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THE ROLE OF POSITIVE DIAGNOSIS IN SOCIAL REHABILITATION FROM THE PERSPECTIVE OF THE THEORY OF EVIL – A PSYCHOPEDAGOGICAL REFLECTION

By exploring a particular life,
I hope to understand a way of life
(Ellis, Bochner, 2000, p. 737).

Abstract: This article analyses the role of positive diagnosis in social rehabilitation. It has been assumed to be a priority in identifying socially maladapted individuals. The sufficiency of the negative diagnosis model, used so far in social rehabilitation pedagogy, has been questioned. Referring to the main features of psycho-pedagogical diagnosis (e.g. infinity, complexity, multidimensionality), the fundamental principles of diagnosing the so-called difficult phenomena, which include social maladaptation, have been formulated. The analysis has been conducted referring to the results of empirical studies (own and other authors' studies) concerning the complex and ambiguous descriptions of maladapted people (self-concept, self-assessment, self-acceptance, concept of the world, concept of one's own life). The article proposes a model of social rehabilitation diagnosis from the perspective of positive psychology (quality of life) and cognitive psychology.

Keywords: social rehabilitation, diagnosis, diagnosis model, fundamental principles of diagnosis, positive psychology, cognitive psychology, self-esteem, self-acceptance, concept of the world, concept of life

INTRODUCTION
SOURCES OF HUMAN EVIL

Kelley found some darkness in every person.
Gilbert found a unique darkness in some.
They were both right
(Dimsdale, 2017, p. 210).

Evil fascinates and at the same time engages individuals, institutions and entire societies in order to eliminate it or be able to predict it (to protect oneself against it), and unfortunately on frequent occasions also to use it (Dimsdale, 2017). Since the theory or theories of evil are not the subject of a systematic analysis in this article, but only a starting point for assessing the role of a positive approach to diagnosis in social rehabilitation, this issue has been touched only briefly and selectively indicating, in my subjective opinion, the most important aspects justifying the need to change the diagnostic perspective - from the pathogenic approach prevailing in resocialization to the still underestimated or too cautiously developed salutogenic approach (Wysocka, 2015, 2019).

According to some, evil is inscribed in human nature, according to others, it is connected with the process of "becoming" and therefore is the result of the influence of the world in which a man develops, having better or worse chances of living in harmony with it and with himself. This can be made a determinant of proper adaptation and achieving the status of a mature personality (or their alternative poles). This process is defined in various ways, but its positive effect is always the balance between an individual and the world in which they live, measured both by achieving personal developmental goals (education, self-fulfilment) and meeting the requirements set for an individual by the society. From the minimalist perspective, it is a conformist adaptation (at least not harmful to the world). From the maximalist point of view, these are non-conformist, transgressive tendencies to improve the world of one's own (and other people's) life. Roman Schulz (2004, p. 117; after: Marynowicz-Hetka, 2006, pp. 36–37) claims that a man is cared for and cares for others at the same time, which can be related to balancing out and sometimes contrariness of the need to support others and getting support from them. Also, he is always subject to the process of socialization and inculturation, but at the same time he individualizes his existence based on his personal possibilities or possessed (although often undiscovered) potentials. Therefore, a person is brought up to actively create themselves. We should keep in mind that these: (1) more subjective (e.g. self-creation, self-education) or (2) more objective (e.g. education, socialization, formation) determinants and factors of his "becoming" determine them to a varying degree at each stage of human life. It is a natural

developmental phenomenon, but it must be assumed that in particularly unfavourable conditions (lack of stimulating support from the environment, individual deficits difficult to reduce or compensate) a person remains at (fixates themselves on) earlier stages of development, without being able to constructively overcome subsequent developmental crises (Erikson, 1997, 2002, 2004).

