

ROLA KONSTRUKTÓW OSOBOWYCH W PROFILAKTYCE UZALEŻNIENÍ, INTEGRACJI SPOŁECZNEJ I RESOCJALIZACJI SKAZANYCH MŁODOCIANYCH

Husak Petro

doktor habilitowany nauk pedagogicznych, profesor
kierownik katedry Pedagogiki Społecznej oraz Pedagogiki Wyższej Szkoły
Wschodnioeuropejskiego Uniwersytetu Narodowego
imienia Łesi Ukrainki (m.Łuck, Ukraina)
phusak@ukr.net

Martynyuk Tetyana

docent katedry Pedagogiki Społecznej oraz Pedagogiki Wyższej Szkoły
Wschodnioeuropejskiego Uniwersytetu Narodowego
imienia Łesi Ukrainki doktor nauk pedagogicznych, docent (m.Łuck, Ukraina)
martynyuk.t@gmail.com

Streszczenie. Artykuł obejmuje problematykę przeciwdziałania używaniu substancji psychoaktywnych, integracji społecznej i resocjalizacji młodocianych skazanych i rola konstrukcji osobowych w tym procesie. Udowodniono, że wejście w niebezpieczną sytuację lub otrzymanie telefonu z otoczenia zewnętrznego, który motywuje jednostkę, młodociani skazani próbują się do tego przystosować lub zmniejszyć stres, stosując określone strategie, aby go przetrwać. Do takich strategii przetrwania autora obejmuje postrzeganie własnej skuteczności, poczucie samokontroli i samoregulacji. Z punktu widzenia społeczno-poznawczego widzenia, Kluczowymi elementami wszelkiego leczenia psychologicznego środkami psychoaktywnymi stosowanymi w celach profilaktycznych powinny być: identyfikacja sytuacji wysokiego ryzyka, które stymulują używanie substancji psychoaktywnych, rozwój i postrzeganie własnej skuteczności, stosowanie odpowiednich strategii radzenia sobie.

Słowa kluczowe: substancje psychoaktywne, socjalizacja nieletnich, integracja społeczna, zasoby do pokonania, strategie radzenia sobie.

ROLE OF PERSONAL CONSTRUCTS IN THE PSYCHOACTIVE SUBSTANCES USE PREVENTION, SOCIAL INTEGRATION AND RESOCIALIZATION OF JUVENILES CONVICTED

Abstract. The paper deals with the issue of the psychoactive substances use prevention, social integration and resocialization of juveniles convicted and the role of personal constructs in this process. It is proved that facing danger, threat or a challenging event motivates individuals, juveniles convicted, to adapt or reduce stress by use of coping strategies. Among the coping resources authors consider personal coping resources, in particular, perceived self-efficacy, a personal sense of control, and self-regulatory efficacy. From a social-cognitive viewpoint, the key ingredients of any psychological treatment in the psychoactive substances use prevention should be the identification of high-risk situations that stimulate psychoactive substances use, the development and cultivation of perceived self-efficacy, and the application of adequate coping strategies.

Keywords: psychoactive substances, resocialization of juveniles, social integration, coping resources, coping strategies.

Introduction. Several models of addiction have proposed that stress increases risk of psychoactive substances abuse and relapse of juveniles convicted. However, the mechanisms by which stress exposure may enhance drug use and increase relapse risk

remain elusive. There has been a dramatic increase in research to understand neural circuits associated with stress and those underlying addictive behaviors, juveniles convicted.

Formulation and Solution a Problem. The term stress is frequently defined as “a process involving perception, interpretation, response and adaptation to harmful, threatening, or challenging events” (*Lazarus & Folkman 1987 p. 159*).

This conceptualization permits separate consideration of:

events that cause stress (stressors or stressful life events);

cognitive and affective processes evaluating the event and available coping resources (appraisal);

biological responses and adaptation needed to cope with the stressor;

behavioral and cognitive response to the stressful event (coping).

