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"My god…how did I miss it?": Women's experiences of their spouses' alcohol-related relapses

Belle Gavriel-Fried | **Rotem Izhaki** | **Ofir Levi**

The Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv, Israel

Correspondence
Belle Gavriel-Fried, Tel Aviv University, The Bob Shapell School of Social Work, Tel Aviv, Israel.
Email: bellegav@tauex.tau.ac.il

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Accessible summary

What is known on the subject:

- Alcohol addiction is manifested by periods of abstinence and relapse in which the individual returns to previous problematic alcohol use. This may lead to unstable and stressful routines for the family and for women who live with a spouse diagnosed with an AUD.
- AUD may mentally and physically affect women living with a spouse diagnosed with AUD. However, most studies have focused on the influence of AUD in general, and the way they cope with it; few have dealt with the experience of relapse as a distinctive stage.

What the paper adds to existing knowledge:

- Women's experiences of their spouses' relapses are embedded within their broader life experience in the shadow of alcohol addiction.
- The pattern of transitions from closeness to distance in the ways women think, feel and actively respond to their spouses' relapses shows similarities with the ways in which individuals cope with repeated trauma. This helps relate these women's experiences of their spouses' repeated relapses to the potential complex trauma these women experience and leads to a better understanding of the internal emotional dynamics of these women's behavioural patterns.

What are the implications for practice:

- These women need a therapeutic solution that can help them cope with long-standing emotional burdens.
- Therapists should be sensitive to the complexity of their experience. When relevant, therapy should be based on therapeutic strategies from trauma practice, along with Alcohol Behavioural Couples Therapy that can reinforce the couple's mutual efforts to achieve sobriety or reduce AUD severity

Abstract

Introduction: Alcohol use disorder (AUD) is manifested by periods of remission and relapse which can serve as a source of continuous stressors on the individuals and family. Women living with a spouse diagnosed with AUD can be mentally and physically affected by this behaviour. Most studies have focused on the general influence of AUD on these women and their attempts to cope with AUD; there are scant data on the influences of relapse as a distinctive stage.

Aim: To better understand how women whose spouses are diagnosed with AUD experience their relapses.

Method: A qualitative-naturalistic approach was implemented. Semi-structured, in-depth interviews were conducted with 12 women whose spouses were diagnosed with AUD.

Results: Content analysis revealed three main categories representing the transitions from: a) ignorance to realization, b) emotional opposition to acceptance and c) activity to inactivity. Each category reflects one cognitive, emotional or behavioural dimension of this experience. The overarching theme emerged as shifts from closeness to distance in the way these women think, feel and actively respond to their spouse's relapses and addiction.

Discussion: The shift from closeness to distance as manifested by the three transitions is argued to reflect the ways these women experience and cope with the chronic nature of AUD. It is suggested that this experience parallels the phenomenology of symptoms of complex trauma.

Implications for practice: Nurses should be alert to the potential accumulative stressors experienced by these women and implement intervention strategies developed in the trauma field in addition to Alcohol Behavioural Couples Therapy.

KEYWORDS
alcohol use disorder, relapse, spouses, trauma, women

Relevance statement

Alcohol use disorder (AUD) is a global mental health disorder whose deleterious effects impact the individual, family members and society as a whole. Women living with individuals diagnosed with AUD are affected by their behaviour, may face their own mental, physical and social problems and may experience repeated and continuous trauma. Nurses and other clinical professionals encounter this population at different stages of alcohol addiction, including periods of recovery and relapse, and as such should be alert and sensitive to the potential repeated trauma these women undergo. Interventions from trauma practice should be considered

1 | INTRODUCTION

Alcohol use disorder (AUD) is a global mental health disorder whose deleterious effects impact the individual, family members and society as a whole (Grant et al., 2015). The clinical course of AUD and its chronic nature is manifested by periods of remission and periods of relapse that involve a return to previous problematic alcohol use after an attempted period of abstinence (Maisto et al., 2016). While some people diagnosed with AUD will recover across the adult life span, the recovery process is challenging (MacKillop, 2020; Tucker et al., 2020; Wemm et al., 2019). Clinical studies show that after one treatment episode, only one out of four individuals remain abstinent in the first year (Miller et al., 2001). A recent cross-sectional US study reported a mean of 5.35 recovery attempts and a median of two in a sample of 2002 individuals who reported resolving alcohol and other drug problems (Kelly et al., 2019).

Relapse is sometimes defined as a binary treatment outcome (the individual is either healthy or ill) or as a broader dynamic process that includes a backward trend in behaviour in terms of alcohol consumption and personal, social/environmental functioning (Brandon et al., 2007). Relapse threatens treatment efficacy and recovery (Brandon et al., 2007; Volkow & Baler, 2013), and can result in unstable, unpredictable daily routines and continuous stressors impacting the domestic and family environment (Schmid & Brown, 2008).

