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## Quality of Life and Therapy Effects among Alcoholics

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### **Abstract:**

The purpose of this study was to analyze the correlation between an alcoholic's quality of life and the results of therapy which were defined as the ability to maintain abstinence for one year. The Life Satisfaction Questionnaire FLZ by Fahrenberg and others, and the the Positive and Negative Affect Schedule (PANAS) by Watson and others were applied in this study. The study was conducted at the beginning and end of therapy, one year after subjects started maintaining abstinence, with one group (n = 64) sustaining their abstinence and the second group (n = 81) relapsing into drinking. Results indicate that at the beginning of treatment the groups' levels of life satisfaction and affect did not differ. When therapy ended, people maintaining abstinence were characterized by higher levels of overall satisfaction with life and satisfaction with health, leisure, and friends. Throughout the treatment, patients who remained abstinent experienced significant increases in several dimensions of life satisfaction, overall satisfaction, and positive affects. These were not observed among patients who relapsed into drinking.

**Keywords:** alcohol dependence, quality of life, therapy, maintaining abstinence

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### **Introduction**

Alcohol dependence contributes to many negative consequences in all relevant areas of human functioning - physical and mental health, relationships in family and at work, value hierarchies, and the spiritual realm (a.o. Cierpiąkowska,

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Ziarko, 2010; Laudet et al., 2009; Lindenmeyer, 2007; Mellibruda, Sobolewska-Mellibruda, 2006). The destructive nature of the disease and its surroundings on a person's life implies the need for multifaceted recognition in research. It therefore seems that the quality of life issue (Quality of Life, QOL), popular in recent years, particularly in medicine and psychology, should play an extremely important and helpful role in this area. Such research may in fact provide relevant information as to how alcoholics subjectively evaluate themselves and their life situation, and answer the question as to how this evaluation changes during the therapy they participate in.

Unfortunately, as the experts acknowledge, quality of life is very often overlooked in studies of alcoholics or is treated in a limited way (a.o. Evren et al., 2010; Donovan et al., 2005; Foster et al., 1999; Lahmek et al., 2009; Laudet et al., 2009; Zubaran, Foresti, 2009). The limits are connected among other things, with the fact that such studies generally concern the quality of life conditioned by the state of health (Health-Related Quality of Life – HRQOL and focus on comparing the results obtained among addicts with the general population, or show changes that occur within the variable during therapy treatment. The study of the first group show that the quality of life conditioned by the state of health in dependent patients, starting therapy treatment, is significantly lower than in the general population and in patients with chronic somatic diseases, including cancer (i.a. Daepfen et al., 1998; Foster et al., 1998, 2000; Smith, Larson, 2003; Stein et al., 1999, see also Habrat et al., 2000). The study of the second group indicates that the level of quality of life increases during therapy treatment, regardless of its length and type of therapy, but in some reports it was shown that after therapy it is similar to the level of healthy individuals and in others, that despite growth it continues to be significantly reduced (i.a. Berglund et al., 2004; Donovan et al., 2005; Ginieri-Coccosis et al. 2007; Kraemer et al., 2002; Lahmek et al., 2009; Smith, Larson, 2003).

The multiplicity of measurement methods used in the addicts' life quality research is limited as well. Donovan and others (2005) in reviewing research on this issue, available in MEDLINE in the period 1993-2004, found only 36 reports, with 12 different research tools being used. Unfortunately, a specific method for testing the quality of life in addicts has not been developed yet, as is the case of many other chronic diseases.

Among the literature studies available, reports are very rare which might be more inspiring than ever to introduce specific therapeutic interventions, or modify existing ones. This is primarily a reflection on the relationship between the level of the broader quality of life and the completion of therapy and subsequent maintenance of abstinence. In other words, it seems very significant to try to answer

the question whether the various life quality changes during therapy are connected with the alcoholic's further fate to maintain sobriety. From the few studies in this area, tests by Foster and others deserve attention (1998). It was found that patients who experienced relapses within 12 weeks after therapy had lower physical and mental life qualities, but these variables were measured at the beginning of therapy, immediately after detoxification. Similarly, Laudet and others (2009) showed an important role depending on the initial level: the higher the quality of life at detoxification's start, the better the prognosis. In other studies, Foster and others (2000), found a negative relationship between increased quality levels during treatment and the amount of reported alcohol consumed in an average week after its completion. While the Polish study (Chodkiewicz, 2001, 2002), on dependent men only, showed that there were no differences with life satisfactions in the early treatment stages between those who had finished therapy and those who discontinued it. Differences were related to changes that occurred during treatment between the group of abstainers, and those who experienced a relapse.

