

**PROCESSING TRAUMA AND ADDICTION THROUGH
CONGRUENCE COUPLE THERAPY**

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DEDICATION

To my loving family, especially my parents, Luiz Eduardo and Marcia, who have been my biggest source of inspiration and strength. They have guided and supported me through the most challenging times of my life. I love them more than words can say. To my late brother, Luiz Felipe, whose joy and spirit inspires me to accomplish what I could not have done alone. He has helped me in more ways that he could have ever imagined. I love and miss you so much. To my partner, Russell, who unexpectedly came into my life, but since the beginning has supported and encouraged me. Thank you for being there for me during all of those hard times when I needed a comforting hug or someone to just listen to me.

ABSTRACT

The literature has shown a clear connection between trauma and addictive disorders, including problem gambling. However, most treatment methods for addiction and trauma are individually based. The purpose of this study is to examine and describe how Congruence Couple Therapy (CCT) addresses trauma and addiction within the couple therapy context. The case study design allowed an in-depth secondary analysis of transcripts of two couples with problem gambling who underwent CCT. The five themes that emerged from the thematic analysis revealed how CCT works with couples on both trauma and addictions: (1) Building the foundation for couple therapy: Therapeutic alliance; (2) Understanding gambling patterns and building the timeline of addictions; (3) Connecting addiction with life-stressors, trauma, and childhood wounding; (4) Exploring trauma within the context of relationships; and (5) Healing from trauma and addiction through re-connection with self and others. Study limitations and recommendations for future research were discussed.

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LIST OF ABBREVIATIONS

ACE – Adverse Childhood Experiences
ACT – Adapted Couple Therapy
APA – American Psychological Association
CBCT for PTSD – Cognitive-Behavioural Couple Therapy for Post-Traumatic Stress Disorder
CBT – Cognitive-Behavioural Therapy
CCT – Congruence Couple Therapy
CPT – Cognitive Processing Therapy
CSA – Childhood Sexual Abuse
CTAP – Couple Treatment for Alcohol Use Disorder for Post-Traumatic Stress Disorder
DSM – Diagnostic and Statistical Manual
EFCT – Emotionally Focused Couple Therapy
FOO – Family of Origin
PG – Problem Gambling
PTSD – Post Traumatic Stress Disorder
RCT – Randomized Controlled Trial
RCT – Relational-Cultural Therapy
SAT – Structural Approach Therapy
SUD – Substance Use Disorders
TF-CBT – Trauma-Focused Cognitive-Behavioural Therapy

CHAPTER 1. INTRODUCTION

Psychological trauma has been found to have negative intrapersonal and interpersonal effects on relationships, including intimate relationships (Oseland, Schwerdtfeger, & Goff, 2016; Pukay-Martin, Macdonald, Fredman, & Monson, 2016). Further, up to 66% of individuals who are in treatment for substance abuse have been exposed to traumatic events (Gitberg & Van Wyk, 2004) while 75% of individuals have experienced a stressful event that can cause Post-Traumatic Stress Disorder (PTSD) in their lifetime (Monson & Friedman, 2006). However, it is important to highlight that the PTSD diagnosis does not include all psychological problems found in individuals that experienced trauma (Courtois & Ford, 2016). Childhood traumas and many adult traumas may lead to complex psychological problems that are not PTSD symptoms, such as anxiety, depression, developmental effects, emotion dysregulation, loss of self-integrity, and notably, compromised relationship in adult life (Courtois & Ford, 2016; van der Kolk, 2005). Considering the high prevalence of trauma in addictions, its intrapersonal and interpersonal impacts, and the fact that the treatment for both conditions has been highly focused on individual and cognitive-behavioural models, it is important to expand our examination of other modalities that address trauma, addiction and relationships. Therefore, this study examines and describes how the Congruence Couple Therapy (CCT) model addresses trauma and addiction within the couple therapy context.

Study Rationale

Research has shown a high prevalence of trauma in individuals with substance abuse problems, and that individuals with PTSD have a higher chance to develop addiction problems (American Psychological Association [APA], 2013; Bailey &

Stewart, 2014; Giordano et al., 2016; Sacks, McKendrick, & Banks, 2008). A self-perpetuating cycle has been noted between trauma and addictions. Individuals with trauma history may turn to substance abuse as self-medication, which may lead to further trauma (Briere & Scott, 2013; van den Brink, 2015). Gambling Disorder is now classified with Substance-Related and Addictive Disorders in the DSM-V (APA, 2013). Studies of problem gambling have shown high rates of childhood maltreatment, including childhood abuse and neglect, among individuals with PG (Hodgins et al., 2010; Petry & Steinberg, 2005). Additionally, Poole, Kim, Dobson, and Hodgins (2017) have suggested that PG treatment should address clients' adverse childhood experiences (ACEs).

The consequences of trauma and addictions are not limited to the individuals who experience them. Literature has shown the impact of both conditions for couples and family relationships (Pukay-Martin et al., 2016; Fals-Stewart, O'Farrell, and Birchler, 2004). The relationship between trauma and addictions symptoms and couples' distress is complex and reciprocal. PTSD and addictions symptoms can create distress in the relationship, and couples' distress may exacerbate PTSD and substance abuse (Blount, Friedman, Pukay-Martin, Macdonald, & Monson, 2015; Fals-Stewart et al., 2004; Fals-Stewart, Birchler, & O'Farrell, 1999; Maitso, O'Farrell, Connors, McKay, & Pelcovits, 1988).

