Family Forum 2022
DOI: 10.25167/FF/4875

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Alcoholism as a way of dealing with emotions and transformation in relational family therapy[1]

Abstract

Alcoholism, which is a major public health and social problem, can be viewed from several perspectives, as its occurrence is a multifaceted phenomenon in terms of its development (causes), effects, and maintenance. The Relational Family Therapy paradigm looks at alcoholism and its dynamics in relation to dysfunctional affect regulation. Dysfunctional affect regulation and the general inability to manage emotions are often mentioned in relation to the development and maintenance of alcohol addiction. The mechanism of affect regulation generally refers to internal processes that allow an individual to maintain their emotions to a degree that feels still bearable for them. According to these assumptions, alcoholics drink in order to cope with difficult emotions, either because they have more negative emotional states than others do, or because they lack the internal resources to cope with these negative emotions. For them, consuming alcohol is a series of repeated attempts to regulate heavy emotions, which often stem from painful past experiences. The process of Relational Family Therapy, therefore, as treatment of addiction, focuses on identifying and transforming the dysfunctional regulation of affect, which is behind

[1] The results were partly obtained within the project No. J5-2570, financed by the Public Agency for Research of the Republic of Slovenia from the state budget.

addictive behavior. By means of action research methodology, this paper presents the approach of Relational Family Therapy in working with an alcoholic client, with an emphasis on the aspects of affect regulation. We show how the client's alcohol use appeared as a dynamic of inappropriate regulation of a painful core affect. In the process of Relational Family Therapy, a more functional regulation of the core affect was established, thereby reducing symptomatic behavior (alcoholism) in the client.

Keywords: addiction, alcohol, psychotherapy, affect regulation, family life

Introduction

Alcoholism is a phenomenon that permeates multiple dimensions of life. Alcohol is the most common and most abused drug in our socio-cultural environment. Its abuse is a major public health and social problem, and the consequences of its harmful use affect the individual (e.g. poor well-being, deterioration of health, problems in relationships and at work, traffic and other accidents), his family (e.g. worse relationships or violence, mental health problems in children and other loved ones), the wider environment (problems at the workplace, conflicts in relationships, misunderstanding, crime) and society (worse health of the population, premature deaths, loss of income due to reduced efficiency, costs of medical treatment and healing, costs of police work (Kober, 2013, p. 428; Solis et al., 2012, p. 136; VanGeest, Johnson and Alemagno, 2017, pp. 3-4).

Repeated harmful use of substances leads to an addiction syndrome characterized by behavioral, cognitive, and psychological symptoms. These include a strong need for the substance, difficulty in controlling its use, continued use of the substance despite harmful effects, prioritizing the substance over other obligations and activities, increased tolerance (more and more of the substance is needed for the same effect), and sometimes withdrawal symptoms (World Health Organization, 2016, pp. 289-291). The fundamental trait of alcoholism is dependence on or addiction to alcohol. Addiction is a chronic disease of the brain, as it reshapes the brain and consequently changes the individual's personality (Ashok, 2021, p. 4-18; Urschel, 2009, p. 5). Alcoholism affects one's physical and mental health, as well as their functioning in society and in relationships. The consequences of alcoholism are therefore multifaceted.

1. Alcohol addiction and family life

Alcoholism often has devastating consequences for the entire family system. Alcohol abuse by parents can have a long-term impact on the intimate couple relationship as well as on the children. Compared to non-alcoholic families, alcoholic families have a higher level of conflict, combativeness, accusations, and antagonisms, and a lower level of connection and family closeness. Lower levels of physical and verbal expression of positive emotions, and less emotional support, warmth, and care among family members are reported (Johannessen et al., 2022, 1-3; Mayshak et al., 2022, pp. 2-5; Rangarajan and Kelley, 2006, p. 657; Vernig, 2011, p. 535). Alcoholic families are usually poorly differentiated. Because of high tension, their members are often worried, they adapt and react to the behavior of the alcoholic, there is no possibility for their autonomous development, and their self-image is markedly negative (Crespi and Rueckert, 2006, pp. 36-37). Excessive drinking and alcohol addiction have a negative impact on satisfaction and stability in marriage. Partners of alcoholics experience more marital stress, more physical and psychological abuse, and divorce is common (Leonard and Eiden, 2007, p. 285), which also affects children.