In the context of constitution of human evil, in the last decades numerous publications have referred to the phenomenon of empathy (e.g. Baron-Cohen, 2014; Blake, Gannon, 2008; Davis, 1983, 1999; Dolan, Fullam, 2004; Hoffman, 1990a,b, 2003; Jolliffe, Farrington, 2004; Marshall, Marshall, 2011; Nowogrodzka, 2014; Seidel et al., 2013). Empathy is treated as a factor of human development taking place "in harmony with oneself and with the world" and, above all, as a factor of protection against evil. Simon Baron-Cohen (2014, pp. 9–10) describes empathy as the world's most valuable resource and its lack as the root of human cruelty. Empathy is a complex, at least two-component, phenomenon, including the affective aspect, i.e. the ability to experience the same emotions as other people, and the cognitive aspect, i.e. the ability to decentrate, look at the situation from the perspective of another person, their needs and desires. The author mentions two types of factors determining human evil, which results from the lack of empathy: a) brain mechanisms that create the so-called empathy circuit[1], b) early childhood experiences, which are the basis for creating close relationships with other people and the ability to trust them. The basic condition for the development of empathy, i.e. proper functioning of the brain's empathy circuit, is not sufficient, however, as an individual also needs to have the so-called internal pot of gold - the result of always specific emotional experiences collected in the early childhood. According to Baron-Cohen, the result of deficits in cognitive and emotional empathy (empathy circuit) and the lack of developed moral principles (early childhood experiences) is the emergence of various disorders in the psychosocial functioning of an individual, i.e. human evil. It is easy to notice that despite indicating the primary, biological determinants of empathy (the source of determinism), this concept has an optimistic overtone; the author believes and proves that the world can be made better just by increasing the level of empathy. The positive overtone of this concept can also be seen in the perspective of thinking about crimes, offences or socially unacceptable behaviours. If we make the brain responsible for the human ability to differentiate between good and evil (dependent on the level of empathy),

[1] The brain's empathy circuit comprises the following structures: anterior part of the insula, amygdala, caudal part of the anterior cingulate cortex, dorsoventral part of the medial prefrontal cortex, frontal operculum, inferior frontal gyrus, inferior parietal lobe, inferior parietal fissure, middle part of the cingulate cortex, orbitofrontal cortex, posterior part of the temporal sulcus, right temporoparietal junction, somatosensory cortex.

we should also change our repulsive and stigmatising (negative) attitude towards acts committed by people that do harm to others to the understanding and supportive (positive) one, which does not mean acceptance, because it is difficult to punish people for something they cannot control due to a naturally (biologically) conditioned empathy deficit. However, this does not release us from the obligation to look for solutions to "correct" those mechanisms which, being beyond human will and control, lead a man to evil.

Social rehabilitation pedagogy is still among negative sciences, because it deals with negative phenomena relating to the individual (developmental dysfunctions) and determining the conditions and quality of his life (loss-making conditions of development). It can be said that metaphorically it is the evil of the human and the world in which the human lives. This is confirmed by the dominance of the positivist trend in social rehabilitation, focusing mainly on the negative aspects of an individual's life. This approach is characterized by "tight determinism", although for sure differently-oriented: either to individual psychopathology or social pathology (cf. Błachut, Gaberle, Krajewski, 1999, p. 46; Harris, 2005, pp. 311–328; Stańdo-Kawecka, 2010, pp. 108–124; Wysocka, 2015).

By exposing the psychopathology of an individual (the individualistic trend that stresses the importance of personal and individual variables, indicating the internal source of evil), we construct a paradigm of "types of people" inherently bad, biopsychically determined (the so-called dispositional factors, internal source of evil). This releases educators from taking measures that would serve internal transformation, "because people are like that" or "because they do not change".

On the other hand, by exposing social and environmental pathology (the social trend highlighting the importance of social and environmental variables, indicating the external source of evil), we construct a paradigm of kinds /types of bad environment that determine human evil (Błachut, Gaberle, Krajewski, 1999, p. 46; cf. Biel, 2010, p. 142).

Neither of these orientations treats an individual experiencing developmental problems as an entity that can choose and decide about their own self-creation, equipped with various potentials that could be used in developmental change. And after all in our times, even in social rehabilitation, we do not question subjectivity of the human and therefore we make him "personally" responsible for who he becomes (the moral model of help), but also responsible for the process of his internal transformation (if it is to be permanent, i.e. effective) (Wysocka, 2015, 2019). Regardless of the trends of thinking about man and his "becoming" (the development model – man as a work of nature which cannot be "evil"; socialization model – man as a "work" of the society where "evil" exists; personalization model – man as "his own work", able to defeat the "evil" in himself and in the

world), the transformation taking place in a maladapted person needs to be autonomous (subjectively controlled) and voluntary (internally motivated), but to make it possible it is necessary to discover the person's potentials, sometimes the few ones, that are a factor stimulating internal motivation to change (Deci, Ryan, 2000a, b; Ryan, Deci, 2000, 2001).

It is easy to notice that these trends propose different visions of man, taking into account or not the criterion of his subjectivity in self-creation. In the personalization model, this vision is certainly the most positive, as it assumes full subjectivity, autonomy and agency of a human in creating himself. The remaining ones, i.e. the development and socialization models, naturally assume human determinism; the first one relates to biological determinism (development) and the other one to social determinism (socialization and education).