Each of these components is associated with specific and overlapping neural systems that interact in a complex and intricate manner to coordinate the experience and response to stress.

Facing danger, threat or a challenging event motivates individuals, juveniles convicted, to adapt or reduce stress by use of coping strategies. Different ways of coping have been found to be more or less adaptive. In a meta-analysis, Suls and Fletcher have compiled studies that examined the effects of various coping modes on several measures of adjustment to illness (*Suls, Fletcher 1985 p. 281*).

The authors concluded that avoidant coping strategies seem to be more adaptive in the short run whereas attentive-confrontative coping is more adaptive in the long run. It remains unclear, however, how the specific coping responses of a patient struggling with a disease can be classified into broader categories. There are many attempts to reduce the total of possible coping responses to a parsimonious set of coping dimensions. Some researchers have come up with two basic dimensions—such as instrumental, attentive, vigilant, or confrontative coping on the one hand, in contrast to avoidant, palliative, and emotional coping on the other (*Shedler, Block 1990; Suls, Fletcher 1985 p. 262*). A well-known approach has been put forward by Lazarus and Folkman (1984), who discriminate between problem-focused and emotion-focused coping. Another conceptual distinction has been suggested between assimilative and accommodative coping, the former aiming at an alteration of the environment to oneself, and the latter aiming at an alteration of oneself to the environment (*Brandstädter 1992 p.132*).

Coping has also a temporal aspect. One can cope before a stressful event takes place, while it is happening (e.g., during the progress of a disease), or afterwards. Beehr and McGrath (1996) distinguish five situations that create a particular temporal context: (a) Preventive coping: long before the stressful event occurs, or might occur; for example, a smoker might quit well in time to avoid the risk of lung cancer; (b) Anticipatory coping: when the event is anticipated soon; for example, someone might take a tranquilizer while waiting for surgery; (c) Dynamic coping: while it is ongoing; for example, diverting attention to reduce chronic pain; (d) Reactive coping: after it has happened; for example, changing one's life after losing a limb; and (e) Residual coping: long afterward, by contending with long-run effects; for example, controlling one's intrusive thoughts years after a traumatic accident has happened.

Five coping strategies were identified Klauer and Filipp (1993) that turned up as dimensions in a factor analysis: seeking social integration, rumination, threat

minimization, turning to religion, seeking information. These factors were established as subscales of a psychometric inventory.

There are many other attempts to conceptualize coping dimensions, and those mentioned above may serve as examples (*Zeidner, Endler 1996 p. 31*).

Which of the above dimensions is suitable for a valid description of an actual coping process depends on a number of factors, among them the particular stress situation, one's history of coping with similar situations, and one's personal and social coping resources, or the opposite, one's specific vulnerability. The following main sections of this article deal with a more detailed account of the coping resources.

Personal Coping Resources. Individuals who are affluent, healthy, capable, and optimistic are seen as resourceful and, thus, are less vulnerable toward the stress of life. It is of most importance to be competent to handle a stressful situation. But actual competence is not a sufficient prerequisite. If the individual underestimates his potential for action, no adaptive strategies will be developed. Therefore, perceived competence is crucial. This has been labelled 'perceived self-efficacy' or 'optimistic self-beliefs' by Bandura (1992, 1995). The subsequent section will focus on this particular personal resource factor.

Behavioural change is facilitated by a personal sense of control. If juveniles convicted believe that they can take action to solve a problem instrumentally, they become more inclined to do so and feel more committed to this decision. While outcome expectancies refer to the perception of the possible consequences of one's action, perceived self-efficacy pertains to personal action control or agency (*Bandura 1992 p. 19*). A person who believes in being able to cause an event can conduct a more active and self-determined life course. This "can do"-cognition mirrors a sense of control over one's environment. It reflects the belief of being able to master challenging demands by means of adaptive action. It can also be regarded as an optimistic view of one's capacity to deal with stress.

