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Without Anaesthetic: Transformative Learning Among Therapy Ward Seniors

Bez znieczulenia – transformatywne uczenie się seniora oddziału terapeutycznego

ABSTRACT

In this article, I attempt to portray the symptoms of an elderly person being in crisis circumstances that encourage change through taking individual risks to increase control over one's own life. The goal of my research was to (re)construct the process of transformative learning trajectory of a senior patient in a therapeutic ward, which constitutes the stages of healing. This study was an attempt to understand the subject's inclusive effort on the road to recovery from the perspective of a therapist working in the Alcohol Addiction Treatment Unit (AATU). My focus on the principles of the interpretative paradigm led me to choose the concept of the kinesthetic subject and attempt to reformulate it on the basis of Jack Mezirow's transformative learning theory. The empirical part sought to find an answer to the question: how do interactions in AATU settings with a patient with alcohol use disorders enable transformative learning? The empirical material was derived from an in-depth interview with an addiction psychotherapy specialist, including the patient's subjective testimonials on the effectiveness of intentional and unintentional therapeutic interactions which illustrate the patient's learning experience during behavioral changes. The findings indicate that a change in the patient's frame of

KEYWORDS
hazardous alcohol use, senior therapeutic interactions, crisis, transformative learning

SŁOWA KLUCZOWE
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reference may result from an adaptive commitment to the rules of the therapy process, which force radical transformations of their previous behavioral patterns.

ABSTRACT

Inspiracją do podjęcia próby przedstawienia przejawów kryzysu kondycji starszego człowieka w okolicznościach mobilizujących do zmian była potrzeba zaakcentowania możliwości podejmowania ryzyka indywidualnego, zwiększającego kontrolę nad własnym życiem. Celem badań uczyniłam (re)konstrukcję konstytuującego etapy zdrowienia procesu trajektorii transformatywnego uczenia się pacjenta w wieku senioralnym w przestrzeni oddziału terapeutycznego. To próba rozumienia inkluzyjnego wysiłku podmiotu w drodze do zdrowienia z perspektywy terapeuty pracującego na Oddziale Terapii Uzależnień Alkoholowych (OTUA). Koncentracja uwagi badacza na założeniach paradygmatu interpretatywnego zadecydowała o wyborze koncepcji podmiotu kinestetycznego oraz próbie przeformułowania jego statusu w teorii uczenia się transformatywnego Jacka Mezirowa. Część empiryczna zmierzała do znalezienia odpowiedzi na pytanie: W jaki sposób oddziaływania w warunkach OTUA wobec podopiecznego z zaburzeniami używania alkoholu umożliwiają transformatywne uczenie się? Materiał empiryczny pochodzi z wywiadu pogłębionego ze specjalistą psychoterapii uzależnień, obejmującego odniesienia subiektywne pacjenta, efektywność celowych i niezamierzonych oddziaływań terapeutycznych w sytuacji doświadczenia uczenia się zmian zachowania pacjenta. Wyniki eksploracji wskazują, że zmiana ramy odniesienia pacjenta może wynikać z adaptacyjnego zobowiązania do przestrzegania reguł obowiązujących w procesie terapii, wymuszających na nim radykalne przekształcenia dotychczasowych schematów postępowania.

Introduction

A significant feature of addiction syndrome among seniors is its complexity. The layering of symptoms in various combinations and with varying degrees of severity—in addition to changes in neurobiological or cognitive structure, revealed before taking the risk of using/abusing a psychoactive substance and perpetuated during the process—combined with emotional disorders and changes in consciousness are only a part of the problem faced by patients in

therapy wards. The process of becoming sober, on the other hand, is a long-term path of struggle for oneself, which requires a significant effort from the addicted individual. Systemic measures from the state regarding prevention, counteracting substance abuse and constructively involving the staff of therapy wards aim to help addicts. For researchers, this is also material that can be described in a methodical and multifaceted manner. The actual causal capacities of therapy centres with the goal of patient sobriety are described in abundance in the literature on the subject. Undeniably, the individual, narrative approaches of therapists of addicts, full of arguments and meanings, are also of undeniable exploratory value in the patient's process of overcoming addiction. Research describing their recovery can be considered universal, and it can be analysed from a variety of perspectives, as the phenomenon of addiction, by virtue of its dynamics and important individual and societal effects, requires diagnostic exploratory action. On the other hand, the problem of learning in a situation of change is itself a specific application.

