COUPLES' PERSPECTIVES IN CONGRUENCE COUPLE THERAPY AND TREATMENT AS USUAL: A SERVICE-USER ENGAGEMENT STUDY

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Abstract

Couple therapy in addiction treatment is not a widely available service, despite relatively strong evidence for its efficacy. This study solicited service users' perspectives on their experience of Congruence Couple Therapy (CCT) or individual-based Treatment as Usual (TAU) for alcohol use disorder and/or gambling disorder in a randomized trial. Twenty participants were interviewed on the benefits and limitations of CCT and TAU based on their lived experiences with addiction, treatment, and change in a couple context. Eight other service users were engaged in the research process as advisors who provided input on developing the interview protocol and gave feedback to the findings. The findings highlighted the service users' preferences and values regarding couple therapy in addiction treatment compared to individual-based treatment, which could help inform service providers to address the current gap of couple therapy in our addiction and mental health services.

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List of Abbreviations

AA	Alcoholics Anonymous
ABCT	Alcohol-Focused Behavioural Couple Therapy
ACE	Adverse childhood experience
Al-Anon	Alcoholics Anonymous Family Groups
AUD	Alcohol use disorder
BCT	Behavioural Couple Therapy
CALM BCT	Counselling for Alcoholics' Marriages Project Behavioural Couple Therapy
CBT	Cognitive Behavioural Therapy
CCT	Congruence Couple Therapy
EFT	Emotionally Focused Therapy
GD	Gambling disorder
IBCT	Integrative Behavioural Couple Therapy
ICT-PG	Integrative Couple Treatment for Pathological Gambling
IP	Identified patient
MSTH	Moms Stop the Harm
RCT	Randomized controlled trial
S-BCT	The shortened version of Behavioural Couple Therapy
SCN	Strategic Clinical Network
SMART	Self-Management and Recovery Training
SUD	Substance use disorder

Chapter 1: Introduction

1.1 Background

Couple therapy in addiction treatment has garnered a corpus of findings on its efficacy (O'Farrell & Clements, 2012; Lee, Dei, Brown, Awosoga, Greenshaw, & Shi, 2021), cost-outcomes (Fals-Stewart, O'Farrell, & Birchler, 1997; Finney & Monahan, 1996), and uptake (e.g., Fals-Stewart & Birchler, 2002; Fals-Stewart, Klostermann, Yates, O'Farrell, & Birchler, 2005; Lee, Rovers, & Maclean., 2008; O'Farrell, Richard, & el-Guebaly, 2010). However, couple therapy is not a widely available service in the addiction and mental healthcare system in North America (e.g., Fals-Stewart & Birchler, 2001; McGovern, Fox, Xie, & Drake, 2004; Wild et al. 2014). Individual-based treatment services remain dominant.

In the research-to-practice continuum of the healthcare system, end users' perspectives are instrumental in guiding the production and broader implementation of research knowledge to match service needs (Banner et al., 2019). Among the end users (service providers, service users, etc.), service users are an often underrepresented group in health research (Canadian Institute of Health Research, 2011). Service users' preferred treatment regimens at times contradict the routine practices in healthcare (Sleep et al., 1984). Service users' evaluation of treatment services may provide insight into incongruences between the services available and the service users' values and priorities (Albani, & Prakken, 2009). Further, understanding a particular group of service users' context can help adapt an evidence-supported treatment program to community-based services (Hanson, 2015). Therefore, service users' perspectives are important in informing the translation of evidence-based interventions and best practices.

Service users in the field of addiction include both the identified patients (IPs) and their intimate others. The investigation into the service users' perspectives in couple therapy in

addiction treatment and regular treatment services will shed light on the service users' preferences and values related to aspects of conjoint and individual-based treatment programs. Greater knowledge in service users' perceived treatment needs between the two modalities may inform the integration of couple therapy in addiction treatment services.

Further, service users not only can assist end-of-grant knowledge translation towards implementation, but their involvement in the process of knowledge production can also help steer research towards greater applicability to service users' priorities (Canadian Institute of Health Research, 2014). To integrate the goals of knowledge translation from the launch point of inquiry, engaging service users in the research process is a practical step (Hanson, 2015).

1.2 The Current Study

This study inquired into the perspectives of service users (IPs and their intimate partners) in a systemic couple therapy program and individual-based treatment as usual in addiction services. The sample consisted of couples who had participated in Congruence Couple Therapy (CCT) or Treatment as Usual (TAU) for alcohol use disorder (AUD) and/or gambling disorder (GD) in a randomized controlled trial (RCT) at two provincial addiction and mental health clinics in Alberta, Canada. The participants were interviewed one-on-one on the benefits and limitations of CCT and individual-based addiction services based on their lived experience with addiction, the treatment, and change in a couple context.

A separate group of service users who or whose family members had lived experience with addiction were engaged as advisors in the research process. The service-user advisors provided input on developing the data collection instrument (i.e., the semi-structured interview protocol) and gave feedback to the findings which helped shape the discussion. The service-user

advisors' engagement in the research process was intended to support the credibility and service-user relevancy of the findings.

The couple therapy of interest, CCT has shown positive results in treating AUD and GD, enhancing emotion regulation, and improving couple relationships (Lee et al., 2021). However, its benefits and limitations in comparison with individually focused addiction treatment programs have not been explored from the service users' perspectives. Service users' perception of the helpfulness and limitations of CCT compared to individual-oriented TAU will help illuminate the service users' preferences in various aspects of the two treatment modalities and inform the broader uptake of couple therapy in addiction treatment.

1.3 Research Questions

The research question of the study was: *What aspects of Congruence Couple Therapy (CCT) and Treatment as Usual (TAU) do the individuals with addiction and their partners find helpful and lacking in assisting their addiction recovery as individuals and as a couple?*

Chapter 2: Literature Review

This literature review presents a brief overview of (1) the theoretical foundation, key programs, and outcome findings of couple therapy in addiction treatment, (2) the findings related to knowledge translation, including cost outcomes and clinician training of couple therapy in addiction treatment, and (3) the service users' perspectives in couple therapy in addiction treatment.

Addiction in this review refers to both substance use disorders (SUDs) and gambling disorder (GD), which are the addictive disorders recognized in the DSM-5 (American Psychiatric Association, 2013). The empirical foundation of couple therapy in addiction treatment is primarily built upon the findings on treatment for alcohol use disorder (AUD) and other SUDs (McCrady, Ladd, & Hallgren, 2012; O'Farrell & Clements, 2012). It was not until the last two decades when couple therapy was introduced to treat GD (Lee, 2002; Bertrand, Dufour, Wright, & Lasnier, 2008; Hodgins, Stea, & Grant, 2011). Therefore, when discussing the theoretical basis and empirical evidence of couple therapy in addiction treatment, references are mostly drawn from the literature on treatment for AUD and other SUDs.

As our evolving understanding of the concept of addiction is reflected in the terminology, the use of terms needs to be considered in this literature review. The term *alcoholism* will be used when referencing theories where this particular construct is central (e.g., the theories of the family disease model, which was derived from the 12-step literature on alcoholism). When citing research findings, the definition of addiction in the original context will be honoured, and the terms of addiction will vary depending on the particular DSM criteria used in the cited studies. For example, recurrent maladaptive gambling with addictive phenomenology such as preoccupation, tolerance, and withdrawal is termed *pathological gambling* in DSM-IV and

gambling disorder in DSM-5. Another term, *problem gambling*, which is a commonly used psychometric measure for gambling behaviours that cause harmful consequences, will be retained from the cited reports. When the term *alcoholism* was used in the original study (often in the 1990s – early 2000s), it will be substituted in this literature review with the corresponding DSM-IV terms *alcohol abuse* or *alcohol dependence*. When reporting combined findings, DSM-5 terminology, i.e., *substance use disorder*, *alcohol use disorder*, or *gambling disorder*, will be used.

2.1 Conceptualizing Addiction within the Family

The theories that define the relationship between an individual's addiction and family dynamics set the foundation of couple and family therapy in addiction treatment. These theories have evolved over the last four decades since couple and family therapy was first hailed as a promising advancement in addiction treatment (Keller, 1974). These theories are at the root of various models and approaches of family and couple therapy programs for addictive disorders today.

Family disease model. The *family disease model* emerged from the 12-step communities and has influenced the public conceptions on how family members could encourage addiction (McCrady et al., 2012). The model views addiction, particularly alcoholism, as a family disease, where the spouses/family members of the alcoholics suffer from *codependency* and engage in behaviours that *enable* alcoholism. *Codependency* involves a personality substrate where an individual invests one's self-esteem in caregiving and tends to be enmeshed in relationships with a pathological other (Cermark, 1986). This model is criticized for pathologizing and blaming the family members (e.g., Calderwood & Rajesparam, 2014) and the extrication of family members with an emphasis on individual interest (Lee, 2014). Research findings have repeatedly

challenged the validity of codependency (e.g., Hands & Dear, 1994), and the family disease model, therefore, has not received substantial empirical support.

Although the family disease model is not empirically supported, its influence on public notions and many 12-step oriented clinicians should be recognized. Further, some concepts derived from this model, such as healthy *detachment* (Gorman & Rooney, 1979), still have important clinical utility today. In 12-step based family support programs such as Al-Anon (Al-Anon Family Groups, 1995), family members are encouraged to practice detachment from their loved ones' addiction to cope. They learn to let go of their need to control the addiction and focus on making changes in themselves. Healthy detachment has also been broadly adopted in other counselling and support programs in the community for affected others.

Family system model. The *family system model* posits the notion of an *alcoholic family* in which family interactions are organized in a way that sustains the addiction behaviour (e.g., Steinglass, Bennett, Wolin, & Reiss, 1987). The family system model is derived from the observation of family interactions with chronic alcoholic members (Steinglass, 1981; Steinglass, Davis, & Berenson, 1977; Steinglass, Weiner, & Mendelson, 1971). It hypothesizes that drinking fulfills adaptive functions for the family, such as affective expression and open discussion, which may not take place when the alcoholic members are sober (Davis, Berenson, Steinglass, & Davis, 1974). Therefore, an alcoholic family has alcohol fixed into its regulatory behaviours (routines, rituals, and problem-solving) that maintain the *homeostasis* of the family system (Steinglass et al., 1987).

The system perspectives are fundamental to couple and family therapy that examine patterns of relationship interactions (McCrady et al., 2012). System perspectives view phenomena as a system of parts that interact with each other to form a dynamic whole (Bowen,

1966). Family system approaches attend to interactional patterns and facilitate healthy boundaries and roles (McCrady et al., 2012; Stanton & Welsh, 2012). Today, family system approaches are commonly used for adolescents with substance abuse (Huey, Henggeler, Brondino, & Pickrel, 2000; Rowe, 2012; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013). The couple therapy investigated in this thesis, Congruence Couple Therapy, aligns with the systems philosophy and aims to facilitate change at a systemic level rather than in individual behaviours (Lee, 2009).

Cognitive-behavioural model. The *cognitive-behavioural model* hypothesizes that addiction is reinforced by negative family interactions (e.g., O'Farrell & Fals-Stewart, 2006). Studies on characteristics of interactions in alcoholic families (e.g., Jacob, Ritchey, Cvitkovic, & Blane, 1981; Hersen, Miller, & Eisler, 1973; Leonard & Jacob, 1997), spouses' coping styles (for review, Hurcom, Copello, & Orford, 2000), and the impact of communication styles on drinking outcomes (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998; Shoham, Rohrbaugh, Stickle, & Jacob, 1998) contributed to the development of the cognitive-behavioural theories.

In recent years, couple and family programs in addiction treatment based on the cognitive-behavioural model have accrued a considerable body of research evidence (O'Farrell & Clements, 2012). It should be noted that most of these interventions also draw insight from the family system perspectives (McCrady et al., 2012). For example, the well-known Behavioural Couple Therapy (Epstein & McCrady, 2002; O'Farrell & Fals-Stewart, 2006) conceptualizes an interactive and reciprocal relationship between addiction and couple dysfunctions. While addiction contributes to couple relationship issues, relationship distress and communication deficits, in turn, escalate and perpetuate addiction.

The next section will follow this bidirectional relationship between addiction and family dynamics in organizing its content, which is a common structure in literature reviews of similar topics (e.g., Kourgiantakis, Saint-Jacques, & Tremblay, 2013). The negative impact of addiction on the family and the influence of the family on the development and recovery of addiction will be discussed.

2.2 Addiction and Family Dynamics

Addiction (SUDs and GD) affects and is affected by a person's interpersonal relationships and social environment (Graham, Young, Valach, & Wood, 2008). For those in couple relationships, their addiction is intricately intertwined with their couple relationships. Evidence suggests that addiction and couple functioning form an interactive relationship, where couple problems and addiction are mutually escalating, while improved relational functioning is conducive to addiction recovery (Fals-Stewart, O'Farrell, & Birchler, 2004; Lee, 2014, 2015).

Impact of addiction on the family. Addiction affects the well-being of intimate others and creates costly burdens on society (McComb, Lee, & Sprenkle, 2009; Room, 2000; Room et al., 2010). The addicted individuals' primary social systems, i.e., their families (including significant others), often suffer from psychological distress, relationship dysfunctions, and an increased risk of abuse (e.g., Black, Shaw, McCormick, & Allen, 2012; Copello, Templeton, & Powell, 2010).

The family members of the identified patient (IP) live under the stress and strain of addiction (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). Financial loss, changes in the IP (e.g., increasing aggression in the case of substance abuse), disturbances of family life, and social stigma cause tremendous psychological stress on the family members. The family members reported anxiety for the IP's wellbeing, self-blame and damage to self-image,

depression and hopelessness, and symptoms of ill health (Lorenz & Yaffee, 1988; Orford et al., 2010; Wiseman, 1991). Family members of individuals diagnosed with substance use problems were found to have higher medical expenses and a greater likelihood to be diagnosed with some medical conditions (Ray, Mertens, & Weisner, 2007).

Multiple studies have found a negative correlation between addiction and marital dissatisfaction (e.g., Hodgins, Shead, & Makarchuk, 2007; Johns, Newcomb, Johnson, & Bradbury, 2007; Marshal, 2003). Problematic communication such as demand-withdraw dyadic patterns (Shoham, Rohrbaugh, Stickle, & Jacob, 1998), expression of hostility and criticism (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998), and lack of openness and mutual understanding (Lee, 2002, 2014) is common among couples with addicted partners. Estrangement and disconnection are recurring themes among these families and couples, as many reported living separate lives (Tepperman, Korn, & Reynolds, 2006) and feeling isolated from each other (Dowling, Smith, & Thomas, 2009; Lee, 2002).

A high rate of intimate partner violence (IPV) and risk of child maltreatment is associated with substance use (e.g., Fals-Stewart, W., Golden, J., & Schumacher, 2003; Guterman & Lee, 2005) and problem gambling (e.g., Afifi, Brownbridge, MacMillan, & Sareen, 2010). Further, children who live with an addicted parent have a higher risk of addiction, depression, anxiety, antisocial behaviours, and general maladjustment (Harter, 2000).

In sum, psychological distress, poor relationship functioning and communication, elevated incidence of IPV, and high risk of child abuse and children's maladaptation pervade couples and families with members who have substance use and gambling problems. The following subsection will demonstrate the converse – that family environment and couple relationship also affect the prognosis and recovery of addiction.

Family factors contributing to addiction. Family processes and relationship factors may contribute to the development of addiction and relapse. First, relationship dissatisfaction and problematic communication increase the risk of addiction. A longitudinal study with a community sample demonstrated that low marital satisfaction predicts the occurrence of alcohol use disorder in the following 12 months (Whisman, Ueberlacker, & Bruce, 2006). Clinical research on gambling addiction showed that ineffective communication patterns in couples were present before the problem gambling began (Lee, 2014; Steinberg, 1993). Second, couple relationship dysfunctions add to the risk of relapse. Negative couple communication has been found to predict relapse (Maisto, McKay, & O'Farrell, 1998; O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998), and couple conflict is identified as a precipitant to relapse (Maisto, O'Farrell, Connors, McKay, & Pelcovits, 1988).

Family factors supportive of addiction recovery. Some types of family and couple environment is beneficial for addiction recovery. The concern for one's spouse and couple relationship is reportedly the most common motivation for treatment-seeking individuals with alcohol abuse or dependence (Steinburg, Epstein, McCrady, & Hirsch, 1997) and problem gambling (Ladouceur et al., 2004). For alcohol abuse/dependence, Fitcher and colleagues (1997) found that a key family member's attitude (*expressed emotions*) towards the IP that involved a low level of criticism and a high level of warmth predicted a lower risk of relapse. O'Farrell et al. (1998) found the significant others' overall low level of negative expressed emotions (criticism, hostility, and emotional overinvolvement) was predictive of lower likelihood and less severity of relapses. For problem gambling, social support from family and friends was found to be a significant contributing factor to abstinence among Gambling Anonymous members (Oei & Gordon, 2008), and social support predicted better treatment outcomes for pathological gambling

and lower problem severity at the follow-up (Petry & Weiss, 2009). A supportive family environment was also associated with treatment continuation for pathological gamblers (Grant, Kim, & Kukowski, 2008).

Further, studies on spouses' coping styles in response to alcoholism suggested that spouses' confrontational attitude against the addiction behaviours yet supportive attitude towards the IPs may be most helpful in facilitating change, compared to coping styles characterized with withdrawal (Orford et al., 1975) or tolerance (Schaffer & Tyler, 1979). Due to difficulty in distinguishing healthy detachment and disconnection/withdrawal and differentiating tolerance and support (Orford, 1994), there is disagreement on the efficacy of different coping styles. However, generally speaking, clear boundaries, positive reinforcement, and detachment to prevent fruitless conflicts are considered helpful in effecting change in the IPs (Hurcom, Copello, & Orford, 2000).

2.3 Engaging Couples in Addiction Treatment

Given the impact of addiction on the family members and the family members' potential influence on addiction and its recovery, two kinds of family-oriented programs have been developed. First, support groups and therapy are offered to assist the affected others in coping with their loved ones' addiction, such as 12-step based self-help groups (e.g., Al-Anon and GamAnon) and skill-training programs (Copello et al., 2009; Rychtarik & McGillicuddy, 2005; Zetterlind, Hansson, Aberg-Orbeck, & Berglund 2001) for family members and friends. Second, unilateral and conjoint programs have been built to engage the family members and friends to encourage and assist the IPs' effort to change (see review, Nelson & Sullivan, 2007; O'Farrell & Clements, 2012). Unilateral family engagement programs have traditionally been training programs for family members and friends to encourage the IPs' treatment entry and engagement,

such as Community Reinforcement and Family Training (CRAFT; Roozen, Waart, & Van Der Kroft, 2010; Smith & Meyers, 2004). Conjoint programs are primarily couple and family therapy in addiction treatment (Austin, Macgowan, & Wagner, 2005; O'Farrell & Clements, 2012), which assist addiction recovery while simultaneously improve couple and family relationships.

The second kind of family programs that involve family members in addiction treatment have been consistently found efficacious (e.g., Copello, Velleman, & Templeton, 2004; O'Farrell & Clements, 2012). In a recent meta-analysis with 17 independent samples (Ariss & Fairbairn, 2020), involving significant others (e.g., romantic partners, family, friends) in SUD treatment was found to have a significant effect above and beyond the comparing individual-based treatment for reducing substance use and related problems. The significant other involved treatment included conjoint couple and family treatment as well as the Community Reinforcement Approach. The effect was found consistent across the treatment types and lasted 12-18 months after the treatment.

Research attention on couple and family treatment began in the late 1960s (Burton & Kaplan, 1968a, 1968b; Smith, 1967, 1969). There have been findings showing that couple therapy in substance abuse treatment is superior to individual-based treatment in retaining treatment engagement (Stanton & Shadish, 1997), improving couple adjustment, and maintaining treatment results at follow-ups (E.g., O'Farrell & Fals-Stewart, 2006; Powers et al., 2008). Couple therapy programs in addiction treatment could be classified into two types depending on their theoretical frameworks. In behavioural-based therapy (e.g., Behavioural Couple Therapy; McCrady et al., 2016; O'Farrell & Fals-Stewart, 2006), the partners are engaged to assist the IPs' treatment effort, and they are trained in behavioural strategies to discourage addiction behaviours and reward abstinence. In systems-based therapy (e.g., Congruence Couple Therapy; Lee, 2009),

the IPs and partners are viewed as part of a dysfunctional couple system intertwined with the addiction, and they are brought together to make changes in their interactions and relational patterns conducive for addiction recovery.

The proceeding sections will review couple therapy programs known for their benefits in SUD treatment and GD treatment respectively, focusing on Behavioural Couple Therapy (BCT) and Congruence Couple Therapy (CCT). Couple therapy in SUD treatment has accumulated considerable evidence for its efficacy, but most of the research attention has been on BCT. As findings on BCT constitutes the bulk of the evidence for couple therapy in addiction treatment, the review on BCT is necessary. Building upon the findings of couple therapy in SUD treatment, researchers have introduced couple therapy to GD treatment. CCT has become the first empirically supported couple therapy program in GD treatment, and the present thesis aims to explore the couples' perspectives in CCT in comparison with TAU for both AUD and GD treatment.

2.4 Couple Therapy for Substance Use Disorders

Behavioural Couple Therapy (McCrady et al., 2016; O'Farrell & Fals-Stewart, 2006) is the most recognizable model among family and couple therapy programs for addiction treatment with research dating back to the 1970s (for reviews, see Fletcher, 2013; O'Farrell & Clements, 2012).

Behavioural couple therapy. Behavioural Couple Therapy (BCT) rests on the notion that certain couple interactions can reinforce addiction, contributing to escalation and relapse of addiction (McCrady et al., 2016; O'Farrell & Fals-Stewart, 2006). Therefore, BCT's premise is that conducive spousal behaviours can reward change and that happier and more cohesive relationships with better communication could lower the risk of relapse. The interventions in

BCT focus on (1) developing support for abstinence/reduction of addiction behaviours and (2) improving couple relationship and communication (O'Farrell & Clements, 2012). Two BCT programs have dominated the research on BCT: (1) the Alcohol-Focused Behavioural Couple Therapy (ABCT) program (McCrady & Epstein, 2008; McCrady et al., 2016; Noel & McCrady, 1993) and (2) the Counselling for Alcoholics' Marriages (CALM) Project BCT program (O'Farrell & Fals-Stewart, 2006; O'Farrell, 1993).

Interventions. ABCT and CALM BCT are similar in their relationship-focused interventions. They provide cognitive-behavioural skill training to improve communication and problem-solving and utilize homework activities to increase a couple's positive interactions. The two programs differ in their addiction components. ABCT facilitates abstinence with spousal involvement, where the spouse learns specific skills to respond to alcohol-related scenarios, cope with alcohol-related feelings, and provide support to the IP's behavioural change (McCrady et al., 2016). CALM BCT employs a *recovery contract* as a key method for addiction treatment (O'Farrell, 1993; O'Farrell & Fals-Stewart, 2006). The contract includes a daily *trust discussion* between the couple in which the IP states an intent to stay abstinent that day and the couple express appreciation for each other. The couple agree not to discuss the addiction at any other time. O'Farrell and Fals-Stewart believe that BCT and 12-step programs are compatible, as "[t]he underlying philosophy and methods used in BCT are consistent with the 12-step treatment model" (2006, p. 5).

Research findings. As aforementioned, numerous studies have demonstrated that BCT produces more enduring addiction treatment results and better relationship outcomes compared to individual-based treatment (O'Farrell & Fals-Stewart, 2003; Powers et al., 2008). Research on BCT has also extended to investigating its secondary benefits in reducing IPV (e.g., Fals-Stewart

& Clinton-Sherrod, 2009) and improving psychosocial adjustment of the children (e.g., Kelley & Fals-stewart, 2002), which showed positive results. In the past decade, studies on BCT have expanded their subjects of intervention from male substance abuse patients in heterosexual relationships to female patients (e.g., McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009; McCrady, Espstein, Hallgren, Cook, & Jensen, 2016) and same-sex couples (e.g, Fals-Stewart, O'Farrell, & Lam, 2009). The results on addiction and couple functioning in traditional patient populations have been replicated in these emerging patient groups (for review, see O'Farrell & Clements, 2012).

Systemic couple therapy for substance use disorder. The family systems model enjoyed its clinical popularity in the early 1970s and 1980s, but there has been little empirical support for its efficacy partly due to a paucity of well-controlled research (McCrady, 1989). A meta-analysis on systemic therapy for adult psychiatric disorders (Pinquart, Oslejsek, & Teubert, 2016) found insufficient evidence for the efficacy of systemic therapy for addiction in adulthood. A study on systemic couple therapy in addiction treatment compared Family Systems Therapy (FST; Rohrbaugh, Shoham, Spungen, & Steinglass, 1995) and Cognitive-Behavioural Couple Therapy (CBT; Wakefield, Williams, Yost, & Patterson, 1996) for male patients with alcohol abuse or dependence (Karno, Beutler, & Harwood, 2002; Kuenzler & Beutler, 2003; Shoham, Rohrbaugh, Stickle, & Jacob, 1998). The results showed better drinking outcomes of CBT during the 4-5 months of treatment (Karno et al., 2002) and comparable treatment retention between FST and CBT (Shoham et al., 1998). Unfortunately, no follow-up was conducted. Additionally, a subgroup of couples with a demand-withdraw pattern of interaction (where the wife demands and the husband withdraws) at baseline had worse attendance and retention rate in CBT, while the demand-withdraw pattern did not affect attendance or retention in FST. Another systems-

based couple therapy, Systemic Couple Therapy (SCT; Nelson, McCollum, Wetchler, & Trepper, 1996), which combined family systems approaches and BCT in its design, was found to have superior drug use outcomes compared to treatment as usual at 12-month follow-up (McCollum, Lewis, Nelson, Trepper, & Wetchler, 2003). Due to the scarce findings on systemic couple therapy for addiction, research on CCT is important to further investigate the utility of systemic couple therapy in addiction treatment.

2.5 Couple Therapy for Gambling Disorder

Building upon the relatively robust evidence of couple therapy in SUD treatment (Nelson & Sullivan, 2007; O'Farrell & Clements, 2012), researchers turned to couple therapy in pursue of an effective intervention for GD (Bertrand et al., 2008; Lee et al., 2021; Nilsson, Magnusson, Carlbring, Andersson, & Hellner, 2020; Tremblay et al., 2015). Congruence Couple Therapy (CCT; Lee, 2009) has spearheaded the relatively new area of couple therapy in GD treatment.

Gambling disorder, family impact, and couple therapy. The Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5; American Psychiatric Association, 2013) has included "gambling disorder" in "substance-related and addictive disorders". Gambling addiction is accompanied by a high rate of indebtedness, gambling-related crime, social isolation, and suicidality (Böning, Meyer, & Hayer, 2013). Compared to substance abuse, gambling addiction has fewer telltale signs and often causes greater financial loss (Lee, 2015). The discovery of the gambling problem often comes as a devastating shock to the significant others, which shatters their trust towards the gamblers and leaves them in anger and feelings of hopelessness (Dickson-Swift, James, & Kippen, 2005; Lorenz & Yaffee, 1998, 1999). Emotional distress is prominent among pathological gamblers and their spouses. Hurt, distrust, and resentment against the gamblers are often reported by the spouses, and guilt and loss of

confidence are common among the gamblers (Dickson-Swift et al., 2005; Downs & Woolrych, 2010; Hodgins et al., 2007; Lee & Rovers, 2008; Lorenz & Yaffee, 1998, 1999). The emotional damage undermines the couple relationships and threatens the integrity of their family units.

In recent years, family involvement in GD treatment has gained research attention (e.g., Hodgins, Toneatto, Makarchuk, Skinner, & Vincent, 2007; Ingle et al., 2008; Jiménez-Murcia et al., 2017; McComb, Lee, & Douglas, 2009). There are two main teams of researchers leading the investigation on couple therapy in GD treatment. First, Lee developed CCT (Lee, 2002, 2009), which is a systemic couple therapy building on Satir's model (Satir, Banmen, Gerber, & Gomori, 1991). Lee has led two earlier clinical studies on CCT for pathological gambling (Lee, 2002; Lee & Rovers, 2008), one pilot RCT comparing CCT and a wait-list group for GD (Lee & Awosoga, 2015), and one full-scale RCT comparing CCT and TAU in AUD and GD treatment (Lee et al., 2021). The findings consistently supported the benefits of CCT in reducing addiction symptoms and improving couple relationships. In the full-scale RCT (Lee et al., 2021), CCT was found to show superior outcomes in addiction, depression symptoms, emotion regulation, and couple adjustment compared to TAU. Second, Tremblay and colleagues developed the Integrative Couple Treatment for Pathological Gambling (ICT-PG; Tremblay et al., 2015), based on literature reviews on couple treatments and clinical experimentation. ICT-PG is developed upon the cognitive-behavioural model of couple therapy (Baucom, Epstein, & LaTaillade, 2008; Christensen, Jacobson, & Babcock, 1995) and unilateral treatments for family members (Thomas, Yoshioka, & Ager, 1996; Smith & Meyers, 2004), and it incorporates the concepts of acceptance and meaning-making that went beyond the classic behavioural methods (Christensen, Jacobson, & Babcock, 1995; Gurman, 2008). ICT-PG is currently under clinical investigation (Tremblay et al., 2015), and its outcomes are unavailable at the time of this thesis.

Apart from the emerging couple therapy models in GD treatment, BCT has been examined on its efficacy in treating GD in a recent RCT conducted in Sweden (Nilsson et al., 2020). The results showed no significant difference in self-reported gambling and psychiatric outcomes of gamblers and partners between BCT and individual-based cognitive behavioural therapy. However, the treatments in Nilsson et al.'s study (2020) were delivered online through therapist-guided self-help modules, which was a caveat when drawing implications on applying regular BCT for GD treatment. Combining evidence to date on couple therapy in GD treatment, CCT has been the only couple therapy with RCT findings that support its efficacy (Lee & Awosoga, 2015; Lee et al., 2021) and its advantage over TAU on relationship adjustment and mental health measures (Lee et al., 2021).

Congruence Couple Therapy. CCT is a systemic and integrative therapy, predicated on systemic, humanistic, existential, experiential, and social constructionist traditions (Lee, 2009). These five philosophical pillars guide the interventions in CCT. CCT posits a relational framework of pathological gambling and puts forth a solution centring on the concept of *congruence* (Lee, 2014, 2015). The relational framework places the couple dysfunctions and gambling addiction in the context of families of origin, past trauma, and stressors in the gambler's and partner's history. It theorizes that couple dysfunctions and gambling perpetuate each other through recursive feedback loops. CCT proposes *congruence* as the solution to extricate the couples from the recursions of addiction and couple issues. *Congruence* is achieved through *attention*, *awareness*, *acknowledgement*, and *alignment* of the four human dimensions specified in CCT's relational framework (Lee, 2015). The four dimensions include *intrapsychic, interpersonal, intergenerational,* and *universal-spiritual*, which map out the domains of interventions in CCT (Lee, 2015, 2009).

Interventions. CCT typically consists of 12 weekly sessions (Lee, 2009) and progresses iteratively through alliance building, assessment, intervention, and consolidation (Lee, 2017). CCT is a principle-based therapy, which means its interventions are guided by the five philosophical tenets and the four dimensions as a framework instead of focusing on certain areas of exercises. The four dimensions are analogized as an iceberg of human experiences. The relational problems are only the tip of the iceberg connected to what is beneath the "waterline". *Figure 1* illustrated the interrelationship of the four dimensions.

To work on the couple's communication, their communication patterns are first delineated using a typology of communication *postures* (Lee, 2017). This typology was born from Satir's concept of congruence (Satir et al., 1991) and went beyond it to describe a person's relationship with the self, other, and context. CCT emphasizes the dynamic fluidity of the three areas. Communication postures are delineated as *congruent*, *superior*, *inferior*, *enmeshed*, *fixing*, and *avoidant* communications. A person presents a congruent communication when this person is aware of, acknowledges, and aligns the feelings and needs of oneself, those of the other person, and the context of their interactions. The imbalance between the self, other, and context impairs communication and strains the relationship.

The couple's families of origin, past relationships, and major life events are explored, with the use of *genograms* and *timelines*. Past traumatic experiences often come up during this process. As the IP and partner develop a deeper understanding of the impact of their traumatic experiences, they can deepen their self-understanding, acknowledge their resilience and inner spirit, and regain hope to move towards change.

With its humanistic-existential perspectives, CCT emphasizes reframing narratives to acknowledge the self-actualizing human spirit, assume responsibilities, and reclaim choice-

making, while accepting tragedies and limitations of human existence (Lee, 2009). In CCT, addiction is reframed as "an attempt to meet…universal human needs that are thwarted throughout the individual's lives" (p. 96, Lee, 2017), which can be replaced with self-compassion and new ways to achieve connection, safety, and worth.

Interventions in the four dimensions are intertwined, and the key is to make linkages between dimensions to create deeper and synergistic changes. For example, linkages could be made between a husband's avoidant communication posture and his abusive family environment growing up. Understanding the linkage, the wife may gain empathy with the husband's shortcomings in communication. Changes that the husband made in his ways of communication may also ameliorate the traumatic impact of his adverse childhood experiences (ACEs) at the intrapsychic level.

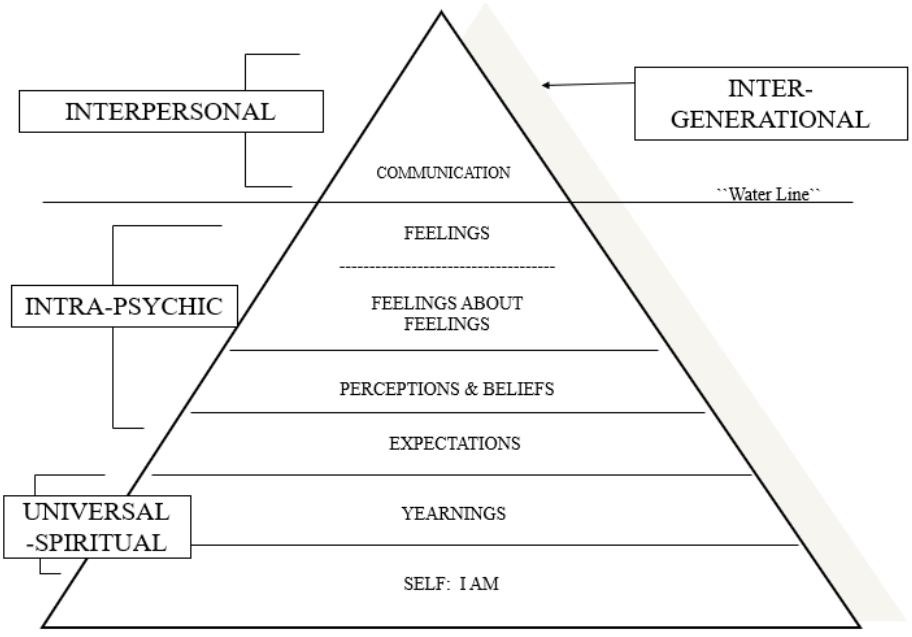


Figure 1. The iceberg: Four interrelated human dimensions. Reprinted from "Congruence Couple Therapy for Pathological Gambling", by B. K. Lee, 2009, *International Journal of Mental Health and Addiction, 7*(1), p. 49. Copyright 2009 by Springer Nature.

Research findings. Studies on CCT thus far include: (1) an initial in-depth clinical study with eight couples of pathological gamblers and spouses (Lee, 2002), (2) a subsequent mixed-method study that evaluated 21 gambling counsellors' CCT uptake with 24 couples (Lee & Rovers, 2008; Lee, Rovers, & MacLean, 2008), (3) a pilot RCT with 15 couples that compared CCT with a wait-list control group (Lee & Awosoga, 2015), and (4) an RCT with 46 IPs and partners that compared CCT and TAU in two provincial addiction and mental health clinics for AUD and GD. All four studies found positive outcomes of CCT in addiction and couple adjustment.

The initial clinical study helped to establish the theoretical foundation of CCT (Lee, 2002). The investigation on counsellors' CCT uptake (Lee & Rovers, 2008) found that the CCT delivered by the newly trained CCT counsellors resulted in significantly reduced gambling urges and behaviours and improved spousal relationships. The counsellors also reported spin-offs of CCT where self-growth and improved communication in the couples led to better parent-children relationships and enhanced workplace relationships (Lee & Rovers, 2008). In the pilot RCT comparing CCT with a wait-list control group (Lee & Awosoga, 2015), the couples in the control group received three brief check-ups over the 12-week treatment period. The CCT couples showed significant improvement in mental distress symptoms, dyadic adjustment, and family systems functioning as well as a positive trend in the gambling symptoms post-treatment. The CCT couples' changes in dyadic adjustment and family functioning were maintained at the 2-month follow-up. Meanwhile, the control group showed no significant change in these measures and a smaller trend of gambling reduction than CCT.

The RCT comparing CCT and TAU for AUD and GD (Lee et al., 2021) was conducted within two provincial addiction and mental health outpatient clinics. CCT was delivered by five

addiction counsellors in the clinics who completed a 5-day CCT training prior to the study and received ongoing clinical consultations with the trainer and principal investigator throughout the study. The TAU couples participated in regular programs, which were individual-based, such as one-on-one counselling, group therapy, psychoeducational programs, and family support programs. The TAU participants joined one or any combination of these programs to their preferences and were free to access any programs outside the provincial clinics. CCT resulted in a significantly greater percentage reduction of symptomatic participants than TAU in alcohol use at post-treatment, gambling at 3-month follow-up, and depression, emotion regulation, and couple adjustment at both points.

The findings of the four CCT studies combined provided evidence for the benefits of CCT in treating addiction, facilitating mental health, and improving couple adjustment, and the recent RCT (Lee et al., 2021) in particular demonstrated CCT's outperformance over TAU in these areas.

2.6 Knowledge Translation of Couple Therapy in Addiction Treatment

Lack of adoption. Despite the extensive evidence on couple therapy in addiction treatment, the service landscape of addiction treatment does not reflect the empirical picture. Addiction treatment agencies predominantly use an individual-focused approach (White, Kelly, & Roth, 2012), allowing minimal family engagement in addiction treatment. A recent gap analysis of Alberta's addiction and mental health services (Wild et al., 2014) identified a gap of service that treats the family system instead of the individuals. Generally speaking, even in the family-oriented treatment centres, the family programs are often limited to unilateral treatment for affected family members alone, family-training programs in group formats (e.g., Jiménez-Murcia et al., 2017), and informal or low-dosage conjoint sessions (e.g., Missouridou, Segredou,

Esseridou, & Papadatou, 2019; Orford et al., 2009). Conjoint family and couple therapy is a rarity. Nevertheless, with these low-intensity family-involved programs, the IPs' retention is improved compared to no family engagement at all (Brigham et al., 2014; Ingle, Marotta, McMillan, & Wisdom, 2008; Jiménez-Murcia et al., 2017; McPherson et al., 2017). The wider dissemination of couple therapy can be a step forward to capitalize on the full potential of family and social support in facilitating addiction treatment and family recovery as a unit.

Barriers to implementation. The barriers to implementing couple therapy in addiction treatment have been identified from the perspectives of program administrators and clinicians (Fals-Stewart, & Birchler, 2001; Lee, Christie, Copello, & Kellet, 2012). At the organizational level, funding priorities and evaluation structures have been primarily focused on individual-based services and outcomes, which limits the budgets for family-based programs (Lee et al., 2012). At the service providers' level, couple therapy programs such as BCT may not be a popular option for service uptake due to its numerous sessions (12 sessions) (Fals-Stewart, & Birchler, 2001). Further, clinicians reported low self-efficacy in practicing family and couple work (Lee et al., 2012) and perceived training to be necessary before they could engage families in treatment.

Findings on cost-outcomes, program adaptation, and counsellor training of couple therapy in addiction treatment can address aspects of these barriers. In the following section, research evidence will be reviewed for positive cost-outcomes of couple therapy in addiction treatment, the cost-effectiveness of an abbreviated BCT, and short-term clinicians' training for their uptake of couple therapy programs.

Cost-outcomes of couple therapy in addiction treatment. Implementing a new service requires additional training and resources, and cost naturally becomes a concern to policymakers

and program managers (Fals-Stewart, Klostermann, & Yates, 2005). The proponents for couple therapy in addiction treatment argue that, for a comparable cost, family and couple therapy will achieve a greater return than individual-based treatment by (1) treating a greater number of people (the IP and the family numbers) and (2) building supportive family dynamics to maintain treatment results and prevent relapses (Fals-Stewart, Klostermann, & Yates, 2005; Stanton & Shadish, 1997). Several studies found that couple therapy in addiction treatment more cost-effective than individual-based programs due to its superior addiction outcome with the same monetary input (e.g., Fals-Stewart, Klostermann, Yates, O'Farrell, & Birchler, 2005; Finney & Monahan, 1996).

Further, couple therapy reduces the hidden social cost of addiction. The social costs of addiction are associated with addiction-related legal problems, healthcare services, income support and social assistance (Fals-Stewart, O'Farrell, & Birchler, 1997; O'Farrell et al., 1996), and the family members' informal caretaking and health issues caused by the stress of the addiction (Copello, Templeton, & Powell, 2009). Couple (and family) therapy is considered more cost-beneficial than individual-based addiction treatment, as its superior outcomes on couple/family relationship adjustment and addiction symptoms (O'Farrell & Clements, 2012) are more likely to alleviate the social costs of addiction. Fals-Stewart and colleagues (1997) found that a combined therapy of BCT and individual-based treatment was substantially more cost-effective and cost-beneficial than regular individual-based treatment for male substance-using patients. The combined therapy resulted in a greater decrease in the patients' substance use and related social and legal cost in the year following their treatment.

Abbreviated couple therapy in addiction treatment. For cost containment, a shortened version of Behavioural Couple Therapy (S-BCT) was developed (Fals-Stewart, Klostermann,

Yates, O'Farrell, & Birchler, 2005). S-BCT included 6 sessions, instead of 12 sessions in a standard BCT. In their study comparing the cost-effectiveness of S-BCT, BCT, individual-based therapy, and psychoeducation in alcohol abuse/dependence treatment, Fals-Stewart et al. (2005) found that S-BCT was more cost-effective than the other three treatment conditions. In this study, the standard BCT consisted of 12 BCT sessions and weekly 12-step oriented group counselling for the IPs over 12 weeks. The other three treatment conditions consisted of 6 treatment condition-specific sessions plus weekly 12-step sessions for the IPs over the 12 weeks. The results showed equivalent heavy drinking outcomes between S-BCT and standard BCT at 12-month follow-up, which were superior to the results of individual-based treatment and psychoeducation. S-BCT yielded better dyadic adjustment than the two control treatment conditions at post-treatment and 12-month follow-up. Treatment delivery of S-BCT was less costly than standard BCT and similar to the other two programs. Therefore, the S-BCT was more cost-effective than individual-based therapy as well as standard BCT. It is feasible to develop an abbreviated BCT for agency uptake while preserving its effectiveness.

Counsellors' training. One of the greatest hurdles in implementing couple therapy in addiction services is the lack of counsellors with combined skills of couple therapy and addiction counselling (Center for Substance Abuse Treatment, 2004). Faced with this issue, researchers leading clinical trials on couple therapy in addiction treatment have developed short-term training programs in the particular couple therapy under investigation, which yielded positive results. These short-term training programs offer the potential to relieve the clinician shortage in couple therapy in addiction treatment and build a viable service capacity for community-based treatment.

Short-term program-specific training. With little training available for family/couple therapy in addiction treatment in our post-secondary education, brief training in a particular couple therapy model for clinicians at an organizational level is needed to develop the service capacity. There have been a handful of reports on brief training programs in BCT and CCT for addiction counsellors (e.g., Fals-Stewart & Birchler, 2002; Lee et al., 2008) with a combination of manualized learning and supervised uptake, which produced positive training results.

Fals-Stewart and Birchler (2002) examined the outcome of a BCT training programs for addiction counsellors in the U.S. The counsellors included those with bachelor-level education and no previous experiences of BCT and those with master-level education and 5 years of experience in practicing manualized BCT. The BCT training program consisted of both didactic and experiential components: (1) six 1-hour didactic discussions to review the BCT manual with video recordings of BCT sessions and (2) supervised practice of a complete BCT with 2 couples. The bachelor-level counsellors received both training components, and the master-level counsellors only received didactic training. As a result, the bachelor-level counsellors showed equivalent adherence in delivering BCT and achieved comparable treatment results with the master-level counsellors, though they scored lower competence in BCT delivery.

Lee and colleagues (2008) investigated the outcome of a CCT training program for counsellors in gambling treatment services in Ontario, Canada. The CCT training program consisted of (1) a 4-day residential workshop (7 hours per day) and (2) monitored application of 12 CCT sessions immediately after the workshop with weekly group consultations. The counsellors reported no previous training in couple therapy in GD treatment. The evaluation results showed that, regardless of the counsellors' ages, years of experience, and levels of education, they equally benefited from the CCT training and improved significantly in their

theoretical understanding and clinical skills of CCT. The CCT programs delivered by these counsellors overall led to significant improvement in addiction symptoms and couple relationship and were rated with a high level of satisfaction by the couples.

The above two trials showed promise of effectively training addiction counsellors in couple therapy with a combination of manualized learning and monitored practice in the short term. Regardless of the counsellors' levels of education and years of clinical experience or the theoretical model of the couple therapy (behavioural vs systemic), addiction counsellors new to couple therapy could develop an acceptable level of proficiency in delivering the specific program with short-term training.

Cost of training. There is also evidence indicating comparable costs of training in conjoint therapy and individual-based treatment for addiction treatment (Tober et al., 2005). A study investigated the outcomes and cost of training in Social Behavioural Network Therapy (SBNT; Copello et al., 2002) and Motivation Enhancement Therapy (MET; Miller, Zweben, DiClemente, &, Rychtarik, 1995) for 72 U.K. counsellors of various professional registrations (medical practitioners, nurses, psychologists, therapists, and social workers). SBNT engages the IPs and members from their social network to aid the IPs' effort to change, by helping all participants develop behavioural skills of communication, coping, and relapse management. MET is an individual-focused therapy based on motivational interviews. The study found that the costs of training (i.e., 3-day group training) and supervision required to produce a competent counsellor in SBNT and MET were comparable. Although SBNT was not a specialized couple/family therapy, Tober and colleagues' findings (2005) suggested that the training cost of a conjoint form of therapy can be equivalent to that of an individual-based program.

Given the feasibility of short-term training in couple therapy for addiction treatment and its likely comparable cost with training in an individual-based program, it is a viable option to implement short-term training for clinicians to build up the service capacity to offer couple therapy in addiction treatment to the wider community.

The findings reviewed in this subsection demonstrated a level of readiness for broader implementation of couple therapy in addiction treatment, with consideration of its cost-outcomes, adaptability to treatment settings, and clinician capacity. However, the concerns regarding costs and training reflect primarily the policymakers' and service providers' perspectives. What is missing to further guide knowledge translation is the service users' perspectives on couple therapy in addiction treatment.

2.7 The Missing Piece of the Puzzle: Service Users' Perspectives

Apart from the research evidence on its efficacy, cost-outcomes, adaptability, and uptake, the service users' perspectives on couple therapy in addiction treatment are an important piece of the puzzle in understanding the prospect of its wider adoption.

Service users as a key stakeholder in knowledge translation. It is well-accepted that the implementation of evidence-based healthcare practice should be an integration of research evidence and clinical expertise based on the specific patient's "clinical state, predicament, and preferences" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 72). Costly lessons have been learned that the evidence-supported interventions may not match the patients' preferences (Chalmers & Glasziou, 2009) and that the clinical endpoints may not reflect the patients' treatment experience and their quality of life (Thornton, 2008). As the "principal protagonists" of treatment services (Orford, 2008, p. 4), patients hold experiential expertise of the condition and treatment. Having lived experience with the condition, patients can offer an

alternative yet equally valid viewpoint in setting treatment priorities and evaluating treatment programs. Patients' perspectives can inform effective translation of research evidence to improved patient well-being, which will ultimately improve the cost-effectiveness of the healthcare system (Canadian Institutes of Health Research, 2011; Sullivan, 2003).

