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Theoretical-methodological rationales in caring for family members of people with alcohol use disorders

Racionalidades teórico-metodológicas no cuidado aos familiares de pessoas com transtornos por uso de álcool

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Abstract

Objective
The present study aims to understand the theoretical-methodological rationales which guide psychological care practices for family members of people with alcohol use disorders.

Method
For this theoretical-reflective study we conducted a systematic search for literature review articles to learn about the modality of interventions, their theoretical-methodological frameworks and clinical or efficacy results. Afterwards, a complementary search for articles and book chapters was conducted to map and analyze the most used professional care practices and their theoretical assumptions.

Results
We identified six theoretical-methodological rationales that guide the professional's clinical reasoning in caring for family members, which are organized around key concepts about their emotional suffering: 1) family stress; 2) family dynamics; 3) behavioral repertoire deficit; 4) codependency; 5) inflexibility; 6) potential for psychological change.

Conclusion
The identification of these rationales can aid professionals when planning their practices in a critical and informed manner.

Keywords: Alcohol abuse; Family relation; Professional practices.

Resumo

Objetivo
Este estudo objetiva compreender as racionalidades teórico-metodológicas que guiam práticas psicológicas de cuidado a familiares de pessoas com transtornos por uso de álcool.

Método
Para este estudo teórico-reflexivo realizamos uma busca sistemática de artigos de revisão de literatura para compreender as modalidades de intervenção, seus enquadres teórico-metodológicos e resultados clínicos ou eficácia. Na sequência, uma busca complementar de artigos e capítulos de livro foi conduzida a fim de mapear e analisar as práticas de cuidado profissional mais utilizadas, bem como seus pressupostos teóricos.

Resultados
Foram identificadas seis racionalidades teórico-metodológicas que guiam o raciocínio clínico do profissional em torno de conceitos-chave sobre o sofrimento emocional dos familiares: 1) estresse familiar; 2) dinâmica familiar; 3) déficit de repertório comportamental; 4) conduta codependente; 5) rigidez das defesas psíquicas; 6) potencialidade para a mudança psicológica.

Conclusão
A identificação dessas racionalidades auxilia o profissional no planejamento de suas práticas de modo crítico e informado.

Palavras-chave: *Transtorno do abuso de álcool; Relações familiares; Prática profissional.*

While the focus of specialized psychological care is on people with alcohol use disorders, their family members may have their own suffering neglected, especially when they are seen as co-therapists. According to Cordeiro et al., (2021), the family experiences the consequences of abusive or dependent alcohol use by one of its members. Family members often experience insecurity, fear, helplessness, and hopelessness and may show signs and symptoms of anxiety and depression (Takahara et al., 2017; Tucci & Oliveira, 2019). To face the suffering that comes from living with the conflicts resulting from the abusive or dependent use of alcohol by a family member, as well as from the lack of support from the extended family and health system (Carias & Granato, 2020; Teixeira et al., 2015), family members resort to emotional survival strategies.

Haverfiel et al. (2015) analyze communication in the families of people with alcohol use disorders and identify aggressive and conflictive communication in the relationships established between the individual who consumes alcohol and other family members. This type of interaction includes offenses, secret slanders, superficiality in the subjects dealt with, and the unpredictability of the mood of the people involved. Horta et al. (2016) argue that family members feel humiliated and powerless regarding the family member's alcohol consumption. Faced with hopelessness, there are family members who keep their family member's consumption of alcohol or drugs a secret, while others turn away and/or break the bond with the user family member, given the burden of suffering experienced.

Despite evidence on the therapeutic efficacy of family care practices and their benefits in the treatment of people with alcohol use disorders (Bortolon et al., 2017; Hellum et al., 2019), there is still a lack of institutional services for the emotional needs of family members (Copelo et al., 2006). To investigate this contradiction, Lee et al. (2012) interviewed health professionals to understand the difficulties in creating or implementing services that aim to meet the needs of family members. The authors highlight the lack of human and financial resources for the implementation of care practices, in addition to conflicts in the roles experienced by professionals who are divided between caring for people with alcohol use disorders and caring for family members. The authors also point out that many professionals do not feel prepared to meet the emotional needs of family members, which gives rise to reflection on the importance of continuing education for professionals in the context of emotional care for family members of people with alcohol use disorders.