Pronounced alcohol use by a parent significantly increases the risk that they will be abusive towards the child in some way. The more members in the family who abuse or are addicted to alcohol, the more likely the children in the family will be abused or neglected (Gold and Adamec, 2010, p. 153). The risk that the child will become a problem drinker in adulthood also increases significantly, which is confirmed by the results of studies on troublesome childhood experiences, which often occur in families with alcoholic parents (Caan, 2013, p. 11). Parental alcoholism also greatly increases the chance that the offspring will develop some form of mental disorder (McLaughlin et al., 2012, p. 291). Children of alcoholics often show several behavioral problems, e.g. delinquency, addictive behavior, resistance to social norms (Caan, 2013, p. 12), as well as poorer cognitive functioning and academic achievements (Khemiri, 2022, p. 757; Solis et al., 2012, pp. 137-139). Many families affected by parental drinking thus suffer extreme damage that is either obvious or occurs in more indirect forms (Marshal, 2002, p. 88).

2. Alcoholism as affect regulation

Alcoholism can be observed from several perspectives (e.g. biological, medical, economic, criminological, moral, educational, social, and psychological), since its incidence, as far as development (causes), effects and maintenance are

concerned, is a multifaceted phenomenon (Reingle Gonzalez and Akers, 2017, pp. 28-29). There are many reasons for the emergence and maintenance of addiction (to alcohol), but it is usually a combination of biological, environmental, and social factors. There are different ways of classifying addiction theories and models that help us understand addiction, its origin, and its development. In professional literature, the moral, physiological, sociological, and psychological models are most often used (Jerebic and Jerebic, 2012, p. 297). From a psychological point of view, alcoholism is perceived as a mental disorder manifested by signs such as reduced awareness, distorted experience and perception of the world and relationships, and inappropriate behavior (American Psychiatric Association, 2013, pp. 490-491).

A common trait of all forms of addictive behavior, which also accompanies alcoholism, is that an individual who is addicted to certain activities or substances feels strong tension, anxiety, and adrenaline before indulging in these activities or substances, and after consuming / performing them, they feel happy, satisfied, and calm. This relief, however, is only temporary, as the result of intoxication with behaviors - just like with chemical substances, such as drugs, alcohol, cigarettes, etc. - is the impaired quality of life. The individual begins to lose control and to achieve ecstasy, they need more and more, which is accompanied by specific chemical dynamics in the brain systems for reward, motivation, and memory (Petit et al., 2015, p. 2472). A fundamental psychological mechanism behind the development and maintenance of such addictive behavior is the understanding of addiction as a means or model of coping with pain, sadness, defeat, distress, and problems in the family and wider society (Simonič, Poljanec and Katona, 2013, pp. 273-276).

Psychological, i.e. emotional background of addiction is quite complex. Dysfunctions of affect regulation and the inability to manage emotions are often mentioned in relation to the development and maintenance of alcohol addiction. Lack of adequate emotional regulation is thus often considered a central theme of alcohol addiction and a primary reason for alcohol abuse (Kober, 2014, pp. 430-434; Sher and Grekin, 2007, p. 560). Alcoholism or other forms of addiction are unconsciously used to help addicts regulate their affect (Emery and Simons, 2020, 2558-1559). The mechanism of affect regulation, which poses a problem for addicts, generally refers to internal processes that allow the individual to maintain emotions to a degree that is still bearable for them (Dermody, Cheong and Manuck, 2013, pp. 297-298). Effective emotional regulation is often understood as a necessary condition for optimal social functioning, and in the case of alcoholism, it is at least partially related to successful alcoholism treatment (Petit et al., 2015, p. 2471).