Self-efficacy makes a difference in how juveniles convicted feel, think and act. In terms of feeling, a low sense of self-efficacy is associated with depression, anxiety, and helplessness. Such individuals also have low self-esteem and harbor pessimistic thoughts about their accomplishments and personal development. In terms of thinking, a strong sense of competence facilitates cognitive processes. Self-efficacy levels can enhance or impede the motivation to act. Individuals with high self-efficacy choose to perform more challenging tasks. They set themselves higher goals and stick to them (*Locke, Latham 1990*). Actions are preshaped in thought, and juveniles convicted anticipate either optimistic or pessimistic scenarios in line with their level of self-efficacy. Once an action has been taken, high self-efficacious persons invest more effort and persist longer than those with low self-efficacy. When setbacks occur, the former recover more quickly and maintain the commitment to their goals. Self-efficacy also allows people to select challenging settings, explore their environments, or create new situations. A sense of competence can be acquired by mastery experience, vicarious experience, verbal persuasion, or physiological feedback (*Bandura 1992 p. 28*). Self-efficacy, however, is not the same as positive illusions or unrealistic optimism, since it is based on experience and does not lead to unreasonable risk taking. Instead, it leads to venture some behaviour that is within reach of one's capabilities.

Perceived self-efficacy has been studied with respect to prevention of unprotected sexual behaviour, e.g., the resistance of sexual coercions, and the use of contraceptives

to avoid unwanted pregnancies. For example, teenage women with a high rate of unprotected intercourse have been found to use contraceptives more effectively if they believed they could exercise control over their sexual activities (Levinson 1982 p. 17). Gilchrist and Schinke taught teenagers through modeling and role-playing how to deal with pressures and ensure the use of contraceptives. This mode of treatment significantly raised their sense of perceived efficacy and protective skills (*Godding, Glasgow 1985 p. 586*).

Influencing health behaviours that contribute to the prevention of AIDS has become an urgent issue. Perceived self-efficacy has been shown to play a role in such behaviours. Kok and Strecher (1991) reported a study from their laboratory that analyzed the use of condoms and clean needles by drug addicts. Intentions and behaviours were predicted by attitudes, social norms, and especially by efficacy beliefs. Perceived self-efficacy correlated with the intention to use clean needles (.35), reported clean needle use (.46), the intention to use condoms (.74), and reported condom use (.67). Bandura (1995) has summarized a large body of research relating perceived self-efficacy to the exercise of control over HIV infection.

Condom use not only requires some technical skills, but interpersonal negotiation as well (*Bandura 1995 p. 35*). Convincing a resistant partner to comply with safer sex practices can call for a high sense of efficacy to exercise control over sexual activities. Programmes were launched to enhance self-efficacy and to build self-protective skills in various segments of the population to prevent the spread of the HIV virus.

Personal Coping Resources and Addictive Behaviours. Another area in the health field where perceived self-efficacy has been studied extensively is smoking. Quitting the habit requires optimistic self-beliefs which can be instilled in smoking cessation programmes. Efficacy beliefs to resist temptation to smoke predict reduction in the number of cigarettes smoked ($r = -.62$), the amount of tobacco per smoke ($r = -.43$), and the nicotine content ($r = -.30$) (*Godding & Glasgow 1985*). Pretreatment self-efficacy does not predict relapse, but posttreatment self-efficacy does. Overcoming addictive behaviours such as substance use, alcohol consumption, and smoking poses a major challenge for those who are dependent on these substances as well as for professional helpers. Smoking, for example, remains the number one public health problem in spite of declining prevalence rates. Almost one hundred scientific publications per year deal with the issue of smoking cessation. Clinical approaches include multisession, multicomponent counseling or therapy programmes where individuals or small groups receive abstinence and relapse prevention training, often combined with medical treatment. The most promising pharmaceutical aid is the use of a nicotine patch that achieves a transdermal nicotine substitute to help counteract withdrawal symptoms.

