“ALÉM DE VESTIR AS CALÇAS DO MARIDO, ELA TEM QUE CONTINUAR DE VESTIDO” (IN ADDITION TO WEARING THE HUSBAND’S PANTS, SHE NEEDS TO WEAR THE DRESS): THE PROCESS OF RECOVERY FROM ALCOHOL DEPENDENCY AMONG NORTHEAST BRAZILIAN COUPLES

by

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B.S., Universidade Católica de Pernambuco, 2005
M.S., Kansas State University, 2010
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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Family Studies and Human Services – Marriage and Family Therapy
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

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Abstract

The purpose of this study is to expand our understanding of alcohol dependency and its recovery in Northeast Brazil by exploring the lived experience of this disorder and its recovery process among couples whose husbands are seeking treatment for alcohol dependency. Culturally specific values such as patriarchy and gender roles were explored to gain insight into the recovery process. Findings from in-depth interviews conducted with couples and mental health professionals indicated that wives had a major role in the recovery process but were not included in the treatment process. Wives are expected to wait and temporarily "wear the pants" while husbands attend to their personal problems in treatment. Wives were viewed as a major support to husbands in treatment as well as the "stone in the middle of the road" that obstructed progress. The cultural values and gender norms appear to play a major role in how alcohol dependency is managed within the couple system and by mental health professionals. The use of metaphors to externalize problems and religious scripts helped couples cope. Clinical implications for systemic treatment and research implications are discussed.

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Dedication

To my son Arthur the experience of completing this dissertation while expecting you was unique and such a blessing.

Preface

Nunca ouvira elogios de parentes, tampouco dos filhos ou do marido, suas sementes despontam alheias à dinâmica de um lar repleto de afazeres e individualismos. Quem percebe a mulher de dentro da casa? (Quintas, 2013)

(Never heard praise from relatives, either from the children or husband, her seeds emerge outside the dynamic of a home filled with chores and individualisms. Who notices the woman inside the house?) (Quintas, 2013)

Chapter 1 - Introduction

Alcohol Dependency and Brazil

Brazil is the fifth largest country in the world with a population of almost 202 million people. It is a country with rich cultures and multiple ethnic and racial traditions as a result of colonization by the Portuguese, Dutch and French. The importation of African slaves–in the sixteenth to nineteenth century–and influx of immigrants from Germany, Italy, Poland, Ukraine, Lebanon, and Japan over the years lend to its rich cultural diversity. Brazil is quickly gaining recognition as an industrialized society and is expected to become the world's fifth largest economy by 2023 (Centre for Economics and Business Research, 2013).

Like other fast developing countries, advancement in education, health and industry is accompanied with increased stress and mental health problems such as alcohol dependency. The rise in alcohol use was evident with rates of consumption increasing by 74.5% from 1970 to 1990 (World Health Organization (WHO), 1999). Today, 5 to 10% of adults in Brazil ages 18 and older have a problem with alcohol dependency (Centro Brasileiro de Informacoes sobre Drogas Psicotrópicas – CEBRID, n.d.), making Brazil among the fifty countries with the highest levels of alcohol consumption (WHO, 2014). Of all the regions within Brazil, the Northeast consumes the most alcohol (Laranjeira, Pinsky, Zaleski, & Caetano, 2013) with men outnumbering women in their consumption (Laranjeira, Pinsky, Zaleski, & Caetano, 2013).

This study conceptualizes alcohol dependency as an illness, according to the definition adopted from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (2013). The definition of alcohol dependency adopted from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (2013), is henceforth—"substance use disorder is a cluster of

cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (p. 483).

Treatment of mental health problems should be sensitive to the cultural contexts. Norms of familism are particularly important in Brazil. As a collectivist culture (Hofstede, Hofstede, & Minkov, 2010), where self-image is defined as "we" and not "I," there is a strong sense of familism that may encompass the formation of identity and the support given to and expected from extended family members (Hofstede, 2001). Consequently, family groups often function as a protective factor buffering the negative effects of adversities (Carlo, Koller, Raffelli, & Guzman, 2007). Nonetheless, currently most treatment for alcohol dependency in Brazil does not include family members (Moraes 2008). From a systemic perspective (Bowen, 1994), alcohol dependency affects not only the individual but close family members. As such, treatment protocols should include family members, especially the caregivers (O'Farrell & Clements, 2012).

Furthermore, research has shown the importance and the need to include family members, especially spouses, when treating alcohol dependence (Schenker & Minayo, 2004). Spouses and other family members may also suffer negative consequences of alcohol dependency (O'Farrell & Clements, 2012), such as depression, and anxiety (Rychtarik & McGillicuddy, 2005). A review of outcome research on treatment of alcohol revealed that marriage and family therapy (MFT) is more effective in comparison to individual therapy, both in situations when the person with the alcohol dependency is unwilling to seek help and when the person initiates treatment (O'Farrell & Clements, 2012). Before couple and family treatment protocols can be developed for Brazilian families, it is necessary to better understand how couples and families are affected by and cope with alcohol dependency in their families. Couple

and family treatment protocols need to consider cultural norms such as familism and other cultural factors unique to the respective social groups.

For example, the Northeast region of Brazil is more prone to social inequalities compared to other regions in Brazil (Nepomuceno & Pinheiro, 2010). The Northeast has the highest rates of poverty, the lowest levels of schooling, and the highest level of social exclusion (Amorin & Pochman, 2005). These alarming indices, however, coexist with a fast-growing economy: in 2013, this region had an economic growth three times that of the national growth rate in Brazil (Caldas, 2013). The wealth among the middle class in the Northeast grew by 20% accounting for 42% of the economic growth of Brazilian's population. This reflects the social contrasts in this region: the disparities among the rich and the poor have increased such that while there is an alarming level of poverty, the rich are getting richer. These social disparities have led authors to highlight the need to refer not to one, homogeneous Brazilian Northeast, but to recognize the multiple "Northeastern" sub-groups that emerge from having varied social statuses (Araujo, 2002).

Traces of patriarchy are also alive in Northeastern Brazilian families, regardless of social class. Even though women have gained social status in many areas in society (Alves & Cavenaghi, 2013), gendered power imbalance–characterized by male dominance and primacy, both in society and in family contexts (Alves & Cavenaghi, 2013) is still prominent (e.g., Sequeira & Stella, 2012). To inform the development of treatment protocols for this region of Brazil, this study will examine the experience with alcohol dependency in couples, while taking into account cultural values of the people in the region. Given the systemic nature of alcohol dependency and how it affects couples, Bowen family systems (1974), the socio-emotional relationship therapy (Knudson-Martin & Huenergardt, 2010), the systemic-transactional stress

theory (Bodenmann, 1995) and the family resilience framework (Walsh, 2006) will be applied in this study. These theories are elaborated below.

Purpose of the Study and Research Questions

This study on alcohol dependency is designed to expand our understanding of alcohol dependency in couples and help develop more culturally sensitive and systemic treatments. Previous research with family members and professionals in northeast Brazil has highlighted the need for the inclusion of spouses and other family members in the treatment of alcohol, yet little is known about their experiences and their role in this process (Moraes, 2008). Considering the reality of northeastern Brazilian families and its cultural context that embraces patriarchy and gendered ways of being, this study aims to explore the lived experience of couples from this region who are dealing with alcohol dependency. This study also seeks to understand couples' roles in the recovery process. In addition to eliciting the couples' stories, perspectives of mental health professionals will also be elicited. The research questions that pertain specifically to eliciting the experience in the Northeast Brazil region include:

1) How do wives experience alcohol dependency and recovery?

2) How do husbands experience alcohol dependency and recovery?

3) How do couples experience alcohol dependency and recovery?

4) What do wives see as their role in their husbands' recovery process?

5) What do husbands see as their wives' role in the recovery process?

6) What do clinicians see as the couples' role in the recovery process?

Chapter 2 - Literature Review

Northeast Brazilian Women's Identity and Role in the Family

The reference of Northeast Brazil as the "the Northeast" emerged in the 16th century when, due to political discourse, the northeast became known as "the problematic region" (Villa, 2005). The reference to this region was primarily focused on the dryness of its soil that was a huge contrast to the richness of the soil in the coastal and other regions. Its dry soil made it a costly region to maintain. To continue to receive government assistance, the Northeast has had to prove its worthiness.

There are two images of this region: The traditional Northeast–whose economy is primarily based on cattle raising and on agriculture–and the new Northeast, characterized by a strong emergence of industry (Bernardes, 2007). Women have gained more space in diverse aspects of Brazilian society (Alves & Cavenaghi, 2013), such as workforce and politics, which can be related to high divorce rates and birth rates—in 2010, Brazil had the highest divorce rate since 1984 (1.8%) (IBGE, 2011) and there has been an overall decline in birth rates (IBGE, 2013). This rapid social transformation, however, coexists with expectations towards women that are linked to notions of machismo. Gendered power imbalance remains prominent (Muszkat & Muszkat, 2003; Sequeira & Stella, 2012) and women are still responsible for household and reproductive labor—Brazilian women spend twice as much time working on household tasks than men, even in contexts where both partners have outside jobs (Fernandes, 2014). In fact, it has been suggested that the increased insertion of women in society, such as having the right to vote, to get a divorce, to have a job (Canezin, 2004) has not granted them increased power in the couple systems. Instead, it has added roles and responsibilities that they are expected to master, while being obedient to male's primacy (Pinto & Amazonas, 2006).

There is still a notion that the power for decision-making belongs to husbands, who are expected to be the main provider and protector of the family system; whereas, wives should take care of the family and give moral support (Gomes, Diniz, Araújo, & Coelho, 2007; Samara, 2002). Women in Northeast Brazil are raised to be strong, to have courage, to take care of the family, and to be hard workers, while concurrently expected to be sensitive and somewhat fragile—showing signs of what has been traditionally identified as feminine characteristics. Raised in a patriarchal culture, these women grow up with messages that they should take care of the family and be strong to manage their households. "In addition to the preparation to be a good mother, the woman should also be educated to support her husband when he is absent, for example, when he is working outside the home" (Souza, 2010, p.55). Accordingly, in a study with women that were experiencing intimate partner violence, participants had built notions about gender roles according to which women are expected to suffer and be submissive to men (Silva, 2010).

What seems to be contradictory messages about women's emancipation and their expected submission to male authority reflects conflicts between values of patriarchy and feminism. The feminist movement, as a social movement in Brazil has changed in the last four decades, and it still has room for growth (Costa, 2013). In the 1960s-70s, women fought against the government and the Catholic Church, focusing on democratization, on gaining social autonomy and against oppression in society in general. In the 1980s, the feminist movement gained more political space and women ascended to the congress, both in terms of representation, as well as in terms of civil rights: Brazilian women gained civil rights equal to men, under the Federal Constitution in 1988 (Canezin, 2004). In the 1990s, there was an impressive growth of the so-called "popular feminism"—the development of multiple feminist

non-profit organizations in diverse areas and social classes. Although the feminist movement has grown in the past decades, it has yet to gain recognition and space in Brazilian's congress, and there is still a fight for the implementation of policies that respect women's rights, both in society and in the family systems (Costa, 2013). The current conservatism of the government, reflected on the overall lack of public policies that favor women, may perpetuate notions of male dominance and female submission (Silva, 2010).

The changes in women's position in society as well as their perspectives about marriage and divorce were captured in a study that compared two editions of a renowned magazine in Brazil—one published in 1978, a year after divorce became legally accepted in Brazil, and one published in 2013 (Silva & Lunkes, 2014).While in 1978, women that got divorced were referred to as "mulher descasada" (unmarried woman), in 2013 they were referred to as "solitária" (lonely). The authors reflect on differences in the social context in these two generations, in terms of how marriage, divorce, and women's social position are seen: in 1978 women's desire was emancipation, but also being married. The authors suggest that the meaning behind the term "mulher descasada" (unmarried woman) reflects that being unmarried alluded to a lack of marriage and this was something women wanted to pursue. Differently, in 2013, after having conquered more space in society, women desire love and to be in a relationship; therefore, the term "solitária" (lonely) suggests an image of a woman who needs a husband and a romantic relationship. Accordingly, "in this movement of meanings, the biggest difficulty is no longer in getting a divorce, but in keeping a marriage, which means a feminine condition" (Silva & Lunkes, 2014, p. 147).

In order to "keep a marriage," it is suggested that that these women are expected to respect the male authority that in turn robs them of their voice (Sequeira & Stella, 2012). The

need for these women to be strong and resilient (Grijó, 2011) may unintentionally pressure them to be silent about their life challenges.

Understanding Alcohol Dependency and its Treatment

Alcohol is commonly seen positively—its consumption is encouraged in many societies and it is associated with notions of power and social status (Room, 2005). Alcohol becomes the enemy when used excessively—beyond what would be considered "normal." When a person is identified as having problems controlling the use of alcohol, the prestige that accompanies social drinking is replaced with stigma and marginalization (Room, 2005).

Alcohol dependency can be conceptualized as an immoral act or as an illness (Thombs, 2006). The immoral or sin-based perspective considers alcohol dependency a misbehavior or vice about to which the person has a choice. This act affects not only the person but others connected to the person. The illness model of alcohol dependency sees the person with the problem as having an illness and deserving proper treatment. Treatment of alcohol dependency has historically focused solely on the person presenting with the problem (Fals-Stewart, O'Farrell, & Birchler, 2004). Research, however, has highlighted the need to include family members in the treatment and the importance of adopting a systemic lens—where consideration is given to the role of family members and how they influence each other as well as the entire family system (Bowen, 1974).

To understand the recovery process (e.g., Gagne, White, & Anthony, 2007). Evidence-based practice research has demonstrated the efficacy of family and couple treatment. It has been found that incorporating a systemic view in the treatment of alcohol dependency might have as good or even better outcome, in comparison with individual treatment (O'Farrell & Clements, 2012). Couples receiving conjoint treatment have been found to have higher levels of abstinence

and relationship satisfaction, as well as improvement in other aspects of family and relationship functioning, including the interaction with children and levels of partner violence (Fals-Stewart et al., 2004).

In Brazil, substance dependency is considered a psychosocial problem and the public policy for treatment is rehabilitation and social reinsertion (Costa-Rosa, Luzio, & Yasui, 2003). While it is common for persons seeking treatment to be accompanied by their families—mostly spouse or adult children—treatment at public healthcare facilities has yet to include these family members (Moraes, 2008).

There is, however, a vast amount of literature supporting the importance of including family members, especially spouses, in treatment. Most research on efficacy and effectiveness of couple treatment for alcohol dependency was tested using cognitive behavioral therapy (e.g., McCrady, B. S., Epstein, E. E., & Kahler, 2004; O'Farrell & Clements, 2012; Vedel, Emmelkamp, & Schippers, 2008). This treatment primarily focuses on teaching partners coping skills and contingency management interventions. In a previous study, couples received cognitive behavioral therapy interventions based on the behavioral marital therapy couples group program, in which they were further coached to decrease overall level of marital distress, more effectively handle alcohol related situations, and encouraged to reinforce sobriety distress (Vedel et al., 2008).

Alcohol Dependency and the Family

Bowen (1974) conceptualizes alcohol dependency as a symptom of family dysfunction that may stem from intergenerational transmission of anxiety. Alcohol dependency can occur when there is an imbalance in the functioning of the family system, and partners handle stress and anxiety differently (Bowen, 1974). Considering that the way through which individuals

handle stress and anxiety are related to levels of differentiation (Bowen, 1974), when working with couples that present with alcohol issues, levels of differentiation of self become important. Accordingly, persons with a "solid self" are emotionally mature and confidently uphold principles that guide their life, whereas those with lower levels of differentiation, present a "pseudo self," characterized by inconsistent principles and higher possibility of being influenced by others. Levels of differentiation are further transmitted through generations and influences how people handle unresolved attachment issues with parents. It is assumed that people carry over unresolved emotional attachment issues to other relationships, especially to their marriages. As a result, partners with lower levels of differentiation present higher risk for emotional fusion.

Couples may present different configurations of emotional fusion, but the most common is one characterized by a partner being dominant while the other becomes adaptive—allowing the dominant partner to make decisions. The adaptive partner is then at risk of becoming overly dependent and voiceless— a "functional no self" (Bowen, 1974). Having "no self" makes one vulnerable "to some kind of chronic dysfunction, which can be physical or emotional illness, or a social dysfunction such as drinking, the use of drugs, or irresponsible behavior" (Bowen, 1974, p. 118). Those symptoms may occur especially in response to high level of anxiety and tension.

Family members may react to anxiety by triangulating, engaging in conflict, distancing, and overfunctioning or underfunctioning (Gilbert, 2006). Although any of these patterns can occur and/or co-occur in families with alcohol dependency, it is suggested that drinking problems itself can be a form of distancing (McKnight, 2013). Further, the role that family members, especially spouses, take in response to alcohol dependency is often conceptualized as overfunctioning/ underfunctioning (Bowen, 1974; McKight, 2013). As such, in times of crisis, families may develop a pattern of functioning where one member may drop some of his or her

responsibilities (underfunction), leading to another family member assuming those roles (overfunction) (McKnight, 2013). It is important to highlight that neither level of functioning is comfortable because both experience high levels of anxiety. It is just that over- and under-functioners tend to handle anxiety differently. In general, couples that present with alcohol issues have skewed perception of give and take in the marital relationship (Bowen, 1974).

Anxiety in the family system can further lead to emotional isolation and more anxiety. This vicious cycle may continue unless an intervention is introduced. As for treatment, Bowen (1974) proposes involving the entire family. However, if only one member of the partner dyad is willing to engage in therapy, it is more fruitful to help the overfunctioning member reduce responsibilities in order to allow the underfunctioning person to increase responsibilities.

Addressing Gender Issues in Couples Therapy

Couples seeking therapy indicate a wide range of presenting problems. Sometimes partners are unaware of issues associated with gender differences that might contribute to marital problems, due to cultural influences. Although there have been sociocultural changes that have proportionated more egalitarian marital relationships (Canezin, 2004; Unbehaum, 2001), Brazilian couples still present traditional values, especially those associated with marriage and the formation of the family unit as major feminine goals (Coutinho & Menandro, 2010).