Women living with individuals with AUD are affected by their behaviour and are called upon to confront their own psychological, physical and social problems (Sharma et al., 2016). The presence of alcohol in the domestic arena increases the likelihood of intimate partner violence (Morrison et al., 2007). Women with a spouse with AUD are known to be exposed to various forms of domestic violence (Kahler et al., 2003; Stanley, 2012). They have a higher probability of experiencing more life stressors and more negative life events including injuries, victimization, as well as mood, depression and anxiety disorders (Ariyasinghe et al., 2015; Dawson et al., 2007; Gandhi et al., 2017). Overall, they tend to be in worse physical and mental health than women whose partners do not diagnose with alcohol

problems (Dawson et al., 2007; Gandhi et al., 2017). Studies also indicate that these women report a range of negative emotions such as shame, anger, isolation and fear (Sharma et al., 2016), and experience long-term abuse and hurtful communication behaviour (Sreeja Sreekumar & Varghese, 2016).

Women living with a partner diagnosed with AUD are often defined by researchers and clinicians as co-dependent, a term that refers to unhealthy and dysfunctional family/couple relationships in which maladaptive coping strategies are implemented by the partner to maintain a sense of homeostasis, which paradoxically reinforces the maladaptive behavioural pattern of the family member who diagnosed with AUD (Steinglass, 2009; Zaidi, 2015). However, this term has been criticized by feminist scholars who claim that it blurs the power relations between men and women, ignores the role of oppressive socio-political structures in shaping gender roles, and overall blames and pathologizes the victim (Calderwood & Rajesparam, 2014). Co-dependency has also been criticized by proponents of the stress and coping perspective who view the spouse who does not have addiction problems as an active agent who employs multiple coping styles (e.g. avoidance, withdrawal, engagement) to handle the stress associated with their partner's drinking (Hurcom et al., 1999, 2000).

Studies on relapse in the context of marriage and the family have primarily focused on the role of the family in relapse. Family pressure (Öjesjö, 2000) and spouses' expressions of strong emotions (hostility, criticism and emotional over-involvement) were found to predict relapse (O'Farrell et al., 1998). A longitudinal study of 23 married couples attending behavioural marital therapy indicated that while the husbands diagnosed with AUD attributed their relapses to situational factors, their wives tended to relate their relapses to their husbands' internal traits (Maisto et al., 1988). Another study of 74 men who met the DSM-III criteria for alcohol abuse or dependency, and who had completed a behavioural marital therapy programme, found that 40% blamed their spouses for their relapses (Maisto et al., 1995). A recent study of four couples in therapy for substance addiction reported that relapse was associated with shame, guilt, depression and confusion about the relapse (Fletcher & Macintosh, 2018).

Most research has dealt in general with the impact and influence of AUD on women living with a spouse diagnosed with AUD. These studies have examined the ways in which women are affected and their attempts to cope with AUD (Hurcom et al., 1999; Sharma et al., 2016). By contrast, there are scant data on the ways they experience relapse as a specific stage of AUD. Although relapse is a key feature of AUD that reflects its circular and chronic nature (Seo & Sinha, 2014) which can undermine the efforts made by the individual and the family circle to enhance recovery (Schmid & Brown, 2008), most studies have concentrated on the perceptions of these women and their spouses diagnosed with AUD regarding relapse. These show that the reasons for relapse tend to be attributed to the women themselves (Maisto et al., 1988, 1995; Maisto, O'Farrell, McKay, et al., 1988). There appears to be only one study to date that has specifically examined the experience of relapse, but in the context of therapy for four couples, where one of the spouses had a substance use disorder (Fletcher & Macintosh, 2018). To the best of our knowledge, no study has centred on relapse as experienced specifically by women whose spouses have AUD. Thus, given the importance of the wellbeing and mental health of women who are in a relationship with an individual diagnosed with AUD, and the centrality of relapse in the addiction field, the current study was designed to explore the ways women who have a spouse diagnosed with AUD experience his relapses. In so doing, it contributes to the literature on addiction, women's studies and may help guide nurses and other clinical personnel working with individuals diagnosed with AUD and their spouses.

This study was conducted in Israel where the prime approach implemented in alcohol and drug treatment centres (available through health and welfare services to both Jews and Arabs) is the traditional abstinence-oriented method that has limited tolerance for relapse. Israel is characterized by its highly family-oriented culture (Gavriel-Fried & Shilo, 2017). Despite social and cultural changes in recent years in the status of women generally (for both Israeli Jews and Israeli-Arab women), their expected gender role is still constructed around being wives and mothers whose main obligations are related to home and family, while men are perceived as the head of the household (Cinamon et al., 2016; Fogiel-Bijaoui & Rutlinger-Reiner, 2013).

