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SAFE ENVIRONMENT AND PERSONAL ENGAGEMENT: A RETROSPECTIVE ANALYSIS OF FACTORS THAT HELP YOUTH COPE WITH THE RISK OF SOCIAL MALADJUSTMENT

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maladjustment
identity processing styles
cluster analysis

Summary

Objective: This exploratory study aimed to identify the external and internal conditions that supported the respondents' process of social adjustment according to their auto-narratives. It sought to answer the question: Is it sufficient to place an individual at risk of social maladjustment in a safe environment (sociotherapy center) to enhance their long-term adaptation?
Method: The study was both quantitative and qualitative. Data were obtained from multiple sources: psychometric tools (RISB, KSP, ISI-5), psychological and pedagogical assessments, and interviews with graduates of sociotherapy centers (n = 31), providing rich information on the subjects.
Results: Through cluster analysis, three groups of respondents were identified. They differed in their level of adaptation, identity processing style, and narratives regarding the impact of various life circumstances and actions undertaken on their current situation and satisfaction with achieving their goals. The article includes three case studies that represent each of the groups.
Conclusions: Placing young people at risk of social maladjustment in a safe environment, such as a sociotherapy center, supports their adaptation. However, a critical factor for enhancing their level of adaptation is their active engagement in personal development, which serves as a mediator between a safe environment and changes in adaptation levels. This research could be significant for psychological and pedagogical staff working with young people at risk of social maladjustment.

Introduction

The study presented herein is both diagnostic and exploratory. It aims to identify the conditions—psychological factors, life events, and actions taken—that influence improvements in the adaptation levels of young adults previously identified as at risk of social maladjustment, based on assessments conducted by psychological and pedagogical counseling centers. The primary objective is cognitive, contributing to a deeper understanding

of maladjustment among youth; however, the findings may also have significant practical implications for psychological support targeting this population.

As part of the research, interviews were conducted with graduates of social therapy centers to determine which external and internal factors, in their view, contributed to improvements or declines in their functioning. Comparing participants' personal beliefs about the causes of their successes and failures with results from standardized instruments was intended to inform conclusions about identity development in young adults previously identified as at risk of social maladjustment.

The individuals in this group exhibit inappropriate, undesirable, or risky behaviors. These behaviors manifest as non-compliance with social norms, difficulties in emotional regulation, interpersonal conflicts, social withdrawal, and a propensity to become either victims or perpetrators of violence, as well as tendencies toward psychoactive substance use [1]. Such behaviors are often linked to mental disorders or illnesses, adverse familial or social environments, or psychological trauma. The negative outcomes associated with these behaviors may include mental illness, suicide attempts, self-destructive actions, addiction, involvement in criminal activities, and difficulties in fulfilling the role of a student or functioning effectively within the traditional educational system [2, 3].

Currently, a growing number of adolescents experience difficulties adapting to the conventional school system due to various psychological challenges. This trend is reflected in the increasing diagnoses of maladjustment and risk of social maladjustment reported by psychological and pedagogical counseling centers in Poland in recent years. Adolescents at risk of social maladjustment are those who, due to mental disorders, learning difficulties, or disturbances in social functioning, require specialized educational interventions, psychological and pedagogical support, and sociotherapy [4]. These individuals typically do not engage in unlawful behavior and are capable of voluntarily participating in self-improvement activities, such as those offered in sociotherapy centers.

Numerous prior studies have concentrated on elucidating the origins of maladjustment [1, 5]. In parallel, research conducted among Polish junior high school students [6] has identified both risk and protective factors that substantially influence the mitigation of maladjustment. The present study seeks to deepen understanding of the factors that facilitate adaptation among individuals at risk of social maladjustment, analyzed through the lens of identity development, specifically employing Berzonsky's model. This approach builds on the pioneering research by Haertlé and Oleś [7]. The findings from this investigation may be valuable to practitioners in evaluating the likelihood that individuals at risk of social maladjustment will successfully integrate and adapt within society.

The mixed-methods design of this study, which integrates both quantitative and qualitative approaches, is particularly noteworthy. Multiple data sources were used to obtain

a comprehensive understanding of the participants, including psychological tests and questionnaires, semi-structured interviews, psychological and pedagogical assessments, and school promotion data. This multifaceted methodology offers a more holistic perspective on the phenomenon under investigation. Furthermore, the convergence of findings across diverse data sets enhances the internal consistency and overall credibility of the results, contributing to a robust and coherent interpretation.

According to Erikson and Havighurst's theory of psychosocial development [8, 9], the paramount developmental tasks of late adolescence encompass identifying pathways for educational and vocational advancement, establishing intimate partnerships, and delineating roles within romantic, peer, and broader social relationships [9, 10]. Failure to successfully negotiate these tasks may engender internal conflicts, psychopathological conditions, and, ultimately, maladjustment [9, 10].

