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Contents

History of autism. The beginnings. Collusions or serendipity

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Abstract

The article presents the first years of the autism and the way it was viewed since the autistic features were first observed until 75 years ago when Leo Kanner coined the term "autism". It took 36 years to Kanner's "infantile autism" to be formally recognized by the American Psychiatric Association in the third edition of the Diagnostic and Statistical Manual (APA, 1980). Fifty years after Hans Asperger published his four cases of "autistic psychopaths", whose traits were described as early as 1938 in his postdoctoral thesis, APA introduced the Asperger syndrome in the fourth edition of DSM(1994). However, two decades before Kanner and Asperger, a Russian psychiatrist, Grunia Sukhareva, reported six cases of "schizoid psychopathy" in children and used the term autistic to describe their "tendency towards solitude and avoidance of other people" (Wolff, 1996, p. 129). We bring together three recent extensive accounts on autism history and try to establish who was the first to observe, describe, and label the autistic traits as a separate clinical picture from childhood schizophrenia.

Keywords: infantile autism; Asperger syndrome; schizoid psychopathy.

"Nothing is totally original. Everyone is influenced by what's gone before."

Lorna Wing (1981)
the architect of the spectrum model of autism and mother of a girl with ASD

1. Introduction

For decades, when presenting the history of autism, authors usually start by quoting Leo Kanner's landmark articles on autistic disturbances (Kanner, 1943) and early infantile autism (Kanner, 1944), also known as Kanner syndrome. Immediately after, Kanner is cited in Hans Asperger's work, and Lorna Wing (1981) name it as Asperger Syndrome. Instead of going directly to those two great pioneers' papers or delve into the vast databases of scientific literature, we propose to take a trip to the past and travel around with some

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special guides, nor psychiatrists or psychologists. The first is Steve Silberman, an American science journalist, who wrote the book *Neurotribes:The Legacy of Autism and the Future of Neurodiversity* (Silberman, 2015). Our second guide is Adam Feinstein, a journalist, Hispanist and father of Johnny who is autistic (Introducing myself | Adam Feinstein's blog," n.d.), author of *A History of Autism: conversations with the pioneers* (Feinstein, 2010). The lasts are two American journalists, John Donvan, multiple Emmy Award-winning, and Caren Zucker, mother of Mickey, diagnosed with autism, authors of the book *In a different Key. The story of Autism* (Donova&Zucker, 2016). Although not academic books, the authors support their writing with rigorous citations to sources and impressing extensive documentation (Odom, 2016).

Each of the authors mentioned above was greatly acclaimed and received numerous prizes, but also their books reaped a whirlwind from some academics or part of the public. That is the reason why we were interested in having a scientific, hence impartial opinion on those three accounts of autism history. While researching for our project on ASD (Luştrea, A; Al Ghazi, L.; Borca, C., 2017), these books were brought to our attention by Simon Baron-Cohen who wrote: "a stunning big book *NeuroTribes,* big in size and big in vision, spanning the history of autism from the late 19th century to the present day" (Baron Cohen, 2015, p. 1329), "terrific book" (Baron Cohen, 2017, p. 746). About *A History of Autism: conversations with the pioneers,* Baron-Cohen said is "a treasure-trove" ("Praise for my new autism book | Adam Feinstein's blog," n.d.). The book *In a different Key. The story of Autism* is "a book whichmakes a remarkable contribution to the history of autism", in Baron-Cohen words ("A Definitive History of Autism - The Crown Publishing Group," n.d.). Baron-Cohen has his well-set place in the autism's history as the author of the book *Theory of mind* ( ), and as a multi-awarded scientist. He is also professor of developmental psychopathology at University of Cambridge, and director of Autism Research Centre. After 40 years spent in the field of autism, if "Simon says" about a book that it is "one of the most fascinating accounts of autism I have ever read" and promise to "uncovers the secret that one scientist tried to hide" (Baron-Cohen, 2015, p. 1329), then that book is a must-read for anyone interested in autism. Silberman is taking us back in the 40s and brings together both Kanner and Asperger in revealing "a well-kept secret about autism."

2. The West Side Story. Kanner

The scientist who supposedly had secrets to hide would be Leo Kanner himself, not only the father of autism syndrom, but the father of child psychiatry in USA (Eisenberg's tribute to Kanner, cited by Feinstein, 2010)). Child psychiatrist at Johns Hopkins University School of Medicine in Baltimore, in 1943, he reported in his groundbreaking article that "since 1938 there have come to our attention some children whose condition differs so markedly and uniquely from anything reported so far" (Kanner, 1943, p. 217). Kanner described eleven cases of his child patients: they appeared isolated from the world, withdrawn from social contact, and most of them had severe intellectual difficulties (Kanner, 1943). He labeled these observed features as autistic. Actually, Kanner borrowed from Eugene Bleuler the term autism (from the Greek term *autos* = self), which means, literally, being absorbed in oneself, a morbid self-absorption (Evans, 2013) and credited the Swiss psychiatrist with introducing the term in psychiatry. Kanner repeatedly claimed that it was for the first time, in 1943, that such cases were described in the literature, so he was the first to name those features as autistic.

Silberman believes things are quite different and he also thinks he can prove it. As Baron-Cohen put it, "In science, as in commerce, or exploring space, being there first is important, and Silberman sees the real importance of what he has stumbled upon" (Baron-Cohen, 2015, p. 1329). What Silberman stumbled upon was the Hans Asperger's work and other authors publications that clearly shows Kanner descriptions of autistic traits were not the first ever reported, nor Kanner is the first to use the term autistic. However, Silberman was not the first to suggest that Kanner borrowed more than the term autism for his syndrome, but also the ideas of other psychiatrists. Adam Feinstein (2010) pointed on the same issues in his book, as well as Fitzgerald in the chapter "Autism: Asperger's Syndrome— History and First Descriptions"(Fitzgerald, 2008; Lyons & Fitzgerald, 2007). Silberman however made a step forward by mentioning in premiere the link between Kanner and the Viennese scientists Georg Frankl.

Silberman made his case based on to the fact that before Frankl's arrival in the US, in Kanner's clinic, there is no evidence that Kanner had any interest in what we now call autistic behaviors (Robison, 2017). Frankl was the principal diagnostician in Asperger's

Clinic in Vienna, where he worked for eleven years, five close to Asperger. As other jew colleagues before him and as well as his future wife, Anni Weiss, he ran from Nazi terror and left Vienna for the US. Silberman implies that through Frankl and his wife, Kanner saw the opportunity to make history in medicine describing a new condition, namely the autism, and never credited Asperger in his demarche. It is also Silberman's assumption that the Frankls remained silent feeling greatly in debt for Kanner facilitated their new life in the US. According to Kanner, his article presents "characteristics form of an unique syndrome, not heretofore reported" (Kanner, 1943, p. 242). Nevertheless, Frankl would have known that this was not the case, since he himself and his wife had presented similar descriptions as early as 1933-1935 (Donvan, Zucker, 2016; Robison, 2017; Silberman, 2015).

Anni Weiss-Frankl published in American Journal of Orthopsychiatry (Weiss, 1935) the case of Gottfried, a boy she consulted while she was working at the University Children's Clinic in Vienna. She left Vienna in 1934 and her future husband, Georg Frankl, in 1937. So, on 3 October 1938, when Asperger presented his thesis (Feinstein, 2010), in which he called his patients *Autistischen Psychopathen*, autistic psychopaths[1] (Donvan & Zucker, 2016), the Frankls were not in the auditorium. They were no longer in Europe, but in Kanner's inner circle at Johns Hopkins (Silberman, 2015). Silberman advanced the idea that if not from Anni Weiss, then Frankl surely must have heard the word autistic right from Asperger's lips, as a label for the children he consulted in his Clinic. Feinstein (2010, p. 11) citing Asperger's daughter, Maria Asperger Felder (2008), evokes a letter dated April 14, 1934, in which Asperger "discusses the difficulties of diagnostic concepts and suggests the possibility that *autistic* might be a useful term".

How close Frankl and Kanner's relation was, how much the two men talked about their cases, if Frankl really informed Kanner with details about his work with Asperger and how Asperger denominated the traits he observed in children, we do not know. Kanner only named Frankl as one of many clinicians whom he helped immigrate to America and credit him for conducting his observations and evaluations of two of his eleven cases, but never mentioned him in his work again (Silberman, 2015, citing Kanner's Unpublished memoirs).

[1]To note that in German, "psychopathy" has not the connotations of a profound mental illness as in English.

However, if the two men have had talked about Asperger's work and vision, we can speculate it was not in 1938, but later. We say so because on 7 October 1938, four days after Asperger defended his thesis on autistic psychopaths in Vienna, Leo Kanner met five years old Donald Triplett for the first time in Baltimore.

After reading the detailed letter sent by Donald's father and meeting with the child, the most renowned child psychiatrist in the US was not able to provide a diagnostic to the parents. Instead, he sent little Donald to Frankl for further evaluation. After two weeks of tests and observations, Frankl notes "? Schizophrenia"(Silberman, 2015). Although the mother insisted for a diagnostic, Kanner had no label to give. "Donald was different from any other child he had treated and unlike any description in any textbook" (Donvan & Zucker, 2016, p. 36). A year later, the diagnostic was still unclear. Kanner and Donald's mother wrote each other at least twice a month for the next four years. In 1942, the mother wrote again, reproaching that Kanner gave her only "generalities" whereas she needed "specifics" (Donvan & Zucker, 2016). "Nobody realizes more than I do myself that at no time have you or your husband been given a clear-cut and unequivocal (…) diagnostic term"(Autism's First Child - The Atlantic, 2010). Finally, the name *autistic* for the disturbances Donald displayed is announced in a letter to Donald's mother on September 28, 1942, and became part of the title of his 1943 article (Donvan & Zucker, 2016). A year later, Kanner comes with the name for the syndrome- early infantile autism (Kanner, 1944). However, the Frankls were not in Kanner's circle anymore. They left Baltimore at the end of 1940 (Silberman, 2015). So Kanner was on his own when he formulated his conception of the syndrome, between 1942 and 1944. How much the two-man talked about Frankl experience shared with Asperger, as a principal diagnostician in the Viennese Clinic, remains unknown.

Silberman produced however more circumstantial evidence than the others who accused, indirectly or directly, Kanner of plagiarism of ideas, by identifying Frankl as the connection between Kanner and Asperger. However, in Kanner's defense, we may say that his first case, the notorious Donald T., was referred to him in 1938 by the child's pediatrician and Donald fathers' letter stands for it. It is true that Frankl was involved in Donald's case (as well as in another one, Elaine's, who came an year later, in 1939), but it is also proved

that in 1942 Kanner was still unsure how to label Donald's condition (see Kanner letter to Donald's mother). In a three year window (1938-1940), Frankl probably had many opportunities to talk to Kanner about the resemblances between his cases and Aspergers'. If Frankl did suggest the term autistic, taken from Asperger, why was Kanner hesitant in using it and waited until 1942 if he was eager to come first? If Kanner included aspects of Asperger's thinking into his own model of autism, without crediting him, still cannot be ruled out as a possibility.

If we admit that Kanner was not aware of Asperger work and that they applied the identical word to the independently observed behaviors, we can not agree with Kanner's claim that he was the first to describe those peculiar behaviors in children. Feinstein, citing Gilberg, inform us that Kanner was ''so very well aware of people writing in other languages at the same time that Asperger was working'' (Feinstein2010, p. 11). Even if he was not aware of Asperger's 1938 thesis, undoubtedly he was in current with the first account of "childhood schizophrenia" in America, published in 1933 by Howard Potter and also with Louise Despert several case histories reported in 1938 or in 1942 in a paper published in the same journal, *Nervous child*, in which Kanner published his seminal article in 1943 (Feinstein, 2010). Despert's reaction to the claims that the condition Kanner wrote about was "heretofore unreported" and "unique" was kind of "Had he not been reading my papers?". Silberman is quoting Despert commenting Kanner: "It seems to me that the greatest contribution this article is making is in its thorough, accurate, and illuminating description of clinical cases," she wrote. "However, if you will permit me to say so, I object to the coining of new terminology for entities which, if not so carefully described, have been previously reported" (Silberman, 2015, p 124). She herself even referred to her cases with *autism*, but in Bleuler's sense of the term, as a clinical sign of schizophrenia. However, Kanner never considered autism as an early form or prodromal phase of schizophrenia, as Despert did, but as a condition sui generis.

3. The East Side Story. Asperger and Sukhareva

Almost two decades before Kanner (1943) and Asperger (1944), Grunia Sukhareva described what we now call autistic traits in her original article, first published in Russian, in 1925, and next year, in German, under the title *Die schizoiden Psychopathien im Kindesalter.* For 2-years, she observed the children at Psychoneurological Department for Children in Moscow and then published six case reports of what she had called *schizoid psychopathy in children*, according to Bleuler and Kretschmer classification. Wolff translated in English Sukhareva' s German version of the article (Wolff, 1996) and implies that Asperger must have been aware of Sukhareva's "structured, elegant and detailed descriptions" (Manouilenko & Bejerot, 2015, p. 2). Wolf then raised the question: "How was it that Asperger…did not apparently know of this paper?" (Wolff, 1996, p. 120).

How much Asperger actually knew of Sukhareva's observations and her dilemma on the "disorder whose clinical picture shares certain features with schizophrenia, but which yet differs profoundly from schizophrenia" (Wolff, 1996, p. 131) it is hard to tell. Supposedly, at the University Clinic in Vienna, Frankl, Weiss or Asperger did not know about Sukhareva article, since none of them is citing her, although at the time there were not too many journals printed in German in the field of psychiatry. These journals were the first source of information for academics as well as for practitioners,so it is hard to believe that Asperger, who cited an article on child psychiatry published in the same journal, in 1938, never came across with his Russian colleague's paper. Sukhareva and Asperger both cited Bleuler and Kretschmer ' s early work on schizoid personality in adults (Manouilenko & Bejerot, 2015). However, none used the term autistic in relation to the cases described until Asperger gave the first public lectures on autism as early as 1938.

Asperger called his boys *Autistischen Psychopathen*. In German, the word *psychopathy* was akin "to the term personality disorder with none of the connotations of the deranged or criminal mind that it bore in English" (Donvan & Zucker, 2016, p. 238). Asperger consciously has designated the word *autistic* to describe the inward, self-absorbed aspect that was reminiscent of schizophrenic withdrawal, but also unlike it. Schizophrenia is not present in young children, as early as the age of two and the children did not experience hallucinations or hear voices, as was typical of schizophrenia. The lack of social contact is

present in schizophrenia and autism, like the fever is present in many conditions: as a symptom.

Asperger published *The 'Autistic Psychopaths' in Childhood (*in German, *Die 'Autistischen Psychopathen' im Kindesalter) in Archiv fur Psychiatrie und Nervenkrankheiten*, in 1944, an year after Kanner published *Autistic disturbances of affective contact*, in *Nervous Child* (Robison, 2017). Neither Asperger nor Kanner cited Suhkareva. The non-German-speaking researchers remained unfamiliar with the work of Asperger until 1981, when Wing presented the features of what she named Asperger Syndrome, and Uta Frith translated Asperger`s article, 47 years after his publication in German (Asperger, 1991).

4. Rewriting the history of autism

After bringing together Feinstein, Silberman and Donvan&Zucker accounts an early history of autism, we concluded that *Kanner's syndrome* and "Kanner- father of autism" are myths demolished, in part, by the above mentioned. We limited ourselves to mention just the published articles of other authors prior to 1943-1944, to show that Kanner, in his own words "never discovered autism; it was always there" (Silberman, 2015, p. 188). Hundred years before 1943, there were records of what we now call autistic features and autistic people (see Donvan and Silberman's descriptions of Basil, the holy fool from Russia, Hugh Blair, Itard's wild boy of Aveyron, Howe's Case 27-Billy). If we can ignore those livresque accounts, we can not overlook the Suchareva, Weiss, Asperger and Despert reports, all the articles-published before 1943.

5. Conclusions

What we know:

1. Asperger was the first to use the word autistic to describe the unusual behaviors observed in children. He borrowed the term from the Bleuler's schizophrenia symptom list. In Bleuler's schizophrenic adult patients, the cutoff communication and the preference for isolation appeared to come and go, while Asperger observed that children do not withdraw and isolate, merely they "were never in". Although "extreme emotional isolation" from other people, which is "the foremost characteristic of early infantile autism",

bears so close a resemblance to schizophrenic withdrawal (Feinstein, citing Kanner, p. 27), both Asperger and Kanner designated the term autistic being aware of these differences and explaining it repeatedly.

2. Sukhareva pointed out, two decades before Asperger, the distinction between the early-onset of the features observed in her children patients and the schizophrenic signs that appear later in adolescence and in young adults. In the last case, the patients almost invariably decline and disintegrate, while the children's condition often improves in time. Her merit is to accurately describe the traits such as the lack of interest and the lack of engagement in social contact, along with restricted and repetitive behaviors, and astutely observed that these differ from schizophrenia. Asperger concluded the same, but he came with the name *autistic psychopathy* instead of *schizoid psychopathy* for what later was labeled as Asperger syndrome.

3. Kanner was not the first to describe autistic traits, but he was the first to publish an article in which appeared both the differential diagnosis of the features he observed from childhood schizophrenia (as in Sukhareva and Asperger) and the label for them, autistic disturbances. He was the first to show that this complex set of behaviors constituted a single, never-before-recognized diagnosis: autism.

4. For years, Kanner maintained that his syndrome was monolithic by definition, limited to childhood. He also insisted that the autistic traits were innate, a hasty assumption since he never observed babies. Asperger, on the other hand, built his concept of autism as a broad and inclusive spectrum, a "continuum", as his diagnostician, Georg Frankl, called it in an unpublished draft from the '50s, cited by Silberman(2015). Wing, the architect of modern autism model as a spectrum, also noticed that.

Asperger and Kanner, although both labeled their cases *autistic*, they were focusing on different populations of children, and the conditions they described diverged in several important respects. The authors themselves insisted on the differences between them, until the very end: "Asperger, despite listing numerous similarities, considered his syndrome to be different from Kanner's" (Donvan & Zucker, 2016, p. 241, citing Wing, 1981). Also, Kanner considered that Asperger "independently described what he called autistic psychopathy, which, if at all related to infantile autism, is at best a 42nd cousin" (Silberman,

2015, p. 140, citing Kanner,1970). The spectrum model of autism set by APA in the 1980s represented a decisive defeat for the father of the this diagnosis and we will develop the suject in another paper.

What was implied but never proved:

Kanner appropriated the work of others.

In our opinion, there is no irrefutable evidence that Kanner was aware of Asperger's or Sukhareva's cases or that he appropriated or at least replicated their work in his Clinic, in Baltimore. We believe that Kanner could take the word autistic from Bleuler, as well as he could take it, via Frankl, from Asperger. Maybe he considered that in the worldwide psychiatric community the paternity of the term is so well-known, that in his first article he did not even mention Bleuler. He mentioned Bleuler years after, for introducing the word in psychiatry.

Kanner may have been unaware of Suckareva's and Asperger's preoccupation in children displaying what we now call autistic features, in an epoch in which access to European journals (or lectures) was not solely at a click distance. German-language papers were not very popular in the US, in the war-time, and remained unpopular many years later, as well as the German authors (if they were not jews or suspicions of Nazi collaboration planed upon them) as in Asperger's case (Donvan & Zucker, 2016; Feinstein, 2010; Silberman, 2015). Although, Kanner may have been interested in German publications since he was a native speaker and the language barrier did not exist in his case. More than this, he was aware that psychiatry and psychopathology were born in Europe and the Americans have a lot to learn especially from German written literature in the field. It is our guess that if Kanner read German language psychiatry journals, it happened in US. At the time he was in Europe, he was not a psychiatrist so it is less probable that he was interested in the field (that is reading Suckareva's article).

Silberman's hypothesis that Frankl informed Kanner on his work with Asperger and Kanner took Asperger ideas and integrated into his own model of autism is not ungrounded, but was never fully proved. The same stands true for the allegations that Asperger knew about Sukhareva's cases in Moscow and all he did was to replicate her work in Vienna and stick the label autistic on it.

Some questions still remain, but, without strong evidence, these are merely speculations. Our suspicions do not refer to the 40s, but to the 1970s events: why Kanner never cited Asperger? Even after that night in July 1969, when he stated that "I never discovered autism. It was there before", he maintained the view that somehow Asperger's work was unworthy of serious consideration. Why did Asperger not say more on Kanner's work? Why they never met, why they never wrote to each other? Was the *scientist's pride*, was it that "jewish-german thing"? The only person in the world to answer those questions could have been Georg Frankl. But he decided to remain silent. Like Gottfried in Annie's 1935 article, Frankl's case, Karl, was not described as autistic, although he met all the criteria to be portrayed in this way, due to his "lack of contact with persons in its most extreme form" (Silberman citing Frankl, 1943). Frankl knew from Asperger that *autistic* term would be best suited to describe Karl K. He preferred not to. Why? Maybe because his article appeared in the same year and in the same journal in which Kanner published. And, by doing that, he would somehow contradict his former boss and benefactor's theory?

Silberman (2015) was talking about Kanner's sin of omission. Echoing Silberman, we would rather point on Frankl's sin of omission and conclude with Silberman's words: "And the one clinician in America who knew the real story was not apt to say anything about it in public, because he owed Kanner the ultimate debt: his life" (Silberman, 2015).

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Quality of life for children with autism. Legislation and public policies

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Abstract

The present contribution discusses the legislation referring to persons diagnosed with Autistic Spectrum Disorders (ASD). From international documents (The Charter for Persons with Autism, the Convention on the Rights of Persons with Disabilities), to national legislation (The Law on Autism, The Methodological Norms for Applying the Law on Autism), we show these are still perfectible. We underline although there is a Romanian legislation for people with ASD, this is insufficiently known by parents of children with ASD, thus affecting the chances of children's evolution. Some legislation articles are partially or incomplete respected in our country, and the equality of chances for autistic adult is missing, with no access to specialized services or labor market. Romanian legislation insufficiently regulates and does not establish any clear procedure to ensure access to specialized recovery services (medical, social, educational) for persons with ASD, the screening for early detection of ASD symptoms and periodical evaluations for children are not performed, and more, legislation infringes the right to education and work for people with ASD.

Keywords: autism; legislation; rights, education; discrimination.

1. Introduction

Autism, together with its „alternatives" (ASD, atypical autism, Asperger syndrome), whose definitions may be also found in the Methodological Norms of the Law 151 from July 12 , 2010 (art. 1, parag. a-d)[2], represents a developmental disorder with a causality

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[2]a) "Infantile autism or autistic disorder is a pervasive developmental disorder characterized by permanent impairment of socially-related capacity, through a deviation of communication and restrictive, stereotypical behavioral patterns. Early onset (before the age of 3) by manifesting disturbances or deviations that concern at least three areas of development: 1. Deficiency in initiating and developing social relationships, expression of interest and emotions; 2. Inability to use language and communication; 3. presence of stereotypical behavior, including a restrictive and repetitive behavioral repertoire; b) Autistic Spectrum Disorder (TSA) or atypical autism is a pervasive developmental disorder with the same characteristics as Autistic Disorder, which causes deterioration or deficiency in relationship, communication and behavior, but which does not meet all the necessary criteria for the diagnosis of the autistic disorder or infantile autism. Pervasive

extremely debated, both by media and specialty literature. The last evidences, disseminated (quite insufficiently we consider to Romanian audience) by the Association Autism Europe[3], show that "there is no scientific evidence showing a causal association between autism and vaccination;rates of early gastrointestinal disorders prior to diagnosis are not higher in children with ASD than in thegeneral population; there are no differences in the urinary profiles of children with ASD and a recentgroup control study does not justify the use of casein and gluten exclusion diets" (Barthelemy et al., 2000).

