

REFLECTING ON LIFE SCRIPT, RELATED UNCONSCIOUS BELIEFS, AND FUTURE PROJECTIONS AS A FACTOR OF REMISSION DURATION IN MALE PATIENTS WITH ALCOHOL DEPENDENCE

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A cross-sectional study performed in a Moscow hospital for addiction treatment (2019—2020) tested a hypothesis that the capacity to reflect on a life script exerted a positive effect on alcohol dependence (AD) remission duration. The sample included 61 males with AD and without dual diagnosis; the mean age was 44.1 (SD = 10.1) years. Methods. (1) Socio-demographic and clinical data was collected using a semi-structured therapeutic interview. (2) Explicit representations of one's future were evaluated using a Self-defining Future Projections task; "Life Line", and a "Cultural script" task. (3) Data on life script characteristics was gathered using the semi-structured "Script Questionnaire". Qualitative data was processed by means

of quantitative content analysis performed by experts based on relevant guidelines. Effects of verbalized life script characteristics on several remission parameters were assessed using multiple linear regression. Results and Conclusions. People with AD who were capable of verbalizing and reflecting on long-term, self-relevant representations of the future related to the basic beliefs about their own life course, were capable of maintaining longer remissions in contrast to those who failed to reflect on these topics and limited their memories and future projections by overgeneral cultural script events.

Keywords: alcohol dependence, remission, reflection, cognitive therapy, future thinking, autobiographical memory overgeneralization, life script.

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РЕФЛЕКСИЯ ЖИЗНЕННОГО СЦЕНАРИЯ И СВЯЗАННЫХ С НИМ БЕССОЗНАТЕЛЬНЫХ УБЕЖДЕНИЙ И ПРОЕКЦИЙ БУДУЩЕГО КАК ФАКТОР ДЛИТЕЛЬНОСТИ РЕМИССИИ ПРИ СИНДРОМЕ ЗАВИСИМОСТИ ОТ АЛКОГОЛЯ У МУЖЧИН

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В поперечном исследовании на базе наркологической клиники (Москва, 2019—2020 гг.) проверялась гипотеза о связи способности к рефлексии жизненного сценария с длительностью формируемых ремиссий. В выборку вошли 61 пациент мужского пола, с диагнозом АЗ, средний возраст — 44,1 (SD=10,1), без сопутствующих психических расстройств. **Методический комплекс:** 1) для сбора социально-демографических и клинических показателей проводилось полуструктурированное терапевтическое интервью; 2) для оценки параметров эксплицитных (осознаваемых) представлений о будущем и отдельных параметров сценария применялись методики исследования самоопределяющих проекций будущего — «Линия жизни», «Культурный сценарий»; 3) сбор данных о параметрах сценария осуществлялся в рамках «Сценарного интервью». Обработка качественных данных проводилась методами количественного контент-анализа на основании руководств с помощью экспертной оценки. Эффект эксплицируемых параметров сценария на различные параметры длительности ремиссий оценивался в ходе множественного линейного регрессионного анализа. **Результаты и выводы.** Пациенты с АЗ, способные к вербализации и рефлексии параметров жизненного сценария — плохо осознаваемых долгосрочных, лично значимых представлений о будущем, отражающих базовые убеждения о собственном жизненном пути — способны к поддержанию более длительных ремиссий по сравнению с пациентами, не рефлексирующими на эти темы и ограничивающими свои воспоминания и проекции будущего глобализованными стандартными для данной культуры сценариями.

Ключевые слова: алкогольная зависимость, ремиссия, рефлексия, когнитивная психотерапия, проспективное мышление, глобализация автобиографической памяти, жизненный сценарий.

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Introduction

Alcohol dependence (AD) is a major cause of increased mortality among Russian males [3]. This underlines an urgent need for studies

targeting improvement of effectiveness of psychosocial rehabilitation in AD.

Contemporary cognitive science argues that people remember their past to construct their future [36]. Future thinking (FT) as the capacity to create mental representations of plausible future events [8] is impossible without key autobiographical memory mechanisms: (1) “scene construction” by integrating episodic (specific) details into a more abstract semantic knowledge (“semantic scaffolding”); (2) self-projection into the future by switching the focus from “the here-and-now” on to a specific temporal context while experiencing oneself as acting within it (“autonoetic consciousness”) [19]. FT impairments tend to co-exist with autobiographical memory deficits and are considered a transdiagnostic factor of mental disorders [15; 24].

