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ALCOHOL ADDICTION FROM THE ATTACHMENT THEORY POINT OF VIEW – A CASE STUDY

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Summary: Addiction to alcohol in terms of the attachment theory is considered to be a reaction to the disorders concerning the attachment and it is highly probable that the alcohol abuse will develop among people with insecure attachment styles, as it is indicated in quantitative research results. It is often claimed that the addict's basic problem is the inability to internalize an experience of having proper relationship with others, which — assuming that the main function of the attachment is the acquirement of emotion regulation skills — makes it impossible for the person addicted to rely on his/her own internal resources or on any human attachment figure. Psychoactive substance appears to be a substitute for the secure base, a new attachment figure which is associated with the feelings of being cared and soothed. The article comprises, in the view of the attachment theory, a case study of a patient addicted to alcohol who is treated in an individual psychodynamic therapy. The presented case study stands for an attempt to understand the life story, attachment relationships, identity and the addiction of the patient in the context of the attachment theory tenets.

Introduction

According to the contemporary researchers, Bowlby's theory of attachment, describing the essence of the bonding that evolves between the caregiver and the infant in the early childhood, is very significant in order to understand and explain a healthy development or etiology of any mental disorders in all stages of human development [1]. The attachment does not determine the development definitively, but it will conduce to certain ways of development, because — according to Bowlby — the attachment styles constitute different human development paths [2, 3]. The correspondence between the attachment and the future development may be explained by four, not mutually exclusive, mechanisms [3]. Firstly, it is believed that the infantile experiences, also those concerning the attachment, have an

influence on the developing brain of a child, which results in long-term changes at a neural level, as it was indicated in various neurobiological studies. The bond between the child and the caregiver profoundly shapes the structure and the functions of the limbic system and the right hemisphere which are crucial for processing emotions. According to Schore, they are responsible for the development of bonds, internal working models, emotions, non-verbal communication and unconsciousness [3–5]. Secondly, the attachment relationship can be a base for molding the emotion regulation ability because of the process of internalizing the ways of affect regulation involved in this relationship [3]. It is claimed that the effective emotional self-regulation is connected with the secure attachment; whereas the insecure attachment styles are related to the disorders of emotional regulation [5], which is important due to the fact that the emotional regulation disorder is said to be one of the primary mechanisms of any kinds of mental disorders nowadays [4]. The third mechanism, which explains the relation between the attachment and the further development, includes the behavioral regulation and synchrony. The infant, who observes the caregiver and interacts with him/her, "learns" how to be in a relationship with another person and understand him/her. Thus the child develops certain social skills [3] and also an ability to mentalize [6]. The last mechanism refers to creating, while being in an attachment relationship, the representations of self and caregiver which encapsulate the convictions and expectations. These internal working models, created through the interactions with the caregiver, embodying the image of self, other person and the relationship with this person, are relatively constant, which means that they are regenerated in new relationships, having an influence on the behavior of the person, as well as the experience of oneself and the other person [3, 7]. What is important, only the secure attachment style features a positive representation of self and other people [8].

The concept of a bond emphasizes the significance of child's dependence on its caregivers and at the same time it gives an explanation of a popular opinion that a traumatic experience deriving from the close relationship in the childhood can be, in the context of forming a psychopathology, more significant than the genetic, constitutive or social factors [4].

There is a popular belief that a person who experienced an interpersonal trauma may be more susceptible to alcoholism. The relational trauma is considered as a specific risk factor that may undermine the capacity to create a healthy attachment to another person and self-regulate [9]. The alcoholism becomes then a complicated compensatory mechanism, which is also a manifestation of certain unsatisfied developmental and relational needs [9, 10]. It is said that the basic problem of a person addicted to alcohol, which prevails in his/her mental reality, is the inability to internalize the experience of being in a good relationship with others, which — assuming that the main attachment function is the acquirement of the emotion regulation skills — indisposes the addicted person to make a use of internal resources as well as to any attachment figure [10–12]. As a matter of fact, people with the secure attachment style develop their disposition to search, use and maintain the social support in order to cope with negative emotions [12]. Whereas people with insecure attachment styles, whose lack of trust towards others and feeling of being unwanted, abandoned, neglected, unimportant and unloved are easy to observe [13, 14], may use the alcohol as a pathological method of emotional regulation which compensates any deficits in this matter [10, 12].

