Social Work in Addictions and Health Care

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(coordonatori)

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Introduction

This volume includes a selection of papers presented at the thirteenth edition of the international conference: "Social Work in the Addictions and Health Care – Interdisciplinary Collaboration to Improve Quality of Services and Quality of Life", which took place in Alba Iulia during December 9-10.

The conference organized by the ”1 Decembrie 1918” University of Alba Iulia aimed to bring together researchers and practitioners in the field of social work applied in the field of health and addictions to share the results of research and professional practice.

The conference also aims to stimulate the interest of practitioners in the social field for the research of various aspects related to the practice of social work in health and the knowledge of the problem of addiction.

Sharing the results of research and professional practice in the field of health care and addiction recovery is of great interest to social workers, doctors, psychologists, social pedagogues, occupational therapists and other categories of social professions and the publication of the papers presented at the conference tries to respond to this interest.

In this way, we want to inspire successful practices and dedicated public policies so that we contribute to the improvement of professional practice to improve the lives of beneficiaries through knowledge, scientific evidence and successful practices.

This volume includes a series of works that reflect the complex theme of dependency and health care in connection with social work practice.

Among the themes addressed in the works selected in this volume is the one related to palliative care ethics addressed by Zeljko Kaluderovic. The relationship between maladaptive cognitive schemas and social anxiety present in adults hospitalized for alcohol addiction was the subject of the paper presented by Mihaela Ferlai.

The common objective of improving the quality of life addressed by bioethics and social work was analyzed by Željko Kaluđerovic and Orhan Jašić and presented at the conference.

Also in the field of health care is the work presented by Zorica Kaluđerović Mijartović, Choosing the right care solution for patients suffering from dementia.

The paper entitled The role of communication in health care addressed another issue of interest in the field and was carried out by Florina Pascu.

Mihnea Preotesi addressed a topic that makes the transition to addictive behaviors: Mechanisms and factors with an impact on the rationality of social behaviors in crisis situations.

A paper dealing with the role of social work in addictions was made by Mucea Bogdan and Murat Serpolat: The role of social work in the treatment of addictions, a general approach.

Sebastian Fitzak wrote about the trends regarding alcohol consumption during the pandemic and the impact of this consumption on domestic violence.

All the topics covered in the conference that can be found in this volume contribute to a better understanding of the role of social work in health care and the tools and conditions that increase the effectiveness of the practice. Likewise, in the case of addictions, we have a contribution to the understanding of the phenomenon and the ways to improve the practice in the recovery of addicts.

We can say that this edition of the conference also fulfilled its purpose of increasing knowledge in the field of social work in health care and addictions and suggesting ways to improve professional practice, being a useful tool for practitioners in the field.

Two Ends of the Stick: The Euthanasia and the Ethics of (Palliative) Care

Dejan Donev[*]

Abstract

The fundamental human right to life and human dignity in suffering and dying is an equally practical and theoretical academic question. In this sense, euthanasia forced upon someone's life and death does not resolve the question of human dignity but opens up a new, very emotional and distressful question which possible, effective and proven answer compatible with the human right to life and dignity in dying, is ethics of (palliative) care.

Should we accept this request, which represents a dangerous challenge to the Hippocratic principles, both for doctors and for all those who deal with the social integrity of medicine, especially when there is another solution – palliative care, medicine, ethics is the questions with which author deals in the paper.

***Keywords**:* ethics of palliative care, bioethics, euthanasia, human dignity.

Introduction

From an anthropocentric perspective, every human has the right to life, which is a fundamental human right – the right to live. However, in the contemporary world, it often becomes a "subject" of manipulation[1], especially at the end of life, the life's finale – dying and death! This is because "in the daily bombardment with information from the field of biomedical development, there are mixed feelings of awe, admiration, and doubt. Moreover, these are very susceptible to manipulation: awe and admiration concerning the new

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[1] Often because of the distinction creature-person and an ambiguous concept which comes out from it: biological life-life of the person, as well as biological death-death of the person.

perspectives opened in terms of creation or treatment of life, while the doubts are in relation to the open possibilities of the individual and society in the processing, exploitation and management of the new knowledge and potentials, and also the abilities to be reconciled with the already established ethical and social perceptions" (Георгиадис, 2017, 40).

Hence, in today's modern society, the question of the right to dignity in dying and death and the right to a painless death is increasingly opposed. Frequently discussed "exceptions" of the legal protection of human life, i.e. the area of abortion, death penalty, and euthanasia, especially the last example, raises the crucial question: can we decide when and how we can finish our life and can a human make "beautiful" and "sweet" the upcoming death? In this context, the issues of death and dying, which are considered as the most certain happening in one's life, together with the question of the beginning of life, are always the leading ones in the scientific debate, not only from the point of view of religion, philosophy, medicine..., but also from a general view.

They argue it is about all those cases of extending the patient's life with the help of devices in cases of brain death or the possibility of keeping them alive in various cases, which are usually followed by unbearable pain. This opens up a whole spectrum of questions about the limits of life and the limits of human interventions on them, which in turn brings to the surface again the question of rethinking the concept of freedom, autonomy and responsibility.

So, the fundamental human right to live and human dignity in suffering and dying is no more than an opportunity for each patient to decide if and when it will end his life, possibly with the help of others and if this is the only possible solution. But what about palliative medicine, care and ethics?

What is and why euthanasia?

The complex ancient Greek word "euthanasia", which consists of two words: "good" and "death", and which in its original meaning means a

glorious, happy and painless death[2], today more than ever, has been changed in its meaning[3] and according to the international community's definition means the killing of people who are afflicted with serious and incurable diseases or conditions and whose life becomes particularly unpleasant or intolerable as a result.

This is because the doctor's task is to cure sometimes, relieve often and comfort always! That is, the principle prevailing in medicine was prevailing until recently is that the patient's life must be prolonged in every possible way, regardless of the chances and prognosis for his cure or avoidance of death. Hence, medical ethics formed on the foundations of the Hippocratic principle and the almost universally accepted position on the sanctity and uniqueness of every human life created an obligation for the doctor to protect and not interrupt the patient's life, which under no circumstances should be changed and become worthless. In this way, the doctor is the patient's companion, not only in illness but also in his death. He is the one who resists death, although very often, he knows in advance that the struggle will be lost.

Nevertheless, today, this principle seems to be changing. The physician is called upon by society and individuals to become an ally and accomplice in death. This previously mentioned old medical ethos is nowadays facing increasing criticism. Medical practice with moral principles and values seems to be shifting to moral consensus. This is because today, there are more and more voices in favour of rejecting or replacing the Hippocratic Oath, which, as they consider it, is outdated concerning the logic and requirements of modern society. In this way, a new practical medical ethos is being shaped

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[2] a concept that the world understands conceptually as "good dying", i.e. a good, honest, happy death, or a peaceful, sudden death, for example for the country or for the faith, in the sense of a sacrifice.

[3] nowadays, the term "euthanasia" means something completely different. Namely, as Francis Bacon translated it from ancient Greek to English, euthanasia took on a completely new meaning: "the hastening of death, in order to end a life full of pain and suffering." So today, euthanasia is generally understood as "the conscious and intentional taking of life from an incurable patient, with or without his consent, for the purpose of relieving or relieving deathly painful agony or excruciating pain as a cause, which existing medical therapy fails to 'relieve'", i.e. euthanasia is understood as "a method of causing death by any cause."

in which a certain number of factors influence the reasoning and decision-making of doctors regarding the care of patients in critical and extreme situations. From the multitude, we single out the key four factors:

1. patient autonomy

Patient autonomy and freedom of self-determination are inalienable and constitutionally guaranteed rights. However, in any case, the patient's right to self-determination is respected if he refuses treatment, not his request to the doctor to end his life.

2. medical futility

The futility of medical treatment represents a clinical assessment that specific medical interventions will not lead to the achievement of the goal in a specific patient and is often directly related to the subjective assessment of the patient's quality of life. However, even mathematical models for prediction and assessment are not reliable and certain. Furthermore, according to an article by Aksoy, "measuring a person's quality of life accurately and reliably is not possible, and hence the same assessment cannot be used as criteria for offering medical services." (Aksoy, 2000, 19-22)

3. distributive justice and allocation of resources

The economics of medicine and health worldwide is not going well. The thinking and the trend that tend to dominate today are aimed at reducing the costs of resources and human potential for caring for patients with a poor prognosis for the end of therapeutic treatment, as well as transferring these funds to those patients with a higher probability of a good therapeutic effect. Many advocates that the costs of ending a patient's life, caused by keeping them alive with the help of high technology, are disproportionately large and that savings can be made through "advanced directives" by patients in the terminal stage. However, in an article published in February 1994, the authors Ezekiel J. Emanuel and Linda L. Emanuel concluded that "the hope of cutting the amount of money spent on life-sustaining interventions for the dying to reduce overall health care costs is probably vain". (Emanuel & Emanuel, 1994, 540-544). Moreover, the exclusion from applying high

technologies for treating certain patients due to the low probability of a good therapeutic effect represents an apparent injustice!

4. age of the patient

Nowadays, older people are increasingly attacked by politicians, philosophers and health managers because they are excessive consumers of medical resources. It is openly debated whether the elderly should have access to intensive care units and advanced medical technologies in the current situation where available medical resources are limited and should be channelled to young people with longer life spans. Hence, the goals of protecting economic resources include the legalization of assisted suicide, which the elderly are often forced to do. Discussions about the care of the elderly are not only of a theoretical character but reflect the current practice and the future trend. So, for example, in an article published by Katarina Sjögren Forss, it is_concluded that in Sweden, although there is no age discrimination under current official policy, intensive care unit doctors largely consider the age of patients persons upon their admission to the departments. (Forss, 2020, 113-115)

Summa sumarum, the view that there is a life that is not worth living, is the basis of euthanasia. Dr Leo Alexander made this observation, a prominent American psychiatrist, who was the chief U.S. medical consultant at the Nuremberg War Crimes Trials that judged Nazi leaders following World War II, considering that "it is obvious that if the medical profession of a small nation under the conqueror's heel could resist so effectively, the German medical profession could likewise have resisted had they not taken the fatal first step. It is the first seemingly innocent step away from the principle that frequently decides a life of crime. Corrosion begins in microscopic proportions". (Alexander, 1949, 39-47) After all, and it seems that the same attitudes have been adopted by modern society, placing this request before doctors and pushing them into another role that they should play for "humanitarian", utilitarian and economic reasons. So should we accept this request, which represents a dangerous challenge to the Hippocratic principles, both for doctors and all those who deal with the social integrity of medicine, especially when there is another solution – palliative care, medicine, ethics?

Palliative medicine and care as an opposite response to the requests for euthanasia

In this sense, euthanasia forced upon someone's life and death still does not resolve the question of human dignity but opens up a new, very emotional and distressful question which possible, effective and proven answer compatible with the human right to live and dignity in dying, is *ethics of (palliative) care.*

In other words, regardless of culture, civilization and time, dying is always difficult, regardless of how human life relentlessly rushes to its end – death. Sometimes it ends up as a long-term process of dying in sickness, suffering, pain and agony, which inevitably and of great importance to the individual and the society, raises the question of the meaning, way, and living of this last phase of life. It is so because illness and death today, as always, are and will be an inevitable and integral part of the human experience. Therefore, the way we try to determine and respond to the unique and individual needs of those who are dying and their families as they struggle with illness and the loss of the appreciated person is an indicator of the maturity of a society in which medicine has its part.

Hence, several viewpoints, apart from their role and importance in dying. Following the possibilities of modern medicine, which can all costs prolong life, for various authors, this becomes meaningless because it means continuing deaths and suffering. (Šeparović, 1990, 297-307) Hence, it is considered that euthanasia is a way that helps the individual to be saved from suffering.

On the other hand, burdened with compulsory identification with the achievements of Western civilization, we failed to separate positivity from negativity and even thoughtlessly accept the consequential products of modern society, spiritual alienation, and moral crisis. Impoverished emotional generational solidarity leads us to the loss of ourselves, the faith in helping, the empathy, the support of loved ones in moments of illness or ageing, in the destruction of the basic nucleus – the family and its values. Hence, according to the thesis of the opponents of euthanasia, one complete and

quality solution related to the question of the sick and elderly can be the hospice, where palliative medicine is conducted, i.e., access to palliative care and carefulness.

The hospice is a philosophy of carefulness and modern health institution, with a number of levels of offering help to people at the end of life, through its caregivers, even after death, in mourning. It is about linking compassion in the suffering of the terminally ill and those who die, with the highest medical advances, creating the basis for the development of the hospice movement and palliative medicine, in whose centre is the autonomy of the personality of the ill patient who alone has the right to decide on where to die, of whether takes the drugs or not, whether wants to follow cultural customs etc.

For this type of activity (hospice), nowadays prevails, the term "palliative care" or "palliative medicine" appears. Palliative medicine is a type of medicine that deals not only with the disease but also turns to suffer, i.e. to patients. The same can understand that at some moment, the priority is no longer fighting disease but pain and suffering, instead favouring the natural process of end of life, i.e. trying to complete life in the less painful way possible. Hence, the same as the aim to control the pain and suffering of those who die, or relief in dying and death. This shows that palliative medicine is not used to monitor dying but to recover the patient's remaining life skills. Its centre of gravity is focused on raising the quality of life before death, regardless of its length, which indicates that the primary goal of palliative medicine is emotionally and spiritually stabilizing the physically and mentally decompensate-sick ones, thus enabling their normal functioning with the family and the staff who nurtures.

The advancement of drug therapy in the second half of the 20th century, combined with a growing understanding of the psychosocial and spiritual needs of dying patients, paved the way for the development of palliative care which indicates the approach with which improves the quality of life of the patients facing terminal illness and their families. It is about the active and comprehensive, complete care of patients whose disease no longer responds to curative treatment, so it is necessary that control the pain and the other symptoms, as well as psychological, social and spiritual problems

as the main ones. (World Health Organization, 1990, 11) Therefore, palliative care includes all treatments designed to ease the suffering: psychological, mental and physical, that it is done through prevention and relief of symptoms with means for early detection, assessment and treatment of pain, as well as through the facilitation of other socio-psychological problems.

Given that palliative care is active complete care of patients whose disease no longer responds to treatment, it includes the medical, ethical and social aspects, as well as psychological help, because its aim is a better quality of life for the patient and his family. In this sense, palliative care accepts death as a normal process, as the last phase in life, as a particular time for integration and reconciliation, hence accepts the need of those who are dying to live completely proud and comfortable until they die, which means that neither hastens nor postpones death, but provides support for the grieving family and friends. (World Health Organization, 1990, 11)

The previous speaks that on the issue of euthanasia, there is an alternative that occurs today! Although euthanasia attempts to regulate itself legally, the best solution seems to be an ethical alternative – palliative medicine, or care, that seeks to be an integral part of any health system and an integral element of the right of the citizen's health care. It is undeniable that palliative medicine is trying to promote a culture of life at the end of it and connects the highest medical advances with empathic carefulness for the patient and his family, with emotional and spiritual support, which significantly reduces the demand for euthanasia and it becomes unnecessary. Moreover, according to the proponents of this idea, euthanasia destroys the foundation of the value system and, thus, the entire human community. Euthanasia, as violence over human life, regardless of its motive, is contrary to human dignity. Dignity in dying, which hospice provides through palliative care for those who die, and an emotional soothing heat that relieves pain and removes symptoms of dying, are the only human and humane solutions at the end of life. It is a striving for those who die not to feel abandoned, undesirable and worthless. Example of, Mother Teresa is in favour of this. (Кудо, 2006)

The hospice and the hospice movement are not considered an alternative to euthanasia in the world, but as some followers love to say, they are the

only proper human care proceedings for those at the end of their life. As stated, it must not be allowed for the public to accept the fashion of euthanasia easily, but it must be ready to offer the right solution – hospice! (Jušić, 1997, 214-215) It is even more because of today's so-called justification of euthanasia that, for the proponents of palliative care, it is neither ethical nor medical, but a social, according to which terminal suffering is an excessive financial burden for society.

Finally, euthanasia is not a solution! Its only ethical alternative is palliative medicine, which helps the terminally ill to enjoy the last moments of life with the help of top medical achievements, most notably with sincere human compassion and love towards close ones, with human dignity emphasized until death. In this context, such as pain becoming a significant factor in the decision of the patient to die, palliative care should become imperative.

Conclusion

Euthanasia, unfortunately, or fortunately alike, is still a penalty act in most countries in the world. Nevertheless, it is not just a legal issue but also a human and ethical one. It comes out as a result of still lacking a single generally accepted view for it, which in turn is understandable if we take into account a large number of cultural, civilizational and historical loads, as well as the influence of the dominant philosophical, religious, ethical and moral beliefs related to attitude towards life and death, human dignity, fundamental duties of a physician and medical deontology, the progress of medicine...

According to prevailing trends, although the more significant the demand for legalization or decriminalization of euthanasia, the contrary-response increases as well, expressed through the hospices, which are considered more humane, retaining the reliability and authenticity of human existence while treating euthanasia as violence against human life that regardless of motive, it is variance with human dignity. That is why many insist on palliative care as a contrary response. A counteract for the increased demands for the

decriminalization of euthanasia. In this context, as opposed to promoting the right to a dignified "mild" death, there is more and more insisting on teaching the younger generations about a dignified death and the return of emotional warmth, as Mother Teresa was doing.

It means that every life, at all stages, is worth living and needs all the medical care and human attention. In the context of this, the Declaration of the World Association of Physicians (WMA – World Medical Association), which was made at the General Assembly in Madrid in 1987 concerning this question, say that: "Euthanasia, i.e. desirable termination of the life of the patient, either upon its request or at the request of its close relatives, is unethical". (www.wma.net/e/policy/el13b.htm.) However, that does not prevent doctors from respecting the patient's desire not to let the natural course of death be in the terminal phase of the disease. (Iglesias, 1998, 31) By this, the World Association of Physicians expressly indicates that it is aware of all developments on the issue of euthanasia, which is a medical-ethical problem.

Hence, what will modern times accept for the future as an appropriate response and practice? In the meantime, it is a bioethical problem to which bioethics seeks an interdisciplinary and pluriperspectively way of approaching and offering a possible solution. In this context, precise terminology is the first step in offering ethical "right" solutions because people are social beings. We communicate with one another, converse, and exchange ideas and different points of view via language/s and signs. Language constructs affect and change reality, facilitating communication, promoting understanding, and helping erect bridges between cultures. That is why concepts and categories in the field of bioethics should convey a clear meaning and not be open for interpretation. This is so because phenomenology is important – language plays a critical role in shaping and reshaping our existence – it is important to reflect the language people use to describe their experiences, especially those concerning life and death. (Cohen-Almagor, 2000, 267-278)

It is so because we are talking about one relation between euthanasia and palliative care which is very confusing: the first being about ending life, the second about improving the quality of life, and the experience across

countries show that these two concepts tend to converge and mix when it comes to end-of-life decision-making.

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Choosing what to Do with Dementia Patient. Ethics of Care versus Comfort

Zorica Kaluđerović Mijartović[*]

Abstract

Dementia is most common mental disorder among the elderly. There are multiple ways to care about patient with dementia. To keep them in the family, to send them to nursing home or to employ a foster family which cares for the patient in their own home. Centres for social work sent such patients in foster families under the guidance of state.

The subject of this article is the person-centred care for the patient when kept at home and cared by family. By careful developed dementia plan and providing comfort the life expectancy and the quality of life of the dementia patient significantly increase. There are services of support for people who are performing care in home. Family care can also be stressful this is why understanding in needed not only for support in not essential only for the quality of life of a patient but also that of the care giver, because caregiver intentionally engrave its quality of life to give the best care to the patient.

Keywords: Dementia, Quality of life, Comfort, End of life care, support.

Introduction

Dementia a clinical syndrome that encompasses difficulties in memory, language, and behaviour that leads to impairments in activities of daily living. (Robinson, Tang Tailor 2015:1)

How to diagnose dementia? First, if there are any suspicions because of memory loses that occur, general practitioners should be contacted to distinguish dementia from other illnesses with similar early-stage symptoms. *Depression masquerading as dementia is the most common differential diagnosis*

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and should ever be considered, however they may coexist, and depression may precede dementia (Robinson, 2012). The second, if the suspicions to early dementia still remain, one should contact a specialist to confirm the diagnosis and determine the type. Third when dementia is diagnosed when one need to decide which type of care will patient receive.

Alzheimer's is the most known type of dementia, especially among people in their eighties. The risk of Alzheimer's can be reduced by mental activity. There are several means to delay cognitive deterioration, among the most important being maintaining an active lifestyle. Increased mental activity in the third age after retirement it is essential to keep mental activity at the same level as it was working, such as by going to the new courses at third age universities or learn a new language. But once when it is discovered it should be carefully treated. Besides Alzheimer's there are several types of less known dementia.

Vascular dementia happens at cardio vascular patients, often after stroke. Small unnoticeable stokes, happen to vascular system in the brain, and doing damage to some functions of the brain. This type bears a great resemblance to Alzheimer's, and it is called also mixed dementia because interferes with Alzheimer's (Robinson, Tang, Tailor 2015, p. 2).

Frontotemporal dementia leaves the memory intact. But it is behavioural type of dementia, with changes in personality and behaviour (Robinson, 2012).

Dementia with levy bodies provokes complex visual hallucinations in early stages and it may occur during the periods of intensive stress, during infections. In early stages it effects the movements and it is accompanied by variations in cognitive functions and sleep disturbance. This is present long time before dementia appears. Parkinson disease can be accompanied with dementia also. There are fewer types of dementia known, many of them accompanied with other illnesses: alcohol related dementia, HIV related dementia, multiple sclerosis dementia etc (Robinson et all, 2012).

Once when it is diagnosed *initial assessment should include history from both the patient and the mail care giver with the emphasis on disturbance function of functions of daily living* (Robinson et all, 2012).

Care for dementia patient trough phases

When it comes to dementia, we have three choices about what to do with patient. To isolate him or her, cover only basic needs and live him or her to die. Second options is to send them away in the nursing home allowing the professionals, or foster family. Or to keep ill family member in home and provide a full care making his or her life worth living, and respecting their sense of dignity.

Historically the most common one in our realms was this: When someone would get too old, he had been given the food and water, isolated and left to die, as less the person suffers bather for the family, and the person. (We have even some of inhumane behaviours towards our elders from the past to just perform the euthanasia when the time comes, or when the individual is no longer capable to provide for the family).

However, with the immense increase in ethical, humanistic debates of sanctity of life and quality of life, not just in old age, but throughout the life as whole the way we view of our elders slightly began to change. With the idea that medications can be used to make the dementia easier, some people became less scared to admit that their parent, husband, or wife has become dementia patient. Dementia was a rare thing in the past, because of shorter life expectancy.

One important area to be discussed in the earlier stages of dementia, while people still have mental capacity its personal wishes for future and who will make decisions when the patients are no longer able to. In Dementia such discussions – timed advance planning – have been shown to reduce inappropriate hospital admissions towards the end of life (Robinson, 2012, p. 9.)