POSITIVE DIAGNOSIS IN SOCIAL REHABILITATION – ITS ROLE AND SELECTED PROBLEMS IN ITS DETERMINATION

The mission of the humanities is to multiply stories about human experience and to interpret them in various ways (Markowski, 2013, p. 66).

Leaving aside a detailed description of the positive diagnosis model in social rehabilitation, which can be found in other publications[2], I will focus only on the reflection aimed at indicating a few premises arguing in favour of the importance of this approach, and the problems related to using this approach in diagnostic practice in social rehabilitation.

In the humanistic model of diagnosis, the essence of which is its relational nature, but mainly its positive orientation (discovering the potentials of a socially maladapted individual), the need to individualize human existence and individual biography is assumed, and at least caution in making assumptions about the nature of developmental disorders (explaining them with an evil nature of the person himself or the evil nature of the world in which he lives). An important principle of

[2] In the relevant literature we can find analyses regarding various approaches to positive or creative social rehabilitation (e.g. Ostrowska, 2008, 2010; Konopczyński, 2007, 2014a, b) or positive prevention, a part of which can be the model of positive development of young people (Ostaszewski, 2014) and indirectly a diagnosis prepared for their needs; and finally the Good Lives Model as well as the concept of resilience and the sense of coherence, and most generally the concept of risk factors and protective factors. They are described relatively well in the Polish literature (e.g. Biel, 2010; Muskała, 2016; Opora, 2009, 2011, 2015; Wysocka, 2015, 2019).

cognition in the humanistic approach is not to create patterns for both the subject and the object of cognition. This is especially important when you are tempted to take a shortcut in learning about the so-called difficult phenomena (complex ones and influenced by the need for social approval). Social maladaptation leading to crime and recidivism despite rehabilitation measures taken is certainly one of the phenomena susceptible to creating patterns ("he is like that – he is bad"; "nothing can be done to change him", where the internal change is treated as the goal of rehabilitation). This schematisation is reinforced by the natural tendency to protect against evil (individual and socially sanctioned). In the context of diagnosis and rehabilitation activities directly related to it, schematisation always results in a natural limitation of the area of cognition ("what for, if I know anyway") and also makes it impossible to understand the nature of the problems experienced by a person demonstrating adaptation disorders.

We need to bear in mind that the indicated and empirically confirmed maladaptive mechanisms (leading to disorders or constituting their correlates) are not homogeneous and are reflected in various functioning mechanisms of the maladapted individuals. As an example, I can mention the mechanism of disorders related to the need to protect one's own value. The tendency to low (overly low) self-esteem in the maladapted individuals has been widely stated in previous studies, which was later verified in a completely different way as a tendency to high (overly high) self-esteem. Both tendencies (Anderson, Bushman, 2002, pp. 27–51; Baran, Bielawiec, 1994, pp. 17–32; Berkowitz, 1998, pp. 49–72; Bielawiec, 1999; Gaszczyńka-Płuciennik, 2004, pp. 9–14; Kupiec, 2014, pp. 117–134; Levy, 1997, pp. 277–283; Paszkiewicz, 1974, pp. 192–208; Siemionow, 2011, pp. 161–162; Urban, 2012; Waśkowicz, 2002, pp. 9–15) were to explain the inclusion of non-normative behaviours as functionally effective for people with disorders, because they were connected with the protection of a positive self-concept (the need for respect, recognition, positive self-esteem). I have explained these issues in more detail in other co-authored publications (Wysocka, Ostafińska-Molik, 2014, pp. 233–254; 2016a, pp. 307–329; 2016b, pp. 119–144), selectively analysing the problems of directional differentiation of similar features in people with diagnosed social maladaptation ("similarly maladapted, and yet different") and initially exploring the determinants of the indicated polarisation of self-esteem or comparing analogous descriptions of correctly and incorrectly adapted people. As we know, regulation of human behaviours is explained by various mechanisms, but they can also be located in the processes taking place in human consciousness, which is stressed in cognitive psychology. Nowadays, it is also used in social rehabilitation, because the mechanisms of social maladaptation are very often associated with such constructs as: self-concept, self-esteem (self-assessment) or self-acceptance.