There are, however, a variety of interventions or care practices aimed at relieving family members' emotional distress. Copello et al. (2005) divide these interventions into three groups,

according to the social place allocated to family members in health facilities. In the first group, there are interventions that aim to train family members to help the family member to accept and/or participate in a treatment. In the second group, care practices that focus on the relationship between family members and people who use the substance stand out, which is why they favor joint care for family members and people who abuse or are dependent on alcohol and/or drugs. In the third and final group, there are interventions that focus on the personal needs of family members, that is, the experiences lived by this audience and their existential and emotional repercussions. It is worth mentioning that the authors describe professional practices from different theoretical perspectives in the field of Psychology and make considerations about the effectiveness of these interventions.

Considering the theoretical diversity in the field of care for family members, Selbekk et al. (2015) present another classification of these practices based on two models of clinical reasoning. The first model is called Stress-Tension-Coping-Support and encompasses interventions for embracing the family member's suffering and developing strategies for coping with stress. The second model, referred to as Socio-Ecological, is based on practices that work on interpersonal relationships between family members. While, in the first model, individual settings predominate, in the second one, family therapies and group interventions stand out. The authors argue that the two models complement each other in clinical practice, insofar as there are cases that require help in the development of stress-coping strategies and cases in which the professional works with historically established family relationships.

Despite the interpretive analyzes by Copello et al. (2005) and Selbekk et al. (2015) offer a guide given the theoretical diversity of interventions, there is a lack of arguments about the theoretical-methodological rationales that guide clinical-psychological reasoning in the care of family members of people with alcohol use disorders.

Schneider (2010) argues that human beings are socially organized through systems or horizons of rationales that facilitate the understanding of the world. According to the author, rationales are socio-historical substrates that underlie conceptions about human and social phenomena. There are theological, metaphysical, and political rationales that are organized through conceptual or logical coordinates and that are respectively supported by dogmas, hermeneutic principles, and political-ideological systems. On the other hand, scientific or theoretical-methodological rationales are supported by the description, observation, and categorization of human and social phenomena according to the theoretical-methodological systems that organize the practices. The identification of theoretical-methodological rationales in the field of health helps professionals to understand health perspectives and emotional suffering that underlie their practices. We highlight the heuristic potential of identifying theoretical-methodological rationales in the work of health professionals from the *Sistema Unico de Saúde* (Unified Health System) in specialized areas in the field of chemical dependence, such as mental health clinics and the *Centros de Atenção Psicossocial de Álcool e Drogas* (CAPS-AD, Psychosocial Care Centers for Alcohol and Drugs). Given the above, the objective of the present study is to identify in contemporary scientific literature the theoretical-methodological rationales that underlie clinical psychological reasoning in care practices for family members of people with alcohol use disorders.

Method

We conducted a theoretical-reflective study on the rationales that guide care practices for family members of people with alcohol use disorders. To achieve our objective, we developed four

procedures in order to add rigor to the investigative path. The first procedure was an exploratory search for literature review articles on interventions for family members of people with alcohol use disorders. Considering the theoretical diversity of Psychology that guides care practices for this population, we decided to consult systematic or integrative literature reviews to learn about the modality of interventions, their theoretical-methodological frameworks and clinical or efficacy results. To locate the review articles, we used the descriptors *family* and *alcohol abuse* in the Scientific Electronic Library Online (SciELO) database for psychological productions in Brazil and Latin America, and the American Psychological Association (APA) database for international productions.

Among the inclusion criteria, we considered peer-reviewed studies published in Portuguese, English, or Spanish. We also included articles that address care for family members of people who exclusively consume alcohol or alcohol associated with other drugs and published between 2001 and February 2021 in order to select reviews from the present century. Among the exclusion criteria, we removed articles that addressed topics that are tangential to the object of our study, such as the analysis of public policies. We also excluded studies that review the results of a single intervention, those that address children and adolescents with needs arising from the use of alcohol or drugs, and those that focus on the Indigenous populations of different countries. We justify the last three exclusion criteria, respectively, by our interest in the theoretical diversity of interventions; for the loss of rigor if we expanded our discussion to studies on the consumption of alcohol or drugs by children and adolescents, which would imply the consideration of child development peculiarities and, finally, the necessary consideration of sociocultural factors for the adaptation of interventions with indigenous populations from different countries, exceeding the objectives of this study.

The use of the descriptors *family* and *alcohol abuse* in SciELO found 263 peer-reviewed articles. Based on this result, when we selected the "literature reviews" filter, eight articles were found. After reading the titles and abstracts, none of the studies was selected. The use of the same descriptors in the APA database found 10,340 peer-reviewed articles. Applying the filter "literature reviews," 363 studies were found. By reading titles and abstracts, we identified 20 review articles on care practices for family members of people with alcohol use disorders. However, after applying the exclusion criteria, eight articles remained that reviewed interventions for family members.