Service users in addiction and mental healthcare, including individuals with addiction and their affected others, form a key stakeholder group of mental health research (Goldner, Jenkins, & Fischer, 2014). The role of service users is equally important to those of service providers and policymakers in influencing knowledge translation and service innovations (Canadian Institutes of Health Research, 2011; Kitson, Harvey, & McCormack, 1998). Clinicians' and administrators' perspectives have been explored to identify service gaps (e.g., Copello, Templeton, & Powell, 2009; Wild et al., 2014) and barriers and facilitators in implementing family-oriented addiction services (e.g., Fals-Stewart & Birchler, 2001; Orford et al., 2009). However, service users' views and treatment experiences have been rarely tapped into to guide decisions on translating research evidence to service adoption of family and couple therapy.

Service users' choice of treatment modality. There is evidence that treatment entry rates of potential treatment seekers (who made inquiries of the treatment) are comparable between individual-based and couple therapy in SUD treatment (Kelly, Epstein, & McCrady, 2004). While Siqueland and colleagues found that 24% of the initial callers entered treatment for cocaine abuse across two studies (Siqueland, Crits-Christoph, Frank, et al., 1996; Siqueland, Crits-Christoph, Gallop, et al. 2002), Kelly et al. (2004) reported that 29% of the initial callers eligible for BCT actually entered the treatment. Factors such as older age, male gender, lower numbers of comorbidity, pressure to change from partners (for female IPs but not male IPs)

(Schünemann, Lindenmeyer, & Heinrichs, 2018), and higher income (Kelly et al., 2004) were found to be predictors of treatment utilization of couple therapy in addiction.

Studies also looked into personal factors that motivated service users to seek couple therapy in addiction or deterring them from it (e.g., McCrady, Epstein, Cook, Jensen, & Ladd, 2011; Copello & Orford, 2002; Kourgiantakis, Saint-Jacques, & Tremblay, 2018; Misouridou, & Papadatou, 2017; Tremblay et al., 2018). In a study on female IPs' treatment choice between individual-based treatment and BCT for alcohol abuse, the IPs' desire for their male partners to understand their problem and treatment, give them support, and cope differently were cited as reasons for choosing BCT (McCrady et al., 2011). Couples' experiences in ICT-PG and individual-based treatment (Tremblay et al., 2018) showed that factors such as the partners' need to understand the gamblers and the couple's perception that the addiction was the couple's shared problem were related to their joint involvement in addiction treatment. Further, some family members found family intervention that aimed to improve affected others' coping inadequate, as it was unable to help the family members actively effect changes in the IPs (Orford, Templeton, Patel, Copello, & Velleman, 2007). These family members hoped to play a more proactive role in the IPs' effort to change. Research on family recovery from addiction implicated that the family members' readiness to change their own behaviours was important in the recovery-oriented changes of the family as a whole (Bradshaw et al., 2016; Hayes et al., 2019).

Conversely, individual factors and family dynamics may discourage service users from seeking conjoint therapy in addiction treatment (Kourgiantakis et al., 2018; Misouridou, & Papadatou, 2017; Tremblay et al., 2018; McCrady et al., 2011). Some IPs were unwilling to reveal all their problems to their family members (Tremblay et al., 2018; McCrady et al., 2011).

Some female IPs were ambivalent about the future of their relationships or simply concerned that their partners would not be supportive (McCrady et al., 2011). Some family members carried feelings of shame with the IPs' addiction and refused to be involved in their addiction treatment (Kourgiantakis et al., 2018). Some were burnout and felt hopeless with the IPs' prolonged addiction problems and lack of change (Misouridou, & Papadatou, 2017). Further, harmful family dynamics, such as blaming, scapegoating, and criticism at the IPs, undermined meaningful family engagement (Misouridou, & Papadatou, 2017). Ongoing substance abuse and mental health issues within the family naturally posed a barrier to family engagement in the IPs' treatment (Kourgiantakis et al., 2018; McCrady et al., 2011). In addition, logistic challenges in attending conjoint therapy (e.g., commute, childcare, and time-off work) could become a practical barrier (McCrady et al., 2011; Lee et al., 2012).

Although not all couples/families are willing and ready to enter conjoint therapy in addiction treatment, the existing findings indicate a service users' demand for conjoint therapy in addiction treatment, which stems from the intimate others' hope to engage in the IPs' treatment to actively promote change as well as the IPs' desire for the family's understanding and support.

Service users' perspectives in couple therapy in addiction treatment. Studies on perspectives of service users in treatment programs have been peripheral in addiction research. My search in the literature yielded one study that explored the service users' perception of individual-based and conjoint addiction treatment programs (Tremblay et al., 2018). Tremblay et al. (2018) interviewed pathological gamblers and their partners on their experience with Integrative Couple Treatment for Pathological Gambling (ICT-PG; Tremblay et al., 2015) and individual-based therapy where the gamblers received treatment as usual and the partners

participated in family support therapy. The treatment conditions were assigned according to the participants' orientation.

Tremblay et al. (2018) identified the couple conditions that favoured one modality over the other. The conditions favouring individual-based treatment involved (1) the gamblers' unwillingness to reveal their addiction behaviours and cravings to spouses, (2) the gamblers' need for in-depth individual therapy (to address complex issues such as childhood trauma), (3) the gamblers' need to develop self-efficacy and skills of self-expression, and (4) the gamblers' and partners' preference to make changes at their own pace. The situations where the couples preferred couple therapy in addiction treatment included (1) the couple's wish to save or build a strong couple relationship and (2) the gamblers' improved feelings of comfort with their partners' presence in therapy, which helped them to open up.

The gamblers who oriented toward individual treatment believed that they would have felt "tense" and unable to speak freely if they entered couple sessions before individual treatment. They also thought that couple therapy would be beneficial after they had sorted out their individual issues. Some partners who elected individual therapy first and couple therapy subsequently felt that their family support therapy helped them better understand the gamblers, which then allowed them to speak more freely without running the risk of hurting the gamblers in the couple sessions. These findings demonstrated the service users' need for both individual-based and conjoint treatment in addiction services and suggested some preference for a particular sequence of services where individual treatment and psychoeducation precedes couple therapy.

Tremblay et al.'s findings (2018) also indicated the advantages of ICT-PG over the individual-based treatment in helping the couples approach the addiction together. For example, the partners in ICT-PG reported learning how to reduce situations that could trigger cravings and

reinforce gambling behaviours. In ICT-PG, the partners' participation improved the gambler's commitment to continue treatment. Meanwhile, the partners in individual-based treatment believed that the gamblers would have attended treatment more regularly and consequentially made greater progress if they had been in conjoint treatment. With ICT-PG, as the partners gained a better understanding of the gamblers, the couples' discussion on the gambler's addiction became possible beyond the treatment meetings, and the gamblers felt that their partners became a resource more accessible than their therapists because of their "physical and emotional proximity".

Aligned with the cognitive-behavioural model (McCrady & Epstein, 2008), the couples who went through ICT-PG (Tremblay et al., 2015) spoke of how the partners learnt skills to help reduce the gamblers' cravings and prevent relapses. In contrast, systemic couple therapy typically focuses on changes in the couple's patterns of interaction (Lee, 2009), where both the person with addiction and the partner are assisted in making changes in their (patterns of) communication. The couples' experience of change in a systemic couple therapy such as CCT will presumably differ from that with ICT-PG, which requires further investigation. Additionally, Tremblay et al.'s study focused on the GD treatment experiences, the experiences of couples seeking treatment for AUD (and/or GD) with the two modalities are yet to be looked into.

2.8 Summary and Conclusion

In this literature review, first, I presented the main family models of addiction, i.e., the family disease model, the family system model, and the cognitive-behavioural model, which constitute the theoretical foundation of today's family and couple therapy in addiction treatment. Second, I delineated the reciprocal relationship between addiction and family dynamics, including the findings on the impact of addiction on the family and family influences on the

development and recovery of addiction. I provided a brief account of family-oriented programs developed based on the relationship between family and addiction. Third, I introduced the well-researched couple therapy for substance use disorders (i.e., BCT) and gambling disorder (i.e., CCT) and presented their theoretical frameworks, interventions, and clinical findings. Fourth, I reviewed findings on cost-outcomes, program adaptation, and counsellor training of couple therapy in addiction treatment, substantiating the feasibility of its broader adoption. Fifth, I identified a paucity of literature on service users' perspectives in couple therapy versus individual-based addiction treatment and summarized the existing knowledge on service users' choice between family-oriented and individual-based treatment. I reviewed findings from the only study to date that investigated couples' experiences with conjoint couple therapy and individual-based treatment for addiction and pointed out the gap of knowledge that the current study was set out to fill.

In conclusion, the evidence base for the benefits of couple therapy in addiction treatment is relatively robust, and the findings on its readiness for wider uptake are generally supportive. However, the findings related to knowledge translation were often produced based on service providers' priorities. Service users, as essential stakeholders in addiction and mental health research, are underrepresented in the literature. The service users' preferences and values regarding couple therapy and individual-based treatment based on their experiences with the two modalities are not well understood. Although one study was located that examined gamblers' and partners' experiences with a behavioural-based couple therapy and individual-based treatment for GD, service users' perspectives on systemic couple therapy in comparison with individual-based treatment for GD and/or AUD remained unknown. Further inquiry is warranted.

Chapter 3: Methodology

This chapter will begin by clarifying the researcher's philosophical stance. The design of the study will then be elaborated, and the methods and procedures will be delineated. The researcher's personal experience, research background, and entering assumptions will be explained. Finally, the rigour of the methods will be briefly discussed.

3.1 Researcher's Philosophical Stance

A researcher's philosophical orientation about the world and the nature of research has important implications for the practice of research (Creswell, 2014). The philosophical orientation that a researcher brings into research is also referred to as the paradigm (e.g., Mertens, 2010), which may be defined as a collection of "logically related assumptions, concepts, and propositions that orientate thinking and research" (Bogdan & Biklen 1998, p.22). There are four widely discussed research paradigms: positivism (and post-positivism), interpretivism/constructivism, transformative, and pragmatism (Creswell, 2014; Mackenzie & Knipe, 2006). Positivism is based on "a deterministic philosophy that causes determine effects or outcomes" (Creswell, 2014, p.7), and it aims to test theories through observation and measurement of "the objective reality that exists 'out there' in the world" (Creswell, 2014, p.7). Post-positivism accepts that absolute reality can not be reached, and it holds that knowledge is provisional and subject to change with new understandings (Creswell, 2014; Mertens, 2010). Positivism and post-positivism are commonly aligned with quantitative research methods. Interpretivism/constructivism grew out of the philosophies of phenomenology and hermeneutics (Eichelberger, 1989, as cited in Mertens, 2010), and it intends to understand the "world of human experiences" (Cohen, Manion, & Morrison, 2007, p.21) by focusing on the participants' subjective meanings of their experiences. Interpretivist/constructivist researchers typically

endorse a qualitative research design and may also choose a mixed-methods approach. The transformative paradigm carries an action agenda for political change to confront social oppression (Mertens, 2010) and is not constrained to any research approaches. Pragmatism focuses on *what works* rather than being committed to a school of philosophies or a system of reality (Creswell, 2014). Pragmatic researchers emphasize the research problem and are free to select any research methods available to approach the research problem.

Among the four main paradigms, my philosophical stance aligns with pragmatism and endorses the action aspect of the transformative perspectives. First, I believe that both the subjective reality and the objective world independent of the human mind exist, and both subjective and objective data support our understanding of the world. I believe that we can approach either reality by utilizing sound methods and employing critical and reflexive thinking. Second, I regard research primarily as a practical tool to solve real-world problems and improve our quality of life. In this way, I not only identify with pragmatism but also hold aspects of the transformative paradigm that promote action towards change through knowledge production. In the next section, I will illustrate the research design of the study guided by my philosophical paradigms.

3.2 Qualitative Design with Phenomenological Perspectives

A phenomenologically informed qualitative design with thematic analysis (Braun & Clarke, 2006) and service-user engagement (Domecq et al., 2014) was employed in this study. With a pragmatic paradigm (Creswell, 2014), I derived the research approach based on the research problem. The research problem centred on a lack of service users' voice in the addiction and mental health literature on their perspectives of conjoint treatment versus individual-based treatment. To gain a better understanding of the service users' views on the two treatment

modalities, I chose to focus on examining the couples' perspectives in conjoint and individual-based treatment services in which they had participated. Naturally, subjective data was required, and a qualitative approach (Parkinson & Drislane, 2002) was adopted. A descriptive account of "hows" and "whys" was necessary to understand the couples' views. As the topic of the study was largely an unchartered territory, data needed to be collected from the ground up, and an inductive approach would be utilized for analysis. To gain an in-depth understanding of the couples' perspectives of the treatments, the couples' experiences living with addiction and seeking treatment in a couple context were tapped into. Hence, phenomenology (e.g., Wertz, 2005) was incorporated in the research design to inquire into the couples' lived experiences.

With a transformative approach (Creswell, 2014), I engaged service users of addiction and mental health services in the research process as advisors to help pivot the findings towards greater relevancy to the service users. Service users as a stakeholder group in mental health research have traditionally assumed a passive role in knowledge production. Studying the service users' perspectives in addiction treatment and engaging service users in the research process may help empower them to play a more active role in steering mental health research towards service-user priorities (Canadian Institute of Health Research, 2011, 2014).

Phenomenology. In classic terms, phenomenology is a discipline that studies the essential structures of consciousness through the analysis of phenomena as they appear to us (Litchman, 2012; Smith, 2013). Today, phenomenological research is commonly understood as the research that investigates the lived experiences about a phenomenon as described by the participants (Creswell, 2014). Phenomenology was originally developed by Edmund Husserl (1900-01/2001, 1913/1963) and was further evolved into a school of diverse orientations with the works of Heidegger and other authors (Smith, 2013; van Manen, 2011).

Husserl (1900-01/2001) contended that the key property of consciousness is intentionality – consciousness is a consciousness of or about something. Our experiences in daily life are directed towards (i.e., representing or intending) things by perception, thoughts, and imagination. Of significance, is the mode in which the object of awareness is presented or intended in our experience – i.e., the way in which we perceive and think about the object/situation. The way in which we experience a particular situation is the *meaning* of the experience, which is at the core of a phenomenological investigation. Another essential aspect of conscious experience is its first-person nature – we experience them (Husserl, 1913/1963). Hence, phenomenological researchers study the phenomena as they are experienced from the first-person perspective.

To achieve a faithful description of the experience as it is lived, Husserl constructed the method of *epoché* (Husserl, 1954/1970). First, the researcher needs to suspend any pre-existing knowledge and hypotheses of the phenomenon. Second, the researcher needs to abstain from the concern of the objective existence or validity of the situation experienced. By practicing *epoché,* a researcher can access the lived experience as it is experienced and reflect on its lived meanings. However, in an advanced stage of phenomenological analysis, *epoché* may be deliberately abandoned, and preconceptions can be used as "heuristic guides for knowledge" (Wertz, 2005, p. 172). Incorporating previously posited theories and concepts to guide analysis aligns with interpretive phenomenology (Tuffour, 2017), following Heiddeger's hermeneutic methods (1927/1962). The method used to interpret meanings beyond the explicit (aided by preconceptions) is referred to as *structural analysis* (Moustakas, 1994; Smith & Osborne, 2003).

Husserl developed *intentional analysis* (1954/1970, 1913/1963) to study the lived meanings of human experiences. A crucial element in intentionality analysis is the ecological context of the human situation. Intentionality of consciousness exists on the basis that we live in

a *lifeworld* (Husserl, 1954/1970) that provides the meaning structure of all particular things and concepts, through a system of social, historical, cultural, and linguistic conventions within social groups as well as universally valid processes and conceptions (e.g., spatiotemporality, sociality, body-subject, and causality). The ontological significance of context is elucidated by Heidegger (1927/1962), who posits that human beings are *being-in-the-world*, existing as part of a historical, social, and cultural context. In classical phenomenology, a person's lifeworld in which the person has lived through the experience is acquired, and the researcher relates to the relevant features of this context to interpret the lived meanings of the type of experience (Smith, 2013).

The goal of the phenomenological analysis is to grasp the essence of the phenomenon (i.e., what something is). Husserl established the method of *eidetic reduction (*or *intuition of essence)* to "descriptively delineate the invariant characteristic(s) and clarify the meaning and structure/organization of a subject matter" (Wertz, 2005, p. 168). Therefore, in phenomenological analysis, the reflections of the lived meanings are synthesized to reach the essential meaning structure of the phenomenon (Creswell & Poth, 2017).

Employing phenomenology in this study. All qualitative research has a phenomenological aspect to it, such as its focus on the perception of the participants and the researchers' practice to set aside presuppositions that could bias their understanding of the participant's account (Padilla-Díaz, 2015). On the other hand, phenomenological methods are not used in all qualitative studies. The current study is defined as phenomenologically informed. To gain an in-depth understanding of the participants' perspectives in CCT and TAU, I examined their lived experience with addiction, various treatment programs as couples, and relevant aspects of their lifeworld (e.g., family of origin, past relationships, current couple and family relationships, and socio-economic conditions). Through reflecting on the meanings of the

couples' addiction-related and treatment-related experiences, I tried to unravel the psychological underlayers of their perspectives and extract the aspects of the treatment programs embedded in these experiences that they valued and vice versa. The attention to the participants' lived experiences and life context coincides with the intentional analysis of phenomenology (Wertz, 2005).

Data collection and analysis in this study was guided by principles of empathy (Wertz, 2005), openness (Finlay, 2008), and reflexivity (Maxwell, 2013), which are recommended on the basis of Husserl's *epoché* (Husserl, 1954/1970) and Heidegger's hermeneutic methods (1927/1962). I strived to "empathically enter and reflect on the lived world" (Wertz, 2005, p. 168) of the couples to grasp their experience from their points of view. I kept myself open and engaged to what emerged from the research process, and I watched for my prejudgements and preconstructions of the findings that would limit my understanding of what was being presented to me (Finlay, 2008). I adopted a reflexive stance (Maxwell, 2013) with which I continuously reflected on my presuppositions and personal experience relevant to the research topic, and I strived to remain mindful of my role in the research throughout the research process. With reflexivity, instead of completely refraining from the pre-understandings of the topic, I utilized my preconceptions of the topic to guide my understanding of the couples' experiences while striving to identify the biases that would distort one's understanding of the data at hand. Techniques from the phenomenological analysis were incorporated in the data analysis, including *horizontalization of data*, organizing data into *meaning units*, and *structural analysis* (Creswell & Poth, 2017; Moustakas, 1994. See details in the data analysis section).

However, the current study was not a phenomenological study, as it was not a purely psychological inquiry into the couples' lived experiences. The study was intended to produce

findings that could directly inform knowledge translation. It was more appropriate to set the research objective on investigating the couples' views on the conjoint and individual-based treatment services than their lived meanings going through the treatments. Therefore, the sampling and analysis were not conducted according to a phenomenological study. Attention was not paid to select a homogenous group of participants with a common experience (Smith & Osborne, 2003) nor to construct the essential structure of the couples' lived experience. Thematic analysis (Braun & Clarke, 2006) was selected as a primary method for data analysis, and the findings were presented in a system of themes (i.e., a thematic map).

3.3 Service-User Engagement

The idea of service-user engagement in the current thesis initially stemmed from a notion that the engagement of individuals with lived experiences of a health condition and treatment services in the research process could steer the research towards service-user priorities, and thus the findings will ultimately lead to improved health outcomes (McKevitt, Fudge, & Wolfe, 2010). Service users were engaged in this study as advisors who steered the data collection and shaped the report of the findings by providing input on developing the interview protocol and giving feedback on the findings. Their engagement could potentially improve the credibility and service-user relevancy of the study (Frank et al, 2015). It was the researcher's hope that service-user engagement in the study could inform advocacy for service innovations towards service users' values and empower service users to play a more active role in mental health research.

Service-user engagement in health research. *Patient engagement* or *stakeholder involvement* as a research method has been gaining a foothold in health research for the past two decades (Domecq et al., 2014; Frank et al., 2015). With the increasing recognition of person-centred medicine (Curtis et al., 2012), a growing trend towards an egalitarian and collaborative

culture in public health (Canadian Institute of Health Research, 2011; National Institute for Health Research, 2006) as well as the developing methodological foundation from participatory research (Bergold & Thomas, 2012; Cargo & Mercer, 2008), service-user engagement is poised to be a new movement in health research. Engagement of service users (*patient engagement*) in health research is conceptualized as a research method where users of healthcare and social services (Brett et al., 2010) or people who represent the population of interest (Frank et al., 2015) actively participate in any or all stages of the research process (preparation, execution, and knowledge translation) and with various degrees of involvement (informing, consultation, collaboration, or leading the research) (e.g., Shippee et al., 2013).

The fundamental values that drive service-user engagement in health research are the following. (1) Relevancy: service-user engagement steers research towards patient priorities and produces results relevant to patient well-being (McKevitt et al., 2010; Oliver, 2009). (2) Quality: service users in health research have a holistic knowledge of their health conditions and experiential expertise of the treatment programs which they have gone through (Canadian Institute of Health Research, 2014; Frank et al, 2015). Therefore, service users' engagement in research improves the credibility and rigour of the research. Knowledge is co-produced with the input from both professional and experiential perspectives, and decisions are made with checks and balances between both researchers and service users (e.g., Whitley, 2005). (3) Impact: service-user engagement helps to gain public buy-ins, reduce barriers of dissemination, and produce creative and effective ways of implementation (e.g., Díaz Del Campo et al., 2011; Evans et al., 2011). (4) Empowerment and education: service users gain useful information and new skills as well as a sense of mastery through active engagement in health research (Tran & Leese, 2016). (5) Democracy: democracy is exercised through the equitable partnership between

professionals and service users during the collaborative process that emphasizes complementary expertise and shared responsibilities (e.g. Israel et al., 2006).

Service-user engagement in this study. Service-user advisors were solicited for input on designing the data collection tool (i.e., protocol of the semi-structured interviews) and interpreting the findings. Although the degree of service-user engagement remained at a consultative level, the service-user engagement in the study allowed for opportunities to co-produce knowledge by complimenting the researcher's theoretical expertise with the service users' experiential insight. The goal of the service-user engagement was to improve the relevancy and credibility of the findings, enhance the social impact, and build the groundwork for knowledge dissemination.

To meaningfully engage the service-user advisors in my thesis, I followed the principles of patient engagement put forth by the Canadian Institute of Health Research (2014) i.e., *inclusiveness*, *support*, *mutual respect*, and *co-building*. I took the time to develop a rapport with the advisors and remained transparent with my roles and agendas as the researcher. I strived to build a safe and mutually respectful environment among the advisors and encouraged honest conversation through which the capacities of the researcher and advisors could all be developed. Working towards co-building, I sought input from the advisors in the major decisions of the study and kept the advisors updated on the progress of the study.

Procedures. Service-user engagement mainly took place before data collection and after data analysis. The timeline of the study with service-user engagement is as follows: (1) recruitment of service-user advisors; (2) the first and second meetings with the advisors for their input on developing the interview protocol; (3) data collection (recruitment and interviews with the participants); (4) data analysis; (5) the third meeting with the advisors to discuss their

feedback on the findings; (6) revising the report of the findings by incorporating the advisors' feedback.

Service-user advisors. Service-user advisors were recruited among individuals who themselves or whose family members (e.g., one's intimate partner, child/parent/sibling, or self-elected family member) had lived experiences of addiction and treatment services in Alberta. Only the individuals who expressed interest in couple therapy in addiction treatment were recruited for the purpose of the study. The advisors were likely to hold a better understanding of the participating couples' lifeworld than the researcher, because of their experiential proximity to the participants.

Recruitment. Service-user advisors were recruited from (1) participants from a previous CCT study conducted in Alberta (Lee & Awosoga, 2015), (2) community networks of family members of persons with addiction, including *Moms Stop the Harm (MSTH;* an advocacy and self-help network of Canadian mothers and families who have lost their loved ones to substance use*) Alberta Chapter* and an *Al-Anon* group in southern Alberta (Al-Anon, a self-help organization for families and friends of alcoholics), and (3) the researcher's community connections (colleagues and associates in the field of addiction and mental health services). Recruitment was attempted with the Alberta Health Services' *Addiction and Mental Health Strategic Clinical Network (SCN)* but yielded zero turnout.

First, two couples who had completed CCT in a previous study (Lee & Awosoga, 2015) were individually invited to join this study as advisors via email. Second, with referrals from Dr. Lee and my colleagues, I established contact with *MSTH Alberta Chapter* and four other individuals who themselves or whose families had lived experience of addiction and treatment.

Third, I attended open meetings in local Al-Anon groups in southern Alberta to recruit interested individuals.

An invitation letter and a recruitment poster were emailed or handed out to potential service-user advisors. Please see Appendix A for the standard version of the recruitment letter for the advisors and Appendix B for the recruitment poster for the advisors. When recruiting through organizations, i.e., MSTH, SCN, and Al-Anon, permission to recruit was requested from the representatives of the group. The SCN and MSTH representatives permitted the recruitment and forwarded my invitation letter and poster to the members. In one of the two local Al-Anon open meetings which I approached, I was able to gain verbal consent from the meeting moderators to approach the members for recruitment after the meeting.

Recruitment ended when eight eligible candidates had consented to participate in the study as service-user advisors (see below for criteria for eligibility and informed consent). The number of advisors was partly determined based on the convention of a focus group that typically includes a minimum of four to a maximum of twelve members (Carlsen & Glenton, 2011). The eight candidates included two past CCT clients who were wives of the individuals with gambling addiction, one member from MSTH, all four individuals from personal referrals, and one member from Al-Anon.

Criteria. The criteria for the service-user advisors include: (1) having utilized Alberta's addiction treatment services in the past 10 years or having a family member– partner, child, parent, sibling, or self-elected family member– who had utilized Alberta's addiction treatment services in the past 10 years; (2) having accessed couple therapy in addiction treatment or interested in couple therapy in addiction treatment; (3) being able to attend three audio-recorded

2-hour advisory meetings (in the form of teleconferences) with the researcher and other service-user advisors on an anonymous basis during the study; (4) being 18 years of age or older.

A phone call was scheduled to screen for each advisor candidate's eligibility. After obtaining their verbal consents, I went over the screening survey with the candidates. The initial greeting and the screening protocol for service-user advisors are included in Appendix C. All eight of the candidates were determined to be eligible.

Informed consent. Following the screening procedure, another phone call was scheduled to complete the informed consent with each advisor candidate. During the call, I explained the purpose and methods of the research, discussed with the candidate the advisor's role and activities in the study, explored considerations of confidentiality, and clarified the advisor's compensation. The potential benefits and risks of participating in the study as an advisor were also outlined. One of the risks involved possible emotional distress. Due to the topic of the study, during the advisors' engagement in the study, unpleasant memories related to their or their loved ones' addiction could be evoked, and negative feelings could arise. To prepare the advisors for the possible occurrence of difficult emotions, a document containing grounding techniques and resources (see Appendix D) was emailed to the advisors together with the consent form.

If the advisor candidates wished to proceed, they were asked to sign *Advisor's Information Letter and Consent Form* (and *Addendum to Advisor's Information Letter and Consent Form* later on during the study) and mail or fax the hard copy back. Please see the advisor's information letter and consent form in Appendix E and the addendum in Appendix F. After receiving signed consent forms from all advisors, an advisory committee for the study was formed.

Description of service-user advisors. The service-user advisors consisted of six females and two males. Two of the service-user advisors were also a couple. Among the eight advisors, three had lived experiences with addiction themselves and gone through Alberta's treatment programs in the past ten years. Two advisors had a child with such experiences. The other three had a spouse or cohabiting partner with a recent history of addiction and treatment.

The advisors' ages were estimated to range from the late 20s to the late 50s. They were located in various regions of Alberta. Four of the service-user advisors worked in addiction and mental health agencies and social services. The other four advisors had occupations in human services and natural resources. The advisor from MSTH was also active in advocacy for social changes to reduce the harm of substance use to families and communities. All the advisors had post-secondary education. At least one of them had a post-graduate degree.

Engagement process. The engagement with the service-user engagement mainly took place within three 2-hour advisory meetings via teleconferencing throughout the study. The first two meetings were held prior to participant recruitment, during which the advisors provided input on developing the interview protocol. The third meeting was organized after data analysis, where they discussed their feedback on the findings. Additionally, one advisor participated in a practice interview with me after the interview protocol was finalized and before the data collection to help me prepare for the actual interviews. Throughout the study, email updates of the study were sent to the advisors periodically.

With the advisors' disperse geographical locations, in-person meetings were difficult. Teleconferences were conducted for advisory meetings, which were hosted through Cisco Webex (2017). The advisors could attend the teleconferences via phones or computers. To protect the advisors' confidentiality, they were asked to find a private space when participating

in the teleconferences and keep their webcams off if they used computers. They were also advised to use a pseudonym for the teleconferences and group emails.

With the advisors' various availability, scheduling meetings with all eight of them turned out to be challenging. Since there was no need for collective decision-making in the advisors' engagement, meetings were scheduled at the convenience of the advisors with one to four advisors in attendance.

Three advisors did not participate in all three advisory meetings required for their engagement in the study. One advisor had to condense the first two meetings into one due to his limited availability. One advisor withdrew from the study after the first meeting, due to personal reasons. One advisor dropped off after the second meeting, due to failed contact.

Advisory meetings. The meeting agenda and the document of focus were emailed to the advisors several days prior to the scheduled teleconferences. The author had developed a draft interview protocol with the input of the thesis co-supervisor, Dr. Lee. The draft interview protocol was emailed to the advisors before the first advisory meeting. Before the third meeting, a summary of the findings was emailed to the advisors.

With the advisors' consent, the meetings took place via teleconferences and were audio recorded for the researcher's review and analysis. At the beginning of each meeting, the advisors were reminded of the emotional risks of participating in the study, due to the potentially sensitive topics of addiction and couple distress. The advisors were encouraged to take breaks throughout each meeting and refer to the grounding resources previously emailed to them as needed.

During the first two advisory meetings, the advisors went over the draft interview protocol with me and proposed revisions. The advisors advised reducing the introduction at the beginning of the interview to make it more conversational. They suggested modifying some

questions to make them less ambiguous and easier to respond to. They advised adjustment to follow-up questions to make them more open-ended and respectful. For example, instead of asking "*What might have caused the issue?*", an advisor suggested asking "*Do you mind telling me more about it?*" The advisors suggested that when asking a question based on a certain hypothesis or concept, the interviewer could begin with a brief explanation of the hypothesis/argument or a primer question on the concept. For instance, when asking whether the participant had made changes in their sense of self-worth, I could start by asking what "*self-worth*" might mean to this participant. The advisors also proposed new questions to capture some experiential aspects that could be unique to individuals going through treatment and changes. For example, a question regarding losses was added when asking a participant about letting go of the past in recovery. For the final interview protocol, please see Appendix G.

In the third advisory meeting, the advisors discussed their interpretation of and responses to the findings. The focus was on the implications of the findings, which would affect the framing and discussion of the findings in the final report. The advisors mainly discussed: (1) the couples' changes through CCT, (2) the significance of couple therapy, (3) the different and similar benefits of CCT and TAU and how CCT might be more beneficial than TAU in certain areas, (4) how to integrate CCT in the addiction and mental health services for service users at different points of treatment and with various service needs, and (5) other learnings on the addiction service system and the treatment as usual. For a summary of the advisors' feedback, please see Appendix H.

Practice interview. One advisor consented to participate in a practice interview with the author based on the finalized interview protocol. The advisor signed a consent to participate in the pilot interview (See Appendix I). This interview took place via teleconferencing before the

participant recruitment began. The advisor provided feedback to finetune the interview protocol and to improve my performance as the interviewer.

3.4 Data Collection

After the semi-structured interview protocol was finalized with the input of the advisors, recruitment and data collection began. The following flowchart (Figure 2. Process of the Research) illustrates the research process.

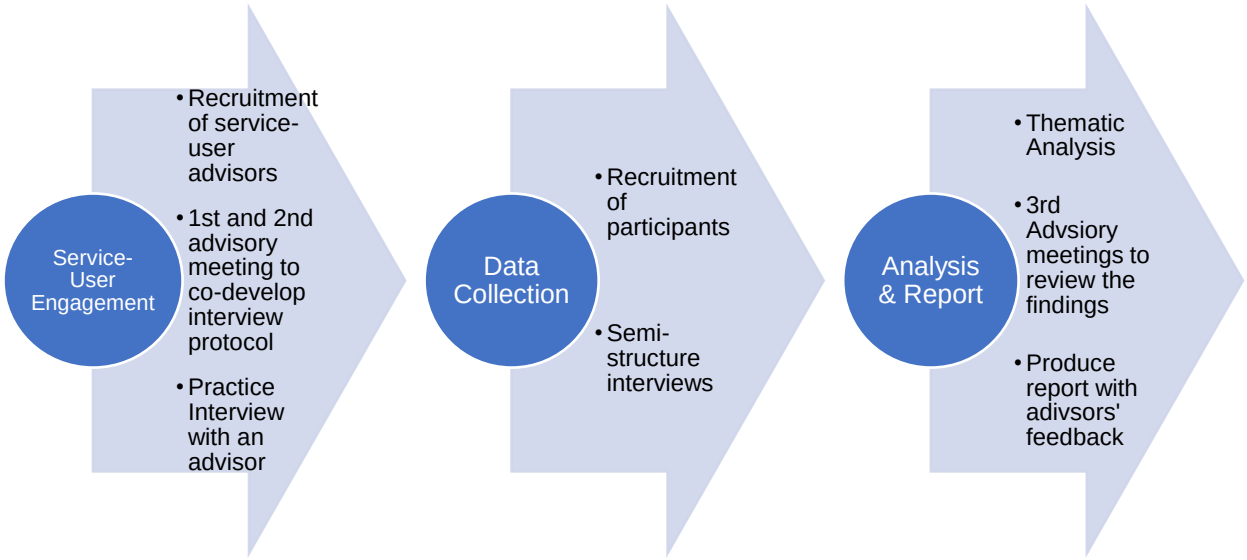


Figure 2. Process of the research.

Participants. Purposive sampling (Creswell, 2014) was used in recruiting participants. As the current study is an adjunct to the RCT comparing outcomes of CCT and TAU for AUD and GD (Lee et al., 2021), recruitment was conducted among the couples who had undergone the randomized treatment of CCT or TAU in the RCT.

Recruitment & screening. Emails were sent out to the potential candidates who had completed their assigned treatment in the RCT to invite them to the current study. When an individual responded with interest, a phone call was scheduled to conduct a brief screening survey with the candidate. The screening survey focused on suicide assessment, which was

adapted from the Columbia-Suicide Severity Rating Scale, Screen Version - Recent (Posner et al., 2008). Suicide intervention was also included in the design of the screening procedures in case of a moderate and high risk of suicide. Please see Appendix J for the participants' initial greeting and screening procedures.

Criteria. The inclusion criteria required the couples to (1) have completed the assigned treatment in the RCT and (2) have no recent risk of suicide. None of the individuals screened presented a suicide risk. An exemption of Criteria (1) was made for one couple who only completed half of CCT, and the decision for them to withdraw from CCT was made due to their elevated life crises.

Informed consent. When a candidate was deemed eligible for the study, *the Participant's Information Letter and Consent Form* (Appendix K) was emailed to the candidate and a call was arranged to complete the informed consent. When both members of a couple agreed to complete the informed consent, the call was made with both members present. A participant's consent included participating in a one-on-one phone interview which would be audio-recorded and allowing the researcher to utilize part of their data from the RCT (Lee et al. 2021) relevant to the current study. Data borrowed from the RCT for this analysis mainly were selected demographic information of the participants. The participants were asked to mail or fax their signed consent forms to my co-supervisor and the principal investigator of the RCT, Dr. Bonnie Lee.

During the informed consent, the potential benefits and risks of participating in the study were explained. There was an emotional risk of participating in the interview, as the interview touched on issues and experiences potentially painful to the participants. To help reduce the emotional harm, a list of grounding resources (similar to the grounding techniques sent to the

service-user advisors; see Appendix L) was emailed to each participant together with the information letter and consent form.

Description of participants. Twenty participants joined the study, including nine couples and two partners of individuals with addiction. Among them, five couples went through CCT, and four couples and the two partners completed TAU. The sample size of the study was determined for pragmatic reasons, including the number of couples who had completed their treatment in the RCT at the time of recruitment and those who responded to the invitations within the window of recruitment. Qualitative research commonly utilizes a small sample size (Creswell, 2014), and the goal for recruitment in this study was set for five CCT and five TAU couples, given the limited time and resources for a Master's thesis. With challenges recruiting individuals with addiction from TAU, four couples and two partners from TAU were recruited instead. The two partners reported no history of addiction. Among the five CCT couples, one couple did not complete all 12 sessions of CCT. They withdrew from the RCT after seven CCT sessions to return to their regular addiction counselling, due to elevated risk factors in their lives.

Treatment conditions. Although only the CCT couples were asked about their experience with CCT, both the CCT and TAU couples spoke of their perspectives of regular treatment services in which they had participated within and out of the RCT in provincial addiction and mental health clinics, other community agencies, 12-step groups, and private practices. These regular treatment programs that the participants had accessed for their addiction or to cope with their partners' addiction were all regarded as TAU in this study.

Congruence Couple Therapy. Congruence Couple Therapy (CCT) is a humanistic systemic couple therapy that was initially designed for pathological gambling (Lee, 2001). CCT takes a systemic perspective and views couple issues and addiction to be mutually perpetuating,

and it explores the families of origin and external stressors to understand the fault-lines of couple communication and the development of addiction (Lee, 2014). CCT offers a way to extricate the couple from the vicious cycle of addiction and couple issues, by achieving a state of congruence in the couple system (Lee, 2015).

CCT typically consisted of 12 weekly sessions, each about 60-90 minutes long (2009, Lee). In the RCT, CCT was delivered by the addiction counsellors in the two provincial clinics. The CCT counsellors went through a 5-day CCT training with the CCT developer and the principal investigator of the RCT. The counsellors also had ongoing consultations with their CCT trainer through weekly teleconferences and additional communications as needed throughout the RCT. The counsellors' level of adherence to CCT was rated 7 out of 10, based on the assessment of their case notes and teleconference reports (Lee et al., 2021). The five CCT couples interviewed in the current study received CCT from three of the CCT-trained addiction counsellors. The couples were asked to refrain from accessing TAU programs during CCT.

Treatment as Usual. It is important to note that the TAU programs that the participants spoke of in their interviews were not exclusive to the TAU in the RCT. TAU programs in the current study also included community programs and private practices that the participants had accessed beyond the RCT for their addiction or to cope with their significant others' addiction. Therefore, both the participants from CCT and TAU spoke of their experiences with regular addiction services before, during, and after the RCT and beyond the services of the provincial clinics. The reasons for the expanded TAU are in the following. First, some participants in TAU accessed little treatment within the provincial clinics during the RCT. For example, one partner in TAU exclusively accessed private counselling in the community, while three other partners only attended 2-3 sessions of their programs in the provincial clinics for the duration of TAU.

One client in TAU reported primarily attending AA programs outside the provincial services throughout the trial. Second, the participants in CCT accessed regular addiction services prior to and/or after CCT, they were in a good position to comment on CCT and regular addiction services comparatively, which was valuable for the purpose of this study.

The TAU programs that the clients spoke of contained both in-patient and out-patient programs. The in-patient programs were primarily provincially-funded residential treatment programs. The out-patient programs included (1) intensive day treatment programs in provincial clinics, (1) one-on-one counselling in provincial clinics, community agencies, and private practices, (3) group therapy and psychoeducational workshops in provincial clinics, (4) self-help programs such as 12-step based groups and SMART Recovery (i.e., Self-Management and Recovery Training program) in the community. The programs in which the partners had participated included (1) family support groups in provincial clinics, (2) one-on-one counselling in provincial and private services, and (3) 12-step based self-help groups for affected others (e.g., Al-Anon) in the community.

Semi-structured interview. Semi-structured interviews, a commonly used method in qualitative research, were chosen for the current study. Semi-structured interviews are typically used to obtain rich and in-depth data, using pre-designed open-ended questions with prompts and follow-ups (Warren & Carner, 2005; Whiting, 2008). The process of a semi-structured interview is iterative and bi-directional between the interviewer and interviewee (Atkinson & Coffry, 2002; DiCicco-Bloom & Crabtree, 2006), through which the interviewee's subjective experiences are transformed into data meaningful to the research.

In-depth semi-structured interviews were conducted with participants one-on-one through teleconferences. Cisco Webex (2017) was used to conduct the teleconferences. Each participant

was asked to complete a two-part interview, each part about 1 hour long (See *Interview questions* section for the focus of each part). Combining the two parts, the participants' interviews ranged from 1.5 to 4.5 hours. All but one participant elected to complete the two parts on separate days. They all consented to have their interviews audio-recorded for analysis. The participants could choose a pseudonym during the interview to protect their confidentiality on the audio recording.

One participant only completed the first part of the interview and did not return contact to begin the second part. Another participant though completed her interview, the first part of the interview failed to be recorded due to technical issues. Therefore, only the first and second half of the two participants' interviews were included in the analysis. Additionally, one participant emailed me after her interview to respond to one question that she had difficulty responding to during the interview. The content of this email was included in the data for analysis.

Interview questions. The interview protocol was finalized by integrating the service-user advisors' input. The interview protocol was structured around the research questions of this study in order to learn about the following areas: (1) The circumstances and motivations that lead the participants to seek couple therapy in addiction treatment (e.g., "*Could you tell me a bit about what was going on in your life [before you joined the CCT study]?*" and "*What motivated you to seek couple therapy?*"); (2) the benefits and limitations of CCT and TAU in the participants' views (e.g., "*Now you've gone through the couple therapy/treatment as usual, what do you find helpful about these treatments, if there are any?*"); (3) the appropriate entry point to couple therapy in addiction treatment in the participants' perspectives (e.g., "*When do you think would have been the best time for you both to be seen together, so that you get on the same page/you can start address the tensions in the relationship?*"); (4) the participants' experiences of change in themselves and in their relationships through CCT/TAU (e.g., "*Have you noticed any changes*

about the way you talk and listen to your partner, now that you've gone through the couple therapy/treatment as usual?"). To see the full interview protocol, refer to Appendix G.

The first part of each interview focused on the first three areas, which involved the participant's views in CCT and TAU and their life context when they sought couple therapy in addiction treatment. The second part of the interview focused on the fourth area, regarding the participant's experiences of change in themselves and their relationships through CCT and TAU.

Interview process. After the first part of the interview was scheduled with a participant, I set up the teleconference on Cisco Webex (2017). An email notification was automatically sent to the participant with instructions to access the teleconference at the scheduled time. The participant could elect to join the teleconference via phone or computer. To protect participants' confidentiality, they were advised to use a pseudonym during the audio-recorded interview and turn off the webcam if they chose to use a computer for the teleconference.

At the beginning of each interview, the participant's rights as an interviewee (e.g., free to stop at any time) and the fact the interview would be audio recorded were reiterated. The participant was encouraged to take breaks as needed and to refer to the grounding resources if the participant began feeling overwhelmed with emotions. After the interview began, field notes were taken on what stood out in the participant's responses (descriptive field notes) and any patterns of meanings or coding schemes that arose (interpretive field notes) (Bogdan & Biklen, 2006). In the end, I debriefed with the participant and invited additional comments and feedback. At this point, the second part of the interview was scheduled.

Demographic Data. Selected demographic information of the participants from the RCT was utilized in the current study to provide a fuller picture of the sample of participants and to assist the understanding of the participants' experiences and perspectives.

Ethical considerations. The ethics protocol of the study was approved by the Health Research Ethics Board – Health Panel, University of Alberta, with the study ID Pro00077938. Considerations of ethics during the research process, including compensation, confidentiality, and safety of the advisors and the participants as well as acknowledgement of the advisors' contribution, are discussed in the following.

Honorarium. As a token of appreciation for the advisors' and the participants' time, digital gift cards were emailed to them after the advisory meetings and the interviews. The service-user advisors received a $20 gift card for each advisory meeting that they had attended. The participants received a $30 gift card upon interview completion. The cash value of one advisor's gift cards was donated to a local charity at the advisor's request.

Confidentiality and anonymity. To protect the confidentiality and anonymity of the advisors and participants, at the beginning of the study (typically during informed consent), they were asked to choose a pseudonym for email communication and during meetings/interviews. Group emails to advisors were sent using blind carbon copies to hide recipients' email addresses. Webcams were advised against during the advisory meetings and interviews.

Emotional safety. As previously discussed, there could be emotional risks for the participants to go over their experiences with addiction and for the advisors to be engaged in a study focusing on couples' experiences with addiction and treatment. Such risks were discussed with the advisors and participants during their informed consent. Grounding resources were provided to assist them in coping with difficult emotions that arose during their participation in the study. During the advisory meetings and interviews, breaks were encouraged to help them regulate their emotions.

Acknowledgement of advisors. The advisors were acknowledged for their contribution to the study as a group without mentioning individual names to protect their confidentiality. The member from the MSTH welcomed the acknowledgement of the MSTH in this study.

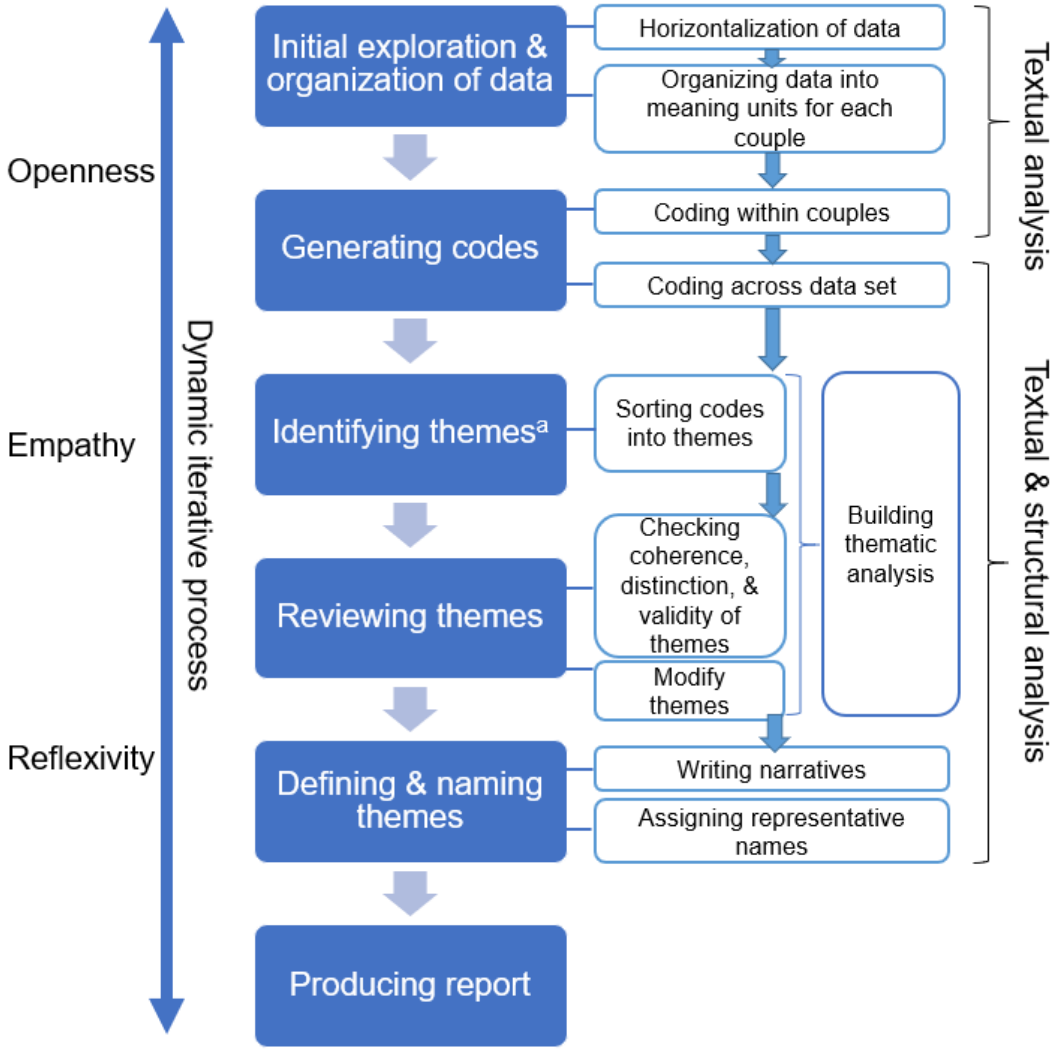
Data handling and storage. The physical copies of the signed consents of the advisors and participants were stored in a locked cabinet in an office at the University of Lethbridge. The audio recordings of the interviews and advisory meetings were immediately downloaded from the cloud drive and transferred to an external hard drive to be stored in the locked cabinet. The online files were then deleted to avoid safety risks associated with cloud storage.