Specific features of the research

In the study, I used the results of research indicating the complexity of the cognitive-executive profile of an alcoholic, manifested by significant changes in the person's physical and mental functioning. What I referred to was a therapist's individual narrative about the meaning and conditions of an eight-week therapy programme undertaken by a patient in an alcohol addiction treatment unit (AATU), collected in an open-ended in-depth interview reflecting the biographical experience of the patient (therapy period), and a problem-focussed interview, i.e. a narrative in which the researcher can return to the main thread whilst supporting the subject, steer the conversation through additional questions when moving off-topic and ask questions about hitherto unresolved topics (Krüger 2007: 163–164). This made it possible for me to capture those experiences intended to induce the expected changes. The aim of the research was to (re)construct the constitutive stages of the patient's transformative learning process in the space of a therapy ward. In other words, it was an attempt to interpret and describe the therapist's statements evaluating the effectiveness of the therapy and certain reflections aimed

at improving the work of the therapeutic institution. The aim of the research can therefore be formulated as a question: How do interactions in an AATU with a client with alcohol use disorder enable transformative learning?

In order to analyse the learning processes in the situation of experiencing change, I used the theoretical background related to the transformative learning theory by Jack Mezirow. I indicate the stages of transformative learning on the example of the therapist's statement, and I describe the processes of objective and subjective transformation of the patient's frame of reference.

I decided to purposively sample the research (meaning that the researcher decides who is included in the sample group) with a specialised subject for working with people manifesting risky alcohol use, and to conduct the interview taking into account the subject's professional experience. This individual had experience of problematic alcohol abuse and had undergone addiction therapy as a form of transformative learning. The therapist's narrative indicates the stages of the patient's learning. The patient was chosen because of the tangible effects of change achieved through the therapy, i.e. a significant level of his thoughtfulness. The researcher's non-interference in the patient's peculiar space resulted from the patient's "burden" and the resulting fear of risking testing his knowledge, the research category I undertook, or potentially evoking a sense of his condition's "separateness". Undoubtedly, the fear of being too subjective and the likelihood of receiving answers that gain approval from both therapists and the researcher could be a factor hindering the patient's narrative. Learning about a person's path of recovery opens up the possibility of identifying those elements of institutional interventions that constitute the framework of the patient's recovery from addiction. The results of the research are presented in the form of an interpretation of the narrator's statements (Maison 2022: 271–272) in line with theory. An attempt was made to expose the boundaries and their transgression in the broad biographical perspective[1] of the patient

1 I identify three stages of transformative learning, using the therapist's narrative as an example, and the processes of objective and subjective transformation of the patient's frame of reference. Marek Ziółkowski (1990: 3–9), Ingeborg K. Helling (1990: 15), Danuta Urbaniak-Zając (2011: 20) and Alicja Jurgiel-Aleksander (2013) point out that biographical research is not

in his entanglement with the existential/social dilemmas he experiences, which undoubtedly makes the researcher and the reader sensitive to the problems and emotions of another person; this in turn can be a condition for understanding the microcosm under study. The therapist's narrative is a subjective, but also social construction; hence, the principles of this construction, based on the stages of the patient's transformative learning, are the aim of the analysis. In order to maintain the integrity of the text as a linear and chronological structure, I use a sequential analysis which respects the order in which the text develops the theme: what has been said causes expectations for the next sequence, i.e. it explores the continuity and biographical breakthroughs. I looked for connections between key decisions made by the patient and the therapist's interpretation of those facts (see Konarzewski 2000: 170–172). In addition, in my analysis I abbreviated the statements, summarising the main idea (Kvale 1996). The research was conducted in the AATU of a district hospital in northern Poland. A therapist with a university degree and eight years of professional experience was the interviewee.

