

# Summary of Best Evidence for Psychosocial Interventions in Adults with Alcohol Use Disorder: An Evidence-Based Review

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**Background:** Alcohol Use Disorder (AUD) is the most common of all substance use disorders worldwide. Psychosocial interventions have been established as a core component of AUD management. However, current research evidence on psychosocial interventions for AUD is fragmented and lacks systematic, standardized protocols in this population, which constrains its standardized implementation in clinical practice.

**Purpose:** To retrieve, evaluate, and summarize the evidence on psychosocial interventions for adults with AUD, aiming to inform clinical decision-making and support healthcare professionals in tailoring personalized psychosocial interventions for patients.

**Patients and Methods:** A systematic search was performed across 22 databases and websites for clinical decisions, recommended practices, guidelines, evidence summaries, expert consensus, systematic reviews, and randomized controlled trials regarding psychosocial interventions for adults with AUD. The search period extended from the inception of the database to February 2025. Two trained researchers independently evaluated the literature's quality and systematically extracted and summarized the available evidence.

**Results:** A total of 20 studies were included, consisting of six clinical decisions, four guidelines, six systematic reviews, and four randomized controlled trials. Synthesis of evidence from these studies identified twenty-seven pieces of evidence, which were further categorized into eight dimensions: pre-intervention assessment, intervention goals, scope of application, multidisciplinary team involvement, intervention timing, intervention frequency, monitoring frequency and indicators, and precautions. These dimensions represent the primary areas of evidence derived from the included studies.

**Conclusion:** This study systematically synthesized the most robust evidence for psychosocial interventions in adults with AUD. The evidence confirmed that implementing psychosocial interventions based on considering hospital resources and patient preferences can effectively reduce alcohol consumption, depression, anxiety, and improve long-term outcomes in adults with AUD. This evidence-based framework established a practical and scientific basis for standardized psychosocial intervention delivery in clinical settings.

**Keywords:** alcohol use disorder, adults, psychosocial interventions, evidence summary, evidence-based nursing

## Introduction

Alcohol Use Disorder (AUD) is defined as a problematic pattern of alcohol use leading to clinically significant impairment or distress.<sup>1</sup> It is the most common of all substance use disorders worldwide, with a prevalence ranging from 4% to 11%.<sup>2,3</sup> The prevalence rates in Liaoning Province, Tianjin Municipality, and Ningxia Hui Autonomous Region of China were 4.2%, 8.5%, and 7.5%, respectively, with most cases occurring among adults.<sup>4-6</sup>

AUD not only severely impacts individuals' physical health but also significantly compromises patients' quality of life and social well-being. Research indicates that 62.9% of individuals with AUD exhibit symptoms of insomnia and prolonged sleep latency, while the prevalence of insomnia in the general population is approximately 28%. The prevalence of insomnia among the AUD population is markedly greater than that observed in the general population.<sup>7,8</sup> In the general population, those with shorter sleep duration (6 hours or less) are more likely to be diagnosed with anxiety disorders compared to those with longer sleep durations,<sup>9</sup> Grant et al identified a positive

correlation between anxiety symptoms and the severity of alcohol dependence, with anxiety symptoms recognized as a significant risk factor for relapse in AUD.<sup>10</sup> Emerging evidence reveals that AUD-comorbid depression is driven by dysregulation of the Menin-GAT1 pathway in amygdala GABAergic interneurons, creating a vicious cycle where alcohol exacerbates emotional distress.<sup>11</sup> Moreover, The evidence supports that AUD is associated with increased risk for cognitive impairments, dementia, or Alzheimer's disease.<sup>12</sup> Mechanistically, chronic alcohol exposure disrupts oral microbiota, which exacerbates neuroinflammation and cognitive decline.<sup>13</sup> The consequences substantially affect patients' quality of life and social well-being, while also imposing considerable medical costs on society.<sup>3,14</sup>

Current AUD interventions encompass pharmacological and psychosocial therapies.<sup>15</sup> Pharmacological interventions frequently produce inconsistent results and pose potential side effects. AUD arises mainly from the interplay of psychological needs and social stressors, which cannot be adequately addressed by pharmacological methods alone.<sup>16</sup> Neurobiological studies further indicate that chronic alcohol exposure induces maladaptive plasticity in cerebellar circuits, driving withdrawal symptoms and relapse susceptibility.<sup>17</sup> Psychosocial interventions promote alcohol cessation or reduction by altering patients' cognitive patterns, behavioral habits, and social contexts. These interventions facilitate the development of long-term sobriety strategies and improve self-control, thereby positioning psychosocial interventions as fundamental to managing AUD.<sup>18</sup> Despite the growing emphasis by healthcare professionals on psychosocial interventions for adults with AUD, the current research evidence is fragmented and lacks systematic, standardized protocols for psychosocial interventions in this population.