The transcripts of the interviews were named with the participants' pseudonyms, encrypted with a password, and transferred to the external hard drive. The master list of the advisors' and participants' contact information was also stored digitally in the same external drive and password protected.

3.5 Data analysis

To analyze the qualitative data from the interviews, thematic analysis with phenomenological methods was utilized. Thematic analysis (Braun & Clarke, 2006) is a method for identifying, analyzing, and reporting patterns (i.e., themes) across the data set. It organizes and describes the data set in rich detail. Themes capture what are important about the data in relation to the research question and represent some level of patterns and meanings within the data set (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013). In the current analysis, data was approached inductively without an overarching guiding theory. The themes were formed both through describing the explicit content and interpreting the latent meanings, borrowing ideas from *textual* and *structural analysis* proposed for phenomenological research (Moustakas, 1994). I strived to exercise empathy (Wertz, 2005), openness (Finlay, 2008), and

reflexivity (Maxwell, 2013) as recommended for phenomenological research as guiding attitudes in the analysis. I followed the six steps of thematic analysis outlined by Braun and Clarke (2006) and incorporated phenomenological techniques. *Figure 3* outlines the process of the phenomenologically informed thematic analysis. Despite its linear layout, the analysis process was dynamic and interactive. The analysis was completed manually without the use of analysis software, due to my preference for the fluidity of manual analysis as well as my lack of proficiency in qualitative analysis software.



[a] Themes imply both themes and subthemes.

Figure 3. Process of the thematic analysis with phenomenological methods

Initial exploration and organization of data. After the interviews, I went over my field notes, listened to the interview recording, and began transcribing. While transcribing, I jotted down any meanings and patterns that emerged. I reviewed the transcription in their entirety to familiarize myself with the depth and breadth of the content and obtain a general sense of the data (Braun & Clarke, 2006; Creswell, 2014, p. 242). I noted my initial ideas of the content and what seemed interesting or important.

In the initial exploration of the data, all statements relevant to the research questions (which included the couples' experiences and life context related to addiction and treatment seeking) were treated with openness and assigned equal value. This practice aligned with what Moustakas (1994) called *the horizontalization of data* in phenomenological analysis, following the principle of *epoché*. The data of each couple were then organized into different units following the chronological development of each couple's experience with addiction and treatment. Identify *meaning units* to organize data for later analysis is a common method in phenomenological analysis (Smith & Osborne, 2003; Wertz, 2005), which was appropriate to incorporate in this analysis. My initial naming of the meaning units was developed with my co-supervisor Dr. Lee's cogent input. The data of each couple's interviews were first divided into six meaning units (subunits were formed when deemed fit): (1) the couple's background and baseline conditions (including families of origin, history and development of addiction, general ways of coping, etc.); (2) changes in the client's and partner's lives due to addiction; (3) treatment programs and experiences; (4) effort and support unrelated to treatment; (5) changes in both the client's and partner's lives through/after treatment; (6) the couple's reflection on and learnings from their experience with addiction and treatment.

Generating codes. After organizing the data, I began coding, first within each couple and then across the entire data set.

Coding within couples. I combed through each couple's data to code what was interesting or significant. All coded data segments were still housed under a certain meaning unit. When suitable, I adjusted the placement of segments among meaning units and modified the naming of codes and meaning units themselves. Some of the codes were revised when relating the segments to the data set of each couple. Samples of the preliminary coded data of the individual couples were presented to Dr. Lee, who then proposed revisions of the codes and suggested potential themes of saliency. Her input was then incorporated into the next step of the analysis.

Up to this point, my analysis remained largely descriptive, retaining the participants' terms in coding rather than coding the underlying meanings. The pure description of what was said by the participants corresponds with *textual analysis* in phenomenological research (Moustakas, 1994).

Coding across couples. Having generated initial codes within each couple's data, I began developing codes across the data set. Codes were phrases that identified potential themes and patterns of the content across all the interview data. I collated the initial codes across the couples to identify common themes and conspicuous features. As I coded the data set, I followed Braun and Clarke's recommendations (2006) to check coded extracts against as many potential themes/patterns as they could fit into. I retained codes for non-dominant discourses.

At this stage, some codes were identified to describe the explicit expressions of the participants, while others were generated to capture the latent meanings of the data. A phenomenological technique *structural analysis* (Moustakas, 1994) was applied for the latent content. I introduced preconceptions from my previous learnings in psychology and counselling

to aid the interpretation of the latent meanings, and some codes were produced with counselling terminologies. The key was to find "expressions which are high level enough to allow theoretical connections within and across cases but which are still grounded in the particularity of the specific thing said" (Smith & Osborne, 2003, p.68). Box 1 and 2 demonstrate an example of the two steps of coding from the explicit to latent content. An excerpt from Elise's interview is presented (pseudonym is used). From this point on, textual and structural analyses were continuously conducted across the data set to generate codes and themes. I continued practicing reflexivity throughout this process, examining whether my prior theoretical knowledge was used appropriately as guidance for interpretation or biased my understanding of the participants' lifeworld.

Box 1. Coding on explicit content

Researcher: Now that you've gone through the couple therapy, have you noticed any changes in yourself? Elise: I would say I'm more self-reliant. I'm less inclined to look to Esther for validation. And I would say my daily routines are calmer because I'm not sort of bidding for attention all the time since we have set up periods where I can count on having some attention, so that is a change. I will say I'm more confidence in my ability if we are having issues or even before they become an issue, that we have the tool to work it out together, so there is less anxiety around how I am going to deal with this. "Are we going to have to go to therapy to figure this out?" Because I think we do have a better communication style now and better skills, and there is a lot less mental energy going to that. Researcher: is there anything that's from the couple therapy that helps you to make these changes? If you could pinpoint anything at all. Elise: Communication skill training. The idea of, just the concept of a being in this together. The idea that the relationship is resource. The idea that I can ask for things in a non-demanding and non-whining and non-	*Changes in self through couple therapy:* More self-reliant & less need for partner's attention. More self-assured & less need for partner's validation. New couple routine helps Elise feel less anxious about getting her partner's attention. Less anxiety for couple issues and more confidence in one's ability to resolve them, due to improved couple communication skills. No need to go to couple therapy for couple issues. *Aspects of couple therapy that promoted the changes in oneself:* Communication skill training. The idea of "being in this together". The idea that relationship can be a resource (to facilitate recovery). Improved communication skills in asking for what she needs, by

complaining way. Focusing a lot more "I" statements and I find that that's particularly useful that way. I feel that I have the tools that I can address things instead of either stuffing them or deciding to tolerate them.	focusing on expressing oneself rather than blaming the other. No longer need to avoid addressing issues with improved communication skills.

Box 1. Coding on latent content	
Researcher: Now that you've gone through the couple therapy, have you noticed any changes in yourself? Elise: I would say I'm more self-reliant. I'm less inclined to look to Esther for validation. And I would say my daily routines are calmer because I'm not sort of bidding for attention all the time since we have set up periods where I can count on having some attention, so that is a change. I will say I'm more confidence in my ability if we are having issues or even before they become an issue, that we have the tool to work it out together, so there is less anxiety around how I am going to deal with this. "Are we going to have to go to therapy to figure this out?" Because I think we do have a better communication style now and better skills, and there is a lot less mental energy going to that. Researcher: is there anything that's from the couple therapy that helps you to make these changes? If you could pinpoint anything at all. Elise: Communication skill training. The idea of, just the concept of a being in this together. The idea that the relationship is resource. The idea that I can ask for things in a non-demanding and non-whining and non-complaining way. Focusing a lot more "I" statements and I find that that's particularly useful that way. I feel that I have the tools that I can address things instead of either stuffing them or deciding to tolerate them.	*Changes in self through couple therapy:* Greater self-assurance with less need for external validation. Improved couple cohesiveness promoted sense of independence. Routines to promote time together improves sense of cohesiveness. Greater self-confidence and self-reliance in resolving couple issues with improved couple communication skills. *Aspects of couple therapy that promoted the changes in oneself:* Communication skill training. Reinforced sense of togetherness (through hardships). Changed perspective on relationship in addiction recovery – as a resource to support change. Improved communication skills to make requests for one's needs, related to enhanced self-differentiation and ability to represent oneself. Improved communication skills to address issues instead of resorting to avoidance.

Meetings with Dr. Lee were held periodically to discuss the coding of certain segments and emerging themes and patterns. Checking my interpretations against hers and comparing her independent coding of some segments with mine aligned with the *cross-checking* method (Guest, MacQueen, & Namey, 2012) to ensure consistent results of analysis. Discussing my views out loud with her and responding to her questions regarding my analysis process allowed for *peer*

debriefing (Lincohn & Guba, 1985), which helped expose my biases in understanding the data and enhanced the credibility of the analysis.

Identifying themes. Having generated a list of initial codes across the entire data set, I sorted the codes into potential themes and grouped all the coded data segments within the matching themes. The codes relevant to the research questions were considered themes and subthemes, and those unrelated were placed aside for later review.

As I searched for themes, I also began developing *a thematic map* to aid the grouping of codes and my understanding of the relationships between the codes, themes, and subthemes. Throughout the mapping process, I kept going back to the transcript and the interview notes to stay in touch with the holistic context of the themes and their relationships.

Reviewing themes. Having devised a set of candidate themes and subthemes, I reviewed and modified the themes in an iterative process that involved two tasks. First, I checked all the themes against their corresponding data extracts to ensure the coherence of each theme and distinctions between themes. Second, I examined the "validity" of the themes – whether each theme reflected a meaning or pattern of the data set and whether the thematic map represented the meanings evident in the data as a whole. During this process, I discarded the themes that did not have enough data to support them. I collapsed some themes, grouped some themes under the others as subthemes, and broke down some themes into separate ones. I also went back to recode some of the segments that I missed earlier in previous steps that could form a new theme or support a current theme. This process continued until a satisfactory thematic map emerged (Braun & Clarke, 2006).

Defining and naming themes. With a satisfactory set of themes, I began writing up definitions of the themes. I composed a narrative for each theme that identified its meaning and

explained how it fits into the overall story from the data. During this process, I continued examining the data within the themes and refining their description. I continued returning to the data set to gain a better grasp of the participants' life world and develop a better sense of the context of each theme. Meanwhile, I revised, added, and deleted subthemes to clarify the hierarchical structure of meanings within the data. After clearly defining the themes, I assigned them with representative names and continued revising them for more representative and concise names. While the naming of most themes had moved away from the participants' terms towards psychological concepts, I strived to honour the participants' perception and language in the description of themes.

Ongoing discussions with Dr. Lee led to multiple adjustments to the definitions and naming of the themes. Several presentations on the preliminary results of my thesis to research and public health audiences during this time also prompted revisions of the themes.

Producing the report. After having defined and named the themes, I produced the first report of the thematic analysis. The report presented the complete story of the data with narratives. In my report, I aimed to make an argument in relation to the research questions with each theme and provide an appropriate amount of evidence from the data (Braun & Clarke, 2006). The feedback from my co-supervisor Dr. Piquette on the report prompted a revision. I restructured the thematic map (Please see Figure 4 for the finalized thematic map) and redefined several themes to improve their coherence and better reflect the research questions.

Integrating advisors' feedback. An executive summary of the findings was presented to the service-user advisors for their review. The summary included the results of the thematic analysis and the collapsed demographic information of the participants. The advisors' feedback contributed to the framing of the discussion. Particularly, their ideas were incorporated in

discussing the significance of couple therapy in addiction treatment, features of CCT, and the potential avenues through which CCT could be integrated into the addiction and mental health system to better serve the service users at various points of treatment (see Service-User Engagement for more about advisors' feedback).

3.6 Reflexivity

A researcher is considered an instrument of qualitative research (Denzin & Lincoln, 2017). A researcher's knowledge, background, and experience can potentially shape the direction of the inquiry (Creswell, 2014; Maxwell, 2013). With the crucial role that a researcher plays in qualitative research, reflexivity is an important exercise for qualitative researchers (Creswell, 2014). Through reflexivity, a researcher reflects on one's role in the research and one's background, experiences, values, and personal beliefs that could potentially shape the research. A researcher's possible biases and assumptions in regard to the subject matter need to be identified through reflexivity (Greenback, 2003).

As a person with an East Asian cultural background who grew up in a relatively collectivistic society, I value family and community, and I recognize their powerful influence over a person's mental wellbeing. Having gone through graduate training in counselling psychology with a focus on addiction and mental health and delved into the research on couple therapy in addiction treatment, I believe that family and community work has tremendous value in enhancing our addiction and mental health services. Dr. Bonnie Lee's work on CCT sparked my interest in family-oriented programs for mental health before I even entered my Master's. Having the opportunities to work with Dr. Lee in her research during my graduate program allowed me to develop my knowledge in family-involved treatment for addiction and mental health. Combining my clinical training and research knowledge, I began developing a career path

on family-oriented work for mental health wellness and became motivated to promote family-related programs.

With Dr. Lee's support, I applied for the 2016 Alberta SPOR (Strategy for Patient-Oriented Research) graduate studentship, which provided funding for the current thesis on the couples' perspectives in couple therapy and regular addiction treatment. My choice to study the service users' perspectives in treatment services was partly anchored on the belief that individuals with lived experiences of a condition and the treatment hold insight beyond the expert knowledge. I believe that our goal in healthcare services is to improve patients' quality of life and that incorporating the patients' agendas in the research focus can produce more translatable results to patient well-being.

I decided to take a step beyond just studying patient perspectives, by trying out the method of patient engagement, which was highly regarded in patient-oriented research (Canadian Institute of Health Research, 2011). Although I had no previous knowledge in patient engagement, with the training from the SPOR studentship program and the consultative support from the Alberta SPOR Support Unit, I was able to begin this complex undertaking in my thesis. I gained a realistic understanding of the challenges and rewards of collaborating with service users in the research process, adjusted my goals of service-user engagement in the thesis for pragmatic limitations, and identified my areas for growth in participatory research.

Entering the research topic of couple therapy in addiction treatment, I held several assumptions which affected my data collection and analysis in the study. First, addiction had deleterious effects on a couple's relationship regardless of whether one partner's addiction behaviour was shared or endorsed by the other. Therefore, I did not control for concordant and discordant couples in addiction in the current sample. Second, couple, familial, and social

relationships could be a source of support in times of stress and hardship. Third, based on the literature, couple therapy was beneficial for couples with addiction in repairing their relationships and improving their skills in communication and emotion regulation. Improved couple relationship functioning will in turn serve as a conducive environment for the IP's addiction recovery. On the other hand, I believed that the couples did not necessarily have a coherent understanding of their specific needs and values when seeking couple therapy. Therefore, questions needed to be asked on their life context, relationship dynamics, experience with addiction and change, and experiences with various treatment programs to shed light on the couples' values of various aspects of systemic and individual-based therapy in relation to their personal context. Additionally, although I had my preconceptions of what a successful treatment, a happy couple, and change in addiction recovery might look like, I tried to refrain from prejudgements during the interviews and analysis. I tried to dive into each participant's lifeworld and sift through the positive, negative, and complicated from their perspectives.

Albeit my belief in the benefits of couple therapy in addiction treatment, I do not see couple therapy as necessarily a superior treatment modality compared to individual-based addiction treatment, nor did I approach the thesis with the intention to find out which treatment was better. My goal was to sort through the nuances of the participants' perception of various aspects of TAU and CCT by entering their lived experiences and take away lessons to adapt and integrate couple therapy in addiction treatment with the services users' preferences in mind. It was because of my passion for couple therapy in addiction treatment and my respect for service users' perspectives, I carried out the study with continuous reflexivity to generate findings as authentic as they could be.

I chose CCT as the model of focus in inquiring into the service users' perspectives. However, it does not mean that I am in favour of CCT compared to other couple therapy in addiction treatment, such as BCT. I believe that one model of couple therapy in addiction treatment may be preferred over the other depending on the clinician's orientations and clients' characteristics and priorities for change. Entering the study, I was aligned with the process-related common-factor models of change (Sexton, Ridley, & Kleiner, 2004; Sprenkle & Blow, 2007) that looked into the client-counsellor alliance, the client's motivation, and contextual factors and examined the nuances in the process to explain outcomes. Therefore, in data collection and analysis, I paid attention to the context and process of the experiences to gain a rich understanding of the participants' accounts.

3.7 Rigour of the Study

Service-user engagement, thesis supervision, and thorough reporting contributed to the credibility and rigour of the study. First, end-user engagement increased the transparency of the research process and the accountability of the researcher. As the researcher, I was held accountable by the advisors to carry out the plan of operation responsibly and produce the results accurately. For example, I was responsible to address the advisors' questions regarding the purpose, design, and results of the study to the best of my ability and to provide periodical updates of the study progress. This kept the research agenda and process transparent and allowed me to be open to feedback and scrutiny. Additionally, the advisors' input helped to balance the researcher's biases and improved the credibility of the findings. Having the advisors review the findings and provide feedback acted as an informal form of *peer checking* (Janesick, 2015), which could enhance the trustworthiness of the study.

Meanwhile, consultation with Dr. Lee in data collection, analysis, and reporting as well as feedback from Dr. Piquette on data reporting allowed for a natural process of triangulation in the production of findings. Dr. Lee's independent review, coding, and theme generation of some segments of the data allowed for *cross-checking* (i.e., comparing independently derived results) (Guest et al., 2012; Creswell, 2014), which ensured the consistency of the findings. Meetings with Dr. Lee and Dr. Piquette served as *peer debriefing* (Lincoln & Guba, 1985; Shenton, 2004). Discussing my thought process in the analysis with them helped me to recognize my biases and orientations and gained new perspectives in interpreting the data and organizing the report. Thesis supervision from both co-supervisors supported the validity and enhanced the rigour of the study.

Additionally, the dependability and confirmability were substantiated with thorough reporting and consistent practice of reflexivity throughout the research. A dependable study is able to withstand scrutiny and allows for the repetition of its procedures to verify the results (Polit & Beck, 2018). The thorough and comprehensive description of the methodology supported the dependability of the findings. Confirmability (Nowell, Norris, White, & Moules, 2017) is considered a proxy measure of objectivity in qualitative research. Exercising reflexivity, adopting an inductive approach in the analysis, providing a detailed description of how themes were born from the data, and accounting for the methodological limitations of the study (see Discussion) ensured the confirmability of the findings to the original data.

3.8 Summary

In summary, the current study employed a phenomenologically informed qualitative approach to explore the couples' perspectives in CCT and TAU in AUD and GD treatment. Engaging eight service-user advisors who or whose family members had lived experience of

addiction and treatment in the research process added weight to the findings. The service-user advisors engaged in developing the data collection tool (i.e., the semi-structured interview protocol) and provided feedback to the findings. The participants of the study were recruited among the existing participants in an ongoing RCT comparing CCT and TAU for AUD and GD treatment who had gone through their assigned treatment. Twenty participants joined the current study, including nine couples and two partners of individuals with addiction. Semi-structured interviews with an average of 2 hours (range = 1.5 – 4.5 hours) were conducted with the participants individually via teleconferencing to inquire into their perspectives of CCT and TAU treatment programs that they had experienced. The TAU treatment programs of which the participants shared their views included all regular programs that they had accessed within and outside of the RCT in various community-based treatment settings. Thematic analysis was conducted to analyze the data from the interviews. The rigour of the study was supported by service-user engagement, thesis supervision, researcher's reflexivity, and detailed reporting.

Chapter 4: Results

In this chapter, the results of the thematic analysis will be reported. The chapter begins with a description of the participants, including their demographics, addiction and comorbidity information, and addiction-related treatment information. Subsequently, the themes of the benefits and limitations of CCT and TAU in the couples' perspectives will be presented.

4.1 Demographics Information

In the current study, 20 participants were interviewed on their perspectives on Congruence Couple Therapy (CCT) and Treatment as Usual (TAU), which they went through in an RCT that compared CCT and TAU outcomes for AUD and/or GD treatment (Lee et al., 2021). The participants included nine couples and two partners of individuals with addiction. Five of the couples went through CCT, while the other four couples and two partners completed TAU.

To protect the participants' anonymity, their demographic information is presented in an aggregated manner. Among the 20 participants, 40% (n=8) were males and 60% (n=12) were females. Their years of age ranged from 32 to 63 (M=48, SD=9.7). The sample included eight heterosexual couples, one same-sex female couple, and two partners who were female. 65% of the participants (n=13) were married; 35% (n=7) were cohabiting; 10% (n=2) were dating but not living together. The years of their couple relationships ranged from 1.5 to 36 (M=13.8, SD=10.8). One couple (n=2; 20%) reported living with their children under the age of 18.

Regarding primary occupations, 25% of the participants (n=5) reported having professional positions in healthcare, education, and other human services; 20% (n=4) reported working in labour, technical support, and sales; 15% of the participants (n=3) held managerial

positions; 15% (3 individuals) were self-employed; 15% (n=3) identified themselves as a retiree or home-maker; 10% of the sample (n=2) were unemployed.

Concerning education, 40% of the participants (n=8) had post-secondary degrees; 30% (n=6) had some post-secondary education; 30% (n=6) had a high school diploma or some high school education.

With respect to household income, 30% of the participants (n=6) reported that their annual household income ranged from $101,000 CAD to $150,000 CAD; 45% of them (n=9) reported an annual household income of $61,000 CAD to $10, 0000 CAD; 10 % (n=2) reported around $41,000 CAD to $60,000 CAD; 15% (n=3) reported $21,000 CAD to $40, 000 CAD or lower.

4.2 Addiction and Mental Health Information

The nine couples included seven singly addicted couples (i.e., discordant couples), where one member was seeking treatment for alcohol use and gambling disorder, and the other had no history of addiction. The other two couples were dually addicted (i.e., concordant couples), where both members were seeking treatment for their addiction. The dually addicted couples were randomly assigned to CCT. For ease of discussion, the participants who sought treatment for their own addiction were referred to as “clients”, and the participants who had no history of addiction were referred to as “partners”. Thus, the sample comprised of eleven clients and nine partners, including seven clients and three partners who underwent CCT and four clients and six partners who completed TAU.

Addiction. All eleven clients reported having an alcohol use problem. Six of them were males (55%) and five were females (45%). Five clients (45%) also identified one other primary

addiction, including gambling addiction (9%), cocaine abuse (27%), or prescription narcotics abuse (9%).

Among the eleven clients, eight of them (73%) reported abstinence for 30 days or longer prior to joining the RCT. All of the eight clients reported sustained abstinence throughout their treatment in the RCT and were abstinent at the time of the interview. The time lapse in months between their treatment completion and their interviews ranged from 0.5 to 13 (M=5.6, SD =5). Nine out of the eleven clients (82%) reported that they continued with regular addiction services after their assigned treatment ended.

Three out of the eleven clients had not achieved abstinence at the beginning of the RCT. They were among the two dually addicted couples. The one couple where both members did not maintain abstinence experienced relapses during their treatment (CCT) and withdrew midway through CCT due to life crises. The third non-abstinent client maintained controlled drinking throughout her treatment (CCT) and prior to the interview.

According to the two partners whose significant others did not participate in the study, the clients in these two couples remained in active addiction throughout the TAU.

Comorbidity. Four of the eleven clients reported having mental health diagnoses (36%): two clients (18%) reported anxiety and depression; one client (9%) reported a diagnosis of Generalized Anxiety Disorder with panic attacks; one client (9%) reported anorexia, anxiety, and depression. Three of these clients were reportedly on medication and/or in counselling to manage their concurrent disorders. No partners reported current diagnoses of mental health issues.

4.3 Current and Past Treatment Information

Among the five couples who had gone through CCT, all but one couple (80%) completely the CCT program. A standard CCT program consisted of 12 sessions. One CCT

couple withdrew after the 7th session due to life crises. One CCT couple had a total of 20 sessions with their CCT counsellor. The other three couples had 12-14 CCT sessions in total. The total number of CCT sessions that the couples attended ranged from 7 to 14 (M=13, SD =4.2). Before joining the RCT, eight of the CCT participants (80%) had utilized some form of addiction services. Six of the seven clients had accessed inpatient and/or outpatient programs for their addiction, and the other client exclusively utilized online self-help services. One of the three partners had sought one-on-one counselling and family support services from the provincial addiction and mental health services. After their CCT, four out of the five couples (80%) continued to receive some forms of treatment as usual, such as one-on-one counselling, 12-step groups, and psychoeducational workshops.

Among the four clients who had been through TAU, their treatment during the RCT generally included one-on-one counselling, group counselling, psychoeducational workshops in the provincial clinics and 12-step programs in the community. The clients were estimated to have attended 12 TAU sessions in total. The total TAU sessions were estimated based on the participants' self-report in the interviews and the survey data from the RCT. The six partners attended 2-12 TAU sessions in total (M=5, SD=3.4). Five out of the six TAU partners accessed one-on-one counselling, family support groups within the provincial clinics, and/or 12-step programs in the community. One of four partners also reported co-attendance to AA programs with the addiction client. One TAU partner did not access any provincial programs for counselling but sought one-on-one counselling through private services, which was also counted as TAU sessions. Prior to entering the RCT, eight of the ten TAU participants (80%) had sought addiction services. All four clients had accessed inpatient and/or outpatient programs, and four of the six partners participated in self-help groups or one-on-one counselling to cope with the

clients' addiction. After their assigned treatment period ended, three of the four clients (75%) and three of the six TAU partners (50%) continued with their TAU treatment.

During the interview, the CCT and TAU participants also spoke of the regular addiction services that they accessed before or after the RCT, which was included in the data for analysis. The TAU programs outside the RCT which the participants attended include: (1) a three-week day program at the provincial addiction and mental health services in Alberta (composed of psychoeducational workshops and group therapy on weekdays for three weeks consecutively), (2) provincially-funded residential programs, and (3) SMART Recovery program (which is a self-help program based on cognitive behavioural methods).

Table 1 and 2 present the summary of the CCT and TAU participants' addiction and treatment information respectively. To protect the participants' privacy, pseudonyms are used. Members of the same couple shared the same first letter of their names.

Table 1

Addiction and Treatment Information of CCT Couples

Name (Pseu-donym)	**Primary addiction**[a]	**Mental health diagnosis**	**Number of CCT sessions**	**How long since CCT completion (Month)**	**How long since last relapse**[b] **(Month)**	**Treatment before CCT**[c]	**Treatment after CCT**[c]
Alex	AUD	None	20	13	22	Inpatient; One-on-one; AA	AA
Ava	None	None	20	13	N/A	None	One-on-one
Beth	AUD	None	12	1.5	12	Inpatient; One-on-one	AA
Beau	None	None	12	1.5	N/A	None	Al-Anon
Claire	AUD	None	7	0.5	1	AA; Group therapy; One-on-one; Inpatient psychiatric care; SMART Recovery	AA; One-on-one; Group therapy; Psychoeducation

Caleb	AUD	None	7	0.5	<0.5	Group therapy; Church-based 12-step program; One-on-one; AA; SMART Recovery	Church-based 12-step program; Psychoeducation
Derek	GD AUD	None	13	11	24 from gambling 18 months from drinking	Inpatient; Group therapy; One-on-one	None
Debra	None	None	13	11	N/A	One-on-one; Family support group	None
Esther	AUD Oxycodone use	Anxiety Depression	14	12	14	Day treatment; Group therapy One-on-one; Couple therapy (non-addiction focus);	Group therapy; One-on-one
Elise	AUD	None	14	12	30	Online self-help network; Couple therapy (non-addiction focus)	One-on-one

[a] Primary addiction: AUD stands for alcohol use disorder; GD stands for gambling disorder; problems of drug use are included if identified by the participant. Same with Table 2.

[b] Relapse: Controlled use of alcohol (with clinician-involved planning) is not considered a relapse. Same with Table 2.

[c] Treatment before and after CCT: Regular addiction services in provincially-funded programs, community agencies, and private practices in Alberta that the participants had undergone before or after their assigned treatment in the RCT. Same with Table 2.

Treatment program abbreviations: AA = Alcoholics Anonymous; Al-Anon = Alcoholics Anonymous Family Groups; Inpatient = Inpatient treatment for addiction; One-on-one = One-on-one counselling; Psychoeducation = Psychoeducational workshops/courses; SMART Recovery = Self-Management and Recovery Training

Table 2

Addiction and Treatment Information of TAU Couples

Name (Pseu-donym)	**Primary addiction**	**Mental health diagnosis**	**TAU (Estimated total number of sessions)[c]**	**How long since TAU completion (Month)**	**How long since last relapse (Month)**	**Treatment before TAU**	**Treatment after TAU**
Frank[a]	AUD	Depression		15	Not abstinent		
Fay	None	None	One-on-one (n=3)	15	N/A	N/A	One-on-one
Greg	AUD Cocaine use	Depression Anxiety	AA; One-on-one; (n=12)	1.5	13	Day treatment; One-on-one; AA; Private couple therapy	AA; One-on-one
Grace	None	None	One-on-one; Psychoeducation (n=5)	1.5	N/A	Private one-on-one; Al-Anon	None
Harry	AUD	Generalized Anxiety Disorder	One-on-one; Group therapy; Psychoeducation; AA (n=12)	5	9	AA; (Private) one-on-one; Inpatient	None
Helen	None	None	One-on-one; Family support group; Psychoeducation; AA (co-attended with Harry) (n=12)	5	N/A	(Private) one-on-one	None
Irene	AUD	Anorexia Nervosa Anxiety Depression	Day treatment; One-on-one; AA (n=12)	3	7	Inpatient	One-on-one; AA
Ian	None	None	One-on-one (n=3)	3	N/A	One-on-one	One-on-one

Joe	Cocaine use AUD	None	One-on-one; Group therapy (n=12)	2	5.5	CA; SMART Recovery; Inpatient; One-on-one	One-on-one; Group therapy
Joanne	None	None	Family support group (n=3)	2	N/A	None	None
Kevin[b]	GD AUD	Anxiety Depression		1	Not abstinent		
Kayla	None	None	One-on-one (n=2)	1	N/A	None	One-on-one

[ab] Names in gray font were pseudonyms of the clients who did not participate in the study.

[c] The estimated total number of sessions was based on the participant's self-report in the interview and the data from the RCT.

Treatment abbreviations: AA = Alcoholics Anonymous; Al-Anon = Alcoholics Anonymous Family Groups; CA = Cocaine Anonymous; Inpatient = Inpatient treatment for addiction; One-on-one = One-on-one counselling; Psychoeducation = Psychoeducational workshops/courses; SMART Recovery = Self-Management and Recovery Training

4.2 Couples' Perspectives in Treatment – Structure of Themes

To answer the research question – *What aspects of Congruence Couple Therapy (CCT) and Treatment as Usual (TAU) do the clients and partners find helpful and lacking in assisting their addiction as individuals and a couple?* – First, the participants' perspectives on the benefits and limitations of TAU in assisting the recovery of the clients, the partners, and their couple relationships are presented based on the participants' lived experiences. The limitations of TAU are discussed in terms of the predicaments that couples faced in their relationship, as they went through addiction recovery as a unit. Second, the participants' views of the benefits and limitations of CCT are described based on their account of experiences. *Figure 3* shows the thematic map of the couples' perspectives on the benefits and limitations of CCT and TAU. In the following four sections (4.3 – 4.6), a thick description of the themes is presented.

It is important to note that the themes of benefits and limitations of CCT and TAU reported below are not necessarily based on consensus but saliency of the narratives. The perception of the couples on the benefits and limitations of a treatment program varied due to a variety of personal and external factors. Therefore, the following report on the benefits and limitations of CCT and TAU in support of individual and couple recovery is a synthesis of the clients' and partners' diverse perspectives.

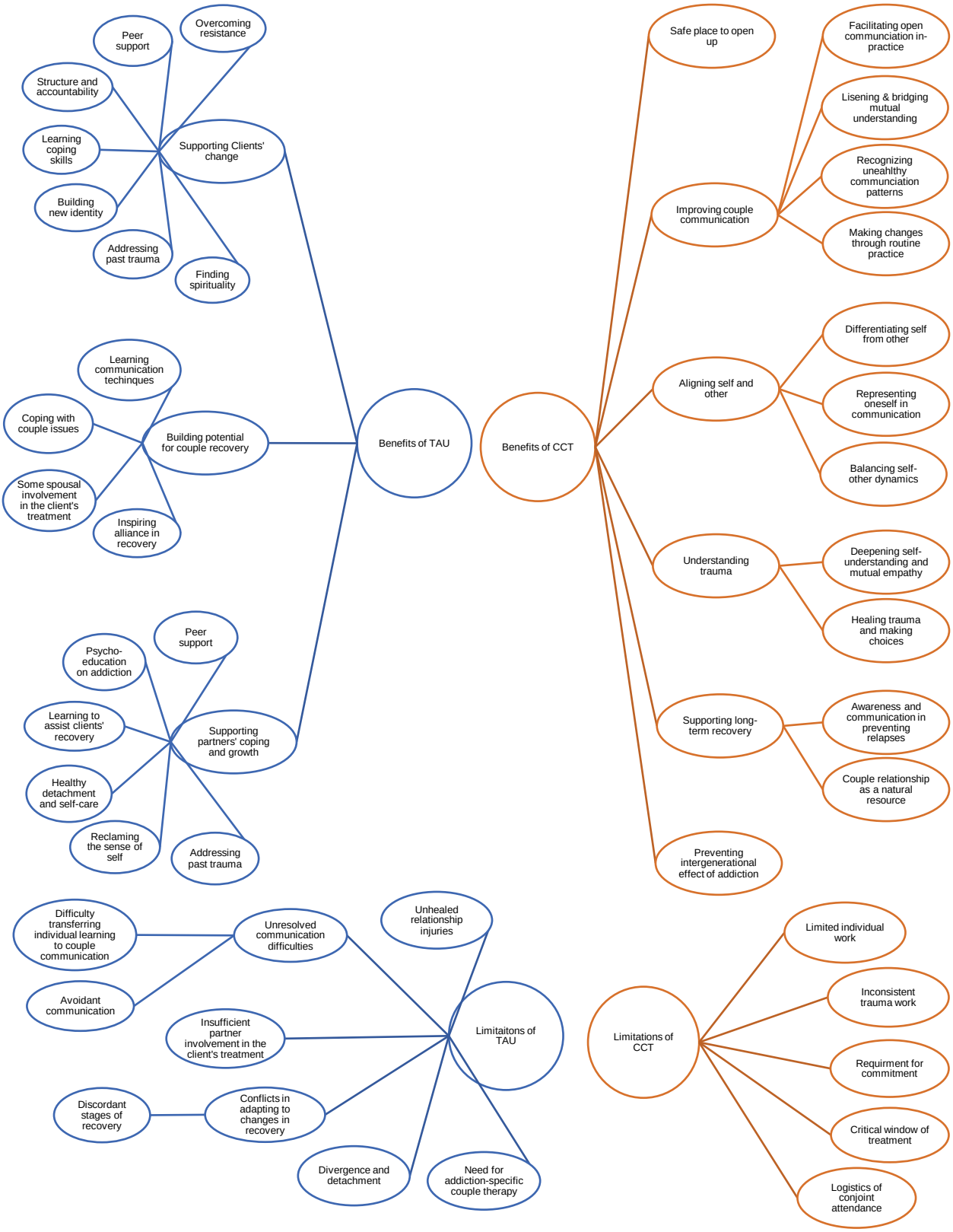


Figure 4. Thematic map – Couples' perspectives on the benefits and limitations of CCT and TAU.

4.3 Benefits of Treatment as Usual

The clients and partners spoke of what they thought was helpful and lacking in regular addiction programs that they had accessed in Alberta within and outside the primary study (the RCT, Lee et al., 2021). The treatment modalities that the clients had undergone included psychoeducational workshops, group therapy, one-on-one counselling, and self-help programs such as 12-step programs and SMART Recovery. The treatment format included both inpatient and outpatient. The programs that the spouses had experienced included one-on-one counselling, counsellor-facilitated family support groups, and self-help programs (particularly Al-Anon groups).

Assisting clients' change and growth. The clients described that regular addiction services had assisted their effort to change in the following ways. (1) In group programs, the clients who had been resisting the fact that they had addiction problems saw themselves in other treatment seekers' stories. Recognizing the parallel between their struggles, the clients came to accept their need to change. (2) Group therapy and self-help programs formed a platform for peer support, where the clients found social support and gained important learning to assist their recovery from other treatment seekers. (3) Through TAU, the clients developed new ways of coping. They learned cognitive-behavioural techniques to manage their emotions and began talking about their feelings in treatment sessions instead of bottling them up. (4) In TAU, the clients learned to manage their addiction recovery by focusing on the present and treating each relapse as an opportunity for learning and adjustment. (5) Attending TAU programs, the clients were able to find structure in their lives and keep themselves accountable in their effort to change, with the help of counsellors and peers. (6) Going through TAU programs, the clients developed a present-focused self-regard and learned to let go of the emotional baggage from

their addiction-plagued past. (7) Addressing their childhood trauma in TAU, the clients gained a deeper understanding of themselves and acknowledged their disowned pains. They developed better emotional regulation by allowing themselves to experience painful emotions instead of suppressing their deeper feelings with the use of alcohol or gambling. (8) Spiritually based programs such as 12-step programs served as a vessel for healing through spirituality. Some clients found self-forgiveness, inner peace and fulfilment, and self-worth in their spirituality.

Overcoming resistance. Some of the AUD clients resisted the idea that they had a "problem" when they first entered treatment. Some were pressured to join treatment by their concerned others. Some were court-mandated to complete treatment due to charges related to their alcohol abuse. In the beginning, they were adamant that they did not have an addiction and refused to make a change. Meeting other treatment seekers who had come to accept their addiction and were seeking changes helped the clients to recognize their own addiction issues. Listening to these treatment seekers' stories of addiction, the clients recognized the parallel between their experiences and their peers. They saw themselves heading towards the same path these peers had been through. It awoke them to see the severity of their issues and motivated them to make a change.

Alex joined a residential treatment program to assist in his court case of an incident caused by his intoxication. He completely resisted the idea that he had an addiction problem when he began the treatment,

> *I kind of went into treatment with the idea that it wasn't going to help me, and nothing was ever going to change, and I didn't want to change. I didn't ever have a drug or alcohol problem, and nobody could tell me anything else.*

In group therapy, listening to other participants' stories with their addiction helped Alex to recognize how alcohol had been affecting his life. He began to take a stark look at how his life

had been and reflect on his choices. He came to the decision that he was going to continue his life sober. He recounted,

> *It really changed my opinion on what I needed to do with my life, so it started to wake me up a little bit. And I kind of opened up my mind right then to what I wanted to do – I wanted to continue my life sober.*

Irene had been in treatment for both an eating disorder and AUD. She refused to accept that she had an eating disorder even after her hospitalization due to severe malnutrition. Any attempt of one-on-one counselling was rendered meaningless by her adamant resistance. It was not until when she joined a group treatment for eating disorder and listened to other patients' stories that it dawned on her that she had the same illness:

> *It took me a while but just listening to their story started to make me see that that was me. Like I was like "Why can't you guys see what you're doing to yourself?!", and all of sudden I was Like "Oh my God! I'm doing this to myself!" So that was the first thing that woke me up.*

Gaining support and learning from peers. Group programs provided a safe space where individuals who went through similar struggles could come together and give each other social and practical support in their recovery. The clients were able to find normalcy, hope, and a sense of belonging in their therapy and self-help groups. Further, peers were a significant source of learning in the clients' recovery. From their peers' lived experiences, the clients gained insight, learned strategies, and recognized pitfalls in managing their own recovery.

Peer support. Participating in therapy and self-help groups, the clients found company and encouragement in their recovery. Caleb shared, "*We are in similar situations... [It helped] to know you're not alone and not in some big crisis. When you're alone that could be a very dark and hopeless area. And with those groups, you're not alone anymore."* Learning that they were not alone in their suffering with addiction helped the clients find a sense of normalcy and

control. Derek recalled, *"[It got] my confidence up again…Just listening to everybody else made me feel that my story wasn't any worse than anybody else.*"

Beth found a sense of belonging and formed a deep bond in her 12-step group, which she could not gain from her psychoeducational workshops. She described,

> *I think we just bonded. I'm in an all women's group, so it's an especially nice sisterhood to belong to. I didn't bond with anybody in the workshops. I just went there and try to learn what I could and go to work or go home...The AA is really not just a Monday night meeting. It goes well beyond.*

It was not only the non-judgement but the empathy that Beth felt from her fellow AA members that supported her emotionally, "*it's not just not judging, but the fact that they've gone through very very similar experience, so they get it!*" The bond with a fellow self-help group member could extend outside of the meetings and became an important source of social support in a client's day-to-day life. Beth commented, "*Talking with the members of the group, knowing that there is someone I can call and talk to, if I'm having a really horrible day, having a homegroup is just a very good situation for me."*

Therapy and self-help groups allowed the clients to gain peer support, regain a sense of normalcy, and develop a sense of belonging from others going through similar struggles in recovery. For some clients, therapy and self-help groups were an invaluable source of support in their day-to-day management of recovery.

Peer learning. Peers also provided the clients with practical support in their journey of recovery. Peers shared strategies and insights to manage their day-to-day life in recovery, and some clients found themselves valuing their peers' experiential knowledge more than their counsellors' clinical judgement.

In a relapse prevention group that Beth joined, she gained diverse perspectives and learn various strategies from other participants in how to manage recovery. She said, "*You're getting a*

lot of perspectives [about] the way different people handle their [recovery], how they keep from relapsing and stuff."

Irene had gone through a residential treatment program for women with trauma in the past. She gained remarkable learnings from other participants. Her peers held valuable insight of healing and addiction management based on their own lived experiences. She stated,

> *I was learning from women that had way more experience in trauma… So the learning didn't necessarily come from a psychologist. It came from the women. And [for] a lot of them, this was their third or fourth time of treatment. So they have so much knowledge to give you about like "you numb [your feelings] tomorrow and you're going to be here next year. We have the experience". So you learn a lot from the actual people.*

Irene took her peers' advice to heart, as it came from their lived experiences with addiction and relapses. She shared that she took a peer's warning of relapse more seriously than if it had come from her counsellor because her peer had lived through the relapse first-hand:

> *When a girl in the program said to me, "Trust me girl, you're going to walk down here and use, and you're going to be like me. Look at me. I'm back a month later." I knew I could see the pattern. But if [my counsellor] says that to me, I'll be like "You're just saying that cuz you want me to go back to treatment. You don't know". But when you see it's hardcore right in front of your face, [you learn that] this was going to happen over and over and over, cuz it was happening to them, Right?*

Learning new ways of coping. A major part of addiction recovery was to learn new ways of coping, as the clients had relied on substances or gambling to cope with negative feelings. The clients learned from their treatment cognitive-behavioural techniques of coping that helped them to regulate emotions and prevent relapses. Additionally, they learned to talk about their struggles rather than running away from them by using substances or gambling.

Practicing techniques of coping. Learning new cognitive and behavioural techniques of coping was instrumental for some of the clients in regulating their emotions and preventing relapses. Irene learned various practices of coping from her 3-week day treatment program. She recounted,

> *I learned meditation. I learned all these different kinds of coping skills, how to manage emotions, how to speak to somebody clearly. You just learn different skills on how to manage [your life in recovery].*

She found that even the practice of a simple cognitive technique could make a remarkable difference in her recovery from her eating disorder and addiction. She related,

> *A whole week of starving yourself could be changed by one little thing that they taught you. To sit back to think about, "What it is that's upsetting you? Is it going to be there tomorrow?" Things that I just couldn't do before. It would just go downhill and go downhill. So you learn the little small techniques just to kind of diverge that panic, and it made a huge difference for sure.*

Talking about struggles. Many of the clients were not used to talking about their problems and expressing difficult feelings before they joined treatment. Being in a supportive environment in group therapy and with peers who were going through similar struggles, the clients felt safe enough to open up.

Alex would rarely talk about his personal struggles before joining addiction treatment. The only people to whom he would talk about the stress and problems in his life were his drinking friends. Even then he would focus on the external problems rather than the struggles that he was experiencing inside. He recounted,

> *The only people I really opened up to were the guys I drank with. I wasn't talking about my problems or issues or anything with them. It was we talked about stuff that bothered us at work and s*** like that. We never went into depth about it.*

In group therapy, Alex was encouraged to talk about his problems in a way that allowed him to express his vulnerable feelings. For the first time in his life, Alex learned that it was "okay" to talk about his difficult emotions with others. Surrounded by peers who empathized with what he was going through, Alex's anxiety to express feelings gradually dissolved.

Harry had always been a reticent person and kept his distance from others. He kept quiet when he first joined his group therapy, and he did not feel pressured to speak. The low-pressure

environment and empathic peers made him feel safe enough to open up. He felt a sense of relief when talking about his feelings that he had been so used to keep inside, "*I never would let things out like that before, I always kept it in. So just letting it out is a huge relief*."

In their therapy groups, the safety and support that clients felt allowed them to open up about their struggles and difficult emotions. Instead of evading their feelings with substance use or gambling, they learnt to openly talk about their difficulties and feelings inside.

Learning to manage addiction recovery as an ongoing journey. The clients learned to manage their addiction recovery as an ongoing journey. They learned to focus on the present rather than worrying about their next relapse. They learned to cope with relapses by treating them as opportunities for learning and readjustment rather than failures.

Focusing on the present. The clients learned from their peers' and their own experience that recovery was a constant ongoing journey. On one hand, they were acutely aware of the possibility of relapse at any moment. Some of them spoke about their perpetual anxiety for the unknown future, even when making solid progress in their recovery. On the other, with the help of TAU, the clients learned to let go of their anxiety over the future and focus on making good choices in the present moment.

Caleb learned from 12-step programs to work on recovery "one day at a time". He had come to accept that recovery was a life-long endeavour where he only had control over his choices at each present moment. He learned that he had no control over what would transpire in the next instance. The thought that he had his addiction under control could be followed by a slip in his drinking. He learned to work on recovery "one day at a time", by focusing on making healthy choices in each current moment continuously. Caleb stated,

> *By going to the treatment, you think you got your tool-box full, you're never going to drink again and then the next thing you know you're drinking…You figured you had it*

figure out when it's a lifelong learning adventure. To never forget that but to put it in perspective is to keep it one day at a time…You don't have to get ahead of yourself on anything.

Greg appreciated a ritual in his AA meetings where the members were asked to put up their hands if they were sober for the day. Greg found it particularly helpful in cultivating a present-focused mindset in his ongoing journey of recovery. The ritual helped him to learn experientially to focus on the present and let go of his worries about what happened next. He stated,

I need to go to the meeting and hear people say, "How many people are sober just for today?" ...I'm putting my hands up because I am sober just for today. And I don't know what tomorrow is gonna bring, and I don't know what the rest of the day is gonna bring. But I'm sober right now, and that's what matters. It's what I'm doing right now.

Coping with relapses. Relapses can be a major crisis to a recovering client, causing a collapse of hope and confidence. From TAU, the clients learned that slips and relapses were part of the process of recovery. They were able to step back, stop "catastrophizing", and see their relapse as a learning opportunity for new awareness. Joe's SMART Recovery group helped him adopt a positive attitude towards relapses and find learnings from them rather than dwelling on feelings of failure and doom. Joe described, "*[The group] don't penalize people who have relapses…They want people to talk about their slips and identify what happened and learn from them. Rather than being afraid of them".* Caleb used to catastrophize his setbacks and was quick to fall back into a "cesspool" of self-loathing and hopelessness. A minor slip would set him off to a full-blown episode of relapse. He now saw relapses as part of his life-long learning adventure. When he had a relapse, he could reflect on what had happened, minimize self-blaming, and hold onto hope. He described,

Now I just slow down and I don't regret…I just say "Okay, this was what happened. What was going on?", and [with my last relapse, there were] the stresses of life and not getting

> *a lot of work. We were able to regroup and get back into the counselling, and not roll over and play dead and keep hiding, hiding from the happiness that I deserve.*

Maintaining structure, discipline, and accountability. Being in TAU programs helped some of the clients to find structure in their lives and stay accountable in their recovery. Their regular attendance in TAU enabled them to retain structure and discipline in their lives, which in turn reinforced their will to change. Importantly, TAU encouraged accountability in the clients' effort to change. The requirement for commitment in some treatment programs, relationships with peers in self-help groups, and the counsellors who called them out on their lack of effort were all part of this mechanism to hold the clients accountable.

