ORIGINAL STUDY

CJA—JCA

OPEN

Characteristics of Seekers of Couple Therapy for Alcohol Use or Gambling Disorder

Bonnie K. Lee, *PhD*[1], Yanjun Shi, *M.Ed*[2], Samuel M. Ofori-dei, *PhD*[2], Naser Miftari, *PhD*[3]

ABSTRACT

Objective: This study examined characteristics of individuals with alcohol use disorder (AUD) or gambling disorder (GD) who were seeking couple therapy based on screening data from a randomized controlled trial on Congruence Couple Therapy at 2 out-patient addiction service sites in Alberta.

Method: Screening data of couple therapy seekers (N = 171) were analyzed.

Results: Seekers cited various motivations for seeking couple therapy including addiction-related relationship breaches and issues, the desire to recover from addiction together, concerns for the well-being of their children, and the lack of available couple therapy in addiction services until this trial. Significantly more females than males were first to indicate interest, and 77% of the sample had attended other treatment and mutual help programs in the past 12 months. The majority of the treatment seekers met DSM-5 diagnostic criteria for AUD and/or GD scoring in the moderate-severe range with nearly half of the seekers reporting a mental health diagnosis at least once in their lifetime. In addition, 30% of treatment-seekers reported past-year suicidal thoughts, citing their own addiction and their partners' addiction as reasons and 57% of those individuals reported having a method/plan to carry out their suicide. Suicidal attempts in the past year was 8% based on the entire sample. Finally, 19% of treatment seekers reported experiencing intimate partner violence within the past 12 months.

Conclusion: Addiction and couple relationship problems are closely connected. Despite the serious multiple concurrent concerns of seekers identified in this study, there is a general lack of couple therapy availability in addiction services. This study highlights the importance for addiction and mental health professionals to note the complex interaction of couple distress and addiction, understand couple therapy as a treatment modality, and make timely referrals for this vulnerable group.

Keywords: couple therapy, addiction treatment, concerned significant others, alcohol use disorder, gambling disorder, comorbidities, intimate partner violence

Objectif: Cette étude a examiné les caractéristiques des personnes souffrant de troubles liés à la consommation d'alcool (TCA) ou d'un trouble lié au jeu (TJ) qui cherchaient une thérapie de couple en se basant sur les données de dépistage d'un essai contrôlé randomisé sur la thérapie de couple par la congruence dans deux sites de services d'addiction en Alberta.

Méthode: Les données de dépistage des demandeurs de thérapie de couple (N = 171) ont été analysées.

Résultats: Diverses motivations ont été citées pour la recherche d'une thérapie de couple, y compris les ruptures et les problèmes liés à l'addiction, le désir de se rétablir ensemble, l'inquiétude pour le bien-être des enfants et le manque de thérapies de couple disponibles dans les services de l'addiction. Beaucoup plus de femmes que d'hommes ont été les premières à manifester leur intérêt, et 77% de l'échantillon avait déjà participé à d'autres programmes de traitement et d'entraide au cours des 12 derniers mois. La majorité des demandeurs de traitement répondaient aux critères diagnostiques du DSM-5 pour le TCA et/ou le TJ, se situant dans la fourchette modérée à sévère et près de la moitié des

Affiliation: [1] Faculty of Health Sciences, University of Lethbridge, Lethbridge, Alberta, Canada, [2] Faculty of Health Sciences, University of Lethbridge, Lethbridge, Alberta, Canada, [3] Prentice Institute for Global Population and Economy, University of Lethbridge, Lethbridge, Alberta, Canada.

Corresponding author: Bonnie K. Lee, PhD, Faculty of Health Sciences, University of Lethbridge, 1440 University Drive, Lethbridge, Alberta, Canada T1K 3M4. E-mail: bonnie.lee@uleth.ca

The randomized controlled trial was funded by an Alberta Gambling Research Institute Major Grant #73.

The trial received approval from the Health Research Ethics Board—Health Panel, University of Alberta Pro000062248.

B.K.L. has received fees and honoraria for workshops and presentations from professional groups and government-funded organizations on Congruence Couple Therapy. The remaining authors declare no conflict of interest.

DOI: 10.1097/CXA.0000000000000174

demandeurs ont déclaré avoir reçu un diagnostic de problème de santé mentale au moins une fois dans leur vie. En outre, 30% des demandeurs de traitement ont déclaré avoir eu des pensées suicidaires au cours de l'année écoulée, citant leur propre addiction et celle de leur partenaire comme raisons, et 57% de ces personnes ont déclaré avoir une méthode ou un plan pour se suicider. Les tentatives de suicide au cours de l'année écoulée étaient de 8% pour l'ensemble de l'échantillon. Enfin, 19% des demandeurs de traitement ont déclaré avoir subi de la violence de la part de leur partenaire intime au cours des 12 derniers mois.