No matter the causes that determine this disorder, the impact on the families is overwhelming. In a recent study, conducted in four European countries, each with a different approach for people with ASD (United Kingdom, France, Poland and Spain), it is pointed out that families of children with autism/ASDare facing "high health expenditure and out of pocket payments for noncovered health services to low employment prospects, poor mental health, anxiety and wellbeing problems". The access to education for these children is fundamental in order to increase their quality of life, autonomy and insertion in society (Roleska et al., 2018, 2).

At the European Parliament meeting from November 6th, 2012 other issues that people with ASD are facing with: less that 10% of people with ASD can get a job compared with 45% of those with a disability and 65.8% of people without a disability; people with ASD are not considered potential members of society, their diagnosis is often inadequate, they do not benefit of proper education and training in order to apply for a job. "They are invisible, without proper support, have no choices, opportunities or future, only to live in segregation" (Morgan et al., 2012).

Developmental Disorder Not Alternately Specified (PDD) is used when there is pervasive and severe deterioration in the development of mutual social interaction or non-verbal or verbal communication skills, or when stereotyped behaviors, interests and activities are present, but the criteria for a pervasive specific development disorder, for schizophrenia, for schizotypal personality disorder, or for an avoidant personality disorder are not met; c) Asperger's syndrome is a pervasive developmental disorder that is characterized by an impairment of social behavior, social interaction, by the existence of restrictive, stereotypical concerns and interests, specific to autism; these people have a good cognitive and language function, with age-specific characteristics, but have a high incapacity for emotional resonance, expressing emotional reciprocity, empathic communication; d) Mental retard refers to the presence of a substantial limitation of neuropsychiatric functions. It is defined by the incomplete development of intelligence, characterized by the lack of cognitive, communication, motor and social skills, process that has emerged during the development period".

[3]Headquartered in Belgium, the association brings together representatives of 80 organizations from 30 European countries, its purpose being to improve the quality of life of children with autism and their families (www.autismeurope.org).

The first European act that acknowledges the distinct nature of autism (when it was thought 1 million EU citizens may be affected by autism, and now estimated to be 3 million)and the necessity for specific measures for people with this diagnosis is *The Charter for Persons with Autism, a*dopted as a Written Declaration by the European Parliament on May 9th, 1996. The Charter stipulates, in its 19 points, the fundamental rights of people with autism, arising from previous documents, such as *The United Nations declaration on the Rights of Mentally Retarded Persons* (1971) and the *Rights of Handicapped Persons* (1975) (Autism-Europe, 1996).

An important step taken at European level from a legislative point of view to support children with autism was *The Convention on the Rights of Persons with Disabilities*, adopted on December 13th 2006 and signed by all EU countries (including Romania). Although the Convention does not explicitly refer to autism, but this is considered a disability among others, its merit is that it requires the signatory countries to respect the right to education for people with disabilities (including autism). The same right is stated by the European Disability Strategy 2010-2020, adopted in 2010 by the European Commission, supporting inclusive education (E.C., 2010).

The Written Declaration on Autism, adopted by the European Parliament in 2015 and co-signed by 418 Members (Bilde et al, 2016)supports the importance of diagnosis and early intervention, and also the importance of a European strategy for autism (unfortunately still missing) (Roleska et al., 2018, 8-9).

At European level there is already a strategy on people with disabilities (European Disability Strategy 2010-2020), carried out when*"one in six people in the European Union (EU) has a disability, making around 80 million who are often prevented from taking part fully in society and the economy because of environmental and attitudinal barriers. For people with disabilities the rate of poverty is 70% higher than the average partly due to limited access to employment. Over a third of people aged over 75 have disabilities that restrict them to some extent, and over 20% are considerably restricted. Furthermore, these numbers are set to rise as the EU's population ages. Access to mainstream education for children with severe disabilities is difficult and sometimes segregated. People with disabilities, in particular children, need to be integrated appropriately into the general education system and provided*

with individual support in the best interest of the child. Lower participation in general education and in the labor market lead to income inequalities and poverty for people with disabilities, as well as to social exclusion and isolation. They need to be able to benefit from social protection systems and poverty reduction programmes, disability-related assistance, public housing programmes and other enabling services, and retirement and benefit programmes"(European Commission, 2010).

The need and importance for a European strategy for ASD has already been stated by the European Parliament on November 6th, 2012, having as a good practice example Wales, with a strategy already adopted in 2006-2007, followed by Northern Ireland: *"Right across the globe we have all these laws, rules and regulations and yet still we are sitting around the tables trying to find the way forward. We don't need any more declarations, what we need is action and we need to have strategies for autism in each country, as well as local and national strategies. This must be directed from a European strategy for autism"* (Pat Matthews) (Morgan et al., 2012).

In this context, on December 2nd the European Commission proposed a *European Accessibility Act*, which will set common accessibility requirements for certain key products and services that will help people with disabilities at the EU level to participate fully in society. In September 2017 the Parliament adopted its final position on the Act before starting negotiations with theCouncil (Autism Europe, 2016).

The European Parliament Written Declaration on Autism (2015), underlines the necessity for a European strategy to *"support accurate detection and diagnosis across Europe; promote evidence-based treatment and support for all ages; foster research and prevalence studies; encourage the exchange of best practices"* (Bilde et al, 2016).

2. Romania's situation

Although it is not explicitly addressed to children with autism, *Decision 1251/2005*on some measures to improve learning, instruction, compensation, recovery and special protection activities for children/pupils/young people with special education requirements within the special and specially integrated education system provides classes/groups of autistic children in the special and specially integrated education system (art. 1, parag. d),

practically admitting the particularity of this disorder and the need for a special approach within the other disabilities.

Children with autism enter, though again, without a clear nomination, under the incidence of *Law 448/2006*on protection and promotion of rights for people with handicap, that, from the beginning, aims to ensure integration and social inclusion for people with handicap(art. 1), arguing among others (art. 3): equality of chances (let. c); equality of treatment for employment (let. d); accountability of community (let. f); adaptation of society for people with handicap (let. h); protection against neglecting and abuse (let. n). Article 7, parag. 2 says that: „*Based on the principle of equalizing opportunities, competent public authorities are required to provide the necessary financial resources and to take specific measures to ensure that people with disabilities have direct and unhindered access to services*", while article 8, parag. 1 says that *„National Authority for People with Handicap and the other central and local public authorities are required to ensure, according the present legislation, the necessary conditions for integration and social inclusion of persons with handicap"*. These two articles are, unfortunately, partially and incomplete respected in our country (Ştefănescu, Oşvat, 2011).

The first Romanian document strictly addressed to people with ASD is *Law 151/2010,*applied from January 1st, 2011, completed by the *Methodological Norms.*The Law is, unfortunately, partial and even discriminatory; as stated in the introduction „its purpose is to regulate special integrated health, education and social services, aiming to early diagnose, treatment, recovery and improving the quality of life and social function for people with ASD and associated mental health disorders, services provided by a specialized multidisciplinary team", completing in cap. II, art. 4, parag. 1, that„early diagnosis is conducted for children between 0-3 years, according to standards established by the methodological norms of the present law", in other words excludes from diagnosis people over the age of 3.

Although Law151/2010 claims that *„health, education and social integrated special services are the following: active early detection, clinical psychiatric diagnosis and clinical psychological evaluation, psycho-pharmacological treatment, early specialized interventions, cognitive behavioral psychotherapy, counseling for parents and family"* (chap. I, art. 2), and

„the multidisciplinary specialized team from mental health centers, as well as other medical services suppliers from public or private health units comprises: specialist doctors in pediatric psychiatry, clinical psychologists, psychotherapists, psycho-pedagogues, speech therapists, kinetotherapists, educators and social worker; continue and monitor treatment is performed by specialist doctors in pediatric psychiatry and/or clinical psychologists and /or psychotherapists in public or private health units" (chap. I, art. 3, parag. 1-2), neither the *Law 151/2010*, nor the *Methodological norms forLaw 151/2010*regulate and establish any procedure to ensure access to services and establishment of this multidisciplinary team.

The methodological norms also include some provisions most parents in Romania could state as utopian, such as art. 3, parag. 1 and 2: *„early detection is achieved through the ASD and associated mental health disorders screening and represents a professional medical service provided by the family medicine doctor (...) early detection is achieved for the entire pediatric population, ranging from 0-3 years, based on a screening questionnaire that will be applied at compulsory periodical evaluations from 12, 15, 18, 24, 36 months by the family doctor of the child".* Although the law practically binds family doctors to perform early detection screening for ASD signs, this is not happening, moreover, most periodical evaluations are made on parents' request. Maybe if parents knew the legislation, they would become also aware of these aspects, essential for their children's future evolution. Very useful for parents, especially for those of children with ASD, would be to know the articles 4 and 5 from Law 151/2010, that explain in detail the entire procedure to follow for diagnosing and then accessingspecial therapeutic services[4].

[4]Art. 4. (1) The infantile autism, ASD or Asperger syndrome diagnosis, as well as other associated mental health disorders diagnosis are established by the specialist doctor, according to European diagnosis criteria. The diagnosis, evaluation and reevaluation are performed in the ambulatory service, in the mental health center, individual medical practices or after hospitalization in a profile section. (2) Psychiatric evaluation and psychiatric diagnosis are made by the doctor specialized in pediatric psychiatry.(3) In order to receive an infantile autism, ASD or Asperger syndrome diagnosis, as well as other associated mental health disorders diagnosisthe following are required:psychiatrically evaluation, psychological evaluation, and, as the case, paraclinical evaluations, on specialist recommendation. (4) The psychiatric assessment is made by the specialist according to the medical standards in force. (5) The psychological evaluation necessarily precedes the medical diagnosis and is performed, upon the recommendation of the specialist physician, by a psychologist certified in clinical psychology, under the conditions of Law no. 213/2004 on exercise on the profession of psychologist with right of free practice, the establishment, organization and functioning of the College of Psychologists in Romania, with subsequent amendments, and the subsequent normative acts thereof.(6) After integrating the information obtained from psychological assessment, paraclinical examinations and interdisciplinary consultations, as the case may be, the specialist physician establishes the psychiatric diagnosis, the psychopharmacological treatment and make recommendations to the professionals providing services complementing the medical act, as the case may be: a) services related to the medical act; b) appropriate educational services for school and professional guidance; c) public social assistance services.(7) The

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After a rigorous analysis of Law 151/2010 and of Application Norms, the Association ANCAAR Iași and the Foundation „Salvation Anchor" (Holland) suggested the Ministry of Health a series of measures to improve the quality of life for children with autism, including at least partial discount of therapies, the answer received being that:*„the economic and financial conditions do not allow the allocated budget to be sufficient to cover the entire cases*

specialist physician informs the family about the diagnosis and the necessary therapeutic procedures for empowerment and / or rehabilitation. (8) At the request of the parents / legal representative, the specialist physician supplements the A5 medical certificate, namely the A5 medical certificate for children with disabilities. (9) The application form for the issue of the medical certificate type A5 is provided in Annex no. 2 which is an integral part of the present methodological norms.(10) The medical certificate form A5 is provided in Annex no. 3 which is an integral part of the present methodological norms.(11) The specialist physician informs the family doctor, by medical letter sent directly or through his / her parents / legal representative, about the diagnosis and the treatments performed and recommended. The specialist physician finalizes the medical act, including the issue of the medical prescription for medications with or without a personal contribution, as the case may be, of the paraclinic ticket, if the conclusions of the medical examination require. (12) The medical letter is a standardized document, which will be drawn up in two copies, one of which will remain at the specialized doctor, and one copy will be sent to the family doctor directly or through the parents / legal representative. The medical letter contains the number of the contract concluded with the health insurance house for the provision of medical services and is used only by the doctors performing the activity under this contract. (13) The model of the medical letter is laid down in the implementing provisions of the framework contract on the conditions for the provision of healthcare under the social health insurance scheme. (14) Access to specialized interventions is based on the recommendation of the medical specialist who made the diagnosis.(15) Family doctors highlight patients with the diagnosis of infantile autism, autistic spectrum disorder and Asperger syndrome and the diagnosis of other associated mental health disorders. Art. 5. (1The therapeutic intervention plan will be developed and supervised by the accredited professional in specific behavioral therapy techniques for persons with autistic spectrum disorder. (2) The specific behavioral intervention plan has specific intervention objectives and is achieved by: a) activities under each specific objective, focusing on social skills, language, attention and compliance; b) modeling, reinforcement and generalization methods used in the implementation of activities, which should support learning as much as possible. (3) The objectives of the specific behavioral therapeutic intervention plan provided in paragraph (1) should aim to: a) develop attentive, imitation and game skills; b) development of functional communication skills; these include language and communication alternatives, such as the image system, gestures and signs; c) learning social skills in an appropriate environment; d) learning daily life skills, such as using the toilet, washing, eating; e) management of sensory difficulties; f) Generalization of learning strategies to new situations and new people; g) management of undesirable behaviors; h) recognition and expression of emotions.(4) The specific interventions are: a) Behavioral interventions - the application of the principles of learning and the development of skills, efficacy techniques in scientifically proven TSAs validated by the international community; b) interventions to develop social and emotional abilities; c) sensory and motor development interventions; d) Developing parental and family competencies to support the child in developing skills. (5) Specialized interventions can be performed individually and / or in groups according to the needs of the person with TSA. The certified psychologist in behavioral techniques specific to children with TSA will determine how to perform the intervention. (6) The interventions are provided by professionals proving training and accreditation in their application, according to the standards developed by the College of Psychologists in Romania. (7) The specialized interventions have the following characteristics: a) they are carried out by professionals accredited in collaboration with the family and by the direct involvement of the family. Through support and information, the family will participate in the development of the child's social skills and the management of repetitive and difficult behaviors; b) are based on a behavioral functional analysis that includes the identification of the behaviors and skills to be taught to the person diagnosed with TSA and associated mental health disorders; c) are based on integrating and correlating behavioral analysis with social and educational services according to the specific needs of the person with TSA and related mental health disorders; d) include mandatory assessment of cognitive, social and emotional functioning before, during and after the intervention; the systematic evaluation is performed at 6 months and includes results of individual assessments (pediatric psychiatrist, clinical psychologist and other specialists as appropriate), and progress / regression is quantified using internationally validated scales, validated on Romanian population. (9) The specialized interventions will be carried out: a) in public or private accredited social services, in accordance with the legal provisions in force; b) in the child's educational environment, such as: nursery, kindergarten, school; c) at the child's home or in its development environment, including through mobile teams; d) by training the family members who are an integral part of the intervention.

of children with ASD, aged between 2 and 18; the association of this disorder to other diseases, the persistency of some symptoms along the entire life, the severe implications over the entire family, will make the extent, duration and costs for treatment to be very high; clinical experience has proved that human and material efforts are rewarded only if the educational program specific for ASD is initiated between the age of 1 and 5; the initiation of the program after the age of 6 might bring improving for a smaller number of children" (apud Gherca, 2011).

In a presentation approaching the autistic people legislation in Romania, at a conference held in Focşani in 2011, the president of ANCAAR Iaşi, Carmen Gherca criticized *Law 151/2010* and the *Norms*, pointing out that these do not ensure the required framework to respect the rights of people with autism, established by the *The Charter for Persons with Autism (1996)*, arguing that the law establishes only early detection and intervention services, excluding people with ASD aged over 6, violating these persons rights for education and work. On the same occasion, Carmen Gherca highlighted the contrasting reality with the provisions of the Romanian legislation, starting with the Romanian Constitution. Lack of specialized training for teachers in mass schools makes the access of children with ASD to integrated education extremely restricted, sometimes non existing, and the equality of chances for an autistic adult is missing, because this diagnosis disappears after the age of 18, thus the access to specialized services and to labor market not being ensured (Gherca, 2011).

Law 151/2010 occurs in the context in which, during August 2009, INSOMAR made a survey onthe *„Discrimination phenomenon in Romania – perceptions and attitudes"*; the survey was conducted on a sample of 1201 people, in 44 towns and 52 villages, with an error of 2,9%, at a trust level of 95%. The survey showed that over 65% of the population does not feel owed to help people with disabilities; 44% of the respondents feel mercy / compassion for people with disabilities, 11% illness and 7% burdens / sufferance. Only2% of those questioned associated the idea of normality with this category of people. 79.9% would not marry (or any relative) someone with a mental illness, 57% do not want to be friend withsomeone with a mental disability, 44.2% does not want a neighbor with a mental disability and 46,9% do not want such a work colleague. Besides Roma people, sexual

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minorities and people with HIV/AIDS, people with disabilities are the most discriminated persons in Romania (INSOMAR, 2009).

On June 27th, 2013 appears the *Law200* that modifies and completes the Law 151/2010 on specialized integrated health, education and social servicesfor people with ASD and associated mental disorders. The most important changes brought the Law 200/2013 would be the elimination of the 0-3 year period for which the Law 151 applied, the present law addressing to "children with ASD and associated mental disorders", without other limitations(art. 2). The second paragraph of the 4th article is modified, thus becoming: (2*) „All persons diagnosed with ASD and associated mental disorders have free access to specialized integrated health, educational and social services mentioned by article 2. Access to education includes the right to education".* Although this isan important step forward, neither this law clarifies all problems, nor offers practical solutions to implement the measures.

In 2013 The Directorate General For Internal Policies, Policy Department C: Citizens' Rights And Constitutional Affairs realized a comparative study in 18 European states (including Romania), concerning Member States' Policies for Children with Disabilities, examined in relation to the obligations arising from the United Nations Conventions on the Rights of the Child and on the Rights of Persons with Disabilities. The research identified a broad recognition of the rights of children with disabilities under national legal systems either through general or specific legislation. However, their practical implementation revealed to be problematic in most Member States resulting in obstacles faced by children with disabilities in their day to day life.

The analysis showed that in Romania, from the point of view of legislation and procedures, the best interests of the child with disabilities are a priority, with social protection measures in the family and criminal proceedings, decisions concerning social protection and education of the child. InRomania there is the National Council for the Fight against Discrimination, which manages effective complaint mechanismsto deal with discriminatory acts. The lack of funds affects accessibility to information and communication technologies requires improvements in order to enable children with disabilities to fully participate in society. With regard to the general recognition of the right

to be heard or express views in all decisions affecting them (the first criterion), Romania has fully and effectively implemented the right of children to be heard. The general right to assistance for children with disabilities is fully and effectively implemented throughout the Romanian Constitution.

In Romania, persons with disabilities living in rural areas have difficulties in accessing social protection services as offices of the competent authorities are mostly located in urban areas. According to the study, Romania is also confronted with a lack of specialized medico-social personnel;for diagnosis of this disorder detailed methodology has not been elaborated.

As for the access of children in Romania to inclusive education, although much debated and promoted in Europe, it is extremely limited. The study revealed that in Romania two thirds of all children with disabilities follow special education programs. The curricula for children with disabilities have not been changed for the past 20 years, while the methodology used by teachers is more than 10 years old. It is surprising that the main source of information in this respect is collected from media (TVR, 2012).

The integration of these children in mass education, although stipulated by law, is not practically achieved, studies revealing for Romania cases of denial of registration, expulsion or pressure put on parents to enroll the child in special education facilities (Ballesteros, Jurkiewicz, Meurens, 2013).

Romania has made important steps to improve the quality of life for children with autism, involving in the program *Autism Spectrum Disorders in Europe* (ASDEU) (2015-2018), aiming to investigate autism prevalence, costs, diagnosis and interventions throughout Europe. The program included 14 countries, the institution that participated from Romania being the Victor Babeș National Institute of Pathology. The investigation undertaken within the program showed that ASD prevalence estimates varies from 4.4 - 19.7 (percentiles 10 and 90) per 1,000 aged 7-9 years; direct costs range from €797 in Romania to €11,189 in Denmark per individual for six months; although most European countries adhered to the European Parliament's Written Declaration on Autism, the promotion and respect to autistic people`s rights by EU Member States is not satisfactory or

evenly spread, with only a few countries (Romania is not among them) having adopted autism plans, strategies and legislation(Manuel Posada de la Paz, 2018).

On October 4th, 2016, it was given the Order 1985,to approve the methodology for evaluation and integrated intervention for granting children a grade disability, school and professional orientation of children with specific educational requirements, as well as for habilitation and rehabilitation of children with disabilities and / or special education requirements. Although autism is not individualized by the Order, its provisions also apply for autistic children. In Chap. I, Art. 2, parag. 3 it is stated that „*the present order promotes the expression "children with disabilities" for a unified approach, but, in direct relationship with children, use of positive terms is suggested, such as "children with different abilities", and, according to CIF-CT, children have the right to be named as they or their parents/legal representatives want".*The document reaffirms the right of children with disabilities to follow mass education (art. 18, lit. b), suggesting support measures[5]*„for preventing and fighting against attitude barriers and environment barriers"* (art. 39, parag. 3)(Order 1985/2016)

Our study reveals several important ideas for the situation of people, and especially children with ASD in Romania: although Romania has adhered to all European documents, and Romanian legislation is one of the most elaborated in this respect, unfortunately there are not enough methodologies to practically apply all these provisions; the effective implementation of legislative provisions is only partially implemented; autistic children are still victims of discriminations; the lack of specialized personnel is strongly felt.

[5]"Support measures for preventing and combating attitudes barriers include at least: a) informing parents whose children attend the educational establishment on inclusive education and social inclusion of children with disabilities and / or ESCs; b) inform pupils in the education unit about inclusive education and social inclusion of children with disabilities and / or ESCs, in an age-appropriate language and preferably using peer education; c) informing the management of the educational unit and the teaching staff about inclusive education and social inclusion of children with disabilities and / or ESCs; d) the presence of the facilitator, named "shadow", along with the child in the educational establishment. (3) Other measures to support the prevention and combating of attitudes barriers are awareness raising campaigns and awareness campaigns on the acceptance of diversity, social inclusion of children with disabilities and / or community-based ESCs"(art. 63, parag. 2-3).

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An ecological approach of Autism Spectrum Disorders

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Abstract

Autism Spectrum Disorder (ASD) is one of the most researched topics in the last decades. The research led to a better understanding of the field and raised the number of children properly diagnosed. But also, the ASD became a social topic because it affects both families and society as a whole. In this paper, we propose an innovative ecological approach of ASD, based on a holistic approach of it. We recognize the fact that sectorial approaches, such as intervention in school, or family therapy are not sufficient to overcome the ASD. Instead, we propose an ecological model, in which the assessment and interventions are made at individual, family, school and societal level in order to structure a support network for the child and family.

Keywords: ASD; ecological approach.

1. Introduction

Autism is a pervasive disorder. The pervasiveness of it means that every aspect of the child's life is shaped by specific patterns of thinking and behaviors. Until we fully understand them, it is difficult to assess them in qualitative terms, but they are clearly inappropriate or inefficient in social life. The pervasiveness of ASD is affecting not only the child but also the family and all its social networks (Karst & van Hecke, 2012). Most of the families report a high level of stress and burnout raising a child with ASD (Hayes & Watson, 2013; Vogan et al., 2014), due to the continuous struggle to respond both to children and to social demands (Karst & van Hecke, 2012).