In a study comparing two generations of married Brazilian women—raised in the 1960s and 1990s—some differences were found in regards to notions of intact marriage and the role of women in the couple systems; marriage, however, continues to be considered of primary importance for women, which makes traditional views of gender roles still prominent (Coutinho & Menandro, 2010).Women raised in the 1990s presented ambivalence between traditional and modern values in regards to marriage and gender roles. Although the emancipation of women is

often seen positively, promoting less submission to the husband and more involvement of the husband in the household, women's passivity was mentioned as an element that could help make marriage work (Coutinho & Menandro, 2010). Although divorce is frequently viewed negatively, being justifiable only under serious circumstances, such as physical aggression, lack of love, and infidelity (Coutinho & Menandro, 2010).

These notions of gender can be present in the therapy setting, even though clients themselves may not acknowledge it. Supporting a socio-emotional approach and the notion that relationship equality is not only an ideal or ethical value, but a pragmatic clinical concern, Knudson-Martin (2013) suggests that clinicians should go beyond the mere identification of power issues in couples therapy and instead help clients process perspectives about gender roles, and how this could be influenced by cultural context. This approach has roots on socio-constructionism, and clinicians utilizing it are encouraged to see clients as socio-cultural persons. Thus, the therapy process is focused on addressing issues of gendered power imbalance, those embedded in societal discourse that perpetuates patriarchy.

Socio-emotional relationship therapy has the goal to help couples develop a mutually supportive relationship. This approach emphasizes discourse, which facilitates the assessment of the influence of social-cultural values. Mostly important, however, is the notion of therapy as a social intervention. Due to the fluid nature of the discourse, by focusing on partners' stories, it becomes plausible for clinicians to help partners consider alternative narratives (Knudson-Martin & Huenergardt, 2010). For that, the therapy process is focused on four primary conditions to mutual support: 1) mutual influence, in the sense that each partner is encouraged to validate each other's worth; 2) shared vulnerability, so that partners become able to build connection, instead of distancing; 3) shared relationship responsibility, so that each partner is held accountable for

the well-being of each other, in addition to bringing the self entirely to the relationship, as well as for being responsible for the relationship itself; and 4) mutual attunement, in the sense that partners intentionally experience and empathize with each other (Knudson-Martin & Huenergardt, 2010).

It is possible the couple's interaction in therapy manifests a dynamic in which "the more powerful are less responsive to their partners' feelings and interests; the less powerful have difficulty influencing them and their needs and interests are less likely to be supported in the relationship" (Knudson-Martin, 2013, p.15). As such, it is recommended that clinicians review with clients possible gender stereotypes and help couples compose an alternative, more attuned, gender discourse, in which the more powerful—typically male—partner would take the lead in being vulnerable and starting connection (Knudson-Martin, 2013). By doing this, it can be possible for women to have independence while experiencing a mutually supportive relationship (Knudson-Martin & Huenergardt, 2010).

Couple Stress Management and Resilience

The systemic-transactional stress theory (Bodenmann, 1995, 1997) suggests that when under stress, partners might provide support for one another and react to each other's responses to the stressful situation, in addition to presenting strategies for coping together as a couple. As one partner communicates his or her stress, the other partner might respond by becoming affected by the stress, ignoring the signals from the partner, or by demonstrating positive or negative dyadic coping (Bodenmann, 1997). In other words, this theory postulates that when dealing with challenges, couples present both individual and dyadic coping strategies.

Dyadic coping behaviors can be positive or negative. There are three forms of positive dyadic coping behaviors: *Problem-and emotion-focused supportive dyadic coping*—a partner

assists the other with daily tasks, and offers practical help; *problem-and emotion-focused common dyadic coping*—partners jointly try to solve the problem and coordinate their responses to the situation; and *delegated dyadic coping*—one partner takes over and becomes in charge of multiple tasks to alleviate the stress level by the other partner (Bodenmann, Charvoz, Widmer, & Bradbury, 2004) —*s*imilar to the over/under-functioning described by Bowen (1974).

Conversely, negative dyadic coping is characterized by *ambivalent dyadic coping*—there is a presence of support from one partner, but that is performed unwillingly; *hostile coping*—there is support from one partner, but it happens with sarcasm or disparagement, and with the minimization of the stress level presented by the partner; and *superficial dyadic coping*—there is also support from one partner, but that is done with lack of empathy (Bodenmann et al., 2004).

There have been a number of studies testing this model with multiple populations, such as with depressed individuals and their partners in Switzerland (Bodenmann et al., 2004), and with couples that had one partner under treatment for breast cancer (Kayser, Watson, & Andrade,2007). In a study with couples whose wives were under treatment for cancer, it has been found that higher levels of depression impair one's capacity for positive dyadic coping, as well as increasing men's negative dyadic coping towards their partner (Bodenman et al., 2004). Couples that present with positive dyadic coping behaviors tend to experience the stressful situation as a "we-stress." Although coping together, being relational and supportive in their coping, partners still keep their individuality and may disagree on any changes for the couple (Kayser et al., 2007). Overall, these couples may consider that they have grown stronger, closer and more resilient.

Couples that present with negative dyadic coping behaviors tend to experience the stressful situation individually, and this can be exemplified by the presence of multiple "I-

statements" in their narratives (Kayser et al., 2007). As a consequence of their avoidance and disengagement during the stressful situation, partners might lack support for each other and focus solely on practical tasks, instead of their emotional experience, both as individuals and as a couple.

The ability to cope is closely linked to resilience. In fact, Walsh (2006) posits that families are resilient and can bounce forward from adversities. Families are further strengthened as they overcome adversities. Although there is no consensus on the definition of "resilience," it has two fundamental elements: the presence of risk or significant threat and a positive adaptation (Masten, 2011; Hill, Staffford, Seaman, Ross, & Daniel, 2007). Resilience is an ongoing process and needs to be nurtured throughout the life span. Walsh (2006) proposes that belief systems, structural resources, and communication processes are elements that will strengthen families' response to adversities.

Belief systems refer to how families cope with adversities and crisis by making meaning of their experiences, the extent of their positive outlook, and their transcendent beliefs, which includes the family's spirituality, larger values, as well as possibility of understanding crisis both as a challenge, and as an opportunity for growth. In addition to belief systems, structural resources are associated with families' capacity to be flexible, yet have structure in the face of adversity. Structural resources include levels of family connectedness, which can be seen as "the emotional and structural bonding among family members" (Walsh, 2006, p. 94). Considering that families exist within a broader social context, structural resources are also related to social support. As such, communication processes are fundamental to family resilience because it is through verbal and non-verbal communication that family members express emotions, transmit beliefs and problem-solve.

In pursuing this study, the systemic nature of alcohol dependency, couples' management of stress and their process of resilience building will be used to facilitate understanding the experience of alcohol dependency in the couple system. This study will move beyond children's outcomes from having alcoholic parents (e.g., Nancie, 1997; Obot & Anthony, 2004) to how couples are impacted by alcohol dependency.

Chapter 3 - Methods

The purpose of this study was to develop an understanding of the effects of alcohol dependency and its treatment process for couples and families. A phenomenological approach was utilized.

Phenomenology

Phenomenology explores the meaning and the essence of the lived experience under investigation through the perspective of those who experience that phenomenon (Patton, 2001). This approach assumes that knowledge is constructed through the interaction with others, therefore, it is relational and subjective (Dahl & Boss, 2005). Investigators then rely on the deep descriptions and interpretations by those who experience and make meaning of the phenomenon (Patton, 2001). Accordingly, the meaning-making process is based both on the experience of the phenomenon and on the description and interpretation of that experience. As a result, listening to the personal stories of participants—the experts on the phenomenon—is necessary.

Considering that the phenomenological approach views knowledge as socially constructed, the researcher might affect the meaning-making process of the participants (Dahl & Boss, 2005). For this reason, researchers need to constantly use self-reflexivity and self-questioning, and be attentive to potential conflicts of interest. Being aware of one's subjectivity and seeing the phenomenon as described by the research participants is what Moustakas (1994) referred to as the principles of Epoche and bracketing. The first refers to the need of the researcher to be aware of his or her own subjectivity and personal bias (Bednall, 2006), whereas through bracketing, it is possible for the researcher to recognize the essence of the phenomenon under investigation through the lenses of those that participate in the research and experience it. The researcher needs to adopt a phenomenological attitude and be aware of personal bias or

assumptions in order to capture and understand the phenomenon without prejudgments (Patton, 2002).

Self of the Researcher

My interest in this topic comes from a personal and professional interest in family issues, particularly those related to alcohol dependency, the role of women and processes associated with family resilience. I have conducted research on family resilience with different populations, such as military youth and their parents, and single African-American women. I also have some experience teaching about cultural diversity to undergraduate students. Having conducted qualitative research, I am fully aware of the need for researchers to be aware of and bracket any personal biases related to the topic studied. For this reason, it is important for me to acknowledge my biases that could potentially influence my research. I am aware of three biases as described below.

First, I am Brazilian, born and raised in Recife, Northeast Brazil, where this study was conducted. Having grown up in this region, I am aware of the overall strength of its people, including women, despite the existence of patriarchy and social inequalities. Most vivid in my memory is the phrase, that "O nordestino é antes de tudo um forte" (The Northeastern is, first and above all, strong) that was repeatedly mentioned in family and academic settings. Second, I have a maternal uncle who struggled with alcohol dependency. His attempts to seek help through Alcoholic Anonymous were unsuccessful. He has been barred from most family gatherings. Alcohol issues are now a sensitive topic in my family. Third, as a marriage and family therapist, I am biased towards family treatment. I know that the systemic perspective, although present, is not fully integrated into treatment processes in Brazil. I hope to help improve the treatment for alcohol dependency by introducing couple and family components to treatment. I made every

attempt to be vigilant about my biases and avoided superimposing my preconceived ideas of strength in this population, how alcohol dependency affects the couple and family, and of the value of family therapy.

Recruitment and Interview Procedures

Prior to contacting potential participants, an Institutional Review Board (IRB) from Kansas State University was obtained to conduct this study. I (researcher) contacted a psychologist who worked for a private mental health agency, located in the city of Recife, Brazil that provided in-patient treatment for alcohol dependency. Treatment for substance dependency at this institution includes in-patient treatment for the first two weeks, with no home visits. After this period, clients undergo a transition period, in which they spend the weekends at home, and workdays at the institution, until they reach termination of treatment. While receiving treatment at the institution, clients are expected to attend group sessions (a total of 19 per week) and individual treatment. In addition, family members are encouraged to participate in weekly family groups (without client), and weekly family meetings (with all clients at the institution).

After providing a brief verbal description of this study, I submitted a written proposal to be approved by the mental health professional team of that institution, and by its directors. After receiving formal permission, I recruited participants for this study. Although participants were identified and recommended by the psychologist, participation was fully voluntary and no monetary incentives were provided to participants or the agency for recruitment.

Four mental health professionals and four male clients undergoing treatment for alcohol dependency were contacted through email and telephone. Of the eight people contacted, one male client declined participation. After agreeing to participate, the clients provided the contact information of their wives; I contacted them and all three wives agreed to participate.

Since the structure of treatment at the agency is such that each client might participate in multiple support groups, in addition to individual therapy, it was possible that the husbands were or had been clients of the mental health professionals that participated in this study, although this was not a requirement for participation.

Participants completed a consent form prior to the interview (Appendix A and B) and were interviewed individually using a semi-structured interview guide (Appendix C, D, and E). Participants were also interviewed as a couple (Appendix F). The couple interviews were conducted only after the husbands and wives were interviewed individually.

All interviews were conducted at the private mental health agency, in Recife, Brazil. The interviews were held in a therapy room. The interviews with the mental health professionals ranged from 30 to 65 minutes; the interviews with the wives ranged from 43 to 56 minutes; the interviews with the husbands ranged from 38 to 56 minutes; and the interviews with the couples ranged from 20 to 25 minutes.

Prior to the interviews, I spent time joining with the couples and other professionals that worked at this agency. As part of the joining process, I attended one weekly group family meeting at the agency. The only data that is included from my observations of the weekly group family meeting is my personal reflection.

The interviews were audio-taped and transcribed verbatim for analysis. I conducted all the interviews and transcriptions in Portuguese, the participants' native language. After analyses were conducted, I translated the quotes presented in this study into English. A Brazilian mental health professional crosschecked the transcription and the translation of the quotes for accuracy.

Participants

In order to answer the research questions, this study elicited participation of couples whose husband was in recovery for alcohol dependency, and mental health professionals with experience in the treatment of alcohol dependency. In order to participate in this study, participants needed to meet the following criteria: married couples where at least the husband was currently under treatment for alcohol dependency. The husbands that participated in this study identified themselves as close to the termination of treatment. Insomuch as the husband reported a history of alcohol abuse, the couple could be included in this study, regardless of whether or not the wife also consumed alcohol.

Statistical Overview of Participating Couples

Three couples participated in this study. Husbands' ages were 47, 54, and 61, and wives' ages were 28, 43, and 59. The length of current marriage ranged from 2 to 34 years (M = 15.33). All participants in this study indicated coming from upper or upper-middle class families. All male participants graduated from high school, whereas all female participants completed 4-year college degrees.

Narrative Overview of Participating Couples

The first couple, Ivan and Joana, had cohabitated for two years and they had a 14-month old female child. The husband (Ivan[1]) was 47 years old, and the wife (Joana) was 28 years old. Ivan had seven children, six of them from two previous relationships. He did not complete a college degree and currently he was receiving governmental assistance due to alcohol dependency. He came from an upper-class family, had three sisters and was the second to the youngest child. His mother died when he was in his mid-30s, and his father remarried his sister's

[1] All personal names used in this text are fictitious

best friend, which truly upset Ivan. His paternal grandfather also suffered from alcohol dependency and he died of cirrhosis of the liver. Joana had a completed college degree in Gastronomy and she had just started her own business—making and selling truffles. She was the younger of two girls. She reported drinking socially, but since forming a relationship with Ivan and witnessing his struggles, she decided to abstain from alcohol, even when he was not present. She had a maternal aunt and uncle who also suffered from alcohol dependency, but with whom she did not have contact. She indicated that she had a history of illicit drug dependency and that she suffered from depression, for which she had been in individual therapy.

Ivan stated that he was exposed to alcohol at a young age—when he was 14 years old—and since then, every time that he consumed alcohol, he unable to control his amount of intake, and always got drunk. When Ivan and Joana met—at a public institution for substance recovery—she knew he had dependency with a psychoactive substance. According to her, he only had a relapse after some time in the relationship—a time when the partners were deciding whether to stay together and they were making plans for pregnancy. This couple reported overall lack of social support for their relationship, mainly due to the assumption that they were unable to conquer things, because of the history of substance dependency. The lack of support from each side of the family predated their relationship. Joana reported being sexually abused by her father and by other men in two other incidents of abuse. She indicated that her mother did not believe this abuse had indeed occurred. This lack of support was the trigger for her substance abuse. Although reporting family support to seek treatment—mainly from his sisters—, Ivan talked about difficulties in coping with his mother's death, the remarriage of his father, and the financial consequences that Ivan suffered from it, at the age of 35.

This couple had many challenges: neither reported having received much family support. They felt alone and had to strive for themselves, both as individuals and as a couple. Further, they described their initiative of helping each other, and brainstorming together possible plans for their future. According to the systemic-transactional stress theory, although focusing primarily on Ivan's recovery process, it could be suggested that the way this couple coped with substance-related issues and other life challenges characterizes the problem-and emotion-focused common dyadic coping. According to this type of positive dyadic coping, partners jointly try to solve the problem and coordinate their responses to the situation (Bodenmann et al., 2004). The words "persistent," "determined," and "strong" were used by them to describe how they would like their 14-month old refer to them when she gets older. This captures some of this couple's resiliency.

The second couple, Roberto and Carmen, had been married for ten years, and together they had a 7 year old son. Roberto was 54 years old, and Carmen was 43 years old. Roberto was in his third marriage, and he had another son, 19 years old, from a previous marriage. He was the third of five children, and had one sister and three brothers. He had a high school diploma, and currently he was working full-time on his own business, along with Carmen. Carmen had completed a four-year college degree in Public Relations, and she worked full-time with Roberto at their business. She was the youngest of four children; she had two sisters and one brother. She also indicated that she did not have any family members suffering from either alcohol dependency or depression.

When they decided to get married, Roberto warned Carmen about his drinking problems, but he also assured her that he had been sober for a long time, and that he would not drink again. After seven years of marriage, he had a relapse. According to Carmen, it was due to his father

passing. Roberto indicated that he did not have any family member with alcohol-related issues, though he started binge drinking at the age of 12, with two brothers and some friends. In addition to alcohol dependency, Roberto presented symptoms of depression. Married for the third time, Roberto reported that each of his marriages lasted for about ten years, and currently, after joining the treatment for recovery from alcohol dependency, he was having doubts about his desire to continuing to live with Carmen, although he wanted to keep their relationship—living in separate houses—which was against Carmen's desire.

Although reporting anxiety and fear in relation to her husband's drinking problem, Carmen considered that the couple was living the recovery process together, which was contrary to Roberto's perspective. Based on the partners' descriptions of each one's role in this process, it could be said that this couple was showing positive dyadic behaviors, according to the systemic-transactional stress theory (Bodenmann et al., 2004). Particularly, Carmen presented delegated dyadic coping, since she took over what she considered as most of Roberto's duties while he was in treatment, as a way to be supportive to him. Nonetheless, it seemed that this new role was experienced with high level of anxiety, which is typical of those that overfunction (Bowen, 1974). Although Roberto stated that he loved Carmen and he wanted to keep their relationship, it seemed that Carmen was the one fighting for a healthy functioning of the family system. Overall, this couple presented elements of family resilience, such as strong faith, along with the flexibility of reviewing household roles and responsibilities, increased time spent together with their son, and intentional communication among all family members, which facilitated the open discussion about Roberto's alcohol dependency, even with their seven year old son.

