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REALITIES AND PERSPECTIVES

Sex Education is considered a Taboo Subject in Schools from Romania

Lăcrămioara Mocanu[1]

Abstract: Sex education is considered a taboo subject nowadays. Parents are mostly embarrassed to talk with their children about this topic, couples are embarrassed to talk to each other, parents even more, feel embarrassed when it comes to sex education of children. If this is the situation, I would believe that it is the communist legacy de, because in that period we can say that sexual relationships beyond marriage were violently challenged, sex education was reduced to encouraging abstinence, and there was no sexual connotation in mass media.

Keywords: Sex education; taboo subject; sexual connotation

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People discussed a lot in the communist period, and much more after, about this aggressive population policy encouraged by the communist regime, and about the devastating long-term effects of the prohibition of abortion and implicitly of the contraceptive methods.

When we talk about the sex education in the communist period most of us think of the decree 770/1966 which was accompanied by "*party and state* directions", intended to influence the reproductivebehaviour of Romanians. (as Mihaela Miroiu, Robert Şerban, Alexandru Ofrim say)

Thus, the field of sexuality encouraged the speeches of the politicians, the codes of behaviour, the imposed rules and constraints. The main, and therefore the only materials intended for sex education were written not only by doctors, but also by psychologists, educators, sociologists, methodologists, militants, journalists etc. (as Mihaela Miroiu, Robert Şerban, Alexandru Ofrim mention)

Sexualityand contraception became anational problem, and the decision regarding conception did not belong to the couple, but to the state.

Contraceptive methods are no longer a problem nowadays, but, statistics show that there are still a lot of people that use traditional contraceptive methods in Romania. According to a study regarding reproductive health, accomplished by the Ministry of Health in 2004, *24% of Romanian women usetraditional contraceptive methods. 6% of the women that are in a relationship use the calendar method, and 25.5% rely on the method of coitus interruptus*. (As Georgiana Dorobantu mentions)

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It would be ideal for the nation to learn something from the past experience of the communist period. To learn that sex education has its role. At every age, sex education can be done by respecting its particularity. Most parents avoid talking with their children, but unfortunately the access to the Internet makes them search for information where they are not criticized for their curiosity. Unfortunately, most of the information on the Internet is highly pornographic, and this does not represent sex education or sexual behaviour at all.

For the children today, parents need to take responsibility for their education, from all points of view, especially since most parents feel the sequelae of the communist sex education.

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REALITIES AND PERSPECTIVES

The Ego Communication Beyond Interpersonal

Lăcrămioara Mocanu[1]

Abstract: During our lives, within multiple and varied interactions with others, we come to interpret a series of roles, to have some statuses and related behaviours and/or derived from these social conditions. And all these have the role to deepen the relationship with the fellow man; and more, to allow "reflection and self-reflection in the other" (Cooley). Communicating with others, regardless of the relationship and reference we have with them, as well as the type of communication network applied, is an active, dynamic and irreversible process that calls for a series of "behavioural strategies" to achieve the goals pursued. For each case, we can say that we have a series of patterns, we have a "social mask" that allows us to adapt more or less to a given situation, hence the reaction of the other to our position. Depending on these established relationships, the coherency between two actors may go one way or the other. It is necessary to emphasize that each of us juggles with these attitudes depending on the psycho-social context, but one is dominant. The position of life is a way of evaluating and interpreting the moments of existence and, by all means an infallible form of being.

Keywords: interactions with others; social mask; behavioural strategies

During our lives, within multiple and varied interactions with others, we come to interpret a series of roles, to have some statuses and related behaviours and/or derived from these social conditions. And all these have the role to deepen the relationship with the fellow man; and more, to allow "reflection and self-reflection in the other". (Alin, 2006, p. 33)

Communicating with others, regardless of the relationship and reference we have with them, as well as the type of communication network applied, is an active, dynamic and irreversible process that calls for a series of "behavioural strategies" to achieve the goals pursued. For each case, we can say that we have a series of patterns, we have a "social mask" that allows us to adapt more or less to a given situation, hence the reaction of the other to our position. Depending on these established relationships, the coherency between two actors may go one way or the other.

Interpersonal communication, irrespective of the type, degree, and depth of the relationship between actors, requires each of them to have many psychic abilities that will be reflected in the evolution of the interaction between them. Communication can easily be evaluated from the perspective of the two basic principles of the universe: the *active* one specific to the male type suggesting action, movement, increased energy and *the passive* one characteristic to the female type that evokes expectation, fixity, etc. This differentiation is related to the two mentioned forms as principles, but it is understandable that the human personality is dynamic, with a constant evolution or involution, and includes both in different proportions. The assessment of the typical female communication as passive, immobile would be incomplete as well as that specific to men. Indeed, between the communicative patterns

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there is a significant difference: women call to "free" - catharsis, hence the great emotional burden, while men communicate to solve the problems. But this does not exclude the idea of their separation, of total independence, on the contrary. How many of us have not met women who have been discussing punctually, strictly in line with the given situation, always pursuing a solution; as there are some men who use many details in their narrations, they remember the emotions and have a special joy when they have someone to "tell" them. However, it is necessary to recall that these communicative styles in relation to the human being can also be appreciated from the perspective of the roles "interpreted" by us in different moments of existence, the relation we want to establish with the other, through which we want the transmission to a certain attitude, a clear optic to whom we transmit not only cognitive information, but also emotions, fears, needs, etc.