The above-mentioned studies and reflections indicate that there should be further exploration about quality of life issues among people addicted to alcohol. It seems that such studies should include as wide a range as possible, not only because the destruction caused by alcohol is multidimensional but because experts suggest such a direction for future research. In their opinion, reducing testing addicts to quality of life conditioned by the state of health, in which the focus was on identifying the impact of disease on physical, psychological and social functioning of the unit, may ignore important, and perhaps even crucial for understanding aspects of their lives and therefore may be insufficient (i.a. Laudet et al., 2009; Zubaran, Foresti, 2009, see also Bonomi, 2000; Skevington et al., 2004).

Given the above results and the controversy, it was decided to examine the relationship between quality of life among people addicted to alcohol and therapy treatment effects. Since the literature (i.a. Heszen, Sęk, 2007; Linley et al., 2009; McDowell, 2010, see also Trawka, Derbis, 2006) draws attention to the fact that one's life may have both cognitive and emotional sides, in the study it was decided to include both components of this variable: satisfaction with life (general life satisfaction and satisfaction with its various spheres) and the experienced affect. It was decided to measure the quality of life twice, at the beginning and at the end of therapy. Therapy was defined as the patient's ability to maintain abstinence for one year after starting treatment. Maintaining abstinence for a year, according to many authors, is a good indicator for subsequent sobriety and further development (a.o. Kucińska, Mellibruda, 1997; McLellan et al., 2005, see also Wojnar et al., 2007). Study results indicating that the largest number of relapses occur within the

first three-to-six months testify to adopting this time period (Beck et al., 2007; Irwin et al., 1999; Monti, Rohsenow, 1999).

The following research hypotheses were developed:

H1. Addicted people who maintain abstinence after treatment, compared with the ones relapsing to drinking, have significantly higher levels of life satisfaction and more positive and fewer negative affect at the beginning and end of treatment.

H2. In the group maintaining sobriety after treatment, there occurs a significant increase in life satisfaction and positive affect throughout the treatment and a lowering of negative affect, which was not observed among people who broke abstinence.

## **Method**

### *Subjects and course of study*

The study was conducted in 2006-2010 in the Municipal Centre for Prevention and Therapy of Addiction in Lodz. The Center uses a comprehensive addiction therapy approach which is both strategic and structured. Patients participate in group and individual therapy, educational and AA (Alcoholics Anonymous) meetings. Psychiatric care is provided. The Centre conducts both ambulatory and stationary therapy: a) Out-patient therapy - the most common form of treatment is carried out two-three times a week and takes about five-six months. There are two stages. First includes participation in the initial group. This participation is designed to trigger motivation for treatment. The second stage involves fulfilling tasks included in individual therapy plans. Individual therapy plans are a set of sobriety tasks carried out individually and through group interactions. The plans are prepared by a therapist who uses biographical information about the patient and other relevant data (Mellibruda, Sobolewska-Mellibruda, 2006). b) Stationary therapy is conducted daily and takes approximately six-seven weeks.

The study was voluntary, and only subjects in outpatient therapy took part in it. They were examined for the first time at the beginning of treatment, that is, during the first week at the Center. All patients met criteria for alcohol dependence according to ICD-10, which was confirmed by a psychiatric examination. The study excluded cross-dependent persons - those who took both alcohol and drugs - gamblers, persons whose central nervous systems had undergone changes, and those entering treatment under court order.

At the first research stage there were 420 people, but after removing incompletely filled questionnaires 397 people enrolled for the analysis. Persons who have completed the therapy (n = 239) were examined again using the same meas-

uring tools just before the end of the therapy (during their last week of treatment). After six months of completion therapy, the subjects received a short questionnaire containing questions about abstinence to be completed by mail or e-mail. Only persons who responded to the survey were qualified to be analyzed (n = 145). Based on the data from the questionnaires and after checking the available documentation concerning the possible use of alcohol, the group maintaining abstinence was identified (n = 64), and the group who returned to drinking (n = 81). Those who responded to the survey, as in the previous stages of the study, were dominated by men (70.63%), people with secondary education (46.80%) and vocational education (23.02%), people living with family (68.25%) and employed (63%). Most patients (60%), reported that one or both parents were addicted to alcohol, for the majority (67.80%) our therapy was the first treatment program they attended. The mean age was 44.69 years (SD = 9.14).

