Received: 14 September 2020 | Accepted: 4 August 2021

DOI: 10.1111/jmft.12546

INVITED REVIEW

JMFT Journal of Marital and Family Therapy

Couple and family therapy for substance use disorders: Evidence-based update 2010–2019

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Abstract

This article updates the evidence-based on couple and family therapy interventions for substance use disorders (SUD) since publication of the previous JMFT reviews in 2012. It first summarizes previous reviews along with findings from more recent reviews and meta-analytic studies. It then presents study design and methods criteria used to select 13 studies of couple and family therapy for level of support evaluation. Cumulative level of support designations are then determined for identified treatment approaches. Findings indicate that systemic family therapy is well-established as a standalone treatment, and behavioral family therapy and behavioral couple therapy are probably efficacious as standalone treatments and well-established as part of a multicomponent treatment. The article then suggests practice guidelines with regard to treatment modality considerations and implementation challenges. It concludes with future directions for delivering couple and family interventions in routine systems of care for SUD.

KEYWORDS

children/adolescents, couples, evidence-based, families, review of literature

[Corrections added on 20 September 2021, after first online publication: The original version published blinded. Schumm et al., 2014, O'Farrell et al., 2015, O'Farrell et al., 2016, O'Farrell et al., 2017, Hogue et al., 2017, Hogue et al., 2018, Hogue et al., 2019, Dunlap et al., 2020; the above mentioned references and their citations has been added in this version.]

INTRODUCTION

Overview of substance use disorders

Substance use disorders (SUDs) are characterized by continued alcohol or other drug use despite the individual experiencing problems related to their use (American Psychiatric Association, 2013). Identifying effective treatments for SUDs remains an urgent public health priority. According to 2019, US national household survey data (Substance Abuse and Mental Health Services Administration (SAMHSA), 2020), 7.4% or 20.4 million people over the age of 12 reported at least one SUD in the past year. Among adolescents, 1.1 million (4.5%) reported a past year SUD. The most common SUDs among adolescents were cannabis use disorder (699,000 individuals; 2.8%) followed by alcohol use disorder (414,000; 1.7%). Among adults, 19.3 million reported a past year SUD, with prevalence being higher among those ages 18–25 (14.1%) versus over age 25 (6.7%). In adults younger than age 25, alcohol use disorder (3.1 million individuals; 9.3%) was more common than all other combined drug use disorders (2.5 million individuals; 7.5%). This was also the case for adults over the age of 25, with alcohol use disorder being present among 11 million individuals (5.1%), whereas all other drug use disorders were found among 4.9 million individuals (2.3%).

Substance use disorders are associated with a variety of couple- and family-related problems. Compared to those without SUDs, couples with SUDs exhibit worse relationship functioning (Marshal, 2003), more frequent intimate partner violence (Cafferky et al., 2016), and greater risk of marital dissolution (Cranford, 2014). Having a parent with a SUD confers greater risk that an adolescent will engage in substance use (Walden et al., 2007). In addition, lower family quality and parental monitoring are predictive of adolescents having more deviant peers and, in turn, engaging in higher substance use (Van Ryzin et al., 2012). These findings demonstrate a clear need for couple- and family-based interventions for adults and adolescents with SUDs.

Couple and family therapy for suds: Previous reviews of the evidence base

Summary of previous JMFT evidence-based updates

In 2012, the *Journal of Marital and Family Therapy* (JMFT) presented two evidence-based updates on SUD treatment research published through 2009, each updating previous JMFT reviews published in 2003 (O'Farrell & Fals-Stewart, 2003; Rowe & Liddle, 2003). O'Farrell and Clements (2012) examined controlled studies of marital and family therapy for alcoholism. They covered two kinds of interventions. With regard to promoting treatment engagement for individuals unwilling to seek help, community reinforcement and family training (CRAFT) was supported by multiple efficacy studies and one dissemination study. With regard to promoting improved functioning among those seeking treatment, the behavioral couple therapy (BCT) approach was supported by several efficacy and effectiveness studies. Treatment models that use the BCT approach for targeting alcohol use have two main components: (a) alcohol-focused interventions to build support for abstinence via helping the client's spouse learn skills for managing alcohol-related situations and/or contracting daily with both partners for abstinence and mutual appreciation (often in combination with pharmacological interventions); (b) relationship-focused interventions to increase positive feelings, shared activities, and constructive communication.

They described advances in research on the BCT approach for women with alcohol problems, couples in which both partners have alcohol problems, gay and lesbian clients, clients with a nonspousal living partner, and veterans with co-occurring traumatic stress. They also presented research on BCT mechanisms of effects and impacts on interpersonal violence and child adjustment. Evidence for family systems and social network approaches for treating alcoholism was deemed inconclusive.

Rowe (2012) reviewed the extant evidence bases for adolescent-focused and adult-focused interventions for drug use problems. For adolescents, she described a host of efficacious family-based treatment models including multidimensional family therapy, multisystemic therapy, ecologically based family therapy, functional family therapy, and brief strategic family therapy. Much of the evidence-based featured racial/ethnic-minority clients and documented long-term effects for drug use, positive impacts on co-occurring problems, model-congruent treatment fidelity and mechanism effects, and promising dissemination and cost-effectiveness outcomes. For adults, several couple and family interventions, including BCT and CRAFT, provided consistent evidence of facilitating treatment engagement; and among those targeting parenting skills, improved child outcomes. She concluded that family-based interventions are widely considered among the most effective approaches for treating SUD in both adolescents and adults.

Summary of literature reviews and meta-analyses since 2012

In the decade since 2012, several literature reviews and meta-analytic studies have emphasized the strong positive effects of manualized couple and family interventions for SUD in youth and adults. Tanner-Smith et al. (2013) completed a comprehensive meta-analysis on adolescent SU treatment that sampled 45 randomized and quasi-experimental studies reporting on 73 treatment-comparison group pairs to test the comparative effectiveness of different treatment approaches. With the important caveat that relative effectiveness was only approximated because no approach was tested against every other approach in the sample pool, they found that family-based treatment models prevailed in almost every comparison, including tests against other manualized treatments representing cognitive-behavioral therapy and motivational interviewing. McCrady, Wilson, et al. (2016) surveyed the literature supporting various models within the BCT approach, summarizing a host of studies confirming BCT's overall efficacy, effectiveness, cost-benefit, and hypothesized treatment mechanisms for SU problems, couple relationship functioning, and intimate partner violence. Hogue et al. (2018) reviewed research on outpatient behavioral treatments for adolescent SU using the same Southam-Gerow and Prinstein (2014) review criteria presented in this special issue of JMFT (Wittenborn & Holtrop, 2022). Family therapy was designated a well-established approach and had accumulated the largest evidence base compared to all other treatment approaches. Most recently, Ariss and Fairbairn (2020) completed a meta-analysis of face-to-face (vs. remote) interventions that directly involved concerned significant others (CSO) in treatment; these included BCT models, family therapy models, and certain versions of the community reinforcement approach. Condensing across 77 effect sizes based on data from 2,115 individuals enrolled in 16 independent trials, they calculated a small but significant effect size that endured up to 12–18 months follow-up and translated to a 5.7% reduction in SU frequency—the equivalent of approximately three fewer weeks per year of SU. They also found that CSO interventions showed consistent impacts across specific treatment models, client and study characteristics, and types of comparator treatments in the respective trials—that is, there was little evidence of meaningful treatment moderation effects.