The third couple, Carlos and Ana, has been married for 34 years, and Carlos, 61years old, was previously married and divorced. Together, they had two daughters, aged 33 and 31. Carlos

had a high school diploma and he was considering going back to school to pursue a college degree in History. He had worked full-time, and had been retired for 16 years. He linked the retirement with the onset of his alcohol dependency. Currently, he had started to volunteer at his wife's workplace. Carlos was the youngest of five children, and he had one sister and three brothers. His paternal grandfather and three paternal uncles also suffered from alcohol dependency. Ana, 59 years old, had a college degree and a post-graduate certificate in History. At the time of the interview, she was working part-time at a public institution. She was born as the third of ten children, and she had four sisters and five brothers. Her father and one of her brothers suffered from alcohol dependency.

Carlos was born and raised in South Brazil. According to him, being raised in a region colonized by the Germans made his community appreciate alcohol in a very unique way. In fact, he indicated that beer was always present in his family life as a child, and that his mother used to brew this drink at home. Although raised around alcohol, he did not associate his alcohol dependency to early stages of his life. Accordingly, it was not until his retirement, about 15 years ago, that he experienced idleness, and gradually increased the amount and frequency of alcohol intake, which led to the dependency. His wife, Ana, experienced alcohol dependency in her family-of-origin during her childhood, with her father. She indicated being fearful about marrying a man with similar issues, and she was particularly frustrated when she noticed her husband's drinking problems. Although it was challenging to live in separate homes for a few years due to Ana's job obligations, and having to deal with financial crisis and issues associated with Carlos' alcohol dependency, this couple decided to stay together. This couple appeared to show distancing from each other during moments of hardship (Gilbert, 2006), which made both of them report feeling disconnected. Further, although Ana tried to be supportive, especially on

daily tasks, which could suggest the problem-focus and emotion-focused supportive dyadic behavior (Bodenmann, et al., 2004), the couple had a long phase of distancing, which contributed to her feelings of uncertainty about how she could approach and help Carlos. Nonetheless, the decision about keeping the marriage, despite all the challenges they were experiencing, was made partly due to religious beliefs, partially because they had hope in their marriage, which suggests the couple's resiliency.

Statistical Overview of Participating Mental Health Professionals

Four mental health professionals participated in the current study. All of them were female -- three were married, two had children, and one was pregnant with her first child. Their ages ranged from 27 to 52 ($M = 33.75$). Three of them indicated having family members with a history of alcohol dependency. All mental health professionals had at least a 5-year college degree in Psychology, and they had each worked with clients dealing with alcohol use from 1 to 8 years ($M = 4.75$). All of them indicated that they worked clinically through a psychoanalytic lens and they were each under clinical supervision.

Narrative Overview of Participating Mental Health Professionals

Mental health professional number one (Ingrid) was 29 years old, married and mother of a two year-old son. She had a master's degree in clinical psychology. She had worked as a psychologist for 8 years, and she started working with substance abuse issues since her internship in clinical psychology, as an undergraduate—1 year prior to graduation. At the time of the interview, she was working three jobs, two of which were related to working with substance use disorders, and another one as a school psychologist. Ingrid indicated that she had a family member dealing with alcohol dependency.

Mental health professional number two (Maria) was 52 years old, married, mother of two adult children. She graduated in 2008 and since then, she had specialized in working with substance-related issues. She indicated that her previous experience providing services to low-income and underserved populations had helped her better understand alcohol dependency as an illness not as much related to socio-economic status as to relational issues. She was working at the agency where this study was conducted as one of the clinic directors, as well as for a public institution, serving low-income individuals. Maria indicated that she had a family member with alcohol dependency.

Mental health professional number three (Lisa) was 27 years old, married, and was expecting her first child. She graduated in 2013, and since then, she had worked at the agency where this study was conducted. In addition to the position of therapist at that agency, she was also working in a project funded by Brazilian government, to prevent substance use, as well as in a private practice. Lisa also indicated that some of her family members dealt with alcohol dependency.

Mental health professional number four (Kelly) was 27 years old, previously in a committed relationship but was now single. She had a master's degree in clinical psychology. She had worked as a therapist at the institution where this study was conducted since her internship during her undergraduate years. She indicated that she did not have alcohol dependency issues in her family. According to her, due to coming from a very religious family, initially she needed to do some self-of-the-therapist work in order to review her assumptions about those who present with substance-related issues. Passionate about the work with this topic, in addition to the position at that agency, she was a member of a research project funded by the Brazilian government, and she was an adjunct faculty member in two college institutions.

Data Analysis

The interviews were read and analyzed by the researcher with the assistance of her major professor and a Brazilian marriage and family therapist. Data analysis was guided by the voice-centered relational method (VCRM)—known as the listening guide—that calls for an epistemological shift from "reading" to "listening" during the analysis, which requires a more active role for the researcher (Gilligan, Spencer, Weinberg, & Betsch, 2003). Following the principles of phenomenology, the method highlights the importance to be attentive to the idiosyncrasy of each participant's narrative, in addition to exploring the narratives in relation to each other in order to identify emergent themes. This method was selected because of its emphasis on participants' voice, for the attention of participants' sense of self, as well as the consideration of the interplay of multiple voices—from the cultural context—and the polyphonic nature of psychological processes (C. Gilligan, personal communication, March 21, 2014).

The analysis was guided by the interview questions, participants' stories, Bowen theory, and notions of couples and family resilience. The listening guide asks for four consecutive steps of reading/listening of the narratives: 1) listening for the plot, 2) writing "I-poems," 3) listening for contrapuntal voices, and 4) composing an analysis (Gilligan et al., 2003). The first reading focused on understanding the overall narrative while I (the researcher) was attentive to personal reactions to the story and looked for unique aspects of each narratives as well as dominant themes. The second reading/listening focused on how each participant voiced their inner experience, by using the pronoun "I." For this reading/listening, "I-poems" were captured by a careful listening to how participants referred to themselves using the first-person (Gilligan et al., 2003). The purpose of this listening is to capture participants' voices and how they spoke about themselves. The process of identifying I-poems consisted of identifying the pronoun "I" with the

verb and other important words that accompany it. These were put in stanzas as a poem and the order of the lines followed the sequence as they appeared on the interviews.

The third reading/listening consisted of identifying contrapuntal voices or multiple voices (Gilligan et al., 2003). Through this listening, I identified contradictory voices—from the participants and/or from the social and cultural discourses. This is what characterizes the polyphony within the narrative. Considering the principle that people build knowledge and construct their identity through the interaction with others (Moustakas, 1994), it is possible for people to have contradictory messages. The identification of contradictory voices was particularly informative to the understanding of participants' experience of alcohol dependency and its treatment process in the couple systems, especially their perspectives and expectations about their role in the recovery process.

The fourth reading/listening focused on trying to answer the research questions based on common themes and on what emerged from previous steps of the listening guide process (Gilligan et al., 2003). Themes were triangulated across transcripts by comparing and contrasting against each other. This was done separately by grouping the wives' narratives, the husbands' narratives, the couples' narratives, and the mental health professionals' narratives. Themes from each group will be presented in the "Findings" section below. Finally, themes from each of these groups of transcripts were compared and contrasted.

Trustworthiness

As acknowledged by Moustakas (1994), Epoche is not necessarily a negative aspect of qualitative inquiry. On the contrary, it is part of the research process, it should be recognized, and accompanied by bracketing so that the experiences and essence of the experience of the phenomenon by the participants can truly be captured. In order to put my personal beliefs in

suspension and avoid the influence of my personal bias on the data analysis, I acknowledge my biases and took steps to ensure rigor in this study as illustrated below.

First, credibility was achieved by giving participants a chance to confirm and/or correct the transcription of the interviews. After the transcriptions are completed, I contacted the participants, through telephone and/or email and made the transcripts available for them to correct or add more information as they judge necessary. No participant indicated interest in reviewing the data, though the mental health professionals showed interest in reading the manuscript. Second, triangulation of the data (Lincoln & Cuba, 1985) was facilitated by using a research team comprising another female Brazilian marriage and family therapist and me with my major professor overseeing the process. Each researcher independently read and coded the transcriptions, then we cross-checked and converged the findings. The codes that were similar between researchers were put together as broader themes that captured the essence of participants' experiences. When different interpretations arose, we discussed to arrive at a consensus. Third, confirmability was achieved by leaving an audit trail, consisted of field notes, transcripts, and products of data analysis. Last, dependability was achieved by having a participating inquiry auditor—my major professor—that supervised the data collection process and analysis phases, making sure that I followed proper research procedures. I consulted with my major professor throughout this study. During the analysis process, I kept her informed of the themes that were emerging from the data. Quotations that supported themes were translated into English for her to review and verify the soundness of the themes. Discussions helped tighten themes identify sub-themes within the themes.

Chapter 4 - Findings

Wives' Experience

All three wives described the experience of alcohol dependency in negative terms, mostly due to its damaging impact to the family system. Their role in the recovery process appeared restrained and bounded by their position as wives and their allegiance to cultural and religious values. Lacking social support— from extended family and friends—these wives had only themselves to rely on. Despite that, they were hopeful for their futures and that of their children's. The following themes emerged from the data analysis: the negative face of alcohol, treatment is mutually benefiting, walking the tightrope, subservience, lack of social support, strengths and changes in the family.

The Negative Face of Alcohol

The wives' stories of alcohol use were fraught with fear and disappointments. For Ana, her fear of her husband developing alcohol dependency pre-dated knowing her husband. For Joana, the fear emerged when alcohol changed her husband. Husband's alcohol problems brought disappointment and fear to Carmen. Alcohol dependence did not only affect their husbands, but it had a way of bringing down the entire couple system.

Joana in particular noticed how alcohol use led to behavioral changes in her husband that included being violent -- "*It's very troublesome, because when he drinks, he changes a lot, he becomes very, you know, he gets violent, he threatens, he tries to do things.*" Carmen who witnessed her husband's relapse shared her disappointment while reminiscing about the time when her husband assured her that his alcohol problem was under control:

> *When we were getting married, we sat and he said, 'Look I have depression, I have trouble with alcohol, but I have been in treatment, and I am sure that I will not drink*

anymore, ever.' At the time he was persevering, attending the Evangelical Church, then I saw it as truth, and also the passion, the love, you truly stay without knowing what the risk is. And there were eight years without him drinking.

She further described experiencing her husband's relapse as chilling as it was related to an event that no one could control: "*In 2013, his father died. There was a strong dependence on his father, so this was another motive. (…) with the death of his father, he began to use alcohol again…when it happens to us, it takes a very scary course.*"

For Ana, her fear of having a spouse with alcohol-related issues dated back to her childhood where she witnessed her violent father struggle with alcohol. She had vowed never to marry a man with a similar condition. As she told her story, the disappointment of having landed into a relationship that turned into one similar to that of her parents emerged.

…bad, right? First it started with my father; it was very bad. I really wanted to leave the house because I was afraid of him. My father was a little violent; he never ended up beating us, but we lived in fear (…) so I was afraid of my father. Before marrying, I was terrified of marrying a man who drank too much, right? When I met Carlos, he did not drink like that…

Treatment is Mutually Benefiting

The wives appeared to agree that the recovery process is an individual process for their husbands who had to deal with their problems that led them to use alcohol. There appeared to also be a consensus that recovery was beyond mere abstinence but a process of self-discovery that could take a while. The wives, however, alluded to being changed by their husbands' recovery process.

Joana shared her view on the recovery process: "*I think that this process of alcohol recovery is a very individual thing for him. It is something he must work on his issue*." Carmen described the recovery process in terms of stages. The first stage is one of shame and sadness: "*The recovery process is such a thing that first there is great sadness in him; maybe so embarrassed that he has succumbed to that* [alcohol] *use, and he becomes fully inert, unwilling to do anything, apathetic; that's full depression*." Noting that the recovery process should not focus solely on abstinence, but on self-awareness and identification of emotional needs, Joana concluded that it could last awhile: "*I think it's a very slow thing, it's one thing at a time, and (...) here* [referring to the treatment center] *there are several groups for the person to get to know him or herself.*"

Although husbands were the ones in treatment, wives spoke of how they could feel the impact of treatment. Joana spoke of how she believed that whatever her husband did impacted her: "*For me it* [the recovery] *is very good because as he changes, he changes me as well, because from the moment he deconstructs himself, he can deconstruct me as well. I think it's wonderful*." Joana who was in therapy for her own personal issues failed to mention that her treatment could likewise have an impact on her husband.

Reaping the benefits of treatment was also shared by Ana who described her husband as more loving since seeking treatment:

> *Even times when there was a separation, although we were living in the same house, but there was separation from him, we were not interacting, we were not having a good relationship, but then once he stopped* [alcohol use], *once he started the treatment, he became more loving. (...) And I 'm finding it good*.

Walking the Tightrope

The wives walked the tightrope of keeping everything together. The wives were supportive of their husbands, protective of their families, and steadfast in adhering to spousal responsibility of keeping family unity. This meant not rocking the boat that may lead to their husbands' relapse.

In Ana's words - "*I have to be by his side, to give him support. I cannot leave him, and go*." Joana sang a similar tune - "*I think the main thing is the support, to support him*" although her husband was abusive when under the influence of alcohol:

> *The more that he curses at me and does things, but I'm still with coração na mão* [heart in hand – an expression used to refer to high level of anxiety and affliction]. *My mom even used to get really frustrated at times because he would drink, I would leave his apartment, my mom would come to pick me up, and I would say 'I'll be back, I will not leave him here alone*.'

It seemed that the belief that it is a wife's role to protect the husband, to be supportive, and to "*hang in there*" (Joana) was influenced by Christian values. Ana shared: "*I endured all this time, I think because, well, my mother is very Catholic and she always said that we have a cross to bear, right? I think* [laughs] *I carried mine.*" Likewise, Carmen indicated that part of her role was to deal with his "*fissures*" [cracks] because that was what was expected from her religious formation:

> *So if it's a family, that's what our religious formation says, it is in health and in disease, in joy and in sorrow. This is the time of the disease, time of sorrow? So as a family, I think that the education I've received would say fight for the family, and for him*.

For Carmen, who assumed the protective role early on, doing so help her prepare for when the 'rope breaks' - "*I stay already in that protective role because I 'm afraid. When the rope breaks*

out, who has to hold the end of the rope, all the weight? Me! So I stay in that position, with that tightness in the heart." The "*tightness in the heart*" (aperto no coração) as described by Carmen, is an expression normally used in Brazil to refer to feelings of uncertainty and anxiety. This feeling was also illustrated by Ana, who, spoke of the fear of her husbands' relapse.

The wives' sense of responsibility went beyond maintaining family stability to preventing their husband's alcohol relapse. Their fear of causing a relapse meant keeping relational issues silent. Ana described her dilemma:

> *But I think I still wanted to say more things to him (but) I'm so afraid to say. So if I say, he can get, he can have a relapse…afraid that he would have a relapse. And sometimes you're in a good mood, thinking that things are better, which have been years since you had a better climate at home, with a better relationship. So then you stay sometimes unwilling to say something with fear, you know?*

Similarly, Joana spoke about the fear of relapse as being present in her reality: "*We deal with the fear of relapse. It's always there; at any time he may fall. So it's something I already deal with*."

The support that these wives render to their husbands is unwavering. Carmen described her efforts to keep everything (household and work) together while giving as much encouragement as she can to her husband: "*I do as much as I can, such as, running to get there at the boy's* [children] *time, running to meet our* [business] *customers as much as I can, to pay the bills. I stretch myself as much as I can. Still, I'm so anxious to encourage him, like 'do not quit."*"

Subservience

It was clear that the wives put their husbands before themselves. The concept of self-care was not well embraced by wives. Although husbands may give verbal permission for wives to

take care of themselves, their actions were contradictory. These mixed messages and cultural scripts of patriarchy appear to solidify wives' subservience.

When asked what she would like her husband to do to support her during the recovery process, Ana was surprised by the question and turned the focus back on her husband: "*You ask certain things we do not ever think about; I have never asked myself that question, what he could do...because I have worried, but with him, you know? Something for him to do, maybe these things, to take care of himself, you understand?*" When probed further, Ana shared that she had used acupuncture to take care of herself and to "*accept those things of life.*" According to her, she used acupuncture "*to live"* – denoting its necessity opposed to it being an enjoyment.

Carmen, who developed anxiety from the added responsibilities she assumed after her husband began treatment sought psychotherapy: "*Only recently, I began to bring to the care with the psychologist here, because I was very anxious with the very large load – the business, child, husband away*." The description of how she came to seek help speaks of the long duration of neglect of self before her decision that included informing her husband. This is captured in the following I-poem:

I am doing almost nothing
I have started therapy
I returned to Pilates
I need
I told him
I am going
I told
I am
All this time doing nothing
Only calculating, calculating
And not living the present.

Eu estou fazendo praticamente nada
Eu estou comecando a voltar a terapia
Eu retornei ao pilates
Eu preciso
Eu disse
Eu vou
Eu disse
Eu estou
Todo esse tempo sem fazer nada
Só calculando, calculando
E deixa de viver o presente.

In Ana's case, her husband "gave" her permission to "do want she wanted."' However, she stifled the impulse to do anything for herself: "*I think I didn't live many things in my life.*

Still, he said 'you have freedom to do what you want.' He said so, but I don't know; too much in my life (...) you 'vai se anulando' [quashing] *on certain things.*" Such verbalized permission was not congruent with his dismissing Ana's feelings when he told her that she made him sad when he was back home and Ana complained because he was smoking cigarettes inside the house - "*I think I stayed way longer sad with him than he stayed sad with me.*"

Such dismissiveness was also experienced by Joana. When she attempted to discuss with her husband the things he did while under the influence of alcohol, she was shot down. This silencing left her with the inability to process these incidents that continue to haunt her:

> [To] *overcome, overcome, I do not think anyone ever overcomes. There is always that wound. Because, for example, sometimes I speak with him, he complains that I speak of the time he locked me* [alone, in his apartment]. *There are things that no one forgets*.