As a second stage of the investigative procedure, we read the selected review articles in full and identified the care practices that are most frequent in the reviews. We identified the different interventions and their main characteristics before moving on to the third stage of the procedure, which consists of the exploratory search for other studies that would allow us to deepen the study of each intervention identified in the second stage, discover new interventions, and assess similarities and differences between these practices. In this third stage, we conducted a new exploratory search for articles and book chapters that could provide information on care practices for family members that had not been covered by the literature review articles.

Finally, in the fourth and final stage of the methodological procedure, we developed a comprehensive interpretation of the theoretical-methodological rationales that guide care practices. We sought to observe the similarities and differences in the therapeutic setting, professional conduct, and the family members' conceptions of health and emotional suffering. Debates in this study's research group improved our interpretation regarding the rationales presented here.

Results

We created two tables to visualize the results of this theoretical study. In Table 1, we present the list of literature reviews consulted as the first methodological step of the study. We emphasize that systematic or integrative literature review articles in the field allowed the identification of the main psychological care practices and their theoretical-methodological foundations.

In Table 2, we present a brief description of the interventions selected for this study. It is possible to observe the diversity of professional conducts aimed at relieving the emotional suffering of family members.

Table 1
Literature reviews found in the exploratory search

Year	Country	References
2001	USA	Thomas, C., & Corcoran, J. (2001). Empirically based marital and Family intervention for alcohol abuse: a review. *Research on Social Work Practice*, *11*(5), 549-575.
2005	United Kingdom	Copello, A. G., Velleman, R., & Templeton, L. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review*, *24*, 369-410.
2006	United Kingdom	Copello, A. G., Templeton, L., & Velleman, R. (2006). Family interventions for drug and alcohol misuse: is there a best practice? *Current Opinion in Psychiatry*, *19*, 271-276.
2006	USA	Fernandez, A. C., Begley, E. A., & Marlatt, G. A. (2006). Family and peer interventions for adults: past approaches and futures directions. *Psychology of Addictive Behaviors*, *20*(2), 207-213.
2010	United Kingdom	Templeton, L., Velleman, R., & Russell, C. (2010). Psychological interventions with families of alcohol misusers: a systematic review. *Addiction Research & Theory*, *18*(6), 616-648.
2010	USA	Morgan, T. B., & Crane, D. R. (2010). Cost-effectiveness of Family-based substance abuse treatment. *Journal of Marital and Family Therapy*, *36*(4), 486-498.
2012	USA	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.
2013	USA	Cox, R. B., Ketner, J. S., & Blow, A. J. (2013). Working with couples and substance abuse: recommendations for clinical practice. *American Journal of Family Therapy*, *41*(2), 160-172.

Table 2
Interventions for family members selected during the exploratory search

Intervention name	Short description
Johnson Institute Intervention	A meeting or a surprise get-together is planned by the health professional to approach the person who is abusive or dependent on alcohol. Family members are encouraged to participate in the meeting and confront the family member who uses alcohol through letters, reports of experiences, and an ultimatum for the family member to seek treatment.
Unilateral Family Therapy	Spouses receive training on alcohol-dependent use, techniques for improving the marital relationship, techniques for managing anger, and strategies for the sexual-affective partner who abuses or depends on alcohol ingestion to seek treatment.
Community Reinforcement and Family Training	Family members receive training to change environmental contingencies that favor alcohol consumption. Family members are encouraged to seek pleasurable/reinforcing activities and to prepare an emergency plan in case of crisis or violence.
Motivational Interviewing	Promotion of dialogue to motivate changes in the family's lifestyle. Focus on the potential and resilience of family members to elaborate ambivalence.
Behavioral Couples Therapy	Identify with the couple the environmental triggers or cues that facilitate alcohol consumption. Improve relapse prevention behaviors. Work on the quality of the marital relationship.
Structural Systemic Therapy	Identify family roles and patterns. Making these roles and patterns conscious through interpretation and experiential techniques.
5-Step Method	Five steps that must be followed by the health professional to embrace the family member's anguish and help them to develop coping strategies and problem-solving skills.
Codependency Therapy	A set of therapies from different theoretical perspectives that aim to raise awareness or reduce codependent behaviors of family members.
Relaxation and Meditation	Set of relaxation and meditation techniques that aim to reduce the emotional suffering of family members.
Experience Sharing Groups	Groups in which family members share experiences and the health professional acts as a facilitator for communication between themselves.