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In this context, it is useful to embed any theoretical approach and practical intervention in an ecological context. Using a theoretical circumplex model (Olson, 2011; Posner, Russel & Peterson, 2005), that has the child in the center; we could define different systems surrounding the children with ASD, from the closest to the more general and comprehensive system. Similarly, any intervention could be assessed according to its depth and focus or to the systems involved. The individual-focused approaches, those based on individual therapies, are ineffective in solving family issues. The more social based interventions, such as state policies, respond to some extent to socialissues, but fail to offer a clear framework for intervention.

In this paper, we will present a theoretical ecological model, based on a systemic approach ofthe ecological development. Then, we propose a five modules intervention that fit this model. The possible benefits and limitations will also be discussed.

2. The ecological model of ASD

The ecological perspective of ASD relies on contextualizing autism in the social environment of the child. We are developing this model of explaining ASD inspired by the von Bronfenbrenner's bioecological model of human development (Fig. 1). We will use the photograph metaphor in order to explain it. If we are looking at the social life from the perspective of the child, we will see a photograph of society that is limited to specific perspectives. This is the social niche of the child. Like in any image, the closer the object, the bigger they are, and more important from our perspective.

First of all, we have to take into consideration the child self, needs, traits and life experiences. Those are the main areas that are affected by ASD. This is the *internal system*, and it is the focus of clinical and psychological perspective of ASD. Most of the assessments are made on specific child's cognitive and social development, and on specific behavioral patterns. Logically, from this perspective, the intervention is made at individual level, attempting to change the child and to facilitate his/her adjustment to external environment.

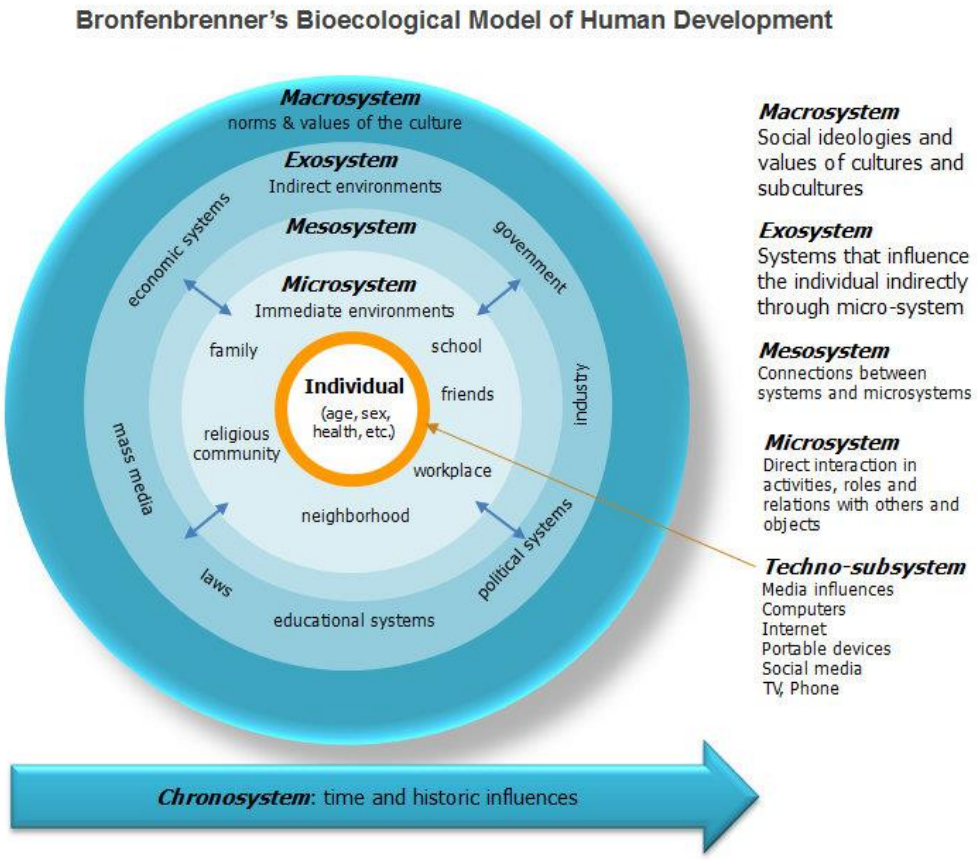

Figure 1: Bioecological Model of Human Development (Bronfenbrenner, 1979)

The closest objects are the family members that are a constant presence in a child's life. The family are part of the *microsystem,* the immediate environment. The parents are important, not just because they meet the most basic demands of the child, but also because they provide the basic structure of a child's social life. They are the mediators between the child and the larger world. ASD has a powerful impact on family life and dynamic (Hayes & Watson, 2013). The existence of a child with ASD is forcing families to change in order to include the child's challenging behaviors (Bekhet, Johnson, & Zauszniewski, 2012). The intervention at this level is mainly family therapy and counseling, parent training and education, aiming to teach and counsel parents to respond properly to child's needs (Preece & Trajkovski, 2017; Spain et al., 2015).

At a middle distance, the child perceives all the support networks of its family. That includes school, therapists, parents' employers/jobs, networks of friends and community.

These dimensions are also parts of the *microsystem*. At this level, including others, are the professionals that are trying to help the child and family. This level is the major support group for the family. Employers are providing financial support; the school is providing educational support, the friends are providing emotional, practical and material supports, and so on. As the main supporting level, we should think about strengthening the social support networks of the child, but it requires a proper coordination.

The *mesosystem* consists of all the inter-relationships and influences between *microsystem* and *exosystem* dimensions.

The *exosystem, as an* indirect environment, is usually overlooked by the therapists. In child's perspective, this is the background, it is not very clear and outstanding, but it gives colors and makes all image to make sense for our eyes. This exosystem consists on society as a whole and its institution: government, political, economic and educational systems, laws, mass-media and industry. The services and education for the child is regulated by specific policies, the society defines the rights and facilities that are available for the child. Its influence is not so easily to assess, but the effects are great and could be seen in comparative studies across countries.

Every photo is a cut from a larger picture. Even if the photo has a meaning in itself, it is still heavily embedded in a larger picture. This is the *macrosystem,* which consists of norms and values of the culture and sub-cultures. In social life it includes beliefs, social attitudes, cultural traits and a general understanding of the subject. In the case of autism, the layman theories of it, as a disease, favors clinical approaches of it from a medical perspective. Our discourse about ASD is full of medical terms like diagnosis, therapy, symptoms, et al. On the other hand, that leads to the idea that the children with ASD are sick and needs to be treated and made sane again.

All photos are contextual, environmental cut from a larger picture. The perspective is important, as well as the technique and materials. The last decades witness numerous attempts to depict ASD from multiple perspectives, to take into consideration different voices of those who are taking pictures. Our technique is constantly improving, and we have more data to design intervention programs. Our therapeutically approaches and programs

are diversifying. We must notice there is a need to build socially agreed perspectives and not just mere individual knowledge.

3. The Spinner Model

One of the gadgets that took the world by storm is the fidget spinner. Even if it is a simple toy, it was marketed as a tool for solving fidgeting problem and as a useful instrument for children with autism, due to their fascination for spinning objects and electronic devices (Zubac, I. et al., 2018). We choose to use the spinner as a model for our proposed intervention (Lustrea et al., 2017) (Fig. 2).

The core of the spinner is a simple ball bearing. In our model, this represents the child, which must be the focus of any intervention in ASD. Around the bearing there are lobes (in our case five) in perfect equilibrium. The lobes are spinning around the bearing in continuous movement, constructing an image of a solid object. If one of the lobes is missing, the whole geometry of the spinner is changing. If the lobes are not symmetrical, they do not work together perfectly, and the movement is faulty.

Figure 2: The SPIN Model

In our spin model, each lobe represents a different challenge for the professionals and responds to a specific ecological need.

The first lobe represents *assessment*. In our current social approach, the services and supports are available on demands and are based on the assessment of needs. This approach is both socially responsible and meets the criteria of efficient resource allocation. From a clinical point of view, assessment means the diagnosis of the condition (e.g. has or not ASD) and the description of the psychological profile of the children (Yates & Le Couteur, 2016). However, the assessment is more than that, is a complex evaluation, psychological and social, as well as educational assessment (Ikeda, Hinckson, & Krägeloh, 2014). The individual assessment offers the basis for a scientific sound intervention (Anagnostou et al., 2014). The assessment must provide a description of the needs for specific services and a prognosis of the intervention outcomes, as well as. The family assessment helps to identify family needs of support, level of adjustment and functioning. School assessment is also useful, especially when inclusion of children is desired.

The second lobe illustrates the *intervention*. As in the case of the assessment, the intervention crosses ecological levels. Most important interventions were designed for individual treatment of the children. Most of them involve families as well as actions in extensive daily activities. Some interventions are more focused on the interaction between therapist and children. Several interventions are designed for school or educational settings. Most of the interventions are rooted in a scientific approach, are data-driven (based on regular assessment), and based on a managerial approach of the problem-solving situation (case management, SMART objectives, structured planning) (Wood, McLeod, Klebanoff, & Brookman-Frazee, 2015).

The third lobe is *education.* One inclusive principle is that every child with disabilities should have the most regular life experience, including socializing experiences with peers, learning in educational setting as well as in other relevant social environment, acquiring competencies for life and for self-development (Lynch & Irvine, 2009). Education is a must-have experience for children with ASD. Anyway, we have to accept that this experience could be a traumatic one if the school is not truly prepared to meet children's needs in a consistent and coherent manner. The school should develop expertise in educating children

with ASD (Zappaterra, 2014; Lindsay, Proulx, Scott, & Thomson, 2014). If we consider curricula as structured educational experiences, then education of children with ASD should be structured in a manner that provides both learning experience and therapeutic activities. As social learning represents an important learning mechanism, it is vital and desirable that the child's whole surrounding environment to be rich in learning experiences and opportunities (Kasari, Locke, Gulsrud, & Rotheram-Fuller, 2011).

The fourth lobe represents *counseling.* It is obvious that the entire family has to make a lot of adjustments when it includes a child with ASD. Most of the parents feel helpless and overwhelmed when they first find the diagnosis, and along usual the steps of dealing with loss: denial, anger, bargaining, depression, acceptance (Kubler-Ross & Kessler, 2005). The entire family requirescounseling and support group to cope with the stress of having a child with ASD (Fiske, Pepa, & Harris, 2014).

The fifth lobe is *advocacy*. ASD is a disability that has a powerful effect of children's life. Major social adjustments are needed to facilitate the inclusion of children with ASD in social life. Advocacy is the main tool to promote the children's rights, to facilitate school and social inclusion and to guarantee access to services. Advocacy is build up by, support networks, NGOs, parents alliances, teachers and direct beneficiaries associations ("Advocacy | Autism Speaks," n.d.).

4. How the model works

A model becomes useful if it provides a better understanding of the reality and if it has a practical utility. Our model has two dimensions. One is the number and type of environments. On these dimensions, we could talk about interventions that are focusing at a single level (individual, micro-level, mezzo level, exo-level or macro-level). The second dimension is the type of intervention (lobes from the spinner model), namely assessment, therapy, counseling, education, and advocacy.

Using the two dimensions' model, we could describe any action in terms of action and level of the action. Also, when we design an intervention, we could use the model to select the most appropriate target. Using the two dimensions' model, we could draw a chart, describing a typology of interventions (Fig. 3).

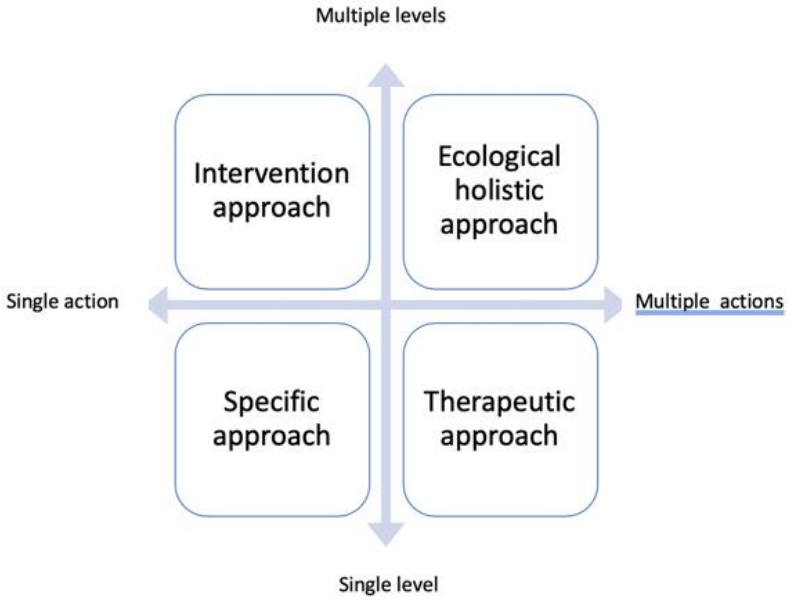

Figure 3. The typology of interventions

According to the two dimensions model, we assign any intervention in one of the four categories. The first type of interventions is based on a specific approach. This type of interventions is locked at a single level and comprises only one type of action. For example, counseling of parents, or a communication therapy for the child with ASD, are specific interventions.

The second type is what we called an intervention approach. This type of intervention is broader regarding the reached level but are still focusing on a single action. Advocacy measures that are targeting families, schools and public institutions are an example of this type of intervention.

The third model is a traditional therapeutic approach. It consists on different coordinated actions, concentrated at a single level. Case-based management is an example of this kind of approach.

Finally, a holistic ecological approach aims to coordinate multiple actions that are reaching different levels from the child's environment. Such measures are more difficult to implement, but they are by far more relevant in terms of results and impact.

All types of interventions have their logic and usefulness according to a specific context. Regarding effects, the more comprehensive is the approach, the better are the chances to have a sustainable impact and change. On the other hand, the more focused the intervention, the better are the chances to solve specific problems. In other words, the selection of a specific type of intervention is a function of the context and the purpose.

A more comprehensive representation of the model is to have represented different levels of interventions and a cylinder of actions (Fig. 4).

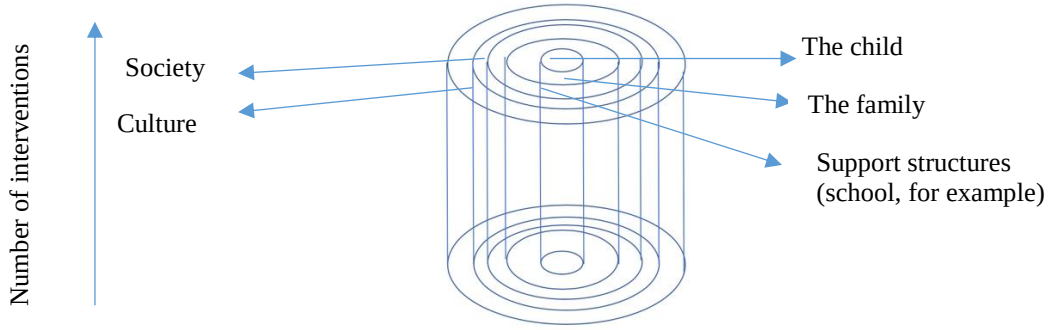

Figure 4. The circumplex model of intervention

The core of the model, and the reason of intervention is the child with ASD. Developing intervention strictly focused on child's needs could be effective but is incomplete. Developing more inclusive approaches should always involve the central core of the model. In other words, any family intervention should also involve the children, and any school-based intervention should also involve the family and its child.

5. Advantages and limits of the model

We intended to provide an easy model of ASD intervention. What makes a good model is a debatable issue because the opinions differgreatly from one discipline to another. However, there are some general agreed characteristics of any good model.

The model should have a target and should be a schematic representation of it. Our target is intervention in ASD. The model is developedin two dimensions: the level of intervention and the specific actions. Our model illustrates the complexity of ASD intervention in an ecological context. That should be useful in redesigning specific interventions in a more comprehensive approach. As a re-presentation, the model only

offers the general traits of interventions and leave some other characteristics outside the model. We must keep in mind that a model is not a complete description, not a magic formula. It must offer space for accommodation, individualization and improvement. For example, our model does not take into consideration the agents of intervention.

The model should allow developing new hypothesis about how the target works. A model is useful if it allows us to test the hypothesis and make predictions. In our case, the model allows us to predict that a change at school level is still hindered by cultural norms and values about disability (in general) and ASD (in particular). Another blockage in developing effective school intervention is the social roles ascribed to schools. The model also permits us to predict that school-level interventions are more effective if they would involve a family approach rather than a child-focused approach.

A model should differ from the target and should to be easier to understand. The main reason of developing theoretical models is to reduce the complexity of the reality to an easier to handle the current situation. In other words, the model is not an *exact* representation of reality. The tension between the need of a model to accurately mirror the reality and, in the same time, the attempt to make it easier to understand by adjusting and explaining it, is not easy to solve. A model too complex would be ineffective, and a model to simplistic would be useless.

Our model is concerned with organizing efficient interventions that are well embedded in the ecological niche of the children with ASD. There are several key-issues that are not solved by our model.

As we said earlier, the issue of the agents of the intervention has not been addressed in our model. The agent could be a professional, a parent, a teacher, a social worker and so on. Another limitation of our model is the temporal dimension of intervention and its interaction with our model. Usually, the more focused interventions are short term. In order to produce social change, there is a need for multiple long-terms interventions.

The resources involved is another issue of the intervention that was not taken yet into consideration in this model.

Conclusions

The main motivation for designing a model of ASD intervention resides in our need to develop better interventions for children with ASD. Most of our previous interventions were focused either on the child, on family counseling or on educational inclusion. In each of the interventions, we experience the urge to enlarge the support networks for intervention, for more sustainability and impact of our therapeutic actions.

The ecological approach of intervention in early education is not a new one. The role of all environments and the interaction between those environments are well documented. But, when it came to ASD, most of the approaches fall into a medical paradigm that decontextualizes the child, turning him into a "patient". We felt the need to contextualize the intervention. Also, clinical terms are usually conceptualizedin medical manner, with a direct link between the subject and the method. For example, assessment is usually reduced to child assessment and, sometimes, to child functioning in family or school setting. Butassessment of school readiness for teaching ASD children or the assessment of the job facilities for children with ASD are not so common.

An ideal intervention consists isdiverse actions along multiple environments. Like any such ideal version of intervention, it is not the most feasible and it requires a lot of human, material, and time resources. Anyway, this personalized and contextualized approach is the most honest, complete and efficient for all issues regarding human mental health. And, for sure, it is a desirable one for the ASD, a condition that is not fading, but is a pervasive, stable condition, another small but still perplexing sample of human diversity.

Authorship statement

The authors of this paper take public responsibility for the content and have had equal contribution in concept development, design, analysis, writing, or revision of the manuscript.

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ASD in school: from theory and research to educational practice

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Abstract

As a result of increase of the Autism Spectrum Disorder (ASD) prevalence, teachers are experiencing real difficulties such as, the curriculum, social, emotional, and behavioural development of these students. The main purpose of this paper is to analyse how the effectiveness and quality of educational and therapeutic practice in ASD are influenced by research in the field, by identifying those interventions and effective, scientifically validated treatments for students with ASD. Initially, we will present the current conceptualization of ASD, the review of scientific literature, analysis of research studies, identification and analysis of practices. We want to find out what is the link between educational practices and studies that provide empirical support for those practices. A range of effective scientifically validated interventions and treatments for children with ASD, evidence-based practices (EBPs), school-based instructional interventions research, research-based principles and practices are presented.

Keywords: Autism Spectrum Disorder (ASD); educational practices; research; evidence.

1. Introduction

The of Autism Spectrum Disorder (ASD) belongs to category of neurodevelopmental disorder, characterized by ”persistent impairment in reciprocal social communication and social interaction (challenges in social reciprocity, nonverbal social behaviours, and establishment of social relationships), and restricted, repetitive patterns of behaviour, interests, or activities (stereotypic behaviour or speech, excessive adherence to routines, and highly fixated interests)from early childhood and limit or impair everyday functioning” (*Diagnostic and Statistical Manual of Mental Disorders* (DSM), 2013; C. Wong& al, 2014). Besides these particularities, in the DSM-5 (2013), ”co-occurring conditions, such as intellectual disability or attention deficit hyperactive disorder, may also be diagnosed when a diagnosis of ASD is made.”

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For this reason, the school integration of children with ASD is probably the greatest challenge for educational systems over seven decades. It has been tried to find a solution that responds to the needs of educational partners: school, family, child itself, but also community. According with Tutunaru (2018), "integrated education is a component of the development of a community that aims to attract the participation of and to actively involve, through combined efforts, schools, families of children with special education needs, and members of their community." In this perspective, "in order to participate as part of the school community, students with Autism need to develop appropriate social behaviours." (Little, 2017, p. 34)

Besides that, according with DSM-5 (2013),"in recent years, reported frequencies for autism spectrum disorder across U.S. and non- U.S. countries have approached 1% of the population, with similar estimates in child and adult samples." As a result of this high increase of ASD prevalence, teachers face real difficulties in implementing curricula and promotingsocial, emotional and behavioural development of this children because of the student's social deficits. (Cavanaugh, C. M., 2012; Boutot, Eman& Farrell, 2010; Parson's & Lewis, 2009)"The prevalence of ASD has increased over the past two decades, rising from 2 per 10,000 in 1990 to between 1 in 50 and 1 in 88 children" (Blumberg, et al., 2013; Centres for Disease Control and Prevention, 2012) (C. Wong & al, 2014). Current estimates that 1 in 68 children are diagnosed with Autism Spectrum Disorder (ASDs) (according to Centres for Disease Control and Prevention, 2015)

For this reason, the subject of school inclusion of students with ASD has been developed theoretically, researched and then implemented in evidence-based educational practices, enhancing the efficiency of educational and therapeutic services.

Educational and therapeutic intervention in ASD has overcome the stage of unidirectional, patterned, no contextualized interventional practices, and it is currently discussed the intervention science applied in comprehensive treatment models. (C. Wong& al, 2014)

2. Comprehensive Treatment Models (CTMs)

CTMs involve a set of "practices organised around a conceptual framework"and they are defined as "a set of practices designed to achieve a broad learning or developmental impact on the core deficits of ASD" (National Research Council, 2001, http://www.researchautism.net/glossary/1528/comprehensive-treatment models)

CTMs have a long history as sources for intervention, therapeutic, and educational services. (Odom, Boyd, Hall, Hume, 2014)

In the last decades, there have been many concerns to find practices leading to the expected results of ASD learning, which have materialized in comprehensive treatment models (CTMs).

