

A Qualitative Study on Family Members' Difficulties and Growth in the Context of Alcohol Use Disorder and Preventative Support Interventions in Family Meetings

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I. Background

The global recovery rate for substance use disorders, defined as sustained sobriety and abstinence, is 20-30%, indicating that 70-80% of individuals discontinue treatment¹⁾. Relapse is common; however, continued efforts toward sobriety remain essential. Traditional definitions of recovery, which classify individuals who discontinue treatment as “non-recovered,” may require reconsideration. While complete abstinence remains the goal, recent harm reduction approaches emphasize minimizing physical and psychological harm and reducing dependence severity²⁾.

In Japan, the abstinence rate after one to three years of treatment ranges from 7% to 30%³⁾, showing that eliminating alcohol-related harm is difficult. If the sole goal is to stop drinking, family members may struggle to find meaning in attending meetings when alcohol use persists, leading to reluctance or withdrawal from participation. Continued codependent behavior may exacerbate feelings of helplessness and lead to the discontinuation of support. Alcohol use disorder (AUD) affects individuals and family systems, which are considered “unwell” when dysfunction occurs⁴⁾.

Morita⁵⁾ reported that 41% of family members were “preoccupied with worrying about the person” and 38% were “overly caring for the person,” reflecting negative involvement and codependency. The systems approach advocates for interventions targeting the family unit rather than assigning blame. Intergenerational transmission of addiction-related pathology is well documented: sons of fathers with AUD are more likely to develop AUD, while daughters often partner with individuals with similar disorders¹⁾. Research and support for Adult Children of Alcoholics emerged because children raised by parents with AUD may often become alcoholics themselves later in life⁶⁾. Previous studies have indicated that children of alcoholic parents tend to start drinking at an earlier age and are more likely to develop AUD^{7), 8)}, as well as exhibiting self-destructive behavior, experiencing developmental issues⁹⁾, having reduced social skills¹⁾, and suffering from mental health problems such as depression and anxiety¹⁰⁾. They are also more likely to make suicide attempts¹¹⁾ and have low self-esteem¹²⁾.

A Japanese study by Morita¹³⁾ found that children with an alcoholic parent often unnecessarily conform to the parent's wishes or engage in “role reversal,” whereby the child cares for the parent. This is similar to the results of Kelley's¹⁴⁾ study. Luthar¹⁵⁾ compared parental factors and stated that maternal depression and paternal alcohol dependence were associated with children's psychopathology. Ohannessian¹⁶⁾ demonstrated that paternal depression and alcohol dependence were associated with adolescent alcohol dependence, whereas parental depression was linked to sequelae and depression in young adulthood.

Consequently, preventing the perpetuation of addiction within families is critical. Previous studies have

identified significant psychosocial difficulties among individuals with AUD, including hypersensitivity to evaluation, low self-approval, impaired empathy, difficulty perceiving loneliness, and cognitive distortions¹⁾. Kobayashi¹⁷⁾ further distinguishes between “obvious” difficulties, such as abuse and neglect, and “implicit” difficulties, which remain hidden beneath seemingly stable family and social lives. These implicit difficulties often stem from over-adjustment and unexpressed negative emotions, such as anxiety and frustration.

Before attending family meetings, family members experience anxiety, pessimism, depression, and sleep deprivation, suggesting that they may be more exhausted than individuals with AUD¹⁸⁾. Consequently, we explored the life experiences of families of AUD patients to clarify how family support interventions can alleviate these difficulties and promote recovery within the family system.

This study focused on family support groups¹⁹⁾, which provides a space for families who are not medically eligible for treatment to openly discuss their feelings, share strategies for dealing with individuals with AUDs, and mutually support each other. In expert-moderated family support groups, those affected feel that they are seen as powerless, unable to stop alcohol addiction, and as codependents. Therefore, we asked families to share what kind of connection they most desire, for their own sake. The findings are expected to inform the development of support strategies.

II. Purpose

This study aims to explore the lived experiences of family members of individuals with AUD and to clarify how family support interventions can alleviate these difficulties and promote recovery within the family system.