Many studies on the motives of drinking confirm that the abuse of alcohol basically serves two motives: it reduces negative feelings in the individual and stimulates positive feelings (Kober, 2014, pp. 429-430; Jakubczyk et al., 2018, p. 49; Petit et al., 2015, pp. 2471-2472). The results of these studies show that people who are prone to negative affectivity (e.g. negative feelings, neuroticism, negative mood, and poor coping strategies) use alcohol more often in order to cope with a negative mood more easily. They do this to cover up fears, shame, anxiety, and other negative emotions. Individuals thus "self-medicate" with alcohol in order to reduce discomfort, distress, and especially anxiety, since alcohol acts as an anxiolytic (Sayette, 2017, p. 79). Alcohol also offers a short-term solution to the fear of closeness, insecurity in a relationship, to conflicts that the individual cannot resolve alone (Gostečnik et al., 2010, pp. 364-365). Addiction can thus be understood as a defense mechanism of escape and defense, where the person is not able to face their emotions, become aware of them, understand them and accept them, but instead fears or rejects them and thus avoids them.

According to these assumptions, alcoholics drink in order to cope with difficult emotions, either because they experience more negative emotional states than others do, or because they lack functional internal resources to cope with these negative emotions. Drinking alcohol is a series of repeated attempts to regulate difficult emotional states (Dermody, Cheong and Manuck, 2013, p. 297), and this turns into addiction at the biological level.

3. Relational Family Therapy and treatment of alcoholism

The Relational Family Therapy (RFT) paradigm also understands alcoholism and its dynamics as a form of dysfunctional affect regulation. This being said, it is also aware of other factors that influence the occurrence of alcoholism in an individual, e.g. biological or sociocultural (e.g. how much alcohol drinking is tolerated in respective cultures). Scientific achievements in the field of various mental and relational disorders in recent decades indicate that, in addition to biological factors (e.g. hereditary genetic predisposition), the so-called non-genetic inheritance that is transmitted from generation to generation through behavior and can even override a genetic predisposition to anxiety, excessive emotionality or stress reactivity, can be instrumental in the emergence of the disorder (Erzar, 2007, pp. 52-56). Negative patterns of perception and behavior, including the pattern of affect regulation, are largely brought by the individual from their family of origin and past experiences.

Although, as mentioned, other factors are important, from the perspective of RFT, the core of an alcoholic's addictive behavior is certainly the dysfunctional regulation of emotional and affective states. Individuals who are addicted, as well as their relatives, during the period of addiction as well as when they recover, therefore face situations where they need help to profoundly transform their emotional patterns, relationships, and attitude. In the field of helping alcoholics and their families, there are many different techniques, counseling methods, and approaches, which often only allow resolution on a more superficial level. Namely, there are not enough opportunities for in-depth addressing and processing of all the dynamics and emotional states that are in the background of alcoholism, with either the individual or their relatives. This is exactly what the modern relational psychotherapy paradigm, which also includes the RFT model (Gostečnik, 2011; 2017), emphasizes: unresolved psychological contents, which are also neurobiologically inscribed in our body, occur in various symptomatic and often dysfunctional behaviors (such as addiction). Through the mechanisms of projection and introjection identification (transference and countertransference), RTD penetrates into the unconscious memory and thus, by bringing it into consciousness, helps to regulate the individual's psychobiological states and the affects that arise from these states.

RFT is a theoretical and clinical therapeutic model that integrates aspects of general system theory with relational psychoanalytic models, including object-relational theory, self-psychology, and interpersonal analysis, as well as contemporary insights from neurobiology and attachment theory. With the RFT model, we aim at identifying and shedding light on pathological relationships to see which periods in the past such patterns stem from, why they are so difficult to change, and how they could be understood and changed or upgraded to become more functional. In its approach, RFT takes into account relational mechanisms and dynamics (projection identification and compulsive repetition) that drive certain relationships, and it also tries to discover the affective psychic construct and, after that, the core affect that underlies all subsequent relationships. The core affect represents the atmosphere to which all relationships are tuned (Gostečnik, 2017, pp. 39-40). Only at the level of mutual affect (the core pain), which drives the entire system of relationships and experiences and establishing contact with new people, is the core of dysfunctional and pathological connections revealed. This is where the psychic construct was created, by means of which family members defend themselves against the pain of mutual affect and is a driver of dysfunctional affect regulation (Gostečnik, 2017, pp. 40-43).

