International Journal of Psychology:
Biopsychosocial Approach 2017 / 20
ISSN 1941-7233 (Print), ISSN 2345-024X (Online)
https://dx.doi.org/10.7220/2345-024X.20.2

THE CHANGES OF SELF-EFFICACY AND PERCEIVED SOCIAL SUPPORT OF ADDICTED TO ALCOHOL WOMEN AND MEN DURING TREATMENT PERIOD

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Abstract. ***Background.*** In order to develop an effective alcohol and other psychoactive substance use prevention programs and improving addiction treatment methods, it is useful to determine the evolution of specific psychological factors of addiction disease during treatment. The aim of the research is to determine the changes in self-efficacy and perceived social support of alcohol-addicted men and women during the treatment. ***Method.*** The study included 101 alcohol-addicted persons, receiving treatment at Kaunas County Centre for Addictive Disorders (KCCAD) according to the Minnesota 12-step program. The study used M. Chesney Coping self-efficacy scale, R. M. Young, T. P. S. Oei & P. A. Hasking Drinking Refusal Self Efficacy Questionnaire – revised, G. D. Zimet, N. W. Dahlem, S. G. Zimet & G. K. Farley Multidimensional Scale of Perceived Social Support, C. M. Hart, T. D. Ritchie, E. G. Hepper & J. E. Gebauer The Balanced Inventory of Desirable Responding Short Form. ***Results.*** The overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted men and women at the end of treatment was higher than at the start of treatment. Changes in the overall self-efficacy, drinking refusal self-efficacy and perceived social support do not differ in alcohol-addicted men and women in the course of treatment. The results showed that there is a link between the overall self-efficacy, drinking refusal self-efficacy and perceived social support in alcohol-addicted women and men both at the start and at the end of treatment, when the participants age ranges from 40 to 59 years. A link has also been found between the overall self-efficacy and perceived social support after the treatment among the participants aged from 18 to 39 years. The Linear regression model showed that a change in drinking refusal self-efficacy in women can be predicted in regard to their perceived social support change, drinking refusal self-efficacy before treatment and perceived social support before

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treatment. A change in drinking refusal self-efficacy in men can be predicted with regard to their drinking refusal self-efficacy before treatment and the change in the overall self-efficacy.

Keywords: overall self-efficacy, specific self-efficacy, drinking refusal self-efficacy, perceived social support, alcohol-addicted persons.

INTRODUCTION

When developing the primary-tertiary prevention programs for alcohol abuse, it is essential to know which of the more or less expressed psychological personality factors guide an alcohol-addicted person to feel that he is able to control alcohol consumption, and to believe that he may refuse alcohol and do not drink. One of the methods of doing this is to examine the alcohol-addicted persons by measuring how specific psychological factors change in the course of treatment for alcohol addiction.

The research has shown (Jaruševičienė, Valius, Veryga & Žemaitis, 2009; Kalasauskas, Klumbienė, Veryga & Petkevičienė, 2011) that alcohol consumption can be also determined by the cognitive motivational factors as expectations, motives, coping strategies, self-efficacy or perceived social support (Baltrušaitytė & Bulotaitė, 2011). Although there are some studies, evidencing that more strongly expressed self-efficacy and perceived social support are related to drinking refusal of alcohol-addicted persons, there is a lack of research, measuring the change of self-efficacy and perceived social support in the course of treatment in case of specific treatment for alcohol addiction.

Self-efficacy refers to the belief of an individual that he can perform the actions well (Legkauskas, 2009). It is argued that self-efficacy is a general attitude of an individual towards his abilities, however, it is usually associated with specific action (specific self-efficacy) (Lemme, 2003).

There is some research, demonstrating the relationship between more strongly expressed self-efficacy and behaviour that is more favourable for health or more successful healing processes during treatment (Cain, Bardone-Cone & Abramson, 2008). According to the research, more strongly expressed overall self-efficacy is associated with more favourable attitude both towards yourself and environment: the research shows that more strongly expressed overall self-efficacy is related with higher life satisfaction (Abiola & Salako, 2014).