2 | METHOD

A qualitative-naturalistic approach (Lincoln & Guba, 1985) guided by a holistic view of human experiences and the notion that there are multiple interpretations of human phenomena was implemented. This approach is well-suited to cases where there are little empirical data available in the literature and as such was appropriate for the current study.

2.1 | Sample

Twelve Israeli women were recruited by purposive sampling (Ritchie et al., 2003) from five outpatient treatment centres where their spouses had or were receiving treatment for AUD. The inclusion criteria were as follows: 1) female spouses of men diagnosed by the treatment centres as having an AUD according to the DSM-5; 2) women living in the same home as their spouses; 3) the AUD spouse had completed treatment for AUD in the past or was still in treatment when the study was conducted; 4) the AUD spouse had been abstinent at least once in his "alcohol use career" and then returned to drinking. The recruitment process lasted until data saturation was achieved, when the depth and breadth of the women's experience was met (Bowen, 2008).

The women ranged in age from 30 to 69 (M=46). Eight women were Israeli-Jewish, and four were Israeli-Arab. The majority were born in Israel; two were born in the Former Soviet Union. In terms of occupation, five women were not formally employed, two worked as kindergarten assistants, one cleaned houses, two were nursing caregivers (a non-academic profession) with the elderly/handicapped, and two had retired. At the time of the interviews, all the women were living with

their spouse, 10 had been married to their current spouse for 10 to 40 years (*M*= 19.83), and two were divorced but were living at the time of this study with their current partner who had also been diagnosed with AUD. All but one had children. Five women were in therapy as the spouse of an individual diagnosed with AUD. Since most of the women in the sample were married, the term spouse is used rather than partner. In the results section, the five quotations from women who were living with their partner are specified as such.

2.2 | Data collection

Semi-structured, in-depth interviews adhering to interview guidelines composed of open-ended questions were conducted. The participants were asked to describe their life and relationship with their spouse diagnosed with AUD with a specific emphasis on the way they experienced his relapses. For example: "Could you describe an instance in which your spouse drank after a period of abstinence?"Describe how you felt about his starting to drink again; describe what you thought about it; how did his relapse affect your relationship?" The interviews lasted 40 minutes to 2.5 hours. The interviews were recorded and transcribed at a later time by the authors. All the interviews were conducted in Hebrew and were translated into English after the analysis. The interviews were conducted between July 2017 and October 2018.

2.3 | Ethical approval and procedure

Potential interviewees who gave their initial consent to take part in the study were referred to the research team by the treatment centres. They were told that participation was voluntary and that non-participation would not impact their spouses' or their own treatment (if they were in treatment) in any way. The interviews were conducted at places and times that were convenient to the women. Special attention was paid to creating a respectful and comfortable atmosphere during the interview (Dickson-Swift et al., 2007). Each interview started with a presentation of the aims of the study. All the participants were informed that the data were confidential and that the interview was voluntary and contingent on the participants' written consent. At the end of the interview, they were informed they could contact the second author if they had further thoughts about what was said during the interview and were also provided with contact numbers for professional support after the interview if the need was felt. In what follows, the women's potential identifying information is masked, and all names have been changed to ensure anonymity. The study protocol was approved by the institutional review board of the researchers' university.

2.4 | Data analysis

A content analysis based on the naturalistic approach was conducted. This method of analysis is appropriate when there is limited information on a phenomenon (Hsieh & Shannon, 2005). The basic working assumption governing qualitative-naturalistic inquiry is inductive, in that it makes no prior assumptions about a phenomenon, thus allowing significant elements to emerge directly from patterns found in the case under study (Patton, 1990).

The analysis took place in five steps (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). First, the interviews were read thoroughly several times to achieve immersion in the data and get a holistic perspective on the women's experiences. Then, words and sentences from the texts that seemed to capture key concepts were coded. Next, the codes were sorted into categories and subcategories according to their similarities and differences in content. These were initially condensed into 50 categories and 16 subcategories and after a discussion among the authors were reduced to three categories and eight subcategories after ensuring that each was exhaustive and mutually exclusive. Then, these categories were re-defined and formulated into three categories to acquire a deeper understanding of their meaning. Finally, the latent content of the categories and the links between them were expressed as one holistic and integrative theme. Table 1 presents the codes, subcategories, categories and the theme that emerged from the women's interviews. Note that the initial analysis of the interviews revealed no differences between the experiences of the Israeli-Arab and the Israeli-Jewish women. Hence, they were pooled.