Alcoholism is therefore understood as an expression of a desire for intimacy, which is too painful to fulfill in a relationship with a human object, towards a neutral, impersonal object, which is the alcohol. The psychoactive substance is experienced as a "secure base", new attachment figure, which fills the internal emptiness that is an effect of the lack of a secure relationship with a human being. It quashes the need for intimacy with another person and provides a person with a false feeling of self-regulation [10, 11, 14, 15].

There is some evidence to suggest that the addiction to psychoactive substances, including the alcohol, and social attachment have a common neurobiological ground [16] which is connected with the dopamine reward system [17]. The psychoactive substance abuse and addiction are defined as attempts at replacing the endorphins (as endogenous opioids), which are produced in a natural way by means of social attachment [14, 17]. Therefore it appears that the alcohol may act as a mean to relieve the pain arising from the lack of a secure attachment [10].

The research shows that the insecure attachment style among people addicted to alcohol is a common occurrence. The percentage distribution of the prevalence of insecure attachment styles in this group ranges from 66% to 94.6%, while the secure attachment style from 5.4% to 40% [18–20]. The research also suggests that among the people addicted to alcohol the attachment dimensions develop differently than among people without an addiction. The dimensions of avoiding closeness and fearing intimacy reach a considerably higher level [21]. Moreover, people addicted to alcohol with insecure attachment styles and adversely intensified attachment dimensions obtain higher results in the range of intensity of symptoms of mental disorders — of depressive and schizoid type, and also of alexithymia and anxiety as a trait [19, 22, 23].

It should be stressed that the result of a developing attachment relationship is, being in a close connection with various biological, environmental and psychological factors, the process of developing the identity. It is often assumed that the "development of a relationship with the object is an essential condition for developing an identity" [24]. A specified and shaped identity is the base of mental functioning of a person and it is the superior regulator of psychosocial functioning, because it facilitates the description of oneself, making choices and introducing changes in life, it determines the stability and behavioral coherence as well as the ability concerning creative adaptation to reality [24, 25]. A sense of individuation, self-continuity, internal coherence and maintaining the internal content constitute the identity [24]. The establishment of a coherent, individual and stable identity is understood as being critical for human development and it is also an indicator of his/her psychosocial maturity [25, 26]. Concerning the developmental and clinical approaches, it is important that the identity based on a solid foundation provides a person with a sense of security [24, 25]. On the other hand, dysfunctional identity may be manifested by: sense of losing the boundaries between the Self and the external world; lack of internal content; sense of emptiness, lack of knowledge of who you are; missing sense of continuity with oneself from the past; sense of the Self being fragmented; lack of internal coherence; losing the sense of existence; or the sense of unreality of person's own existence [24, 25].

People addicted to alcohol appear as suffering from the pathology concerning the relationship with the object and the attachment relationships [10, 27, 28] which results in deficits in the area of the identity: inability to maintain a coherent and satisfying concept of

self [29]; fragility and risk related to the sense of being or representation of self [14, 21, 28]; hurting and impairing of self [10, 30]; experiencing an unconscious, profound uncertainty concerning the right of living, having the individual identity and losing the sense of identity [30]. Having the above description in mind, alcoholism becomes a way to obtain a new identity — as being addicted — and this very identity is to protect the person from the past as well as from the future and helps define his/her place in the world, which to this point remained undefined due to a lack of secure sense of identity [13]. The addiction to alcohol becomes an attempt to rescue from the overwhelming sense of hopelessness caused by the damaged identity [31], broken sense of self [32, 33] and it is a kind of a defense from further fragmentation of self [28]. Alcoholism is perceived as a life-and-death struggle to maintain the living sense of self, still being threatened by the massive uncertainty concerning the self [34]. On the other hand, the addiction to alcohol causes secondary trauma, divestiture of liveliness, identity and internal resources [35], and deteriorates the sense of self [9].

