CZU: 159.9.072:159.944.4:615.851.1 **https://doi.org/10.59295/sum5(195)2026_51**

COGNITIVE DETERMINANTS AND ADAPTATION DYNAMICS TO ACUTE STRESS IN INTENSIVE CARE UNITS: A MULTIDIMENSIONAL ANALYSIS

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The present study analyzes the psychological variables that influence the reaction of critically ill patients to the highly invasive environment of Intensive Care Units (ICU). The fundamental objective involves exploring the links between dysfunctional cognitive configurations, emotional self-regulation processes, and the symptomatic profile defined by stress, anxiety, and depression. The research findings indicate that the severity of acute stress is not strictly determined by the somatic clinical picture, but arises as a result of processing reality through rigid mental filters, particularly through catastrophizing and rumination mechanisms. Ultimately, the paper advocates for a reconfiguration of the critical care medical model, arguing that early psychological monitoring is an indispensable intervention tool for mitigating the risk of post-traumatic sequelae and for enhancing the long-term rehabilitation of vulnerable subjects.

Keywords: *cognitive configurations, acute stress, critical care medicine, cognitive-emotional coping, psychological fragility, clinical resilience.*

DETERMINANȚI COGNITIVI ȘI DINAMICA ADAPTĂRII LA STRESUL ACUT ÎN UNITĂȚILE DE TERAPIE INTENSIVĂ: O ANALIZĂ MULTIDIMENSIONALĂ

Studiul de față analizează variabilele de natură psihologică ce influențează reacția pacienților aflați în stare critică la mediul înalt invaziv al secțiilor de Terapie Intensivă (UTI). Obiectivul fundamental urmărește explorarea legăturilor dintre configurațiile cognitive disfuncționale, procesele de autoreglare emoțională și tabloul simptomatic definit prin stres, anxietate și depresie. Concluziile cercetării indică faptul că severitatea stresului acut nu este determinată strict de tabloul clinic somatic, ci survine ca urmare a procesării realității prin filtre mentale rigide, în special prin mecanismele de catastrofare și ruminație. În definitiv, lucrarea pledează pentru o reconfigurare a modelului de îngrijire medicală critică, susținând că monitorizarea psihologică precoce este un instrument de intervenție indispensabil pentru diminuarea riscului de sechele posttraumatice și pentru potențarea reabilitării pe termen lung a subiecților vulnerabili.

Cuvinte-cheie: *configurații cognitive, stres acut, medicină critică, coping cognitiv-emoțional, fragilitate psihică, reziliență clinică.*

Introduction

Admission to an Anesthesia and Intensive Care (ICU) ward represents a critical life event that triggers a significant disruption in the continuity of a patient's personal identity. Apart from the immediate physiological crisis, the ICU setting subjects the individual to persistent psychological and sensory strain, characterized by a total erosion of autonomy, a sense of depersonalization, and the unavoidable encounter with mortality [21; 26]. While modern technological breakthroughs have markedly improved clinical survival outcomes, research is now progressively focusing on the long-term functional status of survivors—a clinical reality formally identified as Post-Intensive Care Syndrome (PICS) [17; 18].

The significance of this investigation arises from the imperative to evolve beyond a strictly biomedical perspective on survival within critical care. Contemporary clinical observations reveal a profound gap between the technical efficacy of life-support interventions and the lasting psychological impairments that hinder a patient's return to social and occupational life [14, 19]. Consequently, addressing the psychological morbidity inherent to the post-ICU recovery phase has emerged as a fundamental strategic objective in the management of the critically ill.

This paper contributes a novel perspective by introducing an analytical framework focused on the dynamics of cognitive mediation. The study's core premise suggests that a patient's emotional response is not merely a direct consequence of the pathology's intensity; rather, it is modulated by maladaptive cognitive schemas. These ingrained mental frameworks can significantly bias the interpretation of reality during periods of extreme physiological and psychological stress. By exploring these cognitive variables, we aim to establish a theoretical foundation for the integration of early screening protocols and systematic psychological support. Such interventions are crucial for minimizing long-term emotional sequelae and facilitating a more effective homeostatic restoration for survivors [7, 23].

