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Training counsellors in congruence couple therapy: A controlled evaluation study [Final Report]

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TRAINING COUNSELLORS IN
CONGRUENCE COUPLE THERAPY:
A CONTROLLED EVALUATION STUDY

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Final Report Prepared for the Ontario Problem Gambling Research Centre

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Disclaimer: Opinions expressed in this final report are those of the investigator(s), and do not necessarily represent the views of the Ontario Problem Gambling Research Centre (OPGRC).

PREFACE AND ACKNOWLEDGEMENTS

“Be careful what you ask for, you might just get it!” cautioned Dr. Harold Wynne, Research Consultant with the Ontario Problem Gambling Research Centre when he read the proposal I drew up for this Congruence Couple Therapy training evaluation. For any project, the best scenario is when ambition and capacity coincide.

Until the training started, I was a lone-ranger, one person who believed in the potential of this systemic humanistic approach for working with pathological gamblers. From my dissertation immersion into the opus of Virginia Satir, one of family therapy’s pioneers, I discerned an integrity of philosophy and a holistic way of bringing about healing implicit in her work which she had not made explicit to an academic audience. Some marvelled at her “magic” on stage with families, others derided her for being “just a practitioner”. It struck me that her work had been undervalued theoretically and clinically for lack of clear conceptualization and systematization.

A postdoctoral research study funded by the Ontario Problem Gambling Research Centre’s Postdoctoral Research (2001-2002) gave me an opportunity to develop and test out a first version of Congruence Couple Therapy (CCT) that further conceptualized and structured classic Satir into a compact, short-term model that can be manualized for working with pathological gamblers and their spouses. This study yielded some promising results with a sample of eight couples (Lee, 2002c). But what’s next? The one must become many. Congruence Couple Therapy can only move forward when more counsellors are trained in applying it and subjecting it to testing with their clients.

At the end of 2002, I was awarded a second postdoctoral position by Dr. Nancy Edwards, CHSRF/CIHR Nursing Chair in Community Health at the University of Ottawa. An innovative, multi-level, systemic researcher, Dr. Edwards expanded my horizons from the clinic to a vision of research with links to evidence-based practice, application and knowledge transfer at institution and community levels. She is a true mentor and role-model. With this expanded vision of how to link training, practice and research, I was ready to embark on a multi-level evaluation of Congruence Couple Therapy training of problem gambling counsellors in the field.

The CCT training covered 2 cycles of training conducted in (1) November 2004 - March 2005 and (2) March - June 2005. As the planning and implementation of the Congruence Couple Therapy training unfolded, the right configuration of people constellated like stars in a velvet sky – advisors, assistants, participants, clients, institutional support. The commitment I received from many individuals continued over time and distance, even when I moved to Alberta for my faculty position in the Addictions Counselling Program in Health Sciences at the University of Lethbridge in 2005.

My foremost acknowledgment goes to the Ontario Problem Gambling Research Centre, and the people there who saw the germ of something important in my proposal of couple therapy from the beginning -- Rob Simpson, Executive Director and Dr. Harold Wynne, Research Consultant. Harold has been there unfailingly for me at a moment’s notice over the years. Another friend and senior researcher, Dr. Durand Jacobs, took a keen interest in my work and inspired me with his theoretical acumen, verve, and dedication in addressing childhood trauma among those with addictions.

I thank my co-investigators, Dr. Lynne MacLean and Dr. Martin Rovers, who advised and worked along with me as loyal colleagues, Gentium Consulting with Mechthild Meyer and Alma Estable who conducted the focus groups, assisted with the data analysis, acted as observers and note-takers during both workshops and the first set of teleconferences, and produced a technical report on a big part of this study. Robert Murray, from the Centre for Addictions and Mental Health, was an advisor to this project.

Sara Torres, first Research Assistant on this project, worked late nights and extended hours in helping me put together a thorough and multi-layered set of research ethics documents and application. Stephanie Soo, Research Assistant in the last year, managed the data collection, data entry, kept track

of all the details and carried out the many tasks that were assigned to her long distance. Gregory Marr and Frances Cosstick helped with the teleconference notes. Patricia Meyers, Valerie Rowe, and Dr. Martin Rovers spent hours listening to audiotapes to score the role-play tests. Dr. Donna Lockett, Dr. Viren Bharti, Lucie Kocum, and Dr. Rob Williams offered their statistical input on various aspects of the project. My children, Theo and Colleen Chan, gave up their free time to collate my training folders and get me organized for the training workshops. Craig Barlow set up the training venue to welcome the trainees and offered me enormous moral support on my many undertakings during a period of transition.

I am happy to be situated in a new milieu of students and colleagues at the University of Lethbridge -- Cora MacLachlan, Bev West, Jason Solowoniuk, Adam Winnett, Susan Wagner, and Mark Pijl Zieber all lent their skills and hard work in bringing this first evaluation to a close and sending it into the world.

Last, but not least, this project owes the success of its completion to the many talented, dedicated, caring problem gambling counsellors in Ontario – and their organizations and clients. Counsellors and clients gave of their time and substance to participate in this training study, which would not have been possible without them. Their voices and feedback will help us plan our next steps in advancing evidence-based practices into the field.

I thank the University of Ottawa for sponsoring and administrating this project. The Canadian Addictions Counsellors Certification Federation and the Canadian Problem Gambling Counsellors Certification Board supported the training in approving it for 40 continuing education hours. Galilee Retreat and Conference Centre in Arnprior provided a gracious ambience and service that enhanced our two workshops.

Henry David Thoreau wrote, “If you have built castles in the air, your work need not be lost; that is where they should be. Now put the foundations under them.” It is my hope that the pouring of the foundation has begun.

Bonnie Lee

ABSTRACT

Congruence Couple Therapy (CCT) is a new, humanistic, systemic model for problem gambling treatment. In the development of empirically supported treatments, counsellor training is a critical step. This study evaluates the effectiveness of CCT training in imparting key concepts, skills, and values of CCT to a sample of problem gambling counsellors ($N = 21$) from 13 Ontario problem gambling treatment programs. CCT training comprised of a 4-day residential workshop followed by 12 weeks of CCT application, with 1 to 2 clients per counsellor supported by teleconference consultation. Two cycles of training were conducted: Cycle 1 ($N = 21$) was a randomized controlled trial comparing counsellors with CCT training and a control group. Immediately after the completion of Cycle 1, the control group ($n = 9$) received identical CCT training in Cycle 2. A within-subjects design compared Cycle 2 counsellors at three points: at baseline, after a 15-week waiting period, and after 15 weeks of CCT Training. Five interrelated levels of CCT training were evaluated: 1) counsellor satisfaction; 2) counsellor outcomes; 3) organizational support and change; 4) counsellor application of CCT; and 5) client satisfaction and outcomes. Triangulated findings indicated that counsellors significantly increased their knowledge of CCT concepts, values, and skills from both training cycles. Areas of high satisfaction were the trainer-supported CCT application, intense residential workshop in retreat setting, safety and collegiality, experiential learning approach, and framing the training in a research context. Further training was desired by all participants to advance their competence in CCT. The timing of the CCT training seemed to coincide with an emerging trend in some Ontario organizations to adopt more couple-focused counselling for problem gamblers, and an interest in linking research and practice. The need for expanded supervision and support for adopting treatment innovations in organizations is a topic for discussion. Client outcomes with CCT counsellor trainees showed significantly reduced problem gambling symptoms, improved couple communication and relationship, increased self-awareness, and positive spin-offs in family and work relationships. Clients rated their CCT treatment and outcomes very highly. These client results support findings from an earlier CCT pilot study; however, with the absence of a control group, client results should be treated as promising but preliminary. Further studies on CCT and CCT training are recommended in light of the positive multi-level results to date.

Key words: Congruence Couple Therapy, counsellor, training, evaluation, empirically supported treatment, problem gambling, outcomes, innovation

EXECUTIVE SUMMARY

Purpose of Study

The purpose of this study is to evaluate the effectiveness of Congruence Couple Therapy (CCT) training in imparting key concepts, skills, and values of CCT to problem gambling counsellors. A secondary objective is to identify barriers and facilitators for future training.

Background

With the expansion of legalized gambling worldwide, the prevalence of problem and pathological gambling is projected to increase (Volberg, 2000, 2004). Couple treatment models are in short supply. A 2002 meeting of problem gambling researchers and clinicians issued a call for the development of empirically supported treatment models for problem gambling. Undoubtedly, the development of effective treatment for this population is a pressing priority.

Congruence Couple Therapy

CCT was developed to fill a gap in problem gambling treatment by providing a new, humanistic, systemic couple treatment model that goes beyond the cognitive behavioural factors of gambling to addressing deeper underlying psychological and marital issues in pathological gambling. Following up on promising results of an earlier pilot study (Lee, 2001, 2002c), the present study is designed as a step toward a wider application of CCT for empirical validation. Previous preliminary couple results with CCT demonstrated improved psychological and marital functioning, greater life satisfaction, enhanced coping, reduced gambling urges, and continued abstinence of eight gamblers immediately after treatment and at 1- and 3-month intervals post-CCT intervention (Lee, 2002c).

Congruence Couple Therapy Training

A critical step in the development of empirically supported treatment is counsellor training (Rounsaville & Carroll, 2001). CCT training is a 40-hour counsellor training program over 15 weeks. It is comprised of two components: (1) a 4-day residential workshop; and (2) a 12-session application of CCT with couples at the counsellors' home organizations immediately after the workshop. An important feature of the training is the weekly group teleconference consultations to support counsellors during this application period. In the present study, counsellors' training, including travel and accommodation costs, was paid through the research funding.

Participants

The sample included 13 organizations, representing 25% of Ontario-funded problem gambling programs, and 21 counsellors, representing 18% of the problem gambling counsellors in 2004. The modal age range of counsellors was 40 to 49 years. Mean years of counselling experience was 15 with a mean of 5 years in problem gambling. Eighty-three percent of participants had a Bachelors or Masters degree. The majority followed a cognitive-behavioural and solution-focused approach and reported a high compatibility between their pre-existing orientation and CCT. Fifty-nine percent were Certified Problem Gambling Counsellors or were working towards certification. Seventeen percent held other professional registrations in social work, marriage and family therapy, and nursing. A solid base of counselling experience and a minimum of 1 year with problem gamblers were inclusion criteria for this training study.

Twenty-four couples received CCT with their counsellors-in-training. The majority of the gamblers had previous individual or group counselling. Twenty-nine percent were new intakes.

Method

Two controlled designs were used for the evaluation of training. Cycle 1 ($N = 21$) was conducted as a randomized controlled trial comparing counsellors who received CCT training ($n = 12$) with a control group ($n = 9$). Immediately after the completion of Cycle 1, the control group ($n = 9$) received identical CCT training in Cycle 2. A within-subjects design compared Cycle 2 counsellors at three times: at baseline, after a 15-week waiting period, and after 15 weeks of CCT training.

An evaluation framework (Kirkpatrick, 1959, 1977; Guskey, 2000) guided our evaluation covering five interrelated levels: (1) counsellor satisfaction; (2) counsellor outcomes; (3) organizational support and change; (4) counsellor application of CCT; and (5) client satisfaction and outcomes.

Mixed quantitative and qualitative methods were used in our data collection. We developed 10 instruments and protocols, both quantitative and qualitative, for capturing counsellors' data. In addition, four measures were used for clients' data. Qualitative data collected were in the form of written, oral, and role-played materials.

Key Findings

Impact on Counsellors

- On almost all items of all measures, both cycles of participants responded similarly to the training.
- Objectively scored quantitative measures of outcomes operationalizing CCT concepts, values, and skills showed that counsellors in both training cycles demonstrated highly significant positive changes.
- Regardless of age, level of education, and years of experience, counsellors were equally able to benefit from CCT training.
- Counsellors found the 12-week teleconference support to assist with their application of CCT with their clients useful and essential.
- After the application phase, counsellors expressed greater preparedness and intention to use CCT beyond that attained at the end of the workshop.
- Counsellor retention rate in the study was a 100% after training began.

Learning CCT Concepts

- CCT concepts applied in practice were better learned than philosophical concepts.
- Conceptualization of problem gambling shifted from an individual focus on gambling reduction to dealing with the complex and deeper issues underlying problem gambling, such as family of origin influences, couple relationships, communication, self-awareness and self-esteem, crises, and life transitions.
- Another important shift was viewing the marital relationship as a contributor to problem gambling and not only a result of it.
- Counsellors showed an increased ability to think in terms of systems and interrelationships.
- Counsellors did not show a wholesale adoption of the CCT conceptual framework; rather, they incorporated parts and parcels of it with their own approaches and stances.

Learning CCT Values

- Changes in values and philosophy in line with CCT, while present more ostensibly in some counsellors than others, were less pronounced than changes in concepts and skills. Many counsellors already had values compatible with the humanistic base of CCT.
- Counsellors showed greater awareness of themselves in the counselling process and the use of themselves as models in their interaction with clients.
- Counsellors reported a greater propensity for reflection and attunement with their internal and interactional process, as well as that of the clients.
- Also evident was a shift in value from objectivity, impartiality, and directiveness to greater flexibility, exercising one's clinical judgment, following the process, greater freedom in asking questions, and admitting to one's limitations.
- Counsellors spoke more explicitly of their sense of hopefulness, optimism, and a trust in the clients' resourcefulness, as well as their own.

Learning CCT Skills

- A shift was found and reported by counsellors, from working with content to process, from doing mainly psycho-education to facilitating change.
- Clinically, counsellors showed more skilful balancing and containment of couple dynamics, raising of positive energy in reframes of problems and blame into hopes and wishes, focusing on goals, exploring of each partner's issues, shifting communication stances, and efficient and solid engaging of their clients.
- Counsellors' development of CCT clinical skills, though significant, had not attained the level of mastery.
- Counsellors desired further consultative support in their CCT application and a next phase of CCT training to strengthen skills in the Middle Phase, including working on family of origin, attending to pain and trauma, and affirming the universal-spiritual dimension.
- Some counsellors explicitly recognized the importance of their own continued personal integration in order to work effectively with clients' pain and trauma.

Counsellors' Satisfaction

Counsellors in both cycles reported a very high level of overall satisfaction with the training. Counsellors in both cycles gave very high ratings for the following items: training was rewarding ($M = 6.7$ out of 7); will recommend it to a colleague ($M = 6.7$); and want to take part in future training ($M = 6.9$) and research ($M = 6.6$).

Some facilitators and barriers were identified by counsellors and should be taken into account in future CCT training:

- Facilitators:
 - experiential learning approach (e.g., role-plays, demonstrations);
 - safe, supportive learning environment with a skilled, non-judgmental trainer allowing risks, uncertainties, and questions;
 - retreat setting, removed from usual distractions, encouraging inward reflection and outward development of collegiality;
 - small group size for workshop (<12) and teleconference (<5);
 - application of CCT supported by teleconference consultations;
 - collegiality and support among participants;
 - research requirements and framework (increased focus, rigour, and reflection);
 - training paid for by research funds.

- Barriers:
 - amount of paperwork required for research;
 - organizational upheaval for one set of participants, which added stress;
 - not enough notice given prior to the scheduling of teleconferences - needed earlier notice to rearrange work schedule;
 - pace somewhat rushed in workshop and teleconferencing;
 - readings and materials not distributed before training;
 - intensity of experiential training touched on personal issues;
 - training did not cover in-depth family of origin influences, pain and trauma, spiritual dimension, and counsellors' personal integration.

Impact on Clients

- Preliminary but promising outcome results triangulated with client self-reports suggested the effectiveness of CCT for treating pathological gambling.
- Clients showed positive changes on two of the three quantitative outcome measures. Changes reflected increased abstinence, reduction in gambling activities and urges, and improved couple relationship.
- Clients gave high satisfaction ratings for the CCT treatment they received ($M = 6.3$ out of 7).
- Improved well-being and self-esteem, though reported by clients and their counsellors, were not borne out in one quantitative measure.
- Client couple retention rate over the 12-week application with a mean of 8 sessions was 96% (23/24 couples).
- Client outcome results should not be taken as conclusive as no controls were used and we had only a moderate rate test return (60%).
- Keep in mind that these client results were obtained in a monitored application of CCT with a high degree of adherence in consultation with the trainer.

Impact on Organizations

- Organizations of participants supported the CCT training and application.
- Organizational internal changes impacted on how a group of counsellors experienced the training.
- The timing of the CCT training seemed to coincide with an emerging trend in some organizations to provide more couple and family-focused client services.
- There appeared to be a growing interest among problem gambling treatment programs to partner with researchers in problem gambling research.
- Future training should pay more attention to collaborating with organizations' internal supervisors, providing more information on CCT to organization administrators and supervisors, and assisting organizations in developing greater supervisory and consultative capacity to counsellors in monitoring further CCT application.

Unintended Results

- Heightened commitment of agencies, participants, and clients was cited due to the research component.
- An expanded appreciation was expressed by participants for the research process and seeing how it can be applied, useful, and relevant to practice.

- Given the intensive nature of the training, the isolated retreat setting seemed important for allowing a quicker and deeper integration of CCT.
- A strong enthusiastic response came from problem gambling counsellors in finding a community of practice to share clinical concerns and knowledge.
- Participants reported experiencing important personal and professional growth.

Conclusions and Future Directions

Overall, the evaluation on the first CCT training was rigorously conducted with randomized sites, use of controls, strong triangulation of quantitative and qualitative data, and two cycles of training both with positive results for counsellors and clients.

- The study provided some solid evidence that the CCT training approach worked with this one trainer and sample of counsellors. External validity needs to be established in the future with other CCT trainers and counsellors.
- Positive client feedback and outcomes support earlier pilot study's findings with CCT. Future research needs to be conducted with control or comparison groups.
- A review of the training outcome measures with future samples of trainees is required to reduce the number of items and confirm the reliability of these instruments.
- A review of client treatment outcome measures used in problem gambling treatment research should be conducted and measures that allow for comparisons with outcomes from other treatment approaches should be selected.
- Future CCT training will need to segment its training components into graduated units, covering less territory in each training, with each training level emphasizing specific target areas.
- Level 2 CCT training is recommended to address in-depth clinical issues in the Middle Phase to optimize counsellors' use of CCT.
- Counsellors using CCT need to know the limits of their own competence through self-assessment in order to judiciously and cautiously apply and monitor an innovation in clinical practice. Counsellors should seek supervision from registered marriage and family therapists in carrying out couple work.
- Research should explore what levels of academic and professional preparation are necessary for counsellors to adequately and competently deal with issues of childhood trauma, marital distress, coping ability, social isolation, and mental health issues commonly found in pathological gamblers.
- Research should investigate the kinds of professional development and supervisory capacity available in gambling treatment programs that intend to provide services addressing these psychological, couple, and family issues so that clients benefit maximally from treatment programs.
- Gathering the evidence and assessing the merits of an innovation in treatment involve multiple stakeholders. Collaborative and consultative conversations bringing together problem gambling counsellors and their clients, treatment organizations, professional and training institutions, and researchers would be a worthwhile set of initiatives in the near future.

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INTRODUCTION

Purpose

The purpose of this study is to evaluate the effectiveness of a first Congruence Couple Therapy (CCT) training in facilitating the learning of the key concepts, skills, and values of CCT among problem gambling counsellors recruited from provincially-designated gambling treatment programs in Ontario, Canada. CCT was developed and piloted by the Principal Investigator, building upon her doctoral research (Lee, 2001) in a post-doctoral research project funded by the Ontario Problem Gambling Research Centre in 2001-2002 (Lee, 2002c). Preliminary client results on CCT demonstrated improved psychological and marital functioning, enhanced coping, reduced gambling urges, and continued abstinence of eight gamblers and their spouses immediately after treatment and at 1- and 3-month intervals post-treatment (Lee, 2002c). These early positive qualitative and quantitative findings led to the present study to evaluate the effectiveness of CCT training for problem gambling counsellors with a view towards its wider application. Preparation and training of a cohort of counsellors who can reliably replicate the concepts, values, and key interventions of CCT is an essential step in building research capacity for future outcome studies.

Background and Rationale

With the expansion of legalized gambling worldwide, the prevalence of problem and pathological gambling is projected to increase (Volberg, 2000, 2004). Currently, gambling problems have been estimated at around 4% prevalence in North America and other countries (LaBrie & Kidman, 2002; Shaffer & Hall, 2001; Wong & So, 2003) with pathological gambling around 1-2% in most countries (Volberg, 2000). Pathological gamblers are the hardest hit personally and financially by the proliferation of legalized gambling (Williams & Wood, 2004). Hence, the development of effective treatments for this population is a pressing priority.

The devastating consequences of problem gambling on families and the turbulent family dynamics of most problem gamblers are well documented (Ciarrocchi & Hohmann, 1989; Griffiths & MacDonald, 1999; Jacobs, 1989; Lorenz & Shuttlesworth, 1983; Lorenz, 1987; Lorenz & Yaffee, 1988; McCown & Chamberlain, 2000; Steinberg, 1993; Wildman, 1989), yet no studies have been conducted on the effectiveness of couple and family therapy for treating pathological gamblers (Petry & Armentano, 1999; O'Connor, Ashenden, Raven, & Allsop, 2000). A recent literature review confirmed a clear gap in couple and family-focused treatment for problem gamblers (Kalischuk, Nowatzki, Cardwell, Klein, & Solowoniuk, 2006).

A Cochrane systematic review revealed a paucity of robust evidence for effective psychological and pharmacological treatments for pathological gambling (Oakley-Browne, Adams, & Moberley, 2003). Outcome studies in gambling treatment have been loaded on behavioural, cognitive, and combined cognitive-behavioural approaches (Hodgins, 2001, Ladouceur, Sylvain, Boutin, & Doucet, 2002; Lopez Viets & Miller, 1997; O'Connor et al., 2000). A broader spectrum of treatment models needs to be explored for problem gambling treatment, including marital approaches (Nathan, 2005). In Quebec City in 2002, a scientific meeting of problem gambling treatment researchers issued a call for the development of empirically supported treatment models to advance the field (Ladouceur & Shaffer, 2005).

Developing empirically supported treatment models is an onerous task that takes many years. Treatment models with clear conceptual frameworks and specifiable interventions that lend themselves to replication are in short supply. Before large outcome studies can be conducted, training programs to impart requisite skills to clinicians and to assess clinicians' competence and adherence to a model are necessary first steps (Rounsaville & Carroll, 2001). Training evaluation has hitherto not received

sufficient attention in research. Evaluation of training and supervision effectiveness poses an ongoing challenge to researchers and trainers in psychotherapy and marriage and family therapy (Avis & Sprenkle, 1990; Liddle, 1991; Piper, 2004; Ravitz & Silver, 2004).

With the intent of making progress in addressing the suffering of pathological gamblers and their families, this study undertakes an evaluation of the effectiveness of a first training for problem gambling counsellors in CCT. This evaluation represents a step in learning about the effectiveness of such training and the acceptability and promise of a new couple treatment model from the feedback of problem gambling counsellor trainees.

LITERATURE REVIEW

Many intersecting strands of discussion in the field of problem gambling underpin the development of CCT. This section presents the issues that were considered in relation to the development of CCT and the training for counsellors. The backdrop sets the stage for a program of research aimed at developing a viable and effective couple and family systems therapy option for the treatment of pathological gamblers.

Couple Problems among Pathological and Problem Gamblers

Significant marital distress and discord have been described as both the cause and result of problem gambling (Boyd & Bolen, 1970; McCown & Chamberlain, 2000; Lee, 2002c; Lorenz, 1987). Family conflicts were cited as the most frequent reason for a compulsive gambler's relapse (Lorenz, 1989). A high percentage of spouses reported physical symptoms, excessive behaviours used for coping, such as drinking, smoking, under- or over-eating, depression, and unsatisfactory sexual relations (Lorenz & Shuttlesworth, 1983; Lorenz & Yaffee, 1988). Broken trust and intimacy were the inevitable aftermath when the gambling problem was discovered (Heineman, 1994; Lee, 2002c; Lorenz, 1987; Steinberg, 1993).

Couples are frequently found to be matched in their levels of psychological health and integration (Bowen, 1978; Day, St. Clair, & Marshall, 1997; Lesieur & Blume, 1991; Steinberg, 1993). Spouses' family of origin histories parallel those of the gamblers', evidencing a high representation of alcohol or gambling abuse (Heineman, 1987; Lee, 2002c). Spouses of gamblers have been described to suffer from severe emotional difficulties and display low self-esteem, dependency, passivity, limited coping skills, controlling and perfectionistic characteristics, and other symptoms (Boyd & Bolen, 1970; Lorenz, 1987; Lorenz & Yaffee, 1988; Tepperman, 1985). A disproportionately high incidence of childhood abuse, neglect, and trauma was found in the history of both gamblers and their spouses (Broffman, 2001; Jacobs, 1987, 1988, 2001; Lee, 2002c).

Couple Therapy: A Gap in Gambling Treatment

Despite the field's repeated emphasis on the need to address couple and family issues, the predominant approach to gambling treatment remains largely individually focused (O'Connor et al., 2000; Wildman, 1989). Even when spouses were seen in treatment, they were seen either individually or in groups separate from their gambling partners (Boyd & Bolen, 1970; Tepperman, 1985). Inadequate training of counsellors in couple work has been cited as a reason for lack of conjoint treatment (McCown & Chamberlain, 2000; Steinberg, 1993). Engaging both partners for conjoint treatment is a challenge as each partner fears the assignment of blame. Having an angry, volatile couple in conflict in the same room is daunting for counsellors without specialized couple therapy training (Doherty, 2000). The unwary counsellor is drawn into taking sides or placing blame on one partner,

which would quickly result in the dissolution of couple therapy. The traditional 12-step program format, which separates gamblers from their spouses, is modelled by most treatment services (McCown & Chamberlain, 2000).

Organization factors, such as agency policies, funding allocation, mission, values, and beliefs also play a role in the low availability of conjoint couple services.

Couple and Family Therapy in Problem Gambling and Other Addictions

Empirical research on adults and adolescents with drug and alcohol abuse indicates that family therapy is more effective than individual therapy (Pinsof & Wynne, 1995, 2000). Substance addictions programs have looked to couple and family therapy as a complementary or alternative model of treatment (Crnkovic & DelCampo, 1998; Edwards & Steinglass, 1995; Trepper, McCollum, Dankoski, Davis, & LaFazia, 2000). Evidence of the success of behavioural marriage and family therapy in treating clients with substance abuse has been reported (Fals-Stewart, O'Farrell, Birchler, Cordova, & Kelley, 2005). Experienced gambling clinicians have recommended couple therapy as a primary model of treatment from the outset (Ciarrocchi & Franklin, 2002; Steinberg, 1993). Unfortunately, despite evidence of its benefits, marriage and family therapy has not been widely adopted by counsellors as a major treatment modality in addictions or problem gambling (O'Farrell, 1992). The link between research and application in practice is an important one that needs to be addressed (Gotham, 2004; O'Farrell, 1992).

Problem Gambling Conceptual Frameworks

Prevailing models for problem gambling are largely focused on the individual gambler, framing problem gambling as an addictive disorder (Jacobs, 1987; Blume, 1987), unresolved intrapsychic conflict (Rosenthal, 1992; Wildman, 1997), biological/psychophysiological dysregulation (Blaszczynski, Winter, & McConaghy, 1986; Comings, Rosenthal, Lesieur, & Rugle, 1996), learned behaviour (McConaghy, Armstrong, Blaszczynski, & Allcock, 1983), cognitive distortion (Ladouceur et al., 2002), and subtypes of gamblers with impulsive traits, and biological and psychological vulnerabilities (Blaszczynski, 2002; Blaszczynski & Nower, 2002). However, the complexity of the phenomenon suggests that a multi-dimensional framework would be necessary to interrelate determinants and delineate gambling-related causal pathways (Lee, 2002c; Shaffer, LaBrie, LaPlante, Nelson, & Stanton, 2004). A public health framework utilizing a paradigm of human ecology that considers gambling problems within the context of larger family, socio-economic, physical, and cultural environments has been proposed (Korn & Shaffer, 1999). Although the complex and multi-causal nature of problem gambling is acknowledged by researchers (Legg England & Goettestam, 1991; Shaffer et al., 2004), advances in conceptual models that interrelate multiple determinants for problem and pathological gambling are yet to emerge to guide interventions.

Proposition of a Systems Framework for Understanding Problem Gambling

Prominent characteristics of problem gamblers include social isolation (Wiebe, Single, & Falkowski-Ham, 2001), high incidence of childhood trauma and abuse in both gamblers and their partners (Broffman, 2001; Jacobs, 1987; Lee, 2002c), marital distress (Ciarrocchi & Hohmann, 1989; Ciarrocchi & Franklin, 2002; McCown & Chamberlain, 2000; Lee, 2002c); depression and anxiety (Toneatto, 2002), poor coping abilities (McCormick, 1994), and comorbidity with other types of addiction and psychiatric disorders (Stewart & Kushner, 2003; Shaffer, Hall, & VanderBilt, 1999; Rupcich, Frisch, & Govoni, 1997; Toneatto & Skinner, 2000).

A Pathological Gambling Family Systems Framework emerged from the Principal

Investigator's earlier study attempting to interrelate factors in the psychological, marital, spiritual, and intergenerational dimensions with life-transition stressors, poor coping strategies, limited communication, and increased gambling availability (Lee, 2002c, 2003). A core theme of disconnection is found among gamblers and their spouses -- psychologically in relation to themselves, relationally with their marital partner, intergenerationally with unresolved childhood trauma, and spiritually from their own spiritual life force and human yearnings (Lee, 2002c). This profound disconnection from self and others may well be the underlying structure leading to the high incidence of comorbid psychiatric and addiction disorders found among pathological gamblers.

Disconnection severely limits gamblers' and spouses' access to resources for coping with stressors during major life transitions. The increased availability of gambling venues presents a route of escape and self-soothing for disowned and disconnected psychological dynamics. The goal of CCT is to help gamblers reconnect with these disconnected dimensions of self and relationship to increase access to available psychological, marital, and spiritual resources for coping realistically with life's challenges.

Empirically Supported Treatment

The movement towards evidence-based practice ensues from the aim to increase accountability and to ensure that clients benefit from the most effective treatment available. It is disconcerting that effective treatments, such as marital and family therapy for alcohol-use disorders, are not necessarily the ones most frequently used (Gotham, 2004; O'Farrell, 1992). The path of developing an evidence-based best practice model is arduous (Rounsaville & Carroll, 2001). If an innovation is to be subjected to clinical trials, it needs to follow a course consisting of different stages (Gotham, 2004; Rounsaville & Carroll, 2001). Innovation can be defined as a "new idea, technology, product, or service" (Gotham, 2004; Rogers, 1995). Following preliminary testing of the innovation, an important next step is the development of training protocols, followed by the training of counsellors (Rounsaville & Carroll, 2001; Gotham, 2004). A dearth of literature exists in empirical evaluations of training and supervision in psychotherapy and marriage and family therapy (Piper, 2004; Ravitz & Silver, 2004). It is clearly an area that requires attention.

CONGRUENCE COUPLE THERAPY (CCT)

History and Development of CCT

CCT builds on the work of Virginia Satir, whose pioneering contribution to the profession of family therapy is well recognized (Becvar & Becvar, 1996; Goldenberg & Goldenberg, 1996; Nichols & Schwartz, 1998). CCT further conceptualizes and elucidates Satir's implicit underlying philosophical principles and structures the intent of her therapeutic "vehicles" into a compact systemic 12-session couple treatment model for pathological gambling.

CCT is well-suited in dealing with problems commonly identified among problem gamblers, as discussed in the earlier literature review section, namely, their social isolation, low self-esteem, history of childhood trauma, poor coping abilities, and marital discord. CCT uses integrative, synergistic interventions that aim to raise self-esteem, improve personal agency, coping, communication, and relationships that transcend childhood learning within a short-term therapy timeframe (Lee, 2001, 2002a, 2002b). The target of the intervention is the person and not just the symptom. A person is visualized as a complex system made up of four interrelated dimensions: (1) intrapsychic; (2) interpersonal; (3) intergenerational; and (4) universal-spiritual (Lee, 2002c, 2003). When a person lives in integration and congruence of the above four human dimensions, coping

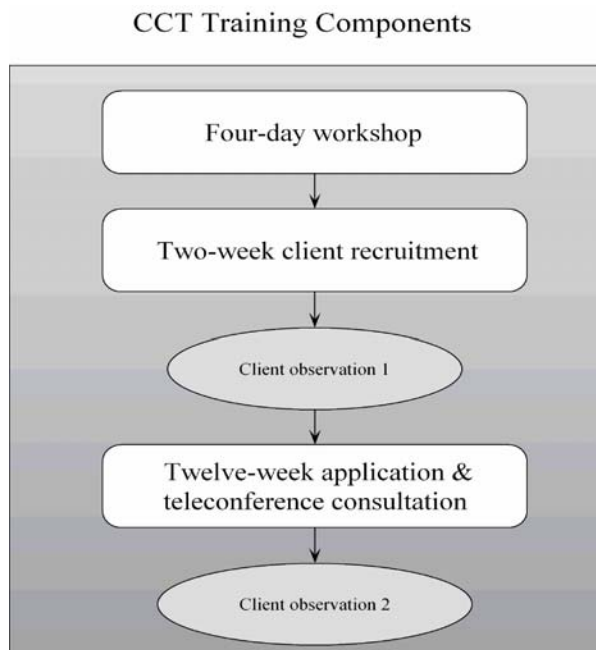
capacity improves and the need for gambling as a vicarious outlet for disowned or disconnected parts of self is expected to decrease.

The Pathological Gambling Family Systems Framework holds forth the core construct of disconnection and CCT as a therapeutic corollary of reconnection to help pathological gamblers integrate the four key dimensions into living (Lee, 2003).

CCT Training

The elements of CCT training were developed based on a clinical study conducted by the Principal Investigator with eight couples, in which one partner was a pathological gambler (Lee, 2002c). A natural, systematic progression of interventions, steps, and stages was noted in the clinical work with these couples. Subsequently, a training framework consisting of 4 days of residential workshops followed by 12 weeks of monitored application of CCT was developed to train problem gambling counsellors to administer CCT (Figure 1).

Figure 1. CCT Training Model



Two areas of CCT, Conceptual Knowledge and CCT Skills and Interventions, are covered in the CCT training.

Area I: Conceptual Knowledge

1. History and development of CCT
2. CCT philosophy
 - Key orientations and values: Humanistic, existential, experiential, social constructionist
 - Four interrelated dimensions of CCT
3. Systems thinking
4. Family systems
5. The Pathological Gambling Family Systems Framework

6. The Congruent Family Systems Framework
7. Individual versus couple counselling: Challenges and benefits
8. Challenges of working with couples versus individuals
9. Ethical issues when working with couples
10. Counsellor's use of self

Area II: Skills and Interventions

1. Recruitment and beginning phase (Sessions 1-3)
 - Recruiting a couple
 - Informing and contracting
 - Engaging, joining, and motivating
 - Setting goals collaboratively
 - Gambling in the context of CCT
 - No secrets policy
 - Reframing blame and problems into hopes and wishes
 - Assessing the couple using the Pathological Gambling Family Systems Framework
2. Middle phase (Sessions 4-9)
 - Interpersonal dimension
 - Communication stances and components of congruent communication
 - Interrupting negative communication cycle and seeding positive cycle
 - Facilitating, coaching, and modeling congruent communication
 - Expanding the range and depth of communication
 - Sculpting
 - Working with pain
 - Healing the breach in the relationship
 - Intrapsychic dimension
 - Surfacing the under-layers of the iceberg
 - Linking intrapsychic awareness with congruent communication
 - Clearing the filters of our perception
 - Inner and outer loops in communication
 - Checking out meaning
 - Expanding the range and depth of communication
 - Intergenerational dimension
 - Family mapping
 - Sculpting relationships
 - Linking past to present
 - Universal-spiritual dimension
 - Self-esteem meditation
 - Affirming and anchoring in essential self
 - Circle of life meditation
 - Quotes of the day
 - Inter-relating the four dimensions: Entry points, pacing, interrelating, integrating
3. Termination phase (Sessions 10-12)
 - Circular questioning: Counsellor and clients
 - Consolidating gains
 - Residual issues
 - Plans and referrals

Henceforth, the CCT Training (Figure 1) is defined as consisting of two parts:

1. Workshop: 4-day intensive residential workshop consisting of didactic and experiential activities conducted by the Principal Investigator in Arnprior, Ontario; and
2. Application: 12-week application phase supported by teleconference consultation with the trainer in small groups of four to five trainees.

A web-based bulletin board and e-mail list facilitated communication between the trainer and trainees. In addition, the trainer was available for individual consultations with trainees as required.

Trainer

The CCT trainer was Dr. Bonnie Lee, Registered Marriage and Family Therapist in Canada, Clinical Member and Approved Supervisor with the American Association for Marriage and Family Therapy, and developer of CCT.

RESEARCH QUESTIONS

This study sought to answer the following research questions:

Primary Question

1. Is the CCT Training Module effective in facilitating problem gambling counsellors in learning the key concepts, values, and interventions of CCT?

Secondary Questions

2. What are the strengths and weaknesses of the CCT Training?
3. What are the facilitators and challenges in training counsellors in CCT?
4. What are the preliminary findings on the effects of CCT when applied to pathological gamblers and their spouses by counsellor trainees?

RESEARCH DESIGN

This study was driven by two quantitative controlled designs for the two cycles of training. It utilized mixed quantitative and qualitative methods for data collection and analyses with triangulation.

Controlled Experimental and Quasi-Experimental Designs

This evaluation used two controlled designs to maximize utilization of our sample of participants, $N = 21$ (Appendix 1). Participants were randomized into an intervention group that received CCT training and a control group that did not (Cycle 1). The control group then acted as their own wait-listed control and received CCT training in a second training (Cycle 2). Three observation points at O1, O2, and O3 were used for data collection. Cycle 1 participants' pre-post data were collected at baseline (O1) and after training (O2). Cycle 2 participants' data were collected at three points: baseline (O1), no training after 15 weeks (O2), and after training (O3).

Randomized Controlled Trial

Counsellors meeting eligibility criteria were grouped according to their organization of employment. Organizations were stratified into two groups: those with one counsellor (Group 1) and those with two or more counsellors (Group 2). Stratification by organization was used for two reasons: (1) to avoid mixing counsellors from experimental and control groups in the same organization, which could confound the results; (2) to maximize a culture of conversation and support for those working in the same organization while learning a new treatment model. Stratification by organization with a similar number of counsellors improves the balance of counsellors in the experimental and control groups. Randomization of organizations was conducted to allocate counsellors into an experimental group that received training and a control group that did not receive training for 15 weeks. Post-training data of the experimental group at O2 were compared to the data collected at the same point for the control group. Collection and analysis of data were based on individual counsellors.

Repeated Measures Controlled Design

Counsellors in the control group were wait-listed to receive CCT training until the experimental group concluded their training. Their post-training data collected at O3 were compared to their control data at O2.

In summary, two groups of counsellors received CCT training at the two trainings conducted during: (1) Cycle 1: November 2004 to March 2005; and (2) Cycle 2; March 2005 to June 2005.

Mixed Methods

This evaluation of training employs both quantitative and qualitative data collection and analyses. Quantitative and qualitative methods are combined to give: (1) *complementarity* so that while the quantitative method gives precision and control with specific variables to address the question of effectiveness of training, a qualitative method substantiates the nature of the effectiveness with narratives and descriptions to yield insights, depth, and understanding; (2) *incrementality* so that quantitative and/or qualitative data are collected and analyzed for different phases and dimensions of the evaluation; and (3) *enhanced validity and reliability* when quantitative and qualitative results are triangulated by comparison and contrast to add strength to the interpretations of the findings (Polit & Hungler, 1999).

Evaluation Framework

The classic professional development evaluation model developed by Kirkpatrick (1959, 1977, 1996, 1998) and elaborated by Guskey (1998, 2000) provided the framework for the five levels of evaluation in this study.