Regarding the quantitative empirical research which involved people addicted to alcohol, it should be stressed that there are very few of them that would be based on identity theories [36]. The research dedicated to the issue concerning identity of people addicted to alcohol tends to focus mainly on the matter connected with acquiring the identity of an "alcoholic", "recovering alcoholic" as well as on the identity reconstruction during a treatment, attending the Alcoholics Anonymous Meetings and the role of these processes in maintaining abstinence, sobering and relapsing [37, 38]. The relevant reports from the research conducted mainly among adolescents and students point out that the development of the identity has a significant influence on the control of alcohol units consumed. People who developed a diffuse identity or an identity which is not flexible during the puberty tend to consume considerably more alcohol than the people with a consolidated, acquired identity, which has better evolved during the puberty [39, 40].

Mr A.: Introductory information and life story

Mr A.[1] went for an individual psychotherapy in a psychodynamic approach conducted by the author of the article. He was 34 years old; graduated from a higher education institution in the field of Physical Education; worked as a physical education teacher in a school located in a small town. In his case the addiction to alcohol was diagnosed 5 years before, when he was subject to his first, year-long ambulant addiction treatment. The addiction to alcohol started to develop when Mr A. began his studies; at that time he was ca. 20 years old.

The main reason for coming forward to therapy was giving up abstinence from alcohol and drinking five beers at once a month before making the decision to go to psychotherapy. At his wife prompting, Mr A. met his case therapist in a centre which he had been visiting regularly before. The therapist recommended an individual in-depth therapy. Regarding the therapeutic contract, the patient agreed to attend a long-term psychotherapy with an indefinite period of termination. After the preliminary diagnosis established during the first consultation meetings with the patient, it was assumed that one of the major problem of the patient (apart from the addiction to alcohol) was a serious difficulty maintaining close relationships with

[1] The personal and biographical data concerning the patient were changed. The permission to publish was obtained from the patient.

others; the patient from the first meeting presented the traits connected with the avoidant attachment style[2]. Establishing a secure therapeutic relationship was considered to be a starting point for the development of a new attachment style for the patient, new ways of affect regulation and also constructing the identity [41]. It was assumed that the alcohol drinking may derive from patient's deficits in the range of attachment relationships and it can be a mean of filling the internal emptiness caused by the lack of a secure relationship with a person [10, 15]. Thereby, the aim of the psychotherapy was to address and change the relational difficulties of the patient on the basis of a secure relationship with the therapist [41]. What is more, the patient committed himself to maintain a total abstinence from alcohol, which was abode by him. After half a year of attending the psychotherapy, the patient gave it up.

Drawing up of the life story of Mr A. is relatively not easy because of patient's poor narration and lack of spontaneity in his spoken expressions concerning both — past and present incidents in his life, what was typical for this patient. Nevertheless, it is significant in the way of understanding the patient.

The family of Mr A. was complete. The patient recalled his mother as dedicated to chores, non-working. The father of the patient was addicted to alcohol, but he had maintained abstinence for 10 years. Mr A. stated that he does not remember any occurrences with him being involved, except for one walking tour: "I remember the hiking route to this day". The patient declared that, later when the father gave up drinking, he motivated his son to start the addiction treatment, but "Nothing he said back then got to me — it still doesn't — it went in one ear and out the other".

