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CORRELATION BETWEEN SELF-EFFICACY AND PEER COMMUNICATION IN ADOLESCENTS WITH CRANIOFACIAL DEFECTS*

Introduction: The results of research on the psychosocial functioning of children and adolescents with facial and craniofacial defects indicate a generally complex situation of this group. Patients are rejected, discriminated against, have low self-esteem and low sense of self-worth. All this, in turn, leads to difficulties in undertaking and maintaining social interactions.
Research Aim: The aim of the study is to identify the correlation between selected sociodemographic variables and self-efficacy among adolescents with facial and cranial malformations and their communication with peers. The research adopts two objectives. The first one is to identify the correlation between self-efficacy and peer communication in adolescents with craniofacial defects. The second one, in turn, is to assess the impact of selected sociodemographic variables on self-efficacy and peer communication in adolescents with facial and cranial defects.
Research Method: The following tools are applied in the research: KompOs (the Personal Competence Scale adapted by Juczyński), SKAR (the Adolescent Peer Communication Scale by Napora) and a survey questionnaire.
Results: Scores on the SKAR suggest that respondents showed slightly lower openness at the same time as perceiving greater difficulties in communication. In the conducted research, variables (age, gender, place of residence) do not significantly differentiate the overall sense of

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self-efficacy. No significant correlation was found between self-efficacy and communication between adolescents with facial and cranial deformities and their peers.
Conclusion: The results of the analysis can provide a basis for designing future research in the area of communication of adolescents with facial and craniofacial defects in a peer group and their sense of self-efficacy. Research conducted to date in this area has shown positive results from the participation of people with this type of defect in interpersonal training.

Keywords: adolescents with facial and craniofacial defects, self-efficacy, peer communication

INTRODUCTION

The face externalises a person's emotional reactions and is an important source of information about them. It also plays an important role in social interactions (Jugowar, 1999) enabling comprehensive communication (Szczupał, 2015). If a deformity involves such a prominent body element, it usually arouses interest in others, which is reflected in the personal and social functioning of a person with said deformity. Facial deformities include several types of deformities due to the area affected (nose, eye, jaw, ear, lip, facial nerve, congenital scars and moles) and can range in severity. Facial deformities may involve the soft tissues or facial bones of the skull, and the type of deformity is assessed by aetiology. They may be congenital, acquired due to trauma, disease or surgery (Jugowar, 2006). The long history of treating people with facial and craniofacial malformations has resulted in the development of treatment standards, yet, it has not resulted in the development of a procedure for collecting epidemiological data on this population neither in Poland nor in Europe. The only data available in Poland is available on an official governmental website and concerns cleft defects in the population of Polish children, with an increasing trend clearly seen in the years 2013–2023 (ezdrowie.gov.pl). The cleft lip and/or palate is one of the most common birth defects in the human population. Indeed, it is associated with 65% of craniofacial developmental anomalies, and the therapeutic management of this defect, due to the variety and complexity of the problems that potentially arise from it, can be extremely difficult (Hortis-Dzierzbicka, 2019).

Young children with facial and craniofacial defects do not feel different from their peers. They have little interest in the features of their appearance but this interest begins when they experience longer and more frequent peer interactions highlighting their otherness. Children also begin to recognise the popularity of physically attractive peers. They tend to regard their unattractive appearance as a cause of rejection, isolation and other failures. Any visible defect that is subject to comments and remarks from those around them causes an earlier-than-average interest in the child's own appearance arousing fear and anxiety and triggering a drive to hide the defect that distinguishes them from the peer group when social standards and physical attractiveness are concerned (Jugowar, 1999).

