor. Specialistul va folosi limbajul clientului şi va elimina orice încercare de a impune agenda sa proprie cu privire la obiectivele procesului de lucru. Deşi acest punct pare aparent banal şi uşor de realizat, specialiştii care intervin în context organizaţional au nevoie de supervizare şi pregătire specifică pe acest palier. Lipsa încrederii şi a unei relaţii pozitive afectează semnificativ tot procesul de dezvoltare. Oferirea şi participarea la sesiuni de acest tip trebuie, pe cât posibil, să facă parte din cultura organizaţională. Atât timp cât nu vor fi considerate normalitate, vor exista dubii cu privire la intenţia angajatorului de a cuprinde unele persoane în astfel de procese, iar percepţia acestora va fi modelată în sens negativ. Angajaţii pot nutri sentimente legate de incapacitatea lor de a rezolva problemele de serviciu, se pot considera stigmatizaţi etc. Strategia cea mai eficientă este ca angajaţii să îşi dorească să facă parte din astfel de programe, din propria iniţiativă, ghidaţi de cultura organizaţională.

Specialiştii vor trebui să analizeze foarte bine sistemul din care provine clientul, cultura organizaţională şi motivele pentru care a fost „trimis” să participe într-un proces de dezvoltare. Astfel, specialistul va trebui să identifice cu exactitate ce rol au aceste sesiuni, dacă reprezintă o „normalitate acceptată” sau dacă demersul are la bază cu totul alte interese: „corectarea” angajatului, respingerea acestuia, confirmarea unor păreri, obţinerea unor date despre angajat (cu neglijarea eticii de lucru) etc.

Legat de aceste aspecte, cele mai bune rezultate se vor obţine dacă specialiştii provin din mediul extern companiei. Astfel, se elimină încă o serie importantă de percepţii negative legate în primul rând de confidenţialitatea discuţiilor. Atât timp cât o persoană simte că elemente din discuţiile cu un specialist intern vor „scăpa” către alte persoane din organizaţie, relaţiile de lucru şi de încredere nu vor putea exista.

Dacă nu există altă modalitate decât susținerea sesiunilor cu specialiști interni, aceștia trebuie să adere la un cod etic solid și să asigure cu orice preț confidențialitatea discuțiilor – în lipsa încrederii nu poate avea loc procesul de dezvoltare.

2. Definirea exactă a problemei, identificarea soluțiilor deja utilizate și acordul asupra obiectivelor

Observațiile empirice arată că în foarte multe dintre cazuri, clienții nu pot defini concret problema cu care se confruntă. Lipsa definirii clare a problemei reprezintă tot parte din problemă.

Chiar dacă demersul poate fi consumator de timp, specialistul va trebui să își asume responsabilitatea și să aloce suficient timp pentru definirea clară a problemei și pentru identificarea modului în care aceasta apare în sistemul clientului, prin raportare la procesele și procedurile terapiei scurte strategice prezentate anterior. Vor fi inventariate soluțiile deja folosite de client, cu scopul de a sparge sistemul rigid de percepție-răspuns care menține problema, sprijinind persoana să se implice în experiențe noi.

După definirea problemei, acordul asupra obiectivelor asigură că atât specialistul, cât și clientul sunt pe aceeași lungime de undă. Reprezintă un ghid al sesiunilor de dezvoltare și asigură, prin sugestia pozitivă indirectă, că persoana va lua parte în mod conștient la proces, asigurând astfel îndeplinirea obiectivelor.

3. Concentrarea pe proces și nu pe conținut – crearea de experiențe noi prin acțiuni concrete

Specialistul trebuie să își concentreze strategia către rezolvarea problemelor curente ale clientului într-un timp relativ scurt (până în 10 sesiuni). Investigația profundă a psihicului clientului, sondarea cauzelor probabile ale problemei (din copilărie până în prezent) și analizarea aprofundată a conținutului prezentat de client nu reprezintă o prioritate în terapia strategică. În plus, studiile metaanalitice (Nardone, 2005) arată că nu există diferențe semnificative cu privire la rezultatele obținute în terapiile de lungă durată în comparație cu cele de scurtă durată. În acest caz, tehnicile vor trebui orientate către sprijinirea clientului pentru a realiza acțiuni concrete din care rezultă experiențe individuale noi (inclusiv emoționale) care să-l ajute la restructurarea percepției asupra realității, într-una care să servească obiectivelor sale.