III. Methods

3.1 Design and Participants

A qualitative descriptive design was employed. Eleven family members of individuals with AUD were recruited via snowball sampling from family support groups. The inclusion criteria were (a) having a family member diagnosed with AUD, (b) age ≥ 18 years, (c) any gender, (d) experience with patient support groups and having participated in a family-run support group for at least six months, and (e) providing written informed consent.

3.2 Data Collection

Semi-structured interviews were conducted between September 2023 and November 2025, either face-to-face or via web conferencing. Participants who had taken part in family self-help groups (SHGs) for over a year were asked about “stories of difficulties experienced as a family,” “benefits of family-run support groups,” and “advantages over support groups run by hospitals or AA.” Interviews lasted 60-90 minutes. Audio recordings were transcribed verbatim, and field notes documented non-verbal cues.

3.3 Data Analysis

Qualitative inductive analysis was conducted. Codes were derived from participants' own words, grouped into subcategories, and abstracted into categories. Credibility was ensured through member checking with four participants and supervision by a psychiatric nurse with a doctoral degree.

3.4 Ethical Considerations

The aim of the study, research methods, and assurances of privacy and anonymity were explained to participants both orally and in writing. Informed consent was obtained through signed consent forms.

Participants were assured that they could withdraw from the study at any time without penalty. Interview locations, schedules, and online settings were arranged according to participants' preferences. This study was conducted in accordance with the ethical guidelines of The Ethics Committee for Human Life Science and Medical Research of the Public University Corporation at Yokohama City University (F23080032).

IV. Results

4.1 Overview of Study Participants

The duration of treatment for family members with AUD ranged from 2 to 35 years. Study participants consisted of eleven individuals (Three men, eight women), with an average age of 59.8 years. Regarding their relationships with individuals with AUD, eight were spouses, two were parents, and one was a child. An overview of the study participants is presented in Table 1. Because the interviews were conducted during the post-COVID-19 period, six were conducted in person and five via Zoom. Each interview lasted between 49 and 103 minutes, for a total duration of 822 minutes and an average of 75 minutes.

Table 1. Attributes of study participants

ID	Age	Gender	SHG history	Blood relationship	Participation in family meetings	Interview length (min)	Interview method
A	65	Female	38 years	Spouse	Member of AA Participating as a couple	103	Face-to-face
B	78	Female	28 years	Spouse	Former member of AA Family members participate long after the alcohol abuser has died.	80	Face-to-face
C	68	Female	25 years	Spouse	Former member of AA Family members participate long after the alcohol abuser has died.	77	Online
D	65	Female	13 years	Spouse	Member of AA Participating as a couple	85	Face-to-face
E	62	Male	10 years	Spouse	Former member of AA Family members participate long after the alcohol abuser has died.	62	Face-to-face
F	59	Female	6 months + 7 years	Spouse	Member of AA Participating as a couple	75	Online
G	40	Female	4 years	Mother	Family members participate long after the alcohol abuser has died.	61	Face-to-face
H	52	Female	3 years	Spouse	Member of AA Couple attending separately	65	Online
I	75	Female	3 years	Son	AA suspended for alcohol abusers Only family members attend the SHG.	90	Online
J	39	Male	2.5 years	Father	Only family members attend the SHG.	49	Online
K	55	Male	17 years	Spouse	Former member of AA Family members participate long after the alcohol abuser has died.	75	Face-to-face

4.2 Experiences of Family Members of Individuals with Alcohol Use Disorder

4.2.1 Desire to Address Alcohol Abuse

The following statements were made regarding AUD: “strong impatience to do something about AUD”; “need to reflect on oneself and be prepared for recovery”; “lack of friends to talk to, accept, and help each other”; “lack of peace of mind and difficulty finding a place to stay”; and “difficulty in maintaining and sustaining a family association with the desire to make contributions.” Family members initially joined family meetings with the goal of helping loved ones cease drinking or out of obligation, as they were in a

codependent relationship with the person with AUD. They demonstrated patience and eagerness to learn how they could help the person with AUD.