Building upon Erikson's theory of identity development, Berzonsky [11] proposed a socio-cognitive model positing that individuals endowed with requisite cognitive resources can construct a coherent self-narrative, integrating their past experiences with future visions. This enables them to perceive themselves as autonomous agents endowed with reflective thought, volitional agency, and personal desires, thereby facilitating intentional self-regulation of behavior. Consequently, such individuals are equipped to undertake social commitments, assume responsibility, and honor agreements, constructs that would lack salience in the absence of a consolidated sense of identity. Grounded in constructivist epistemology, which posits that individuals actively shape both their self-conceptions and realities around them, Berzonsky's framework conceives identity formation as a self-authored theoretical edifice delineating one's core attributes and values.

Empirical research indicates that individuals with an informational identity style demonstrate superior decision-making efficacy and greater psychosocial integration than those with a diffuse-avoidant style. In contrast, those with a normative style occupy an intermediate position. The diffuse-avoidant style typifies individuals characterized by poorer adjustment [7, 12], diminished behavioral regulatory resources, an unstable self-concept, impulsivity, hedonism, and erratic decision-making. In contrast, the informational style correlates positively with autonomy and emotional intelligence [13], enabling more adaptive responses to external challenges than the normative style, which is prone to maladaptive behaviors in the face of environmental ambiguity. Individuals dominated by the diffuse-avoidant style exhibit heightened tendencies toward defensive, accusatory, or hostile reactions, alongside elevated risks of anxiety and depressive symptoms [14].

The present study aims to delineate the factors that respondents identify as influencing adaptation and maladjustment during late adolescence and early adulthood.

Method

Semi-structured interviews were conducted with graduates of sociotherapeutic centers in Warsaw. These interviews followed a bespoke protocol encompassing inquiries into respondents' current circumstances, past experiences, and future plans, with an average duration of 35 minutes. The design aimed to elicit participants' identification of facilitative factors in overcoming social maladjustment, alongside impediments to personal improvement and societal adaptation, rendering the study both diagnostic and exploratory.

Quantitative analyses incorporated archival data from special educational needs assessments for graduates ($n = 31$), issued by psychological and pedagogical counseling centers in Poland. These assessments comprise comprehensive psychological and pedagogical diagnoses conducted by multidisciplinary teams competent for the participant's residence, utilizing validated psychometric instruments such as the NEO-FFI for Big Five personality traits, EPQ-R for Eysenck's dimensions of extraversion, neuroticism, and psychoticism, and STAI for state-trait anxiety, alongside clinical interviews and input from psychiatrists and other specialists. Given the multi-specialist composition of these diagnostic teams and their orientation toward educational recipients, counseling centers present the findings in descriptive form. These reports eschew raw quantitative scores in favor of narrative syntheses delineating identified psychological disorders and traits. A detailed overview of these data and their aggregation appears in Table 1.

Table 1. **Factors derived from psychological and pedagogical diagnoses**

Factor	Description
Depression and anxiety	Individuals exhibiting depressive/anxiety disorders
Social withdrawal	Persons with adjustment disorders, social phobia, and isolation tendencies
Oppositional behavior	Individuals with behavioral disorders, personality disorders, and oppositional defiant disorder
Strong emotional experiences	Intense experiences of stress, tension, and emotions
Learning difficulties	Specific learning disabilities, including dyslexia, dysgraphia, dyscalculia, and attention/concentration deficits
Suicidal thoughts	Suicidal ideation and intentions, current or within the last 2 years
Suicide attempts	At least one suicide attempt in the last 2 years
Social skills deficits	Deficient social competencies; challenges in managing relationships and social situations

Single-parent family	Family structures involving parental divorce, separation, or death
High level of anxiety	Elevated trait anxiety
Psychiatric care	Ongoing psychiatric treatment, including pharmacotherapy
Hospitalized in psychiatric wards	Hospitalization in psychiatric facilities at least once in the preceding 2 years
Self-harm	Regular self-injurious behaviors within the last 2 years
Asperger syndrome	Individuals with Asperger syndrome
Victims of violence	Experiences of peer and/or familial violence
Sexual orientation	Non-heteronormative sexual orientation
The Big Five	Personality traits: conscientiousness, openness to experience, agreeableness, neuroticism, extraversion (introversion)
Court/probation officer	Involvement in legal proceedings or probation supervision due to aggression, truancy, or neglect
Withdrawal, isolation	Tendency to withdraw from activities and avoid difficulties under stress
Self-esteem	Low self-esteem
Eating disorders	Bulimia, anorexia
Intelligence	Average or above-average intelligence per Wechsler or Raven scales (prerequisite for sociotherapy center admission)
Addictions	Substance misuse, including alcohol, drugs, and designer drugs
Social contact	Facility in initiating and maintaining social contacts
Illness	Chronic somatic conditions such as epilepsy, diabetes, cerebral palsy, severe atopy, or other significant disorders

These factors were operationalized as dichotomous variables (1 = presence of the characteristic; 0 = absence), with missing data for certain factors, such as eating disorders or suicide attempts, coded as absent.