This study systematically reviewed domestic and international literature on psychosocial interventions for adults with AUD. Given the multifaceted nature of AUD and its significant impact on individuals and society, we aimed to identify the most effective psychosocial interventions by synthesizing evidence from a wide range of sources. Our evidence synthesis identified twenty-seven pieces of evidence, which were further categorized into eight dimensions. These dimensions represent the primary areas of evidence derived from the included studies and were selected to provide a comprehensive framework for developing a scientific and rational psychosocial intervention protocol. The research was registered with the Fudan University Center for Evidence-Based Nursing (Registration No. ES20257161).

## Materials and Methods

### Establishment of the Problem

The PIPOST model,<sup>19</sup> established by the Fudan University Center for Evidence-Based Nursing, was utilized to develop evidence-based nursing questions and inclusion criteria. P (Population): The target population was AUD patients aged 18–65 years; I (Intervention): The intervention was psychosocial interventions; P (Professional): The professionals involved were clinical or community healthcare providers; O (Outcome): Outcomes included the percentage of relapse days, relapse rate, relapse days, patient engagement, alcohol consumption, Hamilton Anxiety Scale (HAMA), Hamilton Depression Scale (HAMD), Alcohol Dependence Scale (ADS), longest abstinence period, quality of life, and biomarkers; S (Setting): The evidence application settings included outpatient clinics, inpatient wards, and community hospitals; T (Type of evidence): The types of evidence encompass clinical decision-making tools, best practices, guidelines, evidence summaries, systematic reviews, expert consensus statements, and randomized controlled trials (RCTs).

Exclusion criteria were established to refine the evidence pool: 1) Incomplete information or inaccessible full-text articles; 2) Duplicate publications; 3) Literature not in Chinese or English; 4) Superseded publications; 5) Studies with low methodological quality; 6) Non-peer-reviewed or non-research materials: including abstracts, conference proceedings, grey literature, editorials, and narrative reviews; 7) Study designs inconsistent with inclusion criteria: observational studies, quasi-experimental studies, and case reports.

### Search Strategy

A comprehensive search was conducted following the 6S pyramid through various databases and websites as follows: 1) Clinical decision-making systems: BMJ Best Practice, UpToDate; 2) Guideline repositories and professional association websites: World Health Organization (WHO), Guidelines International Network (GIN), National Guideline Clearinghouse (NGC), Registered Nurses Association of Ontario (RNAO), National Institute for Health and Care

Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), New Zealand Guidelines Group (NZGG), Yimaitong, National Institute on Alcohol Abuse and Alcoholism (NIAAA), American Psychiatric Association (APA), China National Knowledge Infrastructure (CNKI), Chinese Nursing Association; 3) Evidence-based databases: Joanna Briggs Institute (JBI) Evidence-Based Practice Database, Cochrane Library; 4) Comprehensive databases: PubMed, Web of Science, CINAHL, CNKI, Wanfang Database, VIP Database, Chinese Biomedical Literature Database (CBM). English keywords used for the search were "alcohol use disorder/alcohol abuse/alcohol dependence/Alcoholism/Alcohol Addiction/Chronic Alcoholic Intoxication/Ethanol Abuse" and "Psychosocial Intervention/Psychological Intervention". The following is an example of the search mode in PubMed: (((((((alcoholism[MeSH Terms]) OR (alcohol use disorder[Title/Abstract])) OR (alcohol abuse[Title/Abstract])) OR (alcohol dependence[Title/Abstract])) OR (Alcohol Addiction[Title/Abstract])) OR (Chronic Alcoholic Intoxication[Title/Abstract])) OR (Ethanol Abuse[Title/Abstract])) AND ((Psychosocial Intervention[MeSH Terms]) OR (Psychological Intervention[Title/Abstract])). The search strategy for each database with advanced search functionality is provided in [Table S1](#).

We searched for evidence from the databases' inception up to February 2025.

## Rationale for Joint Inclusion of RCTs and Systematic Reviews

This review jointly included RCTs and systematic reviews to ensure a comprehensive, unbiased synthesis of evidence on psychosocial interventions for AUD. The rationale rests on three methodological pillars:<sup>20</sup> 1) Complementary strengths: Systematic reviews aggregate multiple primary studies, offering high-level estimates of effect and highlighting knowledge gaps. RCTs, by contrast, supply granular detail on intervention fidelity, frequency, and context. That essential information is often lost in pooled analyses; 2) Alignment with the study's purpose: This review aims to summarize "best evidence" to guide personalized clinical decision-making. Systematic reviews ensure breadth by integrating findings across multiple studies, avoiding over-reliance on single RCT results. RCTs, meanwhile, provide depth by validating the effectiveness of specific interventions under controlled conditions, ensuring that recommended protocols are rooted in rigorous empirical evidence; 3) Methodological rigor in evidence synthesis: During evidence extraction, we established clear prioritization criteria (detailed in "Evidence Extraction, Summary, and Evaluation") to resolve potential conflicts between systematic reviews and RCTs. This approach balances the strength of systematic reviews with the specificity of RCTs, minimizing bias and enhancing the reliability of the synthesized evidence.