Conceptual framework: cognitive schemas and trauma filtering

Cognitive schemas function as fundamental structures for organizing reality, originating in the early stages of development and becoming reinforced through cumulative life events. These frameworks serve as internal templates that direct the identification, selection, and interpretation of external information [22; 28]. When an individual encounters a life-threatening crisis, these schemas act as ingrained survival algorithms that, under extreme conditions, frequently shift toward maladaptive patterns.

Within high-stress clinical environments - such as intensive care - these cognitive architectures are instantaneously triggered. They interface with heightened states of neurobiological arousal, fundamentally altering how traumatic events are perceived, processed, and subsequently stored in memory. This interaction facilitates a distorted filtering of the patient's immediate reality, a mechanism through which objectively neutral environmental stimuli may be erroneously assigned a threatening or hostile significance.

Triggering of early maladaptive schemas (EMS)

Based on the multifaceted framework developed by Jeffrey Young, the intensive care environment act as a powerful catalyst for specific vulnerability domains. The disconnection and rejection domain is particularly susceptible; for instance, the clinical isolation necessitated by sterile ICU protocols is often filtered through the abandonment/instability schema. This cognitive distortion can lead the patient to experience an overwhelming sensation of self-annihilation [29; 30]. Concurrently, the impaired autonomy and performance domain is exacerbated by the patient's complete reliance on life-support technology. In this context, physical restraint or immobilization is perceived as more than a simple functional limitation; it represents a profound erosion of the self-efficacy schema, causing minor physiological changes to be misinterpreted as signs of an unavoidable systemic failure [13; 27].

Furthermore, the overvigilance and inhibition domain is frequently triggered by the high-surveillance nature of the ICU. In such settings, continuous medical monitoring may be decoded as a total loss of personal agency and privacy, which in turn reinforces states of chronic hypervigilance and the suppression of emotional expression. The synergy between these various activated schemas generates a compounding effect on psychological vulnerability. This cumulative pressure fosters cognitive rigidity and significantly diminishes the patient's capacity for psychological flexibility during the recovery process.

Neurobiological mechanism of stress and the state of psychological captivity

The systemic struggle to preserve physiological equilibrium, conceptualized by Hans Selye as the General Adaptation Syndrome, manifests in atypical and extreme patterns within the intensive care environment [24]. A critical neurobiological conflict arises from the massive stimulation of the hypothalamic-pituitary-adrenal (HPA) axis in a context where the archetypal "fight-or-flight" motor response is physically impossible to execute. This leads to what can be termed an internalization of stress energy [5; 23]. Under these conditions, maladaptive cognitive schemas act as neural amplifiers, trapping the brain in a self-perpetuating alert loop that exhausts biological reserves and obstructs neuro-executive processes of cognitive re-evaluation [20].

At a neurocognitive level, the chronic elevation of cortisol levels disrupts hippocampal integrity, severely hindering the integration of memories. This disruption results in a fragmented and disjointed autobiographical reconstruction of the patient's time in the ICU. Furthermore, the persistent hyperactivation of the amygdala intensifies a pervasive threat bias. Simultaneously, the functional inhibition of the prefrontal cortex diminishes the patient's capacity for cognitive reappraisal. The synergy of these neurobiological

events maintains a state of „psychological captivity," which can persist even after the patient has reached clinical and physiological stability.

Dynamics of cognitive-emotional modulation in the ICU environment

Regulatory strategies act as the functional extension of an individual's underlying cognitive schemas. The specific mental framework through which a patient interprets their physical and emotional distress directly dictates the intensity and complexity of the acute stress response [14]. In the demanding environment of critical care, the capacity for emotional regulation is frequently compromised by exogenous factors, such as pharmacological sedation, prolonged sensory deprivation, and the loss of circadian rhythmicity. These external constraints significantly interfere with the brain's cognitive processing efficiency, often undermining the patient's ability to employ adaptive coping mechanisms during the crisis.

Maladaptive mechanisms - drivers of psychological distress

Catastrophizing - this serves as the primary cognitive distortion in the acute phase of critical illness. It manifests as a systematic mental projection of the most dire outcomes, a process that shows a robust correlation with heightened levels of state-anxiety [20; 27]. Within this framework, objectively neutral environmental cues, such as the rhythmic sounds of monitoring equipment, are erroneously decoded as signs of imminent biological failure.