In the treatment of alcoholism and addiction in general, RFT attempts to go deeper, not only to remove the symptoms (abstinence) but to ensure a holistic

treatment of the person, their patterns, and the dynamics in which he is entangled. Stopping drinking and thus addiction is a necessary but not a sufficient condition for better family and other interpersonal relationships. Therefore, for individuals who no longer drink, as well as for other members of their families, expedient and effective support in the process of treatment and recovery is the psychotherapeutic process, where it is possible to more deeply address topics that they have inadvertently avoided until now. Thus, successful therapeutic processing also includes an in-depth insight into the relationships in which the individual is involved, including intergenerational emotional transfers (Gostečnik, 2011, pp. 11-62; 2017, pp. 5-38). After the addiction processes are stopped, many families are faced with a void that they often cannot efficiently cope with. This emptiness must be filled with new knowledge, awareness of and handling of their feelings, new skills, activities, and fuller relationships. In addition, with abstinence, many painful topics begin to open up, of which the individual is now aware and has the opportunity to talk about (Simonič, Poljanec and Katona, 2013, p. 273). In other words, appropriate regulation of affect must be established which is also the goal of therapy.

The goal of the therapeutic process is to enable and strengthen the appropriate and functional regulation of painful affects, which until now have been regulated by addictive behavior. Alcoholics often suffer from internal distress that they cannot deal with in an appropriate way. Intoxication brings oblivion and temporary liberation, as it enables an escape from difficult feelings (core affects). This distress may stem from current or past stressful situations that are or were usually accompanied by difficult and traumatic relationships. A person who is not able to deal with this effectively finds in alcohol on an unconscious level a world where they do not need to think and feel pain, sadness, incompetence, and defeat. In this way, alcohol offers false reassurance, which also leads to physical addiction (Gostečnik et al., 2010, pp. 369-371). Thus, a person who initially saw alcohol as fun, relaxation, or a way to cope with problems may begin to experience distress when they realize they are addicted, a fact that awakens a great deal of shame, guilt, and feelings of helplessness, which are again difficult to face, which can be an additional reason for drinking (Gostečnik, 2003, p. 19). Alcoholism thus represents a continuous escape that has no end in sight, because if the individual is not aware of the feelings, there is always the possibility of returning to a dysfunctional and low-quality way of life, e.g. relapse, emotional alienation, violence, etc. As we have already mentioned, the recognition of unconscious feelings is the key to their regulation (Gostečnik, 2017, pp. 45-50; Schore, 2003, pp. 27-32; Stern, 2004, pp. 221-222), and this opens up possibilities for better, quality relationships and healthy life.

4. Transforming affect regulation in an alcoholic client in Relational Family Therapy: A case study through action research

In the following, we will present an example of transforming and establishing appropriate regulation of affect in marital psychotherapy with a couple with an alcoholic husband. With the help of the action research method, we investigated the part of the therapeutic process where a change occurred in the dynamics and functioning of the couple and the change was mainly based on the establishment of more appropriate affect regulation.

4.1. Action research approach

Action research that is often used in health care (medicine, nursing), education, social work, and family science, is an approach that can also be used in psychotherapy. There are some descriptions of different approaches to action research (Mendenhall and Doherty, 2005). We recognize the description given by Cvetek and colleagues (2011) as particularly suitable for exploring psychotherapy as a process, especially the process of change during therapy. In this action research, the researcher focuses on researching the creation of change in the phenomenon he is researching - which is not usually the case with other research methods (Koshy, Koshy and Waterman, 2011, p. 2). Since psychotherapy is also concerned with creating change in the family, this kind of research methodology is very suitable for studying the practice of psychotherapy. The nature of action research and psychotherapy are both idiosyncratic and contextually dependent. So such action research is close to therapeutic practice; is problem-focused, involves change, and aims at improvement (Cvetek, Cvetek and Gostečnik, 2008, p. 40).