Levels of Evaluation

The five interrelated evaluation levels (Appendix 2; Guskey, 1998, 2000) were:

1. *Level 1: Trainees' Reactions.* Are the trainees satisfied with the training?
2. *Level 2: Trainees' Learning.* What knowledge and skills did the trainees learn?
3. *Level 3: Organization Support and Change.* Are there changes in the organization's openness, advocacy, support, values, beliefs, receptivity, and programs with regard to working with couples?
4. *Level 4: Trainees' Use of New Knowledge and Skills.* How well do the trainees apply their new knowledge and skills back at their home sites during the training period?

5. *Level 5: Impact on Clients.* What changes are evidenced in clients' outcomes? (We considered client satisfaction and client outcomes as two sets of indicators of impact).

The primary focus of evaluation for this first CCT training is on Levels 1, 2, and 4. Levels 3 and 5 are given secondary attention as impact on organizations and clients are anticipated to be more discernible over time and will be studied in greater depth at a later stage. Results from all five levels are reported.

ETHICS

This research project received the approval of the University of Ottawa Research Ethics Board before its implementation. Three levels of consent forms were developed for the organizations, counsellors, and their clients. Consideration was given to the ethical principles in research: balancing harms and benefits; respect for human dignity; respect for justice and inclusiveness; and respect for privacy and confidentiality (Loiselle, Tatano Beck, Polit, & Profetto-McGrath, 2006).

METHODS

Sampling

Inclusion and Exclusion Criteria

Counsellor trainees for this study were recruited from all provincially-funded gambling treatment services representing the seven health regions of Ontario. Eligibility criteria included the following organization and counsellor characteristics:

- Organization inclusion criteria:
 - Ontario funded gambling treatment service;
 - open to collaborating with researchers in developing and researching empirically supported models for gambling treatment;
 - supports counsellors' participation in the study: release time for 4-day residential CCT training workshop and counsellors' post-workshop training support and supervision;
 - supports the evaluation procedures for the research study; and
 - provides technological support with a computer for internet access, phone for teleconferencing, and audiotape recorder.
- Counsellor inclusion criteria:
 - has a minimum of 1 year experience counselling problem gambling clients;
 - has solid basic individual counselling skills;
 - commits to attend a 4-day residential CCT training workshop in Ottawa;
 - commits to apply CCT to at least one couple with concurrent training support and consultation from the trainer;
 - agrees to participate in evaluation procedures as required for the study;
 - obtains support from their organization to participate in the study; and
 - has a stable psychological condition for experiential workshop participation.

Recruitment Procedures

A multi-step process was used to recruit problem gambling counsellors to participate in the CCT study (Appendix 3). An initial email announcement briefly describing the purpose of the study and eligibility criteria was sent to three email distribution lists: (1) a list of counsellors who had expressed interest in CCT during a poster session presented by the Principal Investigator at the Responsible Gambling Council of Ontario (RGCO) 2003 Conference; (2) a list maintained by the Centre for Addiction and Mental Health (CAMH) of all problem gambling counsellors and administrators working at provincially-funded designated gambling treatment sites in Ontario; and (3) Gambling Issues International (GII), an international email list for professionals working in the field of problem gambling, maintained by CAMH.

A web page version of the announcement, posted on the AP Campus website, provided online learning programs for addictions professionals and health care providers. The announcement provided a toll-free phone number and an email address for counsellors to obtain more information. A recruitment letter providing further details about eligibility criteria, procedures, and background information about CCT, study objectives, training dates, and locations accompanied the email announcement.

Counsellors and administrators who inquired were screened on the phone for eligibility and asked a number of questions about their background and interest in the study (screening guide). Those who met the initial screening criteria were sent three information letters and consent forms – for the organization, counsellor, and prospective clients (clients did not sign the consent form until after instructions at the workshop). Counsellors and administrators were also sent a demographic questionnaire which was to be completed by counsellors once they had consented to participate.

A training date in September 2004 was set upon obtaining the approval to proceed from the University of Ottawa Research Ethics Board. This date was moved back to early November 2004 to maximize recruitment and enrolment for the following reasons: (1) September was a high activity month for most organizations; (2) counsellors needed more time to complete the study pre-measures; (3) original training dates conflicted with another major problem gambling conference; and (4) sample size could potentially be increased by postponing the first training date.

A second recruitment announcement was issued after the decision for a later training date. A second email announcement and recruitment letter, both containing the revised dates, were sent to the same three email distribution lists. One follow-up phone call was made to organizations that had not responded to notify them of the new dates.

Recruitment Results

Table 1 summarizes the results of the recruitment process. Of the total number of inquirers, 75% were counsellors and 25% were organization administrators. The large majority of inquirers heard about the training by email. Slightly more than half had heard of CCT previously, largely at conferences. Thirty-nine percent cited a desire to improve their skills in problem gambling couple therapy as their main reason for interest in the training study, and in some cases, because they were already doing couple work. Several inquirers mentioned the desire to be involved in problem gambling research. Other reasons given for interest in the study included a desire to meet new people and to get more experience in the field. A large majority of inquirers were eligible for the study, and close to 50% enrolled by signing their consent to participate. The second recruitment increased the participation rate by 19%. Those who did not enrol after their inquiry cited one or more of the following reasons for not participating: 1) workload for the study was too great; 2) lack of support from organization administration; and 3) study conflicted with other training during the same period.

Table 1. Recruitment Results

	<i>N</i>	<i>n</i>	%	
Total no. of Ontario-funded treatment organizations	52			
Approximate no. of provincially-funded problem gambling counsellors	120			
Inquirer – counsellor and administrator	40	30	75	counsellor
		10	25	organization administrator
How the inquirer learned of the study	40	31	78	email announcement
		4	10	organization administrator
		5	12	another counsellor
Whether the inquirer had heard of CCT	40	23	58	yes
		17	42	no
How the inquirer learned of CCT	22	14	64	conference
		8	36	other
What prompted interest in study	22	7	39	to improve skills in couple therapy for PG
		15	61	other
Years of experience working with problem gamblers	30	9	30	0-2 yrs
		7	23	3-5 yrs
		14	46	6-10 yrs
Eligibility				
Total (<i>all inquirers</i>)	40	35	87	eligible
		5	13	ineligible
Participants from both recruitments	26	21	81	initial recruitment
		5	18	second recruitment

Participants

Number of Participants, Attrition, and Additional Recruits

Twenty-six counsellors enrolled in the study by submitting signed consents, and of these, 24 submitted pre-training data. Three participants withdrew from the study – two due to job changes and one for personal reasons (Appendix 3). The final sample included 13 organizations, representing 25% of the Ontario-funded problem gambling programs, and 21 counsellors, representing 18% of the problem gambling counsellors in Ontario agencies in 2004.

Table 2. Counsellor Participants

Counsellors who enrolled with signed consent	<i>n</i> = 26
Counsellors who submitted pre-training data	<i>n</i> = 24
Counsellors who withdrew from the study	<i>n</i> = 3
TOTAL Counsellors who completed study	<i>n</i> = 21

Demographic Profile

Table 3 displays the demographic profiles of counsellors who submitted pre-training data for the study. The gender distribution was nearly equal, with slightly more males than females. The majority of participants were 30-49 years of age, with 50% falling in the 40-49 years range. Eighty-three percent spoke English as their first language, and the remaining 17% spoke German, French, or

Chinese as their first language. Mean years of total counselling experience was 15, with an average of 10 years of employment in the addictions field and 5 years of experience working with problem gamblers. Over 50% had more than 15 years of counselling experience, reflecting a predominantly experienced and mature group of counsellors.

Table 3. Counsellor Participants' Profiles ($N = 24$)

Number of organizations represented by initial group of counsellors	$n = 17$	
Number of organizations represented by counsellors who completed CCT training	$n = 13$	
Gender	Male	54%
	Female	46%
Age (in years)	20-29	8%
	30-39	29%
	40-49	50%
	50-59	13%
First language	English	83%
	Other	17%
Total years of counselling experience	1-5 yrs	9%
	6-10 yrs	13%
	11-15 yrs	22%
	15+ yrs	56%
	Mean	15 years
Number of years working in the addictions field	1-5 yrs	33%
	6-10 yrs	17%
	11-15 yrs	33%
	15+ yrs	17%
	Mean	10 years
Number of years working with problem gamblers	1-3 yrs	29%
	4-6 yrs	46%
	7-9 yrs	25%
	Mean	5 years

Previous Training, Certification, and Education

Almost all counsellors had introductory level training in problem gambling and most had some advanced training in problem gambling with different approaches. Fifty-six percent reported having attended workshops and training in working with couples, though not necessarily specific to problem gambling (Table 4).

Table 4. Counsellor Previous Training ($N = 24$)

Introduction to problem gambling workshop	96%
Advanced problem gambling workshop	83%
Cognitive behavioural therapy	75%
Solution focused brief therapy	67%
Specialized skills for problem gambling	62%
Couple and family counselling	58%

Fifty-nine percent of participants were certified gambling counsellors or were actively working towards certification, and 25% had no specific certification. Seventeen percent possessed other professional credentials, including two registered social workers, two registered marriage and family therapists, one registered practical nurse, and one counsellor with an addictions studies certificate. Seventy-six percent held professional credentials (Table 5).

Table 5. Certification Status ($N = 24$)

Certified gambling counsellors	38%
Actively working towards gambling counsellor certification	21%
Other certification	17%
No specific certification	25%

All counsellors had a post-secondary education, with a large majority possessing an Undergraduate university degree, and a smaller percentage a Masters degree (Table 6).

Table 6. Highest Education Level Attained ($N = 24$)

College diploma or certificate	17%
Undergraduate degree (B.A., B.S.W., etc.)	66%
Graduate degree (M.A., M.Sc., etc.)	17%

Participants' mean length of employment with their treatment agency was 6.6 years. On average, participants spent 68% of their clinical time counselling individuals as opposed to counselling groups, couples, or families. Couple work constituted 13% of their clinical work (Table 7).

Table 7. Current Clinical Practice ($N = 24$)

Number of gamblers counselled by participant in past year	0-50	50%
	51-100	45%
	over 100	5%
	Mean	52
Mean Number of gamblers served by organizations in past year	Mean	168
Length of employment with current organization	0-5 yrs	46%
	6-10 yrs	29%
	over 10 yrs	25%
	Mean	6.6 yrs
Proportion of clinical time counselling individuals in past year	Mean	68%
Proportion of clinical time spent counselling groups in past year	Mean	14%
Proportion of clinical time spent counselling couples in past year	Mean	13%

Most participants provided their services only in English, however some offered their services in French, Cantonese, Ojibwa, or through an interpreter (Table 8).

Table 8. Languages of Service ($N = 24$)

English only	63%
French	17%
Cantonese	4%
Ojibwa	4%
Interpreter	12%

The majority of participants (58%) did not serve a special population. Of those participants whose agencies served a special population, 25% reported programs for women, 29% served Aboriginals, 21% worked with youth, and 13% worked with ethnic groups (Table 9).

Table 9. Special Populations Served by Participants ($N = 24$)

Participants who serve a special population	42%
Special population – women	25%
Special population – Aboriginal	29%
Special population – youth	21%
Special population – ethnic group	13%

Therapeutic Orientation

The majority of participants reported following a specific therapeutic orientation, with cognitive-behavioural and solution-focused approaches being the most popular (Table 10).

Table 10. Therapeutic Orientation of Counsellors ($N = 24$)

Follow specific orientation	88%
Cognitive behavioural treatment	88%
Solution focused treatment	83%
Brief intervention therapy	58%
Relapse prevention	58%
Narrative therapy	33%
Emotional focused therapy	21%

Again, the majority of counsellors reported their organizations followed a specific therapeutic orientation characterized as mainly harm reduction and cognitive-behavioural (Table 11).

Table 11. Therapeutic Orientation of Organizations ($N = 24$)

Follow specific orientation	79%
Harm reduction approach	62%
Cognitive-behavioural therapy	58%
Abstinence approach	33%
Solution focused therapy	17%
Client centered therapy	8%

Evaluation Instruments

As no instruments exist to evaluate CCT training, the counsellor evaluation instruments were developed by the Principal Investigator and research team. These instruments were found to demonstrate good face and content validity. A more extensive description of the development of the two main counsellor training outcome instruments, namely the Written Test and Role-play Test, can be found in Appendix 11.

The client evaluation instruments consisted of three pre-validated instruments from the research literature, and one instrument, the Client Satisfaction Questionnaire, developed by the Principal Investigator and research team.

Counsellor Evaluation Instruments

Evening Reflections (ER) (Appendix 4)

This self-report questionnaire consists of six items eliciting trainees' evaluation of each day's training during the workshop. It includes trainees' ratings of the topics and activities covered each day, their most important learning, what they most struggled with, questions they wish to have answered the following day, what they would like to see changed about the training, and any other comments. Item 1 covers a total of 19 activities and topics of the workshop content over 4 days. Participants evaluate the helpfulness of these activities on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree). The activities fall under three broad content categories of the CCT workshop: (1) Concepts, Values, and Framework; (2) Tools and Interventions; and (3) CCT Phases. This instrument serves as a tool for formative evaluation so adjustments are made in a timely manner before the next day's activities. They are returned anonymously and take approximately 10-15 minutes to complete.

Workshop Questionnaire (WQ) (Appendix 5)

This self-report questionnaire, completed by participants, consists of 18 items on a 7-point Likert Scale indicating a range of trainee reactions (1 = strongly disagree, 7 = strongly agree). Part 1 covers eight areas of the workshop: facilities; process; materials; training modalities; learning; intended application of learning; trainer; and overall satisfaction. Part 2 covers seven training modalities of the workshop: simulations; short lectures; demonstrations and role-plays; videos; etc. This questionnaire is administered at the end of the 4-day residential workshop and takes approximately 20 minutes to complete.

Training Questionnaire (TQ) (Appendix 6)

This self-report questionnaire consists of 39 items on a 7-point Likert Scale, (1 = strongly disagree, 7 = strongly agree) on areas of the entire training, including the application phase. A number of items overlap with items on the Workshop Questionnaire. Additional items cover the areas of duration and demands of training, training components, counsellor changes, organizational change, and future directions. A section for comments is included. The questionnaire takes approximately 20 minutes to complete.

Workshop Focus Group (WFG) Interview Schedule (Appendix 7)

The WFG covers five broad areas of questions with suggested probes for participants. The focus groups are conducted immediately after the workshops in small groups of 4 or 5 participants. The questions inquire into: new learning from the workshop; participants' experience of CCT; participants' readiness and motivation to apply CCT after the workshop; anticipated challenges and barriers for the application; suggestions for improving the workshop; and other comments. Focus group duration is approximately 1 hour.

Training Focus Group (TFG) Interview Schedule (Appendix 8)

The TFG covers the participants' experience of the entire training. It is conducted as a teleconference in the same groupings of participants from the teleconference consultations. The interview schedule is organized into four major sections to inquire into: CCT training; application of CCT; participation in the research study; spin-offs; metaphors of training experience; and personal and professional growth. Probes are given to encourage participants to discuss specific areas of each section. Focus group duration is approximately 1 hour.

Written Test of CCT Concepts and Values (WT) (Appendix 9)

The WT Concepts and Values consist of two parts. Part 1 is comprised of seven closed-ended questions for short answers and multiple choice questions. Part 2 is comprised of three open-ended

questions to evaluate participants' concepts and values in CCT, including their understanding of problem gambling, couple relationship and problem gambling, counselling approach, and personal experience of counselling couples in problem gambling. The closed-ended questions are scored objectively according to a scoring rubric. The open-ended questions are analyzed qualitatively by two raters for content and themes reflecting CCT concepts and values.

Role-Play Test of CCT Skills and Interventions (RP) (Appendix 10)

The RP consists of six scenarios representing typical vignettes encountered in working with problem gamblers and their spouses across three phases in CCT. Participants role-play the 5-minute scenarios with volunteers who are not actual clients. A 58-item observational checklist allows judges to rate the demonstration of CCT interventions on a 3-point scale. Each skill is rated by judges as follows: 0 = skill not demonstrated; 1 = skill demonstrated; and 2 = skill demonstrated very well in terms of appropriateness, timing, and integration into the flow of the clinical process. Sub-scores for each section and a total score are used as indicators of participants' skills and interventions in CCT. The development of the Written Test and Role-play Test is reported in Appendix 11.

Recruitment Summary (Appendix 12)

The purpose of the Recruitment Summary is to assess the appropriateness and risks of the couples that trainees recruited for CCT and to gain insight into the criteria they use to select the couples for CCT. It also provides them with practice to do some deliberate reflections on the risks and benefits of CCT for couples.

Teleconference Audiotapes and Notes

Most of the teleconference consultation sessions were audio taped. An observer/note taker was present during each of the sessions to take notes on the process and main points of each teleconference. Teleconference notes consisted of the following: session summary; main topics; issues raised by trainees; clients' responses to interventions; trainers' interventions; emerging issues; future training issues; and CCT components applied.

Intervention Summary (Appendix 13A, 13B, and 13C)

At the end of training, trainees were asked to provide a 1-2 page summary of the interventions they used with their couples in the course of their counselling.

Self-Assessment Tool for CCT Use (Appendix 14)

This tool consists of a checklist of items in 10 categories related to counsellors' use of CCT. It is designed to help counsellors follow a high standard of counselling practice, to minimize harm and maximize benefits for their clients, when using an innovation that is still in the early stages of development. Since counsellors' context of practice, training, and experience vary, it is incumbent upon counsellors to conduct a self-assessment to reflect on their own practice and decision-making regarding CCT during and after training. This tool was developed by the Principal Investigator in consultation with Dr. Martin Rovers, Co-investigator, and Robert Murray, Manager of the CAMH Problem Gambling Project and advisor on this study.

Client Evaluation Instruments

Client Satisfaction Questionnaire (Appendix 15)

This 1-page survey is composed of 5 items to gather clients' satisfaction with CCT. Overall satisfaction on the CCT received is rated by clients on a Likert scale (1 = highly dissatisfied, 7 = highly satisfied). Four open-ended questions ask participants to list what was most helpful, how they benefited from CCT, key ideas, words and concepts that come to mind regarding this approach, and an opportunity to offer comments. The questionnaire is meant to be completed in 5 to 10 minutes.

Gambling Symptom Assessment Scale (G-SAS)

The G-SAS (Kim, Grant, Adson, & Shin, 2001) is a 12-item self-rated scale designed to assess the change of gambling symptoms during the past week. It was selected over other gambling diagnostic instruments, such as the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987) and Canadian Problem Gambling Index (CPGI; Smith & Wynne, 2002) as it is more suitable for detecting changes in the primary variables of interest in this study -- gambling urges, thoughts and preoccupation, control, emotional distress, and adverse personal consequences as a result of gambling. A past-week gambling symptom timeframe provides the immediacy required to examine effects in the shorter term. Reliability and utility of the G-SAS has been reported by the authors. Test-retest reliability showed good correlation ($n = 58$; $r = .70$), with Cronbach's Alpha = .89.

Satisfaction with Life Scale (SWLS)

The SWLS (Diener, Emmons, Larsen, & Griffin, 1985) is a global measure of life satisfaction based on conscious cognitive judgments of a person's life. It consists of one factor under the general construct of subjective well-being. The scale has five items rated on a Likert scale and takes only 1 minute to complete. The SWLS reports a coefficient alpha of .87 for the scale and a 2-month test-retest stability coefficient of .82.

Dyadic Adjustment Scale (DAS)

The DAS (Spanier, 1976) measures the quality of marital relationships and can be used for any committed relationship. It is a 32-item measure with four subscales: consensus, satisfaction, cohesion, and affectional expression. The total score can range between 0 and 151, with higher scores indicating better adjustment to one's relationship. Spanier's original mean total score was 114.8 ($SD = 17.8$) for married couples and 70.7 ($SD = 23.8$) for divorced couples. Cronbach's alpha is .96, indicating high scale reliability.

Data Collection

Counsellor Data

The ER questionnaires were administered at the end of each day during the workshop and were completed and submitted anonymously by participants.

The WQ and TQ were completed at observation points O1 and O2 for Cycle 1 trainees, and O1, O2, and O3 for Cycle 2 trainees anonymously (Appendix 2).

The WFGs were facilitated by two independent focus group facilitators at the end of the 4-day workshop in the two training cycles. Trainees were randomly assigned to two focus groups with 4-6 participants in each. With the trainees' consent, the focus group discussions were audio taped. The facilitators worked from a list of focus group questions using an interview schedule (Appendix 8). Focus group discussions lasted between 45 minutes to 1 hour. The audiotapes were transcribed anonymously, and then verified and corrected by the facilitators before analysis. A total of four WFGs were held – two for each cycle.

The WT and RT were collected at observation points O1 and O2 for Cycle 1 trainees, and O1, O2, and O3 for Cycle 2 trainees (Appendix 2). They were scored by independent blind scorers who had no knowledge of whether the tests represented pre- or post-training scores or prior knowledge of the participants. The one exception was the open-ended questions on the WT, which were analyzed by the Principal Investigator who had prior contact with the participants. These same items were also analyzed by the second Co-investigator who had no knowledge of the participants.

The TFGs were conducted on the telephone by independent facilitators 2-3 weeks after the application phase at the end of training. Five focus groups were conducted for the two cycles of

training. The groupings of trainees were the same as those for the teleconference consultations, each with 4-5 participants. With trainees' consent, TFGs were audio taped, transcribed, verified, and then analyzed with no identification of the participants.

Recruitment Summaries were submitted by trainees during the 2-week recruitment period as they considered various couples for the trial application of CCT.

Teleconference audiotapes and notes were selectively analyzed in depth. Sessions 8-12 were selected for in-depth qualitative analysis because they were deemed to contain more reflections and summaries of the entire training process as the cases progressed towards the end. Verbatim transcriptions of excerpts from quotes were done to illustrate the content and themes. These categories were: (1) aspects of CCT applied; (2) client issues; (3) improvement with clients; (4) professional and personal growth; (5) trainee's concerns; (6) trainer's interventions and concerns; and (6) trainees' feedback on CCT.

Intervention Summaries were submitted at the end of training when trainees had terminated with their couples. They used this exercise to reflect on the course of their counselling with their couple(s) and to consolidate their learning.

Client Data

The Client Satisfaction Questionnaire was returned anonymously by clients in a stamped addressed envelope directly to the researchers without going through their counsellor. This ensured confidentiality and strengthened the validity of the results from the questionnaire.

The G-SAS, SWLS, and DAS were administered by the counsellors with their clients immediately before and after the CCT treatment (see Appendix 2).

Data Analysis

Quantitative data were entered into SPSS 13/14 by a research assistant. Descriptives were generated on all the questionnaire scores. Statistical tests were conducted to answer questions of whether there were significant differences between training and control groups. Non-parametric tests were used for the counsellor trainees because of the small sample size. Parametric tests were used for the client sample because of the larger sample size.

Qualitative data from the focus groups were entered into QSR N6, a computer-assisted qualitative analysis software. A coding tree was developed following the categories in the Interview Schedules to answer the main research questions: (1) Were the counsellors satisfied with the training; (2) What learning did the counsellors report; (3) What are the facilitators and barriers for participants learning CCT; and (4) What suggestions were made to improve the training? The same coding tree was used for the WFG and TFG for common items. A few nodes were added to the TFG coding tree (e.g., spin-offs, personal growth, and metaphors).

Qualitative data from the open-ended questions in the Written Test, Recruitment Guide, Intervention Summary, and Client Satisfaction Questionnaire were analyzed manually by key words, content, and themes.

Results from the WQ and TQ were triangulated with the WFG and TFG. Data across the evaluation levels were triangulated after each level of data was analyzed. The triangulation across the various quantitative and qualitative data sources and evaluation levels occurred most clearly at the end when all individual analyses were completed.

RESULTS AND INTERPRETATIONS

Level 1: Trainees' Reactions

Level 1 of the evaluation focused on the reactions and satisfaction reported by trainees at two points: (1) immediately after the 4-day workshop; and (2) 2 weeks after the conclusion of the 15-week training, including the teleconference consultation of their application of CCT.

Trainees' reactions specific to other levels of evaluation, namely learning, organization change, application of knowledge and skills, and the impact on clients, is reported with the corresponding levels of this report.

Data Sources and Analysis

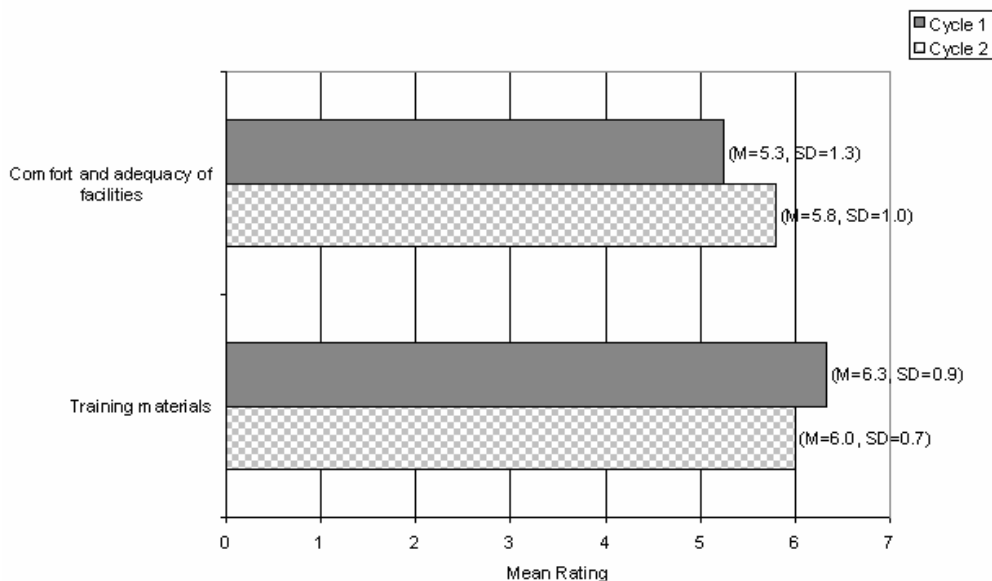
Data sources for Level 1 include results from the ER, WQ, TQ, WFG, TFG, and comments from the Teleconference audiotapes and notes (see Appendix 2). Trainees' satisfaction items on the WQ and TQ and their corresponding graphs are listed in Appendix 16.

The bar graphs for data obtained on the WQ and TQ display the means and standard deviations from the two training cycles for visual comparisons; however, the narratives only refer to the mean based on all cases in Cycle 1 and 2.

Workshop Setting

The two workshops were held at a retreat centre 45 minutes outside of Ottawa, Ontario. This venue was selected because of its natural and peaceful ambience, as well as the reasonable rates. The rooms were dormitory style, and the furnishings Spartan. The large, well-equipped conference room had large picture windows with a view of towering spruce trees and the Ottawa River. A web-link was to the conference site was provided on the registration form. While some trainees viewed the website beforehand, others described how they were surprised when they arrived. The venue did not have what they expected in terms of hotel amenities. The mean rating for both workshop cases on comfort of the workshop facilities was 5.48 ($SD = 1.17$) for combined workshop cycles on the WQ (Figure 2).

Figure 2. Workshop Setting and Materials ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)



By the end of training, trainees from both cycles emphasized the benefits accrued from having had the workshop at a retreat setting. They gradually adjusted to the reduction of external stimulation and entertainment, which allowed them to enter into more reflection and interior integration of their learning. A sense of “bonding” to the place and other participants was expressed by many trainees:

P6: I really grew to like this place, but what I think would have been helpful is, if we had more preparation what's going to be here and wasn't. You know, there aren't a lot of amenities. But it has its own charm and it leaves you with a bond to this place. So I think, if we could have brought games and hair dryers, it would have been better at the beginning.

P3: I would have stuck my portable TV in the bag somehow [laughter].

P6 or 2: Aren't you glad you didn't.

P1: I am glad I didn't, actually, I didn't ... [yeah, affirmation from others] (WFG-1B)

In the evenings, the lack of external distractions provided a space for participants to know one another in greater depth, as well as develop friendships through games and conversations:

M2: For myself, I think that it being here and it being in sort of an isolated location is what made it such a powerful thing. It allowed us to get really comfortable with one another and therefore all those role plays and all of the good stuff that we were doing, it made it more powerful and it made it really personal and it made it impactful. I think it's one of the, I can say right now, it's the best training I've been to. And I think that it affects how I'll do my work more than any other training. (WFG-1A)

F1: That was what we did, the role playing, the bonding, the game, the fun. That's extremely rare. As far as I'm concerned, it made a huge difference for me. (WFG-1A)

Trainees found the choice of location and venue conducive to personal reflection and integration of their learning on a deeper level:

P4: I think the trainer chose an awesome spot. I don't know if it was an accident or intentional, but I think that choice was very important and back to what you said about the process, not only the process of learning this model, but the process that I've gone through as a counsellor during the experience and the things it forced me to look at and gave me time to look at and explore about myself, even as a person and as a counsellor. So I think I've grown a lot as well, not just knowing the words and what to do. Yes, it helped me develop. (WFG-2A)

Although some thought the food could have been better (they especially disliked the “salmon loaf”), the friendliness, courtesy, and respect of the staff more than compensated for some of the material comforts:

P3: I don't know if we thanked the staff, but they were very careful, very accommodating. (WFG-2B)

Looking back at the end of the training 15 weeks later, one trainee vividly summarized the importance of the retreat setting in contributing to the fullness of her training:

P5: I think having the training at the Galilee Center was a really important piece... Because it gave us time in the evening to talk with other people and get to know other people, and learn about what they were doing, and discussing, you know, concerns that we might have had about something or something we weren't clear on. So I think that whole experience to just be away, to focus on the model, helped. Because, had it been, let's say, Toronto or even downtown

Ottawa or whatever, where people could have gone out as soon as the training was done, people were out doing things. Whether they were shopping, drinking, eating, whatever, partying. I think that that would have maybe impacted things in a negative way. I think the Galilee Center was a great opportunity to get back to ourselves and to get real with ourselves and then allow us to do some growing because I think you really needed to do that in order to learn this model too. It wasn't just a matter of getting the information. I think we had to spend some time figuring out whether or not it works with us, and whether or not this was ok with us, and be able to feel confident in applying it with people. So I think the whole journey was really important and the Galilee Center provided the place to do that. (TFG-2I)

Training Materials

Training materials included PowerPoint handouts and CCT documents written by the trainer, and publications on CCT. The book, *The Satir Model* (Satir, Banmen, Gerber, & Gomori, 1991), was purchased for each participant.

Trainees found the training materials very useful as indicated by a mean rating of 6.19 ($SD = .8$) on the WQ from all cases in both cycles (Figure 2). Several times in their suggestions, trainees recommended sending out the materials ahead of time. Several participants said this would have enhanced their learning. They would have liked to do some assigned preparatory reading. For others, having the book and materials during the workshop worked just as well, helping them review what they had learnt that day. Trainees spoke of the usefulness of the CCT handouts and Satir book, and how well these items served them during the application phase of the training. Focus group data indicated that satisfaction and use of the materials persisted over the entire course of training. At the end of training, the majority of trainees mentioned they had referred to the materials extensively during the application phase to refresh their learning, clarify certain aspects of CCT, and plan their counselling sessions.

Group Size

As mentioned in the sampling section, we held two cycles of CCT training with group sizes of 12 and 9 trainees, respectively. The workshop groups were further divided into smaller teleconference consultation groups after the workshop, each consisting of four to five trainees. The comments on group size were raised mainly in the focus groups, as we did not have a questionnaire item to quantitatively measure this aspect of the training. However, group size is an important consideration that may influence the outcome of future training with a dominant experiential component. Trainees felt the group sizes of 9-12 were just right for the workshops and the teleconference:

P3: The fact that there was just nine people here really helped, I could see double that [size] I don't think we would have been able to do the work that was done. So I think the size was really appropriate for the style. (WFG-2B)

The small group sizes were not only conducive to an experiential and interactive way of learning, but also allowed more safety for self-disclosure and trust for both the workshops and teleconference consultations:

P2: I felt like 'ok, I can do this,' it was a small group and I like a smaller group better anyway, had there been 20, I don't think I would have done as much of the personal. (WFG-2B)

P3:[For the teleconference groups], I don't think I would have felt quite as safe and trusting to try something new if it would have been a larger group, since it was experiential. And I have really liked applying the model and I have really liked the teleconferences... Nine was good for the actual training. And then being on the teleconference, I think four was perfect, no larger. (TFG-2B)

Workshop Content

Content of the workshop was evaluated in terms of its helpfulness in trainees' learning of CCT. Data were collected from daily ERs during the workshop and WQs. Content areas correspond to activities covering two domains of the CCT training framework, namely Conceptual Knowledge (Figure 3) and Skills and Interventions (Figure 4). There was no significant difference in the ratings between the Cycle 1 and 2 workshops.

Figure 3. Concepts and Values

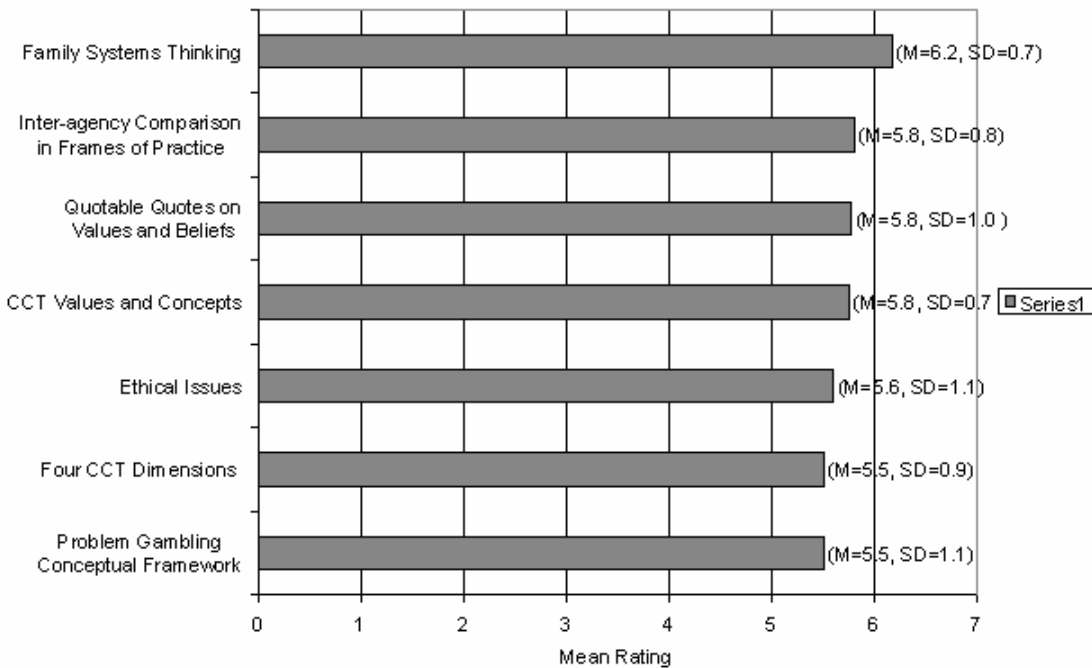
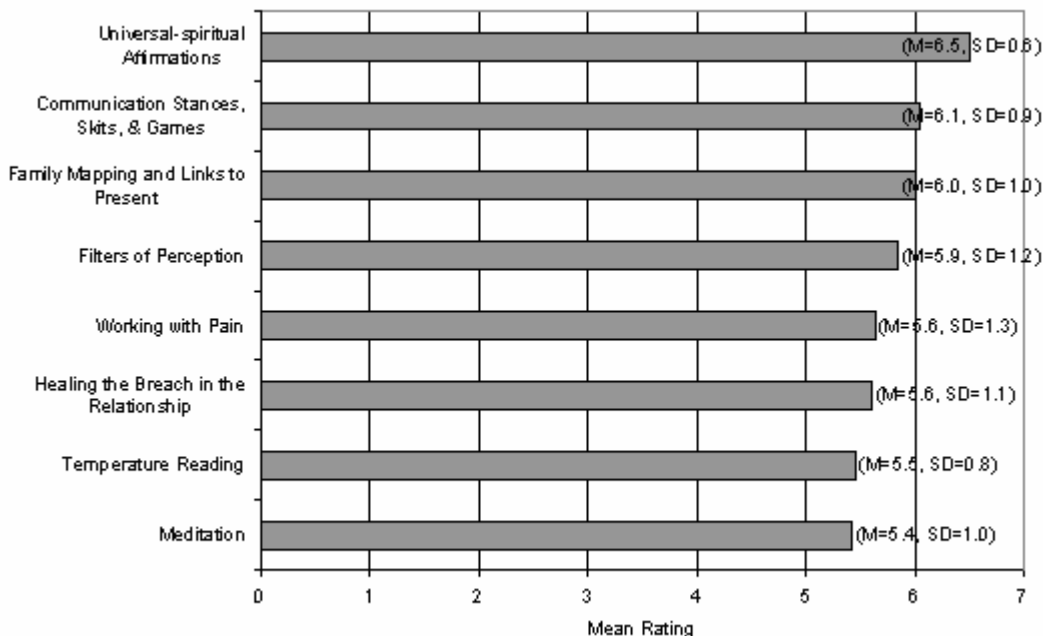
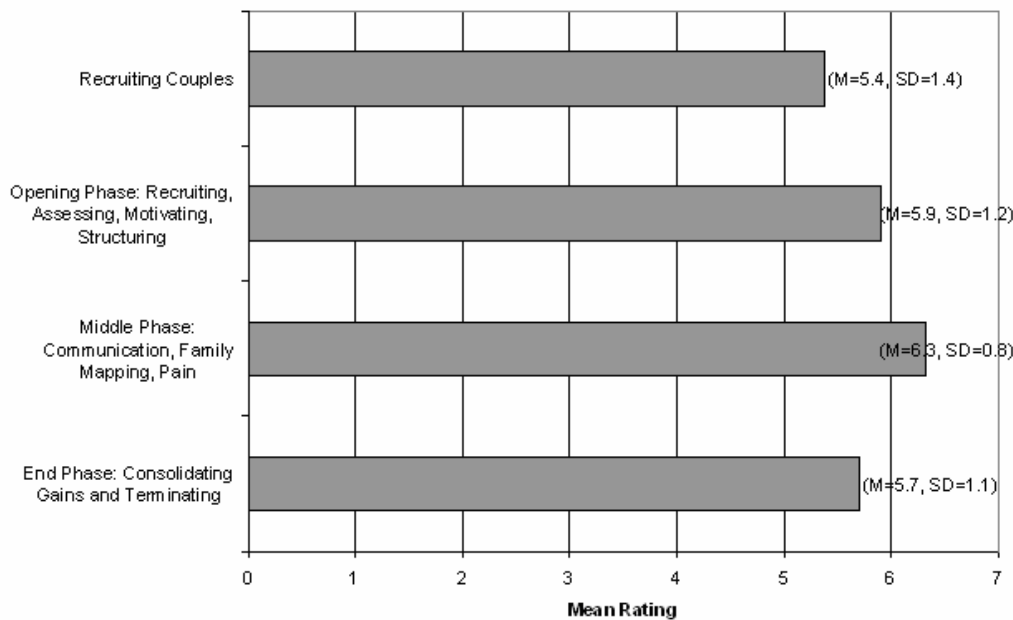


Figure 4. Interventions and Tools



The area identified to be of greatest helpfulness in the Conceptual Knowledge domain was family systems thinking and understanding. Areas of Practice and Interventions found by trainees to be most helpful were universal-spiritual affirmations, interpersonal communication, and intergenerational family mapping. All three dimensions were rated with a mean score of 6 and above (Figure 4). Focus group participants frequently mentioned the meditations, family mapping, and communication stances as being helpful in their work.