The patient had a five years younger brother. When Mr A. was eight years old, his brother died before his and his mother's very eyes: "He choked on something, we couldn't rescue him". The patient still does not know any details concerning the death of his brother. Apart from the funeral, Mr A. does not remember any other incidents connected with his brother: "I do not remember me and my brother playing with each other, I remember only the funeral. I was standing aside, with my uncle, and I was crying. On the whole, I do not know why I was standing aside. I can recall only the condolences from my class teacher". The period of time before and after the death of his brother the patient describes as void of memories: "I cannot remember, how I lived at that time, what was happening next". When he was asked about the relationship with parents of that time, he answered: "Without any doubt, the father was drinking and he was not around. The mother, on the other hand, was at home, but I cannot remember anything when it comes to her".

When he was in the sixth grade, the patient started spending increasingly more time away from home. He joined a group, which he describes as "criminal": "Maybe I was not the leader of this group, but, with my strength, I was ahead of other members". The patient, together with his friends, was initiating some fights and stealing, what at the beginning of high-school eventuated in being caught by the police. Afterwards the man was convicted and had a probation officer's supervision assigned. While attending high-school, the patient did not make any new friends. He was meeting his friends relatively infrequently, preferably in

[2] The diagnosis will be extended and explained in the further part of the article.

order to buy marijuana — the patient, at that time, smoked marijuana several times a month "always being alone" and additionally drank alcohol, mainly beer. According to the patient, the use of psychoactive substances gave him "great pleasure, relax". In high school Mr A. started practicing sports, mainly football. He attended training sessions several times a week: "I liked it then and I like it now".

Soon after Mr A. began studying, he became emotionally involved with Mrs B., currently his wife. While studying, they lived separately, met occasionally due to numerous classes, Mr A.'s job and his progressive addiction to alcohol: "I felt relieved when I quarreled with Mrs B. We did not have to meet on the next day if we had fallen out with each other, so I was able to drink more. I turned on my heel and I got the alcohol"/"I enjoyed the fact that I did not have to call and meet her on the next day". During college years and to this day Mr A. has not been smoking marijuana; still he was indulged in alcohol when alone, up to 5–6 beers at once a few times a week. When Mr A. graduated from college, he moved in with Mrs B. in a rented flat in a small town. Both of them got employed. Soon afterwards, they decided to get married and start a family. During the school year Mr A. used to drink smaller doses of alcohol on weekdays, at the weekends, by contrast, he developed a style of heavy drinking. During the winter or summer holidays, he drank more. Drinking alcohol was interrupted by many periods of time in abstinence (from a few weeks to a few months). Mr A. decided to maintain abstinence partially because of the requests and demands from his wife, partially due to his father's interventions, but also on the grounds of his increasing awareness concerning his addiction to alcohol.

Along with the first pregnancy of his wife, Mr A. got involved in an addiction treatment in an ambulant treatment centre which lasted for a year. After finishing his therapy, he maintained a total abstinence for one year. During that time, he started building a house for his family, and he also intensively began doing physical exercises. One year later, after finishing his therapy, he "agreed" with his wife to drink only one beer twice a week: "in the evenings, after workout". Mr A. referred to his ritual as follows: „I was waiting for these evenings. I enjoyed them. I was always alone, B. never joined me, usually she was already asleep. I was okay with that". Mr A. claims that he never drank more than one beer at once. This ritual lasted for three years, by the time Mr A.'s wife got pregnant for the second time. At the beginning of her pregnancy, Mr B. demanded from Mr A. not to drink alcohol at all. Mr A. obeyed this demand for a while. The following is his account on the relapse that took place half a year later: "One day I was cleaning up the garage, which had not been cleaned for many years, and I found 5 beers. At first I put them in a locker. In the evening I came back to the garage and I drank them. My wife caught me doing that and said that either I go back for a therapy or she will divorce me".

Mr A.: Interpretation based on attachment theory

It was difficult to build a therapeutic alliance in the relation with Mr A. that would allow for better exploration and understanding of his internal world — both by the therapist and by him himself. On the one hand the patient came to every therapeutic session, on the other hand — a lack of unconstrained narration was easy to observe and the moments of silence were filled with tension, anxiety, sadness and emptiness. The question asked by the

therapist and the comments breaking the silence resulted in patient's desultory reactions. Nonetheless, it appeared that it was not a sign of patient's psychological resistance, but his personality answer to a situation of closeness with another person.