#### *The methods applied*

##### *The study used:*

1. Life Satisfaction Questionnaire (Fragebogen zur Lebenszufriedenheit-FLZ) by J. Fahrenberg, M. Myrtek, J. Schumacher and E. Brähler (2000), as adapted by Chodkiewicz (2009). The questionnaire consists of 10 subscales measuring satisfaction with health, work and occupation, financial security, leisure time, marriage/partnership, relationships with children, the self, friends/acquaintances, housing, and sexuality. Each subscale contains seven test items. Responses are assessed on a 7-point scale from 1 (very dissatisfied) to 7 (very satisfied). The overall rate of satisfaction with life is calculated by adding the raw results from all seven scales. In determining this ratio one does not take into account the results of the scales: work and occupation, marriage/partnership and the relationship with their own children, because those scales are not completed by all persons. The higher the obtained score, the greater the satisfaction with life. The Polish version of the questionnaire had good psychometric properties. Cronbach's alpha reliability coefficients ranged from 0.80 (the self) to 0.96 (health). In the study using the test-retest procedure (with one month interval) correlation coefficients were from 0.61 (the self) to 0.97 (satisfaction with relationship). Relevance was assessed by comparing the results with the Satisfaction With Life Scale by Diener and others, the SF-36 (Short Form 36) by Ware and others, and the LOL (Ladder of Life) by Cantrill (Chodkiewicz, 2009).

2. Positive and Negative Feelings Scale PANAS (Positive and Negative Affect Schedule), by D. Watson, L. Clark and A. Tellegen (1988). The authors assumed that affective states can be described by two independent dimensions called posi-

tive and negative affects (see also Watson, 2000). The tool has two subscales: Positive Affect Scale and Negative Affect Scale, with each scale comprising ten adjectives. The frequency of experiencing a given affect is determined on a scale of five (1- slightly or not at all to 5 - very often). PANAS is suitable for measuring both the intensity of your current mood, and its retrospective self-report coverage - depending on the manual - during any time frame. In current study, subjects were asked how they felt during the previous month. The author of the Polish adapted scale is Brzozowski (1995). PANAS, both in its original and Polish version (to be known as SUPIN) has good psychometric properties. Cronbach's alpha reliability coefficients were 0.80 for positive affect and 0.91 for the negative one. The method has already been used both to measure the emotional satisfaction with life (Sobol-Kwapińska, 2007), and in quality of life studies among alcoholics (Wnuk, 2007).

## **Results**

In order to verify the research hypotheses a two way repeated measures analysis of variance was used in the scheme (2) research stages (before treatment, after treatment) x (2) groups (maintaining abstinence, breaking abstinence).

Analysis began with the FLZ life satisfaction questionnaire. With regard to health a significant main effect at the research stage  $F(1,123) = 43.42$  was reported,  $p < 0.001$ ,  $\eta^2 = 0.26$ . A mean comparison by Bonferroni's method showed that respondents declared significantly higher satisfaction with their health after treatment ( $M = 31.91$ ) compared with the beginning period ( $M = 28.65$ ). No significant main effect of group membership -  $F(1,123) = 1.02$ ,  $p = 0.315$ ,  $\eta^2 = 0.08$  was reported. There was, however, significant interaction between the research stage and belonging to a group -  $F(1,123) = 5.18$ ,  $p = 0.02$ ,  $\eta^2 = 0.04$ . Analysis of simple effects showed that at the end of therapy, those who maintained abstinence were significantly more highly satisfied with their health ( $M = 33.49$ ) compared with those who had broken abstinence ( $M = 30.33$ ). Other differences did not reach statistical significance.

The same procedure used for job satisfaction showed both no significant main effect with the research stage -  $F(1,112) = 0.26$ ,  $p = 0.605$ ,  $\eta^2 = 0.02$ , nor with group membership,  $F(1,112) = 1.06$ ;  $p = 0.305$ ,  $\eta^2 = 0.09$ . Interaction of both variables also turned out to be irrelevant -  $F(1,112) = 1.08$ ,  $p = 0.299$ ,  $\eta^2 = 0.08$ . A similar result was satisfaction with the relationship with children, where there was no significant main effect at the research stage -  $F(1,102) = 0.22$ ,  $p = 0.638$ ,  $\eta^2 = 0.02$ , with group membership  $F(1,102) = 3.71$ ,  $p = 0.06$ ,  $\eta^2 = 0.04$  or with interaction  $F(1,102) = 0.19$ ,  $p = 0.665$ ,  $\eta^2 = 0.02$ .