Perceived social support refers to trust, positive attitude or potentially beneficial activity, demonstrated by the people, who are important for an individual, and it has positive effect on both physical and mental health (Lemme, 2003). The research shows the link between more strongly expressed self-efficacy and more strongly expressed perceived social support in general and in the processes of recovery (Haga, Ulleberg & Slinning, 2012).

Attributes of self-efficacy and perceived social support of alcohol-addicted persons. The research provides evidence that more strongly expressed overall self-efficacy is associated with better skills of refusal to drink (Baltrušaitytė & Bulotaitė, 2011). Higher drinking refusal self-efficacy is associated with rarer alcohol consumption (Cicognani & Zani, 2011; Baltrušaitytė & Bulotaitė, 2011). The research shows that self-assessment and self-efficacy of alcohol-addicted persons is higher at the end than at the start of the treatment (Loeber, Croissant, Heinz, Mann & Flor, 2006; Cigasaitė, Dirsienė & Zajančkauskaitė-Staskevičienė, 2010).

Psychoactive substances-addicted persons, characterized by different expression of drinking refusal self-efficacy, have different perceptions of their disease. What is more, their self-control and motivation to discontinue drinking also differs (Zhang, Feng & Geng, 2016). Psychoactive substances-addicted persons tend to overestimate their drinking refusal self-efficacy, self-control and motivation to discontinue drinking. Those surveyed who underestimate their drinking refusal self-efficacy more tend to underestimate their self-control and motivation to discontinue drinking. The same research found the relationship between drinking refusal self-efficacy and perceived social support: more strongly expressed perceived social support is typical for the persons whose drinking refusal self-efficacy is lower. There were more relapse cases in the sample with less expressed drinking refusal self-efficacy (Zhang, Feng & Geng, 2016).

The research results show that selection to consume alcohol by the persons in the course of treatment for alcohol addiction also depends on the factors of their social environment, for example, family, professional field (Bojack, 2014). In treatment for alcohol addiction, the success depends on the person who provides the perceived social support to the addicted person (Bacharach, Bamberger & Biron, 2010; Mendoza, Perry & Derrick, 2015). The research demonstrates that abuse of psychoactive

substances is related with more strongly expressed perceived social support by friends and significant relatives other than family members (Gázquez, Pérez-Fuentes & Molero, 2016). Those alcohol-addicted persons with higher education and more strongly expressed social support by the family get involved in addiction treatment programmes easier (Alexinschi, Chirita & Manuela, 2015).

Furthermore, the research demonstrates that the more strongly expressed perceived social support, the less expressed is his depression and tendency to consume alcohol (Peirce & Frone, 2000). Similar results were found in the study of young people: less expressed perceived social support was positively related with experienced negative emotions and positively related with intensity of alcohol consumption (Hussong & Hicks, 2001). Meanwhile, another research proved that the persons with less expressed perceived social support are characterized by worse stress relief skills, which is positively related with problematic alcohol consumption (McCreary & Sadava, 1998).

The research suggests that lower expression of alcohol-related problem is related with more strongly expressed perceived social support, thus, it is likely that perceived social support and expression of alcohol-related problem of the alcohol-addicted persons should change in the course of treatment, while growing expression of self-efficacy and perceived social support potentially predicts successful treatment of alcohol-addicted persons.

The research demonstrates that application of Minnesota twelve-step program in treatment significantly lowered the feelings of patients' self-accusation for their alcohol addiction and increased the feelings of self-control, recovery from addiction (Morojele & Stephenson, 1992). The alcohol-addicted teenagers, who took part in Minnesota 12-step program, were surveyed: one of them completed the program, while others failed; 53% of the teenagers, who had completed the program, remained sober during the first year after treatment, while 28% of the teenagers, who had not completed the program (had terminated it earlier), remained sober during the first year after treatment (Winters & Stinchfield, 2000). The research proved the effectiveness of Minnesota 12-step program before outpatient treatment for alcohol addiction. There is some research demonstrating that abstinence after Minnesota 12-step program is predicted not only by addiction treatment, but also by patients'

post-treatment care, their satisfaction with treatment and a number of contact interventions during the treatment (Bodin & Romelsjö, 2006). As it has already been mentioned, although the main aim of treatment for alcohol addiction – abstinence – is not always reached, after the treatment, the personality changes do occur in other fields: the research revealed that mental well-being of alcohol-addicted persons, subject to Minnesota 12-step program, was more strongly expressed 28 days after the treatment than before the treatment (Berglund & Berggren, 2004).