2.5 | Standards for assessing the quality of the study

In order to ensure the trustworthiness of the content analysis, Elo et al. (2014) suggested that one researcher should lead the analysis and then the other team members should follow-up the whole process. Hence, the first two stages of the analyses were conducted by the second author with the ongoing involvement of the first author. The last three stages were conducted through ongoing critical dialogue between the first two authors, which facilitated a reflexive exploration and examination of the analysis process. An external check of the whole process was carried out by the third author who was not involved in the data analysis, for purposes of dependability.

3 | RESULTS

The analysis of the interviews showed that the women's experiences of relapse were intertwined with their overall experiences of their relationship, which was affected by their spouse's problematic alcohol use. Three categories were identified. Each represents the women's repeated transitions along a continuum ranging cognitively from ignorance to realization, emotionally from opposition to acceptance and behaviourally from activity to inactivity. These categories coalesced into an overarching theme that was defined as the shift from closeness to distance in the way these women think about, feel and actively respond to their spouse's AUD in general and the ways they experience relapses in particular.

TABLE 1 Illustration of the Theme, Categories, Subcategories and Codes.

Theme	Categories	Subcategories	Codes
From closeness to distance	The cognitive dimension – from ignorance to realization	Naiveté, ignorance and lack of realization	The extent of the women's familiarity with alcohol prior to marriage, lack of awareness, non-identification of the relapses.
		I now know: Realization, recognition, identification and insights	Becoming familiarized with alcohol, the moment of realization that their spouse was abusing alcohol, rationalizations and explanations for the use of alcohol, signs of relapse, attitude towards relapse, the process of getting used to alcohol accompanied by suspicion, discovering the spouse's alcohol use, alcohol becomes a member of the household, identification of changes in the spouse's alcohol use, changes in the women's attitude towards their spouse, identification of periods of abstinence and how the women identified them and perceived them, the women's attitude towards ways of preventing a relapse and factors liable to bring about a relapse.
	The emotional dimension: from emotional opposition to acceptance	Happiness and pride alongside emotional difficulties and fears	Positive feelings towards abstinence, fear and concern about relapse.
		Low point: anger, disappointment and emotional opposition to the relapse	Feeling of instability, shame and concealment, pain, anger and disappointment, betrayal
		Empathy and compassion: acceptance of AUD	Empathy towards negative behaviour, the women's reconciliation with their spouse's alcohol use and their acceptance of it.
	The behavioural dimension – from activity to inactivity	Housekeeping: from activity to letting go	Budget management, childrearing, managing the household, responsibility of the woman as the breadwinner, general household duties letting go (relinquishment).
		Taking care of the spouse: from active involvement to letting go	Taking care of the spouse like a child, help preventing a relapse, referral to professional therapy, taking responsibility for alcohol use and ceasing to take responsibility, taking responsibility for therapy and recovery, the women's "addiction" to caring for their addicted spouse
		Leaving but staying	The woman's intention to terminate the relationship and their spouse's responses to the women's desire to do so, fantasizing escape, reasons for remaining in the relationship

3.1 | The cognitive dimension – from ignorance to realization

This dimension covers the entire timeline of the couple's relationship and reflects these women's dawning realization, recognition and the awareness of their spouse's AUD, along with their growing ability to identify signs of relapse. The first part of this category describes these women's lack of awareness and lack of recognition of their spouse's AUD, whereas the second describes the realization, the knowledge and the search for meaning that followed this realization.

3.1.1 | Naiveté, ignorance and lack of realization

Retrospectively, the women indicated that alcohol was indeed present during their first years of marriage. All the women said that they were unaware of the fact that they were living with someone who drank a great deal or suffered from alcohol problems, or in several cases already from AUD. Despite the numerous warning signs during this period, they did not realize or recognize that their spouse's drinking behaviour was outside the norm. They characterized themselves as naïve and explained that their lack of understanding was due to their unfamiliarity with alcohol:

> I was really naïve. I didn't know about these things. I had heard about it, he told me…but the whole thing with alcohol was unfamiliar to me. I didn't recognize it, … I think I started to realize it when we had children… six children… Before that, I had a feeling, but…I didn't understand because of my naiveté, because I hadn't encountered this type of thing before…. (Nelly, aged 51)

Moriah (aged 33) described how she did not connect her spouse's outbursts of anger to his drinking:

> I didn't know that I was in a relationship with a spouse addicted to alcohol! I didn't know…that there was a

> problem. I didn't understand at all. I lived with it, with the suffering you don't even know you are experiencing… I didn't realize the consequences of the drinking…I would still bring him a glass of wine at the table [laughing]…I didn't absorb it, I didn't see it. The implications of it. You are half-asleep. You get hurt and you laugh…I didn't see when he got overly angry, that the alcohol was providing the fuel….