În ceea ce privește structura sesiunilor, acestea vor fi organizate după cum urmează:

1. Cadru de desfășurare

– Durata: maximum o oră, până la 10 sesiuni. După terminarea sesiunilor agreate inițial, se va analiza gradul de realizare a obiectivelor. După această analiză și în funcție de nevoile specifice, se vor organiza noi sesiuni.

– Format: întâlniri în persoană sau cu utilizarea aplicațiilor informatice, una pe săptămână – cu asigurarea confidențialității și eliminarea factorilor perturbatori.

2. Tehnici utilizate

– Însușirea tehnicilor prezentate în subcapitolul 1.5. și folosirea acestora în cadrul dialogului. Se vor folosi limbajul clientului, întrebări deschise (de poziționare în viitor, magice, „scenariul perfect" etc.), oglindirea și prezentarea discrepanțelor, parafrazarea, reformularea, recadrarea, rezumarea, concluzionarea etc.

– Întrucât desfășurarea sesiunilor nu are loc într-un cadru terapeutic *per se*, ci într-unul organizațional, se vor elimina prescripțiile comportamentale specifice psihoterapiei scurte strategice. Scopul este realizarea obiectivelor și nu psihoterapia.

– Accentul va fi pus pe găsirea de soluții și pe realizarea de acțiuni concrete, pornind de la ideea că persoana are toate resursele pentru rezolvarea problemelor.

– Rezistența la tehnicile utilizate va fi folosită ca oportunitate de dezvoltare și de remodelare a strategiei și nu ca pe o „problemă" a clientului.

– Specialistul își va asuma responsabilitatea asupra tehnicilor utilizate și structurii sesiunilor.

3. Structura sesiunilor

Toate sesiunile, indiferent de numărul acestora, vor fi organizate în trei etape.

a. Etapa I: Definirea problemei și stabilirea acordului asupra obiectivelor de realizat – au loc în prima parte a sesiunii, iar în funcție de complexitatea problemei, poate dura peste 15 minute. Obiectivele vor fi formulate într-o manieră pozitivă și în termenii unor acțiuni concrete, cu evitarea formulărilor conceptuale și generalizate. De asemenea, se va avea în vedere setarea indicatorului de măsurare a îndeplinirii obiectivului. Desigur, măsurarea este dificil de realizat în sensul matematic, însă pentru a constata progresul în direcțiile alese, este necesară stabilirea unor indicatori, în acord cu clientul.

În cazul în care au fost organizate sesiuni prealabile, se vor inventaria rezultatele obținute de la o sesiune la alta – scopul fiind acela de a-l responsabiliza pe client.

b. Etapa II: Majoritatea tehnicilor se aplică în această etapă, pe baza obiectivelor pe care clientul le-a trasat în etapa anterioară. Clientul este sprijinit să conștientizeze și să întrerupă tiparele de gândire și comportament contraproductive, să-și restructureze percepția spre a-i servi obiectivelor sale, să exploreze posibilități, să caute soluții. Ocupă cea mai mare parte a sesiunii, până la 50 minute.

c. Etapa III: În acest punct, clientul este sprijinit să realizeze un plan de acțiune pe baza etapelor anterioare, a explorării și a soluțiilor identificate. Acest plan cuprinde acțiuni concrete în acord cu obiectivele, pe care clientul își asumă responsabilitatea să le întreprindă. Acțiunile vor fi formulate pe criteriul așteptărilor

realiste și „*metodei pașilor mărunți*” astfel încât clientul să fie motivat să trăiască experiențe noi și nu să se autoblocheze/saboteze din pricina frustrărilor legate de dificultatea acțiunilor.

3. CONCLUZII

Lucrarea de față a adus claritate asupra modului în care pot fi organizate sesiunile individuale cu liderii din organizații, în vederea creşterii performanțelor individuale, prin intermediul unei metode bazate pe dovezi științifice, inspirate din psihoterapia scurtă-strategică. De asemenea, poate reprezenta un model pentru cercetările viitoare în domeniul dezvoltării leadership-ului, prin aplicarea metodologiei de orientare scurtă-strategică, prezentată în studiul de față.