Figure 5. CCT Phases



Of the CCT phases covered (Figure 5), trainees found coverage of the Middle Phase most helpful ($M = 6.32$, $SD = .75$), followed by the End Phase of terminating with couples and consolidating gains ($M = 6.0$, $SD = 1.08$). Middle Phase exercises included interrupting the negative communication cycle and seeding a positive one, family mapping, and working with pain. However, trainees also indicated they would like to have future workshops addressing the Middle Phase in greater depth, especially in the areas of family mapping and working with pain:

R1: I think it has been brought up in the past. Like there are parts that are not...in depth enough, like how to do the family of origin stuff, so like, working with the trauma thing, because I think that needs more time. And we're hoping we get the chance that the training can be continued, that part can be studied more in-depth. (TFG-1C)

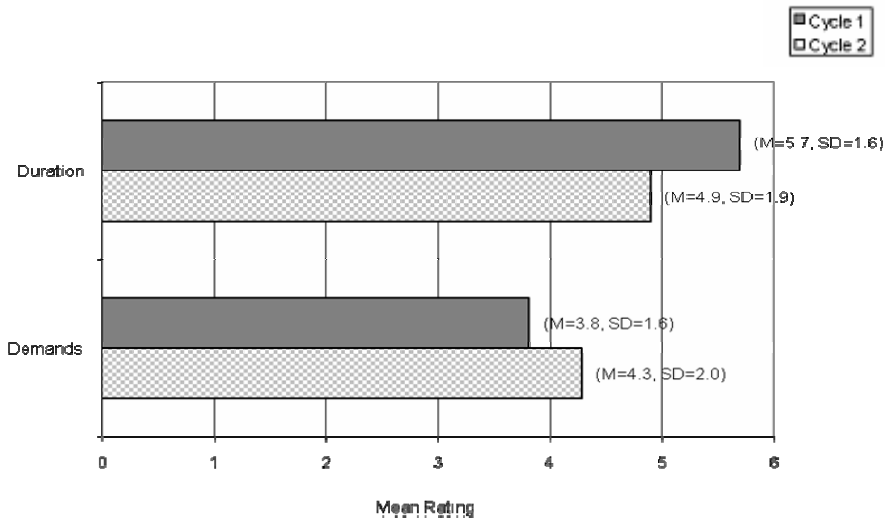
P1: Because I found them to be really two significant pieces and [name 3] mentioned that we spent a lot on the beginning and the end, but just those components in the middle, I think, would have really would have been helpful. And you could have easily spent half a day on one, half a day on the other, umm, during the training. So... yeah." (TFG-2B)

Although trainees in the Workshop Focus Groups reported they were more familiar with practices in the Opening Phase, it was only at the TFGs after the application phase that trainees discovered the importance of the initial stage in motivating, collaborative goal-setting, harnessing the couples' hopes and wishes to generate energy in the system, building an alliance, and sustaining clients' commitment to the couple counselling process.

Duration and Demands of Workshop Training

The TQ at the end of training indicated trainees found the training duration and demands to involve substantial investments (Figure 6).

Figure 6. Duration and Demand ($N = 18$: Cycle 1, $n = 11$; Cycle 2, $n = 7$)



In terms of the appropriateness of training demand, trainees rated it at a mean of 4 ($SD = 1.71$) for combined cycles. The demand experienced was largely due to the paperwork required rather than the training itself. Balancing the demands, nearly all trainees rated the training experience as highly worthwhile and rewarding ($M = 6.67$, $SD = .69$).

In the workshop and training focus groups, trainees described the training as “intense”, “comprehensive,” and “thorough”:

P2: Well, to present in four days an entire way of thinking and then incorporate that, that is a huge task. (WFG-1B)

R 1: To me, the training in and of itself was very thorough, thorough in the sense that this is the first time I attended a workshop and then there’s a follow-up part, which I’m referring to the teleconference. I find that very helpful, it’s not just taking in information, but there’s follow-through to the whole process, whether or not or how I’m going to implement it or what didn’t work out well. So to me, it’s a new experience, but it’s very helpful. (TFG-1B)

At the end of the workshop, all trainees felt that the 4-day workshop could have been longer in order for them to feel completely at home with CCT. However, they also wondered whether a 5-day training would have been too long:

P6: I wish the training were 5 days; it gave me so much to think about, I am exhausted.

P1: I don’t think that she could do that. I think there was so much information and so much to do. We were in this room, what, 8 hours a day? Not including the lunches, and the movies. (WFG-1B)

In their workshop ERs, trainees spoke about needing more leisure time during the workshop. Although the group interaction was stimulating, it was also exhausting for some. Trainees’ engagement with the workshop process and their commitment carried them through:

P1: And we all watched these videos late at night. [More laughter] I thought at first like, nobody is going to be there at that time.

P6: I agree, we all were committed because she was really committed.

With respect to the teleconference consultations during the application phase, trainees from one organization felt the training and teleconferences were long and somewhat stressful, especially because their organization was undergoing some big organizational changes:

R 2: I'll tell you, for myself, and you know, I think I've had this conversation with my co-workers too, I think it was just also a very unfortunate time for us, it really was because we've had a lot going on here in the past couple of months. So I think that was a factor that made it more stressful on me. We had a lot of changes occurring here... so that was one of the things, I think it would have been a little bit easier if we didn't have that going on. (TFG-1A)

Trainees from the same organization also reported that the demand on their time took away from their regular clinical practice. They would have liked shorter teleconferences focused specifically on the questions they raised:

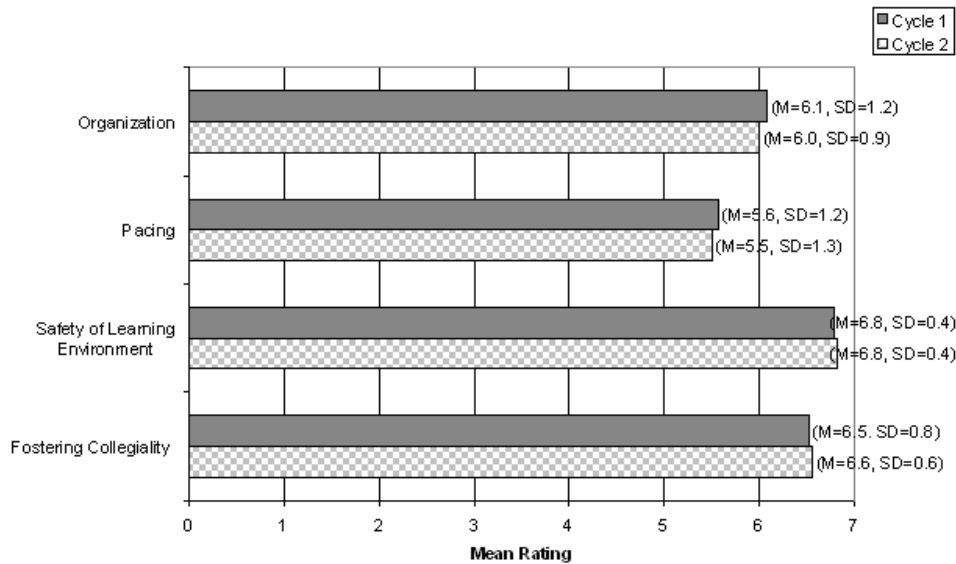
R 1: I do not think they [the teleconferences] should be dropped at all. Actually I think they could be shortened quite a bit, what we were meeting an hour and a half typically, which is way too long for people, that have, you know, our clinical practice is really busy and stuff and I understand it's research and all of that, but that was really difficult too. It's a huge timeframe for us, that's like almost missing out on two clients. It's tough to schedule, so I found they were a little bit too long. (TFG-1A)

Looking back on the entire training, even though the training was admittedly demanding in terms of time and commitment, most trainees found the experience worthwhile, as noted earlier in their ratings and in the following comment:

P1: Really. I think that's one of the reasons why we were ok with the time commitment, because it was worthwhile. We wouldn't have been ok with three people (from our organization) doing that training, and all that time commitment, if it wasn't a worthwhile process. And she certainly made it that so. (TFG-2A)

Training Process

Training Process refers to the workshop organization, pacing, safety, and collegiality. Each of these areas are discussed in the subsequent sub-sections (refer to Figure 7).

Figure 7. Training Process ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

Organization and Pacing of Workshop

Overall, trainees were very pleased with the organization of the workshop and blend of modalities and activities. The mean rating for the workshop organization was 6.05 ($SD = 1.02$) for both cycles (Figure 8). Trainees liked the alternating of different activities and modalities throughout the day to keep their interest and attention:

P1: I think there was a strike of balance that had to occur within a timeframe. I mean there's so much material to cover and how to cover it more effectively and in the timeframe that we had. And I think it was really well done. I think using the evenings to show the videos and during the day, having some lecture, but then right away jumping into an exercise and then working it out and then having a little bit more lecture. I think it worked out really well. (WFG-2A)

The same satisfaction was voiced at the end of training by one trainee who looked back on the workshop and training experience:

P4: ...I found the experience very, very positive as everyone said, and very rewarding, as did my clients. So, I just think it was fantastic. It was a great learning curve for me as well my clients. I enjoyed having the training. Umm. It was pretty packed, but it certainly was a good experience. I liked the experiential ummm, ah, stuff that we were doing in it, as well as the training itself. There was a good blend... like it was very balanced, I felt. (TFG-2B)

A number of trainees expressed that they would have preferred more time focused on the middle phase of CCT and a bit less time on the beginning and closing phases:

P2: That was one spot I wish we. . . I felt a little bit rushed, that maybe we hadn't spent as much of that time there because that was, I agree I probably did the beginning fairly well and the end decently, but didn't do enough of the middle.

P1: I agree.

P3: Yes, I think we could have spent four days just on the middle part of the training.

Facilitator: Yes, I see a lot of nodding. (LAUGHTER) So for the tape. That's good. (WFG-2B)

Some dissatisfaction was expressed by two trainees in Cycle 2 with the way the teleconference dates and times were scheduled. Since they had not been advised of this before the workshop, they did not come prepared to sign up for the dates and times. This caused them anxiety and frustration:

P4: I think the one thing that was the most difficult for me, which sounds like a little thing, but it was trying to get the teleconference organized to suit everyone. And I feel that if that had been arranged prior to the training, um, you know because we book so far ahead, it might have helped me a lot in getting the time. Eventually, we came up with something, but we were really struggling, I know, in the training, to find a time that would suit for four of us, you know. (TFG-2B)

The pacing of the workshop received slightly lower ratings, with a mean of 5.76 ($SD = 1.09$) for the post-workshop and a mean of 5.28 ($SD = 1.41$) for the post-training, with similar ratings from both cycles (Figure 7). Concerns trainees expressed for the workshop included the following: trainer did not always wait for participants to answer after posing a question; trainer moved too fast through some sections; and trainer did not spend enough time on the middle phase of the counselling process:

P3: I think when she asks a question she needs to slow down and give us a chance to think about what she is asking, before she answers it for us. I think that was the one thing. (WFG-1B)

A number of trainees voiced that they would have liked a longer period after the workshop, more than the 2 weeks allowance, to recruit their couples before the teleconference started. Because of the delay in recruiting their couple, some trainees were not able to give their clients the full 12-week sessions. The short client recruitment period produced some anxiety among participants, although other counsellors said they already had a few couples in mind (since enrolment in the training) in anticipation of the application of CCT:

P2: Well, getting the couple in this time and do it in this time... It seems like a lot of pressure to get...we're not as regular as our substance abuse side with referrals and things like that. We have our ups and downs. (WFG-2A)

R3: The other thing that I noticed and I think that was just the calendar year problem, is that the teleconferences started quite quickly after we back from Ottawa and it was right around the holidays, so it was sort of a mad rush in terms of getting your couple.... And so I think for me, I think the first teleconference or the first two, and I think (name 2) had the same problem, where we didn't have a couple right away. (TFG- 1C)

Most trainees liked the structure and focus of the teleconference consultations, although some said the process as somewhat compressed, and at times, rushed because of what needed to be covered. Had there been more time, trainees said they would have enjoyed more feedback from their peers in addition to the trainer's input.

One teleconference group found the content "repetitive" in terms of the details asked about their cases. They also felt that too much emphasis was placed on their clients' gambling profiles and would have liked to proceed more rapidly into examining the root causes of gambling and addressing those issues:

R4: I would have preferred to stay more focussed on applying the model, rather than getting caught up on all the clients history and details. (TFG-1A)

R3: I found that we kept going over the gambling and sometimes it was like working on points that really... We kept rehashing the same points or something like that. I felt that if I was in my own counselling session, I would have moved on from there." (TFG-1A)

Overall, trainees spoke appreciatively of the structure and design of the training in its entirety, particularly the application component supported by teleconference consultations:

R3: I was talking about how I thought it was a very integral piece to the practical application. I think as you progress through the phases of the model, I think there was a real need to have supervision, the consultation with colleagues, to be able to integrate that learned knowledge into the practical experience with the clients. And I thought it was easier in the beginning, but once I got to about the middle phase, then the further away I got from the training, the more I felt like I needed to reconnect with [the trainer], and you know, colleagues around what it was that we were really going to be focussing on and how we were going to go about doing that. (TFG-1B)

P2: I think it's great that it gives you an opportunity to follow through and to build on some of the things that you've learned in the intensive four days. So, I mean really, after having experienced it, I think that a lot of training should have that concept built into it. It makes a lot of sense. (TFG-2A)

Safe and Supportive Learning Environment

Ratings for the provision of a safe learning context were extremely high with a mean of 6.81 ($SD = .40$) for both cycles after the workshop. Ratings remained at the same high level throughout the training, with a mean of 6.78 ($SD = .43$) for both cycles at the end of training (Figure 8).

Trainees confessed to some nervousness and uncertainty at the beginning of training. Their initial apprehension soon gave way to greater comfort and ease as they experienced a safe, supportive, non-judgmental learning environment created by the trainer and other trainees. A safe environment was crucial to trainees' being themselves and going at a pace that optimized their learning:

P1: The trainer made me feel very comfortable, very calm voice, at ease; I did not really feel any pressure to do anything, although everybody did and participated in, kind of the fact that she wasn't at you. The fact that you could learn at your own pace.

P5: Yeah, that's it; there was no pressure what so ever to do anything. There was no evil look, or you felt uncomfortable because you were not participating. You have been here for so long, and everybody had their down moments. I just want to observe, and you felt comfortable just doing that. [The trainer], I think that is a credit to [the trainer]; she made us feel really comfortable. She invited us here and taken us out of our own little world and taken us into this absolute image of God's world here [looking around...laughing from most]. And that made it easier. (WFG-1A)

Many trainees admitted that coming to an experiential training and learning to use a new approach of counselling couples involved some risk. This was evident in the metaphors they used at the end of training, which are discussed later. For such experiential learning to take place, the importance of the necessary support and safety cannot be underestimated:

P2: I am thinking of the role-plays too. I really felt like, [the trainer] did a wonderful job. My experience was that she really coached us, never really judged us for about what you were getting and not getting, a really sort of coaching, which was really, really, helpful. And I think for me, made it safe to do that. To try, to think in that modality for the very first time with my colleagues. So that was absolutely important. (WFG-1B)

Trainees found that the trainer, in disclosing some of her vulnerabilities and uncertainties, helped create a more egalitarian atmosphere and a greater sense of safety:

P6: She really created safety by opening up herself, and that takes a lot of courage, she opened up a lot, and I think that that was wonderful. I did not expect that and it created a real safety. I think she modeled sort of congruence [affirmations from others] and being flexible. (WFG-1B)

Fostering Collegiality

This item was rated extremely high by trainees from both cycles and remained high throughout the training. The joint rating of the two cycles for the trainer's ability to foster collegiality obtained a mean of 6.71 ($SD = .46$), and a mean of 6.33 ($SD = .91$) at the end of training (Figure 8). One of the things that stood out for trainees after the workshop was the friendship and collegiality they formed:

P1: I think it's just new friends. This has just been an awesome peer group and to be honest I really cherish everybody who came. I really think they are very nice people, so. It was a lot of fun.

P2: I'll second that.

Facilitator: Smiles, smiles, people smiling. (CHUCKLES) (WFG-2A)

The element of collegial support and consultation was cited as central to the trial of a new and challenging approach to counselling:

P6: I think it is great that we are all doing this together...it is like this feeling that we can help each other... you assume that because they are from a different agency or whatever that they deal with it in a certain way. But... we are very much in the same type of job, and I think, just the way it is structured I think it gives me a very positive feeling of being united with my colleagues which I am really looking forward to having an opportunity of getting feedback from other people, other agencies, not just through me...(WFG-1B)

A number of trainees felt isolated in their work as they were the only problem gambling counsellors in their organization, and there was a thirst for collegial support and conversation. The face-to-face trust and comfort trainees developed during the workshop laid the foundation for more in-depth sharing during the teleconference consultations when trainees took on further challenges in applying CCT:

P2: I am looking forward to hearing what people are struggling with. When I have done co-supervision with a colleague, I really learned a lot from people who were willing to say, here I am stuck, so I am hoping that I can bring that, and I hope that other people can also bring that, because I think that there is a lot of learning, rather than only bringing things that are going well.

P1: Yeah, I agree... I think with the relationships we formed here, I feel very comfortable doing that.

P3: Yeah, I do too, because in my office, I am the only one. I am the team. First time in a long time to have support, because we all are going to do the same thing.

P2: And I agree, the whole atmosphere, made me, I can only speak for myself, really comfortable.

P6: That's why I am really looking forward to, what happens next. (WFG-1B)

One trainee attributed the fostering of collegial support to the trainer and her managing of the group's dynamics:

P4: I just think [the trainer's] ability to be real, herself. Because it's hard when you have all these counsellors together in one place. Too many counsellors in one room, they all trying to jostle out their positions and try to outdo one another, then you want to go home. I just think her ability to do that and to stick to what we are here for, and not get dragged off into all kinds of therapies and stuff, and that was very good, I enjoyed that, and I never felt pressured by her. (WFG-1A)

The trust and collegiality formed during the workshop was a precursor and an environment that supported further risk-taking and disclosure during the teleconferences that followed. As a result of the trust and collegial bonds formed through the workshop and teleconference consultations, a few trainees said they would continue their peer contact and consultations beyond the training:

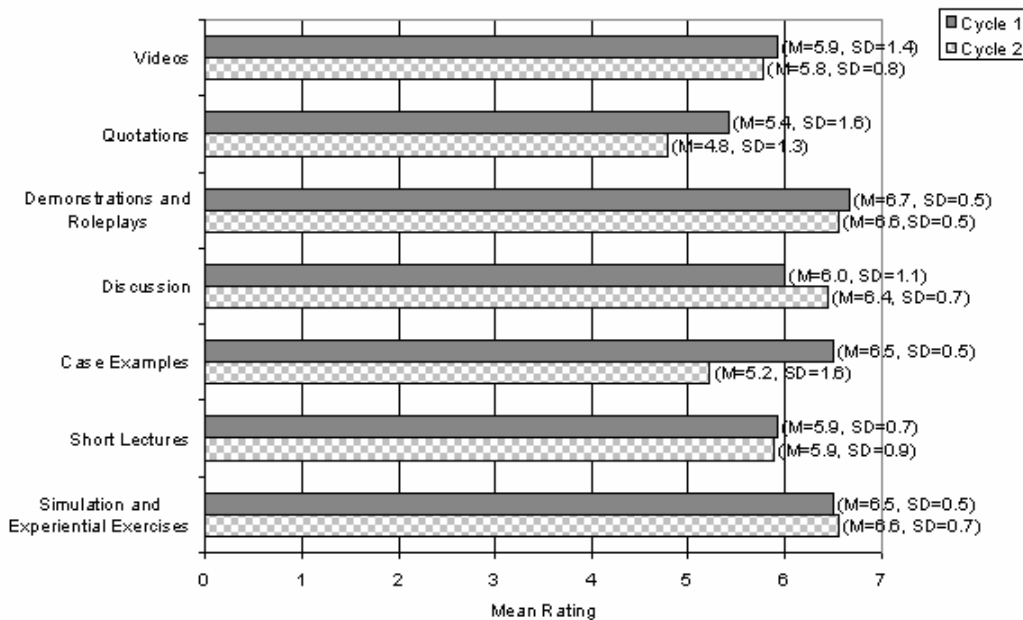
P3: The teleconference just helped us continuing with the whole building of our relationships together as clinicians. You have that, you know, concern that [name 2] is not here because I think we have really built something between us... I think I know for me, I want to apply this model with some other couples, and I feel quite comfortable that I could call any one on this teleconference. (TFG-2B)

Integrity of Vision and Values

At three points in the training, guest trainers assisted the principal trainer in explaining the communication stances, working with couples, and discussing problem gambling. Trainees did not find these additions to be positive to the training, remarking that although these guests had something to offer in their own right, their values, styles, and orientation did not fit with CCT, and they did not convey sufficient in-depth knowledge of CCT. Hence, their participation was experienced as “distracting”, “confusing”, “awkward”, and “disjointed” (WFG-1A; TFG-2A). These reactions suggested that CCT possessed an integrity of vision and values that distinguished it from other therapeutic styles, language, values, and orientation. This information came out in the focus groups, but was not an item rated on the questionnaires.

Training Modalities

Training Modalities refer to the various methods of training that were used in the CCT workshop (Figure 8). Using all cases from both cycles, trainees overwhelmingly preferred the live experiential modalities of demonstrations, role-plays ($M = 6.62, SD = .50$), and simulation and experiential exercises ($M = 6.52, SD = .60$) over the more didactic and textual modalities, such as lectures ($M = 5.9, SD = .77$), quotations, and case studies scripts ($M = 6.0, SD = 1.28$). They indicated a preference for interaction, including discussion ($M = 6.20, SD = .98$). There was wide variability in terms of how Satir videos were rated ($M = 5.84, SD = 1.21$). Some trainees found the videos very “powerful” while others only appreciated the value of the videos after the application phase. The use of quotations to stimulate reflection and elaboration of humanistic-existential values received a luke-warm rating ($M = 5.14, SD = 1.46$). WQ data indicate that trainees assessed demonstrations and role-plays as the most helpful modalities to facilitate learning. Similarly, there was very high satisfaction with the use of simulations and experiential exercise.

Figure 8. Training Modalities ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

The experiential nature of the workshop and the focus on process and application were highly appealing:

P2: It's always nice to come to a process workshop, rather than a content. So I think that's one of the things I enjoyed because a lot of workshops that I've attended lately were primarily content.

P3: I agree too. I need to agree with (Name P2) that the process was great....

P5: I think that's what makes it so much more different, is that we could apply it. It wasn't just somebody standing up in front and dictating what it should look like, these are the steps that you have to go through. This gave us the actual opportunity to apply it. (WFG-2A)

A number of trainees noted that the experiential style of the training corresponded well to the experiential orientation of CCT with clients. They felt there was a parallel process between the method used in CCT training and their later application of the model. As one trainee remarked at the end of the 15-week training:

P3: ... because a model is experiential. You have to learn it that way. And maybe that's just me, because that's how I learn, but for me, it just feels, like to be congruent, that's how you'd have to learn it if you are going to practice it that way. (TFG-2B)

Experiential training gave trainees depth of insight and personal change because they were engaged creatively and intensely:

P3: I think a big advantage for me is the experiential part that we come out of here that leads to some profound insights, because it's different and I think any time we change talk therapy it is something that is different and unique. It offers an opportunity for seeing things in a different way and so I am really liking the experiential part of the model and some of the creativity part.... I love the way she uses the unpacking with these couples.... So, that creates more work and more intensity, but I think there is a potential for profound change and profound insights and creativity. (WFG-1A)

Without the experiential training coupled with the didactic teaching, trainees did not “think it would have taken us to the depth that this did. And in such a short period of time.” (P4, WFG-2A). As one trainee noted in her ER, experiential work coupled with didactic instruction helped her to integrate the conceptual and practice parts of the training objectives:

I really enjoyed the combination of didactic and experiential learning. It helps me integrate the concepts/ideas. (ER – R1)

Trainees especially valued the live demonstrations, something trainees said they seldom found in workshops. They appreciated the teaching dovetailing with the demonstrations:

M1: Just want to say something else which I thought was really great, is that the trainer actually demonstrated some of the concepts. Cause you go to a lot of trainings and they'll talk about it at a theory level [several voices agreeing, mhmmm], but in terms of the actual showing it, right in front of you [several voices agreeing mhmmm, yeah], I think a lot of trainers are reluctant to do that [many voices agreeing loudly, mhmmm]. But she did that on several occasions. That was very helpful. And to be able to stop it and to pull out a commentary about 'this is what I'm trying to do', you know, 'by doing this'. (WFG-1A)

Trainees found the demonstrations and modelling by the trainer important in their learning. These modalities helped them trust that they too could work in that fashion:

P4: I think it's nice to have the trainer to be able to show what we're actually trying to get at and then allowing us the opportunity.

P2: I agree... I know for me I needed to see her set the stage a little bit and then I felt more comfortable going 'ok, that's within the realm of what I know I can do.' Otherwise, I'm a little bit wandering. (WFG-2B)

I found the role plays / experimental exercise very helpful in demonstrating the key concepts in the model. (ER – R1)

Seeing the CCT in live demonstration gave trainees a multi-sensory image of the therapeutic process and hence was an effective way of teaching:

P5: She is, when she's doing role plays, she sure goes with the flow and it's, I know it comes with experience, but she seems to have the knowledge and the experience and is able to be able to pass that on. You know I teach myself, at the college and I will be honest with every body when it comes to clinical stuff, I'm not good at teaching that. It's hard to teach somebody how to be a good clinician and she's able to do that. (WFG-2B)

One trainee commented on how the demonstrations allowed her to make the trainer her internalized mentor:

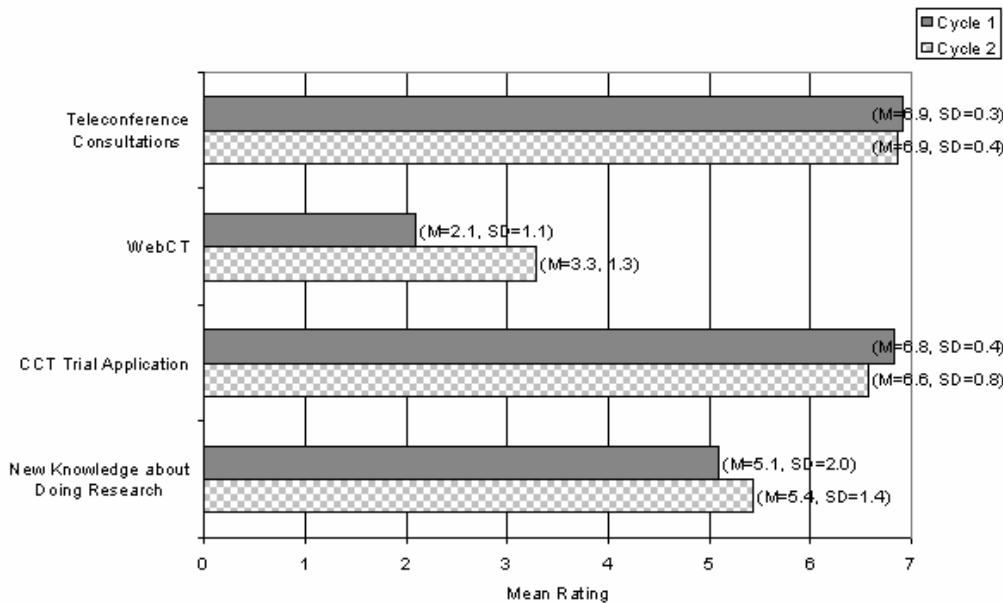
P4: What I think I'll take with me I think is [the trainer]... When I think of mapping, like I'll see her, or I'll see her expressions or I'll see her hand gestures...And it's like she'll be there with me, she'll be sitting on my shoulder probably. (WFG-2A)

Training Components

The major training components, besides the workshop, were: (1) Trial Application; (2) Teleconference Consultations; and (3) WebCT. As shown in Figure 9, trainees from both cycles were unanimous in rating the supreme importance of the Trial Application ($M = 6.72$, $SD = .57$) and

Teleconference Consultations ($M = 6.89$, $SD = .32$) components. These components are elaborated on in the discussion of Level 4 Application of Knowledge and Skills later in the report.

Figure 9. Training Components ($N = 18$: Cycle 1, $n = 11$; Cycle 2, $n = 7$)



WebCT was initially set up for the purpose of posting supplementary readings, housing the bibliography, and encouraging further discussion. However, it became apparent in Cycle 1 that trainees were too busy with their CCT application and teleconferences to utilize WebCT to any great extent. We had a total of five postings by only two trainees from Cycle 1. Most electronic communication and supplementary forms and materials took place via email between the trainer and trainees, which trainees indicated was preferred over WebCT. Cycle 1 trainees indicated that they found the supplementary information sent via email helpful. There was less need for supplementary instructions or forms for Cycle 2 as they were made available in their workshop training package based on what we learned from Cycle 1. Therefore, although WebCT could be potentially useful, it was not used extensively in this training ($M = 2.56$, $SD = 1.30$).

Research

Trainees indicated that the training framed in a research study had contributed to their learning. For some, this research experience had changed their negative preconceptions about research as dry, irrelevant to practice, and objectifying. The mean rating for learning about research from this study for the two cycles was 5.22 ($SD = 1.73$; see Figure 9). They reported that being part of a research study was highly rewarding ($M = 6.67$, $SD = .69$; Figure 11). Many emphasized that their learning experience was enhanced as a result of the structure and rigour of the training as research. A few participants said their agencies supported their participation in the training because of the research component. Further themes on being part of research are delineated below.

Demands of Paperwork

Trainees found the research required a huge amount of paperwork, from the consent forms to completing the pre- and post-tests. Explanation of the research consent was tedious for some trainees and their clients:

R3: They were long and it was time-consuming. The client comes in here for an hour for a session, we're explaining a long, drawn-out confidentiality statement, they found that very boring. Very boring and to keep them interested you had to just run right through it. (TFG – 1A)

However, because of trainees' commitment to the study, they accepted the paperwork as part of the package:

R 3: I think getting all of the, sort of doing all of that paperwork and keeping up on that was I think challenging, but you know, was worth doing. So I don't know that there is anything that I would personally cut out, even though, it would be nice to cut it out of things I had to do, (Facilitator chuckles) I see the worth in doing it. So I don't think there is anything I would cut out. (TFG – 1C)

Enhanced Rigour

Many trainees commented on the enhanced rigour the research had lent to the training:

R1: I really enjoy being part of the research and feel that the different elements of the research definitely allowed for practice and repetition and confirm that 'yes, I know and understand and have grown'. (TFG-1C)

Because the training was embedded in the research, a number of trainees found they applied more rigour to their work and were more thorough in their planning and reflection on what they did. The research deepened their training and made their learning more powerful:

R 3: Well, for me I really liked the fact that it was a research piece because in terms of doing the pre-written test and then the post-written test and then the second post-written test, the two role plays, all of those pieces and plus the ongoing teleconferences, all those pieces sort of really allowed the model to sink in and for me to do, it forced me to evaluate the work I was doing more thoroughly than I would otherwise. Because we get busy, and you don't, you know, you plan your sessions, but if you're booked up, you're booked up and you don't have. This forced, it forced me in really planning my sessions and take more time in looking at how things went. There was a lot more forced time to reflect on the type of work that I was doing or I am doing. And that's what I liked about the fact that it was research-based is that it forces you to do that more so than if it was just the training. And I think that's what made it more powerful and more impactful for me and in improving my skills. (TFG – 1C)

Trainees were conscious of their responsibility and accountability to the research study:

R 1: Yes, it was sort of held, the responsibility of performing was definitely there and you know. That piece that we were asked to present our interventions, you know, was, made us think about what have we done, what have we used. And what has been effective. And so, we, I felt very accountable to the, to this process because it was a research study and because we were looking at end results and therefore I was more accountable. (TFG – 1C)

Heightened Commitment

The research heightened the commitment and investment in both the trainees and their clients. Some trainees reported that their couples initially had mixed feelings about being part of a research study due to confidentiality, but soon warmed up to the process as they experienced the benefits of CCT. The research process of obtaining informed consent and explaining the risks and benefits of taking part in a new therapeutic approach led to an increased commitment from the clients:

R1: it really changed how we worked together and they definitely were more invested in, I don't know that...particularly if he would have followed through so well, because he was a little bit reluctant at the beginning, if he hadn't signed his name on the bottom line. (TFG – 1C)

Clients were interested in the results and showed a commitment to the study:

P1: Yeah, I think for me, my couple certainly was interested in kind of heightened that commitment, being part of a research study. I think I mentioned in teleconferences, they wanted to be part of a teleconference: "Can we sit in on that and hear what you are saying about us?" They were very interested throughout the whole process. So in a way, I think it really kind of heightened their commitment towards it and their interest. So, for them I think that was positive being part of that. (TFG-2B)

Some counsellors said they carried over the practice of explaining the nature of the counselling sessions and contracting with their clients at the beginning into their regular clinical work, which enhanced their clinical practice and their clients' commitment and focus:

R 2: And I agree as well and actually have noticed a real shift in terms of doing that with couples. So I didn't used to do that at all and now I actually have, do it with any new couple that I've had in the past couple of months, I've contracted around so many sessions and clarify what we'll do during that time. Because I found it really helpful with this couple because in the past I didn't do that and it was sort of open-ended and I think it's helpful when its more focussed and this is how many sessions we have to work on this particular part of what's happening. So it helps sort of create a little bit more direction and focuses me, I think. So, I've definitely embraced that. (TFG – 1C)

Making a Contribution

Both counsellors and clients spoke positively of the sense of being a part of a larger project and working as a team on something that could make a difference:

So it was confirming and reassuring for me and to be a part of something bigger, and to be a part of. It was huge for me to be with other clinicians to go through this process. That was probably the most significant thing for me. (TFG – 1C)

So initially, I would say, it was sort of a deterrent for this particular couple. But once they got going, I think they had some sense of commitment to it as well just because they knew that it was part of a larger project. (TFG – 2A)

A trainee described the excitement and privilege of being part of a knowledge-creation process:

R 1: For me the experience was like killing two birds with one stone. Like for sure we are learning something right, but at the same time, I think the way how we try to implement what we learned, we're trying to inform back to the theory part and I feel like the whole experience is, we participate in the theory-building process, we didn't build it from scratch, of course [the trainer] had the whole concept. And we're just, I think the way how we participate in it as research subjects we are adding to it too and I feel good about it." (TFG – 1B)

Expanded Previous Conception of Research

When asked whether this training-research experience had added to their understanding of the research process, trainees said that this way of doing research gave them a different view of what research was about:

*P1: [chuckle] That it can be positive. No. [Laughter]
[group laughter]*

P1: No, that's terrible. No, I [chuckle] ... that it can ... there is many different shapes to research. There is many different ways of doing research and getting what you need to get from it, and this sort of this experiential way was, I don't even connect it to something research orientated when it is done this way, so.

Trainees discovered that research can be a fun and positive experience, leading to results that could impact practice:

P4: I sort of feel the same way as [name 1], that there is some, umm, degree of pleasure, enjoyableness to it in that, you know, it didn't seem as much like research because you were right in there and you had all your contacts, but it was enjoyable. I really felt that what I learnt from it was it didn't have to be all stats and it didn't have to be all, you know, negative. It could be a positive experience. And I think the one thing that I learnt too is, I think we are very fortunate because we will get the results in a year. (TFG-2B)

Another trainee observed that this research made her realize that research can be “experiential” and more than number-crunching. She learned that she can play an active role, which increased her confidence in getting involved in research that mattered:

P3: For me, at our agency, it was very helpful that it was part of a research study, because our office wants to get more into doing research and I think that this made it more credible and I was probably given more time to do it because it is part of research. I think it also made a good shift for our agency, or I'm hoping it will, in that it is a different type of research. It is not just looking at quantifying numbers and looking at change, that research can be experiential. And I think that is good for agencies to see that, you know, research isn't just the black and white, getting the numbers... But for me it made it more comfortable doing research because I am always, I have been involved with one other research study but it took more of a [breath intake] outside, I mean I had my role, but I could have been more involved. This gave me more confidence that I could get involved in the kind of research study that makes sense for me. That there is more than one way to do research. (TFG-2B)

This research experience stimulated an interest in conducting research in one of the counsellors:

P3: No, I am not saying I'm ever going to do what [the trainer] did, but I think that it has my eyes open to different types of research opportunities. Since in the gambling world, research is, you know, a big part of it and certainly can be part of our jobs. And it was an honour to be part of research. And I think my clients were. (TFG-2B)

Research as Secondary or Background to Training

For other trainees, research was not something they consciously thought about as it was simply part of the training. This indicated that for the most part, the training and research blended together and the trainees did not feel objectified as subjects of the study:

R 4: Maybe in the background, but it wasn't in the foreground, it was just like (pause) what was said, it was the reading, the applying, the affirmation from the teleconference, going back to the reading the applying and watching it change. No it was, I didn't, I don't think it affected me being the white rats, no. (TFG – 1B)

Restrictions of Research

Notwithstanding the benefits of research, trainees cited restrictions that the research posed on timelines and protocols. For example, they only had a 2-week period to recruit their couples, and the duration and number of counselling sessions were specified:

I guess having to stop when the time was up. Because, I mean the one couple came aboard late, right? And the other couple missed a couple of sessions. So that was the only piece. And I guess the time, you know, because [the trainer] had said to keep it to an hour. I think ninety minutes would have been more effective. Because there are two people, so it was hard to keep it to keep it to sixty minutes. (TFG – 2I)

Limitations of Research Tools and Instruments

Trainees offered some valuable insight and feedback on the quantitative measure used with their clients to measure change. They commented on the limitation of just using quantitative measures to capture their clients' progress and felt that qualitative methods would have been more adequate to capture the changes their clients made:

R 1: I might have, the forms that the clients use to state where they were at pre-treatment and post...I didn't find them very reflective of how I saw them. And I think maybe to add, have them actually, maybe have a telephone conversation with somebody or have them tape how, you know, more, more, in a different, it was very structured, their answers were very structured, due to the format of the questionnaire, and I just didn't see it very reflective of their movement. (TFG – 1C)

R 2: If I could just, I have a really similar thoughts to (name 1) and I think part of, I know what my clients put before and after, and then I also know the qualitative feedback that they gave me about the process and I didn't think it was reflected on the forms. And I think what happens sometimes, I mean, which we all know, is that when couples come in to counselling, it makes things maybe more difficult or more challenging for a period of time, so I think they're more in tune with that a little bit. Like my clients were definitely more aware of what was happening, so the shifts that they've experienced you might not actually see in their answers, if that makes sense? (Facilitator: Mhmm), their experience is different. (TFG – 1C)

Trainees questioned the validity of the quantitative instruments in demonstrating the changes they had witnessed in their couples:

R3: ...And I don't think it will be as reflective as to the whole process or their experience or how their relationship has shifted, it's just they're having a shitty time right now in life maybe. So they've had a bad day or a bad week, so they're going to answer that questionnaire poorly, it didn't really go into this sort of I think (pause) I don't know (Facilitator: yeah), because I think a lot of shifts happened and I saw that there was some change in how they answered, but I don't think they answered as differently as I would have to show as much of all the changes that happened in their relationship. (TFG – 1C)

At the end of training, trainees commented on the role-play scenarios used for their pre- and post-test to evaluate the training. Some felt the role-plays were too "artificial" and were not sure whether 5-minute excerpts over six role-play scenarios actually reflected what they had learned:

R 2: Yes, I don't feel as though it is. Five minutes, I mean it's amazing how quickly five minutes goes by and I just felt like, I, yeah, it was really hard and I felt like it was almost about, do you have to sort of throw in key phrases or something (Facilitator: chuckles) to make it evident that

I know what I'm doing or that I have learned, because I have definitely learned. And I guess I sort of was thinking, 'I hope this doesn't determine how helpful or how good the training has been because what you're seeing in that five minutes shows how helpful and good the training has been.' (TFG-1C)

Others commented on how the post-tests helped them assess what they learned:

R2: I really found in the second audio tape, I appreciated how much I had learned because I did save a copy of my first one. And I just have a little brief listen, but I think in terms of just what I was able to do in this audio-tape it really underscored for me in terms of how much I had learned. (TFG-1B)

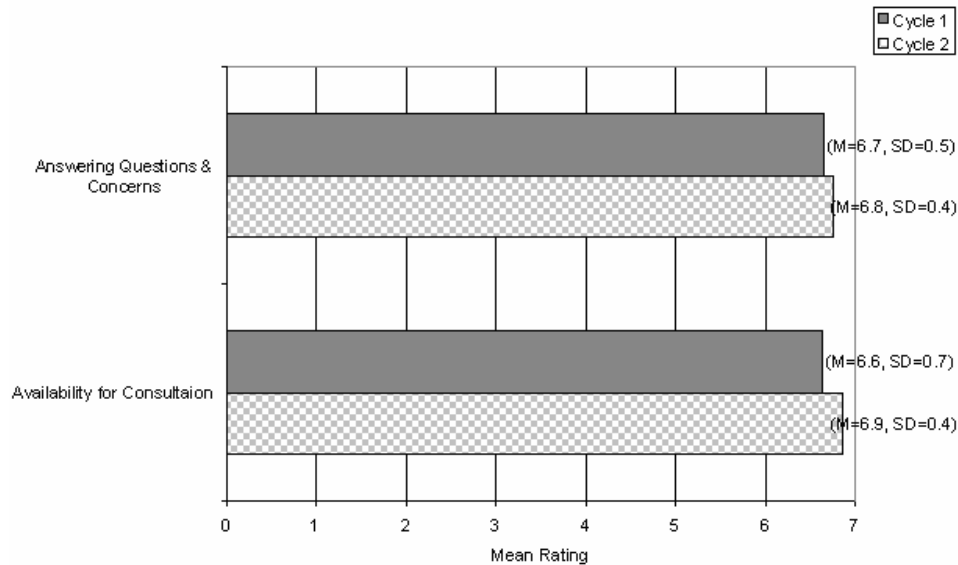
More Client Friendly

Trainees observed that printed information on CCT was made available largely to the counsellor trainee, but clients would have also benefited from some of the materials:

R 4: Do you know what, it was really counsellor driven. And I say that from the perspective that, you know, all the information we collected and received was, almost, for our eyes only. And it would have been nice had it been sort of more client-friendly, had there been some sheets we could share with clients and, you know, it was a learning experience for us, so, you know, something to show them and say, you know, this is what we're talking about. Sort of what (name 3) did, he blew up that Iceberg. (Facilitator: yeah) I was just thinking through that whole process, it would have been really nice to give the client something because they're actually, they volunteered their time, they wanted to be a part of this study. And I just know when I'm working with my other clients, there's usually information I can sort of show them, whatever it is, I can bring back to the session and say you know 'what do you think about this?' You know like pictures or diagrams or something for them to sort of grasp along with me. (TFG – 1C)

Trainer

Trainees in the focus groups spontaneously highlighted the trainer as a key element that impacted their overall training satisfaction. Two questions on the WQ and three on the TQ focused specifically on the trainer (Figure 10). Combining both cycles, the trainer's ability to create a safe learning environment ($M = 6.81$, $SD = .40$ for the WQ; $M = 6.78$, $SD = .43$ for the TQ) and her ability to answer questions and concerns satisfactorily ($M = 6.62$, $SD = .50$ for the WQ; $M = 6.78$, $SD = .43$ for the TQ) were rated very high. The TQ had an added item on the trainer's availability for consultation which was rated equally high for both training groups ($M = 6.72$, $SD = .57$).