Analysing scientific research in the field of psychosocial functioning of children and adolescents with facial and craniofacial defects, it is clear that this issue has not been addressed frequently by Polish scientists (Hortis-Dzierzbicka, 2000; Ruprich & Kamińska, 2023; Seń et al. 2023; Szczyrek et al., 2013; Tracz, 2013; Zdun-Ryżewska, 2017). This issue has been analysed by foreign researchers far more frequently (Akinbami, 2007; de Sousa et al., 2009; Feragen et al., 2010; Hearst, 2007; Hunt et al., 2005; Pope et al., 2016; Reed et al., 1999; Richman et al., 2012; Sajovic et al., 2024). The available analytical results indicate a complex situation of children and young people with facial and craniofacial defects who are usually rejected and discriminated against by those around them. They also present lower self-esteem and lower self-worth compared to their peers, which leads to difficulties in undertaking and maintaining social interactions (Aligheri et al., 2023; de Sousa et al., 2009; Hearst, 2007; Kata, 2018; Opozda, 2024; Rumsey & Harcourt, 2007; Tiemens et al., 2013; Tracz, 2013). Seń et al. (2023) indicate that the majority of adolescents with craniofacial defects they studied (significantly more often girls) declared dissatisfaction with their appearance and would like to have it corrected. In contrast, Akçay et al. (2023), comparing the self-esteem of children and adolescents with cleft lip and palate, highlight that the self-esteem levels of the adolescents studied were significantly lower than those of the children.

Lack of acceptance of the environment tends to have a significant impact on the impaired mental condition of people with cleft (Hunt et al., 2005, 2006). Zdun-Ryżewska (2017) reports that the majority of people with cleft (approx. 67%) experienced teasing from those around them. On the other hand, Seń et al. (2023) emphasise that almost two-thirds of adolescents with congenital craniofacial defects have encountered disapproval from peers and others because of their appearance. Such experiences result in difficulties in establishing social relationships in adulthood, a sense of isolation and sometimes depression (Hortis-Dzierzbicka et al., 2000a, 2000b). Occasionally, research authors indicate that adolescents with facial differences show considerable resilience and are able to cope well with difficult situations. Perhaps the main factor influencing better social functioning is the social context in which the adolescent functions (Riklin et al., 2019). Similarly, this is argued by Chimruang et al. (2011) who highlight that Thai adolescents' adaptability was greater when they received ongoing support from parents, friends and professionals.

Rumsey and Harcourt (2004) emphasise that the difficulties reported by people with visible facial deformities relate to negative self-perception and difficulties in social interactions. It is worth noting that social contact can be disrupted by disturbances in both verbal and non-verbal communication. A person with visible deformities may be unable to use their facial muscles fully or at all to express their emotions. As a result of being overly preoccupied with their own appearance and focusing excessively on how they are perceived by others, they may avoid social

contact or overreact to any kind of attention. Qualitative research by Gifalli's team (2024) shows evidence of varying problems in a group of adolescents who underwent lip and/or palate reconstruction surgery very early in life. They felt fear and shame and even embarrassment before public speaking. They felt uncomfortable communicating because they were sometimes not understood.

Although researchers typically reveal difficulties in interpersonal interactions for people with facial and craniofacial deformities, there are optimistic findings from scientific studies indicating that people with deformities perceive positive aspects of their situation. Sajovic et al. (2024) analysing the results of studies by other authors indicate that young people with cleft may be satisfied with their appearance, especially regarding aspects that are not affected by the cleft. In addition, results indicated increased development of psychosocial skills, personal resilience, appreciation of diversity and better coping mechanisms.

RESEARCH AIM AND QUESTION

The research adopts two objectives. The first one is to identify the correlation between self-efficacy and peer communication in adolescents with craniofacial defects. The second one, in turn, is to assess the impact of selected sociodemographic variables on self-efficacy and peer communication in adolescents with facial and cranial defects. Gender and place of residence are important socio-geographical factors that may influence everyday life, well-being and development of a person. Scientific research indicates that gender plays an important role and differentiates reactions to the challenges associated with facial and cranial defects (Crerand et al., 2020). Place of residence can be important in terms of access to support and medical care and may influence social integration. The research was conducted using a diagnostic survey method. The study attempted to answer the following research questions:

1. What is the sense of self-efficacy in adolescents with facial and cranial defects?
2. How is the communication of adolescents with facial and craniofacial defects with their peers shaped?
3. Is there a correlation between the following areas – the area of peer communication and the respondent's self-esteem, and the area of the respondent's gender and their place of residence. If the correlation exists, what is it exactly?
4. Is there correlation between self-efficacy and peer communication in teenagers with facial defects and craniofacial abnormalities, and if so, what is it?