Discussion

In this section, we present our reflections on the theoretical-methodological rationales that underlie care practices for family members of people with alcohol use disorders. We highlight the importance of specialized psychological care for family members, as the family is directly affected by abusive consumption or dependence by a family member (Cordeiro et al., 2021), although often neglected in treatment plans for disorders related to alcohol use (Lee et al., 2012). In addition, Carr (2018) emphasizes the need for interventions aimed at families to enhance the treatment of the family member who consumes alcohol and/or drugs or who has other experiences of emotional distress, such as anxiety disorders and intimate partner violence. On the other hand, we assume that families deserve specialized professional attention in tune with their own existential and emotional needs in order to contribute to their mental health and well-being, usually affected by the family member's disorder.

We found six theoretical-methodological rationales that guide clinical psychological reasoning in caring for the emotional needs of family members. We observed that each theoretical-methodological rationale can include different theoretical references insofar as they can be grouped around a key concept, despite their different epistemological perspectives. We also emphasize that the key concepts that articulate a theoretical framework to a certain methodology inform the conception of emotional suffering that underlies each of the rationales and guide the professional's clinical reasoning in the analyzed care practices. In this way, we will be presenting each of the theoretical-methodological rationales, and their respective interventions to family members, according to the concept of family suffering that serves as a guide and is signaled by what we call here a key concept.

Stress characterizes the daily life of people whose family members abuse or depend on alcohol

In this first theoretical-methodological rationale, the belief that people whose family members abuse or depend on alcohol suffer from the stress caused by these conditions mobilizes care practices that aim to reduce the stress level experienced. In this rationale, the key concept stress is highlighted, encompassing both the biological aspect of comprehension and the aspect of emotional and cognitive factors (Silva et al., 2018). Stress is a set of physiological responses to a physical, social, emotional, or cognitive stimulus and can facilitate diseases due to the inflammatory response triggered by its chronicity, which attests to the need for care interventions (Antunes, 2019). We observed that, in this rationale, there is the assumption that the family member is an independent and healthy person, but that, due to the stressful coexistence with the person with alcohol use disorders, they need to reduce their stress levels to remain emotionally stable (Selbekk et al., 2015). Such practices are supported by evidence that reducing the stress experienced by family members has a positive impact on the family's health and on their motivation to act as a support network in the treatment of people with alcohol use disorders.

In the context of this first rationale, we identified two interventions that seemed emblematic to us. The first is the 5-Step Method, which was initially described by Copello et al. (2010a). It is a care guideline to assist the professional in the selection of the best strategies to reduce the stress level of family members. The first step is to listen, reassure, and explore the family member's concerns, which makes it possible to understand their experience. The second step aims to provide clinically relevant information that can help in the self-knowledge process, in addition

to reducing stress and anxiety symptoms. Exploring coping responses is the third step, followed by a discussion of the social support that individual receives as the fourth step. And finally, in the fifth and final step, we seek to explore additional needs and discuss them in the context of coping and problem solving. It is noteworthy that the 5-Step Method has an adapted version for children and adolescents who are sons and daughters of people with alcohol use disorders (Templeton & Sipler, 2014), in addition to adaptations of this intervention for care via the internet (Copello et al., 2010b), given the growing demand for the use of information technologies for mental health care, particularly in the current scenario of the Covid-19 pandemic.

The second intervention that responds to the rationale that has stress as paradigmatic suffering is the set of meditation techniques used in emotional care for family members of people with alcohol use disorders. Inspired by Eastern philosophies, such therapies work on the non-judgmental acceptance of thoughts, body awareness, relaxation, self-compassion, and kindness towards oneself and others (Varginha & Moreira, 2020). Despite all these qualities, the main contribution of the intervention is working with the awareness of the present, suggesting its relevance for family members affected by stress and anxiety. Different studies have demonstrated significant therapeutic effects of meditation practices for different groups or emotional demands (Barbosa et al., 2020; Carpena & Menezes, 2018; Carvalho & Votto, 2019; Guilherme & Pimenta, 2018; Moesgen et al., 2019). We highlight that Hernández and Martins (2020) assessed the subjective well-being of meditation practitioners. The authors conclude that people who frequently practice meditation have higher rates of what they called positive affects and life satisfaction. These results suggest that meditation helps when experiencing stress on a daily basis and favor the resilience of individuals.

Family members are victims and co-authors of a sick family dynamics

This second theoretical-methodological rationale presupposes the understanding that family members suffer the effect of a sick family dynamic in which they themselves participate as co-authors and which facilitates a family member's abusive or dependent consumption of alcohol. In this perspective, the key concept of family dynamics and the perspective that the roles and functions of each family member are distorted to ensure homeostasis and/or emotional survival in the face of suffering are highlighted. In order to preserve the family *per se*, family members take on tasks and/or roles that are not theirs, producing emotional overload and a family functioning characterized by difficulties in communication and in establishing limits. In this rationale, the origin of suffering is within the family situation, whose focus on emotional survival makes roles and functions suitable for each individual unfeasible. Thus, there is a feedback of interpersonal relationships, insofar as the family dynamics facilitates the consumption of alcohol and, respectively, the consumption of alcohol facilitates this family dynamics. The care practices that belong to this rationale are based on psychoanalytic or systemic ideas and aim to raise awareness about the roles and standards of conduct assumed by each family member.