While the therapy was moving forward, the internal representations of close persons and relationships with them were manifested in a painful manner.

The loneliness and abandonment dominated Mr A.'s childhood story. The memory concerning his brother's funeral was recalled with agitation. During the funeral ceremony Mr A. was cared for by his — supposedly "random" — uncle (it was not an important figure to Mr A.). This memory contained a story of being abandoned by the parents. The story has its continuation in a bad memory of any interactions with them. At the same time, a detailed memory concerning a single trip with his father seems to express patient's desire for emotional closeness, being noticed and longing for such a state. Regarding relationship with his brother, it appears as thought-provoking, whether the lack of memory concerning time spent together is not a denial of a close or any sort of relationship with him and thereby it seems to be defensive in relation to the feeling of love towards his brother and sense of guilt related to his death.

Despite patient's claim that his relationship with Mrs B. is successful, it did not seem to be based on a sense of security, mutual closeness or intimacy. The wife appeared to him as dominating, bossy and assessing him when it comes to household duties. On the other hand while being passive he had a feeling that he does not actually get involved in the family life or in the relationship with his wife. This is how the patient commented on his attitude towards the wife: "Hugging her never crossed my mind. Surely she would be happy about that, it would be important to her". When he was asked in what way he understands his difficulty in creating an atmosphere of closeness with his wife in such situations, he responded: "If I had to come to my wife and hug her, it would be hard for me to remain serious — I would fall into pieces. I would not be able to say anything smart — as I should at such moment". Concerning the relationship with the wife, the fact that the man explained his motivation for abstinence caused by thinking about children was significant: "I would not drink because I would hurt my children's feeling". When he was made aware of not mentioning the wife in this context, he said: "I am surprised that I did not say it. B. would be truly disappointed if she heard it". What is more, Mr A. never told his wife about his father's addiction to alcohol: "I didn't tell her, because she didn't ask. You did". Ritual, lonely and drunken evenings can be useful to symbolically interpret Mr A.'s behavior as being incapable of creating a secure attachment relationship. It seemed that the patient consciously and unconsciously attributed the functions of an attachment figure to alcohol which appeared to be better than the figure of the wife.

In the sphere of the relationships with other people, a 5-year-old daughter of Mr A. appeared to be important, about whom the man started to talk at the end of the interrupted therapeutic process. The patient said that his daughter slept with him and his wife in one bed until she was three years old: "I liked it, I was lulling her to sleep, I was reading her stories. I felt the lack of it when the daughter started to sleep separately. I missed it". It was Mr A.'s initiative to sleep with her on Sundays: "During the week the daughter was often asking when would Sunday come. I was very pleased. I also enjoyed the fact there was not my wife around during the labor of my second child. When my wife was at hospital, I could sleep with my daughter". At the same time, the patient was talking about his fantasies that one day his

daughter would marry somebody: “I thought about that I will lead her to the altar and I do not feel good about it. I will be lonely — again”. Such an approach concerning the relationship with his daughter can be understood as an expression of unconscious, hidden desire for closeness, which cannot be fulfilled in a relationship with an adult woman (person?) for fear of being rejected. One can get the impression that the patient felt safe in the relationship with his temporarily dependent daughter. Moreover, it appears that the patient could use a defense mechanism of reversal — treating his own desire for being loved and cared for as threatening and dangerous, because it is bound to fail, he indirectly fulfilled his need of being dependent through expressing his affection and care to daughter, at the same time unconsciously identifying himself with the gratification experienced by her [42].