As I mentioned earlier, the studies conducted for many years in the field of psychology (mainly cognitive psychology), and recently also in social rehabilitation pedagogy, aimed at verifying the role of self-esteem for the psychosocial functioning of a disturbed individual, provide different results. The subject of conducted analyses is thus one of the most important mechanisms of regulating human behaviours and consequently development and developmental disorders. The results obtained in the field of the role of self-concept in adaptation disorders are not clear, hence it is difficult to explain the occurrence of adaptation disorders based thereon. The attempt made to partially "solve the mystery" of this ambiguity, i.e. polarisation of self-esteem in people diagnosed with social maladaptation means making an assumption that problems with self-esteem constitute a significant, if not the most important, mechanism of disorders. It is worth emphasizing that the thesis about the role of self-esteem in the psychosocial functioning of an individual has been confirmed in numerous studies conducted by cognitive psychologists. It is hard to deny that the way a person perceives and evaluates himself and the world around him determines both the way he reacts to the tasks set before him (constructive vs. destructive), the quality of his relationships with other people (trust vs. lack of trust in relationships) and his sense of control of events plus the sense of agency (resourceful vs. helpless attitude), which makes up the perceived sense of being able to act in the world (normative vs. non-normative) and predicting the effectiveness of his actions (effective vs. ineffective). Altogether, it makes up a complex development mechanism (progression vs. regression), which is a predictor (positive vs. negative) of personality development, the functioning of an individual in the social roles assigned to him, involvement in pro-development or developmentally destructive activities related to the attitude towards taking up activities (consistent vs. inconsistent with the expectations and requirements of the environment). Therefore, self-esteem as an important regulator of behaviour determines the selection of events and motivates a person to take up activities that potentially serve to maintain or improve self-esteem, along with avoiding situations where self-esteem could be threatened and lowered (Leary, MacDonald, 2003, pp. 401–418).

The research results show that the level of self-esteem (low vs. high), its adequacy (overly low vs. overly high), coherence and stability of the self-concept (independence from the environment) determine the general attitude of an individual to himself, the world surrounding him and his own activities. It is assumed that positive, adequate, consistent and relatively stable self-esteem is a positive predictor of adaptation to the requirements of living in a society imposed by the social environment and by a person himself (Reykowski, 1976, p. 200; Kulas, 1986, p. 6; Kupiec, 2014, pp. 117–134).

The majority of, especially older, studies referring to the self-esteem of socially maladapted people indicate that there is a negative correlation between both variables (self-esteem, maladaptation), which means that in people diagnosed as disturbed there is a significantly greater discrepancy between the "real self" (what I am), "ideal self" (what I would like to be) and the "ought self" (what I should be), which is accompanied by a generally more negative self-concept (Paszkiewicz, 1974, pp. 192–208). This would indicate a simple relationship between self-esteem and adaptation: the greater the discrepancy between the "real self" and the "ideal self" and the lower the self-esteem, the higher the level of maladaptation (Siemionow, 2011, p. 56).

In more recent studies, the identified relationship between both variables is curvilinear, which points to the functions of certain intermediating (moderating) variables in its determination. Thus, depending on the specific characteristics of an individual, yet unidentified and not yet finally confirmed empirically, both high and low self-esteem positively correlate with maladaptation, and the average level of self-esteem is adaptively positive, being associated with good adaptation (Siemionow, 2011, p. 57). Average self-esteem is treated here as adequate self-esteem, because a person who perceives himself realistically perceives both his own limitations, fairly accepting them, and his possibilities, trying to make use of them in what he does. What is important, however, other studies (including my own, mentioned earlier[3]) have confirmed that it also depends on the level of social maladaptation. Its high level, indicated by involvement in criminal activity, is associated with a more negative self-concept and lower self-esteem (Levy, 1997, pp. 277–283; cf. Bielawiec, 1999). This would indicate that one of the mediating variables that co-determine self-esteem is the level of adaptation disorders. Other studies (Urban, 2000, pp. 136–137) show a completely opposite relationship, which is explained by the level of identification with a deviant identity ("identification with evil").

The second feature of self-esteem, which is adequacy, is not clearly confirmed empirically either. There is a tendency towards an overly high self-esteem among the MOW pupils (Gaszczyńska-Płuciennik, 2004, p. 13), i.e. a higher level of similarity of the "real self" (what I am) and the "ideal self" (what I would like to be),

[3] Similar results were obtained in co-authored studies (Wysocka, Ostafińska-Molik, 2014) examining the content-related aspects of self-esteem (multidimensional approach) of MOW (Youth Care Centre) pupils. Properly adapted youngsters obtained higher results than those socially maladapted in terms of all distinguished elements determining the quality of the self-concept: global, general, cognitive-intellectual, physical, socio-moral and characterological self-assessment. The Cohen's d effect in all comparisons was medium, and in global self-esteem was large. This means that there is a significant relationship between the level of social adaptation and self-esteem (positive vs. negative).