Self-discipline and commitment to treatment. Irene believed that her day treatment program in the provincial clinic encouraged her accountability and affirmed her resolve in recovery. The day treatment program had an intense schedule and required abstinence and regular attendance. Irene realized that to complete the treatment, she needed to put herself in a frame of mind where drinking was no longer an option. Pushing herself through this challenging program, Irene found a sense of purpose in her life again. She stated,

> *So it gets you into a frame of mind that like "Okay! This is the life you are about to live in. You are not allowed to get drunk tomorrow. Forget about it! You have to go!" So it gets you into the routine of knowing, you know, life exists.*

Caleb sought to build more structure in his life and maintain self-motivation by making a commitment to therapy and self-help groups. He made sure that he showed up to treatment every day, regardless of the stress and chaos in his life. His discipline fed back to his inner fortitude, and his hope for change remained strong. Caleb held that, with commitment and external support, change was bound to happen:

> *When you are an addict…but you get yourself up in the morning and you get dressed and shower and go to a workshop at 10 o'clock or 9 o'clock or 8 o'clock…Right now, the*

> *motivation to get up and go maybe [is] all that person needs …The supports are there…Things do get better with putting in some work.*

Forces of accountability. Some of the clients preferred to work with counsellors or peers who guided them with a structured plan for change and kept them accountable in achieving their goals. They often preferred the counsellors who were directive in setting behavioural goals, firm on homework exercises, and upfront in confronting the clients' inadequate effort. For example, Beth found what worked better for her in treatment was "no non-sense goal setting" with firm directions:

> *Personally, what worked better for me was the structure, no-nonsense goal set. Not a lot of free "Do that at your own pace", that kind of thing. [It's] "I need you to do this, and I need you to do this in the next 2 weeks"… rather than "Well you know, if you feel like, you might want to do this. You could check it out".*

Ian's experience in his one-on-one counselling as an affected partner echoed this need for accountability and the preference for a strict counsellor. He appreciated that his counsellor would confront him for his resistance to change and push him to do his best in making changes. He found himself responding better to his current counsellor than his previous counsellor who was "nice" and "gentle" to him. He described,

> *My counsellor is very very aggressive towards everything. So I like that. She gives me homework, and she calls me on it. She doesn't let me get away with a lot of things...I now know that I respond better to that approach and would have liked [my last counsellor] to be more forceful, rather than kinder*.

Greg believed that being in a fellowship of AA who looked out for him helped him be accountable in his recovery. Having a sponsor in regular contact and his fellow AA members who would call to check on him for missed meetings motivated him to keep up his effort. He asserted,

> *Probably one thing that AA has the other treatments don't have is the accountability issue. You have a sponsor. You have somebody who keeps you accountable every day. You have people in a community that are looking out for you. If I don't show up in a*

> *couple of meetings, people are going to phone me and say, "Hey, what's going on with you?"*

In sum, the clients were able to maintain structure in life through regular attendance in their TAU programs and keep being accountable with the help of program requirements, goal-oriented counsellors, and self-help group affiliation. Through structure and accountability, they strengthened their commitment to recovery and gained a sense of purpose in life.

Letting go of the past and building a new identity. Some of the clients described how they used to be haunted by shame and anguish for their addiction-ridden past. They were burdened with self-loathing and feelings of hopelessness. With counselling and self-help groups, the clients gradually learned to take on a different view in their self-identity and let go of the emotional baggage from their past.

For a long time, Greg could not let go of the angst for his losses in life due to addiction. Even when he was abstinent and making positive changes, he was stuck with a self-identity defined by his past, which led him to self-destructive patterns and resulted in severe relapses. As he went through TAU, his effort and dedication to turning his life around was affirmed by his counsellors, fellow AA members, as well as his partner and parents. Gradually, he was able to internalize others' recognition of who he was. He slowly learned to see himself for who he was in the present rather than who he used to be. He related,

> *For the longest time, I felt I was a sum of what I've done, and of course, the majority of that s*** isn't really pretty. Now I kind of have to shift my thinking. I'm more of a sum of what I do today than what I've done in the past.*

Similar to Greg, Caleb was tormented with shame and self-loathing for years as he sought recovery until he was able to come to terms with his flawed past and view himself for who was today. What had significantly helped him was the realization that he had the power to choose how he viewed his life. Caleb's counselling drove it home for him that no one was perfect and

that no one needed to view their lives based on the imperfections. He came to recognize that he had the choice to focus on what he did well and to see himself for his achievements today rather than his failures in the past. He recounted,

> *Nobody's perfect! To be striving to be perfect is just the last thing that anyone needs to do, because you will never ever get there! And that's what counselling has really done, is to open my eyes and to say, "Everybody makes mistakes, and everybody doesn't always make mistakes, and you're part of that group." You know, "You did well. You did well today!"*

Change in the clients' view of self in the present in turn helped the clients to let go of their shame for the past. As Greg described, he was finally able to leave his past behind,

> *I literally put behind me what were not part of my life anymore. I don't feel that I need to keep rehashing in my head, and keep bringing up the past, and living with the past. It's definitely been easier for me to move forward now that I don't have that s*** weighing on me anymore.*

Addressing past trauma – Gaining self-understanding and regulating emotions. Many of the clients had experienced childhood trauma. In TAU, they were able to address the traumatic experiences, reclaim their disowned painful emotions, and develop a deeper self-understanding. The clients gained insight into the link between their past trauma and their addiction. They were able to acknowledge and process their painful emotions from the traumatic experiences that they had suppressed. Through trauma processing, they learned to regulate emotions by experiencing negative emotions safely rather than escaping them through substance use or problematic behaviours.

Before Harry began making a serious effort to seek change, he had always denied any abuse from his family of origin. Harry's decision to open up about his childhood trauma was a turning point in his addiction treatment.

By addressing his early trauma in TAU, Harry gained insights into how his traumatic experience had contributed to his low self-worth and addiction. He realized that he had built a

fantasy around his painful childhood to block out his agony from the neglect and abuse in his family of origin. Having a deep-seated distrust against people, he kept his guard up and avoided close relationships. He strived for achievement at work to compensate for his low self-worth. However, unable to express his painful feelings or seek social support, when his feelings became overwhelming, he turned to alcohol for escape. He stated, "*On the emotional level, [talking about the trauma] allowed me to see one of the reasons why I needed to escape.*" He believed that his effort to repress his trauma memory was one of the driving forces of his addiction:

> *Because I had buried that so deep…I got to the point where I didn't even think about it that often. Certain things might trigger a memory or whatnot, but I think holding it down was enough to cause me grief. Probably one of the biggest reasons for my addiction*.

Meanwhile, bringing the trauma to the surface was a double-edged sword to him. Harry stated, "*It was a relief, but I also started thinking about [the traumatic events] more on a daily basis.*" Although Harry saw his healing from his childhood trauma very much as a work in progress, he believed that a better understanding of his past trauma allowed his addiction recovery to be more "complete".

Irene was sexually abused as a child, but she initially resisted addressing her abuse in counselling. She proclaimed, "*I'm a firm believer [that] if you just dig up the past, it's not going to cure the future...Like it's over and dealt with, nothing is gonna change!*" More importantly, her father developed a drinking issue when she was young, and the abuser was one of her father's drinking friends. Irene felt that talking about her abuse was a betrayal to her father, which was as if to accuse him of failing to protect his daughter.

However, Irene's addiction counsellor was able to support Irene in addressing her trauma from the abuse without getting into the details of the traumatic event. Instead, she guided Irene to acknowledge her painful feelings from the abuse. She described,

> *It's not so much about the details. Like I don't find it as invasive. It's not like "what happened?" It's more like "Can you acknowledge you got hurt by somebody? As a child, you weren't protected", rather than the actual act of what was going on.*

Owning her feelings from the sexual abuse helped Irene to reconnect with her wounded self and heal the trauma deep inside.

Further, through her trauma-focused counselling, Irene learned to accept and experience her painful emotions rather than repressing or escaping them. Irene had relied on alcohol, controlled eating, and excessive workout to avoid experiencing difficult emotions, which led to her alcohol use disorder and eating disorder. As she steered clear from drinking and tried to maintain a healthy weight, she was cut off from her old coping tools. Irene felt that she needed to spend all her energy trying to "*push down*" her negative emotions. Otherwise, she would be overwhelmed by her emotions and lose control. In her counselling, Irene learned experientially that she could let her difficult emotions run their course without fighting or fleeing them and that she would be safe in the end. With her counsellor's guidance, she was able to allow herself to experience painful emotions, then calm down, and be "*okay*". In this way, she gradually expanded her tolerance for negative emotions. She described,

> *[My counsellor] will get me into a quite emotional state…so I feel the panic; I feel like it's out of control. That's when I would usually drink, or like go run or whatever. And then what she will do is we will just kind of calm down or go to different [topic]or think about a positive thing. So she's kind of taught me that you can get that upset, And the world doesn't end... And that was definitely a new experience to me...because I think getting sober after being a partier my whole life, there was always this fear like, when things went bad it was going to totally fall apart... I have no idea, cuz I never had let myself get that emotional. So she kind of worked me into this space, letting it hurt for a second and knowing you're okay on the other side.*

Finding spirituality. Caleb gave credit to spirituality for some of his breakthroughs in recovery. Through spiritual fulfilment, Caleb found self-forgiveness, inner peace, and self-worth, which allowed a deeper transformation to set in. It was in one of his most helpless

moments when he stumbled upon his current church, and his church had become one of his greatest resources of support in his journey of recovery and self-transformation. His religious practice kept him connected to a higher power, and his church-based 12-step program helped him integrate spirituality in his endeavour of change.

It was through reading the scriptures, Caleb found self-forgiveness and hope for salvation after years of serving an "*emotional jail sentence*" for his addiction. He felt a wave of revelation when he read that psalms such as "*There is salvation in no other…There is forgiveness with thee.*" He said, "*That's where I started to give up the self-loathing and hopelessness within me to live, because I felt hope*." Caleb used to find uncertainty intolerable and had an excessive need for control in his life. The ritual of praying helped Caleb find inner peace and emotional freedom. He prayed for "*guidance, strength, courage, and peace*". Forgoing his obsession for control, he opened himself up to spiritual guidance. He stated,

> *[I want to] see what unfold frankly, without me controlling the universe, cuz that hasn't worked, cuz my self-will running in the mud hasn't worked. Now I kind of freed myself up to the Lord. And I pray and say, "Please relieve me off this!"*

The routines of scripture study and prayer were integrated into the 12-step group run in his church, where he could practice spirituality to aid his recovery.

Caleb believed that he found fulfillment through spirituality. He recalled carrying a constant feeling of a void in his twenties. He was on a never-ending pursuit for "more" gratifications in life but never seemed to get enough. However, when he found spirituality, he felt as if he discovered what had been missing in his life. He stated,

> *I was a drinker when I was a young man in my twenties…I always looked for more…more excitement, more booze, more girls, more stuff…I couldn't seem to get enough… It was just like I was missing something. When I found a church, it seems like things kind of came to alignment…I was able to put the puzzles together. Cuz there was something missing all the time, and maybe it was my spirituality.*

With spiritual fulfillment, he also became more connected to his intrinsic self-worth: "*I just needed to open my eyes, my heart, and my soul to what I'm really worth being.*"

Caleb found spirituality in his personal life, and his church-based 12-step program supported him to continue his healing and growth in a spiritual path. Through spirituality, Caleb was able to find self-forgiveness, hope, inner peace, self-worth, and fulfillment. All of them were important for his recovery, which, in Caleb's words, was "*a [new] way of living*".

Supporting partners' coping, healing, and growth. The partners believed that TAU for affected others benefited them in the following ways. (1) In family support groups, the partners found a supportive community where they gained perspective on their experiences as significant others of individuals with addiction and grew hopeful for the clients' recovery. (2) The partners obtained psychoeducation on the nature of addiction, which alleviated their judgement against the clients. (3) The partners learned behavioural skills to communicate care and support to the clients while developing a realistic understanding of their power in assisting the clients' recovery. (4) The partners learned to cope with the clients' addiction by developing a healthy detachment from the addiction and practicing self-care. (5) The partners were able to get in touch with their inner strength and honour themselves at the critical junction of their marriage. (6) Some partners addressed their past trauma in counselling and were able to find healing by affirming their self-worth and making positive changes in their current lives.

Finding peer support. Similar to the clients' experience with group therapy, the partners felt no longer alone in family support groups where they connected with others sharing similar struggles. The partners learned about other group members' experiences with their loved ones' addiction, through which they gained perspective on their own experiences. They found a sense of normalcy, community, and hope for change in their family support groups.

Being in a family support group, Joanne no longer felt alone in her struggles, "*It's nice to go to a place where you don't feel like you're the only one suffering and dealing with this problem.*" By listening to other participants' stories, Joanne gained a frame of reference to understand her own experiences as a partner of someone with addiction. She stated, *"You could listen to all these stories, and a lot of these are stories of frustration and stories of hope, so they kinda gave you perspective on your own situation."* The family support groups provided the partners with a sense of community, where they found empathy, hope, and encouragement from each other in coping with their loved ones' addiction and helping their loved ones to make changes. Joanne described:

> *Having heard some success stories, even hearing [the sad stories], I just didn't feel alone, so there was a sense of community, that I could come to a place where no one was judging anybody and no one felt out of place, cuz we were all wanting to learn the same thing about how to help our loved ones.*

The sense of community from the groups bolstered the partners' hope and empowered them to persevere in supporting their loved ones through addiction and recovery. Support from the family groups became a source of resilience for the partners.

Learning about addiction and giving up judgement. When lacking an understanding of addiction, some of the partners had judgement against the clients and often resorted to criticism and shaming to discourage the clients' addiction behaviours. The critical attitude only aggravated the clients' secrecy and deceit. Gaining psychoeducation in TAU, these partners learned that addiction was not a moral failing but a disorder that involved biochemical underlayers. Their education on addiction helped to alleviate their judgement over the clients and adopt a supportive approach in assisting the clients' recovery.

Helen lost respect for Harry when he began abusing alcohol. She would confront Harry's drinking in a punishing manner, which only added to Harry's emotional torment and drove his

drinking underground. Helen and Harry were stuck in a cycle of "hide-and-seek" where Harry would hide his liquor and Helen would hunt down the bottles to confront him. However, Helen's combative response only exacerbated his drinking. Helen recalled,

> *I always had such great respect for Harry and trusted him, and once I saw him starting to abuse liquor, that trust went right out of the window. And the more he did it, the worse it got. And the worse it got, the more drinking there was. So it was a big spiral.*

From TAU, the partners learned that addiction was not moral corruption but a disease. Helen learned that it was not Harry's choice to abuse alcohol. His addiction was the result of neurobiochemical dysfunctions. She said, "*He really didn't have a lot to do with [becoming alcoholic]. It's the chemical in him. It's not determined by [his choice]*." Viewing addiction as a brain disease, the partners no longer held the clients responsible for their addiction. Instead, they emphasized the clients' choice-making in seeking treatment. Fay made the analogy to equate the need for treatment of a patient with a medical condition to that of a person with addiction,

> *It's no different than a cancer patient, he needs to go to chemotherapy, or a heart patient, and he needs heart medication. It's not their fault that they are affected by a physical ailment, but at the same time, it's still up to them to seek the treatment that they need to get to feel better, right?*

Seeing the clients as patients of a disease instead of individuals with corrupted morals, the partners no longer used shaming and punishment to discourage the clients' addiction. They began approaching the clients with supportive communication and shifted from reprimanding addiction to encouraging treatment.

Learning to provide support. From their one-on-one counselling and family support groups, some of the partners learned to assist the clients' recovery as a supportive other. They acquired behavioural skills to be more supportive to the clients, while developing a realistic understanding of their ability to effect change in the clients.

Providing care and support. Some partners learned behavioural strategies from their family support groups to communicate emotional support to the clients. Joanne learned how to approach her partner Joe when he was in distress to encourage him to talk and offer support in a non-intrusive manner. She stated,

> *[My support group] gave me tools to actually ask the questions, but not seem too invading... It gave me the ability to ask the questions in the right language that he could understand, without seemingly nagging or negative…Not a judgement not a prying question, just care.*

Ian learned from his family support group how to properly respond to Irene when she talked about her struggles. Instead of trying to solve Irene's problems, which was what he had tended to do, he learned to listen, show empathy, and provide comfort to Irene,

> *It's more about listening. You know guys don't listen they just solve problems? … It was just more about listening to the problems. Don't even think about the problem, just listen, and console, and have empathy, kind of a different approach to things. It seems to make sense, and it seems to work.*

Understanding the limit of a partner's support. Family support groups not only helped the partners build behavioural skills to be supportive to the clients, but it brought clarity regarding how much influence a partner could have over the client's recovery. Joanne had been committed to supporting Joe's recovery. However, having gone through his relapses and overdoses, she began to question whether her faith in Joe and her commitment to helping him would be enough to bring about the changes that she needed to see in him. Joanne recalled, "*I had hope in him and worried that it just wouldn't be enough to get him better and in order to have a future with him.*" She even wondered whether her support for Joe had been encouraging his addiction rather than assisting his effort to change. What she learned from her family support group helped her gain clarity on her role in Joe's journey of recovery. She recognized that Joe's recovery was ultimately his own undertaking. She did not have the responsibility nor the power

to ensure Joe's sobriety. Even though she could be a significant support, she needed to accept the limit of her power in Joe's sobriety and give the responsibility back to Joe. Meanwhile, Joanne learned that by not trying to share Joe's responsibility in his recovery, she was also being responsible for her own wellbeing. She explained,

> *A lot of [the learning] is to understand what is enabling and what is supporting…Understanding where it's no longer your responsibility and you're responsible for yourself not to always carry the burden of this person's addiction, cuz it's not my addiction, it's his.*

Healthy detachment and self-care. One of the common benefits of TAU programs for partners was their improvement in self-care. The partners learned to develop a healthy detachment from the clients' addiction and to shift their focus from caring for the clients to themselves. The partners' strong emotional attachment to the clients' addiction often filled their lives with toxic stress and deprived them of self-care. They equated their individual happiness with the clients' recovery. They forwent leisure and social life to care for the clients and took it personally when the clients relapsed. With the help of their counselling and support groups, the partners learned to detach themselves emotionally from the addiction, focus on what they could control to make positive changes in their lives, and honour their own needs for self-care and social support.

Through one-on-one counselling, Ian learned to let go of his emotional attachment to Irene's alcohol abuse and eating disorder. He used to take it personally when Irene relapsed, as if he had failed to monitor her or she had relapsed to spite him. To help relieve his emotional burden from Irene's conditions, his counsellor suggested that he carry a card in his wallet with messages such as "*I didn't cause it. I can't stop it*". Ian said, "*[My counsellor] is right. I didn't cause it and it was not to hurt me.*"

Growing up with an alcoholic father, having had an alcoholic ex-husband, and dealing with her husband's alcohol currently, Helen used to believe that "*[her] presence would create an alcoholic.*" She also used to try to control Harry's drinking to stop his addiction. Through her TAU, Helen learned to accept her powerlessness over Harry's addiction, let go of her need to control his drinking, and acknowledge her own need for self-care. Helen used to sacrifice her social life to stay home, as if her supervision would help keep Harry from drinking. However, hearing other spouses' stories with their loved ones' addiction in her family support group, she accepted the harsh truth that a significant other's love and support was simply not enough for a person to achieve sobriety. Coming to terms with her lack of power over Harry's addiction, Helen was able to let go of her need to control Harry. In her counselling, she learned to honour her own needs for self-care. She stated, "*The one-on-one taught me a lot on the things that I want for myself, not for Harry, not for anybody else, but for me, what's important for me.*" With her new-found self-acknowledgement, she allowed herself leisure and social activities rather than revolving her life around Harry's addiction. She described,

> *I used to be terrified to just go out for lunch with a friend, because I'd be afraid of what I had to come home to. So experiences of going out were always nice, but the dread of coming home and finding him drunk was always terrible. Now I don't even think about it when I go out the door. Cuz it's out of my hand. If he's going to drink, he's going to drink* (giggle). *There's nothing I can do about it. I used to think if I stayed here and monitored everything, it wouldn't happen. But I know that's not the case.*

With the help of counselling, Fay recognized that her husband's recovery was ultimately in his own hands and that she needed to look after her own mental health for the rest of her family's well-being. She said, "*[I want to] taking care of myself so I can be healthy for my son. I can be a role model and a positive influence in his life when Ben is unable to.*" Switching her focus from trying to "fix" Ben to caring for herself and her son, Fay lifted herself out of her distress for Ben's conditions. She began building a positive mindset and seeking social support

in her life. She stopped spilling out sobbing stories with her friends and started engaging in uplifting interactions and fun activities with them. She stopped lamenting the loss in her life and began appreciating what she had. She stated,

> *I think my outlook has become more positive, just seeing the world differently, that it is not just all negative, that things happen, that people are affected by different things, that you just have to carry on and do the best you can…Just be more thankful for day-to-day things, for my health and for my son's health, for having family and friends to be connected with us.*

Looking after the welfare of herself and her son rather than stressing over Ben's conditions, Fay reclaimed ownership over her own happiness. She said:

> *How do I feel? A lot better! I can separate myself from when the mental issues and addiction kind of overcome my husband. Being connected to his unhappiness and then I become unhappy, that's not a good cycle to be in, right?*

By learning to better cope with the clients' addiction, the partners began honouring their own needs and regaining control over their own sense of wellbeing.

Reclaiming the sense of self. Living with the stress and strain of the clients' addiction, the partners found themselves losing touch with their sense of self. Through TAU, the partners were able to affirm their resilience and reconnect with their inner strength. They came to accept their personal truth as individuals in their relationships and gained the courage to honour them.

Reconnecting with inner strength. Helen entered counselling feeling defeated by Harry's last relapse. Through her one-on-one counselling, Helen was able to acknowledge her resilience and reconnect with her tenacious spirit. Harry's last relapse was set off by Helen's discovery of his extramarital affair. Helen was devastated with feelings of betrayal while trying to cope with Harry's relapse. She recalled feeling self-pity and yearning for refuge, when Harry was admitted to inpatient treatment while she was left with the aftermath of his relapse on her own. She felt "weak" for having these painful feelings. Harry's extramarital affair also brought up her

woundedness from betrayals in her past by her family of origin. She felt defeated and vulnerable after having been through multiple traumatic experiences in her life. Helen's counsellor pointed out her resilience for the very fact that she had survived these traumatic events in her life. With her counsellor's encouragement, Helen was able to acknowledge her resilience and reconnect with her inner strength. She said.

> *I used to say, "Why can't I just curl up into a ball and just have the world pass by me?", and [my counsellor] said, "Cuz you're too strong" … I used to think that I was such a weak person, "Why am I always in these situations? Why am I always feeling like this way? Why do people do this to me? Blah blah blah blah blah." But really, I'm a strong person, that's why I survived these things (laugh) and can talk about them. And she got me to see that.*

Discovering individual truth at the crossroads. Living with the clients' addiction and going through hopes for change and despairs for relapses, some partners suffered relationship injuries and lost hold of faith in the clients' recovery. They found themselves in a dilemma when confronted with the question of whether they should stay in their relationship and continue the tumultuous journey with the client or end the relationship for their own happiness. In TAU, they were able to reconnect with their own truth and honour themselves at this crossroads.

Having experienced Harry's deceit, betrayal, and unfaithfulness in his addiction, Helen was unable to fully restore trust in Harry and retain faith in his recovery. Despite Harry's diligent effort to change, Helen felt as if she was on a constant lookout for his next relapse. However, Helen chose to stay in her marriage with Harry after his affair and relapse. To her, divorce would mean the loss of the life that she and Harry had built together for over two decades. The grief and the financial consequence of divorce would put her through a new set of challenges. Helen stated,

> *[People ask me] why don't you leave?... You know what, I'm 6X years old, Harry and I have been together for 2X years. We have grown a life together, and we have things together. I have my retirement ahead of me. If I walk away now, I'm left with not enough*

> *because I'm retired now. So what am I walking away from? You are wanting me to walk away from my life.*

However, Helen's family support group helped her to discover her true feelings between preserving her marriage and honouring herself. In one session, the group members were encouraged to get in touch with what they truly wanted, in the scenario where their loved ones relapsed. Helen was faced with a dilemma. She could choose to try to maintain a marriage deprived of trust or break free from it at the price of becoming all alone. Meanwhile, through her TAU, Helen had gradually learnt to acknowledge her own personal truth. She came to realize that she had never been able to accept a husband with addiction, and she knew that she could not let herself live through another of Harry's relapses and endure the trauma of his lies and betrayal again. She came to the decision that in the event where Harry started drinking again, she would leave him. Although she would face the pain of marriage dissolution and the challenges of starting her life anew, Helen had found "inner strength" through her TAU experiences to live her life truthfully. She stated,

> *I feel I have some kind of, I guess, inner strength. Not to say [if he relapses,] it wouldn't be tragic, but it probably wouldn't have affected me the same way… I would ensure my finances, and I'd go probably just check into a hotel until I find a place to live and not interfere with my kids' life. I [will] just put one foot in front of the other and try to build a life for myself.*

Addressing past trauma – insight, forgiveness, and self-growth. Some partners experienced trauma in their youth and previous relationships. In one-on-one counselling, the partners were able to address their experiences of trauma and gained insight into how their past trauma affected their sense of self and their current relationships. Further, they learned to find acceptance and forgiveness for what had happened in the past and focus on making changes in their present lives.

Through therapy, Grace recognized the link between abandonment by her father at an early age and her lack of self-worth in her relationships with men. Her father left the family when she was young, which seeded insecurities in her sense of self. Growing up without a male figure at home contributed to her lack of confidence in relationships with men. In her couple relationships, she relied on her male partner's approval and was unable to feel good enough inside. Therefore, she often felt the need to go the extra mile to please her partner. Having recognized where her lack of self-worth in her couple relationship came from and realized some of her unhealthy relationship patterns, she began focusing on defining her own meaning of self-worth rather than seeking approval from her partner. She stated,

> *Once I had figured out that connection between the abandonment and my worth, I look back hind-sight 20/20 and see mistakes that I made and go "Okay! That's why!" The whole issue with the abandonment was I had no idea what my worth was from a male's perspective, I guess, because I didn't have that model[ling] or relationship with my father. So what I ended up doing in many relationships was going above and beyond, in unhealthy ways. I've learned that my worth should not be measured in those unhealthy terms. I guess I really learned to define my own self-worth, rather than getting it from my "father". So that's a big thing.*

In one-on-one counselling, Helen tried to work through her trauma from her family of origin. Helen was raised by adopted parents and grew up not knowing anything about her biological family. However, she accidentally found out later in her adulthood that her adopted parents and her biological relatives had known each other all along, and they had concealed the truth from her for all these years. Shocked and feeling deeply betrayed, Helen could not let go of the anger with these family members for many years after. Further, she was tormented with not knowing the "whys" – Why did her own family hide the truth about her biological relatives? Why did they not own up to their mistakes and apologize when she found out about the truth?

In counselling, as Helen processed the betrayal from her family of origin, she learned to accept the not-knowing. She had found a way to forgive. She chose to believe that her adopted parents and biological relatives did the best they could with the "tools" they had. She stated,

> *You go through all of those things, you [have] waves of why…That's just the trouble that you will never know why. You just have to assume that it's just something that [they learned from their own upbringing]. I always say my parents did the best they could with the tools they had. And if you don't have all the right tools, [what] do you expect?*

Moving on from her past trauma, Helen learned to stop blaming the past for her current personal difficulties. Instead, she was able to accept what took place in the past and excise her power of choice in the present. She shared,

> *I think for so many years, you go, "I'm like this because this happened to me. I'm like this because that happened to me." Instead of going "Okay, that happened to you, so how do you want to be different? How do you want to be better? How do you want that not to influence you?"*

Further, understanding that it was not the will but the "tools" that her parents and biological relatives lacked that had stopped them from "doing the right thing", Helen was determined to learn better "tools" than her previous generations. In this way, she was not only healing herself but putting a stop to the intergenerational trauma being passed on to her children. She stated,

> *We all bring with us a certain amount of tools to get through life. Our generation of people just probably don't want to accept those tools [that our parents pass on]. We want to have more tools. We want to build on those things. We want to understand why we are the way we are. We want to make amends for the things that we wish we hadn't done. And we need to do that, so our children aren't left with "Oh! Why was it this way?" They already know why because we've sat them down and we said, "I'm really sorry that you had to go through that, because I wasn't able to do that for you."*

Developing potential for couple recovery. Although TAU programs did not include couple interventions, they provided teaching and allowed opportunities to improve the couples' relationships and inspire their alliance in recovery. The benefits of TAU for couple recovery included the following. (1) The clients and partners learned behavioural skills in communication,

and some of them tried to apply the skills to improve their couple communication. (2) They gained assistance in coping with their couple issues from one-on-one therapy, as they learned to tolerate their significant others' suboptimal communication behaviours by trying to understand and accept their perspectives and underlying emotions. (3) Certain TAU programs allowed a low level of spousal involvement, such as group programs open to the concerned others and residential programs that included family/couple sessions. (4) Through involvement in the clients' treatment, some partners recognized their own role in perpetuating the addiction and owned up to their responsibility to make changes, which reinforced the clients' motivation to change and strengthened their couple alliance in recovery.

Learning communication techniques. Some couples mentioned that their TAU helped them to learn techniques of communication, which they had tried to implement in their couple relationships. Ava saw Alex's positive changes in communication as he went through residential treatment. Ava described,

> W*hen he went to rehab, he got to learn the tools on how to better cope with things and communicate. Just having a good old-fashioned heart-to-heart was really helpful. He's got his little techniques that he does.*

Alex believed that the communication skills that he had learnt in individual treatment helped him to begin communicating with Ava on their issues, which set up the foundation for their couple therapy. He recalled,

> *The stuff that I did in [residential] treatment definitely helped in the couples therapy, once I started to actually use the skills and put them into practice a little more…I believe that it helped to start with. It kind of it opened up the line of communication between me and April, and allowed us to see where each other was coming from a lot easier, so when we got into couple therapy it was more comfortable to talk about to some of the problems that we were having.*

To improve their communication with each other, Harry and Helen made a conscious effort to attend psychoeducational workshops on communication and relationships together. They

diligently studied the workshop materials and tried to put their learning to use in their everyday interactions. (Though they acknowledged the difficulty in practicing the communication techniques with each other in their everyday life; see Limitations of TAU). Harry stated,

> *We were lucky that there were two of us. We took notes, and [at home] we watched YouTube videos and listened to podcasts that we had watched at the course. We try to put the methods into play, right?*

Coping with couple issues. Some couples turned to individual counselling to cope with their couple issues. They were encouraged to be more understanding and accepting of the other person's perspectives rather than reacting to the other's unconducive communication behaviours. According to Irene, when she and her husband Ian had arguments with each other, Irene would try to explain to him how his actions had affected her emotionally, while Ian would respond with defensiveness and reproach. Irene stated, "*[Ian] would say, 'It's not acceptable. There's no way I did that to you!'"* She was frustrated with Ian's dismissal of her feelings. It was suggested by her counsellor that she try instead of focusing on Ian's behaviours, looking at the situation from Ian's perspectives and accepting his underlying feelings. Irene described,

> *[My counsellor] would kind of make me step back and go "Okay, we acknowledge he's allowed to be angry… So why can't you say this is where he's sitting, this is what it looks like from his point of view?" So there is the idea that…rather than feeling so neglected and mistreated by his words, I can actually understand that he's coming from a place where he's hurting. And that's all I ask from him.*

Allowing some spousal involvement in clients' treatment. Although couple therapy was unavailable in TAU, some programs allowed opportunities for informal spousal involvement. Helen was able to attend Harry's AA program and psychoeducational workshops, which were open to the concerned others. Helen was able to gain a better understanding of Harry's addiction as well as her role in it through Harry's AA program. She also learned techniques to better communicate with Harry in one of the psychoeducational workshops. Ava and Alex were invited

to a couple session at the end of Alex's residential treatment program, where they were able to have an honest conversation about their relationship issues in a safe environment. Even though they had one session only, the couple hashed out some of their relationship problems and saw positive changes in their communication. Alex recalled,

> *Even that one day [of couple counselling] that we did there. We were able to open up a little more and actually talk about some of our problems and start to communicate a little better.*

What they gained from the one couple session motivated Alex and Ava to further seek couple therapy in addiction treatment.

Inspiring alliance in recovery. Helen's participation in Harry's open TAU programs helped her recognize the significance of treatment for family members and inspired her to take up her own share of responsibility for change. Helen's dedication to supporting Harry's recovery and her effort to make changes in herself further motivated Harry. As a result, the couple were able to form an alliance in their conjoint journey of change.

After Harry's last relapse, to gain a better understanding of his addiction, Helen began going to all the open sessions of Harry's TAU programs, including psychoeducational workshops in an addiction and mental health clinic and his AA program. She ended up gaining more insight and self-growth than she had expected. She realized the importance for the addicted person's intimate others to go through treatment themselves. She believed that it was imperative for the intimate others to understand the client's addiction and change process to truly enable recovery. She recalled,

> *It was at that point, when I was getting way more out of that group than I ever thought I would get, that I realized that partners, family, spouses, anybody involved in an alcoholic's life, needs to have treatment as well. It is imperative for their success that anybody in their lives, need to also understand what they're going through*.

Importantly, Helen realized that she must make changes in herself to support Harry's recovery. She came to understand her share of the problem that had perpetuated Harry's addiction and fed into their couple relationship dysfunctions. She was determined to own up to her responsibility for change. By taking self-responsibility and working on individual changes, she joined Harry in their shared journey of recovery. Helen's action also invigorated Harry's motivation to change. When the couple put in individual effort towards a common goal, their relationship transformed. Helen recounted,

> *When he realized that I was going to step into this 100%...I think our relationship changed. Once he realized it wasn't just his problem, it was also my problem too. Cuz it is. I don't care what somebody says. If there's somebody drinking in your home, there's a reason why that's happening, and you're part of the reason. I'm not going to get better, why should he?*

4.4 Limitations of Treatment as Usual

The clients and spouses perceived the regular addiction programs to be limited in their capacity of supporting the recovery and growth of their couple relationships. (1) The couples believed that individual-based treatment was unable to address couple relationship injuries caused by issues of addiction. While partners carried wounds of betrayal and unresolved resentment, the clients were burdened with guilt, undermining their motivation to change. (2) Without the real-time facilitation for communication and the continual support and reinforcement from a formal program, the couples had difficulty transferring the communication skills that they learned from TAU to changes in their couple interactions. Some clients continued struggling to authentically express their feelings and needs to the partners, and some couples remained avoidant in their communication. (3) The couples faced difficulty adapting to the changes that occurred in the clients' recovery. Some partners resisted the clients' abstinence and growing individuality, and some had difficulty meeting the clients' increasing emotional needs.

The dually addicted couples experienced clashes as one member sought abstinence while the other was not ready to quit completely. (4) The couples saw a lack of spousal involvement in TAU. The partners wished to act as a support to the clients' recovery, but they felt shut out from the clients' recovery process and lacked the emotional insight in what the clients were going through with their addiction and in recovery. (5) Through TAU, the clients and partners gained individual growth but grew apart as a couple, as they developed a stronger sense of self and found support outside their couple relationships. (6) The couples found couple therapy outside of addiction treatment unhelpful in addressing their couple issues, which were intertwined with the addiction problem.

Unhealed relationship injuries. For the majority of the couples, individual-based treatment was unable to help them heal relationship injuries. When the addiction behaviours ceased, the couple relationships did not automatically recover. Having been wounded by the clients' lies and manipulation in the past, the partners carried hurt, anger, and distrust against them. With unhealed relationship injuries, couples kept rehashing the old wounds, and the clients were haunted with guilt. When the guilt and estrangement continued, relapses lurked around the corner.

Betrayal and distrust. Debra was shocked with disbelief when she discovered Derek's gambling problem which had put the couple into a financial crisis. Before meeting Derek, Debra had a failed marriage where her ex-husband squandered their money while Debra worked tirelessly to make the family's ends meet. In Debra's eyes, Derek was trustworthy and dependable, completely the opposite of her ex-husband. She saw him as a blessing in her life. When her trust in Derek crumbled upon the discovery of his gambling addiction, Debra fell deep into a swamp of hurt, hatred, and self-blame. She blamed herself for not having kept a close eye

on their finances, "*I regretted that I didn't check into things more and take control.*" Having a significant other who betrayed her trust and led her to financial ruins for the second time in her life, Debra found herself wallowing in self-pity. She recalled asking herself *"Why is this happening all over again to me?*" Debra sought counselling for herself but was unable to climb out of her "pity pot" and restore her trust in Derek. Debra recalled, "*There was no trust. Even when he was going [to treatment], it was like I want to know where you're going, what you're doing.*"

Although both Harry and Helen had experienced significant healing through TAU, Helen was unable to restore her trust in Harry since his extramarital affair which was exposed before they joined the primary study. Harry had been sober for a year and a half before Helen discovered his affair. The discovery of the affair torn them apart and triggered Harry's relapse. However, prior to that, unaware of his affair and relieved with Harry's abstinence, life to Debra was "blissful". The discovery of Harry's affair blew apart the mirage of peace and happiness and turned Helen's world upside down. She related,

> *I can honestly say in those months, it was such a comfort zone… I've never been so content. It was like so much weight had been lifted. And then to find out that he was cheating blew my world apart. Like it just literally blew my world apart.*

After the revelation of his affair, Harry relapsed into drinking. Harry's addiction counsellor suggested that his affair was only a manifestation of the addiction where he simply substituted his drinking with what happened to be an affair. The couple tried to move on from the affair to focus back on Harry's addiction treatment. As a result, Helen's trauma from Harry's unfaithfulness was left unaddressed. Helen described,

> *It was so mixed. [The affair] was so muddled-up with everything else that it was kind of just taking as a big lump, as part of the addiction. That's how we moved forward. It wasn't handled individually. It was just taken as part of the addiction and moving forward.*

Although Harry had made remarkable changes and achieved stable abstinence through TAU, Helen found herself unable to trust him this time around. She feared that Harry would "*replace [the drinking] again with something else*". Underneath Helen's fear was her unhealed relationship injury. She shared,

> *And even with all the counselling that we had, and even though he's not drinking, there's that little voice now that just keeps looking. Cuz before I wasn't looking. Cuz before I was so happy that there was no drinking... and that blind sighted me … I don't ever want to be in that position ever again.*

Resentment and guilt. Even though Greg had been abstinent for over a year, Grace still carried "*the odd resentment that poke[d] its head up every once in a while*". Grace's resentment came from Greg's manipulation when he was actively drinking. Grace recalled being "walked over" by him. It angered her that Greg would blatantly lie to her, using her kindness to enable his addiction. She recounted,

> *He would lie about alcohol around the house or try to manipulate me to give him some money…It was like holy cow! Really? …They were blatant lies. Was there judgement in some ways? Yes. he was walking on my values.*

She also resented having to be Greg's caretaker and putting aside her own needs because of Greg's drinking. She described,

> *A great majority of the relationship was based around Greg. It was we didn't go out because Greg was drunk, or we missed an event because Greg was drunk. Everything seemed to have revolved around him.*

Grace's unaddressed resentment kept the couple from moving to a fresh start. Frictions between the couple would trigger Grace's anger for the past. Grace spoke of an instance where Greg's thoughtless complaint that Grace did not wait for him to eat together kindled her anger. It became Grace's outlet to let out her frustration for Greg's self-centeredness and dependence on her. She recalled what she professed to Greg, "*I can't take care of you! You need to take action in*

your life to be part of this relationship. Quit relying so much on me to take care of you. I'm not doing it!"

Ian's unresolved anger for the past kept Irene burdened by guilt, as she tried to recover from her eating disorder and alcohol abuse. Although Irene had stayed abstinent from drinking and maintained a healthy weight for months, she sensed that Ian was still angry for what she did when she was sick. Although Ian had never directly expressed his anger to Irene for the past, he would often make snide remarks about Irene's eating and drinking today. The inconspicuous but constant expressions of anger haunted Irene with guilt and eroded her will to continue making changes. Irene painfully stated,

> *I feel that I get so beaten down… He doesn't know that the little remarks make me consumed with guilt. I've got to the point where I'm just constantly feeling so guilty. And I don't want to think or deal with this, because obviously I'm not doing anything right. I just want to give up, I can't actually stand back from the situation and go okay this is just a disagreement and it's about one issue in our life, like I can't, it gets so hurt.*

The guilt at times became overwhelming and drove her to relapses. She would make great strides towards recovery in residential treatment yet regress once she returned home. She confided,

> *Coming back [from treatment] hearing people questioning why you're getting sick, well because I have to look at a man that I feel like I destroyed his life. I feel guilty.*

Although TAU helped the clients to maintain abstinence and assisted the partners in self-care and self-growth, individual-based programs were unable to address their relationship injuries. When the wounds from the past were unaddressed, the couples were stuck in distrust, anger, and guilt, undermining their ability to change and splitting them farther apart.

Difficulty transferring individual learning to couple communication. Although TAU helped the clients and partners to gain behavioural skills in communication and better cope with their couple conflicts, the couples found it difficult to transfer their individual learning to changes in their couple communication. First, without conjoint intervention, the couples lacked

synchronous effort as they each attempted to bring changes to their couple interactions. Their asynchronous effort to change led to more conflicts and further relationship damage. Second, without third-party mediation and continuous reinforcement of a couple therapy program, the couples faced barriers as they tried to improve their couple communication.

Asynchronous effort to change. Without conjoint interventions, the clients and partners were often disjointed in their effort to change. One member would try to change how they act in the couple interactions, while the other member did not recognize the intention and reciprocate the effort. This disconnection may discourage a couple's will to change and lead to a wider rift in their relationship.

Having gone through both regular treatment programs and CCT, Beth believed that a shared intention and conjoint effort to change between her and her husband was crucial in improving their relationship. She said, "*If one person goes to the therapy and brings home tools and starts applying them, and the other person doesn't have a clue what's going on. It's useless.*"

Without reciprocation, there was a lack of reinforcement to sustain a member's effort to make changes, resulting in a lack of improvement in their relationship. As aforementioned, Irene's counsellor advised her to try to understand Ian's emotions when she felt mistreated in their arguments. Naturally, Irene hoped that by being more understanding and accepting of Ian's feelings and perspectives, Ian would respond by modifying his communication behaviours. However, she was disappointed that there was a lack of change in Ian despite her effort. Irene stated, "*He does indicate that he understands [that his words could hurt my feelings] and that he can acknowledge when it happens, but the simple fact is it just keeps happening."* Without any changes in Ian to reciprocate Irene's effort, Irene found it difficult to maintain an understanding attitude to Ian's antagonizing comments when they argued. She stated,

> *[My counsellor] will [teach me to understand his perspectives] one time and then, 30 days later I'll come in and be in the same spot where I'm like "He doesn't get it! I don't understand [why]!" She will have to say it again, "Step back. Look at the situation".*

A couple's asynchronous effort to repair their relationship could leave the members resentful, as they felt that their effort was unappreciated. Irene had tried to build a new routine of date nights for her and Ian to improve their relationship. However, Ian showed a lack of interest and refused to participate at first. Feeling unappreciated in her effort, Irene gave up on planning for date nights. Ironically, once Irene stopped, Ian suddenly appeared interested in doing things together as a couple. As a result of the mismatch, both Ian and Irene ended up feeling resentful that their effort had not been acknowledged and reciprocated. Irene confided,

> *I've been doing this for 5 months. I'm tired! And [Ian] wanted nothing in response to it and now he wants to play this game, because I'm upset…And so then he put the effort in for about 2 weeks, and then he stopped. He said to me the other day "I don't even feel like you're trying', so I'm like, "What are you talking about?!"*

When a couple's attempts to repair their relationship was out of sync, both members would feel unappreciated. Feeling discouraged, they would not be able to keep up their effort. Disappointment and resentment pulled the couple farther apart.

Lack of real-time facilitation and external reinforcement. Without real-time facilitation by an impartial third party and continuous reinforcement from a formal program, the couples found it challenging to turn their learnings from TAU into changes in their couple communication.

Without a nonpartisan party's mediation in real-time, Irene and Ian's attempt to practice open communication to discuss their problems often ended up in arguments. Ian described, "*It either turned into an argument and then we were at odds, or she shuts down and doesn't talk anyway, so there's no point.*" On one hand, Irene believed that Ian would escalate with anger and pressure her to speak, when she just needed time to process her thoughts. On the other, Ian

believed that Irene tended to get upset and shut down during difficult conversations, which cut off their communication. He also understood that Irene would feel "backed to a corner" by his relentless pursuit for an "answer" at times. He hoped to have a third person mediating the conversation who could help Irene understand where he came from, "*[Maybe the third person] will say, 'Listen, [Ian] is not trying to hurt you, he's just trying to communicate with you, and he just wants that answer.'"* Further, Irene emphasized a need for third-person facilitation to help her and Ian break off their unconstructive patterns and enforce healthy ground rules in their problem-solving discussions, "*We actually need somebody sitting in a room with us and stop us in the process and say 'Okay, listen, and you listen, this is how we are going to focus on this.'"*

Trying to implement communication techniques on their own, Harry and Helen found it challenging to create changes in their couple communication without continuous external support and reinforcement from following a couple therapy program. Although Harry and Helen jointly attended some of Harry's treatment groups and practiced the communication tools that they learned together, Harry stated, "*If you are by yourself, it's really hard to work without a lot of support and reinforcement on it.*"

The couples' difficulty in creating changes in their communication without real-time facilitation and external reinforcement demonstrated the necessity of a conjoint program to resolve their couple communication issues.

Avoidant communication. With unhealed relational wounds and lack of ability to authentically express themselves, some couples were stuck in avoidant communication where they avoided addressing their relationship issues and withdraw from each other when under stress.

Clients' struggle in self-expression. Although in TAU the clients learned to open up about themselves and talk about their feelings and struggles, they still had difficulty expressing their emotions and communicating their needs outside the therapy setting. The clients' difficulty in authentic self-expression prevented them from seeking support from their partners, inhibited their relationship intimacy, and hindered the couples' problem-solving.

Rejection of vulnerabilities. Through TAU, the clients became aware of their propensity to repress and deny vulnerable feelings. They used to see vulnerable feelings as a sign of weakness and learned to mask them in their everyday life. Through TAU, some learnt to be more open emotionally and communicate their deeper feelings to their partners, while some other clients still had difficulty expressing their fears and insecurities to their significant others, preventing them from deepening the emotional intimacy in their couple relationships.

Subscribing to a male gender script that prized stoicism, Alex used to regard having vulnerable feelings and needing emotional support as a weakness. Instead, he learned to mask his feelings with drinking. He described,

> *I'm a guy. You're not supposed to talk about your feelings, right? And with the addiction I had, you kind of covered up all your feelings …I was fearful for being seen as weak, not able to handle my own problems… Back then I thought if you didn't deal with your own stuff without anybody else's help, that was no good…*

When under stress, instead of turning to others for support, he resorted to alcohol for a temporary escape. He related, "*Anytime I had a bad day, I would just sit down and drink a bunch of beer and pretend everything was going to be okay.*" His addiction not only inhibited his feelings of vulnerability but also dampened his feelings of love towards Ava and their children. Alex recalled, "*[Alcohol] definitely blocked a lot of emotions, and just the ability to truly love.*" Through individual-based addiction treatment, Alex learnt to open up and communicate his deeper feelings to Ava. Ava remembered, "*When he did the three-week rehab and he was*

worrying so much about himself and so much about me, he wrote me a big letter and apologized for a lot of the mistakes he made and whatnot."

In contrast, Claire still had difficulty expressing her feelings of fear and insecurities in her relationship with Caleb, despite having gone through numeral individual-based treatment programs. Stemming from the abandonments in her teens that deeply affected her sense of self, Claire learned to construct a strong and competent persona to hide her inner vulnerabilities. Claire's parents got divorced when she was young, and she was placed into foster care shortly after a parent's re-marriage. She was unable to process the trauma of the abandonment and blamed herself for it. Her sense of self shattered, and she began to build "a strong, smart, capable, [and] together" persona to mask her fragmented inner self. She called this persona her "walls", which kept her from getting hurt again but also prevented her from getting in touch with her deeper feelings and reaching out for support. Although she went through extensive therapy over the years for her addiction, the "walls" had never come down. Although she was deeply attached to Caleb, she had never let go of her walls and feared to share her insecurities with him. It was not until when they entered couple therapy that she opened up to Caleb about her fear of losing him.