"The National Academy of Educational Interventions for Children with Autism, through education programs for children with ASD, identified 10 CTMs."(National Research Council, 2001)

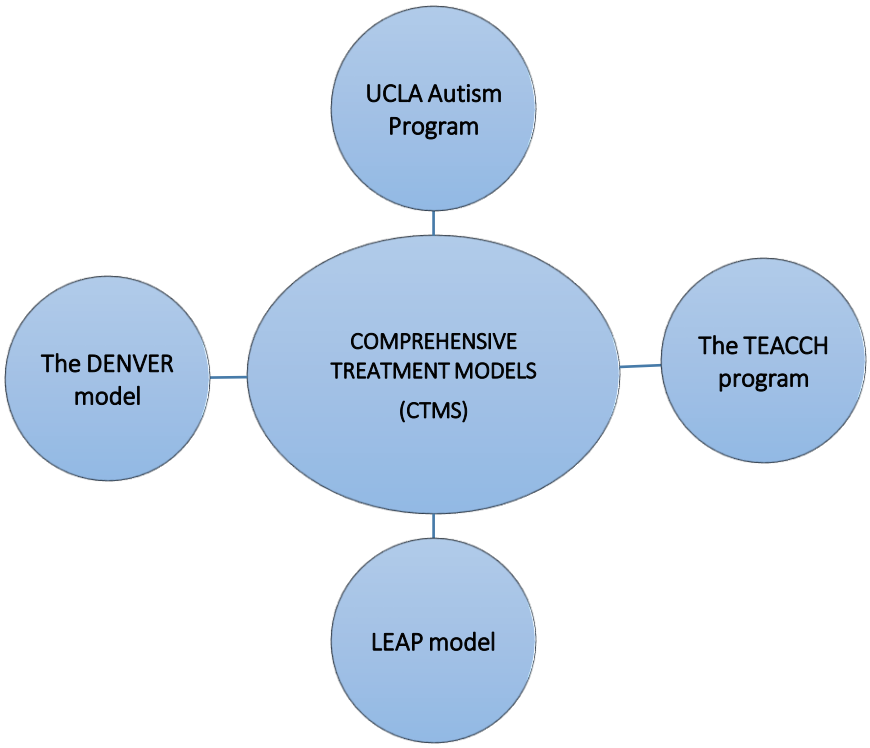

Figure 1. *Comprehensive Treatment Models (CTMs), The National Academy of Educational Interventions for Children with Autism (National Research Council, 2001)*

The Figure 1 includedfour examples from this ten CTMs: "the UCLA Autism Program by Lovaas and colleagues (Smith, Groen, & Winn, 2000), the TEACCH program developed by Schopler and colleagues (Marcus, Schopler, & Lord, 2000), LEAP model (Strain & Hoyson, 2000) and the Denver model conceived by Rogers and colleagues (Rogers, Hall, Osaki, Reaven and Herbison, 2000)". (C. Wong & al, 2014, p. 3)

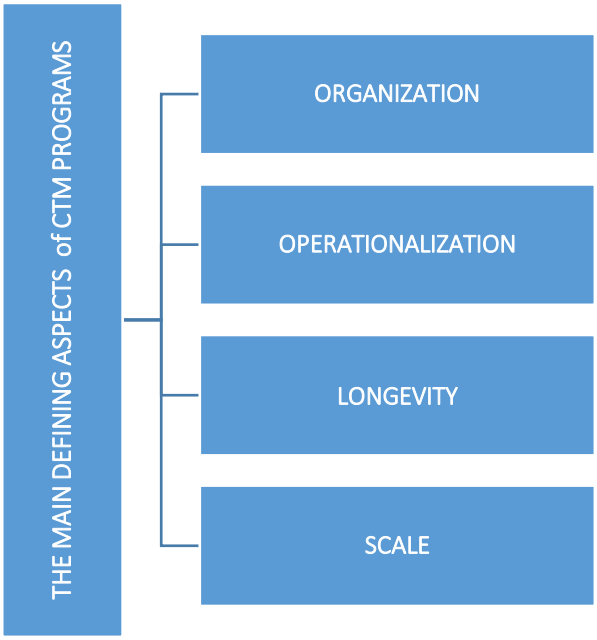

Figure 2. *The main defining aspects of CTM programs*

The main defining aspects of these programs are presented in Figure 2: "organization (around a conceptual framework), operationalization (a substantial number of hours per week), longevity (occurring over one or more years) and scale (multiple outcomes such as communication, behaviour, targeted social competence)" (Odom, Boyd, Hall, & Hume, 2014, p. 3).

Original designs evolved and new CTMs were developed based on different theoretical and conceptual frameworks.

Although there is still a particular focus on operationalization, greater awareness of the need for accurate measurement of fidelity and implementation has emerged.

Following an analysis realised by the National Academy, Odom et al. (2010) identified 30 CTM programs operating in the US. Replications or uses of the CTMs could increase in the future by more accurately measuring implementation and lessons learned from the wider science of implementation. Accompanying such increases is the continuing need to examine the effectiveness of the CTM by the supplier and assess the scalable implementation of CTMs by researchers other than suppliers. Such evidence will strengthen the argument for adoption of CTM through programs to be used in day-to-day practice, although adoption will also be influenced by community and socio-political contexts. (Odom et al., 2014)

Odom et al. (2010) appreciate that ”more than half of the 30 models revised had no evidence of efficacy published in a peerreviewed journal.”

Rogers &Vismara (2008)”finding limited evidence of efficacy for all but the Lovaas model, with some limited support for Pivotal Response Treatment (PRT)”

3. Review of evidence – based practice in ASD

Webster, A; Cumming, J.; Rowland, S. (2017, p. 29) quoting Simpson (2005) says that ”evidence-based practice involves using those interventions, treatments, or strategies that have been shown through scientifically-based research to lead consistently to specific outcomes for students with ASD”

Founded in the 1960s in England, EBP for students with ASD has its origin in evidence-based medical sciences. Later, this conceptual approach to evidence-based practices has also developed in the social sciences of the conceptual approach based on evidence in social sciences.

Since the 1990s, clear criteria have been established in the US to classify an intervention practice as effective or "possibly effective," depending on the precedent for quantification of the quantity and type of evidence needed to establish evidence-based practices (Chambless & Hollon, 1998). The distinction between efficacy and efficacious psychological treatmenthas been achieved.

In this section, we will focus on how reviewing ASD research can make an objective picture of the importance of evidence in choosing intervention practices.

In order to this objective, we will present the complex analysis realised by Wong et al. in The paper titled *Evidence-Based Practices for Young, Young and Young Adults with Spectrum Autism* (2014).

*Table 1. Working Definitions for EBPs(*Connie Wong, Samuel L. Odom, 2014)

Evidence-Based Practice	Definition	Empirical Support	
		Group (n)	Single Case (n)
Antecedent-based intervention (ABI)	Arrangement of events or circumstances that precede the occurrence of an interfering behavior and designed to lead to the reduction of the behavior.	0	32
Cognitive behavioral intervention (CBI)	Instruction on management or control of cognitive processes that lead to changes in overt behavior.	3	1
Differential reinforcement of Alternative, Incompatible, or Other Behavior (DRA/I/O)	Provision of positive/desirable consequences for behaviors or their absence that reduce the occurrence of an undesirable behavior. Reinforcement provided: a) when the learner is engaging in a specific desired behavior other than the inappropriate behavior (DRA), b) when the learner is engaging in a behavior that is physically impossible to do while exhibiting the inappropriate behavior (DRI), or c) when the learner is not engaging in the interfering	0	26

http://cidd.unc.edu/Registry/Research/Docs/31.pdf

Inclusion criteria for "studies in the review articles were published in peer-reviewed, English language journals between 1990 and 2011 and tested the efficacy of focused intervention practices; using a conceptual framework followed by the Cochrane Collaborative - Participants, Interventions, Comparison, Outcomes, Study Design (PICO)" (see the table below) (Wong et al., 2014, p. 9). The Table 2 content the type of diagnostic and intervention used in this research.

Table 2. Inclusion Criteria for Studies (Connie Wong, Samuel L. Odom, 2014)

Population/ Participants	Individuals with ASD between birth and 22 years of age
Interventions:	Behavioral, developmental, or educational in nature and could be implemented in typical educational intervention settings (school, home, community)
Comparison	Interventions compared to no intervention or alternate intervention conditions
Outcomes	Behavioral, developmental, or academic outcomes
Study Design	Experimental group design, quasi-experimental group design, or single-case design

http://cidd.unc.edu/Registry/Research/Docs/31.pdf

As regarding of the scanning of specialized articles and the underlying criteria are concerned, Table. 3 illustrates the keywords used to search in electronic databases.

Table 3. Search Terms (Connie Wong, Samuel L. Odom, 2014)

Category	Qualifying Terms
Diagnostic	**autism** OR **Asperger** OR **pervasive developmental disorder**
	AND
Intervention	**intervention** OR **treatment** OR **practice** OR **strategy** OR **therapy** OR **program** OR **procedure**

(http://cidd.unc.edu/Registry/Research/Docs/31.pdf)

In the screening procedure conducted by Wong et al. (2014) were included a number of 1,090 articles, 213 utilizing a group design and 877 using quasi-experimental group design (SCD) methodology. The articles were identified by a group consists in one hundred fifty-nine reviewers. "All reviewers had a doctoral degree, master's degree, or were enrolled in a graduate education program at the time of the review. Most reviewers received their degrees in the area of special education or psychology and were faculty (current or retired), researchers, or graduate students. The majority of reviewers had professional experience in a classroom, clinic, or home setting and conducted research related to individuals with ASD. In addition, approximately one-third of the reviewers (n=53) had Board Certified Behaviour Analyst (BCBA) or Board Certified Assistant Behaviour Analyst (BCaBA) certification."(Connie Wong, Samuel L. Odom, 2014, p. 14).

Most of the participants in the study were children with ages between 6-11 years, and preschool children (3–5 years).

*Table 4. Outcomes Identified in Studies(*Connie Wong, Samuel L. Odom, 2014)

Outcomes related to	Studies (n)
Social Skills needed to interact with others	165
Communication Ability to express wants, needs, choices, feelings, or ideas	182
Challenging/Interfering Behaviors Decreasing or eliminating behaviors that interfere with the individual's ability to learn	158
Joint Attention Behaviors needed for sharing interests and/or experiences	39
Play Use of toys or leisure materials	77
Cognitive Performance on measures of intelligence, executive function, problem solving, information processing, reasoning, theory of mind, memory, creativity, or attention	15

(http://cidd.unc.edu/Registry/Research/Docs/31.pdf)

According to these analyses, „twenty-seven practices met the criteria for being evidence-based."(Wong, &Odom, 2014, p. 19)

"The evidence-based practices consist of interventions that are fundamental applied behaviour analysis techniques (e.g., reinforcement, extinction, prompting), assessment and analytic techniques that are the basis for intervention (e.g., functional behaviour assessment, task analysis), and combinations of primarily behavioural practices used in a routine and systematic way that fit together as a replicable procedure (e.g., functional communication training, pivotal response training); the process through which an intervention is delivered defines some practices (e.g., parent-implemented interventions, technology-aided interventions)." (Wong, &Odom, 2014, p. 19)

A centralized situation of the intervention practices is presented in Table 5. The authors of this Rapport (Wong at al.) found that 27 focused intervention practices meet the evidence-based criteria, including five new categories of EBP: cognitive behavioural interventions, exercises, modelling, scripting and structured gaming groups.

Also, the new technology-assisted training and intervention practice reflects an extension of the definition of technological interventions for ASD students, leading to

computer-assisted training courses and speech / VOCA generating devices that are included in this classification.

Table 5. Evidence – based practices Raport 2014

NPDC Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: EBP Report 2014	
• Antecedent-based interventions • Cognitive-behavioral intervention • Discrete Trial Teaching • DRA/I/O • Exercise • Extinction • Functional Behavioral Assessment • Functional Communication Training (FCT) • Joint attention interventions • Modeling • Naturalistic teaching strategies • Parent implemented interventions • Peer-mediated strategies • Picture Exchange Communication System (PECS)	• Pivotal Response Training • Prompting • Reinforcement • Response interruption/redirection • Scripting • Social narratives • Self-management • Social skills training • Structured play group • Task analysis • Technology-aided instruction • Time delay • Video Modeling • Visual Supports

Foundations in Autism Spectrum Disorders & Evidence-Based Practices

Conclusions

The main purpose of this article was to analyse how the effectiveness and quality of educational and therapeutic practice in ASD are influenced by research in the field by identifying those interventions and effective, scientifically validated treatments for students with ASD.

Initially, we presented the current conceptualization of ASD, the review of scientific literature, analysis of research studies, identification and analysis of practices.

We intended to identify the link between educational practices and studies that provide empirical support for these practices.

Indeed, an educational and therapeutic practice is based on scientifically guided research if there is clear evidence that the program or practice is working.

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Aggressive Coping Strategy in Situations of Social Conflict. An Attempt to Determine Personality Predictors

Danuta BORECKA-BIERNAT•

Abstract

The purpose of the study was to find personality predictors of aggressive coping strategies in adolescents in situations of social conflict. The empirical studies have been conducted in junior high schools on a sample of 893 adolescents (468 girls and 425 boys) aged 13-15. The study employed the following instruments: the Stress Assessment Questionnaire (Kwestionariusz Oceny Stresu, KOS) designed by D. Włodarczyk and K. Wrześniewski, The Rosenberg Self-Esteem Scale (SES), the Spielberger Three-Factor Inventory of Personality States and Traits (TISCO), as well as the Questionnaire for Analysis of Coping Strategies in Adolescents in Situations of Social Conflict (KSMK) designed by D. Borecka-Biernat. The results of the studies indicate that the assessment of a situation of conflict as a threat increases the implementation of the aggressive coping strategy in young people in situations of social conflict. Participation of adolescents in a situation in which the realization of their goals is under threat increases negative emotions. Aggression is a form of coping with anger experienced in a situation of social conflict.

Key words: youth; personality; aggression; conflict.

1. Introduction

Difficult situations are not exceptional occurrences in life; on the contrary, they are a regular occurrence since early childhood; challenges cannot be eliminated from life. In psychology, the notion of a "difficult situation" refers to actions that an individual performs in order to regulate their relationship with their environment. These actions are, however, disrupted by obstacles and inhibitions which prevent the individual's goal from being achieved. A normal course of the basic action is disturbed and the likelihood of completing

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the task at the regular level decreases (Tomaszewski, 1982). Difficult situations do not constitute a uniform class, but are a varied category. They do not occur individually in an isolated form; multiple types of obstacles can arise in one situation (Tomaszewski, 1982), which means that different types of difficulties can overlap and become dependent on each other. An important category of difficult situations are social difficult situations, which threaten the values to which an individual subscribes and fulfillment of the individual's needs and aspirations (Tyszkowa, 1986).One type of difficult situations in social interactions are situations of social conflict, in which the goals of an individual are contradictory or incompatible with those of others, and realization of the individual's own goals is jeopardised. The word "conflict" is derived from Latin *confligere,* or *conflictatio*, which means clash, argument, discussion, fight, or collision of two or more processes or forces particular to living creatures. A collision might be the beginning of a fight. Many people wrongly associate conflict with direct physical and/or verbal aggression and accompanying hostility that increases the existing contradictions. This type of conflict is saturated with negative emotions. The majority of phenomena which may be described as conflicts take relatively mild forms of a short altercation, discussion, or debate (Olubiński, 1992).

Difficult social interactions marked with a sense of insecurity or risk to realization of one's aspirations or goals (or fulfilment of one's needs) are frequent in lives of adolescents. Every day, young people experience various problems connected with school, peers, or family life. Results of studies conducted by, among others, B. Lohman P. Jarvis (2000), R. Jaworski (2000), J. Różańska-Kowal (2004), and K. Polak (2010) have shown that during adolescence, young people usually consider conflicts with teachers, arguments with schoolmates, romantic partners, as well as parents and other relatives to be the most important sources of personal insecurity, unpleasant experiences, and intense stress.

The area that generates the most conflict between students and teachers are grades, tactless behaviour of the teacher, controlling pressure, and rigidity of requirements (Miłkowska, 2012). The main reasons for arguments with peers are taunts, betrayal, breach of trust, competition for grades, for the interest of the opposite sex, for position among the classmates, and sporting achievements (Różańska-Kowal, 2004; Polak, 2010). Most

problems with mutual understanding between children and parents are caused by the change of young people's attitude towards their parents. Adolescents are less open towards their parents, while the parents frequently do not cope with the growing autonomy of their children and try to limit it (Obuchowska, 2010). Numerous conflicts with parents are caused by elements of daily life: differences in tastes, opinions - including those on learning performance - clothes, music, watching television, using computer, ways of spending free time, or returning home late in the evening (Jaworski, 2000).

Adolescence is a period in which young people experience various, often contradictory needs, and have to cope with inconsistent social expectations. Difficult situations encourage young people to take action oriented towards regaining the balance between expectations and abilities and/or improvement of their emotional state. Activity undertaken in a difficult situation is considered, in a specific situational context, as a coping strategy in a current difficult situation (Heszen-Niejodek, 2000). It is important, then, to examine how young people cope with conflicts which occur at school, in their relationships with peers, or in the family home. Numerous studies as well as casual observation indicate that the school environment, especially conflicts with teachers and classmates, are particularly stressful to adolescents. Empirical material in literature indicates that youth applies many different strategies of coping with school problems (Miłkowska, 2012). The most frequent strategy are behaviours that regulate emotions; fewer strategies mentioned by the participants of the studies were oriented towards working on the problem, an analysis of the situation and an attempt to change it. The strategies that the participants declared to apply in the context of coping with difficult situations at school included aggressive behaviour towards other people as well as objects. Classes and breaks are the times when the risk of young people relieving stress through aggressive coping methods is particularly high (Miłkowska, 2012; Różańska-Kowal, 2004). During classes, aggressive behaviour constitutes purposefully disrupting the lesson, damaging personal items placed on the teacher's desk, and expressing negative opinions on the teacher to friends and parents. Over 50% of the respondents admitted that they engage in aggressive behaviour during breaks. Physical aggression is dominant (it consists of such behaviours as pushing, punching, and kicking), and the most

frequent forms of verbal aggression include name-calling and mockery of another person or items that belong to them.

Conflict situations involving parents become, as the young person becomes an adolescent, an increasingly important source of tensions. The parent-child conflicts are a phenomenon occurring commonly during adolescence (Jaworski, 2000). Older adolescents want to emancipate from the parental control; their entire behaviour is a demand for expansion of rights. The obstacles and failures they face, as well as the expectations and limitations imposed on them by the parents provoke anger, expressed in "talking back", slamming doors, sometimes crying or direct attacks on people or objects (Lachowska, 2010).

The studied performed until now suggest that social conflict is connected with the issue of aggressive coping strategies in a specific situational context, whose aim is to avoid or minimize tensions, losses, and unfavourable outcomes. A question needs to be posed: why do young people in social conflict choose the strategy of aggressive reactions to difficulties? The answer to this question is facilitated by the concept of psychological mechanism of human behaviour in difficult situations, designed by M. Tyszkowa (1986). According to this author, an important role is played by the cognitive schemata determining the processes of perception of the external situation and the individual's emotional reflection of significance of that situation and of the course of their own action.

An individual's actions in a difficult situation is largely dependent on their assessment of their circumstances. A difficult situation that disrupts the routine activities, interferes with, endangers, or prevents realization of one's needs, may be assessed as harm/loss (referring to the sustained damage and losses connected with important objects), threat (referring to similar harm which is anticipated but have not yet occurred), or challenge (indicating the possibility to gain control over a difficult situation and benefit from it) (Włodarczyk, Wrześniewski, 2010).

An individual assessment of an event influences the person's decision on the possibility of activity (a remedial strategy) that will remove the causes of the difficult situation or at least lessen its impact (Heszen-Niejodek, 2000; Winstok, 2007). Thus, it can be said that the manner of coping with a specific situation and the choice of solutions to

problems depend on the result of an individual's assessment of that situation in the category of harm/loss, threat, or challenge.

Data obtained by D. Domińska-Werbel (2014) indicate that adolescents adopting aggressive coping strategies in difficult social situations are characterized by a more frequent situational and dispositional cognitive appraisal of a difficult situation as one of harm/loss.

K. Kowalski, P. Crocker, and S. Hoar (2005) have determined that upon encountering a problem the individuals who assessed a difficult situation as threat applied mainly coping mechanisms based on emotions. Their entire effort was directed towards decreasing the unpleasant tension by means of violent emotional outbursts and/or activation of defensive mechanisms, without attempting to find an actual solution to the problem. Thus, individuals in who the situational and dispositional cognitive appraisal of a difficult situation as harm/loss or as threat is higher, display aggression, hyperactivity, or rebellious behaviour.

The perception of the world by an individual, their attitudes and expectations of themselves and of other people, as well as of the tasks they perform and the results of their own activity, determine the type of cognitive and emotional perception and interpretation of difficult situations. The collection of concepts and notions of oneself and expectations towards oneself - which constitute the structure of the self - plays an important role in an individual's behaviour in difficult situations (Kulas, 1986). From what is known, self-evaluation is an assessing and quantifying component of the structure of the self. Self-esteem is an assessment of one's self from the perspective of specific standards and requirements. It appears that an unfavourable, insufficiently organized and inadequate structure of the self is vulnerable in difficult situations, which causes a shift of the purpose of the individual's activity towards defending the self (Tyszkowa, 1986). As a result, goal-oriented activity becomesdisorganized. A low (adequate, inadequate) or high (inadequate) self-esteem also has unfavourable influence on a young person's behaviour in difficult situations (Baumeister et al., 2003; Borecka-Biernat, 2006; Iskra, 2011; Ostrowsky, 2010; Turner-White, 2015). In difficult circumstances, an inadequate self-esteem leads to an increased sense of personal insecurity, an increase in negative emotions, and progressive disorganization of behaviour. A low assessment of oneself and of one's own abilities and

efficiency in coping with various difficult situations facilitates the appearance of aggressive behaviours. In case of high (inadequate) self-esteem a tendency to release aggression can also be observed. As can be seen, both high and low self-esteem decrease resilience to difficult situations and efficiency, as well as hinders adaptation and ability to cope in the face of difficulties. Even a small obstacle or a low-level threat may provoke unbridled aggression in a person with a low or high (inadequate) self-esteem. This indicates that the level of self-esteem is a crucial factor influencing an individual's functioning in life, which is revealed in particular in situations of conflict in which an increased cognitive, motivational, and emotional involvement is necessary.

Conflict, which is an inherent element of social interactions, provokes a negative emotional tension (Deffenbacher, 1992). A continual, intense, and negative emotional stimulation becomes a basis for aggressive behaviour, irritation, and outbursts of rage (Gross, Halperin, Porat, 2013; Kossewska, 2008). The types of emotions that lead to aggressive behaviour are those that follow the sequence irritation-anger-rage. Their intensity determines the level and form of aggression. As noted by W. Łosiak (2009), anger and rage are related emotional states, connected by the similarity on the level of subjective experience, as well as by the connection with aggressive behaviours. It is worth mentioning that anger and rage are one of many possible negative emotional reactions, which appear in stressful situations, that are perceived as threat or loss/harm (Lazarus, 1986). According to L. Berkowitz (1992), emotions of rage and anger trigger activities aimed at recovery of the endangered or lost goals and lead to aggressive behaviours. D. Domińska-Werbel (2014) and J. Różańska-Kowal (2004) also conclude that the tendency to react with anger is connected with the impulse to fight and unwillingness to surrender in difficult situations.