Another dimension was satisfaction with finances. There was a significant main effect for the research stage  $F(1,123) = 7.97, p = 0.006, \eta^2 = 0.06$  and insignificant main effect for group membership  $F(1,123) = 0.03, p = 0.870, \eta^2 = 0.01$ . Comparison of the mean indicated that respondents at the end of therapy scored significantly higher on this scale ( $M = 29.05$ ) than at the beginning of treatment ( $M = 27.30$ ). Interaction at the research stage and group membership also turned out to be significant -  $F(1,123) = 4.08, p = 0.045, \eta^2 = 0.03$ . Analysis of simple effects indicated that in the subjects who maintained sobriety, satisfaction with this dimension significantly increased in the course of therapy ( $M = 26.90$  at the beginning and  $M = 29.88$  at the end), which was not observed among those who relapsed ( $M = 27.72$  at the beginning and  $M = 28.22$  at the end).

With regard to satisfaction with the self only the main effect at the research stage was significant  $F(1,123) = 7.50, p = 0.007, \eta^2 = 0.06$  - alcoholics after treatment were more satisfied with themselves than before treatment ( $M = 27.94$  before and  $M = 29.68$  after). The main effect of group membership  $F(1,123) = 0.03, p = 0.857, \eta^2 = 0.01$  and interaction  $F(1,123) = 2.14, p = 0.146, \eta^2 = 0.02$  were irrelevant.

Satisfaction with leisure time revealed a significant main effect at the research stage  $F(1,123) = 11.29, p < 0.001, \eta^2 = 0.08$  and an insignificant main effect for group membership  $F(1,123) = 1.37, p = 0.234, \eta^2 = 0.01$ . Patients who terminated therapy were more satisfied with leisure activities ( $M = 32.07$ ) than when it started ( $M = 29.79$ ). Both variables showed significant interaction,  $F(1,123) = 6.64, p = 0.01, \eta^2 = 0.05$ . Analysis of simple effects revealed two significant differences. Among abstainers there occurred an increase in this satisfaction with the area during treatment ( $M = 29.63$  at the beginning,  $M = 33.61$  at the end), which was not achieved in patients broke abstinence ( $M = 29.96, M = 30.40$ ), and “abstainers” compared with “non-abstinent persons” declared a higher satisfaction with leisure activities at the end of therapy ( $M = 33.61, M = 30.40$ ).

A similar result was obtained with friend relationships. There was an instance of a significant main effect at the research stage  $F(1,123) = 9.33, p = 0.003, \eta^2 = 0.07$ , a lack of significance in group membership  $F(1,123) = 0.04, p = 0.834, \eta^2 = 0.00$ , and significant interaction  $F(1,123) = 10.34, p = 0.002, \eta^2 = 0.08$ . Patients were more satisfied with friendly relations at the end of treatment than at the beginning ( $M = 32.88, M = 31.40$ ), and (simple effects analysis) a significant increase in satisfaction took place only in those who maintained sobriety throughout ( $M = 30.83, M = 33.85$ ); they had a higher level of this variable at the end in comparison with those breaking sobriety ( $M = 33.85, M = 31.88$ ).

Satisfaction of their own homes indicates a significant main effect at the research stage  $F(1,123) = 4.01, p = 0.047, \eta^2 = 0.03$ , insignificant group mem-

bership  $F(1,123) = 0.44$ ,  $p = 0.505$ ,  $\eta^2 = 0.00$ , and significant interaction  $F(1,123) = 5.36$ ,  $p = 0.022$ ,  $\eta^2 = 0.04$ . Patient satisfaction with housing changed significantly during treatment; it was higher at the end ( $M = 33.40$ ) than at the beginning ( $32.42$ ), and those who maintained abstinence after treatment increase their satisfaction significantly ( $M = 31.29$  at the beginning and  $M = 33.32$  at the end), which did not occur in the second group ( $M = 33.55$  at the beginning and  $M = 33.48$  at the end).

Lack of correlation has been demonstrated for the last two dimensions: satisfaction with marriage or a relationship, and sex. In both cases there was no significant main effect at the research stage  $F(1,85) = 0.16$ ,  $p = 0.695$ ,  $\eta^2 = 0.00$ ; in the case of marriage  $F(1,123) = 0.28$ ,  $p = 0.597$ ,  $\eta^2 = 0.002$ ; in the case of sex and membership respectively  $F(1,85) = 1.70$ ,  $p = 0.195$ ,  $\eta^2 = 0.02$  and  $F(1,123) = 0.70$ ,  $p = 0.404$ ,  $\eta^2 = 0.06$ . No significant interaction occurred:  $F(1,85) = 0.56$ ,  $p = 0.456$ ,  $\eta^2 = 0.00$  (marriage) and  $F(1,123) = 2.94$ ,  $p = 0.08$ ,  $\eta^2 = 0.02$  (sex).