The aim of this research – to determine how the self-efficacy and perceived social support of the alcohol-addicted males and females change during the course of treatment.

Tested hypotheses:

1. The overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted persons at the end of treatment is higher than at the start of treatment.
2. Higher overall self-efficacy and drinking refusal self-efficacy of the alcohol-addicted males and females are related with higher perceived social support both at the beginning and at end of the treatment.
3. Higher change in drinking refusal self-efficacy is predicted by perceived social support, drinking refusal self-efficacy, the change in overall self-efficacy and the change in perceived social support of the alcohol addicted males and females.

METHODOLOGY OF RESEARCH

Methodology of research. M. Chesney, Coping Self-efficacy Scale, 2006. The scale includes 26 items helping to reveal the belief, whether a person can and whether he is responsible for his abilities in certain life situations. Each item is scored from 0 to 10, where 0 means "cannot do at all", 10 – "certain can do". Higher score shows more strongly expressed overall self-efficacy. Internal consistency of the scale during the first survey was .957, during the second one – .971.

R. M. Young, T. P. S. Oei & P. A. Hasking, DRSEQ-R – Drinking Refusal Self Efficacy Questionnaire – revised, 2005. The answers of the subjects were scored in Likert scale from 1 (I am sure I would drink)

to 6 (I am sure I would not drink). The scale includes 3 subscales: social pressure (shows that a person faces social pressure to consume alcohol), emotional relief (shows that a person seeks for emotional relief while drinking), and opportunistic (person's drinking refusal self-efficacy in situations, where it is usual to consume alcohol). Higher subscale estimates show more strongly expressed drinking refusal self-efficacy. Internal consistency of the scale during the first survey was .961, during the second one – .963.

G. D. Zimet, N. W. Dahlem, S. G. Zimet & G. K. Farley, Multidimensional Scale of Perceived Social Support, 1988. The scale includes 12 statements measuring perceived social support from family, friends and other significant persons. The respondent evaluates each statement from 1 to 7: from 1= very strongly disagree to 7= very strongly agree. Higher score means more strongly expressed perceived social support. Internal consistency of the scale during the first survey was .920, during the second one – .936.

C. M. Hart, T. D. Ritchie, E. G. Hepper & J. E. Gebauer, The Balanced Inventory of Desirable Responding Short Form – BIDR-16, 2015. This scale helps to assess self-deceptive enhancement and impression management (Paulhus & Reid, 1991). Internal consistency of the scale during the first survey was .685, during the second one – .770.

Internal consistency of all the scales in the present study was calculated using Cronbach's α coefficients. Cronbach's α for the all scales was from .685 to .971. Permissions to use all scales in Lithuania were obtained from the original authors.

Subjects. The survey was attended by 101 alcohol-addicted persons, who took part in Minnesota 12-step program in the centre for addictive disorders: 33 females and 68 males from 18 to 59 years old (average age was 39 years old). The period of alcohol addiction of the subjects was from 3 months to 35 years (average was 9 years). Most of the surveyed males and females are with secondary education, and married. The subjects were selected by using convenience purposive sampling on the basis of the following criteria:

- a person is addicted to alcohol and is treated under Minnesota 12-step program;
- a person accepts to take part in the research.

Research procedure. The research was carried out from June, 2016 to April, 2017. Approval of Commission of Research Ethics of Vytautas Magnus University was obtained. The subjects signed the forms of informed consent. The subjects filled the same questionnaires twice: at the beginning of the treatment (on the first or second day of treatment) and on the last day of treatment. Questionnaire filling used to take approximately 30 min. Data was analysed with SPSS 16.0.

