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Priorities for Intervention Content to Support Families and Friends Affected by Gambling Harm: A Mixed Methods Study of Clinician and Researcher Perspectives

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Abstract

Harmful gambling impacts not only the person who gambles but also their partners, families, and friends (affected others; AOs). Although interventions for AOs exist, effectiveness is modest, with little evidence available to guide the selection of intervention content. Behaviour change techniques (BCTs), the active ingredients of behaviour change interventions, provide a framework for identifying and prioritising intervention content for AO interventions. This mixed methods study therefore aimed to: (1) identify BCT groups considered most important by gambling clinicians and clinical gambling researchers for inclusion in interventions that either support the AO's own wellbeing (AO-focused) or support the person who gambles (gambler-focused); and (2) explore gambling clinicians' views on why these BCT groups were prioritised. Gambling clinicians ($n=37$) and clinical gambling researchers ($n=19$) from multiple countries ranked their top five of 23 BCT groups for inclusion in each intervention type, and a subset of clinicians ($n=15$) participated in follow-up interviews. *Social support*, *financial management*, and *restoring a balanced lifestyle* were prioritised across both intervention types, alongside *communication training* for AO-focused interventions, and *goals and planning* for gambler-focused interventions. Clinician interviews highlighted rationales for these priorities but also a tendency to reorient AO-focused support around the person who gambles, reflecting uncertainty about who constitutes the primary client in AO interventions, and to view support for AOs and the person who gambles as intertwined. Findings highlight a need for future interventions to make their intended target explicit, and to address AO wellbeing in its own right alongside AOs' their capacity to support the person who gambles.

Keywords Affected others · Concerned significant others · Behaviour change techniques · Gambling · Intervention · Mixed methods

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Introduction

Harmful gambling affects not only the person who gambles but also family, friends, colleagues, and the wider community, collectively referred to as 'affected others' (AOs) (Castrén et al., 2021; Dowling et al., 2025c; Goodwin et al., 2017; Merkouris et al., 2022). AOs can experience financial harm, relationship conflict, emotional distress, compromised health, reduced work functioning, cultural harm, and involvement in criminal activity (Dowling et al., 2025a; Langham et al. 2016). International estimates suggest AOs comprise between 4–21% of the adult population, although estimates vary according to how AO status is defined and measured (Castrén et al., 2021; Dowling et al. 2025c; Hing et al., 2022; Lind et al. 2022; Rockloff et al., 2019; Salonen et al., 2014; Svensson et al., 2013; Tulloch et al., 2021).

Despite the prevalence and significance of the harms they experience, AOs remain underrepresented in gambling treatment settings, comprising approximately 15–26% of people seeking gambling-specific support (Dowling et al. 2025a; Rodda et al., 2020). Low help-seeking may partly reflect shame or stigma, a perceived lack of entitlement to support given they are not the person experiencing gambling issues, and preferences for low-intensity or self-directed support (Booth et al., 2021; Dowling et al., 2025a; Hing et al., 2013). There may, however, also be a mismatch between available services and AO needs. Emerging evidence suggests AOs have dual support needs: assistance managing their own gambling-related harm and wellbeing ('AO-focused' support) and assistance supporting behaviour change or treatment engagement in the person who gambles for the gambler ('gambler-focused' support) (Dowling et al., 2025b, 2026b; Gandhi et al., 2026; Rodda et al., 2020).

A small number of psychosocial interventions have been evaluated for AOs of gambling, primarily adapted from approaches developed for harmful alcohol and substance use. These include Community Reinforcement and Family Training (CRAFT) (Makarchuk et al., 2002), the 5-Step Method (Orford et al., 2005, 2010), and Coping Skills Training (CST) (Rychtarik & McGillicuddy, 2005, 2006). The 5-step method and CST primarily aim to improve AO coping and wellbeing, whereas CRAFT seeks to facilitate behaviour change or treatment engagement in the person who gambles.

The evidence base for these interventions remains limited. Evaluations of these interventions have identified some within-group improvements in the psychological wellbeing and coping of AOs, as well as behaviour change and treatment entry among people who gamble (Hodgins et al., 2007; Makarchuk et al., 2002; Nayoski & Hodgins, 2016; Orford et al., 2017; Rychtarik & McGillicuddy, 2006). However, between-group effects have generally been modest or inconsistent, and evidence remains limited for outcomes such as AO help-seeking (beyond the intervention itself) and gambling frequency or expenditure of the person who gambles (Hodgins et al., 2007; Makarchuk et al., 2002; Nayoski & Hodgins, 2016; Orford et al., 2017; Rychtarik & McGillicuddy, 2006). However, the evidence base is also characterised by small samples, short follow-up periods, heterogeneous outcomes, and several single-arm studies, limiting conclusions regarding efficacy, effectiveness, and generalisability (Hodgins et al., 2007; Orford et al., 2017; Rychtarik & McGillicuddy, 2006). Moreover, intervention descriptions do not consistently identify the specific components used or how they are intended to address AO- and gambler-focused goals (Merkouris et al., 2023; Rodda et al., 2019). There is therefore limited guidance on which intervention com-

ponents should be prioritised when developing interventions that address the dual needs of AOs presenting to treatment.

Behaviour change technique (BCT) taxonomies provide a structured framework for identifying, describing, and comparing the individual components of psychological interventions (Michie et al., 2013). The first comprehensive BCT taxonomy (Michie et al., 2013) comprises 93 techniques organised into 16 hierarchical groups, including social support, goals and planning, and repetition and substitution. This approach allows intervention content to be compared across different theoretical orientations, formats, and modes of delivery. Although BCT taxonomies have been widely applied across health domains, their application within addiction research has predominately focused on interventions delivered to the person engaging in the addictive behaviour (Gardner et al., 2016; Lyons et al., 2014).