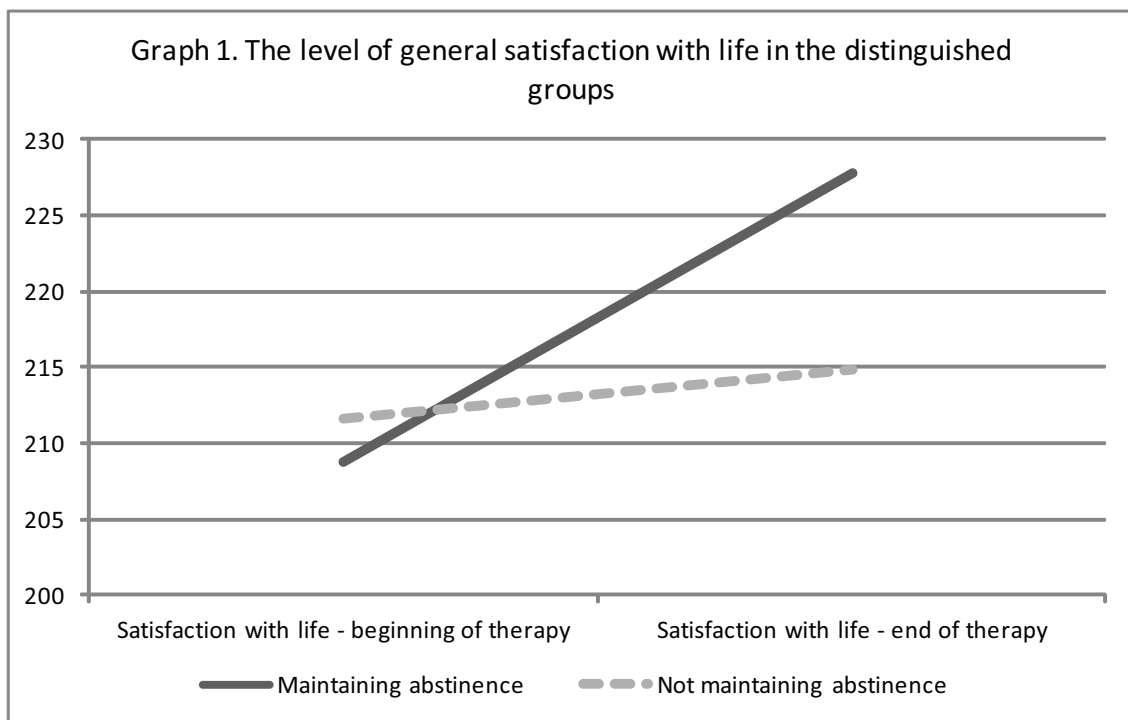
Overall satisfaction with life is the sum of satisfaction with health, finance, the self, leisure, friends, home and sex. Significant overall satisfaction was reported as at the research stage  $F(1,123) = 25.70$ ,  $p < 0.001$ ,  $\eta^2 = 0.17$ . Comparison of the mean indicates that addicts were more satisfied with life after therapy than at the beginning ( $M = 210.22$  before and  $M = 221.42$  after). There was no significant main effect for group membership  $F(1,123) = 0.62$ ,  $p = 0.430$ ,  $\eta^2 = 0.05$ ; there was, however, significant interaction for both variables  $F(1,123) = 13.03$ ,  $p < 0.001$ ,  $\eta^2 = 0.10$ . Patients maintaining abstinence significantly increased their satisfaction during treatment ( $M = 208.78$  at the beginning and  $M = 227.92$  at the end), which did not take place with those returned to drinking ( $M = 211.67$  before and  $M = 214.94$  after therapy). Furthermore, when the two groups were compared at the end of treatment the abstainers had significantly higher levels of overall satisfaction with life ( $M = 227.92$   $m = 214.94$ ). Graph 1 shows the result.

In addition to satisfaction with life, positive and negative affect was analyzed. Regarding positive affect, the situation was similar to many life dimensions - there was a significant main effect at the research stage  $F(1,123) = 20.30$ ,  $p < 0.001$ ,  $\eta^2 = 0.14$  and no significant effect of group membership  $F(1,123) = 0.364$ ,  $p = 0.542$ ,  $\eta^2 = 0.01$ . After therapy, patients had a higher positive affect ( $M = 33.56$ ) than at the start ( $M = 31.15$ ). There was also interaction  $F(1,123) = 4.12$ ,  $p = 0.04$ ,  $\eta^2 = 0.03$ , and the analysis of simple effects revealed that a significant increase in feeling this affect took place only among the abstainers ( $M = 30.92$  at the beginning and  $M = 34.41$  at the end). Graph 2 shows the results.