which exemplifies conformity of the self-concept and thus higher self-acceptance of the socially maladapted youth (Waśkowicz, 2002, pp. 9–15). The authors usually do not explain this issue, but it can be assumed that it is explained by the high level of identification with the "socially opposing self". Socially maladapted people who are characterized by negative self-presentation, which is a derivative of the legitimised acceptability of antisocial behaviours, usually do not see the need to change their self-concept. Objectively, it determines an increase of self-esteem or making it overly high in relation to the applicable norms and the realistically manifested features. The authors indicate that this is the result of numerous moderating variables. One of them is the type of manifested disorders, related to the level of social maladaptation. Overly low self-esteem is characteristic of internalising disorders, usually treated as a manifestation of the initial stage of the social maladaptation process, associated with withdrawal, anxiety-based inhibition and excessive control of one's own behaviours. As a result, it blocks the process of positive adaptation because it frustrates satisfying the basic needs. What is characteristic of externalising disorders, most often treated as a manifestation of a more advanced process of social derailment, associated with aggression and a deficit in behaviour control, is (defensive) overestimating of one's own abilities resulting in an overly high self-esteem (Anderson, Bushman, 2002, pp. 27–51; Berkowitz, 1998, pp. 49–72). This means that the beginning of a deviant career is usually associated with lower (overly low) self-esteem, however, in the process of autonomising a deviant identity a defensive modification of the self-concept towards the positive (high, overly high self-esteem) takes place. Today, we generally accept the thesis about the functionality of adaptive disorders, so deviant activity is functionally justified and legitimate, being in a way a method for "boosting self-esteem". As Bronisław Urban (2000, pp. 136–137) claims, this activity is approved and appreciated in subcultural deviant peer groups, where a maladapted individual satisfies (because he needs to since it's not possible in other groups) the basic needs of acceptance, respect , recognition and even security.

This thesis is indirectly confirmed by numerous research reports on self-esteem as a predictor of aggressive behaviour: low self-esteem as a frustrating factor positively correlates with aggression, which is also an indicator of social maladaptation. However, the situation may be different because frustrating situations, being associated primarily with negating competences, fitness, beauty, etc., may determine maladaptive behaviours of individuals with a positive self-esteem (Baumeister, Boden, 1998, pp. 111–137; cf. Kubacka-Jasiecka, 2006), although – if I may add – it does not have to be an adequate self-assessment, and it is usually also unstable and undetermined. At the same time, it indicates the possibility of defensive formation of an overly high self-esteem, due to questioning basic

personal properties of maladapted individuals by the social environment. This phenomenon is explained, although indirectly and inconclusively, by the concepts of social stigmatisation. Before attaching to himself the stigma of an "evil individual", a socially maladapted person must somehow defend himself, so he can make a symbolic attempt to overstate his own attributes in order to give them, in his opinion, positive connotations or additionally confirm the way of perceiving himself in socially opposing groups (Ostafińska-Molik, 2014) .

As we can see, problems with self-esteem of socially maladapted people can paradoxically be associated with both low and high self-esteem (positive and negative correlation, i.e. curvilinear), and both are inhibitors of proper development. However, with regard to the negative correlation, the disruptive factor is directly low or overly low self-esteem, and if there is a positive correlation here, its developmental destructiveness determines a potential threat of having a high or overly high self-esteem (Wysocka, Ostafińska-Molik, 2016a)[4].

In the context of the role of a positive diagnosis in social rehabilitation, it is important to initially deeply reflect on even apparently positive results, especially when completely opposite features appear in the description of maladapted individuals (e.g. positive vs. negative self-esteem). This, of course, also applies to a negative diagnosis, because it is not always "true" that socially maladapted people present a negative self-image. However, problems with self-esteem (regardless of its direction) are always destructive in terms of development, because both positive and negative self-esteem demonstrates features of inadequate (overly low or overly high) self-esteem, which is associated with unrealistic self-perception also frequently connected with defensive self-attributing of positive features which are not socially valued in such a way.

In other co-authored studies (Wysocka, Ostafińska-Molik, 2016b), the role of self-esteem and related factors were analysed, relating them to selected sociodemographic (place of residence, declared religion, self-declaration concerning the level of religiousness) and personality-related traits (system of beliefs regarding

[4] In the author's own research an attempt was made to solve the mystery of polarisation of self-esteem in socially maladapted people. The differentiation of individuals belonging to the three distinguished groups (clusters) was determined and described, based on the level and a specific layout of self-esteem dimensions (general, global, specific, non-specific, in the cognitive-intellectual, characterological, socio-moral, physical sphere), taking into account the social approval variable. The distinguished groups were symbolically named as: (1) negative "reflected self" (I am the Worst!), which is characterised by a clear contradiction between the "real self" and the "ideal self" plus the "ought self"; (2) positive "defensive self" (I am the Best!), typical of people who are characterised by "forced", defensive agreement between the "real self" and the "ideal self"; (3) "undetermined –unstable self" (Who am I?), which is attributed to persons experiencing a yet unresolved conflict between the "real self" and the "ideal self" plus the "ought self".