Figure 10. Trainer ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

The expansive qualitative data from the focus groups post-workshop and post-training allowed us to delineate in greater detail the specific ways in which the trainer contributed to trainees' satisfaction. We are elaborating on this category as this learning would be useful in the preparation, training, and selection of future CCT trainers and in understanding trainer attributes in a successful training.

Knowledge, Skills, and Competence

A thorough and in-depth knowledge of CCT was seen as critical for the trainer:

P3: And your trainer has to be, if it's not [this trainer], has to be someone who has as thorough a knowledge base [voice overlap] in the model.

P1: Absolutely.

P4: And very dynamic [chuckle].

P1: Absolutely, yeah. (TFG-2A)

Trainees were perceptive of the knowledge and skills of the trainer, as this competence and congruence with CCT would come through in different parts of the training:

P2: It's P2. I would like to say something. I think that [the trainer], and I said this really after this, the four day training, and I'll say the same thing again after this twelve weeks of consultation, that I think that she's, I mean obviously, she is the best person to do it. That a lot of it, was, I mean how she managed our teleconferences, for example. So in a relatively short period of time, she could guide you to present the relevant information. And I've always felt that I got something useful, that she was responsive in that way, that she was very respectful, and obviously, you know, knowledgeable and very skilled even though I had never saw her work clinically. But, I mean, you can tell. So much of it had to do with, I think, her skill and her sensitivity and her passion about the model. And to me, that's what I think created a lot of the success overall.

Interviewer: OK. Thanks.

P1: And I'll just echo that. [Brief pause] (TFG-2A)

Flexibility and Availability

Trainees' anxieties were allayed by the trainer's flexibility and reassurance:

R 3: Well I think (name 5) put that to rest early. My challenge, I thought there was deadlines that we had to meet and get on top of immediately, but she, in (name 5)'s subtle ways, she told us, 'take your time.' You don't have to rush as fast as I assumed we had to go. And that was one of my concerns too, working with my client, I thought 'oh my god, how am I going to get them through this?' Get them all the way through to congruent shape, but (name 5) said 'take your time.' (TFG-1C)

Trainees also felt they could weave in their new learning with their own existing style:

P2: I agree because she felt very safe and very respectful. You know, she respected our knowledge, but also respected that this was still new. That part where you know your style and you just have to know how to weave it in. (WFG-2B)

The trainer's responsiveness and availability made a difference to the trainees, beginning with the workshop:

P5: the biggest thing is that we did not have to ask. You know, she would help us through with it. She wasn't sitting down doing paperwork and not being attentive. That's what made it so exceptional; she kept us doing things all the time. She let us out for 2 hours, and we came back [laughter all around]. (WFG- 1B)

P1: She is very observing; I saw her looking around the room, getting a sense of every body, to know where they were at, like when we were stuck, she knew obviously they need some guidance and coaching. And she did it...

P6: ...and to really listen to what is inside. (WFG-1A)

The trainer was available for individual consultations when the need arose:

P4: But to me, apart from the structured teleconference, I really appreciate the flexibility, because sometimes when things happen, like a crisis, [the trainer] was open for individual consultation, outside the teleconference, which to me is a bonus. (TFG-2A)

Attitudes: Respect, Openness, Egalitarianism

The trainer's ability to foster a participatory and egalitarian training atmosphere contributed to the high level of satisfaction by many trainees:

P4: I just thought [the trainer's] style was phenomenal, just the way that she taught, her openness, her treating us like equals and equally interested in the things we had to say or our lives and her curiosity was neat. I think she approached all of us and talked to all of us about stuff and she kept us in mind and I hope that would never change for whoever is teaching it. I think that's a good piece of it because of the role-playing and the relaxation exercises, it's quite intimate in terms of yourself and if you felt threatened, you maybe would not participate fully. (WFG-2A)

P3: From the training, I'd have to say not only [the trainer's] competence in the training, but the very fact of how open she was to all of us and our ideas and how we operate and what we could maybe add to it. So it wasn't just I am the person and I have all the answers. It was 'how

do you do that?’ Or ‘could I have a copy of that’ or whatever. And I think that was really nice that she could come to our level as well as be the trainer. I really enjoyed the training and I’d like to thank the University of Ottawa actually as well. It was very well done. (WFG-2A)

One trainee observed how the trainer was both teacher and student:

P5: She is very open ... you know, to us and allowing us to share and express, and she is quite quick with making positive comments and validating what we are saying. Or saying, “Oh”, you know. She’s two-sided, you know...She’s the investigator, the teacher, and whatever you want to call it, but she is also the student [chuckle]...So it validates what we do too, so you are not intimidated. So you feel very accepted and welcomed and supported. (TFG-2I)

Commenting on the teleconference groups, some trainees expressed their desire for more input from other participants as the trainer was perceived to take a directive role quite often:

R1: Also, you know, we almost, it was very much sort of getting direction from [the trainer] and not a lot from each other and I think that was because of the time, more so than our desires. You know I, definitely, when I heard from others, I got a lot out of what feedback they gave me...so that was a little bit missing... (TFG-1A)

The above feedback corroborated with the positive feedback in confirming that trainees prefer a more participatory, egalitarian, non-threatening style of training.

Passion and Commitment

Inspired by the trainer’s enthusiasm and commitment, trainees found themselves fully engaged in the training process:

P2: I think it’s her passion. I think that what really makes somebody really want to follow something and believe in something it’s the person’s passion in it themselves. If you have a trainer who’s teaching you something and they’re not passionate about it, you don’t want to follow it, but she has a real strong passion and belief for it. If you watched her, watch Satir, you see her passion and you see the belief that she has in it. So in referring to that, she speaks and she teaches it, she radiates that, so I think that really draws people into it. And if you were going to have somebody replicate this that they would need that same sort of passion otherwise you would lose something. (WFG-2A)

P4: The other piece for [the trainer] would be endurance and with endurance there is enthusiasm because we talked to her at Discovery 2004. So probably over a year ago and that initial excitement and talking to us and I’m still seeing that. So to add that excitement, I mean that’s over a year and that’s still kind of shining through. That’s pretty special. (WFG-2B)

The trainees picked up on the positive energy of enthusiasm and hope:

P5: And [the trainer] was great, she’s got that energy, that real hope. (WFG-2B)

P6: I agree, we all were committed because she was really committed.

P2: She was engaged in the process as much as we were; she was with us, rather than watching over. (WFG-1B)

Embodying the Values of CCT

Values are more caught than taught. They are hard to teach, but must be lived. Throughout the trainees’ comments, they alluded to how the trainer embodied the values of CCT, which they described

as her “congruence”, modelling respect, participation and egalitarianism, openness, welcoming nature, and appreciation for people:

P2: I think she modeled sort of congruence [affirmations from others] and being flexible.

P5: That is a very good way of putting it. She modeled it. She could be the poster child for it. She did such a wonderful job too, taking us all through. (WFG-1A)

Trainees noted that the trainer’s own congruence drew out the congruence in the group:

P2: Well because you took the group of people, some of whom knew each other through work and workshops and things like that and conferences because we’re a very small entity, the gambling profession. And by bringing us together and using some intimate role-plays and things like that, that really process and change some shifts. And she asked people to share some personal information and release some of that barrier and create some congruence within the group.

P3: And within ourselves.

P2: And so I think to complement what (P1) said in that she, not only, teaches it but lives it and taught it (voice fades) (WFG-2A)

Over and over again, trainees placed a strong emphasis on the congruence between the trainer and the model she taught. In other words, the trainer embodied the core values of the model, which allowed the trainees to experience and internalize them:

P1: I think her greatest strength was that she reflected the model.

P3: What a nice way to say it.

P1: I mean she was constantly looking into how we were doing and who we are and well I think we’ve all crystallized within the group. (WFG-2A)

Professional and Personal Growth

In the TFGs, trainees were asked to give a metaphor that captured their experience of the CCT training. Analysis of the metaphors revealed a three-stage learning process for trainees, consisting of initial uncertainty and adventure into the unknown, followed by a process of challenge and effort, and culminating in a sense of professional and personal growth.

Uncertainty

Metaphors of uncertainty and adventure included “riding a wave” and “flying a hot air balloon” as trainees entered unknown territory:

I was going off to, you know, to be with a group of people I’ve never known before, there was a lot of unknowns. But it was also worth the challenge.

I’ve flown before, I mean I’ve been in planes and whatever, but I’ve never been in a hot air balloon. So it’s exciting and it was fun, at the same time you have to be careful, you know, there are some risks involved. I wasn’t exactly sure where we’re going to end up.

I was just kind of riding along on this wave, and I felt like, it felt like, I really felt the training was remarkable in terms of the role-plays and how in touch I got with some of my own emotions

through the role-playing...And I think it still felt like I went through this experience riding this wave and it really, put, like, a certain amount of uncertainty. It was just something very different for me and then it kind of just gently broke at the end.

Challenge

Challenge and effort were conveyed in metaphors of “giving birth” and “climbing a mountain”:

It was painful at times and because you're changing, you're trying something completely different, but if you don't go through the pain, then you're not going to get any gain, you're not going to learn anything. (TFG-1A)

It's kind of like having a baby. The birth is painful, but the results are pretty good. (TFG-1A)

An image of climbing a mountain with support to reach the destination was another potent metaphor:

The image that came to my mind was climbing a mountain. (chuckles). But then you're not digging your own handholds, the handholds were already there, (chuckles), so you had help getting to the top. (TFG-1B)

Professional and Personal Growth

Trainees made many references to feelings of personal and professional growth, acquisition of new ideas and outlooks, opening of doors and horizon, and increased confidence. Metaphors of trees with new branches and flowers with new blossoms, houses with doors opening, hockey players moving up the ranks, snakes shedding their skin, and house renovations with new tools and products all convey growth in one form or another:

I have this tree with these branches and it's still a very young tree, but it sort of has sprung a new branch....over the process of being in this study has sort of begun to see blossoms. (TFG-1C)

Several participants expressed how the training had inspired them to pursue new professional goals, such as going back to school, undertaking in research, and furthering their careers in counselling:

I just enjoyed so much getting back into a learning mode, a growing mode. It's inspired me to go back and do my Masters. (TFG-1C)

It just continued to open more doors in terms of my own personal growth....to continue to move forward in my personal and my professional life. (TFG-2B)

I think I have wanted to do research in clinical work in marriage and family therapy, and I've known that, but it really brought it sort of to the forefront in terms of how I want to move my career to a place where I can start doing some of this stuff. (TFG-1C)

I think it really has helped shape, shape more of a style for me. (TFG-1C)

Many trainees articulated that they felt “inspired”, more “self-aware” and “confident”:

I am feeling a lot more confident. So I am feeling like I am becoming a better counsellor, and I just feel more confident. Personally, I think the tools have helped me as well. (TFG-2A)

The spill over into helping their personal growth was mentioned by several trainees:

...my personal growth, and understanding more about how I communicate to people and connecting more with myself and what's going on there...its was a real benefit for me. (TFG-2A)

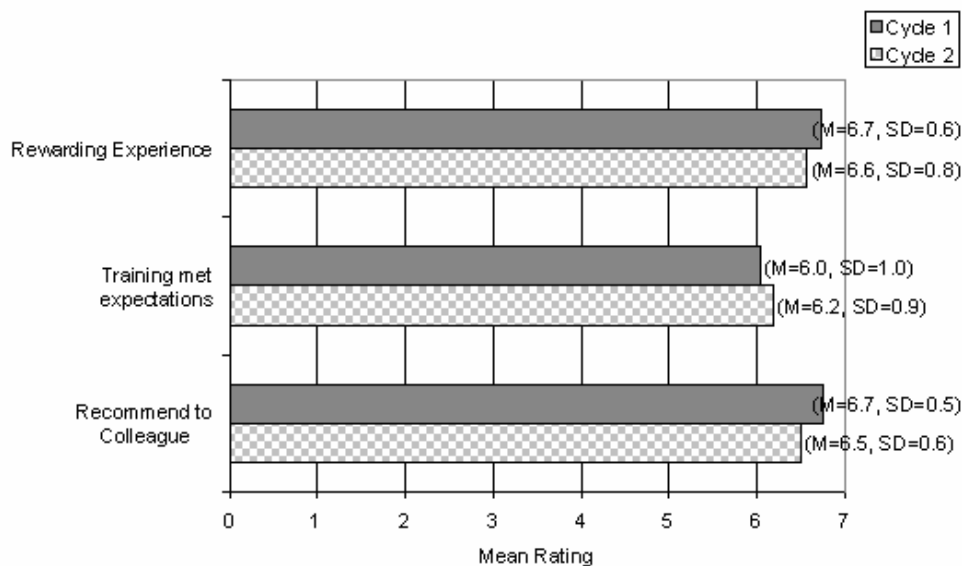
It's certainly has helped me understand my own relationships and communication with people, you know, and it made me take a step back...and understanding where people are coming from. (TFG-2B)

It's good for the clients and for me as well. It helped me learn a lot about myself. My relationship with myself has changed. It's not about blaming parents. By learning to accept what it is, and gaining control over it. Just to see the couple's outlook, facial expression, the way they carry themselves...giving them the tools to go on. Who we are is OK. They may have had negative images of themselves, and then they disappear. It is not a search of ultimate happiness, it is about being content with yourself. (T5S12)

Overall Satisfaction

Two items on the WQ and three on the TQ assess trainees' overall satisfaction of the CCT workshop and training (Figure 11). These items ask trainees: (1) how rewarding they found the research study experience; (2) whether they felt the entire training met their expectations, and (3) whether they would recommend the training to another colleague. Trainees from both training cycles indicated that they were highly satisfied with the training, with no significant mean difference between the two groups. Trainees found taking part in the research study highly rewarding at the completion of training ($M = 6.7$, $SD = .7$). The workshop ($M = 6.1$, $SD = .7$) and entire training ($M = 6.1$, $SD = .7$) met the trainees' expectations to a great extent, with no change in the ratings between workshop and end of training, indicating that trainees' satisfaction was sustained throughout. Another indicator of overall satisfaction was that trainees at the end of workshop ($M = 6.6$, $SD = .6$) and training ($M = 6.7$, $SD = .6$) said they would highly recommend the training to another colleague.

Figure 11. Overall Satisfaction ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)



Following is a list of key words trainees used to describe their overall training experiences (pulled from focus groups transcripts):

- comprehensive, thorough, in-depth, packed;
- helpful, useful, beneficial, valuable;
- hands-on, balanced;
- enriching, refreshing, fresh, new, brand new, unfamiliar;
- good, excellent, remarkable, rewarding, positive, fantastic, fabulous, neat, amazing;
- supportive, supported;
- motivating, interesting;
- repetitive; and
- directive.

In addition to the areas discussed, in which trainees had expressed their reactions, three additional categories in the summary of trainees' overall satisfaction are discussed below:

1. Specific Problem Gambling and Couples Focus

After the workshop, trainees cited how they liked the unique combined focus on couple work with problem gambling. The gambling focus brought a group of professionals together who saw themselves as a minority and quite isolated in the field of addictions and mental health:

What I really appreciated was that it was within the gambling program, that although I have family therapy training, what I haven't had any training in is how they come together, um, so it is a wonderful experience for me. (WFG-B)

I think it is only one, the only workshop that was very, very specific, it's for gamblers. Other workshops they pull from a wide source of populations, it could be nurses or teachers or whatever, but this was so specific. So I think that was a common bond. Before we walked through the door, we will be all working and thinking using the same language, because we are working with those clients. (WFG-B)

2. Structure and Framework

Trainees appreciated the structure of the CCT training with its clear conceptual framework and phases of clinical interventions within a 12-week program. They reported that the structure allowed them to see how the pieces fit together and gave them specific steps, phases, and guidelines they could follow. It is a model that is "very focused" with little waste of time:

P3: I mean the structural parts, some of them I tried before in the past and couldn't and moved away from them to more integration by making the structure .. I like it that there is so much structure from beginning to end, so you can have, you know, put all the pieces into place and have something to judge from in terms of having all the pieces. Things like, hmh, the [sounds like needs] and yearnings, I need to learn more that language, so that is going to be new for me to incorporate some of that language and to incorporate some of the more intimate part, like for example the face-to-face ... but I am not uncomfortable with it and what I did learn, and that's why the exercises were so helpful is that, I probably know more than I think I do.

I think I actually can incorporate this in my style anyways, and I elicited what I needed to elicit to get to the next stage, its just having the structure. (WFG-1B)

M3: Just something just as basic as orientating oneself to 12 sessions, that's a change. Because I wouldn't think of it... because we usually don't see couples that long. And having that orientation, having that structure to work with, you know, the guidelines... will be useful. (WFG-1A)

P4: Now I know what model I work from. (CHUCKLES) I thought it was eclectic for whatever the client needed, but I think after learning the model and reading the literature, it's very much what I do in my practice. There's a lot more to it as well... It was like I was able to put the pieces in the little compartments. So I've got it all down. (WFG-2A)

P5: It was very structured and it was very to the point, and it was very, um, keeping it in the here and now and dealing with what was going on now. And the timeframe allowed us to do that. I would have liked a couple of more sessions with my couples... Um, but time ran out too. But I mean it's all slowed and I think having a more structured approach is a little bit more helpful too on focusing on now... You know, rather than getting caught up in a lot of the historical stuff and dealing with that kind of stuff. Which was helpful I think, but your problem is here and now. Do you know what I mean? Your problem is in your relationship [unclear word], so it needs to be ... that's what we need to look at. (TFG-2I)

P5: Like I always had an unclear approach was the approach that I kind of worked with...but it wasn't as defined, and I couldn't have maybe been able to employ or work with specific tools and understand what I was doing with them, and the purpose of it. (TFG-2A)

3. Wholism and Congruence

When evaluating their training and workshop experience, trainees often referred to the combination of all the factors that worked together for its ultimate impact:

R 3: I think for me, it was very rewarding; it really has been in learning the model from the in-depth, you know the four days in Ottawa and then, that on top of, you know having the book and then knowing that every week we were going to be talking about what we were doing with our couples and hearing everybody else's learning and experience in the, with their counselling with their couples and then hearing [trainer's] feedback and everyone else's feedback really helped me grasp the model and helped me move forward with my couples when I was feeling stuck or overwhelmed. (TFG-2A)

The overall satisfaction was attributed to a “perfect match” or congruence experienced with the training:

P3: And I just fully feel that it has been such a comfortable setting to do it in, I feel very bonded to people and just the overall setting of this is great. I just feel that I was able to be myself, rather than sit there and just go 'I'm here to get this over with and do my days and get the content.' So I really liked it.

Facilitator: So when you say the setting, is it the environment that was created by the trainer? Is it the physical location? Is it the combination of people who were here?

P3: I would say all of the above. It just was a perfect match. (WFG-2A)

A sense of wholism of the entire experience was described for the workshop and training:

P2: To me it's got to be part of the whole process, to watch a video of her doing it, that to me, wouldn't be at all the same. Because I think we also, this is a big part of it, people sharing and bonding together in this atmosphere, so it's the whole layer. (WFG-2B)

Trainees often referred to the total experience of the workshop rather than individual pieces, because the ambience, trainer, colleagues, application and consultations, process, and content were all of one piece, allowing them to be personally changed and experience the potential of the model:

P2: I think that's what I walked away with, a real, you don't have to be perfect in life, it's just enough, that's just a learning sort of thing and Virginia Satir too, we can learn a style and use it similarly, but just the philosophy. You go out and you experience and you live it. I'm hoping I can bring that back to my clients and my agency in general. (WFG-2B)

They mentioned the importance of future trainees getting the entirety of the training because of its experiential nature:

P3: The only cons I can see will be people maybe not getting all the training. So just taking a technique here and there. I mean, that's reality, that happens. Not everyone can maybe do all the training. So that some people may not see the benefit of the whole model if they don't get the full training.

P1: Yeah, I agree with that.

P3: Because it is so experiential, I don't know if this training, if this is something that you can just borrow someone's handouts and talk for 10 minutes.

P4: That's right. (TFG-2B)

Appendix 17 contains a summary of the comments trainees entered on their TQ to supplement their ratings. These comments served to corroborate with the analyses performed for all the various categories in this Level 1 evaluation.

Future Directions

Trainees voted unanimously and unequivocally for Phase 2 CCT training (Figure 12). Trainees from both cycles expressed the same degree of desire for Phase 2 training ($M = 6.9$, $SD = .3$). They would like to see it expand on in-depth work in the Middle Phase, including family of origin, working with pain and trauma, sculpting, and universal-spiritual affirmations.

Some trainees recommended personal integration work using Satir and CCT vehicles to expand their own capacity to work with clients' pain (WFG-1A):

F2: Like a separate training to apply these skills and everything to ourselves in a group. With the support of group members. Without using actual cases or roles, we use ourselves, our experiences, our lives, our issues, whatever they may be, bring to the table. [various voices, mmmm].

Facilitator: So what do you think that would give you that you wouldn't have now?

F2, F1: Energy! All the energy.

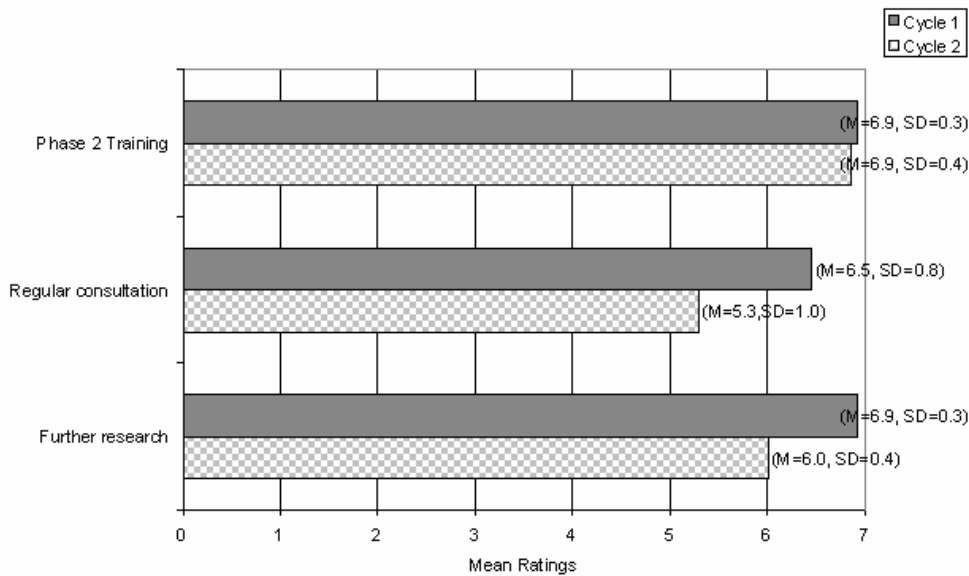
Male voice: energy, yeah.

M1: Like I think that experiencing interventions like a client would....

F2: And that's what she's saying in this model, that we're all, we are all human beings...

F1: ...so we can get a sense of what other people who are just like us have gone through and are going through, at a deeper level...

F3: Sometimes I feel that this is ongoing. Even if you have spent one day or two days or even a week. Because new things keep coming up and you have new issues yourself, right? So. (WFG-1A).

Figure 12. Future Directions ($N = 18$: Cycle 1, $n = 11$; Cycle 2, $n = 7$)

With respect to regular consultations after training, a significant difference was found between Cycle 1 and 2 trainees. Cycle 2 trainees indicated a lower need for ongoing consultation ($M = 5.3$, $SD = 1.0$) compared to Cycle 1 ($M = 6.5$, $SD = .8$). One possible explanation is that one organization in Cycle 2 already had a marriage and family consultant they had contracted for their staff. Another trainee in Cycle 2 was trained as a marriage and family therapist in a Master's program.

Interest to participate in future CCT research studies received a mean of 6.6 ($SD = 1.4$) for cases across both cycles. This was another validation of the high degree of trainee satisfaction in both the training and research components of the evaluation study, as is evident in the findings reported in this section of the report.

Level 2: Trainees' Learning

In the previous section we learned about trainees' satisfaction and reactions to key aspects of the training. In this section, we want to find out if the CCT training produced any change in the participants' knowledge, values, and skills. To determine the effectiveness of the CCT training, we wanted to gauge whether the trainees actually achieved the intended learning goals. This level of evaluation was not always conducted in training evaluations, many of which relied primarily on trainees' reported satisfaction but not necessarily on their learning outcomes.

Data Sources and Analysis

To evaluate trainees' learning, we utilized quantitative data as the dominant data source and qualitative data as the secondary source. A WT and RP were constructed to measure intended learning outcomes from the training (Appendix 9, 10, and 11). An overview of the observation points for data collection of trainees' outcomes in both cycles are presented in Appendix 1.

Quantitative Results

Baseline (O1) and Randomization

At baseline (O1), no significant differences were found in the means or ranks of the trainees' scores on the WT and RP, indicating randomization of the intervention and control groups.

Cycle 1: Intervention vs. Control Group at O1-O2

WT: Because of a high kurtosis in the distribution of the WT scores, a non-parametric test was selected for the analysis of differences in the results of the intervention versus the control group at O2 (minus baseline O1). A Mann-Whitney U test was conducted to determine whether the scores of the intervention group ($n = 12$) differed significantly from the scores of the control group ($n = 9$) with no missing values. There was one missing value for the intervention group, which was replaced with the Linear Trend at Point method. The mean rank of intervention group scores was found to be highly significantly different than the mean rank of the control group scores, $z = 2.71, p = .006$ (2-tailed).

RP: The intervention and control groups each displayed normal distributions. However, to be consistent with the WT, a non-parametric test was also used in the analysis of the RP scores. A Mann-Whitney U test was conducted at O2 (minus baseline O1) to determine whether the scores of the intervention group ($n = 12$) with two missing values differed significantly from the scores of the control group ($n = 9$) with no missing values. The missing values for the intervention group were replaced with the Linear Trend at Point method. The mean rank of intervention group scores was found to be highly significantly different than the mean rank of the control group scores, $z = 3.09, p = .001$ (2-tailed). The results of the highly significant difference between the intervention and control groups on changes in concepts and values as well as skills at O2 are displayed in Table 12.

Table 12. Difference in Trainees' Pre-Post Outcome Scores: Randomized Training and Control Groups (Cycle 1)

Variable	Control ($n = 9$) Mean Rank (O2-O1)	Training ($n = 12$) Mean Rank (O2-O1)	z	Sig. (2-tailed)
Concepts & Values (WT)	6.78	14.17	2.71	0.006
Skills & Interventions (RP)	6.17	14.63	3.09	0.001

Cycle 2: Control Group at Baseline (O1), Control (O2), and Intervention (O3)

WT: Written score distribution was high on kurtosis. A non-parametric Friedman test, equivalent to the parametric repeated measures ANOVA, was selected to determine whether the CCT training resulted in increased scores of trainees from baseline O1 ($M = 5.81, SD = 2.56$) to control condition at O2 ($M = 7.61, SD = 3.72$) to post-training at O3 ($M = 21.41, SD = 5.24$; Table 13). Values were available for nine cases. There were two missing values at O3, which were replaced by the Linear Trend at End Point method. The Friedman test comparing WT scores at three observation points was highly significant, $\chi^2 = 14.97$ ($df = 2$), $p = .001$. Follow-up pairwise comparisons using a Wilcoxon test with a Bonferroni correction found that concepts and values scores were not significantly different between O1 and O2, $z = 1.05, p = .3$ (2-tailed), but there was a significant increase in these scores between O2 and O3, $z = 2.67, p = .008$ (2-tailed).

Table 13. Trainee Means across Observation Points (Cycle 2)

	Baseline (O1) $n = 9$		Observation (O2) $n = 9$		Observation (O3) $n = 9$		χ^2 (df)	Sig. (2-tailed)
	M	SD	M	SD	M	SD		
Concepts & Values (WT)	5.81	2.56	7.61	3.72	21.41	5.24	14.97 (2)	0.001
Skills and Interventions (RP)	24.89	7.76	20.66	10.0	34.46	6.87	9.56 (2)	0.008

RP: Although RP scores were normally distributed for the trainees in the delayed training group at O2 and O3, a non-parametric Friedman test was selected for this analysis in order to be consistent with the WT analysis. Paired values were available for nine cases. There were two missing values at O3 which were replaced by the Linear Trend at Point method. The Friedman test comparing RP scores at three observation points was highly significant, $\chi^2 = 9.56$ ($df=2$), $p = .008$ (Figure 13). Follow-up pairwise comparisons using a Wilcoxon test with a Bonferroni correction found that CCT skills and interventions were not significantly different between O1 and O2, $z = 1.54$, $p = .12$ (2-tailed), but there was a significant increase of these scores between O2 and O3, $z = 2.67$, $p = .008$ (2-tailed).

Item Analysis

Item Analysis of WT: By comparing the scores of the trainees before and after training, we were able to calculate the percentage improvement trainees attained on the test items (Table 14). This analysis informed us that trainees showed a great improvement on the items they had to apply in the clinical work; that is, items that had a direct translation into clinical practice and interventions, such as the four CCT dimensions, communication stances, and components of congruent communication. More abstract items pertaining to values, beliefs, and philosophical underpinnings and systems showed less improvement immediately after training.

Table 14. Percentage Improvement from Baseline in Pre-Post WT

Item #	Content	% Improvement from baseline
1	Four dimensions of CCT	83
2	Systems approach	- 24
3	Beliefs & values in CCT	24
4	Four philosophical underpinnings	28
5	Four communication stances	96
6	Three components of congruent communication	100
7	Four ways to expand and deepen communication	22

In addition to indicating trainees might have more retention and knowledge of practice-related items than theoretical ones, the less improved items call our attention to two issues: (1) strengthening training focus in those areas; and (2) re-working items for improved reliability for future tests.

Item Analysis of RP: Items indicating an improvement of 10% and higher on the RP Scoring Criteria after training constitute 47% of the total 58 criteria items (see Appendix 11). An analysis of these items indicated trainees' most marked improvement in the following areas:

- structuring and balancing couples' sessions;
- tapping into couples' hopes, wishes, and yearning for motivation;
- working on couples' communication;
- deepening intrapsychic exploration;
- working experientially in the here and now with specificities;
- delineating intergenerational patterns; and
- consolidating and anchoring gains.

Only nine items in the RP criteria showed either no improvement or a negative score compared to the baseline scores, constituting 16% of the total 58 items (see Table 15 in Appendix 11). In future use, we need to determine whether these items are discriminating enough to pick up the skills CCT intends to teach and whether the training paid sufficient emphasis in developing these skills.

Correlations on Trainees' Change Scores and Trainees' Characteristics

WT Scores: SPSS 14.0 Kendall's tau-b tests were applied to examine the strength of the relationship between differences in scores on the WT completed by trainees before and after the CCT training, and selected trainee characteristics (Table 15). Three missing values were replaced with the Linear Trend at Point method, resulting in 21 cases available for analysis. The findings indicate that counselling experience in years and age ranges, extent of post-secondary education, and age in years ranges were not significantly related to differences in pre-post training WT scores. While the small sample size limits generalizability of results, these preliminary findings reveal that all counsellors, regardless of age, years of experience, or level of post-secondary education were able to equally benefit from the CCT training.

Table 15. Correlations between Trainee WT Scores and Trainee Characteristics ($N = 21$)

	<i>M</i>	<i>Mdn</i>	<i>SD</i>	τ	<i>p</i> (2-tailed)
Differences in WT scores before and after training*	11.98	15.00	7.68	-	-
Counselling experience in years	14.76	16.00	6.12	-.256	.113
Counselling experience in age ranges 1 = 1-5 years 2 = 6-10 years 3 = 11-15 years 4 = 16-20 years 5 = 20+	3.33	4.00	1.15	-.279	.106
Education in levels 1 = College 2 = Bachelors 3 = Masters	2.05	2	.59	-.073	.688
Age in ranges (years) 1 = <19 2 = 20 to 29 3 = 30 to 39 4 = 40 to 49 5 = 50 to 59 6 = ≥60	3.62	4.00	.87	.006	.974

* Dependent variable

RP Scores: SPSS 14.0 Kendall's tau b tests were applied to examine the strength of the relationship between differences in scores on the RP completed by trainees before and after the CCT training, and selected trainee characteristics (Table 16). Five missing values were replaced with the Linear Trend at Point method, resulting in 21 cases available for analysis. Non-significant negative correlations were found for experience and age, and a non-significant positive correlation was found for education. These findings indicate that counselling experience expressed in years or age ranges,

extent of post-secondary education, and age expressed in age ranges are not significantly related to differences in the pre-post training RP scores. While the small sample size limits generalizability of results, these preliminary findings suggest that all counsellors, regardless of age, years of experience, or level of post-secondary education, were equally able to benefit from the CCT training.

Table 16. Correlations between Trainee RP Scores and Trainee Characteristics ($N = 21$)

	<i>M</i>	<i>Mdn</i>	<i>SD</i>	τ	<i>p</i> (2-tailed)
Differences in RP scores before and after training*	6.65	8.00	17.56	-	-
Counselling experience in years	14.76	16.00	6.12	-.138	.394
Counselling experience in age ranges 1 = 1-5 years 2 = 6-10 years 3 = 11-15 years 4 = 16-20 years 5 = 20+	3.33	4.00	1.15	-.156	.365
Education 1 = College 2 = Bachelors 3 = Masters	2.05	2	.59	.145	.422
Age 1 = <19 2 = 20 to 29 3 = 30 to 39 4 = 40 to 49 5 = 50 to 59 6 = ≥60	3.62	4.00	.87	-.136	.437

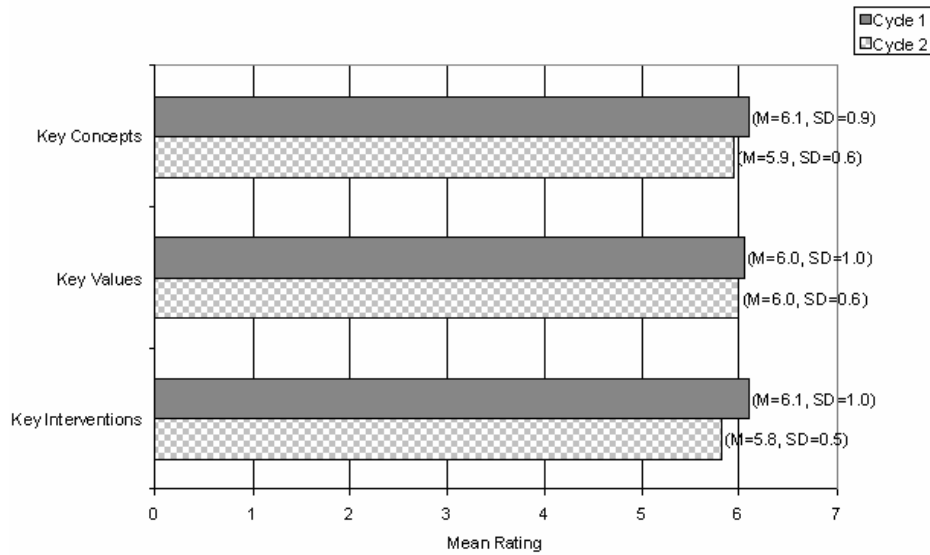
* Dependent variable

CCT Learning: Concepts, Values, and Interventions

After the workshop, the self-rating mean for all cases from both cycles was very high for CCT concepts ($M = 6.0$, $SD = .9$). There was a slight increase in learning after training in CCT concepts ($M = 6.1$, $SD = .7$; Figure 13).

The self-rating for all cases for both cycles for learning CCT values was very high after the workshop ($M = 6.0$, $SD = .8$) and rose to 6.1 ($SD = .9$) after the training. The self-rating mean for both cycles for learning CCT interventions after the workshop was 6.0 ($SD = .8$) and increased to 6.1 ($SD = .94$) after training.