The analysis of variance was different with negative affect. There was a significant main effect at the research stage  $F(1,123) = 20.30$ ,  $p < 0.001$ ,  $\eta^2 = 0.14$  and a significant group membership main effect  $F(1,123) = 5.01$ ,  $p = 0.02$ ,  $\eta^2 = 0.04$ .



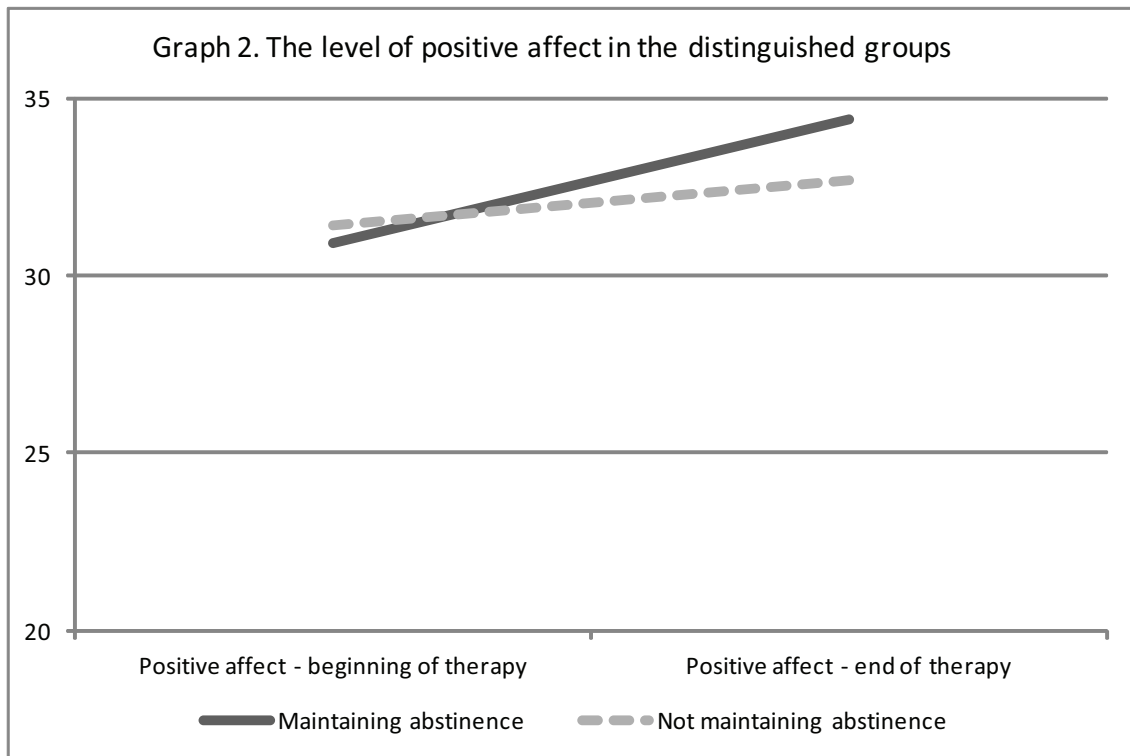
= 0.03. Comparing the mean indicated that the patients' level of negative affect decreased during treatment ( $M = 29.38$  at the beginning and  $M = 23.17$  at the end). In addition, those maintaining abstinence were characterized by a lower intensity of affect ( $M = 24.88$ , with  $M = 27.62$  for those who had broken abstinence). In the negative affect, neither variable showed interaction,  $F(1.123) = 0.14$ ,  $p = 0.700$ ,  $\eta^2 = 0.01$ . (See Graph 3.)