interpersonal relations, attitude towards the world, attitudes towards one's own life)[5]. It was assumed that the self-concept, concept of the world and the assessment of one's own relationship with it as well as the concept of one's own life are formed in the course of development, learning and gathering life experiences. This takes places in a logical and complete way. This is the basis for inferring the role of self-esteem in the formation of personality (generalising influence on the entire system of beliefs) and explaining factors co-determining it (learning from specific experiences, i.e. environmental influences). Although based on selectively treated personality and socio-demographic variables, the conducted analysis has revealed that the polarisation of self-esteem and the problems related to its formation in socially maladapted individuals are a logical consequence of the so-called learning experiences. They constitute a system of logically co-related (though unfortunately cognitively distorted) beliefs about the nature of the world and people (on this basis an individual builds a positive vs. negative self-image), which at the same time determines the quality of beliefs relating to the sense of one's own ability to act in the world (control vs. lack of control; sense of effectiveness vs. helplessness). Creating a system of beliefs is certainly a process, so it is important to identify (diagnose) the course of this process. The obtained results of studies allow us to make a valid, although otherwise obvious, conclusion about the course of this process and the nature of the factors that determine it. This process is determined by specific experiences of an individual polarised by the quality of the living environment (its features), and its course may be as follows: from the originally imposed socially destructive self-identification, i.e. reflected negative self-esteem (I am the Worst!), through the emergence of ambivalence in the attitudes that are formed towards oneself, the world and one's own life, and the internal, unresolved identification conflict (Who am I?), to the secondary adoption of a defensive attitude, the function of which is to protect self-esteem (I am the Best!), which may be connected with the autonomisation of a deviant identity. The polarisation of self-esteem can be co-determined, as I stressed earlier, by the level of disorders or their internal typological differentiation.

The issues of connections between self-esteem (various own attributes – "positive self", "controlling self" and "effective self") and social maladaptation, its increased level and typological differentiation are extremely important from the

[5] The above-mentioned research results were prepared based on the data obtained from the Intrapersonal and Interpersonal Attitudes and Attitudes towards the World and Life Questionnaire (KNIIŚ) developed by Ewa Wysocka (2011), used to measure self-esteem, the concept of interpersonal relations – "others towards me" (threat, support), "me towards others" (socially-oriented, aggressive), the concept of the world – acceptance, organisation and meaningfulness, the concept of one's own life – control and agency, lack of control, learned helplessness.

perspective of effective social rehabilitation impact. It is obvious that different "modification procedures" (methods of operation), differently directed, and also requiring a different social rehabilitation environment (open, closed) and other characteristics of educators are needed by an individual who shows inadequate, but overly low self-esteem than an individual with inadequate, but overly high self-esteem. It can be assumed that this is differentiated by the global level of disorders and their development phase (i.e. the level of identification with a deviant identity) plus their typological differentiation: internalising, externalising and mixed disorders (Achenbach, 1982, 1985, 1993; Achenbach, Edelbrock, 1978). Here as well, there can be no doubt about the need to select and qualify people differentiated in terms of the specificity of adaptation disorders to various forms and methods of social rehabilitation activities.

In the context of social rehabilitation diagnosis, this is associated with the need to measure the orientation of self-esteem (negative vs. positive tendencies in the assessment of personal attributes and own behaviours) and the level of its adequacy (correct/realistic vs. overly low/overly high), which in turn makes up the level of self-acceptance (low vs. high). These are two features of self-esteem, which are interrelated and inconclusively explain adaptation disorders in terms of their level (advancement) and type (orientation). It can be assumed that, depending on the adopted perspective (subjective, internal vs. objective, external), social maladaptation is determined by both low and overly low as well as high and overly high self-esteem, self-acceptance and self-acceptance deficit. The adequacy of self-esteem is the most difficult feature to diagnose, because it requires the assessment of the real resources of an individual in relation to the way they are perceived by the individual, which to some extent is explained by the concept of self-degrading and egotistical cognitive distortions (Barriga, Gibbs, 1996; Barriga, Gibbs, Potter, Liau, 2005; Barriga, Landau, Stinson, Liau, Gibbs, 2000; Gibbs, Potter, and Goldstein, 1995; cf. Mudrecka, 2015). Both types are specifically related to social maladaptation, but refer to qualitatively different disorders, with the former most often connected with internalising and the latter with externalising disorders.

