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Emotionality of people with alcohol problem

A comparison of patients starting therapy with patients after six months of therapy

Emocjonalność osób z problemem alkoholowym. Porównanie pacjentów rozpoczynających terapię i pacjentów po sześciu miesiącach terapii

SUMMARY

Objective. The aim of the study was to compare the emotionality of two groups of patients with alcohol problems – those who have just started therapy and patients after 6 months of therapy.

Participants. The research was transversal. Each group of patients consisted of 40 people. In each group the proportion of women to men was approx. 1:2 (women constituted 36.25% of the total number of respondents).

Method. Three research tools were used: the UMACL Mood Scale, the DINEMO Two-Dimensional Emotional Intelligence Inventory, and the Reality of Feelings Questionnaire (RU-04).

Results. There were no significant differences with regard to current mood in any of the three dimensions. On the other hand, significant differences with regard to emotional intelligence were found; however, contrary to expectations, they were in favor of patients starting the therapy ($t = 2.62$, $p = 0.011$). In patients who remained in therapy for at least 6 months, a greater intensity of personality-specific feelings was found – both negative ($t = -2.09$; $p = 0.04$) and (at the trend level) positive ($t = -1.49$; $p = 0.14$). A similar tendency occurred also with regard to many personality-nonspecific feelings, such as jealousy, optimism, sadness, or sense of security.

Conclusion. It should be assumed that after a few months of therapy, patients experience a gradual thawing of feelings, especially the negative ones, and a related dete-

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rioration of well-being. It is a desirable process as it shows an improvement in contact with one's own feelings, even though by patients it is perceived rather as a discomfort and a lack of progress in therapy.

Key words: patients with alcohol use disorders, emotional intelligence, UMACL, reality of feelings

STRESZCZENIE

Cel. Celem pracy było porównanie emocjonalności dwóch grup pacjentów z problemem alkoholowym – rozpoczynających terapię oraz pacjentów po 6 miesiącach terapii.

Metoda i osoby badane. Badania miały charakter poprzeczny. Każda z grup pacjentów liczyła po 40 osób. W każdej z grup proporcja kobiet do mężczyzn wynosiła ok. 1:2 (kobiety stanowiły 36,25% ogółu badanych osób). Wykorzystano 3 narzędzia badawcze: Skalę Nastroju UMACL, Dwuwymiarowy Inwentarz Inteligencji Emocjonalnej DINEMO oraz Kwestionariusz Realność Uczuć (RU-04).

Wyniki. Nie odnotowano istotnych różnic w odniesieniu do aktualnego nastroju w żadnym z trzech wymiarów. Odnotowano natomiast istotną różnicę w odniesieniu do inteligencji emocjonalnej, tyle że – wbrew oczekiwaniom – na korzyść pacjentów rozpoczynających terapię ($t = 2{,}62$, $p = 0{,}011$). U pacjentów pozostających w terapii co najmniej 6 miesięcy stwierdzono z kolei większą intensywność uczuć osobowościowo specyficznych – tak negatywnych ($t = -2{,}09$; $p = 0{,}04$), jak i (na poziomie trendu) pozytywnych ($t = -1{,}49$; $p = 0{,}14$). Analogiczna tendencja wystąpiła też w odniesieniu do wielu uczuć osobowościowo niespecyficznych, takich, jak np. *zazdrość, optymizm, smutek* czy *poczucie bezpieczeństwa*.

Wnioski. Należy sądzić, że po kilku miesiącach terapii u pacjentów następuje stopniowe odmrażanie uczuć, zwłaszcza tych negatywnych i związane z tym pogorszenie samopoczucia. Jest to proces pożądany, gdyż świadczy o poprawie kontaktu z własnymi uczuciami, choć przez pacjentów bywa odczuwany raczej jako dyskomfort i brak postępów w terapii.

Słowa kluczowe: pacjenci z problemem alkoholowym, inteligencja emocjonalna, UMACL, realność uczuć

Introduction

Alcohol addiction is sometimes called a 'feelings disease'. It is hard to disagree with it. In therapy a considerable amount of time and focus is devoted to the domain of feelings and emotions. Emotionality is an area that is particularly susceptible to serious deterioration due to alcohol abuse. An addict, when sober, usually has no idea how to cope with his or her problems. At the same time the feelings that appear seem strange, terrifying even. Finding relief in drinking is much easier than allowing oneself to fully experience the emotions, and deal with them constructively.