And life expectancy is strongly bounded with the quality of life one has during his entire life, it may seem paradoxical but is true, we take medications to reduce all our physical problems to increase our quality of health. By doing so, we increase life expectance, until one day ones brain starts to show its weakness. If noticed and effectively treated dementia progress can be solved up to 10 years. If left untreated, the dementia patient risks lose the life every day, by wandering around, getting lost, not paying attention to money

spending, personal hygiene, routine therapy for other illnesses or by accidentally missing the order of the treatment and forgetting to take medications.

Sound and visual hallucinations start to emerge within the first year. On the other side loneliness and the sense of abandonment can even make the symptoms worse. So, without care nobody survived more than one year with mediate dementia. This is why, the path to left it untreated some sort of passive euthanasia. Illegal though it is still happening in poor families. Especially when the care costs start to rise from a phase to phase. In the first phase the person just needs company and someone to talk to, someone to listen to patients' reminiscence of the past, and someone who can get immune to the rage. Something that can be done by a family member. When care giver is from the family member, in literature is called person *centred care* one caregiver to one patient because psychological sufferings in dementia differ from person to person.

One challenge for researchers and practitioners wishing to promote person centred care and maximise the quality of life for persons with dementia has been to identify a reliable valid and practical method for asserting the impact of interventions. A number of dementia specific measures have been developed that access quality of life from different perspectives. Structured interviews are available enabling person with mild and moderate dementia to self-report their quality of life (Elderman, 2013, p. 60).

In stage two, the person no logger stands the company of care giver but is aware of the lack of same abilities that were usually preformed without asking for help. Here the dementia depression comes into picture, patient starts to feal unneeded, so this is the time to tell and show them how their mere presence is important for the family.

People with dementia and their families require emotional and practical support to help them to live as good a quality of life as possible as they can: the family doctor is a key position to provide support and advice once when diagnosis is confirmed (Robinson Bryane at all. 200).

In the stage tree, the home caregiver cannot help the person alone, even though the patient has been taking medications from the stage one, it is no longer easy to maintain the daily routine. This is the key moment, in which most of family must increase the amount the time and money spend to acquire

good quality care for the patient. The majority of families calculate that is more affordable to send their elders to the care homes. Anyone who has not enough income for affording a nursery home is facing the most difficult choice. The caregiver must forget that is at risk of forgetting their own routine and to devote to that of the patient. Because not maintaining the routine of a person in eighties of age could mean severe advancement of dementia and other illnesses resulting in death. But if we sent them to elderly homes, we risk that they will feel abandoned and decide to refuse food and medications.

A good quality of life should be elevated to a priority goal for long-term care rather than a pious afterthought to quality of care (Kane, 2010, p. 60).

In the fourth phase it is difficult for the patient, and for the caregiver, to cope with difficulties on a daily basis. Because neglecting the patient for a minute may result in fall, in which patient may break a bone and remain tied to the bed, or hit his or hers head which can engrave the symptoms, start new phase of a degradation process dementia which causes to the brain, destroying some of the brain cells.

By every minute means twenty-four four hours, because dementia patients going through fifth phase, or phase of incontinence, tend to wake up at night, and wonder in the dark. Here is where severe injuries occurred in majority of cases. So, maintaining the care for patient in these phases, it is almost impossible without help, not just from family members but also from social systems and from systems of health care, or a geriatric nurse.

Notwithstanding the satisfaction carers experience from caring, the support they receive and their ability to seek help when they needed influence how they cope. Supporting informal carers, monitoring their health and wellbeing, and providing or referring them for additional practical and psychological support is another role for general practitioners and community care services (Cameron Aggar Robinson, 201, p. 76).

Dementia patients have their own income due to the severe illness, but at this moment it is not enough for required high quality care, though it can cover for medications and all need of patients if the care giver is related do patient ad do the care for free. In this period the care giver can risk developing serious physical and psychological disorders. First, the depression,

because it looks like all the care is in vain. Not only the care giver is depressed in this period, there is also visible elevated level of dementia in patient because he is no longer capable to perform the daily routine. *What is now known is that the comfortability of depressive dementia symptoms is high* (Burns, 2009, p. 407). *Non cognitive symptoms (behavioural symptoms in dementia) are particularly distressing the family* (Kaner, 2001).

The period of almost uncurable infections so no matter what caregiver do to cure it in home conditions it will appear again few days later. I was care giver to such patient for five years, to a patient with dementia, in my home, since when I was undergraduate student I was offered to be care giver, I took some scientific articles from the field of medicine on dementia, and ethics of care, and on the ways to improve the quality of life of a patient with terminal illness.

After reading, I accepted the task. During the whole care I noticed every change that was happening and by the help of the scientific articles I was able to distinguish between phases by first signs and to plan care almost six mounts in advance. So, when was time to bring institutions into the story. Dementia financial support was secured for my patient, then in the phase two I registered her in system of remote medical sisters, there was a crew of doctors coming on call to make the analyses, to give her therapy which cannot be done by a caregiver, and with their help, other illnesses she had like hypertension and diabetes were under control.

The most important during the whole care is the patient diet, the patient had taken planned and meals according to her needs and to optimize the general health. And this diet must change with every phase. *Making foods available that appeal to the person with dementia is essential for overall comfort and well-being* (Alonzo 2017, p. 84).

In the phase six, A bed was provided her and all necessary tolls for bed care by a family. These are required when the patient is giving up on walking. Without them end life care is almost impossible, if they came in time the person can survive in such conditions from six months to one year.

Determined by bad living conditions, the lack of money, the care giver may well give up the care and sent the one to nursery home, but this then

mean that he should have done it in first place, or to wait until last stage. Why, moving the patient into unknown conditions and lack of time that nurses have due to the number of patients, may make them even more depressed. So, life expectance can be truly short.

Here we are coming to palliative care, c*reating comfort or palliative care model is giving up new hope to the families and promise less stress for persons living with dementia… Realising the role comfort plays in people with dementia and implementing a comfort and realising the comfort focused program it is not without challenges* (Alonzo, 2017, p. 81).

Wast numbers of dementia patients died during the corona virus pandemic not because of the virus, but just because there were no visits allowed. And the gently touch from the caring family member, makes the dementia patients life worth living, absence of it may make the patient to give up on life. So, if not cared for in home, except the nursery home which can grave the symptoms because of feeling abandoned, and there are some families who cannot support the costs.

There is a system in Serbia for elderly people with dementia who lack the family care at the end of life. They can be moved in foster families as well in Serbia, which are educated to care for them. If the symptoms have not emerged fully, so the person is still able to perform some tasks, there are gerontological wife's who are assisting them with cooking, washing, cleaning, and supplying. At this level reasonable patient can make with care giver advanced dementia plan, about how he would like to be cared about when the illness begin to develop.

Those women are paid from the founding's reserved for social care for grown-ups. So, my conclusion here is this: If one takes care of a dementia patient in home, mustn't see this as an easy task and have to know what to expect, education for care givers, psychological support is a need, and it is almost impossible to perform the task without the help of the social services and help. If one should decide to leave the family member to institutional or foster care (even foster care can be socking for elderly people) he should be aware of the psychological damage to patient, and there is always the

possibility that unknown wouldn't care so good as family member would have done.

If cared at home quality of life, quality of care means longer life expectancy, and less sufferings and it is hard to be achieved, by care giver alone, because it is fighting mother nature daily.

Type of services provided for dementia patients are, Mounty income 200e, Up to 50% discount on medications, Free therapy in rehabilitation centres, Remote medical team available on call, And for the last stage up to 70% for dippers, But we have problem with no support for care givers, not from society, not from some families. Society can tell that the work with the patient is difficult, and most of the people would not do it. And when the care giver is diagnosed with depression there is no understanding for the problems of care giver because in the eyes of everyone the patient is in focus, not the care giver, What can be improved, care givers from family have to have phycological support, education on how to care for them.

Conclusion

Comfort, quality of care and quality of life and life expectance are interfering together. On the one hand we have patient who is dependent on the daily care of caregiver, from the other side non-skilled care giver, as they are in private homes, can become ill also by the difficulty of the task. This is why double understanding, by rest of society, is needed, for patient needs and for caregiver quality of life. In last faze the health of care depends on having support from the palliative medical stuff and family members.

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Alcohol Consumption Trends in Romania During the COVID-19 Pandemic: A Study on the Impact of Alcohol on Domestic Violence*

*Fitzek Sebastian***

Abstract

This article examines the relationship between alcohol consumption and domestic violence in Romania during the COVID-19 pandemic. Secondary data from various European and national databases was analyzed, and online questionnaires were administered to three distinct groups of consumers in Bucharest. The AUDIT-C model was used to assess alcohol consumption over two months, based on three key consumption indicators. The results of the study showed a strong positive correlation between alcohol consumption and domestic violence, with the likelihood of domestic violence increasing with the degree and frequency of alcohol consumption. Additionally, it was found that both men and women can be both victims and abusers in domestic violence, but men are more likely to be the perpetrators. The study concluded that efforts to reduce alcohol consumption can potentially reduce the incidence of domestic violence, and public health policies should be put in place to reduce the availability of alcohol, increase awareness, and provide support to those struggling with addiction.

Keywords: alcohol consumption, domestic violence, Romania, COVID-19, AUDIT-C, public health policies.

Introduction

This article examines the relationship between alcohol consumption and domestic violence in Romania during the COVID-19 pandemic. The

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purpose of this study is to investigate the influence of alcohol consumption on domestic violence in Romania, and to provide an understanding of the factors that contribute to the perpetuation of violent behavior in family relationships. The study was conducted in two stages. In the first stage, secondary data from various European and national databases was analyzed. In the second stage, online questionnaires were administered to three distinct groups of consumers in Bucharest, comprising 52 respondents between the ages of 20 and 70. The AUDIT-C model was used to assess alcohol consumption over two months, based on three key consumption indicators: frequency of alcohol consumption, alcohol level, and average quantity consumed per drink, as well as frequency of binge drinking. The structure of the research was designed in two stages: a. an analysis of secondary data in various relevant European and national databases; b. a hybrid application of online questionnaires, on three distinct groups of Bucharest consumers (medium, high, and low), specifically on 52 respondents (41 men and 11 women between 20 and 70 years old), who agreed to participate in the research. For the application of the questionnaire and data collection, I used the online scientific platform "SurveyMonkey". The Alcohol Use Disorders Identification Test (AUDIT-C) was used to evaluate alcohol consumption over the 2 months (October, November 2021) based on three key consumption indicators: alcohol consumption frequency, alcohol level, average quantity consumed per drink, and frequency of excessive alcohol consumption. The change in consumption was recorded analogously with the AUDIT-C variables (alcohol consumption frequency, quantity of alcohol, and excessive alcohol consumption), through which consumption indicators are reported to the degree of change. The results obtained together with a series of psychiatric, psychoanalytic, and psychological theories bring a variety of explanations of violent behavior perpetuated in family relationships, denouncing their impact and harmful effects on personal education.

The results of the study showed a strong positive correlation between alcohol consumption and domestic violence, with the likelihood of domestic violence increasing with the degree and frequency of alcohol consumption. Additionally, it was found that both men and women can be both victims

and abusers in domestic violence, but men are more likely to be the perpetrators. The findings of this study suggest that alcohol consumption, particularly at high levels, can significantly increase the likelihood of domestic violence. It is therefore important to consider the implications of alcohol consumption on domestic violence, and to develop public health policies that reduce the availability of alcohol, increase awareness, and provide support to those struggling with addiction. To reduce the incidence of domestic violence in Romania, it is important to consider the impact of alcohol consumption on the perpetuation of violent behavior. This article will discuss the findings of the study in more detail and will provide recommendations for reducing the incidence of domestic violence in Romania. These recommendations include:

a) restricting the availability of alcohol, such as limiting the number of hours alcohol can be sold and increasing the price of alcoholic beverages;
b) financial restrictions due to low salaries, reduced working hours, or unemployment;
c) increasing public awareness of the dangers of alcohol consumption and the prevalence of domestic violence;
d) providing support to those struggling with addiction;
e) public policies to combat poverty by regulating alcohol and providing support for addiction.

Severe poverty and excessive alcohol consumption are among the most important factors that can determine the presence of domestic violence anywhere in the world. While social and economic data are analyzed in numerous specialized studies regarding poverty levels, the frequency of alcohol consumption in relation to domestic violence in Romania has received less attention. According to standard definitions, "alcoholism is a progressive pathology, determined by the attraction to alcoholic beverages, with the formation of a dysfunctional state and withdrawal syndrome upon discontinuation of consumption, and in cases of long-term consumption, somato-neurological and mental disorders can be determined" (Cotelea, E. & Lesnic, E., 2020: 78).

The impact of the Covid-19 pandemic on alcohol consumption in Romania: A national and European overview

In general, alcoholism is a difficult subject to study in relation to domestic violence, as the interrelational character of specific sub-indicators such as consumption frequency, alcohol level of the drinks consumed in relation to gender, age, education, income, health, environment, and rural/urban differences has not been sufficiently developed. Combining these sub-indicators into a single picture provides a generous map of the causality and effects of excessive alcoholism on family life. Stress is another factor in the negative determination of quality of life that leads to increased alcohol consumption and its implicit effect on domestic violence (Charles, N.E., Strong, S.J., Burns, L.C., Bullerjahn, M.R., & Serafine, K.M., 2021). On the other hand, restrictions in daily life have been introduced to limit the spread of the SARS-CoV-2 virus (known colloquially as coronavirus). The negative effects of travel restrictions, social distancing, and restrictions for those affected by Covid19 have had direct effects globally. Since the implementation of restrictions in Romania, many Romanians have felt the negative effects on their professional or financial situation, and many of them, especially those in the HORECA industry, have lost their jobs.

The COVID-19 pandemic has not only affected people's physical health, but also their mental health and behavior, including increased alcohol consumption. Coronaviruses are a large family of viruses that cause respiratory infections, including COVID-19, which was first identified in Wuhan, China in 2019. Despite public health measures to control the pandemic, it has had long-term consequences on individuals and society, including economic recession, educational limitations, and rising inequalities. The pandemic has been considered a mass trauma, leading to psychological problems and addictive issues such as alcohol consumption. Alcohol has long-term effects on every organ in the body, making it a public health problem associated with many physical ailments and mental disorders. Excessive alcohol consumption weakens the immune system, making individuals more susceptible to SARS-CoV-2 infection and other diseases, including liver cancer. During the COVID-19 pandemic, people worldwide

have been subjected to various challenges, such as social distancing, quarantine measures, economic uncertainties, and health concerns. These challenges have created a considerable burden on people's mental health, leading to an increase in stress, anxiety, and depression. As a result, some people turn to alcohol consumption to cope with these negative emotions.

There is existing research that clearly demonstrates an increase in alcohol consumption in many countries during the pandemic, leading to a rise in alcohol-related disorders (Calina, D., & All, 2021). This research highlights the impact and interconnections between the COVID-19 pandemic and alcohol consumption. The increase in alcohol consumption during the pandemic is also attributed to the availability of online alcohol sales. With physical distancing measures in place, people are more likely to purchase alcohol online, leading to increased sales. However, while moderate alcohol consumption may be acceptable, excessive alcohol consumption can lead to severe health problems, including alcohol-related disorders. Moreover, alcohol abuse during social isolation and lockdown is not a useful coping mechanism for the pandemic's burden, as recommended by experts from the World Health Organization (WHO). WHO experts suggest that people find healthier ways to cope with the pandemic's impact, such as maintaining social connections, exercising, and practicing mindfulness techniques. In addition, social stressors such as social isolation, unemployment, and loss of loved ones exacerbate psychological imbalance, making alcohol-related disorders a major social problem during the COVID-19 pandemic. Therefore, increased awareness and prevention efforts are needed to address the potential for increased alcohol-related harm during the pandemic.

The COVID-19 pandemic has brought unprecedented challenges to people's lives worldwide. With many countries imposing lockdowns and restrictions on social gatherings, people's daily routines and behaviors have been greatly affected, including their alcohol consumption habits. Mounting evidence suggests that the pandemic has led to an increase in alcohol consumption in many parts of the world. In the United Kingdom, a cross-sectional study conducted with 691 adults found that 17% reported a rise in alcohol consumption during the lockdown, with a higher percentage

among younger subjects aged 18-34 (Calina, D., & All, 2021). Similarly, a survey conducted in Belgium with 3,632 participants indicated an increase in alcohol consumption (d=0.21) and cigarette smoking (d=0.13) compared to pre-pandemic levels (Vanderbruggen et al., 2020). The increase in alcohol consumption was associated with younger age, having more children at home, being a non-healthcare worker, and experiencing technical un-employment due to COVID-19. In Greece, a study of 705 adults showed that all participants drank at home during the lockdown, and 20.7% reported increased consumption, mainly due to isolation, changes in daily routines, or coping with anxiety and depression. Similarly, a research project conducted in Poland found a staggering 146% increase in alcohol consumption, with a higher propensity to drink more observed among individuals with a history of alcohol addiction (Calina, D., & All, 2021). Surveys conducted in Australia during various pandemic periods showed that over 25% of adults reported increased alcohol consumption, primarily due to higher levels of stress (Kyaw Hla, & ALL, 2022). The increase in alcohol consumption during the pandemic has been a cause for concern, as excessive drinking can lead to a range of negative consequences, including alcohol-related disorders and domestic violence. Although it is important to acknowledge the challenges brought about by the pandemic, alcohol abuse is not an effective way to cope with stress and anxiety. WHO experts have emphasized the need to promote healthy coping mechanisms and support services for individuals struggling with mental health issues during the pandemic (Calina & All, 2021). Overall, the increase in alcohol consumption during the pandemic highlights the need for public health interventions and support services to address the negative consequences of excessive drinking during times of crisis.

From a realistic perspective, the Covid-19 pandemic has had significant impacts on various aspects of Romanian society, including the health and economic sectors. The pandemic has highlighted significant vulnerabilities within the Romanian health system, including a shortage of medical specialists, insufficient investments in hospital modernization, poor hygiene, partial digitization of the bureaucratic apparatus, corruption, and inadequate management. The pandemic has also contributed to an increase in alcohol

and drug consumption among vulnerable groups, particularly young people. For example, in 2020, alcohol and drug consumption among Romanian youth increased by nearly 9% (Copăceanu, M., 2021: 85). Alcoholism and drug consumption are related phenomena that require a causal approach rather than a focus on their effects. Unfortunately, both phenomena are not well controlled in Romania. Recent global studies on alcohol and drugs with over 750,000 participants found that almost 90% of cases of sexual assault involved alcohol consumption, while illegal drug use involved only 14% of men and 7% of women (Winstock, A., 2019). The pandemic has led to various changes in daily life and public activities for most Romanians. The effects of the pandemic and measures to limit its spread have been felt not only in the economic and political domains but also in the psychological and mental health domains. The initial stages of the pandemic were characterized by uncertainty and fears of economic losses among the Romanian population (Betsch, 2020). Although the economic consequences of the pandemic in Romania do not seem to be as severe as in other European countries (Eurostat, 2021), the effects of excessive alcohol consumption appear to be different (Eurostat, Alcohol consumption in the EU in 2021).

There is other European research, such as the "COVID-19 and Alcohol" survey by LimeSurvey, which collected information on alcohol consumption among adults (15 years and over) before and during the COVID-19 pandemic. The survey was conducted between April 24 and July 22, 2020, in English and German, and later translated into 19 other languages. The survey targeted groups through various channels, including social media, circulars, and press releases, with underrepresented groups in terms of age and gender recruited through paid announcements on social media. The sample distribution by age and gender was compared with the corresponding distribution in the general population during the survey, identifying underrepresented groups. Targeted advertising through social media was used to increase the proportion of respondents over 40 years old. A detailed description of the recruitment measures can be found in relevant documentation (Kilian & all, 2020). More information about the study design can be found in the study protocol (Kilian & all, 2020) and other study materials, including

complete questionnaires. Regarding the daily alcohol consumption sub-indicator, Romania ranks in the middle of the European average in 2021. However, the pandemic has contributed to an increase in alcohol consumption among vulnerable groups in Romania, highlighting the need for further efforts to address these issues.

From a psychosocial perspective, the relationship between stress and alcohol is closely linked to the generation of behavioral deviance, which justifies why a state needs to produce public health policies to discourage excessive alcohol consumption. Under these circumstances, the proposals for physical distancing imposed since the beginning of the pandemic have also addressed the issue of reducing alcohol consumption through the following two targets:

a) Reducing the availability of alcoholic beverages and opportunities to drink due to the increased mortality rate (no visits to bars and restaurants; restrictions on parties, especially in public spaces);
b) Financial restrictions due to low salaries, reduced working hours, or unemployment (Kilian, C., & All, 2020).

Analyzing the two measures proposed by the authors (Kilian, C., & All, 2020), these proposals would also reduce accessibility and therefore excessive consumption of alcoholic beverages. The real effect is influenced by factors such as pre-crisis alcohol consumption habits, stress experiences during the crisis, and, finally, changes in alcohol availability and accessibility. Regarding alcoholism in Romania, the proposed measures could be effective in reducing alcohol consumption and related problems. Romania is among the European countries with the highest alcohol consumption levels, and alcohol abuse has severe consequences for public health, including an increased risk of liver disease, cancers, and violence. Therefore, public health policies aimed at reducing alcohol consumption, such as those proposed by Kilian et al. (2020), could have a positive impact on the health and well-being of Romanian citizens, as well as on the country's economy. However, their success depends on factors such as public awareness, political will, and the availability of alternative leisure activities, which should be considered when implementing such policies.

The Impact of Excessive Alcohol Consumption on Domestic Violence and Intergenerational Transmission

Alcohol consumption has long been recognized as a significant contributor to domestic violence. Studies have shown that excessive alcohol consumption is the second most important cause of domestic violence, after severe poverty (Ehrensaft, M.K., & Langhinrichsen-Rohling, J., 2022). The negative impact of alcohol consumption on family life can have inter-generational consequences, as studies have shown that parents who are alcoholics often pass on their addiction and violent behavior to their children (Berckmoes, L.H., de Jong, J.T. & Reis, R., 2017), (Caldeira, V., & Woodin, E.M., 2012). Children who are exposed to violence at home are particularly vulnerable, and studies have shown that they are more likely to become violent themselves as a way of coping with the problems they face (Popa, C., & Ciobanu, A.M., 2013). Children who witness violent scenes can also be scared for life, as Melanie Klein's psychoanalytic research has shown (1987). The principle of "violence begets violence" is often observed in such situations, as children tend to copy the deviant behavior of their parents.