Jack Mezirow's transformative learning theory

Jack Mezirow's concept of transformative learning concerns the learning process of an adult, as a result of which a profound transformation takes place in the individual's way of perceiving and interpreting themselves and the world. When the existing frame of reference turns out to be imperfect and the individual is unable to explain new experiences with previous ways of interpretation, the need arises to abandon the existing, dysfunctional frame of reference in order to consciously direct the individual's actions. This change in frame of reference can initiate transformative learning (Mezirow 2009: 90–93). The frame of reference is the culture and language through which the subject constructs the meanings of their experiences. Thus, therapy and self-work in overcoming addiction can foster a transformative frame of reference. In this sense, the frame of reference is the equivalent of a cognitive, emotional and motivational filter

a homogeneously coherent method, but a "perspective" that includes research practices that depend on various conditions.

imposed on sensory experiences. It shapes perception, allows for the pre-selection of cognition, determines the way of interpreting experiences and thoughts and indicates the direction of action. Thus, it is one thing to have the event itself and another to have the meaning attributed to it by the individual in their autobiographical narrative (Muszyński, Wrona 2014: 48). According to the dimensions of the frame of reference defined by Mezirow (2009: 86, 87), changes in mental habits (fixed ways of thinking and acting) occur very rarely, as they are located in the subconscious, and viewpoints are understood as less permanent manifestations of mental habits, constituting judgements, feelings and attitudes towards a given situation or person. Transformative learning can be related to the transformation of mental habits or viewpoints.

In order for it to occur, critical reflection by the subject on the determinants and the context of their knowledge is necessary. Transformative learning occurs in situations of conflict as a result of transcending the revealing symptoms of a problem (Illeris: 2003). Changing the previous frame of reference is a process that consists of three stages. The first stage is a critical reflection on one's own assumptions; the second is discourse (specific internal dialogue); the third is action. This process proceeds in the following order: (1) activating the process of changing the frame of reference as a result of a disorientation dilemma; (2) analysing oneself, which may be accompanied by feelings of shame or guilt; (3) critically evaluating epistemological, sociocultural and psychological assumptions; (4) recognising that other people are experiencing a similar state of dissatisfaction, causing a similar change in them; (5) recognising the possibility of choosing new roles, interpersonal relationships and activities; (6) planning a course of action; (7) acquiring the knowledge and skills necessary to carry out the plan; (8) attempting to take on new roles; (9) building competence and confidence in new roles and relationships; and (10) reinterpreting one's life taking into account the conditions set by the new frame of reference (Mezirow 2000: 10–11; Locraf Cuddapah 2005, after: Pleskot-Makulska 2007: 90). Subjecting a patient to a therapeutic programme involves the patient acquiring new experiences and insights emerging that are incomparable to previous ones.

The patient's experience of the therapeutic process reveals elements of epiphany and provokes changes in functioning. The changes

concern the reformulation of the subject's perception, the acquisition of a new approach to the knowledge they have about themselves, others and the surrounding reality and a change in the way they approach the acquisition of new experiences (Frąckowiak 2012: 147). The theory that explains the process of adult learning, leading to a transformation of vision or interpreting and making changes, is Mezirow's theory, described as an epistemological revolution in individual human development (Mezirow 1991, after: Pleskot-Makulska 2007: 82). This change is a transformation of thinking. As Anna Perkowska-Klejman writes, "transformations may be smaller or larger, and they may have a small or large impact on adult life. Their permanence can also vary. Transformations of thinking are closely related to our cognitive perspective which consists of our experiences, knowledge and sociocultural rootedness" (Perkowska-Klejman 2018: 33).