RESEARCH METHOD AND SAMPLE CHARACTERISTICS

Two standardised research tools and a self-constructed survey questionnaire were used in the study. The first research tool used was the Personal Competence Scale (KompOs) adapted by Juczyński (2001). In the article, the authors use the terms "self-efficacy" and "personal competence" interchangeably. The scale measures generalised sense of self-efficacy and its two components: strength and perseverance. The former relates to beliefs about having the strength necessary to initiate action and the latter relates to the persistence necessary to continue action. The scale consists of 12 statements, both positive and negative. The scale is applicable to the study of children and adolescents, both healthy and ill. The test takes a few minutes and can be conducted individually or in groups. The respondent is asked to indicate the degree of approval of the content of each statement and chooses one of four answers: *yes*, *rather yes*, *rather no* and *no*. Subsequently, the respondent indicates the frequency of certain forms of behaviour: *almost always*, *often*, *sometimes*, *almost never*. Points are assigned to positive statements respectively: *yes* or *almost always* – 4; *rather yes* or *often* – 3; *rather no* or *sometimes* – 2; *no* or *almost never* – 1. Points for negative statements, on the other hand, are assigned in a reversed order. In the analysis of the results, three calculations are done total, subtotal for the sense of strength and subtotal for the sense of perseverance. The range of scores for the total scale is from 12 to 48 points, and for the other two from 6 to 24 points. The higher the scores, the higher the sense of self-efficacy and strength and perseverance. The total score is converted into standardised units on sten scores. Scores within 1–4 sten are treated as low scores, scores within 5–6 as average and 7–10 sten as high.

Another research tool was the Adolescent Peer Communication Scale (SKAR) by Napora (2023) designed to measure adolescents' openness and difficulties in communicating with peers. It helps to assess the quality of relationships with peers. It is designed to survey adolescents aged 14 to 19 years old. The SKAR is a short and simple scale to use. Respondents are asked to express ratings on their perception and experience of communication with peers. The SKAR includes instructions to be read before answering. The survey can be conducted individually or in groups. It is important to provide the respondent with space and sufficient time. It usually takes 15 minutes to complete the SKAR scale. Scores are calculated separately for each subscale and an appropriate key is used to interpret the final results. For the Openness Subscale, scores from statements 1, 3, 6, 7, 8, 9, 13, 14, 17 are added: and for the Difficulty Subscale scores from statements: 2, 4, 10, 11, 12, 15, 18, 19, 20 are added. Each statement is scored on a scale from 1 to 5, where 1 means *completely agree*; 2 – *basically disagree*; 3 – *I find it difficult to decide*; 4 – *basically agree* and 5 – *completely agree*. A total of 10 to 50 points can be obtained on each scale (Napora, 2023). It is worth noting that permission was obtained from the author to use the tool in the research conducted. A third and final tool, the author's survey questionnaire, was used to collect data on the characteristics of the study group, their age, gender, place of residence, type of defect and

treatment used. The selection of the cohort was based on the following criteria: the age of respondents (between 14 and 17 years old) and presence of face and skull defects.

The results presented are part of a larger scientific project on the social functioning of people with facial and craniofacial defects conducted from April to June 2024. The project was also approved by the Ethics Committee (No. 23ZE/2024/WSSD) of the Regional Specialized Children's Hospital in Olsztyn, Poland. The research was conducted via the Internet and on the premises of the Centre for Craniofacial Defects and Maxillofacial Surgery for Children of the above-mentioned institution. The Centre for Craniofacial Defects and Maxillofacial Surgery for Children admits approx. 3,000 patients a year. Tables 1–2 show the number of consultations and the numbers of patients in 2022–2023.

Table 1.
The number of consultations and number of patients admitted in 2021–2023

	2021	2022	2023
Number of patients	2,171	2,293	2,784
Counselling sessions	3,766	4,116	4,949

Source: Authors' own study.

Table 2.
The number of patients admitted in 2021–2023

Age of patients	2021	2022	2023
0–18	1,969	2,034	2,405
14–17	447	488	622

Source: Authors' own study.