Ana's distancing from her husband may be how she took care of herself. That maybe the extent of freedom she has considering the obligation she has towards her marriage and husband. Her I-poem captures her commitment:

I do for him
I think we spend the entire life together
I am also independent
I don't do much
I, sometimes, allow him to do his stuff
but now
I am indeed
I don't know if that's me
or if
I am charging (me cobrando) myself because
[I've] never done
I think our relationship
I think that before
I would not do it because
I used to get away from him
I spent
I spent my entire life getting away (fugindo)
getting away from my father, and now, when

Eu faco para ele,
Eu acho que a gente passa a vida junto
Eu tambem sou independente.
Eu nao faco muita coisa nao
Eu as vezes deixo ele fazer as coisas dele,
so que agora
Eu estou realmente,
nao sei se sou eu,
ou se
Eu estou me cobrando porque
[Eu] nunca fiz.
Acho que o relacionamento da gente,
Eu acho que antes
Eu nao fazia isso porque
Eu fugia dele
Eu passei
Eu passei minha vida toda fugindo:
fugindo de meu pai, e agora quando

he [husband] *really started to drink*	*ele comecou realmente ele comecou a beber*
I started to get away from him	*Eu comecei a fugir dele*
Now it depends a lot on necessity	*Agora depende muito da necessidade;*
what needs to be done	*o que tem que fazer*
I do.	*Eu faço.*

The wives' subservience to husbands can be attributed to patriarchy and gender roles. Joana explained: "*Brazil is very sexist, there is a strong 'machismo,' but here, the Northeast region, surely, is much stronger than if you go to the South*." Carmen further indicated that "*in theory*" her husband should "*be in charge and to be the chief of the family.*" Due to his situation, she had to assume this power and control with which she is uncomfortable: "*I do not feel comfortable not. I wish he had the control, but I see that he does not have that inner condition of being in control today. It would be a … chaos. So therefore, I assume, and I assume it skillfully. But I would rather have him have the control*."

These "*fissures*" [cracks] as referred to by Carmen in their marriages were not sufficient for these wives to abandon their husbands. Said Ana:

> *…we don't want to lose our husband, even with all that he has done, all of his betrayals, his hassles, at this point in life, if I leave him, what would I do? Would I go after another man? I don't want anymore.*

It may be too that they do not see themselves gaining much from leaving their marriages considering that there were "*losses throughout the journey* [marriage] *and they could not be recovered*" (Carmen).

Ana however, would advise other women to leave their husbands, if they were at early stages of marriage:

> *If it was in the beginning, I would tell her to leave. If it has reached certain time, stay, stay, until… but if, for example, I had a daughter that had a husband with alcohol issues,*

I would say, take care of yourself, look for a therapist, and leave. Because I think I needed to seek help a long time ago.

Lack of Social Support

The wives' did not receive any significant support from their own and their husbands' extended families nor did they want to burden their families with more problems. The expectation that wives' were to assume full responsibility for husbands after marriage was another reason for the lack of family support. Carmen who reached out to her husbands' brothers was reminded of her responsibility:

One of his brothers clearly said 'my dear, you were the one who married him, the problems is yours.' This frustrates me, it bothers me. (...) Then he said 'you take care of it.' I said look, you know he already had two marriages, I 'm the third. You have former sisters-in-law, but you will never be called ex-brother. (...) No one ever calls to see how he is doing, so that frustrates me.

Joana attributed her family's lack of support for her and her husband to his multiple relapses:

They [her family] *in the beginning, believed he could change, but then he was having other relapses, others relapses, other relapses, and they were losing faith on him. Today they no longer believe in him. They find that he will have no way out, let's say. (...) Since I have had the problem, they believed he was going to help himself and would help me. So, since he disappointed them, so the sentiment is the same.*

The lack of support from family made it challenging for wives when they had little choice but to reach out to family. Joana, for instance, was livid about the fact that she had to move in with her mother whom she did not get along with. She shared:

*He is getting better and better, and better, which already reached a point of bothering me. Because when we came here [*to the institution, for recovery process*], I moved in with my mother, and my mother is a person who makes me very depressive. (…) I was fucked over* [referring to her hardship and suffering] *while he was really good in here* [in-patient treatment]. *Because he eats breakfast here, he is in his therapy, he has lunch, dinner, he sleeps, while I was there, with my mother being fucked over."*

It was difficult too to reach out to friends because the couples spoke of having his and her friends but not shared friends. For Carmen, the fear of the repercussions for her children if people knew of their family situation made it difficult to seek support:

…a lot of fear in relation to neighbors, acquaintances, what they would think, what they would say… friends of my child at school? People in our city are very selective. No one wants to be next to someone who is a well of difficulties.

Strengths

There were many examples of how strong the wives were. Their commitment to their marriages and families and their adherence to their cultural values cannot be over emphasized. Both Joana and Carmen indicated that people around them noted their "*forte*" (strength)–the term commonly used in Northeast Brazil to refer to resilience. Carmen however, shared that she may have looked strong but in reality she was scared: "…*people see me as very confident, but deep inside I am terrified*." She realized that she was "*lutando*" (fighting, used here to mean persevering), but she was "*scared*." When asked what made her look like she was confident, she referred to her role as a wife and "…[with] *the amount of commitment. I have to 'segurar mesmo a onda'* (handle the waves), *because if I don't, it will disrupt everything.*" Ana used self-talk to remain strong and prevent from developing depression: "[When] *I had problems with him, I*

would go to the bedroom, turn the radio on, and I would say to myself: 'I will not get sick, I will not be depressed because of him; I need to be fine for myself."

The wives' strengths were also indicated when they were able to discover new things about themselves during this stressful time. Carmen learned about patience: –"*Maybe I have learned about patience, about trying to wait.*" Ana recognized that in order to honor her personal needs she had to work on being less fearful:

I learned
I stayed too long in silence
accepting things
I have spoken more
I need to lose this fear
I am still unsure
of saying things
I need to learn to dialogue.

Eu aprendi
Eu passei muito tempo calada,
aceitando as coisas.
Eu tenho falado mais
tenho que perder esse medo
ainda meio receosa
de dizer as coisas
Eu tenho que aprender a dialogar.

The wives were also able to find value in their marriage that helped them persevere. Ana shared: *"Since we live together, since we have children, there will always be, even though with all those problems we have been through, we have never stopped being a couple.* Similarly, Carmen recognized that she and her husband dialogued rather than argued: "*We don't fight. There are some points that we will not agree with each other on, but I always tell him, look, if we get to any question where we don't agree, let's sit down and let's talk. (…) And maybe that influences how we handle it*."

The realization that change is constant and their roles will continue to evolve requiring them to be flexible is another strength of the wives. Joana, for instance, expects there to be ups and downs in life: "*The family does not overcome, the family will overcome; it is ongoing. Each time is a different thing*." Although mostly referring to alcohol relapse in their husbands, the wives were realistic in anticipating declined health as the couples aged. They further anticipate that a history of alcohol abuse would mean more severe declines in health that may call them to

be caregivers to their husbands. This uncertainty and anticipation filled Carmen with fear as she ponders:

> *I fear the future. I know there will be calmness, but I have certain anxiety about the future, because there are the wounds of what happened, and there are a lot of things. And he feels a great need; there are too many years of drinking. So then, I have this thought, and what if there is dementia, and cancer in the future, long-term? Then, for me to remain, no longer to be a woman but to become a mother.*

Regardless of uncertainties in their lives, faith in God gave Ana and Carmen strength and hope for their future:

> *It is God, only God, only God, only God. If you don't have God, there will be no hope. Even during treatment, he has had relapses. Then I am, and... Will he change? Because it is difficult for him, I know it's hard. But we have to have faith in God*" (Ana).

Changes in the Family

Changes in the family were reported by the wives after their husbands began treatment. These changes were for the most part positive and welcomed. For Carmen, she became closer to her son, and that was characterized by more time spent together, playing and learning new skills, such as riding a bicycle. According to Ana, the family unit got closer in terms of time spent together and communicating. When speaking about the changes she had noticed in her adult daughters, she reported more connection, and more shared time: "*My daughters ... ah they have changed, changed a lot. My daughters were in a certain way, now lighter. (...) It has improved their relationship; everyone, since he's in this process, we sit more, talk, although we still have a lot to improve.*"

The changes in the family encouraged the wives to plan conversations with their children about risky behaviors and alcohol use to prevent the transmission alcohol dependency down the family line. Joana indicated that her hopes for her daughter once she grows up was to learn to be intentional and aware when consuming alcohol:

> *I think to have a lot of attention to quantity. If you will drink, why will you be drinking? For her to also perceive that she has a tendency to be depressive because her father is depressive, I am depressive. My mother is depressive, his father, his mother were also depressive, depressive. So, the probability of her having the tendency is very possible. So for her to perceive, have more attention on this question of whether it is depression, and if you have depression, for her to not go get the alcohol*.

Finally, the wives spoke about their hopes for their own relationships with their children and how they would like to be perceived by their children. Joana would like her daughter to see Joana as strong and determined to make her marriage work: "*…she could perhaps say, determination, because my husband, I believe in him."* Carmen, similarly, would like her son to perceive her as *"...loving, dedicated, and a mom that worries about him.*" Ana would like to pass on values that she learned as a young woman to her daughters -- the value of education and independence in order to not be dependent on their husbands: "*I've always told them, since they were little: look, you guys study, get a degree, have your independence. Then you can marry, can cohabitate, you can do what you want, but never be submissive to a husband, be independent.*"

Husbands' Experience

The husbands' narrative about alcohol dependency and its recovery process was based solely on personal, individual issues. When asked to talk about how they would describe the experience of alcohol dependency in their *families*, all three husbands focused on talking about

the history of *their* individual dependency. These narratives included the time when husbands were first exposed to alcohol to when they became aware of their alcohol dependency and how they sought treatment and experienced it. Although the process of recovery was described as their personal process, husbands highlighted the importance of the support from their wives. Themes that emerged from the data analysis were contributors to alcohol dependency and the recovery process.

Contributors to Alcohol Dependency

The husbands indicated that alcohol was part of their young life, but the onset of alcohol dependency occurred only later in life when overcome by stress. It was family members and friends that exposed them to alcohol at a young age.

Roberto described how he would go to bars with his older brother and friends as a teenager: "*In my family, really early, when I was twelve or thirteen years old, I and my older brother, and another younger brother, we used to go to a bar, and normally we would meet some friends and drink 'pinga'* [a type of distilled drink, common in Brazil]." Similarly, Carlos referred to his exposure to beer during his childhood as being part of the culture of the region where he was raised, but that exposure was not viewed as problematic:

> *We always had* [consumption of alcohol], *from my mother's side, and because I was raised in a German colonization region, in Rio Grande do Sul, then we, from a young age, we had a lot of beer, so we always had contact with drinking. Even my mother used to craft beer at home. But I think it was not that what led me to alcohol dependency, because I always had a friendly relationship with alcohol.*

In describing their journey to becoming dependent on alcohol, the husbands shared their understanding of alcohol dependency. From their perspective, it becomes an illness when alcohol

use brings about feelings of imprisonment and lack of control over its intake. Roberto indicated that the compulsivity for increased intakes of alcohol, along with alcohol dependency, only develops with time and it has a genetic component:

> *I believe that the compulsion to drink comes with certain time of use; it does not present in a fast way. I think the person is already born prone to, already has a propensity to reach a certain age and become dependent.*

Ivan differentiates what he termed "alcoholist" from an alcoholic. He considered himself a former *alcoholist* - one who venerates alcohol. But now he no longer idealized it. Instead, alcohol is his "*prison*" since he was an *alcoholic.* According to him, this "*prison*" involved a "*process of self-destruction*."

The experience of alcohol dependency appeared to be associated with experiences of grief - due to a parent's death or due to retirement. According to Carlos, retirement brought him idleness and a loss of certain roles at home, which resulted in problematic drinking: *"After I retired, I started doing nothing without work. My two daughters studying, my wife working, and then the idleness was what led me to increase the consumption of alcohol."* For Ivan, he started to drink heavily when he felt affected by the changes brought to his household after his mother's death when his father brought home a new partner and her family. The new addition to the family resulted in loss of space in the house as well as financial strain, which led him to retaliate/cope with alcohol:

> *While this did not reach me, while I was there in my room, with an overlook to the sea, it didn't affect me. But when I saw my stuff being dumped out of my room, and he decided to cohabitate with this woman, and bring her daughters home, then it began to affect me. And then 'chutei o pau da barraca'* [I kicked the tent's pole—expression used to refer to

the notion of give up]. *It was my way to rebel. (...) So that there was like a trigger for that disease that I had but I did not know.*

The lack of awareness of alcohol dependency as an illness was mentioned by all three husbands. At earlier stages the consumption of alcohol was associated with a social activity, or the act of escaping. Then "*with time*" (as noted by Roberto), the lack of control over its consumption, the unforeseen consequences of drinking evolved into a problem – an illness. This trajectory was captured in Ivan's narrative in the following I-poem:

I came to realize that this disease
I first
I drank
I was fourteen
I drank
[I] was already drunk
I did not drink every day
But when [I] drank
[I] was drunk
I lost a lot of weight
[I] kicked the tent pole
[I] used the alcohol because
I thought
I could have the domain at any time
I went to the street, indeed
I rebelled, indeed
I said
Since they tossed things from my room
I stayed on the street
I had a relationship
I had a son
[I] drank very, very much
[I] received governmental support
I left the hospital
I went straight to drink
[I] drank it all
[I] drank, drank, drank, drank
Until people called home and
they went to get me
I came back
I started to get up
I have a problem with alcohol

Eu vim perceber que essa doenca
Eu primeira vez
Eu bebi
Eu tinha catorze anos
Eu bebi
[Eu] ja fiquei bebedo
Eu nao bebia todo dia
Mas quando bebia
[Eu] ficava bebado
Eu emagreci muito
[Eu] chutei o pau da barraca
[Eu] usava o alcool porque
Eu pensava que
Eu podia ter o dominio a qualquer momento
Eu fui para rua mesmo
Eu andei rebelde mesmo
Eu disse
Ja que tiraram as coisas do meu quarto
Eu fui ficando na rua
Eu tive um relationamento
Eu tive um filho
[Eu] bebia muito, muito mesmo
[Eu] recebi uma indenizacao
Eu sai do internamento
[Eu] bebi tudo
[Eu] bebi, bebi, bebi, bebi
Ate ligarem la para casa e
foram me buscar
Eu voltei
Eu comecei a levantar
Eu tenho problema com álcool

I left again
[I] started working
[I] spent a lot of time
[I] drank again
[I] went to work
[I] was drinking again
[I] went to the hospital
I came to this institution
[I] talked to the doctor
And he said, 'Look, you're an alcoholic.
If you continue this way, you will die.'

Eu sai de novo
[Eu] comecei a trabalhar
[Eu] passei um tempo bom
[Eu] bebi de novo
[Eu] fui trabalhar
[Eu] fui beber de novo
[Eu] fui bater no hospital
Eu vim para essa instituicao
[Eu] falei com o medico
E ele disse: 'olha, voce é alcoolatra.
Se voce continuar assim, voce vai morrer.'

There is also realization that alcohol dependency helps mask deeper emotional needs. Roberto, who at first used alcohol to handle symptoms of social phobia, did not cease his alcohol consumption after receiving treatment for phobia. This led him to realize that his use was linked to unmet emotional needs. He explains:

> …[I] *no longer had the symptoms of phobia nor panic, nothing. But I did not quit drinking, right? I did not quit drinking*. [Then] *[I] got out of here* [the agency]*, but I still have to come back because I think I have not solved my issues. Not the problem with alcohol itself, but it is more an emotional issue, an emotional problem, the problem of really knowing what I want out of life.*

Similarly, Ivan indicated that since he joined treatment, he realized that:

> *The issue of the disease itself, the issue of chemical dependency, the question of, not only that abusive use; that was the tip of the iceberg, the icing on the cake, the problem came more from within. The problem was way more internal than external. Those external ones were simply triggers, excuses, sometimes unconscious.*

The Recovery Process

The husbands expressed feeling fully responsible to recover. Although presented as their personal process, they agreed they needed support from others, especially their wives. Husbands were also well aware of the changes in their families that they attributed to their treatment. Subthemes that will be elaborated below are motivations for treatment, need for social support and changes since treatment.

Motivations for Treatment

The decision to pursue treatment was self-initiated by all three husbands. Husbands took responsibility for their alcohol use and self-identified as the ones to have the problem. This realization however, was a process for some husbands such as Carlos who shared his process of assuming this responsibility, *"Everyone was guilty except me. So in all this time I finally saw that I was the guilty one, I mean, it was a set, and I have to put on my head that to improve, it has to come from me, so that others can believe I want to improve."*

It seemed that after some time of presenting signs of alcohol dependency, all three husbands reached an unbearable point that led them to treatment. For Roberto, this decision was made mostly because he was tired of having the need to rely on alcohol to be able to work, in addition to be scared of having other "*blackout*" episodes:

> *It was my desire, to really want to stop, and also fear, fear of having another, another blackout. While you're remembering things, that's okay. But I was very afraid, very afraid of even not knowing if I would come back. It can happen, right? You can die, kill someone, and you are drinking, completely numb.*

For Carlos, the level of tolerance, in addition to a difficult phase in marriage, as well as a lack of confidence due to the effects of alcohol were the turning points for him to seek treatment:

> *I was in a way that I would get up in the morning: the first thing I did, I picked up a 200ml cup, took 1/3 of glass of whiskey and took it prior to going to the bathroom because I stood trembling. So then I started getting scared to drive because I no longer trusted myself. I did not have pleasure in anything. Then I started to think about treating me.*

He also indicated that *"I think that if I had continued under that pace, I would be dead already, I am sure."*

The husbands also realized the negative effects of their alcohol use on relationships with their wives and children. Both Ivan and Carlos recognized that they became aggressive when under the influence of alcohol, while Roberto talked about his son's negative impressions about alcohol. Referring to a time when he threatened his wife, Ivan stated: *"Indeed, I was drunk and angry, but after a while, you come to realize that this was due to the effect of alcohol. Without it, I would not do it*." Carlos also acknowledged that he became verbally abusive towards his wife and his daughters: "*I started to be not really violent, to use physical aggression, but I used verbal aggression. I used to argue a lot. I have never raised my hand, but I would fight a lot, I would argue a lot.*"

The husbands were aware of the strain alcohol use was putting on their marriage and the decision to seek treatment appeared to be partly due to this strain. Ivan stated that his wife was "*patient*" during his first relapse. But since then, he could tell when his aggressive behaviors would be too much for her making her reach her "*limit.*" Carlos, who noticed how alcohol was impacting his family, said that he knew it was a real problem when he did not have the strength to intervene:

> *I saw that my marriage was going, was running out, I saw that my wife was getting more and more sad, I saw that my daughters were also getting sad about the situation. I was getting sad about the situation. And I did not have strength to react, understand? I did not feel strength to react.*

Looking back Roberto realized the risk he ran in losing his marriage: "*Alcohol could have destroyed our relationship, indeed*."