From a cognitive perspective, children may not be sufficiently prepared to use their discernment as a form of conscience or selection between right and wrong. This, combined with an inability to express negative emotions or a lack of self-control, can lead to irrational manifestations triggered by mental blocks. The inability to establish a rational ratio between losses and gains in planning a criminal act can result in reduced intelligence quotient, according to Eysenk H. (1964). Alcohol and drug use can have a lasting impact on the development of children, perpetuating violent behavior in dysfunctional families (Friedman, A.S., 1998). These findings are universally valid, regardless of social background, and are generally equally well noted in any cross-sectional or longitudinal approach. While data on the impact of alcohol consumption during the Covid19 pandemic on mental and physical health in the general population are still scarce, the few available data suggest that alcohol consumption remains a central risk factor for negative health and social consequences. In Romania, for example, alcohol

consumption was responsible for 2.4% of all deaths in 2016, making it a country with a high mortality rate related to alcohol consumption. However, there has been a significant decrease in alcohol-related mortality in Romania over the last four years (WHO, 2018). It is important to recognize the impact of alcohol consumption on domestic violence and take measures to prevent it. Governments should increase awareness about the risks associated with excessive alcohol consumption and offer support to those who are struggling with addiction. Family members and friends of those struggling with addiction should also be encouraged to offer support and help to those in need. Public health policies should be put in place to reduce the availability of alcohol, particularly in areas where excessive alcohol consumption is a problem. This could involve reducing the number of alcohol outlets in certain areas, increasing the price of alcohol, and imposing stricter regulations on alcohol marketing. Education about healthy relationships and parenting practices should also be promoted, particularly in schools and other educational settings. This could involve providing children with information about the negative impact of violence and alcohol consumption on family relationships and teaching them how to cope with difficult situations without resorting to violence. This is why excessive alcohol consumption is a significant contributor to domestic violence, with intergenerational consequences. Parents who are alcoholics often pass on their addiction and violent behavior to their children, perpetuating a cycle of violence and dysfunction in families. It is important to recognize the impact of alcohol consumption on domestic violence and take measures to prevent it, including increasing awareness and reducing the availability of alcohol.

According to the predictions made by the World Health Organization (WHO) regarding the total alcohol consumption per capita for Romania between 2020-2025, there will be a significant increase of approximately 15% (WHO, 2018). Romania is among the countries with a high level of alcohol consumption per capita, with a significant increase in alcohol consumption, even though there have been some positive changes in the last years of the pandemic. For these reasons, alcoholism remains an important indicator for public health and for determining the risks of health and domestic violence

in Romania. Alcohol consumption remains a key vulnerable point for public health, as more than one third of adults in Romania have admitted to consuming alcohol excessively, consistently, at least once a month (OECD, 2018). Romania ranks second in the European Union in terms of these figures, with an approximately 35% rate of episodic excessive alcohol consumption, a figure far above the European average of only 20% (OECD, 2018). The same "European Observatory on Health Systems and Policies of 2018" highlights certain notable differences in this indicator by gender, showing greater alcohol consumption among men than women. According to the report by WHO, "in Romania, in 2016, the reported alcohol consumption per population aged 15 and over was 12.6 liters per capita annually (WHO, 2018). For men, the level of consumption was 26.6 liters per year, while for women it was only 9 liters per year. Out of the total population aged 15 and over, approximately 70% consumed alcohol in the last 12 months, with 80% being men and 54.5% women. Among those who have never consumed alcohol throughout their lives, there is also a difference: 6.5% among men and 19% among women. According to the same study, compared to 2010, when the level of alcohol consumption was 15 liters per capita, in 2016 it decreased progressively to somewhere around 12.6 liters per capita. Unfortunately, these are the latest official figures made available by the World Health Organization to the public, which show that Romania has exceeded the European consumption averages for the period of 2010-2016 by more than 3%. Finally, the report states that 14% of deaths in Romania are determined by excessive alcohol consumption, another figure that is more than double the European average. The data provided by the World Health Organization have been confirmed by surveys conducted in the 21 European countries: Albania, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Ukraine, and the United Kingdom (see, Kilian et al., 2020).

Alcohol consumption has been a major public health issue in Romania for many years. The significant increase in alcohol consumption indicated by the WHO's predictions for the period of 2020-2025 will only worsen

the situation. The high level of alcohol consumption in Romania is a cause for concern as it has been linked to several health and social problems, including liver diseases, cardiovascular diseases, mental health problems, and domestic violence. The high rate of episodic excessive alcohol consumption is particularly alarming, as it indicates a pattern of harmful and risky drinking behavior. Several factors contribute to the high level of alcohol consumption in Romania. One of the main factors is the low price of alcohol, which makes it more accessible and affordable for people with low incomes. The lack of effective regulations on the sale and marketing of alcohol products also contributes to the problem. Alcohol is widely available, and there are no restrictions on its sale in supermarkets, gas stations, or other non-specialized stores.

According to the World Health Organization (WHO) 2018 report, there is a mounting concern over the excessive alcohol consumption among Romanian adolescents aged 15 to 16, which accounts for 1.3% of the population. The same report reveals that in 2016, 2% of men and 0.6% of women in this age group were dependent on alcohol. Moreover, the report emphasizes that more than half of the Romanian population, approximately 56%, prefer beer, while 28% prefer wine, and 16% prefer spirits. These statistics suggest that a significant portion of the Romanian population is at risk of exposure to excessive alcohol consumption. In fact, according to the WHO's 2018 report, Romania ranks poorly in terms of alcohol-related risk, with a score of 67.2% among men and 31.2% among women. This data indicates that the country is among the worst in Europe for alcohol-related risk. While this is undoubtedly a cause for concern, there is some positive news to be found. The data indicates a notable decline in alcohol consumption in Romania over the medium to long term. Between 2000 and 2018, the consumption of pure alcohol fell from 17.4 liters per person to 12 liters per person. Romania needs to take measures to address the issue of excessive alcohol consumption, particularly among its younger population. This is not a problem unique to Romania; it is a global issue that affects many countries. However, Romania's poor ranking in the WHO report highlights the urgency of addressing the issue. One of the reasons for the high level of alcohol consumption in

Romania is likely to be cultural. Alcohol is often seen as an important part of socializing and celebrating, and this can make it difficult for individuals to control their intake. Additionally, the availability and affordability of alcohol in the country may also contribute to the issue. To address these issues, it is important to increase awareness about the risks associated with excessive alcohol consumption. This can be done through educational programs aimed at young people, as well as campaigns targeted at the general population. Additionally, the government could consider implementing policies such as increasing the price of alcohol and restricting its availability, as well as supporting addiction treatment programs. The issue of excessive alcohol consumption is a growing concern in Romania, particularly among adolescents. The country's poor ranking in the WHO report highlights the urgency of addressing the issue. However, the decline in alcohol consumption over the medium to long term provides some hope for the future. A multifaceted approach, including increased awareness and government intervention, is necessary to address this issue and reduce the harm caused by excessive alcohol consumption in Romania.

Figure.1. ***Romania's alcohol consumption position from 2000 to 2021 compared to other European countries***

Source: Eurostat (2022)

Exploring the Link Between Alcohol Consumption and Domestic Violence During the Pandemic: A Qualitative Inquiry

The primary objective of the qualitative research was to identify the determinants that involve and generate physical and psychological violence within families, based on the degree and frequency of alcohol consumption, using the AUDIT-C questionnaire's psychometric characteristics and properties. The method applied was specific in identifying the deep psychosocial causes through which the variety of disorders generated by alcohol consumption can be observed and explained. The questionnaire was applied in Bucharest on 52 respondents (41 men and 11 women between 20 and 70 years old, with an average age of 41 years), in all six distinct points (i.e., in the six sectors of Bucharest). The participants are daily alcohol consumers and were selected following filter-type questions through which we identified the alcohol consumer's profile. They identified with the daily need, usually in the evening, to consume alcoholic beverages, adding up various degrees of alcohol, brands, and types of spirits. Out of the 52 respondents, 6 had higher education, 12 had secondary education, and 34 had primary education. The chosen subjects are ordinary outdoor alcohol drinkers (present at a single terrace per sector located near residential blocks) and were selected ten from each sector, only those who agreed to participate in the research. Out of the initial target of 60 respondents, only 52 participated and completed the questionnaires online. The completion of the questionnaire was hybrid: online (18 respondents) and face-to-face (34) for those who motivated that they did not want to complete it online or did not have the necessary computer infrastructure. The face-to-face completion was done by me as the operator, on-site with the help of a tablet connected to the Internet. Two research questions were imposed on this objective:

a) Is there a causal relationship between the degree, frequency of alcohol consumption, and the presence or involvement of respondents in domestic violence acts?
b) What are the proportions of the two roles: abuser and victim from the perspective of gender differences in the Bucharest environment?

The research was conducted in Bucharest, in all six sectors (ten respondents per sector, but not with the intention of comparing alcohol consumer behavior across sectors, but only to cover the surface of the city of Bucharest equally). The research took place for two months during the period October 1 – November 30, 2021. In this sense, I used three target groups consisting of women and men of different ages, who spent time together, daily, between 7 pm and 10 pm, around bar-type terraces from the six sectors to consume alcohol. The three groups (A, B, and C) were divided based on the rate of alcohol consumption, from low consumption to medium consumption to high-risk consumption. The differences between the three groups were established based on the relationship between subjects and alcohol consumption (degree plus frequency). The three rates of alcohol consumption were established (see data analysis) based on two criteria: daily, weekly, and monthly alcohol consumption, and then the high degree of alcoholic beverages (beer, wine, and other spirits). As a result of the correlation analysis between the consumption of alcohol and domestic violence, the study revealed a strong positive relationship between the two variables. Furthermore, it was found that the likelihood of domestic violence increases with the degree and frequency of alcohol consumption. Therefore, alcohol consumption can be considered one of the determinants of domestic violence, and reducing the consumption of alcohol can decrease the incidence of domestic violence. In terms of gender differences, the study found that both men and women can be both victims and abusers in domestic violence, but men are more likely to be the perpetrators.

The aim of this study was to assess alcohol consumption in the past months using the three key indicators of consumption: frequency, quantity, and binge drinking, as measured by the AUDIT-C short form (Bush, K. et al., 1998). Changes in alcohol consumption were recorded using the same indicators, with participants indicating the degree of change (significantly less/less/more/much more) or no change for each indicator. The survey was conducted between October 2021 and November 2022 using the AUDIT questionnaire, administered via the online platform Surveymonkey (https:// www.surveymonkey.com/). Using Rosón's (2008) categories of alcohol

consumers, three subtypes of participants were identified from the 52 respondents (41 men and 11 women aged 20-70): low-risk drinkers (16 people, 11 men and 5 women), medium-risk drinkers (14 people, 10 men and 4 women), and high-risk drinkers with physical or psychological problems or major alcohol dependence (22 people, 20 men and 2 women). The first three questions of the AUDIT-C test (Bush, K. et al., 1998) are used to identify alcohol consumption with high risk. The same 11-question survey was used for all three types of alcoholic beverages (beer, wine, and spirits) with a consumption per unit of 0.5 liters. This study demonstrates the effectiveness of the AUDIT-C test for assessing alcohol consumption and identifies subtypes of drinkers based on risk level.

Results analysis

To ensure the reliability and validity of the results, we utilized the AUDIT20 version of SPSS and FACTOR 9.2 software for analysis. Content validity was ensured by analyzing the mean scores of the three groups with significantly different alcohol consumption, specifically a group with high, moderate, and low consumption. Comparing the results of the three target groups over the course of two months revealed notable differences. The respondents' daily alcohol consumption was lower than their weekly and monthly consumption. This can be explained by the fact that in the group with high alcohol consumption, individuals consumed alcohol consistently during the week in large or moderate quantities (e.g., an average of 4 beer bottles in a single evening per individual, and this consumption increased to almost double the score on weekends). The moderate group consumed alcohol on average every 2-3 days (one to two bottles per evening at most), while the group with the lowest consumption consumed at most one beer bottle, limited to this quantity throughout the week.

Group A, characterized by high consumption, had a daily average of 0.5 litres, which translates to approximately 3 litres of beer per day. This group consisted of 20 men and 2 women, with 13 male respondents aged 15 to 63 admitting to consuming less than 0.5 litres of water per day. It is concerning that group A's members consumed little water, which is crucial

for the body's health, while favoring beer with an alcohol content ranging from 3 to 5%. Women were poorly represented in this group, with only two respondents, while the majority consisted of men (20 respondents).

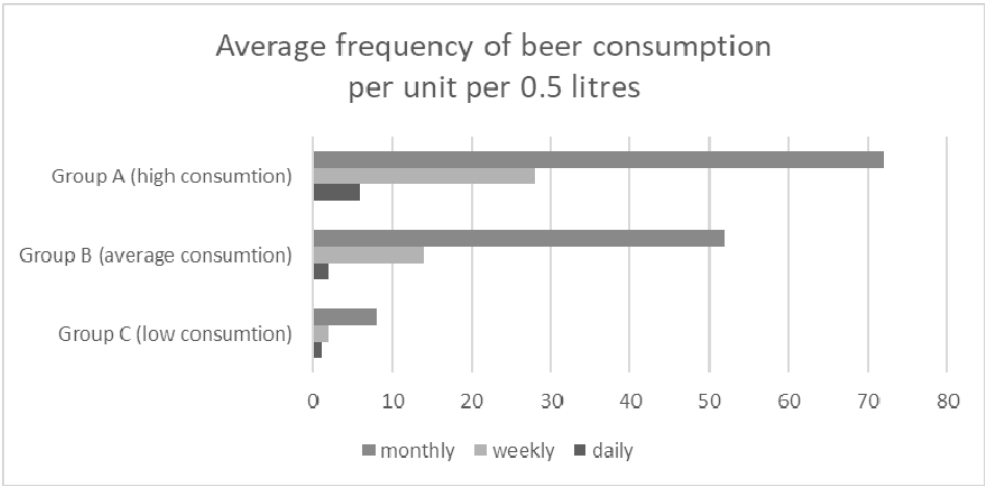

Figure 2. ***Frequency of beer consumption per unit per 0.5 litres during the 2 months (October-November 2022)***

Source: personal research conducted on SurveyMonkey online platform from October-November, 2021

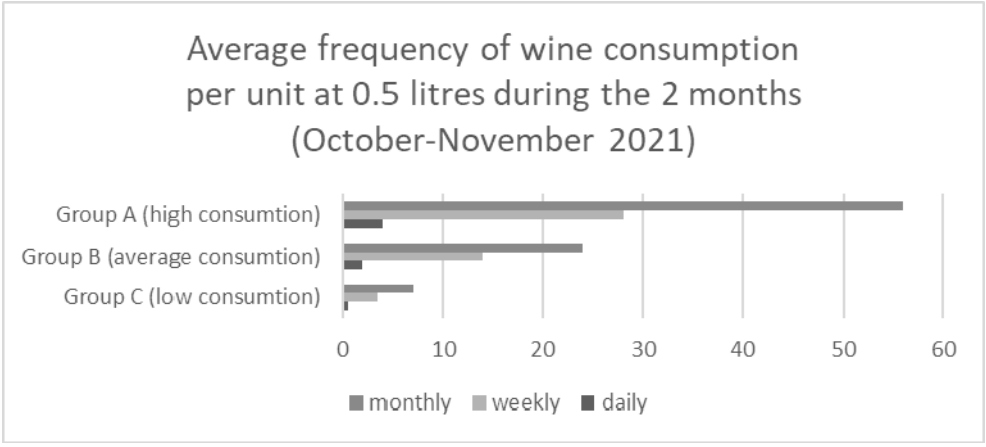

Figure 3. ***Frequency of wine consumption per unit at 0.5 litres during the 2 months (October-November 2021)***

Source: personal research conducted on SurveyMonkey online platform from October-November 2021.

The daily average consumption of 4 wine units, equivalent to 0.5 litres, is observed in group A (high consumption), with a per person frequency of 2 litres, typically in the evening. The gender difference within this group is notable, as the two women in group A consume no more than 1 litre of wine per day, and their frequency of consumption is less than 7 days per week, generally around 5 days per week. To summarize, group A consumes an average of 14 litres of white and red wine per week, with an alcohol content of 8-11%, whereas group B and group C consume around 7 litres and 3.5 litres per week, respectively. The consumption of wine is more prevalent than that of beer during weekends. It is important to highlight that the excessive consumption of alcohol, particularly of wine, can have negative effects on the body, including increased risk of liver disease and cardiovascular problems. Therefore, it is crucial to establish healthy drinking habits and encourage responsible alcohol consumption.

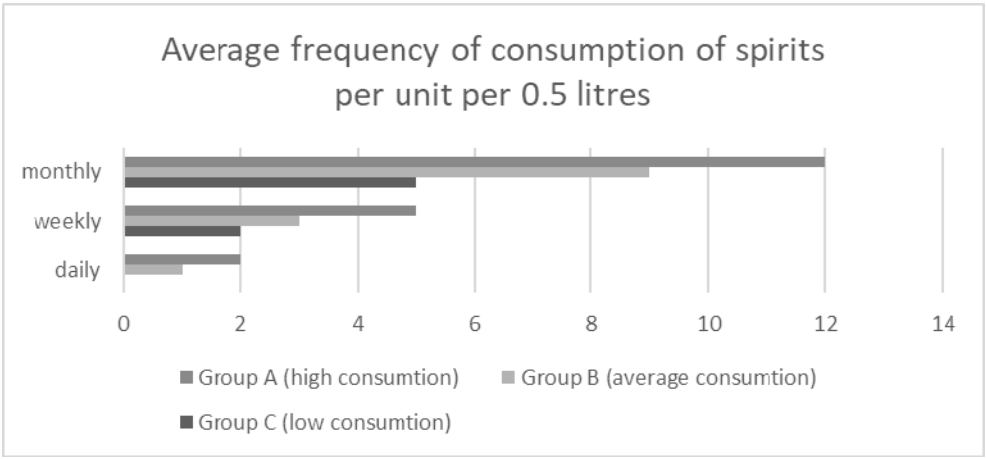

Figure 4. ***Frequency of consumption of spirits (vodka, palinka, brandy and in general beverages with more than 30 % alcohol) per unit per 0.5 litres during the 2 months (October-November 2021)***

Source: personal research conducted on the SurveyMonkey online platform between October and November 2021.

Daily, group A (high consumption) consumes an average of 2 units of spirits (0.5 litres), which equates to a frequency of 1 litre per person, generally consumed in the evening. It should be noted that there is a gender difference,

as the two women in group A consume less than 0.5 litres of spirits per day, with a consumption frequency of 5 days out of 7. In contrast, the frequency of consumption for men is higher, occurring on 7 days out of 7. In summary, group A consumes an average of 7 litres of spirits per week, with a high alcohol content of between 30 and 70%, while group B consumes an average of 3 litres per week and group C consumes an average of 2 litres per week. It is important to note that the frequency of drinking spirits compared to beer and wine is the same, with all three types of alcohol being more frequently consumed on weekends. To provide a visual representation of the comparative frequency of alcohol consumption in all three groups, a graph was produced. The graph displays the average daily consumption of beer, wine, and spirits (0.5 litres) and allows for an observation of the evolution and preference of each group.

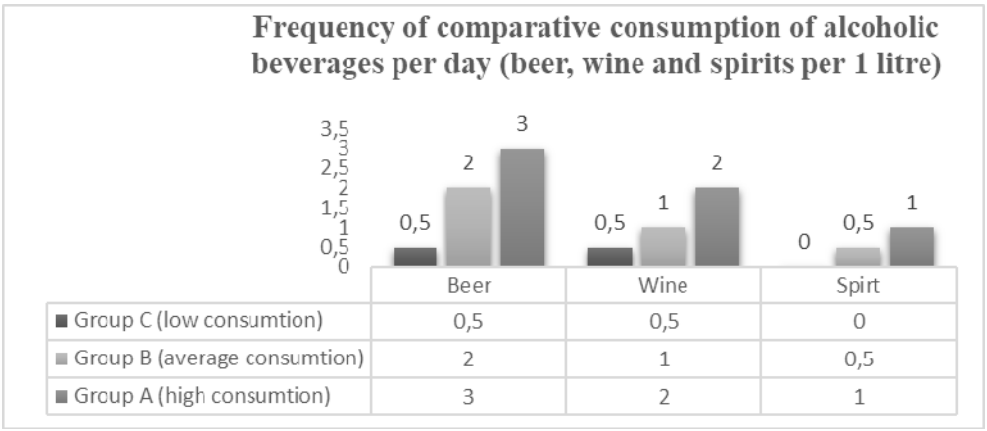

Figure 5. ***Frequency of comparative consumption of alcoholic beverages per day (beer, wine and spirits, 0.5 litre***

Source: personal research conducted on SurveyMonkey online platform from October-November 2021.

In Figure 5, it can be observed that spirits are absent in group C (low consumption) but not entirely. Out of the 16 respondents in group C (11 men and 5 women), only 2 of the 5 women consumed spirits on occasional basis (once or a maximum of 3 times per month), while among men, 11 out of 16 consumed spirits on different occasions (on average twice or 4 times

per month). Comparing date in these graphs, it can be inferred that the respondents who participated in the online questionnaires generally prefer beer, followed by wine, and then spirits. Additionally, a significant variation in alcohol consumption can be observed between the three groups. The second part of the research involved the use of another set of six closed and open-ended questions that inquired about the respondents' involvement or observation of an act of domestic violence. It aimed to gain insight into their experiences and perspectives on the matter. Further analysis of the responses could provide valuable information about the relationship between alcohol consumption and domestic violence.

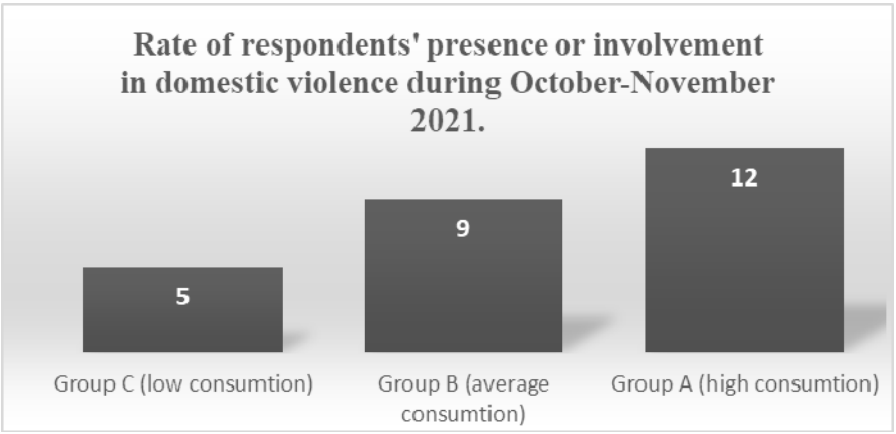

Figure 6. ***Rate of presence or involvement of respondents by group (A, B, C) in acts of domestic violence between October and November 2021***

Source: personal research conducted on the SurveyMonkey online platform between October and November 2021.

In this study, three groups were compared based on their alcohol consumption levels and their involvement in domestic violence. Group A had high alcohol consumption, group B had average consumption, and group C had low consumption. The frequency of domestic violence cases in group C was found to be less than one case per day when alcohol was consumed, but a threshold of two cases per week was observed. Additionally, over a period of two months, only five cases were reported in which individuals in group C were witnesses or direct actors of domestic violence

within their family. Comparing group C with group A, a significant difference in the frequency of domestic violence was noted, with group A having 12 cases over two months compared to group C's 5 cases. The direct correlation between the frequency of alcohol consumption and the increased rate of domestic violence becomes clear, especially when considering the significant difference between the two groups. Both women and men were involved in domestic violence cases in both groups, with women being witnesses and sometimes victims. In group A, out of the 12 respondents who witnessed domestic violence, 5 admitted to being abusers, while 4 reported being witnesses and 3 reported being victims. It is worth noting that the data for this sensitive and optional question came from only 18 respondents in group A, limiting the overall picture. In group B, the average frequency of domestic violence was one case per day, but all respondents reported being in the position of witness or victim, not abuser. These findings suggest that alcohol consumption, particularly at high levels, can significantly increase the likelihood of domestic violence and that the involvement of women as victims or witnesses is a prevalent issue across all three groups.