Unique contributions of the current review

The goal of this update is to review outcomes-focused evidence published in English language journals on couple and family interventions for SUD. To generate results with wide applicability to the diverse workforce of practitioners who treat SUD, findings are summarized according to broad intervention approaches (e.g., systemic family therapy) rather than specific treatment models (e.g., multidimensional family therapy). The current review has two features that distinguish it from previous reviews and meta-analyses. First, in keeping with guidelines for this JMFT special issue (Wittenborn & Holtrop, 2022), it focuses on interventions that target couple and/or family-based relational processes or interactions. Relational interventions are the centerpiece of marital and family therapy and thus especially germane to the workforce of couple and family therapy practitioners. This review therefore excludes individually oriented interventions as well as those that are teacher-based or otherwise primarily psychoeducational in nature. Second, unlike previous JMFT updates (O'Farrell & Clements, 2012; O'Farrell & Fals-Stewart, 2003; Rowe, 2012), this article reviews interventions that target alcohol use along with those targeting other substances. In so doing, it balances focus on treatments designed for adult clients with those designed for adolescent clients. This lifespan approach to evidence review opens the door to considering a transdevelopmental approach to relational interventions for SUD, an issue addressed in the Discussion. Alongside these unique contributions, this review honors the important JMFT convention of curating periodic reviews of the evidence based on couple and family therapies for various clinical disorders. These reviews help the broad provider workforce remain current on effective practices, which can guide intervention selection for individual clients, as well as helping policymakers adjust or redesign treatment policies and parameters for the national system of behavioral healthcare; these issues also are addressed in the Discussion.

METHOD

Study inclusion/exclusion criteria

This evidence-based update focuses on studies of couple and family outpatient treatment for SUDs, including both alcohol and drug use disorders. The following parameters were used to delineate this area of treatment science. As described above, couple and family therapy intervention was defined as a psychological intervention that includes focus on couple and/or family-based relational processes or interactions. Couple and family relational interventions characterize relationships between individuals—as opposed to processes or problems within individuals—as the primary focus of treatment (Sprenkle et al., 2013). As such, they intentionally target aspects of interpersonal functioning such as attachment, cohesion and conflict, goal-sharing and communication, and relationship valuation. We therefore excluded interventions that typically involve family members in sessions but are not fundamentally relational in nature. Several such models and approaches that had been described in previous JMFT reviews were not included herein: multisystemic therapy (which focuses on contingency management and drug refusal; Randall et al., 2018), network therapy (which focuses on relapse prevention and building sobriety supports; Keller & Galanter, 1999), and varieties of the community reinforcement approach (for which relational interventions are a minor or discretionary focus; see Godley et al., 2016). We also excluded interventions to improve coping and self-care among CSO of persons with SUDs, such as Al-Anon. We excluded CRAFT

because its intervention targets are treatment enrollment and CSO self-care, not reduction in substance use (Archer et al., 2020; Kirby et al., 2017). *Outpatient* was defined as care delivered in standard outpatient specialty and/or nonmedical settings by clinical practitioners. We excluded studies conducted in residential, inpatient, or emergency room settings, as these settings have unique milieu and workforce training characteristics that complicate efforts to draw generalizable (i.e., cross-setting) conclusions. That said, several interventions included in this review are commonly delivered in those settings (see de Andrade et al., 2019 for an example review). *Treatment* included any nonpharmacological treatment approach designed explicitly to target acute SU. Because opioid agonist or antagonist medication is the only evidence-based intervention for opioid use disorder (OUD; Volkow et al., 2019), this review does not include OUD treatment studies, though there is strong advocacy for involving CSO in OUD services (Ventura & Bagley, 2017). We excluded studies of continuum of care interventions such as SBIRT (Screening, Brief Intervention, Referral to Treatment), as these primarily target linkage to treatment rather than SU reduction per se. We also excluded studies of follow-up care and adaptive treatment designs, as these focus primarily on post-treatment services retention and successive treatment episodes for those showing minimal initial benefits, respectively. *Substance use* was defined as consumption of alcohol or illicit drugs, or misuse of prescribed drugs, within the prior 30 days; and/or, presence of a diagnosable SUD. We excluded studies focused on tobacco or other nicotine products; nicotine cessation treatments constitute a large literature that features a variety of biological interventions and merits separate review. For all the above reasons, we excluded studies focused on prevention of SU problems.

In addition to the aforementioned criteria, studies had to meet the five methods criteria stipulated by Southam-Gerow and Prinstein (2014), which were applied to ensure that each included study had adequate methodological rigor to support reliable interpretation of the direction and strength of observed treatment effects on targeted outcomes. These criteria were operationalized as follows: *Group Design*: Participants were randomly assigned to either the focal treatment condition or a logical comparison group (e.g., alternate treatment, assessment only, waitlist). Note that by requiring a randomized design, this review excluded quasi- and nonexperimental research on some interventions that may otherwise have met criteria as Possibly Efficacious or Experimental; this was deemed an appropriate level of selectivity given the sizable number of experimental couple and family studies in the existing SUD evidence base. *Independent Variable Defined*: Manuals or a logical equivalent were used to deliver the focal treatment; *Population Clarified*: Treatment aimed to reduce SU among participants who actively used alcohol or illicit drugs and/or were diagnosed with SUD at study baseline; *Outcomes Assessed*: Participants were assessed for SU at baseline prior to group assignment using well-validated metrics and subsequently followed up for assessment at least 3 months after treatment initiation; *Analysis Adequacy*: Each study condition contained at least 20 participants to ensure power to detect a reasonable effect, and attrition from each condition was reported and accounted for in analyses that used an intent-to-treat approach.

Search strategy

To identify potentially eligible studies, we conducted a search of the literature in ISI Thompson's Web of Science Core Collection. We created a set of search items based on a variety of addictive behaviors as well as addictive products such as alcohol, marijuana, cannabis,

and opiates/opioids. Another set of terms was formed to include various treatment orientations (e.g., couple/s therapy, relationship therapy, marital therapy, family therapy, family training) and well-known SU treatment approaches and models (e.g., behavioral couple therapy, multidimensional family therapy). We combined these two sets using "and" logic (i.e., selected records included both addictive behavior/product and SU treatment approach/model terms) and limited the search to studies in the Web of Science categories "Substance Abuse" and "Psychiatry" and published in English from 2010 to 2019. Citation lists of records promoted to full-article screening were hand-searched to identify additional references (snowball sampling), as were the citation lists of several review articles for adolescent and adult SUD treatment.