On the other end of the treatment continuum lie community interventions, including work site cessation programs. This acknowledges the fact that only one tenth of smokers make use of formal clinical programs. In contrast, most are self-quitters who need only minimal assistance (Curry 1993). While relapse rates after professional treatment lie typically between 70% and 90%, those of self-quitters are even higher. Nevertheless, investments in the public health approach are more cost-effective because it reaches a much larger target population and, thus, results in higher overall numbers of persons quitting (*Lichtenstein, Glasgow 1992, p. 523*).

The community-wide minimal treatment programmes benefit from what was learned in clinical settings, although it is not yet clear what the most effective

ingredients really are. It seems as if more is better, i.e., treatment packages that consist of many heterogeneous components are superior to theory-based single strategy approaches.

It has also been found that readiness to quit makes a difference. In clinical settings, most clients are self-referred and therefore highly motivated for behavioural change. Public health messages, in contrast, have to be addressed to smokers who are at different stages of motivation (*DiClemente et al., 1991 p. 300*). Precontemplators who do not consider quitting at all need a different message than contemplators who struggle with the pros and cons of quitting. Furthermore, those who are ready for action need different kinds of assistance than those who just have quit and face a relapse crisis.

From a social-cognitive viewpoint, the key ingredients of any psychological treatment should be (a) the identification of high-risk situations that stimulate smoking, (b) the development and cultivation of perceived self-efficacy, and (c) the application of adequate coping strategies. This can be described as a competent self-regulation process where individuals monitor their responses to taxing situations, observe similar others facing similar demands, appraise their coping resources, create optimistic self-beliefs, plan a course of action, perform the critical action, and evaluate its outcomes.

Marlatt et al. (1995) propose five categories of self-efficacy that are related to stages of motivation and prevention: (a) Resistance Self-Efficacy, (b) Harm-Reduction Self-Efficacy, (c) Action Self-Efficacy, (d) Coping Self-Efficacy, and (e) Recovery Self-Efficacy. Resistance Self-Efficacy pertains to the confidence in one's ability to avoid substance use prior to its first use. This implies resistance against peer pressure to smoke, drink or take drugs. It has been repeatedly found that the combination of peer pressure and low self-efficacy predicts the onset of smoking and substance use in adolescents. Ellickson and Hays (1991) studied the determinants of future substance use in eighth and ninth graders in ten junior high schools. As potential predictors of onset, they analyzed prodrug social influence, resistance self-efficacy, and perception of drug-use prevalence. Social influence or exposure to drug users combined with low self-efficacy for drug resistance turned out to predict experimentation with drugs nine months later. Interestingly, resistance self-efficacy was no longer predictive in the subsample of students who were already involved with drugs.

In a study on smoking onset, Stacy, Sussman, Dent, Burton and Flay (1992) examined prosmoking social influence and resistance self-efficacy in a sample of high school students. Perceived self-efficacy moderated the effect of peer pressure. As expected, many adolescents succumbed to prosmoking influence, but those high in resistance self-efficacy were less vulnerable toward interpersonal power.

With these findings in mind, one would expect that the training of resistance skills would raise resistance self-efficacy, which in turn would reduce future drug use. However, intervention studies that have included such a training have not yet been very promising.

Harm-reduction self-efficacy pertains to juveniles convicted's confidence to be able to reduce the risk after having become involved with tobacco or drugs. Once a risk behaviour has commenced, the notion of resistance loses its significance. It is then of superior importance to control further damage and to strengthen the belief that one is capable of minimizing the risk. This is particularly useful since most adolescents at least experiment with cigarettes and alcohol, which can be regarded as a normal stage in puberty when youngsters face developmental tasks including self-regulation in tempting

situations. Substance use can be seen as being normative rather than deviant and might reflect a healthy exploratory behaviour and a constructive learning process (*Shedler, Block 1990, p. 19*). The conflict here is between solving normative developmental tasks on the one hand, and, on the other, initiating a risk behaviour that might accumulate and habitualize to a detrimental lifestyle pattern. Thus, the question is, "How can a drug be curiously explored without becoming the gateway drug?" The answer lies in the notion of harm-reduction self-efficacy. The individual must acquire not only the competence and skills, but also the optimistic belief in control of the impending risk. The aim of secondary prevention is to let adolescents experiment while at the same time empowering them to minimize and eliminate substance use later on.