“Memories of the future” (MFs) [27] — once constructed, self-relevant images of the future which are remembered and later retrieved voluntarily or involuntarily depending on the context [18] — are a special type of FT. In the face of uncertainty and choice, these “ready-made” future images seem to guide decision-making and human behavior sometimes in an implicit (i.e. outside of the person’s awareness) way [8]. They might feel like some mental tension arising as long as an intention formed remains unfulfilled and resolving upon its implementation [8; 31].

MFs that develop in childhood under sociocultural influences; are linked to the images of future selves in relationship with others and the world and capture mental representations of one’s own life course and its “final scene” (death) [13] — are described as “a life script” [13; 38]. An implicit or unconscious life script differs from a cultural life script, i.e. an explicit representation of the order of events in a typical life course in a certain culture [14]. Its components — “early decisions” [22] or “basic beliefs” [11] in cognitive-behavioral therapy (CBT), may act as semantic scaffolds for voluntary FT. In this sense, life script limits free will and hinders one’s self-efficacy and autonomy. For example, the script content may impact AD severity and fatal outcome [35]; aggressive and suicidal behaviors [37] in people with AD; contribute to high victimization of their codependent partners [33]. Changing a life script by gaining insight into the underlying beliefs and simulating new future and the “final scene”, e.g. as a result of a new decision [22], may help to

achieve more autonomous behaviors and give up self-destructive script patterns [37].

CBT — from Beck’s classical cognitive therapy [9] to the “third wave” approaches (dialectical behavioural therapy; schema-therapy) — helps to change people’s future through awareness and reconsolidation of their cognitive past. An improvement in mental and social well-being occurs through reflecting on one’s cognitive processes, their “deep foundations or certain basic representations” [6, p. 110] as well as through developing ways to restructure them so as to create new cognitive models and change related emotional and behavioral patterns. The ability to *reflect on* the content of one’s psyche is described as metacognitive, encompassing such constructs as mentalization, theory of mind, self-referential process, reflexive consciousness, social intelligence etc. It is closely linked to FT — because both capacities cannot exist without a conscious effort for decentration — shifting the focus from the current self to alternative perspectives [36]. People with AD have a major deficit of the reflexive capacity: they fail to view problems (including AD itself) from alternative perspectives; to recognize and understand interlocutors’ emotions and their own mental states [16]. Severity of reflection deficits increases in parallel with an increase in AD and depression severity [16] and affects treatment outcome, e.g. leading to early drop-out from therapy [34].

New CBT strategies’ orientation on achieving *recovery* for “difficult” patients with chronic mental disorders mirrors a general trend towards a search for new criteria of cure in modern psychiatry and psychotherapy [12]. Recovery of people with addictions is defined as “a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full human potential or personhood” [12; P. 156]. This definition resonates with E. Berne’s concept of autonomy [13] as being free from life script and, in this sense, underlines the relevance of our study, the results of which could be used to identify strategies that people with AD may use to achieve.

Hypothesis. We tested a hypothesis that the capacity for reflecting on a life script and its components (life script semantic scaffolds, such as “the final scene”) was related to a more benevolent AD course as judged by longer remissions achieved by patients. It was assumed that

people with AD who were capable of verbalizing self-relevant images of their own long-term future capturing basic beliefs about their life course, and general autobiographical knowledge (family history, family legends, child’s favorite fictional narratives etc.), which provided semantic scaffolding for one’s life script, were capable of maintaining longer remissions as compared to those who failed to reflect on their life story and future.

Methods and procedure

This cross-sectional study was approved by a local ethics committee and held in 2019 — 2020 in the “Moscow Research and Practical Centre for Narcology of the Department of Public Health”.

Procedure. The sample included male patients aged 25 to 69 years old (y.o.) diagnosed with AD (F10.2) without comorbid mental disorders, who were at the stage of medical rehabilitation; received detoxication treatment minimum 14 days prior to the first examination and abused alcohol for at least 14 years. The patients provided an informed consent for participation.

The patients who met the inclusion criteria according to the results of their medical record analysis and a clinical psychologist’s routine examination were invited to participate in the study. The examination included four to five visits (with up to 5 days in between the visits). Medical and personal history data were collected using a semi-structured therapeutic interview, STI [7]. Psychometric assessment of explicit FT — conscious representations of one’s future — employed several measures described below. The data on life script parameters and script semantic scaffolds (“the final scene”, favorite fictional narratives, intergenerational transmission patterns, etc.) was collected by means of semi-structured interviews — STI, and “Scenario Questionnaire” (SQ) [30]. SQ included registration of the patient’s favorite fictional story and drawing his “family tree” (genogram).