The following validated psychometric instruments were employed:

- Rotter Incomplete Sentences Blank (RISB) [15, 16], assessing adult maladjustment (Cronbach's α = 0,79);
- Identity Style Inventory version 5 (ISI-5) [17, 18], measuring identity commitment and processing styles (informational, normative, diffuse-avoidant; Cronbach's α ranging from 0,68 to 0,80 across subscales);

- Psychological Resilience Questionnaire (KSP) [19, 20], evaluating resilience levels (Cronbach's α = 0,78);

Participants

The study involved 31 graduates from two sociotherapy centers in Warsaw, aged 20–24 years (17 females, 14 males), who volunteered to participate.

Table 2 outlines the demographic and clinical characteristics of this group, based on psychological and pedagogical diagnoses conducted several years before their admission to sociotherapy. Although some diagnoses (e.g., depressive/anxiety disorders, substance misuse, or social skills deficits) may no longer be applicable, their historical records are still relevant to the study's goal: longitudinally tracking participants' developmental paths from diagnosis to current adaptation.

Table 2. **Characteristics of the study cohort – sociotherapy center graduates ($n = 31$)**

Characteristic	n	%
Raised in single-parent families	17	55%
Undergoing psychiatric treatment (hospitalization and/or care)	15	48%
Victims of violence	8	26%
Chronic somatic diseases and/or eating disorders	12	39%
Diagnosed with depressive/anxiety disorders	13	41%
Experiencing strong emotional responses	19	61%
Suicidal ideation, self-harm, suicide attempts	9	29%
Diagnosed with oppositional defiant disorder	14	45%
Under court/probation supervision	3	10%
Psychoactive substance abuse	7	23%
Diagnosed with low social skills	14	45%
Specific learning disabilities (dyslexia, dyscalculia, dysgraphia, dysorthography, attention deficits)	11	35%
Diagnosed with Asperger syndrome	3	10%

Procedure

Interviews were conducted at the two Warsaw sociotherapy centers. Participants provided written informed consent for study involvement and data processing, having been apprised of the voluntary, confidential, and exclusively scientific nature of the investigation.

Following consent, participants completed the psychometric instruments (KSP, ISI-5, RISB) and then engaged in semi-structured interviews exploring their current circumstances, past experiences, and future visions. These interviews, averaging 35 minutes, adopted a conversational format to foster trust and psychological safety.

Interview protocol:

1. Tell me about your life right now – job or school, hobbies, relationships, family stuff, where you live, your money situation. What do you like or not like about it?
2. What was life like before you came to the center?
3. Did you manage to follow through on the plans you had after high school? Where are you at with them now?
4. Any big turning points in your life lately?
5. How did you get back on track? Or what's still tough for you?
6. What or who helped you get to where you are today? People, events, traits, situations? Who do you thank for it?
7. Any significant challenges along the way, and how did you handle them?
8. What helped or got in the way of your goals while at the center?
9. What's your big life goal? Are you making progress? What makes you successful?

Results and discussion

Table 3 presents the mean scores for the principal variables among graduates of sociotherapy centers, derived from ISI-5, KSP, and RISB instruments.

Within the sample, 12 out of 31 participants exhibited RISB scores indicative of maladjustment, while 19 participants scored within the adjustment range [16]. The group's psychological resilience, as measured by the KSP, aligns closely with normative data from Polish studies of individuals aged 22 to 24 [20], which reported a mean resilience score of 39,56 with a standard deviation of 5,71. It is noteworthy that normative data for the ISI-5 have not been established in the Polish population, which limits comparative analysis of this measure.

Table 3. **Mean scores on ISI-5, KSP, and RISB measures among sociotherapy center graduates (*n* = 31)**

	Maladjustment (RISB)	Resilience (KSP)	Informational style (ISI-5)	Normative style (ISI-5)	Diffuse-avoidant style (ISI-5)	Commitment (ISI-5)
Mean	128.26	38.29	37.10	19.90	21.65	34.10
SD	17.89	6.41	5.37	6.31	6.81	6.20
Coefficient of Variation (%)	13.95	16.74	14.49	31.71	31.48	18.20

Qualitative data from interviews with sociotherapy center graduates yielded factors influencing adaptation, categorized a priori into risk factors, turning points, protective factors, plan implementation, and life goals. Subsequent cluster analysis delineated distinct respondent subgroups based on these factor endorsements. Table 4 depicts the percentage distribution of identified factors; multiple endorsements per category per participant preclude summation to 100%.