The husbands attributed shame to their decision to seek treatment. Ivan's shame came from witnessing how his intoxication saddened and scared his children, "[I] *saw my son, twelve years old, cry when he saw me drunk; my daughter, really young, crying. (…). There was this process with my children. They suffered a lot with it."*

An interesting perspective that husbands shared was how alcohol masked their ability to enjoy life. Ivan used the term "boycott on self," implying the intent act to remove any opportunity to be happy as he did not deserve happiness:

> *I realized, I realize that both in joy or in sorrow, the drink comes as such a thing: in sorrow, then in sorrow, it comes to drown the sorrows, melancholy, to kick the stick, to say that nothing will work; and in the joy is that thing, or you are boycotting yourself because you, as an uncle of mine said "every time you are getting there, you seem to not allow yourself to be happy. Because you are there, you want to be in the international surfing tournament, with the best surfers in the world, you want to be there, yet you drink." (…) Sometimes I feel like I tried to think that I do not deserve to be happy.*

Carlos too drank to drown his guilt but that only increased guilt: "*…enormous feeling of guilt, I drank, I felt guilty about drinking*."

The catalyst for seeking treatment was the inability to avoid alcohol. As Carlos puts it, *"Alcohol and cigarettes are two vices very tough to treat because they are two diseases that you find them in any corner."* Believing that there had to be a way out and determined to find a way out was Roberto's motivator to seek treatment. His advice to others: *"Have hope, to believe that there is a way out of it. If one is really determined to stop using; it is all about self-determination."*

The husbands took responsibility for their recovery process; they all saw negative effects of this alcohol use. They had motivation; however, what seemed to help them make the treatment possible were women in their lives—sisters and wives. These women helped with obtaining health insurance, scheduling appointments with a psychiatrist and getting the husbands into treatment. Once treatment commenced, husbands were for the most part on their own.

Need for Social Support

The husbands were candid with their need for support from their wives. They acknowledged the roles of their wives that were pivotal to their treatment as well as their expectations for wives. Their reliance on their wives for support may have also been influenced by the lack of support from family and friends.

The husbands recognized that their wives carried their load during treatment: "*She helps me a lot, right? Because she is taking care of our little girl, she does her part this way" (Ivan).* The husbands were also appreciative of wives' efforts to help them stay on track. It implied their wives' desire to sustain their marriages. Roberto shared:

> *She helped me so much, she helped by me blocking my credit card, not giving me participation in the firm* [shared business]. *She's my partner in the firm…and giving me*

support in terms of not letting things go into space. She really wants to be with me and that helped me.

Similarly, Carlos referred to his wife's support as "*primordial*" [fundamental] to him. He indicated a change in his wife's attitude towards him throughout the recovery process, i.e., from "*persecution*" to "*company.*" It seemed that both partners learned how to support each other, and that was helpful for his recovery:

She started to follow me, she started to walk with me. She saw that if she was with me, I would avoid drinking because I knew she did not like it; she also stopped complaining. I still did some shit, and I saw that sadness in her, which used to be anger, and then became sadness, and even her sadness helped me, you know? So I think in every way, she, her support is crucial.

The husbands, however, felt threatened when their wives were not there for them. This sense of insecurity led husbands to find solace in alcohol:

S*he gave some support , but not as she gave in other times, and that made me think, no, she doesn't care; no one is caring this time, no one is caring, so then I will drink , I will continue drinking, I will continue drinking, I will continue drinking* (Ivan).

The wives' support appeared to depend on if the husbands were in treatment or not. When the husbands are not in treatment, the wives would either get "*angry*" (Carlos) or behave as if they "*didn't care*" (Ivan). When husbands were in treatment, the wives showed compassion and "*gave her best*" (Roberto) which included handling additional duties for the family. Ivan particularly noticed this from his wife: "[She] *is doing her part. She is doing her part with our daughter. She understands my problem, she doesn't discriminate my problem, she does not put me down because of that; and this is a very good thing."*

Considering that the husbands recognized the important role that their wives had on their recovery, when asked if they would consider couples therapy, only Ivan and Carlos were open to the idea. Noting that the couples interview was for him similar to having had couples therapy, Carlos was thankful for the opportunity: "I wanted to say thank you for your dedication, for listening to us talking". Roberto, who was the most outspoken about his wife's positive impact on his recovery, expressed discomfort because of the lack of intimacy he shared with his wife. He was, however, willing to participate in groups with others. His wife, on the other hand, indicated interest in pursuing with couples therapy and she stated her expectation about the therapist: "If we were to seek couples therapy, it would need to be a very competent professional because my goal is that we indeed receive treatment" (Carmen).

The support the husbands received from their wives was crucial as there was minimal support available from any other family members or friends. Ivan did receive some support from his sister who noticed his alcohol problem and helped him seek treatment. Carlos attributed the lack of support from his family to cultural differences. Coming from South Brazil where familism is not as strong in comparison to Northeast Brazil, he did not expect much support. Consequently, the support gained from his in-laws made him feel like he belonged to her family:

> *My brothers, they are very cold* [referring to being distant]. *I have practically no relationship with them. (…) But, my wife's part of the family, there are ten brothers, in addition to her mother, all of them are married, the in-laws, nephews, all of them give me a lot of support. (…) I feel honored. So I have this side of my family, from my Northeastern side, thank God I have, they give me a lot of support.*

Any support from friends was limited to messages on Facebook. Most of the husbands' friends were their drinking companions, which explained the relational distance that ensued

when treatment was sought. For Ivan, seeking treatment meant taking a different path than his friends whom he then avoided: *"There are some guys there that I used to drink with them, and they say 'hey, you have disappeared'. I say, 'I have been traveling, I'm out,' and I step on the other side."*

This avoidance was also to protect themselves from being shamed by their past behaviors associated with alcohol. This was true for Roberto who had blacked out once in the company of his friends. The embarrassment from this experience was enough to send Roberto into exile:

> *Friends, friends I do have, but although incredible, I avoid them due to the shame of what I went through. They were the ones who took me to the hospital, and I stopped looking for them due to shame. It was not due to what they did, but shame to do what I did.*

Changes since Treatment

The husbands, although still in treatment at the time of this interview, were able to identify changes in themselves as well as in their marriages since commencing treatment. The ability to feel connected to others and to their faith and not feeling alone was noted as a major change. Carlos felt less alone in crowds: "*I used to have loneliness of being in the crowd. I was afraid of the crowd. (...) Now, wow, I'm no longer alone in the crowd, I am the crowd, you know? It is a whole new sensation I'm feeling."* Both Ivan and Carlos felt more connected with their faith. For Ivan, the "*equilibrium*" he was experiencing was also due to his practice of religious life: "*I am experiencing this equilibrium also, God, I started once again to have a strong spiritual connection. I am Catholic, I started to pray every night, every night I pray, every time I have difficulties, I pray.*"

The emphasis on emotional needs in treatment helped the husbands evaluate personal values and their futures. While Roberto's personal reflections got him to ponder on the

depressing state of aging and got him to retreat from his wife, Ivan's and Carlos's reflections gave them hope for a brighter future.

Roberto shared that since being in treatment, he "…*began to have a desire to live alone, to review my values,*" and he felt hopeless about the prospects of ever regaining what he had lost when he was at peak of his life:

> *You get to 54, you start counting the time backwards, you no longer count it forward. Now it's, ah, how I wanted to be 30. How I wanted to be 40. I count now from behind forward. In that age, I was in the highest, the biggest peak of my life. This same peak, I think will no longer be back. (...) Sometimes it's even boring. But that's it. There is no other choice.*

Contrary to Roberto's experience, the evaluation of personal goals got Ivan feeling hopeful about opening his own business with his wife and Carlos saw how he could learn from his past 'mistakes' to have a better future. This is captured in the following I-poem:

I want to rebuild
I do not want to pick up the pieces
I want the pieces to stay right there
I look at them
I want to see those shards
I want to see everything
I broke
I do not want to buy super-glue
and put the pieces together
I want to see those pieces
I make a new home from there
I never forget
what
I broke

Eu quero reconstruir
Eu nao quero juntar os cacos
Eu quero que os cacos fiquem ali
Eu olhar para eles
Eu quero ver aqueles cacos
Eu quero ver tudo
Eu quebrei
Eu nao quero comprar uma super-
glue e juntar os caquinhos nao
Eu quero ver aqueles caquinhos
Eu fazer uma casa nova dali
Eu nunca esquecer
do que
Eu quebrei

In addition to personal change, changes in family relationships were also noted by the husbands. Carlos clearly talked about the positive effects of his change on the family system, in

terms of his initiative to seek interaction with his daughters that has led them to be emotionally closer:

> *At home, I changed a lot, because at home, I did not speak with anyone anymore. I was closed, locked to myself, and then things were like, "leave him alone, leave him on his corner." And then I began to change, since I started seeking to engage with them* [his daughters]*, they also began to seek for me. Then things greatly improved, it is much better.*

Ivan also noticed changes in his family, mostly with his children, in terms of their understanding of his disorder, and their interaction with him: "*My kids are understanding more and more, understanding it better. They are way happier in seeing me here*." The children also seemed to take on protective role towards their fathers. All three husbands spoke about the support received from their children prior and during treatment.

When asked about what they perceived as the family's strengths, the husbands talked about the "*love*" their family members had for them and for each other, their "*strong personalities.*" Last, the husbands talked about messages they wanted to send to their children about alcohol, as well as what image they would like their children to have about them. All three husbands acknowledged the genetic component of alcohol dependency, which put their children at increased risk for alcohol dependency. Ivan also talked about the importance of handling life's challenges and not trying to escape from them by drinking. The message he wanted like to pass to his children was:

> *Try to walk in their lives, as very difficult as it may be, through the more difficult path, which is the narrowest route. If you have a well large route and a very narrow path, that they go through the narrow one because the path, the easiest ways are also the easiest for*

you to get into drugs, to go into depression, for you to lose the focus. The best achievements are made by the most difficult paths, the most painful ones.

Couples and Mental Health Professionals' Experiences

After all the individual interviews were conducted, partners were interviewed together as a couple to talk about their perspectives in relation to the alcohol dependency, its recovery process, and its impact on their marriage. Because the mental health professionals' reflection were on their perspectives about the couples, findings from these two sets of interviews were combined. The themes that emerged were stressors on the marital system associated with the onset of alcohol dependency and during treatment, and couples' strengths.

As a note of observation, in all three interviews with the couples, the wives were the first ones to respond to my first question, about how it was for them to talk about the recovery process. Both wives and husbands reflected on the interview process as a venue to reflect and as an opportunity for meaning making. In Ana's words:

It was good, right, I think it was a way for us to think of something we never thought or spoke to someone before. Indeed, it was a way to us, there are things that we never say, and you asked, and we say, it starts to go out, and we also reflect about what we said, what you asked, what has passed, what we will do from now on.

For Carlos, being in treatment seemed to have helped him reach a point where he can talk about his situation:

I also liked especially because you made us comfortable to talk. I can talk, I can talk about the treatment. Perhaps the most important thing of the last 10, 15 years, I like to talk about my recovery, I like to talk about the moment I 'm living today, I am not ashamed to say I'm an alcoholic.

Stressors on the Marital System

The couples and the mental health professionals weigh in on the stressors that alcohol dependency and its recovery puts on marriages. Both groups are aware of the strain on marriages from the onset of the alcohol problem that continues throughout the recovery process. Although the same themes of multiple roles were found in the individual interviews with wives, the focus here is on the couple relationship.

Couples recognized that although the husband was the one to have "*the problem*," wives were also affected by *"the problem."* Ivan spoke about how this problem, the "*monster*" in him, spilled over and pushed his wife's limits:

> *Because we had a relationship that began without alcohol, then there were the episodes with alcohol, and then these episodes with alcohol were bringing bad consequences, because the monster, the alcohol develops the monster worse in me. The monster gets worse and worse. And the person who is on the other side also absorbs some of that monster. (...) Because there's a limit for her; when it reaches that limit, she begins to seek revenge.*

Ivan's wife, Joana, further elaborated and shared of how Ivan's alcohol use affected their marriage, decreasing couple intimacy:

> *The question of his drinking, he changes, then it ceases to be a relationship. There is a relationship, of course. But we no longer have that intimacy, no longer have it all, because he begins to move away, because he becomes depressive, to stay in on the defensive, and I also stay on the defensive because of my fear as well.*

The mental health professionals echoed the couples' take on how alcohol can impact relationships. In addition, they believed that alcohol use is rooted in relationship and family issues. Kelly stated that*: "We consider that when there is a process of chemical dependency in*

the family, it is not only the patient that gets sick; the entire family is sick." Referring to alcohol dependency as the "*cereja do bolo*" [similar expression to "top of the iceberg"], Lisa implied that there is more than what meets the eye. Symptoms of alcohol dependency are only what is visible and the real problem lies beneath: *The use of the substance is like the cherry on the cake. It's there as what is shown; it is there as the symptom, as to what is visible. So we work not only on the drug abuse itself."*

Ingrid on the other hand, took a broader sociocultural perspective by bringing in the influence of cultural values that emphasize gendered power imbalance, such as "machismo." She said: "*To be a man, one needs to have an addiction. So I see it as a big social problem, not solely as a health problem*." She implies that alcohol dependency is of the masculine gender. Maria further explained that the machismo culture has families that revolve around men who are addicts, implying that men are not held accountable for their vices:

> *The role of the Northeastern woman, I think we were accustomed by this culture to understand this process as normal and expected. So being a wife of a person with drinking or smoking problems means to have a husband, a man, a male.*

Women are then socialized to accept, to tolerate and support the men which includes assuming their roles when they are not able to. Having become accustomed and familiar with their new roles, wives have a hard time transitioning back the traditional roles. Ingrid elaborates:

> *They* [wives] *end up wearing the husband's pants. As he ceases to occupy that place, she starts to occupy this position and to exercise the whole function, to put them in that position to take care of everything. I think this about being a woman, of motherhood, that ends up make it happen. So then it is very difficult for this man to come back, to want to*

resume this function, and for this woman to allow this space and this role to be given back to him. So this is a process that we face here with great difficulty.

Interestingly, there did not seem to be much awareness or complaint by the husbands about wives' reluctance to relinquish the roles they acquired from them. The husbands did, however, wish that their wives would understand that the in-patient treatment process was challenging and difficult. Ivan in particular wanted his wife to be patient and to know that his process will bear fruit that will benefit the family:

She understands. I'm not here on vacation, I'm here treating myself; it is not easy to be here. (...) I'm treating myself to see if from this plantation I have a better I harvest, good fruit, better than other times I planted, that these fruits will bring benefits to our relationship, for my life, to our relationship and in consequence for our daughter, and the family environment. I hope she'll understand that and have a little bit of patience.

The stressors experienced by the couples from the husbands' recovery process continued post-treatment. The stress of transition back home after in-patient treatment was too much for Roberto, who indicated that he had thought of moving out to live by himself. This idea made his wife question his commitment to their marriage. Carlos named his stress with transitioning back home as "*living between two worlds.*" Having had an opportunity to return home briefly during his in-patient treatment made him feel like he was "living double lives:"

I think the biggest challenge, there are so many challenges, but I think the greatest of all was to stay all this time, living between two worlds. I was living part of the week here and the rest at home. So I was almost living a double life. There was a time when I felt good at home and not good at home at the same time; I felt good in the institution [in-patient treatment] *and I felt not good in the institution.*

Being aware of Carlos' feelings, Ana, his wife, questioned his desires to "*face the world out there*" and her role in his recovery. She was afraid of triggering him and cause a relapse in his alcohol use: "*I think it is hard, so how should I behave with him? It is difficult, should I 'passar a mao'* [pass the hand—expression used to refer to pretend nothing happened] *on some things to say that I did not see, what should I tell him?"* This concern was shared by the other wives'.

Kelly posed an interesting idea about the role of alcohol problems in couples. She wondered if having these problems would give women some leverage perhaps the "voice" that they need to be visible. Otherwise they would remain silent. She reflects:

> *I do not know if we could say that there is a profile in the Northeastern families, that women have little voice and that they will have more say if the husband is an alcoholic. I do not know, it is very serious, this is very serious. But within these families, specifically, perhaps that's true.*

The extent to which couples are stressed by alcohol dependency would probably quite naturally lead to interventions for the entire family system: "*I consider that there will only be change if change occurs in the family*" (Maria). However, other than family groups where only husbands' voices are heard, there is no other family-focused interventions at this in-patient agency.

Couples' Strengths

The couples spoke about what they considered their strengths and important elements that helped make them stay together: love, understanding, hope, flexibility and the confidence they have in each other. Roberto noted that despite having challenges, love for his wife was the glue in his marriage: "*There are some setbacks, but I love this woman very much*." Roberto's wife

agreed: "*It is the love that we have for each other, it is really good, and it is a healthy love*." Understanding what the other has gone through was also important: "*He understands me a lot, he understands what I go through. I, at least I think I understand what he goes through, and this, I think, is really good, right?*" (Joana).