Furthermore, it is important to emphasize the fact that when the psychotherapy matters related to the daughter occurred, Mr A. decided to end the therapeutic contact. It appears that the daughter symbolized actually his own, very powerful need for closeness, which could not be fulfilled in a relationship with the wife or with the psychotherapist because of the pain deriving from his experiences of not fulfilling it by parent figures. The further exploration of this strand would be excessively threatening. What also appeared as crucial was a feeling that patient’s unconscious fear of being abandoned provokes the patient to attempt to take control over the therapist by means of abandoning the therapist. At the same time, while holding an internal model of the self seen as abandoned by others (parents, brother), and internal operational model of others as abandoning — bearing in mind that the present functioning of a person is the reflection of a relationship with objects in the past [43] — he provoked abandonment. This also happened in a transferential-countertransferential relationship. Before one of the sessions at the beginning of the psychotherapy process, the psychotherapist got a text message from Mr A.: “I am sorry. I will not make it at 10 a.m. because I am in hospital”, which the psychotherapist interpreted as absolutely explicit that the patient will not come to a session and she left the office. A few minutes past 10 a.m. she received a phone call from a psychotherapist from the next-door office saying that Mr A. is waiting for her. Taking into consideration the problematic issues concerning the patient, it was understood as a reconstruction and repetition of one of the most important, unconscious fears of the patient — that he will be abandoned. Two types of feelings occurred in countertransference during the therapy meetings with Mr A. On the one hand, the psychotherapist identified herself with patient’s pain, sadness, anxiety and emptiness (symmetrical countertransference) [44]. On the other hand — she recognized in herself a need to account the patient for his activity in the process of psychotherapy, to aggressively confront him with his passivity, to make him talk. It appears that in the above mentioned case she identified herself with patient’s wife, feeling at the same time that this way of being with him is equal to abandoning him.

Mr A. appears to be a person devoid of content in terms of his personality. He uneasily discussed various elements of his life story; it seemed that a considerable part of his experiences remained hidden and therefore obtaining a feeling of coherence of his own personality proved limited. A defensive lack of access to his psychic and emotional contents as well as his impaired ability of exploring and embodying meaning caused an impression of incoherence concerning his identity. In everyday life (as well as in the therapeutic relationship) it was expressed in the lack of ideas on the topic of involvement in household duties. The patient functioned from day to day thanks to his wife who would write down what

should be done on a specific day and then hold him responsible for these activities. Furthermore the man played a role of a non-autonomous child who is permanently controlled in a relationship with his wife (the woman was repeatedly doing drug screening for her husband; she was bringing him to the therapeutic sessions and taking him back after its end). It seems that sport was the only domain in which Mr A. fulfilled his needs for autonomy in a more mature manner, and this most likely served as means to counteract his depression. In the context of the need for affiliation, the role in the world of the patient or his sense of belonging were not clearly defined. He did not have any close friends in his surroundings. The acquaintances who accompanied him in sport activities, did not know much about him.

Taking into consideration the available information concerning the patient's life story, current life situation and therapeutic relationship, including the transferential-countertransferential relationship, it appears that Mr A. was a person with an avoidant insecure attachment style, with strong tendencies of attachment avoidance and a high level of unconscious fear of intimacy. Considering the patient's difficulty in gaining access to the internal content, overwhelming sense of emptiness, lack of confidence concerning the definition of himself, his desires and fears, Mr A. appears to be a person who is not integrated and with an unstable sense of identity.

The role of alcohol in maintaining and creating the patient's psychopathology is noteworthy in terms of holistic understanding of the patient. It seems that — because he was unable to sufficiently interiorize good enough experience of being important and cared for in childhood by the parental figures, which was for example expressed in the lack of good memories of maternal and paternal love and care [15], and also taking into account his traumatic relational experience [9] of the brother's death — by the end of his adolescence, patient developed vulnerability for alcohol abuse, with alcohol being a symbolical substitute for human closeness [10]. The inability of creating a satisfactory relationship with another person (parents and the dissolved "criminal group" — not providing care or attention by definition) relatively fast led to generation of an internal operational model of relationship with a psychoactive substance, associated with a sense of security, calmness and protection [15]. At the same time, it seems that the alcohol functioning as an attachment object and filling the internal emptiness caused by the lack of a secure relationship with another person cancelled the need for closeness which significantly impeded, or even indisposed, creating a trustful and intimate relationship with the wife, other people or with the therapist [10, 14, 15]. Taking into account the phenomenon of substance preference, the selection of alcohol is associated with a profound defense from anxiety and discomfort experienced while being in a close, dependent and intimate contact with another person [29].