4.2.2 Self-Reflection and Readiness for Recovery

At first, family members attended meetings without a clear intention to participate actively. However, despite differing thoughts and opinions, they viewed every moment as a learning opportunity and gained wisdom from shared experiences. Examples of participants' statements include: "Even for my family, we are powerless against alcohol, and even if I wanted to help them, I must accept that I cannot help them" (C-5) and "I don't know what will happen, but I am ready to accept that too" (D-23). These statements reflect their readiness to accept suffering and face AUD (G-12).

After learning about the importance of family meetings, one of the three pillars of recovery—through an educational program, participants realized that while they could attend meetings alone, it was crucial for family members to participate even if the person with AUD did not (I-27). Their purpose for attending evolved from supporting the person with AUD to recognizing "the need for family members to be connected to the family association for their own sake" (E-55). Some participants reported personal growth. For example, "I have realized changes in myself by attending family meetings" (E-34), "My way of thinking and the points I learn have changed as I am exposed to the same content repeatedly," and "I have developed a greater capacity to listen to others calmly" (E-47). Others acknowledged that continued participation helped prevent a return to previous codependent behaviors: "If I stop coming to family meetings, I will return to my old ways and become codependent again. Attending family meetings made me realize that the problem was not alcohol, but my own behavior" (J-42).

Another participant stated: "I have realized that this is a place to learn, not only about alcohol but also about how to live" (J-43). Family members recognized that "even if the person with AUD is sober, the family members themselves have not recovered" (G-19). Thus, they engaged in self-reflection and aimed to support recovery for both themselves and their loved ones.

4.3 Difficulties in the Lives of Family Members

Based on the findings, we extracted an item pool of difficulties participants experienced in their lives. Table 2 compares item pools for individuals with AUD and their family members. While the items for individuals with AUD included "I want to end my life," this was absent among family members. Other items included awareness of one's cognitive characteristics and maintaining appropriate distance from others; finding support amid disappointment, helplessness, and resignation; and acknowledging the difficulty of living yet persevering.

Table 2. The difficulties faced by families of alcoholics and the significance of participating in family support groups run by families.

	Narrative Code
Lessons learned from family	"Even for my family, we are powerless against alcohol, and even if I wanted to help them, I must accept that I cannot help them" (C-5) "I don't know what will happen, but I am ready to accept that too" (D-23) "I have realized changes in myself by attending family meetings" (E-34) "My way of thinking and the points I learn have changed as I am exposed to the same content repeatedly" (E-47-1) "I have developed a greater capacity to listen to others calmly" (E-47-2) "The need for family members to be connected to the family association for their own sake" (E-55)
The importance of meetings	"My wife repeatedly relapsed into drinking, moving further away from recovery, and I felt helpless. But then I heard the story of another alcoholic who had recovered by staying sober, and it gave me hope" (E-42) (K-7) "I continue to participate in these events to deepen my understanding of my own struggles in life, and also to understand the illness of alcoholism" (C-48) "These statements reflect their readiness to accept suffering and face AUD" (G-12) "Even if the person with AUD is sober, the family members themselves have not recovered" (G-19) "Continued participation helped prevent a return to previous codependent behaviors" (A-5) (B-22) (D-41) (H-24) (K-28)
The ripple effect of family associations	"I have realized that this is a place to learn, not only about alcohol but also about how to live" (J-43) "I think there is no other place as appealing as SHG. I understood what was good about SHG and continued to go there for a long time" (F-56) "It is good to have lots of people who make others think, 'I want to be like this person.' You can only find those people by participating in family support groups" (F-60) "(An older family member of someone who suffered from alcohol-related illness) has been exceedingly kind to me. There are people who care about me and look out for me. That is something to be grateful for" (F-63) "Through an educational program, participants realized that while they could attend meetings alone, it was crucial for family members to participate even if the person with AUD did not" (I-27). "If I stop coming to family meetings, I will return to my old ways and become codependent again. Attending family meetings made me realize that the problem was not alcohol, but my own behavior" (J-42)

Table 3. Comparison of item pools between alcoholics and their families.