We identified that the main practice that works with this rationale is structural systemic therapy applied to chemical dependence. We rescued Minuchin's proposal (1982), which seeks the structure that sustains speeches, behaviors, and symptoms within the family. He understands the family as composed of subsystems, such as the individual's relationships with himself, the fraternity between siblings, the couple's conjugality, and parental relationships, whose boundaries dialogue with each other, but which should never overlap. According to the author, the boundaries between the individual and the family are well established when each subsystem is clear and there

is respect for the individuation process of family members, which implies space for privacy and psychological development. However, in families with a family member who abuses or depends on alcohol, boundaries are blurred, and the functions of each subsystem are confused. This family condition produces suffering and can be observed in the sons and daughters of people with alcohol use disorders who assume early adult responsibilities to contain the anguish, sacrificing the spontaneity that would guarantee them a more authentic relationship with themselves and with the other. In this way, systemic-structural therapists work to establish the boundaries between family subsystems, to understand and unveil the roles and functions assigned to each member, to strengthen cohesion and healthy differentiation, and to face the static-pathological tendencies of the homeostatic balance that hinder changes in family dynamics (Andolfi, 2018).

Payá (2017) reflects on systemic interventions for the treatment of alcohol and drugs in the family. The author presents characteristics that these psychological care practices have in common, which includes Minuchin's structural therapy (1982) and other proposals for systemic therapy: (a) assuming that the family is an open system interacting with the environment, which enables cultural exchanges; (b) understanding the family as an independent organization in which patterns of interpersonal relationships are formed; (c) searching for homeostasis in the family dynamics; (d) searching for morphogenesis to enable growth trends; (e) clinical reasoning of circular causality that guides the professional towards understanding the dialectic in interactions; and (f) observing the communication/language of family members.

We observe the characteristics described by Payá (2017) in the care practices that belong to this rationale, which attests to the assumption that family members are victims and co-authors of the dynamics of interpersonal relationships. For this reason, such interventions aim to make each family member aware regarding the role assumed, facilitate dialogue and helping the family to break the patterns of conduct that produce emotional distress.

There is a deficit in the family's cultural or behavioral repertoire that undermines the provision of qualified support to the family member with alcohol use disorder

This third theoretical-methodological rationale is organized around the concept of lack of cultural or behavioral repertoire of the family so that it materializes into support for the family member with alcohol use disorder. We emphasize that the term "repertoire" is the key concept of this rationale that is based on behavioral-analytic and cognitive-behavioral ideas. Therapists who work in this perspective seek to offer family members a set of trainings aimed at teaching the necessary skills for appropriate supporting the treatment of the family member who uses alcohol and the skills for maintaining their own mental health. The training is focused on social skills, improving the marital relationship, problem solving, assertiveness, among other topics.

We present three emblematic interventions that belong to this rationale. The first one is called Unilateral Family Therapy, in which spouses are invited to assume the role of rehabilitation agents for the person who abuses or depends on alcohol. In this intervention, the spouses receive training on the organic and psychological consequences of alcohol consumption, learn anger management techniques, and strategies to improve the marital relationship. Through therapists, spouses also learn about possible triggers or problematic situations that facilitate a family member's relapse into alcohol consumption (Thomas & Ager, 1993).

The second intervention that we highlight is Behavioral Couples Therapy, which seeks to work on the couple's self-knowledge regarding risk and protective factors in the abusive or dependent consumption of alcohol by one of the spouses (Epstein & McCrady, 1998; O' Farrell &

Fals-Stewart, 2000). In this care practice, there are weekly or biweekly sessions in which strategies for maintaining abstinence are discussed with the couple. Among these strategies, we have identification of triggers or problem situations that facilitate relapse into alcohol use, construction of alternative repertoires for situations at risk of relapse, improvement of the marital relationship, and strengthening of available support networks (McCrady et al., 2019). Currently, the Behavioral Couples Therapy is being adapted for couples in the LGBTQIA+ community and for remote care (McCrady et al., 2016). It is also being used for the relief of emotional distress from comorbidities associated with alcohol abuse or dependence, such as people with post-traumatic stress disorder (Schumm et al., 2019).