Methods and variables. For the purposes of analysis, three groups of variables were singled out:

The data on **socio-demographic variables, AD course and severity, quality and duration of remissions** was collected using STI [7] and

through the analysis of medical records and information provided by clinicians and relatives.

(2) Assessment of **quantitative** (future event frequency and word count), **phenomenological** (emotional valence, vividness, self-projection, simulation frequency, temporal distance) **and content-related** (specificity, theme, correspondence between personal future and cultural script events, interpersonal orientation, etc.) **parameters of explicit representations of one's future** employed:

- Self-Defining Future Projection (SDFP) task [20; 41]. SDFPs are future events that have high personal relevance and reflect one's central life themes. The patients were asked to write down one of these plausible events, in as much detail as possible, as if they were sharing it with a stranger, and to rate its characteristics on a 7-point scale (from the lowest parameter's intensity / positivity to the highest).

- "Life-Line" (LL) graphical method [4]. The patients were asked to mark their current age on a drawn line representing their life course, and to depict relevant past and anticipated future events indicating the age of their occurrence using the current-age mark to orient themselves. The higher the event was depicted, the more positive it was assumed to be, the lower — the more negative it was.

- "Cultural Life Script" (CLS) task [1; 14]: the patients were asked to imagine a child of the same sex who was born on the same day and in the same country as they were, to name 7 plausible events in that child's life, and then to assess the likelihood and valence of these events. The CLS events were contrasted to the Life-Line events to analyze the way the patients "owned" the events of a culturally approved life script, and to identify the "omitted" events.

(3). The data on **life script parameters** was collected using "The Script Questionnaire" (SQ) [29], which was filled in by a researcher during the interview and verified by an interviewee at the end. When analyzing the SQ material, the following cultural, family, and individual semantic scaffolds, which are believed to characterize life scripts in various psychotherapy modalities [9; 13; 17], were identified, codified, and subjected to quantitative and qualitative content analysis:

- Intergenerational transmission patterns (somatic / mental disorders, including AD, family life expectancy, professional dynasties, etc.); repeating early deaths (under the age of 69);

- Family narrative patterns (family stories, secrets, and legends; fictional narratives). E.g., a patient, whose favorite childhood story was “Cinderella”, verbalized the legend about his birth grounding it in the fairy tale storylines, *“Father thought that I was not his son... It was my grandmother who told [him] this suspecting [her] daughter-in-law of infidelity. Father believed that I did not look like him, he was jealous of me. And now [I’m] his spitting image”*;

- Patterns of destructive / positive belief transmission through external attributions — specific naming patterns (having been named in honor of relatives or celebrities who had disorders or died early; cultivation of a specific name meaning within the family) (*“[I was] named in honor of my grandfather — a veteran of war. He drank much and died because of injuries at 40”*); the respondent’s specific interpretation of his name (*“Konstantin [means] the Winner”, “Tolik-alcoholic”*); conviction in a “special nature” of certain numbers and dates (“family anniversaries”) (*a patient [with a durable remission] believed that he would die on the 21st, since it was the date on which his father was born and died; his father’s twin brothers were born and died of pneumonia in infancy, and his own brother — who (like the patient himself) was named in honor of one of his twin uncles — committed suicide*); episodes of “premonitions” of the respondent’s fate by his relatives or himself (involuntary FT) (*“In childhood, mother used to say [to a patient who develops no remissions of AD]”, “You will get to the hospital and you will not get out of there”*);

- Explicit, conscious but script-related representations of the future describing one’s life quality and expectancy (planning life in 5 years; expectations with regard to the age and cause of death).

Qualitative data was processed using valid methods of content analysis [2; 40] typical of autobiographical narrative research. To ensure the analysis quality, 30% of the narratives were rated by independent experts and Cohen’s kappa was calculated [41].

Sample. The analysis was performed within a sample of 61 males with AD, mean age — 44.1 (SD = 10.1), who agreed to participate in STI and SQ. This sample size was sufficient to achieve the targeted statistical power (80%, effect size (f^2) — 0.15, type 1 error — 0.05, 95% two-tailed confidence interval) needed to test the study hypothesis.