Disconnection to self. Through TAU, the clients became increasingly aware of their difficulty staying connected to their feelings. Although they made a deliberate effort to talk about their emotions in TAU, they still found it difficult to assimilate and articulate how they felt in their everyday lives. Unable to express themselves, the clients tended to become withdrawn and emotionally shut down when under stress. In their couple relationships, they became disengaged when tension arose, which prevented problem-solving. Lacking the understanding of the clients'

struggles with expressing their emotions, the partners perceived the clients' withdrawal as callousness and secrecy, further exacerbating their couple conflicts.

Greg found it difficult to understand and express how he felt. He stated,

> *It's still a struggle for me to get out what I'm feeling. I have a hard time connecting with my own emotions. So for me to communicate that to somebody else is really, really, tough. I think it's just something I learned growing up. And it's been hard for me to kind of break that cycle.*

His difficulty in self-understanding and self-expression affected his communication with others, as he described, "*I have issues expressing what I want and what I need … I just kind of let [things] go.*" In stressful conversations with Grace, Greg tended to withdraw. He recalled a conversation where Grace confronted him about his procrastination. Flooded with emotions and unconfident to communicate himself properly, Greg became quiet and shut down. He related,

> *As much as she didn't mean to do an interrogation, that's what it felt like. And I didn't say that. I just sat there and listened to what she had to say, and I completely shut down… I'm afraid I'm going to hurt [her] feelings. I'm going to say something that makes me look stupid or whatever.*

Similar to Greg, Irene's struggle in expressing herself would drive her to withdraw from stressful conversations with Ian. Ian would take her withdrawal as rejection and callousness, which only aggravated his anger and intensified his demand for her response. She related how their discussion turned into a full-blown fight because of this demand-withdrawal dynamic,

> *He wants some kind of explanation from me, and I don't have it. I actually need time to put my thoughts together and I'd want to stop [the conversation]. And he is just angry. He thinks I'm walking away, or this situation is not important enough, or I'm hiding something from him, rather than being able to acknowledge that I can't formulate, I literally can't formulate what I'm trying to express emotionally. He doesn't understand that. He just wants the answer and he wants it now… And it got to the point [where] he would push and push and push, and I finally screamed at him.*

Avoidance in couple communication. With the clients' difficulty in self-expression and the partners' unhealed relational wounds, some couples remained avoidant in addressing issues and expressing their feelings with each other.

Even after Derek went through treatment and became abstinent from gambling and drinking, Derek and Debra's relationship remained strained. Derek described, "*We weren't talking to each other…When we did talk about [the gambling], it was pretty heated.*" Habitual avoidance, rigid interactions, and negative emotional undercurrents built up an iron barrier between the couple. Derek stated, "*There were times when I came home [from counselling], she'd say, 'What did you do?', and I said, 'I really don't want to talk about it.' She would do the same.*" Behind the silence and occasional outbreaks of arguments was a well of love, fear, and pain that the couple were unable to communicate to each other. Debra shared, "*We knew we loved each other very, very, very, very much, but we were living together like roommates.*" She described feeling "stomach aches" when returning home, "*I was always scared to come home. You don't know what you're coming home to. Basically, he would sit on one end of the couch, I will sit on the other end.*" The couple sought couple therapy in the hope of saving their relationship and restoring communication between them.

Alex and Ava's account demonstrated how avoidant communication and addiction worked together to drive a couple apart. Alex recalled, "*We really didn't talk in-depth about our problems, or anything that was going on. We would kind of just shuffle stuff on the side until it was easier to deal with to move on.*" He would refuse to talk about any problems that he and Ava had, "*It was like I don't want to talk about it today. We won't talk about it.*" Instead, he relied on alcohol to cope with his stress. Through Alex's residential treatment, the couple had one session where they jointly met with a counsellor. In the single couple session, they came to recognize their tendency to "*shovel everything under the rug and carry on*" and saw the benefit of open communication. They realized that they needed to learn to openly communicate with each other in order to save their marriage. Alex recalled, "*We knew if we wanted to remain together [and]*

continue building our life together, we would have to learn how to communicate with each other." They promptly joined the primary study, hoping to enter CCT.

Ever since Kayla found out about Kevin's gambling addiction, despite her effort to communicate, Kevin remained closed off. When Kayla approached him, he became tense and defensive, driving their conversation to a halt. Kayla stated, "*His strategy is to avoid everything until it's dealt with*." Demoralized by Kevin's constant avoidance, she gave up on trying to address any issues with him and let them build up. She described,

> *It's always waiting. I will bring something up and he's like "Oh, I don't want to talk about that now" …So after it happens a few times, you don't even bring up anything anymore that you really need to talk about. Just life as usual without dealing with things. Because on my end, I can't really change that. I can't really force someone to talk, if they don't want to.*

Gaining no help with couple communication from TAU, Kayla saw couple therapy as their only hope to begin communicating with each other again.

Avoidance in communication created a rift in the couple relationships and prevented healing of the relationship injuries. Addiction could be managed with individual therapy, but the relationship injuries and communication difficulties seemed to require a conjoint approach.

Conflicts in adapting to changes. As the clients made individual changes in recovery, the couples faced changes in their couple dynamics. Asynchronicity and clashes took place, threatening to tear the couples further apart. While some of the clients were determined to adopt an alcohol-free lifestyle, the partners struggled to leave behind social drinking. While some clients grew in individuality and autonomy, their partners feared for their disconnection and detachment. As the clients became more attuned to their emotional needs, the partners felt inept to provide the emotional support that they needed. Among dually addicted couples, when the

couple were not changing at the same pace, a member's effort towards sobriety could be met with the other's resistance and sabotage.

Challenges in adapting to abstinence in recovery. The clients' abstinence from drinking also eliminated social drinking in the couple's life, which had served as the couple's bonding time in the past. Without an understanding of what addiction recovery entailed, some partners tried to reengage the clients in social activities that involved drinking. While the partners' insisted on having their lives "go back to normal", the clients felt unsupported and even sabotaged in their effort to maintain sobriety.

Trying to abstain from drinking and maintain healthy eating, Irene began refraining from the social activities that she and Ian used to enjoy such as partying. In this way, she could avoid putting herself in situations that could trigger her alcohol use and eating disorder. Lacking an understanding of what Irene's recovery entailed, once Irene stopped binge drinking and attained a healthy weight, Ian expected her to return to their old lifestyle, where partying and social gathering was their main leisure activity. Irene described, "*He wanted me to go partying, which of course is people drinking and using drugs. Like he expected me to just carry on this life.*" Irene's need to avoid triggers to relapse in her environments clashed with Ian's desire to resume their old lifestyle. Irene recounted an argument that the couple had over whether they should go camping with friends. When Irene voted against it to avoid the risk of relapse to her eating disorder and drinking problems, Ian took her choice as selfishness. Irene stated,

> *I didn't know how to go camping and eat properly…they'd put out all the food in camping and be around with people that are drinking and smoking and doing drugs. So I was saying "I'm not secure enough in myself yet", like "I need to keep going to AA." … [He was] like "You should be able to do this and go camping and have fun!". Like it wasn't acceptable that I couldn't put myself there…like I'm irresponsible because of that.*

While the clients tried to build a new lifestyle to maintain sobriety, the partners held onto their old ways that could jeopardize the client's recovery. Without effective communication, the couples were unable to empathize with each other's perspective and negotiate alternative leisure activities to honour the clients' abstinence and the partners' need for a sense of normalcy.

Resistance to growing individuality. As Irene moved further into her recovery, she developed a greater sense of self and increased her need for autonomy. However, Ian responded to her growing individuality with resistance and suspicion. He feared for Irene's disconnection and worried for her relapse once given greater independence.

Feeling guilty for subjecting Ian to her addiction and eating disorder, Irene used to try to make it up to him by trying to do what he pleased. As she went through treatment, she got in touch with her sense of self and began acknowledging her own preferences. Wanting to be her authentic self, Irene stopped trying to appease Ian and began honouring their differences. However, Ian seemed to perceive Irene's self-acknowledgement as detachment and her newly occurring differences as disconnection. Irene related,

> *I come from a place where I was constantly trying to please him, all because I had my own guilt for when my eating disorder and the drinking [was active]. I was always making [it] up for him. I was always trying to accommodate him and make him happy. So now that I'm just trying to be a person, it feels like I'm disconnecting… "I don't want to sit and watch hockey with you. I don't like it. I don't want to force myself to do it." And now all of a sudden, [it's] "I don't want to spend time with you?" No! "It's just that's not the way I want to spend time with you. I don't want to take that away from you, but I'm not going to force myself to sit there anymore." And to him, that's me disconnecting, but that's really just me being a person!*

As Irene grew more connected with her individuality, she became more independent. Irene started building a social life outside her couple relationship and began spending more time away from Ian. However, Ian reacted to Irene's sudden growth of independence with worry and suspicion. He feared that Irene was trying to escape his help and monitoring, without which she

would revert back to drinking and disordered eating. However, Irene found Ian's worry groundless and believed it was his excuse to retain control over her. She stated, "*He follows me on my phone, he knows when I'm going to a [AA] meeting, but he'll say [he doesn't know where I am], because he knows that I feel guilty and bad and I try to make it up to him."* On the other hand, compelled by guilt, she wondered whether she should let go of her individuality to keep doing what would please Ian. Irene saw herself torn between her needs to be herself and to make her husband happy. She described,

> *I feel he's not doing it intentionally, but he wants me to fit into this box that's comfortable for him. So when I try to do other things that I think might work in my life, it's uncomfortable for him. I feel guilty that I even go out and try to be happy. So it's kind of like two worlds right now battling.*

Ian's resistance against Irene's increasing individuality was related to his insecurities in their couple relationship, and his issues with Irene's growing independence reflected his fear for her relapse. Without ways to strengthen their connection and rebuild Ian's trust in Irene, the couple's tension surrounding Irene's changes continued, which divided the couple farther apart and discouraged Irene's effort in recovery.

Starving emotional needs. Through treatment and recovery, Irene learned to honour her emotional needs. However, after being in a marriage devoid of emotional intimacy for almost two decades, Ian had difficulty keeping up with Irene's newly awakened emotional side. He stated,

> *I'm not romantic, and I'm not very emotional. You know, a logical kind of guy. I try to say I love you all the time, and but we don't have too many overly emotional conversations…The way I act around [Irene]is not very emotional, which causes some problems too, right? Not being able to connect emotionally.*

Although Irene would like Ian to be more emotionally connected with her, she felt guilty for wishing Ian to change. She recognized that her entire being was transforming as she went

through treatment, while Ian remained more or less the same. To her, it simply was unfair to ask Ian to change to meet her newly occurring emotional needs, after the couple had made it through decades by being the way they were. She related,

> *Ian's very unemotional. He's a very hard man…And I came into the relationship quite numb… so there wasn't a lot of emotional needs for either of us. We fit well together in that sense. When I start recovering all of the sudden, it's like everybody wants you to feel and that you were supposed to go through these things and you're supposed to have a voice. He's still numb, he's still where we were when we met, but now I'm not in that anymore…So it's not he's doing something wrong. It's that my full person is changing, to ask what I need and stuff …And he doesn't know how to do that. He hasn't known how to do that in [so many] years.*

Irene felt that not only her husband but also her family of origin were ill-equipped in handling her newly rising emotional side. In Irene's eyes, her parents and siblings were inept in providing emotional support to someone in distress, just like how she herself used to be. Irene recalled a recent instance when she broke down and cried in front of them, to which they responded by asking whether she had relapsed. Irene had learned to mask her emotions in front of them, which only magnified her feelings of disconnection and alienation in her family,

> *Now I'm feeling like I'm hiding … Like hiding that something might have affected me. And it makes a full-time job trying to make myself happy all the time around them, so my emotions are not affecting them… There's definitely a disconnect within my family dynamics. But that's because they're living still the way that I was.*

In her couple relationship, deprived of emotional intimacy, a sense of loneliness grew. As Irene continuously failed to get the emotional support she needed from Ian, her feelings of loneliness became overwhelming, which drove her to relapse. She confided, "*I relapsed into drinking, because I felt so lonely. Like emotionally I couldn't get my needs met by Ian. Finally, I was just like, 'Screw it I'm just going to drink!'*"

Irene's growing emotional needs clashed with a lack of emotional intimacy in her couple and family systems. Hiding her authentic feelings from her loved ones created alienation in her

relationships with them. Deprived of emotional connection from her loved ones, she suffered loneliness in silence, which eventually drove her back to drinking. Without changes in the couple relationship to allow deepened connection and support, the intensifying alienation between the couple would only undermine their addiction recovery.

Discordant stages of change. Esther and Elise used to be a dually drinking couple. When Elise decided to abstain from alcohol, Esther was not ready to stop. With their clash surrounding drinking, tension and conflicts began plaguing their relationship.

Elise felt that, as she tried to build an alcohol-free lifestyle, Esther was working against her. Esther first nudged Elise to resume social drinking, while Elise insisted that it would be impossible for a "*professional drinker*" to go back to being an "*amateur drinker*". After Esther had agreed to maintain an alcohol-free household in support of Elise's sobriety, Elise kept stumbling upon empty alcohol bottles in the most obscure places around their house. At the time, Elise did not seek therapy. She worked on recovery alone with online self-help resources. Having no social support in her pursuit of sobriety while her effort was sabotaged by her partner, Elise felt alone in her battle for sobriety, "*It was me by myself and the internet.*"

On the other hand, Elise tried to control Esther's drinking and prodded Esther to join her in quitting, which only caused more conflicts in the couple. The couple's clash around drinking along with other ongoing stressors took a toll on Esther's emotional wellness. Her deteriorating emotional state prompted Esther to finally seek help for her drinking issues and awoke the couple to see the toxic dynamics between them. They looked for guidance to help them work with each other rather than against each other on their individual paths of recovery. They looked to couple therapy and hoped to find a therapist "*who can help guide [us] to how we, at the very*

least, get out of one another's way...[and] how we stop hampering one another and start helping one another."

When only one member within a jointly drinking couple worked towards sobriety, the couple were at odds. Without mutual understanding and acceptance, the couple were stuck at an impasse, obstructing each other's path to recovery. They wished to be one another's support while remaining the captain of their own paths of change. They sought out couple therapy in addiction treatment for help.

Insufficient spousal involvement in addiction treatment. In the TAU programs that the participants had accessed, there were limited opportunities to involve the partners in the clients' treatment, and conjoint programs were nearly absent. The couple therapists in the community often lacked expertise in working with couple issues intertwined with addiction problems. With little spousal engagement in treatment, the partners lacked insight into the clients' deeper struggles, such as their feelings of guilt and shame. Without effective couple engagement, the couples were unable to mobilize their relational resource to assist the clients' recovery.

Unutilized resources for clients' recovery. The partners hoped to be engaged in the clients' recovery as a source of support. Some partners believed that their involvement in the clients' treatment could help ensure the clients' accountability in their treatment effort. However, TAU lacked conjoint interventions to fully activate the clients' support system and effectively utilize the clients' relational resources from their natural environment.

Ian believed that spouses could provide support to the clients' recovery, which was available in the clients' everyday environment and therefore more accessible than professional and peer support. He explained,

> *Cuz [partners are] part of the support staff. Right? Cuz counsellors aren't always there. Where you put in your [stake] aren't always waiting around the corner, right? Sometimes*

> *the sponsors aren't available. So if you can turn to the person lying next to you, that would be great right?*

Irene held that it would be beneficial for individuals with addiction to have a supportive person in their everyday lives as they went through recovery, "*Obviously if an addict has somebody that can understand and support them as they are working through it, it would be a lot easier to go through recovery."* However, as a couple, Ian and Irene were growing apart as Irene worked towards recovery (see previous themes). TAU was limited in helping the couple reconnect and enabling the partner to provide the client with the support that she needed in recovery.

Fay hoped to help Ben in his recovery, but her effort was responded with misunderstanding and animosity. Fay took it upon herself to research various treatment programs for Ben's depression with a comorbid addiction problem and encouraged him to try out new treatment programs. However, her effort to help was perceived as controlling, which was met with Ben's resistance and drove him further away. Even though Fay learned to step back and honour Ben's autonomy in his recovery, she felt that Ben remained guarded against her when it came to his conditions and treatment. Fay felt shut out in Ben's recovery and wished that Ben would open up to her support. She stated, "*I hope that he sees that I've been able to step back, 'You know what? I can do all the research I can and try to help you, but I'm not here to fix you.'"* Along with her hope to be a support in Ben's treatment was her yearning to be understood, trusted, and needed by her husband. Feeling rejected and shut out by Ben, she longed for a closer connection where she and Ben could turn to each other for strength and support. She had not achieved this goal through TAU.

Kayla voiced her disappointment and frustration with Kevin's deteriorating conditions since he began treatment for gambling and alcohol use disorders. From what she observed, Kevin's counselling had not "*[made] him better in any shape or form*", and the psychiatric

medications that he was recently put on had only exacerbated his substance abuse. According to Kayla, since Kevin began TAU, he had stopped working entirely and left his debts unattended. She suspected that Kevin was not transparent with his clinicians on his problems, which had led to the counterproductive treatment outcomes. Kayla held the opinion that Kevin had turned his TAU into an excuse to continue avoiding responsibilities in his life. She attributed Kevin's lack of accountability in treatment to the individual-based addiction programs' lack of means to objectively monitor the clients' progress and effort to change. She saw that the only way to hold Kevin accountable was by having conjoint therapy. She contended that when they were both engaged in treatment, Kayla's perception of Kevin's issues and recovery could provide checks and balances to Kevin's own views, contributing to a more objective account regarding Kevin's addiction problems and treatment effort. She said,

> *I really don't see that his counselling or anything is [resolving his mental health issues] and making him accountable for anything. So it's just perpetuating and him getting worse. That's how I see it. And I think the only way really to change it is having couples counselling, because [what I see] can be brought up, because I can't really go to his counsellor or his doctor to tell them, "Oh he's doing this, this, this."*

Kayla brought up a unique angle of the benefit of spousal involvement, which was to improve the client's accountability in their treatment effort by providing checks and balances to the client's perception on their effort to change.

Partners' lack of emotional insight into the clients' addiction. Although the partners gained psychoeducation in TAU that improved their understanding of addiction, without open and deepened communication with the clients, the partners were unable to gain insight into the clients' underlying struggles with addiction and develop empathy with their deeper emotional torment.

Even though Harry had maintained abstinent for over nine months, Helen would still make references to the past about Harry's addiction, which brought up Harry's feelings of shame and guilt. Helen had trouble comprehending Harry's choices in addiction. She was baffled that Harry would go to lengths to keep drinking even though drinking was destroying his life and tearing their marriage apart. The couple had always enjoyed yard work together and took pride in their beautiful garden. However, during Harry's active addiction, he often evaded his share of the yard work to drink, and the couple's yard was left unattended like their marriage. Now seeing them resuming their routine of yard work, Helen could not help but asking Harry, "*I don't understand why, I still have a hard time understanding, if you enjoy this and we are getting along. it feels good, why would you choose to drink and make it not feel good?"* However, Harry did not like to talk about his choices in addiction, as rehashing the past brought back his feelings of shame and unworthiness.

Ian witnessed Irene being tormented by guilt as she went through her 12-step program. Ian expressed sympathy for Irene's regret and self-pity, "*She just feels so guilty about everything she did …She kept kind of feeling sorry for herself.*" On the other hand, Irene was frequently met with Ian's subtle remarks on how she was during her active addiction and eating disorder, which signaled Ian's unresolved anger towards her. Irene stated,

> *He's angry at me for the things that are recurring for the last eight years or whatever, and so he doesn't realize that that's going to get expressed to me in a lot of ways. Like just snide little comments or side marks, he doesn't understand that I feel the anger.*

Ian's small references to the past only exacerbated Irene's guilt, which discouraged her from making changes. She felt so disheartened at times that she wanted to give up on trying to save their relationship. Irene confided,

> *He doesn't know that the little remarks just make me consumed with guilt…I've got to the point where I'm just constantly feeling so guilty. It's like I want you to be with someone*

> *and be happy…because obviously I'm not doing anything right. And I just want to give up… It gets so hurt, after I let the little things build up then I just give up.*

Although Ian was sympathetic to Irene's feelings of guilt for the past as she went through recovery, his frequent snide remarks on what Irene did in the past suggested his lack of empathy with her guilt. Without deeper communication, Ian did not understand the depth of the anguish that Irene was going through.

Divergent growth and detachment. The growth in the individuals did not necessarily result in improved couple relationships. Fractures in the couple relationship grew further into detachment, as the clients and partners developed a stronger sense of self and found support and connection from outside of their couple relationships, such as their TAU and social circles.

Irene felt that, although she and Ian became healthier and stronger as individuals through individual counselling, they had grown apart as a couple. She commented, "*We are okay both as individuals, but we're still separate. Like I couldn't tell you what I need from him anymore, cuz I've just given up wanting to need anything from him.*" Ian took his one-on-one counsellor's advice to "*give [Irene] space*" to help them communicate with each other, but he also felt that they were growing distant as a couple. Both Irene and Ian looked to couple therapy in addiction treatment as their only hope to revive their relationship.

With individual therapy, Fay learned to let go of her need to influence Ben's recovery and focus on self-care, with which she was able to take charge of her emotional wellness rather than attaching her emotions to her husband's mental health functioning. Fay stated, "*It's not just living at the whims of someday else's behaviour and illness. It's having my life too.*" Fay became more connected with her family members and allowed herself to enjoy fun activities with her friends. While Fay learned to detach from Ben's addiction and mental illness, seek social

support, and enrich her own life, Ben continued to stagnate in his own recovery. The couple drifted further apart. Fay stated,

> *There's less of me trying to influence. So maybe there is less communication now but maybe it's for the better. I feel less connected to him, I guess. I try to be less connected for my own sake, but I don't know, more connected with friends.*

As Ben's symptoms deteriorated, Fay began taking their young child to stay at her parents' home during Ben's depressive episodes. She described,

> *I think I've been trying to make an effort not to respond or react [to his illness] ... I go to my parents. I take my son, and we stay with my parents when things get really bad. Cuz I don't want to my son see his father depressed and not functioning.*

Although Fay's detachment helped her to recover from the toxic stress of Ben's conditions and kept their child from the influence of Ben's mental illness, their relationship continued to disintegrate.

Need for addiction-specific couple therapy. Some of the couples had attended couple therapy with therapists who lacked expertise in addiction counselling. They found couple therapy outside of addiction treatment settings unhelpful in addressing their couple problems intertwined with addiction issues and providing support to manage recovery in a couple context.

Esther and Elise had periodically sought couple therapy over the years for their relationship issues related to addiction and other life stressors. However, they had little luck finding a couple therapist who could work with them in the context of addiction, particularly when they were on separate paths of recovery. Elise stated,

> *We have not found anyone who was particularly good at dealing with couples in the context of addiction…Finding somebody who was able to deal with us as a couple with addiction on both sides and with [the task to manage] each other's addiction as well was super difficult.*

The couple's therapist at the time lacked the skills in addiction treatment to provide helpful input. Elise recalled, "*We were open with her about our addiction issues, but she just does not*

have the skills working with addicts." She added, "*We used her sort of as a sounding board.*" Elise also noticed that the therapist with insufficient understanding of addiction also held biases between the drinking and non-drinking partners, which only fractured her therapeutic alliance with the couple. Elise recounted,

> *When one person is actively drinking and successfully making moves through recovery, it's hard for someone who doesn't understand addiction not to go "Yay, you are a good one!" or "No, you're the bad one!" ... I did find that it was hard for [the therapist] to have a good relationship with Esther, once I had stopped and she had not.*

Greg tried couple therapy in his previous marriage when he and his ex-wife were having issues surrounding his drinking. In the very first session, his therapist told him, "*We really can't do anything until you stop drinking.*" Not ready to accept his drinking issues, Greg terminated the couple therapy: "*That was the absolute last thing I wanted to hear. So that was the last time I went to couples counselling.*" The therapist's claim that Greg's drinking needed to stop before it was possible to deal with his couple issues suggested the therapist's lack of ability to work with couple issues intertwined with addiction problems.

The couples found couple therapists without expertise in addiction unhelpful in working with couple issues in an addiction context and facilitating the recovery of both members. Unable to find what they needed with regular couple therapists, the couples sought couple therapy in addiction treatment from the primary study.

4.5 Benefits of Congruence Couple Therapy

The five couples who participated in the Congruence Couple Therapy (CCT) saw the following benefits of CCT in assisting their individual and couple recovery. (1) CCT provided a safe place for the couples to open up to each other and address sensitive issues in their relationships. (2) The couples were able to improve their couple communication through in-session facilitation and homework exercises to build new patterns of communication. (3) As the

couples developed congruent communication, they improved self-differentiation and learnt to better represent themselves and acknowledge each other in their communication. (4) The couples were able to explore their traumatic experiences in childhood and in past relationships in CCT sessions, with which they gained a deepened understanding and compassion in themselves and each other. (5) Greater self-awareness, congruent communication, and more cohesive couple relationships served as resources that helped the clients prevent relapses. (6) As an auxiliary effect, the couples' transformation through CCT also improved their communication with their children.

A safe place to open up. CCT provided a safe place for the couples to discuss sensitive issues that they had difficulty addressing on their own. Opening up to each other, the couples found emotional relief and confidence in resolving their couple issues.

With a CCT counsellor's mediation, the couples felt safe and supported to bring up issues that they feared to talk to each other about at home. Ava related how their CCT counsellor facilitated the couple's conversations on sensitive issues by helping them to understand each other's perspectives without overthinking or overreacting,

> *[Being in couple therapy] is when I got to say everything that was on my chest that I would normally not have ever said while we were at home, because I didn't know how Alex was going to react, or there were some things that were hurtful for him to hear, and there's a lot of things that he said in our couple counsellor's office that were hurtful for me to hear. But having [our counsellor] there with us, she really helped us understand the other person's perspective and where they were coming from. She didn't give us a chance to overthink or overreact.*

When attempting to talk about Derek's gambling and treatment at home, Derek and Debra would find themselves shutting down and withdrawing from each other. In the couple therapy, they were finally able to communicate over this sensitive topic. Derek related,

> *We would [try communicating] on our own; we still don't really talk about it…Like there were times when I came home, she'd say "What did you do [in the treatment]?" and I*

> *said "I really don't want to talk about it", and she would do the same. But with the couples counselling, I've actually seen us communicate about that stuff more.*

Importantly, the couple was finally able to address the deeper issue in their relationship – Debra's loss of trust in Derek. Debra recalled, "*One of the biggest things we started with was about 'How much do I trust you?' At that point of time, it was nothing, zero."* Bringing out the issue was the first step towards the recovery of their relationship injury.

Burying their issues and repressing difficult feelings only amplified the couples' problems and added to their emotional burden. Constructively discussing the issues allowed the couple to relieve their distress and raised their confidence in resolving their problems. Caleb described,

> *When you are actually calm and communicating over difficult issues or perceived difficult issues that I don't want to bring up… It's not that big!... We sometimes can make mountains out of a molehill. Something we just let the mind take over instead of discussing it getting it out.*

Improving couple communication. The CCT counsellors' facilitation helped the couples practice open, mutual, and empathic communication, through which they begin learning to listen to each other without reacting with defensiveness. The CCT counsellors acted as translators who assisted the couples' mutual understanding, allowing them to develop empathy with each other's inner struggles. The CCT counsellors also provided analysis that helped the couples to recognize their unhealthy communication patterns. Beyond in-session facilitation, the CCT counsellors devised homework excises for the couples to expand and implement their learning through routine practices and to resolve specific couple problems at home.

Facilitating open communication through in vivo practice. The CCT counsellors used prompts and provided feedback to facilitate open communication and intervene in the couples' unconducive communicational behaviours. With the CCT counsellors' facilitation, both

members of the couples were able to express themselves without being interrupted and be heard and acknowledged by each other.

At the beginning of couple therapy, some couples experienced discomfort in expressing themselves to each other. Instead of speaking to each other, they were simply taking turns to speak to their CCT counsellors, who, in turn, continued prompting them to turn to each other. Debra recalled that her counsellor instructed her to turn to Derek as she was expressing her feelings of hurt and self-pity after discovering Derek's gambling addiction, *"[Our counsellor] goes, 'Don't tell me that. I want you to look at Derek, and you tell him that.'"* Gradually, through deliberate practice to talk to rather than about each other, the couple overcame their discomfort and became more willing to express their feelings to each other. Debra described, "*Each time we went [to the couple therapy], it was a little bit better."*

The couple counsellors intervened in the couples' interjections and reactiveness with each other, which allowed both members to have a voice and be heard. Mutual conversations in turn enabled mutual understanding. Claire spoke of an instance where their CCT counsellor stopped Caleb from interjecting as she was speaking about her worries with Caleb's growing attachment to his church. Allowed the space to explain her feelings, Claire was finally able to express the fear that she had carried for months for losing Caleb to his church community. Claire saw him becoming more attached to his church members and feared for his disconnection from her. She had kept it from Caleb, as she thought that Caleb would only argue with her when she brought it up rather than trying to understand. With their couple counsellor's facilitation, Claire was able to express her feelings fully without Caleb's interjection. Conversely, Caleb was able to hear her deeper insecurities and respond with support and reassurance. Claire recalled,

> *[Caleb] tried to introject, and [our counsellor] was like, "No, no, just wait and let her finish", which was really nice. Just to have a mediator there, who he listens to, and then I*

> *got to get that out, and that was a big deal. Because I felt so much better after, that I'd gotten it out for one, but also [that] he heard me. And then we were able to address that. He told me that [what I worried about] would never happen…So that was really, that was really important to me.*

A CCT counsellor could encourage the client and partner to delve into their deeper feelings, which helped nurture the couple's emotional intimacy. Debra described how their CCT counsellor drew out their deeper emotions, "*It was like she knew us from the beginning. She has her little tactics, the way she talks, to get things out of you, to talk about yourself*." Hearing their significant others' deeper fears and pains, the clients and partners were able to develop empathy with each other and respond with support. Caleb described how their CCT counsellor's in-practice facilitation guided him and Claire to communicate with openness, mutuality, and empathy, which deepened their connection and intimacy:

> *We got to do it together in front of [our CCT cousnellor]. As she facilitates and guides us through the conversation, allowing one person to completely finish what they're thinking, through the tears and the emotion, and having the other one respond, through their emotions and feelings, which we have never ever done before.*

Learning to listen. In CCT, the couples came to realize the importance of listening and the difficulty in achieving it in their communication. Particularly, it would be challenging for a couple to listen with an intent to understand and provide emotional support to each other when their conversations were about the issues that they had with each other. Elise said, "*Supportive listening is much harder to do when you're supporting someone venting about you."*

Caleb worked hard to overcome his tendency to interject and improve his listening. He stated, "*Even though it takes time and there's tears and there's emotion, to just listen, listen, listen. You don't jump in with an answer or a life lesson, just simply listen."* To become a better listener, he learned to be mindful and accepting of any difficult feelings that arose in him when

listening to Claire. Being able to accept these difficult emotions while listening allowed him to engage in open and honest communication. He said,

> *With listening, it's how you feel. What do you feel at that time when the partner is talking about that serious information that she wants to get through? So be mindful again of how you are feeling during all of this…Like if it's anxious, or you're afraid of hearing what the other person has to say, just allow the sensation to go through you. Not around it, or jump in, or make excuses, just to feel the emotion as it presents itself. It's not a bad thing to feel a little nervous or anxious about what the other person is thinking, because you are regarded to a degree…Cuz open and honest communication isn't always pretty.*

The couples also learned behavioural skills from their couple therapy to facilitate their listening. For example, Beau and Beth learned a technique of "*parroting*" to check for misunderstanding when listening. Beth said,

> *One of the tools that worked really good is telling them what they said. That way you know you heard it right and they know you heard what they said. Cuz sometimes we get things confused and if you just sort of play it right back to them what they just told you, then everybody knows you're all on the same page.*

Bridging mutual understanding. The CCT counsellors not only provided safety and support for constructive ways of communication, but also bridged the gap of understanding between the couples by providing appropriate translation of one member's views, feelings, and intentions to the other. With their CCT counsellor's translation, the partners gained insight into the clients' inner processes related to their addiction.

Beau had difficulty understanding Beth's perception and thought process when she tried to explain to him. Their CC counsellor was able to explain it in the way that he understood, which allowed him to better comprehend Beth's inner world related to her addiction. Beth believed that a couple counsellor's translation could help bridge the gap of understanding between the person with addiction and the partner. She said,

> *I don't think the non-addict, the spouse of an addict, fully understands the way an addict's mind works. To have a professional help talk through that thought process is very helpful. I can try to explain to Beau what I think, why I think that way, and he would*

> *just be baffled. But a counsellor could…break it down from A to B to C to D to E. And then he could go "Okay! Now I know how she goes from A to E, without informing me what goes in between." So it's very important to have that outside resource to be able to bridge the gap, so to speak.*

What was crucial for Ava's couple therapy was not gaining an understanding of addiction but Alex's perspectives. She learnt to view events from Alex's point of view. She said,

> *One of my biggest things was learning to see things from Alex's point of view, because I don't understand what it is like to be an alcoholic or to have a dependence or how not to cope with something…It's not so much understanding the addiction itself, it's understanding that, you know, when Alex goes down to the farm and his dad's sitting there drinking and stuff, how it can bother Alex.*

Ava pointed out that the key to effective communication was not open conversations, but mutual understanding and empathy. She stated, "*Healthy and productive conversation is not just sitting around and having the talk. It's really taking into consideration each other's feelings and each other's perspective.*"

Recognizing problematic communication patterns. The CCT counsellors provided feedback on the couples' communication behaviours in their sessions. With the counsellors' feedback, the couples became aware of their patterns of interactions that disrupted mutual understanding and strained their relationships. For example, Debra and Derek realized that some of their non-verbal communication behaviours would incite negative feelings and provoke antagonistic reactions. Debra described,

> *Certain tones when I'm asking questions [might bring out bad reactions from him] …[Like] he's rolling his eyes at me, and it's [making me feel bad]. I used to say, "How was your treatment tonight?", and he's like "Uhh", giving me the eye-rolling and things like that, right? Making me feel bad for asking him the question. [I'd be wondering,] "Am I being annoying? Am I actually being concerned?"*

They also learned how ambiguity in communication would only elicit overthinking in the other person. When under stress, the couple's tendency to communicate with ambiguity had led each other to a vicious cycle of negative thoughts. Debra described,

> *I used to rather than saying "I'm hungry. I want to go out for dinner", I would say to him "Do you want to go out for dinner?" And if he just says nothing, then I put in my head that he just doesn't want to go out for dinner, we really can't afford it, rather just being blunt to the point…Making up things in my head just like he would make things up in his head. Not actually saying what do you want to say. You just think, and then it goes into a whirlwind of bad thoughts. And then you get yourself all worked up rather than just putting it out there.*

Making changes through routine practice. The couples kept practicing what they had learned from their CCT sessions with homework exercises. The CCT counsellors would assign them customized homework exercises, which helped the couples expand and transfer their in-session learning to everyday practice. For some couples, their homework exercises not only assisted their behavioural integration of changes in general but also helped resolve the couples' specific communication problems at home.

Esther and Elise's CCT counsellor explained to them that good communication was an acquired skill rather than a natural gift, which required continuous practice to develop. Esther initially showed a lack of effort in practicing new ways of communication. Viewing healthy communication as a learned skill, she found interest and confidence in becoming better at it. She began making a greater effort to complete homework exercises and apply what she learned from CCT in her everyday interactions with Elise. Elise described,

> *The fact that [our counsellor] was there saying "No, it's a useful skill. It's a learned skill. It's not something that comes naturally to people. You have to practice it! It's hard and you have to take turns doing it", that I think really burnt into her, that this was something she could learn to do, and it was a fairly reasonable thing to expect people to do.*

Despite his initial reluctance, once Alex tried practicing the homework exercises, he saw the benefits of applying communication techniques in his daily life. Performing new behaviours of communication in turn brought him a new perspective on how to effectively communicate, which motivated him to actively adopt helpful communication behaviours. Alex explained,

> *At the start, I was pretty reluctant. I'm pretty stubborn. I don't like to try new things. But [the homework] challenged me to kind of change my way of thinking, and it's beneficial in the end…For example, just using "I" statements, "I feel" or that type of thing, you don't think about it, when you're not using them, until you try it for a little while, and it actually really helps you to explain yourself better, and to be able to get the way you're feeling across, without sounding condescending to your partner…And then it just gives you a lot more understanding about how the other person is feeling, And it gives you the chance to be understood yourself.*

Homework not only served as a learning tool to help the couples develop and solidify new communication skills, but it was also devised to alleviate the couples' specific communication issues at home. For Esther and Elise, a homework practice that their CCT counsellor proposed helped to resolve the couple's ongoing "re-entry" problem at home. The couple clashed in the ways they liked to unwind and recharge after work. While Elise preferred to engage and reconnect with Esther when first arriving home, Esther preferred to retreat into solitude. As a result, a pursue-withdraw pattern was formed between Elise and Esther upon their return to home every day, causing tension between them. To balance both members' needs, their CCT counsellor suggested a brief check-in at the point of re-entry without any further engagement and a delayed meeting around dinner time for the couple to reconnect and debrief their day. The couple tried this homework assignment, which turned out to be successful enough that it had become the couple's daily ritual. Twelve months after their CCT completion, the couple kept practicing this ritual that both helped to maintain their couple connection and honour their individual differences.

Aligning the self and the other. While the CCT couples worked to resolve their couple issues and built better communication skills, they developed greater self-other awareness and a healthier level of self-differentiation. With sufficient self-differentiation, they were able to recognize their own responsibilities in couple issues and exercise their power of choice in regulating their emotions in response to outer stressors. They developed skills of self-

representation with which they were able to express their feelings and negotiate their needs effectively. Their enhanced self-differentiation and self-representation further led to greater self-confidence and more satisfying interpersonal interactions beyond their couple relationships.

Improving self-differentiation. As the CCT couples practiced how to constructively respond to their relationship issues, the couples grew in their self-other awareness and self-differentiation. They learned to accept their lack of power over the other person and reclaimed the power over their own actions. Instead of trying to influence each other's behaviours, they began owning up to individual responsibilities and taking control over their own choices. Instead of blaming other people and outer circumstances for their experiences of distress in daily life, the couples learned to take ownership of their emotions and take charge in regulating how they felt.

Beau had always attributed the couple issues between him and Beth to Beth's alcohol abuse. To Beau, the only solution to his marital problems was to "cure" Beth's addiction. In CCT, Beau came to recognize that the addiction was a problem that belonged to Beth, over which he lacked power. Meanwhile, the issues that Beau experienced in his marriage belonged to him as much as Beth and that he could only resolve the problems that were his. He learned to focus on what he could do to resolve the couple issues and began making changes in himself. Beth commented,

> *I think that realizing that somebody else's problem is somebody else's problem, and the only problem that you can fix is your own is a huge step for Beau. And I think a lot of that came in realization in the couples therapy.*

Beth's recent episode of alcohol abuse began after she had been through a series of adversities in life, which left her feeling alone, helpless, and resentful. After her mother passed away, she looked after her widowed father and shouldered up the handling of her parents' properties by herself. While struggling to grieve, Beth was angry at her brother who left her

alone to carry the burden of their family affairs. The last straw was the mistreatment that Beth experienced when she returned to work after her bereavement leave, which filled her with resentment and drove her to a downward spiral of alcohol abuse. She felt as if the world was out to get her, and she lashed out with drinking. Through TAU, Beth managed to pick herself back up and maintained sober. The learning through CCT helped Beth to let go of her resentment that had fueled her alcohol abuse by reclaiming ownership over her emotions. Through developing a greater awareness of self-other differentiation in relationship dynamics, Beth learned not to let other people's actions dictate how she felt inside. She knew now that the only person who had control over her emotions was herself, and she was determined not to give the power away. She recalled a recent instance where she did not let a frustrating interaction at work disturb herself emotionally. She related that when her co-worker commented, "*Oh, that must really piss you off!*", Beth responded, "*No. I'm not gonna give that person that kind of power*." In differentiating the self from the context, Beth learned to approach problems in a detached manner, where she chose not to take problematic circumstances personally. No longer relating to problems as personal attacks, the resentment that she carried gradually dissolved. Beth stated,

> *I'm able to let go, a lot more realistically, a lot sooner. I'm not taking things so personally. It's not a personal attack on me if something goes wrong. It just goes wrong. It's not because the whole world is out to get me.*

Similar to Beth, Caleb was able to let in the idea that the only person having control over him was himself as he went through TAU and CCT. He declared,

> *It's being confirmed from all these different [therapies], that the only thing you can control is yourself and everything outside is just interference… It really is the goal, knowing you can't control anybody else's actions, you can't control anybody else's feelings. They can't make you mad, you allow yourself to be mad, that kind of thing. The important idea is you're the one in control, and you can't give that control away to anybody else.*

Representing oneself in communication. With enhanced self-differentiation, the couples learned to represent themselves rather than blaming and controlling the other person when clashes took place. Through CCT, they developed skills of self-representation with which they were able to authentically and effectively express their feelings and needs. With an improved ability to represent themselves, the clients and partners gained self-confidence and relationship satisfaction.

Beth believed that with CCT, she developed both skills and confidence in asserting herself. She stated,

> *I think that I'm a little better at telling people when I'm uncomfortable with the situation. I think I can both feel better about communicating it, and I communicate it better. That's two different sides to the same deal. I not only feel that I'm allowed to have a voice, but I'm also able to be clear about why I feel that way. If I'm bothered by something, I don't want to do that. This is why I don't' like this idea. I can be clear, I can be intelligent, I can be non-belligerent about it.*

As Elise became more assertive in expressing her needs and making requests in her relationships, she grew more confident and self-assured. She began to feel that her feelings and needs were valid, and she was more comfortable making requests in her relationships. She spoke of how her improved self-representation led to more satisfying relationships with her sons,

> *I'm certainly more able to ask my son for attention when I want it, instead of pouting, "Hey, we need to do something! Let's get together!", instead of waiting until they choose to do something. So I definitely find myself feeling kind of my requests are valid.*

With improved ability in representing themselves, the couples were able to gain each other's acknowledgement of their needs without interfering with each other's autonomy, which reduced unnecessary frictions between them. Having learned to honour the differential needs between her and Esther, Elise stopped trying to control Esther's drinking for her own needs of an alcohol-free house. Instead, Elise asserted her needs and boundaries regarding alcohol use at home. Asserting herself rather than trying to stop Esther's drinking took away the coercion and

invited cooperation from Esther. Instead of opposition, Esther responded to Elise's self-assertion with respect and collaboration. Elise described,

> *I think my willingness to hold the line on things that I need - as in I need an alcohol-free home, I'm not comfortable with there being alcohol around, I'm not tempted to drink, I just don't like it…I don't like Esther drinking at home with me around - my willingness to be clear on that and to say "This is not me controlling you. This is me making my own boundaries clear." … I think that makes her more likely to go along with it, just because it's not about her, it's about me. So being able to assert my own needs helps that way.*

The benefits of congruent self-representation extended beyond their couple relationships and led the clients and partners to more fulfilling family and social relationships. Before CCT, Alex's relationship with his father was strained. He was disappointed with some of his father's behaviours, but he felt obligated to comply with his authority and had never spoken up about his issues with his father. As he developed communication skills in CCT, Alex was able to communicate his stance to his father assertively and respectfully. As a result, their communication became more open and mutual, and their relationship strengthened. Alex said,

> *Like with my dad, you know the way you're with your parents sometimes? It's kind of just, they are the parents, so you kind of go along with what they say. But not anymore, I find that I can state my position without being an a****** about it…So with my self-confidence and everything kind of comes in, it changes my relationship. It's kind of strengthened a little bit with my dad.*

Balancing self-other dynamics. With improved awareness and acknowledgment in themselves and each other, the couples were able to build a more balanced and reciprocal relationship with each other. Before CCT, Esther and Elise were stuck in unbalanced couple dynamics where they were entangled with power struggles and cycles of pursue-withdraw. While Elise tried to stop Esther's drinking to maintain an alcohol-free household, Esther resisted Elise's control with drinking in secrecy. When under stress, Esther withdrew into seclusion, and Elise pursued communication and connection, which drove Esther further away. Through congruent

self-representation and mutual acknowledgement, the couples were able to effectively negotiate for their own needs while honouring each other's.

One main conflict between the couple as they worked towards recovery was their different stances on abstinence. While Esther preferred to continue with moderate drinking, Elise was firm on practicing abstinence. With the conflicting agendas, the couple frequently fell into power struggles as they tried to influence each other's drinking behaviour. With the help of CCT, Elise was able to let go of her need to control Esther's drinking and shifted focus to her own self-growth. Seeing Elise stepping back to honour her autonomy, Esther felt acknowledged and respected. She became more motivated to make changes and take charge of her own recovery. Elise related,

> *When I was no longer so actively being the boss of her sobriety and trying to make her stop…and started focusing much more on my own self and the way I could talk about how I was feeling, once I let go, it made it easier for her to say "Yes. I'm going to try" and feel as if she had a choice.*

The couple used to fall into pursue-withdraw cycles. As an introvert, Esther would like to withdraw from social interactions for self-care, while Elise, as an extrovert, preferred social connection to destress. When Esther withdrew, Elise in turn felt shut out and pursued reengagement. Learning to honour Esther's needs for time alone while acknowledging her own need for social connection, Elise began to find social outlets outside her couple relationship and spend more time with her friends. Elise's stepping back left more personal space for Esther and allowed her to take on the pursuer's role at times and initiate interactions with Elise. The couple found a balance between connection and independence in their relationship. Elise described,

> *When I find company elsewhere and go off to do things with other people, Esther realized that she actually misses me when I'm not here, and wants to engage with me more…You can hold more grains of sand in a loose hand than in a tight hand.*

Understanding trauma. An important part of CCT was exploring the clients' and partners' past relational trauma and timelines of stressors in life. By delving into their past, the couples gained insight into how trauma and adversity in their lives had impacted how they were today. They were able to connect their current personal afflictions and unhelpful communicational patterns to their past traumatic experiences. Understanding the traumatic root of their unhealthy patterns, the couples became more compassionate and accepting towards themselves and each other. With greater self-acceptance and deepened empathy with each other, the couples were able to move on from the shadow of past trauma and reclaim the captainship of their lives today.

Deepening self-understanding and self-acceptance. Using therapeutic tools including family genograms and timelines (of life stressors), the couples deepened their self-understanding. They were able to see how their early traumatic experiences had a profound impact on who they were today. They recognized the link from their past trauma to their fragmented sense of self and unhealthy interpersonal patterns today. By linking their current self to past adversities, the couples were able to view themselves with greater compassion and acceptance. Self-acceptance was a crucial step towards healing of trauma.