Correct development of an individual in cognitive concepts is understood as formation of positive beliefs about one's own functioning in the world (in the context of its perceived determinants), which should (or may) functionally serve eliminating cognitive distortions resulting from previous learning experiences in the life environment specific to maladapted people. These beliefs are related to the way of perceiving: a) oneself (intrapersonal functioning), other people and relations with them (interpersonal functioning), the surrounding world (functioning in the world, perceiving personal possibilities of acting effectively satisfying the needs); b) coping in the world (constructive vs. destructive), with identifying styles of coping

with difficulties and limitations. In the case of socially maladapted people, it is necessary to support the process of restructuring these beliefs (Mudrecka, 2015) and shaping the styles of constructive problem-solving.

FINAL REFLECTION – CONCLUSIONS FOR TARGETING A DIAGNOSIS IN SOCIAL REHABILITATION

– Lord [...] let me understand other people other languages other sufferings
(The Prayer of the Traveller Mr. Cogito by Zbigniew Herbert)

Defining social rehabilitation as a process of internal transformation taking place owing to the change of the system of beliefs, which in cognitive psychology are treated as structural elements of personality, we also make an assumption about the quality of activities that need to be taken. They are aimed at shaping positive beliefs of a socially maladapted person about themselves, the world, relations with others and their own life (the effect of rehabilitation procedure) and the conditions in which it can be achieved (moderating and causative factors). It also means that the second pillar of these activities is the diagnosis of cognitive distortions (negative diagnosis) which are self-degrading and egotistic (Barriga, Gibbs, 1996; Barriga, Gibbs, Potter, Liau, 2005; Barriga, Landau, Stinson, Liau, Gibbs, 2000; Gibbs, Potter, Goldstein, 1995; cf. Mudrecka, 2015). In this approach, they are the main symptoms and factors of adaptation disorders. This assessment, however, cannot be devoid of elements of a positive diagnosis, which is associated with the use of its results for post-diagnostic planning and its use to verify the results of the rehabilitation measures taken. The first way of using a positive diagnosis is related to the diagnostician's orientation to identify at least a few positives (individual traits and living conditions) that can be functionally used in the process of change (change mechanism)[6], offering a better effect thanks to a two-way impact

[6] We have a different situation and a different mechanism of internal transformation if they concern asocial, dissocial or antisocial individuals. It is not a generally accepted division, although it has been partially confirmed empirically, and observations of the behaviour of people with problems in social functioning validate this typology, which was promoted by Czesław Czapów and Stanisław Jedlewski (1971) and referred to and confirmed in research by Jan M. Stanik (2013). The asocial type: a person who ignores social requirements, but does not act aggressively, does not attack their social environment (indifferent, "harmless" type). The dissocial type: a person who has become included, identifies with and respects the rules of groups or other social systems that are dysfunctional and hostile to the whole society. Strong identification and emotional ties within the opposition groups can be observed here. The antisocial type: a person who resists all rules of

(reinforcing positive resources and reducing negative deficits of an individual and its living environment). The second method, on the other way, uses a positive diagnosis in the area of monitoring the processes taking place in a maladapted individual (in the positive direction), consequently giving a basis for concluding about (successful) completion of rehabilitation activities or about the need to redefine the problem (diagnostic error), change the mode of action (post-diagnostic planning error), or – which happens most often because it is immanently related - redefine the problem and restructure the model of operation at the same time.

In the diagnosis process, developmental resources and deficits can be identified simultaneously, always creating an individual model of the discovered factors determining development and a specific arrangement of salutogenic and pathogenic tendencies. Planning post-diagnostic activities that support internal transformation depends mainly on the adopted theoretical perspective. However, it should be a principle in building support systems to prioritise actions relating to potentials and resources (ergotropic actions), as these were verified long ago as the most effective from the praxeological and psychological point of view. A simple argument justifying its use is the fact that actions referring to potentials (positive diagnosis) eliminate resistance of a maladapted person to change (imposed externally) or the uncertainty and fear of the risk of ineffectiveness of undertaking activities aimed at making a change (actions complying with norms were previously ineffective). Moreover, it is often impossible to eliminate the primary deficits, which were the basis of adaptation disorders, and restrictive elimination of manifestations of unapproved behaviours stigmatises dysfunctionality of an individual, which is psychologically difficult, as it is most often the only possible way of coping, as perceived by an individual, although developmentally and socially destructive (thesis about the functional nature of disorders). On the other hand, supporting measures referring to potentials and resources strengthen an individual's beliefs about their own positive values and possibilities, and at the same time constitute the basis for new, alternative to the negative ones from the past, learning experiences. This helps an individual to better function in all spheres, primarily in the distorted ones.