Varianta prezentată oferă atât elemente legate de perspectiva și modul de gândire pe care specialiștii vor trebui să le însușească, cât și metoda de organizare a sesiunilor propriu-zise.

Asemănător procesului clientului, și în cazul specialistului importanța cade mai mult pe „cum” organizează și susține sesiunea și mai puțin pe „ce” tehnici folosește și cum le ierarhizează în funcție de impactul acestora. Măiestria personală a specialistului, charisma, intuiția și experiența practică reprezintă, de cele mai multe ori, factori mult mai importanți în sesiunile cu clienții decât bagajul bogat de tehnici și teorii cu privire la funcționarea umană. Chiar dacă etapele procesului de dezvoltare sunt, aparent, simple și relativ ușor de însușit, un efort considerabil trebuie depus în internalizarea și conștientizarea reală a utilității „elementelor de bază”, prezentate pe parcursul lucrării.

Primit în redacție la: 8.03.2021

BIBLIOGRAFIE

1. CHAUDHURI, A., *Belief and brain*, Journal of neurosciences in rural practice, **4**, *4*, 2013, p. 379–380.
2. CHRISTIAN, C., SAFRAN, J., MURAN, J., *The corrective emotional experience: A relational perspective and critique*, 10.1037/13747-004, 2012, p. 51–67.
3. DAFINOIU, I., VARGHA, J., *Psihoterapii scurte – Strategii, metode, tehnici*, Editura Polirom, 2005.
4. FESER, C., MAYOL, F., SRINIVASAN, R., *Decoding leadership: What really matters*, McKinsey Quarterly, 2015.
5. Financial Times, *Therapy sessions help MBAs become better leaders*, 2019.
6. GOLEMAN, D., *Ce înseamnă să fii un lider bun*, Curtea Veche Publishing, 2014.
7. HASLAM, A., REICHER, S., D., PLATOW, M., J., *The New Psychology of Leadership: Identity, Influence and Power*, Routledge, **65. 10.1111**/*j.1744-6570.2012.01249_1.x. 2010*, 2012.
8. HEATH, C., HEATH, D., *Ia decizii bune!*, Editura Niculescu, 2013.
9. HOLDEVICI, I., *Psihoterapii de scurtă durată*, Editura Trei, 2011.
10. KAHNEMAN, D., *Gândire rapidă, gândire lentă*, Editura Publica, 2011.
11. LIPTON, B., *The Biology of Belief*, Hay House Inc, 2016.

12. NARDONE, G., WATZLAWICK, P., *Brief Strategic Therapy*, Rowman & Littlefield Publishers, 2005, p. 35–55.
13. PFEFFER, J., *Leadership BS: Fixing Workplaces and Careers One Truth at a Time*, HarperCollins, 2015.
14. ROWLEY, A., *Leadership Therapy*, Griffin, 2008.
15. RUSSELL, M., B., *Psychotherapists Becoming Leadership Consultants: The Manking of an Institutional Entrepreneur*, University of Vermont, 2016.
16. SENGE, P., *A cincea disciplină*, BusinessTech International, 2012.
17. SHERMER, M., *The Believing Brain*, John Wagner Studios, 2011.
18. SMITH, R.,S., *Giving credit where credit is due: Dorothy Swaine Thomas and the* „*Thomas Theorem*", American Sociologist, **26**, 9–28, 1995, p. 62–67.
19. YOUNG, L., SAXE, R., *The neural basis of belief encoding and integration in moral judgment*, Neuroimage, **40**, *4*, 2008, p. 1912–1920.

REZUMAT

Organizațiile sunt din ce în ce mai mult interesate de creșterea performanței liderilor și a persoanelor-cheie – contextul pandemiei a dezgolit și accentuat și mai tare probleme vechi, cu impact negativ asupra culturii organizaționale și a rezultatelor așteptate.

În ultimii zece ani au apărut numeroase resurse la care organizațiile au făcut apel pentru creșterea performanței liderilor și pentru îmbunătățirea culturii organizaționale, însă rezultatele au întârziat să apară sau nu au putut fi măsurate – pare că atenția este orientată către false orizonturi.