Through CCT, Claire and Caleb explored Claire's family genogram and gained insights into how Claire's trauma of abandonment had shaped who she was today. In her teens, after her parents' divorce, she was given up to foster care and subsequently moved among different foster families and group homes. In her adulthood, she was abandoned again by her ex-partner to whom she devoted almost a decade of her life. The trauma of abandonment in her life shattered Claire's sense of self and destroyed her trust in people. Since her teens, Claire had constructed a persona, who was strong and competent, to protect her traumatized inner self and mask her

deeper insecurities. Delving into her history, Claire realized how these traumatic experiences affected her identity, meaning making, and patterns of communication. Understanding the impact of her past trauma deepened her self-understanding. She said,

> *I guess maybe, for lack of a better word, the consequences of these things in these places I was put in has shaped how I think about some things, how I react to some things, and how I maybe speak sometimes. I think it just opened up like a different level of understanding [in myself].*

Gaining insight into how her past trauma affected who she was today, Claire was able to let go of self-blame for the hardships in her life today and became more compassionate in herself. She stated,

> *I guess partly [I gave] up some of the responsibilities and meaning, like it's not all my fault that my life is this way. There are some things that actually have happened, that have caused me to be who I am today and have caused past decisions that I've made. So [I'm] being kinder to myself.*

With deeper self-compassion, Claire found greater self-acceptance, which was a breakthrough in her individual recovery. Being able to accept herself, Claire could let go of self-loathing while assuming responsibilities for the choices that she regretted for making in the past. Finding self-acceptance, she was able to move on from a bleak past and focus on making positive changes in her current life. She described,

> *[I began] accepting myself…I've been working on [addiction recovery] for a long time, but I feel like in my personal growth, I'm really turning a corner…I know something's happened to me that caused me to think the way that I do, et cetera, but I still have to accept my part. I'm still responsible for the actions…No one has ever made me drink ever. That was a choice that I made… I am responsible for the bad choices that I've made. It's not as glaring as it used to be…I'm not beating myself up so much and being more at peace [with myself]. Basically, I can let it go more easily than I used to.*

Going over his timeline in life, Caleb came to realize the losses and trauma that he had been through but never truly processed. He learned from his family of origin to "deal with it" when encountering hardships in life. He kept on shoving aside his pains and forced himself to

move on from any traumatic events in his life. Alcohol use helped to numb his emotions and maintain his tough facade. However, gaining an understanding of how his past trauma had impacted his life, he recognized that he had never been able to move on from these painful experiences. Caleb came to these realizations when one of his past traumatic experiences was brought up in CCT. He recounted,

> *I didn't realize that I put that on the back shelf, when really that's the stuff you need to talk about and find out where you are in all that. And then, we got that out, and Claire didn't even know that. Cuz I thought "Deal with it! Deal with it!", cuz I was raised to deal with it. Till [I realized] I wasn't built that way. I was a compassionate and emotional guy. And that's okay that's who I am. I can serve the world a lot better being me than being an active alcoholic*.

Through reviewing adverse events in his past, Caleb came to acknowledge his unhealed wounds and the need to attend to them. He was able to accept that he was not as stoic as he was raised to be and that he needed to be true to who he was.

Furthering mutual empathy. As the couples explored their past trauma together in CCT, they gained insight into each other's deeper wounds and came to understand how each other's past trauma had led to their insecurities and maladaptive patterns today. The couples deepened their empathy with each other and gained compassion for each other's shortcomings. Further, knowing how far they had come from their past, they began to see each other in a more appreciative light.

Working through Debra's timeline, Debra and Derek discovered how the trauma from her ex-marriage had made it difficult for Debra to recover from Derek's gambling addiction. In her ex-marriage, Debra carried the burden of being the sole bread earner while her ex-husband abused her hard-earned money. To hold together her family while surviving the toxic marriage, Debra kept the anger and pains to herself and devoted all her energy to raising her children. In CCT, Debra realized the profound impact of her ex-marriage on her psyche, "*I learned [in CCT]*

that I actually lost my spirit for life. I didn't cry for years. I was just numb and just going through the motions." When she met Derek, she had worked hard for years to build an established life as a single mother. She saw Dereck as a "beautiful person" that she could trust completely. She was ready to offload some of her life responsibilities to her trusted partner in life, which included her finances. However, like a crew joke that life had played on her, what happened in her ex-marriage happened again in her current relationship. Her finances were destroyed again by her spouse, even though she saw him as the complete opposite of her ex-spouse. After the initial shock of discovering Dereck's gambling, Debra fell into deep anguish and self-pity. Debra stated,

> *I worked very hard all my life and I got, pardon my language, but I got screwed over once [by my ex-husband]. I worked hard to get to a good place in my life and all this happened. I appreciate and value money, and my kids are very successful. I taught them well and for this to happen to me, I felt like "Why is this happening all over again to me?". I was in a pity pot.*

Anger and hurt plagued her relationship with Derek in the aftermath of his gambling addiction. Realizing the impact of Debra's last marriage, Derek came to grasp what it meant for her to go through the financial loss with his gambling. He recognized the extent of hurt that Debra had experienced.

Through Esther's genogram, Elise learned about Esther's emotionally devoid family environment and how this "emotional dessert" had shaped Esther's personality. Elise came to realize that, as Esther learned to openly communicate, she was "working against everything" that she was wired to be. Having gained insight into Esther's upbringing, Elise was able to empathize with the difficulty that Esther had in learning to better communicate and stopped judging her for not making as much effort as Elise would have liked her to. Elise became more tolerant of Esther's difficulty in communication, acknowledged her perseverance in trying to change, and accepted the gradual process of Esther's communication improvement. Elise stated,

> *I have more empathy for how truly difficult it is for her to be other than who she is. And yes, she's lazy about it, yes, she needs to make more effort, and at the same time, I understand how she's going against everything she was programmed to be, when she's communicating and being open. She's just not wired that way and did not have the experience of being that way. I think I have more tolerance for her difficulty, but I still have expectations that she will make that effort. But I have more understanding for why it has such an effort.*

Caleb already knew about Claire's experience when she was placed in foster care by her parent. However, exploring Claire's family genogram helped to shed new light on how Claire's experiences of abandonment had affected her in their couple relationship. Caleb came to recognize the trauma that Claire suffered from the abandonment and how it planted her deep fear for loss of relationships. Gaining insight into Claire's deeper pains, Caleb was able to empathize with Claire's strong attachment towards him and her insecurities in their relationship. Caleb recalled,

> *I didn't realize the hurt and loss that Claire felt in her teenage years of abandonment, people leaving her, hurting her. Part of the reason why she holds onto me so hard [was that] she's been abandoned several times in her life. And I didn't know the severity of that hurt and that insecurity of losing somebody again. It came out of the couple therapy. I really didn't know the extent of her fear on so many levels.*

Healing trauma and making choices. Deepening their understanding and compassion towards themselves and each other, the couples were ready to move on from the past and make new choices in their lives. Choosing to depart the past and venture towards self-realization, the couples were able to take back charge over their lives.

Through Caleb's timeline exercise, the couple discovered the numerous traumatic events in Caleb's life and how he was still carrying the emotional baggage from the past. Caleb recalled, "*Claire didn't know that I held onto things so hard…I don't know why I was like this."* However, Caleb also remembered Claire uttering, "*We don't need to be like that!",* which resonated with him, "*We know when we're hurting, and we know that we don't need to hurt.*" The couple's

shared pain and compassion for each other became a catalyst in their healing, freeing them from the shackle of the past. Caleb proclaimed,

> *I don't need this emotional jail sentence…[I'm] kind of living in a cesspool of garbage and hopelessness and self-loathing. And it's just an exhausting place to be, and I don't need to be there.*

Caleb now recognized that it was a matter of choice for him to leave behind his self-loathing for what happened in the past and acknowledge who he was in the present:

> *It's a choice. It really is a choice. Through talking and treatments, you can choose to live differently. You can choose to either be in that jail sentence or you can choose to look forward and say, "Here's what I did great today. Here's some stuff I'm going to work on tomorrow to get better", and then that's it. Put it to rest and move on.*

Caleb understood that although he had no power to choose what life served him, he had the freedom to choose what to do with it. By being true to himself with each choice he made in life, he could steer towards self-fulfillment. He recounted,

> *Just looking at the stressor chart that we did with our counsellor and of the family tree sort of thing, some of the stuff is just the menu of life that I was given. However, I don't need to change people around me, I need to look at what I can change. Choose either to be with certain people or not. Choose to be part of this group or not. What's better for me? Because without being 100% true to yourself, you're not gonna be good to anybody around you.*

With insight into the traumatic root of her maladaptive patterns, Claire's self-identity transformed. She no longer saw herself as a broken person but someone to whom tragedies happened. She no longer saw herself as deficient but needing to learn new ways in conducting herself to straighten her life out. She said,

> *Just trying to understand where [the way I think and act] comes from and that I'm not a broken person, I just had kind of broken things happen to me. And then relearning how to do things in a different way than I've ever done before, because the way that I've been doing things obviously hasn't been working for me…So [I'm] trying a lot of different ways and therapies to find my way out of the tangle that my life has been thus far.*

Although Claire and Caleb withdrew from CCT in the middle of the program due to extensive life crises, Claire's learning from CCT motivated her to pursue a deeper level of change in

herself. As aforementioned, Claire's sense of self shattered when she was given up by her parent to foster care in her teens. Claire imagined herself like a rainbow with a spectrum of loveable qualities before the abandonment. After she was put in care, Claire lost her sense of self, and to find a place in the world for herself, she constructed a persona of a "strong, capable, [and] together woman". She called this persona her "walls". These "walls" were to hold together the broken pieces of her old self and protect her through the chaos during her years in care. However, her "walls" also kept her from being authentic to others and congruent with her inner herself. Keeping her "walls" up, she had never truly opened herself up to treatment despite years in and out of various programs. However, following her seven sessions of CCT, Claire had for the first time, spoken truthfully about her "walls" with her addiction counsellor and asked for help to take them down. She was ready to reconnect with her inner self and to reconstruct an identity that would integrate both her vulnerable and formidable sides.

> *Now I feel like maybe I can start taking the walls down a bit. I can be more vulnerable, to my own benefit, and I won't actually lose those valuable attributes [of my walls]. They don't have to always be so rigid or even present, and maybe I will become a complete rainbow again.*

Supporting long-term addiction recovery. The changes that the couple achieved in CCT helped them to activate their inner resilience and relational resources that could support long-term recovery. The clients developed a greater awareness of outer stressors and inner experiences that precipitated relapses, which helped them to manage ongoing recovery. The clients' improved openness in communication allowed them to seek social support in time. The couples' enhanced communication and an amplified sense of togetherness enabled them to form a strong partnership in recovery.

Awareness and communication in preventing relapses. In developing congruence, the couples learned to pay attention to and became more aware of their interactions with the outer

context, particularly with stressors in their lives. In managing their addiction, the clients learned to pay more attention to the signs of their elevated stress that could precipitate relapses and re-adjust how they responded to stressors. They learned to step back and reassess the situation, attend to their inner needs, and seek support through congruent communication.

Attention and awareness were crucial for Alex to manage his recovery and prevent relapses. Alex's CCT counsellor brought to Alex's attention that his withdrawal and avoidance behaviours in communication were "red flags" of elevated stress, which, if not attended to, could lead to relapse. He learned that when noticing his "old habits" perking up where he would avoid talking about his problems, he needed to step back to re-evaluate his stress level and readjust himself. He stated,

> *One thing that I got to watch out for is when I start to sweep my problems under the rug…[My CCT counsellor] can recognize that I'm starting to revert back into old habits, where I'm kind of avoiding stuff instead of talking about it…If I do start to get overwhelmed, I will start to be like, "Well, whatever." That's a sure sign for me that things are starting to get too much, and I need to take a break or to step back, and really, really, evaluate how I'm doing things. Cuz it's getting close to the point where it could lead to a relapse. It's a red flag for me.*

Awareness helped Alex to be more alert to the red flags of a potential relapse. To regulate his stress and seek self-care, Alex found it beneficial to openly talk about his stress and struggles. Alex said,

> *I think the communication [practice] is the biggest [help] for me. Being able to recognize certain triggers or stress points in myself, and to be able to recognize them when they are starting to get to me, and then to be able to discuss them, and allowing me to be more open, and being able to talk about things has really helped me a lot.*

Ava also believed that open communication is an antidote to Alex's emotional avoidance and thus, a natural method for his relapse prevention. She stated,

> *I'm not worried about Alex relapsing, but I think if the situation were to ever happen, it would be a result of him bottling up his feelings again and storing everything inside. whereas if we just keep the communication going and the talking going, I don't ever think he will relapse.*

Couple relationship as a natural resource for recovery. Through CCT, the couples were able to enhance their communication, resolve their couple issues, and heal their relationship injuries. With restored trust and connection, the couples were able to maintain open and honest communication. As they worked through conjoint therapy, they gained a stronger sense of togetherness. The couples' strengthened relationships became a natural resource in their joint adventures of change.

Improved communication and problem-solving. After their CCT concluded, the couples continued practicing the communication skills and the couple routines that they built during CCT. They were able to maintain an emotionally intimate relationship with each other. Eleven months after their CCT, Debra and Derek kept practicing what they learned from CCT in their everyday interactions and maintained trust and intimate connection with each other. Debra described,

> *The trust is there...We appreciate one another. We talk a lot more. Just practice not eating dinner in front of the TV, we sit at a table. Things like that, we're still practicing what we learned to try and keep that communication. We try and get out as much as we can, even if it's just keeping the date nights.*

Almost two years after their CCT, Alex and Ava maintained open communication and constructive problem-solving. They did not revert to their old habits of avoidance and anger withdrawal. Ava stated,

> *We can just talk through any problems that we have...a lot more calmly and openly, and we're able to talk to one another about our problems and deal with them, instead of not dealing with them at all or one of us getting angry and just shutting down.*

With the ability and skills that they developed through CCT, Esther and Elise felt that they no longer needed to rely on couple therapy to resolve problems between them. Elise believed that CCT empowered her and Esther, because it was not just a safe space to hash out issues but a

vessel for learning and self-growth. The impact of CCT on their couple relationship was sustaining. Elise stated,

> *I have more confidence in our ability to get together and work through communication in a more open, safe, and not-exhausting way on the issues we have together, rather than always taking them to a therapist to have somebody hash it out there. So [our CCT counsellor] has more empowered us I think to be able to communicate better.*

Healing relational injury and forming unity. The couples were able to heal their relationship injuries and nurtured a sense of togetherness through the continuous practice of congruent communication. Significantly, the couples learned to turn to each other in times of crisis, as Beth proclaimed, "*We are in this seriously together.*" Debra recovered from her wounds of betrayal, as she had learned to trust Derek and weather through adversity together with him. Debra said, "*I'm done with regret now…because I've learned how to deal with that… Just being together with Derek, holding this together.”* For Esther and Elise, their relationship was no longer a source of conflicts but a resource for their dual recovery. For Caleb and Claire, after withdrawing from CCT, although they continued with their respective TAU and had different approaches of recovery, they were able to maintain a deepened intimacy and mutual appreciation. Caleb stated,

> *[We] tell each other that we care about each other, we love each other, we appreciate each other. Do things together and do things separately, we still know that we're willing to keep working at this and support each other.*

Maintaining honesty. With mutual trust and congruent communication, the clients became more honest about their using and relapses. Claire and Caleb both were recovering from alcohol use disorder. They used to hide their slips from each other, feeling ashamed and worrying about the other person's reaction. Claire noticed that they had become more transparent with each other about their slips since CCT. Claire stated,

> *I think just being a little bit more honest. In the past five years there have been times when both of us have tried hiding drinking, cuz we don't want to bring the other person down, or we don't want them to know because of shame or whatever. But now, even just over the last two weeks, when he did have some slips, he told me right away.*

Elise believed that honesty was the cornerstone of her relationship with Esther. It was not Esther's drinking that Elise could not live with, it was Esther's dishonesty about it that she could not tolerate. Elise divulged,

> *We had to become much more honest about pretty much everything with one another… Being honest about things was the absolute crucial step. I'm not going back! I mean I could live with her drinking …but I could not in any way tolerate being lied to about it regularly, so that had to change, and it did change mostly.*

Partners in recovery. For the couples with a shared problem of addiction, although the path of dual recovery was extremely challenging, they could become invaluable partners in recovery with the help of congruent communication. For Claire and Caleb, when one person slipped, the other could be easily dragged back into drinking. After CCT, the couple strengthened their boundaries surrounding drinking while maintaining respectful interactions in case of one member's slip. Claire recounted how she responded to Caleb's recent slip by expressing care for his safety while asserting her boundary to protect her own sobriety. She related,

> *Caleb kept on saying "Well, I'll just leave". And I said to him, "I don't want you to, because if you stay here, I know where you are... I don't have to panic." But I did say to him, "If this is going to be a continued binge for you. you have to leave, because it puts me at risk, and also, you're not fun to be around." So I did put that boundary there… which maybe I wouldn't have done before, cuz the likelihood that I would have actually joined him was higher for me before.*

Both working towards sobriety, the couple could turn to each other to share experiences and seek empathy and support. With a shared journey of change and mutual understanding of what they were going through, Caleb and Claire became partners in their journey of recovery. Claire stated,

> *We were each other's partner-in-crime kind of thing. It's nice to have someone there, who knows pretty much exactly what I'm going through, like the changes in my thoughts and stuff like that. Just having someone to be able to talk to you about that on a daily basis, who understands me intimately. It's nice having a partner in recovery.*

Preventing the intergenerational effect of addiction. Alex and Ava noted the changes in Alex's interactions with their children after he had gone through regular treatment and CCT. Alex believed that, with the help of all the treatment programs that he had undergone, he became more in touch with his own feelings, which also allowed him to be more caring and compassionate to others. As a father, he was more willing to listen and show compassion to his children. Alex described,

> *I definitely try to communicate with my kids a little better. Sometimes they don't listen as well as I'd like them to…With quitting drinking and being able to kind of explore and have my feelings, I'm a lot more compassionate than I was, a lot more caring than I used to be…I'm a bit more understanding and I try to listen to them a bit better than how I used to.*

Alex regretted having exposed his children to his alcohol abuse, particularly his heavy drinking in social settings. He remembered how he began heavy drinking because it was "what people did" back then as he grew up. He did not want his children to have the same impression and follow in his footsteps. As Alex maintained sobriety, he hoped to model a sober and fulfilling life path for his children, so that they would not fall into the same misstep with alcohol use and make good choices as they grew older. He said,

> *When I was drinking quite a bit, I'd have friends over, we'd be sitting there around a fire and drinking and stuff. Now that I've quit, I kind of regret exposing our kids to that, you know, sitting around drinking, cuz then they get in their heads that that's what you do. Like that's the way I grew up, and that's not really the way I want them to grow up. I'm kind of hoping that they will make better choices than I made. They are still pretty young, but in a few years they're going to be the same age as I was when I started drinking and stuff like that, so I'm kind of hoping maybe with me quitting drinking, and getting my life back on track, maybe I'll be a little better role model for them growing up, and they might not go down the same path that I went down.*

Individual recovery and improved communication helped Alex enhance his parenting and gave him hope in preventing the intergenerational transmission of addiction.

4.6 Limitations of Congruence Couple Therapy

The couples' account indicated the following perceived limitations of CCT. (1) CCT allowed limited time to address individual issues and thus could be limited in working with specific individual issues related to addiction. (2) The trauma work in the CCT that the five couples received was inconsistent and lacked adherence to the original CCT. (3) CCT required a relatively high level of commitment compared to regular addiction services in community-based settings, which could deter the couples with competing priorities in life from participating. (4) Some participants believed that there was a critical window of treatment entry to couple therapy and that a couple relationship could be past the point of saving with delayed entry. (5) Conjoint therapy could pose logistic challenges for couples who both worked, had young children, or lived in remote areas.

Limited individual work. The couples found that, compared to one-on-one counselling with the sole focus on the individual, CCT allowed limited self-expression and self-exploration, which could be a limitation in addressing specific individual issues related to addiction. Some partners felt that they needed one-on-one therapy to vent about their spouses without worrying about the other person's feelings. Importantly, some clients found that CCT did not allow the time for in-depth self-exploration and direct work on addiction, which they were able to achieve in one-on-one counselling. Alex stated,

> *[One-on-one counselling] allows you to kind of focus on yourself and the stuff you really need to work on yourself, as opposed to the stuff you're working out as a couple type of thing. Just like, I struggle with self-confidence and self-esteem issues, so I'm able to work on that a little bit more, in my own counselling sessions, as opposed to in the couples therapy where we can work on problems that me and [Ava] have…So I'm able to work on some of the problems and underlying issues that resulted in my addiction and stuff like*

> *that. In our an hour long couple sessions, sometimes you just don't have the time to be able to get in-depth into some of the stuff.*

Inconsistent trauma work. There was a noticeable lack of consistency among the CCT couples' accounts of the family of origin and trauma work in their CCT. Among the five CCT couples, two couples reported an absence of family-of-origin and trauma work in their CCT. Further, out of the three couples who were guided to explore their past traumatic experiences, one couple found the trauma exploration beneficial but emotionally strenuous. This couple also faced ongoing life crises and had a severe relapse midway through their CCT program, at which point they decided to withdraw from CCT.

Although Caleb found CCT was "*as good of a therapy as [he had] ever had*", it was "*emotionally draining*". Part of what was emotionally taxing in Caleb's CCT sessions was its concentrated trauma work. In the process of uncovering the past traumatic experiences and exploring their impact today, Caleb experienced an overwhelming range of emotions,

> *There was a lot of tears. There was anger, there was sadness, there was, you name it. All of the emotions on the spectrum are coming out within the hour and a half [of the therapy session].*

Caleb felt his CCT counsellor delved much deeper than other counsellors in his one-on-one and group therapy. Although he was unsure whether he was ready to dig up his buried wounds, he dived right in with a strong will to learn and grow. He stated,

> *It's difficult to talk about abandonment issues and insecurity and inferiority and all these things that we developed as a small child and you don't know where they come from, and start looking at your timeline and seeing where and what happened in your family make you the way you are.*

Undoubtedly, Caleb and Claire gained remarkable learning and insight through their in-depth trauma work. However, they also struggled with unemployment and housing insecurity along with health and legal issues during CCT, which added tremendous stress to their lives and

competed for their energy. Additionally, they had been having difficulty abstaining over the years due to ongoing life stressors. Shortly after they had begun the CCT sessions where they delved deep into their family of origin and past trauma experiences, the couple had a severe relapse. Caleb revealed that their relapse was triggered by the emotional straining therapy process in combination with their continual life crises,

> *The problem is we're making great stride and we are very honest, and we were making so much progress, but I think it was hurtful and emotionally draining, incredibly emotionally draining, because we've never had these conversations before. Cuz we didn't know …we were children going into the couple therapy, we were at the infantile state of learning. And it was very overwhelming, and life was hitting me left and right and center. And one of us broke down, then the other one joins in*.

After their relapse, Caleb and Claire chose to withdraw from CCT and resumed individual therapy and 12-step meetings.

Caleb and Claire's case brought up questions regarding the appropriate delivery of trauma work in CCT for couples at different levels of recovery. The concentrated trauma work delivery in Caleb and Claire's CCT sessions differed from the recommended CCT practice, where trauma exploration took place in a more gradual and iterative manner throughout the 12 sessions (Bastardo-Gaelzer, 2019). The five couples' experiences with the different counsellors suggested inconsistent inclusion of family of origin work and its timing and depth.

High level of commitment. When Caleb and Claire withdrew from CCT, they chose to return to TAU to "go back to the basics". Caleb stated,

> *We weren't mentally ready for couple therapy even though we got a pile of good information out of it… Cuz we're struggling with some stuff and we need to regroup and go back to the basics and meet with our counsellors, meet with my church and AA…Because we obviously needed to be in counselling. I need that support network.*

Caleb's account indicated his perception that the CCT he received was a more demanding therapy compared to individual counselling and AA meetings. As previously mentioned, Caleb

believed that his CCT counsellor delved into issues much deeper than his TAU, and he perceived the work in his CCT to be beneficial but "emotionally draining".

When Caleb and Claire withdrew from CCT, they were faced with escalating life crises, including unemployment and housing insecurity, which compromised their ability to engage in treatment. When asked about an ideal time to re-enter CCT, Caleb stressed the importance of stable employment and financial security. Only when he did not have to worry about his survival and achieved a sense of self-reliance, could he commit to the 12 sessions of CCT to work on his couple relationship and further his personal growth. He stated,

> *I'd like to go back and do [CCT] when I can commit to 12 weeks, and not going "Oh I have an interview here. I got to go to work" and be so sidetracked, and really focusing on it for 12 weeks, obviously have some sober time, and have some money in the bank, have some balance cuz I need balance…I need to be able to pay bills. I Need to have some self-reliance.*

A TAU client Joe expressed similar views with Caleb and believed that stability in addiction recovery and everyday life – the absence of imminent risk of relapses and life stressors that compete for one's mental energy for personal improvement – was necessary to properly engage in couple therapy in addiction treatment. He stated,

> *I think the individuals need to be stable in their recovery, and there's no specific timelines for that…just at the point where they are not at an imminent risk to relapse, where their life has returned to some level of stability. So that there's not a lot of other worries on a day to day basis that would impede them from doing work on themselves and on their relationship together.*

Joe did not believe that he was in a good place to begin couple therapy at the time of the interview, because of his busy schedule in the upcoming months with career transition and multiple life commitments. Although Joe had never participated in CCT, his assumption that couple therapy in addiction treatment would require a high level of commitment suggested that

he saw that conjoint couple work for relational and personal transformation could be by itself demanding, regardless of the therapy structure or the depth of work.

In sum, some couples saw that CCT required a greater level of commitment compared to TAU, possibly due to the nature of conjoint couple work and the specific content of the therapy. This need for commitment may pose as a deterrent for the participants with recurrent stressors and competing priorities in life.

Critical window of treatment. Although the TAU couple Irene and Ian were on the waitlist to enter CCT at the time of the interview, Irene expressed a sentiment that her relationship with Ian was beyond the point of repair. Irene believed that they should have begun couple therapy when they each had just completed individual-based counselling, at which point they had freshly gained individual growth, recognized the damage of their relationship, and emotionally opened up to each other for re-connection. Irene recalled,

> *As individual people, we were becoming more solid, and we both kind of could see maybe what we both needed from each other, or we could see the breakdown in a marriage happening, so we were ready…It could have been a really great time to go [to couple therapy].*

Even though the couple continued to grow as individuals as they went through more TAU, their relationship issues persisted and deteriorated. Irene spoke with disappointment that she and Ian might have missed their optimal point of entry to couple therapy. She had given up on seeking support and connection from Ian and felt emotionally detached from him. The couple had drifted apart. Irene stated,

> *Now we just have grown apart again…We are like roommates. If at that time we were kind of both open and raw and vulnerable, then we could have come together, we didn't. And now it's like we are okay both as individuals again, but we're still separate. Like I couldn't tell you what I need from him anymore, cuz I've just given up wanting to need anything from him.*

Irene's experience suggested that there could be a critical window of treatment for couple therapy in addiction treatment. When the relationship issues went on unresolved for too long, a couple's hope for reconnection worn off. They could grow complacent to detachment and lose the motivation to repair their relationship. The longer the wait, the greater the risk of relationship dissolution.

Logistic challenges with conjoint attendance. Some CCT couples described the logistic challenges of conjoint attendance with respect to time-off work, commute, and other practical issues. Alex and Ava had to attend CCT less frequently than they had hoped because they both worked, had young children at home, and lived in a rural area. Debra, whose husband was working on recovery from GD, spoke about the hidden cost of time off work and the time spent commuting to attend CCT at a downtown clinic in a large city. Debra stated,

> *When you were in this type of situation, you are already financially down a notch. To take time off work and maybe just that one hour and a half, but there's still your travel time, it's hard on some people.*

However, for Debra and Derek, their CCT counsellor was able to provide counselling in the evening hours to accommodate their need. To Debra, the evening hours was "a big bonus". The logistics of attending conjoint therapy for couples who both worked, had young children, or lived remotely from the treatment site could pose a practical challenge.

4.7 Summary

Twenty participants who had gone through CCT and TAU in the RCT (Lee et al., 2021) joined the current study. In one-on-one interviews, the participants spoke of their experience with CCT and TAU and their perception of the helpfulness and limitations of these programs. The TAU programs that the participants discussed also included regular programs that they

accessed outside the provincial clinics (e.g., private counselling practices) and prior to/after the RCT.

Based on the couples' account, TAU programs were helpful in facilitating individual changes and supporting the couples' efforts to improve their relationships. Both the clients and partners described finding social support in group therapy, acquiring new coping skills from various TAU programs, and addressing their trauma experiences in one-on-one counselling. Some of the clients were able to let go of their negative self-regard associated with addiction and build a new identity associated with change. The partners whose lives had been consumed by the clients' addiction were able to reclaim their sense of self. Through TAU, the couples learned new communication techniques and the attitude of acceptance in an effort to improve their relationships. TAU also inspired a couple's alliance in recovery, as the partner's decision to take responsibility for her own issues contributing to the couple's problems motivated the client to make a commitment to change.

Despite these benefits, TAU allowed limited opportunities for the partners' engagement in addiction treatment and lacked the capacity to help repair the couple relationships. The couples' relationship injuries caused by the addiction remained, and their communication difficulties persisted. As the clients achieved abstinence and self-growth, changes occurred in the couples' lives. The couples' difficulty adapting to the changes further strained their relationships. Couple therapy in the community failed to address the couple issues intertwined with addiction. Carrying guilt and shame for their addiction and unable to gain the support that they needed from the partners, some of the clients relapsed. With the help of TAU, some participants found support systems outside of their couple relationships, but their couple issues continued. As a result of their separate individual growth, the couples grew farther apart from each other.

On the other hand, CCT was able to enhance the couples' relationships as well as support their individual growth. Through CCT, the couples improved their communication, deepened their self-understanding and mutual empathy, and built a more cohesive couple relationship. The clients became more self-aware and ready to seek support through communication, which helped them to manage stress and prevent relapses. Their self-growth and improved communication also transferred to better ways of parenting. Further, the couples' behavioural changes through CCT were largely retained at the time of the interviews (0.5-13 months after their last CCT sessions). Thus, CCT showed promise to facilitate sustained changes through assisting individual and relational growth. The changes in a CCT client's parenting also suggested CCT's potential in preventing the harmful intergenerational impact of addiction, which merits future research.

Despite its benefits, the couples commented on the limited time in CCT to work in-depth on their individual issues related to addiction, indicating the service users' need for both couple therapy and individual-based programs. The inconsistent account among couples on the trauma and family of origin work in CCT implicated the counsellors' need for greater adherence to standard CCT protocol and more training in systems-based therapy (see Chapter 5. Discussion). Some couples suggested that CCT was more demanding for participant commitment compared to many TAU programs, which deterred these couples with competing life priorities from participating. A critical window of treatment for entering couple therapy in addiction treatment was also suggested, as a couple could grow detached from each other and lose the motivation to save their relationship over time. Finally, some couples pointed out the logistical challenges to attend conjoint therapy, particularly when they both were working.

In conclusion, although TAU was beneficial in supporting individual change, it was limited in assisting relationship recovery. It failed to address relapses due to relationship stress

and allowed further detachment between the couples as they made individual changes. CCT was able to provide the support that the couples were looking for to improve their communication and relationships. A cohesive relationship with congruent communication then could become a continuous resource for the couples' long-term recovery. Therefore, integrating CCT in TAU was necessary to address the service users' need for both individual and relational change.

Chapter 5. Discussion

In this chapter, first, a brief comparison between the current study and an existing study on similar topics is presented, pointing out the new knowledge from the current findings. Second, the service users' needs for couple therapy in addiction treatment based on the couples' perspectives on the benefits and limitations of Congruence Couple Therapy (CCT) and Treatment as Usual (TAU) will be discussed. How CCT may fill the service gap in our individual-based treatment system will be highlighted, particularly in addressing couple issues, engaging relational resources in addiction treatment, and promoting long-term recovery and intergenerational well-being. Third, selected benefits of CCT are discussed in further detail. Fourth, considerations of integrating CCT in the addiction treatment system will be presented, including the critical window of treatment, options to adapt CCT for agency uptake and various clientele, and training suggestions for CCT. Fifth, limitations of the methodology and the caveats in interpreting the findings will be addressed. Finally, the significance of the study and directions of future research will be discussed to conclude this chapter.

5.1 Comparison with Tremblay et al.'s Findings

As discussed in the literature review, Tremblay et al. (2018) was the only known existing study on service users' perspectives on couple therapy in addiction treatment. Compared with Tremblay et al's report on pathological gamblers' and partners' experiences with ICT-PG and individual-based treatment, the current findings have multiple parallels and noticeable differences on the couples' needs for and perceived benefits of couple therapy in addiction treatment. The overlaps regarding their service needs included the couples' need for assistance in having mutual communication and gaining insight in each other's experiences, the partners' need to understand the clients' change process, as well as the couples' belief that their addiction

problem was intertwined with their couple relationships. The common benefits of ICT-PG and CCT in the participants' experiences included facilitated communication and the mediation by a neutral person in the therapy process, the partners' better understanding of the clients' struggles, and the couples' togetherness in approaching the addiction problem.

The current study extended Tremblay et al.'s findings (2018) on the couples' need for couple therapy in addiction treatment, as it went in-depth to delineate the couples' unhealed relationship injuries in addiction recovery, their couple conflicts that emerged with the changes brought by the clients' addiction recovery, and their growing divergence with individual-based treatment only. Further, aspects of the perceived benefits of CCT differed from those of ICT-PG, which corresponded with their distinctive couple therapy models. In CCT, which was a systemic model, the couples deepened their mutual empathy and developed congruent self-other patterns in their relationships, and the couple relationship became the clients' natural resource in recovery through their improved communication and greater cohesion. In ICT-PG, a behavioural model, the partners learnt the behavioural skills to discourage cravings and addiction behaviours and prevent situations that led to relapse, and the couples were able to discuss the addiction problem beyond the therapy sessions. The partners became a proximal resource to support the clients' recovery. Therefore, the perceived benefits of the two models aligned with their respective theoretical orientations. Additionally, the current sample included couples seeking treatment for AUD and/or GD, while Tremblay et al's sample were exclusively GD couples. The current findings captured several couple struggles likely specific to the types of addiction. Couple issues such as those that arose after the clients' abstinence may be more distinctive among couples with AUD, while the distrust in the clients related to finances was particular to GD couples. On the other hand, the couple problems seemed to largely overlap regardless of GD or AUD.

The current findings added to the literature by depicting the couples' perspectives on a systemic couple therapy in addiction treatment versus individual-based treatment for both AUD and GD. The intersection between the current findings and Tremblay et al. (2018) indicated common themes of service users' needs for couple therapy in addiction treatment and suggested non-model-specific benefits of couple therapy in addiction treatment.

5.2 Service Users' Needs for Couple Therapy in Addiction Treatment

The couples' account indicated a clear need among the service users for couple therapy in addiction treatment to address couple issues and allow meaningful spousal engagement in treatment. The predicaments that the couples reported as they sought addiction treatment were similar to the existing literature, including relationship damage (e.g., Orford et al., 2010), communication issues (e.g., Lee, 2002; Tremblay et al., 2018), problematic family dynamics hindering changes beyond abstinence (e.g., Steinglass et al., 1987), and barriers to family engagement in individual-based addiction treatment (e.g., Selbekk, Adams, & Sagvaag, 2018). The couples' difficulty in finding addiction programs that allowed couple engagement or couple therapists with addiction expertise reflected a documented service gap in Alberta's addiction and mental health system for couple and family systems (Wild, Wolfe, Wang, & Ohinmaa, 2014).

(1) Healing couple relationship injuries. The couples' relationships suffered injuries, as the couples went through the stress and strain of the addiction. The partners had difficulty recovering from the hurt and betrayal, their anger and distrust persisted even after the clients achieved abstinence. The findings enriched the literature regarding spouses' emotional strain (Dickson-Swift, James, & Kippen, 2005; Harvey, Trudel, Poirier-Arbour, & Boyer, 2007; Hodgins, Shead, & Makarchuk, 2007; Lee, 2002), by depicting how distrust and resentment played out in couple interactions. The healing of their relationship injuries that the participants

experienced through CCT echoed prior findings in case studies of CCT (Lee, 2002; Bastardo-Gaelzer, 2019). Open expression of feelings and mutual understanding was the first step to build emotional intimacy and restore trust. Further, the trauma exploration in CCT also helped the couples gain deeper self-compassion and mutual empathy.

(2) Adapting to changes in the couple system during recovery. The couples experienced changes in their lifestyle and interactions as the clients worked towards addiction recovery, posing new challenges to their relationships. Some clients' abstinence and growing individuality elicited fear for disconnection in the partners. Family members sometimes react negatively when clients ceased substance use (Center for Substance Abuse Treatment, 2004). Feelings of alienation from one's spouse had triggered relapses in the present sample. Family relationship issues have long been reported as a precipitant to relapses of addiction (e.g., Britton, Haddad, & Derrick, 2019; Maisto, O'Farrell, McKay, Gonnors, & Pelcovits, 1988). Hence, couple cohesion is particularly important after the clients achieved control over their addiction behaviour (Lee, 2015) to sustain their recovery. In previous reports of CCT (Lee, 2009; Lee, 2015), less attention was afforded to how interventions were used to address the couples' emerging issues as they adapted to changes in their relationship during recovery. In the current couples' experience, developing congruence in their interactions – awareness and acknowledgement of the self and other – helped honour both the clients' and partners' dynamic needs for addiction management, individual growth, and relationship intimacy in their continual recovery as a couple unit.

(3) Conjoint intervention with in-vivo facilitation. The couples' difficulty in transferring their individual learning of communication from TAU to their couple interactions indicated a need for conjoint intervention to make symmetrical changes and transform old

patterns of communication. The TAU couples hoped for third-party in-vivo facilitation to interrupt problematic interactions and external reinforcement from a formal program to sustain changes. The potential pitfalls of utilizing individual-based therapy for couple problems have been discussed elsewhere (Gurman & Burton, 2014; Simon, 2008), which involved the lack of focus on interactions and the absence of change mechanisms intrinsic to a conjoint format. The theorized principles of change in interaction-based conjoint therapy included (1) interruption of maladaptive interactions, (2) cultivation of awareness of interactional patterns, and (3) improved mutual acceptance often facilitated by expression of deeper emotions (Gurman & Burton, 2014), which are confirmed in the CCT couples' experiences in the current findings. First, some couples were able to break off their constraining patterns such as avoidance and interjection with their CCT counsellors' real-time facilitation, which allowed new sequences of mindful listening and open sharing to develop. Second, with the counsellors' delineation, the couples became aware of the circular process of their conflicts and maladaptive patterns of their interactions. Third, the couples began to accept each other's suboptimal communication behaviours by learning their unexpressed feelings and became more compassionate towards each other by learning how their past traumatic experiences affected who they were today. It should be noted that in TAU some participants also learned to accept their significant others' unconstructive communication behaviours through empathy. However, this accepting attitude was quick to dissolve, due to a lack of reciprocity from the other member. The vulnerability of new behaviours against the couple system's homeostasis seemed to be a structural limitation of individual-based therapy for couple problems (Gurman & Burton, 2014).

Nurturing mutual acceptance was an essential ingredient of change in conjoint couple therapy. Emphasis on rule-governed behavioural training without cultivating deeper change of

attitude may fail to create sustainable outcomes in couple communication (Baucom, Baucom & Christensen, 2015). When comparing Traditional Behavioural Couple Therapy (TBCT; Jacobson & Margolin, 1979), which focused on explicit behavioural training, and Integrative Behavioural Couple Therapy (IBCT; Jacobson & Christensen, 1996), which focused on delineating a couple's emotional reactions and fostering mutual empathy and acceptance, Baucom and the colleagues (2015) found that TBCT produced more rapid yet short-lived changes in dyadic communication compared to IBCT. While the couples' dyadic communication regressed after TBCT, it continued to improve in the two-year follow-up period after IBCT. CCT shares features with IBCT in that CCT also aims to nurture a couple's empathy and acceptance with each other, by deepening mutual understanding. It is reasonable to speculate that CCT is likely to create more sustainable changes in couple communication than traditional behavioural models.

(4) Allowing spousal engagement in addiction treatment. TAU permitted few avenues for partners to engage in the clients' treatment. All the partners expressed a desire to support the clients in their effort to change. A family member's supportive attitude indeed has a positive impact on an IP's recovery (Fichter et al., 1997; Petry & Weiss, 2009). However, beyond social support, the partners could provide more active assistance to the clients' recovery by being involved in their addiction treatment. Some studies reported that conjoint programs had higher retention (Stanton & Shadish, 1997) and better attendance (Trembley et al., 2018). Further, the participants in this study offered another perspective regarding the potential utility of conjoint attendance to addiction treatment. A partner's views of the client's conditions and effort to change could provide checks and balances to the client's perception, which will allow a more rounded report to the clinician for effective intervention and help keep the client accountable in their treatment effort.

(5) Supporting recovery in natural habitat. The notion of "recovering in natural habitat" emerged during the discussion with the service-user advisors on the findings. The advisors brought up the idea of "realistic recovery", referring to when a person makes changes in their natural context (within their family and community). As an advisor held, "*Good therapy means you not only learn skills from it but incorporate these skills in your everyday life.*" Therapy that is readily integrated in everyday life can promote noticeable and sustainable changes. The advisors compared the traditional model of residential treatment with couple therapy in addiction treatment. They believed that because residential treatment created an artificial environment detached from the clients' real life, the clients would often fail to learn "realistic skills" to manage recovery. Once the clients returned to their actual habitat, they would not be able to apply the skills learned from an unnatural setting. This downfall of residential treatment was confirmed in a client's experience in this study, who did well during inpatient treatment but relapsed after returning home, because living with her husband amplified her guilt and shame for her addiction. The fragmentation of services between inpatient to outpatient treatment has been a well-recognized issue in our mental healthcare system (e.g., Brunette, Mueser, & Drake, 2004).

The advisors also suggested that learning to prioritize one's natural support could be crucial in a person's long-term recovery, and couple therapy could help the client to learn the skills to utilize these natural resources from family and social relationships. Although outpatient programs, peer support groups, and housing services could all serve important functions to support integrated recovery, couple and family therapy specifically addresses recovery in one's primary social system. The uptake of programs to support recovery in one's local habitat may have important implications in further transforming the mental health system.

Despite the benefits of CCT that could complement the limitations of TAU in supporting a couple's change as a unit, some clients believed that CCT lacked the capacity to meet their individual counselling needs. These clients alluded that their individual counselling allowed more focus to work through specific issues related to addiction recovery. Accounting for both the benefits and limitations of CCT and TAU, integration of both individual-based and conjoint services would be a sound approach to satisfy the multitude of service users' needs in their long-term recovery. In the following sections, several benefits of CCT will be further discussed, and ways to integrate CCT and TAU will be touched upon.

5.3 Engaging the Client and Partner as a Couple System

In CCT, the clients and partners were engaged as a couple system with a shared responsibility to change. In contrast, the more widely researched BCT programs (McCrady & Esptein, 2008; O'Farrell & Fals-Stewart, 2006) treat the clients and partners as individuals with differential roles in addiction recovery. The partners are enlisted as helpers who learn behavioural skills to provide support in the client's behaviour change (McCrady & Epstein, 2008) or act as a reinforcer to the client's effort to change (O'Farrell & Fals-Stewart, 2006). The persons with the responsibility to change are still the clients. It could be argued that regardless of its individual or systems paradigm, a conjoint format of therapy helps a couple develop a greater sense of togetherness. Through ICT-PG (Tremblay et al., 2018), the participants were able to approach the addiction problem together as a couple. It may be the sense of togetherness (rather than the specific role that the client and partner play) that acts as a key ingredient to change in couple therapy in addiction treatment. In a BCT study (Hallgren & McCrady, 2016), the IPs' and significant others' greater use of "we" language during therapy sessions was found to predict

greater improvement in abstinent days during treatment and over the 6-month follow-up respectively.

Evidence suggested that BCT first improved couple relationships, which then led to reduced substance use (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004; Powers et al., 2008). However, the current findings suggested a different change mechanism specific to a systems approach. Engaging the client and partner as a couple system paradoxically helped the couple to develop greater awareness of their individual responsibilities to change, and their individual changes triggered reciprocal growth in the couple system with positive feedback loops between the client and partner. As the CCT couples were guided to pay attention to and acknowledge the self and the other in their couple system, they developed greater self-differentiation and were able to see their individual responsibilities in their shared issues instead of resorting to blaming and polarizing. One person's effort to make personal changes encouraged the other to change, while strengthening their sense of togetherness. Such a mutual feedback loop formed a propelling force in the couple system towards continuous growth and deeper connection. Further research is warranted to examine the possibly circular and recursive process of change in systemic couple therapy in addiction treatment.

5.4 Bolstering Relational Resilience in Conjoint Recovery

The resilience that the couples gained through a healthier couple relationship may find its theoretical footing from the construct of *family resilience* (Walsh, 2003). Family resilience consisted of three main aspects – a belief system that upholds hope and meaning, healthy patterns of family organization, and open and effective communication. The couples' description of their changes through CCT reflected these three aspects. First, through counsellor facilitation and homework practices, the couples were able to develop open and constructive ways of

communication. Second, in building congruence communication, the couples formed healthier self-differentiation while learning to acknowledge each other, which allowed for more balanced and reciprocal organizational patterns in the couple systems. Third, through linking their past traumatic experiences to their current personal struggles and viewing their adversities through a humanistic lens, the couples were able to find meaning and hope in personal tragedies and reclaim the power of choice moving forward. Compared to other well-known couple therapy models, which tend to focus on either communication skill training (such as Behavioural Couple Therapy; O'Farrell & Fals-Stewart, 2006) or family organizational structure changes (such as Minuchin's Structural Family Therapy; Minuchin, 1974), CCT brings in another level of change – universal-spiritual. Its humanistic-existential philosophies allow a couple to tap into their spiritual resources and nurtures resilience at a deeper level.

5.5 Addressing Trauma in a Relational Framework

Family of origin trauma and ACEs were a salient theme among the participants' therapy experiences in both CCT and TAU. ACEs are prevalent among individuals with substance use (Khoury, Tang, Bradley, Cubells, & Ressler, 2020) and regarded as an underlying issue of addiction (Lee, 2002, 2009). CCT differed from TAU in its trauma work, as it approached trauma in a relational framework. In CCT, the clients' and partners' traumatic experiences from their families of origin and past relationships were explored to draw insight into their current relational patterns. While both CCT and TAU participants described gaining a deeper self-understanding and greater self-worth as a result of the respective trauma work, CCT couples highlighted deepened empathy with each other's unconstructive patterns in their relationships by understanding their past relational trauma. As a service-user advisor suggested, intergenerational trauma could be at the root of a person's interpersonal triggers, and couple therapy creates

"convenient windows" to address these intergenerational issues within the context of the couple relationship.

Healing the past through the present. In CCT, developing insights into the past traumatic experiences and making changes in current behaviours took place simultaneously. The changes in the present towards authentic self-representation and congruent self-other interactions bolstered the couples' self-esteem and improved their confidence to further strive for self-fulfillment. In trauma recovery, making positive changes in the present situation helps a person reauthor the meanings of their past traumatic experiences and rewrite one's identity (Herman, 1992). It was likely that as CCT concomitantly fostered the couples' understanding of their traumatic experiences and facilitated their changes in the here and now, the couples' healing and transformation deepened. As simply put by a service-user advisor, "*CCT combined insight with practical skills [to promote change]*."

Existential growth. The humanistic-existential perspectives in CCT were instrumental for the participants' individual healing. The couples were guided to recognize their inner spirit through the adversities that they had gone through. They began to re-author their lives through the lens of resilience and self-compassion. The desire to be true to oneself and to live fully was a driving force for some participants to stay abstinent and continue making changes in their lives. They were able to be reconnected with their inner agency to make choices towards self-realization, despite the limitations of life. Spirituality (Elkins 2015; Maslow, 1968; Satir, 1988), self-actualization (Rogers, 1961), positive regard (towards oneself; Rogers & Stevens, 1967), and choice-making (Frankl, 1953; May, 1981) are key concepts in humanistic-existential philosophies. Further, it is theorized that post-traumatic growth involved spiritual growth and

improved perception of personal strength (Jayawickreme & Blackie, 2014), which is supported by the current findings.

Healing relationship injuries. Through exploring the clients' adverse experiences in their families of origin and past relationships, the partners gained insight into the clients' maladaptive communicational patterns and underlying afflictions in the context of trauma. The link between traumatic life events and addiction is well documented (e.g., Anda et al., 2002; Farley, Golding, Young, Mulligan, & Minkoff, 2004; Fetzner, McMillan, Sareen, & Asmundson, 2011; Schilling, Aseltine, Robert, & Gore, 2007). Similarly, the clients also gained compassion for the partners' personal difficulties by understanding their past adversities. The current findings aligned with the existing CCT findings that when the couples gained insight into each other's past trauma, they came to grasp each other's disowned pains and repressed yearnings, which were underlying issues of the addiction and constrained communication (Bastardo-Gaelzer, 2019; Lee, 2002; Lee, 2014).