## Literature Quality Evaluation

Two evaluators conducted independent screenings of the retrieved articles.

- 1) The guidelines were assessed using the Appraisal of Guidelines for Research and Evaluation II (AGREE II).<sup>21</sup> AGREE II comprises six domains and twenty-three items. Items are evaluated using a 1–7 scale, where 1 represents "strongly disagree", and 7 represents "strongly agree". The standardized percentage for each domain is determined using the formula:  $(\text{Total score from all evaluators} - \text{Minimum possible score}) / (\text{Maximum possible score} - \text{Minimum possible score}) \times 100\%$ . The minimum possible score is calculated as 1 multiplied by the number of items and the number of evaluators, while the maximum possible score is calculated as 7 multiplied by the number of items and the number of evaluators. A higher standardized percentage reflects improved quality of guidelines. Guidelines are classified into three tiers: Grade A: All six domains with standardized percentages exceeding 60%; Grade B: Three or more domains with standardized percentages of 30% or greater; Grade C: More than three domains with standardized percentages below 30%.
- 2) The Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Systematic Reviews (2016 edition) was utilized to evaluate systematic reviews independently.<sup>22</sup> The Cochrane Risk of Bias Tool evaluated the methodological quality of the included RCTs,<sup>23</sup> with details provided in [Table S2](#). Quality evaluations were linked to their origins for optimal practices, clinical decisions, expert consensus statements, and evidence summaries, with criteria customized for each study design.

## Evidence Extraction, Summary, and Evaluation

Two researchers (Lu Yan and Wenxi Sun) proficient in evidence-based care conducted an extraction of evidence. In the event of disagreements, a third researcher (Li-Ping Xia) was consulted. In conflicting evidence from various sources, precedence was assigned to the most recently published authoritative literature, high-quality evidence, and evidence-based principles. For instance, a comparison reveals that the recommendation to sustain contingency management for 8–16 weeks until patients reach long-term abstinence (from a 2024 clinical decision) contrasts with the suggestion to maintain it for 3 weeks followed by 1 month of follow-up (from a 2020 randomized controlled trial evaluated using the Cochrane Risk of Bias tool, which rated three items as “unclear”). The former recommendation was ultimately adopted. In a comparison of recommendations, “motivational interviewing should be conducted 1–4 times, with each session lasting 15–45 minutes” (from a 2024 clinical decision) was prioritized over “motivational interviewing should be conducted 1–4 times, with each session lasting 5–30 minutes” (from a 2021 guideline).

The JBI evidence-based healthcare center’s evidence grading system<sup>24</sup> was utilized for quality evaluation. The assessment was performed according to the evidence levels of the articles included.

## Results

### Results of the Article Screening

A total of 1124 articles were identified, and after removing duplicates and reviewing titles, abstracts, and full texts, 20 articles were finally included. These included six clinical decisions,<sup>18,25–29</sup> four guidelines,<sup>30–33</sup> six systematic reviews,<sup>34–39</sup> and four RCTs.<sup>40–43</sup> The literature screening process is illustrated in [Figure 1](#). The basic characteristics of the included studies are summarized in [Table 1](#), which details key information such as author/s, year of publication/update, article source, nature of the article, the topic of the article, and results of each included study.

### Quality Evaluation of Guidelines

This study included four guideline,<sup>30–33</sup> and the results of the guideline quality assessment are presented in [Table 2](#). Three guidelines<sup>31–33</sup> achieved standardized percentage scores over 60% in all domains, meeting the Grade A criteria, while one guideline<sup>30</sup> scored over 60% in five domains with a 54.17% score in the applicability domain, meeting the Grade B criteria, all of which were included.