Articolul de față argumentează de ce este nevoie și de alte tipuri de intervenții și programe pentru creșterea performanței, prezentând mecanismele psihice conștiente și inconștiente implicate în leadership, explicând instrumentarul strategic și utilitatea acestuia în context organizațional și oferind o metodologie de lucru. Eficiența acestui demers urmează a fi demonstrată în cercetări empirice ulterioare.

STEVE PETERS, *Călăuzele tăcute. Înţelegerea şi dezvoltarea minţii pe tot parcursul vieţii*, Bucureşti, Editura Publica, 2021, 304 p

Steve Peters este un psihiatru englez, care şi-a desfăşurat timp de zeci de ani cercetările în aria psihiatriei clinice. Având o licenţă în matematică, educaţie şi medicină, el şi-a completat aceste studii finalizându-le prin obţinerea unor titluri de master în educaţia medicală, precum şi prin efectuarea unor studii postuniversitare, certificate în domeniul medicinei sportive şi al psihiatriei. Printre alte cercetări de succes popularizate în zeci de articole de specialitate, profesorul Steve Peters este şi creatorul modelului mintal-explicativ denumit „Managementul cimpanzeului", model care a fost făcut cunoscut într-o lucrare ştiinţifică denumită *Cimpanzeul meu ascuns*, vândută în peste un milion de exemplare. De o certă valoare ştiinţifică este şi lucrarea prezentată aici, intitulată *Călăuzele tăcute. Înţelegerea şi dezvoltarea minţii pe tot parcursul vieţii* şi care a apărut de curând la Editura Publica, Bucureşti, 2021. Economia acestei lucrări debutează în partea întâi cu o „Introducere", în care se aduc explicaţii despre utilitatea acestui demers ştiinţific original, orientat spre câmpul neurologiei aplicate „ţintit" în domeniul psihoeducaţional. Aici se regăseşte o amplă descriere, despre cum se poate utiliza neurologia într-un mod eficient şi practic, la nivelul actorilor implicaţi în mediul şcolar de debut, respectiv, educatorii, profesorii şi părinţii elevilor.

Autorul evidenţiază printre altele şi faptul că indivizii, încă din timpul copilăriei, au învăţat să gestioneze emoţiile şi gândirea, prin dezvoltarea de convingeri şi strategii de adaptare, care devin ulterior în viaţa de relaţie socială productive sau contraproductive. Aceste constelaţii neurale sunt „arhivate" în memorie şi se transformă mai apoi în obiceiuri de viaţă fixate durabil. Prin urmare, aceste obiceiuri inconştiente în mare parte ne însoţesc de-a lungul întregii noastre existenţe, afectând uneori prin stresul generat şi prin efectele negative manifestate de calitatea vieţii emoţionale şi a relaţiilor noastre pozitive. Deci, pentru a oferi un sistem referenţial popular şi accesibil oricui, autorul aseamănă aceste obiceiuri de viaţă cu nişte „călăuze tăcute" care ne ghidează şi ne influenţează încă din copilărie gândirea şi acţiunile.

Această explicaţie ştiinţifică inovatoare are un prim obiectiv de a sprijini părinţii, educatorii şi profesorii în demersul lor de înţelegere a comportamentelor şi a convingerilor nesănătoase dezvoltate de unii copii. Un alt obiectiv al lucrării de faţă se doreşte a fi acela de a oferi ajutor direct copiilor, pentru ca aceştia să-şi înţeleagă gândurile, trăirile, emoţiile şi pe cale de consecinţă să-şi responsabilizeze comportamentele de relaţie socială.