Table 4. **Categories of factors identified in interviews with graduates and their percentage frequency of occurrence**

Category	Factor type	% of Cases (*n* = 31)
Risk factors	School problems	81%
	Other mental health issues	71%
	Mental disorders, including:	65%
	– Depression	45%
	– Anxiety	39%
	– Trauma, PTSD	32%
	Avoiding responsibilities	48%
	Breaking rules	45%
	Family problems	45%
	Experience of violence	26%
	Addictions	19%
	Other	19%
Turning points	Sociotherapy center	74%
	Change of attitude toward life	61%
	Independence	29%
	Starting treatment	26%
	Mental crisis	23%
	Meeting partner	26%
	Other	13%

Protective factors	Staff support	84%
	Sense of security	77%
	Personal development	74%
	Taking responsibility	74%
	Passion/work	61%
	Peer relationships	61%
	Social skills development	58%
	Attitude change toward the world	55%
	Treatment	45%
	Teachers' approach	42%
	Goal striving	42%
	Romantic relationship	23%
	Family support	19%
	Helping others	16%
	Religion	10%
	Future prediction ability	6%
	Fulfilling dreams	6%
Plan implementation	Success	61%
	Job satisfaction	55%
	Relationships	55%
	Artistic development/passions	52%
	Passing the high school leaving exam	48%
	Independence	39%
	Failing the high school leaving exam	39%
	No university	39%
	Path to autonomy	39%
	Family support	32%
	University enrollment	32%
	Partial goal achievement	26%
	Happy love life	23%
	Chronic depression	19%
	Enjoying life	13%
	Could have achieved more	10%
	Life failure	13%
	Addiction	6%

	Independence from parents	45%
	Professional career	45%
	Start a family	32%
	University	26%
	Help others	26%
Purpose in life	Go abroad	23%
	Own business	16%
	Lack of faith in dreams	10%
	Be rich, no work	13%
	Change character	3%
	Peace/stability	3%

Hierarchical cluster analysis employing the unweighted pair-group method with arithmetic mean (UPGMA) was conducted on interview-derived factors supplemented by RISB-derived adaptation scores (dichotomously coded: 0 = adjusted; 1 = maladjusted) to identify homogeneous subgroups. Qualitative interview data were binarized (0 = absent; 1 = present) for analysis. This procedure yielded three distinct clusters among the 31 cases, each characterized by unique factor profiles, alongside one outlier case (Fig. 1).

The identified clusters differed significantly across 42 of the 64 factors analyzed. Table 5 presents the frequency distribution of individual characteristics within each cluster, with particular emphasis on those that exhibit intergroup differences. Figure 1 depicts the corresponding dendrogram derived from average linkage within groups.
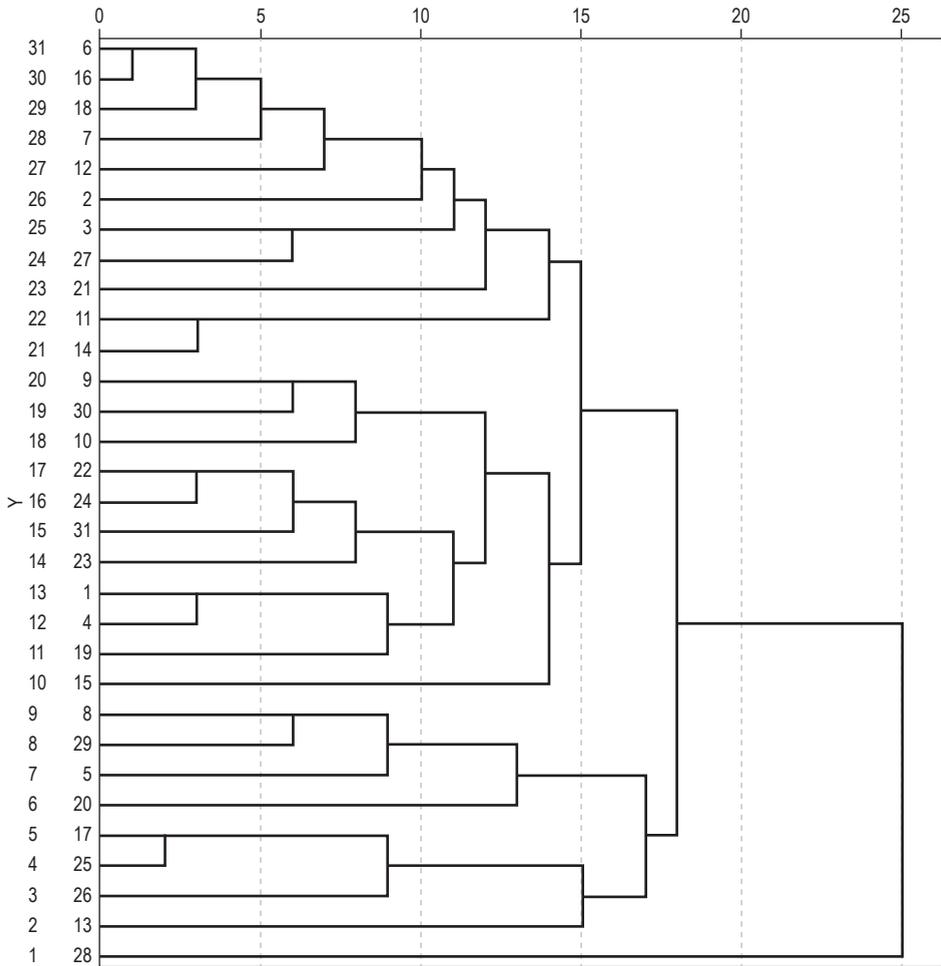
Figure 1. **Dendrogram of hierarchical cluster analysis (UPGMA method)**