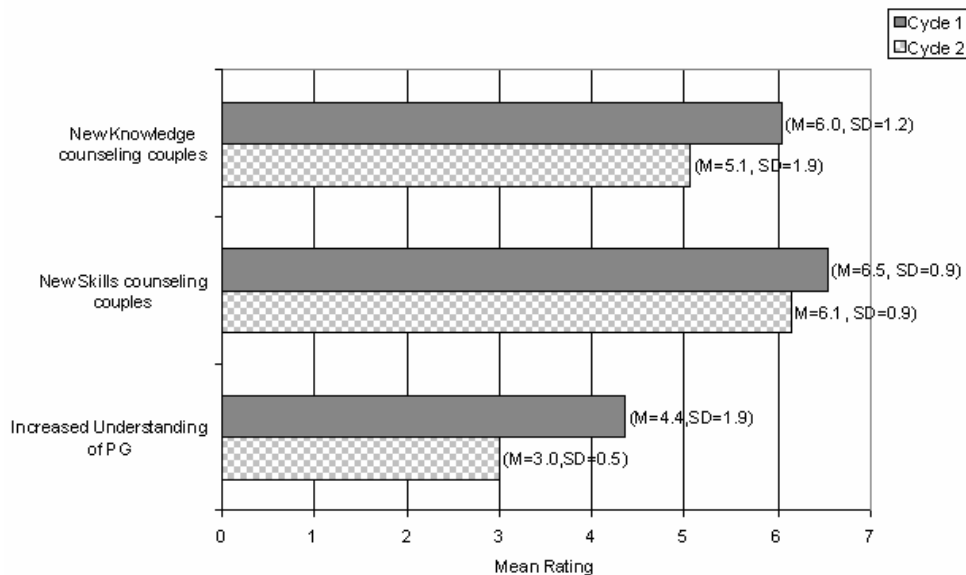
Overall, trainees' self-reported ratings of learning CCT concepts, values, and interventions were very high and consistent across concepts, values, and interventions. There was a slight increase in reported learning from the workshop to the end of training. These results correspond strongly with WT and RT objectively rated scores.

Figure 13. CCT Learning ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

Problem Gambling Learning

The mean for all cases in both cycles of trainees' ratings on applying CCT to problem gambling was rated highest for the acquisition of new skills, with a mean of 6.3 ($SD = .9$). Mean ratings of new knowledge on CCT for problem gambling was lower than those for skills. The rating of new knowledge on problem gambling decreased from 5.9 ($SD = 1.3$) after the workshop to 5.4 ($SD = 1.9$) after the training (Figure 14). This might reflect the greater application and practice focus of the training as opposed to the academic and theoretical.

When asked about their new learning of problem gambling from the training, trainee ratings reflected a moderate change ($M = 5.4$, $SD = 1.8$). A few reported that they interpreted the question to refer to gambling-related activities of the clients rather than the conceptualization of the etiology of pathological gambling and its contributing factors. The wording of this question warrants clarification in future use.

Figure 14. Problem Gambling Counselling ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

Areas of Change

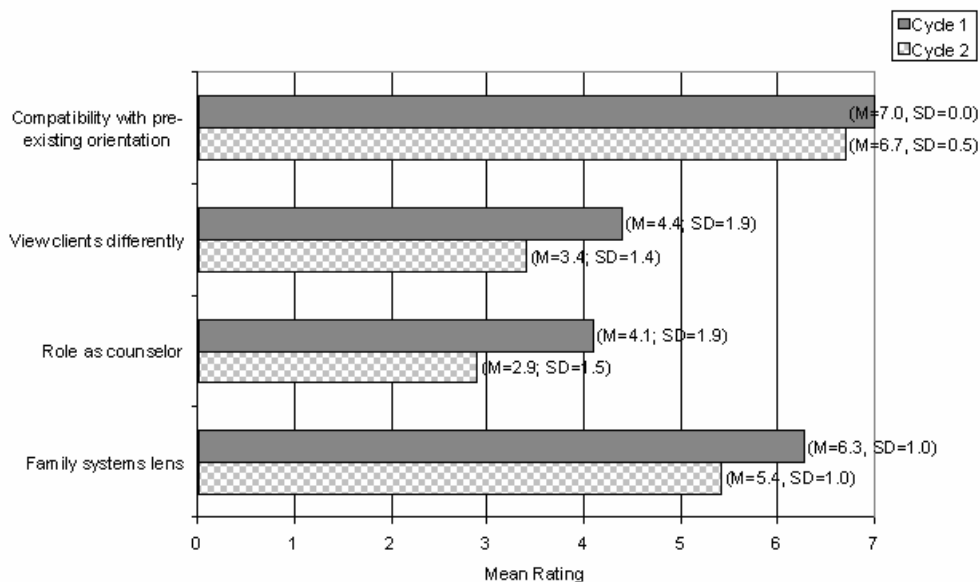
Figure 15 displays counsellor changes in four areas from baseline. Trainees in Cycle 1 rated a big shift to a family systems focus after the training ($M = 6.3$, $SD = 1.1$), but less so for trainees in Cycle 2 ($M = 5.4$, $SD = 1.0$). This could be explained by the fact that four of the nine trainees in Cycle 2 had prior formal training or consultation in marriage and family therapy in their organization, so the family systems lens might not have been as huge a departure for them.

Trainees rated the two areas of viewing their clients and living their role as a counsellor as largely unchanged, and again with less change for Cycle 2 than Cycle 1 trainees, although not significantly. The small change in these two areas accords well with the trainees' baseline humanistic values and positive orientation as revealed in the elaborations in the open-ended questions on the WT. The high compatibility ratings of the CCT with the trainees' pre-existing orientation explain the minimal shift in the way they live their role as a counsellor and view their clients.

Compatibility with the CCT Orientation

Trainees from both cycles rated their pre-existing counselling orientation as highly compatible with that of CCT (Figure 15). At the end of training, the mean rating based on cases in both cycles was 6.9 ($SD = .32$), indicating a strong goodness-of-fit.

Figure 15. Counsellor Changes ($N = 18$: Cycle 1, $n = 11$; Cycle 2, $n = 7$)



Qualitative Analysis

WT Open-Ended Questions

Three questions on the WT were open-ended to elicit qualitative data on the effect of the CCT training on trainees' understanding and experience of the following:

- development of pathological gambling;
- couple relationship in pathological gambling;
- their gambling treatment approach, philosophy and values; and
- their experience of themselves as problem gambling counsellors when counselling couples.

A research assistant entered the counsellors' answers into a matrix. The Principal Investigator and the second Co-investigator analyzed the matrix of responses for the above areas independently. They then compared their findings, which were found to corroborate very closely except for some

difference on the last question on the counsellors' experience of themselves while working with couples. The first Co-investigator was asked to give his opinion, which resulted in our interpretations below.

The summary of findings that reflects changes before and after the training on the above areas is as follows:

- *On Problem Gambling and Couple Relationship in Problem Gambling*

Pre-Training: Answers focused on ideas around the individual experiences of gamblers, bio-psycho-social underpinnings of gambling, and learning theory aspects. A number of counsellors cited other models they draw on, such as Blaszczynski's Pathways Model, Jacobs' Model of Trauma and Addiction, Narrative Therapy, Robert Custer's Model, Solution Focused, and Ladouceur's Irrational Beliefs about Winning. Discussion of the couple relationship focused most on the negative impacts of gambling on the relationship (e.g., issues of trust, shame, intimacy, etc.).

Post-Training: These responses, while still expressing ideas around the individual experiences of gamblers, bio-psycho-social underpinnings, and learning theory, held many more ideas around the ideas of systems – of systems balance. The responses revealed greater appreciation for addressing the complex broader and deeper issues underlying problem gambling. Discussions of unmet needs seemed to be greater, and ideas of engaging in fantasy and life trauma, crises, and transitions, all part of the CCT Pathological Gambling Family Systems Framework, were mentioned by participants. There was greater specificity in their frameworks other than naming someone else's model, as well as increased specificity in treatment focus. Also, for the first time, there was an emphasis on the marital relationship being part of the cause of gambling rather than just the result of gambling. There were increased citations of elements in the CCT framework; however, very few counsellors articulated the CCT framework as an integrated whole with all the pieces. Rather, their answers reflected an integration of parts and parcels of the CCT framework blended with other frameworks they were already familiar with, as well as with their own experience and observations.

- *On Gambling Treatment Approach, Philosophy, and Values*

Pre-Training: In general, trainees described using individual, group, family, and couples approaches in their counselling. Almost everyone did individual, with group coming next in popularity. Most counsellors reported using some kind of standardized assessment tool (e.g., SOGS). The Pathways approach was commonly cited as a way of conceptualizing gambling problems. Goals were described as either client-directed or in terms of abstinence or reduction of gambling. They used a variety of treatment approaches, with almost all incorporating some kind of cognitive-behavioural approach. Other popular models were brief, solution-focused, Rational Emotive Therapy (RET), motivational interviewing, stages of change, and psycho-educational method. Feminist therapy was only mentioned once. Average duration with clients varied widely from two sessions to three years. Longer time periods seemed to be more common with counsellors using systems and other non-behavioural approaches. Most people reported general satisfaction by their clients who stayed. Some reported returns due to relapse. Those with longer treatments found they lost some clients who were not willing to commit to such an in-depth approach. Reported strengths included a provision of a safe place, a willing, non-judgmental ear, understanding about gambling, and useful goals. A common weakness was the length of time of some approaches. Retention and engagement of clients was often a problem. Counsellors realized the lack of in-depth work and expressed concerns about relapse and recycling of "chronic" clients; however, to do this kind of work is often time consuming.

Post-Training: There was a greater emphasis on incorporating couples work into problem gambling counselling ("working to repair relationships"), meeting unmet needs, and working on re-establishing trust in the relationship. In fact, more than one participant discussed a weakness of her

regular approach as having a, “lack of focus on trans-generational issues and client yearnings” or having insufficient time to spend on the needs of couples. The “family system” and “larger system” received greater emphasis. Goals were less focused on gambling reduction and more focused on dealing with broader and deeper client issues and emotional needs (“I was not getting to the layers of the problem”). There was more emphasis on client-driven goal selection.

The post-test responses showed an awareness of the approach being taught by CCT training (“the CCT was my toolkit”). Five trainees specifically mentioned CCT. Two of these discussed how they had changed from a prior approach to CCT – the couple focus – and seeing how not getting to the root of a problem was a weakness of their old approaches. Other CCT-related comments included: “addressing underlying issues underneath gambling and despair, depression, self esteem, communication”; enhancing coping and “reducing stigma, loneliness and isolation”; “working with the larger system”; “relating past to present”; “instilling hope”; and, “envisioning a changed future.” Even the word “congruent” cropped up (“direct intervention using congruent skills”). Interestingly, the Stages of Change Model continued to surface as salient, perhaps even more so than in the pre-test.

- *On Experiencing Oneself in Couple Counselling*

Trainees were asked to supply three adjectives with a brief description or example to illustrate their experience of themselves while working with couples.

Pre-Training: Almost all counsellors described themselves with adjectives that are consonant with a humanistic, solution-focused, non-pathologizing approach. For example, “compassionate, respectful, understanding, non-judgmental, sensitive, open, constructive, patient, empathic, attentive, genuine, humanizing, empowering.” Counsellors also described how they found working with couples challenging, describing their couples as “combative, angry, distrustful, dynamic, slow” with “lots of surprises” and “heightened emotional level.” There was a tendency for counsellors to describe themselves as “uncomfortable” and their experience with couple work as “frustrating, draining, impatient” while citing their positive attributes as being “sturdy, relaxed” while being “open” and “empowering.”

Post-Training: Seventeen out of nineteen people who had entries at more than one observation time showed a change in at least one adjective. Although the changes in many cases were more subtle than dramatic, a few counsellors had quite noticeable changes in how they saw themselves. Adjectives after the training suggest a greater self-awareness and ability to use oneself in relation to what is needed in the session. Counsellors appeared to have a stronger sense of themselves in the process. There was less focus on objectivity, impartiality, and directiveness. In contrast, there was a greater sense of agency on the part of the counsellor as one who chose when and how to intervene, having greater freedom in asking questions, and in viewing oneself as a model in the interaction with clients.

Trainees described use of self in the counselling process:

Direct/ honest/ clear: Modeling clear and effective communication. Asking for clarification if I am unclear again, this is good modeling for the couple as they can observe my own interaction with the other as well. (C03, post-training).

The following is an example of self-awareness, self-openness and propensity for reflection:

It is not uncommon that I encounter impasse where I feel stuck and overwhelmed. The ability to differentiate between my own issues or those of my clients and the courage to deal with my own limitations are crucial elements in therapy (B02, post-training).

Sincere: open to others’ feelings and my own and in touch with what the couple is relating (T28, post-training).

The following is an example of greater congruence with self and tuning into process:

I was slow often and took more time to prepare as I wanted to do the study/model/clients justice. I thought a lot and even closed my eyes in sessions with couples to try and focus on the congruence process. Most often it flowed well from the body of knowledge I already had and gradually I learned to trust it would integrate well together which I believe it did. (R23, post-training).

It is important to work from a philosophy that is congruent with who I am as a person as well as a counsellor to provide the most effective treatment to my clients....(C03, post-training).

The following is an example of greater flexibility while working with the process:

Calming: even when couples are heated in session with rich emotion, I feel I can allow a certain amount to keep it real, however also can diffuse it quickly if it starts to get unhealthy (D08, post-training).

Patient: will time my interventions carefully to gain greatest impact (D08, post-training)

Intuitive: I can tune into people's emotions and am able to reflect these observations to the clients (K13, post-training).

Calming - eased and validated tension and negative feelings shifting to the positive while addressing the negative (R24, post-training).

The following is an example of increased resourcefulness in self and belief in the resourcefulness in the client:

Resourceful: in trying to assist clients in the resolving their concerns (O17, post-training)

Educate client with new information when they are stuck or uncertain (O20, post-training)

Respectful: They (clients) can conjure up inner resources to help them overcome whatever they get stuck with. (B02, post-training).

Counsellors had an increased sense of hope and optimism about their clients post-training. This theme was expressed by many counsellors:

Reassuring - I feel positive most of the time and wanted to end the session well and bring out the positive highlights and elaborate on them whenever possible. I enjoyed learning and growing from it and mirrored that hopefulness (R23, post-training).

Optimistic: related to the fact that they are in counselling together. (E06, post-training).

Hopeful: This adjective refers to times/occasions where change even in the face of immense adversity has been accomplished (E04, post-training).

Hopeful: direct couple to similarities and yearnings shared with each other, sharing compliments, observations, and progress. (R24, post-training).

Respectful: They can reach whatever goals they have for themselves (K13, post-training).

Counsellors voiced an appetite for learning and growing and were less inhibited about admitting their limitations:

Therapy, to me, is a two-way, give-and-take process in which clients and myself grow at the same time. This cannot be possible without a reflective ability on my part as a therapist. It is not uncommon that I encounter impasse where I feel stuck and overwhelmed. The ability to differentiate between my own issues or those of my clients and the courage to deal with my own limitations are crucial elements in therapy in general (B02, post-training).

Also important here is my continued learning both as a person and as a professional (C03, post-training).

Inexperienced: one couple for 7 visits does not make me experienced in all aspects of couples counselling (I11, post-training).

Educative: as a learner and instructor--provide me with the tools, the supports—watch me fly (I11, post-training).

Motivating: My experiences working with couples have added satisfaction to my work and furthered my want to learn more and try new techniques and models (E05, post-training).

One trainee who described herself as feeling “challenged” for how hard it was to work with couples before the training, used the same word “challenged” for how she was “looking forward to my time with couples.”

RP Scorers' Comments

In addition to numerically scoring the audio taped role-plays, scorers were asked to write their comments after each scenario on their assessment of the strengths and weaknesses of each trainee. We collated their comments and performed a content analysis of scorers' comments at baseline (O1), control (O2), and post-training (O2, O3). The results are as follows:

Baseline (O1):

- too cognitive;
- too teachy;
- took a didactic, educational approach;
- focused on feelings of one partner;
- focused on a problem-solving rather than therapy approach;
- taught the causality of gambling and addiction rather than working experientially with clients;
- lectured; and
- summarized for clients rather than allowing clients to summarize themselves.

Control group (O2)

- teachy;
- provided empathy;
- did not explore motivations, feelings;
- abrupt;
- struggled to follow his own agenda; and
- did most of the talking and did not allow clients to go introspectively.

Post-training (O2, O3)

- *Comments on Change:*
 - assesses clients' commitment to marriage;

- empathizes with client;
 - normalizes reactions of wife;
 - does a good job eliciting clients' motivations;
 - more skilled use of questions;
 - explores clients' presenting problem well;
 - established goals;
 - follows flow of the client's narrative;
 - structures session and does not let clients detract from issue under exploration;
 - makes appropriate interventions;
 - goes more deeply into topic;
 - balances input from both partners;
 - reframes blame into hope to build trust;
 - interrupted argument to delineate negative communication cycle;
 - a good job differentiating each partner's experience and perception;
 - elicits responses to each other's statements;
 - elicits appreciation and hope;
 - more exploration but not deep enough;
 - does an excellent job exploring and assessing intergenerational and interpersonal pattern; and
 - links past and present patterns well.
- *Comments on Lack of Change:*
 - did not deepen exploration of their perceptions;
 - did not explore impact of interaction in depth;
 - stayed at behavioural level;
 - did not facilitate congruent communication;
 - more exploration but not deep enough; and
 - could have explored more of their emotions about these patterns.

One scorer wrote the following narrative to summarize the pre- and post-training role-play demonstrated by one counsellor, which describes some of the subtle but important changes that occurred as a result of the training:

In the pre-tape, the counsellor focused more on the effect of each partner's behaviour on the other. The focus is more on behaviour. In the post-tape, the counsellor facilitates more interaction and direct communication between the couple, elicits more feelings and yearnings. She demonstrates more intrapsychic exploration and not only the behaviour. There is a greater variety and richness of interaction, shorter exchanges between the couples through the counsellor's structuring of interventions and explorations.

In summary, triangulating quantitative and qualitative findings on the role-plays, trainees definitely made significant improvement in their CCT skills. Before training, many trainees used a didactic, psycho-educational approach with their clients. They struggled in staying centred and in charge of a couple session. They focused on behaviours and problem solving. Their skills in opening up the process of interpersonal, intrapsychic, and intergenerational exploration were limited.

After the CCT training, trainees were more attuned to their clients' process, to go into more depth in exploring issues with their clients. They were observed to structure, assess, motivate, set goals, reframe blame and negativities, and generate hope and change more readily in the simulated role-play sessions.

Taken together, scorers' comments, trainees' own comments, and the outcomes from the WT

and RP paint a consistent picture. Trainees experienced and demonstrated significant learning of CCT concepts, values, and skills from the CCT training regardless of their age, education, and experience. However, these significant results do not imply a level of mastery of CCT. Trainees recognized the need for further in-depth CCT training at the next level and were motivated to pursue such training, as indicated in their reactions reported earlier in Level 1.

Level 3: Organization Support and Change

The major interest of Level 3 is to evaluate the organizations' advocacy, support, accommodation, and facilitation of the training process (Guskey, 2000). This is sometimes referred to as "organizational capacity" (Guskey, 2000; p.173). The interdependence of organizational and individual efforts needs to be assessed and taken into consideration in the adoption of an innovation (Guskey, 2000). In this study, we collected some preliminary data on organization support and barriers from the trainees, but not directly from the organizations' administrators. We recognize that a post-training evaluation would be valuable as the effects of CCT become more palpable and observable on organizations.

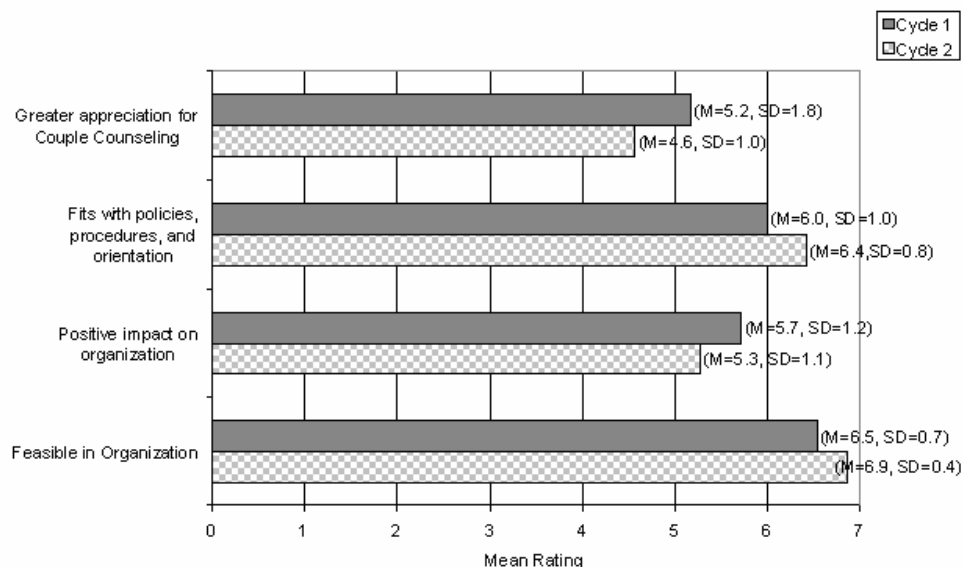
Data Sources and Analysis

Organization support was evaluated based on counsellors' ratings (TQ), focus groups (WFG, TFG), and teleconference notes.

Quantitative Results

Trainees rated their CCT training with organization's receptivity, compatibility, impact, and feasibility (see Figure 16). Trainees rated the feasibility of applying CCT in their organization very high in both cycles ($M = 6.7$, $SD = .6$). They also agreed there was a good fit ($M = 6.2$, $SD = .9$) of policies, procedures, and counselling orientation between their organization and the CCT model. Using all cases, increased appreciation for couple counselling ($M = 4.9$, $SD = 1.5$) and positive impact of CCT on the organization ($M = 5.6$, $SD = 1.1$) were rated lower. Triangulation with qualitative data suggested that these areas may be too early to evaluate.

Figure 16. Organization Support and Change ($N = 18$: Cycle 1, $n = 11$; Cycle 2, $n = 7$)



Qualitative Results

Receptivity and Support

There was a consensus among trainees that their organization had been very supportive of their involvement in the project and allowed them the time they needed for the workshop, teleconference consultations, and paperwork for the research. One counsellor noted:

R2: Our manager was very accommodating when it came to that, they gave us all the time we needed. But there was uncontrollable factors in here, certain things that were going on that we just had no control of. (TFG-1A)

Most trainees felt they had the full support of their organization to implement the model with couples. A few mentioned their organization was particularly interested in them learning this model:

Actually, we have been encouraged [by our organization] to explore this model ... learning it and applying it. (WFG-1A)

Others stated that their organization seemed to be aware that participation in this project would require some additional time. They would not have been sent to the training otherwise. One participant explained that although he/she did not feel pressured by his/her organization to limit the time that he/she was spending on this project, he/she felt some pressure in meeting the expectations of the study while carrying on with his/her clinical and administrative duties:

The agency is really supportive of it. I am not worried about that. It is more the fact that there is a large number that needs to be seen and then the time that is needed for administration, it is more my problem, I guess, because my agency is supportive. (WFG-1B).

Trainees in one focus group mentioned that their organization was previously reluctant to support research given the amount of paperwork and lack of benefit to the organization. However, these counsellors were pleasantly surprised by the practical hands-on approach to research in this study and felt that their organization had benefited from their involvement.

Compatibility and Feasibility

Trainees rated both the compatibility and feasibility of CCT with their organization's policies and procedures very highly, with means of 6.2 ($SD = .9$) and 6.7 ($SD = .6$), respectively. A number of trainees mentioned that their organization was already placing a strong focus on working with couples and that this training was timely in supporting an emerging direction:

P1: We were already quite involved with working with couples and that was a big focus. And so maybe a spin off would be just to help solidify that, and maybe raise confidence levels in being able to work with couples in different areas. (TFG-2A)

P4: My organization is now looking at the idea of couple counselling and family counselling being part of the services we provide and formalizing it. (TFG-2A)

Another commented on the compatibility and feasibility of CCT in her organization:

P3: I know for me, I have, now that we are done I need to let my manager know sort of a summary of what has happened, but she has been very supportive, and this model fits very well with the work that we do. It's very client centered, very empowering, hope-focussed. I think it fits very well. (TFG-2B)

Challenges and Barriers

Organization Internal Changes

One organization was going through a major internal reorganization, which had an impact on how the counsellors experienced the training:

R2: I'll tell you, for myself, and you know, I think I've had this conversation with my co-workers too, I think it was just also a very unfortunate time for us, it really was because we've had a lot going on here in the past couples of months. So I think that was a factor that made it more stressful on me....I think it would have been a little bit easier if we didn't have that going on. (TFG-1A)

Relationship with Internal Supervisor

The relationship between training consultations and the organization's internal supervision needs to be better clarified in future studies. In one organization, counsellors believed they had to keep the discussion of their cases in the teleconferences confidential. This created some tension between the supervisor who was not involved in the study and the counsellors who were part of the study. These trainees also felt their organization might not have had sufficient information about the study to help them appreciate the value of the study.

Other trainees had not interpreted the confidentiality agreement in a similar way and discussed details about their clients with their supervisor as usual:

P: The only pieces were generally the only one that ever did couples with was our manager who had a lot of experience in couple and relationship work. So, the pieces that we as counsellors, we never really did it without going through her first and then brainstorming or evaluating the situation and doing the criteria whether or not this couple would be appropriate to work with together. But no, in terms of the model, and knowing that I was going to have two couples, it wasn't an issue because of our policy already, so the manager knew that I would know what was acceptable or not or that if the study asks you to do something that was against our policy, or questionable, that I would either go to her or not do it. There was a lot of trust. So. (TFG-2I)

Policies and Procedures

The understanding for the research was that counsellors would follow the policies and procedures of their organization in matters of documentation, case management, referrals, crisis intervention, and confidentiality. By and large, this agreement worked out satisfactorily.

There was some concern that the required number of sessions to be implemented with a couple did not necessarily coincide with what was usually done within their organization – they would include more or less sessions – although none of the participants mentioned strict organizational procedures that would limit the number of sessions they were allowed with a couple. Some discussion arose regarding whether CCT required new or different procedures in handling couple files, such as opening a new file when engaging couples in counselling separate from their individual files. The administrator of this organization was in agreement with the recommendation that a new and separate file be opened for couples.

Post-Training Supervision

Trainees reported variability in their organization with respect to available supervision from internally or externally contracted supervisors for couple work. The trainer was bounded by the 12-session limit of this study in providing ongoing consultation. It was strongly recommended to supervisees to seek continued couple counselling supervision with registered marriage and family therapists in their community using supervisors from the Ontario Association for Marriage and Family

Therapy roster. Table 17 shows that 94% of counsellors had plans to obtain some form of supervision beyond the study.

Table 17. Counsellors' Plans for Supervision after Training

Counsellor Plans for Clinical Supervision after CCT Training		(N = 18)	%
To receive supervision	yes	17	94
	no	1	6
<i>Internal Supervision</i>			
From peers	yes	10	56
	no	8	44
From supervisors	yes	8	44
	no	10	56
<i>External Supervision</i>			
From peers	yes	6	33
	no	12	67
From supervisors	yes	0	0
	no	18	100

Impact

There was some indication that a few organizations' receptiveness to engage clients in couple counselling had increased as a result of the CCT training. However, the extent of this impact might be too early to judge, as revealed in our quantitative ratings. Overall, counsellors were hopeful that the CCT training would have an eventual positive impact on their organization's focus on increasing couples counselling services. There was certainly internal dissemination of their CCT knowledge:

P3: I know for me, um, the colleagues that I have spoken with more about this model, now really want to refer some clients. So I think it's got our agency thinking a little more couple focused versus individual, and I think that that's absolutely fabulous. I know for me the new clients, I am bringing in partners a lot quicker. They may not choose to do couples counselling, but at least to be a part of the counselling minimally. So I think for our agency, I think that's been good for clients, it's been helpful. And for me personally, I think that I am feeling a lot more confident and it has really energized me in my work. (TFG-2B)

Two counsellors reported they were asked to present what they learned from the CCT training to other staff in their organization:

P4: But I certainly did have the support of my manager and he has asked me to present the training, briefly, but to present that and some of the tools to the other staff. So, that in itself is a compliment to the model. Because I would be telling him about it in my supervision and he said, "I would like you to share this with the rest." So, that was nice. (TFG-2B)

CCT training appears to have come on the scene at the right time in supporting some organizations in their move towards more services for couples and families:

P1: We were already quite involved with working with couples and that was a big focus. And so maybe a spin-off would be just to help solidify that, and maybe raise confidence levels in being able to work with couples in different areas. (TFG-2A)

P4: ...like I said, my organization is now looking at the idea of couple counselling and family counselling being part of the services we provide and formalizing it. (TFG-2A)

In summary, a large majority of trainees felt supported by their organizations in undergoing the CCT training and trial application. There appeared to be a timeliness to the CCT training in relation to an emerging trend in a few organizations to adopt more couple-focused counselling with their clientele, as well as an interest in treatment organizations to partner with researchers. Future training should pay more attention to collaborating with organizations' internal supervisors, providing them and their administrators with more information on CCT, and working with organizations to develop greater supervisory capacity and consultative support in the application of CCT.

Level 4: Trainee's Application of New Knowledge and Skills

Most of the time, evaluation on the use and application of new knowledge and skills cannot be gathered immediately after a workshop. Guskey (2000) observed that few participants, after a workshop, would venture into the uncertainty of application without ample support. The natural terrain is understandably bumpier and more challenging than scenarios streamlined for training purposes. What makes the early stages of application challenging is that the problems encountered are often "multiple, pervasive, unanticipated, and context-specific" (Guskey, 2000, p.181). The capacity to deal with these problems with new knowledge and skills "promptly, actively and in some depth" is likely the biggest determinant of successful learning (Guskey, 2000, p.181; Miles & Louis, 1990), just as "trialability", a chance to experiment with a new knowledge and skill, is one key factor influencing the adoption of an innovation (Rogers, 2003).

Data Sources and Analysis

The primary source of data for Level 4 evaluation includes teleconference tapes, notes, and excerpts of transcripts. Sixty sessions of teleconferences, with an average duration of 1.25 hours, were each audio taped. Sessions 8-12 were analyzed intensively for content and themes in the following categories: (1) aspects of CCT applied; (2) client issues; (3) improvement with clients; (4) professional and personal growth; (5) trainees' questions and concerns; (6) trainer's interventions and concerns; and (7) trainees' feedback on CCT. The analysis of the teleconference tapes stopped at saturation point.

Trainees' recruitment summaries were analyzed to help us learn about their couple recruitment criteria. Trainees' written summaries of their interventions with clients were triangulated with teleconference data.

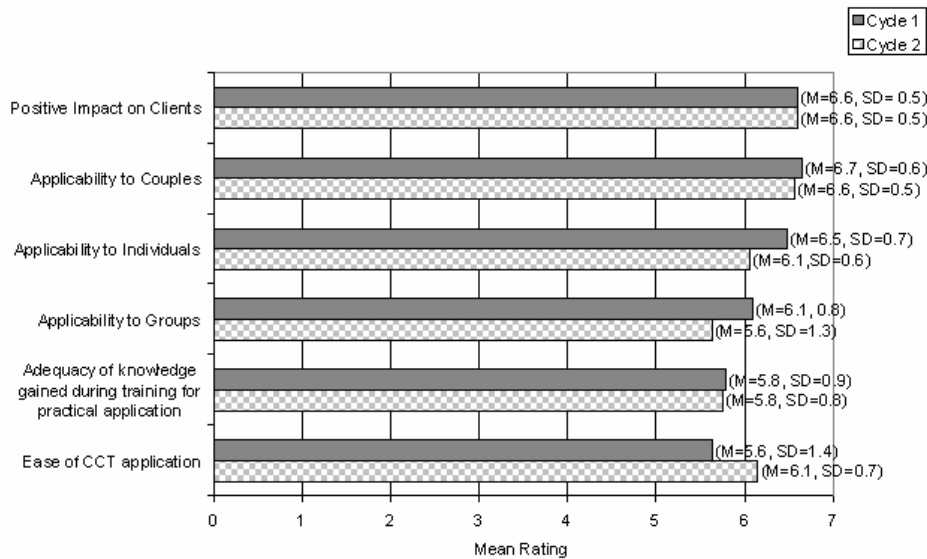
Qualitative data were collected and analyzed in the WFG and TFG under the categories of key learning moments, challenges in applying CCT, impact on clients, and professional and personal growth. Quantitative data were collected from the WQ and TQ.

Quantitative Results

Applicability of CCT

On the WQ and TQ, at the end of the workshop and training, trainees were asked in a slightly different way each time about their intent to apply CCT to couples in the future. There was no significant difference in trainees' responses from Cycle 1 and 2 (Figure 17). Both groups were highly motivated to apply CCT to couples ($M = 6.7, SD = .5$). There was a slight increase from a mean of 6.6 to 6.7 based on all cases in their motivation after the trial application compared to after the workshop.

In addition, trainees from both cycles were asked whether they thought CCT was applicable to individuals and groups (Figure 17). Their ratings for the applicability of CCT to individuals were higher than those for groups. Cycle 1 participants answered significantly more favourably about the applicability of CCT to individuals and groups than Cycle 2 participants. The reason for the marked difference in their responses is not immediately clear.

Figure 17. Applicability of CCT ($N = 21$: Cycle 1, $n = 12$; Cycle 2, $n = 9$)

Preparedness for CCT Application

At the end of the workshops, trainees rated themselves at a moderate level of preparedness in applying CCT to couples based on their knowledge and skills ($M = 5.6$, $SD = .9$). There was no significant difference in means between Cycle 1 and 2 trainees. At the end of training, trainees were asked about their readiness to use CCT with couples in their settings (Figure 17). They showed an increased readiness to implement CCT after trial application ($M = 5.9$, $SD = .7$). However, trainees' ratings for all cases in both cycles at the end of training were still below a mean of 6, which corroborated with their earlier indication that more training and practice supported by consultation would be desirable (Figure 12).

Cycle 2 trainees reported greater "ease", implying comfort, in applying CCT ($M = 6.1$, $SD = .7$) compared to Cycle 1 trainees ($M = 5.6$, $SD = 1.4$). As reported earlier in Level 1, there was also less of a need among Cycle 2 trainees in obtaining regular consultation after the training. The reason for this difference was attributed to a few Cycle 2 trainees having more background and experience in marriage and family work through external consultation in couple work provided by their organization.

Centrality of Application and Consultation

The importance of the trial application with consultative support in the training was rated at a mean of 6.9 ($SD = .32$) by trainees in both cycles. The opportunity for trial application of CCT was rated equally highly at a combined mean rating of 6.72 ($SD = .57$; Figure 9).

Qualitative Results

Preparedness for CCT Application

The WFG data indicated that the level of confidence and comfort varied among trainees after the workshop in anticipation of their CCT work with couples. Several trainees stated feeling confident in their ability to implement CCT and felt a certain excitement to find out how clients would respond. Others mentioned uneasiness and anticipated that the process would be challenging for them. These trainees were relying on and looking forward to the teleconferences to support them during the application process. They also anticipated that the teleconferences would help them clarify some of the issues they had questions about at the end of the workshop, particularly techniques in the Middle Phase,

such as family mapping and working with pain. Some were concerned about the emotional intensity CCT might evoke, while others did not think CCT would evoke different feelings from their clients other than what they would usually expect in their counselling practice. This likely reflects the differences among counsellors in terms of the “usual” work they do with their clients prior to training and their comfort level in working with deeper issues. Some counsellors were concerned about being able to recruit a couple to participate in the study within the 2-week timeframe, and keeping the work within the 12-session limit of the research study.

Several trainees mentioned at the end of training that they already had incorporated certain aspects of CCT into their “style” of working (TFG-1C). They also felt confident that they would be able to continue applying CCT. In fact, using CCT had energized them and they felt it had improved their counselling. One counsellor had tried the communication stances in a group setting, and another had tried CCT with an individual who had a substance abuse problem. One trainee indicated the need to obtain permission from the organization to continue with CCT. Another trainee did not feel that he/she had sufficient experience yet with the model to continue using it on his/her own.

Overall, the application of CCT and the degree to which trainees intended to implement it varied across individuals. Counsellors’ prior practice, sense of their own competence and confidence, support of the organization, and available supervision and consultation resources all factored into the equation.

Since trainees’ background, training, and organizational context differed, such as in the couples they see, a CCT Self-Assessment Tool consisting of a checklist of ethical and professional considerations was distributed to trainees to conduct their own self-assessment of their decision to use CCT. Results were reviewed with the trainees during the teleconferences.

Trainees’ Recruitment of Couples

Trainees were given two weeks to recruit one to two couples in their work settings following the four-day CCT workshop. A sample of two couples per counsellor allowed trainees sufficient time to discuss their cases during the weekly group teleconference consultations. Application to two different couples gave trainees an opportunity to compare and contrast variations in which CCT could be applied, thus extending their learning. A contingency of one couple as a backup was built in should clients decide to withdraw from the study.

Inclusion and exclusion criteria for recruitment of couples were deliberately kept to a minimum for the following reasons: (1) trainees varied in their training, background, and expertise with couple counselling; allowing them to exercise their discretion in selecting the couples based on their clinical judgment in consultation with the trainer best respected trainees’ self-assessment of their comfort and competence levels; (2) the clientele best suited for CCT was still under research, so no definitive exclusion criteria were posited. The only stipulation for inclusion in this study was that the gambling client had met DSM-IV criteria for pathological gambling in the absence of intimate partner violence.

Trainees could consult with the trainer on their recruitment decisions, especially when they were uncertain. In Cycle 1, all counsellors made use of such consultations either individually or during the group teleconference. In Cycle 2, only one counsellor made use of individual consultation for case selection, reflective of the fact that a higher number of counsellors in this cycle had some previous couple therapy training.

Recruitment success rate was 60% based on the number of couples approached and the number who consented (Table 18). Couples who did not come on board had scheduling difficulties, or the spouse was unwilling or unmotivated to participate. Nearly 80% of trainees worked with one couple and 20% had two couples.

Table 18. Recruitment Frequencies

Total number of couples approached		40
Total number of couples consented		24
Average successful recruitment rate for counsellors		60%
Number of couples treated by counsellor	one couple	79%
	two couples	21%

Trainees' Criteria for Recruitment

The following inclusion and exclusion criteria were used by counsellors in recruiting their clients. These criteria were elicited from counsellor trainees in their Recruitment Summary (Appendix 12) and in their discussion with the trainer:

Inclusion Criteria for Couples:

1. indication of marital and couple communication problems contributing to or resulting from pathological gambling;
2. both partners showed motivation and willingness to work on their relationship;
3. couple was already engaged in couple counselling at the organization;
4. couple was committed to their relationship;
5. clients indicated unresolved issues in family history;
6. couple had existing rapport, alliance and trust in the counsellor and the organization;
7. clients' issues could benefit from interventions of CCT;
8. counsellor had comfort level with the couple and their issues; and
9. couple was available for scheduling and commitment for weekly sessions for 12 weeks.

Exclusion Criteria for Couples:

1. client felt overwhelmed by feelings around sexual abuse and incest in her life;
2. comorbidity: bipolar diagnosis, anorexia, which are issues beyond trainee's self-assessed level of competence;
3. one partner's issues required more individual counselling;
4. couple was on the verge of separation and divorce and lacked commitment to couple work;
5. client's ability to communicate clearly was impaired by mental instability;
6. active major legal issues; and
7. hostility between spouses.

Depending on the experience, self-assessed competence, confidence, and comfort level of the counsellor, couples recruited included one client suffering from schizophrenia, one with suicidal ideation, one with a history of possible sexual abuse and incest, and two with criminal and legal issues.

In summary, we followed a client recruitment process that respected the trainee's judgment and self-assessment in consultation with the trainer's input:

O20: During the recruitment phase I found myself really trusting my own judgment in terms of whether or not I thought a couple was suitable. I'm happy I followed my intuition now as I believe I have the couples I feel most comfortable with and vice versa. My comfort level is most important for me at this time simply because this is a new method of therapy. (Recruitment Summary)

Centrality of Application and Consultation

What is unique with this CCT training is the incorporation of a 12-week teleconference support to assist counsellors in applying the CCT knowledge and skills they learned in the 4-day workshop.