The third and final intervention that stems from this theoretical-methodological rationale, supported by the idea of a deficient cultural or behavioral repertoire, is Community Reinforcement and Family Training (CRAFT). This practice seeks to teach family members new behavioral repertoires for managing the environmental contingencies of the home, to reduce the family member's risk of alcohol consumption and motivate them to start a rehab program. Family members are the main agents of the CRAFT intervention. They are trained by professionals to analyze family relationships and modify behaviors that encourage alcohol consumption and interpersonal conflict (Meyers et al., 1998). Throughout the process, family members learn different strategies to avoid alcohol consumption triggers, train communication skills to avoid future conflicts, learn to reinforce sobriety, develop strategies to prevent domestic violence, maintain an emergency plan in case of violence, and expand the repertoire of rewarding activities in order to strengthen resilience and preserve mental health (Archer et al., 2019).

The family member establishes a bond of codependency with the family member who is abusive or dependent on alcohol

The fourth theoretical-methodological rationale assumes that the family member may develop a unique emotional dependence on the family member who is abusive or dependent on alcohol. The term "codependency" appears as the key concept that explains the emotional distress that is expressed in the excessive concern of family members in relation to the person affected by the disorder. Although mutual help groups work with the concept of codependency as if it were a family member's obsession to control another person's alcohol consumption (Timko et al., 2012), the concept received other definitions, becoming the target of theoretical discussions among researchers. In our reflection, we adopted the definition of codependency as a personality trait that leads individuals to abdicate their own needs in favor of "excessive care" to the other, to the point of neglecting themselves, putting themselves at risk and not being able to impose limits when relationships become abusive (Wright & Wright, 1991).

People with a codependent behavior pattern is constantly worried with the problems of others, ruminating strategies to solve them. This difficulty in prioritizing personal projects, as they often sacrifice themselves for the sake of others, can lead the codependent to put themselves in risky situations or suffer significant emotional, social, and/or financial losses (Melo & Cavalcante, 2019). Codependency is fed back by physical, emotional, or financial dependence on the other. The family member with this pattern of conduct feels responsible and guilty for all the problems and sufferings experienced by the person with alcohol use disorders, which attests to the relationship between codependency, low self-esteem, need for control over others, anxiety, and depression (Xavier et al., 2015).

Psychological interventions that express this rationale aim to facilitate the family members' insight into their functioning pattern, to develop self-knowledge about the impacts of codependency in their lives, and to develop strategies to change their behavior. Treating codependency is an opportunity for family members to reframe the relationship with the family member who abuses or depends on alcohol ingestion. When reviewing models of therapeutic approaches to codependency, Abadi et al. (2015) identify group interventions in which there is an exchange of experiences between those involved, family interventions that elucidate the interpersonal pattern of the codependent person and cognitive-behavioral interventions focused on the beliefs and automatic thoughts of their codependents. As clinical effects of these interventions, we have increased self-esteem and self-determination, reduced symptoms of anxiety and depression, reduced feelings of guilt and improved assertive, and improved communication skills.

Faced with the abusive or dependent use of alcohol by a family member, the other members structure defensive behaviors aimed at their emotional survival

In the scope of the fifth theoretical-methodological rationale, we identified the understanding that the unpredictability, impulsiveness, and/or aggressiveness of the person who abuses or is dependent on alcohol leads the other family members to structure rigid defensive behaviors that aim to guarantee their emotional survival. In this rationale, the use of the term "defense" stands out as a key concept that explains the movement of family members to avoid social situations that may publicly embarrass them in the face of the attitudes of the person who is intoxicated by the substance. To protect themselves from this exposure, many family members avoid social contact, restricting the circle of friends and social interactions. We also highlight the defensive communication of family members, which is expressed by superficiality in when talking about different subjects and vigilance towards the unpredictability of the environment, since these family members ultimately aim to preserve themselves (Carias & Granato, 2021; Haverfiel et al., 2015).

In view of the vast psychoanalytic literature, we rescued the contributions of Bleger (1963/1984) who defines defensive behaviors as emotional survival strategies developed from the field of interpersonal relationships. We assume that emotionally unstable and unpredictable environments establish environmental/social conditions for the development of rigid emotional defenses that are possibly present in different areas of the lives of family members of people who are abuse or depend on alcohol ingestion.