### Quality Evaluation of Systematic Reviews

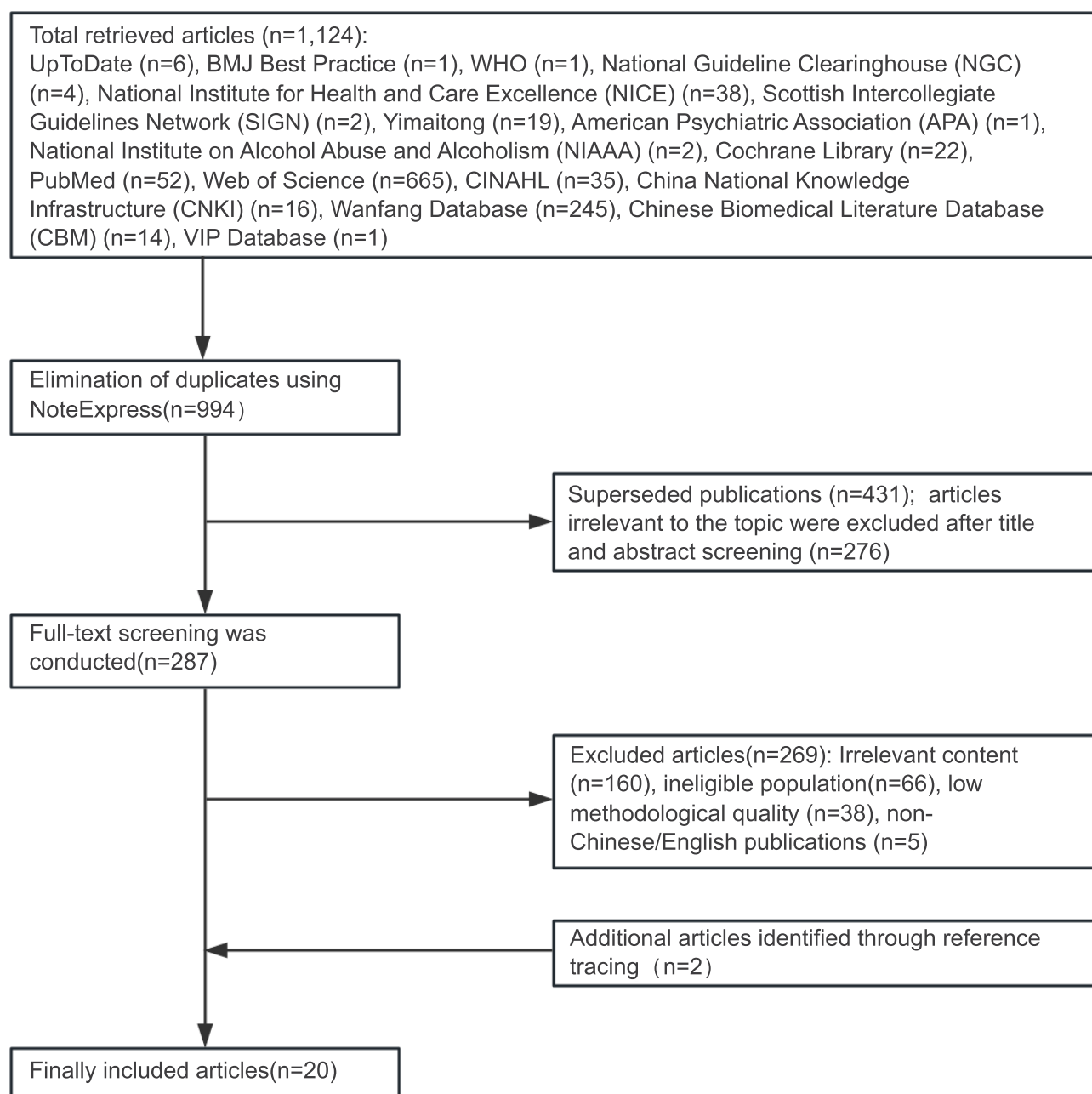
This study included six systematic reviews,<sup>34–39</sup> and the evaluation results are shown in [Table 3](#). Kelly et al’s study<sup>38</sup> received “yes” ratings for all items. Hemrage et al’s study<sup>34</sup> received “yes” for all items except item 9, which was rated “unclear.” Byrne et al’s study<sup>35</sup> received “no” for item 4 and “unclear” for items 7 and 9, with all other items rated “yes.” Ghosh et al’s study<sup>36</sup> received “no” for item 4 and “yes” for all remaining items. Zhang et al and Zhao et al’s studies<sup>37,39</sup> received “no” for items 3 and 4, with “yes” ratings for all other items. Overall methodological quality was high, thus all studies were included.

### Quality Evaluation of RCTs

This study included four RCTs,<sup>40–43</sup> and the evaluation results are shown in [Table 4](#). Conner et al’s study<sup>41</sup> was rated “Low risk” for all items except items 5, 6, and 7, which were rated “Unclear.” McKay et al’s study<sup>42</sup> received “Unclear” ratings for items 2 and 6, with all other items rated “Low risk.” Johansson et al’s study<sup>43</sup> had an “Unclear” rating for item 6 and “Low risk” for all remaining items. Hammarberg et al’s study<sup>40</sup> was rated “Unclear” for item 7 and “Low risk” for all other items. Overall methodological quality was high; therefore, all studies were included.

## Evidence Summary

After extracting and integrating evidence, we organized 27 pieces of information into eight dimensions: pre-intervention assessment, intervention goals, scope of application, multidisciplinary team, intervention timing, intervention frequency, monitoring frequency and indicators, and precautions. The findings are presented in [Table 5](#).