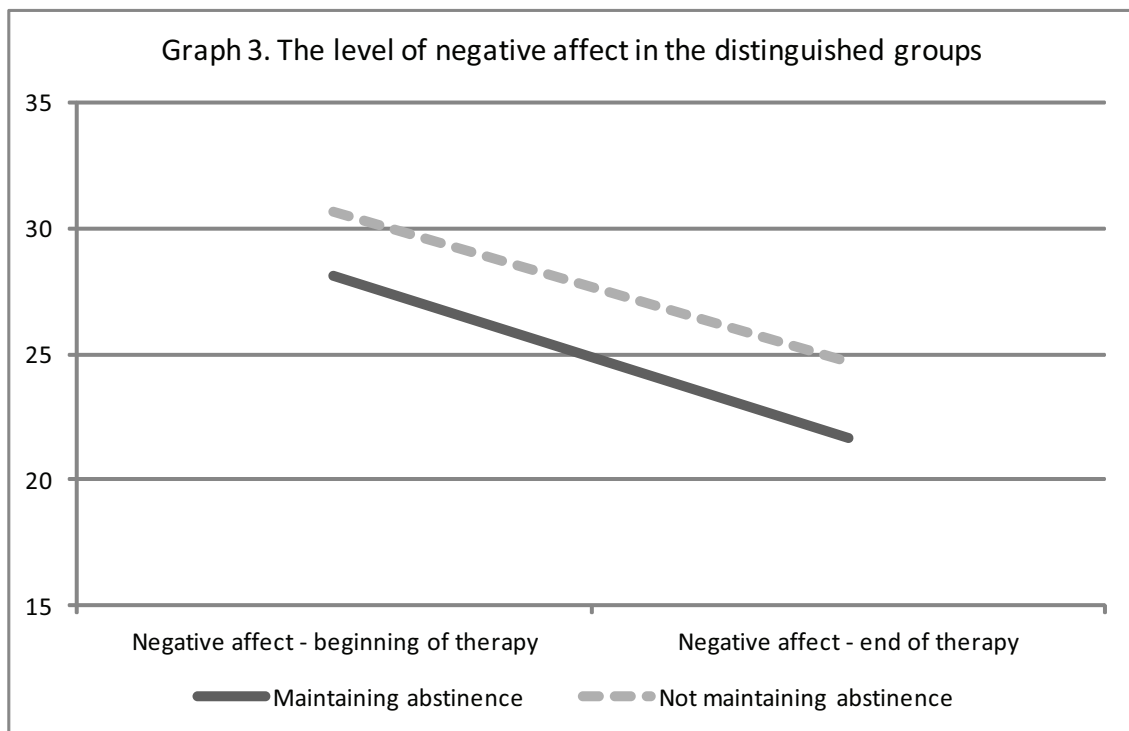
## Discussion of results

Among the many challenges that alcohol dependence brings, low therapeutic effectiveness should be regarded as basic, with a high percentage of patients discontinuing treatment, or returning to drinking after its completion (a.o. the COMBINE Study Research Group, 2006; Hester, Miller, 1995; Project MATCH Research Group, 1997, see also Wojnar et al., 2007).

The present study was part of a wide trend to examine the relationship between patient characteristics and effects at therapy, but also concentrated on the sparsely explored quality of life. It was assumed that the level of this variable in patients maintaining abstinence after treatment would be higher than in those returning to drinking (H1) and that in the course of treatment only the abstainers' quality of life would significantly increase (H2).



The results indicated that at the early stage of treatment among those who maintained abstinence and those who relapsed to drinking, there were no sta-



tistically significant differences in overall life satisfaction as well as in positive and negative affects. The results that Foster and others obtained (1998), showing a positive correlation between life quality at the beginning of therapy and the incidence of relapse in alcoholics, are therefore not confirmed. The explanation for this discrepancy may lie in the methods - those researchers used a method to measure the quality of life conditioned by health (Rotterdam Symptom Checklist, Nottingham Health Profile), whereas in the present study tools were used that measured life satisfaction and affect. Moreover, the researchers monitored the patients within a relatively short period of 12 weeks. In future studies it might be worth measuring with various tools the relationship between quality of life and relapse (breaking abstinence), and during both shorter and longer times after treatment.

With regard to the variables measured at the end of therapy, the situation was different. Finishing treatment, alcoholics who maintained abstinence were, in comparison with those who did not succeed, more satisfied with their overall health, mental and physical condition, resistance to disease and pain (health), leisure, hobbies, time spent with closest persons, and social relations with colleagues, friends, neighbors, and relatives. General satisfaction with life was higher as well. The remaining variables did not differ in the two groups. It is noteworthy that in the literature there are no reports on the relationship between life quality measured at the end of therapy and how the addicted patients subsequently fared.

All results indicate that the first hypothesis was partially confirmed.