Conclusion: Les addictions et les problèmes de couple sont étroitement liés. Malgré les multiples et graves problèmes concomitants des demandeurs identifiés dans cette étude, il y a un manque général de disponibilité de la thérapie de couple dans les services de traitement des dépendances. Cette étude souligne l'importance pour les professionnels de l'addiction et de la santé mentale de noter l'interaction complexe entre la détresse du couple et l'addiction, de comprendre que la thérapie de couple est une modalité de traitement et d'orienter en temps utile les personnes concernées vers les services compétents pour ce groupe vulnérable.

Mots clés: thérapie de couple , traitement de l'addiction, personnes significatives concernées, trouble

INTRODUCTION

Alcohol use and gambling problems are major psychiatric and public health concerns.[1,2] Approximately 15% of Canadians consume alcohol above Canada's Low-risk Alcohol Drinking Guidelines[3] and 0.6% of the population are identified as problem gamblers, and 2.7% as at-risk gamblers.[4] These problems negatively affect not only individual physical and mental health, occupation, finances, and crime but are also sources of family relationship conflict and breakdown[5,6] and intimate partner violence (IPV)[7] with extensive harm to significant others.[8] A person with gambling problems is estimated to affect at least 6 others in close relationships with them.[9]

Attention to the treatment of affected others as a result of addictive disorders has been increasing.[8,10] However, treatment for affected others commonly views them as separate individuals who experience stress and strain due to the addicted person.[11] Interventions have focused on the significant others' coping skills[12] or training them to help the individuals with addiction in their treatment initiation and retention.[13] The framing of treatment and its research is predominantly on the affected other, not the couple's relationship.[14]

Couple therapy focuses on the interactive processes between both members of the couple that allow for direct observation and intervention.[15] A conjoint format renders a more accurate understanding of the reciprocal nature of how the couple members affect each other in relation to addiction, representing views from both sides to facilitate mutual changes. Since couple therapy is not commonly an option in addiction treatment services[14,16] data on seekers of couple therapy are difficult to obtain and little is known about their characteristics.

We examined the data of individuals in couple dyads seeking to take part in a randomized controlled trial (RCT) of Congruence Couple Therapy (CCT) an compared to individual-based treatment for members separately as controls. Both randomized groups consisted of couples seeking couple therapy for alcohol use disorder (AUD) or gambling disorder (GD) at 2 sites in Alberta's addiction and mental health outpatient services.[17,18] CCT is a new systemic, integrative, and relational model of addiction treatment. At the time of the RCT, conjoint couple therapy was not a routine addiction service in the provincial health system. Through the RCT, conjoint couple therapy in the form of CCT was made available as an addiction treatment modality for the first time.

Couples who passed the inclusion criteria were randomized into the CCT group with a trained CCT counsellor; the treatment as usual group received addiction counselling for individuals and their partners in separate sessions. They could also attend psychoeducation and family groups for GD and AUD. The aim of this article is to report on the motivations and characteristics of the individuals seeking couple therapy for themselves and their partners with AUD and/or GD.

The study was approved by the University of Alberta Health Research Ethics Board-Health Panel.

METHODS

"Treatment seeker" refers to individuals in the couple dyads who received screening to join the couple therapy trial. "Initiator" refers to the first person in the couple to inquire or indicate an interest in the trial. "Partner" refers to the spouse or significant other of the person with AUD or GD.

Sampling

Participant recruitment

Recruitment and screening for eligible participants for the RCT of CCT was conducted at 2 outpatient addiction clinics for a duration of 22 months from 2016 to 2018. Announcements of the couple therapy trial were made via posters, tele-info screens, and handouts for internal referrals by other addiction counselors at the 2 addiction outpatient clinics. Participation in the study

could be initiated by the person with an addiction or the partner through a phone call or email. If the initiator met inclusion/exclusion criteria, they were then asked to have the other member of the couple contact us for screening. Both partners had to pass screening to be eligible for the study. Treatment seekers were either current clients in the system or new couple treatment seekers with concerns of AUD or GD.