Final review pool: Review procedures and study descriptions

Study review procedures adhered to guidelines of preferred reporting items for systematic reviews and meta-analyses (PRISMA; Moher et al., 2009); see Figure 1 for flow chart depicting the review process. The initial search yielded 1,478 records. These were screened for inclusion by a library scientist based on the criterion of being an intervention research study; 208 records were subsequently promoted. A second level of screening for topical relevance was then completed by the first author, who reviewed those 208 records, plus an additional 19 records located via search of reference lists, to identify randomized studies focused on outpatient couple and family therapy for SUDs, using the five methods criteria described above. From this overall pool of 227 records, 30 articles whose records met methods criteria, or whose records did not contain sufficient information to evaluate all criteria, were independently reviewed by two authors apiece to determine which full studies met all criteria defined in the Study Inclusion Criteria section. For those infrequent instances when paired authors disagreed on whether a study should be included in the final pool, that study was discussed by all authors to obtain consensus. A total of 13 studies were promoted to the final review pool, seven targeting adolescents (ages 13–21) and six targeting adults.

The 13 studies in the final review pool are described in Table 1: intervention conditions, sample characteristics, primary SU outcome measures and assessment periods, and results, including effect sizes (standardized indicators of the strength of the given effect) calculated for the main experimental comparison in each study. Table 1 divides the review pool by age of target client (adolescent, adult) and also categorizes study interventions along two dimensions (see Hogue et al., 2018). First, it distinguishes behavioral versus systemic approaches. The behavioral approach focuses on teaching communication, coping, and problem-solving skills to members of a self-defined couple/family unit. It includes both comprehensive interventions to improve relationship quality between adult partners (i.e., couple therapy) or other family members (i.e., family therapy) as well as discrete protocols focused on parenting skills or a singular aspect of family functioning (e.g., communication training). Hallmarks of the behavioral approach include reliance on standardized protocol content and a fundamentally didactic (i.e., teaching) therapeutic style. The systemic approach differs from the behavioral approach in two primary ways. Regarding intervention focus, it directly targets both intrafamilial relational processes (e.g., roles, attachments, cohesion, conflict) and relational processes between family members and key extrafamilial systems (e.g., school, peer, child welfare, justice) with which families interact. Regarding intervention content, it features one core set of treatment techniques that clearly distinguish it from

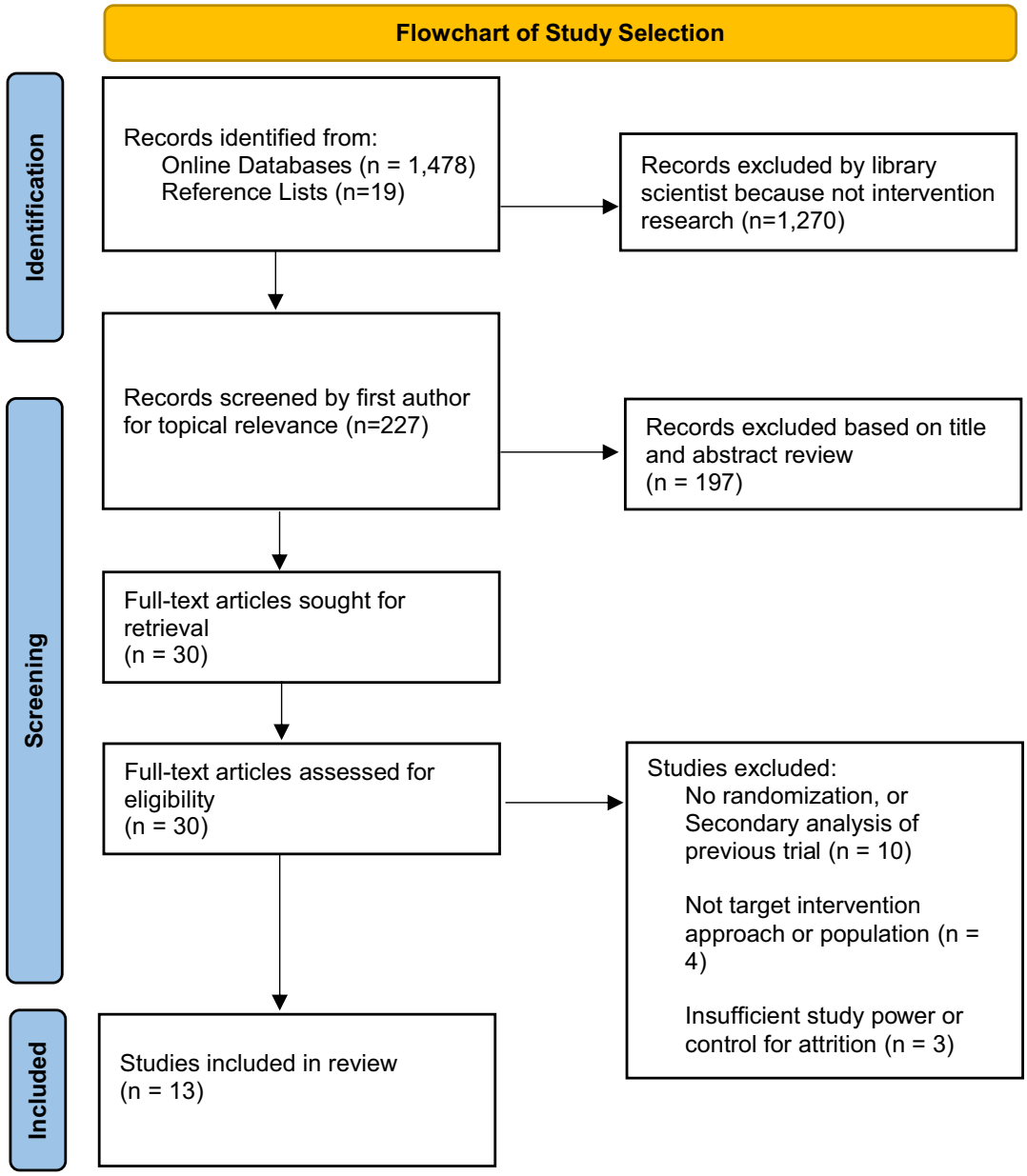

FIGURE 1 Preferred reporting items for systematic reviews and meta-analyses (PRISMA) diagram

the behavioral approach (see Hogue et al., 2019): relational reframing. Relational reframing techniques involve therapist efforts to transform symptom-focused and/or person-focused perceptions of clinical problems into a new understanding of those problems as being fundamentally relational, thereby motivating clients to pursue changes in relationships as the primary clinical solution. Hallmarks of the systemic approach include reliance on emergent session content and a fundamentally egalitarian therapeutic style. Second, Table 1 distinguishes standalone versus multicomponent models. Multicomponent models refer to intervention packages that contain more than one intervention component and seek to leverage

TABLE 1 Study and sample characteristics of the final review pool of 13 randomized studies of couple and family therapy for substance use disorders (2010–2019)