Although facial and craniofacial defects are not exceptionally rare among children and adolescents, assembling the study group proved to be a difficult task. Consent to conduct research among underage patients was obtained from the parents or legal guardians and then from the patients themselves, who were informed about the purpose of the research. Parents/legal guardians and patients were informed of the anonymity and voluntary nature of participation in the study. A total of 54 completed survey instruments were obtained. Incomplete questionnaires or questionnaires not meeting the conditions related to the project conducted were rejected.

Thirty-six patients aged 14 to 17 years old, 58.33% female and 41.67% male, took part in the study using the KompOs and SKAR scales. More respondents resided in an urban area (61.11%) than in a rural area (38.89%). Almost all respondents had undergone surgical treatment (97.22%) and only a small percentage had received physiotherapy (11.11%), speech therapy (5.56%) and ENT treatment (5.56%). Only one respondent had already completed treatment.

Table 3.
Characteristics of respondents (N = 36)

Variables	M±SD	Me	Min-Max
Age	16.06±1.01	16.0	14.0–17.0
		N	%
Gender	woman	21	58.33
	man	15	41.67
Place of residence	rural area	14	38.89
	urban area	22	61.11
Surgical treatment applied	yes	35	97.22
	no	1	2.78
Physiotherapy treatment applied	yes	4	11.11
	no	32	88.89
Speech therapy applied	yes	2	5.56
	no	34	94.44
ENT treatment applied	yes	2	5.56
	no	34	94.44
Completed treatment	yes	1	2.78
	no	35	97.22

Source: Authors' own study.

In order to characterise the study group and the responses to the SKAR and KompOs scales, counts and percentages were used, as well as descriptive statistics such as mean, standard deviation, median, first quartile, third quartile, mode, minimum and maximum. The relationship between the characteristics of the respondents and the results of the above-mentioned scales was then analysed, with the assumption that the size of each group being compared must be at least 5.

STATISTICAL DATA ANALYSIS PROCEDURE

The normality of the distribution was checked using the Shapiro–Wilk *W* test and the homogeneity of variance was checked using the Levene test. In the case of the SKAR scale, both the assumption of normality of distribution and homogeneity of variance were met ($p > 0.05$), so the parametric Student's *t*-test was used. For the KompOs scale, on the other hand, the Shapiro–Wilk *W* test rejected normality in many cases, and so the non-parametric Mann–Whitney *U* test was used. In the correlation analysis, due to the significantly different from normal distribution of the age variable, the non-parametric Spearman correlation coefficient and the t-test for this coefficient were used.

RESULTS

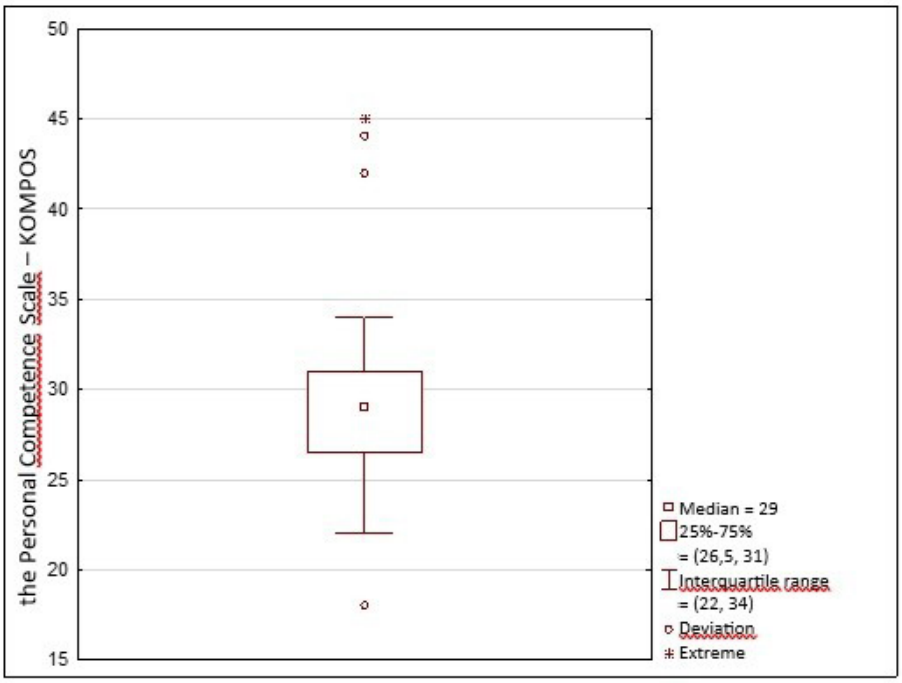
The mean total score of the KompOs scale was 29.44±5.48, while for the strength factor it was 14.0±3.36 and for the perseverance factor it was 15.44±3.51. The maximum score was 24 for the strength factor, 30 for the perseverance factor, and 54 for the total score. Referring to norms and other studies, it can be observed that in the study group the results were at a lower level. The results obtained by the respondents thus indicate a rather low sense of self-efficacy (Juczyński, 2000) (Table 4, Figure 1).