Carlos shared that when he doubted that there was love in his marriage, what helped was having hope: "[When] *the love was left in doubt…hope was always there*." The hope that things would improve, in addition to the uncertainty about what could happen if they were to dissolve their relationship helped Carlos and Ana stay together: "*I always had a lot of hope and also that fear, so if I leave, where should I go? So we always had hope, one day, one day it improves. But there was always something that caught me."* (Ana). Ana also reflected on the similarities between Carlos and her father, the length of her marriage and also the love she had for Carlos that has grown with time:

> *I think we, we settled. It was long time that we spent together through this issue* [of alcohol]. *I think I saw a lot of my father there, I saw in him. So there was this thing: I went through with my father, I went through with him, so well, we get used to. But deep inside, I think even though we thought that love was lost along the way, I don't think we lost it; if not, we would not be here today. This love is not a teenager's love. Even he has all his faults, I have my faults, we worry about each other, we care for each other.*

One of the strengths that were identified in the wives by the mental health professionals, was the wives' ability to wear multiple hats. Referring to a cultural script of needing to "*wear the pants and also the dress,*" Ingrid explained that it is not an easy tack to balance between being sensitive and feminine yet strong -- wives need to be available despite all their suffering:

I think this culture; I think it has a lot about the woman being submissive still. Very often they are in this position of being available all the time and suffering, and yet she is on his side, together, and yet she bears too much. (...) There is a lot of it, this thing of being a good woman, a good wife, a good mother, and to support, and be strong and handle it. (...) So I think the woman in society in general, she has a very hard place to be because there was this whole process of emancipation, but she has not detached from the social expectations that were imposed to her for a really long time.

The couples' ability to trust in the treatment process that helped them regain confidence in each other was another aspect that helped them pull through. Carlos shared how treatment helped Ana regain her confidence and trust in him:

For me, the recovery of confidence, the confidence of her in me, because her trust…with fair reason, was almost zero. (…) So I think this aspect became critical because we had stopped dating, we had completely stopped having intimacy. Today, we kiss, we hug each other, we walk holding hands with pleasure.

The mutual appreciation of each other was evident in how the couples exchanged affirmation. Ana noted that Carlos' willingness to seek treatment and his efforts helped change her views of him. She did not give up on her marriage and she believed that it was good for her children to witness the couples' struggle. She explained:

For me also, all of this; it is because he is under treatment, he is willing, right? I no longer see that drunk man I used to see. I wondered a lot, my God, sometimes it is like a weakness, because I've seen so many women, sometimes suddenly end the marriage too soon. And I think I held a 'barra desse casamento' [this marriage's weight bar]. *Then I kept thinking, my daughters, was it good for them?...Even with all these problems, but I*

know they felt something that was good. So they saw all of that we went through, and we remained as a couple.

Summary

Overall, alcohol dependency is understood as rooted on relational issues, but the recovery process focused only on the person with the dependency problem. Husbands' ability to focus on their personal process of recovery was made possible by wives who followed cultural scripts of subservience to the husbands and that promote the importance of keeping the family united. This role was performed alone with no support from extended family, friends, or mental health professionals, who saw the wives as obstacles to treatment. These professionals instead blamed wives for compensating their husbands when patriarchy had placed wives in their position – forced to overfunction yet omitted from the recovery process.

Chapter 5 - Discussion

The purpose of this study is to expand our understanding of alcohol dependency and its recovery in Northeast Brazil by exploring the lived experience of this disorder and its recovery process among couples whose husbands are seeking treatment for alcohol dependency. Culturally specific values such as patriarchy, notions of machismo, and its influence on gender roles were explored to gain insight into the recovery process and components that are important for sustained recovery. The discussion will be presented in two sections—challenges of recovery, and how couples coped.

Challenges of Recovery

Despite the emancipation of women in Brazilian society, both in the legal system, in the workforce (Canezin, 2004), and women's presence in politics, aspects of patriarchy are still present not only in families but in the treatment of alcohol dependency. Husbands bear the full responsibility for recovery while wives' role in this process goes unheeded. Treatment that only includes the person with the dependency issue is consistent with previous research that has found the focus of some programs to include maintaining habits that are considered fundamental to abstinence (Shinerboune & Smith, 2011), as well as engaging in process of self-forgiveness and acceptance (Scherer, Worthington, Hook, & Campana, 2011). Individual focused treatment, however, omits a crucial component of the couple system that has a major impact on the recovery process.

There is apparent overfunctioning by wives to maintain the equilibrium of the family system while husbands are away seeking in-patient treatment. Overfunctioning is, according to Bowen (1974), a dysfunction of the system. Systems need to change to accommodate new input, i.e., the treatment pursued by husbands. It appears that wives' intentions are noble - to maintain

the system while the husbands are gone. This overfunctioning however, is not a comfortable task. It is performed in silence and resentment with the knowledge that in a patriarchal society, husbands are the leaders of the couple system (Samara, 2002). These traditional roles are prominently portrayed in Brazilian's media, mainly soap operas. A "good wife" means being supportive to the husband, including when he is absent (Souza, 2010). This need to support and maintain family unity keep wives silent. The silencing of wives is apparent in the conversations with wives and practitioners. Wives referred to their husbands' drinking problems as a "*cross to carry*" and that every man has "*flaws*" that the wife should handle. Mental health professionals, likewise, reflected on notions of "machismo" where for many women in Northeast Brazil, to be married is to have a man that "…*drinks or smoke…a man, a 'macho.'"* This idea of tolerance and suffering is similar to findings with women victims of intimate partner violence where participants believed that part of being a married woman was to suffer and to submit to the husband (Silva, 2010). Likewise, a case-study with mother and daughter victims of family violence found that women want to have families that embrace patriarchal values, and that may mean having to silence their needs and be submissive to forms of violence and male domination (Narvaz & Koller, 2006).

The literature on gender roles and on women's movement in Brazil presents emancipation of women burdensome, noting that women's "added (household) responsibilities," is overwhelming for them (Pinto & Amazonas, 2006; Sequeira & Stella, 2012) because it has not been accompanied by men's taking responsibility for parenting and household work. This could be because the structure of Brazilian families is built on patriarchal values characterized by men's authority and supremacy (Sequeira & Stella, 2012). Feeling overwhelmed may be related to wives feelings of "not having other choices," but to perform the added roles in the couple

system, in order to be a "good wife" and to keep the family united. Wives' silence is coupled with resentment of having to do double duty and "to wait and see" if husbands indeed recover. This is another aspect that is not acknowledged in current treatment and adds stress to the system which in turn can impede treatment's progress. The uncertainty if husbands can maintain abstinence and the fear of relapse further explains wives' reluctance to relinquish back authority and the power to husbands post treatment. Wives then continue to overfunction in their new roles contributing to husbands' underfunctioning (Bowen, 1974) that allows this cyclical motion to persist. In fact distancing is said to be most common among those with alcohol problems (McKnight, 2013). Wives in the meantime, busy with multiple roles – maintaining a professional life (if they have one) and single-handedly maintaining the household - find little time for self-care. They are "*stretched*" to the point of feeling trapped, with no alternatives, which increases stress levels.

The threat posed to the new homeostasis of the system may further explain wives' reluctance to relinquish roles acquired from husbands. Wives may get use to the 'new' system without their husbands to the extent that they resist the natural tendency of systems to change to find equilibrium after husbands return from treatment (Smith-Acuña, 2011). The fear of husbands' recovery being temporal until a relapse occurs, may further explain wives' motives for overfunctioning.

The 'stuckness' of the couple system can be further captured using the metaphor of a "spiral platter," Hoffman (1981) highlights that change is mostly nonlinear, in that the system might move forward, but it might retreat for a period, due to its tendency to maintain homeostasis. "Rather than spiraling, often our attempts at change leave us stuck in vicious cycles, feeling that we are walking the same circle again and again" (Smith-Acuña, 2011, p. 76).

Wives' position as support for husbands by assuming new roles and resisting change appear to feed this vicious cycle. Wives' position is akin to the "stone" in a well-known poem by one of the most influential Brazilian poet of the 20th century, Carlos Drummond de Andrade: "No meio do caminho tinha uma pedra" (In the middle of the road was a stone). That "stone" in this context has dual function - to provide support and keep the family united, but because it sits in the middle of the road, it causes rigidity in the system. This rigidity supports previous research on ambivalence experienced by Brazilian women raised in the 1990s - even though there is an increased involvement of husbands in couple system, women's passivity is still seen as a fundamental element to make marriage last, which contradicts women's emancipation in other areas of society (Coutinho & Menandro, 2010).

Another challenge to the recovery process is the overall lack of social and extended family support. Only one couple indicated receiving support from the wife's side of the family, but even that support was experienced with some reservations especially by the wife. The lack of family support seems contradictory to cultural messages that values family cohesiveness and familism (Carlo et al., 2007). Beliefs about familism are associated with psychological health, through mediating effects of closeness to family members and social support (Campos, Ullman, Aguilera, & Schetter, 2014). Therefore, strong beliefs about familism with lack of closeness to family members and social support, can contribute to lower levels of psychological health. This is also supported by previous research with Mexican emerging adults (Hernandez, García, & Flynn, 2010), in that those with stronger positive beliefs about familism experience more distress when there is conflict in the family system. Accordingly, it is possible that since persons from Northeast Brazil overall have a strong sense of familism, the presence of alcohol dependency in the family may impose higher stress to the family system because it disrupts positive

expectations about family relationships (Campos et al., 2014). Without much support from the extended family members and friends, possibly because alcohol dependency imposes a significant distress to that system, couples are left to cope on their own, leading to more distress.

How Couples Coped

Couples' resilience is apparent (Bodenmann et al., 2004; Walsh, 1996). Love, understanding of each other, hope, trust, and renewal of couple's intimacy were all strengths that couples attributed to their ability to remain united in marriage. Couples also presented with the belief that the family will be able to "*overcome*" other stressful situations, such as possible future relapses. This speaks to the family's resilience.

Couples use of metaphors to describe their experiences with alcohol and the recovery process appears to be an effective way of externalizing problems. This is an intervention commonly used in social constructionism whereby stories are used to externalize problem as well as find solutions to the problem (Freedman & Combs, 1996; White & Epston, 1990). The externalization of the problem allows clients to see the problem as an entity external to the person or to the relationship (White & Epston, 1990), thus allowing family members to more freely talk about themselves, in addition to seeing the symptom from another, nonproblem-saturated perspective. The personalization of problem through externalization provides distance from the problem thus allowing persons to develop a more objective view of the problem and have more control over it. The use of metaphors and popular sayings are very common in Brazil, especially in the Northeast. There is vast literature on the importance of the use of these metaphors and popular sayings, both to the transmission of cultural knowledge and for meaning-making process (e.g., Cavalcanti, 2014; Costa & Sacramento, 2012; Fonseca & Hanke, 2013). Husbands used expressions such as "*chutei o pau da barraca*" [I kicked the tent's pole] and

"*prison*," mostly to describe their individual experience of alcohol dependency. Whereas wives used metaphors to help name aspects related to their role during the treatment process—e.g. "*cross to carry,*" "*carry the weight bar of marriage,*" "*Quando a corda estoura, quem tem que segurar a ponta da corda, o peso? Eu!*" [When the rope breaks out, who has to hold the end of the rope, all the weight? Me!]. Metaphors were also used by mental health professionals. Alcohol dependency was referred to as the "*cherry on top of the cake,*" noting that there is more to the problem than meets the eye. Henceforth, treatment needs to consider emotional needs, and its focus should be on what lies beneath the problems. Wives were referred to as "*wear(ing) the husband's pants*" while husbands were in treatment. The use of metaphors denotes the importance of the social construction of knowledge, as well as the use of language and narrative to facilitate meaning making process. Metaphors and analogies can facilitate the communication of how one experiences the world as well as the meaning of that singular experience. According to White and Epston (1990), analogies are embedded in cultural values, and they may portray the dominant discourse. The metaphors utilized by the participants express their cultural discourse that is often influenced by society's dominant discourse (Freedman & Combs, 1996).

In addition to the utilization of metaphors as a possible coping mechanism , couples present with other elements of family resilience, such as positive outlook and spirituality (Walsh, 2006). Couples clearly talk about their hopes for their future, especially as a family. Couples also refer to the importance of their faith - both during difficult times, and when there is a sense of control and calmness. Accepting their fate or role as wives ironically adds to resilience despite having to suffer through it. The commitment of women to cultural scripts is supported by previous studies such as this one where women tolerated their husbands' infidelity in order to

keep the marriage (Coutinho & Menandro, 2010). Strangely, the outcome of suffering in silence is applauded by society when it totally dismisses the needs of women.

Wives' silence is illustrative of the "culture of silence," as presented by Paulo Freire (2000), a famous educator in Brazil. The author argues that those in subordinate position lose the possibility to present their own opinions and to respond critically to the knowledge that is imposed to them by the dominant culture. By occupying a submissive position in relation to their husbands, and following patriarchal values that men are the ones to have authority, wives may silence their own needs.

There appears to be a silent war within these women—should they stay (in their marriages) or should they go—and the fear of "going" meant being weak. All the wives had college degrees, they were all financially independent, yet they spoke about their need to maintain the marriage. The stigma placed on relationship dissolution is another aspect that women need to contend with (Silva & Lunkes, 2014). The wives expressed hesitation about leaving their marriages mostly because they wanted to be in a relationship with their husbands and feel loved. The dilemma about staying or leaving the relationship and the uncertainty about their future in case they were to get a divorce resonates with the notion that marriage continues to be seen as a "feminine condition" (Silva & Lunkes, 2014). Different than in previous decades, today divorced Brazilian women, though possibly independent, are viewed as "solitária" (lonely).

Although the systemic-transactional stress theory (Bodenmann, 2005) highlights the dyadic component of the way partners handle stress and its effects on their resilience, findings suggest that cultural expectations of wives' role and intact families helped wives perform positive coping behaviors, even when their husbands were absent. For the wives, coining their

position in the family as "*fundamental*" to their husbands' treatment process and turning their attention to building shared dreams post-treatment is what gives them hope. Support from the wives did not go unrecognized by husbands, who noted wives' position changed from "*persecution*" to "*company*" and from acting as if they "*didn't care*" to "*being supportive.*" The opportunity for wives to participate in family group sessions may have provided sufficient information about alcohol dependency that in turn allowed them support their husbands' treatment. Cuing in family members to the problem and recovery can play a significant role in the recovery process as noted by EnglandKennedy and Horton's (2011) study where the lack of information and resources was an impediment to recovery from mental health disorders.

Only after some treatment were couples able to experience "we-stress" (Kayser et al., 2007), a component of positive *dyadic* coping behaviors (Bodenmann et al., 2004): Couples presented with intentions of mutual support and strategies for handling stressful situations together. Husbands and wives mentioned being more connected, increased time spent together, restored family rituals, and better communication. The increased connection and communication between partners could be seen as a sign of family resilience (Walsh, 2006), since it promotes meaning-making and problem-solving. Family communication is encouraged during the treatment process through family groups, in which family members are invited to join. It appears that this opportunity to communicate openly and the husbands' home visits help improve the couples' and families' communication.

All couples that participated in this study referred to the importance of talking with their children about alcohol dependency. Both husbands and wives want their children to have a positive image about their parents—as individuals and as a couple—and to be resilient: mostly characterized by being able to be independent, to handle stress in life, bravely, without escaping

through the reliance on psychoactive substances. The hopes for their children and family as a whole seem to be a major motivator for the couples to strive and not give up.

The expression "*wear the husbands' pants*"—used to refer to women's position when husbands are absent—although associated by the mental health professionals as a possible challenge for treatment, captures the flexibility of the couple and the family systems. These families present structural resources (Walsh, 2006) that are flexible enough, so the family could function in the face of adversity.

Strengths and Limitations

This study had several strengths and limitations. First, to my knowledge, up to this date there is no study conducted in Brazil on alcohol dependency to include both partners, and mental health professionals. The possibility of conducting individual interviews with each partner and then the couples provided a venue for partners to express their perspective about the phenomenon and to share their feelings more comfortably. In addition, as highlighted by two couples, the couples' interview enabled a moment of sharing feelings and emotions together, which seemed to have created an opportunity for meaning-making process for those couples. It was interesting too that all three wives were surprised when invited to participate in this study, which may confirm how much they have been omitted from their husband's treatment.

Second, since I am originally from the region where this study took place, this could have made participants more comfortable during the interviews, especially when they talked about expectations from the culture, as well as when they utilized metaphors typical of this region in Brazil.

Last, the most common types of treatment and research on mental health conducted in Brazil are either based on psychoanalysis or cognitive-behavioral therapy. This study proposes

an implementation of a socio-emotional approach (Knudson-Martin & Huenergardt, 2010; Knudson-Martin, 2013), which is based on socio-constructionism. This could help highlight couples' strengths and better address the impact of social and cultural stereotypes and expectations. This could be an opportunity for couples to also address gendered power imbalance in their relationship and possibly co-construct new narratives.

It is important too to consider the limitations of this study. First, couples were identified by a psychologist at the treatment center. Although the researcher informed them about the inclusion criteria—married couples where at least the husband was currently under treatment for alcohol dependency—it is possible that these professionals were biased with whom they recommended for this study.

Second, due to the young age of most the children of the couples that participated in this study, it was not feasible to include the children in this study. The inclusion of a second generation could have provided another layer of information and more clear direction for further family treatment.

Third, all mental health professionals were female clinicians. This may have had an impact on their perspectives about gender and women's role. Another important limitation was the lack of feminist theories about Brazilian women and their role in the couple systems. Although the researcher was able to find extant literature on the feminist movement in Brazil, there is an overall lack of family theories specifically formulated to consider the social and cultural context of Brazilian families. This could because family therapy is a young field in Brazil, and the vast use of psychoanalysis and cognitive-behavioral therapy in this country.

Clinical Implications

Findings from this study have several implications for the treatment of alcohol dependency in Brazil and possibly other similar collectivist societies. Considering the constant use of metaphors and analogies by all participants of this study, and based on previous studies that highlight the use of these units of language in Northeast Brazil (e.g., Cavalcanti, 2014; Fonseca, & Hanke, 2013), findings of this study suggest that the use of client-generated metaphors in the treatment process could be an important tool. Client-generated metaphors can be an entrance to a reflection of their worldview. Instead of interpreting the client's metaphor, clinicians should assess what their metaphors mean to them, personally, even if the client utilizes a well-known popular saying (Sims, 2003). Metaphors can reflect not only the cognitive, but also the affective aspects of the client's experience. When clinicians are attentive to these units of language, clients may feel a stronger therapeutic alliance and more confidence about building a narrative about their experience. As proposed by Sims (2003), clinicians should be attentive to client-generated metaphors, validate and encourage clients to expand these metaphors in order to link them to other aspects of their experience, play with possibilities, mark and select what might work for them, and finally connect with the future—which could be seen as the clients' construction of their preferred story – a Narrative Therapy intervention (White & Epston, 1990).