Screening procedures

One hundred eighty one individuals gave verbal consent to a phone screening with the research coordinator. Of these, 171 individuals completed the screening and were included in the current analysis. Data were collected on demographics, addiction, mental health, recent therapy, suicide, and IPV in victimization, which were entered on Qualtrics.[19]

Eligibility

Inclusion screening criteria for the RCT were: (1) 18 years of age or older; (2) self-report of being in a committed relationship; (3) one or both members in the couple met the DSM-5 criteria for AUD or GD in the past 12 months.[20] Exclusion was based on meeting any one of the following: (1) current serious suicidal thoughts with method/plan or a suicide attempt in the past 12 months; (2) past-month psychotic symptoms; (3) recurring IPV; (4) involvement with loan sharks. In ambiguous cases, the level of suicide risk was determined jointly by the clinical judgment of the researchers and clinicians. The exclusion criteria were meant to reduce risk in the trial.

Screening instruments

DSM-5 AUD. DSM-5 AUD consisted of 12 items to assess symptoms of AUD in the last 12 months.[20] The total score is from 0 to 11 (excluding Item 12, which was a specifier of remission). The minimum qualifying score for AUD is 2; a score of 2–3 is considered mild; 4–5 moderate; 6 or above is severe. DSM-5 AUD was not administered if the participant reported no drinking in the past 12 months.

DSM-5 GD. DSM-5 GD comprises of 9 items of GD symptoms in the last 12 months with scores ranging from 0 to 9.[20] The minimum qualifying score for GD is 4. A score of 4–5 is considered mild; 6–7 moderate; a score of 8–9 is severe. Only the participants who reported gambling in the past year were administered DSM-5 GD.

Hurts, Insults, Threatens Harm, and Screams (HITS). HITS is a brief screen for domestic violence.[21] The scale consisted of 4 items, assessing the risk of victimization to physical violence, psychological violence, threats of physical harm, and verbal aggression, respectively. The total score range from 4 to 20, with the cut-off score of 10 indicating IPV. HITS showed good internal consistency (Cronbach alpha = 0.80) and good construct validity in differentiating abuse victims from patients of family practice.

Suicide Risk Screening. The suicide risk screening questionnaire consisted of 8 questions developed for the RCT to determine *current* and *past-year* suicidal thoughts, methods/ plans, and attempts, as well as *life-time* suicidal attempts.

Psychosis Screening. The 5-item psychosis screening questionnaire was developed for the RCT to assess past-month hallucinations, delusions, thought disturbance, and feelings of social disconnection. The total score ranged from 0 to 20, and a score of 15 or above indicated concerns for past-month psychotic symptoms, resulting in the exclusion from the RCT.

Mixed methods analysis

SPSS software Version 24 was used for all quantitative analysis, and statistical significance for all analyses was determined at 95% CI (2-tailed test).[22] Descriptive analysis was conducted on the demographics, addiction symptoms, mental health, recent treatment, and other inclusion criteria. χ^2 tests were conducted for statistical difference of group differences for categorical variables, and *t* test for continuous variables, the Mann-Whitney *U* test for non-normally distributed continuous outcome variables. In addition, content analysis was conducted on responses to the questions regarding how seekers found out about the study, what motivated their call, and suicidal ideations. Responses were coded as categories.

RESULTS

Demographics

Treatment seekers refer to both the individuals with addiction or their partners. Treatment-seekers (N = 171) were mostly female (57%) with an average age of 38 years (SD = 10.3). Couple relationship duration ranged from 1 month to 44 years, with a median of 6 years. Seventy-four percent identified as White, 20% First Nations or Metis, and 7% other.

Treatment initiation

Initiators of treatment numbered 102, including 71 females (63%) and 31 males (37%), showing significantly more females were initiators of couple therapy ($\chi^2 = 15.63$, $P = 0.001$), calculated on a weighted proportion of the entire sample. There was no significant difference in the proportions of individuals with addiction (58%) and those without addiction (64%) initiating couple therapy ($\chi^2 = 0.65$, $P = 0.42$).

How couple therapy seekers learned about the study

The majority of the seekers learned about the RCT from mental health/addiction professionals (55%), others from info-screens and posters at treatment facilities (35%), and from their partners (31%).

Motivation for seeking couple therapy

Content analysis of reasons presented by those seeking couple therapy reflected the inextricable entanglements of relationship and addiction concerns. Their comments highlighted the following:

(1) Relationship problems both contributed to and resulted from the addiction: "*Relationship problem caused by my drinking and gambling*"; "*Relationship issues led to relapse.*"
(2) Desire to repair the relationship, learn better communication, and increase mutual understanding and support, "*I'd like him to understand what addiction really is, work through his anger with my addiction, and support me the best he can in my sobriety*"; "*A lot of trust issues.*"
(3) Jointly-addicted couples wanted to recover together, "*We both struggle with addiction and want to get better together.*"
(4) No place to find couple counselling in addiction treatment, "*There's no place for a partner of the addict [in treatment]*"; "*There's no couples counselling.*"
(5) Concerns about their children, "*safety of the children,*" "*I want to get better for our baby on the way.*"

Past-year therapy

A high percentage (77%) of the treatment seekers reported having received therapy in the past 12 months: individual therapy (53%), group therapy (35%), AA and other addiction self-help groups (33%), and inpatient programs (7%). Programs that involved significant others were self-help groups (4%) and couples therapy sought outside of the health care system (3%).