In action research, the researcher examines the family system through action. It aims to solve current practical problems (taking actions) while expanding scientific knowledge (theory about that actions) (Styhre and Sundgren, 2005, p. 54). "Action research is a group activity with an explicit value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem-identification, planning, action, and evaluation are interlinked. Knowledge may be advanced through reflection and research, and qualitative and quantitative research methods may be employed to collect data." (Waterman et al., 2001, p. 4)

Different types of action research emphasize different characteristics. For example, some action researches emphasize a collaborative stance between

researchers and participants in all stages of action research and local community involvement (Koshy, Koshy and Waterman, 2011, p. 13). However, one of the most common types of action research uses repeating cycles of the four basic steps. Most action researchers agree that action research consists of repeating cycles of (1) observing and gathering information (also called analysis, fact-finding, evaluation, problem identification), (2) reflecting (conceptualization, diagnosis), (3) planning, and (4) acting or intervening (Cassell and Johnson, 2006, p. 784; Melrose, 2001, p. 166; Cvetek, Cvetek and Gostečnik, 2008, p. 40; Cvetek et al., 2011, p. 52).

Cvetek, Cvetek and Gostečnik (2008) and Cvetek and colleagues (2011) adapted these four repeated phases of action research for research in a specific therapeutic situation:

Step 1. Observing and gathering information

In this step, therapist (or research team) describes and defines (usually after the therapy session) what has happened, what the current situation is (what the problem is), and what the context is. Within the therapeutic process, that means the description of the client system, previous actions and outcomes, expectations of previous actions, and possible differences between expectations and outcomes. Different types of important data can be presented: transcripts of therapy sessions, information from clients and family members, results of questionnaires, scales and observations, etc. (Cvetek, Cvetek and Gostečnik, 2008, p. 41; Cvetek et al., 2011, pp. 52-53).

Step 2. Reflecting

In this phase of action research, information from the first phase are interpreted, analyzed, and explained. We can find an appropriate theory to explain the problem. Outcomes of previous activities are evaluated as well. Further insights about therapy, relations, clients themselves, etc. from previous cycles are exposed. Supervision, intervision, consultation with colleagues, focus groups, selfreflective notes, and study of professional literature are helpful in this phase (Cvetek, Cvetek and Gostečnik, 2008, p. 41; Cvetek et al., 2011, pp. 53-54).

Step 3. Planning

At this stage, the therapist identifies the need for change, the possible direction of the change, and possible solutions for identified problem. It is helpful

to define the outcomes the therapist is hoping to achieve in the next therapy session and why she/he believes they are worth pursuing. The therapist also defines actions that could lead to desired outcomes (Cvetek, Cvetek and Gostečnik, 2008, p. 41; Cvetek et al., 2011, pp. 54-55).

Step 4. Acting

In this stage, planned activities (usually in the therapy session) are carried out.

It is important to note that the described four phases of action research are only one cycle of action research. The cycle is usually repeated until the problem is (hopefully) solved to the desired solution. The repeating cycles are seen as a specific value of described action research methodology for psychotherapy or family therapy (Cvetek, Cvetek and Gostečnik, 2008, p. 41; Cvetek et al., 2011, pp. 55-56). Cvetek and colleagues (2011, p. 51) also emphasize that this cycle of four steps or phases can be used in different manners: one cycle for one therapy session (most promising), one cycle for a set of therapy sessions, a cycle of action research when therapy faces important challenges, etc.