We highlight Johnson's intervention (1980/1992) as arising from this theoretical--methodological rationale. The author understands that the abusive or dependent use of alcohol can have a chronic, progressive, and fatal evolution, if not treated and controlled. In this care practice, it is assumed that people who consume alcohol are defending themselves from reality, denying the consumption of the substance, and projecting their emotional contents on family and friends. The professional, in turn, brings together family members to arrange a family meeting to confront the emotional defenses of the person who consumes alcohol. In this meeting, the therapist takes advantage of the family members' speech to sensitize the individual to seek multiprofessional care. In addition, Johnson (1980/1992) recommends that family members, particularly spouses, be cared for during the treatment of the alcoholic individual. According to the author, family members also develop rigid emotional defenses during daily coexistence with the unpredictability of alcohol consumption. Through family care, it is expected that family members can redefine the use of their defenses, improve communication skills and reflect on the feelings experienced.

Family members have the potential to redefine experiences and promote changes facilitated or compromised by the environment

The sixth and final theoretical-methodological rationale is based on the idea that family members are independent people capable of re-signifying their experiences and promoting changes as long as they are offered a facilitating interpersonal environment. In this perspective, the key concept of "potential for change" is highlighted, as there is an emphasis on the physical and emotional health of family members, despite the intense suffering experienced by this population. The therapeutic potential of the care practices that are included here is based on the meaningful intersubjective encounter capable of embracing the anguish of family members and offering a therapeutic experience of emotional support. In opposition to the rationales that focus on training or self-knowledge, in this one there is an emphasis on the therapeutic potential of the encounter, capable of raising new experiences that help family members to face problems. Here, the humanist and existential assumptions that recognize the potential of family members in the elaboration of conflicts, in solving problems and in the ability to integrate lived experiences are highlighted (Almeida & Basseto, 2020).

We emphasized two emblematic interventions: motivational interviewing and therapeutic groups. Motivational Interviewing (MI), which is often used to motivate people who are abusive or dependent on alcohol and other drugs to start their treatment, has been used to motivate family members to take care of their own emotional needs. According to Miller and Rollnick (1991/2013), MI is configured as a collaborative encounter in which professionals help individuals to elaborate the ambivalence regarding the necessary changes in their lifestyle. Instead of working with a view of pathology or emotional suffering, MI bets on the potential for change and psychological reorganization, denoting the influence of Carl Rogers in its theoretical framework (Figlie, 2017). There is a deep respect for the client's autonomy and a professional attitude of acceptance, partnership, and genuine interest. During MI, the professional asks open-ended questions, statements, reflections, summaries and offers information that helps the individual in the elaboration of ambivalence (Miller & Rollnick, 1991/2013).

In the study by Bortolon et al. (2017), MI is used to motivate family members of people with alcohol use disorders to change their lifestyle. Magill et al. (2010) identify that the use of MI for people with substance abuse or dependence in the presence of a family member or a significant other has therapeutic efficacy. Figlie (2017) argues about the importance of MI for family members of people with alcohol or drug use disorders. According to this author, during MI, family members can develop ambivalence regarding the change in lifestyle through a collaborative meeting that facilitates feelings of security and trust.

Therapeutic groups for family members aim to provide a safe and reliable environment as the main ingredient for psychic change. In these groups, the experiences of family members and mutual support for the elaboration of collective reflections are valued. The clinical objective is not to cure and/or treat any dysfunction of the family member, but to offer a space to listen, speak, and generate affection, capable of strengthening the family to live with the abusive use or alcohol dependence of a family member. People who participate in emotional support groups reported a decrease in symptoms and a positive impact in coping with adversity (Peres & Santos, 2018).

Reflections on theoretical-methodological rationales

The six theoretical-methodological rationales that we identified allow us to understand the establishment of therapeutic foci around which interventions aimed at the care of family

members of people with alcohol use disorders are grouped. Among these therapeutic foci, we highlight the reduction of stress, the insight into the roles and functions that make up the family dynamics, the expansion of the cultural and behavioral repertoire for qualified support to the family member in abusive or dependent on alcohol, the family's self-knowledge about their own pattern of codependent behavior, the insight into the defensive behaviors of family members, and the perception of their own potential in the re-signification of lived experiences and conflict resolution.

Given the complexity of the experience lived by family members, we believe that these different rationales do not operate in an excluding way, leading to overlaps and complementarity. For these reasons, it seems productive for professionals specialized in caring for family members of alcoholics get to know them and reflect on them, so that they can make an informed choice in planning their interventions, whether psychoprophylactic or psychotherapeutic. In addition, we emphasize that the preference or choice of a certain rationale and its consequent care interventions are due to multiple factors. Among them, we highlight the academic/professional training of the members of the mental health team, the culture of the country or region in which the service is located, the human and financial resources available for the implementation of the intended interventions and the demand itself that originates from the family members' suffering.