Addiction and comorbidities

Majority of the treatment seekers (69%, n = 118) met the DSM-5 criteria for AUD and/or GD with mean scores in the severe range ($M = 8.4$, SD = 2.5) for AUD, and the moderate-severe range for GD ($M = 7.3$, SD = 1.6). Among the individuals with addiction, 70% of them met the criteria for AUD, 5% met GD criteria, and 25% both AUD and GD. The remaining treatment seekers (n = 53) reported no history of AUD or GD or had abstained for at least 12 months.

Comorbidities

Among the seekers with AUD and/or GD, 25% were comorbid for both AUD and GD, and 51% reported at least one life-time mental health diagnosis. Comorbidities in this study refer to both AUD and GD or having one or more life-time mental health diagnosis (58.5%). There was no significant difference between individuals with AUD and/or GD (51%) and those without (40%) in reports of a life-time mental health diagnosis ($\chi^2 = 1.85$, $P = 0.174$).

Past month psychotic symptoms

Treatment seekers scored 0–16 on the psychosis screening for past month symptoms with a mean of 2.5 (SD = 3.4). One percent of the sample met the cut-off score for past-month psychotic symptoms and were excluded from the RCT.

Life-time mental health diagnoses

Nearly half of treatment seekers (47%; 35% of individuals with addiction and 12% individuals without addiction) reported lifetime mental health diagnoses apart from AUD and/or GD including depression (27%), anxiety (19%), attention deficit/hyperactivity disorder (6%), post-traumatic stress disorder (5%), bipolar disorder (4%), and "other" (12%) such as fetal alcohol spectrum disorder, obsessive-compulsive disorder, borderline personality disorder, and oppositional defiant disorder.

Addiction severity and comorbidities

Individuals with AUD and GD and other life-time mental health comorbidities (n = 64) and those without (n = 48) had similar DSM-5 AUD mean scores, 8.6 versus 8.2 ($t = 0.95$, $P = 0.34$). The sample size for those with only GD was too small to perform a similar t test analysis.

Singly versus jointly addicted couples

Treatment seekers comprised of 69 couples. Among them, 39 consisted of one member with AUD and/or GD (57%) and 30 were jointly addicted couples (43%), that is, couples where both members of a couple had AUD and/or GD.

Addiction severity in singly versus jointly addicted couples

Individuals with AUD in singly addicted couples (n = 38) and jointly addicted couples (n = 57) had equivalent DSM-5 AUD mean scores in the severe range (8.1 vs. 8.5,

$t = -0.72$, $P = 0.47$). GD subsamples were too small for t test analysis.

Illicit drug use

A total of 23% treatment seekers voluntarily disclosed other drug use. The most common substances were opioids, cocaine, and methamphetamines. Since illicit drug use was not part of the screening protocol, these statistics were likely an underestimation.

Gender

Gender and addiction status

Significantly greater proportions of males than females met the DSM-5 criteria for AUD (88% vs. 49%, $\chi^2 = 27.72$, $P < 0.001$) and GD (27% vs. 15%, $\chi^2 = 3.76$, $P = 0.053$).

Gender and mental health

Significantly greater proportion of females than males reported a life-time mental health diagnosis, 55% versus 37% ($\chi^2 = 5.51$, $P = 0.019$). This gender difference in mental health became more significant among individuals with addiction (67% vs. 38%, $\chi^2 = 10.08$, $P = 0.002$).

Suicide risk

A total of 30% of treatment seekers reported suicidal thoughts, among which 57% reported having a method/plan. In the entire sample, 8% reported suicide attempts in the past 12 months. In addition, 32% reported lifetime suicide attempts. Among those with past-year suicidal thoughts, 90% reported their thoughts were related to their own (78%) or their partner's (12%) addiction.

Addiction and suicide risk

Significantly greater proportion of individuals with addiction than those without addiction reported a life-time suicide attempts (39% vs. 17%, $\chi^2 = 8.11$, $P = 0.004$) and suicidal thoughts in the past 12 months (36% vs. 15%, $\chi^2 = 7.96$, $P = 0.005$).