Table 4.
KompOs scale results among surveyed patients

KompOs	*M*	*SD*	*Min*	*Max*	*Me*	*Mo*	*Mo (n)*
Force factor	14.0	3.36	9.0	22.0	13.0	13.0	9
The perseverance factor	15.44	3.51	6.0	23.0	15.0	15.0	9
Overall result	29.44	5.48	18.0	45.0	29.0	Multiple	

Source: Authors' own study.

Figure 1.
Overall sense of personal competence according to the KompOs scale among the surveyed patients



Source: Authors' own study.

Table 5 shows the level of personal competence of the patients surveyed according to the KompOs scale in relation to the norms. This confirmed the findings in Table 2, because as many as two-thirds of the respondents felt that their level of personal competence was low (66.67%). A quarter of the respondents had an average level of competence (25.0%) and 8.33% had a high level of competence (Table 5).

Table 5.
Level of personal competence according to the KompOs scale among surveyed patients

Level of personal competence	*N*	%	Result	Sten
Low	24	66.67	12–30	1–4
Average	9	25.0	31–36	5–6
High	3	8.33	37–48	7–10

Source: Authors' own study.

Statistical analysis showed no significant correlation between age and the factors of stamina ($p = 0.881$), strength ($p = 0.529$) and the total score of the KompOs scale ($p = 0.564$). There were no significant differences in the strength factor according to gender ($p = 0.432$). However, men showed a slightly higher strength factor than women. Urban residents were characterised by slightly higher strength in action than rural residents. However, the differences observed were not statistically significant ($p = 0.200$). No significant differences were found in the perseverance factor according to gender ($p = 0.441$). However, it can be noted that women were slightly more persistent than men. Statistical analysis showed no significant differences in the perseverance of the respondents according to place of residence ($p = 0.506$). Urban residents showed only slightly more perseverance in action than rural residents. Gender did not significantly differentiate the overall sense of personal competence ($p = 0.962$). The results of the KompOs scale were similar in the male and female groups. The overall sense of personal competence was slightly higher among urban residents ($Me = 30.0$) than rural residents ($Me = 28.0$). However, the differences shown were statistically insignificant ($p = 0.163$).