The most significant differences between groups maintaining abstinence and those relapsing to drinking related to changes in the course of therapy. Statistics indicate that only abstainers experienced during treatment a significant increase in satisfaction with their living standard, income, ownership state, leisure activities, relationships with close friends and acquaintances, and the size, condition, location, connections, and cost of their own homes. General satisfaction with life and the frequency of positive emotions increased as well. At the same time no growth was recorded in patients who returned to drinking. The result confirms Chodkiewicz's study (2001, 2002), which demonstrated a similar dependence on life satisfactions (as measured by the Satisfaction With Life Scale by Diener et al.) in men participating in the treatment - growth during treatment occurred only in people who had maintained abstinence following its completion. Also confirmed by Foster and others (2000) was the relationship between increased life quality conditioned by one's state of health during treatment, and the reduced amount of alcohol drunk later. It is worth noting that most previous studies focused on this variable's changes without ever analyzing future patient fate (e.g. Ginieri-Coccosis et al., 2007; Morgan et al., 2004; Lahmek et. al., 2009). The present study also showed

an increase in the multiple dimensions of life quality during treatment for all the abstinent alcoholics; but in maintaining their abstinence, the subjects showed considerable heterogeneity. This conclusion corresponds with Bętkowska-Korpała's results (2011), which show favorable self-regulatory changes in implementing the therapy in those who maintained abstinence after it.

In trying to explain the results, it seems desirable to appeal to the transtheoretical model of change by Prochaska and DiClemente (e.g. Prochaska et al., 2008). According to this model the action phase involves introducing real-life behavior modification and requires the greatest commitment of time and energy. In this phase, reward and counter conditioning are the most helpful processes. It seems that better life quality and the satisfaction felt by some patients with this new behavior (e.g. more leisure time, improved financial situation, friendships, perceived feelings) can play such a role and thus contribute to maintaining change (in this case abstinence).

The result provokes further research on the question, Why, in some patients, is treatment duration a period of positive changes, while in others these changes are not present? More research is needed that covers a wide set of variables instead of isolated ones. In practical terms, these results suggest the necessity to pay attention to how patients subjectively rate their lives during treatment and to pay attention to "risk groups" (those who do not experience positive changes but undergo only changes for the worse). This can be done, for example, by working closely with patients to analyze the pros and cons of alcohol use and abstinence (see Beck et al., 2007). It is also worth looking closely at therapy plans prepared by therapists. Perhaps in relation to some patients, therapists falsely discern the main problem areas or insufficiently recognize the patient's real needs and abilities.

The findings also indicate that there are quality of life dimensions within which no changes occur during treatment in both those who abstain after treatment and in those who do not. It is about satisfaction with work, children, marriage and sex. This result seems understandable, since therapy treatment focuses primarily on losses associated with addiction, disarming its mechanisms, coping with craving for alcohol, and recognizing that in fact one is an alcoholic (Cierpiałkowska, 1997; Cierpiałkowska, Ziarko, 2010; Mellibruda-Sobolewska-Mellibruda, 2006). In addition, the destruction caused by alcohol in those areas where satisfaction has not changed seems to be biggest and often requires further therapy (such as marriage and the family), conducted just after basic treatment (Cierpiałkowska, 1997; Lindenmeyer, 2007). Attention, however, should be drawn to the fact that quality of life changes conditioned by health (e.g. SF-36) show significant improvement across all dimensions related to physical and mental health (e.g. Lahmek et al., 2009; Morgan et al., 2004). The obtained result thus speaks to the validity of the

postulate concerning the expansion of the quality of life tested in alcoholics with aspects not related to health, what enables us to see the functioning of patients in a much broader perspective (see Laudet et al., 2009). From the practical point of view it has been confirmed that patients must realize that participating in therapy, and even its completion, does not necessarily translate into immediate changes in many important areas of life. As pointed out by Woydyłło (1992), alcoholics are prone to unrealistic expectations about sobriety, and may break their abstinence in a “clash” with reality. Furthermore, as Beck and others (2007) explain, many addicts have a low tolerance for frustration, and focus only on the present. It seems that such patients find it difficult to stay sober in situations where they expect changes (e.g. concerning improved relations with the spouse) but which do not occur despite participating in treatment and maintaining abstinence. So work on patient expectations in relation to sobriety appears to be much needed. In summing up the above analysis, it is clear that the second hypothesis was partially confirmed.

The entire foregoing considerations indicate that quality of life has numerous links with alcoholics’ maintaining abstinence, which should be an inspiration for further study and for modifying treatment programs according to their results. In such studies, time perspective should be taken into account, which can show the dynamics of changes in life qualities during treatment, and later as abstinence lengthens. Future exploration should take into account not only the dichotomous classification of patients drinking and not drinking, but changes in the frequency and the amount of alcohol drunk by them after treatment as well.

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