Mental health and suicide risk

Significantly greater proportion of treatment seekers with a life-time mental health diagnosis than those without reported a life-time suicide attempt (46% vs. 20%, $\chi^2 = 12.88$, $P < 0.001$) and suicidal thoughts in the past 12 months (41% vs. 20%, $\chi^2 = 8.76$, $P = 0.003$).

Gender and suicide risk

Equivalent proportions of females and males reported a life-time suicide attempt (33% vs. 32%, $\chi^2 = 0.025$, $P = 0.874$) and suicidal thoughts in the past 12 months (29% vs. 32%, $\chi^2 = 0.172$, $P = 0.678$).

IPV

Treatment seekers' total HITS score ranged from 4 to 20 for victimization in IPV, with a mean score of 7.4 (SD = 3.0). Further, 19% had a total HITS score at or above the cut-off score of 10, meeting IPV criteria for exclusion from the randomized trial.

Addiction status and IPV

Individuals with addiction scored significantly higher than those without on the HITS item measuring physical violence (91.3 vs. 74.3, $U = 3746.5$, $P = 0.006$) and threat of physical harm (89.4 vs. 78.4, $U = 3532.0$, $P = 0.044$), but not on psychological violence and verbal aggression items (insults: 88.6 vs. 80.3, $U = 3431.0$, $P = 0.294$; scream/curse: 89.0 vs. 79.4, $U = 3476.5$, $P = 0.225$) or the total HITS score (90.7 vs. 75.6, $U = 3678.5$, $P = 0.063$).

Gender and IPV

Males and females had equivalent mean ranks in victimization for the total HITS score (86.9 vs. 85.3; $U = 3510.0$, $P = 0.833$) and the score of each HITS item (physical violence: 89.2 vs. 83.6, $U = 3342.0$, $P = 0.329$; psychological violence: 83.0 vs. 88.2, $U = 3793.5$, $P = 0.485$; threat of physical harm: 86.2 vs. 85.9, $U = 3563.0$, $P = 0.948$; verbal aggression: 5.9 vs. 86.1, $U = 3584.5$, $P = 0.981$).

IPV in singly versus jointly addicted couples

Jointly addicted couples scored significantly higher than singly addicted couples on the HITS item measuring physical victimization (78.3 vs. 62.8, $U = 2866.0$, $P = 0.003$), but not on the total HITS score (66.3 vs. 73.7, $U = 2592.5$, $P = 0.274$) or any other HITS items (psychological victimization: 66.0 vs. 74.0, $U = 2611.5$, $P = 0.226$; threat of physical harm: 67.3 vs. 72.3, $U = 2510.0$, $P = 0.251$; verbal aggression: 68.9 vs. 70.3, $U = 2386.5$, $P = 0.834$).

DISCUSSION

To the best of our knowledge, this is the first study to document the characteristics, motivations, and risks of individuals and couples seeking conjoint couple therapy among those afflicted by AUD and/or GD. The findings helped us recognize the severity of their addiction and mental health problems, and other signs of vulnerability to suicide and IPV risks, and joint addiction in couples. Seekers' concerns about their couple relationship and their children were closely

intertwined with their addiction issues. Past studies showed that severity of addiction has been associated with a greater likelihood for treatment seeking in both AUD[23] and GD.[24] Further, greater severity and comorbid psychopathology have been associated with those using illicit substances with alcohol.[25,26] The composite seekers' profile from our study suggests that those seeking couple therapy are severely affected by their co-occurring conditions.

Nearly half (43%) of couples were jointly addicted. Since jointly-addicted couples are not uncommon and addiction in both partners could affect couple dynamics and recovery,[27] questions about both members' addiction should be included in future screening and intake. The couple therapy seekers saw their addiction and relationship problems as inextricable, and that working out both issues together was what they were seeking. These motivations align with earlier studies where concerns for one's spouse and couple relationship were among the leading motivators for treatment-seeking for alcohol and gambling problems.[28,29] Hence, the pressure of relationship and family difficulties and the concerns for partners could be leveraged to encourage addiction treatment initiation and engagement.