Expressed in simple words but deeply understood, transpersonal analysis, an alternative to the traditional models in psychology, is a "personality theory and systematic psychotherapy centred on personal change and development". (International Transactional Analysis Association, *apud* Nuță, 2005) By addressing in a unique way the psychological research on the individual subject is extended to the "spiritual dimension of existence" (Mânzat, 2002, p. 17), giving special attention to "the states and processes by which people can experience profound bonds within the Being (Self), overcoming the consciousness of the Ego". (Mânzat, 2002, p. 17) By looking "beyond the person" (or "above the person"), this theoretical trend provides an image of the states of the ego, a representation of those emotional, cognitive and behavioural constellations approached at a certain point in life, their awareness allows the intellectual and emotional development of the individual with respect to his fellow man. In this way, one can find the way to answer a series of questions that each of us has encountered at a certain moment of our existence: *Who am I? Why do I behave in this way?, What is the origin of my behaviours? How did I get here?* etc.; all these interrogations, as well as many other derived ones, represent the individual's desire to understand and deepen those transpersonal experiences accessible to the individual, as well as to stimulate the process of individual development through the permanent change of "psychic and spiritual structures" (Mânzat, 2002, p. 18)

According to this model of human and individual assessment, we are responsible for everything we live in, so our destiny does not have an a priori nature, it is not created by mockers or quack, but by ourselves. It is in our power to build a certain life, or to rebuild a certain "system of desires and values". In this way, the philosophical principles on which transpersonalism is based are the following: ♪ people are OK, ♪ everyone has the ability to think (excepting those individuals suffering some disorders or brain damage), ♪ the individual is directly responsible for his life, and some capital decisions can only be changed by him; this last assumption highlights the antideterministic character of the transpersonal analysis. Of course, this theoretical model accepts the influence of interaction with others, those particularities of social influence, which are very pregnant during childhood, when we are strongly dependent on the "big ones", but these decisions can be revised, adapted or replaced with others. The "affective, cognitive, but mostly behavioural, metamorphosis" approaching a *state of the Ego*, that "consistent pattern of emotional thoughts and emotions, directly linked to an appropriate behavioural pattern" (Berne, 1966), which points out that the behavioural and affective side develops and manifests itself concurrently. From a communications perspective, transpersonal analysis describes what happens when an individual interacts with another, and the verbal and /or nonverbal exchanges are called *transactions.*

At the basis of the development of the paradigm regarding the *states of th*e *Ego* (McGraw, 2003), three models were grounded: *the state of the Father Ego, the state of the Child Ego and the state of the Adult Ego*, all these represent the most accessible part of the three psychological Freudian instances

(Id, Ego and Super Ego or Self, Ego and Super Ego). The two approaches to psyche cannot be overlapped, even if the Father Ego feels like the Super Ego (the one full of norms, rules, observation, and criticism), the Adult Ego state reminds the Ego, (the one who tests the reality), and the Child Ego looks like the Self (the one dominated by desires and instincts uncensored). The major difference between the two models of psychic representation is that the states of the Ego are observable behavioural terms, while the psychic instances are purely theoretical concepts. It is impossible to observe the Self of an individual, but we can easily appreciate the behaviour as the state of Child Ego through his rebellious, spontaneous, whimsical behaviour. Moreover, the three states enunciated by Bern refer to people with their own unique identities, while the Freudian instances are generalized. In other words, an individual in the child's state does not act in general, as is specific to the Self, on the contrary, it exhibits specific behaviours, thoughts and attitudes (emotions).

A. Nuță (2005, p 14) expresses the three states in a very simple manner, thus defining them as follows:

- "I am in the Child Ego state whenever I behave, think and feel the same way as when I was a child" - encompasses the instinctual ensemble of the individual: desires, needs, pleasure or contempt without a specific cause, his spontaneity and creativity etc.;

- "I am in the Father Ego state whenever I behave, think and feel in the same way as my parents"- are those cognitive behavioural and emotional components perceived by their own parents or to some significant persons in the relational space of the individual (teachers, patrons, domineering colleague);

- "I am the Adult Ego state whenever I behave, think and feel in ways that are direct answers to what happens "*hic et nunc*""- dominated by objectivism, the individual collects data and information, evaluates and interprets, listens and communicates, especially in immediate cases requiring a rapid solution to the problem.

The transpersonal analysis has triggered a signal on the *Ego states* interchange, since each of us succeeds in creating a "self-portrait" and believes that the created image is the result of the evaluations based on the self-worth of other individuals, as well as the knowledge of "exterior", of the world around us can only be appreciated by reference to our own axiological systems, this phenomenon occurs more or less consciously. Starting from this reasoning, one can explain the position towards an individual's life, namely the proportion occupied by the feeling of being OK or not-OK, this determines a certain quality of the relationship with the others. It influences the degree of openness of an individual when interacting with others. *I deserve this*! *I'm smart and well prepared*! *I have effective resources to deal with today's society! I'm nothing good*! *I do not deserve this! I'm an incapacitated*! The polarity of attitudes to one's own person influences the perception of one's own person: I + (I am OK - self-acceptance, the individual feels good in his own skin, is pleased with his potential, is in agreement with himself) or I – I am not OK - is in conflict with the own Ego). Of course, these polarizations vary throughout one's live, there are moments when we come to "embrace" ourselves with satisfaction for our own achievements, we are proud and happy about us, as there are moments when self-esteem is affected when the non-OK state dominates us a lot.