Redressing this gap, a recent systematic review and meta-analyses (Merkouris et al., 2023) examined BCT groups used in psychosocial interventions for family members and close friends affected by harmful alcohol, substance use, or gambling. Across 32 studies describing 57 interventions, 23 BCT groups were identified, including seven groups not represented in the original BCT taxonomy (Michie et al., 2013). In this review, BCT groups associated with better outcomes varied depending on whether the outcome examined was AO wellbeing or behaviour change in the person engaging in the addictive behaviour, rather than any BCT group being inherently AO- or gambler-focused. For example, *restoring a balanced lifestyle* was associated with greater improvements in AO psychological distress, whereas *repetition and substitution*, *behavioural practice/rehearsal*, and *non-specific reward* groups were associated with greater improvements in the frequency of use by the person engaging in the addictive behaviour (Merkouris et al., 2023). Only five studies included in this review, however, focused on gambling, limiting the extent to which these findings can guide the development of gambling-specific AO interventions.

Within the gambling AO literature, Booth et al. (2021) developed a consumer-derived taxonomy from online lived experience accounts, identifying 16 family-focused and 11 gambler-focused BCT groups. Frequently reported family-focused strategies included professional support, financial management, and planned consequences, whereas frequently reported gambler-focused strategies included feedback on behaviour, financial management, and professional support. Although the study did not evaluate effectiveness, Booth et al. (2021) indicated that the effects of some strategies may depend on implementation. For example, financial management may be poorly implemented by some AOs and therefore associated with heightened family conflict. Findings highlight the value of lived-experience perspectives while also indicating a need to understand which BCT groups professionals consider most important for intervention delivery.

Clinicians and clinical researchers may prioritise intervention components differently. Clinicians may draw on practice-based knowledge and considerations of feasibility, acceptability, and implementation (Damschroder et al., 2009; Green, 2008), whereas clinical researchers may place greater emphasis on evidence derived from controlled trials (Glasgow et al., 2003; Green, 2008; Grol & Grimshaw, 2003; Louie et al., 2021). Incorporating both perspectives may be particularly important when developing interventions for AOs, given their heterogeneous circumstances, differing relationships with the person who gambles, and dual intervention needs. Examining convergence and divergence between clinicians and clinical researcher priorities may therefore support the development of interventions that are theoretically grounded, evidence-informed, and clinically feasible. The

current mixed-methods study therefore aimed to: (1) identify the BCT groups considered most important by gambling clinicians and clinical researchers for inclusion in AO-focused and gambler-focused interventions for AOs; and (2) explore gambling clinicians rationales' for prioritising these BCT groups.

Methods

Study Design and Terminology

The current mixed methods study integrated top five BCT rankings from gambling clinicians and clinical gambling researchers, recruited through two parent Delphi studies (Dowling et al., 2026a; Keshani et al., 2025, 2026), with qualitative interviews exploring clinicians' reasons for BCT prioritisation. This study uses person-first, non-stigmatising language that does not attribute gambling harm primarily to individual responsibility and recognises the broader social, cultural, regulatory, environmental, product, and commercial determinants of harm. *Harmful gambling* is used to describe repeated gambling that produces adverse consequences, including both features of behavioural dependence and adverse consequences; while *gambling harm* is used as a generic term when specificity about clinical issues is not required.

Participants

Two stakeholder groups participated: gambling clinicians and clinical gambling researchers. The clinician sample comprised 37 of the 68 clinicians who completed Round 2 of a two-round modified Delphi study exploring clinical consensus on effective psychological interventions and change techniques for gambling treatment (Dowling et al., 2026a; Keshani et al., 2025). Eligibility criteria included: (1) being aged 18 years or older; (2) residing in Australia or New Zealand; and (3) having current or previous experience providing treatment or support for gambling-related harm. No minimum duration of clinical experience was required. Of the 37 clinicians who completed the survey, 15 also participated in a semi-structured interview. Clinicians were aged 25–76 years ($M = 47.2$, $SD = 13.1$), mostly women (67.6%), Australian-based (85.3%), and postgraduate-qualified (81.1%). Most had 10 or more years of general clinical experience (67.6%), though gambling-specific experience was more evenly spread (0–5 years: 35.1%; 6–10 years: 27.0%; 10 + years: 37.8%). Just over half worked full time (51.4%), and most were psychologists (41.7%), social workers (25.0%), or counsellors (16.7%), working primarily as counsellors/clinicians (83.8%) delivering in-person treatment (91.9%). Full demographic characteristics of participating clinicians are presented in Table 1.

The clinical researcher sample comprised 19 of the 35 international gambling researchers who completed Round 2 of a separate two-round modified Delphi study exploring consensus on effective change techniques in gambling treatment (Keshani et al., 2026) and elected to complete an optional component on AO interventions. Eligibility criteria included: (1) being ranked among the top 50 gambling experts worldwide on Expertscape.com or among the top 10 experts in one of the 15 highest-ranked countries; (2) having authored at least one peer-reviewed publication concerning the development or evaluation of a psychological