44.3% of respondents (n = 27) had higher education; 77% (n = 47) were employed; 72.1% (n = 44) were married, and 34.4% (n = 21) had

experienced at least 1 divorce. Most of them (62.3%, 38 people) had served in the army. 16.4% (n = 10) had a criminal record. 15% (n = 9) of respondents had a record of insignificant birth and child development issues.

The average levels of clinical variables in the sample indicated a typical course of the middle stage of AD. The mean AD duration was 21 years (SD = 9.7) since the start of regular alcohol abuse (usually at the age of 23 y.o. (SD = 5.3)), with the age at first drink being 14.5 (SD = 3) y.o. AD usually progressed at a moderate rate with an average of 6 years (SD = 3.1) before the onset of withdrawal symptoms. Most respondents engaged in occasional heavy drinking episodes. 23% were hospitalized for the second time that year. Most participants had alcohol-related somatic disorders (68.9%). 75.4% had at least 1 episode of severe alcohol poisoning including those that required emergency care; 16.1% had alcohol-related psychosis and 21.3% had pathological intoxication at least once.

Statistics. The Shapiro-Wilk test was used as a normality test. The script effects on remission duration in the course of AD were evaluated using stepwise multiple linear regression. The dependent variables included the remission duration parameters — maximum remission days; remission days for 2 years before the examination; remission index (ratio of total remission days to total AD days) — that had weak or no associations with the participants' age and AD duration. The number of independent factors per model did not exceed 8 parameters, with a similar number of explicit FT and life script variables. Multicollinearity was controlled for through an a priori correlation analysis between the factors and calculation of tolerance and variance inflation index. This analysis showed that there was no multicollinearity in the models. The Durbin-Watson coefficient was calculated to control for autocorrelation in the residuals. The distribution of residuals checked using a normal probability plot was close to normal.

Results

Table 1 summarizes the parameters of the regression models for remission duration. The only explicit non-script parameter that was in-

cluded in the model was *the percentage of the CLS events of all the LL events*. Participants could explicate some other explicit FT variables (e.g. *predictions regarding one's own death, involuntary images of alcohol-related death*), however, we qualified these as characterizing an implicit life plan — script — since they reflected its main semantic scaffolds, i.e. the content of the autobiographical knowledge base of a high level of abstraction, which allowed to simulate mental representations of one's future, and of one's “final scene”, in particular, and could be retrieved automatically.

Table 1

Models of the influence of the parameters of the life scenario and explicit prospective thinking on the duration of remission

No.	Factors	β	SE	t	p
Model 1. «Maximum Remission Days»					
1	Constant		495.3	2	.05
2	Sudden (quick) death expectation	.28	459.1	2.8	.007
3	Percentage of CLS events of all LL events	-.28	8.5	-2.8	.007
4	Specific naming (unclassified)	.31	357	3.2	.002
5	Remitted relatives with AD	-.39	369.4	-3.8	.000
6	Number of relatives on the genogram	.29	16.8	2.8	.006
7	Involuntary images of alcohol-related death	-.25	387.2	-2.6	.01
Model 2. «Days of Remission for 2 Years before Examination»					
1	Constant		450.2	-2.7	.02
2	Verbalized age of death (years)	.66	6.1	3.4	.01
Model 3. «Remission Index»					
1	Constant		.06	2.4	.02
2	Presence of (great)grandparents with AD	-.4	.04	-4.4	.000
3	Following traditional family profession	.4	.04	4	.000
4	Partner's / child's early death (younger than 69 years old)	.3	.05	3.5	.001
5	Number of relatives on the genogram	.3	.002	3.2	.002
6	Percentage of CLS events of all LL events.	-.25	.001	-2.6	.01

Note: β — standardized regression coefficient; p — level of statistical significance; SE — standard error; t — t-test; CLS — cultural life script; LL — Life Line

According to Table 1, most factors that influenced remission duration reflected the life script content. This finding confirms the hypothesis that unconscious script parameters affect the duration of remissions in AD to a greater extent than explicit FT parameters. Although we considered the percentage of the CLS events of all the LL events to represent the explicit plane of FT since most representatives of a given culture seem to easily recognize and verbalize the CLS content as early as at school age [1], in a natural context, CLS provides implicit semantic scaffolding for autobiographical narrative and its recall may be more of an automatic character beyond one's reflection.