Table 5. **Inter-cluster comparison of 42 interview-derived factors among three respondent groups (sociotherapy graduates)**

Category	Factor	Group 1 (= 11)	Group 2 (= 11)	Group 3 (= 8)
Risk factors	Depression	18%	55%	63%
	Anxiety	27%	45%	50%
	Trauma	18%	64%	13%
	Other mental health issues	36%	100%	75%
	Experience of violence	27%	45%	63%
	School problems	45%	27%	63%
	Family problems	36%	55%	63%
Turning points	Sociotherapy center	91%	55%	75%
	Starting treatment	9%	36%	25%
	Change of attitude toward life	82%	73%	13%
	Metting partner	9%	0%	38%
	Independence	27%	9%	63%
Protective factors	Staff support	82%	100%	63%
	Peer relationships	45%	82%	63%
	Treatment	36%	73%	13%
	Personal development	100%	91%	25%
	Attitude change toward the world	55%	91%	13%
	Social skills development	55%	100%	13%
	Goal striving	82%	27%	13%
	Taking responsibility	100%	91%	25%
	Sense of security	82%	91%	50%
	Religion	27%	9%	38%

table continued on the next page

	Success	91%	36%	50%
	Job satisfaction	36%	55%	75%
	Happy love life	18%	9%	38%
	Independence	18%	45%	75%
	Passing the high school leaving exam	82%	27%	38%
Plan implementation	Family support	55%	9%	38%
	University enrollment	55%	36%	0%
	Partial goal achievement	9%	55%	13%
	Path to autonomy	64%	36%	0%
	Failing the high school leaving exam	9%	45%	50%
	No university	18%	36%	63%
	Life failure	0%	9%	38%
	Independence from parents	45%	64%	25%
	Professional career	55%	27%	63%
	Start a family	45%	27%	13%
	Go abroad	27%	9%	25%
Purpose in life	Help others	36%	27%	13%
	University	18%	9%	50%
	Own business	9%	36%	0%
	Lack of faith in dreams	0%	0%	38%
	Adaptation	91%	45%	38%

Cluster 1 profile (*n* = 11): Optimal adaptation

Group 1 comprises individuals least encumbered by mental disorders, exhibiting the highest adaptation levels per RISB scores (91% adjusted). These participants derived maximal benefit from sociotherapy center interventions, particularly psychological-educational staff support (82%), frequently citing personal development (100%), goal striving (82%), self-responsibility (100%), and sense of security (82%) as pivotal, underscoring internal transformation within a supportive environment. Key turning points included the sociotherapy center entry (91%) and attitudinal shifts toward life (82%). This cluster reports the

highest goal attainment (91%), secondary school exam success (82%), and postsecondary enrollment (55%), alongside elevated family support (55%) and aspirations for independence (64%, 45%), career development (55%), family formation (45%), and altruism (36%). Identity profiles favor an informational style (73%) over a normative style (27%), with no diffuse-avoidant orientations (Fig. 2, Table 6).

In summary, individuals in this cluster exhibited the lowest prevalence of risk factors, derived the most significant benefit from sociotherapeutic interventions, demonstrated profound internal transformation, achieved superior adaptation outcomes, and predominantly employed adaptive identity-processing styles, namely, informational and normative orientations.
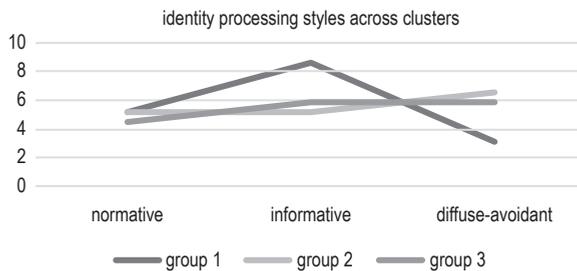
Figure 2. **Identity processing styles across three clusters**

Table 6. **Dominant identity styles across three clusters (raw counts)**

Group	Normative	Informative	Diffuse-avoidant
1 (n = 11)	3	8	0
2 (n = 11)	3	3	5
3 (n = 8)	2	4	4

Cluster 2 profile (*n* = 11): Moderate maladjustment with recovery motivation

Cluster 2 exhibits the highest prevalence of trauma (64%) and other mental health issues (100%), distinguishing it from other groups. Similar to Cluster 1, 73% identified attitudinal shifts toward life as a pivotal turning point, with universal benefit from psychological-educational staff support (100%). Predominant protective factors included peer relationships (82%), treatment initiation (73%), attitudinal changes toward others (91%), social skills development (100%), and sense of security (91%), as well as personal growth (91%) and self-responsibility (91%). This group reports partial goal attainment (55%), aspirations for rapid independence (64%), and entrepreneurship (36%). School outcomes reveal 45% failure of the secondary school leaving exam and 36% non-enrollment in higher educa-

tion, with 36% expressing satisfaction with their current situation versus 9% goal non-achievement. RISB indicates 45% adjustment; ISI-5 reveals equivalent diffuse-avoidant dominance (45%; Table 6, Fig. 2).