Table 1 Demographic and clinical characteristics for gambling clinicians

Characterics	n (%)	
	Clinician sample (n=37)	Clinician interview subsample (n=15)
Age (years) (M, SD)	47.2 (13.1)	41.5 (11.8)
Gender (% female)	67.6%	60.0%
Country of residence		
Australia	(85.3%)	11 (73.3%)
New Zealand	(14.7%)	4 (26.7%)
Clinical experience		
0-5 years	9 (37.8%)	3 (20.0)
6-10 years	3 (8.1%)	–
10+ years	25 (67.6%)	12 (80.0%)
Gambling clinical experience		
0-5 years	13 (35.1%)	5 (33.3%)
6-10 years	10 (27.0%)	2 (13.3%)
10+ years	14 (37.8%)	8 (53.3%)
Highest level of education		
Undergraduate degree	7 (18.9%)	1 (6.7%)
Postgraduate degree (including PhD)	30 (81.1%)	14 (93.3%)
Current employment status (full-time)	19 (51.4%)	11 (73.3%)
Discipline qualification		
Psychologist	15 (41.7%	5 (33.3%)
Social worker	9 (25.0%)	4 (28.6%)
Counsellor	6 (16.7%)	–
Psychotherapist	2 (5.6%)	2 (14.3%)
Alcohol and other drugs support worker	1 (2.8%)	1 (6.7%)
Other	1 (2.8%)	1 (6.7%)
Main role in sector		
Clinician/counsellor	31 (83.8%)	11 (73.3%)
Team leader	3 (8.1%)	1 (6.7%)
Case worker	2 (5.4%)	2 (14.3%)
Manager	1 (2.7%)	1 (6.7%)
Current organisation type [a]		
Face-to-face treatment	34 (91.9%)	13 (86.7%)
Online/telehealth treatment	18 (48.6%)	6 (40.0%)
Health promotion	5 (13.5%)	3 (20.0%)
Government/university	3 (8.1%)	2 (13.3%)
Brief treatment (e.g., helpline)	(5.4%)	–
Past service type [a]		
Face-to-face	36 (97.3%)	15 (100%)
Telephone	27 (73.0%)	13 (86.7%)
Online/telehealth	17 (45.9%	6 (40.0%)

M mean, *SD* standard deviation

gambling intervention; and (3) having a publicly available email address. Clinical researchers were aged 37–74 years ($M=50.6$, $SD=11.0$), mostly men (78.9%), based in Europe (42.1%), North America (31.6%), and Australasia (26.3%). They had an average of 20.3 years (SD = 10.8) of clinical research experience, and 84.2% had addiction-specific clinical experience ($M=14.1$ years, $SD=12.1$). Most held a clinical degree in psychology (63.2%) or

psychotherapy (21.1%). Familiarity with the treatment-outcome literature was more mixed for alcohol/drug treatment outcomes (42.1% moderately familiar, 26.3% extremely familiar), compared to behavioural addictions, where most were extremely familiar (63.2%). Full demographic characteristics of participating clinical researchers are presented in Table 2.

Procedure

Clinicians

Clinicians were initially recruited to the parent Delphi study through professional networks, gambling treatment services in Australia and New Zealand, and snowball sampling (Dowling et al., 2026a; Keshani et al., 2025). Following completion of that study, all 68 Round 2 completers were invited by email to participate in the current study. After provid-

Table 2 Demographic and clinical characteristics for clinical gambling researchers

Characteristics	Clinical researcher sample ($n=19$)
Age (years) (M, SD)	50.6 (11.0)
Gender (% male)	15 (78.9%)
Country of residence	
Australasia	5 (26.3%)
North America	6 (31.6%)
Europe	8 (42.1%)
Clinical research experience (years) (M, SD)	20.3 (10.8)
Addiction clinical experience	16 (84.2%)
Addiction clinical experience (years) (M, SD)	14.1 (12.1)
Field of clinical degree[a]	
Psychology	12 (63.2%)
Psychotherapy	4 (21.1%)
Psychiatry	2 (10.5%)
Counselling	2 (10.5%)
Family Therapy	1 (5.3%)
Youth Work	1 (5.3%)
Familiarity with the treatment outcome literature for alcohol/drugs	
Not at all familiar	1 (5.3%)
Slightly familiar	1 (5.3%)
Somewhat familiar	4 (21.1%)
Moderately familiar	8 (42.1%)
Extremely familiar	5 (26.3%)
Familiarity with the treatment outcome literature for behavioural addictions (including gambling)	
Not at all familiar	0 (0%)
Slightly familiar	0 (0%)
Somewhat familiar	0 (0%)
Moderately familiar	7 (36.8%)
Extremely familiar	12 (63.2%)

M mean, *SD* standard deviation

ing informed consent, 37 clinicians completed a 15-minute online survey via *Qualtrics*. At survey conclusion, clinicians were invited to participate in an optional 30-minute interview by telephone or *Zoom*. Fifteen clinicians completed an interview and received an AUD$50 or NZD$50 shopping voucher; no reimbursement was provided for survey completion in the current study. Interviews were conducted by the lead author (MG), a female researcher with accredited fourth-year psychology training and semi-structured interviewing experience who had no prior relationship with participants. Interviews were audio-recorded, transcribed verbatim, and de-identified.

Clinical Researchers

Eligible clinical researchers were invited by email to participate in the two-round parent Delphi study (Keshani et al., 2026). Before Round 2 invitations were distributed, the current study questions were embedded within the Round 2 *Qualtrics* survey as an optional component. Nineteen of the 35 researchers who completed Round 2 completed this component. Researchers received AUD$100 shopping vouchers for completing both Delphi rounds. Researchers were not invited to participate in interviews because consent had not been obtained for a separate follow-up study; consequently, researchers contributed quantitative survey data only.

Ethics Approval

The clinician and clinical researcher Delphi studies were approved by the Deakin University Human Research Ethics Committee (HEAG-H 11_2021 and HEAG-H 118_2022, respectively). The current study was approved under HEAG-H 11_2021.

Measures

Demographic and Professional Characteristics

Demographic and professional information was obtained from Round 1 of the respective parent Delphi studies (Keshani et al., 2025, 2026) and was not collected again. Clinician characteristics utilised in the current study included age, gender, country of residence, highest level of education, professional discipline, general clinical experience, and gambling-specific clinical experience. Researcher characteristics included age, gender, country of residence, and years of clinical research experience.

Ranking of Behaviour Change Technique Groups

Clinicians and researchers completed the same ranking task. Participants were presented with 23 BCT groups and their definitions, as shown in Table 2. These groups were derived from a recent review (Merkouris et al., 2023) identifying BCT groups used in at least five psychosocial interventions for AOs across the addictions. Participants ranked the five BCT groups they considered most important for 'AO-focused' (supporting the AOs' own wellbeing) and 'gambler-focused' (supporting the AO to help the person who gambles) interventions separately. The same list of 23 BCT groups was presented twice. Participants first

selected and ranked the five BCT groups they considered most important for 'AO-focused' interventions (supporting the AOs' own wellbeing), and were then shown the same list again to select and rank the five most important for 'gambler-focused' interventions (supporting the AO to help the person who gambles). A rank of 1 indicated the highest priority and a rank of 5 indicated the fifth-highest priority.