Four bipolar combinations can be developed in relation to each other

1. I+ YOU+; (I am OK, YOU are OK);

2. I+ YOU-; (I am OK, but YOU are not OK);

3. I - YOU+; (I am not OK, but YOU are OK); and

4. I- YOU-; (I am not OK but neither are YOU).

Each of these four life positions stems from more or less conscious existential beliefs and attitudes, planted in a person's minds from the very first childhood and continued through subsequent experiences, these states can juggle around two central axes, forming four dials - *Corral OK* (Frank Ernst); we use the (+) or OK + sign for the case where value is assigned and the (-) or OK (-) value for the missing value assignment. To better understand this permutation of the four positions, we propose the detailed presentation of each of them, as well as, at the same time, a comparative analysis:

1. *I am* OK, *You are* OK is how to resonate optimally with others, to be in optimal relationship with them, the individual manifests an optimistic, active attitude, which implies self-acceptance and self-satisfaction, allowing him to be open and receptive to others, to new relationships: *I believe in people. I trust you and the fact that you trust me too! I am also available because you are also available and honest*. An individual faced with a problem manifests a proactive attitude, appeals to *Winner's Optics*, seeks to find the best solution and not to find the guilty. It is specific to Adult and Free Child state. The individual manifests unreserved emotions felt at certain times. Living the position of life (++) means you only learn from time to time on the other positions;

2. *I am OK, You Are Not OK* - is the attitude of the superior who addresses the subordinates, seeking to dominate, intimidate, wanting perfection, uniqueness and vengeance, hence the hypersensitivity to criticism and hostile behavior if is not appreciated as expected. He is a fair, insensitive and tyrannical person in the relationship with others. The dominant feelings of this position are mistrust, anger, compassion; contempt and disgust, always tend to the power that he adores: *When I am in this position, I am pleasantly impressed by myself and I abhor you wholeheartedly. I am the first, then the rest*! *Everything is right to me!* The position of life is specific to the Persecutor, who not only controls his "subordinates", regardless of the relationships he has with the others, but seeks to impose their own point of view. On the other hand, he can also play the role of the Savior, who offers his help not to increase the autonomy of others, but to enforce his power and make others dependent: *Without me you will not be able to do it!;*

3. *I am not OK, You are OK* - it is the attitude of the obedient individual with a deficient self-esteem, hence the tendency to denigrate his own person, while the arrogance and the infatuation of others admire it unacceptably. Chooses a banal life, ready to pay dearly for any gesture and attention from the others, especially since these individuals are not capable of anything significant and worth not rewarding. Turning to insignificant activities, looking for deplorable partners, showing great uncertainty, hence the constant need to receive directions and approvals, easily take over the guilt of others: *I could only be so chaffed, I'm not good for nothing! I'm an incapacitated! Only you can help me! Without you I can die!* The beloved role is that of the Victim, played to exhaustion, has a very low affective tone, is depressed, disappointed, and easily appeals to self-destructive and self-centered act;

4. *I am not OK, you are not OK* denotes an attitude of resignation, of helplessness before the fate: *What is the meaning of life? Everything is superfluous! Nothing works, nothing makes sense! Why should I live anymore?* The existence of others, the unfolding of events is seen from the position of the passive spectator, confronted with problems blaming others for their own failure, always postpones the fulfillment of duties, tasks and optimal actions to improve the situation. It is dominated by anxiety and mistrust, helplessness, and appreciates everything as derisory. The position of life varies with the context, the temporary psychic disposition, the psycho-emotional maturity of the partner. They are positive when they are around the family, when they are praised by their inferior, but they become suddenly negative when they are hit by problems *they cannot face, when everything is meaningless*!

It is necessary to emphasize that each of us juggles with these attitudes depending on the psycho-social context, but one is dominant. The position of life is a way of evaluating and interpreting the moments of existence and, by all means an infallible form of being.

As mentioned above, throughout the life of the person, the individual appeals to different forms of reconfiguration of the relationship with the others, regardless of the degree of significance held by the other. Thus, the child understands at one time that he cannot always demand the attention and affection of the mother, so that he is turning to other forms of satisfaction by referring to other family members, which leads to the widening of the "social area" by appreciating the satisfaction offered by school colleges, prefects, neighbors, etc. Throughout life, the individual faces two important aspects that will determine a certain "destiny", the first one is to maintain and continue a certain affectionate mother-baby climate, and the second relates to the desire to relive this intimacy. (De Lassus *apud* Berne, 2006) These two dilemmas awaken a series of desires that run counter to general social norms, which leads to a reorganization and change of interactions with the peers. This explains the need for each of us to know how to interact with each other, to have a purpose for social action, to respond to *What are we here for? What is the reason for this gesture?* All this explains the need for a structure that is acutely felt by any person, is that form of avoiding boredom, maintaining an optimal affective level, maintaining control over the time of communication with others and ourselves. Building, developing and maintaining a balance between the three states of the Ego: *Father, Adult,* and *Child* allow maintaining an internal and external state of well-being, fruitful and effective communication with the fellow men, preventing possible dissensions and, last but not least, genuine and valid personal development.

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The Family Environment and its Influence on the Children's Delinquent Behavior

Neaga Susanu[1]

Abstract: Throughout this paper, I tried to point out the importance of the family environment on the psycho-behavioral development of the child, of the adult-to be. Even if due to permanent social changes the family can no longer perform certain functions, it remains the place where any child sets the foundation for his biological, psychological, educational, social, cultural training, etc. I have presented the most important family functions considered to be fundamental and responsible for children's psycho-behavioral training. The family has the role of shaping and maintaining the small group, of passing on to the next generations the cultural patterns, thus being formed traditions and customs that maintain and define a whole nation.

Keywords: family; psychosocial behaviour; deficiencies; child; adaptation- misfit; environment - family relations

Family is and behaves as a basic life matrix for the existence and formation of the child's personality, as a determinant educational environment, but also as a source of misfit and deviant behavior of the child. The family is the first and most important context of life with a special role in socializing the child. Sociologically, the contemporary family experiences a process of structural erosion and resignation from its fundamental functions, a continuous degradation of authority, and implicitly of the quality of the educational environment.

Several risk factors have been identified, some of which are placed at the level of personality but with elements of family origin, which have been classified in factors that regard the whole and the main tendencies of evolution of economic and social conditions, factors that are related to family structure and factors that concern the educational capital of the family.