Couples want treatment to not only focus on the alcohol use but on recovery at a deeper level of the self. They imply that such deeper level recovery requires changes in the couple system, i.e., a, second-order change. Second-order change is often alluded to as "the golden thread that unifies effective treatments" (Fraser & Slovery, 2007, p.4). For second-order change, treatment needs to take a more systemic perspective. The absence of wives does nothing to serve the husbands' treatment process especially when the "*emotional needs*" of the husbands (as noted by the practitioners) are imbedded in a history of relational issues. What participants

identify as "*emotional needs*" seem to be related to the lack of authorship in their lives; a feeling of displacement, or lack of positioning that comes from being silenced. Trying to find a meaningful role during challenging moments or transitions, husbands escape to alcohol, whereas wives "*dress the husbands' pants.*" These roles lead to discomfort because they oppose cultural script. Similar to the character Fabiano of *Vidas Secas*, (Ramos, 2000), another famous masterpiece in Brazilian Northeastern literature originally published in 1938, when left with no voice, the husbands experience fear, they become fragile. In order to show virility, or to avoid the stressful context, they turn to alcohol. Similar to the character "Sinhá Vitória" (Ramos, 2000), wives respond by taking on husbands' duties while suppressing their own feelings/voice. Wives are forced to overfunction to take care of the emotional needs of husbands.

Inclusion of wives can further prevent wives from being the impediment to treatment. Practitioners allude to wives as "*a problem that we face here*," similar to the "stone" in the middle of the road, as in Carlos Drummond de Andrade's famous poem. As "stones," wives apparently block the progress of treatment. This may be attributed to wives being "stuck" with having to adhere to cultural expectations that sometimes contradict each other–be independent and strong while supportive and docile. Being stuck in the middle of road is akin to being the stone that needs some movement so the system can change (Smith-Acuña, 2011). This "stone in the middle of the road" could be reframed from being an impediment to a solid rock that holds things together: "ser uma rocha" (being a rock). Such a reframing would help turn the focus to strengths opposed to weaknesses.

Without imposing personal and outside cultural values that dismiss clients' culture (Keeling & Piercy, 2007), clinicians should consider that persons from Northeast Brazil—and other collectivist societies—may still expect couples' systems to follow notions of patriarchy

(e.g. Narvaz & Koller, 2006), in which to be a man means to have authority and power, whereas to be a woman means to be caring and docile (Sequeira & Stella, 2012). Through adopting a socio-emotional approach (Knudson-Martin, 2013), clinicians could address issues of gendered power imbalance, while acknowledging the influence of the culture. As a result, therapy can be a venue for social change (Narvaz & Koller, 2007), through the facilitation of discussions about stereotypes and notions of power. Clinicians of the same culture as clients would need to be aware of the potential gridlock that they may experience from having to also dealing with a patriarchal system. Furthermore, the gender of the clinician would play a significant role in how attuned they would be to the needs of female and male clients.

Although the four elements for creating a mutually supportive relationship—mutual influence, shared vulnerability, shared relationship responsibility, and mutual attunement (Knudson-Martin & Huenergardt, 2010) sounds ideal for any couple working on improving emotional connection, clinicians should consider its cultural appropriateness. Its appropriateness may depend on the age and the worldviews of clients. Older clients who are more likely to hold onto cultural values of patriarchy may not be as inclined to mutuality but rather are more comfortable with distinct gender roles. Younger clients raised in the postmodern era may be more amenable to relational mutuality. Regardless of couples' age and considering the importance of couples' communication and attunement (Jonathan & Knudson-Martin, 2012), clinicians should consider helping partners provide affirmation and validation to each other, which might enhance their intimacy and validation (Greenberg & Goldman, 2008).

Research Implications

This study on alcohol dependency and its recovery process among Northeastern Brazilian couples highlights the need for further research. First, this study focused only on husbands that

were under treatment for alcohol dependency. Recent data, however, has indicated an alarming increase in the number of women presenting with this same issue (Laranjeira, Pinsky, Zaleski, & Caetano, 2013). Research should explore wives' recovery process and what is the impact on the couple system as well as the recovery process when both partners are in recovery.

Second, this study was conducted in a private institution that serves upper-middle class individuals. Future research should include clients from other social classes. Although the four mental health professionals in this study had worked with clients from lower socio-economic groups, and did not perceive major differences in terms of alcohol dependency and its recovery process, studies should still elicit the experiences of clients from varied socioeconomic backgrounds.

Third, an issue raised by two of the mental health professionals was the overall lack of prevention work conducted in this region, especially with younger populations. Considering that all three husbands indicated history of alcohol abuse since early adolescence, and that previous research conducted in the U.S. has highlighted the high incidence of binge drinking during adolescence, research should focus on adolescents' drinking habits.

Fourth, all three husbands indicated the use and abuse of alcohol in their family-of-origin when they were growing up. Future research should consider including children of individuals that present with drinking problems, to explore the intergenerational transition alcohol dependency in order to develop early intervention programs.

Last, findings of this study suggest the importance of adopting a systemic view when treating alcohol dependency and to include both partners in the treatment process. If couple treatment is to be implemented for those seeking treatment for alcohol dependency in Brazil, additional research is needed to develop and evaluate the efficacy of such treatment.

Conclusion

Alcohol dependency is a serious problem worldwide and research on its treatment process is much needed, especially in societies that have high prevalence rates for this disorder. Through in-depth phenomenological interviews, this study sought to expand our understanding of alcohol dependency and its recovery in Northeast Brazil, by exploring the experience of its recovery process among couples whose husbands were under treatment for alcohol dependency.

It was found treatment that focuses on only husbands, omitted a very crucial component involved in recovery - wives. The expectations of wives to manage the household and wait for their husbands to return from in-patient treatment and the fear of husbands' relapse left wives on edge and reluctant to return the reins to husbands post-treatment. Meanwhile, the cultural scripts of patriarchy that perpetuates gendered power imbalance and religious scripts that held wives responsible for maintaining their marriages did not provide wives with an ideal resolution. They found themselves having to "*wear the pants and also wear the dress*." The lack of support from extended families and friends that seemed contradictory to a culture that is known for strong sense of familism, did not help. Wives were left to wait in silence. Ironically, this "position" wives took was perceived as an impediment to treatment.

Interestingly, a study that began with an interest in exploring the lived experience of couple systems culminated with a focus on wives. Instead of being seen as flexible in their ability to manage multiple roles single-handedly and with minimal help, strong in their ability to remain steadfast while keeping the marriage and family stable, and committed to their cultural and religious expectations, wives were perceived negatively by practitioners. Could the gender of the practitioners (all female) tint their lens making it difficult for them to view wives more positively? If wives were viewed as "solid rocks" versus "stones that obstruct" would it be easier to create space for them in the recovery process?

As a native Northeastern Brazilian woman, the opportunity to hear the layered voices of these couples validated the call for clinicians to "empower" clients – to activate an inside out movement that will allow clients to conquer things on their own, to have a voice in their lives (Freire, 2000) regardless of where they are from.

Chapter 6 - References

Alves, J. E. D., & Cavenaghi, S. M. (2013). Indicadores de desigualdade de genero no Brasil. *Dossie – Analises Quantitativas e Indicadores Sociais*, 83-105.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5),* 5th edition. Arlington, VA: American Psychiatric Association.

Araujo, T. B. (2002). *Nordeste, Nordestes: Que Nordeste?* Retrieved from http://www.fundaj.gov.br/index.php?option=com_content&view=article&id=1956%3Anordeste-nordestes-que-nordeste-&catid=58&Itemid=414

Bednall, J. (2006). Epoche and bracketing within the phenomenological paradigm. *Issues in Educational Research*, *16*(2), 123-138.

Bernardes, D. M. (2007). Notas sobre a formacao social do nordeste. *Lua Nova*, *71*, 41-79.

Bodenmann, G. (1995). A systemic-transactional view of stress and coping in couples. *Swiss Journal of Psychology*, *54,* 34–49.

Bodenmann, G. (1997). Dyadic coping – a systemic-transactional view of stress and coping among couples: Theory and empirical findings. *European Review of Applied Psychology*, *47*, 137-140.

Bodenmann, G., Charvoz, L., Widmer, K., & Bradbury, T. N. (2004). Differences in individual and dyadic coping among low and high depressed, partially remitted, and nondepressed persons. *Journal of Psychopathology and Behavioral Assessment*, *26*(2), 75-85.

Bowen, M. (1974). Alcoholism as viewed through family systems theory and family psychotherapy. *Annals of the New York Academy of Sciences*, *233*(1), 115-122.

Caldas, L. (2013). O Nordeste cresce mais que o Brasil e ganha poder economico. *Revista Exame.* Retrieved from http://exame.abril.com.br/revista-exame/noticias/o-nordeste-quer-

mais.

Cavalcanti, V. C. (2014). *A Constituicao Discursive-Identitária do Brasileio na Triangulacao Musical: O Samba, o Forró e a Música Sertaneja*. Trabalho de conclusao de curso, Universidade de Brasília, Brasília, DF.

Campos, B., Ullman, J. B., Aguilera, A., & Schetter, C. D. (2014). Familism and psychological health: The intervening role of closeness and social support. *Cultural Diversity and Ethnic Minority Psychology*, *20*(2), 191.

Canezin, C. C. (2004). A mulher e o casamento: da submissão à emancipação. *Revista Jurídica Cesumar*, *4*(1), 143-156.

Carlo, G., Koller, S., Raffaelli, M., & Guzman, M. R. T. (2007). Culture-related strengths among Latin American Families: A case study of Brazil. *Marriage & Family Review*, *41*(3-4), 335-360.

Centre for Economics and Business Research (December, 26, 2013). *World economic League Table Report*. Retrieved from http://www.cebr.com/reports/world-economic-league-table-report/

Centro Brasileiro de Informacoes sobre Drogas Psicotrópicas (n.d.). *Bebidas Alcoólicas*. Available from http://www.cebrid.epm.br/folhetos/alcool_.htm

Costa, A. A. A. (2013). O movimento feminista no Brasil: dinamicas de uma intervencao política. *Revista Genero*, *5*(2), 1-20.

Costa, M. M. S. C., & Sacramento, S. M. P. (2012). Sinha Vitória e os desafios de uma mulher Nordestina. *Revista Língua e Literatura*, *14*(22), 60-87.

Costa-Rosa, A., Luzio, C. A., Yasui, S. (2003). Atenção Psicossocial: rumo a um novo paradigma na saúde mental coletiva. In: Amarante P. (org.) *Arquivos de Saúde Mental e Atenção Psicossocial.* Rio de Janeiro: Nau Editora, 13-44.

Coutinho, S. M. S., & Menandro, P. R. M. (2010). Relações conjugais e familiares na perspectiva de mulheres de duas gerações: "Que seja *terno* enquanto dure". *Psicologia Clínica*, *22*(2), 83-106.

Dahl, C. M., & Boss, P. (2005). The use of phenomenology for family therapy research. In D. H. Sprenkle & F. P. Piercy, (Eds.), *Research Methods in Family Therapy* (2nd. ed.) (pp. 63-84). New York: The Guilford Press.

EnglandKennedy, E. S., & Horton, S. (2011). "Everything that I thought that they would be, they weren't:" Family systems as support and impediment to recovery. *Social Science & Medicine*, *73*, 1222-1229.

Fals-Stewart, W., O'Farrell, T. J., & Birchler, G. R. (2004). Behavioral couples therapy for substance abuse: Rationale, methods, and findings. *Addiction Science & Clinical Practice*, *2*(2), 30-41.

Fernandes, D. (2014). *Mulher Ainda Gasta Quase Dobro do Tempo em Trabalho Doméstico Que Homem*. Availale from http://www.bbc.co.uk/portuguese/noticias/2014/03/140304_ trabalho_mulheres_df_lk

Fonseca, M. G. C., & Hanke, M. M. (2013). Signo/Seu Lunga: Significados difundidos pela literatura de cordel. *Revista Internacional de Folkcomunicação*, *11*(22), 64-82.

Fraser, J., & Slovery, A. D. (2007). *Second Order Change in Psychotherapy: The Golden Thread that Unifies Effective Treatments*. Washington, DC: American Psychological Association.

Freedman, J., & Combs, G. (1996). *Narrative Therapy: The Social Construction of Preferred Realities.* New York: Norton.

Freire, P. (2000). *Pedagogy of the Oppressed*. New York: Bloomsbury Publishing.

Gagne, C., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of

mental health and addictions. *Psychiatric Rehabilitation Journal*, *31*(1), 32-37.

Gilbert, R. M. (2006). *The Eight Concepts of Bowen Theory: A New Way of Thinking about the Individual and the Group*. Front Royal, VA: Leading Systems Press.

Gilligan, C., Spencer, R., Weinberg, M. K., & Betsch, T. (2003). On the listening guide: A voice-centered relational method. In P. M. Camic, J. E. Rhoades, & L. Yardley (Eds.). *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. (pp. 157-172). Washington, DC: American Psychological Association.

Gomes, N. P., Diniz, N. M. F., Araújo, A. J. S., & Coelho, T. M. F. (2007). *Compreendendo a Violencia Doméstica a Partir das Categorias Genero e Geracao*. Acta Paul Enferm, *20*(4), 504-508.

Grijó, W. P. (2011). Telenovela e subalternidade: A representação das camadas populares nas telenovelas da Rede Globo. In: *Seminário Internacional de Pesquisa em Comunicacao* – SIMPECOM. Santa Maria: UFSM.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused Couples Therapy: The Dynamics of Emotion, Love, and Power*. Washington, DC: American Psychological Association.

Hernandez, B., Garcia, J. I. R., & Flynn, M. (2010). The role of familism in the relation between parent-child discord and psychological distress among emerging adults of Mexican descent. *Journal of Family Psychology*, *24*(2), 105-114.

Hill, M., Stafford, A., Seaman, P., Ross, N., & Daniel, B. (2007). *Parenting and Resilience*. York, UK: Joseph Rowntree Foundation.

Hoffman, L. (1981). *Foundations of Family Therapy: A Conceptual Framework for Systems Change*. New York: Basic Books.

Hofstede, G., Hofstede, G.J., Minkov, M., (2010). *Cultures and Organizations: Software of the Mind*. (3rd Ed). New York: McGraw-Hill

Hofstede, G. (2001). *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*. Second Edition, Thousand Oaks CA: Sage.

Instituto de Geografia e Estatística (IBGE). (2013). *População Brasileira Cresce 0.9% Entre 2012e 2013.* Available from http://memoria.ebc.com.br/agenciabrasil/noticia/2013-08-29/populacao-brasileira-cresce-09-entre-2012-e-2013

Instituto de Geografia e Estatística (IBGE). (2011). *Registro Civil 2010: Número de Divórcios é o Maior Desde 1984*. Available from http://saladeimprensa.ibge.gov.br/noticias?view=noticia&id =1&i dnoticia=2031&busca=1&t=registro-civil-2010-numero-divorcios-maior-desde-1984

Jonathan, N., & Knudson-Martin, C. (2012). Building connection: Attunement and gender equality in heterosexual relationships. *Journal of Couple & Relationship Therapy*, *11*(2), 95-111.

Kayser, K., Watson, L. E., & Andrade, J. T. (2007). Cancer as a "we-disease": Examining the process of coping from a relational perspective. *Family, Systems, & Health*, *25*(4), 404-418.

Keeling, M. L., & Piercy, F. P. (2007). A careful balance: Multinational perspectives on culture, gender, and power in marriage and family therapy practice. *Journal of Marriage and Family Therapy*, *33*(4), 443-463.

Knudson-Martin, C., & Huenergardt, D. (2010). A socio-emotional approach to couple therapy: Linking social context and couple interaction. *Family Process*, *49*(3), 369-384.

Knudson-Martin, C. (2013). Why power matters: Creating a foundation of mutual support in couple relationships. *Family Process*, *52*(1), 5-18.

Laranjeira, R., Pinsky, I., Zaleski, M., & Caetano, R. (2013). I Levantamento Nacional Sobre os Padroes de Consumo de Álcool na População Brasileira. *Gabinete de Segurança Institucional Secretaria Nacional Antidrogas*.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Masten, A. S. (2011). Resilience in children threatened by extreme adversity: Frameworks for research, practice, and translational synergy. *Development and Psychopathology*, *23*, 493–506.

McCrady, B. S., Epstein, E. E., & Kahler, C. W. (2004). Alcoholics anonymous and relapse prevention as maintenance strategies after conjoint behavioral alcohol treatment for men: 18-month outcomes. *Journal of Consulting and Clinical Psychology*, *72*(5), 870-878.

McKnight, A. (2013). Family systems with alcoholism: A case study (263-298). In P. Titelman (Ed.). *Clinical Applications of Bowen Family Systems Theory*. New York: Routledge.

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage.

Moraes, M. (2008). O modelo de atenção integral à saúde para tratamento de problemas decorrentes do uso de álcool e outras drogas: Percepções de usuários, acompanhantes e profissionais. *Ciência & Saúde Coletiva*, *13*(1), 121-133.

Muszkat, M., & Muskat, S. (2003). Permanencia na diversidade: Um estudo sobre a conjugalidade nas classes de baixa renda. In P. B. Gomes (Ed.). *Vínculos Amorosos Contemporaneos: Psicodinamicas das Novas Estruturas Familiares*. Sao Paulo, SP: Callis Editora, 109-131.

Nancie, P. (1997). Resilience in adult children of alcoholics: A nonpathological approach to social work practice. *Health & Social Work*, *22*(3), 201-209.