I have already stressed that it is significant in the positive approach to combine rehabilitation activities with a diagnostic and therapeutic relationship which develops easier and better when we perceive a maladapted individual from the perspective of their potentials and we treat them as "having deficits only selectively". This strengthens their conviction that an internal pro-developmental

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both normative and non-normative groups (the general public and groups opposing it). No sense of bond with any social group can be observed here.

transformation and functioning as a full member of the community that does not exclude or stigmatise them is possible, because although you cannot change certain things that happen in life due to your fate (non-stimulating conditions of development), you can change your own approach to them (understand and use them in the process of change).

Restructuring beliefs about oneself and the world plus the "closed past" and "potentially open future", as well as the possibilities of acting in one's own life in harmony with the binding norms may improve the mutual relations between the two worlds of socially maladapted people and the society that stigmatises them, and also change the perspective of seeing one's own life, eliminating functionality of disturbed behaviours towards indispensable needs that cannot be satisfied in a socially accepted way.

It is certain that the system of beliefs of maladapted people needs to be diagnosed if we are to effectively restructure them. Revealing the polarisation of self--assessment and its correlates can therefore be an important premise for designing educational, rehabilitating and therapeutic activities, adequately to the revealed cognitive distortions – an incorrect image of oneself, relationships with other people, image of the world or image of one's own life.

A clear polarisation of self-assessment among socially maladapted people disqualifies post-diagnostic activities that standardise rehabilitation procedures regardless of the specific mechanisms of disorders, their intensity and typological differentiation. This also applies to other features of psychosocial functioning of a maladapted individual, which have not been analysed in this article (control vs. helplessness, interpersonal attitudes, attitudes towards the world; see Wysocka, Ostafińska-Molik, 2014). Polarised self-assessments (of one's own various attributes, including functioning in the social world and the possibility of effective acting in it) clearly positively or negatively include extreme, least numerous groups (which is statistically and methodologically obvious, but also reflects the actual distribution of people demonstrating it). People experiencing internal conflicts with regard to assessing their own attributes: undetermined, unstable self-esteem generalizing into an undetermined image of the social world and the image of the way of functioning in it, constitute the most numerous group (which is also validated).

Diagnosing various attributes of socially maladapted people and their intragroup differentiation is an important criterion for their selection for various types of rehabilitation activities, because the needs of people with clearly polarised features and people experiencing internal conflicts in this respect are certainly different. Unfortunately, in rehabilitation activities we rarely take into account such differentiations, which applies not only to a specific image of oneself, although this is an extremely important mechanism of disorders.

Therefore, we must assume the relative validity of the concepts explaining the mechanisms of human functioning, due to the changing conditions of human life, determining the indefiniteness, infinity and non-schematic nature of the cognitive process, which requires adopting its form as a dialogue and adopting as a principle the possibility of manifold interpretations of the reality.

Diagnostics as a discipline dealing with the methods of data collection and analysis is a set of directives that allow for an accurate and reliable assessment of phenomena that are of interest to a given scientific discipline. It is worth thoughtfully following the findings already confirmed in the difficult case diagnosis and epidemiological diagnosis.

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ZNACZENIE DIAGNOZY POZYTYWNEJ W RESOCJALIZACJI W PERSPEKTYWIE TEORII ZŁA – REFLEKSJA PSYCHOPEDAGOGICZNA

Streszczenie: W artykule została przeprowadzona analiza znaczenia diagnozy pozytywnej w resocjalizacji. Założono jej priorytetowość w poznawaniu osób niedostosowanych społecznie. Zakwestionowano wystarczalność modelu diagnozy negatywnej, obowiązującego dotychczas w pedagogice resocjalizacyjnej. Odnosząc się do głównych cech diagnozy psychopedagogicznej (np. nieskończoność, złożoność, wielowymiarowość), sformułowano podstawowe zasady diagnozowania tzw. zjawisk trudnych, do których zaliczono niedostosowanie społeczne. Analizę przeprowadzono z odniesieniem do wyników badań empirycznych (badań własnych i innych autorów), dotyczących złożonych i niejednoznacznych charakterystyk osób niedostosowanych (obraz siebie, samoocena, samoakceptacja, obraz świata, obraz własnego życia). W artykule zaproponowano model diagnozy resocjalizacyjnej w ujęciu psychologii pozytywnej (jakości życia) i poznawczej.

Słowa kluczowe: resocjalizacja, diagnoza, model diagnozy, podstawowe zasady diagnozy, psychologia pozytywna, psychologia poznawcza, samoocena, samoakceptacja, obraz świata, obraz życia