The emotional sequence of fear-panic-anxiety, however, usually leads to withdrawal and escape (Borecka-Biernat, 2006; Borecka-Biernat, Ciuladiene, 2015; Łosiak, 2009). It appears that in natural conditions anger is an emotion that facilitates the fight response, while fear facilitates flight. Observations indicate, however, that if circumstances do not offer any escape route and if aggression is the only remaining solution, fear may cause an attack (Borecka-Biernat, 2006; Janowski, 2005; Nowosad, 2002).

A study conducted by W. Sikorski (2015) has shown that young people with a high level of communication fear frequently applied aggressive coping mechanisms in situations of conflict in the classroom. Confronted with a conflict with peers, those students tend to "attack the problem" instead of attempting to solve or alleviate it, using physical violence against other people and objects, and/or manifest their hostile attitude towards others through accusatory, harmful, and humiliating comments. The results of the study indicate that aggression is an efficient strategy that allows to cope with fear experienced in difficult situations and conflicts, and it constitutes a reaction that facilitates hiding fear or diffusing the tension that it has caused.

To summarize, the concept of psychological mechanism of human behaviour in difficult situations, designed by M. Tyszkowa (1986), allows to describe certain personality determinants of the aggressive coping strategy applied by young people in situations of social conflict. Despite this, researchers should attempt to find determinants of the determinants of the aggressive coping strategy in social conflict applied by young people.

2. Research problem and hypothesis

The empirical studies were focused on the personality predictors of the aggressive coping strategy in youth in the situation of social conflict, with particular focus on the role of the type of cognitive appraisal of the situation of social conflict, level of self-esteem, as well as the intensity and the type of emotions. The studies were oriented towards answering the following research question:

1. What is the connection between the group of variables and the increased application of the aggressive coping strategy in a situation of conflict?

In this form, the research question allows to formulate a hypothesis, that will be verified through analysis of the results of the conducted empirical studies:

H.1 The aggressive coping strategy in youth in situation of social conflict is connected with assessment of the situation of conflict as a threat or harm/loss, as well as with a low or high level of general self-esteem and a high level of the negative emotions (anger, fear).

3.Method

Participants and outline of the study. The study was conducted on a sample of 468 girls and 425 boys aged 13-15. In total, 893 students participated in the study. The participants were students of the first, second, and third year of junior high school. Voluntary and anonymous participation were ensured for all participants; the study was conducted in compliance with standards for psychological research. The basic criterion for selection of the participants was age. The influence of age on the choice of aggressive coping strategy in a situation of social conflict was studied on a sample of participants aged 13 to 15 (early adolescence). As a time of transition from childhood to adulthood - also described as the period of rebellion and resistance - adolescence is an important stage in an individual's life. It is during adolescence that many biological, psychological, mental, motivational, and social changes occur, which causes numerous difficulties connected with adjusting a young person's behaviour to accommodate new situations, tasks, and social roles (Czerwińska-Jasiewicz, 2003).

4.Research tools

The following instruments were applied in the study:

The Stress Assessment Questionnaire (Kwestionariusz Oceny Stresu, KOS) designed by D. Włodarczyk and K. Wrześniewski (2010), comprised of 35 adjective phrases describing stressful situations. The questionnaire consists of two versions containing the same sets of the adjective phrases but different instructions for the participants. In version A (measurement of the situational assessment of stress) the participants are asked to indicate a specific difficult situation that occurred the previous week (the present study used a situation of social conflict). Version B (measurement of dispositional assessment of stress) contains an instruction in which the participants are asked to mark the degree to which the provided adjectives are consistent with what they most frequently experience in difficult situations (the present study used a situation of social conflict). KOS consists of 6 subscales which indicate specific types of stress assessment, including state-anxiety, trait-anxiety, trait-harm/loss, state-challenge, and trait-challenge. The "anxiety", "challenge", and "harm/loss" subscales consist of 10, 6, and 4 items respectively. The questionnaire is

sufficiently accurate and reliable (Cronbach's α for version A was .76-.90, and for version B .79-.90).

The Rosenberg Self-Esteem Scale (SES), adapted by M. Łaguna, K. Lachowicz-Tabaczek and I. Dzwonkowska (2007) allows to calculate the level of overall (global) self-worth both in adolescents and adults. SES consists of 10 diagnostic descriptive statements referring to the participant via which they are able to outline their self-worth. A high result indicates a high level of global self-worth. The scale is characterized by accuracy (Cronbach's α was .81-.83) and diagnostic relevance.

The Spielberger Three-Factor Inventory of Personality States and Traits (TISCO) is a Polish adaptation of the American State-Trait Personality Inventory (STPI) designed by C. Spielberger (Wrześniewski, 1991). TISCO consists of two independent parts. Part one (SPI) measures anxiety, anger, and curiosity interpreted as emotional states experiences in a specific moment. Part two (TPI) is applied to study the same emotions interpreted as personality traits. The Inventory contains 6 subscales: state-anxiety, trait-anxiety, state-anger, trait-anger, state-curiosity and trait-curiosity. Each subscale consists of 10 short, simple statements referring to subjective emotions of the participant. The relevance and accuracy of TISCO are sufficient and close to the original version of the instrument (STPI).

The KSMK Questionnaire designed by D. Borecka-Biernat (2012) examines coping strategies in situations of social conflict applied by adolescent youth. It is comprised of descriptions of 33 situations of social conflict. Each description is accompanied by four types of coping behaviour in a situation of social conflict: aggressive coping ("A"), coping by avoidance ("U"), coping by submission ("UI"), and task-oriented coping ("Z"). The results are obtained separately for each scale, by summing up the behaviours marked by the participant in the 33 situations. The aggressive coping scale ("A") for youth in situations of social conflict was used for the purpose of the study. The Questionnaire is characterized by sufficient accuracy (Cronbach's *α* was around or above .07) and diagnostic relevance.

5.Analysis of the results

Due to a large number of independent variables hierarchical regression was applied and the method of backward elimination was used (criterion: probability-of-f-to-remove

>=.100). In this method, all potential predictors are introduced into the model and the irrelevant variables are subsequently removed, after which the model is recalculated until the final version is obtained (Bedyńska, Książek, 2012). The regression analysis was performed on the results obtained from the entire studied group of young people; separate regression analyses were also performed after dividing the participants by gender. The results are presented in Table 1.

Table 1. Multiple stepwise regression for the result of the Aggression scale (A) in Questionnaire for Coping Strategies in Adolescents in Situations of Social Conflict (KSMK) in relation to the following scales: the Stress Assessment Questionnaire (KOS), the Self-Esteem Scale (SES), the Three-Factor Inventory of Personality States and Traits (TISCO): results for the entire group: (N=893); results for girls (N=468) and boys (N=425)

Participants	Variable	Beta	B	Standard error. B	t	Level p<
Total						
	State-threat	.08	.06	.02	2.58	.010
	State-anger	.19	.13	.03	4.44	<.001
	State- anxiety	-.08	-.12	.06	-2.08	.040
	Trait-anger	.31	.23	.03	7.34	<.001
	Trait- anxiety	-.09	-.08	.04	-2.29	.020
	Trait-curiosity	-.09	-.09	.03	-2.74	.006
	Free term		3.64	1.39	2.63	.009
Multiple correlation coefficient: R=.38. Coefficient of multiple determination: R^2=.14 Significance of the equation: F(6,886)=24.59; p<.00001 Standard estimation error: 4.32						
Girls						
	State-threat	.12	.08	.03	2.60	.010
	State-anger	.23	.17	.04	4.01	<.001
	State- anxiety	-.17	-.24	.07	-3.21	.001
	Trait-anger	.34	.25	.04	5.72	<.001
	Trait- anxiety	-.14	-.13	.05	-2.49	.013
	Trait-curiosity	-.10	-.09	.04	-2.09	.037
	Free term		5.75	1.84	3.12	.002
Multiple correlation coefficient: R=.40 Coefficient of multiple determination: R^2=.16 Significance of the equation: F(6,461)=14.78; p<.000001 Standard estimation error: 4.28						

Boys						
	State-anger	.15	.11	.04	2.91	.004
	State-curiosity	-.11	-.11	.05	-2.38	.020
	Trait-anger	.26	.20	.04	5.05	<.001
	Free term		2.20	1.46	1,51	.132

Multiple correlation coefficient: R=.37
Coefficient of multiple determination: R^2=.14
Significance of the equation: F(3,421)=22.44; p<0.000001
Standard estimation error: 4.31

The first regression analysis was performed on the results obtained from the entire studied sample, regardless of gender. As can be seen in Table 1, the following six variables had significant influence on the aggressive coping strategy in youth in situations of social conflict: situational assessment of the conflict as threat, anger as an emotional state, fear as an emotional state, anger as a personality trait, fear as a personality trait, and curiosity as a personality trait. These predictors explain 14% of variance in application of the discussed strategy, and the described model is well adjusted (F(6.886)=24.59; p<.00001]. The remaining predictors were not significant determinants of the frequency with which young people apply the aggressive coping strategy in situations of social conflict. The beta slope indicates that a higher level of situational assessment of the conflict as threat, a higher level of anger as an emotional state, a lower level of fear as an emotional state, a higher level of acquired tendency to react with anger, a lower level of acquired tendency to react with fear, as well as a lower level of tendency to react with curiosity have influence on the increase in frequency of incidence of aggressive coping strategy in youth in situations of social conflict.

Separate regression analyses were conducted after dividing the participants by gender (compare: Table 1). Stepwise regression analysis has shown that among thirteen independent variables introduced in the regression model, six were of low significance for explaining the use of aggressive coping strategy by girls in a situation of social conflict. The remaining monitored indicators did not show statistically significant correlations with aggressive coping strategy in girls. The calculations indicate that situational assessment of conflict as threat, anger as an emotional state, fear as an emotional state, anger as a personality trait, fear as a personality trait, and curiosity as a personality trait play an important determining role for application of the aggressive coping strategy by girls. The

enumerated predictors explain 15% of variance in application of the discussed strategy by girls, and the described model is well adjusted [F(6.451)=14.78; p<.000001]. It is evident that the more a current conflict situation is assessed as threat, the higher the level of anger as an emotional state and of the acquired tendency to react with fear, and the lower the level of fear as an emotional state, of acquired tendency to react with fear, and of tendency to react with curiosity, the more frequently the studied girls apply the aggressive strategy.

Another examined problem was which group of personality variables has influence on the level of aggressive coping strategy in boys in situation of social conflict. The following three independent variable proved significant in the regression equation: anger as an emotional state, curiosity as an emotional state, and anger as a personality trait. The discussed model proved to be well adjusted to the data [F(3.421)=22.44; p<.000001] and explained 13% of the variance of the dependent variable. The standardized *beta* coefficients revealed that the increase of the use of aggressive strategy in boys in the context of social conflict is influenced by a higher level of anger as an emotional state and of the acquired tendency to react with anger, as well as a lower level of fear as an emotional state.

To summarize the conducted regression analysis, the assumed personality variables have partially confirmed the validity of the formulated hypothesis H.1.

4. Summary of the results

An analysis of the results has revealed that a situational assessment determining classification of a conflict as threat is connected with aggressive coping strategy in youth, particularly in girls involved in a situation of social conflict. It can be suspected that a situational assessment of a conflict as threat increases the application of aggressive coping strategy by young people in situations of social conflict. It should be concluded that an adolescent who has found themselves in a situation of social conflict which they assess as threat will apply aggressive strategy in order to cope with that situation (Ratajczak, 2000). This tendency appears to be consistent with the statement by L. Berkowitz (1992) according to which aggression is generated as a result of perceived threat, a conviction that one is an object of intentional, wrongful treatment, and violation of an individual's sense of self-worth.

Statistical analyses of the results have not indicates a dependence between the level of self-esteem and aggressive coping strategy in adolescents. It may be caused by a large number of variables introduced in the model causing other variables to prove more statistically significant for the aggressive coping strategy than the global assessment of self-worth. Moreover, an explanation should be sought for the obtained results for the global assessment of the self (as measured by the SES questionnaire) - that is, without referring to the sense of self-worth of individual participants which might significantly conceal the full image of the overall self-esteem of the participants of the study. Self-worth, studied with the Rosenberg questionnaire adapted by M. Łaguna, K. Lachowicz-Tabaczek, and I. Dzwonkowska (2007), is the attitude of an individual to their Self, a type of a global assessment of oneself. Therefore, the assessment of self in particular dimensions - such as intellectual capacity, social skills, physical fitness, or resourcefulness - correlates with the self-esteem, but it is not neither empirically, nor conceptually identified with it (Marsch, 1996, as cited by Łaguna, Lachowicz-Tabaczek, Dzwonkowska, 2007).

After conducting the analysis it has been determined that aggressive coping strategy in situations of social conflict is influenced mainly by anger as an emotional state experienced in a specific moment, as well as the acquired tendency to react with anger. It can be suspected that with the increase of the level of the state-anger and trait-anger the aggressive coping strategy will be applied more frequently by young people (both overall and with regard to gender) in a situation of social conflict. A similar result was obtained in the studies conducted by D. Borecka-Biernat and G. Ciudalene (2015), D. Domińska-Werbel (2014), and J. Kossewska (2008). Moreover, a significant negative relationship was noted between the aggressive coping strategy and fear as a current emotional state, fear as a personality trait, as well as curiosity as an emotional state in a specific moment and curiosity as a relatively permanent personality trait. It can be expected that a more frequent application of the aggressive coping strategy by youth in situations of social conflict is connected with a proportionately lower level of fear (as state or trait) and curiosity (as state or trait) (Domińska-Werbel, 2014). It should be noted that the attempt to find determinants of the aggressive coping strategy in situation of social conflict in fear as a state and fear as a trait was unsuccessful. It can be suspected that the high level of fear in adolescents in

situations of social conflict causes forms of indirect aggressive behaviour, such as mistrust and hostile attitude towards the environment (Leary, Kowalski, 2001; Nitendel-Bujakowska, 2001). It is worth noting that a situation of social conflict, perceived as threat, does not generate positive emotions (such as curiosity) which facilitate an active approach to coping with difficulties (Łosiak, 2009). This result seems to be consistent with the conclusion formulated by M. Tyszkowa (1986), according to which the structure of an individual's personality and their traits decide whether the emotional tension provoked by a difficult situation is interpreted as in terms of information-compensation (in relation to the purpose of the activity) or as a signal of a personal threat.

To summarize the obtained result, it can be concluded that a young person's cognitive reaction to a situation of social conflict may have influence on their choice of coping strategy. If the situation of social conflict is perceived as a threat, an adolescent is more likely to apply an aggressive strategy. It should not be forgotten that an individual's reaction to social conflict is emotional, and they may experience anger. It should be, therefore, suspected that an assessment of a situation of social conflict as a threat may provoke aggression. This strategy facilitates the release of anger experienced by young people in circumstances which endanger the realization of their aspirations. The aggressive strategy is primarily a form of coping with anger experienced during conflict. It should also be noted that, together with the increase of anger (as a tendency) in adolescents in situations of social conflict, the aggressive coping strategy is also increased. It suggests that an adolescent assessing a social conflict situation in terms of threat will apply aggressive coping methods which may, even temporarily, free them from the unpleasant emotional tension, and which are not oriented towards finding a solution and overcoming the difficulties.

Finally, it is difficult to ignore that fact that the selected personality variables are not strong predictors of the aggressive coping strategy in youth in situations of social conflict; this means that there may exist numerous other variables which co-determine the level of aggressive coping strategy in youth in situations of social conflict. The area that appears to be worthy of further scientific exploration is conducting research with reference to the genetic (related to the temperament) nature of an individual's functioning in conflict and to the influence of the family environment on the ability to overcome the biological

determinants and become a person capable of proactively coping with conflict. It should be considered that the results of these studies may become the beginning of exploration of those areas within the problem of the determinants of the aggressive coping strategy in adolescents in situations of social conflict which have, until now, been neglected.

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Bullying in schools: An interdisciplinary approach from the legal and psycho-pedagogical perspective

Tudoriţa GRĂDINARIU•

Abstract

The purpose of this study is to analyze bullying behaviors from an interdisciplinary perspective: legal, psychological and pedagogical. From a legal point of view, the Romanian legislative framework on respect for children's rights has undergone a number of changes in recent years with the accession of Romania to the European Union in 2007. International legislation on respect for children's rights requirescountries that have ratified these provisions to ensure that they are respected and to take measures to ensure that they are not prejudiced. Aggressiveness in students is a predictor of antisocial behaviors in adolescence and adulthood.

The psychological perspective of bullying refers to the consequences of this type of behavior.Students involved in aggression are at increased risk of developing a range of psychosomatic symptoms, involvement in delinquency, alcohol and drug abuse, absenteeism.The consequences of these behaviors on the victims are associated with anxiety, depression and suicidal ideation.

Through the pedagogical approach to bullying, we focus on the role of teachers in addressing the issue of aggressive behavior in students. The perceived gravity and teacher's response to bullies and victims of bullying are important indicators to be taken into account in making a successful intervention.

***Keywords**:* bullying; bully; victim; child rights; teacher response.

1. Introduction

In Romania, 2016 marks the beginning of national studies on the bullying phenomenon in schools.A image of the frequency of this phenomenon in schools is provided by the National Institute of Public Health (INSP) within the National Report on the Health of Children and Young People from Romaniaas a result of a national survey conducted to assess the frequency of some forms of harassment (social isolation, direct and indirect physical and verbal bullying and threat). The results show that 17.9% of the questioned

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students were bullied by their peers, and the most common forms of bullying are direct physical and verbal.

Also, this study shows that boys who are aggressive in the primary school have an increased risk of juvenile delinquency and substance abuse. Another important aspect presented in this study is that early aggression is a predictor of antisocial behavior in early adolescence such asmissingschooland scramble with other children (INSP 2016, p. 70).

The literature from this fieldshows that bullying is an international phenomenon that affects children and adolescents all over the world. No culture and no country is immune to the problem of aggression(Stockdale et al., 2002). Bullying behavior is a complex form of interpersonal aggression and is manifested in different patterns of relationship (Swearer&Hymel, 2015).

According to the Report byNational Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, Washington, DC, in the 2009-2010 school year, 85% of public schools experienced one or more incidents of crime of a total of about 1.9 million crimes.Specialists have estimated a rate of 40 offenses per 1000 public schools.In the same year, 60% of public schools reported at policean offense that occurred in school, respectively 15 offenses per 1,000 pupils in public schools(Robers, Kemp, Rathbun & Morgan, 2014).

In Romania, over the past two decades, there has been an alarming increase in the number of criminal offenses committed by infants (Kurkó-Fabian, 2006, p.10).According to the statistics of the Superior Council of Magistracy in Romania, over 20,000 juveniles were sued in 2011-2015, of which 15,000 were convicted.Major offenses committed by minors include robbery, hitting, simple or serious bodily injury (Danilet, 2016).

In 2014, the New Penal Code, which regulates the criminal liability of juvenile offenders, invokes the importance of non-custodial educational measures for juvenile offenders. Thus, in 2014-2015, about 800 children were sentenced to detention measures (Danileț, 2016).

According to the statistical data presented in the Activity Assessment carried out by the Police Inspectorateof Iași in 2014, compared to 2013, a total of 98 crimes were recorded in 2013, out of which 94 were committed in schools, and 4 in areasacrossschool. According

to the same document, 73 offenses were recorded in 2014, of which 66 were committed in schools, and 7 in the area acrossto the school. In the year 2016, there were 72 offenses, of which 69 in schools, and 3 acrossschools.These data show that school is the place where most offenses are committed by underage children. In addition to these serious behaviors among minors, it adds those that escape a legal investigation and which, through the frequency and complexity of the manifestations, seriously affects the school climate in which students have to study and develop.According to Debarbieux's statements (1996, p. 69), school is not just the placein which crimes are committed, but also the placeof "incivilities" that should not be underestimated.

2. Definition of bullying

The concept of "bullying" was introduced for the first time in 1978 by Norwegian psychologist Dan Olweus as a result of school surveys on violent behavior among students (De La Rosa, 2013).Arseneaultand collaborators (2010) statedthat bullying can be defined as a deliberate, malicious form of proactive aggression. It is different from other types of violent behaviors that occur between individuals of similar age, it is repetitive and is characterized by an imbalance of the real or perceived power in which the victim is defenseless.Summarizing the results of allstudies conducted in schools in Scandinavia, Olweus concludes that bullying is a subtype of violent behavior (Olweus, 1997).In the bullying behavior the victim has difficulties in defending herself (Olweus, 1995, p. 197);bullying can be done by a single individual aggressor or by a group the victim may be an individual or a group(Olweus, 1994);bullying is an interaction in which a dominant individual (the bully) repeatedly displays aggressive behavior with the intention of causing harm to a less dominant individual (the victim) (Olweus, 1991; Smith& Thompson, 1991).

3.The bullying behavior from the legal perspective

A number of international documents refer to human rights and fundamental freedoms as well as to the rights of the child. Countries that have ratified these provisions have an obligation to ensure that they are complied with and to take measures to ensure that they are not prejudiced.

*The Universal Declaration of Human Rights adopted by the General Assembly of the United Nations on September 10, 1948,*proclaims the recognition of human dignity and equal and inalienable rights as the foundation of freedom, justice and peace in the world.It also highlights the importance of education that "must promote understanding, tolerance, friendship among all people and all racial or religious groups ..." (article 26).

*The UN Convention on the Rights of the Child Convention on the Rights of the Child adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989*recognizes a number of fundamental rights such as the right to life, the right to education, the right to free expression, the right to protection against all forms of violence, injury or abuse, physical or mental, abandonment or neglect, treatments or exploitation.

*The Treaty of Lisbonamending the Treaty on European Union and the Treaty establishing the European Community adopted in 1 December 2009*regulates the the basic values of social functioning: respect for human dignity, freedom, democracy, equality, compliance with the law, respect for human rights in a society characterized by pluralism, tolerance and non-discrimination.The Romanian legislative framework in the field of children rights protection has supported in recent years a series of modifications and additions as Romania joined the EuropeanUnionin 2007. By adjusting the Romanian legislation to the European one, the status of the child in family and society is reconsidered.

*The Constitution Of Romania (1991)*guarantees ~~a~~ specialconditionsfor the protection and assistance of children and young people in the realization of their rights (article 49) and in the protection of health of article 34 paragraph 2).

For the first time in Romania, the legislationdefines the child's best interest in *law no. 272 of 21 June 2004* on the protection and promotion of the rights of the child.The art. No

2paragraphNo 1 defines the best interest of the child that includes the child's right to normal physical and moral development, to socio-affective balance and to family life.

Law No. 1 of 5 January 2011 of National Education (The Romanian Parliament,2011) states the indispensable factorsneededin the process of the individual development: "the free, integral and harmonious development of human individuality, thedevelopmentof the autonomous personality and the assumption of a system of values that are necessary for personal fulfillment and development".(The Romanian Parliament, 2011, art.2, alin.3). From the perspective of this law, the purposeof education is represented by the competencesdevelopmentneeded forpersonal fulfillment and growing, social integration and social pro-active beliefs, education in the spirit of dignity, tolerance and respect forhuman rights and fundamental freedoms; cultivation of sensitivity to human issues, to moral-civic values, respect for nature andforthe natural, social and cultural environment " (The Romanian Parliament, 2011, art. 4).

*The New Penale Code of Romania*adopted in 2014*(The Romanian Parliament,2009*, has undergone a series of transformation, the main changes being those relating to the criminal liability of juvenile offenders.The new perspective of the Penale Code emphasizes first of all the educational component by including sanctions that are designed to correct the infant's behavior in the setting in which he or she lives and develops (house, school) for the case of non-custodial educational measures, or in educational detention centers in the case of educational deprivation of freedom. In Romania, the age for which an infantis legally charged for his acts is 14.