It is natural for humans to strive for pleasurable states, and to avoid the unpleasant ones, or to overcome or at least alleviate them as fast as possible when they happen. However, if one resorts to alcohol as a means of manipulating feelings, one's emotional life becomes unstable. Many people discover that alcohol allows them to affect unpleasant experiences, and change them to pleasurable states; thus becoming a source of relief. In time, the unpleasant state becomes a harbinger of relief. The relief, which is caused by alcohol, turns into something pleasant, and desired for. Prolonged alcohol abuse raises the reactivity threshold, and causes daily routine

to become insufferable, which conduces to manipulating one's emotions. When it occurs, monotony may spark anxiety, and the person experiencing it may seek to change the state. As a result of addiction, alcohol becomes the major cause of emotional lability, causing the addicted person to lose access to very important information. Such person becomes increasingly more isolated from his or her environment; his or her natural bond with the world and one's Self is severed (Mellibruda, Sobolewska-Mellibruda, 2011). The life of an addicted person starts to revolve around soothing the unpleasant emotional states as this is the source of relief and pleasure. Such individual may even resort to causing such states in order to provide themselves with a rationale to have a drink.

It is worth noting that as opposed to somatic disorders that are accompanied by pain or regular discomfort driving an individual to consult a healthcare professional – or, in general, to seek help – the borderline between using and pathologic abusing alcohol is heavily blurred. It easily eludes the social environment's grasp, and is nearly impossible to be noticed by the individual in question. Another important issue is the fact that in the Euro-American culture alcohol consumption is accepted, sometimes even desired, on many occasions, and the ubiquity of beer commercials is enough to make one's head spin. As a consequence of the fact, the individuals who enter therapy – and do so mostly because of being pressured by family or friends – are usually heavily addicted. Let us review, how alcohol addiction process is currently defined by the DSM-5.

1.1 Alcohol-related disorders in the light of the DSM-5 criteria

Published in May 2013, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* was a major watershed in the approach to alcohol-related disorders. The distinction between alcohol abuse and alcohol dependence has been dispensed with, and a new sub-category was created in its place, namely, the "alcohol use disorder" (DSM-5). Additionally, three degrees of severity of the disorder have been established, based on the number of symptoms (cf. Miller et al., 2014). The change in the approach was motivated by research showing that the diagnoses of alcohol abuse by the means of the DSM-IV had been less reliable than the diagnoses of alcohol dependence. The former being based on only one criterion, which raised some doubts. Furthermore, some criteria (e.g., failing to properly take care of one's home or family as a result of alcohol consumption) that supposedly reflected a mild form of addiction have been deemed as highly problematic. The rules proposed by the DSM-IV proved to be insufficient for unambiguous diagnoses, which, in a longer perspective, could be detrimental for the patient. In DSM-5, craving (a strong need for consumption) was added as another criterion of alcohol use disorder diagnosis, which now can be made if any two of the 11 criteria have been met in the past 12 months. Because of the scarcity of space, let us remind the first three of them:

- Had times when you ended up drinking more, or longer, than you intended?
- More than once wanted to cut down or stop drinking, or tried to, but couldn't?
- Spent a lot of time drinking? Or being sick or getting over other after effects?

Based on the number of criteria met, the DSM-5 distinguishes three degrees of severity of the disorder: mild (2–3 criteria met), moderate (4–5 criteria met), and severe (6 or more criteria met). This way the binary conceptualisation of alcohol addiction is transformed into a more dynamic one.

1.2. Emotionality. Multifacetedness of emotions and a variety of approaches to them

Emotions occupy a very wide and complex field of psychology. What is stressed, when talking about emotionality, is its multifacetedness. The feelings experienced may be examined on various levels – in the context of a given situation (short term) or a longer time frame. They may be analysed with regard to

individual differences, or to abilities, as in the case of the so-called emotional intelligence. According to Frijda (2002), emotions can be seen as either a process, as a current state (mood), or as a relatively stable disposition of temperament or personality. When thinking of emotions in the category of a process (and that is what we usually do), we focus on their dynamics, in most cases – over a short period of time. Emotions – or intense feelings, as some prefer – appear, grow in intensity, and fade. However, should we wish to stress the fact that emotions are complex processes, we need to add that they also comprise physiological arousal, particular action readiness, and patterns of expression. Furthermore, what is especially important, they profile and direct the course of cognitive processes that adjust to the 'emotional tone'.

In general, at least five approaches to emotions may be distinguished. Each of them applying different categories, and operating on different levels, such as: motivational and activational, evolutionary and adaptative, biological and physiological, componental and integrative, as well as social and cultural. Let us delve into the last one. Undoubtedly, the way of experiencing emotions is shaped by language, social roles performed, and all other aspects of culture one is immersed in (Shweder, Haidt, 2005; Łosiak, 2007). It is also known that there are differences in emotional expression between individualistic and collectivistic cultures. Or between artists and special forces agents. This also holds true with regard to individuals abusing alcohol in social contexts, in solitude, or to those who refrain from it completely. There is one more way of analysing emotions worth mentioning, one that is most similar to the commonsensical one, and which focuses on phenomenological, subjective, and narrational aspects of emotions (cf. Shweder, Heidt, 2005).