The experiences of a person who abuses alcohol undoubtedly generate life-long disorientation dilemmas, starting from the initiation of drinking, through changes in functioning and growing personal, family and professional crises, to a sense of helplessness and humiliation. Moreover, the disorientation dilemma of a subject exhibiting risky behaviour is the social space that excludes and stigmatises the alcoholic. The research refers to an attempt to understand the subject's efforts in overcoming addiction with institutional support. In the effort to change a lifestyle in which risky behaviour loses its appeal, meaning schemas are activated, i.e. specific cognitive structures with an expanded emotional and volitional sphere which function as a frame of reference (individual map or conceptual identity). It is formed by mental habits and points of view (Mezirow 1997, after: Pleskot-Makulska 2007: 86). According to Mezirow's theory, learning is a dimension of transgression in a human being that focusses not only on the status quo (the here and now), but is also orientated towards what may possibly happen and what should be made real and improved. Potentiality situated in education is constitutively linked to the idea of a "possible" human being, constantly becoming, aiming at something, striving for something (Ostrowska 2020: 36). Using this theory, I conducted an analysis of the therapist's reflections on the patient's learning in the space where they experienced changes.

Objectives of alcohol addiction treatment

In accordance with the appropriate standards, treatment in the alcohol dependence treatment unit is focussed on achieving the therapeutic goals of the basic therapeutic programme. The treatment process allows for learning about the mechanisms of addiction and gaining the ability to recognise changing patterns of thinking and reacting. During the diagnostic process, the patient is introduced to the basic concepts of identification, genesis and possibilities of constructively overcoming cravings and avoiding relapses. This is a particularly important stage of therapeutic work. The vicious circle of new life problems emerging and the inability to solve them as a result of changes in the patient's psyche can only be broken by stopping the drinking habit. Another therapeutic goal is to profile the real identity, i.e. become aware of the problem, its scale and the areas in which the addiction is destructive. In addition, the person with a cross-addiction problem has the chance to understand their own situation. This is about being able to see the consequences and the reactivity of substance use, but also about accepting one's addiction, recognising one's powerlessness and agreeing to consciously participate in the long-term rehabilitation process. The overarching aim of treatment in a therapy ward, however, is to create relatively sustainable motivation for further treatment, incorporating elements of interpersonal training, such as assertiveness training, communication workshops or emotion management workshops. The aim is to help those in the early stages of abstinence to increase their chances of maintaining that abstinence. This is achieved through lectures and talks on treatment options and the benefits of continuing treatment. The intended effect of these activities is to create intrinsic motivation in the patient, i.e. to help them take responsibility for their own treatment, to benefit from it and to improve themselves (Brusik 2012: 452).

Transformative learning space of the patient in a situation of change – therapist's narrative

Analysing the subject's everyday experiences, it can be presumed that he ceases to fulfil the formative roles ascribed to him (husband,

father and architect). At the same time, it reveals a state of cognitive dissonance, which is the first stage of transformative learning: the subject critically reflects on his existing beliefs. The previous ways of assigning meaning fail in the existing frame of reference; the subject experiences certain disproportions or discrepancies in his perception of himself and his environment, whilst becoming aware of his own deviation. From the therapist's narrative it can be concluded that gaining insight into the patient's behavioural change is a difficult and complex task, if only due to the unavoidably subjective axiological evaluation or the patient's assessment of his own behaviour, which inform about his internal states and the circumstances. This generates the need to initiate change. Another issue is the context of behavioural change and its determinants. The reactivity of the behaviour and the self-design of the change are conditioned by past experiences constituting the essence of their genesis or the change of the behavioural pattern. With reference to the patient's case, these areas are located in the space of favourable/unfavourable behavioural changes resulting from maintaining abstinence. From the perspective of achieving behavioural changes in the patient, it is important to define a targeted direction for therapy in the AATU programme, supporting the evaluation of intended changes or those that are a side effect of the round-the-clock stay in the unit, which forces the patient to adapt to the rules there.

The next stage in the change of the frame of reference is the search for a way of evaluating one's own and others' rationality. This is a kind of internal dialogue of the subject, resembling an analysis or deliberation of how to perceive oneself and others. It is a struggle with a very complex matter, connected with cognitive diversity, the multiplicity of meanings and senses discovered in the perspective of the dialectic of becoming a subject, the redefinition of the situation in which the subject finds himself and the difficulty of answering the same questions he asks himself again and again. According to the therapist, an important aspect of this is the positive self-perception of change by the patient. Initially, the patient struggled with not being able to stop the destructive activity, and his functioning was significantly different than his established habits of reaching for alcohol. Despite the cessation of drinking in the therapy ward, destabilising and compulsive patterns of behaviour continued on a spectrum from