We assume that the first five rationales are supported by a medical conception of health and disease according to which it is necessary to identify the pathogenic element in order to alter, minimize, or eradicate it. For example, if stress is the source of family suffering, efforts are made to reduce it through meditation strategies or the 5-Step Method (Copello et al., 2010a). However, if codependency is the source of family suffering, efforts are made to reduce or eradicate the pattern of codependent behavior through interventions that favor the family member's insight (Abadi et al., 2015). We also observed that the first five rationales are based on a pedagogical concept of care, according to which the family member needs to be taught, corrected, or trained to deal with the dramatic situation they face. According to this perspective, family members would be unaware of the emotional phenomena that disturb them, whether in the case of stress and its psychosomatic consequences, the unconscious roles or functions in family dynamics, the necessary repertoires for living with a family member with alcohol use disorders, or the rigid emotional defenses that spread to the different areas of family members' lives.

In addition to its curative or pedagogical purposes, there seems to be a basic assumption that articulates the care practices that belong to the first five rationales, according to which the promotion of self-knowledge, whether through psychoeducation, training, or interpretations would be the key element for the change. In the sixth and final rationale, there is a focus on the potential of family members to elaborate the experiences lived from an embracing interpersonal environment that facilitates human development. This last perspective dialogues with the findings of Carias and Granato (2020) who observe that family members are so busy emotionally surviving that they sacrifice spontaneity and the possibility of a minimally authentic and, therefore, fulfilling life – since, in this perspective, the suffering of family members comes from the impossibility of a spontaneous and creative existential record (Aiello-Vaisberg, 2017).

Finally, we emphasize the fruitful discussion on intersectionalities (Crenshaw, 2002) for understanding the emotional suffering of family members and planning professional care tailored to their needs. In addition to the suffering that comes from stress, family dynamics, lack of repertoires, codependency, or rigid defenses, family members face financial difficulties, prejudice, and lack of specialized services in their basic needs, including emotional ones. Considering that the Brazilian reality is characterized by historical social inequality (Iamamoto, 2018), there is a high

possibility that family members of people with alcohol use disorders in Brazil will suffer the impacts of unemployment and economic difficulties, particularly in the current context of financial crisis and Covid-19 pandemic. The multiple vulnerabilities that affect the suffering of family members lead us to a multi and interdisciplinary action capable of offering an adequate service to the social and existential needs of this population.

Conclusion

The present study sought to reflect on the theoretical-methodological rationales that guide care practices for family members of people with alcohol use disorders. This reflection invites a re-reading of existing care practices and encourages the creation of new practices aimed at this audience, particularly those that are guided by the personal needs of family members.

It is indisputable that the emotional suffering of family members of people with alcohol use disorders is intense and that different interventions seek to alleviate it. We also know that each modality corresponds to a certain theoretical-methodological rationale as a guide for clinical reasoning, which explains the diversity of objectives, techniques, and clinical management. For example, when we contrast the CRAFT intervention with a practice that works with codependency, we observe some diverging orientations in the care of family members. While family members in CRAFT interventions receive training and learn to manage contingencies in order to reduce domestic violence and favor the sobriety of the person who consumes alcohol, in the treatment of codependency the family member is invited to understand their own codependent functioning and its impacts on their relationship with a family member who is abusive or dependent on alcohol. It is this divergence in care actions that suggests the need for reflection on the different rationales that guide the professional's therapeutic focus.

In this sense, we highlight the need for further studies in the field of caring for families of people with alcohol use disorders. Considering the Brazilian context, we emphasize the need for research on care practices for family members of people with alcohol use disorders in the services of the Brazilian Unified Health System and, particularly in CAPS-AD as a public service of reference for the Unified Health System. Studies that investigate the theoretical-methodological rationales used in CAPS-AD, as well as in other health services, would contribute to the qualification of existing professional practices.

Among the limitations of the present study, we highlight the impossibility of covering all care practices for family members of people with alcohol use disorders. Our exploratory search for literature reviews only found studies produced in the United States and the United Kingdom, already indicating a historical and cultural background of most interventions, although this was not our intention. For this reason, we are aware that the interpretation we have arrived at on theoretical-methodological rationales is necessarily limited to the criteria used to select the articles that make up the scope of this theoretical-reflective study in favor of methodological rigor.

To conclude, we recommend that new studies be conducted to explore the universe of care practices for family members of people with alcohol use disorders and the rationales that guide the clinical reasoning of these interventions, given the suffering and cost that the abusive or dependent use of alcohol generates in everyone involved and in all dimensions of living.

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Contributors

A.R. CARIAS was responsible for the conception and design of the research, analysis and interpretation of data. T.M.M. GRANATO was responsible for the conception and design of the research, analysis and interpretation of data, and reviewing and approving the final version of the article.