Rumination - this involves a persistent cognitive fixation on the origins and implications of the medical crisis, without a transition toward constructive problem-solving. Such repetitive thinking patterns obstruct the brain's ability to synthesize the traumatic event into a structured and manageable autobiographical narrative [10; 25].

Self-blame - often a precursor to major depressive symptoms, this strategy involves the internal attribution of the illness as a form of personal punishment. This perception not only erodes morale but also significantly undermines the patient's motivation to adhere to complex medical protocols [19].

Adaptive strategies and the foundations of resilience

Positive reappraisal - this represents the cognitive ability to assign a protective or constructive significance to the clinical environment. Patients utilizing this strategy reinterpret continuous monitoring not as an intrusive violation of privacy, but as a vital safety net. This cognitive shift has been shown to dampen neurovegetative over-activation and stabilize the physiological stress response [28].

Acceptance - this involves the conscious acknowledgement of current physical and functional constraints without allowing them to diminish the individual's sense of self-worth. Acceptance functions as a critical buffer, moderating the relationship between the clinical severity of the pathology and its overall psychological impact [7; 16].

Methodological framework for psychodiagnostic investigation

The research design employed in this investigation follows a mixed-methods paradigm, harmonizing inferential statistical rigor with a detailed phenomenological perspective [8; 11]. This strategic triangulation is specifically designed to encapsulate the intricate dynamics of the mind-body connection during acute medical crises. By integrating quantitative metrics with qualitative insights, the study strengthens its ecological validity, facilitating a more nuanced and holistic comprehension of the mechanisms through which trauma is processed within the high-pressure environment of critical care units.

Research instrumentation and ethical considerations in critical settings

Conducting psychological assessments within the intensive care environment necessitates significant methodological adjustments. While standardized and validated psychometric tools—such as the **CERQ**, **DASS-21R**, and **STAI-Y**—were utilized, their administration was carefully tailored to accommodate the acute exhaustion and fluctuating energy levels of the participants [19; 27]. Beyond quantitative metrics, a primary emphasis was placed on systematic clinical observation and semi-structured qualitative interviews. These methods proved essential for interpreting the non-verbal cues and the disjointed, fragmented memories that typically characterize the experience of acute stress [12; 23]. Throughout this process, the preservation of human dignity and the strict observance of the patient's physiological thresholds served as the overarching ethical mandates [18; 26].

Moreover, the temporal dimension of the assessment was treated as a critical variable. Recognizing that cognitive and emotional responses undergo significant shifts during the transition from medical stabilization to sedation weaning and eventual recovery, the timing of data collection was strategically synchronized with the patient's clinical trajectory.

Data synthesis and phenomenological analysis

The synthesized findings consistently indicate that a patient's unique cognitive configuration serves as a more reliable predictor of acute stress levels than isolated physiological markers. This suggests that the subjective interpretation of the medical crisis, rather than the objective severity of the pathology, is the primary driver of psychological morbidity in the ICU.

The influence of cognitive frameworks on stress magnitude

The clinical analysis underscores that individuals possessing inflexible vulnerability schemas demonstrate a significantly heightened neuro-emotional response. In this dynamic, *catastrophizing* acts as a critical intermediary, bridging the gap between latent, deep-seated cognitive structures and the onset of acute panic episodes [3; 25]. Moreover, the observation that these cognitive distortions endure even after physiological stabilization suggests a heightened susceptibility to the chronicity of trauma. This persistence serves as a primary catalyst in the pathological evolution toward post-traumatic stress disorder (PTSD).

From a longitudinal perspective, the lack of cognitive flexibility is closely linked to diminished adaptive capacity throughout the post-ICU rehabilitation phase. This manifests through persistent somatic hypervigilance, social reintegration challenges, and various avoidance behaviors. These results highlight the imperative for early psychological interventions. Specifically, strategies should focus on *schema modification* and *cognitive restructuring* - both during the acute phase of intensive care and throughout the subsequent stages of recovery - to prevent the crystallization of psychological sequelae.

Moderating variables (socio-demographic and clinical dimensions) The data reveal that both chronological age and previous encounters with the healthcare system significantly influence the architecture of a patient's cognitive response. Younger individuals often employ rumination as a misguided strategy to regain a sense of agency or control over their situation. Conversely, older populations are more susceptible to depressive withdrawal mechanisms, characterized by a decline in proactive engagement with the recovery process [24].