hiding alcohol to entrenched aggressive responses in overcoming stress. The therapist emphasised that the common belief that it is impossible to return to drinking in a controlled manner points to abstinence as an effective measure for treating addiction. He noted that the patient's maintenance of abstinence is only one element of therapy in the AATU. However, taking into account the long period of drinking, this is a beneficial manifestation of the transformation of the frame of reference which gradually becomes more flexible to the changes introduced. The third stage of transformative learning in Mezirow's theory is action, i.e. taking action or not. In the complex therapeutic procedure (behavioural training: assertiveness vs aggressiveness or submissiveness; so-called recommendations for sober alcoholics: overcoming anger and alcohol cravings), it is important to understand self-destruction and to motivate the patient to change, specifically through constructive learning in order to change established addictive reactions and to broaden the range of one's behaviour. Apart from the targeted interaction with the patient, he is influenced by additional pharmacological, hygienic and dietary stimulation; he participates in occupational therapy, meetings with the therapeutic ward community and fitness classes. These are prerequisites for therapy in the unit, and failure to comply with them may lead to exclusion from therapy.

The patient participating in the individual and group therapy programme was an older man, married, with a secondary-school education, working as an expert auditor. He had started three therapy programmes, attended AA meetings continuously for one year, had been abstinent for about one and a half years and had been referred to therapy by court order (initiation of the blue card procedure).

One of the methods used in therapy is self-analysis by means of a "self-discovery guide", i.e. a kind of notebook in which the patient writes down his reflections on his family, work or his own aggressive behaviour. The patient is supported by educational lectures, because—as his case shows—the internal, perceived emotional burden is somehow redirected as the responsibility of others or fate, which in turn reduces his own sense of responsibility. The patient grew up in a family in which an authoritarian style prevailed, so he had a sense of misunderstanding of his needs or problems. The conversational dimension of the support relationship, as well as the

programme of the therapeutic ward, are assessed by him as elements that reinforce his potential and self-discipline. The patient makes an attempt to confront his previous way of thinking and functioning with the new understanding, finding himself in a new reality. The patient treats the therapeutic process in a task-orientated manner; he does not perceive attribution in the process of changing meanings; he is not intrigued by the tasks. Instead, he shows discouragement and resignation towards the suggested written forms of interaction. The effect thus achieved does not depend on the therapist's intentions and actions.

A turning point in the process of recovery took place in the fifth week of therapy. A significant predictor in the course of therapy was the patient's formative reformulation to match the expectations of the therapist and the group. Then, the patient made some adaptive inferences appropriate for the circumstances. He was reluctant to actively complete the written work, although he recognised some symptomatic benefits and made some behavioural adjustments. Personally, he demonstrated the ability to identify his own benefits: knowledge derived from symptoms, phases and stages of sobriety; a recognition of his powerlessness, limitations, opportunities, symptoms of losing control and alcohol cravings. A decidedly positive aspect in the patient's therapy was the deeper awareness of his personal problem, though it was difficult for him to make value inferences in the statements contained in the self-discovery guide under the heading "consequences of abuse". A problem that remained an unsolved "puzzle" in his case was the issue of family relationships. He definitely showed a tendency to avoid, keep silent or marginalise this topic; he felt a sense of shame, became angry and consistently avoided addressing the issue of the blue card procedure. The patient's self-testimony occurred in the first, second, sixth and seventh weeks of therapy, although it was largely located within the wishful, future sphere. This is a typical manifestation of the mechanism of addiction, also indicating that he perceived the problem and had potential motivations to change: avoiding places, people and situations with a risk of alcohol cravings; quality relationships with loved ones; his work situation; new interests or returning to previous ones. In his case, the assessment of the actual motivation to change patterns of his functioning was essentially predictive and declarative. The patient's apparent plan