Trainees found the application with the 12-week consultative support to be a novel and desirable feature of the training, based on data collected in the TFG and teleconference notes.

Both quantitative and qualitative data supported the great importance trainees placed on the teleconference consultations as an essential part of the training (Figure 9). Below is how one trainee highlighted the centrality of the application with teleconference consultations:

P3: To me the teleconference was fabulous. Without it, I don't think I would have applied anything...to have [the trainer's] input, have everyone else's input, was really valuable because, you know, when you are doing something new to get some ideas, "Well I was going to go down this path, but maybe I'll try this instead..." Umm. And then hearing the new interventions based on the model, like it gave me the confidence to apply them. And to come back and say this is what worked or what didn't, this is where I am going, to me that was totally beneficial. If we didn't have the teleconference, I don't think this [training] would work at all. (TFG-2B)

Functions of Application with Consultation

This section reports on the main functions and benefits trainees named for the application with consultation phase in the CCT training. Data were gathered and analyzed from the TFG and teleconference audiotapes and notes.

Expansion and continuation of workshop. Trainees saw the application of CCT with teleconference support as a continuation and expansion of CCT. The application with consultations gave them an opportunity to understand the elements of CCT in greater depth and clarity. It aided their understanding of how CCT functions *in vivo*. The application makes CCT "come to life" (TFG-2A). One trainee said he/she would likely not have used CCT if it weren't for the supported trial application:

P2: That's been the beauty of this, for me anyway, is having everybody here on the team, and we're actually using the model, otherwise I know I probably would have fallen apart by, maybe week three, and gone back to mainly my old style. (T5S11)

The application component facilitated transfer of new knowledge and skills to clients immediately through a monitored research process:

P3: I really appreciated being part of something that was very, umm, clinically based, very... We were transferring it to clients right away. (TFG-2B)

Adherence. Adherence to a model is an important consideration in the testing of empirically supported therapies (Rounsaville & Carroll, 2001). Guided applications helped trainees adhere to CCT:

P1: I think without the teleconferences, I am not sure that I would have been sticking to the model quite as closely. (TFG-2A)

P1: The biggest difference was the fact that it was a teleconference so that it would help me stay on track with the model. And they [the clients] saw that as a benefit. (TFG-2A)

Trouble-shooting. Trainees' related their key learning moments to timely and specific input from the trainer that helped them troubleshoot problem spots in their sessions. For example, one trainee narrated a shaky alliance he had with one spouse:

P1 The one moment that kind of stood out for me, the one couple I was seeing...I was struggling with him a bit...and the teleconference, [the trainer] had kind of encouraged me to almost spend the whole session working with him. And I think that was a real key point. That

seemed to turn our sessions around. (TFG-2A)

For another, the consultation helped her find the right moment to bring up family of origin issues:

P2: Yeah, I think one of the most important things for me was when [the trainer] first guided me at the right stage to bring up some family of origin issues, and the context in which to bring those up. (TFG-2A)

Community of practice. The applications of CCT supported by peers and the trainer allowed trainees to learn from one another's cases and feedback:

P4: I would agree with what both [name 1] and [name 3] have said. Um, it was very valuable and for me it was like a continuation of the training because I'd hear how others were actually handling their situation even though they are unique and different with their couples. It sort of brought it to the surface and allowed me to know that there were people there that I could rely on as well, if I was having a problem or wanted some feedback. And I think the feedback was just fantastic. (TFG-2A)

A community of practice lent support and feedback, and demonstrated a broad variety of cases and applications that expanded trainees' conceptual and intervention repertoire. The group consultations added richness to the discussion and in a subtle way, gradually helped trainees develop a sense of clinical judgment about the appropriateness of application and timing in their clinical work. The teleconference consultation format and safety created a network of collegial support for trainees that they could draw from in the future:

P3: I think that speaks to the value of the teleconference. Not only did we get the clinical support, but I think as counsellors, we've built our own relationships together.

Interviewer: OK. Mhmm. OK. So it has had a different kind of peer professional development aspect as well?

P3: Very much so. And for me, it feels like I could continue that on, ongoing, clinically, and look forward to meeting people at different workshops. And, but I wouldn't hesitate to call anyone, you know, on the teleconference... in the future about other clients. (TFG-2A)

Integration. The supported application enabled the trainees to integrate CCT:

R 1: I agree with (name 2) overall, my experience was excellent, I really got a lot out of it, from all aspects from the very beginning, the book, I found to be very helpful, [the trainer] was excellent, extremely supportive. I got a lot just out of her conversation and the way she puts things, the ways she is able to articulate things made a lot of sense to me, her metaphors, I used and thought about a lot. But the most important part of it was as (name 2) said, the integration part, the, from the process to the integration part was really meaningful, ... to put it into practice. (TFG-1C)

The full understanding and integration of CCT in its multi-dimensionality came together for a trainee only at the very end of the application phase:

Oh, for me, it took till the end of the week, because I struggled at seeing how it was different. Because [the trainer] kept saying how it was very structured and yet I couldn't see the obvious structure because to me it felt like something that I had been doing and of course there were some things that were different. So, I was struggling until probably the end when it all fit in.

And then I kind of went, “Ah-ha! Now I see it”. I had to experience it all to see what was new, what was different, and how it could fit in. (TFG-2I)

Most Frequently Applied CCT Components

The most commonly used CCT components, based on our teleconference analysis, are listed below.

Reframing blame into hopes and wishes. This was a way of generating hope and positive energy at the beginning phase of counselling. It was an important first step in engaging couples often burdened with losses, anger, and disappointments when they first arrived. Trainees were able to help their clients turn negativity and blame into hopes and wishes that set the momentum and future direction for the collaborative work in CCT. This initial step, though seemingly small, was enormously significant in motivation and engagement:

B02: I did a lot of reframing. Reframing complaints into hopes and wishes, a lot of negativity into positive. For example, they received yesterday a letter of eviction, the wife was devastated. They would have to move out, and the bank will take the house. The wife almost broke down and told the husband, “You abandoned me! You did this to hurt me!” Now are you going to leave me alone?’ These are accusations. I asked husband what he heard from statements, he said, “She’s blaming me.” Of course when he heard it this way, he says he will try to defend himself, say “I’ve done all I can. I can’t do anything more at this point.” I said, “It seems you can hear it in another way. When she says ‘are you going to desert me?’, she’s saying ‘I need you and you are important to me’. I saw right away the wife nodded so much, and the husband seems to get a new perspective in the situation. His response is “oh”, and silence, and they look at each other. I think they got it. The negativity just turned more positive. Very helpful. Trainer: That’s beautiful. It helps them re-bond and reconnect.

B02: Of course, the negativity comes back and I have to reframe again. (T3, S1)

Building a strong balanced alliance with both partners through collaborative goal-setting. A trainer complimented a trainee on the way he role-played – how he would turn the couple’s problems into specific collaborative goals with the positive outcome in mind:

T: That’s terrific! You did a great job narrowing them down and getting a more concrete picture. It forced the client to get a picture in mind of what he’d like. You invited him to describe what would they would be doing together if they’re having good time with each other, get visualization process going. They make a different movie, and you want to get them to use their mind’s camera to start making a new movie. (T2, S3)

Goal-setting came out of exploring clients’ presenting concerns, reframing them, circumvented blame, and then generating a positive direction that both agreed on to move forward together:

O19: We had our second session last night. We talked about pulling some goals and we focused on some really good goals. After some interpreting, I had them rewording things. They realised a lot of their goals were similar. (T2 S3)

Shifting couple communication. All trainees in the CCT application used communication interventions. This involved identifying the communication stances, interrupting negative cycles, seeding positive communication cycles, checking perceptions, and “meaning-making”. One trainee talked about the exciting effects the enhanced communication brought to her couple:

Yes, I guess one of the things I liked most about the work, working with the couple that I had, was that he was really able, she really opened up, she started to communicate, and I guess after all these years he didn't have a clue about what she thought or how she felt about anything. And he was, he continued to be surprised throughout these sessions and became very emotional once at the time that she was really feeling and thinking the thoughts she had and feeling the way she felt. So it was really nice to see, that, he was excited about the fact that he was getting to know his wife, she was excited about the fact that she was getting to use her voice. (TFG-2B)

A trainee mentioned how the communication work was the biggest asset for the clients:

P1: Umm. For me, I had two couples and the one couple was kind of a great couple to work with right from the get go. And the second couple was the one that I was struggling with a little bit early on in the sessions. But both couples, by the end, were very pleased. I'd noticed quite a bit of change in the relationship. Probably communication would be the biggest thing for both of them. (TFG-2A)

Clients were often unaware of how their former communication patterns were negatively impacting their relationships. The value of shifting communication stances in the spousal relationship was described:

P2: My clients did not realize the destructive pattern of communication they had. It was such a pattern, it was such a habit, they didn't even realize that that's what was going on, and because the way they weren't communicating it was causing a serious problem between the two. They didn't realize that up until about probably four or five sessions ago. So it's amazing when you get into a habit or a pattern of things that you don't even realize what is going on. (TFG-1B)

Encouraging mutual appreciation between the spouses. Trainees noted the effect that mutual appreciation had on the couples. Temperature Reading from the Satir Model, for example, was a useful tool:

D08:...when we did the temperature readings and the appreciation, I think it gave them that feeling - 'you know what it's kind of nice to have your spouse say...I appreciate when you do this'. (T4S11)

Selectively applying family mapping. Several trainees expressed how family mapping was a critical intervention when applied at the right time and in relation to present issues:

L14:...I got them to express to me the family life...talk to me about their parents, some of the problems on both sides...then I said 'so when you look at that, what does it mean as far as today? ...does it have an influence or an impact on things? (T4S10)

P21: The family mapping was helpful...for them to really look back at some patterns in their family, and especially with her with...her grandparents raising them, and the impact of her father leaving... (T5S10)

P2: I found the usage of the genogram at that point in time with my clients extremely useful and it seemed to suit them in changing, actually. Changing their understanding of each other, so, so it was very useful. (TFG-1B)

For some clients, family mapping was a key exercise in helping clients connect with their past to see how it was affecting them in the present:

P1: Yeah, I think the couple that I worked with didn't realize the connection, that, like the deeper connection they would have, especially it was highlighted during their family mapping, that when we did it, to see it done on paper, I really don't think that they anticipated themselves connecting, umm, to their past and how that sort of is relevant, and kind of highlighting some things among themselves. They were really, umm, because I actually, early in the sessions, I mentioned that something that we are going to do, and I think they thought, "Oh, well that will be nice. We will just talk about some things related to our parents, etc" but I think they really didn't realize the emotional part of it when they started doing it. And they had a real appreciation of more of their past and connecting that into the present. That, I didn't think they thought would happen so that was both kind of a defining moment, but a really, umm, in highlighting some things about the process, I think that was a real key part. (TFG-2B)

Inconsistently Applied CCT Components

CCT components applied by a few trainees, but not all, are described below. More training and support may be needed in these areas.

Linking and assessing gambling urges and activities with psychological and marital changes. Some, but not all, counsellors used the Pathological Gambling Family Systems Framework in their assessment and work with their couples. Gambling was linked with couple behaviour in a clear fashion by one counsellor:

Q22: They say "Wow! How does it help me with my gambling!?" So I said, "Here are some charts I got in training. When someone is gambling in the family, it impacts the family. But understand that gambling was a coping mechanism. When gambling stopped, you had to face the problems that were still there. The disconnect still exists and this creates further estrangement in the relationship. And this is how the family is impacted. When the system heals, it creates change. By stopping gambling and focusing on family issues, the family changes accordingly as well. The congruency within yourself helps you manage stress in your family better." (T5, S7)

Working with pain. Because counsellors indicated they needed more training to learn to work comfortably with pain and trauma issues, a supportive rather than active approach was recommended when clients' painful emotions surfaced, without the counsellor further eliciting or heightening these emotions. Trainees practised acknowledgement and comfort when clients' pain arose, thus helping clients integrate pain and emotions. One trainee tried to help her clients make the association between emotions held inside for a long time and his chronic pain:

R23...I said to them last time 'as you're releasing a lot of this...trust issues...how has that affected your pain in your body...do you feel that there is any correlation?' and they both...did a 'like, you know there may be a connection here! (T1S8)

Universal-spiritual affirmation and use of meditation. The inclusion of a spiritual dimension in the process of treating clients brought hope, encouragement, and peace to the process. One trainee was surprised at the impact of the universal spiritual dimension on a client:

R2: The one piece, I don't know if this was entirely new, but I think I, in terms of it goes back to the four dimensions and like, the a universal spiritual and the importance because that was certainly I think underscored in my case, my client had a number of, for gambling, she has a number of challenges, you know; and these were, a lot of these were new developments that rose over the course of her involvement....And like it was the first time ever in her life that she

had done that. She was talking about what a positive, encouraging experience, in terms of just increasing her hopefulness and a real sense of like, 'I'm going to be Ok.' Like as long as I continue to really believe that I'm going to be ok. And I think to experience that, you know with her, really underscored for me, how powerful, you know, that universal spiritual dimension can be for some clients. So in that regard, it was something new, something different for me. (TFG-1B)

Process and Challenges of CCT Application

Trainees' described their application of CCT in their case reports during the teleconferences and in their written summaries of the interventions they used when training ended. Although most trainees obtained permission from their clients to tape their sessions, only one played an excerpt of her actual clinical session during the teleconference.

Our analysis of the interventions summary and teleconference notes revealed variability in the appropriateness and adeptness in which different trainees applied CCT skills and knowledge. Trainers used a combination of commentary, role-plays, reframes, and suggestions using CCT concepts, values and interventions, discussion, and questions to guide trainees' clinical application of CCT.

The changes observed in the trainees during the CCT application phase with their couples are described below.

Moving from content-oriented approach to process-oriented approach. Similar to our role-play findings reported in the Level 2 section of this report, the majority of counsellors demonstrated a gradual shift from a psycho-educational approach to a more process-oriented approach over time. The helpfulness of the model in bringing about this shift was mentioned:

One of the things I think is really beneficial about the model is it's really helped me move from content to process, so helping clients focus on the process of what's happening. And I find that the model is really helpful in doing that, in terms of slowing it down, and looking at the ingredients the interaction...I find that particularly challenging, 'cause clients, I feel, really want to sit in content, so I found some of the ideas and skills of this model very helpful...' (F05, T1S8)

The process-oriented approach of CCT allowed clients to explore multiple layers of their issues as opposed to strictly focusing on their behaviour:

P3: A lot of couple counselling before, I think, can be very psycho-ed: this is how you communicate, this is the effect. Instead, the actual structuring things in the session made a big difference, a different learning. But I just found, I really believe that my clients became much more compassionate for each other. And we went to a very much deeper level with the whole spirituality and what they really want to get out of their relationship. Not strictly focussing on the crisis of the gambling, because my clients, I mean, they had you know, fair amount of impact of the gambling, so they had a lot of anger and a lot of conflict. But I feel like we did some of that, but also moved to a different spot as well. So it was more than just sort of crisis intervention with a little bit of tips on how to have a better relationship. It was much more intense, much more thorough, holistic. (TFG- 2B)

Middle Phase challenges. Trainees found the Middle Phase of working with their couples challenging and appreciated the consultation support:

I'll speak for myself, I made reference to the Middle Phase, once I got to that phase I think I started to have more challenges with the implementation of the model and I think (sigh) the familiarity with the model, with the engagement piece and the, you know, the initial stage or

phase of the model, was for the something that was stronger for me than the Middle Phase and how to do the work in the Middle Phase. Yes, so I think that, that's where I started to experience challenges. (R3, TFG, R1C)

Integrated appropriation of CCT interventions. While some trainees applied what they learned from the workshop psycho-educationally with their clients, others were able to facilitate their clients' process and weave the interventions into this process:

K13: I like that it's experiential and helping during the session. I like the fact we're coaching them during the session instead of just sending them home with homework and information to work on. Psychoed seems to tell you what is wrong and how to fix it. I like how in this we're not so content driven but we give them information and then facilitate. It makes it more complex but it's a difference I really value in this model. (T5S12)

Selective and partial usage of the CCT repertoire. Trainees acknowledged that they were able to use only a selected and partial set of interventions from the CCT palette:

R2: I shared this before with [the trainer] and for me it's just, I used bits and pieces of the model as I went along, but I think there's just things that I will not get to know or become more comfortable with unless I try it more, and practice with it more. There's just things in the model that, unless you do it, and experiment with it basically, that you're not going to learn it. (TFG-1B)

The need to continue learning in order to apply further CCT interventions was recognized:

R4: Yes, there's a lot of information in the model, certainly I didn't get anywhere near applying probably half of what's in there, maybe three quarters of it, . I think I just, it's like a small portion of it I was able to apply, so there's a lot that I still need to learn. (TFG-1B)

Overzealous application of CCT interventions. Some trainees were overzealous in applying certain CCT interventions immediately after the workshop and had to be guided to make clinical judgments around the selection and pacing of different CCT components:

R2: So it was a challenge for me in terms of wanting to have the experience of using these various interventions and to be able to have the supervision through them and also needing to stay with my clients and to here and now. So sometimes I would feel like I want to move them, but them not be ready to move yet. So that was part of my own (experience?). (TFG-1C)

Vulnerability and risk. Trainees recognized the depth to which CCT is able to take clients; hence, it also carries greater potential vulnerability and risk for counsellors and clients:

R2...for me, for there being a risk...as being the counsellor is a lot of this work is new work for me...going to those deeper places is also chartering ground that...I haven't really had too much experience of working with... problem gamblers and then going into those deeper issues" (R2, T1S8)

R1: For me, definitely at the beginning, that whole, I had just been introduced to the whole stances and certainly we had done different things like that in training workshops, but to actually take the risk, take some risks that [trainer] encouraged, really was, gratifying for both me and I think I helped the couples move along. So some of those risks in terms of, you know, having couples sort of face each other or hold hands, you know, like I actually had them do the stances in their couple training, that was pretty profound, I think, for me. Also, just some of the

(human?) beliefs I've been able to, I think enrich or add some depth to my own practice and learning because of them, because of those beliefs. (TFG-1C)

Challenges of working with couples. Counsellors revealed the many challenges they found in working with couples in the teleconference transcripts. Among them were motivating both partners to attend the counselling, conflicts between partners in counselling, communication between partners, and risks taken by partners in being open and vulnerable with each other. These were all areas they learned to work with in the CCT application:

CO3: It must be weird for them to be put on the spot...you're making yourself vulnerable and it may be embarrassing so they are taking a big risk by saying to someone, "I really appreciate your for this..." (T5 S12)

Trainees' Feedback on CCT

Listed below are the ways trainees found CCT of benefit in their work with their clients.

Positive focus and energy. Trainees highlighted the value of the positive focus and energy brought into the sessions through appreciations, hopes, wishes, yearnings, affirmations of self-worth, and present and future orientation. They cited the value of family of origin work, but were aware of the need for further training and guidance in this area. Working on communication, as discussed earlier, was a major component in their CCT application.

Structured but fluid. Trainees liked the "movement and fluidity" of CCT and how they were able to adapt and use their own skills when working with clients. They found flexibility coupled with structure, and the freedom to choose and go with the flow:

P1: ...she was able to give us very good, usable feedback, and I think that was good. The other thing she encouraged, and I know it happened a couple of times, is she might have given us feedback, but then the way the next session kind of unfolded, it went in a different direction. But we were able to have that flexibility that we didn't have to kind of stick to it. So we weren't forcing the model onto the couple. (TFG -2A)

Phase 2 training. Corresponding with ratings on the TQ, trainees wanted to see family of origin work, working with pain and trauma issues, sculpting, and the use of meditation and universal-spiritual affirmations in Phase 2 CCT training. It was mentioned in the WFG that personal work for the trainees themselves would be important to prepare them to go into deeper areas with clients:

K13: I'd like more practice. My concern is that the training is very experiential...so by just sitting down and describing it, I'm not sure if my colleagues will get it. I don't feel like a real vet with this, to carry on I need more support so I would love if there was another phase to it. For another phase, I'd like more practice, more family sculpting, and more on the family of origin piece. (T5S12)

CO3: This has been a really good foundation and now I want to do more. (TFG-2I)

Strong potential for problem gambling clients. Counsellors recognized the potential of CCT in addressing deeper issues related to problem gambling, including self-esteem, relationship, and communication:

DO8: I would say, in both [my] cases, it had tremendous impact. I think that one of the things that both couples really liked, is it didn't just focus on the gambling behavior. It went beyond

the gambling behavior but we were able to relate that back. Because I know it's one of the things we often talk about is, gambling has a huge ripple effect, with communication, with trust, with respect and self-esteem. I think that self-esteem is a huge one with gamblers. I think casinos and a lot of the gambling activities really play up on the ego. They get comps, valet parking. It can really help with someone that is struggling with their self-esteem. And I think that if that self esteem improves more in a healthier way, they aren't looking for it from the casino. (T4S12)

A counsellor saw the wider potential of CCT for mental health beyond problem gambling:

P2: Well I think it could, I mean, it could be of great benefit to the whole problem gambling field. I think it could be a great benefit to the mental health sector, to, you know, family and children services, to all kinds of, so not just problem gambling. (TFG-2B))

Along with its promise, some trainees felt the need for a significant amount training and experience in CCT necessary:

D27: The model has tremendous potential. It would be really interesting to see it compared to the Cognitive Behavioural Model. I agree, I can't think of another, besides more of a 12 step oriented treatment that are done in the States, I can't think of anything that would be more different than the Cognitive Behavioural Model compared to your model. I think that would be great, and it has a lot of potential to help gamblers and family members. I think I said this before, the only... and I don't think this is a drawback, it's just an understanding, is to be able to adhere to this model, a person needs a significant amount of training and experience. (T4S12)

Level 5: Impact on Clients

The first two levels of evaluation focused on trainees' reactions to the training and their learning. The third level placed attention on the organizations and their support and change related to the training. The fourth level of evaluation delved into trainees' application of CCT. Level 5 evaluates the impact of the training on the ultimate intended beneficiaries of the training – the pathological gambling couples.

Some may deem an evaluation at the level of client outcomes to be premature given that novices in CCT conducted the application of CCT. However, we decided to collect some limited data on clients to serve as preliminary feedback on CCT as experienced by clients, as this information may implicate future counsellor training. We limited our data collection to: (1) clients' satisfaction; and (2) their outcomes in three dimensions – gambling urges and activities, well-being, and couple relationship. Client reports and outcomes were triangulated with trainee reports on their clients' progress. A same group pre-/post-test design was used for the outcome measurements. We consider this set of data a bonus that would help us pitch our efforts in future training and client outcome studies.

Data Sources and Analysis

Data on client outcomes were collected from four sources: (1) trainees' reports in teleconferences; (2) an item on "positive impact on client" on the TQ; (3) Client Satisfaction Questionnaire; and (4) pre- and post-test data on three previously validated instruments – G-SAS, SWLS, and DAS.

Clients

What do we know about the clients sampled for this training study? Data were collected anonymously as reported by trainees.

Client Demographics

Twenty-four couples took part in the study. Sixteen couples were from Cycle 1 and eight couples were from Cycle 2. Of the problem gamblers, 75% were male and 25% were female (Table 19). The majority of clients (76%) were 40 years of age and older. The mean number of years clients had been married was 20. The mean number of years gamblers had gambled was 12.

Table 19. Client Demographics ($N = 24$ couples; 48 individuals)

Gender of gambler	Male	75%	
	Female	25%	
		gambler	spouse
Age in years	20-29	12%	12%
	30-39	13%	13%
	40-49	33%	42%
	50+	42%	33%
Number of years married	Mean	20 years	
Number of years gambling	Mean	12 years	

Previous Counselling History

Out of all clients, 71% of problem gamblers and 38% of their spouses had received previous problem gambling counselling (Table 20). Only 29% of clients were new intakes of problem gamblers, reflecting that most counsellors selected to work with existing clients rather than new referrals. The majority of both gamblers (75%) and their spouses (90%) had received less than 6 months of previous counselling. The type of previous counselling received by most gamblers (88%) was individual-based; however, a number of problem gamblers and their spouses (43%) had previously received some type of couple counselling. The most common types of counselling received by these clients were cognitive-behavioural and solution-focused therapy. Other counselling approaches reported by clients were brief intervention, narrative therapy, relapse prevention, emotional therapy, “eclectic”, Eye Movement Desensitization and Reprocessing (EMDR), Gamblers’ Anonymous, psycho-education, and “residential counselling”.

Table 20. Previous Counselling History ($N = 24$ couples; 48 individuals)

		Gambler (%)	Spouse (%)
Clients with previous problem gambling counselling		71	38
Length of previous problem gambling counselling	< 6 months	75	90
	6 -12 months	19	0
	>12 months	6	10
Format of previous problem gambling counselling among clients with previous counselling history	Individual	88	50
	Group Couple	59 43	70
Type of previous problem gambling counselling among clients with previous counselling history	Cognitive-behavioural	41	30
	Brief intervention	6	0

	Gambler (%)	Spouse (%)
Solution focused	24	10
Relapse prevention	6	0
Narrative therapy	0	0
Emotional focused	0	0
Unknown	4	0
Other	35	30

Gambling Status and Crises during Study

Fifty-eight percent of clients reported not gambling upon entry into the study, and 33% reported gambling occasionally (Table 21). During the study, 65% of gamblers abstained completely and 35% either continued to gamble or relapsed. Twenty-one percent of couples experienced a crisis during the study. The most common crisis was job loss.

Table 21. Gambling Status and Crisis during Study ($N = 24$ couples)

		<i>n</i>	%
Gambling status upon entry	Not gambling	14	58
	Gambling occasionally	8	33
	Gambling regularly	2	8
Abstention from gambling during study	Abstained	15	65
	Did not abstain	8	35
Crises during study	Crisis experienced	5	21
	Job loss	3	13
	Hospitalization	2	8
	Gambling relapse	2	8
	Suicide ideation	1	4
	Bankruptcy	1	4
	Violence	1	4
	Divorce	1	4
	Legal problems	1	4

Client Termination Status

This set of data was obtained from the trainees' reports on their CCT application. The mean number of sessions conducted by trainees with their couples was 8 (Table 22). The number of sessions conducted ranged from 0-12, as two trainees were not able to find suitable clients during the training period. Trainees reported that 42% of their couples fully achieved their goals within the timeframe of the study, 54% met their goals in part, and 4% achieved their goals minimally.

Forty-two percent of couples had no further counselling plans with their counsellor, 42% elected to continue counselling as a couple with their counsellor beyond the study, and 17% decided to continue individually, in some cases in addition to couple counselling.

Table 22. CCT Client Termination Status ($N = 24$ couples)

		<i>n</i>	%
Mean no. of sessions with couples	8 (range: 0-12)		
Status at termination	Goals achieved	10	42
	Goals partially achieved	13	54
	Goals not achieved	1	4
Post-termination counselling plans	No further counselling	10	42
	Continue counselling as a couple	10	42
	Continue counselling individually	4	17

Client Satisfaction

Clients' reported satisfaction was collected on a one-page Client Satisfaction Questionnaire with five items. Clients rated their overall satisfaction with the CCT received on a Likert scale (1 = highly dissatisfied; 7 = highly satisfied). Four open-ended questions asked participants to list what was most helpful, how they benefited from CCT, ideas, words, and concepts regarding this approach, and any additional comments. Results were analyzed for mean rating on overall satisfaction. Short answers were analyzed qualitatively by content, key words, and themes.

Quantitative Results

The mean client satisfaction rating for CCT was 6.3 ($N = 48$; $n = 31$) with a return rate of 65%. The mean rating indicated a high level of satisfaction substantiated by the qualitative data below. The mean rating given by trainees on the positive impact on clients was 6.6 ($SD = .5$), with identical ratings by trainees from both training cycles (Figure 17). These results triangulated well with the qualitative results from clients' reports of their gains, trainees' reports of clients' progress, and the outcome measures.

Qualitative Results

Counsellor characteristics referred to as most helpful by clients were the counsellor's patience, listening, paraphrasing, non-judgment, understanding, facilitation and encouragement, neutrality, insight, analysis, perceptiveness, respect, and compassion. Clients reported the following benefits from CCT, captured by a sample of their quotes:

- Reachable goals

"Wanting us to communicate and check our goals as we went along"

"assisted in setting potentially achievable goals as a couple"

"talk about reachable goals and working better together"

- Improved honest and open communication

"not having negative feelings without talking them over to each other"

"same page, going forward, caring and sharing, communicate"

"not be afraid to talk about feelings. Better communication skills."

"learn how to listen and be patient and love"

"It has helped me to understand how my partner feels instead of thinking wrongly about how he feels."

"My husband talks more with feeling and is trying to know me better and so I am not so afraid to voice my feelings and concerns."

- Dealing with feelings, hurts and loss

“the counsellor took time to listen and drew out the true feelings we kept in ourselves so we were able to show more and to listen to each other.”

“counsellor assisted with spouse feelings”

“understanding gambling addiction to overcome the hurts and loss”

- Understanding impact of family of origin

“how my actions impact upon my partner and how my ‘family’ is still impacting on my life now”

“family of origin was a great impact for me”

“understand by looking at family history why we behave/react the way we do”

- Insight into the causes of spouse’s gambling urges

“a better understanding of a thing I had no understanding of”

“my therapist gave me some insight into my partner’s urges and reasons for gambling”

“I really think that couple therapy gave me more help because I can understand the problem better.”

“helpful to my husband, the gambler”

- Gamblers’ understanding of the effects of their gambling on loved ones

“it is easier to see both sides of things”

“to talk it out with my wife before I do anything that might upset her or my kids.”

“the sessions were enlightening learning about each other”

“effect of gambling on loved ones”

“Helping my husband to understand how his gambling affects me as well as our relationship”

- Impact on gambling behaviour

“it allowed me to see the reasons for my gambling and how I can improve”

“Loving and understanding the why’s of gambling”

“gambling is no longer all-consuming”

“There is so much more to do besides gambling.”

- Closer relationship and support for each other

“two together can help each other from the heart”

“I now have a support system”

“It’s because we have learned how to talk with each other and try to find out the problem to fix it.”

“Building and sustaining relationships”

“my wife and I are extremely happy with our new-found respect for each others emotions and concerns”

- Self-awareness

“heightened my awareness of issues, I can set the communication patterns or styles in this setting.”

“I have a clearer understanding of gambling motivations”

- Questionnaire can be more use-friendly

“Being a simple man, I would like you to look over the working of many of your questions.”

- Key words

walls coming down, helpful, honest, free, open, calming, hope, very beneficial

- Overall satisfaction

Comments from clients reflect a high level of satisfaction with the CCT counselling they received and said they would gladly recommend this counselling to others:

“I’m very pleased with this therapy model.”

“This has been a great experience, talking through experiences and feelings with my partner present.”

“I found the CCT to be very beneficial in assisting couples with communication.”

“That’s good for people have problem to come here. If I had a chance, I’ll have somebody else come.”

“I recommend for other couples to do this.”

“I recommend this to other couples who are experiencing the same or worst situation”

“Bringing torn lives together again.”

“It has me feel like there is good assistance to overcome addiction.”

“We started the therapy a bit late in the game. I believe we would have benefited even more had we started in the beginning.”

Clients’ Progress and Outcomes: Trainees’ Reports

There was a high correspondence between trainees’ reported outcomes for their clients and the clients’ own reports of the benefits of CCT:

- Decrease in gambling activities and urges

Trainees reported that many clients found better ways to manage their stress, thus reducing their urges to gamble:

CO3: In terms of what was the impact on the gambling behaviour from when they began? She stopped and remained abstinent the entire time. With respect to the frequency and intensity of gambling urges, they are reducing in frequency and they’re less intense, easier to get over when they do start... (T5S10)

One trainee reported that his client developed new hobbies and was better able to handle stresses and used communication as an alternative to gambling:

L14: Well, some of their hobbies, some of their interests, and...purely being able to talk things out and work as a couple and not against one another...and reducing the stressors (T4S10)

- Improvement in couple communication

Nearly all trainees reported on the communication change being primary among their client outcomes:

DO8: their biggest change that they've been able to work on is their communication to each other, and she's even recognizing where she'll say something and as soon as it's out of her mouth she'll say 'wait a minute, I need to rephrase that' (T4S10)

DO8: his tone of voice...you could really pick up the anger, even when he might have been trying to give her a compliment it had a bit of an edge to it...and it's much softer now (T4S10)

T28: Usually when he talks, and that's been the whole thing with him, is his analytical manner...she will start to turn away and not pay attention, but they really gave each other equal time...I just gave them some support and...pointed out posture differences" (T5S10)

T28:...they look at each other a lot with this wonderful smile...they're just truly appreciative of one another...he's actually allowing the...gentle side of him to show..." (T5S10)

CO3: ...he knows that was a huge part of it because all that stuff that he was carrying around with him. And being able to...when he feels anxious to talk to his wife, or to feel comfortable enough to go talk to his partner about what's going on gives him...the feeling of the safety net... (T5S11)

- Insight and emotional release from family of origin work

One trainee talked about how her client experienced a release of some emotions between sessions:

R23: he's had a couple of releases...after sessions, though...crying and sobbing at home and realizing that he's really carrying a lot of his past with him...how hard that's been for him (T1S6)

T28: it was about session five...where she talked about how her father just got up and left one day, she was around seven...she certainly recognized that there's a lot of pain there and that she directed a lot of that pain and blame towards her spouse...she said 'this is the very first time in my life I've ever talked about this'...I could tell during the sessions that she really tried to hold back...part of it... was the discomfort with him there and remembering this is a fellow that would rather just analyze this and say 'well just...work it out and move on...he did make a comment that in hearing her talk about it...he didn't even recognize the full scope of how that has impacted her emotionally and said to her 'I really want to be there and try to support you, and listen more, and talk about it'...and she was receptive to that..." (T5S11)

- Increased awareness of triggers for gambling

FO5: they're new parents right now, and ...he's especially finding that a struggle...he describes feeling quite bored... (T1S8)

CO3: And finances were another trigger...when she felt that things were getting tight financially she would also go and gamble, but now that they're talking more, and they're able to plan things out, and she feels comfortable checking in with him about what's going on with finances and he's less angry so he's not freaking out so much when a bill comes in...so then again that's reduced the one trigger for her...the feeling of not belonging was related to going to gamble... (T5S10)

- Spin-offs at work and with children

Counsellors reported that their clients were more effective at the workplace and as parents because of improved communication, self-esteem, and boundaries:

DO8: One thing she mentioned...is...the spill-over effect into other areas of her life and she's been much more assertive at work (T4S12)

DO8: He feels he's been communicating better with his coworkers...and he's been doing that 'do you mean'...with some of his coworkers that he didn't really get along with before and he's finding that a lot of times what he was hearing isn't what they meant at all (T4S11)

Another couple was able to set up rules for their adult son living at home by asking him to pay rent. Another couple found improved relationships with their children:

CO3: The relationship with the children has improved...they've even noticed how the daughter communicates and responds to them...with less friction because there's less choppy answers, and you know, huffing and puffing and demands....they're approaching their daughter even in a healthier way. (T5S10)

- Increased awareness of self and other

T28: I really think the sculpting was huge for them...visually to watch him see where...Jill put herself in relation to not only him, meaning up on the shelf, just where she put her whole family and everyone in her life, and visually to see his expression on that and the absolute realization that 'I just, I didn't know she felt that way' (T5S10)

GO9: she said, 'I never really thought of how he grew up, I only thought of what I knew and what I'd done all my life, and now suddenly I've been given a clear understanding from him of where he came from, even though I may have been aware of it, I never connected it to our relationship or to his gambling' (T5S10)

- Improved self-esteem and a connection and compassion with self

CO3: it's not only them getting better at their relationship, but it's also their relationships with themselves that's improving through this...finding a better way to be more congruent with themselves...less critical of themselves" (T5S10)

BO2: Another thing...when somebody cannot explain why they did something or they behave certain ways when they see the reason they became the person they became from a broader view...it enhances a kind of compassion in themselves (T3S8)

In summary, trainees' reports on their clients progress triangulated with the ratings and written comments on the Client Satisfaction Questionnaire in showing important changes in areas of communication, couple relationship, self-awareness and insight, understanding problem gambling, changes in gambling urges and behaviour, coping, and self-esteem, with spill-over into work and parenting relationships.

Client Quantitative Outcomes

Table 23 and 24 display the means, standard deviations, and statistical significance of change scores for gamblers and spouses before and after CCT treatment.

Table 23. Gamblers' Outcomes

Variable	Pre-Treatment		Post-Treatment		<i>t</i>	<i>df</i>	Sig. (2-tailed)	
	<i>N</i> = 24	<i>M</i>	<i>SD</i>	<i>M</i>				<i>SD</i>
G-SAS	<i>n</i> = 16	15.87	10.20	9.94	6.55	2.60	15	<i>p</i> = .02*
SWLS	<i>n</i> = 19	22.95	8.71	21.63	6.49	0.88	18	<i>p</i> = .39
DAS	<i>n</i> = 14	98.28	18.35	105.86	20.37	-2.49	13	<i>p</i> = .03*

Table 24. Spouses' Outcomes

Variable	Pre-Treatment		Post-Treatment		<i>t</i>	<i>df</i>	Sig. (2-tailed)	
	<i>N</i> = 24	<i>M</i>	<i>SD</i>	<i>M</i>				<i>SD</i>
SWLS	<i>n</i> = 13	28.12	7.10	24.00	6.64	3.15	15	<i>p</i> = .01*
DAS	<i>n</i> = 19	99.07	25.83	112.85	17.50	-2.56	12	<i>p</i> = .03*

* significant change $p < 0.05$

G-SAS

At baseline, gamblers in this study, on average, scored in the mild range of symptom severity in terms of craving, preoccupation, and hours spent gambling, with scores ranging from mild to extreme (0-41). A significant decrease in severity symptoms was found after treatment, with scores ranging from 0-24, within the mild to moderate range. Means, standard deviations, and changes are reported below.

Gamblers. G-SAS scores were normally distributed for gamblers. Paired values were available for 16 out of 26 cases. Missing values were not replaced. A repeated measures *t* test was conducted to determine whether participation in CCT over 12 weeks decreased the G-SAS scores of gamblers ($M = 15.87$, $SD = 10.20$) compared to immediately after CCT ($M = 9.94$, $SD = 6.55$). Results indicated a significantly decreased value in symptoms of gambling urges and activities immediately after CCT had ended, $t(15) = 2.60$, $p = .02$ (2-tailed).

SWLS

At baseline, on average, gamblers scored in the "slightly satisfied" range of life satisfaction (21-25) based on global cognitive judgment of one's life. They remained in this range after treatment. The spouses, on average, rated themselves in the range of being "satisfied" (26-30) with their lives at baseline, but with a significant decrease in satisfaction after treatment to "slightly satisfied". Overall, gamblers tended to be less satisfied than their spouses in their global assessment of life satisfaction.

Examination of each of the five test items on the SWLS revealed that while the mean for items 1-4 increased for both gamblers and spouses, item 5 showed a decreased score for both. Item 5 stated, "If I could live my life over, I would change almost nothing." A non-significant change score for the gambler and a significantly lower score for the spouse on the SWLS appeared to indicate regret and realization that things could have been different as a result of couple counselling.

Gamblers. SWLS scores were normally distributed for gamblers. Paired values were available for 19 out of 24 cases. A repeated measures *t* test was conducted to determine whether participation in CCT over 12 weeks increased the SWLS scores of gamblers prior to CCT ($M = 22.95$, $SD = 8.71$) compared to immediately after CCT ($M = 21.63$, $SD = 6.49$). Results indicated a non-significant change in the value in life satisfaction immediately after CCT had ended, $t(18) = .88$, $p = .39$ (2-tailed).