RESULTS

While comparing overall self-efficacy, drinking refusal self-efficacy and perceived social support of males and females before treatment and after treatment and the changes of these indicators, no statistically significant differences were found in the groups of males and females and in the groups of persons with higher and lower education. Thus, further analysis of research data was performed in the general sample of males and females, except the cases, when the changes in self-efficacy, drinking refusal self-efficacy and perceived social support were analysed. Upon comparing overall self-efficacy, drinking refusal self-efficacy and perceived social support before treatment and after treatment in various age groups, it might be stated that overall self-efficacy after treatment (t=2,132 and p=.035) and perceived social support after treatment (t=2,076; p=.041) are more strongly expressed in the group of younger persons (from 18 to 39 years old).

It was found that drinking refusal self-efficacy after treatment is more strongly expressed in case of those surveyed with longer duration of addiction (t=-2.021; p=.046).

The differences of overall self-efficacy, drinking refusal self-efficacy and perceived social support both before treatment and after treatment were analysed by taking into account the results of the socially desirable responding scale. The results of this scale were divided into two groups, according to how strong the indicator of socially desirable responding is expressed. Those subjects with higher indicator of socially desirable responding were characterized by more strongly expressed drinking refusal self-efficacy at the beginning of the treatment than the subjects with lower indicator of socially desirable responding (t=-3.278; p=.001). No

other differences were found, considering socially desirable responding of the surveyed persons.

Change in overall self-efficacy and drinking refusal self-efficacy of alcohol-addicted persons in the course of treatment. The results of the first survey were compared with the results of the second survey by using the paired samples t test (see Table 1).

Table 1. *Comparison of overall self-efficacy and drinking refusal self-efficacy means of alcohol-addicted persons in the course of treatment.*

	Mean	*Standard deviation*	*Standard Error Mean*	*t*	*p*
Overall self-efficacy at the start of treatment	156.94	41.58	4.14	-7.21	.001
Overall self-efficacy at the end of treatment	184.02	44.94	4.47		
Drinking refusal self-efficacy at the start of treatment	81.77	23.82	2.38	-4.66	.001
Drinking refusal self-efficacy at the end of treatment	91.85	20.88	2.09		

As it might be seen, overall self-efficacy and drinking refusal self-efficacy is more strongly expressed after treatment than before treatment.

There is a change in perceived social support of alcohol-addicted persons in the course of treatment. The averages of perceived social support before treatment and after treatment were compared by using the paired samples t test (see Table 2).

Table 2. *Comparison of perceived social support of alcohol means of addicted persons in the course of treatment*

	Mean	*Standard deviation*	*Standard Error Mean*	*t*	*p*
Perceived social support at the start of treatment	61.20	16.27	1.62	-4.23	.001
Perceived social support at the end of treatment	66.16	15.25	1.52		

Perceived social support of those surveyed was more strongly expressed after treatment than before treatment.

Relationship between overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted persons. As differences were found in overall self-efficacy, drinking refusal self-efficacy and perceived social support in different age groups, hypothesis 1 was tested in age groups (Table 3).

Table 3. *Relationship between overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted persons at the beginning of treatment and at the end of treatment in different age groups.*

	Age groups	*Perceived social support at the start of treatment Correlation*	*p*	*Perceived social support at the end of treatment Correlation*	*p*
Overall self-efficacy at the start of treatment	18–39 40–59	.223 .453	.093 .002		
Overall self-efficacy at the end of treatment	18–39 40–59			.480 .503	.001 .001
Drinking refusal self-efficacy at the start of treatment	18–39 40–59	.195 .351	.143 .021		
Drinking refusal self-efficacy at the end of treatment	18–39 40–59			.067 .701	.617 .001

As Table 3 shows, the relationship between overall self-efficacy and perceived social support before treatment is found in the age group from 40 to 59 years old, while the relationship after treatment is presented in both age groups. The relationship between drinking refusal self-efficacy and perceived social support before treatment is also found in the age group from 40 to 59 years old, and this relationship remains unchanged after treatment.