Pentru atingerea acestor deziderate, autorul schematizează şi simplifică într-un mod excepţional, în vederea popularizării, structura minţii umane la debut, pe care o plasează pentru o mai bună înţelegere într-o comparaţie de tip psihopedagogic. Schema de funcţionare a minţii umane propusă de Steve Peters este adaptată în sensul stilului didactic, dar este de asemenea şi foarte eficientă pentru înţelegerea structurii mentale a copilului aflat în diversele ipostaze de dezvoltare şi acţiune. Astfel, în partea a doua a lucrării, structura minţii este descrisă de autor ca având următoarea organizare pe echipe: „*tu, maşinăria gânditoare şi computerul*". Corespondentul neurologic al acestor termeni explicativi la nivel pedagogic este următorul: „tu" este sinonim cu cortexul prefrontal dorso-lateral; maşinăria gânditoare se indentifică cu cortexul orbito-frontal (cu ajutor de la nucleul amigdalian) şi în sfârşit pentru computer, este desemnată relaţia comparativă cu girusul hipocampului (cu ajutor de la nucleul amigdalian). În efortul său de simplificare explicativă eficientă, autorul readuce în atenţie modelul cimpanzeului. După precizarea obligatorie că nu avem cu adevărat în structura noastră mentală caracteristicile un cimpanzeu, autorul ne reprezintă schema dinamică de înţelegere a minţii umane aflată la debut. Astfel, el utilizează corelaţia între cei trei actori principali ai minţii umane, simbolizaţi atractiv pentru copii şi care sunt reprezentaţi ca aflându-se în contact şi colaborare directă, pentru adaptare, rezolvare de sarcini sau probleme, pe diferite perioade de timp. Aceste instanţe neuropsihice sunt imaginate de autor drept „umanul", „„cimpanzeul" şi „computerul". După „setarea" termenilor care desemnează dinamica interioară a minţii şi prezentarea manierei de interinfluenţare stimulativă, circulară cu exteriorul, autorul oferă publicului cititor o abordare ştiinţifică centrată pe problema neurobehavioristă a comportamentelor productive şi benefice dezvoltării. În sensul celor descrise de autor, vom realiza o scurtă evidenţiere a elementelor de compensaţie psihoterapeutică, care sunt cuprinse în capitolele părţii a treia din lucrare. Aceste obiceiuri pozitive şi totodată productive, dezvoltate şi analizate în capitole separate, sunt următoarele: *1) Zâmbeşte; 2) Cere-ţi scuze; 3) Înţelegerea şi gestionarea incidentelor; 4) Fii bun cu ceilalţi; 5) Teoria minţii; 6) Vorbeşte despre emoţiile tale; 7) Cere ajutor; 8) Fii politicos; 9) Încearcă lucruri noi; 10) Acceptă când nu înseamnă nu; 11) Învaţă să împarţi; 12) Fă ce ai de făcut.* Beneficiul acestor informaţii şi transformarea lor în comportamente asumate conştient includ pe cale de consecinţă factorii cognitivi, asociaţi cu succesul, abilităţile interpersonale îmbunătăţite şi nu în ultimul rând cu bunăstarea personală care decurge logic din practicarea acestor obiceiuri pozitive, utile în dezvoltarea minţii şi personalităţii aflată în formare. O altă idee importantă avansată în corpul conceptelor lucrării este demonstraţia personală a educatorului *vis-a-vis* de cel educat. Autorul precizează: „*O modalitate bună de a-l învăţa pe un copil un obicei sănătos este de a-i fi model în acea privinţă*".

În finalul lucrării, autorul este de părere că aceste obiceiuri benefice se formează şi se achiziţionează lent de către unii copii şi deci pentru a avea succes în implementarea acestor constelaţii de gândire, trebuie abordate cu răbdare şi încurajare,

iar repetarea lor este obligatorie. Demonstrându-şi valoarea ştiinţifică, această lucrare de succes popularizează metodele cognitive-comportamentale şi prezintă printre altele dinamica interdependent a unui ansamblu de actori sociali, respectiv educatori, profesori, părinţi şi elevi care-şi aduc aportul continuu pentru atingerea succesului educaţional şi psihologic. La timpul prezent şi uneori chiar alături de noi se petrec adevărate drame emoţionale, care neînţelese pe deplin sunt lăsate să se cronicizeze alterând uneori iremediabil sănătatea mentală a copiilor; această lucrare trebuie citită, promovată şi adusă spre cunoaştere celor direct interesaţi. Credem că această lucrare ar trebui să intre şi în atenţia factorilor de decizie ai organizaţiilor şcolare pentru popularizarea conceptelor prezentate aici, deoarece acestea sunt foarte utile, facil de înţeles şi de aplicat. Astfel, importanţa acestei abordări inovative devine inestimabilă pentru accelerarea proceselor de stabilizare emoţională şi comportamentală la nivelul comunităţilor şcolare.