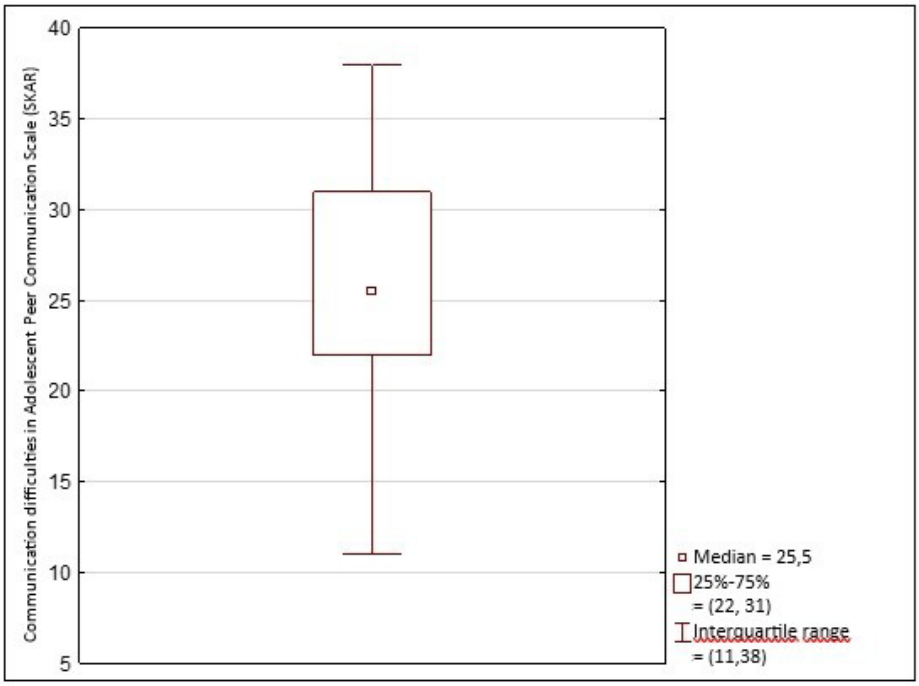
On the openness scale (SKAR), on the other hand, respondents had an average of 37.14±7.36 points, half of the patients had at least 37 points, and scores ranged from 21 to 50. The results oscillate around values above the middle of the distribution (30 points), indicating higher than average satisfaction with open communication with peers. On the communication difficulty scale, on the other hand, respondents scored between 11 and 38 points, with an average of 25.02±6.28, and half of them had at most 24.50 points. The results oscillate below the middle of the distribution (30 points), indicating lower than average difficulties in communicating with peers. The results of the SKAR scale are quite similar to those obtained so far in other studies (Napora, 2019), although when comparing them, it can be noted that the respondents were slightly less open and perceived greater difficulties in communication (Table 6, Figure 2).

Table 6.
Communication with peers according to the SKAR scale among surveyed patients

SKAR scale	*M*	*SD*	*Min*	*Max*	*Me*	*Mo*	*Mo (n)*
Openness	37.14	7.36	21.0	50.0	37.0	36.0	4
Communication difficulties	25.58	6.63	11.0	38.0	25.50	24.0	4

Source: Authors' own study.

Figure 2.
Difficulties in communication with peers according to the SKAR scale among the surveyed patients



Source: Authors' own study.

The statistical analysis of the SKAR scale showed no significant correlation between age and openness with peers (p = 0.544) and communication difficulties (p = 0.311); gender and openness with peers (p = 0.825) or place of residence (p = 0.415). Furthermore, statistical analysis showed no significant differences in communication difficulties according to gender (p = 0.415) and place of residence (p = 0.081). Urban residents had less difficulty in communicating with their peers (24.05±7.08) than rural residents (28.0±5.20).

There were also no significant correlations between sense of personal competence and communication with peers (Table 7). All Spearman correlation coefficients were positive, however their value below 0.2 indicated a weak relationship. The *t*-test confirmed that the correlation between personal competencies and communication with peers was not statistically significant in any of the analysed aspects.

Table 7.
Sense of personal competence versus communicating with peers (N = 36)

KompOs scale	Correlation with SKAR					
	Openness			Communication difficulties		
	R	*t*	*p*	*R*	*t*	*p*
Force factor	0.099	0.577	0.568	0.125	0.736	0.467
The perseverance factor	0.112	0.655	0.517	0.129	0.757	0.454
Overall result	0.181	1.070	0.292	0.169	1.002	0.324

Source: Authors' own study.

DISCUSSION

.Research on people with facial and cranial defects is of great importance. It is worth emphasising that the findings so far point to the highly individual way in which the defect is perceived by the affected person themselves.