Prediction of change in drinking refusal self-efficacy of alcohol-addicted males and females. Seeking to test the hypothesis whether the change in drinking refusal self-efficacy during the course of treatment can be predicted on the basis of perceived social support, drinking refusal self-efficacy, the change in overall self-efficacy and the change in perceived social support, linear regression was applied. Demographic indicators and the indicator of socially desirable responding did not improve the model, therefore, they were not included into the final one.

The results were calculated separately in the groups of males and females. The models are statistically significant when p<.001.

Table 4. *Coefficients of prognostic equation of the change in drinking refusal self-efficacy of alcohol-addicted males and females.*

Gender	*R*	*R Square*	*Adjusted R Square*	*Standard Error of the Estimate*
Women	.800	.640	.589	16.493
Men	.702	.493	.461	14.264

Considering determination coefficient, it might be seen that 64% of the dispersion in female sample, and 49% of the dispersion in male sample can be explained by linear regression equations.

Table 5. *Prognostic equation of the change in drinking refusal self-efficacy in female sample.*

Model	*B*	*Unstandardized Coefficients Standard Error*	*Standardized Coefficients Beta*	*t*	*p*
Constant	2.545	16.150		.158	.876
Change of perceived social support	1.158	.373	.444	3.102	.004
Drinking refusal self-efficacy at the start of treatment	-.481	.117	-.511	-4.108	.001
Perceived social support at the start of treatment	.612	.223	.355	2.740	.011
Change of overall self-efficacy	.102	.082	.168	1.243	.224

Taking into account the point estimates, it might be stated that as the change in the perceived social support of females increases by one point, while the change in drinking refusal self-efficacy increases by 1.158 point; as drinking refusal self-efficacy before treatment increases by one point, the change in drinking refusal self-efficacy decreases by .481 point; as perceived social support before treatment increases by one point, the change in drinking refusal self-efficacy increases by .612 point.

Table 6 *Prognostic equation of the change in drinking refusal self-efficacy in male sample.*

Model	*B*	*Unstandardized Coefficients Standard Error*	*Standardized Coefficients Beta*	*t*	*p*
Constant	36.156	9.008		4.014	.000
Change of perceived social support	.214	.180	.139	1.192	.238
Drinking refusal self-efficacy at the start of treatment	-.429	.092	-.487	-4.689	.001
Perceived social support at the start of treatment	.045	.129	.039	.351	.727
Change of overall self-efficacy	.197	.059	.355	3.329	.001

Table 6 demonstrates that in case of males, statistically significant relationship is found between drinking refusal self-efficacy, the change in overall self-efficacy and the change in drinking refusal self-efficacy. The point estimates show that as drinking refusal self-efficacy before treatment increases by one point, the change in drinking refusal self-efficacy decreases by 4.689 points; as the change in overall self-efficacy increases by one point, the change in drinking refusal self-efficacy increases by 3.329 points.

Thus, higher change in drinking refusal of females is predicted by higher change in perceived social support, lower drinking refusal self-efficacy before treatment and more strongly expressed perceived social support before treatment. Higher change in drinking refusal of males is predicted by lower drinking refusal self-efficacy before treatment and higher change in overall self-efficacy.

DISCUSSION

The research comparing cognitive-behavioural coping skills therapy, motivational enhancement therapy, and 12-step therapy program was carried out. All these 3 therapy forms were applied for alcohol-addicted persons with the aim to reach abstinence. In the first year after treatment, there was statistically insignificant difference in abstinence