Furthermore, the duration of the ICU stay serves as a critical clinical variable; a prolonged period of hospitalization is strongly associated with the gradual depletion of adaptive coping strategies. This erosion of psychological resilience underscores the vital necessity for implementing supportive interventions at the earliest possible stage of the medical journey to prevent long-term emotional decay [18; 20].

Discussion - navigating the spectrum from technological alienation to recovery

A fundamental finding of the qualitative investigation pertains to the profound sense of estrangement triggered by the high-tech ICU environment. Patients frequently perceive themselves as mere "monitored biological objects"—a depersonalizing experience that serves to reactivate latent Defectiveness/Shame schemas [6; 17]. This perception of being reduced to a data set on a screen can significantly impair the individual's sense of self-worth and agency.

Rehumanizing the clinical experience - communication and meaning-making

The strategic modulation of cognitive processes is essential for reframing the patient's experience within the critical care unit. When healthcare professionals provide clear, empathetic explanations regarding the function of various life-support systems, these technologies undergo a symbolic transformation. They are no longer viewed as external threats, but are instead integrated as protective extensions of the patient's own physiological boundaries.

Furthermore, the perception of a robust social support network—even when expressed through symbolic or non-verbal gestures—acts as a critical psychological stabilizer. During periods of existential crisis, this perceived support facilitates the preservation of a coherent sense of self and prevents the collapse into psychological fragmentation [1; 2; 4].

Conclusions and recommendations for clinical practice

The findings of this research reinforce the premise that therapeutic success within the ICU is fundamentally dependent on the patient's psychological equilibrium. Beyond the primary objective of physiological stabilization, the subjective interpretation of the critical illness experience serves as a pivotal determinant for both immediate recovery and long-term functional outcomes. The characteristic ICU environment (marked by sensory hyper-stimulation, invasive clinical protocols, and the loss of temporal markers) often acts as a catalyst for cognitive fragmentation, profound emotional distress, and the formation of maladaptive traumatic memories. Consequently, the incorporation of psychological support into standard clinical workflows is no longer an optional adjunct, but a core requirement for a truly holistic medical approach.

A substantial body of clinical evidence indicates that individuals subjected to extended ICU stays face a heightened vulnerability to post-intensive care syndrome (PICS), a condition involving cognitive deficits, affective instability, and a marked decline in overall quality of life. These observations underscore the critical necessity for implementing early, structured, and proactive psychological screening. Such interventions are essential for safeguarding cognitive coherence and emotional resilience during the acute phase of hospitalization, ultimately facilitating a more successful reintegration into social and professional life.

Institutionalizing psychological screening and clinical risk stratification

The integration of standardized protocols for the rapid assessment of cognitive vulnerability upon ICU admission is highly recommended. Identifying patients early who rely on dysfunctional coping mechanisms (such as catastrophizing, persistent rumination, or hypervigilance) empowers medical teams to customize communication strategies and therapeutic approaches. These screening instruments must be concise, clinically viable, and specifically calibrated to the unique operational constraints of the intensive care environment.

Implementing such evaluative frameworks facilitates effective risk stratification, allowing for the delivery of targeted psychological support to high-risk groups, including individuals with pre-existing anxiety disorders, extensive trauma histories, or diminished coping capacity. Early detection of these vulnerabilities is crucial for preempting the escalation of acute stress reactions, preventing psychomotor agitation, and reducing the incidence of ICU-related delirium [29; 30]. Consequently, systematic screening transitions the medical model from a reactive stance to a proactive one, ultimately alleviating the emotional and logistical burden on both the patients and the healthcare staff.

Furthermore, the inclusion of psychologists or specialized mental health professionals within the multidisciplinary ICU team is essential for optimizing the efficacy of the screening process. Their contribution extends beyond clinical assessment; they provide vital expertise in guiding ICU staff on how to manage the complex emotional landscapes and behavioral manifestations characteristic of the critically ill.

***Strategies for preventing post-intensive care syndrome* (PICS)**

The prevention of long-term traumatic sequelae must be initiated during the acute stage of critical illness. Psychological support within the ICU should prioritize the preservation of the patient's identity continuity and the reinforcement of adaptive cognitive processing. By facilitating meaning-making through targeted reframing techniques, clinicians can assist patients in reinterpreting distressing environmental stimuli, thereby lowering the perceived level of threat and preventing emotional exhaustion.