Evidence suggested that ACEs were prevalent among the spouses of addiction clients (Lee, 2002; Kogan & Jackson, 1965; Lee & Awosoga, 2015). Some partners in this study spoke of abandonment, betrayal, and substance use in their families of origin and past couple relationships. Upon discovering the clients' addiction, some had feelings of déjà vu, as if life had "screwed [them] over" again. These partners' trauma reactions towards the clients' addiction may involve a re-activation of their deeper psychological wounds stemming from past trauma, as reported in an earlier analysis of CCT (Lee, 2014). It was reported that a partner's difficulty acknowledging their deeper emotional trauma would keep the person from finding forgiveness and reconciliation to recover from relationship injuries (Zuccarini, Johnson, Dalgleish, & Makinen, 2013). In CCT, the partners were able to explore their individual trauma history and

gain an awareness of their deeper wounds from the past. Permitting oneself to mourn over the losses helps a person lessen their psychological grip over the past trauma (Herman, 1992). By exploring their past trauma, the partners were able to begin healing and decouple their past wounds from the current crises in their relationships.

Couple therapy often focuses on working with relational injuries within the context of the current couple relationship only (Makinen & Johnson, 2006; Zuccarini et al, 2013). Given the intergenerational cycle of trauma and addiction (Black, 2018; McComb, Lee, & Sprenkle, 2009) and the link between relationship patterns in the family of origin and adult relationships (Conger, Cui, Bryant, & Elder, 2000; Dinero, Conger, Shaver, Widaman, & Larsen-Rife, 2008), couple therapy in addiction treatment could benefit from expanding the trauma work from the present couple relationship to the trauma from previous relationships and the family of origin, as in CCT.

5.6 Fostering Individual Growth through System-Level Changes

As the couples made changes at the system level, they were also growing as individuals. By learning to congruently represent their inner experiences in outer expressions, the participants strengthened self-connection and mitigated experiential avoidance. By building the awareness of both the self and the other and learning to acknowledge them in communication, the participants developed a healthier level of self-differentiation, which was associated with improved emotional regulation. Studies that analyzed the change mechanisms in couple therapy for addiction treatment (McCrady, Hayaki, Epstein, & Hirsch, 2002; O'Farrell et al., 2004; Powers et al., 2008) have only investigated the possible linear relationships from improved couple functioning to targeted individual outcomes (e.g., addiction behaviours). In the present study, the couples' account demonstrated that the couple-level changes and individual-level changes seem to take place simultaneously in a mutually reinforcing manner.

From experiential avoidance to self-connection. Prior to CCT, many clients reported avoidant communication postures in their couple relationships. They tended to withdraw from interactions when under stress, sweep their problems under the rug, and bottle up difficult feelings. In CCT's typology of communication postures (Lee, 2017), avoidance is considered the most distressed posture, as the individual is disconnected from the self (i.e., inner experiences), the other, and the context. The clients disclosed their difficulty in assimilating how they felt. Individuals with a tendency to inhibit authentic emotional expressions often lack attention to, awareness of, and clarity in their emotions (Gross & John, 2003). The clients' lack of connection to their feelings can be related to experiential avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). It is a phenomenon where an individual is unwilling to stay in contact with certain private experiences (e.g., bodily sensations, emotions, and thoughts) and seeks to alter these inner events or the context that occasion them. Literature has long been indicating experiential avoidance in the etiology of addiction (e.g., Baker, Piper, McCarthy, Majeskie, & Fiore, 2004; Kingston, Clarke, & Remington, 2010). Substance abuse is prevalent among individuals with affective and anxiety disorders (e.g., Mirin, Weiss, & Michael, 1987) and those with traumatic histories (Druley, Baker, & Pashko, 1987), who are more likely to experience negative emotions.

The couples' experience in CCT confirmed that, through developing congruent communication where they learned to align their outer expression of self with their inner experiences, the couples became more connected with their own feelings and self-assured with their inner needs. This seemed to demonstrate that improved self-representation at an interpersonal level could improve self-acceptance and ameliorate experiential avoidance at an individual level, illustrating the interconnectivity of the individual and relational systems. As

experiential avoidance is considered an underlying phenomenon across various psychopathologies, it is worthwhile to further investigate the potential of using relational interventions to alleviate experiential avoidance.

Renegotiating boundaries. As the clients worked towards recovery, the couples faced changes in their relationships and experienced increasing dissonance between them. They encountered challenges in negotiating boundaries in their relationship that could both support individual changes and preserve couple connection. According to Minuchin's Structural Family Therapy (1974), when the boundaries in a relationship are too loose, the individuals would become emotionally and psychologically enmeshed, dampening their individual identity; when the boundaries are too rigid, the individuals became disengaged and disconnected from each other. A healthy balance between independence and connection in the relationship calls for an appropriate level of self-differentiation (Bowen, 1978). Sufficient self-differentiation has been found to be associated with high marital adjustment (e.g., Bartle-Haring, Rosen, & Stith, 2002; Miller, Anderson, & Keala, 2004). Congruence in CCT strives for a balance between the self, other, and context (Lee, 2015). Through CCT, the couples learned to view themselves as individuals and as part of a relational system. With awareness and acknowledgement of each other and their context (e.g., history of trauma and recent stressors), the couples developed a healthy level of self-other differentiation and were able to develop boundaries that balanced autonomy and togetherness in their relationships.

Improved emotion regulation. A healthy level of self-differentiation is not only synonymous with having balanced self-other boundaries but indicative of good psychosocial adaptation (Bowen, 1978; Kerr & Bowen, 1988). When having blurred interpersonal boundaries, a person tends to be easily influenced by others' emotions around them or drag others into their

own emotional turbulence (Gelzo & Fretz, 2008). Sufficiently differentiated individuals are considered to function better under stress and to be less prone to the deleterious effect of stress than poorly differentiated individuals (Kerr & Bowen, 1988). The CCT couples' experiences in this study showed enhanced self-differentiation went hand in hand with better emotional regulation and stress response. The CCT couples learned that others' behaviours did not dictate their mood and that it was they themselves who held the power to control their emotions. Their improved self-regulation in turn helped to reduce interpersonal conflicts and facilitate self-other alignment in their couple relationships.

These current findings affirmed the interconnectivity of the relational system and the individual systems, where interventions at an interpersonal level also affect the changes at an individual level. Further, there might be specific benefits of using systemic interventions to achieve individual changes compared to using individual-based therapy, as individual learning and change are augmented with interactional practice. Future research may be of interest in comparing the effectiveness of systemic therapy versus individual-based therapy in accomplishing specific goals of individual growth and emotion regulation.

5.7 Potential in Preventing Intergenerational Impact of Addiction

Improved couple relationships and sustained addiction recovery gave the couples hope to stop the harm of addiction from passing down to the next generation. A couple reported their growth and recovery spilled over to enhanced parenting. A secondary but significant goal of family and couple therapy is to interrupt the intergenerational transmission of addiction-related dysfunctions (Center for Substance Abuse Treatment, 2004). Substance abuse in a parent is the most salient risk factor in maladaptation and substance abuse in the offspring (Johnson & Leff, 1999). Research on Behavioural Couple Therapy (BCT) indicated that couple therapy in

substance abuse treatment was more beneficial than individual treatment in protecting the psychosocial functioning of the children, likely due to its superior effect on the clients' couple adjustment and addiction outcomes (Kelley & Fals-Stewart, 2002). The current findings suggest CCT's potential in preventing the intergenerational impact of addiction by promoting the couples' individual healing and improving their communication, which would in turn enhance their interactions with their children. However, this current sample only contained one couple with underaged children. Further investigation is warranted on the effect of CCT on parent-children relationships and the children's psychosocial well-being.

5.8 Critical Window of Treatment

Some participants contended that there was a critical window of treatment for couple therapy in addiction treatment. The couple's hope and motivation to repair their relationship may wear off over time, if no effective intervention is available. The literature on couple therapy in addiction treatment has discussed the point of treatment entry (Centre for Substance Abuse Treatment, 2004) but not the window of treatment. However, couples often do not seek couple therapy until years after serious problems develop (Gottman & Gottman, 1999), and it is common for a couple entering couple therapy to wonder whether it is too late. The window of treatment implies a finite expiration point of a couple's ability to repair and salvage their relationship, stressing the urgency of treatment entry. To prevent unnecessary delay of service, improving the accessibility of couple therapy in addiction treatment is the first step.

5.9 Adapting Congruence Couple Therapy

The findings showed that CCT was perceived by some clients to be more demanding of participant commitment than TAU programs, which could discourage the couples with multiple life stressors and competing priorities from participating. Within the RCT, there was a need to

complete the 12 sessions of CCT within a reasonable time frame, typically 3-8 months, which resulted in less flexible scheduling in CCT compared to common TAU programs. Further, as a structured program with a specified number of sessions, CCT can be more intensive than the therapy/self-help programs with no pre-determined length and/or attendance requirement.

Populations affected by addiction often struggle with financial, employment, medical, and legal issues (French, Rachal, & Hubbard, 1991) that could destabilize their day-to-day living. Adapting CCT into a scaled-down program may lower the barrier of entry and improve retention. A brief version of CCT is worth considering, as greater cost-effectiveness was found comparing an abbreviated BCT compared to regular BCT (Fals-Stewart et al., 2005). A group CCT can also reduce its demand for commitment and fit in with the common format of addiction treatment. However, a previous study showed that a group format of BCT with rolling admission resulted in worse addiction and relationship outcomes than standard BCT in the follow-up period (O'Farrell, Schumm, Dunlap, Murphy, & Muchowski, 2016). More research is needed to determine whether scaling down CCT would compromise its effectiveness and what may be the optimal way to adapt CCT while preserving its core ingredients of change.

It should be noted that the fact that some couples perceived CCT to be a relatively demanding program does not mean that CCT or other couple therapy in addiction treatment needs to be considered a “second-stage” treatment that requires extensive individual work beforehand. The CCT couples’ account in this study showed that individual change could take place simultaneously with relational growth. Tremblay et al’s (2018) found that some clients and partners preferred to have individual therapy before couple therapy in addiction treatment, while the current findings presented an important consideration of the critical window of couple therapy to prevent further deterioration of the couple relationship.

5.10 Training considerations for Congruence Couple Therapy

The CCT couples' inconsistent description of their program content regarding relational trauma work suggested issues of adherence among their newly trained CCT counsellors. The family of origin and relational trauma work, which was an integral element of CCT, was not introduced to two out of the five couples in their CCT programs. In a couple who were guided to explore their past relational trauma, better titration of the trauma work seemed to be needed. Considering CCT's integrative systemic framework and fluid approach, training and adherence is crucial. The following discussion offers some thoughts on CCT training for addiction counsellors unfamiliar with this model.

First, as an integrative therapy, CCT draws from five different psychotherapy traditions and works with all four dimensions of human experiences. Depending on the individual counsellors' prior training, they may be more closely affiliated with one school of psychotherapy over the other and anchor themselves to certain dimensions of CCT. In fact, in a previous study on a CCT training program with 21 gambling addiction counsellors, Lee and her colleagues (2008) reported that the counsellors did not show "a wholesale adoption" of the CCT framework (p. 108) but incorporated parts of CCT into their existing approaches. However, once a strong base is established in one area, a CCT trainee should gradually expand their practice to the rest of the theoretical framework and dimensions of CCT. Importantly, CCT is a theory-based approach, and its interventions are grounded in its philosophical foundation rather than a collection of techniques. It is important for any counsellor practicing CCT to develop an in-depth understanding of its philosophical pillars, while having a solid foundation of the basic skills in systemic interventions.

On the other hand, counselling approaches in systemic therapy require more structuring, directiveness, and behavioural interventions compared to individual therapy (Doherty, 2002; Lawrence, 2012). There remains an ostensible gap in counsellors' training that most counselling programs do not include courses on systemic interventions.

Further, among CCT interventions, exploring the family of origin and past relational trauma to draw linkage from the past to present could be challenging to addiction counsellors unfamiliar with systemic therapy. In a comparative case study on the process of change in CCT (Bastardo-Gaelzer, 2019), trauma work was found to unfold in progressive iterations through different stages of CCT. Gradual and incremental trauma exploration in accordance with the level of the therapeutic alliance and the couples' needs should be stressed in CCT training to ensure couples' emotional safety, particularly for those in early recovery with a high risk of relapse. Restoring a sense of safety and stability in life should be considered the foundation of trauma recovery (Herman, 1992). Referrals to trauma-specific individual therapy can be an adjunct for complex trauma issues to supplement CCT's work within the couple context.

5.11 Lessons Learnt from Service-User Engagement

Service-user engagement in this study had its limitations. First, some service-user advisors did not appear invested in the study, possibly due to the later stage of their engagement in the research process and their consultative role. Second, no evaluation was carried out to verify the theorized benefits of the service-user engagement. The learnings from the service-user engagement in this study could inform future projects for meaningful and effective service-user engagement.

First, several service users did not appear highly invested in this research. The drop-out rate of 25% among the advisors was substantial. The difficulty in scheduling advisory meetings

due to the advisors' lack of availability implied that participating in the study was not the advisors' priority compared to their other commitments and activities. There was also minimal communication initiated by the advisors throughout their engagement in the research. The main reasons for the advisors' moderate engagement may include the relatively late point of their engagement in the research process and their consultative role, which lacked leadership and limited the room for active participation. If the advisors were engaged at the beginning of the process, including steering the agenda and deciding the research focus, the advisors could have felt a greater sense of authorship and been more invested in the research. In their review of studies with patient and service user engagement, Shippee and colleagues (2013) found that it was important to begin engagement as early as possible in the research process so that the service users could provide "a values context" (p.1155) and steer the agendas and outcomes. Shippee et al. (2013) also emphasized creating the potential for participation to ensure meaningful service-user engagement, while in the current study, the scale of service-user participation was more or less confined within the tasks of the interview protocol and findings review. Further, some advisors' lack of previous knowledge on couple therapy in addiction treatment could have also discouraged them from further contributing to the research process.

For future initiatives of service-user engagement, it will be crucial to engage the service-users earlier on in the research process, promote the possibility of equal participation between the researchers and the service-users, and encourage authorship and leadership of the service-users throughout the study (Domecq et al., 2014; Shippee et al., 2013). Support may need to be provided to the service users for them to gain greater subject knowledge to optimize their engagement (Tran & Leese, 2006).

Second, although the service-user advisors in this study provided valuable input on the research, evaluation is yet to be carried out to verify the theorized benefits of their engagement such as the enhanced credibility (Cashman et al., 2008) and service-user relevancy (Cotterell, 2008) of the findings or empowerment of the service users (Tran & Leese, 2016). There is a paucity of formal and rigorous evaluation research on service-user engagement (Bombak & Hanson, 2017). Esmail and colleagues (2015) outlined procedures to evaluate the outcomes of service-user engagement in research. Ideas and methods from Esmail et al. (2015) could be employed to guide future evaluation of the service-user engagement in the current study.

5.12 Limitations and Caveats

The present study explored the couples' perspectives on the benefits and limitations of CCT and TAU in individual and couple recovery from addiction. Limitations of the methodology and caveats in interpreting the findings are discussed in the following.

Limitations of methodology. The limitations of the research methodology are related to the sampling and lack of member checking. With respect to sampling, first, because the couples joined the primary study (RCT, Lee et al., 2021) to seek couple therapy in addiction treatment, it could be assumed that the current sample held biases in favour of conjoint therapy. This self-selection bias would influence the participants' perspectives of the benefits and limitations of CCT compared to TAU. The same bias applied to the service-user advisors and this researcher, who were interested in services for couples and families to begin with. To reduce the researcher's biases in the process, I continuously exercised reflexivity in the study, from clarifying entering assumptions, clarifying the analysis process, to staying close to the data in conclusions. Second, the particular sample in this study is not representative of the entire population of potential treatment seekers for couple therapy in substance use and gambling

addiction. For example, due to attrition in the RCT, the current sample who almost all completed their assigned treatment were likely to have more positive treatment experience than the participants who dropped out. Due to the small sample size, caution is needed in assessing the applicability and transferability of the findings to other client populations and treatment settings.

Due to time constraints, *member checking* (Lincoln & Guba, 1985) was not officially conducted. The participants were not asked to verify my emerging theories or inferences of their account after the interview ended. However, informal member checking was conducted throughout the interview, when I verbally reflected on what the participant had said before asking follow-up questions or transitioning into the next question. At the end of the interview, I often debriefed with the participant by giving a brief summary of the interview and invited the participant to add what they might have missed and give comments.

Caveats in interpretation. First, it should be reiterated that the goal of the study was not to compare CCT and TAU to decide which treatment was superior. It was to investigate the service users' experiences with CCT and individual-based regular addiction programs and their perception of the beneficial and limiting aspects between them. Second, the reporting of the benefits and limitations of the participants was not based on consensus but saliency. Because the degree of adherence to the CCT model differed among the three CCT counsellors, the couples' accounts of what their CCT entailed were not uniform. Similarly, the participants' experiences with TAU reflected the varying quality of services among different organizations and practitioners.

Third, it was challenging for the couples to parse out their values on different aspects of the treatment programs from their lived experiences with addiction, couple relationship, and change. This makes sense, as an individual's responsiveness to and assessment of treatment

interventions is often organic, involving their readiness to change and complex personal processes in their life contexts. The participants tended to speak of their therapy in terms of their experiences with their therapists (or peers in group therapy) rather than the content of the programs. It was possible the participants' perceptions of their treatment were largely influenced by the therapeutic alliance and their preferences of the therapist's characteristics, styles, and approaches, instead of the program content. Further, it was also possible that the participants' evaluation of the programs that they had attended was skewed by how successful they felt in recovery at the time of the interview. The tension between honouring the participants' lived experiences with treatment and separating out their values regarding the treatment to inform service uptake should be noted for future patient-oriented research.

Finally, the current study focuses on the service users' perspectives to bring out a lesser heard voice of the stakeholders in addiction research and services. The hope was to help level the playing field so that our knowledge of the perspectives of service users, service providers, and researchers can be triangulated in making decisions on service improvement. There is evidence suggesting that client and clinicians' perspectives can differ on what affects treatment retention (Palmer, Murphy, Piselli, & Ball, 2009). While the clients attributed retention largely to social support, the clinicians focused more on individual-related factors of the clients. As consumers' buy-in is important in service uptake, triangulating the service users' perspectives with empirical findings and service providers' views can help inform service advancement.

5.13 Significance of the Study

The present study is one of the few studies that looked into service users' perspectives on couple therapy and individual-based treatment for substance use and gambling disorder. Unlike existing studies that explored participants' feedback of family-engaged treatment programs

(Kourgiantakis, et al., 2018; Orford et al., 2007; Tremblay et al., 2018), the current study did not limit its exploration to the couples' opinions of the programs. It took a phenomenologically informed approach that delved into the couples' lived experiences of predicaments and changes in their joint pursuit of recovery. On the other hand, the examination of the couples' perception of treatment services was challenged by the participants' difficulty in separating their lived experiences from their values and preferences of aspects of treatment programs. This tension between honouring service users' lived experiences and the goal of informing service advancement may serve as a lesson for future patient-oriented research.

In discussing the benefits and limitations of the CCT and TAU, the present study delineated the specific relationship issues that the couples faced that motivated them to seek couple therapy. In this way, the study sheds light on the service users' needs for conjoint services which individual-based TAU programs have failed to meet. Further, the couples' accounts of CCT demonstrated that CCT held the potential to facilitate long-term addiction recovery, by helping resolve the couple issues that heightened the risk of relapse and mobilizing their natural resources within the couple systems to support their ongoing recovery and growth. Meanwhile, some couples perceived CCT to be more demanding of participant commitment than TAU, which could pose as a deterrent to couples with complex stressors in life. Timeliness of entry was also essential, as the couples suggested a critical window of couple therapy before their relationship further deteriorated beyond repair. Therefore, making couple therapy in addiction treatment available and accessible is crucial for those needing relationship interventions while working towards addiction recovery.

Wider implementation of conjoint couple services calls for a paradigm shift in the addiction and mental healthcare system from focusing on individual changes to building healthy

couples and leveraging relational resources. A shift from a "particle" paradigm (individual-focused) to a "system" paradigm (relational system-focused) in our addiction treatment system accords with the literature that advocates for wholistic solutions to achieve sustained outcomes (Adam, 2008; Selbekk, Sagvaag, & Fausk, 2015). Utilizing service users' relational resources may not only empower the service users but also prevent the cost of service users' revolving access to the addiction treatment services.

Further, this study utilized an emerging method in mental health research of service-user engagement (Ennis & Wykes, 2013) to enhance the reliability and service-user applicability of the findings. It is hoped that the service-user engagement in this study could contribute to the advocacy for greater service-user involvement in steering mental health research towards service-user priorities and the empowerment of the service users to play a more active role in mental health research.

5.14 Implications and Future Research

The couples' account in the present study articulated the reasons for service users' need for conjoint couple therapy in addiction treatment. The cost-effectiveness of incorporating an integrated couple therapy model such as CCT should be investigated in terms of its long-term individual and relationship outcomes. To accommodate agency capacities and meet specific clientele needs, abbreviated CCT and scaled-down CCT are developments worthy of future research.

The current findings suggested CCT's secondary benefit for the children's well-being. Further inquiry on the effect of CCT on parent-child relationships and children's psychosocial outcomes will be of importance. Incorporating systemic therapy has important implications for

preventing child maltreatment and other domestic issues among addiction families and interrupting the intergenerational cycle of trauma and addiction.

A unique element of CCT is its intergenerational dimension compared to other couple therapy models for addiction treatment. Linking the family of origin and past relationship trauma to current individual and interpersonal issues can be highly beneficial, as it is likely that couples experience healing from their past wounds and present relationship injuries in a mutually reinforcing manner. Further research on using a systems framework for trauma work within a couple unit as in CCT should be pursued.

The findings also suggested that preparation in systemic couple therapy in counsellor training programs for working with addiction is much needed. Broadening the training of counsellors to include systemic couple therapy will maximally benefit addiction clients and their families.

Lastly, the lessons learnt from service-user engagement in this study stressed the importance of engaging service users early in the research process, such as in setting agendas and research focus. Evaluation to verify the expected benefits and intended outcomes of service-user engagement is recommended.

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Appendix A: Recruitment Letter for Service-User Advisors

University of Alberta Ethics ID Pro00077938

Dear _____,

You are invited to become **an advisor** in a research study, titled ***Exploring Couples' Need for Couple Therapy in Addiction Treatment— A Qualitative Study with End-User[1] Engagement***.

My name is Yanjun Shi. I am a graduate student at the University of Lethbridge. I am conducting this current study as a master's thesis towards a Master of Education degree in Counselling Psychology.

In this study, I am planning to collaborate with 6-8 advisors who will give input on the study design and feedback to the findings. Specifically, advisors' input is needed to design an interview guideline used in this study to interview the research participants, who have completed couple therapy or treatment as usual for alcohol/gambling addiction.

The end-user advisors I am looking for are adults (18 years or older) **(1) having accessed Alberta's addiction treatment services in the past 10 years, or having a family member (e.g., spouse, child, parent, and sibling) who have accessed Alberta's addiction services in the past 10 years, and (2) having experience or interest in couple therapy to assist addiction recovery in their family.**

The advisors will be asked to meet with me 3 times (via teleconference) throughout the study (Apr-Oct 2018). To thank you for your time and valuable input, you will receive a $60 gift card.

If you are interested in research on couple therapy for addiction, if you would like to help improve Alberta's addiction treatment services, or if you want to help raise end users' voices in addiction research and services, becoming an advisor in this study will be a fitting opportunity for you.

If you would like more information, please contact me at:

Office: 1-(403) 329-2049
Cell: 1-(403) 892-8287
Email: yanjun.shi@uleth.ca

With appreciation,
Yanjun Shi

[1] Please note that the term *end user* and its related terms *(end-user engagement, end-user advisors, etc.)* were used at the beginning of the thesis, and *end user* has been replaced by *service-user* in the writer-up of the thesis.

Appendix B: Recruitment Poster for Service-User Advisors

University of Lethbridge
Faculty of Education

University of Alberta ID Pro00077938

ADVISORS

for a research study on
COUPLE THERAPY
in addiction treatment

Study title: *Exploring Couples' Need for Couple Therapy in Addiction Treatment— A Qualitative Study with End-User Engagement*

- Are you in recovery from addiction?
- Is your partner or a family member in addiction recovery?
- Have you tried or are you interested in couple therapy in addiction recovery?

Your input is needed for the interview design & findings of the study.

To find out more: Yanjun Shi
403-892-8287, yanjun.shi@uleth.ca

$60 gift card as honorarium

Advisors will take part in 3 teleconferences over the course of 6 months.

1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca | 1-(403) 892-8287 yanjun.shi@uleth.ca

Appendix C: Initial Greeting and Screening Protocol for Service-User Advisors

Hello, my name is Yanjun Shi. I am conducting the current study as a thesis project to pursue a degree in Master of Education, Counselling Psychology, at the University of Lethbridge.
In this study, I will interview couples who have undergone couple therapy or treatment as usual in a study on couple therapy in addiction treatment to learn about their experience and perspectives towards the treatment services they received.
Your advisory input from an end-user standpoint, as you engage in the research as end-user advisors, will help me (1) to develop interview questions that are more applicable to the clients' reality and (2) to frame the findings with a better understanding of the end users' priorities.
Thank you for your interest in becoming an advisor for this study. Is this a convenient time to talk?
This study has a set of criteria for people who would like to be an end-user advisor in the research process. I would like to ask you a few questions to see whether you have the experience that this study is looking for in an advisor. This will take about 5 minutes.
These are personal questions. You might want to answer them in private and a place where you feel comfortable.
All of your answers will be confidential, unless there is a threat of harm to yourself or others, suspected abuse to a child or another vulnerable person, or if the records are required by law.
If it is determined that you will be eligible for the study, your answers may be used anonymously as part of the data in the study. If it is determined otherwise, your answers will be destroyed to protect your confidentiality. Responding to the questions implies that you consent to take part in the screening of the study.
As we go through the questions, you can stop me at any time if you are feeling uncomfortable.
Do I have your consent to start? (If yes, begin the questions below.)

<u>Screening questions:</u>

(1) Do you have a family member, including your partner, who has struggled with addiction?

If 'yes', (1.1) Who is this family member? (Your partner, child, parent, sister/brother, or someone else?)

(1.2) What addiction does/did this family member struggle with? (alcohol, drug use, or gambling?)

If 'no', go to (2)

(2) Do you think you have struggled with addiction yourself?

If 'yes', (2.1) What addiction do you have?
Then go to (3)
If 'no', go to (3).

(3) Do you have a family member, including your partner, who has accessed Alberta's addiction treatment services in the past 10 years?

If 'yes', (3.1) What was the addiction treatment for? (alcohol, drug use, or gambling?)
And (3.2) What type of addiction treatment was that? (individual counselling, group counselling, 12-step, psycho-educational courses, medication?)
If 'no', go to (4)

(4) Have you accessed Alberta's addiction treatment services for your addiction in the last 10 years?

If ‘yes’, (4.1) What was the addiction treatment for? (alcohol, drug use, or gambling?)
And (4.2) What type of addiction treatment was that? (individual counselling, group counselling, 12-step, psycho-educational courses, medication?)
If ‘no’, go to (5).
If 'no’ to all (1), (2), (3), and (4), ineligible.

(5) Have you thought about couple therapy, for you (your family member) when (he/she was) trying to recover?

If ‘yes’, go to (6)
If 'no’, go to (7)

(6) Have you (she/he) actually tried couple therapy? What was the couple therapy for? (E.g., helping with the addiction recovery, getting the partner more supportive for the recovery, improving the relationship)

(7) Would you be interested in trying, if there was couple therapy for addiction treatment available at the time?

(8) What made you interested in (or opposed to) couple therapy in addiction treatment?

If responses to (5) (6) (7) and (8) indicate no interest/thoughts in couple therapy, ineligible.
If responses to (5) (6) (7) and (8) showed negative opinions about couple therapy in addiction treatment, but with sensible argument or personal insights, still eligible.

If eligible:
Thank you for taking the time and answering these questions honestly. Based on your answers, your experience meets the criteria of the study.

To recruit couples (when the advisor’s partner is the person with addiction or the advisor is interested in couple therapy for addiction for oneself or partner):

Since this is a study about couple therapy, I would also like to invite both you and your partner to be end-user advisors in the study. If your partner is also interested in joining the study, could you please ask him/her to give me a call?
Once your partner is also determined eligible to be an advisor in the study, I will arrange a phone call to explain to you both in detail about the study and your roles it the study.
Now, do you have any questions or comments for me at this time?

If the partner is uninterested:

You are welcome to join the study without your partner. Next, I will email you the detailed information about this study and the advisor’s consent form to join the study. After you read over the information letter of the study and the consent form, I would like to call to explain to you about this study, your role in the study, and any questions you might have. When will be a good time to call?
At the end of our next call, if you consent to join the study, I will email you a link for you to electronically sign the consent form online. You can save a copy of your own signed consent.
Now, do you have any questions or comments for me?

If ineligible:
Thank you for taking the time and answering these questions honestly. Based on your answers, what this study is looking for does not match with your experience. I would still like to thank

you for being interested in partaking in this study. It means a lot that end users and families are willing to contribute to this research. Do you have any questions for me?

To determine eligibility:
If the person does not and does not have a family member who has accessed Alberta's addiction treatment services in the past 10 years – 'no' to (3) and (4), or if the person is not interested in couple therapy for addiction treatment – 'no' to (5) (6) (7) and lack of content in (8), this person is ineligible.
If the person has accessed Alberta's treatment services in the past 10 years – 'yes' to (3) or (4)— and shows interest in couple therapy for addiction – 'yes' to (5) or (6) or (7), this person is eligible.

Appendix D: Grounding Resources for Service-User Advisors

University of Lethbridge
Faculty of Education

Investigator: Yanjun Shi
1(403)-892-8287
yanjun.shi@uleth.ca

Helpful Resources for Grounding

Grounding techniques helps to bring down the intensity of emotional pain. It works by focusing outward on the external world, rather than inward on the self. Grounding anchors you in the present reality.

Four types of grounding exercises are presented (mental, physical, soothing and talking support) below. Try different techniques until you find one that works for you.

Mental

1) Describe your environment in detail: 4-3-2-1
   - Name 4 items you can see, 3 sounds you can hear, 2 textures you can feel, and 1 thing you can smell
   - "I see a blue chair with grey metal arms and legs. The chair has black wheels. The back of the chair is high. I can hear a buzz from the ceiling…"
2) Say a Safety Statement
   - "My name is ____; I am safe right now. I am (state where), not the past. Today's date is ____."

Physical

3) Focus on your Breathing
   - Notice the cool air entering through your nostrils, notice your chest expanding, notice the warm air leaving through your lips, notice the pause before your next breath. Repeat 6 times
4) Stretch
   - Extend your fingers, arms and legs as far as you can, then contract them and stretch them out again. Pay attention to how your body feels as you stretch Repeat 3 times.

Soothing

5) Say kind things to yourself
   - "I'm a good person; I'll get through this; This feeling will pass." Animal, nature, season, food, TV show, etc.
6) Name your favourite things

- Animal, nature, season, food, TV show, etc.

7) Plan a safe treat to reward yourself
   - Warm bath, dinner with a friend, a walk, a movie, etc.

Talking Support

If you wish to talk to someone for support, you can access 24/7 distress lines and local walk-in counselling services or community mental health services.

Mental Health Help Lines and Counselling Services in Alberta: Contact Info

24/7 Mental Health Help and Crisis Lines

Northern Alberta: 1-800-232-7288
Cold Lake: 1-866-594-0533/ (780) 594-3353
Fort McMurray & Northeastern Alberta: 780-743-HELP (4357) / 1-800-565-3801
Edmonton & Northern Alberta: 1-800-232-7288, (780) 482-HELP (4357);
Edmonton: 780-342-7777
Southwestern Alberta: 1-888-787-2880, (403) 327-7905
Calgary and greater areas: (403) 266-4357
Strathmore: 1-877-934-6634/ (403) 934-6634
Alberta (St Paul): 1-800-263-3045; (780) 645-5195
Alberta Mental Health Help Line: 1-877-303-2642
Alberta Addiction Healthline: 1-866-332-2322

Local Walk-in Counselling/Community Services

High Level, Northwest Health Centre: 780-841-3229
Fort McMurray, Queen Street Building: 780-793-8360
Peace River, Mental Health Clinic: 780-624-6151
Fairview, Health Complex: 780-523-6490
Grande Prairie, Aberdeen Centre: 587-259-5513
Grande Cache, Pine Plaza Building: 780-827-4998
Edmonton, Community Services: 780-342-7700, 780-342-7600 (service contact)
Red Deer, Walk-in Single Session**:** 403-340-5466
Calgary, Access Mental Health: 403-943-1500
Calgary, Walk-In Counselling: 1-800-563-6106
Brooks, Walk-In/Addiction Counselling: 403-362-1265
Medicine Hat AMH outreach: 403-529-8030
Lethbridge, Community Support: 403-381-5777

Appendix E: Service-User Advisor's Information Letter and Consent Form

University of Lethbridge
Faculty of Education

Yanjun Shi
(403)-329-2049
(403)-892-8287
yanjun.shi@uleth.ca

ADVISORS' INFORMATION LETTER & CONSENT FORM

Title of Study: *Exploring Couples' Need for Couple Therapy in Addiction Treatment—A Qualitative Study with End-User Engagement*

Principal Investigator: **Yanjun Shi** 1(403)- 892-8287 yanjun.shi@uleth.ca

You are being invited to give advisory input to the current study. The study is being conducted as a master's thesis by Yanjun Shi. Yanjun Shi is a graduate student pursuing a degree in Master of Education (Counselling Psychology), at the University of Lethbridge.

The thesis is conducted under the supervision of Dr. Bonnie Lee (first co-supervisor), Faculty of Health Sciences, and Dr. Noella Piquette (second co-supervisor), Faculty of Education, University of Lethbridge.

What is the reason for doing the study?

Couple therapy in addiction treatment show multiple benefits in helping long-term addiction recovery and improving the clients' couple relationship and well-being. This study aims to explore (1) the treatment experience of the clients who have undergone Congruence Couple Therapy or Treatment as Usual at the Alberta health Services for alcohol and/or gambling addiction, (2) the clients' mental health needs when signing up for couple therapy in addiction treatment, and (3) their views about the helpfulness and limitations of these addiction counselling programs.

The couples have been randomly allocated in Congruence Couple Therapy (CCT) and Treatment as Usual (TAU) in an ongoing clinical trial, which is the primary project of the current study.

Congruence Couple Therapy (CCT) is developed to help couples as a unit to live a healthy and fulfilling life, free of addiction. Treatment as Usual (TAU) include the addiction counselling programs available at the local Alberta Addiction and Mental Health services, likely to include individual and group counselling and psychoeducation workshops.

In this study, I (Yanjun Shi) will interview 5 couples who have completed CCT and 5 couples who have undergone TAU. Yanjun will conduct a 1-hour telephone interview with each participant to learn about their experience and perspectives towards CCT or TAU.

Why are you being asked to take part in this research study?

I (Yanjun Shi) am seeking to recruit 6-8 people who have been end-users of the Alberta's addiction treatment services to be the **end-user advisors** for the study. The 6-8 end users will form an advisory committee in the research, who give input to help design the interview guideline and provide feedback to the findings of the study. End user advisors' input can help me to ask more relevant questions in the interviews and to develop more meaningful findings.
You are invited to become an end-user advisor in the study, because (1) you and/or your family member have used Alberta's addiction treatment services and (2) you and/or your family member have accessed (or desire to access) couple therapy, while working towards addiction recovery.

This family could be your (i) partner, (ii) child, (iii) parent, (iv) sibling, or (v) significant person who you identify as a family member, with or without a blood relationship.

Your experience with addiction and Alberta's addiction services will offer valuable insights. With your input, the findings of the study will be more applicable to end users' needs in addiction and mental health services.

Before you decide whether to join the study, I will go over this form with you. You are encouraged to ask questions if you feel anything needs to be made clearer. You will have a copy of this form for your records.

What are the criteria an end-user advisor needs to meet?

To become an end-user advisor for the study, a person needs to meet the following criteria:

(1) being 18 years of age or older.
(2) having used Alberta's addiction treatment services in the past 10 years,
OR (2) having a family member – partner, child, parent, sibling, or family-member-like person (self-definition) – who has used Alberta's addiction treatment services in the past 10 years.
(3) having accessed couple therapy in addiction treatment,
OR (3) desiring for oneself or for that family member to access couple therapy in addiction treatment.
(4) ability to attend THREE teleconferences with the researcher and other end-user advisors during the course of the study (about 6 months). Each teleconference is about 2-hour long.

At your initial contact, I will ask you a number of questions to determine whether your situations meet the above criteria.

What will you be asked to do?

1. You will be asked to complete a brief **background information questionnaire**, which will ask about your demographics and relevant addiction/mental health and counselling information. It will take 10 minutes to complete. You can choose one of the two ways to complete this questionnaire:

First, with your consent, I can go over the questionnaire with you on the phone and type your responses in the form.

Second, if you prefer to complete this questionnaire on your own, a fillable questionnaire will be encrypted and emailed to you. You can email it back once you have completed it. The password to open the encrypted questionnaire will be given to you on the phone (not in the email).

Whether you choose to complete the questionnaire via phone or email, you are asked to give your consent to using email to communicate with the researcher in the study.

2. If you agree to become an advisor in this research, you will be asked to attend **three 2-hour teleconferences** under a pseudonym, with me (Yanjun Shi) and the other advisors, during the course of the study. The study is estimated to run from April to October 2018.

The first two teleconferences will be scheduled in April and the last one will be in July. The teleconferences will be audio recorded for me to gather and review your input. You can use either the internet or the phone to join the teleconferences. You are NOT asked to appear on the screen.

In the first two teleconferences, you and other advisors will be asked to give input on developing an interview guideline for this study. Because the research participants will be interviewed, asking the right interview questions is important. Yanjun will email a draft of the interview guideline before the meetings for your comments.

The third teleconference will be scheduled after all the interviews have been analyzed for you to respond to the findings. I will send out a summary of the findings prior to the third teleconference.

3. If you are interested in following the progress of the study between the teleconferences, I will post updates online for your information. Your advice may be solicited, should unforeseen changes of the study take place.

4. You are also asked to provide your contact information to me and my first co-supervisor—Dr. Bonnie Lee, to be contacted again for related future research and disseminating activities (such as presentations and reports of the study).

What are the risks and discomforts?

There are some potential risks by participating in this study as an advisor. [First], your anonymity cannot be guaranteed. Although you will be using a pseudonym during the teleconferences, your voice is not disguised. However, all the advisors will be asked to respect everyone's confidentiality and not to speak about other advisors outside the research.

[Second] in this study, you may hear and read about others' stories related to addiction and couple difficulties. Some of these stories might evoke unsettling feelings or negative memories in yourself. To address this risk, I will check in with the advisors after discussing emotion-laden

content and invite people to practice some grounding techniques (see *Helpful Resources for Grounding*). We may take a break after discussions on heavy topics.

To provide you with additional support, along with this information letter and consent form, I have also emailed you a document *Helpful Resources for Grounding*. You can find grounding techniques and a list of contact information for your local counselling services and 24/7 mental health help line.

It is not possible to know all of the risks that may happen in a study, but I have taken all reasonable safeguards to minimize any known risks to a study participant.

What are the benefits to you?

You may gain knowledge on couple dynamics in addiction recovery and couple therapy for addiction treatment. You may experience a sense of accomplishment by contributing to a research project that will help improve Alberta's addiction services. Your participation will help to enhance the quality of the research and the findings.

Do you have to take part in the study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop participating at any time, and it will in no way subject you to any form of penalty.

When you leave the study, you can also request to have all your individual information in the study deleted, provided the data have not been entered into analysis. Noted that the teleconference recordings and your input that has been given in a group format (during teleconference discussions) also cannot be deleted after your withdrawal.

If both you and your partner have consented to partaking in the study, when you withdraw from the study, your partner can still choose to stay.

Will you be paid to be in the research?

Yes. You will be gifted a $60 gift card at the completion of your engagement in the study. If you decide to leave the study early, you will still be gifted pro-rated value of gift cards, i.e., $20 per teleconference.

Will your information be kept private?

During the study I will be collecting data about you. I will do everything we can to make sure that this data is kept private. No data that includes your name will be released outside of the researcher's office or published by the researcher.

While I will strive to protect the confidentiality of your data, I cannot guarantee that other advisors from the advisory committee will do the same. If required by law, I will have to release

your information with your name. For these reasons, I cannot promise absolute privacy, but I will make every legal effort to ensure that your information is kept private:

1. You will be asked to choose a made-up name to use throughout the study, in the teleconferences and in all online communication.

2. If you choose to complete the background information questionnaire via email, a fillable questionnaire will be emailed to you pre-encrypted, so your personal information will be protected with encryption when the filled-out form is emailed back.

In compliance to the procedure *Emailing Personal Identifiable Health Information (#1113-10)*, I will ask for your consent to using email to transfer with encryption the Advisor's Background Information Questionnaire. I will delete the emails with participants and advisors from my email account, once I have obtained the needed information. When you provide me with a new email address, I will send you a verification email to make sure I have the correct email address.

Please note that the use of email in the study carries risks including but not limited to breach of privacy (i.e., someone without permission might view, obtain, use, or transmit your information) and authentication of the recipient (i.e., someone else might get access to your account and pretend to be you). If you share email access with another person, please be aware the risk with others viewing your emails.

3. Your contact information, including your email address and phone number, will not be given to other advisors, or appear in any group emails, messages, or on the teleconference interface.

4. To protect all advisors' confidentiality, you are asked not to share another advisor's personal stories or information you have learnt in the study with anyone else.

5. I will take caution when using the web-based service, Cisco WebEx, in this study. The teleconferences will be hosted and recorded on Cisco WebEx, which is operated on the University of Lethbridge system.

The recordings will be stored in the University of Lethbridge's database. To minimize the exposure of your data to the online world, I will download each teleconference recording and delete it on my WebEx account immediately after each teleconference.

However, due to the nature of the online world, your anonymity cannot be guaranteed when web-based services are used. As an option to better protect your privacy online, you are recommended to install a free software on your computer that will help to protect your IP addresses for anonymous communication, such us TOR, Ultrasurf, and MegaProxy.

6. In publications and report of the study, acknowledgement of the advisors' contribution will be made without identifying the individual advisors, except when an advisor request to have his/her name announced.

7. When reporting the findings on end-user engagement, the individual advisors will be referred to with a new set of made-up names, differing from the ones you used during the study. Quotes and excerpts from you may be modified to substitute any identifying information (e.g., important dates and places) with made-up ones.

How will the data be stored and for how long?

Your data will be stored in digital format, encrypted with passwords, and stored in a password protected external drive. The external drive and hard copies of the signed consent forms and transcripts will be placed in a locked cabinet in an office at the University of Lethbridge.

My first co-supervisor (Dr. Bonnie Lee) and I will have access to the data in this study. All identifiable data such as the audio recordings will be securely kept in an office at the University of Lethbridge for 5 years after the study is completed and destroyed afterwards. The data with no identifiable information will not be destroyed. If you leave the study early, we might need to keep the data that we have already collected (see section: *Do I have to take part in the study?*).

How will the results of the study be used?

Transcripts of the interviews and teleconferences, quotes and excerpts from the participants and advisors, and pooled data will produce the following products: a thesis project, possible published journal articles, and public presentations.

The data from this study may be used for related future research led by me (Yanjun Shi) and/or Dr. Bonnie Lee, as well as in publications and training materials on Congruence Couple Therapy. If this study determines that the treatment program(s) you have experienced is (are) helpful, researchers and service agencies may use the results of the study to the service(s).

What if you have questions regarding the study?

If you have any questions about the research now or later, please contact me, Yanjun Shi, at 1-(403) 892-8287, yanjun.shi@uleth.ca

Alternatively, you can contact my two co-supervisors: Dr. Bonnie Lee, at (403) 317-5047, bonnie.lee@uleth.ca, and Dr. Noella Piquette at (403) 394-3954, noella.piquette@uleth.ca

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at 780-492-2615, reoffice@ualberta.ca This office has no affiliation with the study investigators.

The researcher, Yanjun Shi, has been awarded with the 2016 Alberta SPOR (Strategy for Patient-Oriented Research) studentship to cover the costs of doing this study. The Alberta SPOR studentships are jointly funded by Alberta Innovates and the Canadian Institute of Health Research. You are entitled to request any details concerning this funding from Yanjun Shi.

Advisor's Consent to Participate in
Exploring Couples' Need for Couple Therapy in Addiction Treatment
—A Qualitative Study with End-User Engagement

Please INITIAL next to the items where you agree.

____I understand that I have been asked to be in a research study.

____I have read and received a copy of the Advisor's Information Letter of the study.

____I understand the benefits and risks involved in partaking in this study.

____I have had the opportunity to ask questions and discuss this study.

____I understand I am free to withdraw from the study at any time, without having to give a reason or facing any form of penalty.

Has the issue of confidentiality been explained to you? YES____NO____NOT SURE____.

Do you understand who will have access to your study records? YES____ NO ____ NOT SURE____.

I consent to…...

____Participate in the three teleconferences, conducted through Cisco WebEx, as explained in the Advisor's Information Letter.

____Allow the researcher to collect my background information using a questionnaire that is encrypted and transferred via email, as explained in the Advisor's Information Letter.

____Be contacted via WebEx messages and/or email outside the teleconferences, when communication is needed with the researcher and other advisors during the study.

____Allow the researcher to release research findings, including quotes, excerpts, and pooled data of the advisors' background information, for a thesis and possible publications and presentations, provided that any identifying information is removed.

____Allow the researcher and her first co-supervisor to use the data collected in the current study for related future research and publications.

____Allow the researcher and her first co-supervisor to contact me for future research and/or dissemination projects.

Who explained this study to you? _____
I agree to take part in this study:

Participant's Name (Please Print)	**Participant's Signature**	**Date**

You can send in your signed consent form by mail or by fax, **addressing Dr. Bonnie Lee and RE: Yanjun Shi.**

Fax**:** 403-329-2668

For mail or fax, the address label reads as the following:

Bonnie K. Lee, Ph.D., Associate Professor. RE: Yanjun Shi
Faculty of Health Sciences
University of Lethbridge, Markin Hall 3037
4401 University Drive
Lethbridge, Alberta T1K 3M4

I am willing to provide my contact information and to be contacted for future research & disseminating activities:

Participant's Address: _____

City: _____Province: _____ Postal Code: _____

Phone No. (H) with area code: _____messages Yes/No

(W – optional) _____messages Yes/No

(cell) with area code: _____ messages Yes/No

Personal E-mail: _____

University of Alberta Ethics ID Pro00077938

Appendix F: Addendum to Service-User Advisors' Consent Form

Investigator: Yanjun Shi
Cell: 1(403) 892-8287
Office: 1(403) 329-2049
yanjun.shi@uleth.ca

ADDENDUM TO **ADVISOR'S INFORMATION LETTER & CONSENT FORM**

Title of Study: *Exploring Couples' Need for Couple Therapy in Addiction Treatment—A Qualitative Study with End-User Engagement*

Principal Investigator: **Yanjun Shi** 1(403)- 892-8287 yanjun.shi@uleth.ca

The addendum is made to obtain the advisor's consent for the following changes:

(1) The teleconferences with the advisors can be hosted in both group and one-on-one formats, without having to have all the advisors present. This change is to accommodate the advisors' differential availability and allow flexibility in scheduling.

To assist group collaboration, the advisors' input and meeting accomplishment in each individual and partial-committee teleconference will be reviewed in its subsequent teleconference. Periodic updates on meeting accomplishments will be emailed to all advisors, when a teleconference with the entire advisory committee is not possible.

Decisions regarding the study will be made by combining and balancing the advisors' input, the researcher's discretion, and the thesis supervisors' recommendations.

(2) An optional pilot interview may take place with an advisor playing the role of an interviewee during the second teleconference, after the attending advisors have finished giving their input to developing the interview protocol, given that the meeting does not go overtime and that all the attending advisors have given their verbal consent to having such pilot interview.

(3) During the pilot interview with an advisor, the advisor's responses will be not analyzed nor published, unless they are deemed highly relevant and the advisor has given consent to having their responses analyzed and published as data. If published, advisor's responses in the pilot study will be specified and distinguished from the participants' interview responses.

____I have read and received a copy of the Addendum to Advisor's Information Letter and Consent Form of the study.
____I have had the opportunity to ask questions and discuss this study.

____I understand I am free to withdraw my consent to the changes or to participating in the study at any time, without having to give a reason or facing any form of penalty.