3.1.2 | I now know – Realization, recognition, identification and insights

After several years, there came a point when the women recognized that their spouse's alcohol drinking patterns were problematic and that they were suffering from a disorder. This moment of realization was frequently related to changes in the spouse's drinking patterns and to deterioration in his physical and mental state, which were described as leading to a decline in the couple's relationship:

> That night he drank and shouted at me. That made it clearer to me [i.e. the realization that there was a problem] and he shouted at me all day that I was a bad spouse… And the children saw this…and he was drinking at the same time. After he drank, he calmed down, and then again… From here, it just snowballed. I only started to understand what was happening then. (Shani, aged 69, lives with her partner)

These women's realization of their spouse's disorder thus constituted a point of no return when they identified the (vicious) circle they were in. Periods of abstinence were described as an ascent and periods of return to alcohol use as a descent or fall, such that the women had no control over the swings from one state to the other:

> Ups and downs and plenty of arguing…and then there was a period during which he stopped [drinking] on his own, without help. Three weeks of cold turkey and then he fell again…like, you know, when you are up and all of a sudden – boom – and suddenly you are down…I feel like I am in…some kind of loop… (Shani, aged 69, lives with her partner)

Once they had identified the cyclical nature of the AUD, the women described the ways they became adept at identifying the phase of the relapse, as described by Abir (aged 45): "Afterward, I slowly realized that he would come home from work…and then sleep for 12 hours. I started to understand that something wasn't right…."

At the same time, they became aware that their spouses were trying to hide their relapse:

> When he is drinking, he doesn't come near our bedroom. And then I started to think why isn't he coming near our bedroom?… In the beginning, I didn't say anything. Afterward, I said "Tell me, why are you sleeping here? … Why are you coming home so late?"…and he started to talk nonsense and I also smelled it … (Abir, aged 45)

The eureka-moment and their identification of AUD and its cyclic nature prompted these women to look for explanations for the disorder and the factors that encourage relapse. In the interviews, they put forward a variety of reasons, including a combination of physical illness and an emotional need for attention, lack of confidence and a feeling of low self-worth in the presence of women, and alcohol as a way to reduce mental suffering: "I understood why he does it. It helps him loosen up a bit…since I saw how much he suffers, … and he suffers less when he drinks. He is a little happier." (Tami, aged 35).

They also suggested external causes, such as a lack of other activities, unemployment or pressure at work, the negative effects of spending time with friends who drink, and the stress and pressure of everyday life:

> What drives him in my opinion is the pressure of day-to-day life. It seems to me…when the children are in the hospital, when I say to him that we are short on money …that we need to cut back a bit. (Liran, aged 35).

3.2 | The emotional dimension – from emotional opposition to acceptance

This dimension reflects the variety of feelings experienced by the interviewees towards their spouses, depending on the phase of alcohol use. Periods of relapse and alcohol use were described as times of anger and opposition to their spouse's drinking, while periods of abstinence were described by positive emotions. A number of such cycles (abstinence and then relapse) led at times to acquiescence and acceptance of the disorder.

3.2.1 | Happiness and pride alongside emotional difficulties and fears

During the periods of abstinence, the women expressed positive emotions such as happiness, pride and hope. They expressed appreciation for their spouse's efforts, as noted by Liran (aged 35): "When he doesn't drink…I salute him. I tell him: Well done!", described their satisfaction and expressed connection and closeness: "First of all, I am happy that he has stopped…I know now that he is connected to himself and not just to himself, but to me as well." (Moriah, aged 33).

However, alongside the happiness and closeness, several women expressed concerns about relapses. Nelly (aged 51) commented: "I pray all the time that he won't touch it." The women

also acknowledged the emotional difficulties that their spouses go through during this period of transition, which they also experience: "It's a terrible thing. That's something that I don't want to think about at all… he is at war with itself, every day, a daily war. It is very difficult thing… but…I don't believe he'll touch it [again]…." (Moriah, aged 33).

3.2.2 | Low point: anger, disappointment and opposition to the relapse

The interviewees' awareness of the cyclical nature of AUD, and an upcoming relapse was experienced as a strong intuition: "I had a gut feeling… my whole body started to…a gut feeling …There's something that I can't explain. …In Russian it's called the'sixth sense'." (Yana, aged 60, lives with her partner).

For others, their husband's relapse was perceived as a sudden shift that occurred unexpectedly after a number of weeks of abstinence and without warning or lead-up: "And then, one day, we simply found the alcohol…on a Sabbath [Saturday]…and from there… he went back to drinking. He went back to the nightmare…We are currently at real rock bottom." (Nelly, aged 51).