Authors (year)	Intervention approach	Intervention type	Study conditions	*N*	Sample Characteristics	Focal SU outcomes	Assessment points	Results (effects sizes if reported)
Adolescent								
Dakof et al. (2015)	Systemic family therapy	Standalone	1. MDFT 2. AGT	112 youth	Age 13–18 ($M = 16.1$); 88% Male; 59% Latinx, 35% African American; USA	TLFB: Frequency of SU past 90 days; PEI (youth)	Baseline, 6, 12, 18, 24 months	Both conditions produced decreases in SU (6 months: TLFB $d = 3.63$; PEI $d = 5.21$); (7 to 24 months: TLFB $d = 0.47$; PEI $d = 0.42$) No between-condition differences.
Esposito-Smythers et al. (2011)	Behavioral family therapy	Multicomponent	1. I-CBT 2. Enhanced TAU	40 youth	Age: 13–17 ($M = 15.7$); 68% Female; 88% White Non-Latinx, 5% Latinx; USA	TLFB: Frequency of SU past 30 days (youth)	Baseline, 3, 6, 12, 18 months	I-CBT associated with fewer heavy drinking days and days of cannabis use. Between condition: IRR = 0.54 (heavy drinking days); IRR = 0.65 (days cannabis use)
Liddle et al. (2018)	Systemic family therapy	Standalone	1. MDFT 2. RT	113 youth	Age: 13–18 ($M = 15.4$); 75% Male; 68% Latinx, 18% African American, 13% White Non-Latinx; USA	TLFB: Frequency of SU past 30 days; PEI (youth)	Baseline, 2, 4, 12, 18 months	Both conditions showed decreased SU problems (PEI: $d = 1.10$) and SU frequency (TLFB: $d = 1.36$) in early treatment. MDFT kept decreased SU problems (PEI: $d = 0.51$) and frequency (TLFB: $d = 0.24$) more effectively in months 2–18

(Continues)

TABLE 1 (Continued)

Authors (year)	Intervention approach	Intervention type	Study conditions	*N*	Sample Characteristics	Focal SU outcomes	Assessment points	Results (effects sizes if reported)
Rigter et al. (2013)	Systemic family therapy	Standalone	1. MDFT 2. IP	450 youth	Age: 13–18 ($M = 16.3$); 85% Male; 40% 1st- or 2nd-generation foreign descent; 5 European countries	ADI-Light; TLFB: Frequency of SU past 90 days (youth)	Baseline, 3, 6, 9, 12 months	MDFT superior in reduced SU symptoms (SU dependence: $d = 0.65$; SU dependence symptoms: $d = 1.27$) and reduced SU frequency within a subgroup of severe users ($d = 0.60$)
Robbins et al. (2011)	Systemic family therapy	Standalone	1. BSFT 2. TAU	480 youth	Age: 13–17 ($M = 15.5$); 79% Male; 44% Latinx, 31% White Non-Latinx, 23% African American; USA	TLFB: Frequency of SU past 30-day windows over 12-month duration (youth)	Baseline, 4, 8, 12 months	No between-condition differences in growth trajectories. BSFT had lower median number of SU days at 12 months
Rohde et al. (2014)	Systemic family therapy	Standalone	1. CWD/FFT 2. FFT/CWD 3. FFT+CWD	170 youth	Age: 13–18 ($M = 16.1$–16.8); 78% Male; 61% White Non-Latinx, 28% Latinx; USA	TLFB: percentage of days of SU in past 90 days (youth)	Baseline, post-treatment (20 weeks), 6 months, 12 months	FFT/CWD produced better SU outcomes than FFT+CWD (12 month: FFT/CWD vs. FFT+CWD: $d = 0.52$). CWD/FFT produced intermediate outcomes (12 month: CWD/FFT vs. FFT+CWD: $d = 0.52$)

(Continues)

TABLE 1 (Continued)

Authors (year)	Intervention approach	Intervention type	Study conditions	*N*	Sample Characteristics	Focal SU outcomes	Assessment points	Results (effects sizes if reported)
Slesnick et al. (2013)	Systemic family therapy	Standalone	1. EBFT 2. CBT 3. MI	179 youth	Age: 12–17 ($M = 15.4$); 52% Female; 66% African American, 26% White Non-Latinx; USA	TLFB: percentage of days of SU in past 90 days (youth)	Baseline, 3, 6, 9, 12, 18, 24 months	No between-condition differences. 3 SU change classes: Decreasing, Fluctuating High, *U*-Shaped. In Decreasing class, MI produced more rapid changes, but faster relapse, than EBFT
Adult								
Donohue et al. (2014)	Behavioral family therapy	Standalone	1. FBT 2. TAU	72 mothers	Age: ($M = 29.0$); 47% White Non-Latinx, 25% African American, 11% Latinx; USA	TLFB: Frequency of SU days during 4 months prior to assessment (mothers & primary adult SO)	Baseline, 6, 10 months	No between-condition differences. Both conditions showed reductions in SU (partial $\eta^2 = 0.16$). For the subgroup of mothers of nondrug-exposed children, FBT showed a greater decrease in SU
McCrady, Epstein, et al. (2016)	Behavioral couple therapy	Multicomponent	1. ABCT 2. Blended-ABCT	59 females (and male partners)	Age: ($M = 46$); 95% White Non-Latinx; USA	TLFB: percentage of days of SU in past 90 days (females)	Baseline, 3, 9, 15 months	No between-condition differences in drinking or heavy drinking outcomes. Blended-ABCT superior in weeks 1–8 for PDD ($d = 0.41$) and PDH ($d = 0.46$) and weeks 9–16 for PDD ($d = 0.28$) and PDH ($d = 0.38$)

TABLE 1 (Continued)

Authors (year)	Intervention approach	Intervention type	Study conditions	*N*	Sample Characteristics	Focal SU outcomes	Assessment points	Results (effects sizes if reported)
O'Farrell et al. (2016)	Behavioral couple therapy	Multicomponent	1. Group BCT-SUD+DC/12 2. Standard BCT-SUD+DC/12	101 adults (and opposite sex partner)	Age: ($M = 48.4$); 70% Male; 97% White Non-Latinx; USA	TLFB: PDA; InDUC (patient, partner)	Baseline, 3, 6, 9, 12 months	Both conditions improved at all time points on PDA ($d > 0.97$) and InDUC ($d > 0.90$). Standard BCT-SUD was superior on InDUC at 9 ($d = 0.37$) and 12 months ($d = 0.52$)
O'Farrell et al. (2017)	Behavioral couple therapy	Multicomponent	1. BCT-SUD+DC/12 2. DC/12	61 females (and male partners)	Age: ($M = 38.7$); 87% White Non-Latinx, 6% African American, 6% Latinx; USA	TLFB: PDA and PDDU; InDUC (patient, partner)	Baseline, 3, 6, 9, 12 months	Both conditions improved on PDA, PDDU, and InDUC at all time points ($d > 0.80$ for most time points). BCT-SUD+DC/12 superior in reducing SU problems ($d = 0.85$)
Schumm et al. (2014)	Behavioral couple therapy	Multicomponent	1. BCT-SUD+DC/12 2. DC/12	105 females (and male partners)	Age: ($M = 44.4$); 97% White Non-Latinx; USA	TLFB: PDA; InDUC (patient, partner)	Baseline, 3, 6, 9, 12 months	BCT-SUD+DC/12 was superior for PDA ($d = 0.33$) at 12 months and for InDUC at 6 ($d = 0.32$), 9 ($d = 0.41$), and 12 months ($d = 0.51$)
Slesnick and Zhang (2016)	Systemic family therapy	Standalone	1. EBFT 2. WHE	183 mothers	Age: 22–54 years ($M = 33.9$); 54% White Non-Latinx, 43% African American; USA	TLFB: percentage of days of SU in past 90 days (mothers)	Baseline, 3, 6, 12, 18 months	Mothers receiving EBFT exhibited a faster rate of decrease in alcohol use ($B = 0.23$, $SE = 0.11$), marijuana use ($B = 0.23$, $SE = 0.11$), and cocaine use ($B = 0.49$, $SE = 0.21$)