Semi-Structured Interviews with Clinicians

Semi-structured interviews were conducted to explore the reasoning underpinning the survey rankings provided by clinicians. Clinicians were asked two questions: one about the BCT groups they personally prioritised for AO-focused interventions, and one about those prioritised for gambler-focused interventions, based on their rankings in the quantitative survey. For example, they were asked: "In your survey, you indicated [A-E] were the 5 most important BCT groups for inclusion in an affected other-focused intervention. Can you tell me more about why you chose them?" Follow-up prompts were used as necessary to clarify their reasoning and explore how the selected BCT groups could be operationalised, such as: "Can you give me an example of what that might look like in an intervention?".

Data Analysis

Quantitative data were analysed descriptively using Stata version 19. Endorsement was defined as the proportion of participants who ranked each BCT group among their top five. For each endorsed BCT group, mean ranks and standard deviations were calculated separately for clinicians and clinical researchers, with lower mean ranks indicating greater perceived importance. Endorsement was treated as the primary indicator of priority, as it reflects how widely each BCT group was valued. Mean ranks were reported as a secondary, descriptive indicator of relative importance among those who endorsed each group, and only for BCT groups endorsed by five or more participants. Given the ordinal nature of rankings and small subgroup sizes, no inferential comparisons were made. No threshold for prioritisation was specified a priori, as none has been established such ranking tasks. Instead, prioritised BCT groups were identified descriptively as those most frequently endorsed across all experts. The same groups were prioritised when clinician and clinical researcher endorsement rates were averaged, so that each expert group contributed equally despite their different sample sizes. Although participants were recruited from Delphi studies, the current prioritisation task was administered once and did not form part of the Delphi consensus process. Formal consensus was therefore not assessed. Rather, convergence and divergence between clinicians and clinical researchers were examined descriptively. Ranking items were forced-response, and only participants who completed both ranking tasks were included in analyses. There were therefore no missing data.

Semi-structured interview data was analysed using reflexive thematic analysis (Braun et al., 2023). Interview transcripts were read and re-read by multiple members of the research team (MG, SM, and AT) to support data familiarisation, with the lead author (MG) leading

inductive coding of patterns of meaning relating to the BCT priorities. The analytic team consisted of three researchers with considerable experience in the gambling field, including clinical research work involving both people who gamble as well as AOs. Positionality was reflected upon throughout the analysis, given the team's familiarity with gambling-related harms and treatment approaches, and reflexive discussions were held to examine how the backgrounds and assumptions of the team may have shaped interpretation. Attention was also paid to alternative readings of the data that challenged emerging themes. Coding and theme development were iterative, with codes refined, merged, or expanded throughout the analysis. MG and AT met regularly to review the developing analysis and construct themes that captured shared patterns while retaining sensitivity to individual accounts. NVivo (version 15) was used to support the qualitative data management and organisation. To preserve participant anonymity while providing context, illustrative quotes are accompanied by a participant ID along with their age, gender, and years of gambling-specific clinical experience (e.g., P01, 53, Female, 10 + years).

Results

AO-Focused BCT Group Rankings

Clinicians and clinical researchers showed substantial agreement in the BCT groups prioritised for AO-focused interventions (Table 3). More than half of both groups endorsed *social support*, *financial management*, *communication training*, and *restoring a balanced lifestyle* among their top five priorities. The fifth most frequently endorsed group differed across participant groups, with clinicians prioritising *shaping knowledge* and clinical researchers prioritising *goals and planning*. Among those who endorsed each group, *shaping knowledge* received the highest average priority ranking from the clinicians ($M = 2.3$, $SD = 1.4$), while *social support* received the highest average priority ranking from the clinical researchers ($M = 2.4$, $SD = 1.7$).

Gambler-Focused BCT Group Rankings

Clinicians and clinical researchers also showed substantial agreement in the BCT groups prioritised for gambler-focused AO interventions (Table 4). Both groups most frequently endorsed *social support*, *financial management*, *restoring a balanced lifestyle*, and *goals and planning*. The fifth most frequently endorsed group differed across the participant groups, with clinicians prioritising *shaping knowledge*, and the clinical researchers prioritising *monitoring and feedback*. *Shaping knowledge* received the highest average ranking among BCT groups endorsed by clinicians ($M = 2.1$, $SD = 1.5$), while *goals and planning* received the highest average priority ranking endorsed by clinical researchers ($M = 2.4$, $SD = 1.3$).

Table 3 Description of behaviour change technique group labels and their definitions