4.2. Transformation of affect regulation in the therapeutic process

We researched the therapeutic process by action by conducting one cycle of action research for each session, i.e. 12 cycles with four steps (observing and gathering information – reflecting – planning – acting). By means of a four steps cycle of action research, we will present a part of the therapeutic process (the fifth and sixth therapy session), where changes in affect regulation could be detected and (in our opinion) the most important interventions took place.

The treatment according to the RFT model, which the couple began due to the husband's alcoholism, took place for 3 months (12 sessions of 1 hour each). Both clients were informed and agreed (signed informed consent) to the collection of data for the analysis / research of the therapeutic process. In doing so, they were guaranteed respect for all aspects of the ethical principles of research and treatment. The data were collected based on the therapist's notes of the therapy sessions and the audio recordings of the sessions. In addition, the clients filled out questionnaires that enable the evaluation of various aspects of experience and functioning and thus the possibility to monitor changes in the therapeutic process: Scales of the STIC instrument (Systemic Therapy Inventory of Change) (Pinsof et al., 2015) and Instrument for evaluation and monitoring of patients (symptoms of psychopathology according to DSM V-TR) of American Psychiat-

ric Association (2013). They filled out the questionnaires at the beginning of the process (after the first session), in the middle (after the sixth session), and at the end of the therapeutic process (after the twelfth session).

- *Step 1 (Observing and gathering information) of one cycle action research of psychotherapeutic process with an alcoholic client*

As in every session, at the end of the fifth and before the start of the sixth session, the therapist performed session observing. The couple began psychotherapy treatment because of the husband's alcoholism. They were married for 28 years. The husband was 55 years old at the time of treatment and the wife was 51 years old. Alcoholism was present in the husband from the very beginning of the relationship, but over the years it developed into addiction. He had already undergone medical treatment, but he had relapses, especially in his moments of weakness, as he reported high levels of anxiety. Based on the data gathered so far, it was obvious that he used alcohol as a way of regulating psychological distress: drinking helped him endure it. The source of his distress were mainly complications in his business, which increased especially with the unpredictable situation due to the Covid-19 epidemic; there were also problems in his marriage where the spouses experienced many conflicts, estrangement, mistrust, and loneliness. The husband was not able to face challenges, as he also had very poor self-esteem and a strong sense of inferiority, which had followed him since his childhood. He felt that he was incapable of doing anything right and that the easier solution to this anxiety and the feeling of entrapment was to retreat to intoxication. Because of this, his wife suffered deeply but still wanted to do something to save the relationship. She felt, however, that the solution did not only depend on her and that especially the husband needed support. The husband's wounded self-image presumably originated from his childhood, when he lived with an extremely demanding and unyielding father, who was himself an alcoholic. The client took over the business from him but (according to the information obtained from the client) received no approval from his father, who did not trust him to be able to manage anything. He was rude, insulting, and even intentionally detrimental. He always let his son know that he was not satisfied with him, he was never proud of him, and he was always criticizing and contemptuous. Nothing the son did was ever good. The client reported that he never got real approval from anyone (even the mother was emotionally absent and herself the recipient of her husband's criticism and rudeness) and did not build self-confidence, so lingering in his very core were the feelings of incompetence, helplessness, a feeling that

he was a loser and that he knew nothing. At the beginning of the treatment, the clients filled out questionnaires that showed that the husband had a high level of depression and anxiety, a low level of self-acceptance, and both had a rather low level of marriage satisfaction.

- *Step 2 (Reflecting) of one cycle action research of psychotherapeutic process with an alcoholic client*

Based on the aspects revealed in the first five sessions and defined in Step 1, the therapist made an individual and supervisory reflection of the events according to the RFT paradigm. This paradigm sees complications on the systemic, interpersonal, and intrapsychic levels of the client's experience as an echo of unresolved and unregulated painful affects originating from past relationships or traumas, especially in the earliest periods of life. The client's dysfunctional patterns were constantly repeated (when faced with a challenge, he reacted on the belief that he was incapable, knew nothing, and was useless, his levels of anxiety were high, and he regulated it with alcohol), which showed that this was a construct that had been built on some deeper foundations. These were not only cognitive but were driven by unprocessed or improperly regulated pain that was the basis for a distorted reality. For the client, anxiety seemed to be a "safer" state for facing challenges than effective action, which required risk and exposure.