It has been found that most of the times, emotional deficiencies produced in particular by family-type deficiencies can lead to frustrations, which in turn lead to high levels of aggression. Lack of family structure, quite common during the transition period, are situations that conduct to serious risks in children's education, but it can not be said with certainty that all young people raised in such families inevitably become deviant behaviors.

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The literature highlights a series of parental "mistakes" that can lead to the emergence of deviant behaviors at teenagers such as hyperprotective attitudes, disinterested family attitudes, busy or home-gone parents, hyper-attitude, child abuse through neglect etc.

In any society, family represents a form of human community, made up of at least two individuals, united by marriage and/or paternity, who achieve more or less the biological and/or psychosocial side. This definition was formulated as follows because the social reality generated a variety of family types that can no longer be summed up to only one of the two aspects present in the couple. For example, single-parent families include parental elements and accomplish only the psychosocial side.

Generally however, the life of individuals within the family includes two essential elements:

- *a constant biological side, which has remained almost unchanged over time;*

- *a social side, in constant motion, representing morality, education, economic, legal, psychosocial aspects, etc.*

Family is a social institution and any institution has its own functions. Throughout time these functions have obviously manifested differently – as they represent the total responsibilities that are taken care of in the overall architectonics of economic and social activity in a certain period of time.

There are two types of factors that favor or change negatively the functionality of a family:

1. **External factors** – which are factors from outside the family and act very strongly upon it. The most important are considered to be the political regime of the society, the level of economic development, the law and social policies, the general level of education, education, and civilization;
2. **Internal factors -** those who can be easily accused of malfunctions. Among the most important, we mention: the family dimension, with implications in achievement of socialization and solidarity, the family structure, with an impact on the economic and reproductive function, the division of roles and authority, with repercussions mainly on the function of solidarity. These factors do not act simplistically on the functions defined and attributed to the family, because the disturbances within a function cause changes in all the others in a higher or lower proportion.

The literature speaks of several functions, which are compressed into four functions that the family fulfills, considered by most specialists to be "fundamental":

- *the economic function;*
- *the socializing function;*
- *the solidarity function;*
- *the sexual and reproductive function.*

But it is hard to say whether today these functions are really fundamental, because this feature is very suitable for a traditional society. The contemporary family, however, violates the taboo of the fundamentalities of the functions, most of them consciously.

Regarding its functionality, the family environment can be analyzed according to several indicators, of which the most important are considered:

- the parents' interpersonal reporting model, by understanding the level of closeness and understanding, agreement or disagreement in the absence of various problems;

- the degree of cohesion of family members;
- how the child is perceived and considered;
- the assembly of attitudes of members in relation to different norms and social values;
- the manner in which parents exercise their authority;
- the degree of acceptance of various children's behavior;
- the level of satisfaction felt by members of the family group;
- the dynamics of the emergence of tense and conflicting states;
- the pattern of rewards and sacrifices;
- the degree of openness and sincerity shown by members of the family group.

Most of the *behavioral and social inadequacies* of young people have their causes in educational shortages both in family life and in the function of social institutions. *Conduct disorders* can be different: difficult, disaffected, domestic, social, scholastic, etc.

Inadequacy is a lack of integration into the environment and the situation where it occurs; we speak of *family, school, professional or social inadequacy*. A social misfit is that individual who can not integrate into the conventional social environment in which he lives. This state has negative consequences not only on the psyche and behavior of the child or the young man, but also on the whole social complex with which he is in a perpetual conflict. The causes of *social inadequacy* differ from one individual to another according to his/her personality and from one environment to another. *Social inadequacy* is a slow, lasting process in which the influences of the environment intertwine with the reactions of the individual. It can sometimes have latent tendencies that trigger only in the event of incidents or conditions (eg parental divorce, or the death of a parent - can radically change a child's behavior).

The process of social inadequacy is favoured by many causes, many of which are found in the family environment in which the child lives. Therefore, a brief overview of family situations generating deviant behaviors in children is required. For a better and more complete understanding of the influence of the family environment on the pro-social or pro-delinquent behavior of the child, it is necessary to present the educational styles.

It has been found that the multitude of educational climate is organized around two axes:

1. authority - liberalism or constraint – permissiveness axis;

2. love- hostility or attachment – rejection axis.

In the case of the first axis, there are used indicators which reflect:

- *the limits and constraints imposed by parents on the children's activity;*
- *responsibilities assigned to children;*
- *how parental control is exercised;*
- *the rigor with which rules are applied and controlled, etc.*

For the second axis, the indicators reflect:

- *the degree of parents' involvement in the activity of the child;*

- *the help that parents provide to the child;*
- *the time the parents dedicate to the child;*
- *receptivity towards his emotional states and needs;*

While combining the two variables - parental control (1) and parental support (2),most authors have identified three functional patterns of parental action:

- *permissive model;*
- *authoritarian model;*
- *authorized model.*

The first one, the permissive model, is characterized by the low level of control associated with identification of the parent with the emotional states of the child. It is subject to few rules of conduct and few responsibilities, and the way it responds to parental expectations is subject to poor control. Therefore, parents strive to understand the needs of the child and to respond appropriately to these needs. The second model, i.e the authoritarian model, is characterized by a high level of control, but this level is associated with a great support for the child's activity, and there are imposed principles and rules of inviolable conduct.The values that parents systematically transmit to children are: *authority, tradition, work, order, discipline*. The third model, the authorized model - is characterized by a systemic control, and it combines this control with strong parental support. Parents form rules and control their observance, but they do not impose these rules, and remain open to verbal dialogues with children, explaining to them the reasons why the rules must be respected and the situations in which they apply, thus stimulating the autonomy of their thought.

Expert studies indicate a correlation between *the educational model and the social class*. Thus, upper classes generally practice a light educational model that allows the free development of children's personality and the manifestation of their autonomy, and educational constraints are poor.