Alcohol use disorders	Family members of alcoholics
Aligning with the expectations of others	Aligning with the expectations of others
To be in tune with others' expectations	Always accompany my husband to AA meetings
Wanting to be nice	I want to be a good mother.
Worried about being seen	Acting like a good wife
	Taking over tea duty, even though I do not really want to
	I take my children to AA meetings even though I want them to go to bed early.
Seeking perfection	Seeking perfection
Can only think in terms of 0 or 100	Black and white thinking
Thinks in black and white daily	Zero or one hundred
The slightest failure makes me so anxious that I try to throw away what I am trying to do.	No, he is not good enough... Criticism of others without thinking.
I can overlook other people's failures but cannot forgive my own.	It must be this way.
	Climbing to the idea that it is right
	Very earnest

Numbing the senses and emotions	Numbing the senses and emotions
Try to drown my feelings	Confused to the point that they do not know how to organize and deal with things. Thinking only about others while the family itself is in shambles Ever since I was a small child, I have always thought about others and put them first in my life Unable to focus on my own suffering I cannot take care of myself because I am constantly cleaning up after myself.
I cannot accept myself as I am.	I cannot accept myself as I am.
Always chasing after the ideal Unable to see myself in the past I am ashamed of myself.	I must be this way or that way. I cannot look at and think about my past. I have problems with adult children and adult children of alcoholics. I have relapses, slips, hospitalizations, failures, and successes.
I cannot trust anyone.	I cannot trust anyone.
I have never had anyone I can call my best friend. I believe that people will always betray me.	I ended up in despair and devastated by the words of my older family members The preaching, harassment, and methods are dirty. Too many people are too selfish Feeling shaken by the fear of drinking again I feel disrespected and evaluated.
I cannot speak my mind.	I cannot speak my mind.
I do not have confidence in my own words and actions. From the beginning, I believed that other people would not listen to me.	I thought I should not show my family's sadness in front of him. Not focusing on myself There are family members who are too absorbed in the situation. I want to be a good wife and parent.
Wants to disappear.	Wants to disappear.
I have wanted to die. I have self-harmed.	Not applicable
I want to be confident in my abilities.	I want to be confident in my abilities.
I have thought that I am better than others at work or study. My abilities are not recognized by others.	Ability to relate to people who say things I do not like Skills to relate in a non-hurtful way Ability to enjoy life with alcohol abusers and their friends
Ability to see things from my perspective	Ability to see things from my perspective
I have been told I am self-centered I have felt that I do not understand other people's feelings. I am not good at reading the air I take pleasure in exposing others' mistakes through good argumentation.	Alcohol-dependent family care starts with the couple. Awareness of the tendency to take the perspective of the family and the victim Choosing the right people and places to talk about experiences to avoid being hurt Family meetings are a place where you can present yourself without putting on air and graces. Spend time with people who know what I am going through

Background of the difficulties of life for family members of alcohol abusers	Background of the difficulties of life for family members of alcohol abusers
Not applicable	Anger at unreasonable behavior, sadness, frustration, exhaustion Escaping from the hellish original family Why? Conflicted hesitation without answers Love, hate, and conflicting feelings toward the alcohol addict Burden of multiple care for family members (caregivers and children) who need advocacy Anxiety that follows them everywhere
What I have learned from the difficult experiences of family members of alcoholics	What I have learned from the difficult experiences of family members of alcoholics
Not applicable	Awareness of one's own cognitive characteristics and appropriate distance from others Finding support during disappointment, helplessness, and resignation. Acknowledging the difficulty of living and persevering to stay there.

V. Discussion

5.1 The Reality of Families of Individuals with AUD

Before attending family meetings, family members experienced anxiety, pessimism, depression, and sleep deprivation, suggesting that they may be more exhausted than individuals with AUD¹⁸⁾. Our findings indicate that these members participated in family meetings out of an ardent desire to mitigate alcohol-related harm—to stop drinking and eventually eliminate its consequences. Morita⁵⁾ reported that 41% of family members were “preoccupied with worrying about the person” and 38% were “overly caring for the person,” reflecting negative involvement and codependency.