Spouses. SWLS scores were normally distributed for spouses. Paired values were available for 16 out of 24 cases. Missing values were not replaced. A repeated measures *t* test was conducted to determine whether participation in CCT over 12 weeks increased the SWLS scores of spouses prior to CCT ($M = 28.12$, $SD = 7.10$) compared to immediately after CCT ($M = 24.00$, $SD = 6.64$). Results

indicated a significant decrease in spouses' life satisfaction immediately after CCT had ended, $t(15) = 3.15, p = .01$ (2-tailed).

DAS

For both gamblers and spouses, the DAS pre-treatment scores were slightly under 100, below the range for married couples. These scores rose significantly to above 100 post-treatment, indicating greater marital satisfaction in terms of consensus on issues, expression of affect, happiness, and commitment to the relationship.

Gamblers. DAS scores were normally distributed for gamblers. Paired values were available for 14 out of 24 cases. Missing values were not replaced because of their large numbers. A repeated measures t test was conducted to determine whether participation in CCT over 12 weeks increased the DAS scores of gamblers prior to CCT ($M = 98.28, SD = 18.35$) compared to after CCT ($M = 105.86, SD = 20.37$). Results indicated a significant increase in dyadic adjustment immediately after CCT had ended, $t(13) = -2.49, p = .03$ (2-tailed).

Spouses. DAS scores were normally distributed for spouses. Paired values were available for 13 out of 24 cases. Missing values were not replaced because of their large numbers. A repeated measures t test was conducted to determine whether participation in CCT over 12 weeks increased the DAS scores of gamblers prior to CCT ($M = 99.07, SD = 25.83$) compared to after CCT ($M = 112.85, SD = 17.50$). Results indicated a significant increase in dyadic adjustment immediately after CCT had ended, $t(12) = -2.56, p = .03$ (2-tailed).

Summary

The couples recruited by trainees were largely from their existing caseload of active clientele with 71% of gamblers and 38% of spouses having received previous problem gambling counselling, predominantly in cognitive-behavioural therapy. The majority of clients had been seen individually, but some were also seen in group and couple settings. This sample appeared relatively stable psychologically with self-reported life satisfaction in the satisfactory range at baseline. However, 21% reported a crisis of some kind during the CCT treatment period, with job loss being the most common. Clients did not receive other services during this study with CCT. Trainees reported that the majority of gamblers at baseline were not gambling or gambling only occasionally, with 8% gambling regularly. This corresponds to the mean scores of gamblers at baseline on the G-SAS in the mild range of gambling symptom severity.

After CCT treatment, gamblers significantly decreased in gambling symptom severity on the G-SAS, with lowered urges, preoccupations, and activity. A good percentage of them migrated into abstinence, from 58 to 65%, as reported by the trainees. This can be triangulated satisfactorily with qualitative data in the teleconference notes.

On the DAS, couple relationship improved from a mild to moderately distressed range of scores before treatment to a significant improvement into a range approaching the norm for average married couples after treatment for both gamblers and their spouses. This improved couple adjustment triangulated well with clients' reports and counsellors' observations.

Interestingly, gamblers and their spouses did not show a significant positive change on the SWLS. In fact, their global cognitive ratings of their life satisfaction went down, especially for the spouse. Gamblers were in the "slightly satisfied" range to begin with, and spouses were in a higher "satisfied" range. An examination of their scores on individual test items revealed the drop in satisfaction hinged largely on their answer to a question that revealed regrets and things they would have done differently. It is queried whether the SWLS, not designed as a clinical measure, would be appropriate for a clinical population, given that counselling often leads one to become more reflective of how one has lived one's life and offers better ways of coping that can be utilized for moving

forward, but not necessarily helpful in remedying the past. The way this item is phrased casts some concerns about the SWLS' validity with this clinical population, especially when results failed to triangulate with clients' own reports on their satisfaction and changes with the effects of CCT. Trainees had also remarked in the focus groups that they wondered whether brief quantitative indicators were sufficient to capture the impressive changes they witnessed in their clients in the course of CCT application.

In sum, clients' self-reports and ratings of their satisfaction ranked high with a correspondingly high evaluation of their progress by the trainees. At the end of an average of eight sessions, according to trainees' reports, 42% of their couples achieved their goals and 54% achieved their goals in part, with nearly all of these couples wanting to continue CCT beyond the study. Some gamblers and spouses intended to continue counselling individually.

Our quantitative results suggest that a significant degree of change in gambling symptomology and couple relationship could be achieved with CCT in a short period of time, with an average of eight sessions, keeping in mind that many of these couples had previous problem gambling counselling of some kind. These client-improved results on gambling symptoms and marital adjustment were well triangulated all around qualitatively and quantitatively. Improvement in self-esteem, family and work relationships, and well-being were reported qualitatively by clients and counsellors, but the strongly affirmed improvements in the latter areas were not sufficiently corroborated with the SWLS. Given the strength of qualitative evidence on the clients' improvement in well-being, and the single item on the SWLS for which they rated lower in the post-test, we conclude that the validity of the SWLS needs to be revisited in future studies for use with clinical populations.

DISCUSSION

The purpose of this study was to evaluate the effectiveness of CCT training in teaching counsellors the key concepts, skills, and values of CCT. A secondary objective was to identify barriers and facilitators for future training. Four levels of indicators were used to evaluate training effectiveness: counsellors' satisfaction, counsellors' learning, counsellors' application of learning, and client outcomes and organizational change (Appendix 2).

Impact on Counsellors

Two cycles of CCT training were conducted over two 15-week periods using two controlled designs. Cycle 1 ($N = 21$) participants were randomized into a training and control group by organizations. The control group subsequently received training and participants were used as their own waitlisted controls ($n = 9$). The results for both training cycles showed highly significant increases in scores on CCT concepts, values, and skills. These results were obtained by comparing (1) two independent groups (randomized training vs. control groups) in Cycle 1, and (2) same group during waiting period (O1-O2) versus pre-post training (O2-O3) in Cycle 2 (see Appendix 3). These training outcome results were obtained from two training outcome measures demonstrating good content and construct validity, internal consistency, and sufficient specificity in capturing changes in the areas of CCT concepts, values, and skills (Appendix 11).

Quantitative results based on these outcome measures are reinforced by qualitative data with the inclusion of open-ended questions that were analyzed by content and themes. The RP was scored both quantitatively and qualitatively. This triangulation of mixed measures and analyses added robustness to the results and interpretations.

Another built-in reliability check was the use of two blind scorers for the WT and three blind scorers for the RP. The inter-rater reliability for the WT was very high (intraclass correlation = .998).

The three independent scorers yielded results that were of combined statistical significance on change in counsellors' skills and interventions, suggesting strong reliability of the RP.

Qualitative findings on open-ended questions on the WT added depth to our evaluation of counsellors' outcomes. CCT concepts applied in practice were better learned than concepts that were philosophical in nature. A shift was noted in counsellors' focus on individual experiences to becoming more systemic in their focus. After training, goals were less focused on gambling reduction and more focused on dealing with the complex and deeper issues underlying problem gambling, such as family of origin issues, couple relationships, communication, and life crises and transitions. Also notable was the shift from viewing the marital relationship as being one of the causes of gambling instead of only a result of it.

A change in counsellors' values was reflected in their greater awareness of themselves in the counselling process and the use of themselves as models in their interaction with clients. There was a greater propensity for reflection and attunement with one's internal process as well as that of the clients'. Also evident was a shift from a value in objectivity, impartiality, and directiveness to greater flexibility, use of clinical judgment, greater freedom in asking questions and following the process, and admitting one's limitations. A sense of hopefulness, optimism, and trust in clients' resourcefulness as well as their own was also evident in counsellors' narratives on open-ended questions.

These qualitative findings from the counsellors' own descriptions correspond with the scorers' comments on counsellors' role-plays. After training, counsellors showed greater attunement to clients' process, more structured and goal-oriented sessions, better exploration of clients' issues, more skilful balancing of couple dynamics, and reframing problems and blame into hopes and wishes. Also demonstrated were interventions to explore inter-generational patterns that impact on the present.

Quantitative analysis showed a significant change in many counsellors' skills. The majority of criteria met with a 25% or less improvement from baseline. This finding corroborates with scorers' comments of observed marked improvement of counsellors' skills, and with remarks indicating room for improvement.

Correlational analysis revealed that regardless of age, level of education, and years of experience, counsellors were equally able to benefit from the CCT training, leading to significant learning outcomes. However, statistically significant positive learning outcomes are not equivalent to individual counsellors' competency and mastery of CCT. Our results suggest that more training and monitored practice would be necessary before counsellors attain a level of competence and confidence with CCT. This finding squared with many counsellors' own self-assessments.

Counsellors' Satisfaction, Barriers, and Facilitators

On almost all items of all measures, both cycles of participants responded similarly to the training. Both cycles reported a very high level of overall satisfaction with the training, with a mean rating of 6.7 out of 7. Both cycles gave very high ratings for wanting to take part in future training ($M = 6.9$) and research ($M = 6.6$) on CCT.

Counsellors' reactions in the questionnaire and focus groups provided us with some rich and valuable information in delineating the barriers and facilitators of the training.

- Facilitators:
 - experiential learning approach (e.g., role-plays, demonstrations);
 - safe, supportive learning environment with a skilled, non-judgmental trainer allowing risks, uncertainties, and questions;
 - retreat setting removed from usual distractions, encouraging inward reflection and outward development of collegiality;
 - small group size for workshop (<12) and teleconference (<5);

- training paid for by research funds;
 - application of CCT supported by teleconference consultations;
 - collegiality and support among participants; and
 - research requirements and framework increased focus, rigour and reflection.
- Barriers:
 - amount of paperwork for research;
 - organizational upheaval for one set of participants, which added stress;
 - teleconference scheduling was not done early enough to rearrange work schedule;
 - pace was somewhat rushed in workshop and teleconference;
 - readings and materials were not distributed before training;
 - intensity of experiential training touched on personal issues; and
 - training did not cover in-depth family of origin influences, pain and trauma, spiritual dimension, and counsellors' personal integration.

The triangulated results drew attention to the counsellors' desire for further training and support in future CCT application. The centrality of the CCT application was highlighted. The teleconference consultation was seen as novel and essential, which gave lasting energy and deepened learning to participants.

Impact on Clients

For gamblers, results indicated significantly reduced gambling symptoms in activities and urges. For gamblers and their spouses, couple communication and relationship improved significantly. Clients reported a high level of satisfaction with a mean rating of 6.3 out of 7 for the CCT received.

Counsellors and clients were equally positive about the results and potential of CCT in their qualitative input. They talked about a greater understanding of gambling causes, increased self-awareness, and new discovery about their spouse's thoughts and feelings. They were happy with a newfound support system with their partner. However, the improved sense of well-being was not borne out on an item on the SWLS. This item focused on clients' assessment of the past and was discussed in the Client Outcomes section. The validity of the SWLS for a clinical population in treatment needs to be reviewed.

Quantitative results on client outcomes should be taken as preliminary and not definitive because of the small sample size, low return rate of questionnaires (60% return rate), one questionable instrument, and lack of control group. However, the results on effects on gambling symptoms, self, and relationships with spouse, family members, and work colleagues strongly support earlier findings with CCT applied with eight couples in pathological gambling (Lee, 2002c). Taken together, the triangulated preliminary findings on the impact of CCT on clients point to the promise of future studies on CCT client outcomes.

Impact on Organizations

A large majority of counsellors felt well-supported by their organization in obtaining this training and its application with their clients. There appeared to be a timeliness to the CCT training in relation to an emerging trend in organizations to adopt more couple-focused counselling, and an openness of some treatment organizations to forge partnerships with researchers. Organizational internal changes can have an effect on participation in training. Future training should pay more attention to collaborating with organizations' internal supervisors, providing more information on CCT to administrators and supervisors, and assisting organizations in developing greater supervisory and consultative capacity to counsellors for the application of CCT.

Unintended Results

- Heightened commitment of agencies, participants, and clients was cited due to the research component.
- Participants expressed an expanded appreciation for the research process and seeing how it can be applied, useful, and relevant to practice.
- Given the intensive nature of the training, the isolated retreat setting seemed important for allowing a quicker and deeper integration of CCT.
- Problem gambling counsellors had a strong enthusiastic response to finding a community of practice to share clinical concerns and knowledge.
- Participants reported experiencing important personal and professional growth.

Limitations and Delimitations

The Principal Investigator was also the trainer and developer of CCT, and is therefore a potential bias in this study. To offset this influence, we relied on the use of independent focus group facilitators, anonymity in the interviews and transcripts, and the use of multiple member-checking by the research team in the analysis and interpretation of data. Independent scorers who did not know the participants, their assigned groups, or the observation points for the measure scored all the outcome measures. Similarly, to guard against clients' feedback bias, Client Satisfaction Questionnaires were returned to the researchers anonymously in a stamped, addressed envelope not mediated by their counsellors.

Other limitations in this study concerning validity and reliability of measures and outcomes were addressed earlier in the discussion.

The sample of counsellor participants in this study represented 25% of Ontario-funded problem gambling programs and 18% of the problem gambling counsellors in 2004. The modal age range of counsellors in this study was 40-49 years. Participants reported a mean of 15 years experience in counselling and a mean of 5 years in problem gambling counselling. Eighty-three percent had a Bachelors or Masters degree. The majority followed a cognitive-behavioural and solution-focused approach to problem gambling counselling and reported a high degree of compatibility between their pre-existing orientation and CCT. For lack of population data, we cannot ascertain how representative this sample is of Ontario-funded problem gambling counsellors and their organizations or of problem gambling counsellors elsewhere. The generalizability of the results of this CCT training to problem gambling counsellors must therefore be moderated in light of the characteristics of this self-selected group of counsellors and their organizations.

Contributions to the Field

Counsellors found CCT to be a new, fresh, and systemic model for working with problem gambling that goes beyond gambling behaviour to addressing its underlying personal and interpersonal determinants. CCT addresses problem gambling by improving couple communication and relationships, raising self-esteem, and enhancing coping capacity. The focus moves from dealing with problem gambling as an individual cognitive-behavioural problem to working with the roots of gambling within the family of origin, couple dynamics, and increased self-awareness. Preliminary but promising results from this study on clients support the strengths of CCT, but are currently far from conclusive. Future work is needed to strengthen the assertions of what CCT intends for client outcomes.

The training model of CCT developed for this study presents an innovation in clinical training that combines an intensive experiential workshop followed immediately by a supported and monitored application of the model for 12 weeks. This experiential, hands-on training model received high

reviews from the participants. The counsellor learning outcomes from both cycles were impressive, although they should not be considered equivalent of to individual counsellors' competence in or mastery of CCT. Although the sample size was small ($N = 21$), the outcome findings were reinforced by similar outcomes in two training cycles with randomized and waitlisted same-subjects controls.

In relation to the training objectives of imparting the concepts, values, and skills of CCT to problem gambling counsellors and whether the training was effective, the evaluation results were strongly positive.

This research developed two CCT training outcome measures, the WT and RP, with sufficient discrimination and specificity that can be useful contributions to the void of valid and reliable clinical training evaluation instruments. A battery of other tools and instruments useful to clinical training have also been developed, including the Self-Assessment Tool, TFG and WFG Interview Schedules, TQ, and Client Satisfaction Questionnaire. As a training evaluation toolset and some tools individually, these instruments elicit quantitative and qualitative data for training evaluation and self-assessment that strengthen the validity of the results through triangulation.

From a research standpoint, this type of research engages counsellors, their organizations, and clients in training and treatment research. It draws on the expertise and experience of clinicians and encourages working collaboratively with them to test new models. Participants in this study reported finding this way of doing research meaningful, rewarding, and conducive to practice. It is a kind of research partnership that promotes collaborative knowledge creation, exchange, and transfer.

Conclusions and Future Directions

Overall, this training evaluation study was rigorously conducted with randomized sites, use of controls for the counsellors, two cycles of training, strong triangulation of qualitative and quantitative measures, and interrelated evaluations across five levels. Results suggested that the CCT training approach worked with this trainer, and that CCT can be learned by counsellors. External validity needs to be established in future studies with other CCT trainers and counsellors.

In response to participants' strong expression of interest, a Level 2 CCT training with an intensified focus on Middle Phase interventions is strongly suggested. The second training can be preparation for a multi-site study of CCT as it is applied to a larger sample of couples. This will give us further quantitative and qualitative data to establish treatment criteria, streamline the CCT process, and further assess the effectiveness of CCT for problem and pathological gamblers and their spouses.

Future research should review the number of items on the training outcomes measures to reduce the load of testing and scoring. Reliability of these instruments should be confirmed with future samples of trainees. It will also be useful to review client treatment outcome measures used in problem gambling treatment research and select measures that would allow for comparisons with outcomes from other treatment approaches.

Future training with CCT will need to segment its training components into graduated units, covering less territory in each training, with each training level emphasizing specific target areas.

Based on our findings, a next-level CCT training seems to be called for to optimize what CCT potentially has to offer problem gamblers and their partners.

We need to ask what levels of academic and professional preparation are necessary for counsellors to adequately and competently deal with issues of childhood trauma, marital distress, coping capacity, poor communication, and social isolation, mental health issues found among pathological gamblers.

We also need to look at what kind of professional development and supervisory capacity are available in gambling treatment programs that intend to provide services addressing these psychological, couple, and family issues so our clients will benefit maximally from our treatment programs.

Gathering the evidence and assessing the merits of an innovation in treatment involve multiple stakeholders. Collaborative and consultative conversations among counsellors, organizations, clients, professional and training institutions, and researchers would be a worthwhile set of initiatives in the future.

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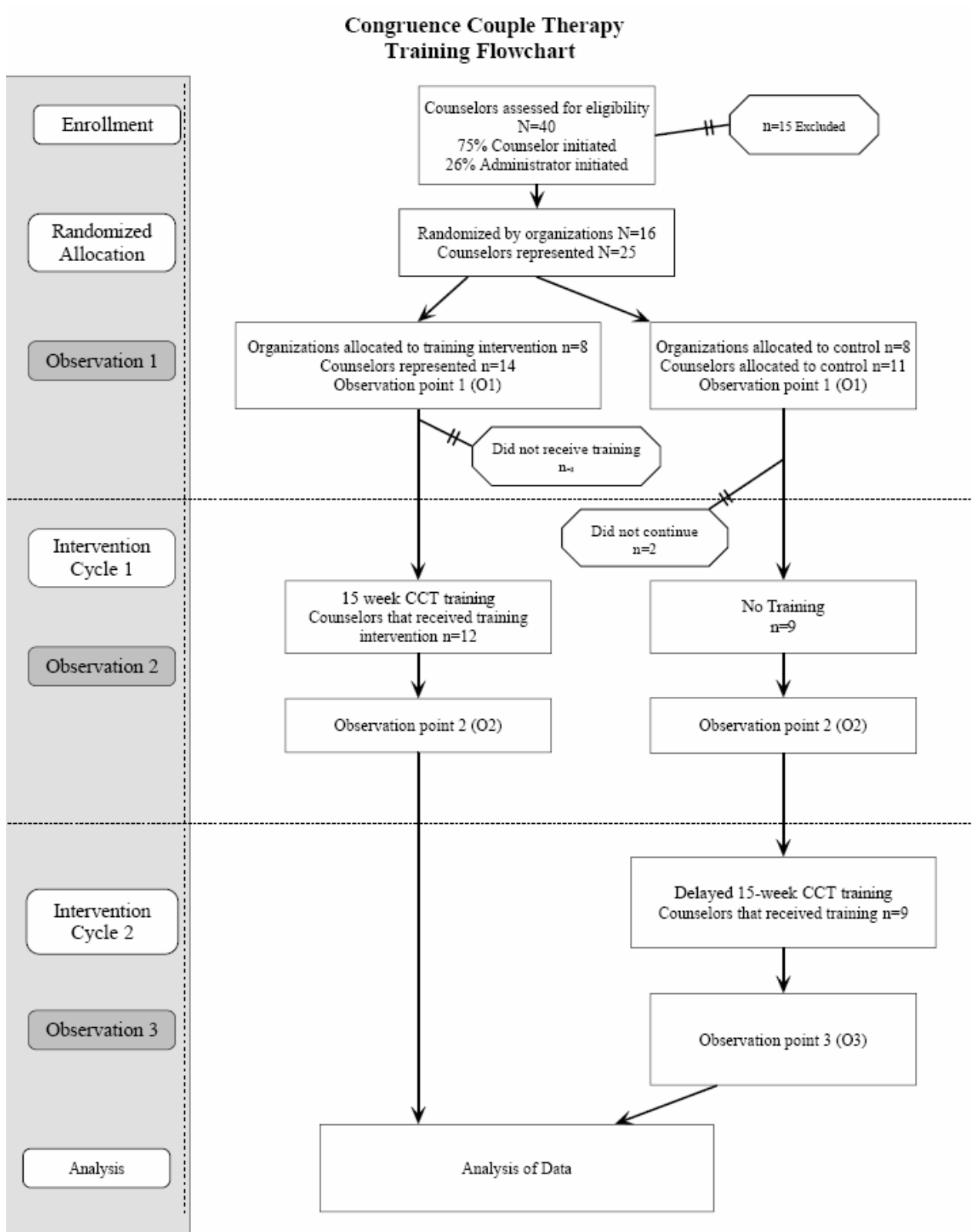
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Appendix 1. CCT Training Flowchart



Appendix 2: Levels of Data Collection

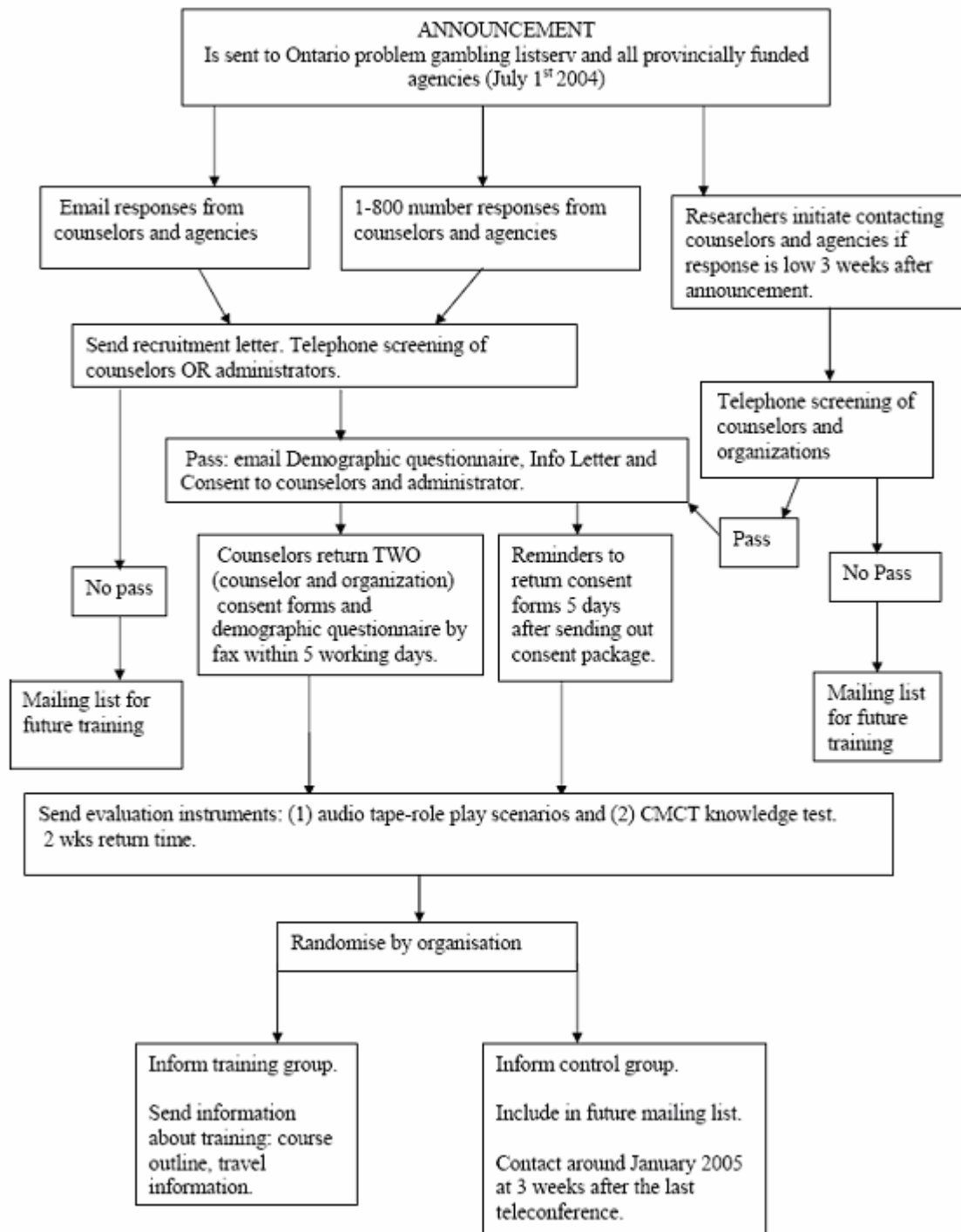
	Evaluation Instruments	Level One: Counsellor's Reactions	Level Two: Counsellor's Learning: Concepts, Values, Skills)	Level Three Organizational Support and Change	Level Four Counsellor's Application: Knowledge and Skills	Level Five (A) Impact on Client's Satisfaction	Level Five (B) Impact on Client's Outcomes
4-Day Workshop	Evening Reflections						
	Workshop Questionnaire						
	Workshop Focus Group						
Application and Teleconference Data	Teleconference Notes and Audiotapes						
	Recruitment Summaries						
	Intervention Summaries						
	Training Questionnaire						
	Training Focus Group						
Pre-post Trainee Outcome Data	Pre-Written Test						
	Post-Written Test						
	Pre Role-play Test						
	Post Role-play Test						
Client Data	Client Satisfaction Questionnaire						
	Dyadic Adjustment Scale						
	Satisfaction with Life Scale						
	Gambling Symptom Assessment Scale						

Type of Data - Quantative data =

Qualitative data =

Mixed Methods =

Appendix 3. Counsellor Recruitment Flowchart



Appendix 4. Evening Reflection Questions

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1. How helpful were the following topics/activities in the workshop for your learning the Congruence Model with couples?

	Not helpful at all					Extremely helpful	
	1	2	3	4	5	6	7
a) Introduction and Family Systems Thinking	1	2	3	4	5	6	7
b) Filters of Perception	1	2	3	4	5	6	7
c) Building a PG Conceptual Framework	1	2	3	4	5	6	7
d) Communication Stances and Communication Games	1	2	3	4	5	6	7

2. What was my most important learning today:

- About counselling...
- About the Congruence Couple Therapy...
- About problem gambling....
- About myself...

3. What did I struggle with most today?

4. What questions do I have that I hope will be answered tomorrow?

5. What would I like to see changed about the training?

6. Other comments:

Appendix 5. Workshop Questionnaire

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The complete questionnaire can be requested from bonnie.lee@uleth.ca

SAMPLE ITEMS ONLY

	Strongly Disagree					Strongly Agree	
1. Training facilities were comfortable and adequate.	1	2	3	4	5	6	7
2. The training was well-organized.	1	2	3	4	5	6	7
3. The instructor fostered a safe learning environment.	1	2	3	4	5	6	7
4. The instructor answered my questions satisfactorily.	1	2	3	4	5	6	7
5. The training built collegiality among participants.	1	2	3	4	5	6	7
6. I know the key concepts of the CCT.	1	2	3	4	5	6	7
7. I know the key values of the CCT.	1	2	3	4	5	6	7
8. I know the key interventions of the CCT.	1	2	3	4	5	6	7
9. The training provided me with enough knowledge and skills to begin implementing the CCT with consultation support.	1	2	3	4	5	6	7
10. I will use what I learned in future work in problem gambling with couples.	1	2	3	4	5	6	7
11. The training fully met my expectations.	1	2	3	4	5	6	7
12. I would recommend the training to a colleague.	1	2	3	4	5	6	7

Appendix 6. Training Questionnaire

© Bonnie Lee

The complete questionnaire may be requested from bonnie.lee@uleth.ca

SAMPLE ITEMS ONLY

	Strongly Disagree							Strongly Agree
	1	2	3	4	5	6		7
1. My CCT skills and knowledge have had a positive impact on my clients.	1	2	3	4	5	6		7
2. It has been difficult to use the CCT in my couple counselling.	1	2	3	4	5	6		7
4. The trainer fostered a safe learning environment	1	2	3	4	5	6		7
5. The trainer answered my questions and concerns satisfactorily.	1	2	3	4	5	6		7
6. The trainer was available when I needed to confer or consult.	1	2	3	4	5	6		7
7. I know the key concepts of the CCT.	1	2	3	4	5	6		7
8. I know the key values of the CCT.	1	2	3	4	5	6		7
9. I know the key interventions of the CCT.	1	2	3	4	5	6		7
10. The training provided me with enough knowledge and skills to implement the CCT with the couples I work with in my setting.	1	2	3	4	5	6		7
11. I will use the CCT in future work in problem gambling with couples.	1	2	3	4	5	6		7
12. CCT conflicts with my own counselling orientation.	1	2	3	4	5	6		7

21. The teleconference consultations were NOT an important part of the training.	1	2	3	4	5	6	7
22. The duration of the training study is just right.	1	2	3	4	5	6	7
23. The entire training fully met my expectations.	1	2	3	4	5	6	7
24. Being a part of this research study has been a rewarding experience.	1	2	3	4	5	6	7

Comments:

Appendix 7. Workshop Focus Group Interview Schedule

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The complete Interview Schedule may be requested from bonnie.lee@uleth.ca

SAMPLE QUESTIONS ONLY

1. What did you learn that was new for you during this workshop?
2. Are there things that were left unanswered for you about the CCT?
3. What do you like or dislike about the CCT model?
4. Did the training provide you with enough knowledge and skills to now implement the CCT with a couple?
Why, why not?
5. What did you like best about your training in the CCT? Least?
6. How could the training be improved?
7. Any ideas or expectations for the follow-up conference calls?
8. Any other comments?

Appendix 8. Training Focus Group Interview Schedule

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SAMPLE QUESTIONS ONLY

1. How would you describe your overall experiences with the CCT training (workshop + teleconference consultations)?
2. Do you think this model will be helpful to PG? How so?
3. What was it like for you to apply the CCT over the last twelve weeks?
4. Please describe the progress, if any, you found in your clients, including PG:
5. What has it been like for you to participate in a research study?
6. Have there been any unintended results or spin-offs from your participation in this project? (for yourself, your clients, your organization?)
7. How would you summarize your CCT training ex.perience from beginning to end, using a metaphor (or image)?
8. What impact, if any, has the CCT had on you personally and professionally as a result of the training?
9. Anything else.....?

Appendix 9. Written Test of CCT Concepts and Values

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The complete Written Test may be requested from bonnie.lee@uleth.ca

SAMPLE QUESTIONS ONLY

1. What 4 interrelated dimensions of the client are addressed by Congruence Couple Therapy ?
2. Congruence Couple Therapy has been characterized as (1) humanistic, (2) existential, (3) experiential, and (4) social constructionist. Define each of these terms in relation to the Congruence Couple Therapy.
3. Name the 4 communication stances commonly found among problem gambling couples.
4. To help a couple expand the depth and range of their communication, what would you encourage them to share with each other? Name 4 areas.
5. Describe the ideas and assumptions that guide your approach in assessing and counselling pathological gamblers. Include in your comments your view of: (i) how pathological gambling develops; and (ii) the couple relationship in pathological gambling.
6. What three adjectives best describe your experience of yourself as a problem gambling counsellor while counselling couples? Qualify each adjective with a brief description or an example.

If you do not have experience providing couples counselling to gamblers, please choose three adjectives that occur to you when you think about yourself doing couple counselling and qualify briefly.

Appendix 10A. Role-play Test of CCT Skills and Intervention

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The complete Role-play Test may be requested from bonnie.lee@uleth.ca

SAMPLE INSTRUCTIONS

Instructions:

We would like to ask you to role play counselling a couple in problem gambling and audiotape your role play for us. The entire role play should take about 40-45 minutes.

This is what you need to do:

- 1) Obtain an audiotape recorder to tape the role play.
- 2) Identify yourself with your Participant Code as you begin to record.
- 3) Find two volunteers to act in the roles of Tom and Karen. Two co-workers would be ideal as they are likely familiar with the issues and challenges of clients who gamble. You might also consider asking your friends. However, please do not ask your clients as this could be confusing for them.

You will assume the role of the problem gambling counsellor.

Role-play Scenarios

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The complete set of Role-play Scenarios may be requested from bonnie.lee@uleth.ca

SAMPLE SCENARIOS ONLY

Tom, 46, engineer

Karen, 45, owner of clothing store

Nick 16

Jason 14

1. Scenario 1 (5 minutes): First / Intake Session with the Gambler

Tom comes in alone for the first session. He tells you that he and Karen have been married for 20 years and they have two boys aged 16 and 14 years. Karen just discovered that Tom has been taking large sums of money out of their joint savings account on a regular basis. When pressed about the credit card debt and the bank debits, Tom finally told Karen that he had run up a big debt from his gambling which started 5 years ago. He plays blackjack and poker at the casino. Tom called in for an appointment to see a gambling treatment counsellor as Karen threatened to leave him.

Tom tells you that Karen was upset when she found out that he had been lying to her and hiding his gambling losses from her. He is afraid to go home after work for fear of more arguments. Karen could throw a tirade. He asks your advice as to what he could do.

Task for therapist for scenario 1:

- 1) Show how you would engage Tom in this first session.
- 2) Show what you would suggest to him.

3. Scenario 3 (5 minutes) Broken Trust

Tom promised Karen that he would quit gambling. In this fourth session of therapy, Tom says he has not been to the casino for three weeks. Karen snickers and says she doesn't think Tom's resolve would last. She finds it hard to restore her trust in him. Tom reacts with anger and tells the therapist: "What's the use!" Karen talks about the impact of Tom's gambling on her.

Task for therapist for scenario 3:

Show how you would intervene to bring about some understanding and reconciliation.

6. Scenario 6 (5 minutes) Consolidating Gains

In session #12, the couple report on the gains they have made for themselves and in the couple relationship.

Task for Therapist in scenario 6: Show how you help the couple consolidate their gains.

Appendix 10B. Role-play Scoring Criteria

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SAMPLE CRITERIA ONLY

Scenario 1: Intake Session with Gambler

Criteria	Score = 1	Score = 2
1.1 Expresses empathy through repeating client words, paraphrasing, reflecting feelings, summarizing		
1.2 Explores topic: going deeper and further into a presented topic		
1.5 Assesses motivation		
1.6 Assesses commitment		

Scenario 3 Broken Trust

Criteria	1	2
3.1 Affirms successes and changes		
3.2 Explores the Intrapyschic layers: feelings, feelings about feelings, thoughts, beliefs, expectations		
3.3 Explores and validates yearnings, hopes and wishes		
3.4 Validates self-worth and encourages self-appreciation and self-love		
3.5 Stays with the here and now and works experientially: slows down the client, explore feelings, stays with feelings, refers to body sensations		
3.6 Directs partner to speak to each other at appropriate moments (not to escalate negativity)		
3.7 Focuses on process, eg. How did you manage to not gamble for 3 weeks?		
3.8 Reflects back to couple their patterns and process		

Scenario 6 Consolidating Gains

Criteria	1	2
6.1 Circular questioning in getting the perspective on a change from both spouse and counsellor		
6.2 Contrasts old and new cycles of interaction		
6.3 Elicits details and specific examples to concretize and anchor changes		

6.4 Summarizes gains and changes		
6.5 Counsellor makes observations of changes couple made		
6.6 Explores intrapsychic and interpersonal processes that led to desired outcomes, e.g. gambling abstinence, reduction of urges		
6.7 Encourages spouse's mutual acknowledgment and appreciation of progress.		
6.8 Identifies remaining issues to be addressed in future counsellor or by couple themselves		
Comments:		

Appendix 11. Development of the Written Test and Role-play Test

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Two measures were developed to assess the impact of the CCT training: a Written Test on CCT Concepts and Values (WT) and a Role-play Test of CCT Interventions (RP).

Written Test of CCT Concepts and Values (WT)

The Written Test on CCT concepts and values consists of two parts. Part One comprises of 7 closed-ended questions for short answers and multiple choice. Part Two comprises of 3 open-ended questions to evaluate participants' concepts and values in the CCT in narratives of their understanding of problem gambling, couple relationship and problem gambling, counselling approach, and their experience of themselves when counselling couples in problem gambling. The close-ended questions are scored objectively according to a scoring rubric. The open-ended questions are analyzed qualitatively by two raters for content and themes reflecting CCT concepts and values.

Criteria for test construction

Criteria for constructing the Written Test as a measure of training outcome consist of the following:

- 1) the test has to exhibit content validity reflecting the key concepts and values covered in the CCT training;
- 2) the test has to be of reasonable length so that participants can complete it within an hour;
- 3) consisting of a quantifiable section amenable to objective standards for scoring;
- 4) consisting of a qualitative section without a scoring rubric but which be analyzed qualitatively by content, key words and themes.

Procedures

- The Principle Investigator identified key concepts and values in the classic Satir model and her additions and extensions forming the CCT.
- A list of items were drawn up based on the concepts and values from the above.
- Three expert counsellors on the Satir Model were asked to rate the salience of each of the Satir-specific items on a five-point scale. All items rated lower than three were discarded.
- The items retained consist of beliefs and values of the Satir Model, communication stances, components of congruent communication, and ways to expand the depth and range of couple communication.
- The CCT items not in the original Satir model were discussed with members of the research team for clarity, relevance to the CCT and wording of the items. One item on the benefits of couple therapy was dropped because of its ambiguity for scoring.
- CCT-specific items consist of the four CCT dimensions, systems approach to therapy, and philosophical orientations for the CCT for items that can be objectively scored.
- Three open-ended CCT-specific items aiming to tap into understanding of pathological gambling development, couple relationship in pathological gambling, problem gambling treatment approach, and counsellors' experience of themselves when counselling couples are included in the WT. These items are believed to have the capacity to capture trainees' individual changes in their knowledge, concepts, value orientation, and practice within their clinical contexts in PG counselling. In case of a small sample size, these qualitative, open-ended

questions would provide valuable data additional to the quantifiable items. They would also allow us to gather a diversity and richness of data not possible with quantitative items alone.

- In all, ten items reflecting the content and objectives of the CCT training constitute the WT.
- Four members of our research team met for 3 sessions to determine scoring criteria for the closed items. A scoring rubric was developed by consensus among the four researchers.

Validity

- Content and construct validity of the WT was ensured by the use of expert judges of items. The results on the WT were compared to the overall improvement on the WT from trainees' ratings (WQ, TQ) and their reports in learning CCT concepts and values (TFG).
- Further content and construct validity of the WT items (Q8,9,10) was ascertained by trainees' ratings and reports of their counselling orientations, change to family systems focus and Interventions Summaries (Appendix 13A, B).

Reliability

- Internal consistency of items on the WT was calculated using the Cronbach Alpha correlation. A reliability coefficient of 0.74 was obtained based on eight items and 20 respondents, indicating good internal consistency of the test.
- Twenty-five percent (n=5) of the returns on the WT were scored by two independent scorers using the scoring rubric which yielded an intra-class correlation coefficient of 0.998, indicating an extremely high inter-rater reliability.
- Three other methods for assessing the WT reliability were based on principles of educational measurement and evaluation (Sax, 1997). These other methods were employed because estimating the reliability of learning mastery tests using classical indices of reliability (e.g., Cronbach's alpha and Kuder-Richardson methods) is largely unsuitable, as these methods are dependent on score variability (Sax, 1997). For instance, if training yields perfect scores for all trainees, the reliability index would be zero. As such, it would be misleading to conclude that the post-test is unreliable, or that there is something amiss with training that has yielded perfect scores. Thus, an item analysis is proposed, using simple calculations to isolate well- versus poorly-performing items, using trainees' pre- and post-training scores which had been found to carry no significant difference at baseline.
- Specifically, two values will be calculated for each item, namely the *difficulty* and *discrimination* of each item. The associated indices, namely the *sensitivity* and *D* indices, will also be described and calculated for each item.