level among the patients with different psychological interventions. Meanwhile, three years after treatment, the percentage of abstinence level was highest among the patients subject to 12-step therapy (36%), than the patients subject to motivational enhancement therapy (27%), and finally, the patients of cognitive-behavioural coping skills therapy (24%) (Süss, 2004). Although the research proved that male gender and low drinking refusal self-efficacy is associated with higher quantity of consumed alcohol (Baltrušaitytė, Bulotaitė, 2011), and in case of disease, perceived social support of females is more strongly expressed than the one of males (Svirušytė, Zajančkauskaitė – Staskevičienė, 2013). Our research did not find any statistically significant differences between overall self-efficacy, drinking refusal self-efficacy and perceived social support in different gender samples. While comparing the aforementioned indicators in separate age groups, it was revealed that more strongly expressed overall self-efficacy and perceived social support after treatment was typical for younger age group (from 18 to 39 years old). Thus, it might be stated that treatment in Minnesota 12-step program is characterized by higher impact on overall self-efficacy and perceived social support of younger age alcohol-addicted persons. This impact is also related with duration of alcohol addiction. The research involving the alcohol-addicted participants of Minnesota 12-step program in Lithuania revealed that self-assessment of alcohol-addicted persons is related with duration of addiction: the longer the addiction, the more strongly expressed negative self-assessment (Cigasaitė, Dirsienė & Zajančkauskaitė–Staskevičienė, 2010). Furthermore, positive self-assessment after Minnesota 12-step program was more strongly expressed than before treatment (Cigasaitė, Dirsienė & Zajančkauskaitė–Staskevičienė, 2010). Thus, the results showed that drinking refusal self-efficacy after treatment was statistically significantly higher for the persons whose duration of addiction was longer (more than 108 months).

The research, carried out in Great Britain, where the change in self-efficacy was compared in the course of treatment of alcohol-addicted persons in two ways, demonstrated that there is no statistically significant difference in the way of treatment for alcohol addiction – in both cases, self-efficacy to discontinue drinking of alcohol-addicted persons increased (Loeber, Croissant, Heinz, Mann & Flor, 2006). This research revealed that both drinking refusal self-efficacy and perceived social

support were more strongly expressed after treatment in Minnesota 12-step program than before treatment. Furthermore, analysis of the scientific literature demonstrated that although 12-step program promotes the alcohol-addicted persons to recognize that they are no longer in control of their lives, it also gives them the belief that there is the power above them, which provides them with capacities to refuse alcohol (Dossett, 2013). Thus, it might be argued that Minnesota 12-step program is effective in increasing overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted persons. It might be assumed that all psychological interventions (individual psychological counselling, group psychotherapy, relaxation), provided by Minnesota 12-step program, contribute to increasing self-efficacy and perceived social support. It is presumed that treatment among people with the same addiction and continuous care of the staff increased perceived social support of those surveyed.

The research demonstrates the relationship between perceived social support and drinking refusal self-efficacy of the alcohol or drug-addicted persons (Majer, Callahan & Stevick, 2016). Meanwhile, this research showed that overall self-efficacy and drinking refusal self-efficacy of alcohol-addicted persons is related with their perceived social support both before treatment and after treatment in the group of older age (from 40 to 59 years old). However, overall self-efficacy of those alcohol-addicted persons, whose age is from 18 to 39 years old, is related with their perceived social support only after treatment. Following these results of the research, it might be stated that Minnesota 12-step program had higher impact on self-efficacy and perceived social support of younger subjects than older ones. It was verified by comparing the changes in overall self-efficacy, drinking refusal self-efficacy and perceived social support in different age groups. Thus, it is evident that the changes in overall self-efficacy and perceived social support of younger age persons (from 18 to 39 years old) are statistically significantly higher than in case of older persons.

It was sought to find out which of the psychological factors, measured in research, allow predicting higher change in drinking refusal self-efficacy in the samples of males and females. It was determined that the change in drinking refusal self-efficacy of females can be predicted by considering their perceived social support before treatment, drinking

refusal self-efficacy before treatment and the change in perceived social support. In case of males, drinking refusal self-efficacy can be predicted on the basis of their drinking refusal self-efficacy before treatment and the change in overall self-efficacy.

CONCLUSIONS

1. The overall self-efficacy, drinking refusal self-efficacy and perceived social support of alcohol-addicted men and women at the end of treatment was higher than at the start of treatment.

2.1. Higher overall self-efficacy after treatment of younger alcohol-addicted persons is related with higher perceived social support after treatment.

2.2. Higher overall self-efficacy and higher drinking refusal self-efficacy of older alcohol-addicted persons is related with higher perceived social support both before treatment and after treatment.