In this paper we will mostly refer to emotions understood as a relatively stable disposition of personality, which translates into a permanent propensity to certain reactions to events. It is an individual's tendency to frequent and repetitive experiencing of a particular set of emotions (cf. Lazarus, 2002; Frida, 2002; Mudyń, 2007). From this perspective, the idea of emotionality semantically approaches the emotional component of attitude. Undoubtedly, people differ with regard to the proneness to experience certain emotions. For example, a depressive person will experience sadness more intensely and more often than other people (Watson, Clark, 2002). One could argue that enthusiasm and euphoria would be unknown (or long forgotten) to such a person, and thus hardly real. According to this approach it is even possible to talk about a person's *emotional patterns* or *emotional profile* (Mudyń, 2007; 2009).

Foreshadowing further deliberation, and referring to one of the research tools applied, a few words of commentary on *mood* seem in order. Mood is often juxtaposed to intense emotions that are robust, dynamic, and short-lived. It is more of an emotional backdrop or emotional tone – a state extended in time. Mood is also thought to be unrelated with any object or *quasi*-object (Russel, 2003; Goryńska, Ledzińska, Zajenkowski, 2011), and that it is lacking in any physiological arousal component, or that it is characterised by moderate intensity and certain recurrence (Watson, 2000; Ciarkowska, 2003).

Matthews, Jones and Chamberlain (1990) proposed a model consisting of three correlated mood dimensions: energetic arousal, tense arousal, and hedonic tone. The energetic arousal is connected with motivation to act (energy–fatigue). The tense arousal is related to anxiety (tension–relaxation). The hedonic tone is a dimension spanning from pleasantness to unpleasantness. It is this three-dimensional model that one of our research tools – the Polish adaptation of the UMACL – refers to.

2. The aim of the project

The aim of the study was to determine whether – and if so, then to what extent – the amount of time in therapy influences the

kind and intensity of emotions experienced, and whether the ability to discern one's own and other people's emotions changes during therapy. The direct (and operational in a way) goal of this project was to verify if patients whose therapy was at its early stages would differ from patients who had been in therapy for at least six months with regard to their mood at that moment in time, to the kind of experienced emotions, and to the level of emotional intelligence.

The study was cross-sectional in nature, that is, there were two groups of patients, who differed in the time they had been in therapy. Although it seems that a longitudinal study conducted on the same group with the same methods being administered several times would be methodologically more convincing, due to organisational difficulties they would have been considerably more challenging, as many patients quit the therapy at a different moment. In terms of study conditions, it means that the initial group of patients qualified for the study would have to be relatively large. Furthermore, that fact alone raises some questions regarding the differences between the individuals who remain in therapy from those who quit. In order to research that information, one would have to reach the patients who quitted, which proves to be a rather difficult task. Longitudinal studies are also burdened with the so-called practice effect, meaning that the very fact of being tested by the means of the same research tool may modify the results either in plus or in minus. Hence, it seems that both approaches are on a par with each other with regard to their methodological value.

Research to date on the influence of therapy (its length) on broadly understood emotionality is rather scarce, and the results – ambiguous. Kun and Demetrovics (2010) reviewed 51 studies pertaining to the ability to discern emotions in individuals addicted either from psychoactive substances, or from new technologies, or gambling, or shopping. The results were very diverse and hardly conclusive. To quote the researchers, "Decoding of emotional states is less accurate in cases of alcoholics, intensive smokers, cannabis users, and problematic internet users. These results fit well with the line of research intended to reveal the relationship between alexithymia and addictions […], if we consider that underdeveloped ability of the differentiation of emotions is also a component of alexithymia" (op. cit., p. 1151).

On the other hand, the research focusing on the emotionality of alcoholics showed, among others, that after a year of abstinence the intensity of depressiveness and sadness in individuals addicted to alcohol dropped (Nowakowska, Jabłkowska, Borkowska, 2007). Other studies (Bętkowska-Korpała, 2012a) found differences between drinkers and non-drinkers; the individuals who managed to maintain abstinence were more friendly, open, and experienced less anger, as compared to those who failed to refrain from consuming alcohol, and who more often felt depressed, sad, or helpless. Similarly, a study by Flora and Stalikas (2015) revealed that the individuals in therapy experienced relatively more positive than negative emotions as the therapy progressed. It needs to be mentioned, however, that the patients who participated in such research had been in therapy for varying amount of time – in some cases it was 3–4 weeks, in other 7–8 weeks, and in other yet 5–6 months or even over a year.