In Model 1, an increase in the frequency of the CLS events on the LL; the presence of remitted relatives with AD; involuntary images of alcohol-related death led to a reduction in maximum remission days (risk factors). Voluntary expectation of sudden (quick) death (*"I would like to be like my grandfather: [He] sat down and died, without suffering, at the age of 96"*); the number of relatives (that is, representations of parental figures) on the genogram and unclassified specifics of naming (*"[They] wanted to call me Boris (Mom wanted this), and the sister — 5 years old — insisted on Tolik, and everyone agreed [with her]"*) exerted protective effects.

In Model 2, remission days for 2 years before the current examination depended solely on the factors associated with reflecting on one's "final scene": the longer participants "planned" to live, the more prolonged remissions they achieved.

In Model 3, protective factors with respect to the days of sobriety throughout the entire period of AD ("remission index") included variables describing the family situation — the number of relatives on the genogram, adoption of a traditional family profession by the patient, and the "transitional" events [21] associated with an awareness of one's mortality (early partner's/child's death). Risk factors included a high percentage of the CLS events on LL, and the presence of (great)grandparents with AD.

All the models obtained were of satisfactory quality; explained about 50% of the dependent variable variance; had sufficient statistical significance and no autocorrelation in the residuals (Table 2).

Table 2

Assessment of Models' Quality

Model	R ²	Adjusted R ²	SE	F	p	DW
1	.51	.45	1281.5	9.2	.000	1.8
2	.44	.4	242.3	11.8	.004	1.59
3	.53	.5	.13	12.3	.000	1.86

Note: DW — Durbin-Watson statistics; F — Fisher criterion; p — level of significance; R² — coefficient of determination; SE — standard error

Discussion

The data obtained provided evidence in favor of the study hypothesis.

Reflecting on the script “final scene”. Reflecting on one’s own death, thinking over its possible causes and simulating certain expectations (predictions) seemed to be a protective factor as far as maximum remission days and remission days for 2 years before the examination were concerned. In contrast to the patients’ personal expectations, the factor of relatives’ life expectancy (which failed to reach any significance and was omitted in the models) did not influence the remission duration in our study.

Case 1. Patient D. (66 y.o.) who had multiple somatic conditions and disability, had AD for 30 years, during the last 17 years of which he had maintained therapeutic remission. D. had a clear expectation of dying at the age of 85 just as a gypsy had “foretold” him. All the important male relatives in D.’s family died: one uncle was murdered at the age of 64 y.o.; another one (66 y.o.) died during a surgery; brother (40 y.o.) died due to medication-induced anaphylactic shock; father (63 y.o.) died after a car accident. D. has stayed alive and sober for two years after the examination now.

Reflecting on the expected age of death and deaths of loved ones also helped to prolong remissions.

Case 2. Patient J. (60 y.o.), who had had AD for more than 35 years, achieved a 25-year therapeutic remission and came for supportive sessions in stressful situations under the threat of a lapse. Answering a straightforward question about the age of his death, J.

assumed that he would die at the age of 82 y.o. He indicated a similar age in his self-defining future projection, *“In 20 years. Death. Of the dead, they say nothing but good. It is important what they will [say] about me. As for me, let them say something. ([They’d] better [say] something good)”*.

It should be noted that J. developed sustained remission soon after his brother (who had AD and gambling disorder) had suicided. Some respondents achieved the longest (and sometimes the only) remission solely as a result of these self-relevant “transitional” events (migration, divorce, wedding, a child’s birth, or death etc.). This complies well with the findings of studies of the natural AD course [21].

Impairment of Reflection on “Final Scene” and Future Projections; its Aversive Impact on Remissions and Ways of Coping.

Involuntary implicit future thinking. More automatic, less reflexive forms of thinking about one’s future life and death had a negative effect on remission duration. As an example, the presence of involuntary, sudden, and often unpleasant images of one’s death reduced the maximum remission days. The latter may indicate the use of primitive defense mechanisms of denial and their unexpected failures with subsequent engagement in acting out and avoidance to make meaning of one’s life in the context of inevitability of one’s death and the need to accept this fact. According to Heidegger, “Although the physicality of death destroys man, the idea of death may save him: <...> the awareness of our personal death acts as a spur to shift us from one mode of existence to a higher one” [42, P. 30—31]:

Case 3. Patient G., 30 y.o., used to have opioid addiction; has a current diagnosis of AD. Being in a prison cell, he got a *“passionate thought”* about suicide (G. imagined himself lying dead in blood and suddenly realized that he wanted to open his veins); grabbed someone’s *“shiv”* and started *“chopping”* the veins. Having heard a cell-mate’s calm voice that this *“shiv”* was *“for bread”*, G. *“woke up”*; realized *“how to live further”* and that it would be *“stupid”* to suicide. The suicide attempt was interrupted, G. has had no suicidal ideas so far and developed a 10-year remission of opioid dependence. Nevertheless, G. continues using alcohol as a substitute of opioids and fails to achieve any prolonged remissions of AD.