However, there are constraints in all social classes, and in each of them there is a tendency of evolution towards *permissiveness*.

However, the correlations between the educational model and the social class are far from being perfect. Another feature is the family's internal structure. In 1980, the French sociologist J. Lautrey confirms the hypothesis of the educational style's dependence to the way the family is organized. He builds three types of families:

1. **poorly structured families** - which show little regularity to the child, the rules being almost absent;

2. **families with a rigid structure** - placing the child in front of rules whose application does not allow any exception;

3. **families with a thin structure** - providing the child with regularity and flexible rules applicable to the situation.

So, it can be said that the family environment can be positive or negative, i.e "good" or "bad" and it interposes as a filter between the educational influences practiced by the parents and the psycho-behavioral acquirements made at the level of the personality of the child.

The positive family environment favors the fulfillment of all functions of the marital and family couple at high efficiency rates. In the middle of the family, the individual is awaited, preferred, valued, respected, asked for opinion or advice, and if all these become motivational factors together, they will

increase the degree of integration of his/her life behavior and family activity, and at the same time, will increase the unity and cohesion of the family group.

Through this presentation of the family environment, it can be noticed that the family is the first and the most powerful environment in which the child socializes, moving from the state of **dependence** to the state of **independence.** Also, it can be concluded that the particular influence that the family environment exerts on the behavior and development of the child acts in a double direction. Through its permanent and coherent character, the family is an educative environment with key formative valences essential for the normal development of the child, but in the case of a poor environment, it disadvantages the child's education, its normal development, and generates the risk of inadequacy. In today's society, the *typical nuclear family which is numerically reduced* in spouses and their unmarried children is threatened by the *atypical nuclear family* (such as the single-parent family consisting of a single parent and child, the family without descendants, the family rebuilt through marriage, concubinage, etc.) and the non-nuclear life styles (celibate, divorced, grandparents-grandchildren cohabitation, aunts-grandnephews cohabitation etc.).

The main causes of endangering of the typical family are: the dynamics of modern life, professional status, material insecurity, more and more complex medical conditions, cohabitation accidents, the labor market (death, detention, etc.).

These deep changes in the family have even generated a new terminology that attempts to explain the new and complex family reality. Roger Mucchielli, like other psychologists and sociologists, calls *the family desertism* -an environment stabilized on tension and conflict, an environment marked by attitudinal deficiencies generated by precarious living conditions and traumatic events such as death, disability, divorce, abandon, etc. This environment affects cohabitation relationships between spouses, parents and children, threatening family unity and balance. Conflict stress is the source of profound suffering that marks each member of the family and makes it a formal and traumatic cohabitation. The unnatural behavior of the "frustrated mother"- excessively authoritative behavior, anxious, inconsistent, neurotic, hyperprotector and unnatural behavior of the father, violent, neurotic - all these wrong attitudes of parents towards children's behavior, are behaviors that will in turn generate , in tandem, aggressive, destructive behaviors and social inadequacies that can end in multiple failure (psychological, cultural, professional, social).

A positive family environment, characterized by consistency, balance and security is the environment that meets the needs of safety, protection, social affiliation and prestige. The unity, balance and harmony of family life are challenged by some stressful events (misunderstandings, failures, illnesses) that can occur at any time within the family.

When cohesion resources do not resist these stressful events, tensions and permanent misunderstandings generate the phenomenon called *family desertism*, which seriously damages family relationships. *Positive (cordial) relations* of attraction, love, understanding, solicitude, respect, friendship, as well as their opposite - relationships of division, hatred, indifference, with devastating consequences for all members can be established within the family.

Due to the complex conditions of family life - emotional lability and confusion, successes and school failures, professional, right or wrong feelings of infidelity, achievements or material difficulties – can even occur paradoxical changes of emotional relationships.

Thus, the relations of attraction are transformed into hostile relations, and the hostile relations in relations of attraction, the relations of comprehension are transformed into relations of division, and

the relations of division in affective relations of understanding and so the relation of love transforms into relations of hate.

Once established these contradictory relationships, they will deeply put a mark on communication between and within generations. In extreme situations of misunderstanding and conflict, the family breakdown and the trauma of separation occur and they will affect each of the family members and the child in particular.

It is well known that mono parenthood and in particular that resulting from divorce, generates a poorly educated family environment, which is generally correlated with a dicrease of educational activity and especially with a lower efficiency of educational efforts.

These complicated situations of family life apply to a person with essential special needs: the child. According to French psychologist Henri Wallon (quoted by I. Mitrofan and N. Mitrofan), for the child, the family is an *existential and fundamental* problem, a problem of to be or not to be, and who is placed by its nature, in a group designed to ensure his/her support , security, first education and his/her further social path. The family environment becomes a framework of material, spiritual and moral environment in which individuals are formed as social actors, as the family is the closest and most appropriate medium of intellectual and emotional structure for children's personality.

Specialists in the field of analysis and intervention on the family group have come to a common conclusion: among all the backgrounds that influence human development (family, school, friends group, mass media), the family has some of the most important tasks, building as well the affective, social and cultural universe of the adult-to be.

Therefore, defective family environments present the risk of favoring or obstructing the normal development of children.

It is extremely useful to be aware of the specific characteristics of the family environment in the prophylactic and therapeutic intervention in order to prevent and cure the conflicting relations that are unfavorable to the balance of each member of the family and the child in particular. Thus, the following types of deficiency family environment are distinguished in the literature:

- *rigid family environment;*
- *the libertine family environment;*
- *the naive family environment;*
- *the anxiogenic family environment;*
- *the conflict family environment;*
- *the environment of disorganized families.*

In conclusion, the deficiencies of the family environment (taking into consideration this type of family) do not favor the normal and balanced development of children. Although it does not only lead to negative consequences on development in terms of social maturity of children, the deficiencies of the family environment present a great risk in the development of the adult-to be. The risk lies in further unfulfilment of young people from a socio-cultural point of view at the level of their capacities and aspirations.