A large percentage of couple therapy seekers (77%) reported having received past year counselling and mutual help programs. The fact that they were looking to take part in this couple therapy trial suggested that these other programs had not fully met their needs. It was found that gambler-focused treatment approaches responded to respond to a different set of concerns compared with family-focused approaches.[30]

Gender of couple therapy seekers

In this sample, females were much more likely to initiate help-seeking for couple therapy than males, and 58% of female initiators were partners. This accords with the observation that women are quicker to recognize distress in a relationship and to suggest professional help.[31] Women are found to be more attuned to and supportive of their spouses' emotional needs and play a greater role in the emotional work of promoting mental health care.[32] Because of gender scripts and stigma of men in seeking addiction and mental health services, female partners could be instrumental in urging individual and couple services for their partners and their relationship.[31]

IPV

IPV is a salient indicator of couple distress.[33] In the present sample, about 19% of treatment seekers met the screening threshold for IPV victimization in the past 12 months, comparable to the rate of 14.1%–18.4% of victimization reported in problem gambling.[34,35] Meta-analysis of the association of substance use, including alcohol use, with IPV reveals the significance of this association, with stronger correlations for problematic alcohol use than alcohol consumption.[36] Although the sequence of IPV and substance use is complex, evidence supports the bidirectional effect of substance use and IPV.[37] Problem gambling is significantly associated with both the perpetration and victimization in IPV.[38,39] In the present sample, those with AUD and/or GD reported greater victimization than those without, particularly on items of physical aggression and threat of physical harm. Male and female victimization is similar in the present sample, consistent with what had been suggested in earlier studies exploring the relationship of problem gambling and IPV[40] and alcohol and IPV.[41] Jointly-addicted couples scored significantly higher in IPV than singly addicted couples on physical harm indicating the higher risks of couples when both partners are affected by AUD and/or GD.

Suicidality

A percentage of both individuals with addiction and partners reported suicide ideation (30%), and among these individuals, 57% reported a method/plan. In the entire sample, suicide attempts in the past year was 8%. Suicide ideation reported by the individuals with addiction (78%) and partners (12%) indicated that both were affected emotionally, relationally, socially, and financially.[42] Associations of suicide with familial discord, domestic violence, familial stress, and negative self-perceptions in relation to the family are shown to be robust risk factors for lethal suicidal behaviour across the lifespan.[43] Given that suicide risks are found in both individuals with addiction and partners without addiction and 90% cited addiction was a motivating factor, both members of a couple should be screened for suicidal risks in addiction with referrals for appropriate services.

Couple therapy: a gap in addiction treatment services

The severity and risks reported by this sample highlights the importance in making conjoint systemic couple counselling/therapy services widely available in addiction treatment. Addiction services typically provide services for affected others individually and treat them separate from the individuals with addiction, and often rejecting partners' involvement in addiction treatment and individualizing their concerns.[14] Treating affected others and the addicted patient separately isolates family members from each other who are in fact closely connected in their interactions in real life.[44] Those seeking couple therapy in this RCT attests to the couples' needs and the long-standing gap in couple-based service.

IPV and couple therapy

In our screening for enrollment in the RCT, we excluded seekers who exceeded the threshold on the HITS for IPV victimization. However, those with mild, situational and episodic IPV victimization were included. The jury is still out on the safety and effectiveness of using couple therapy for IPV, although more conventional methods of gender-specific use of group therapy, individualized treatment and psychoeducational program for IPV had not yielded expected outcomes.[45] Based on a systemic review and meta-analysis of randomized trials on using couple therapy for IPV consisting of six studies, the results of couple therapy for IPV showed moderate effectiveness in reducing male-perpetrated IPV. However, the study samples were diverse and use of couple therapy for IPV requires attention to the severity and type of violence, characteristics of the individuals involved, presence and severity of their addiction and mental health issues, their cultural background, and gender-related factors. These considerations should inform IPV research to ensure that couple therapy is appropriate and safe for IPV couples, as couple therapy could raise tension in the couple, expose vulnerability and trigger retaliation. Studies on the use of couple therapy for reducing IPV is an important avenue for research.

Suicidality and couple therapy

The factors of thwarted belongingness and perceived burdensomeness have been posited to be causes of suicidality,[43] hence couple therapy to rebuild connection and mutual understanding in couples should be researched as a viable intervention to prevent and reduce suicidality. In a recent purportedly first comprehensive couple-based suicide-specific intervention study with 5 veterans and their partners, results showed improved couple relationship and decreased perceived burdensomeness, thwarted belonging, and suicidal ideation, suggesting the feasibility and acceptability of a couple-based suicide prevention as an additional avenue for suicide prevention in veterans.[46] The potential of using couple-based interventions in suicide prevention warrants further examination and research.

Limitations

The characteristics and concerns of couple therapy seekers in this study were limited to screening data from an RCT on CCT. Other questions of interest such as history of adverse childhood experiences, polysubstance use, relationship and addiction history, and current psychiatric diagnoses were not included. Future studies on those seeking couple therapy with addiction concerns should be conducted to further understand their motivations and narrative construction of their problems to differentiate those seeking couple therapy versus those seeking separate individual treatments for themselves.