An intervention study to accomplish this goal has been conducted at the Addictive Behaviours Research Center at the University of Washington (*Baer 1993 p. 122*). College students received one of three treatments: (a) an alcohol-information class dealing with negative consequences of alcohol, (b) a moderation-oriented cognitive-behavioural skills-training class, and (c) an assessment-only control group. The second treatment group was trained to enhance their harm-reduction self-efficacy, which indeed resulted in the greatest decrease in alcohol consumption.

The above two types of self-efficacy are related to prevention. When, however, it comes to behaviour change for those who are already addicted, the focus turns to action, coping, and recovery. Action self-efficacy concerns the confidence to attain one's desired abstinence goal (or controlled use). If, for example, someone sets a date for quitting, then a commitment is made, moving the person beyond the mere contemplation stage. When intentions to quit are translated into preparatory acts, the individual needs optimistic self-beliefs to make detailed plans how to refrain from the substance, imagine success scenarios, and take instrumental actions. This applies to unaided cessation as well as to formal treatment settings. Action self-efficacy has been found to predict attempts to quit smoking. These findings corroborate consistently the beneficial influence of optimistic self-beliefs, but this effect is restricted to posttreatment self-efficacy. Typically, pretreatment self-efficacy does not predict relapse, but posttreatment self-efficacy does. This generalizes, by the way, to a broad range of domains of human functioning (*Kok et al., 1992 p. 235*). Pretreatment self-efficacy is not based on personal experience with quitting and is, therefore, inappropriate for the prediction of treatment outcomes. During the cessation training, self-efficacy is being developed with a realistic sense of one's capabilities, resulting in more accurate self-knowledge that allows one to foresee one's most likely reactions in tempting situations.

Coping self-efficacy relates to anticipatory coping with relapse crises. After one has made a successful attempt to quit, long-term maintenance is at stake. At this stage, quitters are confronted with high-risk situations, such as experiencing negative affect or temptations in positive social situations. Lapses are likely to occur unless the quitter can mobilize alternative coping strategies. Believing in one's coping reservoir assists in making sound judgments and in initiating adaptive coping responses. Relapse prevention training aims at making use of a variety of situation-tailored coping strategies which in turn enhances coping self-efficacy (*Curry 1993 p. 792*). This includes behavioural as well as cognitive coping modes.

Recovery self-efficacy is closely related to coping self-efficacy, but both tap different aspects within the maintenance stage (similar to the distinction between

resistance and harm-reduction self-efficacy in the prevention stage). If a lapse occurs, individuals can fall prey to the "abstinence violation effect", i.e., they attribute their lapse to internal, stable and global causes, dramatize the event, and interpret it as a full-blown relapse. High self-efficacious individuals, however, avoid this effect by making a high-risk situation responsible and by finding ways to control the damage and to restore hope. Self-efficacy for recovery of abstinence after an initial lapse has been found to promote long-term maintenance. Clinical interventions focus on specific recovery strategies after setbacks, such as reviewing and reattributing the situation, balancing alternative ways of coping, making an immediate plan for recovery (e.g., renew initial commitment to quit, mobilize social support, reframe the lapse as a normal event within a productive learning process). This restores self-efficacy and helps to return quickly to the path of maintenance. However, Haaga and Stewart (1992) found that not high but moderate self-efficacy for recovery leads to the best survival rates (continuation of abstinence). If this finding can be replicated in further research, it would reflect an "overconfidence effect," since too high self-efficacy would embolden trials of risk behaviours. Conclusions

As these examples from research on addictive behaviours demonstrate, it is essential to identify several stages at which self-efficacy operates in different manners. Specific kinds of self-efficacy are protective as the individual, juvenile convicted, moves through the process of peer influence, substance experimentation, cessation, and abstinence maintenance.

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