**Figure 1** Flow chart of literature screening for psychosocial interventions in adults with AUD, detailing the number of articles retrieved, duplicates removed, and exclusions at each stage, culminating in the final inclusion of 20 studies.

## Discussion

### The Formation Process of the Best Evidence in This Study Is Characterized by Scientific Rigor and Methodological Thoroughness

This study summarizes the most robust evidence regarding psychosocial interventions for adults with AUD, grounded in evidence-based nursing practices. Utilizing the 6S model, we systematically searched domestic and international databases and websites for literature on psychosocial interventions for adult AUD from the databases' inception. A total of 20 articles were included following a thorough screening process. All literature underwent evaluation through research tools, demonstrating a high overall quality. It should be noted that all this literature was published or updated within the past five years. Six clinical decision<sup>18,25-29</sup> primarily addressed the types and implementation of psychosocial interventions for

**Table 1** Characteristics of Included Studies

Author/s	Year of Publication/ Update	Article Source	Nature of the Article	The Topic of the Article	Results
Saxon et al <sup>25</sup>	2024	UpToDate	Clinical decision	Psychosocial Treatment for AUD	Reduced alcohol consumption and promote abstinence
Holt et al <sup>26</sup>	2024	UpToDate	Clinical decision	Overview of Treatment for AUD	Reduced heavy drinking and increased the number of abstinent days
Ingersoll et al <sup>28</sup>	2024	UpToDate	Clinical decision	Motivational Interviewing for Substance Use Disorders	Reduced the frequency of drinking and the number of drinking days
McKay et al <sup>29</sup>	2024	UpToDate	Clinical decision	Psychosocial Treatment for Substance Use Disorders	Reduced the number of drinking days, the percentage of heavy drinking days, and the amount of alcohol consumed per day, while increasing the percentage of abstinent days
Stitzer et al <sup>27</sup>	2024	UpToDate	Clinical decision	Training, Implementation, and Effectiveness of Contingency Management for Substance Use Disorders	Reduced alcohol use
Elisabeth et al <sup>18</sup>	2024	BMJ Best Practice	Clinical decision	Overview of Management for AUD	Increased proportion completely abstinent, while reducing drinks per drinking day
Evan et al <sup>31</sup>	2023	Yimaitong	Guideline	Clinical Management of High-Risk Drinking and AUD	Made small to moderate treatment effects on various alcohol outcomes
NICE <sup>30</sup>	2023	NICE	Guideline	AUD: Diagnosis and Management	Reduced the relapse rate
Katherine et al <sup>32</sup>	2021	PubMed	Guideline	Reducing Risks Associated with Problematic Alcohol Use	Reduced health risks from drinking alcohol
Haber et al <sup>33</sup>	2021	PubMed	Guideline	Overview of Treatment for Problematic Alcohol Use	Reduced health risks from drinking alcohol
Kelly et al <sup>38</sup>	2020	Cochrane Library	Systematic review	Alcoholics Anonymous and Other 12-step Programs for AUD	Produced higher rates of continuous abstinence, increased the percentage of days of abstinence and increased participation, while reducing the intensity of drinking
Hemrage et al <sup>34</sup>	2023	CINAHL	Systematic review	Effectiveness of Psychosocial Interventions in Reducing Alcohol Use	Reduced alcohol consumption, frequency of drinking, and number of drinking days
Byrne et al <sup>35</sup>	2024	CINAHL	Systematic review	Mindfulness and Acceptance Commitment Therapy for Problematic Drinking and Disorders	Reduced drinking, depression, anxiety, and improved quality of life
Ghosh et al <sup>36</sup>	2024	PubMed	Systematic review	Effectiveness of Psychosocial Interventions for AUD	Improved abstinence
Zhang et al <sup>37</sup>	2022	PubMed	Systematic review	Impact of Psychosocial Interventions on Abstinence in Patients with AUD	Improved abstinence
Zhao et al <sup>39</sup>	2023	CNKI	Systematic review	Network Meta-Analysis of Psychotherapy Efficacy for AUD	Reduced the relapse rate, the number of relapse days, anxiety and depression
Conner et al <sup>41</sup>	2023	PubMed	RCT	Application of Brief Cognitive-Behavioral Interventions in AUD	Reduced alcohol consumption, number of drinking days

McKay et al <sup>42</sup>	2021	PubMed	RCT	Efficacy of Telephone- and Smartphone-Based Remote Continuing Care Interventions for AUD	Reduced percentage of days heavy drinking
Johansson et al <sup>43</sup>	2021	PubMed	RCT	Internet-Based Therapy vs Face-to-Face Therapy for AUD: A Comparative Analysis	Internet-delivered treatment was non-inferior to face-to-face treatment in reducing alcohol consumption
Hammarberg et al <sup>40</sup>	2023	PubMed	RCT	Effectiveness of Behavioral Self-Control Training vs Motivational Enhancement Therapy in AUD	Reduced alcohol consumption