Active relapse was described as leading to distance between the spouses: "Suddenly when you see him drinking, that he is there – down below…He is down there and not with me …he has crashed. Completely. A real crash…" (Nelly, aged 51).

In such cases, the respondents talked about their strong emotions, composed primarily of anger, pain, helplessness, abandonment, disappointment and depression, which were expressed in their emotional opposition to this stage: "I shout at him. I tell him to get out of the house; that I don't want to see him right now. Give me some peace and get out of the house." (Shani, aged 69, lives with her partner).

3.2.3 | Empathy and compassion – acceptance of AUD

After years of experiencing the chronic cyclic nature of alcohol addiction, the women tended to accept and reconcile themselves to the relapses and the disorder. Several women expressed some degree of understanding and empathy with respect to these relapses:

> …I feel bad for him. It's hard for me to think that he's going back to it again, because I know that tomorrow morning he will get up and tell me he's sorry, that he made a mistake and so on. And I see the crisis he's experiencing inside. (Liran, aged 35)

Other women expressed acceptance of the disorder itself, which led to acceptance of living with it: "I had days when I accepted things… and I thought that perhaps things weren't as bad as I thought…and maybe I could start living with this and gradually bring about some kind of change…" (Nelly, aged 51).

3.3 | The behavioural dimension – From activity to inactivity

This dimension was manifested in three areas: housework, taking care of their spouse and steps to end the marriage without actually terminating it. The transitions between activity and inactivity tended to occur cyclically over the duration of these women's relationships. The interviews suggested that during the early years, the women were more proactive. Their positioning at the non-active end of the spectrum appeared to take place after years of being together and was a result of feelings of AUD-related despair, helplessness and fatigue with its cyclic nature.

3.3.1 | Housework: from activity to letting go

All the women bore full responsibility for household chores and childrearing. They considered this to have been forced upon them by their spouse's lack of ability to function and their inability to rely on him: "I raised four sons alone. My spouse never helped me. He would always be running off. It was all on me – the housework, the budget, childrearing – anything you can think of…." (Dina, aged 50).

The women stated that they took on all these responsibilities until they experienced what they termed a turning point after years in which the burden was entirely on their shoulders. Once there, they tended to let up, in particular as regards housework, to give themselves a little more time off:

> I always felt sorry for him and I thought – never mind…that he should rest…but that was also my mistake… when the children were small…I came home from work and did everything…Now, I've given up… Once I wouldn't have gone to bed if there was even a spoon in the sink…Today…dishes in the sink don't interest me as much. (Liran, aged 35).

3.3.2 | Taking care of the spouse: from active involvement to letting go

The women described their responsibility and concerns for their spouse and taking care of him:

> It seems to me that I was always taking him somewhere. Every step he took and whenever he needed it. Whether it was making an appointment for him or reminding him, giving him money when he didn't have any…whether it was waiting for him to come home from a therapy session even if it was late… Everything… (Liran, aged 35)

This pattern was also expressed in active attempts to identify the onset of a relapse. Liran also described her obsessive efforts to

discover whether her spouse had started drinking again: "I would get up in the morning looking for bottles, and would find a bottle here and a bottle there and one in the storeroom…".

The shift to less active caring and in some cases ceasing to take care of the spouse occurred when the women understood the chronicity of alcohol use itself. This was said to be the result of feelings of despair, helplessness and fatigue, as presented in the second category, which led to withdrawal and ceasing to care for the partner:

> I thought that I could help him. But I couldn't do anything…After I collapsed, I felt real apathy… Nothing can help him … I tried everything, I saw that it wasn't working…In the initial stages, I tried…I already knew there would be a fall and that I could not stop it no matter what I did…I did everything at the beginning. I didn't succeed (Yana, aged 60, lives with her partner).

3.3.3 | Leaving but staying

This stage was considered a manifestation of the tension between the women's desire to end the relationship and the decision not to do so. The difficulties of living with a spouse diagnosed with AUD were said to lead to recurring thoughts of ending the relationship. Nonetheless, some of the women reported they had only taken partial steps (such as leaving for a short time) while for others leaving was simply a threat. For some of the interviewees, a threat or leaving temporarily was an expression of proactivity on their part, since it led to a period of abstinence:

> Afterward, when he didn't succeed, it was hard for me and I told him to do whatever he liked. That's it, I've had enough. All that time coming and going, coming and going. I left. I took the kids and left. He went to my parents' place and told me that he was giving up alcohol… that was three years ago. And then he went into therapy. That's what made him decide to stop. For the first time I did it, I really left. Before that, I only said I would. (Abir, aged 45)