We deemed it worth, therefore, to address the problem with a more systematic approach.

3. Method

3.1. Research tools

Three research tools were used. One of them was the Polish adaptation of the UWIST Mood Adjective Checklist (UMACL) by G. Matthews, D. M. Jones, and G. Chamberlain. The scale measures current mood, defined as affective experience of moderate duration. The UMACL scale consists of 29 adjectives. The participants mark on a 4-point scale (strongly agree, rather agree, rather disagree, strongly

disagree) to what extent each of the items describes their current mood. The scores are calculated within three sub-scales: Hedonic Tone (HT), Tense Arousal (TA), and Energetic Arousal (EA). The raw scores of the TH and EA sub-scales ranges from 10 to 40 points, while in the TA it assumes the value of 9–36 points. The higher the number, the higher the level of a given mood dimension. The reliability of the final version of the Polish adaptation of UMACL was assessed by the means of internal consistency. Cronbach's alpha that was calculated for each sub-scale ranged from 0.71 to 0.9. High internal accuracy was confirmed by factor analysis, while the external accuracy was verified by correlation with respective personality traits.

Another tool used was DINEMO, Two-dimension Emotional Intelligence Inventory by A. Matczak and A. Jaworowska. The inventory consists of 33 items, each comprising a description of a situation that is a source of emotion, and four different ways of reacting. In each case only one answer is deemed correct and awarded 1 point. The general score is the sum of points from all 33 answers. Furthermore, there are two scales that are calculated: *the interpersonal* one (Others) with a maximum of 21 points, and *the intrapersonal* one (Self) with a maximum of 14 points; two answers are counted in both scales. The reliability of the method was assessed by the means of Cronbach's alpha for each of the scales, and for the general score. For adult women it reached 0.82 for Others, 0.61 for Self, and 0.81 for the general score. In the case of men, Cronbach's alpha equalled 0.74, 0.62, and 0.76, respectively.

The last of the three measures was ***Kwestionariusz Realność Uczuć (RU-4)*** [Feelings' Reality Questionnaire] by K. Mudyń (2007; 2010). Since this (half)projective tool has not gained much popularity, we will dedicate some space to it. The idea for it came from the question "What – and for whom – is real?" which was related to Mudyń's research described in his two books: *W poszukiwaniu prywatnych orientacji ontologicznych* [In search of private ontological orientations] (2007), and *Rzeczywiste–Nierzeczywiste* [Real–Unreal] (2010). The method RU-04 refers to the so-called transactional analysis by E. Berne (1961, 1972/1993), and more precisely – to his taxonomy of life positions. Each of the four positions distinguished by Berne is characterised by a tendency to experience particular feelings. The premises the questionnaire RU-04 is founded on are as follows:

1. Every person has a unique 'emotional profile' or a repertoire of emotional patterns.
2. The individual 'emotional profile' is contingent on the structure of personality, meaning that, among others, the individuals who have a certain dominant life position more often than others experience corresponding feelings.
3. What we experience stronger or more often is more real (to us) than what we experience rarely or never.

The questionnaire RU-04 comprises 60 one- or two-word descriptions of feelings and impressions. The answers are given on an 11-point scale (0–10 points), and the following instruction is provided, "Based on your subjective impressions, rate the reality of feelings connected with the phrases listed below, marking a suitable number of points next to each of them." The questionnaire allows to distinguish four factors that correspond to four life positions by Berne, "I'm not OK – you are OK", "I'm OK – you are not OK", "I'm not OK – you are not OK" and "I'm OK – you are OK", as well as to distinguish *personality-nonspecific feeling*, and to compare particular feelings.

The internal consistency markers (Cronbach's alpha) for every scale consecutively found by factor analysis (life positions) assumed the following values: 0.90, 0.85, 0.80, and 0.72. The external accuracy was also verified with the help of, among others, the Polish adaptation of the Coping Inventory for Stressful Situations (CISS) by Endler and Parker, the Polish adaptation of the Dissociative Experiences Scale (DES) by Eve Bernstein Carlson and Frank Putnam (the participants

for this purpose recruited from secondary school students and senior citizens – in retirement age). High positive correlations between emotion-focused coping and the feelings constituting the position *I'm not OK – you are OK* were found in both groups. In the case of youth the correlation was $r = 0.57$, $p = 0.001$, and in the case of seniors it was found to be a little higher ($r = 0.77$, $p < 0.001$). In the latter group a correlation between emotion-focused coping and emotions included in the position *I'm OK – you are OK* was also observed ($r = 0.56$, $p = 0.001$). Furthermore, in the senior group numerous significant correlations ($0.30 \leq r \leq 0.48$) were established between DES and the 7 negative nonspecific feelings, such as depression, impatience, and feeling threatened, or ashamed.