**Notes:** NICE refers to the National Institute for Health and Care Excellence in the United Kingdom.

**Table 2** Quality Evaluation of Guidelines

Author/s	Standardized Percentage Scores for Each Domain (%)						Domain Scores ≥60%	Domain Scores ≥30%	Recommendation Level
	①	②	③	④	⑤	⑥			
Evan et al <sup>31</sup>	100.00	100.00	100.00	100.00	62.50	83.33	6	6	A
NICE <sup>30</sup>	77.78	80.56	62.50	77.78	54.17	83.33	5	6	B
Katherine et al <sup>32</sup>	66.67	75.00	80.21	63.89	62.50	66.67	6	0	A
Haber et al <sup>33</sup>	69.44	66.67	71.88	69.44	60.41	66.67	6	0	A

**Notes:** NICE refers to the National Institute for Health and Care Excellence in the United Kingdom; ①Scope and purpose; ②Stakeholder involvement ③Rigor of development; ④Clarity of presentation; ⑤Applicability; ⑥Editorial independence.

**Table 3** Quality Evaluation of Systematic Reviews and Meta-Analyses

Author/s	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪
Kelly et al <sup>38</sup>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hemrage et al <sup>34</sup>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	unclear	Yes	Yes
Byrne et al <sup>35</sup>	Yes	Yes	Yes	No	Yes	Yes	Unclear	Yes	unclear	Yes	Yes
Ghosh et al <sup>36</sup>	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Zhang et al <sup>37</sup>	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Zhao et al <sup>39</sup>	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

**Notes:** ①Is the review question clearly and explicitly stated? ②Were the inclusion criteria appropriate for the review question? ③Was the search strategy appropriate? ④Were the sources and resources used to search for studies adequate? ⑤Were the criteria for appraising studies appropriate? ⑥Was critical appraisal conducted by two or more reviewers independently? ⑦Were there methods to minimize errors in data extraction? ⑧Were the methods used to combine studies appropriate? ⑨Was the likelihood of publication bias assessed? ⑩Were recommendations for policy and/or practice supported by the reported data? ⑪Were the specific directives for new research appropriate?

**Table 4** Quality Evaluation of RCTs

Author/s	①	②	③	④	⑤	⑥	⑦
Conner et al <sup>41</sup>	Low risk	Low risk	Low risk	Low risk	Unclear	Unclear	Unclear
McKay et al <sup>42</sup>	Low risk	Unclear	Low risk	Low risk	Low risk	Unclear	Low risk
Johansson et al <sup>43</sup>	Low risk	Low risk	Low risk	Low risk	Low risk	Unclear	Low risk
Hammarberg et al <sup>40</sup>	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Unclear

**Notes:** ①Random sequence generation; ②Allocation concealment; ③Blinding of participants and personnel; ④Blinding of outcome assessment; ⑤Incomplete outcome data; ⑥Selective reporting; ⑦Other sources of bias.

adults with AUD; Four guidelines<sup>30–33</sup> all from international authoritative institutions, comprehensively addressed the diagnosis, management, treatment, and risks of AUD; Six systematic reviews<sup>34–39</sup> focused on the effectiveness of psychosocial interventions for adults with AUD, providing comprehensive and detailed content; Four RCTs<sup>40–43</sup> detailed specific protocols for various psychotherapies, closely aligned with clinical practice to facilitate translation.

Integrating these 20 high-quality articles, we developed a novel framework organizing evidence into eight dimensions. This framework collectively addresses critical implementation aspects from pre-intervention assessment to precautions. The systematic evidence formation process ensures comprehensive coverage of all relevant clinical content.

## Pre-Intervention Assessments for Adults with AUD Enable the Identification of Individual Needs and Improve Patient Engagement

Psychosocial interventions are essential for decreasing alcohol consumption and encouraging abstinence in adults with AUD.<sup>37</sup> Adults with AUD encounter considerable obstacles in participating in psychosocial interventions. Research indicates dropout rates may reach 30% for 12-step Facilitation and Acceptance and Commitment Therapy