In cases where the husband continued to drink, some of the women remained in the relationship primarily because of the difficulties of raising children without a father. In this case, they described the decision to stay as the lesser of two evils:

> I decided to get to a different place…At the beginning, in recent years, I said "that's it." If it happens once more I am getting a divorce no matter what… Afterward I understood that getting divorced isn't simple either. To be alone with five kids and to raise them is not easy…So you have to decide where you are headed…I decided that divorce is not the right solution – not for me, not for him and not for the children. (Liran, aged 35)

4 | DISCUSSION

This study examined the ways in which the spouses of men diagnosed with AUD experience their relapses. The findings reveal the complex and multidimensional experiences of these women over the years and show that the relapse experience is embedded within a broader life experience that covers the full range of these women's thoughts, emotions and behaviours. This makes it difficult to differentiate between the women's experience of relapse as a separate stage and their experience of addiction as a whole. Each dimension of relapse was reflected in the women's global experience of their lives as spouses of individuals diagnosed with AUD. For example when the women came to the realization that their spouses had an alcohol addiction, they could identify the relapse and its warning signs; at the same time, they could emotionally resist the addiction and actively try to end it as a whole, by trying to resist and prevent the relapse. As in previous studies, the findings suggest that women who are in relationships with spouses who are diagnosed with AUD live chaotic lives and undergo complex emotional experiences involving tension, sorrow, anger and despair, and gender-based violence which is expressed in conflicts and verbal if not physical violence (Dostanić, 2016; Sharma et al., 2016). This range of emotions and experiences are liable to interfere with the identification and differentiation of the stages of the addiction cycle, including the relapse stage.

Patterns of closeness and distance are consistent with studies of women living with spouses who are diagnosed with AUD. These patterns are viewed in previous studies as coping strategies that require emotional and behavioural efforts to minimize, reduce or dominate the stressful circumstances associated with their spouses' drinking (Barman, 2019; Hurcom et al., 1999; Sharma et al., 2016). In these studies, closeness is defined as "engaged coping" in which the woman is engaged with her spouse through active interactions. Distancing is defined as "withdrawal coping" which involves avoiding the spouse and engaging in self-regulating activities.

The centrality of the distance and closeness pattern in this study is reflected in the ways the women cope with the chronic nature of AUD and its accumulated stressors they experience in their domestic environment and may be related to complex trauma (Herman, 1992b). Specifically, the three transitions characterizing the women's subjective experiences of their spouses' relapses and their broader life experience in the shadow of alcohol appear to correspond to the three conflicts identified in the literature that describes how individuals cope and deal with complex repeated trauma (Levi, 2013, 2017). In general, these individuals grapple with an undermining of their beliefs with respect to relationships and basic assumptions about the world, which threaten the existence of the self (Janoff-Bulman, 1995). This suggests that the prime conflict is between the need to believe in significant others and the difficulty of firmly establishing that belief. The second conflict has to do with the tension between the individual's need to preserve his/her identity which has developed in response to an ongoing trauma, and the emotional need to separate from that identity. The third conflict has to do with the

individual's need to return to the adaptive functioning that existed before the traumatic events and the difficulty of doing so. Implicit in this difficulty is the fear of change, which in some cases is accompanied by feelings of guilt.

The emotional aspect of the experience described here from opposition to acceptance of the disorder is perhaps reflective of the first conflict that involves the difficulty of (re) establishing trust. This conflict was expressed for example in disappointment at each relapse, which makes it difficult for these women to firmly establish bonds of trust with their spouses. The desire to disentangle themselves from an identity that has evolved over the years as the spouse of a man diagnosed with AUD, and the longing to change the way in which they function that results from their exposure to long-term trauma (the second and third conflicts), go hand in hand with identification of the AUD and the acknowledgement that in some cases it can lead to a yearning to end the relationship. The lack of awareness of the disorder over the years may thus be related to the unconscious emotional difficulty of realizing that acknowledging the disorder will force them to make a change. It can be assumed that by remaining in their relationship, these women are sustaining the conflicts and the post-traumatic symptoms they suffer from. Sustaining the conflict fully exposes the extent of the emotional and functional investment in this process. Changing this situation is perceived as being particularly difficult to implement because of the feelings of guilt attached to abandoning a spouse who is and has been in need of empathy throughout their lives together. More broadly, the parallel between the conflicts faced by individuals who have experienced complex trauma and the categories identified in this study may provide a new perspective on the internal emotional dynamics of these women.

These findings should also be interpreted in light of what remained unsaid. Although the participants described the conflicts between them and their spouses, none with the exception of one, defined these conflicts and their spouses' angry outbursts as domestic violence but nevertheless noted that their children often witnessed their father's relapses, anger and the conflicts between their parents. Previous studies have shown that children of a parent who has been diagnosed with AUD are also exposed to these conflicts (Mackrill & Hesse, 2011; Murphy, 2018). Hence, this omission may be partly due to feelings of shame or an unwillingness to reveal violent episodes related to AUD and the fear of being perceived as mothers who fail to protect their offspring.