3.2. Research procedure

The study was conducted between February and December 2019 in four centres for addiction therapy: in Kraków, Gliwice, and Częstochowa. A shortlist of prospective participants was prepared based on the time they spent in therapy; group 1 consisting of individuals being in therapy for no more than a month, and group 2 – for no less than six months. Prior to the start of the procedure an informed consent was obtained. Subsequently, a meeting arrangement was made on a date convenient to each of the participants.

The patients completed the three above-mentioned questionnaires, and a short demographic data survey. Then a short conversation with the participants took place; its aim was to answer any questions that might have arisen during filling-in the questionnaires.

3.3. Hypotheses

$\mathbf{H_1}$ The patients who remained in therapy longer (i.e. no less than 6 months) differ from the patients whose therapy is at its early stages with regard to current mood. The insights on the direction of the relation diverged. We expected the patients who were in therapy for at least six months to score higher on Energetic Arousal and lower on Tense Arousal.

$\mathbf{H_2}$ The patients who remained in therapy for no less than six months are characterised by higher levels of emotional intelligence on the intrapersonal scale (Self), meaning that discerning their own emotions is easier to them than to the patients who completed no more than a month of therapy.

$\mathbf{H_{3a}}$ The patients who remained in therapy for no less than six months are less susceptible to experience the so-called negative emotions (related to the remaining three life positions by Berne) than the 'beginners'.

$\mathbf{H_{3b}}$ The patients who remained in therapy for no less than six months are more prone to experience positive emotions, which are treated as personality-specific feelings related to the position *I'm OK – You are not OK*, as compared to the 'beginners'.

$\mathbf{H_4}$ The patients who remained in therapy for no less than six months more strongly experience the so-called personality-nonspecific feelings (regardless of their valence), as compared to the patients whose therapy is at its early stages.

3.4. The characteristics of the study group

In total, 83 individuals participated in the study; the data from three of them was incomplete, and subsequently rejected. The analyses were conducted on the results from 80 people (40 + 40). The RU-04 results from two participants (one from each group) were also excluded from the analyses at a later point due to flaws in the way they were filled-in.

Age of the participants: in the 'beginners' group the mean age was 41.27 years ($SD = 13.61$), and in the other group $M = 44.6$ years ($SD = 12.98$). The remaining demographic data in both groups were similar, therefore, the following information pertains to both of the groups combined. *Sex:* men $n = 51$ (63.75%), women $n = 29$ (36.25%). *Place of living*: large town (>100,000) $n = 46$ (57.5%), small town (<100,000) $n = 19$ (23.75%), countryside $n = 15$ (18.75%). *Education:* primary $n = 5$ (6.25%), vocational $n = 23$ (28.75%), secondary $n = 23$ (28.75%), higher $n = 29$ (36.25%).

Table 1. The comparison of mood dimensions in UMACL in both groups

Mood dimensions	Patients with ≤1 month of therapy ($n=40$)		Patients with ≥6 months of therapy ($n=40$)		*t*	*df*	*p*	*d*
	M	*SD*	*M*	*SD*				
HT	28.85	6.01	30.52	4.83	–1.37	78	0.173	0.12
TA	17.82	5.14	16.38	3.99	1.41	78	0.163	0.16
EA	**39.95**	5.91	31.57	4.25	–1.41	78	0.162	0.16

4. The results

Below we present the most important results, directly related to the hypotheses. The analyses were performed by the means of the two-sided Student *t*-test for independent samples, one-way analysis of variance, and the Pearson correlation coefficient. Significance level was set at $p \leq 0.05$. The effect size *d* was also calculated. The results pertaining to the H_1, postulating differences between the results between current mood, are presented in Table 1.

As can be seen (Tab. 1), the hypothesis was not confirmed. Although some trends were observed to be in line with our expectations – the patients with no less than six months of therapy scored higher on Energetic Arousal, and lower on Tense Arousal than the patients beginning the therapy – they did not reach statistical significance ($p=0.16$). The direction of the changes (e.g., the lowering of tense arousal) should be deemed beneficial, and seems to support the effectiveness of the therapy. It is also worth mentioning that in the group of ≥6 months of therapy, in all three mood dimensions, the variance is smaller (lower *SD*-values). The results related to emotional intelligence are shown in Table 2.