Abbreviations: ABCT, alcohol behavioral couple therapy; ADI-Light, Adolescent Diagnostic inventory—Light; AGT, adolescent group therapy; BCT-SUD, behavioral couple therapy for substance use disorder; BSFT, brief strategic family therapy; CBT, cognitive-behavioral therapy; CWD, coping with depression; DC/12, drug counseling/12-step approach; EBFT, ecologically based family therapy; FBT, family behavior therapy; FFT, functional family therapy; I-CBT, integrated cognitive-behavioral therapy; InDUC, Inventory of Drug Use Consequences; IP, individual psychotherapy; IRR, Incidence Rate Ratio; MDFT, multidimensional family therapy; MI, motivational interviewing; PDA, percentage days abstinent; PDDU, percentage days drug use; PDH, percentage of heavy drinking days; PEI, Personal Experiences Inventory; RT, residential treatment; SO, significant other; SU, substance use; TAU, treatment as usual; TLFB, Timeline Follow-Back interview; WHE= women's health education.

multiple treatment mechanisms to address the expansive set of risk and protective factors that influence SU, maximizing both the intensity and diversity of interventions delivered. Mapping the 13 review pool studies onto these two dimensions yielded the four broad categories depicted in Table 1: systemic family therapy, behavioral couple therapy, behavioral family therapy, and multicomponent treatments.

Final review pool: Strength of evidence and level of support designations

For the final review pool, each study's strength of evidence was assessed via two complementary frameworks. Risk of Bias Assessment Tool (RBAT), developed by the Cochrane Collaboration (Higgins et al., 2011), captured one strength-of-evidence domain (assessment bias) based on five criteria: random assignment, allocation concealment, incomplete outcome data, blinding on outcome assessment, and selective outcome reporting. Agency for Healthcare Research and Quality (AHRQ) strength of evidence criteria (Berkman et al., 2015) captured four additional domains that were deemed germane to the current review: directness, precision, strength of association, and reporting bias. Two study authors (AM, AH) provided independent ratings in all five domains for each study; consensus determined a final rating in the few instances when initial ratings disagreed. Table 2 defines each criterion and lists final ratings for all nine strength of evidence criteria for all 13 review pool studies. Table 3 presents final Level of Support designations based on criteria defined by Southam-Gerow and Prinstein (2014, described in Wittenborn and Holtrop (2022)).

RESULTS

A total of 13 studies published from 2010 to 2019 meet all review criteria for couple and family interventions for SUDs; seven targeted adolescents and six targeted adults. These studies are described in Table 1 and summarized below.

Well-established standalone treatment: Systemic family therapy

Adding to numerous studies published prior to the current review, seven reviewed studies tested standalone, systemic family therapy models. Three focused on multidimensional family therapy (MDFT) for adolescents. Rigter et al. (2013) conducted an ambitious study of cannabis-using youth that tested MDFT against individual-based usual care in clinic settings across five European countries. Study conditions showed equivalent effects in reducing cannabis disorder rates at one-year follow-up (FU). MDFT was superior in treatment retention, reducing cannabis dependence symptoms, and reducing cannabis consumption among youth with the highest baseline severity. Dakof et al. (2015) tested MDFT against group-based usual care in a juvenile drug court setting. Treatments showed comparable decreases in SU frequency and SU-related problems at two-year FU. MDFT was superior in decreasing externalizing symptoms and serious delinquent activity (based on self-report and arrest records). Liddle et al. (2018) compared MDFT delivered in an outpatient setting versus residential treatment featuring individual- and group-based services for adolescents with co-occurring SU, mental health, and delinquency problems.

Both conditions produced significant clinical progress on SU and mental health outcomes during the first two months of care. Between 3-month and 18-month FU, MDFT maintained early treatment gains to a greater degree for SU issues and delinquent behaviors and equivalently for mental health symptoms.

Three other reviewed studies tested three different systemic family therapy models for adolescents. Robbins et al. (2011) compared brief strategic family therapy (BSFT) to usual care across eight clinics and found no differences in primary SU outcomes at long-term FU. BSFT was more effective at engaging and retaining youth and improving family functioning. Slesnick et al. (2013) compared ecologically based family therapy (EBFT) to two individual-based manualized treatments among runaway youth with SU problems. All conditions performed equally well in reducing SU, with moderate differences in the trajectory of SU change across groups. Rohde et al. (2014) assigned youth with co-occurring SU and depressive disorders to one of three conditions: functional family therapy (FFT) delivered first, followed by a group-based treatment for depression; depression treatment delivered first, followed by FFT; and FFT and depression treatments delivered simultaneously. FFT followed by depression treatment emerged as the most effective condition and produced significantly better SU outcomes at one-year FU than the condition in which FFT and depression treatment occurred simultaneously. All conditions showed equivalent improvement in depression symptoms.

One study tested systemic family therapy with adults. Slesnick and Zhang (2016) compared EBFT (home-based or office-based) with a health education intervention for mothers enrolled in SU treatment. To be eligible, mothers needed to identify at least one biological child age 8–16 years in their care who could participate in family sessions. Across 18-month FU, EBFT produced more rapid declines in three substances: alcohol, marijuana, and cocaine.

Probably efficacious standalone treatment: Behavioral family therapy

Adding to studies published prior to the current review, one reviewed study tested a standalone behavioral family therapy approach. Donohue et al. (2014) compared family behavior therapy (FBT) to usual services among mothers referred by child protective services for combined treatment of SU and child neglect problems. Mothers were required to be living with the child victim identified for protective service referral. No overall between-condition effects were found for SU at 6-month or 10-month FU. FBT did produce superior SU declines among a subgroup of mothers whose referrals for child neglect were not due to their children being exposed to illicit drugs.

Well-established multicomponent treatments

Behavioral family therapy plus other approaches

Adding to prior published studies, a reviewed study by Esposito-Smythers et al. (2011) recruited adolescents with co-occurring SU and suicidality and assigned them to either usual care or a multicomponent treatment containing motivational interviewing and individual cognitive-behavioral interventions for SU, individual cognitive-behavioral interventions for suicidality, and behavioral family therapy sessions. At 18-month FU, the multicomponent treatment produced greater reductions in two of three SU outcomes, greater reductions in global impairment and suicide attempts, and equivalent reduction in suicidal ideation.