Discussions and solutions

The purpose of this study was to examine the relationship between alcohol consumption and domestic violence across three respondent groups with varying levels of alcohol consumption. The study found that the more frequent alcohol consumption, the greater the chance of being a witness, victim or perpetrator of domestic violence. This relationship is evident in Table 1, which displays the number of reported cases of domestic violence per month by respondent group.

It is important to note that among men, there were only 5 cases (all in group A) who admitted to playing the role of perpetrator. Furthermore, no women played the role of perpetrator in any of the three groups. To further highlight the differences in alcohol consumption between the three groups, the study divided the consumption of each type of drink by group. Group A consumed the most alcohol, with a daily consumption of 3 liters of beer,

1 liter of wine, and 3 liters of spirits. Group B consumed an average amount of alcohol, with a daily consumption of 1 liter of beer, 1 liter of wine, and 0.5 liters of spirits. Group C had the lowest alcohol consumption, with a daily consumption of 0.5 liters of beer, 0.25 liters of wine, and no consumption of spirits. It is important to note that occasional consumption at various events or celebrations is not taken into consideration for Group C when it comes to spirits. Connecting the two representations of alcohol consumption and domestic violence, it is evident that increased alcohol consumption increases the chance of being a witness, victim, or abuser within family life. The study concludes that efforts to reduce alcohol consumption can potentially reduce the incidence of domestic violence.

Table 1: ***Number of cases of domestic violence by assisting or involving respondents by level/frequency of alcohol consumption***

Group	Number of cases of domestic violence
Group A (high alcohol consumption)	12
Group B (average alcohol consumption)	9
Group C (low alcohol consumption)	5

At a European level, the study found that since the beginning of the pandemic, there has been a relative reduction in alcohol consumption, particularly among younger people and those with no subjective experience of stress who have been exposed to small amounts of alcohol. However, the study found that Romania has shown an average-decreasing trend in alcohol consumption, which differs from other EU countries.

Based on the information provided in Figure 9, Romania experienced a relative decrease in alcohol consumption during the pandemic compared to other European countries. This decrease can be attributed to several factors, including the level of education and income, subjective stress, and restrictions on everyday life. Additionally, these factors had a direct impact on the rate of increase in domestic violence, as was shown in the primary research on three respondent groups. Despite the decrease in consumption,

data on the overall effect of alcohol consumption per capita is still difficult to ascertain. While those at low risk of drinking tended to consume less during the pandemic, those with alcohol dependence continued to drink the same, or sometimes even more. As much of the high alcohol consumption can be attributed to a minority of dependent drinkers, it is possible that widespread per capita consumption in Romania may still have increased.

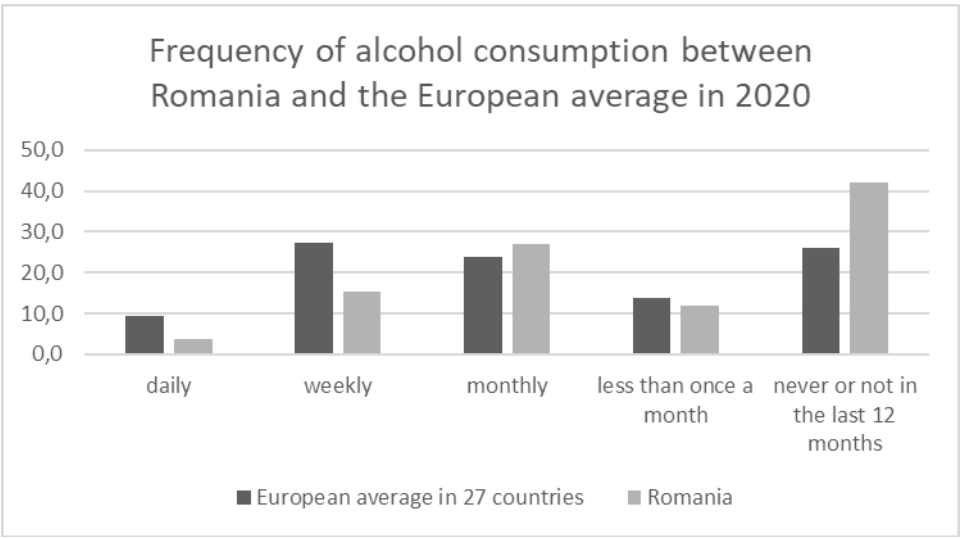

Figure 7. Frequency of alcohol consumption between Romania and the European average in 2020

Source: Eurostat, Alcohol consumption at EU level (update 27 October 2021), link accessed 27.03.2022: https://appsso.eurostat.ec.europa.eu/nui/setupDownloads.do)

This is in line with earlier reports from the World Health Organization (WHO) in 2011. Furthermore, the pandemic had varying effects on alcohol consumption by gender in Europe. Women in Europe generally reduced their consumption less than men, except for a slight increase in consumption among women in Germany. This gender difference persisted even after adjusting for various stressors. Additionally, a study conducted in the US during the SARS-COV-2 pandemic showed that alcohol consumption increased more among people with at least one child in the household. It is worth noting that financial cuts on alcohol consumption during the pandemic may have contributed to the relative decrease in consumption observed in Romania.

Achieving international targets of reducing global per capita consumption by about 10% by 2025, as set by the WHO in comparison with 2010, may be difficult to achieve given the current development. The implementation of effective strategies and policies aimed at reducing alcohol consumption, particularly among dependent drinkers, may be necessary to achieve this goal.

Conclusions

In the case of alcohol-dependent individuals in urban Bucharest and in general, any increase in alcohol consumption represents an added risk to both health and domestic violence, particularly among women and children. The study recorded a higher incidence of domestic violence in groups with higher alcohol consumption. Men who drink are more likely to be perpetrators of domestic violence, while women in the same situation are more likely to be victims. Gender differences in this area are significant and cannot be ignored. However, there is a limitation in the study regarding the role of female alcohol users as abusers due to the limited number of subjects, and women being under-represented in the three groups. The pandemic did not significantly affect drinking behavior, and Romania faces a systemic problem of inadequate resources for treating alcohol addiction. The implementation of screening in Romania to determine the rate and trend of alcohol consumption could contribute to the identification of heavy drinkers and providing care according to the guidelines proposed by the World Health Organization.

The study's limitations include the sample not being representative of the entire Romanian population, as the respondents were only from Bucharest. Additionally, the conclusions only apply to the urban environment, while rural areas may have different trends and situations. Therefore, further research is necessary to accurately quantify changes in consumption behavior. Routine screening for alcohol consumption should be extended to general health care, and reasonable taxation should be imposed to discourage alcohol availability and prevent negative consequences, especially among young people.

In conclusion, the study highlights the interconnection between frequency, level of alcohol consumption, and domestic violence. The higher the level of

alcohol consumption, the higher the rate of involvement in domestic violence. The pandemic did not have a significant effect on drinking behavior, and Romania faces a systemic problem in treating alcohol addiction. To prevent negative consequences, authorities should implement routine screening for alcohol consumption in general health care and reasonable taxation to discourage alcohol availability. Further research is necessary to accurately quantify changes in consumption behavior, as the conclusions drawn only apply to the urban environment.

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The Relation between Early Maladaptive Schema Domains and Social Anxiety among Adults Seeking Residential Treatment for Substance Addiction

Alexandra Mihaela Ferlai[*]

Abstract

Cognitive schemas are cognitive structures through which the individual encodes, analyzes and interprets the information from the environment. Previous research has shown that people with addictions have more active early maladaptive cognitive schemas compared to people without addictions, that early maladaptive cognitive schemas are the strongest predictor of anxiety, depression, paranoia, and substance abuse. The purpose of the current study is to determine the role of early maladaptive schemas domains in predicting social anxiety *in adults with substance addiction undergoing residential treatment. We used the* records of patients admitted for substance addiction residential treatment in a private psychiatric hospital in Romania. We excluded the patients with psychotic comorbidities and patients with mental retardation, obtaining a total of 52 participants (n=52, 63.46%, 36.54% female, mean age was 30.92). All participants were Romanians. To measure the early maladaptive schemas, we used the Romanian adaptation of the Young Schema Questionnaire – Short Version (YSQ-S3), and for social anxiety symptoms we used the subscale from the Romanian adaptation of the Psychiatric Diagnostic Screening Questionnaire (PDSQ). To examine whether EMS domains were associated with social anxiety symptoms in adults with substance use disorders, we conducted stepwise multiple regression analyses and the results indicate that the Impaired Autonomy and Performance (IAP) schema domain has a statistically significant effect on the social anxiety in patients with substance addiction.

Keywords: early maladaptive schema, schema domains, substance addiction, social anxiety.

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Introduction

Cognitive schemas, whether adaptive or maladaptive, are cognitive structures through which the individual encodes, analyzes and interprets information from the environment (Beck, 1967). Early maladaptive cognitive schemas are broad themes about the self and about the relationships with others that are formed in childhood, develop throughout life and are dysfunctional to a significant degree (J. Young, Klosko J, Weishaar M., 2003). Early maladaptive schemas tend to self-perpetuate and are resistant to change (Young et al, 2003, Riso et al, 2007). Early maladaptive schemas may have their origins in environments characterized by violence, natural disasters, or a lack of safety and stability. Early maladaptive schemas (EMS) are formed when interacting with an environment where children experience intense emotions and do not learn how to manage and regulate them, or when children lack a stable relationship with a loving adult, when they have harsh and punishing parents and the child internalizes the punishing voices as a means of maintaining self-control. Also, the early maladaptive schemas develop in environments with an unavailable parent, parents affected by illness, depression, financial difficulties, emotionally unstable or unpredictable person, abuse or violence that frustrates the need for love, safety and connection (Young et al, 2003). In a situation when natural manifestations are discouraged, ignored or mocked, the need to learn to express emotions and needs in appropriate ways is not satisfied (Young et al, 2003). Another origin for the EMS could be overprotective parents who encourage dependency and do not encourage children to venture into the world, do not explain the world to them and this does not meet the need to be supported during growth, in the transition from helplessness and dependence to competence and autonomy. The origins of early maladaptive schemas are the frustration of fundamental emotional needs in childhood, and the cause of the frustration of these needs is influenced by a series of factors related to the child's parents or caregivers on one hand but also by factors related to the child's temperament, on the other. Basic emotional needs are universal, and in some people, they are stronger compared to

others. Individuals are considered to be psychologically healthy if they can adaptively meet these basic emotional needs. Five fundamental emotional needs were identified: the need for secure attachment to others (safety, stability, support), the need for autonomy, competence and a sense of identity, the freedom to express well-founded needs and emotions, spontaneity and play, realistic boundaries and self-control (Young et al, 2003).

Related to the five fundamental emotional needs, five domains of schemas have been identified that comprise 18 early maladaptive cognitive schemas. Thus, the first domain is called Disconnection and Rejection (DS) and it refers to the belief that the needs for security, safety, care, empathy, acceptance and respect will not be met and includes five early maladaptive schemas: Emotional Deprivation, Abandonment/Instability, Mistrust/Abuse, Social Isolation/Alienation and Defectiveness/Shame. The second domain, Impaired Autonomy and Performance (IAP) refers to the individual's belief of being unable to survive and function independently and includes four schemas: Failure, Dependence/Incompetence, Vulnerability to harm/Ilness, Enmeshment/Undeveloped self. The third domain, Impaired Limits (IL), involves the existence of faulty, inaccurate boundaries that translate into difficulties or even the inability to establish responsibilities without the help or without support of others or inability to establish realistic and long-term goals and includes two EMSs: Entitlement/Grandiosity, Insufficient self-control/Insufficient self-discipline. The fourth domain is called Other-Directness (OD) and involves an excessive focus on satisfying the desires and the needs of others at the expense of satisfying one's own desires and needs in order to gain the love and approval of those around and comprises three schemes: Subjugation, Self-sacrifice, Approval/Recognition-Seeking. The fifth domain, Overvigilance and Inhibition, involves the fact that the individual does not express his feelings, impulses, spontaneous choices, believing that he has no right to be happy or relaxed, and includes four schemes: Negativity/Pessimism, Emotional Inhibition, Unrelenting Standards, Punitiveness.

Early maladaptive schemas lead to the formation of maladaptive reactions that include cognitive, emotional and behavioral components, and

the activation of these schemas lead directly or indirectly to psychological suffering, such as depression, anxiety, professional difficulties, substance abuse and interpersonal conflicts (Young et al., 2003).

A study conducted by Pinto-Gouveia, Castilho, Galhardo & Cunha in 2006 comparing the core beliefs between patients with social anxiety, patients with other types of anxiety and healthy adults indicated higher levels of EMSs in patients with social anxiety, especially in the area of Disconnection/ Rejection, compared with patients with other types of anxiety and compared with healthy adults. Also, according to the study (Pinto-Gouveira et al, 2006), the EMSs Mistrust/abuse, Social undesirability/defectiveness, Entitlement, Emotional deprivation, Unrelenting standards and Shame explain most of the variance in subject's anxiety in social situations and in fear of negative evaluation.

According to the APA Dictionary, addiction or substance dependence is defined as the frequent use of a substance despite significant substance-use problems, resulting in tolerance and the cessation of substance use leads to the onset of a withdrawal syndrome characterized by symptoms of discomfort and craving/need for reuse, ultimately resulting in physical and psychological destruction (APA Dictionary of Psychology, 2015).

Previous studies have shown that people with addictions have more active early maladaptive cognitive schemas compared to people without addictions (Dale, Power, Kane, Steward, Murray, 2010). Brummet (Brummet, 2007). People with Defect/Shame, Dependence/Incompetence, and Insufficient Self-Control/Self-Discipline schemas are more likely to use substances. Petrocelli, in a study investigating the relationship between early maladaptive schemas and personality disorders and depression, showed that 76% of personality impairment and of addiction variance can be explained by the schemas of Emotional Deprivation, Dependence/Incompetence, Entitlement/ Grandiosity, Protectionism/Undeveloped Self (Petrocelli, 2001). A study investigating changes in depressive and anxiety symptoms in individuals undergoing residential treatment for substance abuse demonstrated a significant relationship between self-esteem, the general score of early

maladaptive cognitive schemas, and the severity of depression in these individuals (Kirsch, 2009).

Alcohol consumption may be a mean of coping with distress triggered and sustained by early maladaptive schemas, particularly Emotional Inhibition, Emotional Deprivation, and Dependence/Incompetence schemas (Ball, 2007; Rafaeli et al., 2010; Roper et al., 2010), and alcohol-dependent individuals are more likely to show high levels of activation in almost all early maladaptive cognitive schemas (Brotchie et al., 2004; Shorey et al., 2015). Welburn showed in a study of 196 people admitted to a psychiatric hospital that early maladaptive cognitive schemas are the strongest predictor of anxiety, depression, paranoia, and substance abuse (Welburn, 2002).

Chodkiewicz & Gruszczynska, starting from the idea that early maladaptive cognitive schemas do not act in isolation, and the dysfunction of a schema manifests itself in a context defined by other schemas, propose a different approach compared to previous studies that were based exclusively on an approach centered on variables and treated schemas as orthogonal. The authors adoped a profile analysis to test whether a specific pattern of schemas can be identified for a clinical sample relative to adults without a clinical diagnosis (Chodkiewicz & Gruszczynska 2018). The results of the study indicate heterogeneity but not specificity in terms of early maladaptive cognitive schemas in alcohol addicted adults, the difference between the profile of early maladaptive cognitive schemas of alcohol and healthy adults being their level of activation but not and profile shape of schemas.

Current study

Previous studies have shown that early maladaptive schemas play an important role in substance use, depression, and anxiety. The purpose of the current study is to determine the role of early maladaptive schemas domains in predicting social anxiety in adults with substance addiction undergoing residential treatment.

Methods

We used the records of patients admitted for residential substance addiction treatment in a private psychiatric hospital located in the Pianu de Jos, Alba County, Romania. Adults over the age of 18 years or older that were admitted to the hospital with a substance addiction are eligible for admission in the study, according to the psychiatric and psychological evaluation made by the psychiatrists and clinical psychologists of the hospital.

Participants

We searched patient records from January 2020 to January 2023 and included all patients admitted to the hospital during this time with substance addiction, that completed the psychological measurements selected for the study. We excluded the patients with psychotic comorbidities and patients with mental retardation, obtaining a total of 52 participants. The majority of were male (n = 52, 63.46%), and the mean age was 30.92 (SD=10.29). All patients were Romanians.

The most common substance addiction was alcohol addiction (65.38 %), the others, polysubstance addiction (34.61 %). All patients provide informed consent for their medical records to be reviewed for research purposes, with granted confidentiality, at admission in the hospital. All study procedures were approved by the chief of medicine of the hospital.

Measures

We used the romanian adaptation for the Young Schema Questionnaire – Short Version 3 (YSQ-S3) to assess patients' EMS. YSQ-S3 consists of a 114 items and assess al 18 EMS grouped in five domains, as proposed by Young and colleagues. The items of YSQ-S3 are rated on a six point Likert-scale ranging from 1 (completely untrue of me) to 6 (describes me perfectely). The romanian adaptation for the Young Schema Questionnaire-Short Version, Third Edition demonstrated very good reliability (0.68-0.96) and a good dicriminative validity (Trip, 2006).

In order to measure social anxiety (SA), we used the Romanian adaptation for the Psychiatric Diagnostic Screening Questionnaire (PDSQ). The Romanian adaptation for PDSQ consists of 125 questions, 111 numbered items, 2 items consisting of multiple questions, to which participants respond "yes" or "no." Every "yes" on an item scores for 1 point, for the "no", there is 0 points given. The points then are summarised and a higher score on the subscale indicates greater symptoms within the given subscale. The PDSQ contains subscales for several clinical diagnoses, including social anxiety (16 items). The PDSQ has demonstrated very good validity, test-retest reliability (0.67-0.93) and internal consistency (0.68-0.94) (Zimmerman, Ciuca, Albu, 2010).

Data analysis

All data analyses were conducted using SPSS version 20. To examine whether EMSs were associated with social anxiety symptoms in adults with substance addiction, we conducted stepwise multiple regression analyses. The five schema domains were simultaneously entered as predictors and the social anxiety score on PDSQ entered as dependent variable. The p-value to be referenced is 0.05 and the confidence interval value is 95%.

Results

The results of the stepwise regression excluded the schema domains Disconnection and Rejection (DR), Impaired limits (IL), Other-Directedness (OD), Overvigilance and Inhibition (OI) as predictors for Social Anxiety (SA). The excluded schema domains were not statistically significant predictors of social anxiety in this sample, as determined by their coefficients' p-values exceeding the predetermined significance level ($p > .05$).

Table 1. ***Model Summary***

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	,630[a]	,397	,385	3,910

a. Predictors: (Constant), IAP

The model summary table (Table 1) shows that the model has a multiple R of 0.630, indicating a moderate positive relationship between the Impaired autonomy and performance domain and social anxiety. The R-squared value (0.397) indicates that approximately 40% of the variance in social anxiety can be explained by the impaired autonomy and performance domain. The Adjusted R-squared value (0.385) takes into account the number of independent variables in the model and is slightly lower than the R-squared value, indicating that adding additional independent variables may not significantly improve the model's predictive power. The Standard Error of the Estimate (3.910) represents the average distance between the observed values and the predicted values, and can be used to assess the accuracy of the model's predictions. Overall, these results suggest that the impaired autonomy and performance domain is moderately effective in explaining the variation in social anxiety in adults undergoing treatment for substance use related disorders, but may benefit from further refinement or additional variables.

Table 2. ***ANOVA***[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	502,762	1	502,762	32,883	,000[b]

a. Dependent Variable: SA

b. Predictors: IAP

The ANOVA table (Table 2) indicates that the model is statistically significant, $F(1, 98) = 32.883$, $p < .001$. The model's Sum of Squares (SS) value is 502.762, indicating the total amount of variation in the dependent variable explained by the independent variable in the model. The p-value (0.000) indicates that the probability of obtaining an F-statistic as large as 32.883 by chance alone is extremely low, providing strong evidence that the model is a good fit for the data. These results suggest that the single schema domain retained in the final model, specifically the impaired autonomy and performance domain is significantly associated with social anxiety, and that the model provides a statistically valid representation of the relationship between these variables.

Table 3. ***Coefficients***[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
IAP	,146	,026	,630	5,734	,000

a. Dependent Variable: SA

Table 3 shows the results of the stepwise regression analysis indicating that the variable Impaired autonomy and performance domain has a statistically significant effect on the social anxiety. The regression coefficient (B) for IAP is 0.146, indicating that a one-unit increase in IAP is associated with a 0.146 unit increase in social anxiety, holding all other variables constant. The beta coefficient (β) for IAP is 0.630, indicating that IAP is a strong predictor of SA in the model. The t-value for IAP is 5.734, indicating that the coefficient estimate is 5.734 standard errors away from zero. Finally, the significance level (p-value) for IAP is 0.000, indicating that the effect of IAP on SA is statistically significant at the 0.05 level. These results suggest that IAP is an important predictor of SA in the model and should be considered when making predictions or interpreting the results of the analysis.

Conclusions

The field of research in social sciences and psychology seek to identify the causes that underlie the development of addictions in order to prevent and treat them effectively. The causality of addictions is influenced by many factors such as biological, psychological and socio-cultural. Alcohol is frequently used as a tool to facilitate socialization, given its specific characteristics of inducing euphoria and well-being when consumed in groups (Darkes & Goldman, 1993; Hull & Slone, 2004). Also, alcohol is used as a tool for reducing psychological pain, as a way of numbing emotional discomfort.

In a cognitivist approach, the behavioral response is determined by the way the experiences are organized (Wagner, 2001). The current study aimed to identify the schema domains responsible for the variance in the social anxiety symptoms in adults with substance addictions.

The results indicate that four of the five schema domains do not account for a significant variance of social anxiety symptoms in adults with substance addiction. The one schema domain that is particularly relevant to symptoms of social anxiety, according to our results, is the Impaired autonomy and performance domain. Consistent with the theoretical view, these findings fit with our understanding of the subject matter as the EMSs of the Impaired Autonomy and Performance describe core cognitions, emotions and behavioral reactions of people prone to experience symptoms of social anxiety. This schema domain is characterized by the conviction that one is unable to cope, perform, or function autonomously in the absence of others, the strong belief that one is unable to manage life's challenges without the assistance and guidance of others, the perception of oneself as being too weak, fragile, or vulnerable to function independently and succeed without the aid of others.

Given the fact that symptoms of social anxiety are excessive worry that the individual might do or say something wrong in social contexts, the tendency to avoid some social situations, it is logical and reasonable to assume that individuals with EMSs of Impaired Autonomy and Performance may also be more susceptible to experiencing symptoms of social anxiety.