BCT group label	BCT group definition
Goals and planning	Behavioural and outcome goals are set or agreed upon. Behavioural contracts and action plans are used to specify agreed behaviour. Triggers of behaviour are identified and strategies to overcome obstacles are developed. Goals and plans are reviewed at specified intervals.
Monitoring and feedback	Monitoring or self-monitoring of behaviour or outcomes of behaviour, with or without the provision of feedback is conducted.
Social support	Practical help is arranged or provided in order to practice or perform the desired behaviour. A person is identified that can provide emotional support.
Shaping knowledge	Information on the antecedents (e.g., triggers and high-risk situations), nature of addiction, treatment and the change process is provided. Alternative explanations for the causes of the behaviour, and information on how to perform the desired behaviour is provided. Testing hypotheses about the behaviour, its causes and consequences is conducted by collecting and interpreting data.
Natural consequences	Information on the health, social, environmental and emotional consequences of performing the behaviour is provided. These consequences are emphasised, and awareness raised about future regret if the unwanted behaviour is performed. Emotional consequences are monitored and the consequences of the unwanted behaviour are allowed to occur naturally and without interference.
Comparison of behaviour	An observable demonstration of the behaviour is provided. The performance of the behaviour is compared to other people's performance. Information about other people's approval of the unwanted behaviour is provided.
Associations	Environmental or social stimuli that prompt or cue the behaviour are introduced or removed, and access to any reward or aversive stimuli are removed. Stimuli that signal a reward are provided after the performance of the behaviour are identified. Repeated exposure to a stimulus that reduces the drive for the unwanted behaviour, and systematic exposure to a feared stimulus is conducted. Repeated exposure to a neutral stimulus along with a stimulus that elicits the behaviour is presented.
Repetition and substitution	The performance of the behaviour is practiced and/or rehearsed in different or similar contexts. The unwanted behaviour is substituted with an alternative behaviour, and rehearsal and repetition of this alternative behaviour is prompted. The wanted behaviour is repeated in an exaggerated fashion. Tasks are performed that gradually increase in difficulty until the behaviour is performed.
Comparison of outcomes	Information from a credible source is presented that is either in favour or against the behaviour. The pros and cons of changing the unwanted behaviour are identified. Different future outcomes are imagined and compared based on whether the behaviour is changed or remains unchanged.
Reward and threat	Material, social or non-specific incentives or rewards are provided depending on whether the behaviour is performed or behavioural outcomes are successful. Self-incentive or self-reward is arranged or provided. If the unwanted behaviour is performed, future punishment or reward removal is arranged.
Regulation	Pharmacological support, advice on how to reduce negative emotions, advice on how to minimise demands on mental resources and paradoxical instructions are provided to help facilitate behaviour change.
Antecedents	The physical or social environment is altered. Objects are added to the environment. Routines are changed or distraction is employed to avoid cue exposure. The body structure, functioning or support is altered to facilitate behaviour change.

Table 3 (continued)

BCT group label	BCT group definition
Identity	One's own behaviour may be used as an example to others. A new perspective about the behaviour is adopted. Discrepancies between the behaviour and self-image are identified, and a new self-image based on changing the unwanted behaviour is constructed. Personal strengths and values are explored.
Scheduled consequences	If the unwanted behaviour is performed, rewards are removed and adverse consequences are arranged. If the wanted behaviour is performed, rewards are provided (i.e., gradually, situation-specific) and adverse consequences are removed.
Self-belief	Positive self-talk is prompted, and verbal persuasion is used to argue against self-doubts about performing the wanted behaviour. Successful performance of the behaviour is imagined, and focusing on past times the behaviour was performed successfully is encouraged.
Covert learning	Performing the unwanted and wanted behaviour, followed by unpleasant and pleasant consequences, is imagined, respectively. The consequences experienced by others when they perform the behaviour is observed.
Restoring a balanced lifestyle	Restoring a balanced lifestyle via self-care and arranging pleasant activities is advised.
Referral to additional help seeking	Information, advise or direct referrals to help-seeking outside of what is offered in the study's intervention is provided.
Confrontation of the addicted person to engage in treatment	Confrontation or attempts to engage the addicted person into treatment is conducted.
Safety training	Strategies on how to deal with dangerous situations, such as family violence, are provided.
Communication training	Strategies on how to improve communication, including assertiveness training, are provided.
Financial management	Strategies on how to manage one's finances are provided.
12-step approaches	12-step approaches and traditions are discussed.

BCT behaviour change technique. Reproduction from Merkouris et al. (2023) under CC BY-NC-ND 4.0 license

Semi-Structured Interview Findings

Semi-structured interview data provided insight into how clinicians conceptualised AO interventions. The first theme describes why clinicians prioritised particular BCT groups, encompassing both protecting AOs from harm and involving them to support the recovery of the person who gambles. The second theme explores a more complex pattern evident across interviews: the uncertainty of clinicians about who constituted the primary client and their tendency to conceptualise gambler- and AO-focused needs as intertwined rather than as separate intervention targets.

Supporting AOs: From Harm Protection to Active Participation in Gambling Recovery

Clinicians discussed how BCT groups could support the wellbeing of AOs independently of the person who gambles. A strong focus was preventing AOs from experiencing further gambling-related harm. Clinicians talked about the need to advise AOs on safeguarding assets, safety planning in the context of domestic and family violence and recognising risks to dependent children. Discussions reflected understanding that AOs often carry signifi-

Table 4 Clinician and clinical researcher priorities for BCTs for inclusion in an AO-focused intervention

Technique	Endorsed in top 5 (*n*, %)		Mean rank (SD)	
	Clinicians	Researchers	Clinicians	Researchers
Social support	27 (73)	14 (74)	2.6 (1.4)	2.4 (1.7)
Financial management	27 (73)	13 (68)	2.4 (1.3)	2.8 (1.5)
Communication training	21 (57)	11 (58)	2.8 (1.2)	3.4 (1.4)
Restoring a balanced lifestyle	19 (51)	10 (53)	3.9 (1.1)	2.8 (1.4)
Shaping knowledge	19 (51)	3 (16)	2.3 (1.4)	–
Safety training	13 (35)	5 (26)	3.4 (1.3)	4.6 (0.9)
Referral to additional help-seeking	13 (35)	2 (11)	3.8 (1.1)	-
Goals and planning	12 (32)	10 (53)	3.2 (1.8)	2.8 (1.5)
Monitoring and feedback	6 (16)	8 (42)	3.3 (1.5)	3.5 (1.4)
Regulation	6 (16)	4 (21)	2.2 (1.5)	–
Self-belief	9 (24)	4 (21)	3.6 (1.2)	–
Confrontation of the addicted person to engage in treatment	3 (8)	4 (21)	–	–
Natural consequences	3 (8)	1 (5)	–	–
Identity	2 (5)	2 (11)	–	–
Associations	2 (5)	0	–	–
Repetition and substitution	1 (3)	1 (5)	–	–
Reward and threat	0	1 (5)	–	–
Comparison of outcomes	1 (3)	0	–	–
Scheduled consequences	0	1 (5)	–	–
Covert learning	1 (3)	0	–	–
12-step approach	0	1 (5)	–	–
Comparison of behaviour	0	0	–	–
Antecedents	0	0	–	–