The H_2, postulating that the patients who were in therapy longer score higher on intrapersonal intelligence (Self scale), was not confirmed. Moreover, a contrary trend was observed ($p=0.06$) – the patients who continued the therapy for no less than six months scored lower than the 'beginners'. Furthermore, it is worth noting that a somewhat surprising result was found, the patients who had participated in therapy for a longer period scored lower on the overall emotional intelligence, and especially on its interpersonal scale (Others), wherein the difference was highly significant ($t=2.86$; $p<0.005$). It seems plausible that the process of reconstructing one's habits (which accompanies the therapy) and the overall psyche restructuring fosters patients' egocentrism, which lowers the levels of emotional intelligence. An alternative interpretation – that in patients who continue the therapy longer, the sensitivity to the so-called social approval decreases – is also possible. Perhaps with time being accepted by the therapist, or

Table 2. The comparison of emotional intelligence (DINEMO) in both groups

Emotional Intelligence	Patients with ≤1 month of therapy ($n=40$)		Patients with ≥6 months of therapy ($n=40$)		*t*	*df*	*p*	*d*
	M	*SD*	*M*	*SD*				
Self	7.03	2.35	5.90	2.87	1.92	78	0.059	0.22
Others	11.60	3.99	9.18	3.57	**2.86**	78	**0.005**	**0.32**
General score	17.38	5.04	14.35	5.28	**2.62**	78	**0.011**	**0.30**

Table 3. The comparison of the intensity of personality-specific emotions related to life positions by Berne in both groups

Feelings connected with life positions by E. Berne	Patients with ≤1 month of therapy (n = 39)		Patients with ≥6 months of therapy (n = 39)		*t*	*df*	*p*	*d*
	M	*SD*	*M*	*SD*				
I *I'm not OK – You are OK*	**5.48**	1.78	**6.27**	2.26	–1.73	76	0.093	0.39
II *I'm OK – You are not OK*	**4.11**	2.28	**4.79**	2.40	–1.28	76	0.204	0.29
III *I'm not OK – You are not OK*	**4.67**	1.88	**5.97**	2.19	**–2.82**	**76**	**0.006**	**0.65**
IV *I'm OK – You are OK*	**6.33**	1.57	**6.79**	1.16	–1.49	76	0.140	0.34

by people in general, loses on importance in favour of the experienced effects of therapy.

The following two mutually related hypotheses 3a and 3b pertained to the differences in the intensity of experiencing (personality-specific) positive and negative feelings in both groups. For the sake of clarity, 'more intense experiencing' was operationalised by higher scores on reality levels of feelings in the RU-04 questionnaire. Also, the personality-specific feelings were distinguished by the means of factor analysis, and were connected to the four life positions described by Berne. Positive feelings are represented solely by position IV (*I'm OK – you are OK*), which is understood by the author of transactional analysis as the only constructive and desired position. Relevant results are presented in Table 3.

As can be seen in Table 3 the H_{3a}, postulating lower intensity of negative feelings in the group of patients with no less than six months of therapy, was not confirmed. In a way, it may seem that the opposite hypothesis was confirmed. Although the differences in intensity (reality) of feelings assigned to positions I and II failed to reach the significance level, in both cases an analogous trend was found. The only significant differences were found in position III ($t = -2.82$, $p = 0.006$, $d = 0.65$), which, according to Berne, is considered as the most destructive. The feelings associated with it are *boredom*, *distrust*, *dejection*, and *indifference*. However, if the feelings constituting the first three positions are treated as one set of negative feelings, then the difference between the groups also becomes significant ($t = -2.09$; $p = 0.04$).

A similar trend can be observed in the case of positive feelings ($t = -1.49$; $p = 0.14$). It would seem that with the progression of the therapy, contrary to expectations, both the negative and the positive feelings grow in intensity. The tendency is not incomprehensible, as in the course of the therapy patients' emotionality – blocked, reduced or unstable for a long time – is gradually thawing. It is also worth mentioning that the positive feelings did not occur so abundantly because in the RU-04 questionnaire they are represented unequally, by 25% of all items. Despite that, hypothesis 3b was not confirmed.

With regard to H_4, postulating that the patients who stayed in therapy longer (i.e., no less than six months) experience the so-called personality-nonspecific feelings more intensely than the patients whose therapy is at its early stages.

The comparison of relevant results is shown in Table 4.