**Table 5** Summary of the Best Evidence for Psychosocial Interventions for Adults with AUD

Item	Evidence Summary	Evidence Level
Pre-intervention assessment	1. Assess patients, families, and caregivers regarding history of alcohol withdrawal or delirium and collect information on risk factors <sup>31,33</sup>	3c
	2. Assess the amount, frequency, and timing of the last alcohol consumption to determine whether the patient is experiencing or at risk of alcohol withdrawal <sup>30</sup>	5b
	3. Motivational assessment: To avoid making patients feel judged, evaluate their willingness to reduce or abstain from alcohol by asking, "How do you feel about your drinking now?" If responses include contemplation (e.g., "I am considering stopping") or action-oriented statements (eg, "I want to stop now"), the likelihood of patient engagement in interventions and changes in drinking patterns increases <sup>33</sup>	5b
Intervention goals	4. Collaboratively decide on psychosocial interventions based on disease severity, medical history, treatment goals, clinical guidelines, and patient preferences <sup>26</sup>	5b
	5. Abstinence, reduction, or moderation of alcohol consumption <sup>18,32</sup>	1a
Scope of application	6. Restore the patient's physical and social health by controlling alcohol use and its consequences <sup>25</sup>	1a
	7. Adults diagnosed with mild, moderate, or severe AUD according to DSM-5 criteria <sup>18,31,36</sup>	1a
	8. Adults with mild AUD: Use brief motivational counseling and mutual support groups. Adults with moderate to severe AUD: For those capable of critical self-reflection, use motivational interviewing, cognitive behavioral therapy (CBT), behavioral couples therapy, contingency management, or comprehensive behavioral interventions; for those incapable, use 12-step Facilitation and encourage participation in mutual support groups <sup>26</sup>	5b
Multidisciplinary team	9. Recommend forming a multidisciplinary team including trained clinicians, specialized nurses or caregivers, psychologists, and social workers <sup>40</sup>	1c
Intervention timing	10. Within two weeks after alcohol withdrawal, symptoms subside in patients diagnosed with AUD <sup>30</sup>	5b
Intervention frequency	11. Motivational interviewing: 1–4 sessions, each lasting 15–45 minutes; longer and more frequent sessions enhance effectiveness <sup>28</sup>	1a
	12. Cognitive behavioral therapy: Weekly sessions of 45–60 minutes for 12 weeks <sup>30</sup>	1a
	13. Brief cognitive behavioral therapy: A single 45–60 minute intervention <sup>41</sup>	1c
	14. Behavioral couples therapy: Weekly 60-minute sessions for 12 weeks <sup>30</sup>	1a
	15. 12-step Facilitation: Weekly 30-minute sessions for 12 weeks <sup>38</sup>	1b
	16. Contingency management: Provide tangible rewards to patients. These incentives should be activated when the patient begins the intervention and continues during the first 12 weeks. Follow-up is recommended for 8–16 weeks until long-term abstinence (eg, 6–12 months) is achieved <sup>27</sup>	1b
	17. Motivational enhancement therapy: 4 sessions over 12 weeks <sup>40</sup>	1c
	18. Brief motivational counseling: Each session lasts 5–15 minutes, typically conducted 2–3 times and repeated as needed <sup>29,30</sup>	1b
	19. Peer support: Participation in Alcoholics Anonymous (AA) or similar groups, with weekly meetings to share experiences related to drinking and recovery, aiming to reduce drinking or achieve abstinence; continued participation is recommended <sup>38</sup>	1b
	20. Comprehensive behavioral intervention: Patients may benefit from a combination of interventions (eg, CBT combined with motivational interviewing enhances clinical efficacy) <sup>15,29</sup>	1a
Monitoring frequency and indicators	21. Follow-up: At least twice monthly for 2–3 months, followed by monthly monitoring with frequency adjustments based on symptom severity, increased stressors, or relapse <sup>26</sup>	5b
	22. Biomarkers: Gamma-glutamyl transferase (GGT), alanine transaminase (ALT), aspartate transaminase (AST), mean corpuscular volume (MCV), uric acid, high-density lipoprotein cholesterol (HDL-C), carbohydrate-deficient transferrin <sup>18</sup>	1b
	23. Outcomes: Percentage of relapse days, relapse rate, relapse days, patient engagement, alcohol consumption, Hamilton Anxiety Scale (HAM-A), Hamilton Depression Scale (HAM-D), Alcohol Dependence Scale (ADS), longest abstinence period (LPA), quality of life <sup>30,35,38,39</sup>	1b

(Continued)

**Table 5** (Continued).

Item	Evidence Summary	Evidence Level
Precautions	24. When selecting psychosocial interventions, healthcare providers should inform patients of all options, provide optimal clinical recommendations, and allow patients to choose <sup>26</sup>	5b
	25. Remote vs face-to-face interventions: Similar effects on drinking days, abstinence rates, and quality of life; select the appropriate format based on circumstances <sup>43</sup>	1c
	26. Due to potential ceiling effects in intervention efficacy, evaluate the importance of combined interventions in research and design rational combinations to avoid unnecessary complexity <sup>42</sup>	5c
	27. Given the chronic or relapsing nature of alcohol addiction, all interventions listed above can be implemented within a sustained treatment model <sup>25</sup>	5b

**Abbreviations:** DSM-5, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HAMA, Hamilton Anxiety Scale; HAMD, Hamilton Depression Scale; ADS, Alcohol Dependence Scale; LPA, Longest Period of Abstinence.