The noticeable deficits in the range of the early attachment relationships and internalized representations of parental figures could contribute to developing an apparently fragile identity, without an ability to maintain a coherent, continuous and satisfying concept of the self and defined needs for a mature individuality and affiliation. The abuse of marijuana and alcohol and the subsequent addiction to alcohol appear to be the patient's answer to his failure concerning the formulation of his own identity. This failure was intensified by the absence of constant, stable and multidimensional representation of the mother (who was not mentioned by the patient while telling his story) and the father (whose words "go in one ear and out the other"). The condition of overwhelming identity emptiness and deriving

helplessness and non-liveness seemed to be fixed by the alcohol which symbolically stands as a remedy bringing a sense of fulfillment, giving the meaning, being awaited.

Conclusions

Taking into consideration the prevalence of cognitive behavioral theories in the field of the psychology of addiction in Poland and also the low effectiveness of addiction treatment, it appears that developing other ways of understanding a person addicted to alcohol is justified and necessary [45]. The psychodynamic theories, including the attachment theory, may provide — as presented in the above case study of this article — a deep conceptualization of a person addicted to alcohol, through, for instance, the assumption that the addiction is a symptom of human psychopathology in a broad sense [46]. As far as these theories are concerned the object of an addiction does not attract as a magnet. It is the person who provides this magnetism [29, 46]. Whereas the essence of an addiction is a psychological pain which is eased by the use of a substance that makes the addiction a remedy, regulation, adaptation or a treatment [32]. The treatment of an addicted patient with an insecure attachment style is entwined with an attempt of providing the patient with a reflecting and supporting surroundings which is able to contain and copy with his negative, destructive urges and give him an opportunity to create internal representation of secure objects and identification with them. On the basis of such a relationship it is possible to help an addicted person to develop an ability of maintaining a mutuality and attachment in contact with others, which may help break the addictive cycle of alienation and isolation [10]. Developing the above-mentioned attachment process is crucial. It forms a potential to create new models of thoughts and emotions regulation and also it allows for the introduction of fundamental changes in the field of experiencing the external and internal reality by the patient [41]. The attachment relationship established on the sense of security shall help the patient in comprising a soothing internal "presence of the other", thanks to which it is possible to experience understanding and care and these feelings can be internalized [10]. This was the aim of the psychotherapy of Mr A., which, at the beginning, had been successfully pursued through systematic (although silent) attendance of Mr A. on the therapeutic sessions, clarification and giving the meaning to Mr A.'s difficulties in terms of the relationship with his wife and through the exploration of unsettled life motifs of Mr A (e.g. relation of the patient with his daughter). However, Mr A.'s abandonment of the psychotherapy may be interpreted as — typical to a patient with insecure attachment style — unconscious (comprising the suffering) compulsion of reproducing, in an interaction with the therapist, certain old models of relationships with parental figures of attachment, in which there was a lack of closeness, safety or support [41]. In this way, it can be concluded that any benefit from psychotherapy, which makes the patient to turn to another human (and not a psychoactive substance), was suppressed by, stronger at this point in life, the relational psychopathology. Nonetheless, as it is stressed in literature on the subject [10, 47] — conducting therapy with an addicted patient featuring insecure attachment style requires an effort in creating an attachment bond and developing a therapeutic alliance (for instance by means of containing the patient's characterological deficits). It should be also emphasized that impersonal deficits of the patient contribute, to a certain extent, to developing the substance dependence problem.

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