Individuals in Cluster 2 demonstrate inferior psychological functioning compared to those in Cluster 1, having endured greater prior mental health burdens. Interpersonal deficits predominate, evidenced by elevated endorsement of attitudinal shifts toward others (91%), social skills development (100%), and treatment initiation (73%) as critical facilitators. Notwithstanding these challenges, participants universally leveraged sociotherapy staff support (100%), safe environments (91%), internal transformation, self-responsibility (91%), personal development (91%), and changes in life outlook (73%)—paralleling Cluster 1 dynamics. Adaptation remains partial (45% RISB-adjusted), with equivalent diffuse-avoidant identity style prevalence (45%; Fig. 2, Table 6), yielding suboptimal functioning relative to Cluster 1. Yet motivational indicators persist: 64% prioritize independence, 55% report partial goal attainment with aspirations for further progress, characterizing this cluster as maladjusted yet tempered by adaptive striving.

Cluster 3 profile (*n* = 8): Poor adaptation with high risk burden

Individuals in Cluster 3 exhibit the poorest psychological functioning compared with peers in Clusters 1 and 2, characterized by the highest prevalence of depression (63%), anxiety (50%), violence exposure (63%), school problems (63%), and family issues (63%). Primary turning points include achieving independence (63%) and sociotherapy center admission (75%). This group endorses the fewest protective factors overall, prioritizing staff support (63%) and peer relationships (63%), with half valuing the center's sense of security (50%). They report the highest plan non-fulfillment (38%), secondary exam failure (50%), and educational discontinuation (63%). Adaptation is lowest (38% RISB-adjusted), with 50% exhibiting diffuse-avoidant identity style dominance (Fig. 2, Table 6).

Cluster 3 participants appear most encumbered by risk factors, particularly depression (63%) and violence exposure (63%), with minimal endorsement of internal transformation factors such as personal development (25%), life outlook change (13%), and self-responsibility (25%). This group exhibits the highest maladjustment (62%) and the highest prevalence of diffuse-avoidant identity style (50%), alongside 38% expressing pessimism about goal attainment.Clusters 2 and 3 demonstrate similarity in identity styles (Fig. 2, Table 6) and adaptation levels (45% vs. 38% adjusted), contrasting markedly with Cluster 1's informational dominance, absence of diffuse-avoidant style, and superior adjustment (91%). Conversely, Clusters 1 and 2 converge in leveraging sociotherapy's supportive environment and substantial internal character work to enhance life functioning.

To determine whether differences across key variables in the three clusters identified via cluster analysis were statistically significant, one-way ANOVA for independent groups

was conducted. RISB data on individual adjustment/maladjustment (coded 0, 1) and dominant identity style (coded 0 or 1) were used, while continuous resilience and commitment scores assessed mean differences across groups. Significant main effects were obtained for adjustment $F(2,27) = 4.136; p < 0.05$ and diffuse-avoidant identity style $F(2,27) = 4.491; p < 0.05$, with homogeneous variances for both variables. Gabriel's post-hoc comparisons revealed significant differences ($p < 0.05$) between Clusters 1 and 3 on adjustment, and between Cluster 1 vs. 2 and 1 vs. 3 on diffuse-avoidant style. No significant differences in psychological resilience emerged across groups. However, commitment yielded a significant effect $F(2,27) = 9.953; p , 0.05$ with homogeneous variance. Gabriel's post hoc tests confirmed significant differences ($p < 0.05$) between Cluster 1 vs. 3 and Cluster 1 vs. 2 on commitment. Figure 3 presents mean scores across clusters for adjustment, diffuse-avoidant style, and commitment.
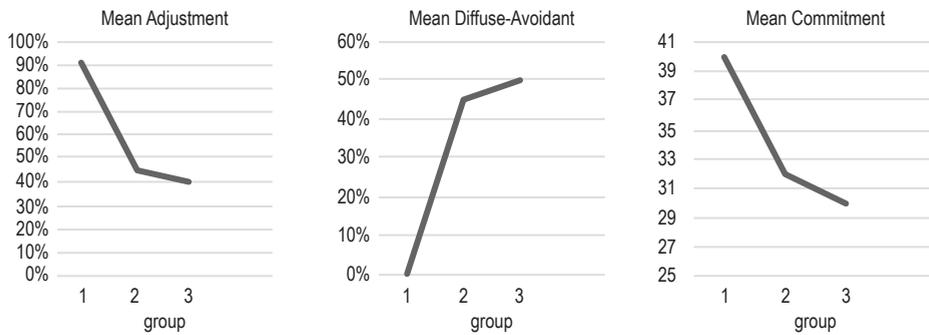

Figure 3. **Mean scores across clusters for adjustment, diffuse-avoidant identity style, and commitment**

The results above indicate that Cluster 1 participants exhibit significantly superior adjustment relative to Cluster 3, reduced prevalence of diffuse-avoidant identity style compared to Clusters 2 and 3, and greater commitment to goal attainment than both. To elucidate inter-cluster distinctions, illustrative case vignettes featuring one representative from each cluster are presented below.