Mean ranks (SD; standard deviation) are calculated for participants who endorsed a BCT (behaviour change technique) group in their top five (1 = highest priority; lower mean values indicate higher overall priority). Mean ranks are reported only for BCT groups endorsed by five or more participants; blank fields indicate techniques endorsed by fewer than five participants. Clinician sample $n = 37$; clinical researcher sample $n = 19$. BCT groups in bold were prioritised, i.e., the most frequently endorsed across all experts

cant personal risk exposure, and clinicians spoke most clearly about AO-focused intervention goals in this context. Clinicians frequently linked this focus to concerns AOs raised in practice, particularly financial security, often referring AOs to additional services such as financial counselling:

> "One of the things we did when we ran some groups for significant others was [to] have the financial counselling team come in and talk about setting things up that can protect you if someone is not stopping gambling. You know, family protection orders and all of those kinds of things. I think it's important to help people understand that there's things they can do to help them protect the assets. Because that's one of the things that a lot of people will say when they come in, that they're really worried about losing financial assets and financial security" (P14: 54, Female, 10 + years).

Table 5 Clinician and clinical researcher priorities for BCT group inclusion in a gambler-focused AO intervention

Technique	Endorsed in top 5 (*n*, %)		Mean rank (SD)	
	Clinicians	Researchers	Clinicians	Researchers
Social support	25 (68)	11 (58)	2.6 (1.5)	2.8 (1.3)
Financial management	23 (62)	11 (58)	2.8 (1.5)	3.2 (1.3)
Restoring a balanced lifestyle	19 (51)	10 (53)	3.6 (1.2)	2.7 (1.7)
Goals and planning	18 (49)	15 (79)	2.4 (1.4)	2.4 (1.3)
Shaping knowledge	16 (43)	5 (26)	2.1 (1.5)	2.6 (1.8)
Communication training	15 (41)	7 (37)	2.5 (1.6)	3.4 (1.4)
Monitoring and feedback	12 (32)	9 (47)	3.3 (1.3)	2.7 (1.6)
Referral to additional help-seeking	9 (24)	5 (26)	2.8 (1.5)	2.8 (1.6)
Self-belief	8 (22)	2 (11)	4.0 (1.1)	–
Regulation	7 (19)	2 (11)	3.3 (1.3)	–
Repetition and substitution	4 (11)	4 (21)	–	–
Confrontation of the addicted person to engage in treatment	4 (11)	2 (11)	–	–
Natural consequences	4 (11)	2 (11)	–	–
Safety training	4 (11)	1 (5)	–	–
Identity	3 (8)	2 (11)	–	–
Comparison of outcomes	3 (8)	0	–	–
Scheduled consequences	3 (8)	0	–	–
Antecedents	3 (8)	2 (11)	–	–
Associations	2 (5)	4 (21)	–	–
12-step approach	2 (5)	1 (5)	–	–
Comparison of behaviour	1 (3)	0	–	–
Reward and threat	0	0	–	–
Covert learning	0	0	–	–

Mean ranks (SD; standard deviation) are calculated for participants who endorsed a BCT (behaviour change technique) group in their top five (1 = highest priority; lower mean values indicate higher overall priority). Mean ranks are reported only for BCT groups endorsed by five or more participants; blank fields indicate techniques endorsed by fewer than five participants. Clinician sample $n = 37$; clinical researcher sample $n = 19$. BCT groups in bold were prioritised, i.e., the most frequently endorsed across all experts

Clinicians also emphasised that gambling-related harm frequently intersected with domestic and family violence risk:

> "Domestic violence is a significant issue. So you know, I need to make sure they [AO] are safe, that the house is safe, that their income is safe, and if they understand the risks if their husband or wife or partner has access to the joint account, that you know, that that's a risk. That you could lose that and you need to make sure and talk with a financial counsellor or someone who can help you make sure that you're going to be okay through this so that they're safe, you know, and not going to find out that they lost the house overnight with promises that they [person gambling] won't gamble when that's not achievable when the urge gets high" (P05: 60, Female, 10 + years).

Clinicians also discussed supporting AOs' coping, sense of self, and social connection. This included techniques within the restoring a balanced lifestyle and shaping knowledge groups, like building self-belief, restoring enjoyable activities, and accessing gambling psychoeducation to help AOs make sense of their loved one's behaviour. Supporting AOs to maintain a balanced lifestyle and access peer and professional support was seen as particularly important, given the isolation, shame, and stigma they may experience:

> "So, it's just keeping up with their activities, their recreation, connecting with friends, particularly if they're supportive friends, being able to make sure in their relationship with the person who's experiencing gambling harm, that they can still have enjoyable times together, that it's not all about harm. Because, you know, we say people aren't defined by their gambling, so being able to get some separation between the gambling part, and the whole other part of that person [who gambles]" (P15: 53, Female, 0–5 years).

Alongside strategies addressing the needs of AOs, clinicians discussed how BCT groups could assist AOs facilitate behaviour change in the person who gambles. A recurrent pattern was the positioning of AOs as active participants in recovery. Clinicians broadly shared that AOs often assumed substantial responsibilities, including finances, monitoring behaviour, and knowledge of harmful gambling, to better understand how to respond. Communication training was commonly highlighted, with clinicians applying skills that could help AOs engage with the person who gambles in supportive and non-destabilising ways:

> "I think being able to articulate and communicate a sense of understanding and empathy for the person who's experiencing the gambling difficulty but also being able to explain the AOs' own position in things without using accusatory or alienating language" (P02: 54, Male, 10 + years).