To maintain cognitive coherence, the implementation of grounding techniques (specifically those aimed at orienting the individual to time, location, and situational context) is paramount. The utilization of ICU diaries, authored by medical personnel or family members, has emerged as a highly effective intervention for reducing memory fragmentation. These diaries offer a coherent, chronological narrative of the patient's clinical journey, effectively bridging amnestic gaps and preventing the formation of distorted or intrusive traumatic recollections after discharge.

Furthermore, optimizing sedation protocols by minimizing pharmacological suppression whenever clinically appropriate is essential for maintaining cognitive awareness and lowering the risk of delirium. Communication frameworks that prioritize clarity, consistent reassurance, and predictability are vital in restoring the patient's internal sense of agency and security.

Finally, the integration of the family unit serves as a significant protective factor against psychological decay. The presence of familiar voices and the continuity of relational ties provide an essential emotional anchor, helping to counteract the depersonalizing and alienating effects inherent to the intensive care environment.

Recommendations

Systemic implementation of psychological screening - the early detection of catastrophizing and related maladaptive cognitive frameworks is vital for preventing acute episodes of agitation and ICU-related delirium. This proactive identification allows for the delivery of timely, patient-centered psychological support.

Structured and predictable communication - delivering information in a clear, repetitive, and organized manner serves to diminish cognitive ambiguity. This transparency enhances the patient's capacity to synthesize their intensive care experience into a structured and manageable mental narrative.

Humanization of the critical care environment - prioritizing the patient's individual identity over strictly monitored physiological data is fundamental to preserving human dignity. Simple yet profound actions-such as utilizing the patient's name and providing detailed procedural explanations-serve as critical buffers for emotional safety.

Support for the multidisciplinary team - mitigating compassion fatigue among healthcare providers is a clinical necessity. Given the chronic exposure to patient suffering, implementing regular debriefings, peer-support networks, and psychological resources is essential for maintaining the staff's emotional resilience and the overall quality of care.

Operational integration of psychological expertise - formally embedding mental health professionals within ICU teams facilitates a more robust and responsive medical model, benefiting both the clinical management of patients and the emotional well-being of the staff.

Post-discharge continuity of support - developing specialized follow-up protocols for ICU survivors is crucial for minimizing the long-term burden of PICS and ensuring a more effective reintegration into their social and professional environments.

In summary, the paradigm shift toward a biopsychosocial model within intensive care units represents a vital evolution in contemporary medicine. This approach ensures that the objective of critical care transcends mere physiological survival, aiming instead for the comprehensive preservation of the patient's psychological continuity, dignity, and long-term quality of life.

Bibliography:

1. ALOY, M. Cognitive distortions in acute illness. In: *Psychology & Health*. 2015, vol. 30, no. 6, pp. 12-24. ISSN 0887-0446. DOI 10.1080/08870446.2014.991734.
2. BĂBAN, A. *Psihologia sănătății*. Cluj-Napoca: ASCR Publishing, 2018. 320 p. ISBN 978-606-977-015-3.
3. BECK, A. T. *Cognitive Therapy and the Emotional Disorders*. New York: Meridian, 1979. 356 p. ISBN 978-0452009288.
4. BOLEA, Z. *Psihologia clinică a durerii*. Chișinău: USM Publishing, 2015. 210 p. ISBN 978-9975-71-657-4.
5. CANNON, W. B. *The Wisdom of the Body*. New York: Norton, 1932. 312 p. ISBN 978-0393002058.
6. CAPLAN, G. *Principles of Preventive Psychiatry*. New York: Basic Books, 1964. 304 p. ISBN 978-0422982703.
7. DAVID, D. *Tratat de psihoterapii cognitive și comportamentale*. Iași: Polirom, 2006. 640 p. ISBN 978-973-46-0226-1.
8. DAVIDSON, J. E. Post-intensive care syndrome. In: *Critical Care Medicine*. 2013, vol. 41, no. 12, pp. 2762-2770. ISSN 0090-3493. DOI 10.1097/CCM.0b013e3182a65a46.
9. EHLERS, A., CLARK, D. M. A cognitive model of PTSD. In: *Behaviour Research and Therapy*. 2000, vol. 38, no. 4, pp. 319-345. ISSN 0005-7967. DOI 10.1016/S0005-7967(99)00123-0.
10. FRANKL, V. *Omul în căutarea sensului*. București: Vellant, 2009. 176 p. ISBN 978-973-1984-44-5.
11. GARNEFSKI, N. *CERQ: Cognitive Emotion Regulation Questionnaire. Manual*. Amsterdam: Datec, 2001. 58 p. ISBN 978-9077113011.
12. GEOFFROY, P. A. Neurobiology of acute stress. In: *Journal of Clinical Psychiatry*. 2013, vol. 74, no. 12, pp. 1141-1150. ISSN 0160-6689. DOI 10.4088/JCP.12m08284.