Limitations of the study and further research

The study was conducted on a sample of patients undergoing treatment for substance addiction so the results of this study may not be generalizable to non-substance use treatment-seeking populations. Also, all patients in the study were Romanian, which limits generalizability to more diverse populations. Finally, the sample size was small, which excluded the possibility of the examination of all 18 individual EMS. Future research could be conducted on larger samples in order to allow for the statistical power to examine all 18 individual EMS simultaneously

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Mecanisme și factori cu impact asupra raționalității comportamentelor individuale și sociale în situații de criză

Mihnea Preotesi[*]

Abstract

The last years have been under the sign of global crises, the succession of which has made vulnerable a consistent part of the world's population and the population of Romania. The social anguish generated by the pandemic period was amplified by the sharp and sudden increase in the price of energy and negatively potentiated by the situation generated by the Russian invasion of Ukraine. The analysis proposed in this paper aims at the decision-makers' response to the socio-economic crisis generated by the increase in gas, heat and electricity prices, the decision-makers' approach in providing support to energy consumers is a normative one, being structured by an ad-hoc normativity, which postulates the correlation of the support granted with the degree of desirability of some categories of beneficiaries, positioned according to the energy consumption behaviors. Thus appear categories of virtuous consumers, who deserve to be helped, and categories of vicious consumers, who have demonstrated, by having consumed too much in the past, that they have bad consumption habits, and do not deserve – probably, nor do they need – to be helped. Even if the consumption thresholds start from the calculation of some consumption averages, such averages are irrelevant, given that the profile of consumers, as well as the characteristics that define the ways of consumption are very different – households with different socio-demographic profiles, different energy sources, consumption needs and different types of consumption. In this context of analysis, the theoretical background of the proposed approach is that of the rationality of behaviors, and rationality targets both the categories of population concerned and the measures of the decision-makers addressed to them. The proposed approach is an exploratory one, which aims to crystallize some research hypotheses that will be validated in subsequent researches.

One of these hypotheses concerns the negative effect of this type of intervention to focus the support provided support to certain categories of consumers quasi-

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arbitrary selected and the exclusion of other categories of consumers on whom the impact of the accelerated price growth of public utilities will lead to the forced change of consumption behaviors in a direction incompatible with the rationality of consumption and to the alleviation of energy poverty.

Keywords: social anguish, energy poverty, rationality of consumption, normative approach

Introducere

Pe parcursul ultimilor trei ani termenul *criză,* a căpătat o prezență cvasipermanentă în mass media, în discursul public al politicienilor, precum și al experților în diverse domenii și, în general, în viața de zi cu zi a oamenilor. Termenul a rămas același, conținutul și referențialul său s-au modificat- criza sanitară/pandemică, a fost urmată de crizele generate de războiul din Ucraina-criză umanitară/criza refugiaților, apoi, criza energetică, inflația, criza economică. Crizele s-au succedat, dar anumite componente ale acestora s-au suprapus, adâncind angoasa socială, teama și incertitudinea, factori favorizanți în creșterea impactului așanumitelor *teorii ale consipirației*, ca substitute gnoseologice ale explicațiilor *oficiale* furnizate de instituții investite cu un grad scăzut de încredere pentru segmente largi de populație, ne-încredere alimentată de percepția lipsei unor soluții eficiente de compensare a impactului acestor *crize* suprapuse.

Analiza pe care o propun vizează răspunsul decidenților la criză, focalizându-se pe o componentă de mare actualitate și cu impact social important, criza energetică și măsurile de reducere a impactului creșterii accelerate a prețului utilităților publice-gaze, energie electrică, energie termică.

Abordarea decidenților este una normativă, fiind structurată de o normativitate *ad-hoc,* ce postulează corelarea sprijinului acordat cu gradul de dezirabilitate al unor categorii de beneficiari, poziționați în funcție de comportamentele de consum de energie. Apar, astfel, categorii de consumatori *virtuoși*, care merită să fie ajutați și categorii de consumatori *vicioși*, care au demonstrat, prin faptul că au consumat prea multă energie, în trecut, că au obiceiuri proaste de consum, rispisesc resursele și nu merită – probabil, nici nu au nevoie – să fie ajutați.

Chiar dacă pragurile de consum pornesc de la calculul unor medii ale consumului, astfel de medii sunt lipsite de relevanță, în condițiile în care profilul consumatorilor, precum și caracteristicile ce definesc modalitățile de consum sunt foarte diferite-gospodării cu profiluri sociodemografice diferite, susrse de energie diferite, necesități de consum și tipuri de consum diferite.

În acest context de analiză, backgroundul teoretic al abordării pe care o propun este cel al raționalității comportamentelor, iar raționalitatea vizează, atăt categoriile de populație vizate, cât și măsurile decidenților, ce le sunt adresate.

Demersul propus este unul exploratoriu, această fază incipientă a cercetării pe care îmi propun să o dezvolt în perioada următoare este dedicată cristalizării unor ipoteze de cercetare ce vor fi validate ulterior.

Cadrul teoretic și conceptual

Abordarea normativă și metodele de cercetare aferente se bazează pe demersuri analitice prin care se stabilesc anumite *norme*, în raport cu anumite criterii. Spre deosebire de abordările *relativiste*, ce utilizează drept referential o situație socială, economică *reală*, din perspectivă static și dinamică, abordarea normativă propune anumite valori ale unor indicatori, sau *praguri*, calculate în raport cu o realitate *ideală*, construită pornind de la un set de norme/ principii, fără a avea, în mod necesar, o legătură cu situația reală înregistrată la momentul respectiv.

Un exemplu de abordare normativă ce fundamentează deciziile de politică publică este modul de calcul al unui coș minim de consum, sau a unui coș minim de consum decent, al cărui cost aferent reprezintă *norma* ce orientează politici sociale, precum cea a salariului minim, sau cea a venitului minim garantat.

De asemenea, pornind de la un astfel de coș minim, este calculat un prag al sărăciei absolute, prag ce poate diferi semnificativ de cel calculat din perspectiva sărăciei relative, fundamentat pe un calcul ce pronește de la distribuția reală a veniturilor gospodăriilor, la un moment dat și de la calculul medianei acestor venituri, translatat, prin utilizarea unor scale de echivalență, de la persoană, la adult echivalent.

Din perspectiva consumului populației, abordarea normativă postulează respectarea anumitor principii, unul dintre principiile de bază fiind cel al raționalității comportamentelor de consum. Comportamentele de consum sunt rezultatul unor decizii individuale ale consumatorilor, iar raționalitatea comportamentelor depinde de raționalitatea acestor decizii.

Teoriile clasice ale alegerii raționale pornesc de la premisa raționalității acestor alegeri, proprii comportamentului economic al unei specii de *homo economicus,* descris de unul dintre cei mai importanți economiști neoclasici (A. Marshall, 1890, apud. Frois,1994). Pentru Marshall conceptul cheie în definirea comportamentului economic este cel de *utilitate.* Obiectivul principal al agentului economic, fie el producător, fie consumator este cel de *maximizare a satisfacției* (Marshall, apud. Frois, 1994). Pentru a atinge acest deziderat, alegerea trebuie făcută în condiții de certitudine, adică decidentul trebuie să cunoască și să poată compara utilitățile fiecăruia dintre comportamentele economic alternative. O a doua condiție este ca alegerea să vizeze utilitatea maximă, adică alternativa ce oferă cea mai mare satisfacție din punct de vedere economic.

Modelul propus de Marshall a fost rafinat ulterior de economiști ce translatează problematica comportamentelor de consum de la nivel individual, la nivel societal și de la determinanții deciziilor de consum, la efectele acestor decizii, la nivel individual și societal.

A.G. Pigou (unul dintre studenții lui Marshall) propune o translatare a conceptului de utilitate de la nivel individual la nivel societal (Pigou, apud. Pop, coord.,2002) și propune un model agregat al *bunăstării sociale* ca sumă a *bunăstărilor individuale,* model rafinat de Pareto, ce introduce în modelul său explicativ condiția îndeplinirii așa numitului *optim Pareto* – condiție îndeplinită dacă o creștere a bunăstării unui individ nu duce la scăderea bunăstării altui individ.

Revenind la problematica raționalității comportamentelor de consum, alegerea rațională a consumatorului se bazează pe existența a două categorii de premise, a căror îndeplinire este absolut necesară alegerii rationale.

Pe de o parte, o decizie rațională de consum presupune o alegere informată, ce presupune cunoașterea completă a tuturor alternativelor și posibilitatea de a le compara în mod riguros;

Pe de altă parte, alegerea individuală trebuie să urmeze cea mai bună dintre variantele posibile, pornind de la premisa maximizării utilității individuale.

Pe lângă factorii economici, alegerile ce generează comportamentele de consum sunt, însă, influențate de factori psihologici și sociologici, ce influențează, într-o măsură mai mare sau mai mica, raționalitatea comportamentelor economice. În funcție de importanța acordată fiecărei categorii de factori, modelele explicative ce vizează raționalitatea consumului sunt guvernate de paradigme diferite (Stanciu, 2001).

Din perspectivă psihologică, modelele explicative ce privilegiază factorii psihologici ai consumului sunt structurate de paradigme diferite, precum cea behavioristă (modelul Pavlov, modelul Festinger), sau cea psihanalitică, propusă de Freud.

Între modelele de consum bazate pe factori socio-culturali ai consumului cel mai influente sunt cele propuse de T. Veblen (modelul prestigiului social) și cel propus de P. Bourdieu, ce conectează comportamentelor de consum la caracteristicile poziției consumatorului în spațiul social.

Acest scurt excurs teoretic relevă faptul că acel *homo economicus* descris de Marshall rămâne doar un construct teoretic, deciziile oamenilor fiind, în realitate, bazate pe o raționalitate limitată. În cele mai multe cazuri alegerile comportamentelor de consum se fac în condiții de *certitudine limitată*, atât din perspectiva cunoașterii complete a alternativelor, cât și din perspectiva cunoașterii complete a caracteristicilor fiecăreia dintre ele, pentru a putea permite comparații riguroase.

Pe de altă parte, la nivelul fiecărui consumator, anumite constrângeri situaționale pot îngrădi și limita această raționalitate a consumului, consumatorul fiind obligat, în anumite situații de viață, să ia decizii de consum ce pot fi considerate neraționale, dar care sunt, de fapt, decizii forțate de astfel de situații.

În acest context, se pune problema adecvării unei abordări normative, bazată pe premise precum cea a raționalității abosolute a comportamentelor de consum ale oamenilor.

Tema raționalității consumului este una care necesită să fie explorată și analizată în contextul în care definiția socială a alegerii raționale este în continuă schimbare, dar reacțiile factorilor de decizie sunt decuplate de o astfel de dinamică socială.

O astfel de ”explorare” a raționalității comportamentelor de consum mi-a fost prilejuită de o experiență recentă, participarea la studiul de corelare a salariului minim cu coșul minim de consum decent (CES, 2022[1]). În calculul valorii coșului de consum decent perspectiva abordării este una normativă, pe mai multe dimensiuni:

- structura consumului nu este corelată cu patternurile reale de consum, pe tipuri de familii. De asemenea, nu sunt luate în calcul cheltuieli pentru bunuri considerate dăunătoare-alcool, țigări, cafea, deși ele, conform structurii reale a consumului, reprezintă, pe medie, în jur de 10% din totalul cheltuielilor unei gospodării. Chiar dacă argumentul privitor la efectele negative ale consumului unor asemenea bunuri este unul valid, realitatea socială este una ce necesită o abordare mai nuanțată, în contextul în care, de exemplu, consumul de alcool poate fi asociat și cu practici de consum modelate cultural, precum în cazul unor evenimente în familie, sau sărbători religioase, sau, pur și simplu, întâlniri cu rude, prieteni, cu alte cuvinte, practici ce definesc o funcționare socială normal;
- familia standard, luată în considerare este cea formată din doi adulți și doi copii, rezidenti într-un apartament de bloc–nu sunt luate în considerare familiile rezidente în locuințe individuale, nici problemele specifice ale unor tipuri de familii, precum cele monoparentale-cheltuielile cu utilitățile sunt semnificativ mai mari la locuințele individuale. Alegerea acestui reper pornește de la istoricul stabilirii valorii pragului pentru consumul minim decent, calculate, initial, în cadrul unui proiect, pentru acest tip de familie și extrapolate, ulterior, pentru toate tipurile de familii. Explicația acestei extrapolări

[1] În secțiunea dedicată referințelor bibliografice se regăsește lista completă a proiectelor ale căror rezultate au servit drept suport acestei analize

este aceea că valoarea pragului calculate relative la acest tip de familie a fost considerată una maximală, care poate acoperi toate situațiile de familie/locuire, iar pragul reprezintă o țintă in raport cu care se structurează decizia politică privitoare la dinamica salariului minim.

Nu intenționez să analizez în această lucrare, nici metodologia studiului ce a stat la baza calculării pragului minimului decent, nici abordarea normativă, în sine, dar consider chestionabile două dintre presupozițiile unei astfel de abordări:

1. Existența unui om mediu, cu consum mediu, cu nevoi medii – de fapt, o ficțiune, un construct statistic;
2. Existența unei raționalități absolute a comportamentelor, cu accent pe comportamentul economic.

Tranziția postcomunistă a generat schimbări importante în toate sferele vieții socioeconomice. Comportamentele de consum reprezintă unul dintre domeniile ce au cunoscut schimbări semnificative după 1989. În perioada imediat următoare momentului decembrie 1989 s-a produs, o creștere a volumului și o diversificare a ofertei de bunuri și servicii, cu un impact social cu atât mai important cu cât acest fenomen s-a produs într-un timp foarte scurt, consecutiv unei perioadei de mai bine de un deceniu de penurie accentuată caracteristică ultimilor ani ai regimului comunist.

La rândul lor, veniturile populației au cunoscut un proces de diferențiere accentuată, ceea ce a favorizat diferențierea comportamentelor de consum.

În acest context, o abordare normativă, unitară, a consumatorilor de energie are o relevanță scăzută, iar sprijinul pentru compensarea efectelor creșterii accelerate a prețului energiei, gândit dintr-o asemenea perspectivă, este inadecvat și inechitabil.

Scurt excurs istoric

În Bucuresti, in decembrie 2002, prețul mediu al căldurii și apei calde pentru un apartament cu 3 camere a reprezentat peste 80% din veniturile cumulate ale unei familii formate din doi salariați la nivelul minim pe

economie și doi copii minori. O astfel de situație a pus o astfel de familie în fața unei dileme decizionale în ceea ce privește comportamentul consumatorilor, o dilemă care poate fi operaționalizată prin întrebări precum ″ *Ce facem, cumpărăm alimente pentru copii sau plătim facturile* ?" (Preotesi, în Stanciu, coord., 2004, p. 38).

Această întrebare ar putea fi reformulată, din perspectiva raționalității consumului, în felul următor: "Ce comportament de consum este mai rațional, în condițiile date, plata facturilor la utilități, sau acordarea de prioritate altor nevoi de bază ale familiei și, mai ales, ale copiilor din această familie?". Din perspectiva teoretică a alegerilor raționale, se pune problema care dintre comportamentele de consum maximizeaza utilitatea consumatorului?

La un prim nivel de analiză, faptul că accesul la utilitățile publice și consumul aferent se poate face în avans față de momentul plății acestor servicii, în timp ce, în principiu, alte cheltuieli, cum ar fi cele pentru achiziționarea de alimente trebuie făcute "cu banii jos", ar reprezenta un argument în favoarea maximizării funcției de utilitate prin amânarea plății întreținerii și direcționarea resurselor financiare către satisfacerea altor nevoi de bază, cum ar fi cele ale securității alimentare a familiei.

Acest tip de alegere pare să fi fost, de fapt, cea privilegiată de o mare parte a populației care s-a confruntat cu primul "șoc " al creșterii prețului de încălzire a locuinței, cel din 2002. În sprijinul acestei declaratii vin datele furnizate de furnizori de utilități, precum Romgaz.

Conform principalului furnizor de energie termică (Romgaz), după iarna 2002-2003, o treime dintre rezidenții la bloc din București aveau restanțe la plata întreținerii, pentru perioade între o lună și un an. La nivel național, creșterea datoriilor la plata utilităților publice a determinat sistarea distribuției de energie termică în mai multe localități, fapt ce I-a afectat nu doar pe “datornici “, ci și pe cei care, deși nu au datorii la întreținere se văd în situația de a nu mai putea beneficia de anumite utilități publice.

Problema costului utilităților publice și, la modul mai general, cea a ponderii foarte mari, în România, (comparativ cu țările UE dezvoltate) a așanumitelor *costuri fixe,* apare, în mod recurent, în toată perioada tranziției postcomuniste.

În 2013, după mai bine de 10 ani de creștere economică și după 7 ani de la aderarea la UE, 30,5% din totalul populației României se găsea în dificultatea de a-și putea achita costurile locative (rată la bancă sau chirie) și facturile la utilități, de trei ori mai mulți decât în urmă cu șase ani (10,1% în 2007), procent total triplu față de media europeană – 11,7% (cf. Zamfir, ș.a. 2015):

Politicile promovate de guvernele ce s-au succedat în perioada de tranziție postcomunistă au dus la accentuarea sărăciei energetice, pentru o parte importantă a populației. Una dintre direcțiile de actiune a fost cea a retragerii treptate a subvenției consumului de energie, efectul fiind creșterea prețurilor energiei pentru populație. De la o abordare orientată spre susținerea întregii populații, suportul social s-a reorientat spre sprijinul consumatorilor vulnerabili, a „celor mai săraci dintre săraci" (Zamfir, ș.a., 2015).

În 2006–2007 se înregistrează un vârf de creștere a beneficiarilor de ajutor de încălzire. Numărul consumatorilor vulnerabili în România acoperea aproape jumătate din numărul total de gospodării. Modificarea legii cv reglementează VMG și ajutoarele de căldură a dus, prin introducerea unor criterii eliminatorii legate de bunurile mobile și imobile, numărul de gospodării considerate vulnerabile s-a redus la mai puțin de 10% din total.

Una dintre problemele importante cu care se confruntă o mare parte a populației, este cea a dificultăților legate de posibilitățile de plată a unui serviciu absolut indispensabil într-o țară cu temperaturi scăzute aproape 6 luni pe an. O parte consistentă a românilor experimentează angoasa socială a riscului pierderii apartamentului pentru neplata datoriilor. Patternul migrației interne se modifică, mulți români aleg să plece din orașele mari, în localități rurale și își vând apartamentele cu prețuri mici, ca urmare a creșterii relativ bruște a ofertei imobiliare.

Pericolul tot mai mare de a pierde o locuinta a dus la o schimbare a tipului de rationalitate economica. O cercetare la care am participat în anul 2006 relevă aceasta schimbare a tipului de raționalitate, prin trecerea de la maximizarea utilității pe termen scurt, la maximizarea utilității comportamentelor de consum pe termen lung.

Conform datelor culese în cercetarea amintită, peste o sută de parinți intervievați în opt judete si 16 localități rurale și urbane au numit ca principală

prioritate în ordinea cheltuielilor lunare, plata utilităților publice. Cam în aceeași proporție, cei intervievați au spus că, deși consideră că actualul lor comportament de consum este dictat in mare parte de constrângerile unei situații economice personale precare, chiar dacă ar câștiga mai mulți bani, ar păstra ordinea acestor cheltuieli și ierarhia corelativă a importanței pe care le-o acorda (Preotesi, 2007,p.105).

Cercetarea din 2006 relevă reacții adaptative ale unei populații non-sărace, dar aflate la limita posibilității de a îți asigura un trai decent. O soluție adaptivă era, la acea vreme, limitarea orizontului de așteptare. Iata cum defineau angajatii intervievati traiul decent, in 2006:

> *"O viață decentă înseamnă să nu ai datorii la întreținerea locuinței pentru că aceste datorii sunt un motiv de anxietate pentru toată lumea și să nu simți lipsa lucrurilor absolut necesare, adică minimul necesar"* (angajat, 35 de ani, Iași). *"Un trai decent este să poți sa-ți plătești toate datoriile astea către stat, să poți să-ți cumperi un lucru pe care ți-l dorești, să poți să mănânci ceva bun ca să poți să trăiești în condiții normale, să poți să trăiești și eu știu, nu mai spun de altceva, atât …"* (muncitor calificat, 36 de ani, Iași).

Această limitare a orizontului de așteptare pare a reprezenta o modalitate de a scădea într-o oarecare măsură presiunea generată de o situație caracterizată printr-o *inconsistență de status*. Mai concret, statusul de salariat nu poate fi asociat cu acela de sărac, astfel încât definiția celui din urmă devine mai restrictivă, lărgind astfel conținutul categoriei de non-sărac, cea in care este dezirabil a fi in continuare inclus (Preotesi, 2007,p.106).

În 2022, problemele par a fi similare, dar populația care le experimentează este, totuși, foarte diferită, comparativ cu cea din 2006. Nivelul de trai a crescut considerabil, iar orizontul de așteptare al oamenilor a crescut semnificativ, în contextul experienței interacțiunii cu statele dzvoltate din Uniunea Europeană.

Cu toate acestea, abordarea decidenților nu pare a fi una potrivită pentru această nouă situație Sprijinul diferențiat al guvernului generează discriminare. Așteptările și reacția guvernanților sunt inadecvate, dintr-o dublă perspectivă:

– din perspectiva definirii problemelor;

– din perspectiva definirii solutiilor.

Politicile publice de spijinire a consumatorilor de energie, între dezideratul declarant al reducerii sărăciei energetice și măsurile concrete cu efecte de adăncire a sărăciei energetice

La momentul izbucnirii războiului din Ucraina, in februarie 2022, pretul gazului, deja, aflat într-un proces de creștere, ca urmare a liberalizării pieței energetice în România, precum și prețul energiei electrice se dublează ”peste noapte”, iar prețul energiei electrice continuă să crească necontrolat, la anumiți furnizori, ajungând și la valori de 5-6 ori mai mari în mai puțin de 2 luni.

Un sondaj recent comandat de o firmă furnizoare de soluții pentru confortul și securitatea locuințelor (Resideo, august, 2022), arată că valorile în creștere ale facturilor la energie sunt o sursă reală de îngrijorare, 95% dintre respondenții din România declarându-se "îngrijorați" (36%) sau "foarte îngrijorați" (59%) de evoluția costurilor cu energia.

O particularitate a României este faptul că, în România, procentul populației ce trăiește în case individuale este, conform datelor EUROSTAT,[2] unul semnificativ mai mare decât media europeană. O primă cauză a acestei discrepanțe este procentul mare, în context european, al populației rurale, corelat cu procentul foarte mare al locuințelor individuale în mediul rural. În timp ce, în mediul rural, peste 80% din populație trăiește în case individuale, în mediul urban, acest procent nu depășește 20%.

Pe de altă parte, conform *Strategiei energetice a României 2019-2030, cu perspectiva anului 2050*, în prezent, există în România peste 2,2 mil gospodării cu centrale termice individuale, majoritatea în mediul urban. Deși astfel de centrale pot asigura, fără probleme, confortul termic al locuinței în sezonul rece, o parte a gospodăriilor optează pentru încălzirea parțială a locuinței, din rațiuni economice – în special cele cu locuințe individuale, unde costurile cu încălzirea sunt mai mari[3].

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[2] https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Living_conditions_in_Europe_-_housing

[3] Analiză realizată în cadrul proiectului “Evaluari ale impactulului economic si social al majorarii preturilor la energia electrica’, Academia Română, 2021 (echipa de cercetători ai ICCV:Sorin Cace, Preotesi Mihnea, Adina Mihăilescu)

Gospodăriile ce utilizează gaze naturale pentru încălzire, dar care nu dețin centrale termice individuale, dispun fie de convectoare pe bază de gaze naturale, fie de sobe tradiționale de teracotă. Conform sursei citate, În mediul urban și periurban, o practică obișnuită este utilizarea, în paralel, a gazelor naturale și a lemnului de foc în sobele de teracotă. Peste 250.000 de gospodării folosesc astfel de instalații de încălzire.