3. Higher change in drinking refusal self-efficacy of females is predicted by higher change in perceived social support, lower drinking refusal self-efficacy before treatment and higher perceived social support before treatment. Higher change in drinking refusal self-efficacy of males is predicted by lower drinking refusal self-efficacy before treatment and higher change in overall self-efficacy.

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NUO ALKOHOLIO PRIKLAUSOMŲ MOTERŲ IR VYRŲ SAVIVEIKSMINGUMO IR SUVOKIAMO SOCIALINIO PALAIKYMO POKYČIAI GYDYMO METU

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Santrauka. ***Problema.*** Siekiant sukurti efektyvias alkoholio bei kitų psichoaktyviųjų medžiagų vartojimo prevencijos programas bei tobulinti priklausomybės ligų gydymo būdus, naudinga nustatyti, kaip kinta konkretūs psichologiniai veiksniai priklausomybės ligos gydymo metu. ***Tyrimo tikslas*** – nustatyti, kaip kinta nuo alkoholio priklausomų moterų ir vyrų saviveiksmingumas ir suvokiamas socialinis palaikymas gydymo metu. ***Metodika.*** Tyrime dalyvavo 101 nuo alkoholio priklausomas asmuo, gydomas stacionare pagal Minesotos 12 žingsnių programą. Tyrime naudota: M. Chesney Bendro saviveiksmingumo skalė (*Coping self-efficacy scale*), R. M. Young, T. P. S. Oei, P. A. Hasking, Atsisakymo vartoti alkoholį saviveiksmingumo klausimynas – pataisyta versija (*Drinking Refusal Self Efficacy Questionnaire – revised*), G. D. Zimet, N. W. Dahlem, S. G. Zimet, G. K. Farley Suvokiamo socialinio palaikymo skalė (*Multidimensional Scale of Perceived Social Support*), C. M. Hart, T. D. Ritchie, E. G. Hepper, J. E. Gebauer socialinio pageidaujamumo skalė (*The Balanced Inventory of Desirable Responding Short Form – BIDR-16*). ***Išvados.*** Nuo alkoholio priklausomų moterų ir vyrų bendrasis saviveiksmingumas, atsisakymo vartoti alkoholį saviveiksmingumas bei jų suvokiamas socialinis palaikymas gydymo pabaigoje aukštesni nei gydymo pradžioje. Nuo alkoholio priklausomų moterų ir vyrų bendro saviveiksmingumo, atsisakymo vartoti alkoholį saviveiksmingumo bei jų suvokiamo socialinio palaikymo pokyčiai gydymo

metu nesiskiria. Tyrimo rezultatai parodė, kad nuo alkoholio priklausomų jaunesnių asmenų aukštesnis bendras saviveiksmingumas po gydymo susijęs su aukštesniu jų suvokiamu socialiniu palaikymu po gydymo, o nuo alkoholio priklausomų vyresnių asmenų aukštesnis bendras saviveiksmingumas ir aukštesnis atsisakymo vartoti alkoholį saviveiksmingumas susiję su aukštesniu jų suvokiamu socialiniu palaikymu tiek prieš gydymą, tiek po gydymo. Moterų didesnį atsisakymo vartoti alkoholį saviveiksmingumo pokytį prognozuoja didesnis suvokiamo socialinio palaikymo pokytis, mažesnis atsisakymo vartoti alkoholį saviveiksmingumas prieš gydymą ir didesnis suvokiamas socialinis palaikymas prieš gydymą. Vyrų didesnį atsisakymo vartoti alkoholį saviveiksmingumo pokytį prognozuoja mažesnis atsisakymo vartoti alkoholį saviveiksmingumas prieš gydymą ir didesnis bendro saviveiksmingumo pokytis.

Reikšminiai žodžiai: bendras saviveiksmingumas, atsisakymo vartoti alkoholį saviveiksmingumas, suvokiamas socialinis palaikymas, nuo alkoholio priklausomi asmenys.

Received: 14 08 2017
Accepted: 08 11 2017