1. *Case 1: Adam, 24 years old, Cluster 1, dominant normative identity style, high level of psychological resilience, optimal adjustment per RISB criteria*
   Previously, Adam manifested behavioral disorders, including substance use, truancy, and affiliation with a local maladjusted peer group offering diversion, belonging, acceptance, and intimacy, potentially compensating for deficits in his single-parent family environment. Classified as high-risk for personality disorders and criminality, court-mandated intervention at age 16 led to a two-year psychiatric hospitalization followed by sociotherapy center placement, alongside specialized addiction treat-

ment. Institutional support proved efficacious, particularly psychological-educational staff facilitation, enabling Adam's openness to novel values: altruism, healthy relationships, and sports passions. This secure milieu fostered personal development and intrinsic motivation, culminating in a redirection toward family formation, travel, and healthy living. Currently self-sufficient and on the verge of full independence, Adam exemplifies successful adaptation at age 24.

2. *Case 2: Agnieszka, 20 years old, Cluster 2, dominant diffuse-avoidant identity style, moderate psychological resilience, adjustment per RISB criteria*
   Referred to the sociotherapy center due to escalating depressive-anxiety disorders, adaptation difficulties, social skills deficits, and school problems, Agnieszka initially experienced profound loneliness, alienation, and overwhelming tension. Gradually, as she perceived the environment as supportive and secure, she formed peer relationships, initiated a romantic partnership, and increased her school involvement. However, persistent self-discipline deficits manifested as procrastination and responsibility avoidance. Despite aspirations, Agnieszka failed her high school leaving exam and secured an incidental job that provided financial stability and career prospects but lacked fulfillment. Ambitious aspirations, operating a music bar or influencing others, remain unrealized, unaccompanied by actionable steps or realistic goal recalibration, yielding only partial dissatisfaction. Notable strengths encompass financial independence, vocational potential, resolution of prior depressive-anxiety symptoms, and social skills advancement; future self-realization hinges critically on overcoming motivational barriers. Although adjusted, her diffuse-avoidant identity style constitutes a substantial impediment to optimal self-actualization.

3. *Case 3: Maria, 23 years old, Cluster 3, dominant diffuse-avoidant identity style, moderate psychological resilience, maladjustment per RISB criteria*
   Before sociotherapy admission, Maria presented with polysubstance use, behavioral dysregulation, depressive-anxious disorders, affective lability, oppositional defiance, school problems, and familial discord stemming from parental divorce and divergent intervention strategies of each of her parents. Persistently evading self-responsibility, Maria externalized blame, initially to a substance-providing partner, subsequently to parents who serially transferred her across schools in futile adaptation attempts, fostering chronic school instability and learned helplessness. The pivotal turning point, per Maria, occurred upon relocating from her mother's residence to her boyfriend's at high school completion, reportedly conferring „life energy" and attenuating depression; nevertheless, dependency persists, precluding imminent autonomy and engendering discomfort. Characterized by profound self-efficacy deficits and a fatalistic, intractable goal orientation, she forgoes proactive efforts. Sociotherapy facilitated school completion, environmental security, and the consolidation of interests, but

yielded negligible personal development. At elevated risk for mood and personality disorder exacerbation, Maria's maladjustment and diffuse-avoidant orientation necessitate targeted psychotherapy to avert psychosocial deterioration and foster self-actualization.

The three illustrative cases encapsulate cluster distinctions: Adam (Cluster 1) exemplifies intrinsic motivation propelling multifaceted goal attainment, leveraging institutional support alongside personal agency to achieve adjustment and fulfillment. Agnieszka (Cluster 2), prototypical of moderate adaptation, demonstrates aspirational intent yet insufficient action, yielding qualified satisfaction despite sociotherapy-facilitated interpersonal gains and adjustment. Conversely, Maria (Cluster 3) manifests a motivational deficit and energetic inertia, engendering pessimism and life dissatisfaction unmitigated by proactive change. While benefiting from staff support and environmental security, she exhibits negligible internal transformation, sustaining maladjustment and heightened vulnerability to psychopathological deterioration. These vignettes underscore identity-style adaptation linkages, with informational/normative orientations (Adam) facilitating resilience, and diffuse-avoidant styles (Agnieszka, Maria) constraining self-actualization.

These findings demonstrate that situating at-risk individuals within secure environments substantially enhances life circumstances and functioning; however, such placements alone are insufficient for profound adaptive transformation. Essential complements include deliberate self-work, manifested as commitment to behavioral and attitudinal modification, alongside targeted interventions such as psychotherapy to mitigate entrenched diffuse-avoidant identity styles. Without such interventions, this maladaptive style perpetuates goal-attainment barriers across subsequent developmental stages, underscoring the necessity of identity-focused sociotherapeutic protocols.