Pentru anul 2030, proiecțiile prezentate în Strategia energetică a României arată că aproape 3,2 mil gospodării vor utiliza în principal gaze naturale pentru încălzire.

"Cartea albă a Eficienței energetice în România", elaborată de Asociația Română pentru Promovarea Eficienței Energetice (ARPEE) estima faptul că "pierderile energetice reprezintă una din cauzele importante ale sărăciei la români. Se consumă/pierde inutil foarte multă energie, pe care oamenii cu venituri mici nu o pot plăti. În medie, consumurile energetice în gospodării sunt de ordinul 250-300 kWh pe m.p. și an, de câteva ori mai mari decât media țărilor UE."

Conform studiului Academiei Române, citat mai sus, chiar dacă situația s-a îmbunătățit în ultimii ani datorită programelor de reabilitare termică cofinanțate din fonduri europene, acestea au fost focalizate pe blocurile de locuințe din mediul urban, în timp ce o parte semnficativă a caselor individuale continua să înregistreze pierderi energetice importante și consumuri energetice mari, ce includ aceste pierderi. Situația este una diferențiată și în ceea ce privește sursa dominantă de încălzire în locuințele urbane, în majoritate conectate la rețeaua de gaze natural, comparativ cu cele rurale, din care, o pondere semnificativă folosesc drept combustibil lemnul.

De asemenea, există diferențe semnificative, atât în ceea ce privește consumul, cât și în ceea ce privește costul încălzirii locuințelor individuale, comparativ, cu cele colective.

În ipoteza unei izolări termice de nivel similar, prin natura lor, locuințele individuale consumă semnificativ mai multă energie termică, comparativ cu cele colective.

O documentare pe care am realizat-o în cadrul studiului din 2021, amintit mai sus și care a presupus interogarea cătorva zeci de consumatori

de gaze ce locuiesc în locuințe individuale, relevă costuri mult peste acele medii calculate, aferente tuturor categoriilor de familii prezentate mai sus.

Reacțiile publice, prezentate pe blogurile ce analizau măsurile de compensare a creșterii accelerate a costului energiei electrice și termice, cu precădere, pe componenta de gaze naturale, confirmă un consum semnificativ mai mare decât cel referential pentru măsurile de compensare a costului gazelor natural.

Consumurile medii ce au stat, atât la baza calculelor realizate prin metoda normativă a ICCV (calcule actualizate anual de Adina Mihăilescu), cât și la baza stabilirii pragurilor de consum până la care se acordă compensarea, reflectă ponderea semnificativ mai mare a populației urbane rezidentă în locuințe colective, și ponderea semnificativ mai mica a celor din locuințe individuale cu centrale termice ce folosesc drept combustibil gazele naturale.

De asemenea, în calculul pragului de compensare se regăsesc și locuințe care, fie utilizează gazul doar la încălzirea apei și la gătit, fie nu reprezintă singura sursă de încălzire. De asemenea, în această medie a consumului se regăsesc și casele partial locuite sau locuite doar sporadic, precum casele de vacanță.

La un nivel similar de suprafață încălzită și de confort termic, o proporție semnificativă a locuințelor individuale cu astfel de sisteme de încălzire au, însă, consumuri ce generează cheltuieli semnificativ mai mari.

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Sursele de date amintite mai sus relevă o medie a consumului lunar de gaze ce depășesc 300 de mc, în lunile de iarnă, pentru case cu 3 camere si suprafețe de până în 100 de metri pătrați. Acest consum mediu estimat pentru locuințele cu suprafețe medii, în contextual asigurării unui grad mediu de confort termic, depășește însă plafonul maxim eligibil pentru acordarea de compensații la creșterea prețului gazelor naturale.

Așadar, angoasa socială a riscului excluziunii de la servicii absolut indispensabile, precum energia electrică și sistemele de încălzire, revine în România, după 20 de ani, iar suportul decidenților nu este orientat către cei care au mai multă nevoie de ele, ci urmează o abordare care îi premiază pe cei *virtuoși*-cei care au avut un comportament rațional, adică au consumat

puțină energie termică și electrică și îi pedepsește pe cei care au avut un consum *irațional*.

Chiar dacă, de la primul act normativ, OUG 118/2021, până la ultima variantă, OUG 119, adoptată la 1 septembrie 2022 legile, și OUG-urile succesiv modificate au mers în direcția orientării sprijinului și către o parte dintre cei care au mai mare nevoie de el (familii cu mai mult de doi copii, personae ce folosesc dispozitive medicale consumatoare de curent), principiul premierii consumului redus de energie și al pedepsirii unui consum mai ridicat rămâne și tocmai acest principiu este cel pe care îl consider contestabil, din mai multe puncte de vedere.

Un al doilea criteriu contestabil în acordarea compensărilor este cel al raportării retroactive a plafoanelor de consum la consumul de anul trecut. Așadar, cei care au fost ”nesăbuiți” și au consumat, cu un an în urmă, mai mult decât consumă *omul mediu*-locatar la bloc și aflat încă în sistemul centralizat de termoficare, având energia termică masiv subvenționată deja, indiferent de veniturile gospodăriei (și aici, există discriminări importante, cel mai dezvoltat oraș, capitala, are și cel mai mare procent al subvenționării prețului energiei termice, în jur de 70%!!), ce consumă gaze doar la aragazul de la bucătărie și nu folosește current pentru încălzire sau/și pentru încalzirea apei.

Toți ceilalți, cu precădere cei care au avut ”nesăbuința” să nu se încadreze în profilul consumatorului descris mai sus, nu trebuie sprijiniți în nici un fel în fața creșterii fără precedent,”peste noapte” a costului gazelor naturale și curentului.

Este adevărat că, la mai bine de un an de la adoptarea primului act legislativ de compensare a prețului gazului și energeiei electrice, guvernanții s-au gândit să introducă și un plafon pentru cei ”nemeritorii”, pe lângă plafoanele dedicate doar celor ”virtuosi”. Problema poate fi pusă însă, în continuare în acești termeni, atâta timp cât, de exemplu, pentru consumul de energie electrică, primele două plafonări, (la consumuri lunare sub 100, respectiv, 250 de kwh), sunt dedicate doar celor care consumă sub 300 de kwh pe lună. Pentru toți ceilalți, și primii 100 de kwh, precum și următorii 150 de kwh sunt taxați la prețul maxim plafonat, preț care, atât în ceea ce

privește energia electrică, cât și în ceea ce privește cazul consumatorilor de gaze natural, amintit mai sus, sunt, pe medie, duble față de iarna 2020-2021.

Până la plafonarea generală a prețului, prin OUG adoptată la 1 septembrie 2022, un "consumator nerațional" – de exemplu, având un consum de 301 kwh-a plătit prețul pieței*301 kwh-total: 390-1.505 lei, în funcție de furnizorul de energie electrică la care este abonat În această categorie de "consumatori neraționali" au intrat 550.000 de gospodării din România (conform ANRE, 2022)-peste 1 milion de "români neraționali".

Un efect corelativ al evoluției prețurilor energiei a fost și creșterea prețului combustibililor alternativi, precum lemnul de foc, domeniu în care încercarea de plafonare a prețului a reprezentat un demers prost gândit, ce a dus la efecte contrare celor scontate și, la care, de altfel, decidenții au renunțat ulterior.

Așadar, în mod indirect, categoria celor care folosesc combustibili fosili poate fi arondată ”nerațonalilor”.În cazul acestora, lipsa de rațonalitate derivă din faptul că au avut ghinionul de a nu fi racrodați la rețeaua de gaze naturale și de a nu avea casele izolate termic, măcar și parțial, pe banii Primăriei...

”Nerațonalii” sunt toți locatarii din locuinte individuale, care folosesc gaz sau electricitate pentru incalzire, locuiesc in case cu pierderi mari de caldura si folosesc aparate vechi, mari consumatoare de energie – putem face o paralelă cu *personajul* generic descris de Elliot Liebow, trăind într-o o subcultură marginală, având o orientare prezenteistă, care bea banii în loc să-i investească (banii pe care, de fapt, nu îi are) în educația copiilor și în îmbunătățirea condițiilor de locuit ale familiei (Liebow, 1967/2003) – în exemplul analizat aici, în îmbunătățirea eficienței energetice a casei si in achizitionarea de aparate electrocasnice moderne, cu consum redus de electricitate.

O asemenea abordare a acordării sprijinului adresat compensării creșterii accelerate a prețului utilităților publice este contrară angajamentelor de respectare a politicilor europene de reducere a sărăciei energetice.

Sărăcia energetică este definită de Comisia Europeană drept ”o situație în care gospodăriile nu pot avea acces la servicii energetice esențiale”. Dat fiind că, în 2018, aproape 34 de milioane de europeni nu își permiteau să își

încălzească locuințele în mod corespunzător, sărăcia energetică reprezintă o provocare majoră pentru UE, provocare adresată prin recomandarea 1563 a comisiei din 14 octombrie 2020 privind sărăcia energetică.

Între direcțiile de intervenție necesare documentul identifică, conform Observatorului român al sărăciei energetice[4]:

- asigurarea necesarului de căldură în locuință, pe timpul iernii;
- răcire pe timp de vară (pentru a cuprinde conceptul de sărăcie energetică pe timp de vară);
- iluminat și energie electrică (pentru a face referire la nevoie de bază ale unei gospodării în vederea derulării optime a activităților zilnice);
- accesul la resurse sigure și de calitate cu referire la existența unui serviciu universal (în vederea identificării de surse diverse, accesibile și cât mai curate pentru toate gospodăriile);
- piață liberă și prețuri nediscriminatorii, cu posibilitatea unor tarife speciale pentru gospodăriile sărace (pentru a atrage atenția asupra echității în raport cu consumul de energie).

În altă ordine de idei, pentru sute de mii de gospodării din România actuală prețul prohibitiv al energiei și angoasa repectării *plafoanelor* de consum va duce la o scădere a confortului locuirii și la găsirea de soluții, fie la limita legii, fie/și generatoare de poluare accentuată-de exemplu, din arderea unor deșeuri toxice, fapt semnalat deja de Garda de mediu, drept cauză a creșterii gradului de poluare în București.

Concluzii

Ultimii ani au stat sub semnul unor crize globale, a căror succesiune a vulnerabilizat o parte consistentă a populației globului și a populației României. Angoasa socială generată de perioada pandemică a fost amplificată de creșterea accentuată și bruscă a prețului energiei și potențată negativ de situația generată de invazia rusă în Ucraina.

Analiza pe care am propus-o în lucrarea de față vizează răspunsul decidenților la criza socioeconomică generată de creșterea prețurilor gazelor,

[4] https://saracie-energetica.ro/legislatia-ue-pentru-combaterea-saraciei-energetice/

energiei termice și energiei electrice, Abordarea decidenților în acordarea spijinului consumatorilor de energie este una normativă, fiind structurată de o normativitate *ad-hoc,* ce postulează corelarea sprijinului acordat cu gradul de dezirabilitate al unor categorii de beneficiari, poziționați în funcție de comportamentele de consum de energie. Apar, astfel, categorii de consumatori *virtuoși*, care merită să fie ajutați și categorii de consumatori *vicioși*, care au demonstrat, prin faptul că au consumat prea multă energie, în trecut, că au obiceiuri proaste de consum, rispisesc resursele și nu merită – probabil, nici nu au nevoie – să fie ajutați.

Chiar dacă pragurile de consum pornesc de la calculul unor medii ale consumului, astfel de medii sunt lipsite de relevanță, în condițiile în care profilul consumatorilor, precum și caracteristicile ce definesc modalitățile de consum sunt foarte diferite-gospodării cu profiluri sociodemografice diferite, susrse de energie diferite, necesități de consum și tipuri de consum diferite.

În acest context de analiză, backgroundul teoretic al abordării propuse este cel al raționalității comportamentelor, iar raționalitatea vizează, atăt categoriile de populație vizate, cât și măsurile decidenților, ce le sunt adresate.

Demersul propus este unul exploratoriu, ce își propune cristalizarea unor ipoteze de cercetare ce vor fi validate în cercetări ulterioare.

Una dintre aceste ipoteze vizează efectul negativ al acestui tip de intervenție de sprijinire a unor categorii de consumatori selectate cvasiarbitrar și excluderea altor categorii de consumatori asupra cărora impactul cești erii accelerate a prețului utilităților publice va duce la schimbarea forțată a comportamentelor de consum și la adăncirea sărăciei energetice.

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Roles of Social Workers in the Treatment of Substance Dependence – a General Approach

Bogdan-Nicolae Mucea[*], *Murat Sertpolat*[**]

Abstract

Drug addiction is a complex problem that affects individuals, families, and society as a whole. The use of drugs can lead to physical and psychological harm, as well as social and economic consequences. Treating drug addiction requires a comprehensive approach that involves medical, psychological, and social interventions. Social workers play an important role in the treatment of drug addicts, providing support, advocacy, and education to help individuals overcome addiction and regain control of their lives. Overall, social workers are an important resource for individuals struggling with addiction, providing support, advocacy, and guidance to help them achieve recovery and improve their quality of life.

Keywords: social workers, addictions, substance dependence

Introduction

The basic aim of social workers is to assist, support and enable those affected by poverty, disadvantages and who suffer from the negative effects of social inequalities. They paintings successfully in quite a few multi-disciplinary contexts and for them, the middle expert values, along with human rights and social justice, are greater vital than organizational structures. The features of social paintings encompass social integration and managing disasters of coverage withinside the regions of health, training or crime (Asquith, Clark and Waterhouse, 2005; Faludi and Neamțu, 2020, 27).

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Social work needs a holistic analysis of the micro, meso and macro-structures of the contexts of the resources and problems of individuals and communities. The consequences of ecological crises and shortage of natural resources have strongest impact on the most vulnerable people (Rocha, 2018, 2). Social workers are trained professionals who work with individuals, families, and communities to promote well-being and social justice. In the context of drug addiction, social workers help individuals navigate the complex systems of care, providing information and resources to help them access treatment and support services. Social workers also provide emotional support and counseling, helping individuals cope with the challenges of addiction and recovery.

A substance abuse social worker evaluates and treats people who have substance abuse problems. The substances could include alcohol and illegal or prescription drugs. Once a person starts abusing a substance, he or she may be at risk of developing a physical addiction which can be extremely difficult to overcome. A substance abuse social worker helps individuals overcome their substance abuse by counseling them, and helping them find additional services and resources. The correct perception and adoption by other social institutions of the methods followed by the social work discipline in its effort to increase social welfare and produce solutions for social problems is important in terms of creating a holistic perspective (Zengin and Çalış, 2007).

Center for Substance Abuse Treatment in 2014 and acording to National Association of Social Workers, we mention that one of the key roles of social workers in the treatment of drug addicts is to provide case management services. Case management involves coordinating and monitoring the various aspects of a person's treatment plan, including medical, psychological, and social services. Social workers work closely with other members of the treatment team, such as physicians, therapists, and counselors, to ensure that the person receives comprehensive and coordinated care.

Social workers also play a critical role in addressing the social and environmental factors that contribute to drug addiction. For example, social workers may help individuals access housing, employment, and education opportunities, which can support recovery and reduce the risk of relapse.

Social workers may also work with families and communities to reduce stigma and discrimination against individuals with drug addiction, promoting greater understanding and support.

What is Addiction and What are its Implications?

Addiction is a complex psychological and physiological condition characterized by compulsive engagement in rewarding stimuli (such as drugs, alcohol, food, sex, gambling, or video games) despite adverse consequences. Addiction is often marked by physical dependence, withdrawal symptoms, and a loss of control over the behavior. Addiction is considered a chronic disease that affects the brain's reward, motivation, and memory circuits. It can lead to a range of negative outcomes, such as health problems, financial difficulties, relationship issues, and legal troubles. Addiction can be treated with a combination of behavioral therapies, medications, and support groups.

Addiction can have a wide range of implications for individuals, families, and society as a whole. Here are some examples of addiction implications:

- Physical health: Addiction can lead to a range of physical health problems, such as heart disease, liver damage, respiratory problems, and infections.
- Mental health: Addiction can also have negative effects on mental health, including anxiety, depression, and other mood disorders.
- Social and familial relationships: Addiction can cause strain on relationships with family and friends, leading to conflict, mistrust, and alienation.
- Financial problems: Addiction can be expensive, leading to financial difficulties such as debt, bankruptcy, and job loss.
- Legal issues: Certain addictions, such as drug and gambling addictions, can lead to legal problems such as fines, imprisonment, and a criminal record.
- Stigmatization and discrimination: People with addictions may face stigmatization and discrimination from society, leading to a lack of understanding, support, and access to resources.
- Public health and safety: Addiction can have broader public health and safety implications, such as an increased risk of accidents, violence, and the spread of diseases such as HIV/AIDS.

In his work, the social worker must take into account all kinds of implications that work with an addict has. It is important to note that these implications can vary depending on the type of addiction, severity and individual circumstances. However, in general, addiction can have significant negative consequences for individuals and society.

Social Workers and their Role in Addiction Treatment

The public's image of the social work profession and the variables influencing its growth were first studied by academics in the middle of the 20th century. Some information includes a comparison of the social work profession's standing with other professions (Ayre, 2001; Searle and Patent, 2013; Tulebayev and Abdiraiymova, 2019). In one of C.D. Condie et al (1978) .'s experiments, 250 householders from four different US states were included. The study's findings demonstrated a considerable increase in public awareness of social work compared to the first wave of comparable research carried out in the 1950s. Observing public perceptions of social workers was one of the objectives of the Australian study (Ellett et al., 2007; Buy, 2020; Chenot, 2011; Tulebayev, 2021, 717).

Individuals who are defined as having mental health problems according to the Social Work profession and the relationship with their families and groups falls not only within the area of psychiatric treatment but it is also based on many corporate structures and services outside of it. Psychosocial interventions are administered and welfare services are offered in order to improve the lives of those in the community who need to be protected and those with special needs and risk groups where a substantial proportion of the children, youth, elderly and disabled are victims of abuse or neglect. Psychosocial work has been done with marginalized minorities who are exposed to social stigmatization, gays, children pushed into crime, offenders and addicts for the past hundred years. Psychiatric social work continues to Show its effectiveness in many areas of health and social welfare through using practice methods such as individual counseling, community work, group work, social action, social planning and social policy. Extensive mental health knowledge is required in order to administer professional interventions with the groups

mentioned above. Courses offered in social work education prepare graduates to practice in various areas and the comprehensiveness of the interventions brings professional advantages in the field of mental health (Oral and Tuncay, 2012).

Social workers had an important role in interacting with substance abusers for several reasons:

- Support – they can provide emotional support and encouragement to individuals struggling with addiction. They can listen to their concerns, offer guidance, and provide referrals to support groups or other resources that can help them on their journey to recovery.
- Treatment planning – can help individuals with addiction develop a treatment plan that addresses their unique needs and circumstances. They can work with them to set goals, identify barriers to recovery, and develop strategies to overcome these obstacles.
- Advocacy – Social workers can serve as advocates for individuals with addiction, working to ensure that they have access to the resources and support they need to recover. This may involve advocating for policies and programs that promote recovery, such as access to healthcare and employment opportunities.
- Coordination of care: Social workers can work with healthcare providers and other professionals involved in an individual's care to ensure that all aspects of their treatment are coordinated and integrated. This can help to prevent gaps in care and ensure that individuals receive the support they need to achieve long-term recovery.
- Education and prevention: Social workers can also play a role in educating the public about addiction, its causes, and its impact on individuals and society. They can also work to prevent addiction by promoting healthy behaviors and addressing the social and environmental factors that contribute to substance abuse.

The best differentiate the role of a substance abuse social worker from the other professions in mention, it's best to consider the "umbrella" of social work without the substance abuse angle for a moment: In cases of intervention for a loved one. Social workers are a great resource to pull on to help you

navigate through what this process looks like. Social workers can also be referred to and serve as a therapist, as therapists are professionally trained in the use of therapy. They can serve as a sounding board, as well as a haven for professional advice and direction. As policy makers, care managers, administrators, and service providers working directly with clients with a SUD, social workers may choose, provide, or push for evidence-based SUD treatment practices. This serves to help those in need that may not have a voice.

The Similar Situation in Romania and Turkey

In Romania and Turkey, social workers play an important role in working with drug addictions, providing support, advocacy, and education to help individuals overcome addiction and lead a healthy, fulfilling life. In both countrys, social workers advocate for policy and legislative changes to improve access to treatment and support services for individuals struggling with addiction. They also work to reduce the stigma and discrimination associated with addiction, promoting greater understanding and support for individuals in recovery.

In Turkey, social workers provide individual and group counseling services to those struggling with drug addiction. They help individuals identify the underlying causes of their addiction and develop coping strategies to manage triggers and prevent relapse. Social workers also work with families and communities to reduce the stigma associated with addiction and to provide support to those in recovery. In addition, they provide case management services, helping individuals access medical, psychological, and social services to support their recovery.

Turkey has a long-standing problem with drug addiction, with the government and various non-governmental organizations (NGOs) working together to provide treatment, prevention, and rehabilitation services to those affected by drug addiction.

One of the key roles of social workers in Turkey is to provide individual and group counseling to those who are struggling with drug addiction. Social workers help individuals identify the underlying causes of their addiction and develop coping strategies to manage triggers and prevent relapse. They

also work with families and communities to reduce the stigma associated with addiction and to provide support to those in recovery.

Social workers in Romania also provide counseling services to those struggling with drug addiction, helping individuals address the emotional and psychological aspects of addiction. They also work with other members of the treatment team to develop a comprehensive treatment plan for each individual, including medical, psychological, and social interventions. Social workers in Romania also play a crucial role in preventing drug addiction, working with schools, community organizations, and government agencies to promote awareness about the dangers of drug addiction and to provide education and support to individuals and families at risk.

Social workers play an important role in Romania when it comes to drug addiction, being involved in different stages of the process of prevention, treatment, and social reintegration of individuals who struggle with drug addiction. Firstly, social workers are involved in drug prevention campaigns, educating young people and adults about the risks and consequences of this behavior. They also provide counseling and emotional support to individuals struggling with drug addiction and their families. Regarding treatment, social workers work together with doctors, psychologists, and therapists to offer an individualized treatment plan and monitor the progress of patients. They also help identify and access the necessary resources for drug addiction treatment, such as rehabilitation centers and group therapies.

Social workers are also involved in the process of social reintegration of individuals who have recovered from drug addiction. They offer counseling and support to help patients find employment, housing, and rebuild relationships with their family and community.

Conclusions

Social workers shall promote interdisciplinary and interorganizational collaboration to support, enhance, and deliver effective services to clients with substance use disorders and their families (National Association of Social Workers, 2013). Social workers play a vital role in the treatment of drug addiction. Through their knowledge, skills, and expertise, social workers

provide support, advocacy, and education to help individuals overcome addiction and achieve greater well-being. The integration of social work into drug addiction treatment can improve outcomes for individuals and families, as well as promote a more just and equitable society.