TABLE 2 Strength of evidence domains

	Revised Cochrane risk of bias assessment						AHRQ strength criteria			
		Deviation from intended interventions								
Study	Randomization process	Assignment effects	Adherence effects	Missing outcome data	Measurement of the outcome	Selection of reported results	Directness	Precision	Reporting bias	Strength of association
Dakof et al. (2015)	Low risk	Low risk	Low risk	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs. not	Some Concern: RAs not perfectly blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
Donohue et al. (2014)	Low risk	Low risk	Low risk	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs. not	Low risk	Low risk	Direct	Precise	Undetected	Strong/acceptable
Esposito-Smythers et al. (2011)	Low risk	Low risk	Low risk	Some Concern; No BL analysis of attritted vs. not	Low risk	Low risk	Direct	Precise	Undetected	Strong/acceptable
Liddle et al. (2018)	Low risk	Low risk	Low risk	Low risk	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
McCrady, Epstein et al. (2016)	Low risk	Low risk	Low risk	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs. not	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
O'Farrell et al. (2016)	Low risk	Low risk	Low risk	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs. not	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable

(Continues)

TABLE 2 (Continued)

	Revised Cochrane risk of bias assessment						AHRQ strength criteria		
		Deviation from intended interventions							
Study	**Randomization process**	**Assignment effects**	**Adherence effects**	**Missing outcome data**	**Measurement of the outcome**	**Selection of reported results**	**Directness**	**Precision**	**Reporting bias**	**Strength of association**
O'Farrell et al. (2017)	Low risk	Low risk	Low risk	Low risk	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
Rigter et al. (2013)	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Direct	Precise	Undetected	Strong/acceptable
Robbins et al. (2011)	Low risk	Low risk	Some Concern: No fidelity data for TAU to show condition differentiation	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs not	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	No effect sizes reported
Rohde et al. (2014)	Low risk	Low risk	High Risk: Uncontrolled inclusion of non-protocol interventions stated as a limit to confident interpretation of results	Some Concern: Non-negligible attrition rates, BL analysis of attritted vs. not conducted for SU variable only	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
Schumm et al. (2014)	Low risk	Low risk	Low risk	Low risk	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	Strong/acceptable
Slesnick and Zhang (2016)	Low risk	Low risk	Some Concern: No fidelity data to show condition differentiation	Some Concern: Non-negligible attrition rates, no BL analysis of attritted vs. not	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	No effect sizes reported

(Continues)

TABLE 2 (Continued)

	Revised Cochrane risk of bias assessment							AHRQ strength criteria		
		Deviation from intended interventions				Selection of reported results				
Study	Randomization process	Assignment effects	Adherence effects	Missing outcome data	Measurement of the outcome		Directness	Precision	Reporting bias	Strength of association
Slesnick et al. (2013)	Low risk	Low risk	Low risk	Low risk	Some Concern: Not stated RAs were blind to condition	Low risk	Direct	Precise	Undetected	No effect sizes reported

Abbreviations: BL, baseline; RAs, research assessors; SU, substance use; TAU, treatment as usual.

Risk of Bias Assessment = Assessing whether a given study is protected against bias and can yield an accurate unbiased estimate of the true effect.

Randomization Process = bias arising from the randomization process; whether or not the study used an allocation sequence generation, which specifies how participants will be assigned to interventions, including an element of chance, and concealment from participants and trial personnel prior to assignment.

Deviation from Intended Interventions = bias due to deviations from intended interventions.

Assignment effects = deviations from the intended intervention in relation to trial context, inconsistencies with the trial protocol(s), and/or those that affect the outcome.

Adherence effects = deviations from the intended intervention that are inconsistent with the trial protocol(s) and affect the outcome.

Missing Outcome Data = bias introduced by procedures used to impute or account for missing outcome data; missing outcome data can lead to bias depending on whether the missingness mechanism is related to the true value of the outcome.

Measurement of the Outcome = bias introduced by inappropriate measurement of the outcome, differential measurement between experimental and comparator intervention groups, and the potential for assessment of the outcome to be influenced by knowledge of the intervention received.

Selection of Reported Results = bias introduced when the reported result is selected (based on direction, magnitude, or statistical significance) from among multiple intervention effect estimates.

AHRQ = US Agency for Healthcare Research and Quality

Directness = directness of evidence; whether evidence links interventions directly to a health outcome of specific importance for the review, and for comparative studies, whether the results are based on head-to-head comparisons.

Precision = the degree of certainty surrounding an effect estimate with respect to a given outcome or the potential for random error with respect to an outcome, based on the sufficiency of sample size and number of events.

Reporting Bias = bias due to selectively publishing or reporting research findings based on the favorability of direction or magnitude of effect.

Strength of Association = the likelihood that the observed effect is large enough that it cannot have occurred solely as a result of bias from potential confounding factor.

Behavioral couple therapy plus other approaches

Adding to prior published studies, four reviewed studies tested BCT models in combination with other approaches. Schumm et al. (2014) compared behavioral couple therapy for substance use disorder (BCT-SUD) plus 12-step-oriented drug counseling (DC/12) to DC/12 only for women with alcohol dependence and their male partners. In comparison to those who received DC/12 only, women who received BCT-SUD plus DC/12 had greater percentage days abstinent and fewer SU-related problems at 12-month FU. Male partners in the BCT-SUD plus DC/12 condition had higher relationship happiness at posttreatment. Regarding women's relationship satisfaction, BCT-SUD plus DC/12 had an increasing advantage only at 12-month FU, and BCT-SUD plus DC/12 was superior to DC/12 only for women who had lower pretreatment relationship satisfaction. In a different study of women with alcohol use disorders, McCrady, Epstein, et al. (2016) compared a standalone version of alcohol behavioral couple therapy (ABCT) to a blended version that included individual cognitive-behavioral therapy. They found that the blended ABCT version produced greater treatment attendance, a lower percentage of heavy drinking days, and for women with lower self-efficacy, a lower percentage of heavy drinking days. The conditions did not differ on relationship satisfaction. O'Farrell et al. (2016) compared group-based BCT-SUD plus group-based DC/12 to standard, one couple at-a-time BCT-SUD plus group-based DC/12 among individuals with alcohol dependence. Those who received standard BCT-SUD plus DC/12 had post-treatment improvements on SU-related and relationship outcomes that lasted through 12-month FU. In contrast, those who received group-based BCT-SUD+DC/12 showed post-treatment improvements but then exhibited significant deterioration on SU-related problems and relationship satisfaction beginning at 6–9 months FU. O'Farrell et al. (2017) compared BCT-SUD plus DC/12 to DC/12 only for women with drug use disorders (74% primary opioids) and their male partners. Both conditions were associated with large improvements on SU-related problems, although BCT-SUD plus DC/12 had fewer problems at post-treatment. BCT-SUD plus DC/12 showed higher male-reported relationship satisfaction and less percentage days of separation at 12-month FU.