*Law no. 61/1991 Republished for sanctioning the facts of violation of norms of social coexistence, of public order and tranquility,(The Romanian Parliament, 2014)*describes antisocial behavior as having a low degree of socialdamage.Thus, at art. 2, par. 1, the anti-social behaviors mentioned as being contraventional charged are: obscene, insulting or vulgar expressions, acts or gestures, violence acts against people or their personal objects the disturbance of the order and the public silence; or damaging their dignity and honor or the ones of the public institutions. "

4. The bullying behaviour from the psychological perspective -Consequences of bullying behaviors

Bullying has lifelong negative consequences for everyone implied (bullies, victims and bystanders) and affects in a serious way many aspects of children's livesthat are involved in this type of behavior (Guilory, 2013). Students involved in bullying are at an increased risk of developing a lot of psychosomatic symptoms, being exposed to risks such as leaving home, alcohol and drug abuse, absenteeism, and self-harm. The effects of bullying also extend to adulthood, with research revealing a significant correlation between the aggressive behavior of the child and subsequent psychiatric morbidity(World Health Organisation, 2010).

Victimization is closely linked to the decrease in self-esteem and high rates of depression and anxiety, amongst the victims of bullying, an also a growing occurrence of suicidal thoughts (Losey 2009 apud Limber et al., 2004).

Bullying has an impact on children in adolescence and continues to affect them in adulthood (Espelage & Swearer, 2004). There is an increase in the interest of specialists in the long-term impact of bullying in order to provide an insight into the urgency in preventing and understanding this phenomenon.

5. The bullying behaviour from the pedagogical perspective

Most of the researches areconcerned on the bullying actors and little attention is paid to their teachers and their reactions to the aggressive behavior of students(Yoon&Kerber, 2003). Although teachers play an important role in the school's safety, little is known about their attitudes towards addressing issues such as bullying (Duong &Bradshaw, 2013).

Teachers' reactions to aggression can influence the future behaviors of both victims and offenders(Yoon&Kerber, 2003).The lack of teachers' reaction to school bullying sent unconscious to students the idea that this behavior is accepted and tolerated (Olweus, 1993; Yoon &Kerber, 2003)

The perceived severity of aggression is a significant factor for the probability of intervention in bullying.There is a possibility that many teachers may not know the extent

of the verbal and relational aggressions and the damages they cause to the victims (Howard et al., 2001).

A significant number of teachers do not regard social exclusion as aggression, and ignoring this type of aggression can be interpreted by students as being tolerated and permissible (Yoon & Kerber, 2003). The same authors argue that changing teachers' perceptions and attitudes towards aggressors and victims of social exclusion depends on the degree of knowledge of the social and psychological damage. A positive feedback from teachers will encourage students to report incidents of aggression, while a lack of reaction may result in students the desire torevenge or to ignore the aggression (Small, Neilsen-Hewett& Sweller, 2013).

A prevention program should generally try to raise teachers' awareness of aggression, to develop policies that outline the consequences of intimidation, and provide training and support in the field of qualifications for both victims and bullies.

6. Conclusions

Olweus was the first researcher to focus on the issue of bullying and has provided important studies and research over the years and has raised the interest of scientists from different countries and continents for this phenomenon (Sanders&Phye, 2004).The international research has taken up this subject for the purpose of understanding its nature and size, and then to be able tobring solutions to this social problem (Carra, Hedibel, 2009, p. 98).

Over the last four decades, specialists have conducted various studies to guide the prevention of this problem and to stop the violence among students.However, aggression is present in the school settings, and many children suffer quietly every day.The results of the studies show that bullying in school is a "gateway" behavior towards future criminal behavior (Carter, 2012).

Studies show that most teachers are not aware of classroom aggression, which explains the discrepancy between perceived teachers' intervention and effective intervention (Craig & Pepler, 1997 apud Small, Neilsen-Hewett & Sweller, 2013).On the

other hand, Veiga (2001) shows that students who know their rights are better able to defend themselves.

The Romanian criminologist Florian believes that a solution to crime prevention is to take in the consideration of human rights, individual freedoms and responsibilities, and the protection of infants.At the same time, the author presents the necessity of conceiving long-term prevention programs "where specialists intervene based on a scientifically approach" (Florian, 2005, p.4).

In agreement with Florian (2015), we support the importance of an interdisciplinary approach to preventing juvenile delinquency and victimization of infants in which specialists work together for the same purpose.At the same time, like Milsom and Gallo (2006), we consider that an effective program to prevent aggression among students should also refer to the teacher's training from the perspective of recognition and awareness of aggression, the consequences of this problem on the student's health and the possibility of counseling.Additionally, teachers need to be aware of their legal role, namely to be an active participant in respecting children's rights and how to protect them from any form of physical or psychological abuse, abandonment or negligence, unappropiate treatment or exploitation (The UN Convention on the Rights of the Child, 1989).

We conclude that a teacher training program should also refer to the international and national legislative framework alongside of awarenessactionson the severity of bullying and the recognition of the students aggressive types of behaviors.

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The influence of emotional regulation strategies in the relationship between test anxiety and performance in the educational competitions context of adolescents with high intellectual abilities

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Abstract

Competitions are one of the most important and attractive activities for students in Romanian schools because they give them the opportunity to deepen the study of a certain discipline and to achieve performance in the favorite field.What is somewhat neglected in literature about educational contests is precisely the presence and influence of emotions experienced by students in the context of competitions that may have a positive or negative impact on the performance achieved. Test anxiety is the most frequently studied phenomenon and mentioned as a problem in the educational psychology, but there are no studies (at least identified by us) that have approached this topic with direct reference to the context of educational competitions (except for sports studies that frequently addresses the issue of competitive anxiety). Another aspect that is rather little studied in research concerned with academic emotions is the influence of emotional regulation on academic performance. Very few studies address the role that emotional regulation strategies have in the relationship between test anxiety and performance.Given the lack of studies on the impact of test anxiety and emotional regulation strategies on performance in educational competitions of adolescents with high intellectual abilities, we have investigated this issue in this study. The selected group of subjects consisted of 541 teenagers who participated in various national Olympiads (2017). The results show that cognitive test anxiety has a positive influence on the performance achieved in educational competitions. Even though emotional regulation strategies do not moderate the relationship between test anxiety and performance, they still have some relationship with both. Thus, test anxiety has positive relationships with all emotional regulation strategies, less with cognitive reappraisal. Performance has only positive relationships with two of the emotional regulation strategies (task-focused strategies and emotion-focused strategies) and negative relationships with other two of them (cognitive-appraising strategies and suppression). These links identified between the variables analyzed can be a contribution to the educational practice,

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both for students participating in various educational competitions as well as in the case of day-to-day school performance.

Keywords*:* test anxiety; performance; emotional regulation strategies; educational competitions; high intellectual abilities.

1. Introduction

Test anxiety is the most frequently cited factor that has a negative influence on academic performance. Test anxiety is a strong emotional reaction that an individual experience before and during an examination (Akca, 2011). When students are placed in an evaluative situation, comparative and competitive behaviors will lead to increased anxiety that will disrupt their focus on doing what they need to successfully complete their work tasks (Zeidner & Matthews, 2011). Test anxiety is a serious problem for many students in secondary school, high school and higher education students (Ergene, 2003). Although large-scale studies have seen a decrease, approximately 33% of students experience test anxiety (Methia, 2004), and those with high levels do not give a very high academic performance (Bedell & Marlowe, 1995; King, Ollendick, & Prins, 2000). Test anxiety is studied in the context of the field dedicated to academic emotions. Pekrun and collaborators (2002a) defined academic emotions as "those emotions experienced in academic contexts and associated with learning and achievement activities". Such emotions, for example, relate to the pleasure of learning, the success offered, the anger manifested when the tasks received are too difficult or impossible to achieve, or the anxiety experienced in an assessment context. In the past, academic emotions have largely been neglected in research in the field of educational psychology, with the exception of test anxiety.

In terms of research in the academic field on emotions and emotional regulation, the subject that attracted attention was the anxiety manifested in the evaluative context (Pekrun et al., 2002a; Schutz & Pekrun, 2007) and how students manage their anxiety during the examination process (Kondo, 1997). Conclusions of studies suggest that the regulatory function is associated with academic outcomes through behaviors and attitudes towards tasks. For example, students with a higher level of control tend to participate more actively in classes, and this has led to higher levels of academic performance (Valiente et al.,

2014). Also, students with higher levels of emotional regulation also had better skills in carrying out certain academic tasks, and a higher level of academic competence (Trentacosta & Izard, 2007).

The objective of our study is to identify the extent to which the anxiety manifested in the context of educational competitions influences the performance of adolescents with high intellectual abilities participating in national academic competitions. We also want to investigate the relationship between emotional regulation strategies used by participants and their performance. Finally, we want to test the moderator role of emotional regulation strategies in the relation between test anxiety and performance for the educational competitions context of adolescents with high intellectual abilities.

2. Test anxiety concept

Sarason (1980), Spielberger and Vagg (1995) define test anxiety as the predisposition of an individual to react through a state of excessive concern, intrusive thoughts, mental disorganization, tension, and physiological activation when is exposed to an evaluation situation. Obtaining lower scores or results in tests, experimenting shame and embarrassment, and the fact that they might disappoint some important people around them are some of the consequences of the evaluation that students perceive to be threatening (Zeidner, 2007, Pekrun et al., 2011).

For those with test anxiety, both preparation for an examination and the examination itself are causing a high level of mental anxiety and discomfort (Cohen et al., 2008). As a result, affected students fail to meet their potential, and the results of their evaluation do not represent them or their real level of knowledge and learning (Shobe, Brewin, & Carmack, 2005).

At the beginning of the research on the "test anxiety", the construct was considered to be one-dimensional and was measured by scales such as the *Test Anxiety Questionnaire,* Mandler & Sarason, 1952). Subsequently, field research has demonstrated that there are at least two dimensions present in measuring test anxiety. Liebert and Morris (1967) argued that "worry" and "emotionality" are present in measuring test anxiety and that they are two different dimensions. The Worry dimension refers to mind-distracting thoughts, self-

disapproving rumination, and other types of distractors of the thinking process associated with evaluation. Vasey, Crnic and Carter (1994) refer to the cognitive characteristic of anxiety as "an anticipatory cognitive process involving repetitive thoughts associated with possible threatening outcomes and their potential consequences" (p.530). The Emotionality dimension refers to the body responses that are associated with anxiety (increased heart rate, headaches, sweating, etc.) (Cassady, 2004a). *Test Anxiety Scale* (Sarason, 1978), and Test Anxiety Inventory (Spielberger et al., 1980) are two of the most popular tools that have been developed in close connection with these two dimensions of the test anxiety. While the studies confirmed the presence of the two dimensions, repetitively, unsolved psychometric problems persisted, such as the strong overlap between the two factors (Ware, Gallasi, & Dew, 1990; Ferrando, Varea, & Lorenzo, 1999). The cognitive component of test anxiety (worry) is the most commonly found factor associated with the decline in performance (Hembree, 1988). In addition to the evidence available through traditional correlation studies and meta-analyzes, it has been confirmed that cognitive test anxiety has the closest connection to performance. While the analyzes did not support the existence of significant influence of the emotional component, the link between worry and academic results proved to be significant in adolescents (Williams, 1991) and students (Bandalos, Yates, & Thorndike- Christ, 1995).

However, there have been studies that have shown that test anxiety can also have a positive influence on performance. More specifically, it has been shown that anxiety affects performance in complex or difficult tasks that require cognitive resources, such as the difficult items of an intelligence test, while performance in mild, less complex and repetitive tasks is not affected, on the contrary (Hembree, 1988; Zeidner, 1998, 2007). Also, although anxiety is likely to have negative effects among many students, it may facilitate general performance in those who are more flexible and can use in a productive way its motivational energy (Pekrun & Linnenbrink-Garcia, 2012).

3. Emotional regulation in academic context

Emotional regulation can be defined as a set of processes through which people seek to redirect the spontaneous flow of their emotions. During emotional regulation, people can

intensify, maintain or reduce positive and negative emotions. Therefore, emotional regulation often involves changes in the emotional response. These changes can occur in the type of emotions that people have when they live, or in the way of experimentation and expression of emotions (Gross, 1999). Emotions have several components, consisting of behavioral and physiological responses that are accompanied by specific thoughts and feelings (Parkinson et al., 1996; Mauss et al., 2005), and because emotional regulation acts on people's emotions, it results that the effects of this process can be observed on all emotional responses, including behavioral, physiological, or thoughts and feelings (Koole, 2009).

Regarding the evaluation in the academic context, some students can consciously engage in trying to reduce unpleasant feelings during evaluations, but there is a possibility that the adoption of specific strategies may not necessarily produce the results they want (John & Gross, 2007). Otherwise conceptualized, emotional regulation is one of the forms of affect regulation that involves attempts to modify some aspects of the interaction between the individual and the environment, coded by the individual in a certain manner (Gross, Richards, & John, 2006).

In terms of research in the academic field on emotions and emotional regulation, the subject that attracted attention was that of anxiety manifested in the evaluative context (Pekrun et al., 2002a, Schutz & Pekrun, 2007) or “test anxiety” and the way that students manage their anxiety during the examination process (Kondo, 1997).

Although empirical evidence is limited, there are still some premises in the literature that emotions and emotional regulation are associated with academic performance, indirectly through motivation and involvement. Emotions have a substantial effect on motivation, cognition and action of the students by orienting mental and physiological energy in accomplishing the tasks and also by directing attention to the positive or negative aspects related to themselves and their tasks (Pekrun et al., 2002a). Indeed, there are results of studies that indicate that emotions are associated with academic motivation (Mega, Ronconi, & De Beni, 2014, Pekrun et al., 2002a), and that dispositional affect is associated with the degree of involvement of students in the tasks (Linnenbrink-Garcia, Rogat, & Koskey, 2011).

Gross and Munoz (1995) present five different families of emotional regulation strategies: situation selection, situation modification, attentional deployment, cognitive change, and response modulation. The selection of the situation refers to the fact that individuals avoid certain situations, persons or contexts to try to reduce unpleasant emotions or, on the contrary, look for certain situations, people or contexts as a way to enhance the pleasant emotions. Changing the situation involves efforts to change a situation so that the emotional impact is different. In the evaluative context, most students do not have the opportunity to approach this strategy. Evaluations are mostly set by teachers or by regulations regarding their format, time, or other organizational details. In attentional deployment, individuals try to focus on the more or less important aspects of the context in trying to regulate their emotions. The goal is either to distract attention or to focus on the elements of the situation. Davis, Schutz, and DeCuir (1999) found that students with lower levels of test anxiety used focusing strategies by focusing on easy tasks in a test at an initial stage, then returning to the most difficult ones. Cognitive change refers to the attempt to build a more positive sense by reevaluating the experience. Each of these four types of regulatory strategies could be considered as focus-based strategies, because when they are used, the intention is to try to modify some elements of the context or the judgments that cause the emotion. Instead, during modulation of the response, individuals act directly on the experimented emotion (such as trying to suppress it).

Regarding the evaluative context, Schutz and collaborators (Schutz et al., 2008) identified three different dimensions of coping that students use in managing the difficulties encountered during evaluations: *task-focused processes*, *regaining task focus*, and *emotion-focused processes*. In terms of the first of these dimensions, that of task-focused processes, its key element is that the students wonder what strategies they need to use when solving the task. For example, during an assessment, students' thoughts might be about how they will manage their time in solving tasks, or how to formulate the answer to a question using the answers of other questions already solved. These thoughts help students keep their focus on the test and not on some possible disrupters. This strategy largely reflects what Gross (2002) highlights by attentional deployment, namely that students focus on those elements of the assessment they can control, such as reading instructions in solving,

identifying key ideas in questions, eliminating responses, and so on. This change in the way of managing attention favors students to eliminate the elements that confuse them and focus on what they understand, supporting not only the regulation of emotions but also how to organize and solve the concrete tasks of the evaluation (Davis, DiStefano & Schutz, 2008).

The second dimension is about emotion-focused processes, and it refers to the fact that the attention of the students is reoriented from the task to themselves and the emotions related to the task. More specifically, this involves a disengagement from the task received and a reorientation of the focus on feelings and thoughts about their performance related to the work task and the possible causes of that performance. These emotion-focused thoughts tend to distract the attention from the assessment task and may decrease performance and results (Davis, DiStefano & Schutz, 2008). This strategy can be similar to what Gross (2002) calls attentional deployment (because students can focus on thinking about how the teacher will note that task) or cognitive change (by student taking responsibility for the insufficient training for the evaluation).

Davis and collaborators (2008) argue that there is still a third dimension involved in the management of the difficulties during the evaluations, called the processes of regaining the focus on task, which refers to the students' attempts to "return" to the task by reducing the tension experienced or by bringing the evaluative task to the foreground. Thus, these processes tend not to be focused on either task or emotion. Realizing a parallel with the strategies proposed by Gross (2002), the two previously mentioned seem to target different families, of which the reduction of tension reflecting students' attempts to modulate the response (e.g. suppressing unpleasant feelings) and re-appraising the importance of the test, reflecting the students' cognitive change (for example giving the assessment another importance in achieving its own goals).

4. Method

4.1. Participants (Sample)

The selected group of subjects consisted of 541 teenagers (357 girls and 184 boys), 9th-12th grade students, aged between 15 and 19 years (M= 16.71, SD= 1.17) who

participated in various national Olympiads. Distribution by gender variable was as follows: 66% girls and 34% boys. In the study were selected students participating in various competitions targeting the following subjects: Romanian Literature, English, French, Italian, Portuguese, Spanish, Reading as Life Skills, Socio-Human Sciences, Religion, Geography, History, Mathematics, Biology, Informatics, Physics, and Chemistry. They were selected from the public lists on the official Olympics websites and contacted online to complete a set of 3 questionnaires.

4.2. Measures

Test Anxiety Invetory

Developed by Spielberger (1980), the Test Anxiety Inventory (TAI) is according to Chapell et al. (2005), the most important and often used tool in measuring test anxiety among high school students and higher educationstudents. The Test Anxiety Inventory translated and adapted for an educational competition context (Olympiads and Interdisciplinary Competitions) (Holic, 2018a) consisting of 20 items, grouped into three distinct dimensions (Worry, Emotionality and Total Anxiety).Test Anxiety Inventory is a scale of responses that is measured by the 4 steps (Likert scale), the respondents options for choosing the answer are as follows: "1" – "Almost never", "2" - "Sometimes", "3" – "Often", and "4" –"Almost always".

The TAI is a self-reporting questionnaire consisting of 20 items, which are distributed on the three scales as follows Test Anxiety-Total (TAI-T) with items 1, 12, 13 and 19; Test Anxiety-Worry (TAI-W) containing items 3, 4, 5, 6, 7, 14, 17, 20; and the Test Anxiety-Emotionality (TAI-E) Scale consisting of items 2, 8, 9, 10, 11, 15, 16, 18. Thus, TAI-W contains 8 items, TAI-E 8 items, and 4 items make up the TAI-T scale.

The internal consistency for each of the three subscales in the case of the translated and adapted version (Holic, 2018a) for the competitive contexts was: .89 for the Test Anxiety-Total (TAI-T); .73 for Test Anxiety-Worry (TAI-W); and .86 for the Test Anxiety-Emotionality (TAI-E), and .86 for the entire questionnaire.

Emotion Regulation Questionnaire

Emotion Regulation Questionnaire (ERQ, Gross & John, 2003) contains 10 items distributed on two scales that measure the usual use of cognitive reappraisal and suppression. The results presented below indicate that ERQ is a valid tool to measure individual differences in cognitive reappraisal and suppression. In recent years, this tool has been translated and adapted into many languages, all of which have acceptable internal consistency indicators for both scales.

The answers to the questionnaire items relates to the level of agreement with the statements presented in the items and are measured by the seven-points rating scale (Likert), where the respondents options for selecting the answer are as follows:1 - "strong disagreement" and 7 -"strong agreement" with the statement. For calculating the final score for each scale, the arithmetic mean of the scores of the items corresponding to the scale is calculated.

Alpha Cronbach's internal consistency coefficients of scales translated into the Romanian language (Heilman, 2011) were .74 for cognitive reappraisal, and .72 for suppression.

Emotion Regulation during Test-Taking

The translated and adapted version of Emotion Regulation during Test-Taking (ERT) for a competitive context (Holic, 2018b), after the original one (Emotion Regulation during Test-Taking, Schutz et al., 2008). Emotional Regulation during Test-Taking Scale (Schutz et al., 2008) consists of four dimensions: 1) Task-focusing Processes associated with the evaluation process; 2) Emotion-focusing Processes associated with evaluation process; 3) Regaining Task-focusing Processes associated with evaluation; and 4) Cognitive-appraising Processes associated with the transaction between the person-directed goal and the environment.

Each dimension comprises one or more subscales as follows:

• The Task-focused Processes dimension includes the Task-focused Strategy Use subscale

• The Emotion-focusing Processes dimension includes Wishful Thinking subscale and Self-blame subscale

• The Regaining Task-focusing Processes dimension includes Importance Reappraisal subscale and Tension Reduction subscale

• The Cognitive-appraising Processes dimension includes Goal Congruence subscale, Agency subscale and Testing Problem-Efficacy subscale

The answer to the questionnaire items refers to the frequency with which respondents use that type of strategy, and is a 5-point Likert response format with the following anchor labels 1 = "Almost Never", 3= "Sometimes", and 5 ="Almost Always".

Alpha Cronbach's internal consistency coefficients of scales translated for the Romanian version were: .56 for Task-focused Processes dimension; .72 for Wishful Thinking Subscale and .86 for Self-blame Subscale; .64 for Importance Reappraisal Subscale and .81 for Tension Reduction Subscale; .65 for Goal Congruence Subscale, .82 for Agency Subscale, and .82 for Testing Problem-Efficacy Subscale. The internal consistency for the entire Emotional Regulation during the Test-Taking Scale was an acceptable one (Alpha Cronbach = .706) (Holic. 2018b).

4.3. Results

Correlation analysis

To test the moderation relationship, the correlations between the scales of test anxiety, emotional regulation strategies (Gross&John, 1998; Schutz et al., 2008) and performance were initially analyzed.

Table 1 shows correlations between test anxiety, cognitive test anxiety, emotionality test anxiety, cognitive reappraisal, suppression, task-focused strategies, emotion-focused strategies, regaining task-focusing strategies, cognitive-appraising strategies, and performance.