Item Difficulty (*p*)

Item *difficulty*, or *p*, is simply the proportion of people answering the item correctly. For instance, if 4/10 people answer an item correctly, then *p* equals .40. In the case of the Written Test scores among counsellors, the following item difficulties were calculated (see Table A):

Table A. Item Difficulties (*p*) on the Written Test (*N* = 23)

Item	Pretest <i>p</i> Value	Posttest <i>p</i> Value
1	.00	.83
2	.52	.28

3	.04	.28
4	.00	.28
5	.04	1.00
6	.00	.00
7	.17	.61

The item difficulty for Item 1, for instance, was .00 for the pre-test, and .83 for the post-test. This means that no one answered the item correctly on the pre-test but, after training, 83% answered correctly. Sax (1997) provides a rough guideline for estimating item difficulty:

easy items range from .85 to 1.00
 medium difficulty items range from .50 to .84
 difficult items range from .00 to .49.

The items on the WT represent the full range of item difficulties. Thus, item 5 is seen as an easy item, particularly after training. Items 1 and 7 are of medium difficulty. Items 3, 4, and 6 may be considered difficult. Item 2 is behaving oddly, as training has actually decreased the probability of answering this item correctly. Either the training, or the question, needs to be modified in the future. It may be useful to generate an easy item based on the content of item 2 in order to achieve a better balance among item difficulties.

The Sensitivity Index

Criterion-referenced (as opposed to norm-referenced) tests are developed with the intention of evaluating the effects of a training program. The more effective the training, the more the test scores are expected to increase post training. One way to determine *how good* items are is to calculate a *Sensitivity Index* (SI) for each item. The SI is simply the difference between the proportion of students responding correctly on items presented pre-test versus post-test. Although Sax (1997) does not provide thresholds and their interpretation, the SI is relatively easy to interpret as the proportional increase in correct responses. The higher the SI, the more sensitive the item is to improvements in knowledge between pre- and post-tests.

In the present analysis, all items but one were quite sensitive to increases in knowledge, with SI values ranging from .22 to 1.00 (see Table 2). For instance, Item 6 of the WT, training yielded a 100% improvement between the pre- and post-tests. This means that, before training, students had no knowledge of the content area related to Item 6, and all answered the item incorrectly. After training, however, all participants answered the item correctly, reflecting a perfect knowledge of the content area, as measured by the item. At 22% improvement, Item 7 yielded the lowest SI, save for Item 2 with a negative SI. Nonetheless, Item 7 did tap into at least some improvement in the knowledge of the content area it was designed to assess. Item 2 was the only problematic item. The negative SI for this item means that lower scores are yielded *after* training, and indicates that this item must not have been well understood by participants. This finding corroborates the suggestion made previously that Item 2 should be either discarded or rewritten.

Table B. Sensitivity Indices (SI) for Written Test Items ($N = 23$)

Item	Sensitivity Index
1	.83

2	-.24
3	.24
4	.28
5	.96
6	1.00
7	.22

Item Discrimination

Item *discrimination* takes p one step further. Discrimination is an index of how well items distinguish between high-scorers and low-scorers. In other words, if an item is highly discriminating, high-scorers should score well, and low scorers should score poorly. If the probability of responding correctly does not change according to the skill level of the respondent, the item discriminates poorly. A reliable test is one in which the items discriminate well among respondents.

The D Index

One way of determining item discrimination is by calculating the D index. The D index is the difference between the proportion of respondents answering correctly in the high- versus the low-scoring group. It is calculated by first dividing the group into high- and low-scoring groups (in this case, since the sample size is small, we use the median split to divide the group at the 50th percentile on the post-training scores). Then, difficulty indices are calculated for each group. In our case, we can take it one step further, still, and calculate D in the pre- and post-training conditions.

Table C. D Indices for Written Test in the Pre- Versus Post-Training Conditions

Item	Pre-test p Value		Post-test p Value		D Index	
	Low Scorers	High Scorers	Low Scorers	High Scorers	Pre-test	Post-test
1	.00	.00	.67	1.00	.00	.33
2	.44	.56	.11	.44	.22	.33
3	.11	.00	.11	.44	-.11	.33
4	.00	.00	.11	.44	.00	.33
5	.00	.11	1.00	1.00	.11	.00
6	.00	.00	.00	.00	.00	.00
7	.11	.11	.44	.78	.00	.44

Overall, the test discriminates well between high- and low-scorers (see Table 3). We can see that Items 1, 3, 4, and 7 discriminate well between those who have done well on the test overall, and those who have not. In fact, after training, all high-scorers fulfill the criteria of Items 1 and 6, and 78% of them fulfill the criteria of Item 7. Interestingly, low-scorers perform better than high-scorers on Item 3 before the training; but, after the training, high-scorers surpass low-scorers, whose scores remain identical to their pre-training scores. Low-scorers do as well high-scorers on Item 5 ($D = 1.00$), therefore researchers might consider making this item more difficult if distinguishing among very able versus satisfactorily able trainees is desired. (Of course, if the goal is for 100% of participants to fulfill 100% of the criteria after training, the test needs to be made easier, or the training needs to be modified). On the other hand, Item 6 is not answered correctly by anyone in any condition. Researchers might consider making this item easier, or modifying the training to ensure that the concept measured

by item 6 is adequately covered.

Taking into account item difficulty, sensitivity, and discrimination, the WT is a reliable measure that represents a full range of easy to difficult items, distinguishes well between high- and low-performers, and is sensitive enough to measure improvements in knowledge. Only Item 2 was problematic. As recommended, this item should be re-written as an easier item, or discarded if possible.

Role-play Tests of CCT Skills and Interventions (RP)

The Role-play Test consists of six scenarios representing typical clinical vignettes encountered in counselling couples with problem gambling across 3 phases in Congruence Couple Therapy. Participants role-play the 5-minute scenarios with volunteers who are not actual clients. A 58-item observational checklist allows scorers to rate the demonstration of CCT interventions on a 3-point scale. Each skill is rated as follows: 0 = skill not demonstrated; 1 = skill demonstrated; and 2 = skill demonstrated very well in terms of appropriateness, timing, and integration into the flow of the clinical process.

Criteria for test construction

Criteria for constructing the Role-play Tests of CCT Skills and Interventions consist of the following considerations:

- 1) content validity in relation to the key interventions in 3 CCT phases through the course twelve-sessions of couple counselling;
- 2) a standard method of assessing counsellors covering specified content areas so comparisons can be made across counsellors;
- 3) minimal ethical concerns for confidentiality and other issues by not using actual clients;
- 4) the test needs to be completed in a reasonable length of time, preferably no more than an hour;
- 5) the test has to have sufficient specificity to discriminate discreet changes made by the participants before and after training;
- 6) benchmark criteria can be established for the interventions to be scored as CCT interventions;
- 7) parsimonious but thorough and comprehensive in coverage.

Procedures

- The Principal Investigator constructed six standard scenarios representing what typically transpires in three phases of the CCT based on her work with eight case studies when the CCT was first developed. Her interventions will serve as benchmark interventions from which the RP criteria will be based;
- These clinical scenarios were described in writing with specific tasks for the participants to demonstrate in their role-plays with two volunteers who are not clients;
- The time for role-playing each scenario was limited to five minutes;
- The role-play scenarios were piloted with three master's level counsellors: one counsellor with only individual counselling training, one with couple therapy training but not CCT, and one with couple therapy and CCT training;
- The pilot role-plays were audio taped and the interventions were transcribed;
- The pilot interventions were used to ascertain the discriminatory power of the tasks within a 5-minute time period among those with couple therapy training, with CCT training, and with only individual training;

- The pilot testing and pilot counsellors' feedback contributed to further refinements of the tasks;
- The Principal Investigator, also the developer and trainer of the CCT, role-played the six scenarios and her interventions were transcribed to serve as a benchmark;
- Each of the benchmark interventions was distilled into its essence, thus eliminating overlapping items and reducing the entire pool of interventions to 58 observational criteria of interventions expected to be salient in a course of a 12-session CCT application;
- Criteria were checked against the CCT Interventions Skills Checklist for the CCT Training for three phases of the CCT to ensure that the criteria correspond to targets of CCT training.

Validity

Content and construct validity of the Role-play items are assessed by their correspondence to the checklist of CCT Interventions Skills used in the training. Results of the Role-play scores are commensurate with the trainees' reports of their levels of self-assessed competence and confidence in the CCT. Items of observed change also correspond to the skills trainees reportedly used with their clients during the trial application during the teleconferences and in their summaries of interventions. Thus, these triangulated outcome indicators suggest a strong content and construct validity to the representativeness of CCT skills demonstrated in the Role-play Test.

Reliability

- The observational scoring criteria were tested in two training sessions with three scorers on six sets of role-plays to determine the reliability of scoring with these criteria.
- Each criterion is scored on a scale of 0-2; 0 = intervention not demonstrated at all; 1 = intervention is used; 2 = intervention is used very well in terms of appropriateness, timing, integration with the flow of the session. Raters are asked to record the interventions verbatim for each scenario. Although the criteria for scoring are organized according to scenarios, raters are allowed to go to other sections to score an intervention if it meets a criterion in an earlier or later section. Raters will also supply a brief qualitative evaluation of each scenario in the role-plays in addition to their numerical scoring.
- Three raters with no knowledge of the participants were used for the scoring of the role-plays in the study. The distribution of the audiotapes did not allow us to obtain sufficient duplicate scores by two different scorers to conduct a meaningful inter-rater reliability test for the time being.
- Internal consistency of the items was gauged by Cronbach Alpha correlation yielding a coefficient of 0.79 based on 58 items and a sample of 16 respondents.
- correlations of items
- A Cronbach Alpha reliability coefficient of 0.70 was obtained based on baseline O2 and control group scores at O2 with 9 respondents. However, we note that this reliability reflects a considerable lapse of time between the two administrations and hence might not reflect a true test-retest reliability, which is normally done within a week.
- Further reliability analysis was conducted using the three methods of Item Difficulty (p), the Sensitivity Index, and Item Discrimination Index described earlier. These results will inform further development of the Role-play Test of CCT Interventions and Skills.

Sensitivity Index

An assessment of SI values for the RP scenarios indicates that all six of the scenarios contained at least some items that were sensitive to improvements in CCT skills. Scenario 3 yields the highest sensitivity

to the impact of improvement in training (i.e., 39%). Scenario 1, in contrast, is the most problematic in terms of showing any impact of training, with 5/7 items yielding a training impact of less than 10% improvement in scores. This finding suggests that, although the scenarios all yield valuable information, the number of evaluation points within each scenario may be reduced, or the items modified, if possible.

Table D. Sensitivity Indices (SI) for Role-play Test Items ($N = 16$)

Item	Pre-test p Value	Post-test p Value	Sensitivity Index
1.1	.23	.50	.27
1.2	.41	.44	.03
1.3	.05	.13	.08
1.4	.00	.06	.06
1.5	.05	.19	.14
1.6	.09	.06	-.03
1.7	.23	.25	.02
2.1	.14	.19	.05
2.2	.05	.25	.20
2.3	.05	.38	.33
2.4	.05	.25	.20
2.5	.00	.06	.06
2.6	.00	.19	.19
2.7	.00	.00	.00
2.8	.05	.06	.01
2.9	.05	.38	.33
2.10	.05	.06	.01
2.11	.00	.00	.00
2.12	.05	.19	.14
2.13	.00	.06	.06
2.14	.09	.13	.04
2.15	.05	.06	.01
3.1	.05	.13	.08
3.2	.32	.63	.31
3.3	.05	.44	.39
3.4	.14	.06	-.08
3.5	.14	.31	.17
3.6	.09	.44	.35
3.7	.00	.06	.06
3.8	.05	.13	.08
4.1	.05	.13	.08
4.2	.18	.44	.26
4.3	.05	.13	.08
4.4	.00	.00	.00
4.5	.14	.19	.05
4.6	.05	.00	-.05
4.7	.00	.19	.19
4.8	.00	.19	.19

Item	Pre-test p Value	Post-test p Value	Sensitivity Index
4.9	.00	.31	.31
4.10	.00	.00	.00
5.1	.32	.56	.24
5.2	.14	.13	.01
5.3	.18	.25	.07
5.4	.09	.25	.16
5.5	.00	.25	.25
5.6	.00	.19	.19
5.7	.00	.13	.13
5.8	.00	.06	.06
5.9	.00	.00	.00
5.10	.09	.38	.29
6.1	.09	.13	.04
6.2	.14	.25	.11
6.3	.23	.44	.21
6.4	.05	.25	.20
6.5	.27	.19	-.08
6.6	.00	.25	.25
6.7	.00	.25	.25
6.8	.00	.06	.06

Note: Bolded items are those yielding over a 10% improvement after training.

RP Item Difficulty and Discrimination

To review, item difficulty is represented by p , the probability of responding to an item correctly. P is compared for high- versus low-scorers, and should be higher for those who achieved higher overall scores on a test. Discrimination is represented by the D Index, which is the *difference* between the probability of correct response for those scoring high and those scoring low on a particular item. Negative D values indicate that those who scored more poorly overall actually have a higher probability of achieving a higher score on the item than those whose overall scores were higher. Items such as these require reconsideration, as the test -- in order to be valid and reliable -- must be tapping ability in a linear fashion (i.e., the higher the score, the higher the ability). For the sake of parsimony in our explanation, and because the test is intended as a gauge of post-training skill level, we will focus only on the p values and D indices for post-test scores (see Table 5 for all p and D values).

As can be seen, the RP test was much more difficult than the WT. All items were highly difficult (p between .00 and .49) for low-scorers, whereas 46/58 (79%) of items were highly difficult for high-scorers. Also for high-scorers, ten items (17%) were of medium difficulty, and only one item could be interpreted as having been easy (with a $p > .85$). In terms of discrimination, a majority of the items discriminated in the appropriate direction. That is to say, 74% of items were answered correctly more often by high-scorers than by low-scorers. In other words, there was an absence of discrimination, or negative discrimination, on 15 items (26%; i.e., items 1.3, 2.6, 2.7, 2.8, 2.10, 2.11, 2.15, 4.3, 4.9, 4.6, 4.10, 5.2, 5.9, 5.10, and 6.1).

Table E. Difficulty (p) and Discrimination (D) Indices for Role-play Test in the Pre- and Post-Training Conditions

Item	Pre-test p Value		Post-test p Value		D Index	
	Low Scorers	High Scorers	Low Scorers	High Scorers	Pre-test	Post-test
1.1	.21	.25	.13	.88	.04	.75
1.2	.36	.50	.38	.50	.14	.12
1.3	.07	.00	.13	.13	-.07	.00
1.4	.00	.00	.00	.13	.00	.13
1.5	.00	.13	.13	.25	.13	.12
1.6	.07	.13	.00	.13	.06	.13
1.7	.21	.25	.13	.38	.04	.25
2.1	.14	.13	.13	.25	-.01	.12
2.2	.00	.13	.13	.38	.13	.25
2.3	.07	.00	.13	.63	-.07	.50
2.4	.00	.13	.13	.38	.13	.25
2.5	.00	.00	.00	.13	.00	.13
2.6	.00	.00	.25	.13	.00	-.12
2.7	.00	.00	.00	.00	.00	.00
2.8	.07	.00	.13	.00	-.07	-.13
2.9	.07	.00	.13	.63	-.07	.50
2.10	.07	.00	.13	.00	-.07	-.13
2.11	.00	.00	.00	.00	.00	.00
2.12	.07	.00	.13	.25	-.07	.12
2.13	.00	.00	.00	.13	.00	.13
2.14	.07	.13	.00	.25	.06	.25
2.15	.07	.00	.13	.00	-.07	-.13
3.1	.07	.00	.00	.25	-.07	.25
3.2	.36	.25	.50	.75	-.11	.25
3.3	.00	.13	.25	.63	.13	.38
3.4	.07	.25	.00	.13	.18	.13
3.5	.14	.13	.25	.38	-.01	.13
3.6	.07	.13	.25	.63	.06	.38
3.7	.00	.00	.00	.13	.00	.13
3.8	.00	.13	.00	.25	.13	.25
4.1	.00	.13	.00	.25	.13	.25
4.2	.21	.13	.25	.63	-.08	.38
4.3	.07	.00	.00	.25	-.07	.25
4.4	.00	.00	.00	.00	.00	.00
4.5	.07	.25	.00	.38	.18	.38
4.6	.00	.13	.00	.00	.13	.00
4.7	.00	.00	.00	.38	.00	.38
4.8	.00	.00	.00	.38	.00	.38
4.9	.00	.00	.38	.25	.00	-.13
4.10	.00	.00	.00	.00	.00	.00

Item	Pre-test <i>p</i> Value		Post-test <i>p</i> Value		<i>D</i> Index	
	Low Scorers	High Scorers	Low Scorers	High Scorers	Pre-test	Post-test
5.1	.43	.13	.38	.75	.30	.37
5.2	.07	.25	.13	.13	.18	.00
5.3	.21	.13	.13	.38	-.08	.25
5.4	.14	.00	.13	.38	-.14	.25
5.5	.00	.00	.13	.38	.00	.25
5.6	.00	.00	.00	.38	.00	.38
5.7	.00	.00	.00	.25	.00	.25
5.8	.00	.00	.00	.13	.00	.13
5.9	.00	.00	.00	.00	.00	.00
5.10	.14	.00	.38	.38	-.14	.00
6.1	.07	.13	.13	.13	.06	.00
6.2	.14	.13	.00	.50	-.01	.50
6.3	.29	.13	.25	.63	-.16	.38
6.4	.21	.00	.13	.38	-.21	.25
6.5	.00	.38	.00	.38	.38	.38
6.6	.00	.00	.13	.38	.00	.25
6.7	.00	.00	.00	.50	.00	.50
6.8	.13	.00	.00	.13	-.13	.13

The overall evaluation of the sensitivity, difficulty and discrimination of the items constituting the RP test indicates that nearly half the items were sensitive to the impact of training, and a majority of items discriminated well. Items were too difficult overall, however, and consideration should be given to simplifying a proportion of items within each scenario to improve the balance among easy items, and those of medium and high difficulty. Doing so would also improve the sensitivity of items to pick up on the impact of training, and would improve item discrimination (as an item too difficult for even high-scorers cannot discriminate at all between high- and low-scorers). Of note is that Scenario 2 contained the largest number of problematic items. This set of RP tasks, in particular, should be re-examined and the problematic items revised, or eliminated if possible. Particular attention should be paid to modifying items 2.6, 4.9, and 5.10. These items had adequate sensitivity, but non-existent or negative discrimination.

Although several modifications have been recommended to the RP test, the number of changes is reflective of the large number of items in the test. There remain a large number of adequately sensitive and discriminating items. The recommended focus would be to modify items to better represent a wider range of difficulty levels.

Appendix 12. Recruitment Summary

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- Date:
- Pseudonym:
- One partner meets/ met DSM-IV Pathological Gambling criteria: YES NO
- Brief description of couple background and general presenting issues (no specific identifying data please) :
- Your reasons for selecting this couple:
- Any other Concurrent Diagnosis
of Gambler:

of Spouse:
- Previous and Concurrent Treatment (e.g. PG group sessions; PG individual sessions; anxiety clinic etc.). Please indicate approx. # of sessions and time period covered, e.g. Gambler has been attending a 2-hour PG group /week for 8 weeks.

Other treatment for gambler:

Other treatment for spouse:

- Potential Risks:
- Potential Benefits:
- Your comfort level with this couple (Rate 1-10, 10 = highly comfortable):
- Your concerns:
- Other comments:

Appendix 13A. Intervention Summary A

NAME: XXXX XXXXXXXX

SUMMARY**Session I**

We reviewed past success from previous couple counselling that we had been engaging in and then completed new goals which were concrete and specific for the 12 session research study.

By looking at new goals we were able to notice commonalities in their goals and desires and they were able to provide each other with some perspective on the changes they wanted to see. Reframes were used when goal setting so that change was seen as positive and achievable, not “fixing problems”. We also did review some information on the communication stances that occur in relationship

We also focused on hopes and wishes and good intentions that they have always had in their relationship.

Session II

Session two focused on increasing their understanding of each other in a non-blaming way. We also elicited some emotion and did some coaching so that they were able to speak more clearly to each other about what they want and need in their relationship. Much greater understanding was given to Leo about the affects of his gambling on Rosa and Leo was able to explain to Rosa the role gambling has played in his life.

In summary, during this session, we focused on shifting perceptions and interpretation by focusing on communication stances, and old behaviours were seen in a non-judgmental way and change was seen as effective and doable.

Session III

Family of origin and the concept of family mapping was introduced as a way to understand old relationships to make present changes. We also focused on intra-psychoic work- becoming more aware of their feelings and body awareness so that each Leo and Rosa were aware of their own internal states and then were able to see the connection on how their internal states affected the other and how their communication was affected by their own internal states. The issue of congruency became much clearer once they were able to see that they also needed to focus in on their feelings and body awareness. The issues of body awareness and feelings were elicited by asking them how they felt and as well, by acknowledging their body stances that I was able to observe. We also started using the temperature reading as a way to gauge their relationship status, and to begin to have a structure for communication. The temperature reading helped them to focus on hopes and dreams, and concerns were normalized and that they can find their own solutions to increase their sense of self competency and coping skills.

Session IV

Family mapping was continued in Session IV. When we were completing the family mapping, we once again focused on internal states so that with internal recognition, they would be able to shift perceptions of each other, and as well, be able to ask more clearly what they were needing and to be able to gain better understanding of their own behaviours that are based on feelings and body awareness and not simply behaviours that “just occur”. Intergenerational connections were made while we were doing family mapping to see how family of origin has influenced each person and to gain better understanding individually and for each other. We focused on how their behaviour was affected and began to focus on what changes they could now make in their present relationship without getting stuck in the past. By looking at family of origins, their positions and behaviours were normalized and as well greater compassion was displayed for their parents when they received better understanding of their parent’s behaviour by looking at the family in a larger picture and not simply focusing on specific things that happened in their family of origin.

Session V

During this session we were using the “iceberg” model to connect intra and inter-psyche aspects of self. They were able to gain greater understandings of their self and began to look for resiliency. They also started checking out each others responses instead of making assumptions by looking at pieces of communication. Their own internal resources were acknowledged focusing not only on their feelings but also their feelings about their feelings and they were able to see their strengths.

Session VI

This session included restructuring communication and we continued with increased awareness of feelings and expressing their feelings. We also refocused their goals to look at successes that have been taking place in their relationship and reframes were made to validate their hopes and wishes. During this session, we were focusing on the awareness of self, accepting self and then connecting these two things so behavioural changes could be continued to be made. We focused on using the new information about themselves to especially assist Leo in identifying with his stress at work that tends to lead to gambling. The new awareness regarding Leo’s triggers and Leo’s self competency to deal with the triggers also assisted Rosa to see that change is possible in their relationship. Communication issues were also discussed and woven into their present day concerns so they were able to normalize conflict and see that under stress they may go back to old behaviours, but with focusing on the present, they could make choices to use a more congruent communication.

Session VII

We completed the self and values meditation, and as well the self esteem maintenance tool kit. We discussed values and focused on change by choice and focused on the positives of changes. We were able to continue with the theme of connecting personal awareness with interpersonal interactions. I used the ice-berg model as a point of reference and seeing the layers of change.

Session VIII

We started some family sculpting to acknowledge and validate that some needs were not met in childhood and to focus on how they can now meet those needs in adulthood. We were able to increase awareness of family of origin issues and to be able to focus on internal resources and to be able to ask

for support from each other when they need it. We focused, not only on the fact that things are getting better in their relationship, but focused on what they are actively choosing to do to make things better. Again, affirming that they are making choices and that things are not just happening beyond their control. They were able to acknowledge to each other the changes that they are seeing and the acknowledgement and appreciations that they have done outside of counselling were also affirmed and supported. I encouraged them to continue to make these changes outside of the counselling session.

Session IX

We completed the family sculpting, and as well, focused on their yearnings. We discussed fantasy versus vision and connected self esteem with their present coping system. Once again, their communication changes were validated as they present as being able to ask for what they need clearly from each in their day to day lives. Weaving was once again done in this session to weave some of the needs that Leo thought he did not receive as a child which was his concern with bonding and in fact he was able to see how in fact he has bonded with people. He was able to gain some insight that he has been making some changes, therefore shifting his perception of himself as victim, and instead seeing himself as someone who is resilient and is able to cope.

Session X and XI

We summarized changes they have made individually and interpersonally. Change by choice was once again discussed. We integrated their individual and interpersonal changes with the goals of the CCT model and reviewed their original goals for counselling. They were able to see that they have reached most of their goals and were able to identify that some of their goals are “life-long journey goals”. I empowered them in that they reached so many of their goals and they have been so committed to their relationship that they were able to drive in from another town for 11 sessions.

We also checked to see if there any upcoming stressors that they need to be aware of-none were identified.

We focused on the deep level of changes that they identify –i.e. Spiritual awareness, feeling awareness and the awareness of the other person. Gambling changes were also discussed and we focused on the fact that the gambling changes have significantly changed their relationship and that the new awareness of self and other has greatly reduced the need to gamble.

Appendix 13B. Intervention Summary B

Notes: Capitalized phrases are trainer's comments. Names in summary are pseudonyms only.

NAME: XXXX XXXXXXXX

SUMMARY

- Supported a commitment to process and relationship through **building an alliance** this was achieved by **scaling of commitment** at the beginning and then after 2 sessions (significant improvement) and working at a **trusting equal alliance**
- Supported an acknowledgement by both clients of appreciating what each other is dealing with: acknowledged through understanding **and identification of communication stances, appreciation statements**
- Unpacked some of the reasons why those stances made sense (coping with past, protecting the other) then looking further at **why they aren't working for the relationship or the problem (gambling)**
- **Identified pattern in relationship** that was contributing to the gambling: holding on to stress, stress builds, chooses not to expose Abby to stress (protecting her) Sam gambles to relieve stress, Abby becomes anxious but holds emotions in so that she does not contribute to stress (thus relapses) but feels alone
- Acknowledged why the gambling was happening (coping with the buried stress and holding onto old anger) and **what could be different** so that problem gambling and the associated consequences could no longer be an issue, this was achieved by looking at a decisional balance regarding the theme of "talking about problems"
- **Inter-generational reflections** from Sam: understanding how the adoption secret was interpreted as betrayal and how that information left him feeling defensive "me against the world" (blaming) **BELIEF SHIFT** and thus coming in the way of trusting Abby.
- Unpacking **Abby's family rules around support and conflict** and how that plays out in relationship. Abby recognized she was placating and holding on to her stress often feeling unwell. She acknowledged that by speaking about this she was able to feel better.
- Further, re-examine the **intentions of parents** from a congruent perspective and allowing him to **perceive the betrayal differently thus alleviating some of the anger PERCEPTION SHIFT**
- Looking at Sam's **expectations of parents EXPECTATION SHIFT** and how it may/may not be reasonable to expect parents to be able to understand or react well to his betrayal considering how he perceives their current stances
- Establish **new goal ADJUSTMENTS**: consider other ways to let go of past anger, hurt and other emotions and move towards peace **PEACE AS HARMONY OF PARTS**
- Recognition of gains during counselling: Sam able to consolidate gains **DEEPENING AWARENESS AND INSIGHT; NEW CHOICES; CONTRASTING PAST AND PRESENT** by reflecting on how his perception of past events have effected his life and how those perceptions may be observed in a different way, ability to start the process of identifying and letting anger go, identify positive impact on their relationship including trust and understanding of partner, and improved communication

Appendix 14. Self-Assessment Tool

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This self-assessment tool is designed to help counsellors follow a high standard of counselling practice when using a new innovation such as the CCT for Couple Therapy in problem gambling that is in its early phase of development. The goal of counselling is always to serve your clients' best interests and maximize their benefits from your services.

Each counsellor's context of practice is different, including type of caseload, staffing, existing formats and modalities of treatment, organization treatment philosophy and policies, service delivery model, funding, supervision etc. As well, each problem gambling counsellor's training and experience differ. These variables can support or pose practice challenges and constraints in your work with couples using the CCT.

Doing a self-assessment of your practice when adopting any new model of treatment will help you reflect on your practice and minimize risks. Counsellors are encouraged to monitor and document in their files the effects of various elements of the CCT as they apply in whole or in part with their clients. Monitoring, documentation, and evaluation will contribute to your practice, future research and development of the CCT for problem gamblers.

Reflecting on your current case or current practice, have you carried out the following steps:

1. I am clear about my criteria in using the CCT:

- I have considered all available options of treatment for my clients, including the CCT.
- I have decided that all or part of the CCT would be beneficial to my clients.
- I have documented in the file the rationale for my clinical decision in using CCT with these clients.

2. I inform clients of the benefits, limitations and potential risks of using the CCT in our treatment setting:

- I use language that is appropriate to the age, education, and cultural background of the clients to communicate with them.
- I inform clients of the newness of this approach, its philosophical orientation, and the four areas of intervention of the CCT, namely, the intrapsychic, interpersonal, intergenerational and universal-spiritual.
- I discuss the benefits, limitations and potential risks of the CCT, an innovation that has preliminary promising results. I also point out that the CCT is still in the process of being tested and developed.
- I refrain from making any guarantees of success.

- I mention the potential distress and painful feelings that may arise during treatment of this nature.
- I point out the focus on enhancing client's resources, client's ability to make choices, couple communication, making connections, expanding coping capacity for stress and distress to reduce gambling urges and activities.
- If I am changing my role from working with the client(s) individually or in a group format to a couple format, I discuss how my role and function will change.
- I discuss the potential risks resulting from this change, including loss of an individual counselling relationship, my need to re-balance the alliance if one spouse has been seen previously on an individual basis, and confidentiality issues.
- I provide clients with a written list of alternative services and clinicians in-house and in the community for services from which they could choose for their desired outcomes.
- I allow clients to raise questions and concerns and I answer these queries to their satisfaction.
- I allow clients to choose the best clinical services and formats that best serve their goals and progress.

3. I make a clear demarcation for the beginning of couple work :

- I open a new file for the couple as my new "client unit" with appropriate signed consents.

4. I accurately communicate my professional credentials to my clients and others:

- I use my appropriate title.
- I do not present myself as a couple or marriage therapist.
- I communicate the extent of my training and experience with the CCT, e.g. having attended/ completed a 40-hour training program.

5. I maintain client confidentiality:

- I discuss the limits to confidentiality and other confidentiality policies of my organization with the clients.
- I discuss the Limitations to Confidentiality in Treating Couples and Families in not holding secrets for individuals when I work with the couple/family unit, if this is the policy my organization and I subscribe to.

- I have the clients sign a written understanding of the limitations to confidentiality discussed.

6. I respect the client's independent voluntary decision to decline and withdraw from treatment:

- I inform the clients they have the right to refuse or interrupt any procedure or intervention at any time in the treatment process.
- I inform the clients they have the right to withdraw from treatment at any time.
- I ensure that the consent from each spouse is made voluntarily and independently to engage in couple work.

7. I consult with the clients when establishing a time-frame for treatment and setting realistic goals and plans for review and evaluation:

- Counsellors work within their organization parameters for the types of services offered and the no. of sessions to be given to a program or modality of treatment.
I inform my clients of the time-frame for working with them as a couple.
- I inform my clients that the treatment will be proceed with their ongoing feedback and input.
- At the end of the agreed upon no. of counselling sessions, the treatment process will be reviewed and further plans will be made collaboratively if there are outstanding issues.

8. I monitor, evaluate and modify my interventions based on the client's feedback and outcome:

- I note my interventions and the client's responses in my clinical notes.
- I monitor my client's responses to my interventions and adjust them accordingly.
- I plan and formulate the next steps in my clinical notes before the next session.

9. I practice within the limits of my individual competence in working with couples:

- I prepare, prioritize and plan my interventions by going to the relevant resources to increase my competence and confidence in working with couples.
- I refer my client or clients to another professional when the expertise required exceeds my training, experience and knowledge. (e.g. trauma, abuse, psychiatric disorders, other addictive behaviours, financial and legal assistance, or marriage and family therapy).
- I seek consultation, supervision, peer-supervision on a regular basis and when clients present with conditions outside of my expertise.

- I go to the literature, workshop materials and other sources of information and knowledge to expand my knowledge and skills.
- I continue with education and training on working with couples.
- I continually acquire new knowledge, skills, and updates on ethical issues to provide high quality service.

9. I have criteria to end treatment:

- I discuss with the clients their status at the end of the counselling contract and note any outstanding issues at the end of treatment.
- I document my termination and referral criteria in the client file.

10. I respect and stay informed of the practices, policies and regulations governing my practice:

- I respect and stay informed of the practices, policies and regulations of my profession, my employing agency, and the Ontario government in my work.
- I will take the initiative of improving such policies and practices when doing so will better serve the interest of my clients.

References:

College of Audiologists and Speech Language Pathologists of Ontario (2005). Self-assessment tool in pursuit of quality practice. Toronto: CASLPO.

Canadian Problem Gambling Certification Board (1999). Personal code and ethical standards. Windsor: CPGCB.

Appendix 15. Client Satisfaction Questionnaire

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Thank you for participating in our Congruence Couple Therapy Evaluation study along with your counsellor.

Your contribution is important to help us find better ways of treating gambling problems.

We ask that you take about 15 minutes to fill out this satisfaction questionnaire and return it in the self-addressed, stamped envelope provided.

You DO NOT have to put down your name.

1. My overall satisfaction with the couple therapy I received is:

1 2 3 4 5 6 7

Highly Dissatisfied

Highly Satisfied

2. The things my therapist did and said that seemed most helpful to me were (3-4 sentences or phrases):

3. I feel I have benefited from the couple therapy in the following ways:

4. When I reflect upon the model or approach my therapist was using, I think of ideas, words, and concepts like (3-4 sentences or phrases):

5. Other comments:

Thank you very much for participating in the study and doing this evaluation for us.

Appendix 16. Trainees' Satisfaction Variables

Variables	Graph	Instrument and Items
<i>Workshop Setting and Materials</i>	Figure 2	
Workshop Setting		WQ 1
Training Materials		WQ 3
<i>Workshop Content</i>		ER
Concepts, Values, Framework	Figure 3	ER
Tools and Interventions	Figure 4	ER
CCT Phases	Figure 5	ER
<i>Duration and Demands of Training</i>	Figure 6	TQ 32, 33
<i>Training Process</i>	Figure 7	
Organization		WQ 2
Pacing		WQ 4, TQ 4
Safety of Learning Environment		WQ 5, TQ 5
Fostering Collegiality		WQ 7, TQ 8
<i>Training Modalities</i>	Figure 8	WQ (Part 2) Items 1-7
<i>Training Components</i>	Figure 9	
Teleconference Consultations		TQ 23
CCT Trial Application		TQ 27
WebCT		TQ 24
Research		TQ 37, 38
<i>Trainer</i>	Figure 10	
Answering Questions and Concerns		WQ 6, TQ 6
Availability for Consultation		TQ 7
<i>Overall Satisfaction</i>	Figure 11	
Rewarding Experience		TQ 38
Training Fully Meets Expectations		QQ 17, TQ 34
Recommend to Colleagues		WQ 18, TQ 35
<i>Future Directions</i>	Figure 12	
Phase 2 Training		TQ 25
Further Regular Consultation		TQ 26
Further Research Participation		TQ 36
<i>Learning of CCT</i>	Figure 13	
Knowledge of Concepts		WQ 10, TQ 11
Knowledge of Values		WQ 11, TQ 12
Knowledge of Interventions		WQ 12, TQ 13
<i>Applicability of CCT</i>	Figure 14	
Ease of Application		TQ 2
Preparedness for CCT Application		WQ 13, TQ 14
To Couples		WQ 15, TQ 17
To Individuals		WQ 14, TQ 15
To Group		WQ 16, TQ 16
Positive Impact on Couples		TQ 1

Variables	Graph	Instrument and Items
<i>Counsellor Changes</i>	Figure 15	
Compatibility with Pre-existing Orientation		TQ 18
View of Clients		TQ 19
Role as Counsellor		TQ 20
Family Systems Lens		TQ 21
<i>Organization Support and Change</i>	Figure 16	
Appreciation for Couple Counselling		TQ 28
Fit with Policies and Procedures		TQ 29
Positive Impact on Organization		TQ 30
Feasibility of CCT Implementation		TQ 31
Recommend to Colleagues		WQ 18, TQ 35

Key:

ER = Evening Reflections

WQ = Workshop Questionnaire

TQ = Training Questionnaire

Appendix 17. Trainees' Satisfaction Comments
From Training Questionnaire

Cycle 1 Comments:

The training has been rewarding to me in that the CCT covers all aspects of the individuals self while maintaining the integrity of the couple relationship.

Although time consuming and demanding at times, the overall experience was a benefit to myself and my clients. I have expanded my skills and increased my confidence and abilities to counsel couples. The significant changes occurring in our agency made it more difficult to focus and put as much effort as I would have liked. I concur with the values of CCT and this model is quite similar to my own styles. I believe CCT has a place in working more effectively with problem gamblers and their families.

The training experience has been very enriching. After many years of working in this field, I found it to be extremely gratifying to gain the level of knowledge and sharing provided through this training. I thought Bonnie did an exceptional job and found her to be highly inspirational. I believe on going supervision is an important component and hope the some means can be established. As well, I view further training as important to consolidate my learning and for further development of the model.

A life changing experience. Thanks.

I would liked to have more time to focus on this project...I found the increase in my workload at Problem Gambling Services took away from the time I would have liked to devoted to gaining an automatic understanding of when to apply the interventions.

Thank you for the experience... Take care of you....

I have really appreciated being a part of this research project. It was a wonderful learning experience. I have learned a lot of new skills to use with the couples that I work with. It feels as though my journey of learning the CMCT has just begun and I am looking forward to further integration and skill development as I continue to use parts of it in my clinical work. Thank you for such a great learning experience!

The experience was excellent for me. I enjoyed all aspects. My organization isn't quite "on board: yet, but I know my couples/clients benefited. It was demanding for me, particularly since we are very busy here. However, it was well worth it – personally and professionally. I hope to be a part of future training initiatives as I would like to apply the model more generally – particularly in groups. I feel I can do this adequately, but could use further direction. Bonnie Lee was awesome, supportive, informative, professional. I think we might benefit from it more if it was marketed to our agency more as sometimes it was a fight to meet all requirements.

Cycle 2 Comments:

I enjoyed working with Bonnie Lee. She is an excellent trainer who certainly is quite passionate about the model. I appreciated how available and open she was whenever you required assistance. Through her teaching she often demonstrated how the modeled worked for her. I found these demonstration enlightening not only to the model but education to her wonderful style of empathy and compassion.

This has been a very valuable learning experience for me and my colleagues. The 4 day training packed a lot of info into a small amount of time. However, I feel that is what made the 12 weeks working with the couples and weekly teleconferences so crucial. The feedback at the teleconferences was extremely helpful in working with my couples. Both of my couples were very pleased with the model and service provided and spoke of tremendous gains they had achieved in their relationships. Thank-you for the opportunity to take part in this training.

I found this to be a very valuable experience. Bonnie is an excellent trainer and I found that this experience was very safe and empowering professionally and personally. The other participants were also awesome.

The teleconferences were extremely important to link the theory into practical application. Without the teleconference support, this experience would not have been nearly as effective. The intense training in a small group was also very good. I believe that if our group would have been larger, it would have made it difficult to have had the same intensity of learning.

I also think that this model is very effective. I feel very blessed to have had this opportunity as I feel very energized and feel that I have a very effective model to share with clients.

Great opportunity! Thank you very much!