Both voluntary and involuntary images and thoughts about one's death capture the patients' reflections on the "final scene", and differences in the direction of their effects on remission duration arise most likely due to their functional differences [18]. Voluntary FT function consists in comprehending; adjusting to and getting prepared for death; reducing the anxiety associated with its possibility [25]. Involuntary vivid images of death, traumatic events, i.e. "flash forwards" [26], usually stay beyond one's awareness until their occurrence and "warn" people about a possible aversive event [18]. They often trigger symptoms of emotional disorders and suicidal behaviors [25].

Case 4: Patient L., 30 y.o., abused alcohol regularly since the age of 15 and had no voluntary remissions. While serving in the army (where he was forced to stay sober), he attempted impulsive suicide (trying to jump from a high building having drunk a large dose of alcohol beforehand) having seen erotic images of his girlfriend who had been allegedly cheating on him (the temporal distance between making a suicidal decision, getting alcohol and jumping did not exceed several minutes). He was rescued accidentally by his fellows.

Involuntary images of a fatal future can also be viewed as automatic manifestations (K. Lewin's discharge of tension [31]) of once simulated and waiting-to-be-implemented self-destructive intentions, i.e. destructive cognitive schemata such as "If I stop drinking, I will die", "If something goes wrong, I can always kill myself (with alcohol)", which form the basis of a life script. Patient L. (case 4) described a paradoxical desire "to drink so as to live" arguing that "If [you] stop drinking, the engine will stop".

Autobiographical Memory and Future Thinking Overgeneralization

The negative effect of reflection impairments due to autobiographical memory and future thinking (FT) overgeneralization in our study manifested itself in a finding that displacement of specific personal past and future events by typical, culturally expected events ("*marriage*", "*childbirth*", "*retirement*", "*buying a car*") on LL thwarted the maximum remission duration. Assumingly, "owning" of the CLS events and their instrumental use for autobiographical narrative organization is essential for people's normal mental functioning, their ability to assimilate cultural norms and create a coherent narrative [38]. However, in our case, a different process was observed.

When describing their life in 5 years, many patients (especially those who failed to develop any sustained remissions) simulated overgeneral representations that bore little relation to reality indicating lack of reflection, *“If everything works out, I can even become the Russian president, get another job. I have expertise to start my own business ..., I want to teach my son”*; *“[I will be] Happy, no alcohol, family, so that everything is good in all areas”*; *“Stable job, new family”* etc. The respondents’ SDFPs reflected the same tendency when instead of providing a specific personal life event, which the instruction implied, they simulated a set of culturally-encouraged clichés frequently referring to other people [41], *“Financial independence, birth of a child, building [my] own home”*; *“I hope my son will find his soulmate... there will be a wedding; my son and his wife and all of us will be happy...”*; *“Son will join the military and become a real man”*. The patients depicted similar future events on their LLs.

The main problem of autobiographical overgeneralization in AD is that over time — it turns into an automatic type of response that reinforces feelings of hopelessness, depression, and low self-efficacy [32]. This replacement of autonomous reflection on one’s future and specific mental representations with cultural clichés hinders reconsolidation of the old and integration of the new experiences into the autobiographical memory system, which precludes flexible responding to new situations [32]. As an example, patient H., 52 y.o., wrote, *“I have always believed... that I will retire at 60. But ... this moment was postponed for 13 years until my 65th birthday. Keeping in mind that my children have grown up, I’m sick and tired of working, I wait for the moment when I am able to start living only for myself and my wife. Unfortunately, one may not live to see this time”*.

Although hopelessness seems to be quite infrequent in SDFPs of people with AD (cf. data on emotional valence of SDFP in addictions, [41]), patient H.’s predictions seem to capture the destructive script parental messages *“Don’t succeed”*, *“Don’t feel happy”* which get internalized by children at an early age without due reflection [13; 37]. In H.’s case, these messages got shaped as pessimistic predictions about life expectancy (dying early at an age under 65 y.o., which was below mean life expectancy for men in Russia at the time of the study).