Social workers in both countrys (Romania and Turkey) had a vital role in working with drug addictions, providing counseling, case management, prevention, advocacy, and education services to support individuals in recovery and to promote a healthier, more resilient society. In conclusion, social workers have a crucial role in helping individuals struggling with drug addiction overcome their problems and rebuild their lives. They provide essential support and services for the prevention and treatment of drug addiction, as well as for the social reintegration of individuals who have recovered from drug addiction.

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The Role of Communication in Health Care

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Abstract

Many professions in our society have as a main purpose health care. To ensure a quality life for a person a whole number of specialists are making teams, reuniting their knowledge: doctors, psychologists, social workers, therapists, educators, teachers, and others. Some of them have an important role in healing diseases and ameliorating the symptoms, others are involved in changing unhealthy living styles and preventing health deterioration. To be successful in their efforts all these specialists use a common tool: communication. We can understand communication as an instrument of sharing information about health prevention, as a tool of educate groups of people or communities about a better-living style and as a tool of exchange information and giving support one-to-one to people in need. We used to believe that communication is easy and such a normal process and we do not always invest enough attention in searching the better ways and tools to improve the efficiency of communication for reaching higher results in health care. This paper aims to underline the importance of communication role in health education and health prevention, highlight the main communication methods that can be used and bring to awareness the process of counselling as an important function of communication which plays a decisive role in health prevention and health education. At the same time, this paper plays an advocacy role in encouraging specialists in health care to use empathy in their interactions with clients. Empathy is presented as a key tool in successful healthcare communication.

Keywords: health care, communication, empathy, counselling, health prevention, health education

1. Introduction

Health is one of the most important values for human life. As a result, a series of professions was created in society to support, protect and care for it. Some professions have the role of restoring people's health once damaged,

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such as doctors, therapists, psychologists, and others. They have a priority role in their awareness and prevention: social workers, teachers, trainers, coaches, educators and others. All these specialists have a difficult mission considering the multitude of challenges to which people are subjected in recent years. The Covid-19 pandemic has brought even more attention to the value of health and the importance of maintaining it and has become one of the topics of maximum interest for all the people of the planet. Therefore, it becomes imperative to identify the most accessible ways to maintain health and prevent its loss.

We might think that each person is responsible for their health, but people realize the value of health only after they have lost it. For some people, this awareness may come too late to avoid serious health problems. Accordingly, healthcare specialists need to find a way to help raise awareness of the importance of health before reaching situations of generalized crisis, similar to the covid pandemic.

This article aims to explore in what ways this could be achieved and what could be a successful and easy strategy to apply at any level of intervention. It is a tool that can be improved and used by each of the above-mentioned specialists at any moment of health intervention and can ensure its success and the modification of people's beliefs and behaviors related to health. This tool is nothing else but communication. Improving communication techniques in the relationship with patients/clients/beneficiaries creates the conditions for the necessary changes in health care and even facilitates the improvement of health status.

2. Definition of the concepts of health, health field, health care, health education/promotion

The World Health Organization (WHO) defined *health* in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Later, "the ability to lead a socially and economically productive life" was included in this definition. According to this definition, health has a more complex meaning, beyond the limits of the human body.

The concept of social well-being is brought to attention together with physical and mental health. It is common when we talk about health to think about physical and mental health and not necessarily about the social context in which a person lives.

Social well-being is one of the key points we should look at in a healthcare system. In the practice of social work, it is well known that a person's social network, lifestyle, and the quality of the environment he lives in influence his health quality in the long term. It is exactly the place where health prevention and health education start as early as possible in a person's life. The way a person learns about health in the family, at school and work determines his health status sometimes for his entire life.

According to author Lalonde Marc (1974) and emphasized by the World Health Organization (2011) and The Public Health Agency of Canada (2011) the social key factors that have been found to influence whether people are healthy or unhealthy include:

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetics
- Health care services
- Gender
- Culture

These are even more complex factors that are partially under the influence of medical services, and partially under that of social protection and education services.

Continuing the exploration of health beyond physical and mental boundaries the author Lalonde Marc (1974) introduces the concept of the "health field" as distinct from medical care. The report identified three interdependent fields as key determinants of an individual's health:

- **Lifestyle:** the aggregation of personal decisions (i.e., over which the individual has control) that can be said to contribute to, or cause, illness or death.
- **Environmental:** all matters related to health external to the human body and over which the individual has little or no control.

- **Biomedical:** all aspects of health, physical and mental, developed within the human body as influenced by genetic makeup.

The "*health field*" concept proposes a complex understanding of health and fully covers the factors that influence health, both those that are under the person's control and those that are outside of this control. From these definitions, we can see that there are factors that are under the control of the person itself, but this autonomy is on the one hand socially determined and depends on the degree of culture of a person, the person's income, and on the culture in which he was born. Other factors depend on the particularities of the environment in which a person lives, on the resources that are accessible, on the safety offered by the environment area and, not least, on the genetically predetermined factors. In particular, the last two conditions are predominantly out of a person's control (environmental and genetic influences), and social factors are subject to change, but this does not mean that change is easy to achieve.

The concept of *health care* or *healthcare* is the improvement of health through actions like prevention, diagnosis, treatment, and cure of a disease, illness or injury. Health care is delivered by medicine, pharmacy, psychology, therapy, sports training, nutrition and many other health professions. And a *healthcare system* is the organization of people, institutions, and resources that deliver healthcare services to populations in need.

Health education is a different concept than health care. The World Health Organization (1998) defined Health Education as consisting of "consciously constructed opportunities for learning, involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health."

The National Conference on Preventive Medicine in the USA adopted the following definition of Health education: "It is a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitate this goal and conducts professional training and research to the same end".

The Declaration of Alma-Ata (1978) underlying the need for "individual and community participation" gives a new meaning and direction to health

education. Their definition of health education is: "A process aimed at encouraging people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health and to seek help when needed."

The purpose of health education is extending beyond the health care system and became a concern of the family system and social educational system. The content of health education marks important topics as:

1. **Human body** – understanding human biology and the structures and the functions of the body, the importance of rest and sleep, the effects of different substances on the human body (alcohol, drugs, cigarettes,), reproductive biology and child raising.
2. **Nutrition** – to guide people to choose optimum and balanced diets and to promote good dietary habits. It's known that there is a direct link between dietary habits and chronic diseases and that shows nutrition is a good way to prevent them.
3. **Family health** – the family has an important role in health education, as a result, it is important to make adult parents responsible for fulfilling this role and finally in informing and educating family members about adopting a healthy lifestyle.
4. **Disease prevention and control** – to cure a disease is not the end of the process because it can manifest again if the person does not change his lifestyle.
5. **Mental health** – is important, especially in big cities where people live more isolated than the ones from small towns and in the most difficult moment of human life, such as: giving birth, sending children to school, losing jobs, losing a partner, etc.
6. **Prevention of accidents** – to prevent accidents safety education should inform about possible accidents at home, on the road and at the work-place. Regarding the workplace part of the responsibility of education is taken here by the companies.
7. **Use of health services** – is about keeping people informed of the health services options and creating a feedback loop between the health services and the end users.

Regarding all this information, we can conclude that health and health education must be a constant concern, for individuals, families, communities and all the social systems involved in society.

3. Human strengths as resources for health

The author Susan Kun Leddy (2006) mentioned that "health promotion focuses on positive health intending to build strengths, competencies, and resources, by identifying, acknowledging, concentrating on, and developing individual strengths and environmental resources". To accomplish this ambitious aim it requires a shift in perspective to a strengths/solution-focused, perspective based rather than "reaction, coping, and repair" (Nakamura & Csikszentmihalyi, 2003, p. 262).

This idea is promoted beginning with The First International Conference on Health Promotion (held in 1986 in Ottawa, Canada), by outlining five levels of action: (1) building public health policy, (2) creating supportive environments, (3) strengthening community action, (4) developing personal skills, and (5) reorienting the health system (WHO, 1986). As we can see even from that time developing personal skills became important for promoting health and is important to find which are those skills that can keep a person in a healthy condition.

As evidence of this approach, other authors mentioned that feeling good makes people more optimistic, resilient and socially connected. Positive beliefs may be tied to physiological changes such as enhanced immune function. These beliefs may also affect physical disease by encouraging healthy behaviours, resulting in the consistent application of good health habits, and the appropriate use of health services. Positive functioning incorporates self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, and positive relationships with others including social coherence, actualization, integration, acceptance, and contribution (Keyes & Lopez, 2002).

Other positive attributes include courage, interpersonal skill, rationality, insight, optimism, authenticity, perseverance, realism, capacity for pleasure, future-mindedness, personal responsibility, and purpose. Interpersonal or

relational attributes include patience, empathy, compassion, cooperation, tolerance, appreciation of diversity, and understanding and forgiveness (Aspinwall & Staudinger, 2003).

Susan Kun Leddy (2006) introduces the concept of healthiness as "a process incorporating intertwined purposes, connections, and the power to achieve goals" and it is the basis on which she warmed the Theory of Healthiness. "Healthiness reflects a human being's perceived involvement in shaping change experienced in living. Therefore, healthiness is a resource that influences the ongoing patterning reflected in health." (Leddy, 1997, p. 49). In the Theory of Healthiness, health is conceptualized as a dynamic process that manifests the pattern of the unitary human being. (Leddy, 2006)

The main strengths a person mentioned in The Theory of Healthiness should develop to gain more resources in maintaining and preventing health damage are derived from the mentioned tree category: purposes, connections, and power to achieve goals. As we can see in the figure below, these strengths are focused on an individual internal capacity and ability to connect with others and to channel self-energy and others towards goals and purposes in life.

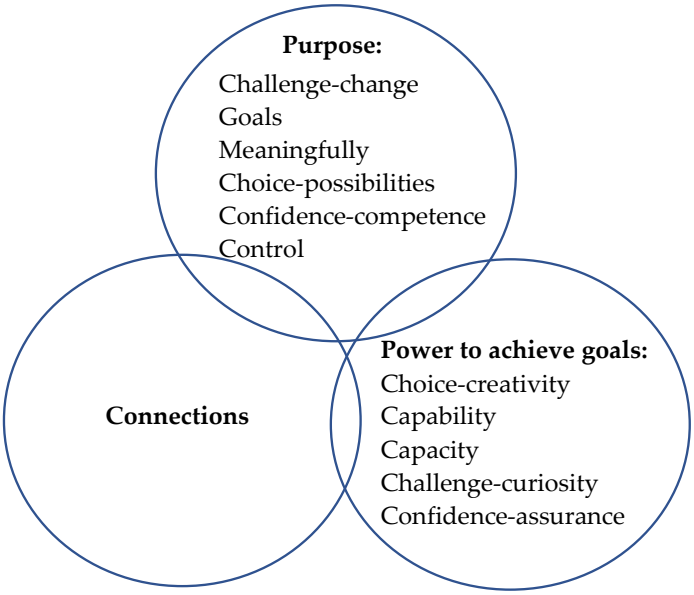

Figure 1: ***Empirically Derived Components of Healthiness by Susan Kun Leddy (2006)***

The purpose is defined as attributing significance and direction to the dynamic pattern of the human-environment mutual process (participation). It is defined as goals an individual wants to reach or accomplish. It incorporates the dimensions of:

- *Challenge–change* – "which is perceived opportunity, excitement, curiosity and/or involvement in change toward meaningful goals" (Leddy 2006). *Optimism* "is a particularly generalized expectancy that good things will happen in life" (Carver & Scheier, 2001).
- *Goals* – "constitute a central element of an individual's meaning system." Goals are actions, conditions, or values that are either desirable or undesirable. Commitment is "the belief that the goal is important and the belief that one can achieve or make progress toward it" (Locke, 2003, p. 305).
- *Meaningfully* – "characterized by seeing an aspect of the present or the future as having meaning, or value". "Is often described in terms of purpose that refers to beliefs that organize, justify, and direct an individual." "A sense that life has meaning is associated with well-being and is seen as necessary for long-term happiness" (Nakamura & Csikszentmihalyi, 2003, p. 95).
- *Choice–possibilities* – "is the perceived freedom, and creativity to select from among alternatives (possibilities) for action". Hope is "characterized by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant" (Dufault & Martocchio, 1985, p. 380).
- *Confidence–competence* – Confidence can be defined as "a strong, generalized, positive belief or certainty that individuals have about who they are. Confidence is closely related to self-image and to the decision-making process that occurs before taking action" (Kear, 2000). In the literature, confidence is related to the notion of self-concept and self-esteem.
- *Control* – "is the perceived ability to influence the rate, amount, and/or predictability of change". (Leddy 2006) "Personal control consists of an individual's beliefs and expectations about how to effectively shape

and alter the environment to bring about positive events and avoid negative ones" (Peterson & Stunkard, 1989; Ross & Sastry, 1999).

Connections are having rewarding relationships with others, (Leddy 2006). Connectedness promotes a sense of comfort and well-being, supports a sense of meaning in life, and reduces anxiety. Connectedness occurs when one individual is actively involved with another individual (interpersonal), object, group (social), or environment (natural or man-made). (Hagerty, Lynch-Sauer, Patusky, and Bouwsema, 1993)

Power is the perceived ability to direct energy toward the achievement of goals. It incorporates the dimensions of:

- *Choice–creativity:* "an increased flexibility, a widened spectrum of possible responses to inner and outer stimuli, and an expanded universe of psychological possibilities" (Abend, 2001, p. 3). "Creative ideas allow the individual to remain flexible, facilitating growth and late-life adaptation." (Leddy 2006)
- *Capability to function* is "the self-perceived belief in the individual's ability to achieve desired goals," and "the perceived ability to work, play, and carry out activities of daily living". Capability requires confidence, creativity, and general intellectual and communication abilities. (Leddy 2006).
- *Capacity* "is a perceived quantity of available energy".
- *Challenge–curiosity:* can be defined as "exerting self-control in the face of adversity and overcoming adversity rather than feeling helpless" (Lazarus & Folkman, 1984). The challenge is experienced when there is an opportunity for self-growth with available coping strategies" (Drach-Zahavy & Erez, 2002, p. 667). Usually associated with the challenge, *resilience* is "the capacity to prevail in the face of adversity… the maintenance, recovery, or improvement to mental or physical health following challenge" (Ryff & Singer, 2003, p. 20).
- *Confidence–assurance* "is a guarantee of the ability to successfully overcome obstacles to achieve goals".

Parse (1981) has defined nine concepts in her nursing theory. This theory is helpful to understand Leddy's concepts of meaning, choice, connection, capacity, and capability. The nine Parse concepts are:

- *Imaging*: "picturing or making real events, ideas, and people";
- *Valuing*: "living of cherished beliefs";
- *Languaging*: "speaking and moving… the way one represents the structure of personal reality";
- *Connecting-separating*: "the rhythmical process of distancing and relating";
- *Powering:* "the pushing-resisting of inter-human encounters that originates the uniqueness in the process of transforming";
- *Transforming:* "the changing of change";
- *Originating:* "generating unique ways of living";
- *Revealing-concealing:* "rhythmical patterns of relating with others";
- *Enabling-limiting:* "infinite number of possibilities within choice".

In conclusion, there is a complex combination of traits and strengths that help a person to gain healthiness and this can become the aim of health education in the effort to prevent, maintain and regain healthiness. These strengths usually are trained in the family system, but reality shows that it is not enough to let all the responsibility to families because it depends on too many factors to be fulfilled. Social and educational systems need to take more responsibility in developing these strengths, as well as, the company's already start doing part of this work by implementing self-developing training programs.

4. Health Communication & Health Education

The term health communication is often used synonymously with health education and is the foundation of a preventive health care system. Communication is an essential tool that can be used by all the professions involved in health care and health education to prevent and inform people about health diseases and cures and to train people in the strengths necessary for preserving health.

The term communication has been derived from the Latin word *communicare,* or *communis* which means "to make common" or "to share" and it means a common ground of understanding. Newman and Summer (1977) give a common understanding definition of communication, as "an exchange of facts, ideas, opinions or emotions by two or more persons".

Gerard R Miller defines communication as a process that "focuses its central interest on those behavioural situations in which a source transmits a message to a receiver, with the expressed intention of influencing his subsequent behaviours". This second communication definition is more closely to understanding the role of the communication process in health education.

In health education communication is not just an exchange of facts, ideas, opinions and emotions, it is more a sending message with intention of influencing and changing others' behaviours. Sometimes it is more a one-way process, as a media communication of a recommended prevention behaviour or a two-way process as a one-to-one discussion or group learning process.

Table no 1: ***Category of communication methods in health education***

Individual Communication	Group Communication	Media Communication
1. Personal contact	1. Group discussion	1. Television
2. Home visit	2. Panel discussion	2. Radio
3. Personal letters or e-mails	3. Symposium	3. Newspaper
4. Online contacts	4. Workshop	4. Social networks
5. Phone contacts	5. Conference	5. Printed materials
	6. Seminary/Training	6. Direct mailing
	7. Role plays	7. Posters
	8. Demonstrations	8. Internet
	9. Film and charts	9. Museum and Exhibitions
		10. Folk media (traditional folk/cultural forums)

As we can see, media communication had a large variety of methods and is widely used in health education and promotion. The main dis-advantage is that is hard to obtain relevant feedback using these methods and the prevention idea needs to be resumed in group communication or

individual communication to have an impact on changing behaviours. Social workers and people from social care together with medical specialists and therapists are the ones which get in contact daily, face to face, with the beneficiaries of their services, and can sustain the health education process.

5. The function of counselling in health communication

Sociologists described three stages in the process of changing behaviour: the *stage of awareness* – acknowledging the problem, the stage of *motivation and interest* – evaluation process and decision making, and the *stage of action* with intention of adopting or rejecting the behaviour. Communication has an important role in all these stages of change and the communication ability of the message senders can make a real difference in creating relevant change.

Counselling is an important part of treatment, disease prevention and health promotion. It helps people to avoid illness, improve their lives through their efforts and to develop positive attitudes.

A counsellor should be able to communicate information, gain the trust of the people, listen sympathetically and empathetically, understand other person's feelings and respond to them in such a way that the other person can feel free to express their feelings, to help people reduce or solve their problems.

Counselling skills are:

- **Active listening** – counsellor wants to know more, ask questions, is curious, patient and they are of great importance (McLeod, 2007);
- **Empathy** – the most advanced level of empathic responding is to show an understanding beyond the client's immediate awareness by communicating the underlying feelings **(**Mearns & Thorne, 2007);
- **Genuineness** – the genuine counsellor is open to the experience, comfortable with themself and those behaviours that help clients (Hackney & Cormier, 2009);
- **Checking out** – pauses in the conversation to find out or enquire about assumptions or experiences at that moment that the client may have (McLeod, 2007).

A very specific example of a situation in health care when a person needs to use counselling skills is when a doctor tells the patient bad news. When he has to communicate an ominous diagnosis for the patient he is treating, the doctor is important to be attentive to what he says and, above all, how he says it. To achieve efficient communication, the health care specialist should be aware if he allowed enough time to establish a relationship with the patient. The doctor must know how to listen actively to the patient, but also respect his opinions and beliefs which he has, even if he does not agree with them. Empathy in communication is also extremely important because with its help the doctor can better understand what the patient is going through and can encourage them to express themselves openly and unfettered.

Robert A. Buckman (2005) describes a context of what happened in 1998, at the annual meeting of the American Society of Clinical Oncology, where approx. 400 oncologists attended a session telling bad news to the patients. Oncologists were questioned about their communication skills and the way they have trained the communication skills. The result of questioning was that less than 5% of those present say they were trained to communicate bad news. Over 66% say that they must communicate bad news 5-20 times/month; and approx. 74% of the participants recognized that they do not have a planned approach, concerning bad news communication. More than 90% felt that the most difficult moment was facing the emotions that appeared during the discussion of bad news.

To come into the help of the health care specialists the author presented a protocol called SPIKES strategy, which focuses on the acceptance and awareness of emotions, and 99% of oncologists said it was a protocol easy to understand and remember. The SPIKES protocol is a strategy, not a scenario. It stands for a 6-step process; the bad news communication process must be achieved gradually and is necessary to follow these steps: finding out information about the patient regarding his level of knowledge in the field of his disease and his expectations, providing information that is understandable for the patient and by his expectations, reducing the emotional impact of bad news and, finally, but not least, the development of therapeutic strategies together with the patient.

Table no 2: ***The SPIKES 6-step process***
(Baile W.F., Buckman R., Lenzi R., Glober G., Beale E.A., Kudelka A.P., 2000)

1. Setting (S)	– *Securing the place* where the discussion takes place; – *Involve other important people* for the patient if he has this request; – *Sit down with the patient* while delivering the bad news and avoid placing physical barriers between you and the patient as much as possible; – *Look carefully and calmly* and keep your own emotions under control, if necessary, calm the patient with light touches and break eye contact if he is crying; – *Active listening* – Silence and repeating information are two communication techniques by which you give the patient the news. Your silence (i.e. don't interrupt the patient when he's talking, don't talk over him) shows that you respect what he has to say and that you are "actively listening". Repetition involves the use of the language (words) used by the patient so that his last sentence will be partially found in the doctor's first statement. – *Availability* – try to create a context in which you will not be interrupted, and if you have limited time for the discussion, communicate this from the beginning.
2. Perception (P)	– Before communicating the bad news, the doctor needs to find out what the patients know and understand about their current medical situation – and about how serious they perceive it. – The doctor listens to the patient's answer, the language, and the words he uses and then uses them in his formulations. This step helps him appreciate the gap (sometimes unexpectedly large) between the patient's expectations and his actual medical situation. It is not indicated to confront the patient from the first discussion if the gap is large in order not to trigger anxiety or adversity on his part
3. Invitation (I)	– The doctor needs to obtain the patient's permission in advance to provide him with details related to his health condition, and he respects the patient's right to know (or not know).
4. Knowledge (K)	– It is important that the doctor, before communicating the bad news, warns the patient that not-so-good news is coming – To avoid technical, scientific language. – Give the information "in pieces" and clarify if the patient understood what you told him after each part (it is often necessary to repeat the information, even several times, especially when the patient seems confused, although he says he understood). – Adjusts the information density. If by a certain point, the patient clearly understood everything, it is possible to move on. If not, the information is resumed.

5. Empathy (E)	– As various reactions and emotions appear during the discussion, the doctor becomes *aware* of them and *manages* them – *The empathetic response technique* in 3 steps: Step 1: Actively listen and identify that emotion (or emotions) If you are not sure, use an open question: "How does this make you feel?", "What have you understood from what I have told you so far?" Step 2: Identify the source or cause of the emotions. Most of the time these are generated by the very bad news he just heard. Step 3: Show the patient that you have made the connection between steps 1 and 2 – referring to the fact that you have identified the emotion and its origin. – *Validation of emotion* – Once the emotion has been identified and the doctor has shown empathy towards the patient's feelings, the effort to diminish as much as the emotions that have arisen follows.
6. Strategy and Summary (S)	– The doctor checks if the patient has understood the information correctly. – Summarizes the information and asks if there are any ambiguities. If there is no more time to clarify, the doctor assures the patient that they will address them during the next meeting. – The doctor and the patient end the discussion with a plan that includes the next steps and the role that each one will still have it

The SPIKES 6-step process is a good example of an approach between a health care specialist and the patient. Leading the communication process in this manner means fulfilling some of the strengths of healthiness Susan Kun Leddy (2006) has mentioned. One of the most important strengths is the connection and empathy approach and active listening that are making possible this strength to develop in the relationship between health care specialist and the patient.