Risk can also be reflected in delinquency or other forms of deviation, having as its starting point the imitation of defects of social achievement and civic integration. On the other hand, the causes of socio-professional failure and delinquency of parents affect the harmonious development of the child.

Of course there are cases that do not confirm these situations, there are cases in which the defects and vice of young people cannot find their explanation in the family lifestyle, but in the suggestive nature lieing under the harmful influence of the extra-family environment.

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THE 13TH EDITION OF THE INTERNATIONAL CONFERENCE
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Psychological Representation of Disease in Breast Cancer

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Abstract: Cancer represents the second major cause of mortality worldwide, after cardiovascular disease. The most common type of cancer that affects women is the breast cancer. This article presents a study about different representations of cancer on diagnosed patients, nurses working on oncology and healthy family members. Previous and actual experience influence the content and structure of representation for all of us, so different individuals will have different psychological representation of the disease. Evaluation of psychological representation of breast cancer was based on Illness Perceptions Questionnaire (IPQ) described by Weinman in 1996 for all five stages of disease: identity, causes, evolution, consequences and control. Results reveal that nurses and family member got high scores on evolution, understanding that cancer is more like a chronic disease under treatment, but patients got low scores on evolution and control of cancer, thinking these are dictated by faith and luck. All participants got high results about identity, the most negative consequence is the impact on women's image. This article presents unique interpretation and results about psychological differences in representation of cancer from perspective of patients, nurses and healthy persons and can contribute to improving both medical care and psychotherapy of suffering patients.

Keywords: psychotherapy; cancer therapy; psychotraumatology; human development

1. Introduction

Generic term of cancer covers more than 200 affections characterized by fast grow of abnormal cells beyond their usual boundaries that can spread to other organs and the latter process is known as metastasizing. Changes produced by cancer are the result the action of both genetic factors and 3 categories of external agents: physical carcinogens (ultraviolet and ionizing radiation), chemical carcinogens (asbestos from tobacco smoke, alfatoxin from contaminated food and arsenic from drinking contaminated water) and biological carcinogens (viruses, bacteria or parasites). All these factors are more likely to produce cancer cells as a person grows older, so age is another factor for this disease, because human cells' repair capacity is reduced by ageing.[2]

This article's goal is to present the results of a study about differences in psychological representations of this disease on distinct categories of populations: women patients diagnosed with breast cancer, nurses from Oncology hospital sections and healthy women. We also tried to describe the nature of the differences perceived for all the five dimensions followed: identity, evolution in time, causes, consequences and control.

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[2] Ferlay, J.; Soerjomataram, I.; Ervik, M,.; Dikshit, R.; Eser, S.; Mathers, C. et al. GLOBOCAN 2012 v1.0, Cancer Incidence and Mortality Worldwide: IARC Cancer Base No. 11-Lyon, France: International Agency for Research on Cancer; 2013.

Breast cancer is the most frequent type of cancer for women worldwide, this is why In 2017, the World Health Assembly passed the resolution *Cancer Prevention and Control through an Integrated Approach* (WHA70.12), urging governments and WHO to accelerate action to achieve the targets specified in the *Global Action Plan and 2030 UN Agenda for Sustainable Development* to reduce premature mortality from cancer.

When people receive cancer diagnosis they have different reactions about the disease, but also about treatment. These differences suggest that patients have different representations of their experiences, based on cognitive factors of psychological response to this extreme situation.[1] Patients' response to this situation is integrated in cognitive structures and mental representations previously created, in order to explain and give sense to the actual health state and the appearance of the disease. Mental representations are defined by five elements: identity (tags, signs, symbols), causes, evolution in time, consequences (results of disease and response to treatment and its effects on the patient) and control (the patient controls the treatment to be followed and its efficiency).

Past and present experience influence content and structure of mental representation of illness. Therefore, different individuals will have different mental representations of the disease, depending on the perspective: weather they are patients, nurses or healthy persons.

2. Related Work

Worldwide, every year 7 million people are diagnosed with cancer and without the proper treatment this disease usually leads to death. It is estimated that cancer will become the leading cause of mortality and morbidity within the next period in the high industrialized countries, since the incidence and prevalence of cancer is constantly growing.

In Romania the situation is similar to other countries and breast cancer is the most frequent type, the situation for every type of cancer is presented in the Table 1 below:

Table 1. Incidence, mortality and prevalence of cancer types in Romania[2]

Cancer type	Incidence	Mortality	5 years Prevalence	% Mortality/incidence
Breast	8981	3244	33388	36%
Colorectal	4496	2446	10516	54%
Cervix uteri	**4343**	1909	14834	44%
Lung	2327	2047	2319	88%
Ovary	1850	1020	4176	55%
Corpus Uteri	*1539*	359	5819	23%
Bladder	*1390*	1236	657	89%
Stomach	*1364*	1149	1593	84%
Brain& nervous system	*800*	732	906	92%
Leukaemia	*741*	501	1517	68%
Liver	*729*	595	1012	82%
Kidney	*690*	295	1866	43%
Thyroid	*662*	109	2602	16%
Skin	*593*	175	2034	30%

[1] (Buick, 1997) In Petrie, K.J. & Weinman, A.J.: Perceptions of health and illness: current research and applications, Hardwood Academic Publishers, Amsterdam.
[2] http://globocan.iarc.fr

Other types of cancer	*1562*	910	2744	58%

And even more specific, in our city Galati, from the evidence of the Public Health Department (DSP) results that thousands of people suffer from a different type of cancer. Doctors from our county diagnose over 1.000 new patients with cancer every year, the most frequent types are breast cancer, prostate and colorectum.