Undoubtedly, the face is the most important part of the human body. It is responsible for externalising the emotional reactions and intentions to. It is also a source of information about the patient. "During the first contact with another person, the face is of the utmost importance. (...). Covering the face makes it difficult or even impossible to identify the other person. In interpersonal relations, unlike the rest of the body, the face remains »naked«. (...) The face is perhaps one of the most important elements in the dynamics of interpersonal relations" (Kępiński, 2002, pp. 101–102). Thus, the first important area assessed in an interpersonal relationship is the expression of a person's face. The second, equally important area, is communication, which in people with facial and craniofacial defects is also disturbed. The disturbances occur not only in the area of transmitting, where the vocal malformations characteristic of this group of patients become apparent, but additionally in people with cleft palate the resonance of the voice with its characteristic nasal colouring is disturbed as well. Due to abnormalities of the facial musculature, there are also secondary difficulties in the area of non-verbal communication and this may underlie difficulties in the area of social relationships and self-esteem (Hunt et al., 2006; Tiemens et al., 2013). Aligheri et al. (2023) analysing the results obtained in their study highlight that appearance has less influence on peer attitudes compared to speech intelligibility. The more intelligible the speaker

was, the more positive attitudes towards him or her were held by peers. Gender was found to have a significant effect on peer attitudes towards adolescents with CL±P. Boys had significantly more negative attitudes compared to girls on two attitude dimensions, i.e. the affective and behavioural dimensions (Aligheri et al., 2023). Other studies found a significantly positive correlation between speech intelligibility and attitude components. When the child was understood better, more positive attitudes were observed. A significantly negative correlation was found between perceptual ratings and all attitude components. Greater hypernasality, nasal airflow or articulatory errors resulted in more negative attitudes. Furthermore, boys and younger children may be more negative towards adolescents with cleft palate symptoms compared to girls and older children (Bettens et al. 2020). Thus, providing a regular and early (from birth) individual neuro speech therapy to a person with an facial and or craniofacial defect will be a prerequisite for progression in active speech. Authors dealing with people with craniofacial defects (Matthews-Brzosowska & Kawali, 2012; Stecko, 2002) demonstrate a cause-and-effect correlation between speech disorders, the child's overall development and the quality of his or her social interactions.

The aim of the study was to identify the correlation between age, gender and place of residence and self-efficacy and communication with peers among adolescents with craniofacial defects. Four research questions were posed:

1. What is the sense of self-efficacy in adolescents with facial and cranial defects? The group of adolescents studied in this research is characterised by low self-efficacy, suggesting that the respondents may experience difficulties in coping with challenges. The results obtained cannot be compared with others in the group of people with facial and craniofacial defects, as no research has been conducted in this area to date. Similar studies have been conducted in other groups, such as a group of boys with ADHD in early school age (Ksiądz-Gołębiowska & Oleś, 2019) and a group of junior high school pupils living in urban and rural areas (Baran & Nawalana, 2015). Self-efficacy plays an important role in achieving and setting goals. The stronger it is, the more likely a person is to cope with various difficult situations, obstacles and setbacks (Bandura, 2007; Juczyński, 2001).

2. How is the communication of adolescents with facial and craniofacial defects with their peers shaped? In our study, it was noted that the adolescents studied were characterised by higher openness in communication, and lower than average difficulties in communicating with peers. Therefore, it can be concluded that the adolescents disclosed themselves to others, thus creating a chance to establish relationships with their peers. However, the SKAR scores analysed in relation to adolescents without craniofacial defects suggest less openness and greater difficulties in peer communication in the cohort. The analysis of the results also indicated that there were no significant correlations between the sense of self-efficacy and communication with peers. The author of the scale used (Napora, 2023, pp. 11–12)

notes that participation in a peer group through communication based on openness fosters self-esteem, creates opportunities to build or organise one's own hierarchy of values, and makes it possible to take on social roles. The results of Napora's (2019) study on adolescent communication within peer groups are worth noting. They indicate greater openness in communication, while the adolescents with craniofacial defects we studied showed a lower level of openness and reported more difficulties in communication. These difficulties are likely related to communication limitations resulting from the defect.

3. Is there correlation between the following areas – the area of peer communication and the respondent's self-efficacy, and the area of the respondent's gender and their place of residence. If the correlation exists, what is it exactly? No significant differences were found in communication with peers based on the gender of the respondents or their place of residence, nor were there any differences in self-efficacy based on the gender of the respondents or their place of residence. The analysis of the available literature indicates that no studies have been conducted to date that directly address the correlation we have identified. However, there are studies that examine the relationships between children and adolescents with facial and cranial abnormalities and their healthy peers. The results of these studies are varied, but their authors emphasise an increased risk of problems in peer relationships (see Feragen et al., 2010; Pope et al., 2016).