DISCUSSION

Current level of support for couple and family outpatient treatment for SUD

The final Level of Support designations for couple and family treatment are presented in Table 3. Designations were determined based on the collective body of evidence to date, incorporating results covered in the previous JMFT updates (O'Farrell & Clements, 2012; Rowe, 2012) along with studies published prior to 2010 that pertained to establishing a cumulative Level of Support designation for a given approach. Specific brand-name treatment models are listed under their respective approaches, with each model given its own Level of Support designation. Regarding distinctions between the Level of Support categories stipulated in Southam-Gerow and Prinstein (2014), notable differences between well-established versus probably efficacious lie in the strength of the comparison condition (active treatment or placebo, vs. waitlist control) and demonstration of effects by an independent investigative team (required for the well-established level). The distinction between probably efficacious versus Possibly Efficacious is based primarily on the number of studies supporting the given treatment. As described previously, review inclusion criteria

TABLE 3 Scorecard: level of support designations for couple and family therapy substance use treatment approaches, with supporting citations

Well-established standalone treatments	
Systemic family therapy	**Adolescent studies:** • BSFT: **Probably efficacious:** Robbins et al. (2008, 2011[a]), Santisteban et al. (2003) • EBFT: **Probably efficacious:** Slesnick and Prestopnik (2009) and Slesnick et al. (2013)[a] • FFT: **Well established:** Rohde et al. (2014)[a], Slesnick and Prestopnik (2009) and Waldron et al. (2001) • MDFT: **Well established:** Dakof et al. (2015)[a], Dennis et al. (2004), Liddle et al. (2001, 2008, 2009, 2018[a]) and Rigter et al. (2013)[a] **Adult studies:** • EBFT: **Probably efficacious:** Slesnick and Zhang (2016)[a]
Probably efficacious standalone treatments	
Behavioral family therapy	**Adolescent studies:** • FBT: **Probably efficacious:** Azrin et al. (1996) and Azrin et al. (2001) • SOFT: **Possibly efficacious:** Smith et al. (2006) • MFT: **Experimental:** Liddle et al. (2001) **Adult studies:** • FBT: **Experimental:** Donohue et al. (2014)[a]
Behavioral couple therapy	**Adult studies:** • ABCT: **Probably efficacious:** McCrady et al. (1999) and McCrady et al. (2009)
Well-established multicomponent treatments	
Behavioral family therapy plus other approaches	**Adolescent studies:** • MI+CBT+BFT: **Well established**: Esposito-Smythers et al. (2011)[a] and Waldron et al. (2001)
Behavioral couple therapy plus other approaches	**Adult studies:** • BCT-SUD+DC/12: **Probably efficacious:** O'Farrell et al. (2016[a], 2017[a]) and Schumm et al. (2014)[a] • ABCT+CBT: **Well established:** McCrady, Epstein, et al. (2016)[a] and Walitzer and Dermen (2004)

Abbreviations: ABCT, alcohol behavioral couple therapy; BCT-SUD, behavioral couple therapy for substance use disorder; BFT, behavioral family therapy; BSFT, brief strategic family therapy; CBT, cognitive-behavioral therapy (individual or group format); DC/12, Drug Counseling/12-Step Approach (individual or group format); EBFT, ecologically based family therapy; FBT, family behavior therapy; FFT, functional family therapy; MFT, multiple family therapy; MI, motivational interviewing; MDFT, multidimensional family therapy; SOFT, strengths oriented family therapy.

[a]Pound sign indicates a study published between 2010 and 2019 and therefore described in the narrative review.

omitted studies that did not use a randomized design, which may have excluded research on some interventions that would otherwise have met criteria as Possibly Efficacious or Experimental. Table 3 does not list couple therapy studies for which William Fals-Stewart was an author due to prominent allegations about the methodological credibility of some research under his direction.

Multiple types of couple and family treatments were classified as having strong empirical support. Systemic family therapy was determined to be a well-established standalone treatment. Numerous studies supported the efficacy of systemic family therapy among adolescents, and one study supported its efficacy among adults. Behavioral family therapy was found to be probably

efficacious as a standalone treatment, with two studies supporting its efficacy among adolescents, and one study finding evidence for its superiority among a subgroup in the adult study pool. Behavioral family therapy was determined to be well-established for adolescents as part of a multicomponent treatment that includes behavioral family therapy plus motivational interviewing and cognitive-behavioral therapy. Based on studies by McCrady et al. (1999, 2009), BCT was found to be a probably efficacious standalone treatment for adults. BCT was found to be well-established for adults as part of a multicomponent treatment that includes either a DC/12 or cognitive-behavioral therapy component.

In summary, systemic family therapy is well-established as a standalone treatment, and behavioral family therapy and behavioral couple therapy are probably efficacious as standalone treatments and well-established as part of a multicomponent treatment. These findings are consistent with prior reviews and meta-analyses of couple and family interventions that have focused exclusively upon adult (O'Farrell & Clements, 2012) or adolescent populations (Hogue et al., 2018; Tanner-Smith et al., 2013) and that have focused exclusively on alcohol (O'Farrell & Clements, 2012) versus other drug use disorders (Rowe, 2012). The demonstrated benefits of these therapies for both adolescents and adults is consistent with the meta-analysis by Ariss and Fairbairn (2020), which showed that age did not moderate the degree of benefit from SUD therapies that included CSO. Importantly, there was an admirable degree of demographic diversity among participants within and across studies, noting the exception that most samples in BCT studies were homogenously White Non-Latinx.

Practice guidelines

Given the superiority of various types of couple and family-based therapies versus bona fide individual- and group-based therapies, SUD treatment programs and practitioners should routinely offer couple and family therapies as a standard-of-care option. Although we offer specific recommendations based on findings from the current review, it is important to consider that Ariss and Fairbairn (2020) did not find differences in SU outcomes among the types of therapy that involved CSO. This suggests that there is probably not a "bad" choice when selecting an empirically supported couple or family-based treatment protocol. However, selection of a specific protocol can be guided by fit to the program or practitioner and/or by client preferences. If the goal is to provide family-based therapy as a standalone option, evidence suggests that systemic family therapy is well-established and should be considered a first-line option. Given the number of high-quality studies conducted with adolescents, systemic family therapy is especially recommended as a standalone intervention for this population. We understand that barriers exist to training in systemic family therapy for providers, and we are deeply invested in developing innovative methods for training in core elements of family therapy (Hogue et al., 2017a, 2017b, 2019) as a way to demystify and democratize systemic family therapy and ultimately make it more accessible to providers and families.

Another standalone option for adolescents and potentially for adults is behavioral family therapy, which is classified as probably efficacious. For adults, behavioral couple therapy is classified as probably efficacious and could also be considered as a standalone option. SUD treatment providers and clients might also be interested in selecting a couple or family intervention that is complementary to individual- or group-based therapies. This could provide flexibility in offering a standard-of-care individual treatment option for all clients, plus couple or family therapy for clients with treatment-involved CSO. There is some evidence that adult women prefer

a treatment program that includes individual therapy plus couple or family therapy versus a standalone couple or family therapy (McCrady et al., 2011). If the goal is to incorporate couple or family therapy as part of a multicomponent treatment, we recommend behavioral family therapy for adolescents and BCT for adults as first-line choices.

Treatment modality

In addition to considerations for selecting a specific treatment approach and protocol, it is worth considering differences in the delivery format of treatments. Because groups are a common format in SUD treatment programs and have lower delivery costs, it is appealing to regard group-based treatments as an alternative to one couple or family at-a-time delivery. However, O'Farrell et al. (2016) found that group-based BCT-SUD produced less durable improvements versus the standard one couple at-a-time delivery of BCT-SUD. Due to its inferiority, the cost effectiveness of group-based BCT-SUD was very low in comparison to standard BCT-SUD (Dunlap et al., 2020). Administrators and therapists are encouraged to consider the possible longer-term outcomes and cost effectiveness that may favor standard one couple or family at-a-time versus group-based delivery of specific protocols.