Confidence and challenge are underlined by step 4-Knowledge from the SPIKES technique and strengths as goal and meaningful are fulfilled in the step 6-Strategy and Plan of action which also provide the patient with the feeling of control and hope in a positive ending of the treatment of health intervention. It is important that the approach we used to help the

patient to develop healthiness strength. This is an act of prevention and in time the patient became again in control of his health.

6. The role of empathy in health communication

There are many perspectives in an attempt to define empathy. The English word "empathy" was translated around 100 years ago from the German word "Einfühlung", which means "feeling into". One perspective about *empathy is a shared emotional response* which means sharing or mirroring someone else emotions or reflecting/feeling exactly identic emotion as the other person is feeling. (Roman Krznaric, 2008)

Another approach is referring to *empathy as a perspective-taking* which the psychology literature refers to as "cognitive" empathy. This means according to Roman Krznaric (2008) "our ability to step into the shoes of another person and comprehend the way they look at themselves and the world, their most important beliefs, aspirations, motivations, fears, and hopes. That is the constituents of their internal frame of reference or "worldview".

And a third approach to empathy is the idea of having an "*appropriate response to a person*", after having engaged in either or both two kinds of empathy noted above. This could be described as "*consequentialist empathy*". (Gordon Mary, 2005) This last approach of empathy is controversial, and the author Roman Krznaric (2008) believes that is not realistic to expect from someone else an action because of understanding one's emotions and worldview.

In the book "Through Other Eyes: Developing Empathy and Multicultural Perspectives in Social Studies" (2004) by Joan Skolnick, Nancy Dulberg and Thea Maestre, the authors completed their empathy approach by mixing the first two definitions in a "Thinking-Feeling Spiral" model, which draws on the work of Jean Piaget and John Dewey.

The "Thinking-Feeling Spiral" model identifies four major kinds of learning experiences which can help in developing empathy skills:

- making personal and concrete connections to the topic and engaging through personal experiences, individual stories, pictures and objects;

- inquiring and imagining someone else's life;
- investigating content resources to learn more about another experience;
- "acting as if" one is actually in another's circumstances, making choices or solving problems.

Empathy is an important topic in fields such as psychology and social science, art theory, music therapy, sociology, religious studies, politics, and conflict resolution and peace studies. The forms of psychotherapeutic counselling that consider empathy central to their method have also increased. One of the most significant areas in which empathy has become very relevant is the study of social change.

Since the 1990s, due to Daniel Goleman's work, there has been an increasing focus on how empathy can aid emotional and personal development and reduce aggressive behaviour. He also emphasises the role of emotional intelligence in helping to build communities and social cohesion.

The historian Theodore Zeldin (1999) suggests that the most effective way of creating empathy is through an intimate conversation between two people. "Conversation is becoming the experience which, more than any other, teaches us how to empathize with people different from ourselves and to develop respect for them." An empathetic conversation, which involves "getting inside another person's skin… is the most effective means of establishing equality. Every time you have a conversation which achieves that, the world is changed by a minute amount". (Theodore Zeldin, 1999)

The role of empathy in health communication is very well presented by the last two authors. One of the objectives of health communication is prevention and encouraging social change regarding good practices in healthiness and the authors suggest that empathy plays a crucial role in the achievement of these objectives.

On the other hand, empathy is extremely relevant in the process of treating and helping a patient who needs health care through the power of authentic connection and empathetic conversation. These skills can help the patient to get in contact with his strengths and this creates the premises for healthiness.

For these reasons, the new trends in health care are that all the specialists starting with social workers, psychologists, and therapists, which already use empathy in their work, and follow up with doctors and other medical specialists need to adopt and use empathy in usual conversation with the clients. This involves a new type of education based on empathy and active listening conversations.

7. Conclusions

As is presented at the start of this paper, empathy is emphasised as a key tool in successful healthcare communication. It is necessary for a change in approaching health and becoming more "human" in our communication that can help clients to change their behaviour and adopt new understandings and actions in their lifestyles.

Also is important to build consciously the strengths that help o person to keep control over this health status and to contribute due motivation and phycological capabilities to healthiness. To reach these ambitious objectives is necessary a convergent effort to improve healthcare systems simultaneously with the individual and community development of new practices in the approach to health. Social workers and other specialists from the health field can initiate and stimulate these changes and, as time passes, increase the results.

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Bioethics and Social Work on the Same Quest: Improving Quality of Life

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Abstract

Authors analyse the phenomenon pf the quality of life that occupies significant place in bioethics and social work. The term quality of life has varied and changed over time, and it was made a subject of many social sciences and philosophy–bioethics. Institutions of social care made as their aim to improve the quality of life of their protégés and clients. In bioethical and philosophical context this subject is related to the notion of life itself and it values. Bioethics it is not only a theoretical field, but also bases itself on bioethical activism, in which bioethicists engage themselves by educating people on how important is to find ways to improve the quality of life of the vulnerable ones, how create qualitative environment around them. Due to its original character, as applied ethics this concern for quality of life can be also extended to the social work. Bioethics and social work have lot in common when it comes to this subject. Bioethics beside its theoretical work on quality of life, addictions and healthcare is involved also in crating public policies to make the work easier for social workers who are out there dealing actual people of low well-being. So while bioethics is try to educate to lessen problems in society social workers trough foster care system do it directly. Institutions of social service play a significant role in improving the quality of life of parentless children, by giving them requirements for leading a life of progress.

Keywords: Bioethics, children at risk. Social work, quality of life, foster family

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Introduction: Bioethics and quality of life

Bioethics and life are closely connected even in the name of the discipline we have term life; it is created as a discipline that tends to put under observation everything that can be considered to be life from ecosystems to human beings.

>Bios< means life and >ethika< is the word for attitude or custom in Greek. The term >bio-ethics< means the ethical behavior towards life[1]

In his book The Birth of Bioethics Albert Jonsen defines this discipline as a common fertile interdisciplinary field in which more than one social sciences are meeting and as such bioethics can contribute to social sciences. It can give a perspective a fresh approach or it can educate wide masses about problems that are risen in the sciences today. Jonsen says that bioethics has emerged as an interdisciplinary field encompassing knowledge from other disciplines philosophy, theology., medicine sociology, and other sciences who are engaged with the questions about life, health, aging, dignified old age and assistive dying (Jonsen).[2]

As a philosophical discipline bioethics create the basis of research surrounded around the term life so it asks about quality of life, the beginning and ending of life, what life means, the purpose one has in life, the ways of prolonging and sustaining life and the what king of life is the life worth living. So it happens that the meeting ground of bioethics and social work can be made on the subject of quality of life and on question how to improve it.

It seems that the concept called "quality of life "can encompass variety of meanings, and various ways in which it can be understood and the multiple means to be improved. The quality of life can also be determined by the perception of each individual about its position in life, the context of its own culture, and value system, the system in which he lives, in relations to his goals, as well as models expectations and achievements. The term itself is influenced by physical and psychological health as well as personal

[1] Sass, H.M. Bioethik – *Archiv für Begriffsgeschichte,* 2014, Vol. 56 (2014), pp. 221-228 Published by: Felix Meiner Verlag

[2] Jonsen, A. The Birth of Bioethics, 1998, Oxford, Oxford University Press.

and moral beliefs, social relationships and rationality itself, and so called data appearing in the life of the individual (WHOQOL).

The quality of life includes everything from physical health to moral and religious beliefs. The authors emphasise these six arias as most important when it camos to improving of quality of life.

Physical health, mental health, level of independence, social relations, personal context (in which is included economic status, since of freedom actual freedom and security access to information, available means of traffic and psychological and weather condition) And in this context personal beliefs moral and religious ones the level of their acceptance, and the possibility to share them with social environment.

Quality of life can be also observed on the level of local community when bioethics trues to educate the whole community about certain problems they may face. When the well-being is tired to be enhanced by the means of public policies and education we are talking about bioethical approach to the problematics.

When we try to improve it at the level of families of specific individual well-being we are in the realms of social work. Social work and the condition in which it is carried out can be also improved by public policies governmental action and volunteering contrary to bioethical attempt to raise awareness that something have to be put in better terms of functionality, bioethicists can also influence governmental decisions by forming committees of protection, bioethical centres at the universities or trough non-governmental organisations.

In other words, the quality of life is encompassing well-being that can include both objective factors and subjective assessment of social emotional well-being, together with personal development and purposeful activity all evaluated to the personal set of values.

In one of it dimensions whish we are going to cover trough this article the quality of life can be seen as subjective experience of one's life, determined by the real circumstances in which the person lives. Personal experience and its characteristics which can influence the one's perception of reality.

Social work and quality of life

Social workers are the ones who are directly involved in cases which need direct improvement of one or all of this mentioned categories, they are taking care of families and work with those whose quality of life is very low and appalling conditions in which they live tend to endanger the bare existence.

The task of enhancing living conditions it is huge it is not only about making a new house or giving them items of clothing, but giving them a sense that they are not alone that the state will help them, they are giving them some insurance that there is some sort of distributional justice and some place in society for poor and for defenceless members of this land.

Weather in mental health, addictions, child protection, intimate partner violence services, youth and adult homelessness programs or any number of social work services, the individuals, families, and groups who come into contact with social workers are disproportionally marginalised, on the basis of the race indigenous status, gender, poverty, sexuality, disability and language.[3] (Blackstock and Trocme 2005: 12-33)

These are categories of people in need of an increase in their general well-being, bioethics is devoted to these categories without influencing governments to make something for them, but without direct meeting wait those people bioethicists are crating the policies to make job of social worker easier, because social workers on the other side are meeting this people and try to find the ways to meet their needs on a daily basis.

After making this difference between our disciplines we will go to our common goal which is improving the quality of life by foster families. Then in our third part we will show why we think the foster family should become a bioethical problem as well.

Addictions already are bioethical problem and there is a link between how children are treated in their biological families and on quality of parenting

[3] Blackstock, C. and Trocme, N. Community based Child Welfare for Aboriginal Children: Supporting Resilience through Structural Change. *Social Policy Journal of New Zealand* 24 (2005): 12–33.

depends whether will young adolescent turn to drugs or not, we will try to explain foster family care tough term life worth living, which encompasses almost all bioethical questions of life.

We have stated that the quality of life is a personal perception of ones way of life in the context of culture that surrounds every individual, their value system, aspirations, outlook for the future and standards and interests, what is more important their chance to fulfil their aspirations and create good outlook for the future.

The children are the most vulnerable group of all groups, because they need a grown up to stand for their rights, on their own children are unable to create conditions that will improve their lives, it makes things worse when they lack parental adequate parental care, or do not have parents at all.

If they had parents and they are taken under state custody, it is very likable that they had suffered in their biological families, probably despicable things, from physical, verbal, emotional abuse to neglect, if the parents did not live up to the task of providing their children with good parental care. Such children are taken and often given for adoption or placed under the state care.

Family conditions and addictions

American scientists have discovered that risk behaviours are in most commonly situations a result of how the child is treated in the family, many biological families in America have problem with their children abusing the dogs.

Serbia is no deferent in recent years we have more and more dys-functional families and a grooving number of divorces, more and more couples are divorcing after only a year of marriage, most of them with the children, then the children are witnessing long court processes of court fighting over the custody.

Under their own frustrations and inhibitions, the parents are transferring their aggression to the children creating conditions for children disobedience. If the parents are fighting the children are more likely to want to spend the time in the home, as they grow up tend to socialise with other children who

are in same situations forming teams. Such team make children to feel more comfortable outside of the parental home, then there is another problem, when parents are having arguments they are self-oriented and they do not pay attention on how the child will fell.

Nowadays more and more children are taken into a foster care for the reason of domestic violence. Those children have shown addictive and delinquent behaviours from the very beginning of teen age.

The strongest associations are between parental discipline and child aggression, and between parental closeness and the child attachment to the parent. Parents who report using punitive methods of disciplining their children or disagreeing with their spouses about disciplining the child are more likely to report that their children are aggressive, have control problems and are disobedient.[4] (Kandel 1990:188)

If the parents use alcohol the situation gets worse, such parents are characterised by poor parenting skills, using punitive methods in upbringing, having unreasonably high expectations for the children, they create stress in a family environment, and are not good in supervising their kid development. (Kandel 1990:184)

Drinkers show *lack of family cohesiveness, inconsistent parenting and parental deviance*.[5] (Zucker and Noll 1982:289)

Then retrieving the children from such families by the social work it the think mast be done and it has to be done with the support of the government and sometimes police. If such families lack parental skills and if they are able to guide well their children, there is highly likelihood of the children ending up in deliquesce and criminal activities.

Since quality of life is and a personal perception of one's life, children would perceive that life with their parents lacks in quality, and that is peaceful and harmonic like in some other homes they have visited, such a person would them accompany with someone similar, and they might get into risk of drinking alcohol or taking some other drugs.

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[4] Kandel B.D. Parenting styles Drug Use and Children Adjustment in families of young Adults, *Journal of marriage and family* 52 1990 103-106

[5] Yuckier and Robert A., and R.A. Noll 1987 „The interaction of child environmental the early development of drug involvement "*Drugs and society* 1, 57-97

If a person perceives their life as low-quality, or in more severe cases not worth living, they may become prone to vices and delinquent behaviours, especially if they are a child teenager or adolescent, which is the age when various addictions can begin. Neglected or abused children have problem with valuing their lives and are more inclined to develop undesirable behaviours.

A person valorises their life according to their own achievements, but if they do not have enough means to realise it, due to poverty or dysfunctional family, they will hardly cultivate correct goals, and truly believe in them. Children in the social system protection receive not only an improvement in material conditions but also, the whole concept of foster family orientated on idea of correct goals and what is most important idea that the goals are now achievable, that they are given suitable chance and that there are team of people who can give them support to bring their goals to closure and become a descent and affirmed grownup, accepted and valorised by the community in which he live as well.

The history of foster care in Serbia

Historically we had institutionalised caring homes, in major cities in Serbia and all around former Yugoslavia in which they get to be cared about until they turn 18 of age. Long time had this been the most common way of helping them. But what happens behind the closed door of their dorms nobody new and what is worse nobody seemed to care. On the other hand, we had children growing up with their abusive biological parents and told nobody about what kind of abuse they are getting inside of home in fear of going to the collective caring homes, sometimes they were threatened with them. If you do not listen to me I will send you away, the classical way of emotional conditioning.

If they had been sent to institutions of collective care once they turn 18 they are released to the street to find their own way of surviving in outside world which was more hostile oriented towards such people. Because of the past for such children was more difficult to socialise and engage themselves in social relations, most of them would associate with the delinquent people

and end up in Jail, or spend their life's on the streets of major cities, where nobody seemed to care about their story, and telling a story like I grow up in a caring home easily could make one's life even worse, they were often stigmatised and out casted.

But when somebody tell the story like I grew up in a foster family it is different, sometimes causes admiration, why because it indicates that the person had adapted to family rules that had fitted in, and family may have succeeded in transcending to them domestic culture and values. So great invention was the professional foster care as an alternative way of caring for children.

There were several types of foster care in Serbia and former Yugoslavia, in our research and Bosnia and Herzegovina. The professional foster care evolved from something called elementary foster care, which meant collecting children from the street by ladies of good heart and bringing them in their own home for care, without any support they would cover their basic needs, providing them with food warm bed and some sort of security. These ladies weren't paid for their work, it works cried out of virtue, spirituality and humanity orientation of individual persons. One of the most eminent name known in Serbia was Milunka Savić, the First World War hero, she had taken part in a war dressed like a man. After war she lived a humble life in Serbia and raised 12 children on her salary as a house keeper, her name was until recently almost forgotten. Such elementary foster care was performed in many homes in Yugoslavia mostly by women. These children who were lucky not to go into institution were cared by these ladies. When socialistic Yugoslavia was formed after world war II it lead to opening of centres for social service which then helped to these ladies in her quest, quest was to improve conditions of foster caring. And state was there to decide which children are eligible to go to the institutions of collective care and which will be placed in the homes of these ladies. By the end of century what had been called fostering out of virtue became professional fostering out of duty and obligation, foster care as a profession, many of people in the institutions of collective care were dreaming of growing up in families.

Jim Rose distinguishes between professional foster care, foster care as a profession and foster care as a community work. He says:

The state in charge of the well-being of the children who fit into category of the most vulnerable in society, and entrust them to the daily care to the individuals and families which accept those children in their homes and care for them behind the closed doors of foster home.[6] (Rose 2013:106)

The evolution of foster care in Serbia bears resemblance with the evolution of this care in UK. Rous emphasise the purpose of the foster care in his article *Community protection in private service. The care of someone else's children under the roofs of one's home.*

Caring of children and the young who express a lot of challenging behaviour and whose life stories point to the terrible experiences of neglect or violence, which requires skills and qualities which are developed trough years. When foster families are selected it is of essence to be clear about the weight of task, difficulty of the job, they are applying for, but also to convince them that adequate levels of support and training are available to every foster care giver (Rose 2013:109).

Foster family care has over 90 years in Serbia, it was going from strength to strength until 90es first form of such care was formed in 1931 as a children colony. These colonies evolved into collective forms of caring for children collective care homes and at the peak of their evolution into the villages for children, the most famous one nowadays is children's village Sremska Kamenica nearby city to Novi Sad.

Then mentioned fostering care from virtue evolved into professional care. Fostering as a professional care started to give its best results at the beginning of 21 century when the children from villages and collective homes were moved into a families most of which have their own biological children. Professional care is going with all the benefits of having a job, of course they have a salary, and a monthly budget that is to be spend on the covering the needs of children. This way of fostering is guided by the government and institutions of counselling for foster care. Professional foster care in not

[6] Rose J. Community protection in private service. The care of someone else's children under the roof of someone elses home. Proceedings: Foster care at the beginning of 21st century, Pp, Belgrade 2013, ISBN: 978-86-87887-07-7

elementary based it need to meet not only basic need of children but also to play a role of the parents to socialise them, to help them with the school assignments and to help them to have healthy emotional development. To help them overcome health and any other problems and to talk to them about their prospects for the future.

At the beginning of 21th century foster care was standardised to give the children everything possible to lessen the difference between them and other children in their schools. Ministry has educated experts so called specialists for foster care among social workers which are intermediate connection between the centres for social work and foster family. They make the yearly plan of development of child which is then revised. Education for new foster families became obligatory and families are licenced and their license is going under re-evaluation in every 2 years.

In the past the food warm, place to sleep and food was enough. Mow minimal requirements are:

1. *Living conditions had to met the standards of normative life.*
2. *The protégé has to have his own room*
3. *Every children has to have his own desk, work table, book shelves, heating and every other necessities.*
4. *Depending of the age of children it has to learn how to keep his rom tidy.*
5. ***Pocket money. Child in independent in deciding how to spend it.***[7]

When this are required then we talk about socialisation developing skills and emotional and intellectual development of every child in foster care. Thin Serbia have developed an idea that is not enough just to cover basic needs of the children but also to gather a team of experts to work with them on overcoming the problems that might arise from the children background.

It is necessary to introduce one article called *Foster family care with additional and intensive support*[8] it is article from international conference

[7] Grujic. D. Frist Five years of Centre for adoption and foster care. Proceedings Challenges of foster care at the beginning of 21th century.

[8] Tijana Jankovic (specialised in pedagogy,) Tamara Borisavljevic (psychologist) and Miodrag Petrovic (psychologist) Proceedings*: Foster care at the beginning of 21st century*, Pp, 33-53 Belgrade 2013, ISBN: 978-86-87887-07-7

holded by ministry of social care, the authors made a study on a sample of foster children to see if additional support and intensive work with children and foster family can make improvement in decreasing unvented behaviours.

The sample on which the study was carried on counts 137 foster children, elementary school children and adolescents. What were question marked as problematic for those children, which were proclaimed urgent to improve during the work therapies and hours of training:

1. *Their ability to tell the story*
2. *Their physical and mental health*
3. *Their intellectual and educational improvement*
4. *Development of their emotions*
5. *Identity*
6. *Family and social relationships*
7. *Their skills of self defence*

Most of them have problems in school, they are often stigmatised and discriminated in multiple ways. Sometimes those children who have excellent marks and are exemplary in school, still have emotional problems (Janković, Borisavljević, Petrović 2013:39)

Through a well-managed system of psychological and educational support a child at risk of consuming cigarettes of alcohol, let alone other substances can become exemplary member of community at age of 18 of 26 if decides to go to university can be independent and create his own family. In addition to eliminating negative conditions with the help of foster family and positive projections about the future can also be obtained. Encouraging the realisation of children's dreams and aspirations by foster parents and family concealer in the centre for foster care and Adoption a young person from margins of the society may well become socially responsible member of his community.

Numbers of children were removed from their families and entered the protection system precisely because of the removal of the risk of the problematic behaviour and possible addiction. The way in which children at risk value their life largely determines their behaviour and their tendencies.

If a child is encouraged not belittled if a teenager is encouraged to attend workshops and trainings and if adolescent is encouraged to contribute to the community and gain the feeling of participating in something that is developing and has his role in it, they will be more appreciated in the community for their contributions, and as such they will not allow themselves to consume alcohol or be exposed to psychoactive substances.

Iskrica the Association of the Foster Families was established with the goals to improve quality of life, and to bring the foster care even on a higher level, to be able to help their protégées trough whole life. In the monography published after 5 years of work, were documented all the achievements the Association did in its short existence since it is closed due to the luck of founding's. They formed the network of foster families with the idea to become national and international, they had activities for children for New Year's and Christmas, it established contacts with the organisations of civil society. It organised the meetings of foster families from other cities to share the experience. They organised training for experts. Local events for young artistes to exhibit their works. They established a club for support and self-support of young in risk of misbehaviours. *With planned activities at the club to answer the needs of young in risk, to work on prevention and to try to eliminate or reduce the consequences that arise from antisocial behaviour that rise from antisocial behaviour among young people. Establishing a heathy life for youth is one of their best interests.*[9] (Iskrica monography 2011: 27-29)

When we look at the activities done in this Association it bear huge resemblance to what centres for bioethics do when it comes to trainings and educational purposes. In addition to the fact that risk behaviours alcoholism and drug abuse, as well as physical and mental illness that are the result of exposure to opiates are social protection problems they are also a serious bioethical challenge. The most common form of addictions that our society faces is alcoholism. Due to its relatively easy availability, unfortunately the toleration of our society to alcohol intake is high, so lot of time passes from consuming small doses to severe intoxication.

[9] Iskrica Monography 5 Years of work 2011.

It is precisely tough some case of united effort on improving the quality of life that one should strive to balance life. That is why social protection and bioethical education can make a significant contribution to raising averseness and solving problems among young people in the age where these habits are formed. The goal of such a new paradigm is to create sustainable and balanced development by creating ethical approach which is able to educate young people how to improve quality of life without using any stimulative substances. In this way the aim is to achieve good under the mentioned quality of life in which can be included and other disciplines such as economists, physicians, sociologists, psychologists, theologians, lawyers and of course social workers.

Based on the similarity of the theoretical aspects of bioethics and mentioned disciplines, the connection is revealed between bioethics as science of life, issues of health as social protection of children teenagers and adolescents. Because these problems are common in practical sphere for both of our disciplines.