to change his behaviour, necessary for immediate implementation, was not fulfilled. He was postponing his responsibilities, as shown in the description in the guide under the heading "focus on drinking". This in turn caused him more emotional tension, reinforcing his need to consume alcohol. Regardless of the time allotted for the patient to fulfil the therapeutic task (up to two weeks), he would do so on the day before the deadline. The patient learnt to adhere to the principles of the HALT programme, an axial part of the philosophy of recovery: "How to overcome danger whilst becoming sober?" In the context of developing a "new" worldview and giving primacy to common sense over negative emotions, the patient came to the conclusion that failing to cope with alcohol cravings during the therapy programme would prompt him to break his abstinence, which discouraged him. As a result, the patient's acceptance of the principles of the therapeutic programme did not develop a resilience to stress, as he neglected to eat regularly due to his desire to lose weight. Moreover, he gave up the optimum amount of sleep because of late conversations with fellow residents. The reasons undermining the effectiveness of his process of consolidating changes, which (according to the assumptions) should have prolonged his abstinence, included a short period of convalescence, an intense psychological mechanism of addiction in the initial phase of treatment or significantly consolidated harmful patterns of behaviour. Undoubtedly, the patient's analysis of his own problems in the in-depth individual therapy was a predictor that strengthened his motivation to make changes, move away from destructive alcohol use, learn about the mechanisms of addiction and gain the ability to recognise his changing patterns of thinking or reacting. In his case, the obstacles to change appeared not only in the therapeutic process, which in turn indicated a declarative, unstable motivation; buffering emotions in the patient's psychological regulatory mechanism oscillated around personality-specific feelings and the dynamics of the recovery process, with a sense of inner confusion and higher egocentrism in this phase of therapy. The emotional rollercoaster in the patient is an example of inevitable difficulties, as well as forgotten and ambivalent feelings which are desirable and beneficial in the long term. From the patient's point of view, this represented the lack of expected outcomes, non-obvious meaning and the meaningfulness of the therapy. The patient made an individual

list of numerous substitutions to facilitate abstinence and suggestions for behaviours to counteract a potential escalation of aggression. He did not find it difficult to make the list, although some of the suggested ways of relieving tension were not realistic in terms of his abilities or the circumstances of their implementation. The activities he indicated, e.g. a film or swimming class, might be a stress reliever in everyday life, but are not feasible in a sudden stressful situation that causes tension. Among the constructive and realistic ways to counteract the escalation of emotions (possible even on the therapy ward) which he presented during the group activities and discussed with other group members, he included physical activity, exchanging thoughts with the therapist and other patients, reading books, listening to music and cooking and eating a meal. The use of several activities is symptomatic, e.g. smoking cigarettes (it was not on the list because it is an addictive behaviour) and eating (assumptions of the HALT programme). However, the patient's style of functioning on the ward did not change significantly over time. The patient went to the gym and played table tennis relatively often, and used the library in the facility. However, he was reluctant to engage in conversations about his emotional states and made no attempt to initiate therapeutic discussions, despite struggling with and being aware of his problem. He tried to delay talking about problems. When confronted with the need to disclose his emotional state, he showed a tendency to avoid talking about what he felt was an unpleasant problem. He displayed episodically aggressive behaviour, had difficulty accepting criticism about his functioning and reacted with irritability and outbursts of anger that he was unable to control. However, it is important to note the change in his attitude (in the final phase of therapy) towards the therapist's feedback, which he finally began to see as specific help aimed at correcting his own deficits. Due to the time constraints of his convalescence, the patient only made some changes to his abnormal emotional reactions.

Undoubtedly, it is always up to the patient to make rational use of the correction of problematic functioning provided through the therapeutic programme. The same should be applied to perseverance in continuing to work on changing one's way of life, which always requires strong motivation, commitment and perseverance.

An important part of living on the therapy ward is also observing the rules of personal hygiene. This mainly concerns the obligation to shower once a day, shave, dress neatly, keep one's space tidy, follow the daily schedule (meals and activities at specific times), clean, do gymnastics, perform designated functions, take medication and get proper sleep. According to the therapist the patient showed no resistance to these requirements, and consistently took care of himself within a strict diet. He allocated five or six hours to sleep, which he explained was due to anxiety and restlessness. The patient's attitude to the suggested therapy was evident in his conservative approach and even in his indifference to attempts to work on changing his current condition.