In the light of the results presented (Table 4.) the H_4 may be deemed accepted. The patients who stayed in therapy longer experienced personality-nonspecific feelings more intensely, that is their assessment of feelings'

Table 4. The comparison of reality assessment of personality-nonspecific feelings between both groups

Personality-nonspecific feelings	Patients with ≤1 month of therapy ($n = 39$)		Patients with ≥6 months of therapy ($n = 39$)		*t*	*df*	*p*	*d*
	M	*SD*	*M*	*SD*				
	5.48	1.5	**6.21**	1.49	**–2.163**	76	**0.034**	**0.5**

reality was higher. It was also tested to find with regard to which of the 31 nonspecific feelings the groups differed most. By the means of Student's *t*-test the comparisons between particular feelings were made. Eleven of the most strongly discriminating feelings are shown in Table 5, in decreasing order. The feelings presented include the ones that reached statistical significance ($p < 0.05$), and those that manifested only at a trend level ($p < 0.10$).

It should be stressed that all the feelings with the greatest discriminative power are more strongly experienced (assessed as more real) in the group of patients who stayed in therapy for a longer period. Perhaps it is possible that they are in better contact with their emotions than the group of 'beginners'. What is also worth noting, is that this is true for both the positive (5×) and the negative (6×) feelings. The importance of this notion stems from the fact that is shows that positive feelings, such as *optimism, satisfaction*, or the *sense of security* also grow in strength in the course of therapy. That is good news for therapists and for patients. Furthermore, as the smaller values of standard deviation of eight out of eleven presented feelings would suggest, the group remaining in therapy for no less than six months appears also to be more uniform.

Additional analyses were performed to take into account such demographic data, as *sex, place of living, education level,* and *age.* Having compared women ($n = 29$) and men ($n = 51$), no statistically significant differences were found with regard to emotional intelligence, analysed either as a general score, or

Table 5. The comparison of the intensity of the feelings best differentiating between both groups

Personality-nonspecific feelings	Patients with ≤1 month of therapy ($n = 39$)		Patients with ≥6 months of therapy ($n = 39$)		*t*	*df*	*p*	*d*
	M	*SD*	*M*	*SD*				
Envy	4.18	3.14	6.18	2.88	**–2.928**	76	**0.005**	**0.67**
Optimism	5.74	2.27	7.03	1.71	**–2.820**	76	0.006	0.65
Sadness	5.26	2.75	6.97	2.85	**–2.708**	76	**0.008**	**0.62**
Satisfaction	6.41	2.31	7.59	1.87	**–2.474**	76	**0.016**	**0.57**
Sense of security	6.13	2.43	7.23	1.56	**–2.383**	76	**0.020**	**0.55**
Impatience	4.97	2.37	6.03	2.19	**–2.034**	76	**0.045**	**0.47**
Feeling threatened	4.54	2.61	5.56	2.36	–1.819	76	0.073	0.42
Shyness	5.13	2.76	6.18	2.36	–1.806	76	0.075	0.41
Feeling of superiority	3.51	2.56	4.56	2.58	–1.804	76	0.075	0.41
Irritation	5.28	1.89	6.21	3.57	–1.808	76	0.075	0.41
Inner calmness	5.44	2.37	6.28	2.25	–1.618	76	0.100	0.37

individually for Self and Others scales. No differences were also found with respect to any of the UMACL sub-scales (i.e., Energetic Arousal, Tense Arousal, or Hedonic Tone). Differences were found in the case of intensity of emotions related to *I'm not OK – you are not OK* position, with women scoring higher ($M = 6.12$: $M = 5.05$, $t = 2.11$, $df = 76$, $p = 0.038$). The interpretation of this result poses some difficulty. However, if we deem it important, we may speculate that, perhaps, addiction wreaks more havoc on women than on men. It could be related with, for example, lesser involvement in professional career, and more limited social network in the case of unemployed women.

Statistical tests performed in order to analyse the possible relationship between *the place of living* and the results of any of the three methods applied yielded no statistically significant correlations.

Similarly, no differences in the results in any of the three tools were found to be significantly related to the *level of education*. Nonetheless, in the case of emotional intelligence a distinct trend – in favour of individuals who received higher education – was observed. Three levels of education were distinguished and the analysis of variance was applied $F(72) = 2.03$, $p = 0.13$.

A possible relationship between *age* and the results of the three questionnaires was also tested for. Statistically significant correlations were discovered neither for the UMACL scale, nor for emotional intelligence DINEMO. A weak negative correlation ($r = -19$, $p = 0.087$) between age and the position *I'm not OK – you are OK* was found, which means that this position was more typical of younger patients than of older ones.

5. Discussion

A terse summary of the results obtained would boil down to stating that no significant differences were discovered with regard to any of the mood dimensions, as understood by UMACL. The differences that appeared as trends were consistent with intuition – the patients who participated in therapy for no less than six months scored a little lower on Tense Arousal, and a bit higher on Energetic Arousal and Hedonic Tone. These tendencies suggest that the process of therapy is progressing constructively.