For example, just for the first three months of last year, 2017, over 200 new cancer cases were discovered in our city. Total number of cancer patients was 17.362, and from the 100 new cases, 27 were breast cancer. 2402 women from our city suffer from this disease.

Despite the gravity of the disease, cancer diagnosis is not the equivalent of a death sentence, nowadays there are efficient treatments to ameliorate the pain and there are intense international programmes for prevention, early diagnosis, screening, treatment and palliative care.[1]

3. Problem Statement

Howard Leventhal and his colleagues, in the early 1980s, departed from the initial researches in the field of mental threat representation and threat processing, focusing on studying how people perceive disease as a threat. They developed a theoretical model, the pattern of self-correction of disease responses, which comprises in an integrated system the emotional and cognitive mechanisms involved in the formation of mental illness representation.[2]

The self-regulation model proposed by Leventhal, Nerenz and Steele[3] describes three recursive stages that regulate behavior.

These studies are:

- cognitive representation of the disease - whose characteristics are: identity, causes, consequences, evolution over time, controllability/curability;
- coping - which involves different ways adopted by the patient to cope with the disease;
- Evaluation - the individual uses various criteria to assess the effectiveness of coping actions; Depending on these results patient determines the changes at the level of previous stages.[4]

The model proposed by Leventhal presents two essential features:

- people are seen as active participants in the accumulation and processing of disease information;
- cognitive representations play an important role in selecting coping modalities that will serve the individual.

[1] http://dsp-galati.ro/.
[2] (Leventhal & Diefenbach, 1991). In J.A. Skelton & R.T.Croyle (ed.) Mental Representations in Health and Illness. New York: Spinger Verlag Inc.
[3] Leventhal, H.; Nerenz, D.R. & Steele, D.J. (1984). Illness representations and coping with health threats. In A. Baum, S. E. Taylor & J. E. Singer (eds.): Handbook of psychology and health. N.J.: Lawrence Erlbaum Associates, Hillsdale.
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4. Concept and Terms

4.1. Objectives of the Study

In this article we present a study starting from the theoretical hypothesis that the individual is an active problem solver and in his attempt to give meaning and sense to the current state of health or illness he represents this state based on his past and present experiences. Starting from this theoretical general hypothesis, the study aims to identify the differences in the mental representation of breast cancer in different groups of individuals: cancer diagnosed patients, Oncology nurses and healthy women.

4.2. Methodology

For the investigations proposed in the research objectives, three groups of subjects were used.

The first group of subjects consisted of 34 patients diagnosed with various forms of breast cancer (N = 34) that completed the survey directly in the Sf. Ap. Andrei County Hospital Galati or intermediated by Association of Cancer Patients Galati. The mean age of the patients was 56.8 years, with the range between 36 and 73 years. Of these, 23 were retired (82.8%) and the rest were professionally active (17.8%). A total of 11 patients (36.11%) came from the rural area and 23 (63.88%) from urban. Depending on the stage of the disease, there were 2 cases (5.5%) in the first stage, 14 cases (38.8%) in the second stage, 17 cases (47.2%) in the third stage and 1 case 7%) in Stage IV.

The second group of subjects consisted of 22 nurses (N = 22) from oncology specializing in breast cancer. The subjects work in the the Sf. Ap. Andrei County Hospital Galati.

The third group of subjects consists of 24 female subjects (N = 24) who have not been diagnosed with any chronic disease. The average age was 59-64 years with the range between 50 and 76 years. We selected female individuals aged 50 years because this characteristic, i.e. 50 years of age with menopause and menarche at 12 years or earlier, the first birth at> 30 years, is the main risk factor of breast cancer. (Ghilezan, 1992)

4.3. Instruments

Assessment of the clinical stage of the disease - for the subjects of the first batch was done according to staging system. The data were taken from the patient's medical records provided by patients themselves.

Stage I - characterizes small-tumor, less than 2 cm, stage II - characterizes the tumor between 2 and 5 cm, stage III - large tumor over 5 cm and stage IV - enlarged thoracic and/or skin tumor, with or without extension.

The evaluation of the mental representations of the disease was based on two questionnaires made for the three groups of subjects. The first questionnaire addresses the batch of patients diagnosed with breast cancer, while the second questionnaire is for the two groups - nurses and healthy people The elaborated questionnaire was based on the Illness Perceptions Questionnaire (IPQ) developed in 1996 by Weinman, Petrie, Moss-Morris and Horn. (Petrie & Weinman, 1997)

IPQ is a new method of assessing the mental representations of the driving disease in Leventhal's mental illness model. The questionnaire contains items for assessing the five components of the disease: identity-related, cause, evolution over time, consequences and control.

4.4. Study Procedures

The questionnaires were completed by patients in the salon where they were hospitalized in the Sf. Ap. Andrei County Hospital Galati or intermediated by Association of Cancer Patients Galati (ABC Galati). There was no time limit for the discussion accompanying the questionnaire completion. This was beneficial, in the sense of clarifying some issues that occurred while filling the survey. The individuals of the three groups included in the study agreed to participate in this research.

5. Analysis of Results

The raw data of the study were processed using the SPSS statistical program. In a first part the descriptive statistical values (averages, standard deviations) were calculated. For the examination of differences between variables we compared the averages obtained by each group (the T test for independent groups and P on the five dimensions of the mental representation of the disease.)