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Table1.*Correlations between test anxiety, cognitive test anxiety, emotionality test anxiety, cognitive reappraisal, suppression, task-focused strategies, emotion-focused strategies, regaining task-focusing strategies, cognitive-appraising strategies, and performance*

	(1)	***(2)***	***(3)***	***(4)***	***(5)***	***(6)***	***(7)***	***(8)***	***(9)***	***(10)***	***(11)***
(1)test anxiety	-										
(2)cognitive test anxiety	.885**	-									
(3)emotionality test anxiety	.923**	.678**	-								
(4)cognitive reappraisal	-.051	-.014	-.096*	-							
(5)suppression	.105*	.173**	.046	.026	-						
(6)task-focused strategies	.140**	.157**	.097*	.241**	-.012	-					
(7)emotion-focused strategies	.614**	.627**	.484**	.020	.093*	.241**	-				
(8)regaining task-focusing strategies	.089*	.092*	.045	.312**	-.042	.187**	.155**	-			
(9)cognitive-appraising strategies	-.475**	-.441**	-.418**	.165**	-.080	-.011	-.415**	-.011	-		
(10)general emotion regulation strategies (Schutz et al., 2008)	.237**	.270**	.147**	.317**	-.004	.458**	.595**	.662**	.263**	-	
(11)performance	.067	.105*	.024	.071	-.085*	.097*	.114**	.061	-.175**	.033	-

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Testing the moderation relationship

In the next step we will investigate the relationship between test anxiety, and its cognitive and emotionality components, emotional regulation strategies and performance through a moderation relationship where emotional regulation strategies are considered as a moderator of the relationship between test anxiety and performance. Because we have used two different conceptualization of emotion regulation strategies (Gross & John, 1998; Schutz et al., 2008), we will test this relationship with each of them. Thus, in the first step of each hierarchical regression, test anxiety, cognitive test anxiety and emotional test anxiety were introduced, then each of the emotional regulation strategies in the second step, and in the third step was included the interaction between the two variables.

The tables contain standardized beta indices are to be found in the Annexes of this paper.

5. Discussion

The objective of our study was to investigate the relationship between test anxiety and the emotional regulation strategies used. We also wanted to identify the extent to which the relationship between test anxiety and performance in national Olympics is moderated by the emotional regulation strategies used. Thus, we assumed that some of the emotional regulation strategies used, such as cognitive reappraisal (Gross & John, 1998), task-focused strategies, emotion-focused strategies, regaining task-focusing strategies and cognitive-appraising strategies (Schutz et al., 2008) will be more effective in managing the effect of test anxiety (and its components) on performance. Because we have used two different models of emotional regulation strategies, it resulted several models of moderation.

In a first step, we have used the conceptualization released by Gross and John (1998), which presents two of the most studied strategies of emotional regulation, the cognitive reappraisal and expressive suppression. Cognitive reappraisal is defined as the attempt to reinterpret a situation that generate emotions in a way that can change its meaning and emotional impact (Lazarus & Alfert, 1964, Gross & John, 2003). Expressive suppression is defined as the attempt to hide, inhibit, or reduce the expressive emotional behavior (Gross & Levenson, 1993; Gross & John, 2003). Thus, we developed a model for test anxiety and each of its components and the two types of strategies mentioned above and the performance achieved. Analyzing the results, it was noted that none of the emotional

regulation strategies used by the Olympics participants (cognitive reappraisal and suppression) was a moderator in the relationship between anxiety manifested in a competitive context and performance.

In a second step, we used the model developed by Schutz and collaborators (2008) which distinguishes between four different categories of coping that students use in managing the difficulties encountered during evaluations: task-focused processes/strategies, regaining task-focusing processes/strategies, emotion-focused processes/strategies, and cognitive-appraising processes/strategies. Task-focused strategies are referring at the student's attempt to acquire and maintain the focus on task. In other words, what the student is thinking at the that moment refers to the activities by which he / she can acquire and maintain his / her focus on the evaluation and tasks that he / she has to accomplish during the assessment time. For example, during the evaluation process, students who use the task-focused strategies, such as "time management" or "identifying the main idea within the exercise / activity", are more likely to remain focused during the evaluation. Ideally, these strategies are useful in gaining and maintaining focus on task. The second dimension of emotional regulation involves emotion-focused strategies / processes associated with evaluation. These involve a focus on the self and the emotions associated with work tasks. It may refer to a disconnection from the task and a focus on emotions (pleasant or unpleasant) and on thoughts about how the student is handling the work task and the potential causes of why things are going in that way. Within these processes, two key emotion-focused strategies / processes have been identified: Wishful Thinking, which involves thoughts about whether the problem simply disappears or the hope that the teacher / evaluator will not take into account the results obtained; and Self-blame, which involves the students' criticism towards their own person about how they are doing during the evaluation or about how they trained for the evaluation (Schutz et al., 2004, 2008). The third dimension of emotional regulation associated with evaluation involves attempts to regain focus on the task (Schutz et al., 2004, 2008). For example, students' attempts to reduce their tension during assessment through the breathing rate or by giving themselves a one-minute break, which may prevent or stop irrelevant thoughts from the work task received. Therefore, this can help students regain focus on the work they have to deal with. The potential usefulness of trying to reduce tension is to increase the chances of redirecting attention from oneself and

the feelings they have about how they do during the assessment, to the concrete fulfillment of the task. In addition, reappraising the importance of evaluation, involving attempts to keep its significance or highlighting positive aspects within it, are also activities that can stop the student's irrelevant thoughts and therefore facilitate the reorientation of the attention needed to accomplish the tasks received.Such an example may be to keep in perspective the importance of evaluation in relation to other aspects of the student's life, which can redirect the self-irrelevant thinking towards self-focusing on the task (Schutz et al., 2004, 2008).

Cognitive-appraising strategies are the fourth dimension and refer to the appraisals that students make during the evaluation process. Schutz (Schutz et al., 2004, 2008) indicates that there are four key types of appraising that are associated with the type of emotions that emerged during the academic assessment. The first type refers to the importance or relevance of the assessment. For example, if a student appreciates the assessment as being not too relevant, an emotional experience is unlikely to occur. In other words, in order for emotions to emerge, the transaction between person and environment needs to be regarded as relevant in terms of its objective or importance. A second type of appraisal refers to the congruence of the perceived objective. A potential question might be the following - "What happens during the evaluation helps me to reach my goals?" If the answer to this question is "No", the emotions of the incongruent objective, such as anger or anxiety, are most likely to occur. If the answer to this question is "Yes", the emotions of the congruent objective, such as joy or pride, are more likely to occur. A third type of appraisal refers to agency, or student's appreciation about who controls or who has caused what happens in the transaction. If students appreciate the assessment as relevant to their objective, but they do not perform properly and consider it to be someone else's fault, this will most likely cause anger. And the fourth type of appraisal refers to the efficacy in solving problems during the evaluation or the potential in managing any issue that may arise during the evaluation. Thus, a model was developed for test anxiety (and each of its components), the four types of emotional regulation strategies and the performance achieved on the competitions. No statistically significant results have been obtained in this case, so we can say that none of the four strategies can be considered as a moderator variable in the case of the relationship between test anxiety and performance. However, some relationships between the variables analyzed were identified. For example, emotionality test anxiety has shown a negative relationship

with cognitive reappraisal, meaning that participants who experience a high level of emotionality test anxiety during Olympics are using less cognitive reappraisal as a strategy to regulate emotion. In the case of cognitive test anxiety, a positive relationship has been identified with suppression, meaning that participants who have to some extent intrusive thoughts during competition use suppression to a high level. The same aspect was also identified in the case of general test anxiety, which showed a positive relationship with suppression. In the case of task-focused strategies, they have shown positive relationships with test anxiety and with each of its components (cognitive and emotionality). Thus, participants exhibiting a high level of test anxiety, or just one of its forms - cognitive or emotionality - use to a large extent strategies that are focusing on tasks. The same remarks can be made about emotion-focused strategies, which also showed positive relationships with test anxiety and its components. Also, participants who use the regaining task-focusing strategies to a high degree are those who experience high levels of general test anxiety and cognitive test anxiety. What can be noticed is that when levels of test anxiety, cognitive test anxiety, and emotionality test anxiety are high, participants use less the cognitive-appraising strategies. In terms of performance, it has a positive relationship with cognitive test anxiety, task-focused strategies and emotion-focused strategies, and a negative relationship with suppression and cognitive-appraising strategies.

What can be remarked in this study is that the results show that, at least in the case of educational competitions involving adolescents with high intellectual abilities, the anxiety experienced during the evaluation has a positive influence on performance. This was also shown in other studies where the results were similar. Authors such as Pekrun and Linnenbrink-Garcia (2012) have argued that test anxiety can have a positive effect on performance when students are more flexible and can productively use the motivational energy provided by anxiety. Also, Hembree (1988) and Zeidner (1998; 2007) showed that the performance in repetitive tasks is not affected by anxiety on the contrary, it is improved. Thus, we can say that the Olympians through the training necessary for the competitions they are participating in are already familiar with the type of work tasks required.

The results also show that there is a positive relationship between test anxiety (and its two components, cognitive and emotionality) and the types of emotional regulation strategies used by the Olympics participants. Test anxiety (and its components) positively

correlates with all emotional regulation strategies, less with cognitive reappraisal. Thus, we can state that adolescents participating in educational competitions who experience a high level of test anxiety (cognitive and emotionality) use to a great extent emotional regulation strategies such as suppression, task-focused strategies, emotion-focused strategies, regaining task-focusing strategies and cognitive-appraising strategies.

What is noteworthy and important to know by teachers and trainers of the adolescents that participate in national education competitions is that task-focused strategies and emotion-focused strategies have a positive influence on performance and cognitive-appraising strategies and suppression have a negative influence. We consider this to be an important thing for educational practice because teachers and trainers can take these aspects into account so that they can conceive activities that will form and develop strategies for teenagers whose influence is a positive one on performance and discourage the use of those strategies that proved to be ineffective.

Even if the results do not support the fact that emotional regulation strategies play the role of moderator in the relation between test anxiety and performance, yet these links identified between the variables analyzed can be a contribution to the educational practice, both for students participating in various educational competitions as well as in the case of day-to-day school performance.

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Annexes

Multiple hierarchical regression of relation between test anxiety, suppression and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.009	4.63*
Suppression	-.093*	-2.15		
Step 3			.008	.06
Test anxiety * Suppression	.010	.235		

*p<.05

Multiple hierarchical regression of relation between cognitive test anxiety, suppression and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		
Step 2			.018	5.99*
Suppression	-.106*	-2.45		
Step 3			.017	.019
Cognitive test anxiety * Suppression	-.006	-.136		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, suppression and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.56		
Step 2			.004	3.99*
Suppression	-.086*	-2.00		
Step 3			.002	.007
Emotionality test anxiety * Suppression	-.004	-.084		

*p<.05

Multiple hierarchical regression of relation between test anxiety, cognitive reappraisal and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.075	1.75
Cognitive reappraisal	.075	1.75		
Step 3			.005	.004
Test anxiety* Cognitive reappraisal	-.003	-.063		

Multiple hierarchical regression of relation between cognitive test anxiety, cognitive reappraisal and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		
Step 2			.013	2.91
Cognitive reappraisal	.073	1.71		
Step 3			.011	.010
Cognitive test anxiety* Cognitive reappraisal	-.004	-.101		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, cognitive reappraisal and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.56		
Step 2			.002	2.98
Cognitive reappraisal	.074	1.73		
Step 3			.001	.000
Emotionality test anxiety* Cognitive reappraisal	.000	-.006		

Multiple hierarchical regression of relation between test anxiety, task-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.009	4.24*
Task-focused strategies	.089*	2.06		
Step 3			.007	.003
Test anxiety* Task-focused strategies	-.002	-.051		

*p<.05

Multiple hierarchical regression of relation between cognitive test anxiety, task-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		
Step 2			.014	3.62
Task-focused strategies	.082	1.90		
Step 3			.012	.141
Cognitive test anxiety* Task-focused strategies	-.016	-.375		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, task-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.556		
Step 2			.006	4.89*
Task-focused strategies	.095*	2.21		
Step 3			.004	.085
Emotionality test anxiety* Task-focused strategies	.013	.292		

*p<.05

Multiple hierarchical regression of relation between test anxiety, emotion-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.009	4.66*
Emotion-focused strategies	.117*	2.16		
Step 3			.008	.220

Test anxiety* Emotion-focused strategies	0.021	-.469

*p<.05

Multiple hierarchical regression of relation between cognitive test anxiety, emotion-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		
Step 2			.011	2.11
Emotion-focused strategies	.080	1.45		
Step 3			.011	.869
Cognitive test anxiety* Emotion-focused strategies	-.042	-.932		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, emotion-focused strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.556		
Step 2			.011	7.52*
Emotion-focused strategies	.134*	2.74		
Step 3			.009	.000
Emotionality test anxiety*Emotion-focused strategies	-.001	-.018		

*p<.01

Multiple hierarchical regression of relation between test anxiety, regaining task-focusing strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.004	1.65
Regaining task-focusing strategies	.055	1.29		
Step 3			.004	1.32
Test anxiety* Regaining task-focusing strategies	.049	1.51		

Multiple hierarchical regression of relation between cognitive test anxiety, regaining task-focusing strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105	2.46		
Step 2			.010	1.45
Regaining task-focusing strategies	.052	1.20		
Step 3			.012	2.09
Cognitive test anxiety* Regaining task-focusing strategies	.062	1.45		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, regaining task-focusing strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.556		

Step 2			.000	1.94
Regaining task-focusing strategies	.060	1.39		
Step 3			.000	.860
Emotionality test anxiety* Regaining task-focusing strategies	.040	.927		

Multiple hierarchical regression of relation between test anxiety, cognitive-appraising strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.056	1.57		
Step 2			.027	14.57*
Cognitive-appraising strategies	-.184*	-3.82		
Step 3			.027	.676
Test anxiety* Cognitive-appraising strategies	.036	.822		

*p<.01

Multiple hierarchical regression of relation between cognitive test anxiety, cognitive-appraising strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		
Step 2			.028	11.33**
Cognitive-appraising strategies	-.159**	-3.37		
Step 3			.026	.154
Cognitive test anxiety* Cognitive-appraising strategies	.017	.393		

*p<.05 **p<.01

Multiple hierarchical regression of relation between emotionality test anxiety, cognitive-appraising strategies and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.556		
Step 2			.030	18.25*
Cognitive-appraising strategies	-.199*	-4.27		
Step 3			.030	1.04
Emotionality test anxiety* Cognitive-appraising strategies	.044	1.02		

*p<.01

Multiple hierarchical regression of relation between test anxiety, emotion regulation strategies (Schutz et al., 2008) and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.003	2.45
Test anxiety (general)	.067	1.57		
Step 2			.001	.167
Emotion regulation strategies (general)	.018	.409		
Step 3			.000	.366
Test anxiety* Emotion regulation strategies	.026	.605		

Multiple hierarchical regression of relation between cognitive test anxiety, emotion regulation strategies (Schutz et al., 2008) and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			.009	6.03*
Cognitive test anxiety	.105*	2.46		

Step 2			.007	.013
Emotion regulation strategies (general)	.005	.112		
Step 3			.006	.003
Cognitive test anxiety* Emotion regulation strategies (general)	.002	.057		

*p<.05

Multiple hierarchical regression of relation between emotionality test anxiety, emotion regulation strategies (Schutz et al., 2008) and performance

	Performance			
	ß	t	ΔR^2	ΔF
Step 1			-.001	.309
Emotionality test anxiety	.024	.556		
Step 2			-.002	.480
Emotion regulation strategies (general)	.030	.693		
Step 3			-.002	1.08
Emotionality test anxiety* Emotion regulation strategies (general)	.045	1.04		

The infantilization of intellectual disability and political inclusion: a pedagogical approach

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Abstract

The present paper looks at the way in which political and scientific frameworks, as well as everyday life dynamics work to exclude people living with intellectual disability (ID) in Romania from political life and how these dynamics could be overcome through crafting communicative-dialogic pedagogical interventions geared at political inclusion. I argue that the political exclusion of people with ID is built into the formal political order, as well as doubled by a twofold infantilizing dynamic. On the one hand, the scientific and academic psycho-pedagogical discourse still operates with classifications that inscribe people with ID with chronological "normal" ages inferior to their biological age. Their subject position is thus "fixed" at an age below the voting limited. This move is seconded by the way in which (formerly) institutionalized people with ID are referred to as "children" (despite their fully adult ages) in a small (post)institutional town, as well as in other care settings that I have explored ethnographically. Finally, the paper explores the stepping stones of alternative interventions, built on a communicative-dialogic methodology for politically including people with ID that could work to overcome the infantilizing dynamics.

Keywords: intellectual disability; CRPD; depoliticization; inclusion; infantilization.

1. The political context for people with intellectual disabilities (ID) in Romania

Recently, the equal political inclusion of people with disabilities has been legally enshrined in Romania's 2010 ratification of the UN Convention for the Rights of People with Disabilities, Article 29[6]. Yet, both before and after this symbolic political act, the recognition of actions of people with intellectual disabilities as politically relevant has been limited to a small number of people in contact with self-advocacy groups.

The widespread political discrediting of people with ID is connected to a common everyday and "scientific" problem – that of seeing people with ID as intellectually and

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[6]See Article 29 of the Convention, available here https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-29-participation-in-political-and-public-life.html accessed on 27.01.2019

politically immature or more plastically and plainly as children. As we will see in the following, different forms of infantilization operate in the Romanian context, both on an academic and scientific level, as well as in the everyday life of (post)institutional care contexts. These infantilizing dynamics serve to consolidate and widen the already legally enshrined dynamics of political exclusion.

The Romanian Constitution still restricts the right to vote for people deemed incapable by a court order, explicitly on the grounds of mental disabilities, art 36, paragraph 2: "The mentally deficient or alienated persons, laid under interdiction, as well as the persons disenfranchised by a final decision of the court cannot vote."[7] The vote restriction itself is not an exceptional one in European terms, since Romania is one of many European countries with such a provision (alongside Bulgaria, Germany and Portugal among others)[8]. Nevertheless, as has been remarked by the CRPD committee (report on Hungary CRPD, 2012), the restriction of this right is not in line with Article 29 of the CRPD.

Yet, the way in which it is worded is also worrying because of the ableist (offensive way of referring to people with disabilities) formulation of the de facto restriction to vote of legally incapacitated people with mental disabilities. Moreover, the enshrining of de facto political exclusion in the Constitution makes it even more difficult to change through a political process that would bring Romanian legislation in line with the CRPD.

Nevertheless, these formal limits to participation still refer to a minority of people with ID, whereas, as I will argue in the following, infantilizing dynamics affect close to everyone living with ID in Romania. Since a "child" cannot be seen as a full political actor (for example voting is conditional upon reaching the age limit 18), challenging the way in which infantilizing dynamics operate is paramount to establishing a discursive climate in which people with ID are recognized as equal conversation partners, and thus as political actors in their own right.

[7] „Nu au drept de vot debilii sau alienaţii mintal, puşi sub interdicţie, şi nici persoanele condamnate, prin hotărâre judecătorească definitivă, la pierderea drepturilor electorale.", full text of the Romanian constitution available here http://www.cdep.ro/pls/dic/site.page?den=act2_1&par1=2#t2c2s0sba36(in Romanian), in English http://www.cdep.ro/pls/dic/site.page?den=act2_2&par1=2#t2c2s0sba36accessed on 27.01.2019

[8] See the graphic illustration provided by the European Agency for Fundamental Rights, available at https://fra.europa.eu/en/publication/2014/indicators-right-political-participation-people-disabilities/legal-capacity accessed on 27.01.2019

Such challenges have been brought forward by disability self-advocacy groups, especially *Ceva de Spus* (Something to Say), a self-advocacy group of people with disabilities including ID in Timişoara[9]. The group has gained local and national visibility, as well as was involved in European policy making processes through the European Disability Forum. Nevertheless, both their visibility and impact could be aided by overcoming the infantilizing dynamics that limit their recognition. Moreover, the more open interventionist methodology that I propose at the end of the paper might aid self-advocacy groups in extending their political activities and membership base.

2. Infantilization of people with ID as classificatory science

Three introductory works to the discipline of special education or psycho-pedagogy (Verza, 2002, Gherghuț, Frumos & Raus, 2016 and Roşan (ed), 2015) can be seen as highly influential in the Romanian context of practice, since their authors are connected to and teach at three of the largest academic centers in Romania (Bucharest, Iaşi and Cluj). All three works introduce classificatory systems for diagnosing people with intellectual disability[10].

Two of the three works (Verza, 2002, pg. 47f and Gherghuț, Frumos & Raus, 2016, 26f.) use a classification of intellectual disability that can be considered infantilizing. Whereas Verza (2002) looks at the severity of intellectual handicap, Gherghuț, Frumos & Raus (2016) term the condition "intellectual deficiency". Nevertheless, both works introduce the different degrees of what could be likened to an understanding of intellectual disability as something strictly pertaining to an individual, based on the assessed person's IQ. The diagnostic categories vary only slightly, the conditions proposed are: liminal intellect (IQ 70/75 – 80/85 or 80-85/90), which is considered to be bordering the condition of "normality" (compare Verza, 2002, pg. 49f.); followed by the three degrees of deficiency, which are relevant to my analysis.

The 1st degree mental deficiency (IQ 50/55 - 70/85) is considered by the authors to be corresponding to "the normal development at a chronological age between 7-12 years" (Verza, 2002, pg. 50) and corresponding to the "operational thought mechanisms of the

[9] http://www.cevadespus.ro accessed on 27.01.2019

[10] Although the cited works do not all use the term disability, for coherence reasons I will continue using it throughout the text, signaling when it differs from the authors' I am quoting use.

specific mental age of 7-9 years" (Gherghuț, Frumos & Raus, 2016, pg. 27). Similarly, age ranges are provided for 2nd degree mental deficiency (IQ 20-50) and ages ranging from 3 - 7 years (Verza, 2002, pg. 56) and 2 - 7/8 years (Gherghuț, Frumos & Raus, 2016, pg. 28) and 3rd degree mental deficiency with an IQ under 20 and an age of up to 3 (Verza, 2002, pg. 59) or 2 (Gherghuț, Frumos & Raus, 2016, pg. 30) years of age.

This classificatory system[11] might be useful, since it includes information related to the likely abilities the person will have, as well as the areas in which a different form (understood strictly as degree, so in a simple progressive manner by the authors) of development can be expected. Nevertheless, what is problematic about the way in which the classification is presented is not only the progressive degrees of development (and not areas of development) considered relevant for assessing the person's abilities, but also the fact that those scoring less on IQ tests are likened automatically to children of different ages. The political consequence of this discursive move is easy to anticipate, people are considered child-like, therefore politically immature and de facto incapable of autonomous decision making. Taking the diagnostic classifications at face value would involve considering people with lower IQ scores automatically as "underdeveloped" in all fields of life.

The underlying position has changed professionally on an internationally relevant level: the shift from IQ-based identification of intellectual disability to a more complex one, based on a person's abilities to "function" in different fields of life (conceptual, social and practical) is documented in the current Diagnostics and Statistical Manual of Mental Disorders - DSM 5 (American Psychiatric Association, 2013, pg. 33f.). This more complex view does not have indirect discursive implications in terms of infantilization and has also travelled into the Romanian scientific and academic context (see Roșan & Bălan-Baconschi, 2015, pg. 104f.).

3. The Infantilization of people with ID in everyday life

[11] I choose to read it as a single system despite the small variations of content between the two works.

The following section is based on one year of ethnographic research conducted in 2015 in several locations in the northeast of Romania, surrounding current and former institutional care settings for people with ID and/or suffering from mental illness.