Who is the Work for? Clinician Orientation and the Default to the Person who Gambles

When clinicians explained AO-focused BCT priorities, they commonly reframed interventions as mechanisms for supporting the person who gambles as the primary client, even when specifically asked about AO-focused interventions. This prominent pattern positioned AOs as agents of change rather than beneficiaries of support. For instance, one clinician rationalised including communication training primarily in terms of helping the AO support change in the person who gambles, rather than its direct benefit to the AO:

> "The AO getting grumpy and angry can often give the person who gambles another executional reason to go and gamble, but it's hard to sort of remain calm. So, communication training around how to approach and when to approach them seeking help" (P07: 49, Male, 10 + years).

This reorientation around the person who gambles appears to reflect that clinicians may have an underlying uncertainty about their primary role: whether to protect AOs from harm or prioritise behaviour change in the person who gambles. Some clinicians explicitly questioned who constituted the primary client in complex family situations:

> "So for me, even when I see affected others, it's still sort of that the person who gambles is my client, you know, and the affected others, they are support" (P04: 50, Male, 10 + years).

The accounts provided by clinicians also suggested that gambler- and AO-focused needs were often conceptualised as intertwined rather than as separate intervention targets. Strategies discussed in relation to AO-focused BCT groups were frequently framed in terms of flow-on benefits for the person who gambles or the couple relationship, alongside benefits for the AO. For example, when discussing social support, one clinician described the support needs of AOs as running in parallel with modelling help-seeking for the person who gambles:

> "For the affected other, it often takes a huge toll from multiple angles. It's emotional work and often a financial burden as well so they themselves need to get their own social support and also model to the person who gambles what it's like to open up about your problems and share it with others. So, in a way, it's just a parallel thing for the affected other" (P13: 27, Male, 0–5 years).

Discussion

To our knowledge, this is the first study to examine gambling clinician and researcher priorities for interventions delivered to AOs affected by gambling. This study identified the BCT groups considered most important for gambler-focused and AO-focused interventions and explored clinicians' reasons for prioritising certain BCT groups over others. In doing so, it identified the types of BCTs experts prioritised for inclusion in interventions for AOs, rather than how these BCTs should be translated and implemented into intervention content.

AO-Focused BCT Groups

Gambling clinicians and clinical researchers showed substantial agreement regarding AO-focused interventions, prioritising *social support*, *financial management*, *communication training*, *restoring a balanced lifestyle*, *shaping knowledge*, and *goals and planning*. Consistent with rankings, clinicians described building self-belief, restoring enjoyable activities, and providing psychoeducation about gambling as important for supporting the coping, sense of self, and social connection of AOs. Merkouris et al. (2023) similarly found that interventions including *restoring a balanced lifestyle* were associated with greater reductions in AO psychological distress. However, stakeholder prioritisation of *goals and planning* differed from the effectiveness evidence. Merkouris et al. (2023) reported that interventions *without goals and planning* were associated with greater reductions in AO-experienced addiction-related harms. Notably, the definition of *goals and planning* does not specify whether the target behaviour belongs to the AO or the person experiencing the addictive behaviour. Goals may therefore focus on the independent needs of AOs or on managing and responding to the behaviour of the person who gambles. This ambiguity may partly account for the apparently counterintuitive finding and highlights the importance of specifying whose goals are being targeted.

Findings from the semi-structured interviews may also be relevant to interpreting this result. Clinicians at times appeared to position AOs less clearly as recipients of care in their own right, instead discussing AO-focused strategies primarily in terms of their benefits for the person who gambles. If AO-focused work is framed primarily around supporting behaviour change, less attention may be given to goals centred on the independent needs and wellbeing of AOs themselves. Comparison with Booth et al. (2021) consumer-derived BCT taxonomy also highlights differences between professional priorities and AO-reported strategies. Clinicians and clinical researchers prioritised *social support*, whereas AOs more commonly reported *professional support-seeking* and structured responses to the behaviour of the person who gambles. Booth et al. (2021) suggested that preferences for professional rather than personal support may reflect shame, stigma, and guilt, which can make anonymous and non-judgemental formal assistance more acceptable. This difference is important for intervention design, as social support components may not align with the forms of support AOs feel comfortable accessing.

A further difference emerged between quantitative and qualitative findings regarding harm protection. During interviews, clinicians spoke clearly about protecting AOs from harm, frequently describing referral to specialist services such as financial counselling and domestic violence support as central components of AO-focused care. However, BCT groups most closely corresponding to these practices (e.g., *safety training* and *referral to additional help-seeking*) were not highly ranked. This may suggest that clinicians view referral and risk management as important aspects of routine care without necessarily conceptualising them as primary intervention targets. For example, Manning et al. (2020) found that although 90% of mental health clinicians considered referral to specialist gambling services important, only 11.7% made such referrals regularly. Although Manning et al. (2020) did not involve gambling clinicians or AO-focused care, it illustrates a potential gap between recognising the importance of referral and prioritising it in practice.

Gambler-Focused BCT Groups

Despite some divergence in rank-order, clinicians and clinical researchers largely agreed on the BCT groups considered important for gambler-focused AO interventions: *social support*, *financial management*, *goals and planning*, *restoring a balanced lifestyle*, *monitoring and feedback*, and *shaping knowledge*. This convergence suggests a shared understanding of key intervention content across professional perspectives. The interviews illustrated how clinicians believed these strategies could be applied. They emphasised the importance of AOs understanding harmful gambling (*shaping knowledge*), communicating constructively with the person who gambles, and actively supporting recovery through strategies such as financial management and behaviour monitoring. These findings align with Merkouris et al. (2023), who found that *restoring a balanced lifestyle* was associated with greater improvements in outcomes for the person experiencing harmful alcohol, substance use, or gambling. *Shaping knowledg*e, which received the highest average priority ranking from clinicians for gambler-focused intervention, was also the most commonly used BCT group (84%) in AO interventions across addictions in this review. Findings also partially align with Booth et al. (2021), who identified *financial management* and *feedback on behaviour* (a technique nested within the monitoring and feedback group) as commonly reported strategies among AOs affected by gambling. In contrast, Booth et al. (2021) found *goals and planning*, which

received the highest average priority from clinical researchers in the current study, was relatively uncommon in the strategies naturally adopted by AOs. *Goals and planning* may therefore represent an area in which professionally informed intervention content could extend strategies AOs use independently.