Who explained this addendum to you? _____

I agree to having the changes in this study that are outlined above:

_____	_____	_____
Advisor's Name (Please Print)	**Advisor's Signature**	**Date**

University of Alberta Ethics ID Pro00077938

Appendix G: The Semi-Structured Interview Protocol

University of Lethbridge
Faculty of Education

Yanjun Shi
(403)-329-2049
(403)-892-8287
yanjun.shi@uleth.ca

Hello! Thank you for joining the interview with me to talk about your experience with Congruence Couple Therapy and other treatment services [the treatment services you and XXX accessed] during the couple therapy study.

This interview will be conducted in two parts. In the first part, we'll focus on your experience with the treatment services and any feedback you have towards them. In the second part, we'll explore any learning you've had and changes you experience, after having participated in the treatment services. Each part will be about 40 minutes to 1 hour. As mentioned earlier, we can go Part 1 today and Part 2 next time, or on the same day with a break in between. What do you prefer?

For the first part, we are going to start by talking about what was happening in your life before you started looking into couple therapy, and what motivated you to seek couple therapy. Then we are going to look at the services you and XXX have accessed during the couple therapy study, talking about your experience and your views towards them.

As we discussed before, if you feel **uncomfortable** at any point during the interview, please don't hesitate to let me know. We can slow down or practice some of the grounding techniques I emailed you earlier. If you would like to take a break and come back, we can do that as well. Please Remember that you can choose to stop the interview at any time.

This phone call will be **recorded**. This is to ensure that I collect the information accurately.

Before we start, I would like to remind you that what we talk about in this interview will be kept **confidential**, **except** if there is a risk of harm to yourself or someone else, suspected child neglect or abuse, or when the record is required by law. Do you have any questions about this?

Do I have your consent to start?

Part 1- Treatment Experience & Feedback

1. Life when seeking couple therapy

First, let's start with what was happening in your life before you and your partner started looking into/seeking the couple therapy (in the study).
Could you tell me a bit about what was going on in your life at that time?

Prompts:
<u>Activities/Occupation</u>

What was a typical workday/weekend day like for you?

Social relationship

If you could tell me 5 significant relationships, whether at home/at work/…., that occupy a lot of your time and attention (mind/heart/energy), who they are, and how they affect you?

Who the people you were close/ you could vent to/you get support from? Who were the cheerleaders in your life? Where did you feel most comfortable to get support?

Did you spend time with anyone on a regular basis?

Did you participate in any social/spiritual/self-help groups? Did you participate in any volunteer work?

Suggestions: Facebook groups, neighbours, clubs, AA groups, counsellors, etc.

Family/Couple relationship

How would you say your relationship with your partner/children/significant family members at that time?

When the interviewee uses a descriptive word--What does XXX mean to you?

What would you say the biggest stressors in your relationship?

Are you okay if we talk about that some more?

Were there any particular things you were fighting about?

Is there anything else about your relationships with… that you'd like to talk about/share – that you think that would be relevant?

Stress

Were there major changes or events happening in your life?

Sleep/appetite/concentration

From 0-10, how would you rate your stress level?

Addiction

Just for basic information, were there any other addictions you would say you (your partner) had?

How big of a problem [your drinking, gambling, drug use, etc.] had it been for you?

How was the problem affecting your relationship with your partner, your family?

Would you say you were (your partner was) recovering from [drinking problem, gambling problem, drug use, etc.] the time?

General satisfaction:

How would you rate your general satisfaction with life, from 0-10?

What about your life that you would want to be different?

2. Past treatment services

Did you and your partner have accessed any addiction and mental health services before the couple therapy study?

I have a checklist here we can follow, but if there's anything not on the list, please feel free to add:

	Private counselling/Alberta Health	How many sessions?	Helpfulness?	What to improve?

	Services/Non-Profit Organizations			What you'd like to be different?
One-on-one therapy				
Family therapy				
Couple therapy				
Group therapy				
Self-help group (12-step, SMART recovery, etc.)				
Medications (by psychiatrist/physician)				
Psychoeducational workshop/course				
Other:				

Follow-ups:
If you (your partner) did not receive any treatment services before the couple therapy study, was there anything that kept you (your partner) from accessing any services?

3. Motivation for couple therapy

What motivated you to seek couple therapy?

Follow-ups:
What were you hoping to get out of the couple therapy?

4. Decision making & Concerns

How did you and your partner decide to join the couple therapy study?

Prompts:

- Was one of you more willing to start couple therapy than the other?
- Did you or your partner have any resistance/hesitation about starting couple therapy?
- What was the resistance/hesitation about?
- Did you talk to someone or try to work out your concerns or reluctance about joining the couple therapy in the study?
- What convinced you/your partner to sign up?

5. Treatment services

Congruence Couple Therapy couples: During the couple therapy study, did you get other counselling treatments besides the couple therapy?

Treatment as Usual couples: During the couple therapy study, what counselling treatment did you and your partner each get?

Did you get any treatment services after you completed the Couple Therapy (Treatment as Usual) within the study?*

I have a checklist here we can follow. If there is anything not on the list, feel free to add:

	How often?		How long?		Notes
One-on-one therapy					
Residential treatment (Northern Addictions Centre, Henwood, etc.)					
Addiction/Mental health day program					
Psychiatric appointments					
Treatment/Recovery/ Relapse prevention group					
Psychoeducational Workshops – Addiction Recovery Series					
Self-help group (AA, GA, SMART Recovery, etc.)					
Couple therapy					
Family therapy					
Family & friends group					

6. Perspective towards treatment – Helpfulness

Now you've gone through the couple therapy (treatment as usual), what do you find helpful about these treatments, if there are any?

Prompts:

Did you learn anything new about yourself or your life from the couple therapy (treatment as usual)?
Did you gain an awareness of/ a better understanding of your (your partner's) addiction?
Did you gain a better understanding of some behaviours you (your partner) had that are related to some of the problems, say in the ways you cope with stress or negative emotions?
Did you notice any positive changes in you/your partner?
Did you notice any changes in how you and your partner cope with stress and deal with problems?

**** "If you didn't get any counselling services:****
(1) Was there anything you did that we haven't mentioned but you would also consider helpful for problems related to addiction and mental health?"

(2) Could you tell me more about that…?
Prompts:

Would you have wanted to get more counselling?
Were you contacted by a counsellor (in the study)?
Did you know about any services you could access? Were you having difficulty finding out about the services?
Were you having difficulty accessing the services?

(3) Do you find your partner's treatment services helpful?
→ Did you notice any changes in your partner, as your partner went through the treatment?
Prompts:

Anything changed about how your partner looked at/dealt with addiction, how he/she dealt with stress and negative emotions, how he/she talked to/listened to/treated you, etc.)?

(4) Did you notice any changes in yourself, as your partner went through the treatment?"

Follow-ups:
Did you access any services since you have completed the treatment in the study?
What motivated you to continue accessing treatment services?

7. Therapeutic alliance – Relationship with Counsellor/Group

How did you find your counsellor (group)? How was your counsellor (group) to you?

Anything you would like to be different about counsellor/group?

Prompts:
Characters & styles (etc., directiveness, authenticity, flexibility/openness).
Approach: more homework/strategies; more explanation less preaching.
Person-centeredness & Relationship: more focus on 'me' rather than the agenda; calls when I didn't show; contact outside the meetings/sessions.

8. Perspectives towards treatment – dissatisfaction

"Next I would like to explore if there is anything about the treatment that you felt dissatisfied with?"
Was there anything negative that stood out about the couple therapy (treatment as usual)?"

(1) Was there anything that you hoped to get out of the couple therapy (treatment as usual) but did not?"

(2) Was there anything about the therapy that just did not work for you and even had a negative effect on your life?"

Prompt:

Say there might be something you learnt from the therapy that collided with how you look at yourself and how you viewed the world, and perhaps made you feel doubtful about who you were and how the world was like;
Or something you learnt from the therapy that might have made your relationship with others even worse than before?
Therapists pushed their own agendas on you (or 'best practices'), rather than genuinely caring about your recovery?

Follow-ups:
Knowing what you know now, what could have been done differently?
What do you feel could have been different (to make things better)?

9. Perspectives towards treatment – Lacking

(1) Looking back, did you feel that you were well-supported with the services at the time, or would you need other services to help you meet your needs/improve your situation?

What do you think might be missing or lacking in the couple therapy (treatment as usual)?

(2) Now that you've completed the couple therapy (treatment as usual), would you like to access more addiction treatment and related services, or do you think you've done enough treatment?

(3) Do you feel you needed support or help **other than** treatment services in your/your partner's recovery?

10. Service improvement

Do you have any feedback for the treatment agencies to improve their services?
What would like to say to your treatment agency?
What would like to say to your counsellor?

Prompts:

For example, diversity of the programs,
availability of specific treatment program,
competence, ethics, and traits of counsellors, other service staff, and managers.
scheduling speed of the services, etc.
ease of access – shorter wait time; more access to the information about the services an agency offers (not only website, but also things like pamphlets about gambling treatment in casinos, or in places where people with addiction tend to hang out)
Intensity of program (more sessions; longer sessions; longer programs)

Follow-ups:

What solutions would you propose to help improve the services?
What would be a small thing you propose that the treatment agencies could do to improve?
(Be specific, build on their answers)

11. Conjoint Therapy vs Individual Therapy

Now I'd like to ask about your views when comparing the conjoint therapy and individual therapy—when the couple attend sessions together and when they each do their own therapy, separately.

Would it make (Have it made) a difference for you and your partner to go through treatment together (where you both attend sessions together), compared to going through treatment on your own?

Explain:
Some people might say the treatment where the couple are involved together offers something the separate treatment can't. Others might argue that when the partners are not ready, having them do counselling together or go through couple therapy would be unhelpful or even harmful.

Prompts:
What's beneficial?
What could be the downside of that?

12. Timing of service entry

Some people believe that there is a specific time when a couple is ready to do couple therapy in addiction treatment and there are also times when they are not ready. This could be something like the partner with addiction is not ready to face the other partner with complete honesty or openness, or the partner without addiction is feeling too hurt to start working on repairing the relationship with the other person?

When do you think would have been the best time for you both to be seen together, so that you get on the same page/you can start addressing the tensions in the relationship?

Prompts:
Would it have been:
Before you (your partner) could fully admit that there was an addiction problem?
After you (your partner) have accepted that there is a problem but are not ready to make a change?
When you (your partner) are determined to make a change and started to seek treatment?
When you (your partner) have started recovery and had some abstinence?
At a later stage of recovery, when you (your partner) have had over a year of abstinence and want to work on deeper levels of change?
When the partner without addiction is willing/ready?

(Further prompt: This could mean that they have worked on their emotional wounds, such as feelings of betrayal, anger, shame, and despair, now they're emotionally ready to do couple therapy)

When [the partner/family, etc.] is/are ready to make changes in themselves to support the person's addiction recovery?

such as their own lifestyle, their own addiction, or the way they talk to and treat each other

13. Importance of couple therapy in addiction treatment

On a scale of 0 -10 (0 being completely unimportant and 10 being extremely important), how important do you think it is to make couple therapy available for couples struggling with addiction (for example, making it part of the Addiction and Mental Health Services)? Why?

Part II: Change and Growth through Treatment

1. Change from treatment – intrapsychic

Next, I am going to ask you about the changes that happened in your life, ~~as you went through~~ now you've gone through the couple therapy/ treatment as usual.

First, have you noticed any changes in yourself?

Prompts:

How you look at yourself? How would you describe yourself? How you talk to yourself? How you treat yourself? How you take care of yourself?

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

2. Change from treatment—communication

Have you noticed any changes about the way you talk and listen to your partner, now that you've gone through the couple therapy (treatment as usual)?

Follow-ups:
Do you think that the couple therapy (treatment as usual) has helped you to change how you communicate with your partner?
What have you learnt from the couple therapy (treatment as usual) that has helped you to make the change?
What have you done to improve your communication with your partner?
→ Have you been able to put what you learnt into practice? Was your new learning from the therapy easy to apply in your everyday life? Has it helped when you put your learning into practice?

3. Changes from treatment – interpersonal

(1) Have you seen changes in your relationship with your partner, now that you've gone through the couple therapy (treatment as usual)?

(2) Have you seen changes in your relationship with other important people in your life, say your children, parents, parents-in-law, friends, people at your workplace, or in your community, now that you've…

Prompts:

Changes in how you choose to look at them, listen to them, talk to them, and treat them?

Follow-ups:
How do you know that your relationship has changed?
Have people told you that the way you communicate/interact with them has changed?
How did they respond to your changes?
Any changes in the way they communicate with you?
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

4. Changes from treatment – Past-present connection

When people go through counselling, they often gain a better understanding of how their past has influenced how their lives are right now.
(For example, our important relationships in the past might affect how we look at ourselves and treat others, or the way we were raised might be linked to our addictive patterns as adults.)

Has the couple therapy (treatment as usual) helped you to better understand/gain a perspective or insight about how your past experiences might have affected your current life, say your relationship and the way you communicate?

There are a few things we can look at, the family we grew up with, important friends, relatives, and mentors you had, social situations when you were growing up – peer groups, bullying, isolation, etc., past couple relationships.

Prompts:

How might the family you had when you were growing up have affected how you feel about yourself and treat yourself/how you communicate with your partner and your own family/how you cope with stress?
Do any of your relationships mirror your relationship with your family (mother, father, siblings, etc.) when you were growing up?
('Are any of your relationships … similar to… in any way at all?')
What about other important relationships when you were growing up?
What about the past couple relationships you had?

What about negative social experience with your peers or in your community when you were growing up? For example, have you ever been bullied, did you feel excluded by your peers or people in your community?

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

5 – 9. Changes from treatment – Universal-Spiritual

Next, I am going to ask you about the changes related to the spiritual domain, now you've gone through couple therapy (treatment as usual).

I am going to go about this by focusing on the concepts of self-worth, sense of safety, connection, and spirituality. The questions might sound abstract, but I can try to give examples and explain the concepts as we go.

If you want to take some time to think about it, you can also let me know. We can take a break or move on to other questions and come back to it later.

5. Changes from treatment – Universal-Spiritual –Self-worth

Let's start with self-worth. First, what does self-worth mean to you?

Prompts:
Do you feel worthy of love? Do you feel worthy of respect? Do you feel worthy of a good life? (compassion, companionship, recognition, etc.)

B. Have you noticed any changes in your self-worth, now that you've gone through therapy? (Could you give me an example? -- how did you know and how did others know-have they mentioned anything)

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

6. Changes from treatment – Universal-Spiritual – Self-Assertion

Have you noticed any changes in the way you assert your self-worth?

This may include how much you are aware of your own needs, and acknowledge them to yourself, as well as the way you assert your needs to others and set boundaries with them.

Prompts:
Any changes in how aware you are of what you need (e.g., your loved one's attention, company, time for yourself, to be heard and acknowledged)?

More willing to speak up for yourself?
Did you become more capable of expressing your needs?
More capable of saying no to set your boundaries
More capable of making requests to others for what you need?
An example?

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

7. Changes from treatment – Universal-Spiritual – Safety

Next, I am going to ask about your sense of safety in who you are, or some people might call it 'basic trust'. This may include two aspects – being okay with who you are and being okay with letting others know who you are.

[A]First, how well you feel you accept who you are?
Prompts:
How do you see yourself? How would you describe yourself?
What would say are your principles in life? What do you value in life?
What have been the major life lessons you have had?
What might have been the things that you do not like about yourself?
What do you think others would say about you? How would they describe you?
[B] Have you seen any changes in how well you accept who you truly are?

[C] Next, do you feel okay opening up to others, and sharing/talking about your mistakes/struggles/failures?
(Do you feel okay with being vulnerable- this could mean being open about your failures and weaknesses?)

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

8. Changes from treatment – Universal-Spiritual – Connection

[A] Have you noticed changes in how connected you feel with others?
[B] Have you noticed any changes in how you connect with others?

Follow-ups:
If the therapy you went through has helped you to make these changes, how might it have helped? (What did you learn from the therapy that has helped?)

9. Changes from treatment – Universal-Spiritual –Spirituality

Have there been any changes in your spirituality, now that you've gone through the treatment?

OR, has your spirituality changed in any way (Do you feel strengthened in your spirituality?)

Prompts:

Are you a spiritual person? Tell me a bit about spirituality? **Use their terms**

Follow-ups: How did the couple therapy (treatment as usual) help you better connect with your Higher Power [Allah, God, the Devine, the Being, etc.]?

10. Changes from treatment – Leaving behind the old life & Loss/Grief

Now that you're on the journey of recovery, has there been anything that you feel you needed to leave behind?

Have you left your addiction lifestyle (including the relationships, and the old identity) behind?
How do you feel about it?
How did the programs/the counselling help you with loss and grief?
Follow-ups:
Are there losses you mourn?
(prompts: loss of friends, loss of a way of coping, loss of the old identity)

11. Changes from treatment – stressors/general

Now that you've gone through the couple therapy (treatment as usual), how is life now, and specifically have you noticed any changes in your stress level in general?
What might be the things that cause you stress nowadays?
How it might have changed in the way you cope with stress?
Have you noticed any changes in your mood?
Have you noticed any changes in your (your partner's) drinking/using/gambling?
Have there been relapses since the time you began couple therapy (treatment as usual)?
Were there triggers that led to the relapses?
Have you noticed any changes in your physical health, say your energy level, appetite, how well you sleep, how well you can concentrate?

12. Interactive change process – Couple Interaction & Synergy of Change

When both partners are going through therapy at the same time (together or separately), we might say that the changes they each make could have an effect on each other, and then this might help them make further changes in themselves and their relationship.

So do you feel that the changes you and your partner made had influences on each other?

Prompts:

As your partner (you) made changes in how to communicate, cope with stress, treat other family members and friends, what changes have you seen happening in you (your partner) and your relationship?

➔ Considering not using specific prompts, but 'tell me more about it', and have follow-ups to learn more about the process and both the negative and positive.

13. Interactive change process – Addiction recovery & couple system

Some people see addiction as a complex social issue that can lead to family and couple relationship issues and also be fueled by them.

(1) How there might have been an impact of your couple issues on addiction?

How has it made a difference in how you see your couple relationship and the addiction, now you've gone through treatment together in the couple therapy (treatment as usual)?

> Prompts
> Did you gain an understanding of some behaviours you had that might not be helpful in your partner's recovery, or in improving your relationship with your partner?
> (Did you gain .... some behaviours you had that might have fueled or played a part in your partner's addiction, or the couple relationship problems?)
> What about the tendencies you had that were helpful or healthy in your partner's addiction recovery or your couple relationship?

People say that when a partner goes into addiction recovery, the couple relationship changes—things in the couple relationship and the family also need to be adjusted to adapt to the new changes in the partner going through recovery. So my next question is about this:

(2) Since you (your partner) started to recover from addiction, have there been changes in your couple/family routines or your partner's (your own) lifestyle?

Prompts:

> For example, Changes in how you spend time with each other as a couple or family
> Changes in how you communicate with each other
> Changes in the atmosphere in the family– say it might have got warmer, safer, more open, more authentic, or stranger, quieter, suffocating, etc.?
> Changes in your and your partner's lifestyle, hobbies, activities, friend groups, etc.

Follow-ups:
(1) How have you adjusted to this?
(2) How do you feel about this?
(3) Looking back, do you think there were changes that you and your partner had to make for your relationship to survive and for the recovery to last?

What do you think is the most important thing you learnt that helped your relationship/addiction?

Follow-ups:
What therapy, programs, or support (not necessarily treatment) do you think that has helped you make those changes?"
What types of therapy, programs, or support do you think would help you make these changes, whether the services exist or not?"

14. Your journey in CCT or TAU

Could you think of a metaphor or an image for couple therapy for addiction couples/treatment as usual you went through? Take a minute to get a sense of what that is?

15. Perspectives – Story of addiction

To partner with addiction:
Now that you've gone through the struggles of addiction and been on the journey of recovery, what kind of story would you tell about your addiction?

To partner without addiction:
Now that you've gone through the struggles living with addiction and have been on the journey of recovery together with your partner, what kind of story would you tell about your experience with addiction?

Prompts:

Cause: What might have contributed to your/your partner's addiction? How was it developed? Any underlying issues that contributed to the addiction (have you been able to deal with them?)

Loss: What has it cost you, your relationship, your family?

Any sense of loss (grief/sadness), as you move forward from addiction (leave addiction behind)?

Gains: What have you learned through your experience with addiction? What might be the gift/values in this journey?

If we take a panorama view of your life where you experienced addiction, where do you see the values (what could be the gift or gains) in your struggles and suffering?

Given that you've been through treatment, would you say that you have gained perspectives about addiction?

Follow-up:
Title of the story? – what was before? And what is now?

16. Passing on the gift
What would you say to someone else and/or another couple who are starting the journey of recovery?
What kind of recommendations would you make about the services? (Advice/suggestions)

Appendix H: Summary of Service-User Advisors' Feedback on Findings

Advisors' Feedback

1. What CCT (couple therapy in addiction treatment) did for the couples?
   - Individual growth (greater self-awareness) through growth in communication
   - Learnt to prioritize couple support rather than any other type of support; ensuring good communication to maintain mutual support
   - Understanding the "why" of the addiction - insight of the addiction and the deeper trauma helps to alleviate the underlying problems driving the addiction (fear, unaddressed wounds, shattered sense of self) as well as the healing from the damage directly caused by the addiction (anger, resentment, distrust, guilt)
   - Addressing the addiction as a symptom of the multiple levels of trauma and dysfunctions within the relationship context
   - Integrative Model of CCT- spiritual, intrapsychic, behavioural, and interpersonal-intergenerational - helps to achieve the insights and build the practical skills for recovery
   - Learnt to integrate therapy in their everyday life (practicing self-awareness, self-other acknowledgement, support and resilience-building), which is self-realization

2. Why is conjoint couple therapy significant?
   - Treatment within the natural context and community enables actual recovery (as opposed to residential treatment that does not address the issue within its natural context and teaches the patient the realistic skills to recover in their lives)
   - Healing the current through changing the present; intervening the cycle of intergenerational trauma through the changes in self-other dynamics
   - If therapy with a stranger can be helpful, therapy with a loved one must be more powerful.

3. Individual therapy vs couple therapy
   (1) Individual therapy may be needed before couple therapy when both individuals lack the awareness of their own triggers and the underlying FOO and trauma issues.
   (2) Individual therapy could do what CCT does (i.e., addressing intergenerational trauma and interpersonal triggers), but the participants did not gain the same insights and change from their individual therapy, possibly because couple issues provide more convenient windows to address the intergenerational issues.

4. How to integrate couple therapy in our addiction and mental health services
   (1) Diversifying services for individual needs of recovery
   (2) Couple therapy could be delivered with focuses on different levels of changes (ranging from couple rejoining, communication facilitation, awareness building, skill development, insight gaining, to trauma healing) for different demographics and stages of recovery. E.g., couples with lower socioeconomic status and more complex mental health issues could focus more on enabling communication and building self-other awareness rather than building the skills and healing the deeper trauma.

(3) Training could be done with service providers at agencies of different points of treatment (detox, in-patient, out-patient, and outreach), because couple and family involvement could be an important element in all levels of intervention
(4) Making the services more accessible so that the people who need it can have it; don't force the service to anyone who's not ready to avoid wasting the resources.
(5) Relational therapy is also needed in youth treatment-- early intervention; issues of youth often are manifestations of family dysfunctions.

5. Funding for couple therapy
(1) Further collaboration between research and treatment agencies in the community helps to bring couple and family therapy to the populations in need of the service.
(2) It's not that there's not enough funding, it's that the funding has been dedicated in the wrong areas. There's plenty of individual treatment options; there need to be options for couples and families
(3) When advocating for couple and family therapy, the message needs to be strong and absolute, and focusing on the urgency - any delay of opting out ineffective programs for an effective therapy program (couple therapy) causes further waste of the public funding.

6. Miscellaneous
(1) Importance of teaching and explaining of 12-step tenets for 12-step group members, otherwise they could only get what's on the surface, dogmatic adherence to behavioural and moral rules for abstinence as well as group influence (which could affect one's well-being negatively through control over the individual).
(2) 12-step is necessary as an introductory level of treatment for recovery, as it helps the addicts to confront avoidance, but the service users would be stuck in the early stage of recovery, if no further therapy is sought.
(3) The success of couple therapy does not mean the consolidation of the relationship; it could mean relationship resolution due to individual growth of both members.
(4) Individual treatment before and possibly after couple therapy as a way to integrate couple therapy in addiction treatment
(5) Good therapy means it promotes learning of skills and integration of the learning into everyday life, thus leading to self-realization.
(6) Comorbidity should be seen as a norm rather than a special consideration when designing addiction treatment
(7) Importance of refreshers of couple therapy

Appendix I: Advisor's Consent to Participate in the Pilot Interview

University of Lethbridge
Faculty of Education

Investigator: Yanjun Shi
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Office: 1(403) 329-2049
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Consent to **Using the Pilot Interview with Advisor as Data**

What is a pilot interview with an advisor in this study?

During your 2nd teleconference, if time permits after you and other advisors have completed giving input on developing the interview protocol, you may be asked to do a pilot interview with me, where you play the role as an interviewee. This is to help me practice conducting the interview in real-time and gather your feedback for improvement. Because the teleconference is recorded, so as the pilot interview.

All the attending advisors' verbal consent will be needed for the pilot interview to take place. You can use made-up information to respond to the interview questions in the pilot interview.

Why are you asked to give this consent?

The content of the pilot interview with you will not be analyzed or published as data, unless there are interview responses relevant to the study and your consent is given to analyzing and publishing the pilot interview or part of it anonymously.

In case anything relevant arises in the pilot interview, I will call to go over with you what in the pilot interview that might be entered into the analysis as data. Only after having your consent, will I analyze and possibly publish the specified content of the pilot interview.

The pilot interview will be not treated as interviews with actual participants, and your responses in it will be analyzed and possibly published as the advisor's input to the study. The context of these responses may be specified as a pilot interview with an advisor. Your anonymity and confidentiality will be protected the way explained in the original consent form.

____I have read and received a copy of the *Consent to Having the Pilot Interview with Advisor Analyzed and Published*
____I have had the opportunity to ask questions and discuss this study.
____The researcher has specified with me what content of the pilot interview in which I participated may be entered into analysis and published anonymously.
____ I consent for the researcher to analyze and possibly publish the specified content of the pilot interview in which I participated, anonymously and in the way outlined above.
____I understand I am free to withdraw my consent to the changes or to participate in the study at any time, without having to give a reason or facing any form of penalty.

Who explained this consent to you? _____

I agree to have the changes in this study that are outlined above:

Advisor's Name (Please Print)	**Advisor's Signature**	**Date**

University of Alberta Ethics ID Pro00077938

Appendix J: Initial Greeting and Screening Protocol for Participants

Initial Greeting and Screening Procedures for Participants

Introduction

Hello, my name is Yanjun Shi. I am conducting a thesis project to pursue a degree in Master of Education, Counselling Psychology, at the University of Lethbridge.
The thesis is a study that looks into the clients' experience and perspectives towards the couple therapy and the treatment as usual programs they underwent during the couple therapy study.
The couples in the couple therapy study will be invited to join this study after they have completed their post-treatment survey.
Thank you for your interest in this study. Is this a convenient time to talk?
I have a couple of questions concerning potential current suicide risks before we begin. It will take about 5 minutes. Would that be ok with you?
**If the person asks why he/she is being asked about suicide risks, I will say:
Looking at the suicide risks is to see whether this is a good time for you to join the study. If a person has strong suicidal thoughts, it will be better if this person seeks appropriate counselling support as soon as possible. **
Since these are personal questions, you might want to stay at a place that is private to answer these questions. If you feel uncomfortable at any time during the questions, please let me know. You can stop at any time.
All of the answers you give here will be kept confidential, unless there is a risk of harm to yourself or another person, suspected child abuse or abuse to another vulnerable person, or if the records here are required by law.
Responding to the questions implies your consent to taking part in the screening of the study. Do I have your consent to start?

Screening for Recent Suicide Risks

Unless specified, these questions will be about how you are <u>in the past month</u>.
(1) Have you wished you were dead or wished you could go to sleep and not wake up?
(2) Have you actually had any thoughts of killing yourself?
***If YES to (2), ask questions (3), (4), (5), and (6). If NO to (2), go directly to question (6)*
(3) Have you been thinking about how you might do this?
The person has thought of at least one method during the past month—NOT a specific plan, which has time, place, or method details worked out.
(4) Have you had these thoughts and had some intention of acting on them?
The person has some intent to act on suicidal thoughts – NOT thoughts without intention of acting up them, e.g., "I have the thoughts, but I definitely will not do anything about them".
(5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
(6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?
***If YES, ask*
(7) Were any of these in the past 3 months?

To determine the person's level of suicide risk:

Low Risk	*The person says YES to (1), or (2), or both, and NO to the rest.*
Moderate Risk	*A. the person says YES to (3), and No to (4), (5), (6), or* *B. the person says YES to (3), NO to (4) and (5), Yes to (6), and NO (7), or* *C. the person says NO to (1) and (2), YES to (6), NO to (7).*
High Risk	*The person says YES to (4) or (5) or (7)*

These are all the questions I have for you. Thank you for answering these questions honestly. How are you doing right now?

If the person's responses indicate a low risk of suicide

Your answers show that this study should be suitable for you to be participating in.
Next, I will need to get in contact with your partner to go over these questions with him/her as well. Once it is determined that this study is appropriate for both you and your partner, I will schedule a time that works for you both to call and explain to you about the study in detail. I will also address any questions you might have about the study.
I will email you the information letter and consent form of the study, before the scheduled call. You can read about the study at your own time and bring in your questions to our call.

If the person's responses indicate a moderate risk of suicide

I will proceed to try to gather the information that would serve as protective factors to the person.
I may ask questions like:
What are some of the things that you have that make you feel more hopeful/happy about life?
Who might be some of the people that you can talk to when you are having the thoughts about ending your life?
***If the person can talk about a number of significant protective factors, this person should be eligible for the study. I will proceed with a similar script when the person's responses indicate low suicide risk.*
***If the person does not have significant protective factors in life, I would say the following:*
Based on your responses, it is not a good time for you to participate in the study.
You mentioned having serious thoughts and some plans of suicide recently, it sounded like it has been difficult for you lately. Have you thought about talking to a counsellor about how you feel and what you have been going through lately?
If you would like, I can give you the number of your local 24/7 distress hotline. I also can give you the contact information of your local walk-in counselling/community mental health (*See Helpful Resources for Grounding for participants*).

If the person's responses indicate a high risk of suicide

Ask **<u>Have you thought about when you would end your life</u>**?
This question will be asked to determine whether I need to contact additional resources such as the local hospital right away, while keeping the person on the line with me (not being left alone).

***If* YES *and* within 24-48 hours.
I would ask the person to stay with me on the phone while I use a different device to call 911 or his/her local crisis helpline. I will then contact the person's partner to inform him/her of the person's acute suicide risk. I will ask the partner to keep the person company until professional help arrives.
If the partner or another trusted person is unavailable, I will keep engaging and supporting the person on the phone while waiting for the professional help to arrive. I will and explore appropriate resources with the person on the phone. I may ask "have you ever felt like this before? What happened then?", "who do you think you can talk to and get support from right now?", "is your partner or a family member around who can comfort you or keep you company?" "what is one thing that you could remind you of the good things in your life, when you are having suicidal thoughts?", etc.
After the person is admitted to the hospital or treatment agency, I will call again to check up on the person the next day.
***if NO or YES but not within 48 hours.*

It sounded like it has been hard for you to feel hopeful about life lately. This might not be a good time for you to go through a research study. But I am wondering if you are open to getting counselling support and give life another chance or two. Life might seem really hard to go through lately, but it might make a difference to have some people who are willing to listen and to work with you to get through the toughest time.
I would like to invite you to call up your local distress helpline today and don't wait to talk to a counsellor/ mental healthcare professional.
Before you hang up the phone, I would also like to ask you to think about and name a list of people and agencies you can contact for support, when your thoughts about suicide get worse, or when you feel that you might not be able to keep yourself safe. You can keep this list as your safety plan before you get further mental health support.
Now if it is okay with you, could you tell me who the first 3 people are that you can contact once you start to feel more suicidal? Could you tell me the 4th person or agency you can contact when the first three are unavailable? Who is this person, or what agency is this? Do you need some help to find out the agencies' contact information?
If you have a pen at hand, I would like to ask you to write them down. This will help to remind you that you have these people you can turn to when you are sinking back in the suicidal thoughts. Could you do that?
Now, could you please write down the 5th one? This time, what about the local Crisis Line? It is XXXXXXX. Thank you so much for hanging in here with me. Now, I would like to ask you to write down that last one on your list, you can put down 911 or your local hospital's emergency room.
When next time you feel that the thoughts about suicide creep up again, don't forget you have this list of support. Work through the list until you get the help you need. Do not give up.
What I have asked you to do is a plan for your safety. To make the plan serve you well, I want to invite you to turn the plan into a safety contract that you have with yourself. I will be your witness. Could you repeat after me? "I, XXXX, agree to contact someone for support if my thoughts of suicide get worse or I feel as though I cannot keep myself safe. Beginning now, XXXX (time), until I get the mental healthcare that is on the way."

Next, I would like to call your partner to let him/her know about how you are right now. I would like your loved one to be with you right now, to keep you safe and to give you support.
I have a list of helpful resources that include the contact information of your local counselling services and stress line. I will email it to you and your partner I am contacting.
I will call you again tomorrow at ___(time) to check up on you.

References

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Posner, K., Brent, D., Lucas, C., Gould, M., Stanley, B., Brown, G., Fisher, P., Zelazny, J., Burke, A., Oquendo, M., & Mann, J. (2008). *Columbia-Suicide Severity Rating Scale, Screen Version - Recent* [Measurement instrument]. Retrieved from http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

Appendix K: Participant's Information Letter and Consent Form

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PARTICIPANTS' INFORMATION LETTER & CONSENT FORM

Title of Study: *Exploring Couples' Need for Couple Therapy in Addiction Treatment —A Qualitative Study with End-User Engagement*

Principal Investigator: **Yanjun Shi**
Office: 1(403) 329-2049 Cell: 1(403) 892-8287 yanjun.shi@uleth.ca

You are being invited to participate in the current study. The study is being conducted by Yanjun Shi, as a master's thesis. Yanjun Shi is a graduate student pursuing a degree in Master of Education - Counselling Psychology, at the University of Lethbridge.

The thesis is conducted under the supervision of Dr. Bonnie Lee, Faculty of Health Sciences, and Dr. Noella Piquette, Faculty of Education, University of Lethbridge.

Why are you being asked to take part in this research study?

You are being asked to be in this study because you:
(1) have completed the CCT or TAU treatment in the couple therapy study;
(2) have no recent suicidal risks.

To determine your eligibility to participate, at your inquiry of the study, I (Yanjun Shi) will go over a list of questions with you to assess your risk of suicide. I will ask for the date of your final session of CCT/TAU in the couple therapy study.

During the interview, if signs of suicide risks occur, I will follow the same screening procedures to assess your risk of suicide. If the suicide risk is deemed high, I will ask you to discontinue with the study and to access appropriate mental health services.

Before you decide whether to participate in this study, I will go over this form with you. You are encouraged to ask questions if you feel anything needs to be made clearer. You will have a copy of this form for your records.

What is the reason for doing the study?

This research study is an adjunct project with the couple therapy study you are partaking, where you and your partner received Congruence Couple Therapy (CCT) or Treatment as Usual (TAU) at your local Alberta Health Services sites.

The purpose of this research is to explore (1) the participants' service needs when signing up for the couple therapy study, (2) the participants' experience throughout Congruence Couple Therapy (CCT) or Treatment as Usual (TAU), and (3) the participants' views regarding the helpfulness and limitations of CCT or the TAU programs they received.

This research is important for the following reasons: (1) understanding the clients' needs for couple therapy will help mental health service providers to make better decisions on applying couple-involved programs for addiction; (2) learning the clients' experience of going through addiction treatment services together with their partner or on their own can help us understand the process of change in a couple context; (3) clients' evaluation of the treatment programs can help researchers and service providers to improve the services to better meet clients' needs in their recovery.

What will you be asked to do?

1. You and your partner will EACH be asked to complete a two-part telephone interview with me. Each part will be about 40 min to 1 hour long. The interview will be audio recorded. I may also take notes during the interview. The phone interview will be conducted and recorded using the University of Lethbridge *Cisco WebEx*. You may participate using the phone or the Internet.

The interview will focus on your hopes and expectations when signing up for the couple therapy study, your experience throughout CCT/TAU, and your views on the programs you went through.

2. You are asked to give consent for me to access some of your data collected in the couple therapy study. For the current thesis, in addition to the interviews, I will analyze the pooled data of part of the participants survey responses during the couple therapy study.

With your consent, I will draw data from the surveys you completed in the couple therapy study, including some or all of the (1) demographic information, (2) results of questionnaires on alcohol and gambling addiction, mental health, and treatment, (3) assessments on couple and family relationship, and (5) results of the client satisfaction questionnaire, to be analyzed together with other participants' survey responses from the couple therapy study

Analyzing these data in addition to the interviews will help paint a fuller picture of the participants' experience during CCT/TAU and better understand their views towards CCT/TAU.

3. You may also be contacted for related future research and/or to partake in disseminating activities (i.e., reports/presentations about the study), provided that you consent to giving your contact information to me and my first co-supervisor Dr. Bonnie Lee for this purpose.

Who else are in the research team?

There is an advisory committee consisting of 6-8 end users of Alberta's addiction services involved in the research process. The end-user advisors have also sought or desire to seek couple

therapy in addiction treatment. They have volunteered to join the research team to give input to the interview guideline and feedback on the findings.

The end-user advisory committee will NOT have access to any of your identifying data. They will review the findings of the study that might include direct quotes from you. To protect your anonymity, only made-up names will be used in the findings, and all the important dates, locations, and other identifying clues in your quotes will be replaced with made-up ones.

What are the risks and discomforts?

First, as you are asked to recall experience during you/your partner's addiction treatment and recovery, negative memories in the past might come up. This may affect your mood and thoughts. Second, during the interview, you might experience mental fatigue.

To minimize these risks, the following steps will be taken. [First], to avoid fatigue, we can divide the interview into two part and complete each part, about 40 min to 1 hour long, on two different times or days. [Second], I will invite you to communicate openly when you feel uncomfortable during the interview. [Third], I will check in with you on your mood and level of distress during the interview. [Fourth], if you start to feel overwhelmed, to help you reduce stress and relax, I can guide you through some grounding techniques. You can find grounding techniques in *Helpful Resources for Grounding* – the document emailed to you together with this Information Letter & Consent Form. If you need to, you can take a short break and resume the interview when feeling better.

[Fifth], you can ask to stop the interview at any time. You will also be reminded that you can call your local 24/7 mental health hotline and counselling services (contact given in the *Helpful Resources for Grounding*). I will call to check on you the next day.

It is not possible to know all of the risks that may happen in a study, but I have taken all reasonable safeguards to minimize any known risks to a participant.

What are the benefits to you?

You will have a safe space to reflect on your experience with CCT/TAU and the changes that have taken place. Through reflection, you may gain new insights of yourself and your important relationships. Further, you will contribute to the knowledge of addiction and couple-involved treatment and help improve Alberta's addiction and mental health services. However, it is also possible that you will not get any benefit from being in this research study.

Do you have to take part in the study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop participating at any time, and it will in no way affect the treatment services you are entitled to or your participation in the couple therapy study.

Although the participants are intended to be couples, when you withdraw, your partner can still choose to stay in the study.
When you leave the study, you can request to have all your individual data in the study destroyed, as long as the data have not been entered into analysis.

Will you be paid to be in the research?

To thank for your time and efforts, each participant will receive a $30 gift card after their interview. You will still receive the gift card or a portion thereof, even if you withdraw early.

Will your information be kept private?

During the study, I will be collecting data about you. I will do everything we can to make sure that this data is kept private. No data relating to this study that includes your name will be released outside of the researcher's office or published by the researcher. When it is required by law, I may have to release your information with your name, so I cannot guarantee absolute privacy. However, I will make every legal effort to ensure that your information is kept private:

1. To protect your anonymity, you and your partner will each choose a made-up name to use throughout the research after you consent to participate. All your data will be marked with the made-up name. You can choose to use your made-up name during the interview and in any email communication afterwards, to protect your identity on the internet. The interview will be conducted using the University of Lethbridge's web-based platform, *WebEx*. It will give you the option to call with a toll-free number or using the Internet.

2. In the report of the study, you will be referred to with a new made-up name, different from the one you use during the study. When direct quotes are used in the findings, any identifying clues, such as important dates or places, will be replaced with made-up information.

3. Although unlikely, in case that your identifying information needs to be transferred via email, the content will be in an encrypted format. There will be one password used for all encrypted documents emailed to you. I will call and tell you the password after I have received your signed consent of the study.

In compliance to the procedure *Emailing Personal Identifiable Health Information (#1113-10)*, you are asked to give consent to using email to transfer your personal, demographic, or health-related information in the study, provided that the information will be in an encrypted format and that more secure ways of information transferring, such as phoning, mailing, or faxing, are not possible. I will delete the emails from my email account, once I have sent or obtained the needed information.

Please note that the use of email in the study carries risks including but not limited to breach of privacy (i.e., someone without permission might view, obtain, use, or transmit your information) and authentication of the recipient (i.e., someone else might get access to your account and pretend to be you). If you share email access with another person, please be aware the risk with others viewing your emails.

Due to the nature of the online world, your anonymity cannot be guaranteed when web-based services are used. You may install a free software on your computer that will help to protect your IP addresses for online anonymity, such us TOR, Ultrasurf, and MegaProxy.

How will the data be stored and for how long?

Your data will be stored in digital format, encrypted with passwords, and stored in a password protected external drive. The external drive and the hard copies of the signed consent forms and transcripts will be placed in a locked cabinet in an office at the University of Lethbridge. My first co-supervisor, Dr. Bonnie Lee, and I will have access to the data in this study.

After the study is done, we will still need to securely store your data collected in the study at the University of Lethbridge. If you leave the study, we might need to keep the data that we have already collected (see section: *Do I have to take part in the study?*).

All identifiable data such as the audio recordings will be kept for 5 years after the completion of the study and destroyed afterwards. The data with no identifiers will not be destroyed.

How will the results of the study be used?

Recordings of the interviews and teleconferences, quotes and excerpts from the participants and advisors, and pooled data will result in the following products: a thesis project, possible published journal articles, and public presentations.

The data from this study may be used for related future research led by me and/or Dr. Bonnie Lee, as well as in publications and training materials on Congruence Couple Therapy. If this study determines that the treatment program(s) you have experienced is (are) helpful, researchers and service agencies may use the results of the study to promote the service(s).

What if you have questions regarding the study?

If you have any questions about the research now or later, please contact me, Yanjun Shi, at 1-(403) 892-8287, yanjun.shi@uleth.ca Alternatively, you can contact my two co-supervisors: Dr. Bonnie Lee, at (403) 317-5047, bonnie.lee@uleth.ca, and Dr. Noella Piquette at (403) 394-3954, noella.piquette@uleth.ca

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at 780-492-2615, reoffice@ualberta.ca This office has no affiliation with the study investigators.

The researcher, Yanjun Shi, has been awarded with the 2016 Alberta SPOR (Strategy for Patient-Oriented Research) studentship to cover the costs of doing this study. The Alberta SPOR studentships are jointly funded by Alberta Innovates and the Canadian Institute of Health Research. You are entitled to request any details concerning this funding from Yanjun Shi.

Consent to Participate in

Exploring Couples' Need for Couple Therapy in Addiction Treatment —A Qualitative Study with End-User Engagement

Please INITIAL next to the items where you agree.

____I understand that I have been asked to be in a research study.

____I have read and received a copy of the Participant's Information Letter of the study.

____I understand the benefits and risks involved in participating in this research study.

____I have had the opportunity to ask questions and discuss this study.

____I know I am free to withdraw from the study at any time, without having to give a reason, without affecting my participation in the couple therapy study or the treatment services at the Alberta Addiction and Mental Health Services that I am entitled to.

Has the issue of confidentiality been explained to you? YES____NO____NOT SURE____.

Do you understand who will have access to your study records? YES____ NO ____ NOT SURE____.

I consent to…..

____Participate in the phone interview, which will be conducted with *Cisco WebEx.*

____Allow the researcher to access part of my data collected from the couple therapy study, specified in the Participant's Information Letter.

____Allow the use of email between me and the researcher to transfer my personal, demographic, or health-related information in the study, provided the information is in an encrypted format and that more secure ways of information transmission, such as phoning, mailing, or faxing, are not possible.

____Allow the researcher to release research findings, including quotes from the transcript of my interview and partial data from the couple therapy study, for a thesis and possible publications and presentations, provided that any identifying information is removed.

____Agree for my information to be securely stored at the University of Lethbridge to facilitate future reuse.

____Allow the researcher and her first co-supervisor to use the data collected in the current study for related future research and publications.

____Allow the researcher and her first co-supervisor to contact me for future research and/or dissemination activities.

Who explained this study to you? _____

I agree to take part in this study:

_____	_____	_____
Participant's Printed Name	**Participant's Signature**	**Date**

You can send in your signed consent form by mail or by fax, **addressing Dr. Bonnie Lee and RE: Yanjun Shi.**

Fax: 403-329-2668

For mail or fax, the address label reads as the following:

Bonnie K. Lee, Ph.D., Associate Professor. RE: Yanjun Shi
Faculty of Health Sciences
University of Lethbridge, Markin Hall 3037
4401 University Drive
Lethbridge, Alberta T1K 3M4

I am willing to provide my contact information and to be contacted for future research and/or disseminating activities:

Participant's Address: _____

City: _____Province: _____ Postal Code: _____

Phone No. (H) with area code: _____messages Yes/No

(W – optional) _____messages Yes/No

(cell) with area code: _____ messages Yes/No

Personal E-mail: _____

University of Alberta Ethics ID Pro00077938

Appendix L: Grounding Resources for Participants

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Faculty of Education

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Helpful Resources for Grounding

Grounding techniques help to bring down the intensity of emotional pain. It works by focusing outward on the external world, rather than inward on the self. Grounding anchors you in the present reality.

Four types of grounding exercises are presented (mental, physical, soothing and talking support) below. Try different techniques until you find one that works for you.

Mental

1) Describe your environment in detail: 4-3-2-1
   - Name 4 items you can see, 3 sounds you can hear, 2 textures you can feel, and 1 thing you can smell
   - "I see a blue chair with grey metal arms and legs. The chair has black wheels. The back of the chair is high. I can hear a buzz from the ceiling…"
2) Say a Safety Statement
   - "My name is ____; I am safe right now. I am (state where), not the past. Today's date is ____."

Physical

3) Focus on your Breathing
   - Notice the cool air entering through your nostrils, notice your chest expanding, notice the warm air leaving through your lips, notice the pause before your next breath. Repeat 6 times
4) Stretch
   - Extend your fingers, arms and legs as far as you can, then contract them and stretch them out again. Pay attention to how your body feels as you stretch Repeat 3 times.

Soothing

5) Say kind things to yourself
   - "I'm a good person; I'll get through this; This feeling will pass."
6) Name your favourite things
   - Animal, nature, season, food, TV show, etc.
7) Plan a safe treat to reward yourself

- Warm bath, dinner with a friend, a walk, a movie, etc.

Talking Support

If you wish to talk to someone for support, you can access 24/7 distress lines and local walk-in counselling services or community mental health services.

Alberta Mental Health Help Lines & Counselling Services: Contact Info

24/7 Mental Health Help and Crisis Lines	Walk-In Counselling/Community Services
Fort McMurray and Northeastern Alberta: 780-743-HELP (4357) / 1-800-565-3801 **Northern Alberta: 1-800-232-7288** **Edmonton & Northern Alberta: 1-800-232-7288, (780) 482-HELP (4357)** **Edmonton: 780-342-7777** **Alberta Mental Health Help Line: 1-877-303-2642** **Alberta Addiction Healthline: 1-866-332-2322**	**Fort McMurray,** Queen Street Building: 780-793-8360 **Grande Prairie,** Aberdeen Centre: 587-259-5513 **Edmonton,** Community Mental Health: 780-342-7700, 780-342-7600 (service contact)