The DINEMO questionnaire provided some surprising insights related to emotional intelligence. As it was ascertained, contrary to optimistic expectations, the ones who scored higher on emotional intelligence were the patients who barely began the therapy – not the ones who at the time of testing had already continued it for at least half a year. The statistically significant differences pertained not only to the general result ($t = 2.62$, $p = 0.011$), but also to the interpersonal scale which is related to the ability to accurately discern other people's emotions ($t = 2.86$, $p = 0.005$). In the case of the intrapersonal scale, the difference was smaller, almost reaching the threshold of statistical significance ($t = 1.92$, $p = 0.059$). It would seem that the sobering process accompanying the therapy may cause temporary decrease in emotional intelligence. This naturally raises some questions, for example, "How is that possible?" or "Why does it happen?" We will address the issues later.

The results yielded by the Feelings' Reality Questionnaire (RU-04) may be succinctly summed up the following way – the patients who stay in therapy for at least six months experience more intense feelings, both positive and negative. This is true not only for the personality-specific feelings, related to four life positions, but also to many personality-nonspecific feelings, that, in a way, are more basic and universal. Although the differences were not always statistically significant, their direction was clear – the patients who participated in the therapy longer, and were more advanced in the sobering process, scored higher. It is contrary to commonsensical expectations and linear thinking. It is easier to believe that sobering process and mental condition improvement progress systematically and change somewhat linearly with

time. The results support therapists' observations, and make us realise that sobering process progresses in phases, and is in a way curvilinear (cf. Mellibruda & Sobolewska-Mellibruda, 2011). It is not without reason that the initial period of the therapy is called a 'honeymoon' (Klimek, 2020) or a *pink cloud*[1]. Making the hard resolution to undergo a therapy, and then actually doing it most probably provides satisfaction from making a radical move, and is a source of hope for the better. Such actions are often supported by family and friends. It does not take long, however, to see that the path is steep, and does not abound in successes or gratifications. Doubts and disappointment soon follow. As if it was not enough that it does not become easier, on many occasions it becomes harder.

Some parallels may be drawn between the process of quitting a habit and a general refurbishment of a house. One has to radically reorganise one's life, beginning with daily routine and way of life, and ending with finding new, alternative goals and gratifying values. Worth mentioning is also the fact that inscribed in every change, from cleaning the house to the general refurbishment, are some degree of disorder and psychological costs, whose amount is often underestimated until they are incurred.

Intensification of experienced emotions, especially the negative ones, may signal a therapist that the patient is regaining contact with his or her forgotten, 'unused', or ambivalent feelings, which is desired and beneficial in the longer perspective. What it means to the patient, on the other hand, is rather the lack of expected progress, and the feeling that things get worse. That is why, one of the therapist's tasks would be to forewarn the patient that some difficulties will inevitable arise, and to show their unobvious meaning and potential sense.

[1] Emotional Rollercoaster in Early Recovery. https://alcoholrehab.com/addiction-recovery/emotional rollercoaster-in-early-recovery/ (accessed: 22.06.2020).

6. Conclusions

1. The results obtained show that during therapy lasting for at least six months patients start experiencing feelings more intensely. This is true for both personality-specific and personality-nonspecific feelings. What was also noted in this group was a significantly lower level of emotional intelligence, which proves that the dynamics of the process of quitting a habit is specific, multiphase, and burdened with the feeling of being lost, as well as with increased egocentrism during therapy phase. It may also indicate that the process of emotional 'thawing' has started, and that patients start establishing a better contact with their ambivalent feelings.

2. It seems that an important task that therapists who work with patients with alcohol problems must undertake is warning the patients that they will inevitably face a phase of lowered mood, discouragement, and feeling that no progress is made. They will also have to show their patients the necessity of the phase, and of the process' deeper sense in spite of the discomfort.

3. Although the process of general mental refurbishment, cleaning one's emotions, and searching for new goals and values progresses with different speed in different persons, it seems that a period shorter than a year is hardly sufficient to expect unambiguously positive effects of therapy. It may be possible that the dynamics and pace of quitting a habit are related in some way to the length of the addiction period. This variable should be controlled for.

4. Out of the three questionnaires used in the study, the most informative proved to be the Feelings' Reality Questionnaire. It appears that the RU-04 is a rather sensitive tool that may be used, among others, to monitor the changes taking place during therapy.

5. In the future it would seem advisable to conduct a longitudinal study with three measurements of various aspects of emotionality – during the first month, after about half a year, and after at least a year from starting the therapy.

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