CONCLUSION

Studying the characteristics and motivations of couple therapy seekers brought new light to the complex picture that consists of the severe range of their AUD and GD, their relationship difficulties tied to the addiction, their concerns for their children and their risks of suicide and IPV. As most couple therapy seekers in this sample were referred by other addiction professionals, such professionals play an important role in identifying the risks affecting both members of the couple. Presumptions, preferences, and barriers of individuals with addiction and their partners in seeking couple therapy should be further studied. New inroads could be made with the development of a decision-making tree to ascertain the urgency, preference, need, readiness and appropriate-ness of referring addiction clients for couple therapy. Specialized training for therapists to work at the inter-face of couple therapy and addiction is urgently needed.

REFERENCES

1. Ayares, G, Idalsoaga, F, Arnold, J, et al. Public health measures and prevention of alcohol-associated liver disease. *J Clin Exp Hepatol* 2022;12:1480–1491.
2. Wardle, H, Reith, G, Langham, E, et al. Gambling and public health: We need policy action to prevent harm. *BMJ* 2019;365:l807.
3. Canadian Centre on Substance Use and Addiction. Alcohol (Canadian Drug Summary). Accessed June 20, 2022. https://www.ccsa.ca/alcohol-canadian-drug-summary
4. Williams, RJ, Leonard, CA, Belanger, YD, et al. Gambling and problem gambling in Canada in 2018: prevalence and changes since 2002. *Can J Psychiatry* 2020;66:485–494.
5. Langham, E, Thorne, H, Browne, M, et al. Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health* 2016;16:80.
6. Rodriguez, LM, Neighbors, C, Knee, CR. Problematic alcohol use and marital distress: an interdependence theory perspective. *Addict Res Theory* 2014;22:294–312.
7. Cafferky, BM, Mendez, M, Anderson, JR, et al. Substance use and intimate partner violence: a meta-analytic review. *Psychol Violence* 2018;8:110–131.
8. Merkouris, SS, Rodda, SN, Dowling, NA. Affected other interventions: a systematic review and meta-analysis across addictions. *Addiction* 2022;117:2393–2414.
9. Goodwin, BC, Browne, M, Rockloff, M, et al. A typical problem gambler affects six others. *Int Gambl Stud* 2017;17:276–289.

10. Edgren, R, Pörtfors, P, Raisamo, S, et al. Treatment for the concerned significant others of gamblers: a systematic review. *J Behav Addict* 2022;11:1–25.

11. Orford, J, Copello, A, Velleman, R, et al. Family members affected by a close relative's addiction: the stress-strain-coping-support model. *Drugs (Abingdon Engl)* 2010;17(s 1):36–43.

12. Copello, A, Templeton, L, Orford, J, et al. The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomized trial. *Addiction* 2009;104:49–58.

13. McCrady, BS. The role of the family in alcohol use disorder recovery for adults. *Alcohol Res* 2021;41:1–19.

14. Kourgiantakis, T, Ashcroft, R. Family focused practices in addictions: a scoping review protocol. *BMJ Open* 2018;8: e019433.

15. Lee, BK. Towards a relational framework for pathological gambling (part II): congruence. *J Fam Ther* 2015;37:103–118.

16. Cassidy, A, Poon, AW. A scoping review of family-based interventions in drug and alcohol services: Implications for social work practice. *J Soc Work Pract Addict* 2019;19:345–367.

17. Lee, BK, Ofori Dei, SM, Brown, MMR, et al. Congruence couple therapy for alcohol use and gambling disorders with comorbidities (part I): outcomes from a randomized controlled trial. *Fam Process* 2022;62:124–159. https://doi.org/10.1111/famp.12813

18. Lee, BK, Ofori Dei, SM, Isik, E. Congruence couple therapy for alcohol use and gambling disorders with comorbidities (part II): targeted areas and mechanisms of change. *Fam Process* 2022:1–23. https://doi.org/10.1111/famp.12816

19. Qualtrics. Released 2005. Qualtrics, version 2016. https://www.qualtrics.com.

20. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. American Psychiatric Association; 2013.

21. Sherin, KM, Sinacore, JM, Li, XQ, et al. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med* 1998;30:508–512.

22. IBM Corp. *IBM SPSS Statistics [Computer Software] Version 240*. Armonk, NY: IBM Corp; 2016.

23. Tuithof, M, ten Have, M, van den Brink, W, et al. Treatment seeking for alcohol use disorders: Treatment gap or adequate self-selection? *Eur Addict Res* 2016;22:277–285.