4. Is there correlation between self-efficacy and peer communication in teenagers with facial defects and craniofacial abnormalities, and if so, what is it? The analysis of the results also indicated that there were no significant correlations between the sense of self-efficacy and communication with peers. The analysis of the available literature indicates that no studies have been conducted to date that directly address the relationship between self-efficacy and peer communication among adolescents with facial and cranial abnormalities. There are scientific studies indicating the influence of self-efficacy on the ability to perform specific activities (Schwartzer, 1997). The analysis of the results of research conducted by Erozkan (2013) indicated that communication and interpersonal problem-solving skills were found to be significantly correlated with social self-efficacy, and that communication and interpersonal problem-solving skills are important predictors of social self-efficacy.

CONCLUSION

Everyday life for a person with a facial disfigurement usually requires an above-average level of social competence and self-confidence. Therefore, it is important that those working with children and adolescents with facial deformities not only put emphasis on therapies aimed at achieving the most expressive and intelligible

speech but also encourage children and adolescents to have open dialogues about the difficulties they encounter, teach effective coping strategies and strengthen their self-esteem. Research by other authors has shown positive results from the participation of people with facial deformities in interpersonal training sessions. It is likely that participation in this type of training would minimise difficulties in social interactions, including peer interactions. The scope of the study did not include the speech intelligibility of the subjects, and this very important area of active communication and its intelligibility requires further research.

STUDY LIMITATIONS

The results of the analysis cannot be generalised due to the small group of adolescents studied. However, the data collected can provide a basis for outlining future research projects on communication of adolescents with facial and craniofacial defects with their peers and their sense of self-efficacy.

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KORELACJA MIĘDZY POCZUCIEM WŁASNEJ SKUTECZNOŚCI A KOMUNIKACJĄ RÓWIEŚNICZĄ U NASTOLATKÓW Z WADAMI TWARZOCZASZKI

Wprowadzenie: Wyniki badań nad funkcjonowaniem psychospołecznym dzieci i młodzieży z wadami twarzy i czaszki wskazują na ogólnie złożoną sytuację tej grupy. Zazwyczaj osoby te, są odrzucane, dyskryminowane, mają niską samoocenę i niskie poczucie własnej wartości. Wszystko to prowadzi do trudności w podejmowaniu i utrzymywaniu interakcji społecznych.
Cel badań: Przyjęto dwa cele badawcze: pierwszym jest identyfikacja zależności między poczuciem własnej skuteczności a komunikacją rówieśniczą u nastolatków z wadami twarzoczaszki, a drugim jest określenie wpływu wybranych zmiennych socjodemograficznych na poczucie własnej skuteczności i komunikację z rówieśnikami nastolatków z wadami twarzy i czaszki.
Metoda badań: W badaniu zastosowano następujące metody: KompOs (Skalę Kompetencji Osobistych w opracowaniu Juczyńskiego) i SKAR (Skalę Komunikacji Rówieśniczej Młodzieży Napory) oraz kwestionariusz własnej konstrukcji – ankietę.
Wyniki: Wyniki w SKAR sugerują, że respondenci wykazali się nieznacznie niższą otwartością, jednocześnie odczuwając większe trudności w komunikacji. W przeprowadzonych badaniach zmienne (wiek, płeć, miejsce zamieszkania) nie różnicują istotnie ogólnego poczucia własnej skuteczności. Nie stwierdzono istotnych korelacji między poczuciem własnej skuteczności a komunikacją między nastolatkami z defektami twarzy i czaszki a ich rówieśnikami.
Wnioski: Zaprezentowane wyniki badań mogą stanowić podstawę do zaprojektowania przyszłych badań w zakresie komunikacji nastolatków z defektami twarzy i twarzoczaszki w grupie rówieśniczej i ich poczucia własnej skuteczności. Badania przeprowadzone dotychczas w tym obszarze wykazały pozytywne rezultaty uczestnictwa osób z tego typu defektem w treningu interpersonalnym.

Słowa kluczowe: młodzież z wadami twarzoczaszki, poczucie własnej skuteczności, komunikacja rówieśnicza