Conclusions

The analyses delineated three distinct respondent clusters. Cluster 1 comprised fulfilled individuals who predominantly exhibited informational or normative identity styles, with superior adjustment rates and greater commitment to goal attainment than in other clusters. These participants reported satisfaction with the objectives achieved, sustained goal pursuit, and realistic perceptions of attainability. Cluster 2 encompassed both adjusted and maladjusted individuals, most of whom expressed incomplete fulfillment, distal goal perceptions, and minimal proactive efforts; diffuse-avoidant style prevalence was substantial. Cluster 3 consisted primarily of maladjusted, unfulfilled participants passively entrenched in adverse circumstances without remedial action, manifesting the highest diffuse-avoidant style concentration. Across all clusters, the overwhelming majority acknowledged substantial benefits from the sociotherapy center's secure environment. However, for many in

Clusters 2 and 3, the secure environment proved insufficient for complete adaptation and fulfillment. Participants from Cluster 1 and a substantial portion of Cluster 2 emphasized that, beyond sociotherapy center support, personal commitment to internal transformation, self-relationship enhancement, and the assumption of self-responsibility profoundly shaped their trajectories. Cluster 3 notably lacked this internal agency, or supportive measures inadequately facilitated attitudinal and behavioral shifts. Thus, dual mechanisms, environmental reconfiguration toward safety/supportiveness, and making an essential change in oneself in terms of how one thinks and interprets reality, stimulate more adaptive behaviors. This duality manifests in respondents' protective factors: external elements (staff support, security) alongside internal processes (personal development, self-responsibility, interpersonal improvement), enabling recovery of the trajectory.

A supportive environment exerts substantial corrective influence and serves as a critical facilitator of adaptation; nevertheless, it proves insufficient for many individuals. Optimal outcomes necessitate concomitant self-directed efforts to transform coping strategies, enabling effective problem resolution, goal attainment, fulfillment, and adjustment.

These results suggest that commitment to personal goals serves as a mediator between perceived security and enhanced adaptation among at-risk youth. Figure 5 depicts this interpretive hypothesis, which requires empirical validation and posits that security satisfaction alone is insufficient to resolve maladjustment [21], necessitating autonomous and competency-oriented personal investment per self-determination theory [22]. This challenges Maslow's assertion [21] that adversity inherently fortifies personality, as substantial maladjustment persists despite environmental supports and is frequently accompanied by diffuse-avoidant identity style. Absent deliberate self-work and developmental commitment, chronic maladjustment remains probable.
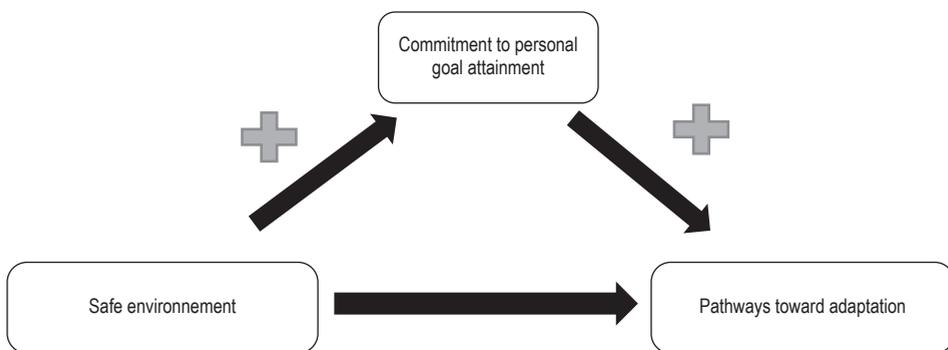

Figure 4. **Self-improvement as a mediator between a safe environment and adaptation**

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W dniach **9–10 maja 2026 roku**
w Centrum Dydaktyczno-Kongresowym w Krakowie
odbędzie się konferencja naukowa:

Osoba terapeuty.
Relacja terapeutyczna

organizowana przez

Krakowską Fundację Rozwoju Psychoterapii
im. Profesor Marii Orwid
w 35. rocznicę jej założenia.

Do czynnego udziału w konferencji zaproszono psychoterapeutów reprezentujących różne szkoły i podejścia psychoterapeutyczne, aby z wielu perspektyw przyjrzeć się roli terapeuty oraz cechom relacji terapeutycznej i temu, jak sprzyjają one bądź utrudniają budowanie przymierza terapeutycznego oraz jak wpływają na rozwój procesu terapeutycznego.

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Warsztaty poprowadzą: Maria Augustyn; Katarzyna Furgał, Piotr Marcinkowski i Dorota Solecka; Paula Hanuszkiewicz; Alina Jasiak; Milena Kansy i Konrad Markiewicz; Beata Kicińska i Barbara Żurek; Artur Krupa; Katarzyna Rudnicka i Dominika Sznajder; Katarzyna Ślęzak.

Krótkie wykłady dotyczące specyfiki relacji terapeutycznej i roli terapeuty w zależności od podejścia terapeutycznego wygłoszą: Anna Bielańska, Tomasz Ptak, Wanda Szaszkiewicz, Kaja Wieczorek-Socha, Agnieszka Wojtaszek.

Analizy przedstawionego przypadku dokonają: Grzegorz Baster, Ewa Nikiel, Krzysztof Szwajca.

Patronat medialny konferencji: Kwartalnik „Psychoterapia".