Summary and perspectives

While analysing the research, it is necessary to refer (according to Mezirow's theory) to the objective reframing of the patient's situation, in which the patient critically reflects on the rationality of the therapist, the patient group, those closest to them and to the subjective reframing in which the patient critically reflects on their beliefs. Changes to the frame of reference can range from a different viewpoint to transformed mental habits (Mezirow 1997: 7). It should be added that the man's learning in the therapy process took place within a specific spatial and temporal framework. He had the chance to be empowered, to grasp a new space of emotions, thoughts, feelings and needs and to confront them during the sessions with others and with the therapist in order to be able to specify his own developmental possibilities, free from determination, yet not deprived of the possibility to move towards authentic cognition and shape his own destiny (thanks to the subjective change of the frame of reference through transformative learning). As a result of the therapeutic experience, in contact with other participants, the patient to some extent recognised other possibilities to perceive reality or to change his beliefs. However, he did not change his own point of view; perhaps participating in further therapy will allow him to make sense of the therapeutic interventions used and to see his own potential without feeling censored by the therapists and other patients.

I relate the next stage of transformative learning to the patient's consideration of behavioural change as potentially being impossible

by virtue of his assumptions (subsequent therapy) and therapeutic experiences not going beyond the routine pattern, narrowing his cognitive and affective analysis. The patient's activity was derived from earlier stages of transformative learning, indicating the effect of change taking place during the therapeutic programme. The patient overestimated his own abilities and skills, which was likely triggered by the lack of real threats to his abstinence during his stay on the inpatient ward. This may have been due to the psychological burden resulting from the mechanism of addiction. According to Mezirow, at the third stage of changing the frame of reference, there should be an attempt to adapt the individual to a new frame of reference, constituted as a result of learning. It is difficult to assess the extent to which potential changes in the patient's behaviour were the result of therapy (adaptation to the rules of the unit) and to what extent they resulted from the regeneration of the post-drinking desire to work on one's own personal development and completely reorganise one's life in order to eliminate alcohol dependence. The research indicates how realistic the possibilities of his behavioural change are. After all, the transformation of the frame of reference is an opportunity for the individual to causally attempt to resolve disorientation dilemmas. However, as the research shows, this procedure is not fully accessible to everyone. The patient's previous understanding of events is supplemented by new experiences, through which he learns to understand his situation. He undertakes a critical self-reflection on his previous mental habits and fixed points of view. In the therapist's view, however, the patient did not display the cognitive humility that would have enabled him to gain a broader knowledge of the risks of his addiction or to understand the meaning of his transformation. In this case, this involves resisting attempts to impose meaning that he did not fully accept. The socialised frames of reference in the process of functioning in a given culture are such strong obstacles that they become, as it were, detached from the patterns of social functioning. The descriptor linking the transformative learning of the senior patient to the therapeutic process is undeniably his thoughtfulness supporting internal change. According to Agnieszka Bron (2006: 12), transformation may result in the emergence of emotional problems, contributing to individual and social crisis. However, the essence of learning is seeking in everyday experience, which implies affective and motivational

learning that also includes a social component manifested in relationships with one's social environment. Knowledge gained through feeling, experiencing and acting results from critical reflection on experience and is orientated towards pragmatism in coping with a new/foreign situation.

However, the senior patient's specific, critical reflection on his threatened, shaky identity, in the face of difficult ways of thinking about his empowerment, paved the way for change. Undergoing alcohol addiction treatment is a transformative mode quite different from the previous one, if only because of the educational potential resulting from the re-evaluation and conducive shift towards self-valuation and self-identification. The difficult process of the therapeutic struggle for oneself, which takes place within a subjective frame of reference, forces the development of change to support the regaining of control over one's destiny or liberation from habits that burden one in the "autumn of life". The loss of oneself from the past and the entanglement in addiction hold back the authentic causativeness of the addicted elderly person. The therapeutic process, however, becomes an opportunity and an attempt to work through and modify the deficits resulting from the addiction.

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