4.1 | What the study adds to the existing evidence

Although previous studies have noted the accumulated stressors affecting women whose spouses have been diagnosed with AUD (Sharma et al., 2016; Stanley, 2012), few studies have analysed relapse as a distinctive stage, and the way it is experienced by the spouse. Here, this led to a clearer perception of the chronic nature of living with a spouse who diagnosed with AUD. At the same time, the findings point for the first time to the fact that the complex emotional charge and the accompanying traumatic events mask and complicate these women's ability to distinguish between stages of addiction and confirm that the relapse experience is woven into the entire addiction experience. In addition, this study innovates by underscoring the similarity between the chronic nature of AUD as manifested by relapse (Seo & Sinha, 2014) and the continuous nature of complex trauma (Herman, 1992a). The parallels between the three transitions identified in the analysis process and the conflicts inherent to complex trauma (Janoff-Bulman, 1995) provide a better understanding of the internal emotional dynamics of these women's behavioural patterns and help grasp their decision to remain in their relationship.

4.2 | Implications

Mental Health nurses and other clinical personnel play a crucial role in early identification and access to care for patients who have AUD in various settings (Nash et al., 2017). Early diagnosis should be expanded to family members who are affected and suffer from this disorder. Hence, nurses treating female spouses of individuals diagnosed with AUD should be alert and sensitive to the complex experiences and conflicts these women experience and the need to provide them with a therapeutic solution to help them cope with the emotional burdens that accumulate over time. Specifically, a set of interventions should be made available to family members individually and together with the individual diagnosed with AUD. For female spouses, interventions such as the Survivor Therapy Empowerment Program (STEP), a psycho-educational programme that was found to be beneficial for survivors of various interpersonal traumas such as domestic violence (Jungersen et al., 2019), could be considered. This programme allows trauma-affected individuals to process their lived experiences while building skills that help to foster wellbeing and strengthen resilience. In addition, behavioural couples therapy for those diagnosed with AUD and their spouses could be offered. This therapeutic approach assumes a reciprocal connection between substance abuse and relationship functioning and focuses not only on learning new coping skills to enhance abstinence or reduce AUD severity, but also on improving relationship functioning (Flanagan et al., 2018; Powers et al., 2008).

Given the implicit way domestic violence was described in this study, nurses should be aware of this factor when treating these women. It is important to raise these women's awareness of the violence that may be associated with relapses and to refer them to the relevant health services if necessary. In addition, specific therapeutic attention should be paid to children who are exposed to this traumatic cycle (Mackrill & Hesse, 2011; Murphy, 2018) since they may experience the three conflicts described above. Future studies should explore these conflicts among children as well.

4.3 | Limitations

There are several limitations to this study. The first is related to the characteristics of the sample. The study was carried out in Israel on 12 spouses of men who had sought therapy for AUD, a fact that limits the findings to the local context and to AUD alone. Future studies should be conducted in other countries and cultures, on other substance disorders, and be based on larger samples using quantitative research methods to confirm these findings. The information collected about the women's spouses allowed us to determine confidentially that they had been diagnosed with AUD according to the DSM-5, had been in treatment at some point of their addiction career and had been abstinent at least once in their alcohol use career and then returned to drinking. Other personal and characteristics related their AUD such as severity, the number of years they had suffered from this disorder, and drinking patterns were not collected. Future studies should include this information when probing this topic.

4.4 | Summary

This is the first study to examine the experiences of female spouses of men diagnosed with AUD in the context of relapse as a distinctive group. The findings show that the experience of relapse is only one aspect of these women's lives. The ways these women respond to the disorder arise from the continual tension engendered by their exposure to ongoing trauma. This association between exposure to trauma and the nature of women's forms of coping can pave the way for future studies on the cognitive, mental and emotional mechanisms implicated in living with a spouse diagnosed with AUD.

CONFLICT OF INTEREST

The authors report no conflict of interest.

AUTHOR CONTRIBUTION

Belle Gavriel-Fried was involved in the planning, analysing and supervision of the study, and wrote the first draft of this paper. Rotem Izhaki was involved in planning the study, conducted the interviews and analysed the data. Ofir Levi reviewed the qualitative analyses and contributed to the interpretation of the results. All authors have commented on and approved the final version of this paper.

DATA AVAILABILITY STATEMENT

Research data are not shared. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Belle Gavriel-Fried https://orcid.org/0000-0001-5528-5339

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