This overgeneralization — projecting negative past experience on to a future situation without trying to reflect on other options — can be changed by means of cognitive psychotherapy. Therapy may consist in

exploration and identification of old life story chapters which get transformed into script schemata of hopelessness reinforced by catastrophizing and diminishing self-efficacy [11; 32; 37]. The techniques of a “Socratic dialogue” [11] or decontamination (gaining insight into prejudices, illusions and destructive beliefs that limit autonomous thinking) when patients are guided to reflect on and to become aware of automatic thoughts about the future are used to clarify destructive scripts. For example, a careful exploration of H.’s future thinking might uncover basic beliefs (“early decisions”) that underlie H.’s pessimistic forecasts about his inability to fulfill his plans, e.g. “I am confused and scared”; “Everything will end bad”; “Nobody can help me”; “I’m a failure” etc. [9; 11]

Unconscious Intergenerational Script Transmission.

The factors assumed to represent script semantic scaffolding within the family — i.e., autobiographical knowledge about family’s experience, history, and future — had varying effects on remission duration. A higher frequency of parental figure representations, as well as adoption and mastering of a family profession were consistently found to be protective factors for remission duration, which may be due to provision of social support facilitating adaptive coping with anxiety linked to uncertainty of the future. At the same time, AD in older generations affected the remission index (i.e. the ratio of sober days to AD days), and the presence of remitted relatives reduced the maximum remission days. This finding can be interpreted from a biological perspective as indicating greater genetic risks in patients with a more severe AD course. At the psychological level, the presence of certain AD recovery patterns in the family might form the basis for cognitive distortions linked to an illusion of easiness of achieving recovery (“*I can quit like my grandfather did*”), normalization of alcohol abuse, and underestimation of AD severity.

Our data is consistent with multiple evidence of the intergenerational transmission of psychopathology, both at the genetic and sociocultural levels, for example, shaped as a translation of specific alcoholic culture [28] which may provide semantic scaffolding for an alcohol-related life script.

Implications for therapy. The obtained findings could be used in recovery-oriented therapy of people with AD. The first type of interven-

tion could aim at enhancing specificity of patients' FT both with regard to their own future life [15] and recovery process in particular: e.g., specification and visualization of the therapy outcome (see J. Beck's foreword by in this issue) in terms of the contract method [13]. At the stage of an established working alliance, patients could be encouraged to reflect on their own mortality. This type of reflection seems to expand the horizon of explicit planning and to neutralize implicit maladaptive cognitions through increasing the value of the long-term consequences of behaviour [30]. Another — more common in cognitive therapy and other modalities — type of intervention may aim at empowering patients to gain insight and to reflect on implicit cognitions, i.e. components of an unconscious life script which capture the “planned” duration and quality of life [10]. The third type of intervention may include enhancement of the autobiographical narrative coherence through reflecting on one's individual and family history.

Limitations. (1) Lack of a control group, although a number of explicit FT and life script indicators were controlled for in terms of the research protocol extensions and additional studies [41], and in terms of the analysis of data on samples of people without (healthy controls) and with AD with similar inclusion / exclusion criteria and in the same setting [5]; (2) Lack of female patients (due to the specific features of the study setting) and a small sample size (96 people were included in the study, 61 person were included in the regression analysis), although its sufficiency was demonstrated by the post-hoc power analysis; (3) Use of qualitative methods for data collection and interpretation, the challenges of which were overcome by using expert assessment, quantitative content analysis, methodological triangulation techniques, which involved verification of qualitative data through diversification of measures, available record analysis, interviews with third parties.

Conclusions

1. Characteristics of an unconscious life plan — a life script, and namely, the degree of reflection and differentiation of script-related past and future events — exerted a more expressed effect on remission duration in patients with AD.

2. Patients with AD, who were capable of reflecting on long-term self-relevant representations of one's future capturing basic beliefs about their own life course and its end (reflecting on the "final scene"), maintained longer periods of sobriety compared to patients who failed to reflect on their future and life story.

3. Overgeneralization of autobiographical memories and images of one's own future which manifested itself in an increase in the percentage of formal events of the traditional cultural life script and using them to replace specific events of the personal past and future on the Life Line, had a negative impact on remission duration.

4. Psychotherapy of patients with AD should focus on enhancing the reflection of unconscious of the script "final scene"; increasing the specificity of non-script- and script-related explicit future thinking.

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