Narvaz, M. G., & Koller, S. H. (2007). Feminismo e terapia: a terapia feminista da família—por uma psicologia comprometida. *Psicologia Clínica*, *19*(2), 117-131.

Narvaz, M. G.; Koller, S. H. (2006). A concepção de família de uma mulher-mãe de vítimas de incesto. *Psicologia: Reflexão e Crítica*, *3*, 395-406.

Nepomuceno, L. B., & Pinheiro, A. A. A. (2010). Elementos psicossociais para compreendero Nordeste. *Revista de Psicologia*, *1*(1), 85-104.

Obot, I. S., & Anthony, J. C. (2004). Mental health problems in adolescent children of alcohol dependent parents: Epidemiologic research with a nationally representative sample. *Journal of Child & Adolescent Substance Abuse*, *13*(4), 83-94.

O'Farrell, T. J., & Clements, K. (2012). Review of outcome research on marital and family therapy in treatment for alcoholism. *Journal of Marital and Family Therapy*, *38*(1), 122-144.

Patton, M. Q. (2001). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pinto, V. C., & Amazonas, M. C. L. (2006). Ser mulher… In M. C. L. Amazonas, A. O. Lima, & C. M. S. Dias (Eds.). *Mulher e Família: Diversos Dizeres*. Recife, PE: Oficina do Livro, (pp. 27-42).

Quintas, F. (2013). *O não-lugar de Mariana.* Available from http://www.fatimaquintas.blogspot.com/2013/03/sobre-mesa-oval-da-sala-de-jantar-o.html#comment-form

Ramos, G. (2000). *Vidas Secas*. Rio de Janeiro, RJ: Ed. Record.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, *24,* 143-155.

Rychtarik, R. G., & McGillicuddy, N. B. (2005). Coping skills training and 12-step facilitation for women whose partner has alcoholism: Effects on depression, the partner's drinking, and partner physical violence. *Journal of Consulting and Clinical Psychology*, *73*(2), 249-261.

Samara, E. M. (2002). O que mudou na família brasileira? (Da Colônia à atualidade). *Psicologia USP*, *13*(2), 27-48.

Schenker, M., & Minayo, M. C. S. (2004). The importance of family in drug abuse treatment: A literature review. *Cadernos Saúde Pública*, *20*(3), 649-659.

Scherer, M., Worthington, E. L., Hook, J. N., & Campana, K. L. (2011). Forgiveness and the bottle: promoting self-forgiveness in individuals who abuse alcohol. *Journal of Addictive Diseases*, *30*, 382–395.

Sequeira, V. C., & Stella, C. (2012). Família e violência: resquícios da cultura patriarcal. *Emancipação*, *12*(1): 71-86.

Silva, S. A. (2010). *A Dor de um Doce Lar: Narrativas da Violencia Doméstica*. Universidade Católica de Pernambuco, Recife, PE.

Silva, S. D., & Lunkes, F. L. (2014). E o casamento acabou: uma análise do arquivo de Veja sobre o imaginário da mulher divorciada. *Conexao Letras*, *9*(11), 133-148.

Smith-Acuña, S. (2011). *Systems Theory in Action: Applications to Individual, Couple, and Family Therapy*. Hoboken, NJ: John Wiley.

Silva, S. A. (2010). *A Dor de um Doce Lar: Narrativas da Violencia Doméstica*. Recife, PE: Universidade Católica de Pernambuco.

Sims, P. A. (2003). Working with metaphor. *American Journal of Psychotherapy*, *57*(4), 528-

536.

Souza, C. F. (2010). *Relacoes Familiares Retratadas em Telenovelas Brasileiras de Grande Audiencia: Aspectos Relevantes e Polemicos em Transformacao.* Universidade Federal do Espírito Santo, Vitória, ES.

Thombs, D. L. (2006). The disease models. In H. T. Blane & T. R. Kosten (Eds.). *Introduction to Addictive Behaviors*, (18-53). New York: The Guilford Press.

Unbehaum, S. G. (2001). A desigualdade de gênero nas relações parentais: o exemplo da custódia dos filhos. In: M. Arrilha, S. G. Unbehaum, & B. Medrado, (Eds.). *Homens e Masculinidades: Outras Palavras* (pp. 163-184). São Paulo, SP: Ecos / Editora 34.

Vedel, E., Emmelkamp, P. M. G., & Schippers, G. M. (2008). Individual cognitive-behavioral therapy and behavioral couples therapy in alcohol use disorder: A comparative evaluation in community-based addiction treatment centers. *Psychotherapy and Psychosomatics*, *77*, 280–288.

Villa, M. A. (2005). Que braseiro, que fornalha. *Revista Nossa História,* 2(15), pages.

Walsh, F. (2006). *Strengthening Family Resilience*. New York: Guilford Press.

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

World Health Organization (1999). *Global Status Report on Alcohol.* Genebra: World Health Organization.

World Health Organization (2014). *Global Status Report on Alcohol and Health*. Luxembourg: World Health Organization.

Appendix A - Consent form to Family Members

KANSAS STATE UNIVERSITY

INFORMED CONSENT TEMPLATE

PROJECT TITLE: Alcohol dependency in the family: The role of Brazilian women

APPROVAL DATE OF PROJECT: 9/10/2014 (#7281) **EXPIRATION DATE OF PROJECT:** 9/10/2015

PRINCIPAL INVESTIGATOR: Joyce Baptist, Ph.D

CO-INVESTIGATOR(S): Patrícia Barros-Gomes, M.S.

CONTACT NAME AND PHONE FOR ANY PROBLEMS/QUESTIONS: Joyce Baptist, Ph.D., (785) 532-6891

IRB CHAIR CONTACT/PHONE INFORMATION*:*

- Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.
-
- Jerry Jaax, Associate Vice President for Research Compliance and University Veterinarian, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.

PURPOSE OF THE RESEARCH: The purpose of this study is to explore the role of northeastern Brazilian women in the recovery process of alcohol dependency in their family, as well as the possible intergenerational transmission of family resilience in that context.

PROCEDURES OR METHODS TO BE USED: Participants will complete a demographic questionnaire, and they will be interviewed individually at a location convenient for them. After individual interviews are conducted, family members will be interviewed together as a family. The interviews will be conducted in person, via skype or telephone by the co-investigator. The interviews will be audiotaped and transcribed verbatim. Participants will be provided a copy of the interview transcript so they can revise or edit it as needed. A further interview may be necessary to clarify findings. Participants will receive no remuneration for their participation.

LENGTH OF STUDY: 60 to 90 minutes per interview.
RISKS OR DISCOMFORTS ANTICIPATED: No risks are anticipated. If participants experience discomfort, they can withdraw or not answer any questions.

BENEFITS ANTICIPATED: Participants will have an opportunity to talk about their own experience of alcohol dependency in the family and their perspective about their role in that process, which might enhance their self-awareness.

EXTENT OF CONFIDENTIALITY: Identity of participants will be kept confidential and will not be linked to the data collected. After transcription of the interview, the data will be destroyed.

PARENTAL APPROVAL FOR MINORS: Only those individuals 18 years and over may participate.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my

consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

Participant Name: _____

Participant's Signature: _____ Date: _____

Witness to Signature (co-investigator): _____ Date: _____

Appendix B - Consent form to Mental Health Professionals

KANSAS STATE UNIVERSITY

INFORMED CONSENT TEMPLATE

PROJECT TITLE: Alcohol dependency in the family: The role of Brazilian women

APPROVAL DATE OF PROJECT: 9/10/2014 (#7281) **EXPIRATION DATE OF PROJECT:** 9/10/2015

PRINCIPAL INVESTIGATOR: Joyce Baptist, Ph.D

CO-INVESTIGATOR(S): Patrícia Barros-Gomes, M.S.

CONTACT NAME AND PHONE FOR ANY PROBLEMS/QUESTIONS: Joyce Baptist, Ph.D., (785) 532-6891

IRB CHAIR CONTACT/PHONE INFORMATION*:*

- Rick Scheidt, Chair, Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.
-
- Jerry Jaax, Associate Vice President for Research Compliance and University Veterinarian, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506, (785) 532-3224.

PURPOSE OF THE RESEARCH: The purpose of this study is to explore the role of northeastern Brazilian women in the recovery process of alcohol dependency in their family, as well as the possible intergenerational transmission of family resilience in that context.

PROCEDURES OR METHODS TO BE USED: Participants will complete a demographic questionnaire, and they will be individually interviewed at a location convenient for them. The interviews will be conducted in person, via skype or telephone by the co-investigator. The interviews will be audiotaped and transcribed verbatim. Participants will be provided a copy of the interview transcript so they can revise or edit it as needed. A further interview may be necessary to clarify findings. Participants will receive no remuneration for their participation.

LENGTH OF STUDY: 60 to 90 minutes per interview.
RISKS OR DISCOMFORTS ANTICIPATED: No risks are anticipated. If participants experience discomfort, they can withdraw or not answer any questions.

BENEFITS ANTICIPATED: Mental health professional participants will have an opportunity to reflect about their practice, and they may feel satisfaction for collaborating with such a relevant clinical issue.

EXTENT OF CONFIDENTIALITY: Identity of participants will be kept confidential and will not be linked to the data collected. After transcription of the interview, the data will be destroyed.

PARENTAL APPROVAL FOR MINORS: Only those individuals 18 years and over may participate.

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

Participant Name: _____

Participant's Signature: _____ Date: _____

Witness to Signature (co-investigator): _____ Date: _____

Appendix C - Interview Guide – Husband

Dados demográficos *(Demographics)*

1. Idade (*Age)*: _____

2. Estado civil e duração de relacionamento mais recente *(Current relationship status, and duration of most current relationship)*: _____

3. Número de filhos e respectiva idade (*Number of children and respective ages)*:

_____

4. Educação *(Education level)*:

☐ Ensino Fundamental *(Elementary School)* ☐ Ensino Médio *(High School)*

☐ Ensino Técnico *(Associates Degree)* ☐ Ensino Superior *(College)*

☐ Pós-Graduação *(Post-Bach)* ☐ Mestrado *(Masters)* ☐ Doutorado *(Doctoral)*

5. Situação de trabalho *(Current employment status)*:

☐ Trabalhando, integral *(working, full-time)* ☐ Trabalhando, um turno *(working, part-time)*

☐ Desempregado(a) *(Unemployed)* ☐ Em benefício *(On disability)*

☐ Outro *(other)*: ____

6. Família de origem *(family of origin):*

Número de irmãos *(number of siblings)*: _____ mulheres *(female)*; _____ homens *(male)*

Ordem de nascimento *(sibling position):* ____

Pessoas na família de origem com problemas de alcoolismo *(family members with alcohol problems)*: _____

- **Alcohol dependency in the family**

How would you describe your experience of alcohol dependency in your family?
When you first started drinking?
How long ago did you notice the problem?
When did you start the recovery process?
When did you seek treatment?
How did you decide to seek treatment?
What sort of treatment you have been through during the recovery process?
Could you describe the process of recovery?
What do you consider important in the process of recovery?
Could you describe your role in the recovery process?
How has your family reacted to your alcohol issues?
How have your friends and community reacted to your alcohol issues?

What kind of support have you received from your family?
How about your friends and community?
What support have you received from your spouse?
How else you wish your spouse would support you in the recovery process?
Are you in the recovery process together as a couple or are you both handling it separately?
How have you been impacted by the alcohol recovery?
How has the treatment impacted you as a couple?
How has the treatment of impacted you as a family?
How has the recovery process changed your family if at all?
What has helped your family cope with the changes?
Do you discuss alcohol and alcohol dependency with your children and wife? What are the discussions usually about?
What messages have you transmitted – or wish to transmit – to your children and grandchildren about alcohol use?
Have you helped others experiencing similar alcohol issues? What was that like?

Resilience

What are some of your family's strengths?
What are some strengths of your marriage?
What are other challenges/vulnerabilities you face as a family?
How have you and your family managed these challenges/vulnerabilities?
What have you learned about yourself and your family during difficult times?
What has helped make you and your family feel hopeful about the future?

Cultural Identity

Does being a citizen of this part of Brazil have a difference for you?
How does being a citizen of this part of Brazil impact your role in your family?
Is it different for men and women?

Final Questions

What advice would you give to other men experiencing alcohol issues in the family?
If you were to seek family and/or couple therapy, what kind to help would you like to receive from the therapists?
What advice would you give to therapists treating families with alcohol issues?
Is there anything else you wish I had asked, or that you would like to share?

Appendix D - Interview Guide – Wife

Dados demográficos *(Demographics)*

1. Idade (*Age)*: _____

2. Estado civil e duração de relacionamento mais recente *(Current relationship status, and duration of most current relationship)*: _____

3. Número de filhos e respectiva idade (*Number of children and respective ages)*:

_____

4. Educação *(Education level)*:

☐ Ensino Fundamental *(Elementary School)* ☐ Ensino Médio *(High School)*

☐ Ensino Técnico *(Associates Degree)* ☐ Ensino Superior *(College)*

☐ Pós-Graduação *(Post-Bach)* ☐ Mestrado *(Masters)* ☐ Doutorado *(Doctoral)*

5. Situação de trabalho *(Current employment status)*:

☐ Trabalhando, integral *(working, full-time)* ☐ Trabalhando, um turno *(working, part-time)*

☐ Desempregado(a) *(Unemployed)* ☐ Em benefício *(On disability)*

☐ Outro *(other)*: ____

6. Família de origem *(family of origin):*

Número de irmãos *(number of siblings)*: _____ mulheres *(female)*; _____ homens *(male)*

Ordem de nascimento *(sibling position):* ____

Pessoas na família de origem com problemas de alcoolismo *(family members with alcohol problems)*: _____

Alcohol dependency in the family

How would you describe your experience of alcohol dependency in your family?

What sort of treatment you have been through during the recovery process?

How long ago did you notice the problem?

Could you describe the process of recovery?

What do you consider important in the process of recovery?

Could you describe your role in the recovery process?

How have your family reacted to your husband's alcohol issues?

How have your friends and community reacted to your husband's alcohol issues?

What kind of support have you received from your family?

How about your friends and community?

What support have you received from your spouse?

How else you wish your spouse would support you in the recovery process?

Are you in the recovery process together as a couple or are you both handling it separately?

How have you been impacted by the alcohol recovery?

How has the treatment of your spouse impacted you as a couple?

How has the treatment of your spouse impacted you as a family?

How has the recovery process changed your family if at all?

What has helped your family cope with the changes?

Do you discuss alcohol and alcohol dependency with your children and husband? What are the discussions usually about?

What messages have you transmitted – or wish to transmit – to your children and grandchildren about alcohol use?

Have you helped others experiencing similar alcohol issues? What was that like?

Resilience

What are some of your family's strengths?

What are some strengths of your marriage?

What are other challenges/vulnerabilities you face as a family?

How have you and your family managed these challenges/vulnerabilities?

What have you learned about yourself and your family during difficult times?

What has helped make you and your family feel hopeful about the future?

Cultural Identity

Does being a citizen of this part of Brazil have a difference for you?

How does being a citizen of this part of Brazil impact your role in your family?

Is it different for men and women?

Did social or religious attitudes about how women should relate to their men influence your ability to assist in your husband's recovery?

Final Questions

What advice would you give to other women experiencing alcohol issues in the family?

If you were to seek family and/or couple therapy, what kind to help would you like to receive from the therapists?

What advice would you give to therapists treating families with alcohol issues?

Is there anything else you wish I had asked, or that you would like to share?

Appendix E - Interview Guide – Mental Health Professional

Dados demográficos

1. Idade (*Age*): _____
2. Educação*(Education level)*:

☐ Ensino Superior *(College)* ☐ Pós-Graduação *(Post-Bach)* ☐ Mestrado *(Masters)*
☐ Doutorado *(Doctoral)*

3. Situação de trabalho *(Current employment status)*:

☐ Trabalhando, integral *(working, full-time)* ☐ Trabalhando, um turno *(working, part-time)*
☐ Outro*(other)*: _____

4. Função no trabalho *(Position at work)*: _____
5. For how many years have you worked as a therapist?
6. How many years you have worked with clients who have problems with alcohol?
7. Do you have expertise or specific training to work with alcohol abuse problem?

*** Perspective on alcohol dependency**

What is your perspective on alcohol dependency?

*** Perspective on the process of recovery**

In your professional practice, what would you consider that contribute to success in the recovery process?
What factors make it more challenging?

*** Alcohol dependency in families**

In your practice, do you include family members in the treatment of alcohol dependency?
What is your perspective about the wives' role in the recovery process?
How do you think that social values and religious beliefs influence how women should relate to their men influence your ability to assist in your husband's recovery?
What about the role of children and other family members?
Based on your professional experience with your clients, do you consider that couples normally experience the recovery process individually or together as a couple?
What do you think is the impact of being a citizen of this region of Brazil on the roles of wives and husbands?

***Family of origin and community**

How do you think that family of origin influence alcohol dependency and its recovery?
How about the community?
How do you think that social expectations and cultural values in relation to gender impact alcohol dependency and its recovery?

***Resilience and self-of-the-therapist**

What are some of the strengths of your clients that you consider help in the recovery process?
What are some challenges or vulnerabilities that you see in your clients and their families in handling alcohol dependency?
What personal and/or professional impact that working with recovery of alcohol dependency has had for you?
What have you done to avoid burnout?

*** Final Questions**

What advice would you give to other professionals working with clients that are handling alcohol dependency and its recovery?
Is there anything else you wish I had asked, or that you would like to share?

Appendix F - Interview Guide – Couple

What is being like for the two of you to talk about the process of recovery from alcohol?

What has been the best aspects of the recovery process for you as a couple?

What has been the most challenging aspects of the recovery process for you as a couple?

If you could go through the recovery process differently, what would you like to do?

[If there was a period of time between when the participant realized there was an alcohol problem until the time they sought treatment]: What has prevented you from seeking treatment?

Who sought treatment first?

How was that like for each of you? (i.e. for you for making the decision to seek help, and for you – the other spouse – to have your spouse seek help)

What have been the benefits of treatment for the family?

How have you been able to seek treatment, despite the stigma that exists around it?