Table 2. Statistical values obtained by the group: cancer patients Vs. Oncology nurses

Dimensions of Cancer Mental representation	Breast cancer diagnosed patients		Oncology nurses		Calcul. T test	P (on 5 dimensions)
	average	standard deviation	average	standard deviation		
identity	1.67	0.35	2.50	0.51	7.82	<oo1
Evolution in time	2.34	0.65	3.85	0.83	8.49	<001
consequences	3.53	0.38	3.98	0.55	3.99	002
control	3.10	0.43	3.74	0.56	5.32	<0001

Table 3. Statistical values obtained by the group: cancer patients Vs. Healthy women

Dimensions of Cancer Mental representation	Breast cancer diagnosed patients		Healthy women		Calcul. T test	P (on 5 dimensions)
	average	standard deviation	average	standard deviation		
identitate	1.67	0.35	2.47	0.49	7.99	<oo1
Evolutie in timp	2.34	0.65	3.63	0.80	7.55	<001
consecinte	3.53	0.38	3.66	0.59	1.16	.246
control	3.10	0.43	3.30	0.56	1.72	.089

Examining average scores for each dimension of mental illnesses indicates the issues: people diagnosed with breast cancer have a lower identity of disease than nurses and healthy women. This implies that the cancer symptoms are little known and insufficiently identified by individuals, which explains the high percentage of people in the late stages of the disease. Studies indicate cancer as a rather asymptomatic than symptomatic disease, the treatment being generally more unpleasant than the disease itself - this distinguishes cancer from other chronic diseases. It is a "*silent killer*".

The high scores obtained by the subjects included in the two groups (nurses and healthy people) are explained by the fact that both nurses in oncology and healthy people perceive breast cancer as a disease that involves a high degree of suffering from both the symptoms and treatment involved in the disease.The differences resulting from these scores indicate that there are some discrepancies in the mode of representation of breast cancer in different populations. The belief of sick people in a limited time span of their illness shows the presence of a poor education of the patient related to the consequences and duration of their illness. And not only poor education, but also a lack of adapted

psychotherapy. Control perceptions can be modified in the direction of increasing self-confidence and the ability to control disease progression through informative programs to learn how to manage the treatment of the disease and the side effects that occur.

Table 3. Causes of breast cancer: perceived by patient Vs. Real caus accordng to medical file

Perceived caused by patient	% of patients indicating the right cause
Stress	47,22%
Blows to the breast	25%
Hormonal disorders	11%
Other causes	11%
By chance	2,77%
Heredity	2,77%

Breast cancer is a chronic disease with serious economic, social and psychological consequences. The high scores obtained by the three study groups confirm the severity and effects of cancer.

In items referring to the consequences of the disease, most people rated them on the highest scale. An important consequence of diagnosing this disease is related to body image impairment. Indeed, for a large population, cancer treatment leads to impaired body image and trauma of the treatment itself (chemotherapy, radiotherapy, surgical).

6. Conclusions

Following the meetings with patients who participated on this study, we can conclude that women with an extinct breast, following mastectomy, wanted to receive information about the purchase of a prothesis (cost, place of purchase, financial help etc.). These questions appear after a while, when we also see the need for group meetings, including specialized breast cancer psychotherapy programs. A first step in this direction could be to produce leaflets with the necessary information specific to the group to which they are addressed: people diagnosed with breast cancer or prone to this type of cancer.

Patients who have chosen lumpectomy instead of mastectomy have different “breast cancer” opinions compared to women who decide for mastectomy. Women who choose partial resection and radiotherapy consider that they will have difficulty adapting to the loss of a breast after mastectomy and are more concerned with their body image and more dependent on the presence of breasts for maintaining self-esteem. In contrast, women who choose mastectomy, perceive their cancer as something ‘strange” that has to be cut away from their body and are more concerned about the secondary effects of radiation.[1]

Interpretation of these data according to Leventhal's model suggests that patients have taken the treatment decision that was congruent with their mental representation of cancer.

The study’s goal is to identify the differences of representation and their nature at the level of three distinct populations, based on the model of mental illness representation. The results of the study confirmed the existence of differences in the mental representation of breast cancer and outlined the characteristics of the five defining dimensions in the representation of cancer.

The processing and analysis of the data obtained on the basis of the two questionnaires revealed the following conclusions:

[1] Ashcroft, J.J.; Leinster, S.j. of Shade, P.S. (1985). Breast, cancer patient choice of treatment: Preliminary communication. *Journal of Royal Society of medicine*, 1978.

• People diagnosed with breast cancer have a lower identity of disease than nurses and healthy people. This implies that cancer symptoms are little known and insufficiently identified by individuals;

• Healthy people and nurses perceive the disease as having a chronic, long-lasting development, but being controllable due to their professional status, confidence in their profession and treatment efficiency;

• The belief of people diagnosed with breast cancer over a limited time period of their illness indicates the presence of their poor education in relation to the consequences and duration of their illness and insufficient psychotherapy for patients

• The perception of control is often related to "destiny" or "chance", which can be changed in the direction of increasing self-confidence and the possibility of controlling disease progression by means of informative programs by which patients are taught various ways of management the treatment of the disease that follows and the side effects that occur and psychological support;

• All subjects estimate the same level of consequences of such a disease with a huge impact on body image

• The causal attributions of the disease vary according to the type of membership and specialized knowledge of the subjects in the present study.

7. Future Work

Further research should identify the nature of the relationships between the components of the mental representations of the disease and the coping mechanisms; also to look at how the mechanisms of coping mediate the relationships between the mental representations of the disease and the aspects of adaptation to the illness (physical, social, mental health and vitality).

Another starting point for future research is the development of disease assessment tools that can be used as clinical methods for detecting patients at high risk for poor disease adaptation.

Future intervention programs for patients diagnosed with breast cancer should provide information on the nature and consequences of treatment that will reduce the discrepancy between what patients think is happening and what is actually happening. We cannot say that there is an effective intervention strategy for all patients, but knowing a disease profile, a certain pattern in which they represent the disease experience, we can streamline the medical act and offer the psychological support that became very important in a breast cancer diagnosed patient.

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