Many people, who are still currently in the residential care system for people with disabilities, also grew up in a care institution for children, and often came to live in a residential institution for adults upon reaching 18 years of age. The people who I met during my fieldwork had grown up in the "system"[12] as a consequence of the pronatalist decree (decree 770/1966[13]), and the legislation supporting the institutionalization of poor and disabled children (especially law 3/1970[14]) during the early years of Ceauşescu in office. Such people would often be referred to as "children", even though the people I had come to meet were in 2015 generally older than 25 years of age.

The fact that they were called "children", thus, had nothing to do with their age. Nor were all the residents and former residents of residential institutions for the mentally ill and disabled called "children" – the label only applied to those people who had grown up in the system after being abandoned at birth or in the first life-years. People who had spent their childhood and early adulthood outside of institutions, and had come to be given into state care as a result of mental illness or difficulties subsisting on the outside, were never referred to as "children". Moreover, in one of the neuropsychiatric institutions that I spent several weeks observing, they were referred to as the "adults" – the contrasting term to "children".

I encountered an even more interesting situation, in another setting that I explored for several months, where some people with ID that had grown up at a neuropsychiatric children's hospital had been part of a complex program of deinstitutionalization preparing them for independent living, whereas others had not. The members of the first group were referred to as "the young people", and members of the second group were commonly referred to as "the children". This was the case even though the "young people" were generally much younger than the "children". The humanitarian organization had insisted on integrating young people in their program in the late 1990s, so at the time of my fieldwork

[12] Growing up in the "system"
[13] http://www.legex.ro/Decretul-770-1966-363.aspx accessed on 27.01.2019
[14] Legea 3 pe 1970, available here https://lege5.ro/Gratuit/gu4tmobu/legea-nr-3-1970-privind-regimul-ocrotirii-unor-categorii-de-minori accessed on 27.01.2019, the law was substantially changed by government decree in 1997.

the "young people" were aged twenty three to over forty. The "children" had been transferred to an adult institution after the closing of a children's institution in 2001, time at which they were at least 18 years of age. In 2015, "the children" were thus at least 32 years old, generally around 10 years older than the "young people". The label "children"/ "copii" was often used to explain why people couldn't do or understand something. Moreover, it was never used to describe people who had grown up at an institution, but were engaged in regular employment and were living on their own.

In both care contexts, the neuropsychiatric institution with the "children" and "adults", and the after-life of the children neuropsychiatric hospital with the "children" and "young people", the "children" themselves would refer to themselves and each other as "children". This was done especially when stressing vulnerability or need, and when asking for a gesture of compassion or generosity. This is emblematic for the asymmetric relationships that were built into the social order in which they were socialized – the subject position of "children" was a fruitful one for asking for things, but not for claiming rights, a position reserved to those understood as full citizens. Thus infantilization served to depoliticize "children", by placing them in an implicitly inferior subject position, that nevertheless allowed to voice claims as requests to more powerful others[15].

4. The potential of re-politicizing ID through communicative and dialogic pedagogical interventions

Although the two forms of infantilization operate on different levels, the scientific and the everyday life of care settings, they are nevertheless entangled in practice. People with ID are understood as "children" both by the academically trained professionals they interact with, as well as by the care settings and their local surroundings, thus making "eternal childhood" an almost inescapable everyday reality. While the individual way out of this situation is through attaining personal independence in terms of having employment, a place to live, one's own social networks, this is not an immediate possibility for all people with ID that are pejoratively understood and come to understand themselves as children.

[15]Since both research settings had been deeply transformed by the transnational humanitarian practices of the 1990s, it is obvious that the humanitarian power asymmetry shaped these relations as well, a point that I will not explore further at this stage.

Infantilization thus comes to normalize the political exclusion of people with ID in a manner that needs to be challenged. Instead of thinking in terms of infantilizing the individuals with ID, an alternative mode of intervention based on the social model of disability would be to create political participation mechanisms that rework the political space in an emancipatory way. This is both a question of taking people with ID seriously as political actors and "experts through experience", as much as it is a question of designing pedagogical interventions that can make substantial political participation possible.

This is the case, since previous research has shown (Redley & Weinberg, 2007) that models of citizenship built exclusively on a liberal understanding work to create contradictions between pedagogical and political representational practices in the activity of ID based self-advocacy groups. The key then is to strike a balance between pedagogical facilitation and creating an authentic and respectful space for people with ID to voice, as well as crystalize their political positions.

Such a space is necessarily built on a communicative and dialogical approach to pedagogy (see Gomez et. al, 2006), since this is one of the few approaches that does not inscribe the pedagogical process with an a-priori asymmetry of knowledge and competences. This is the case since it entails establishing a climate of epistemological equality among actors (including academics, people living with ID, their allies, policy makers, etc.).

Another reason why the approach should be pedagogical is that it should be geared towards creating an appropriate mode of communication, when this appears necessary. Such a mode of communication could be based on using pictograms and recordings, as well as simple language whenever necessary. All the pedagogical intervention modalities should be designed with the help of self-advocates living with ID.

Recent years have brought forward noteworthy developments in including people with ID in national surveys from which they were previously excluded (see Malan, Emerson & Davies, 2014), as well as in local, national and European political decision making processes, as the story of the self-advocacy group *Ceva de Spus* shows. These initiatives should become mainstream, by politically involving a growing number of people that have been de facto depoliticized by subsequent layers of infantilization.

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Introduceţi text aici

Attitudes and behaviors towards mental illness of pre-service teachers in educational sciences

Ioana DARJAN•, Anca LUŞTREA•

Abstract

The personal system of beliefs and attitudes influence emotional and behavioral reactions. In educational field, teachers' systems of beliefs, their set minds are of extreme importance, as they will direct and impact on their classroom practices, relational and instructional approaches. The pre-service teachers in Educational Sciences will become qualified professionals in educational field, in all its forms: mainstream, special, and integrated education. The future teachers face an extremely fluid educational environment, in terms of students' characteristics, educational objectives, both academic and social, instructional and formative needs. With an increasing rate of school inclusion of students with Special Educational Needs (SEN) (Horga, 2016), the future specialists should be prepared, in terms of competences, to promote and sustain inclusion, to act against discrimination and exclusion, to advocate for the rights of all their students. Aiming to prepare highly qualified education specialists, it is important to assess their attitudes and positions towards students with diverse special needs, from diverse special contexts. As future specialists in education, our pre-service teachers will work directly with students with special needs and their families and will represent important agents in changing mentalities and generating adequate attitudinal and behavioral changes. In this study, we investigate our pre-service teachers' the knowledge, attitudes and behaviors towards mental illness. A survey questionnaire covering topics as knowledge, attitudes and behavior towards people with mental illness was administrated to 82 of our pre-service teachers. The study presents the findings and the conclusions of the survey.

Key words: mental illness;pre-service teachers; attitudes.

1. Introduction

Mental illness is a very controversial and complex topic for the public agenda. The importance of this condition derived from the fact that it impacts not only on individual level,

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but affects the entire family, community and society. At individual level, mental illness could affect autonomy, functionality, productivity, relationships, inclusion, and wellbeing of afflicted people. At community and society levels, mental illness might be perceived as important factor for disfunctions, crises, conflicts, damages and budget-consuming, for restoration/repairs and treatments. Furthermore, mental illness is still an important motif for discrimination and stigma.

The relation between knowledge and attitude towards mental illness at college students was researched before (Pascucci et.al, 2017). Good knowledge about mental health seems to be associated with better attitudes towards people afflicted by it.

Personal experience with mental illness, such as having someone with this condition in the close proximity, in the family, close social circle or at work, have also impact in attitudinal and behavioral responses (Waugh, Lethem, Sherring Henderson, 2017; Sottie, Mfoafo-M'Carthy, Moasun, 2018). People tend to have a better attitude towards mental illness if they have close relations with people with mental illness and tend to change their attitudes if mental illness intervenes in their family life.

Beliefs about and attitudes towards mental illness impact on discrimination and stigmatizing actions. Feeg, Prager, Moylan, Smith and Cullinan (2014) find in a population of college students that those who are less familiar with mental illness tend to maintain the social distance and stigmatize more. Our study tried to investigate the relations between attitudes and predisposition for discriminating and stigmatizing people with mental illness.

Mental illness in children and adolescence is a more controversial topic, as it is a developmental pathology, depending of many factors, hereditary and environmental.

The life-trajectory of affected children could be altered by the adopted measures.

The main agencies for socialization and enculturation are families and schools.

Schools are witnessing some extreme effects of under-diagnosticated, unaddressed, untreated mental illness: conflicts, hetero and self-aggressive behaviors, suicidal ideations, attempts and acts.

There are serious issues that solicit and support the necessity and opportunities for schools and their agents to assume and stress their formative and therapeutic roles, alongside the instructional ones (Dârjan et al., 2015, Dârjan, 2018).

The most demanding issues are:

- The increasing number of children with visible and invisible emotional and behavioral disorders (EBD), whom problems are not address appropriately in school (Forness, Freeman, Paparella, Kauffman, Walker, 2012; Kauffman, Mock, Simpson, 2007, as cited by Losinski et al., 2015);

- Insufficient preoccupation during initial teachers' training in developing teachers' competencies for approaching and working with challenging students;

- Irrational beliefs and unrealistic expectations, based on prejudice, discrimination, which encourage stigma, rejection and isolation of the children with problematic behaviors.

Teachers and all the educational professionals are called to broaden their roles, contributing to the early identification, referral and intervention for the children who experience mental illness or are in risk (Forness, 2003, Maag Katsiyannis, 2010, as cited by Losinski et al., 2015).

Furthermore, teachers are role models, they contribute to the building of system of beliefs, values and moral principles, they have the power to change mentalities. Their systems of beliefs and attitudes will impact the students' systems of beliefs and attitudes, which are shaped throughout childhood and adolescence (Beck, J., 2011; Byrne, 2000). Thus, teachers' positive attitudes towards mental illness, knowledge about it, without misinformation and prejudice, have the potential to reduce stigma and discrimination toward people with mental illness in society. Although teachers tend to adopt negative attitudes toward mental illness (Gur et al., 2012), a sounding solution, with long-term impact, is to educate them during initial training so they could develop a more positive framework for the people with mental illness.

Many studies ((Vibha, Saddichha, and Kumar, 2008; Caldwell & Jorm, 2000; Nordt, Rossler, & Lauber, 2006) demonstrate that attitudes and behaviors towards mental illness improve with better knowledge and understanding of this phenomenon, with previous, more experiences with people who had mental illness, greater educational level.

2. Method

Research question

Universities could meet these needs for relevant and sounding knowledge about mental illness, and to develop positive attitudes toward mental illness for the pre-service teachers enrolled in academic programs.

Based on the above arguments the following research question was advanced:

Which individual factors influence the attitudes towards mental illness?

From the multitude of individual factors that can influence the formation of attitudes we have considered the ones that, in our opinion, can have a high impact: the knowledge about mental illness, personal experiences and with mental illness, attitudes towards intervention, openness/willingness to relate with persons with mental illness and the perception of stigma.

Methodology

This study was designed to determine the pre-service teachers` knowledge and attitudes toward mental illness, and to identify possible individual factors that affect them. 82 pre-service teachers from Special Education and Pedagogy specializations of our Educational Sciences Department answered a questionnaire and a demographic survey.

Research hypotheses

1. The pre-service teachers' attitudes towards mental illness correlate with their knowledge in the field.
2. There will be a correlation between pre-service teachers' attitudes towards mental illness and personal experience with the condition.
3. There will be a correlation between pre-service teachers' attitudes towards mental illness and attitudes towards intervention.
4. There will be a correlation between pre-service teachers' attitudes towards mental illness and their willingness to be around people with mental illness conditions.
5. There will be a correlation between pre-service teachers' attitudes towards mental illness and the perceived stigma.
6. There will be a difference in pre-service teachers' attitudes towards mental illness from families with or without a member with mental illness.

Participants and procedure

Data were collected from a convenience sample of 82 pre-service teachers from Special Education and Pedagogy specializations. The age of participants ranged from 18 to 51 years (*M*=23.40, *SD*=8.31). Participants were 3 (3.7%) men and 79 (96.3%) women. The pre-service teachers were from 2 specializations, 42 (51.2%) in Special Education and 40 (48.8%) in Pedagogy. The pre-service teachers from all three study years were included: 24 (29.3%) were from the first year of studies, 35 (42.7%) from the second and 23 (28%) from the third.

Research instrument

This study used asurvey questionnaire. It wasadapted from the instrument used to assess the attitudes to mental illness of adult from England, since 1994 (Attitudes to Mental Illness, 2015). This instrument assesses the knowledge about mental illness, personal experiences of mental illness, and openness and willingness to live or interact with people with mental illness. The questionnaire collected also some demographic data (age, gender, specialization, year of study).

A consent letter, presenting the aims and the conditions of the study, was administered to all the pre-service teachers. From a total of 181 pre-service teachers, 82 filled-out the questionnaire.

3. Results

To determine the potential correlation between the pre-service teachers' attitudes towards mental illness and knowledge, personal experience, attitudes towards intervention, openness/willingness to be around people with mental illness and perceived stigma, the Pearson Correlations was computed (Table 1). Significant correlations were found between attitudes towards mental illness and personal experience r (82) =.23, p=.03, attitudes towards intervention r (82) =.24, p=.02 and openness/willingness r (82) =.36, p=.00. However, the effect size, r^2=0.05 for personal experience and attitudes towards intervention, and r^2=0.12 for openness, indicates a relatively poor coefficient of determinationbetween personal experiences and attitudes towards intervention and attitudes towards mental illness. They explain only 5.29% of attitudes variance. Also, openness/willingness explains only 12.96% of attitudes towards mental illness variance.

Table 1: *Correlations between attitudes towards mental illness and individual characteristics*

	1	2	3	4	5	6
1.Attitudes towards mental illness	-	.02	.23*	.24*	.36**	.07
2. Knowledge		-	.11	.23*	-.05	.22*
3. Personal experience			-	-.03	.22*	.18
4.Attitudes towards intervention				-	.02	.01
5.Openness					-	.05
6.Stigma						-

*. Correlation is significant at the 0.05 level (2-tailed).

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

As mentioned above, the pre-service teachers are enrolled in two different program study: Special Education and Pedagogy. Normally, Special Education curricula exposes students to more disciplines who offers knowledge about groups with special needs, who promote inclusion, and advocate against discrimination. Thus, we consider relevant to determine if there are differences between the two groups, in terms of attitudes and personal characteristics. For this purpose, an independent sample t-test was conducted (Table 2). Given a violation of Levene's test for homogeneity of variances, $F(1,80)=.39$, $p = .53$, a t-test not assuming homogeneous variances was calculated. The results of this test indicated that there was no significant difference in attitudes towards mental illness observed between the two groups, $t(79.98)=1.58$, $p = .11$. These results suggest that there is not a significant difference between Special Education group ($M = 3.81$; $SD = .41$) and Pedagogy group ($M = 3.67$; $SD = .39$), in terms of attitudes towards mental illness.

Subsequently, no significant differences were obtained for most of the other individual characteristics.

Yet, in terms of openness/willingness to interact with people with mental illness, there is a clear difference between the two groups. The Special Education pre-service teachers have a significant more opened attitude towards people with mental illness and willingness to interact with them (Table 2). An independent sample t-test was conducted. Given a violation of Levene's test for homogeneity of variances, $F(1,80)=.34$, $p = .55$, a t-test not assuming homogeneous variances was calculated. The results of this test indicate that there was a significant difference in openness towards mental illness observed between the two groups, $t(77.06)=2.98$, $p = .00$. These results suggest that there is a significant difference between openness in Special Education group ($M = 3.60$; $SD = .77$) and Pedagogy group ($M = 3.05$; $SD = .89$).

Table 2: *Independent t-test Results Between Special Education and Pedagogy Pre-service teachers*

	Special Education		Pedagogy		
	M	*SD*	*M*	*SD*	*t-test*
Attitudes towards mental illness	3.81	.41	3.67	.39	1.58
Knowledge	3.87	.69	3.76	.85	.67
Personal experience	1.63	.58	1.60	.58	.23
Attitudes towards intervention	3.46	.36	3.67	.64	-1.83
Openness	3.60	.77	3.05	.89	2.98
Stigma	2.42	.47	2.43	.49	-.08

Also, another potentialinfluence on type of attitudes is accumulated experience and exposure to the topic of mental illness, both theoretical, through acquired knowledge, and practical, through interventions. So, we compare the results from different study years. A one-way analysis of variance was conducted to determine if the attitudes towards mental illness differ between study years (N=82). The independent variable, study year, included three groups: first year of studies (*M*=3.69, *SD*=.38, *N*=24), second year of studies (*M*=3.80, *SD*=.41, *N*=35), and third year of studies (*M*=3.71, *SD*=.42, *N*=23). For attitudes towards mental illness the assumption of normality was evaluated using histograms and found tenable for all groups. The assumption for homogeneity of variances was tested and found tenable using Levene`s test*F(*2, 79)=.71, *p*=.49. The ANOVA was non-significant for all three groups (Table 4).

Table 3: *One-way analysis of variance of attitudes towards mental illness by study year*

Source	*Df*	*SS*	*MS*	*F*	*P*
Between Groups	2	.238	.119	.711	.494
Within Groups	79	13.233	.168		
Total	81	13.471			

Table 4: *ANOVA Comparisons of Attitudes Towards Mental Illness by Study year*

					Tukey's HSD Comparisons	
Group		*n*	Mean	*SD*	1	2
1.	First year	24	3.69	.38		
2.	Second year	35	3.80	.41		
3.	Third year	23	3.71	.42		

To determine if there is a difference in pre-service teachers' attitudes towards mental illness from families with or without a member with mental illness, an independent sample t-test was conducted (Table 5). Given a violation of Levene's test for homogeneity of variances, $F(1,80)=.13$, $p = .29$, a t-test not assuming homogeneous variances was calculated. The results of this test indicated that there was no significant difference in attitudes towards mental illness observed between the two groups, $t(11.18)=-1.16$, $p =.27$.

Table 5: *Independent t-test Results Between Pre-service teachers without and with a family member with mental illness*

	Pre-service teachers without a family member with mental illness		Pre-service teachers with a family member with mental illness		
	M	*SD*	*M*	*SD*	*t-test*
Attitudes towards mental illness	3.72	.39	3.90	.45	-1.16

These results suggest that there is not a significant difference between attitudes towards mental illness in pre-service teachers without a family member with mental illness group ($M = 3.79$; $SD = .39$) and pre-service teachers with a family member with mental illness group ($M = 3.90$; $SD = .45$).

4. Conclusions

In the context of a growing need of highly qualified teachers in the field of educational mental health we aimed to investigate pre-service teachers` attitudes about mental health and the individual factors that affect it

We designed a quantitative methodology, in which 82 pre-service teachers in Special Education and Pedagogy specializations responded to a questionnaire and a demographic survey.

In the research hypothesis we presume that will be a correlation between pre-service teachers' attitudes towards mental illness and the following individual factors: knowledge about the condition, personal experience with mental illness, attitudes towards intervention, openness to having a relation with people with mental illness and perception of stigma.

Significant correlations were found between attitudes towards mental illness and personal experience, attitudes towards intervention and openness. However, the effect sizes indicate a relatively poor coefficient of determination between these factors, explaining only 5.29% of attitudes variance for personal experience and attitudes towards intervention and

12.96% for openness. The most influential factor proves to be willingness for relations with people with mental illness.

Even though there were no many significant differences between Special Education and Pedagogy pre-service teachers in terms of attitudes towards people with mental illness, it is important to stress the one significant difference obtained: the openness and willingness to work, live and interact with persons with mental illness. The pre-service teachers in Special Education are more opened and willing to have relations with people with mental illness. The possible explanations reside in the specific of their theoretical and practical training. Relevant and scientific proven knowledge, practical intervention sessions, direct contact with people with special needs tend to improve perceptions and attitudes, diminish misinformation and prejudice, discrimination and stigma. This finding sustains the importance of initial formal training in improving attitudes and behaviors towards special groups (Maag et al., 2014; Predescu et al., 2017).

No significant differences were obtained between attitudes towards mental illness between pre-service teachers from the three study years, the level of studies is not a differentiating factor in terms of attitudes towards mental illness.

Also, we want to evaluate if there is a significant difference in attitudes towards mental illness between pre-service teachers who have a family member with mental illness and those who do not. No significant difference was obtained.

Universities have the responsibility to prepare highly specialized teachers, with adequate attitudes and reactions, prepared to respond efficiently to the broad range of challenges and demands pose by this profession.

Teachers are relevant agents in modelling behaviors and changing mentalities. Teachers could become key-resources in early identification and in educational and therapeutic intervention for students with mental illness. For these purposes, teachers' initial trainings should invest more in increasing teachers' awareness regarding mental illness, improving their knowledge and skills in working with children and adolescents in risk, and promoting positive attitudes towards special groups.

Limitations of the study and further research directions

The main limitation of this research is the number of individual factors taken into consideration. From our findings, the best explanation for attitudes towards mental illness with only 12.96% of the variance explained is the openness/willingness towards relations with people with mental illness. Another limitation of the study is the relatively small number of participants; an increase of the responding pre-service teachers being desirable and essential for more relevant and generalized conclusions.

Authorship statement

The authors of this paper take public responsibility for the content and have had equal contribution in concept development, design, analysis, writing, or revision of the manuscript.

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Book Review

Ioana Dârjan's School-level approaches for students in risk (2018, Timisoara: West University Publishing)

In the context of the major socio-cultural changes of the current historical context, traditional educational systems face extremely diverse demands and challenges. School, as an institution, and education, as a process from a modern perspective, need reform. This predictable destiny of the modern school do not express the futility of school's functions, but the necessity of exponential diversification of school's functions and of teachers' roles.

The roles of the school have become increasingly diverse since they are not only institutions with formal educational objectives. They are called to responsibly exercise the role of a true educative institution, to become and act as an essential environment for socialization and acculturation.

From this perspective, inadequate student behaviors can no longer be interpreted only as deviations from social norms. They represent children's strategies to deal with different problematic situations, learned social behaviors. At the same time, these behaviors can be interpreted by specialists as messages, as indicators of inadequate educative or disciplinary approaches.

Adequate and efficient educational and therapeutic interventions could be developed and implemented only if we find and understand the profound causes and undeniable functions of undesirable behaviors.

In this book, the author comprehensively presents effective ways of solving students` educational and disciplinary problems through unitary, comprehensible and consistent approaches at school level.

During the nine chapters of the book, the author presents some relevant concepts for this topic, such as developmental psychopathology, vulnerability and resilience, the ecological perspective on the child, the functions and roles of the school in solving students`

behavioral difficulties. Also, levels of intervention in school and paradigms and models of intervention at the whole school level are presented and explored.

With a warm and pleasant to read style, the author discusses the principles and characteristics of a therapeutic community that can be extremely effective in addressing the different types of vulnerable populations, in this case children and young people with emotional and behavioral disorders, in risk of developing juvenile delinquency. The author discusses the opportunity to transform the school environment into a real therapeutic community.

The final conclusions advocate for a positive approach of students` behavioral problems and for the need of unitary practices at school level for addressing these difficulties.

The list of references is representative, containing influent papers in the field.

This book is an illustration of Ioana Darjan`s theoretical and practical expertise in the field, a reflection of a vast experience in educating students in risk and training their teachers in positive disciplinary techniques. This book represents a valuable resource for the field of special education, but also for teachers and school management in general education. I warmly recommend it as a highly scientific contribution for understanding and educating at-risk students.

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