Implementation challenges

A major challenge in the implementation of the reviewed couple and family-based treatments is training of therapists in manualized protocols. An example is the US Department of Veterans Affairs national dissemination of BCT-SUD. Following best practices from implementation science (e.g., Miller et al., 2004), this training program provided therapists with a three-day in-person training workshop followed by six months of BCT-SUD case consultation and review of recorded BCT-SUD sessions for evidence of protocol fidelity. Program evaluation found evidence for the effectiveness of training and consultation in improving therapist attitudes and skills in delivering BCT-SUD as well as significant client improvements (O'Farrell et al., 2015). But although training and client outcomes were positive, the approach was highly time- and resource-intensive, required strong buy-in from organizational leadership, and required high therapist commitment to completing the training and consultation elements. Similar training requirements and costs are associated with manualized systemic and behavioral family therapy models (e.g., Donohue et al., 2014; Robbins et al., 2011). Research is needed to determine whether more cost-efficient approaches (e.g., remote training) can yield positive outcomes while increasing the reach and sustainability of manualized protocols.

Innovative future directions

Delineating transdevelopmental practices for SUD

As described above, there are several effective couple and family therapy models for adolescent and adult SUD. In our view, a promising way to address implementation challenges for manualized protocols, particularly the challenge of provider orientation to treat either adolescents OR adults, families OR couples, is to identify relational interventions that are transdevelopmental:

effective for multiple family members across the lifespan. For example, some research suggests that family-based interventions for SUD can have important benefits for CSO in addition to symptom reduction for the conventionally named *identified patient* (Slesnick & Zhang, 2016).

Chorpita et al. (2005) developed a framework to organize evidence-based treatments at a more fundamental level than what manuals offer, by focusing on discrete treatment techniques that constitute the core practices of manualized models for a given disorder. To delineate core relational interventions for SUD that are suitable for adolescents/caregivers AND couples, it is necessary to identify both key developmental processes in the etiology of SUD and shared therapeutic processes for effective lifespan treatment. To facilitate this, we posit a developmental crossroads perspective (see McGoldrick et al., 2015) that emphasizes the bidirectional relation between SUD and family development: SUD can emerge as a response to pressures generated by family developmental crises (e.g., divorce, adolescent launch, older adulthood), and SUD can influence how families respond to developmental crises.

Previous research on distilling manualized family therapies for adolescent SUD yielded a set of four core intervention strategies: adolescent engagement, relational emphasis, inviting change in meaning (reframing), and inviting change in family interactions (Hogue et al., 2019). Juxtaposing these core interventions with the core techniques of BCT (e.g., increasing positive activities, teaching communication), a promising common denominator for transdevelopmental intervention can be distilled: relationship improvement in the context of SU and the family life cycle. Moreover, specific treatment techniques that are aligned with a transdevelopmental intervention approach for SUD, and also embedded within numerous evidence-based couple and family therapy treatment protocols, can be tentatively identified. These include multiparticipant engagement, development of multiple perspectives, psychoeducation on SUD and relationships, coaching in landscape of action, coaching in landscape of meaning, and family contract building.

To be sure, substantial conceptual and empirical work needs to be completed in order to confidently delineate a core set of transdevelopmental practices for SUD. We believe the rewards for such effort would be equally substantial. With a focus on overall family functioning and learning new relationship skills, transdevelopmental practice elements can better align with the premise that every family member/CSO has strengths and resiliencies on which to capitalize, and every one can learn more adaptive behavior. Transdevelopmental practices may even prove more effective than targeted manuals in the context of nontraditional family structures such as families of choice, single parenthood, and polyamorous families, aspiring to a psychosocial kinship model for relational therapy (Pattison et al., 1975). They could also help ameliorate acute and far-reaching effects of stigma in families (see Livingston & Boyd, 2010) by decreasing focus on one "problematic" member and loosening often-rigid roles for others.

Transforming the national system of SUD healthcare

In the most recent National Survey of Substance Abuse Treatment Services (Substance Abuse and Mental Health Services Administration (SAMHSA), 2019), the nation's SUD providers reported that compared to the near ubiquitous use of individual and group counseling (99% and 95%, respectively), family counseling was used by 85% of programs and marital/couple counseling by 66%. At face value these data suggest relational interventions are offered by a majority of programs, though to a lesser degree than individual and group. However, the same survey's list of clinical/therapeutic approaches offered within the national system of care does not contain

any of the evidence-based couple or family interventions described in the current review; to the contrary, all fourteen intervention approaches/models included in the survey were individual- or group-based treatments. This omission reflects tacit acknowledgement by SAMHSA that whereas most SUD treatment providers report that they counsel families in some fashion, evidence-based couple and family therapy is not commonly practiced—it is not even on the radar.

Given the strength of the research base supporting couple and family interventions for SUD across the lifespan, we hold self-evident the need to change the national system of SUD healthcare to forge a path for relational interventions. Transforming SUD services to be oriented toward relationships and their ecologies, rather than individuals, is an enormous task, as most practitioners work within the context of a profoundly individual approach, granting implicit and often explicit supremacy to the notion of individualism, self-reliance, and the generally autonomous self (see Rasheed, 2010). A paradigm shift toward relational interventions would invite movement toward systemic conceptualizations of SUD problems and solutions, more fluid and flexible roles for target clients and CSO, thicker and more complex treatment narratives, and recasting "alone" to "together" in SUD treatment. To be sure, pursuing a large-scale shift of SUD services along these lines would require re-alignment of virtually every function of treatment systems, from billing and documentation to clinical interventions to service delivery contexts themselves, with an eye toward focusing on relationships. The potential benefit of this unprecedented transformation would be a SUD healthcare network much better positioned to deliver the most effective treatments for these most vulnerable populations.

CONCLUSION

Based on our critique of multiple randomized controlled trials conducted over the past decade, there is strong evidence for the efficacy of couple and family therapies in the treatment of SUD across the lifespan. This review adds to the literature by examining various types of these therapies, including systemic family therapy, behavioral family therapy, and behavioral couple therapy. We found evidence in support of each of these types of therapies, suggesting that the benefits transcended the particular type of couple or family-based treatment that was implemented. We also examined evidence of these interventions as standalone treatment versus part of a multicomponent intervention. Systemic family therapy is well-established as a standalone intervention, with most of the reviewed studies examining this approach as a SUD treatment for adolescents. Although both behavioral family therapy and BCT are probably efficacious as standalone treatment approaches, they are well-established when delivered as part of a multicomponent intervention. These findings suggest that couple and family-based therapies produce benefits for SUD whether they are being provided as the exclusive treatment or are being delivered as part of a multicomponent SUD treatment program.

ACKNOWLEDGEMENT

We would like to thank the librarian of the Partnership to End Addiction, David Man, for his invaluable assistance in conducting the primary article search and reviewing abstracts for initial study inclusion.

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Wittenborn, A. K., & Holtrop, K. (2022). Introduction to the special issue. *Journal of Marital and Family Therapy*.

How to cite this article: Hogue, A., Schumm, J. A., MacLean, A., & Bobek, M. (2022). Couple and family therapy for substance use disorders: Evidence-based update 2010–2019. *Journal of Marital and Family Therapy*, 48, 178–203. https://doi.org/10.1111/jmft.12546