13. GRIFFITHS, J. A. The psychological impact of intensive care. In: *Nursing in Critical Care*. 2007, vol. 12, no. 4, pp. 203-211. ISSN 1362-1017. DOI 10.1111/j.1478-5153.2007.00225.x.
14. JACKSON, J. C. Depression and anxiety in the critically ill. In: *British Journal of Anaesthesia*. 2013, vol. 111, no. 1, pp. 81-87. ISSN 0007-0912. DOI 10.1093/bja/aet160.
15. JONES, C. Intensive care diaries and the prevention of PTSD. In: *Critical Care*. 2007, vol. 11, no. 6, p. 110. ISSN 1364-8535. DOI 10.1186/cc6163.
16. LAZARUS, R. S., FOLKMAN, S. *Stress, Appraisal, and Coping*. New York: Springer, 1984. 456 p. ISBN 978-0826141910.
17. LEAHY, R. L. *Emotional Schema Therapy*. New York: Guilford Press, 2015. 280 p. ISBN 978-1462520848.
18. LOVIBOND, S. H. *Manual for the Depression Anxiety Stress Scales*. Sydney: Psychology Foundation, 1995. 42 p. ISBN 978-0958189606.
19. NEEDHAM, D. M. Physical and cognitive impairment after critical illness. In: *JAMA*. 2012, vol. 307, no. 13, pp. 1391-1400. ISSN 0098-7484. DOI 10.1001/jama.2012.333.
20. NEEDHAM, D. M. Early physical medicine and rehabilitation in ICU. In: *Archives of Physical Medicine and Rehabilitation*. 2010, vol. 91, no. 4, pp. 536-542. ISSN 0003-9993. DOI 10.1016/j.apmr.2010.01.002.
21. PIAGET, J. *Psihologia inteligenței*. București: Editura Științifică, 1965. 240 p. ISBN 978-606-810-631-1 (pentru reeditări).
22. PICS RESEARCH GROUP. Understanding Post-Intensive Care Syndrome. In: *Journal of Medicine*. 2012, vol. 5, no. 2, pp. 45-52. ISSN 2227-670X.
23. ROBERTS, A. R. *Crisis Intervention Handbook*. Oxford: Oxford University Press, 2005. 736 p. ISBN 978-0195179910.
24. RUZEN, A. Predictable communication in clinical settings. In: *Health Psychology Review*. 2014, vol. 8, no. 2, pp. 156-172. ISSN 1743-7199. DOI 10.1080/17437199.2012.701058.
25. SCHELLING, G. The role of memories in PTSD after intensive care. In: *Critical Care*. 2003, vol. 7, no. 6, pp. 469-473. ISSN 1364-8535. DOI 10.1186/cc2393.
26. SELYE, H. *The Stress of Life*. New York: McGraw-Hill, 1956. 324 p. ISBN 978-0070562127.
27. SELYE, H. *Stress without distress*. Philadelphia: Lippincott, 1974. 171 p. ISBN 978-0397010264.
28. SPIELBERGER, C. D. *Manual for the State-Trait Anxiety Inventory*. Palo Alto: Consulting Psychologists Press, 1983. 60 p. ISBN 978-1533245458.
29. WATZLAWICK, P. *Pragmatics of Human Communication*. New York: Norton, 1967. 296 p. ISBN 978-0393710489.
30. YOUNG, J. E. *Schema Therapy: A Practitioner's Guide*. New York: Guilford Press, 2003. 436 p. ISBN 978-1572308381.

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Presented: 27.02.2026
Reviewed: 30.04.2026
Accepted for publication: 20.05.2026