5.2 The Family Must Recognize Co-dependent Problematic Behaviors

Regarding the “attitude of self-reflection and readiness for recovery,” continued participation was driven by an ardent desire to address alcohol-related harm. Family members often felt powerless as harm persisted despite their efforts, experiencing a form of “bottoming out” like individuals with AUD²⁰⁾. They were compelled to accept that they could not help, even if they wanted to. Just like individuals with AUD, family members recognized that their codependent behaviors were problematic, leading them to relinquish control and prepare to accept pain. Ochi and Nojima²¹⁾ identified “confronting the alcohol problem” as a turning point for families and described “readiness to take on the alcohol problem” as part of a realistic perspective. Subsequently, the purpose of attending meetings shifted from making the person quit drinking to living their own lives without assuming responsibility for the individual's actions, which influenced continued participation.

These findings suggest that family associations that can support the members during their recovery process must be fostered. Therefore, in the process of recovering from AUD, a family's self-esteem may increase by first developing a family SHG. This may demonstrate the possibility of overcoming the difficulties of living with individuals with AUD.

VI. Implications and Limitations

Three cognitive changes were considered important. First, when families understand addiction and

become more knowledgeable about the disease, the chances of recovery increase²²⁾. Second, as family members gain a better understanding of the behavior and emotions of the person with AUD, they can increase their empathy and support²¹⁾. Third, when family members deepen their self-understanding and view themselves positively, recovery progresses²⁰⁾. Through these cognitive changes, families can be freed from AUDs and can restore their relationship with the person with AUD and live independently. Ota et al.²³⁾ and Al-Anon Family Group²⁴⁾ suggest that for families to recover, “restoring the family’s own independence” is necessary. Through these cognitive changes, families find meaning in their efforts to recover and rebuild relationships, despite their suffering.

This study has several limitations. First, participants were recruited through networks related to the researchers, which may have introduced selection bias and limited the diversity of perspectives. Second, participants were individuals who had continued attending family support groups, potentially excluding those who discontinued participation owing to negative experiences. These factors may have resulted in an overrepresentation of positive experiences and should be considered when interpreting the findings. Future research should examine larger sample groups, compare family associations that have conducted voluntary activities such as SHGs and those run by hospitals and governments, and compare families of individuals with AUD in urban and rural areas.

VII. Conclusions

Family members of individuals with AUD experience several difficulties, including an ardent desire to resolve alcohol-related problems, the need for self-reflection, and challenges in maintaining supportive relationships. Participation in family support groups facilitated changes in awareness and perspectives, enabling family members to focus on their own recovery and well-being. These findings highlight the importance of family-focused support interventions in addressing the needs of family members affected by AUD.

Conflicts of Interest

The authors declare no conflicts of interest associated with this manuscript.

Author Contributions

OH.YN. made substantial contributions to the conception and design of the study, as well as to the acquisition, analysis, and interpretation of data. KT.YK. and IM.KS. drafted the manuscript. KT.YN. critically revised the manuscript for important intellectual content. All authors approved the final manuscript.

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アルコール使用症家族会における予防的支援： 家族の困難と成長に関する質的研究

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要旨

本研究目的は、アルコール使用症（AUD）患者の家族が経験する困難を明らかにし、回復促進における家族支援の有効性を検証することである。

定期的に家族会に出席する家族11名を対象に半構造化面接を実施した。データは逐語録に基づく質的帰納的分析法を用いて分析した。

結果、家族が直面する困難は、アルコール関連の害に対処する強い切迫感、自己内省と回復への準備の必要性、相互受容のための支援関係の欠如、心の平穏の欠如と安全な場所を見つけることの難しさ、貢献したいという意欲を持ちながらも家族とのつながりを維持することの難しさが示された。

AUD患者とその家族は、低い自尊心、他者への信頼の欠如、本音の表現の難しさといった共通の特徴を有していた。

家族が主催する家族会は、内省と個人的な成長のための場となり、家族会に参加することで困難感を軽減し、自らを取り戻す場となりえていた。家族による主体的な家族自助グループ（SHG）が回復を促進し、家族の自尊心を高める上で重要である。家族関係の再構築と維持は、AUD患者との共存における課題を克服する上で役立つ可能性が見出された。

キーワード：アルコール使用症、家族支援、共依存、回復、家族自助グループ