Gabriel Ungureanu

SEPTIMIU CHELCEA, *Emoțiile sociale: despre rușine, vinovăție, regret și dezamăgire,* București, Editura Tritonic Books, 2020, 252 p.

Autorul, *professor emeritus* la Facultatea de Sociologie şi Asistenţă Socială a Universităţii din Bucureşti, doctor în filosofie – specialitatea sociologie din 1974, a publicat peste 100 de articole științifice, studii, monografii și volume de specialitate, răsplătit fiind de către Academia Română cu Premiul P.S. Aurelian în 1980 şi, în 2004, cu Premiul Opera Omnia, pentru întreaga activitate de cercetare ştiinţifică.

Lucrarea profesorului S. Chelcea, *Emoțiile sociale: despre rușine, vinovăție, regret și dezamăgire,* se înscrie pe linia cercetărilor asupra sociologiei emoțiilor, continuând și completând volumul *Rușinea și vinovăția în spațiul public. Pentru o sociologie a emoțiilor*, apărut în 2008 și care a constituit o primă abordare sociologică a emoțiilor în literatura de specialitate din România.

Conform afirmațiilor autorului, în această lucrare termenul de emoție este utilizat ca termen umbrelă pentru ansamblul proceselor și stărilor afective, în sensul consacrat în literatura de specialitate națională și internațională.

Cartea este împărţită în patru capitole: „Emoțiile: repere teoretice", „Rușinea – emoție socială primordială", „Vinovăția – emoție morală și liant social", „Regretul și dezamăgirea – emoții sociale contrafactuale". Vom alege câteva dintre aspectele la care s-a oprit autorul, fără a insista în mod deosebit asupra unuia sau a altuia, lăsând cititorului posibilitatea să-şi facă propriile alegeri.

În primul capitol, „Emoțiile: repere teoretice", printre alte aspecte de interes, sunt trecute în revistă elementele structurale ale emoțiilor, este analizată relația lor cu cogniția și sunt prezentate principalele categorii de teorii asupra emoțiilor. Capitolul se încheie cu prezentarea unei viziuni asupra emoțiilor în calitate de construcții sociale.

În Capitolul 2, „Ruşinea – emoţie socială primordială", autorul defineşte termenul: „Ruşinea este o emoţie definitorie pentru om: numai homo sapiens are *conştiinţă de sine* şi numai la nivel uman *sinele evaluează sinele*". Emoţia are un rol important atât în ceea ce priveşte comportamentul personal, cât şi în funcţionarea relaţiilor interpersonale. Ne sunt prezentate principalele similarităţi şi diferenţe între ruşine şi vinovăţie și o tipologie a rușinii.

În Capitolul 3, „Vinovăţia – emoţie morală şi liant social", autorul defineşte vinovăţia: „În sens psihologic, cuvântul vinovăţie desemnează pentru unii autori o emoţie, pentru alţii un sentiment sau o stare afectivă", dezvoltând în continuare conceptul din perspectivă psihosociologică. Un subcapitol este rezervat relației dintre vinovăția vicariantă *versus* rușinea vicariantă.

În ultimul capitol, „Regretul şi dezamăgirea – emoţii sociale contrafactuale” este prezentat conceptul de „regret”, urmat de o tipologie a regretelor pentru ca în final să fie analizată problema relației regret *versus* dezamăgire. „Cei mai mulți cercetători sunt de acord că regretul este o emoţie negativă complexă contrafactuală”. Autorul consideră că și dezamăgirea este o emoţie contrafactuală negativă.

Profesorul Septimiu Chelcea precizează că această carte „nu este decât un îndemn la adâncirea cercetării psihosociologice teoretice, experimentale şi de teren a emoţiilor sociale negative, dar şi pozitive”. Prezentul volum întruneşte multiple calităţi fiind de interes pentru studenţii de la facultăţile cu profil umanist, cât şi pentru toţi cititorii interesaţi de domeniu.

Georgeta Preda