24. Harries, MD, Redden, SA, Grant, JE. An analysis of treatment-seeking behavior in individuals with gambling disorder. *J Gambl Stud* 2018;34:999–1012.

25. Moss, HB, Goldstein, RB, Chen, CM, et al. Patterns of use of other drugs among those with alcohol dependence: Associations with drinking behavior and psychopathology. *Addict Behav* 2015;50:192–198.

26. Bailey, AJ, Farmer, EJ, Finn, PR. Patterns of polysubstance use and simultaneous co-use in high risk young adults. *Drug Alcohol Depend* 2019;205:107656.

27. Derrick, JL, Wittkower, LD, Pierce, JD. Committed relationships and substance use: Recent findings and future directions. *Curr Opin Psychol* 2019;30:74–79.

28. Steinberg, ML, Epstein, EE, MCCrady, BS, et al. Sources of motivation in a couples outpatient alcoholism treatment program. *Am J Drug Alcohol Abuse* 1997;23:191–205.

29. Rodda, SN, Dowling, NA, Thomas, AC, et al. Treatment for family members of people experiencing gambling problems: family members want both gambler-focused and family-focused options. *Int J Ment Health Addict* 2019;18:1318–1334.

30. Booth, N, Dowling, NA, Landon, J, et al. Affected others responsivity to gambling harm: an international taxonomy of consumer-derived behaviour change techniques. *J Clin Med* 2021;10:583.

31. Parnell, KJ, Scheel, MJ, Davis, CK, et al. An investigation of couples' help-seeking: a multiple case study. *Contemp Fam Ther* 2017;40:110–117.

32. Reczek, C, Thomeer, MB, Gebhardt-Kram, L, et al. "Go see somebody": How spouses promote mental health care. *Soc Ment Health* 2019;10:80–96.

33. Sommer, J, Iyican, S, Babcock, J. The relation between contempt, anger, and intimate partner violence: a dyadic approach. *J Interpers Violence* 2019;34:3059–3079.

34. Dowling, NA, Oldenhof, E, Cockman, S, et al. Problem gambling and family violence: Factors associated with family violence victimization and perpetration in treatment-seeking gamblers. *J Interpers Violence* 2021;36:7645–7669.

35. Roberts, A, Sharman, S, Landon, J, et al. Intimate partner violence in treatment seeking problem gamblers. *J Fam Violence* 2020;35:65–72.

36. Cafferky, BM, Mendez, M, Anderson, JR, et al. Substance use and intimate partner violence: a meta-analytic review. *Psychol Violence* 2018;8:110–131.

37. Mason, R, O' Rinn, SE. Co-occurring intimate partner violence, mental health, and substance use problems: A scoping review. *Glob Health Action* 2014;7:24815.

38. Hing, N, O'Mullan, C, Breen, H, et al. How problem gambling by a male partner contributes to intimate partner violence against women: a gendered perspective. *Int Gambl Stud* 2021;22:82–101.

39. Dowling, N, Suomi, A, Jackson, A, et al. Problem gambling and intimate partner violence: a systematic review and meta-analysis. *Trauma Violence Abuse* 2016;17:43–61.

40. Foran, HM, O'Leary, KD. Alcohol and intimate partner violence: a meta-analytic review. *Clin Psychol Rev* 2008;28:1222–1234.

41. Kourgiantakis, T, Saint-Jacques, MC, Tremblay, J. Problem gambling and families: a systematic review. *J Soc Work Pract Addict* 2013;13:353–372.

42. Riley, B, Harvey, P, Crisp, B, et al. Gambling-related harm as reported by concerned significant others: a systematic review and meta-synthesis of empirical studies. *J Fam Stud* 2018;27:112–130.

43. Van Orden, KA, Witte, TK, Cukrowicz, KC, et al. The interpersonal theory of suicide. *Psychol Rev* 2010;117:575–600.

44. Selbekk, AS, Adams, PJ, Sagvaag, H. A problem like this is not owned by an individual. *Contemp Drug Probl* 2018;45:146–162.

45. Karakurt, G, Whiting, K, van Esch, C, et al. Couples therapy for intimate partner violence: a systematic review and meta-analysis. *J Marital Fam Ther* 2016;42:567–583.

46. Khalifian, CE, Leifker, FR, Knopp, K, et al. Utilizing the couple relationship to prevent suicide: a preliminary examination of Treatment for Relationships and Safety Together. *J Clin Psychol* 2022;78:747–757.