- *Step 3 (Planning) of one cycle action research of psychotherapeutic process with an alcoholic client:*

Based on reflection and processing with his supervisor, the therapist decided on a strategy that would make it possible to remove these repressed aspects, address the pain, and establish a more appropriate regulation of painful affects. Until then, this was not possible, as most therapeutic interventions were aimed at establishing abstinence and regulating the intimate couple relationship, which after the fourth session seemed more stable and calmer, but under the surface, emotional energy was still felt that was sabotaging longer-term balance. Still, it felt safe enough to address deeper wounds and heavier emotions. The therapist planned a compassionate conversation about the client's childhood experiences, especially with his father, in an attempt to uncover the unprocessed and painful affects that drove the client's later dysfunctional patterns of behavior, thinking, and feeling.

- *Step 4 (Acting) of one cycle action research of psychotherapeutic process with an alcoholic client:*

During the sixth session, the therapist talked with the client, in the presence of his wife, about his feelings of inferiority and incompetence and connected this experience with the client's experience with his father. Researching these experiences has awakened a lot of bitterness, anger, as well as sadness. The client realized that in the past, as a child, he had no other option but to "believe" what his father told him, and that anxiety is built on this feeling of incompetence, which is a logical reaction when one feels trapped and helpless. As an adult, he was able to understand that his father had his reasons for such behavior (he was a bitter and disaffected man) and that as a child and young man he was not incompetent: he had been only a target of his father's projections and dissatisfaction that originated from somewhere else. With realizing this, he was able to demarcate reality from the construct: he was not incompetent, powerless, lousy, or inferior; he just believed he was. The sadness that was awakened by this realization also indicated a desire for tenderness, acceptance, and validation, which he had not received in his primary family and still did not allow himself in his current family and with his wife. This reduced his anxiety and opened up a space of vulnerability, where it was possible to build mutual trust and connection, then and in the continuation of the therapeutic process. The change in the therapeutic process was also confirmed by the results of the intermediate (after the sixth session) and the final questionnaire, as the average score of anxiety, depression, and self-acceptance decreased, while marital satisfaction also increased. Maintaining abstinence stabilized as well.

4.3 Discussion

The description of the case shows that the client, who had problems with alcoholism, had many psychological complications, which were characterized by emotional pain. He was trapped in the patterns of anxiety based on the feelings of unworthiness and incompetence. In the treatment, it turned out that he had always had these feelings, not only at the time when he succumbed to addiction. Already in childhood, he began to feel that he was incapable and worthless, and this belief had accompanied him throughout his life. This was also strongly reflected in his daily functioning; whenever faced with challenges he felt that he was not good enough to be able to deal with them effectively, and he experienced a lot of anxiety. When alcohol entered this "story", he found himself in a vicious circle of compulsive repetition of dysfunctional behavior and emotions. On the one hand, alcohol at least temporarily helped him reduce (regulate) his anxiety

and function effectively, but on the other hand, the awareness that he was an alcoholic only deepened his sense of incompetence and inferiority, which further fueled his anxiety.

From the RFT point of view, in such dynamics of compulsive repetition of dysfunctional behavior (affective psychic construct), we can recognize attempts to regulate painful psychicological contents (regulation of core affect) (Gostečnik, 2011, pp. 65-66; Gostečnik et al., 2010, p. 371), which, however, in the case of our client was not functional. Relational Family Therapy model assumes that the regulation of the core affect that produces the affective psychic construct maintains the dysfunctionality of the entire system. Affective psychic constructs are reflected in various symptoms, which are a compromise to conceal painful affects. In the background of the construct can be the affects of anger, shame, fear, sadness, etc., which are repeated in the current situation, but can have their roots elsewhere and have been transferred to the current life and relationships from situations that had been notably different (Gostečnik, 2011, pp. 10-11).