Implications for Intervention Development

Although several prioritised BCT groups may appear intuitive, the empirical evidence is inconsistent. Beyond restoring a balanced lifestyle, which has the most direct support for enhancing AO psychological distress as well as decreasing frequency of use for the person with the addictive behaviour (Merkouris et al., 2023), most prioritised BCT groups were not significantly associated with AO- or gambler-focused outcomes. In fact, goals and planning was associated with poorer AO outcomes, although many analyses were based on few studies and may have lacked power (Merkouris et al., 2023). The prioritisation of these BCT groups is instead supported by theory and by the harms AOs experience: social support is central to the stress–strain–coping–support model (SSCS; Orford et al., 2010), communication training underpins CRAFT-based approaches to encouraging help-seeking (Makarchuk et al., 2002), and financial management targets the financial harms AOs commonly report (Gandhi et al., 2026 a). These pathways are therefore partly inferred, and the present findings should be regarded as theory-informed priorities requiring evaluation in controlled trials. Collectively, the quantitative and qualitative findings indicate that professional priorities for AO interventions were often framed in relation to the person who gambles rather than solely around the needs of AOs themselves. This reflects a broader tendency in the literature to conceptualise and evaluate AO support according to its effect on the person who gambles, rather than as care for AOs in their own right (Edgren et al., 2022; Nayoski & Hodgins, 2016; Vassallo et al., 2023). The findings nevertheless demonstrate the expertise of the clinicians in recognising acute risks and protecting AOs from harm. The challenge may be to extend this focus beyond crisis management to the broader support needs and entitlement to care of AOs themselves. Accordingly, it may be useful for clinicians to distinguish between: (1) support that enables AOs to contribute to the treatment and recovery of the person who gambles; and (2) support directed towards the needs of AOs themselves, independently of their role in the other person's recovery. Each would shape how the same prioritised BCT groups are framed, worded, and delivered. For example, financial management could focus on limiting access to money for the person who gambles, or on protecting AOs' own assets and financial security, with outcomes measured in the person who gambles and in AOs, respectively.

The substantial overlap in BCT groups prioritised across intervention targets suggests that these groups are not inherently tied to one target. Rather, their framing and delivery determine whose outcomes they serve. Where these purposes are treated as intertwined, as was common in clinicians' accounts, AO-focused content may default to supporting the person who gambles. Further intervention development should therefore explicitly target AO outcomes to reduce the risk that nominally AO-focused services adopt a gambler-focused orientation. The next steps for this work is to use these formative findings to develop an AO intervention that distinguishes between AO-focused and gambler-focused components. This will require selecting specific BCTs within each prioritised group, assigning them to components that keep AO-focused and gambler-focused aims distinct, and determining delivery

format and sequencing. These components could then be reviewed by AOs, clinicians and researchers prior to finalisation, and tested via an acceptability and feasibility trial. Future evaluations should assess outcomes for AOs in their own right, as well as their capacity to support the person who gambles.

Limitations

This study had several limitations. First, the BCT taxonomy was derived from the broader literature on interventions for affected others across the addictions (Merkouris et al., 2023), rather than being developed specifically for, or with, AOs affected by gambling. Additionally, participants were presented with the same list of 23 BCT groups twice, once for AO-focused and once for gambler-focused interventions, and the groups were not separately tailored to either target. Some may therefore have appeared inherently oriented toward the person who gambles, even during the AO-focused ranking task, potentially contributing to gambler-focused framing evident in the interviews. Participants ranked BCT groups for AO-focused interventions generally, without reference to a particular case, presentation, or stage of need. AO priorities are likely to vary according to factors such as their relationship to the person who gambles, severity of harm, and how recently gambling harm was identified. Future studies could use case-based prompts or vignettes to examine how priorities vary across circumstances. Clinicians were not asked about specific experience treating AOs as clients, potentially limiting interpretation of their perspectives. Future research should assess both the nature and extent of AO-specific experience. Clinical researchers could not be interviewed because consent had not been obtained for follow-up contact. The qualitative findings therefore reflect clinician perspectives only, and the reasoning underpinning the priorities identified by clinical researchers could not be explored. Finally, participants completed a single ranking exercise. Although areas of convergence and divergence could be identified, formal consensus was not assessed. A Delphi study involving iterative stakeholder input could establish clearer consensus regarding priority content for AO interventions.

Conclusion

This study examined gambling clinician and researcher priorities for interventions delivered to AOs affected by gambling. Both expert groups most frequently endorsed social support, financial management, and restoring a balanced lifestyle for both intervention types, as well as communication training for AO-focused interventions and goals and planning for gambler-focused interventions for gambler-focused interventions. Clinician interviews suggested that these BCT groups were viewed as relevant to protecting AOs from harm, supporting their coping and wellbeing, and helping them participate in the recovery of the person who gambles. However, clinicians also commonly discussed AO-focused interventions through a gambler-focused lens, suggesting that AOs were not always clearly positioned as recipients of care in their own right. Together with the substantial overlap in priorities across intervention targets, this suggests that BCT groups may not be inherently

AO-focused or gambler-focused, and the outcomes they serve may depend on how they are framed and delivered. Future interventions should therefore make their intended target explicit, ensuring that AOs' own support needs are addressed alongside their role in supporting the person who gambles. Collectively, these findings highlight the value of incorporating both clinician and clinical researcher expertise into intervention development and the need for theoretically grounded, evidence-informed interventions that distinguish between AOs own support needs and their role in supporting the person who gambles.

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Declarations

Ethical Approval Data for this study were drawn from two studies approved by the Deakin University Human Research Ethics Committee (HEAG-H 11_2021 and HEAG-H 118_2022); the current study was conducted under HEAG-H 11_2021.

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