interventions.<sup>38,44</sup> Analysis indicates that this primarily results from inadequate consideration of the specific needs of adults with AUD in clinical practice, especially in China. Consequently, it is crucial to perform pre-intervention assessments for adults with AUD. Assessments must evaluate withdrawal history, drinking patterns, motivational stages, and collaborative decision-making while integrating patient preferences to enhance shared decision-making concerning psychosocial interventions, ultimately improving patient engagement.<sup>26</sup>

Notably, the motivational assessment emphasizes avoiding judgment by using open-ended questions (eg, “How do you feel about your drinking now?”), which aligns with the “spirit of motivational interviewing” and fosters a therapeutic alliance.<sup>45</sup> This is critical because patients in the contemplation or action stage (eg, “I am considering stopping”) are more likely to adhere to interventions, as their intrinsic motivation replaces external pressure.<sup>33</sup> Additionally, the collaborative selection of interventions according to disease severity, patient preferences, and guidelines ensures that interventions are neither overly intensive for mild AUD nor insufficient for severe AUD, directly reducing the risk of disengagement. For example, a patient with mild AUD may feel overwhelmed by 12-week CBT but respond well to brief motivational counseling. Therefore, pre-intervention assessments for adults with AUD enable the identification of individual needs and improve patient engagement.

## The Evidence Summary for Psychosocial Interventions in Adults with AUD Is Comprehensive and Clinically Significant

Psychosocial interventions are a vital aspect of the treatment framework for adults with AUD, having been thoroughly validated for their clinical efficacy in both national and international research.<sup>37,39</sup> Research indicates<sup>30,31,33</sup> that systematic psychosocial interventions effectively control patients’ drinking behaviors, significantly reduce alcohol consumption, depression, anxiety, and improve long-term outcomes. The continuous refinement, optimization, and innovation of intervention methods highlight the distinct benefits of psychosocial interventions in the treatment and rehabilitation of AUD. Existing literature predominantly emphasizes clinical efficacy while failing to systematically summarize and standardize essential implementation details, including intervention frequency and duration. This study systematically compiles and analyzes evidence for psychosocial interventions in adult AUD through eight evidence-based dimensions, providing essential guidance for clinical practice.

Building upon this evidence base, we propose a systematic multidimensional framework: intervention goals strike a balance between modifying drinking behaviors and restoring physical/social health to accommodate diverse patient needs; scope of application employs stratified interventions based on disease severity and patients’ critical self-reflection capacity, ensuring treatment intensity matches individual capabilities; a multidisciplinary team comprising psychiatrists, specialized nurses, clinical psychologists, and social workers collaboratively addresses the unique biopsychosocial complexity of AUD; Interventions initiated within two weeks after alcohol withdrawal ensure patient safety; detailed and specific intervention frequencies guarantee treatment integrity; monitoring forms a feedback loop via biomarkers and

clinical assessment scales; and precautions emphasize the equivalence of remote versus face-to-face interventions, respect for patient autonomy in treatment selection, awareness of ceiling effects in combined interventions, and recognition of AUD's chronic nature requiring sustained treatment models. This structured approach bridges the gap between established efficacy and real-world implementation by providing clinically actionable operational standards.

## Limitations and Recommendations for Evidence Application

The majority of the literature in this study is derived from international sources. Significant differences in cultural backgrounds and healthcare systems between Eastern and Western populations necessitate rigorous clinical adaptation of existing intervention protocols for localization. In clinical practice, intervention plans must be personalized and actionable, tailored to the specific conditions of patients, the hospital environment, and healthcare providers' knowledge, attitudes, and practices to optimize patient outcomes. Collaboration among multidisciplinary teams, including physicians, nurses, and psychotherapists, can effectively improve patient motivation for behavioral change, decrease alcohol consumption, and reduce the risk of relapse.<sup>37,39</sup>

Insufficient evidence exists to standardize critical elements, including team composition criteria, professional training frameworks, and interdisciplinary workflows, impedes clinical implementation and broader adoption.<sup>37,46</sup> Future research should prioritize the development of standardized multidisciplinary team training frameworks and evidence-based collaborative pathways to ensure reproducibility. Interventions frequently employed, including Acceptance and Commitment Therapy and mindfulness, were excluded due to limitations in the methodological quality of existing original studies. Continuous surveillance of new research and prompt updates of evidence are advised.

## Conclusion

This study systematically summarized the most robust evidence for psychosocial interventions in adults with AUD, establishing a scientific basis for clinical application. A total of twenty-seven pieces of evidence were synthesized across eight dimensions: pre-intervention assessment, intervention goals, scope of application, multidisciplinary team involvement, timing of intervention, frequency of intervention, monitoring frequency and indicators, and precautions. Offering a reference for clinical practice. Implementing evidence-based interventions that take into account hospital resources and patient preferences to decrease alcohol consumption, depression, anxiety, and improve long-term outcomes for adults with AUD.

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## Disclosure

The authors report no conflicts of interest in this work.

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