In the treatment, before the cycle of action research we described above, the client, with the help of the therapist and the appropriate addressing of the processes, recognized how these processes are interconnected. However, change was not possible until he emotionally entered the background of his experiencing of incompetence and inferiority, which occurred during a therapeutic intervention in the sixth session. These feelings originated from his early childhood, when he was a target of constant criticism, non-recognition, and rejection from his parents, especially his father. When he was faced with these memories, a lot of sadness arose, because as a child he constantly longed for recognition, validation, and love. He never gave up hope that one day he might get the feeling that his parents loved him, but it never happened. He kept trying in various ways, but he never got approval. The belief that something was wrong with him, that he was truly incompetent, was confirmed to him over and over again, which he constantly felt even in adulthood. This feeling has unconsciously become even somehow familiar and felt safe, almost like a comfort zone from which it is dangerous to step and take risks, because it may turn out that he is truly incompetent and a total loser.

We thus assume that the painful core affect, in this case, was sadness, with which the client was not properly connected. The core affect, which is created based on the primary relationship with parents and significant others at an early age, represents the constitutive primary relationship and is always unconsciously looking for similar people and situations in which it can develop and act out again, with the unconscious hope that this time in a new situation, with new people, functional regulation of even painful affects can be achieved (Gostečnik, 2011,

pp. 63-64). In the background of complications in the client's life, therefore also his alcoholism, there was a core affect of sadness, which the client was not aware of, but dysfunctionally regulated it with these strategies (affective psychic construct). In addition to the affect of sadness, Relational Family Therapy is familiar with 5 core affects: fear, shame, disgust, anger and joy. As these are painful contents (apart from joy), they are difficult for the individual to cope with. Therefore, defensive reactions (affective psychic constructs) develop that allow escape from these contents. Alcoholism (or any other form of addiction) can also be a dysfunctional way to cope with these affects (Gostečnik et al., 2010, pp. 366-371).

When, in the therapeutic process, the client was able to connect the aspects of incompetence and unworthiness with sadness, which was something new for him, possibilities for different affect regulation opened up. When he got in touch with his grief, which also required a certain experience of self-compassion in therapy, he was able to feel the core of his pain and understand that reality was not as he had been perceiving it. He realized that he was deprived of what should have belonged to him as a child, but his parents were unable to give it to him because of their own hardships, not because there was anything wrong with him. Connection with grief led him to mourn safely for what should have belonged to him but he did not get. Consequently, he was able to begin creating a different self-image. He felt that as an adult he can give credit to and believe in himself and that the feeling of incompetence and unworthiness is just a feeling, not the truth. With this connection with the core affect, a starting point (different affect regulation) was established, where his self-perception was no longer based on incompetence and anxiety, which he partially regulated with alcohol.

5. Conclusion

The example we presented shows how in the background of symptomatic behavior such as alcoholism, there are also unconscious painful psychological contents that force the individual to feel, think and behave in a way that is not always functional. The purpose of such a method (including alcoholism) is assumed to be related to the regulation of psychological pain or tension. Therefore, in the case of complications that are manifested with various symptoms (e.g. addiction, conflicts in relationships, depression, anxiety, violence, etc.), it makes sense to examine what in this psychological depth directs such issues and to process them accordingly. RFT aims at discovering the primary constitutive affective relationships that make up the psychological structure of an individual because of which the latter repeatedly seeks and creates them. These affective

aspects related to mental and somatic contents are reflected in psychological complications at the intrapsychic, interpersonal and systemic level of the individual's functioning and configure their psychological and relational space. RFT examines and reveals where a certain problem has its roots, what justifies specific regulatory strategies, and seeks a way that would enable a concrete resolution of the dysfunctional regulation of painful core affects (Gostečnik, 2011, pp. 74-77).

Data wpłynięcia: 2022-09-01;
Data uzyskania pozytywnych recenzji: 2022-12-15;
Data przesłania do druku: 2022-12-30.

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