Despite the evidence of the impact of trauma and addictions, including gambling, on couples and families, the treatment for both conditions has been mainly focused on individual therapies (Bertrand, Dufour, Wright, & Lasnier, 2008; Oseland et al., 2016; Sherrel and Gutierrez, 2014). According to Pukay-Martin et al. (2016) cognitive-behavioral conjoint therapy (CBCT) is the therapeutic model with the most evidence in

the literature for PTSD treatment. Regarding the treatment of addictions, Ruff et al. (2010) reported that the Behavioural Couples Therapy (BCT) is the relational approach with most evidence. BCT targets individuals with alcohol and substance abuse problems and their partners.

Research Purpose and Significance

The high prevalence of trauma among those in substance abuse treatment and its effects on couple relationships highlight the importance of studying the intersection of trauma, addiction, and intimate relationships, as well as implications for effective therapy. Though researchers have made connections between trauma and addictions, and their effects on relationships, little is known about the connections among these three issues within the couple therapy context and how they can be addressed together. The literature has mostly highlighted cognitive-behavioural models for the treatment for trauma and addictions. Hence, it is important to expand our knowledge on therapeutic approaches that are trauma-informed. That is why Congruence Couple Therapy (CCT) and its systemic approach—with its integrative foundation, intertwining humanistic, existential, social constructionist, experiential and systemic psychotherapeutic tenets—is an integrative innovation in addiction treatment worthy of study (Lee, 2017). CCT was first applied as a treatment of couples in PG (Lee, 2017). Lee and Awosoga (2015) found that gamblers as well their spouses had a history of traumatic events, such as emotional and sexual abuse, neglect, death of significant others, on witnessing life-threatening events. Hence, examining how CCT works with both addiction and trauma within a couple context will be instructive theoretically and in practice.

Thus, the purpose of this study is to conduct a thematic analysis of two clinical cases that took place over 12 CCT sessions to understand and elucidate how the model approaches trauma and addictions in the treatment of couples with PG. The qualitative methodology, through case studies design, allows the researcher to more closely analyse the therapy context of gamblers' and their spouses' history with trauma and addiction. The goal is to add to the limited literature on couple therapy for clients with history of trauma and addictions, by presenting and discussing CCT's systemic and integrative approach.

Research Question

How does the CCT model incorporate the underlying trauma issues in the treatment of people with problem gambling and addictions?

Thesis Structure

Chapter One is an introduction of the study, which includes the rationale, research purpose, the research question, and its research significance. Chapter Two presents a literature review on key aspects relevant to the study, namely, trauma, addictions, couple relationships, and existing therapies/treatment approaches. Chapter Three lays out the research methodology, including research design, epistemological and theoretical stance, data selection, data analysis, and reflexivity. Chapter Four describes the research findings, while Chapter Five discusses the major findings against the existing literature, as well as the study's contributions and limitations, and recommendations for future research.

CHAPTER 2. LITERATURE REVIEW

In this chapter I present aspects related to the main topics of this thesis are reviewed, namely, trauma, addiction, couple relationship, couple therapy, and their intersections. The chapter begins with the definitions and contrast of PTSD and complex trauma. Then I discuss the relationship between trauma and addiction, which includes problem gambling. I continue to discuss the effects of trauma and addiction on couple relationships. I also present a review of the most commonly cited treatments in the literature for couples struggling with trauma and addictions. Lastly, I describe the Congruence Couple Therapy model, which is the focus of the study. The following diagram illustrates the topics covered in the literature:



Figure 1. Literature Review

Trauma: PTSD and Complex Trauma

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V), trauma is an “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). Traumatic events may include exposure to war,

physical assault, torture, sexual violence, kidnapping, terrorist attacks, natural or human-made disasters, and motor vehicle accidents. Exposure to these events could occur through direct experience, or witnessing and learning about traumatic events that happened to close friends and family (APA, 2013). PTSD is characterized by symptoms of intrusion, avoidance, negative alterations in emotions and cognition, and significant alterations in arousal and reactivity, which persist for more than a month after the traumatic event (APA, 2013). The symptoms usually appear within three months of the traumatic event, although delayed onset could happen months or years later.

Regarding the DSM-V changes in the PTSD criteria, Courtois and Ford (2016) highlighted the importance of two additions to the PTSD definition. First, the inclusion of the knowing about a traumatic event as an actual traumatic experience. Second, trauma can include “repeated or extreme exposure to aversive details of events” (APA, 2013, p. 271; see also Courtois & Ford). Repeated exposure to aversive events can result in what is known as “complex trauma” (Courtois & Ford, 2016). This view of complex trauma includes a relational component of trauma that embraces loss, or potential loss, of a primary attachment relationship (Courtois & Ford, 2016) and the effect of knowing about traumatic events that happened to significant others and vulnerable populations, like children (Courtois & Ford, 2016). Even though these changes might be more consistent with the view of complex trauma, Mahoney and Markel (2016) and van der Kolk (2005) observed the fact that the DSM does not include interpersonal trauma, including childhood maltreatment and neglect, as a criterion for a traumatic event.

Courtois and Ford (2016) used Terr’s typology of trauma, namely, “*single-incident trauma*” (Type I) and “*repetitive or complex trauma*” (Type II), and argued that

both types of trauma can be applied to children and adults. Type II has been associated with many forms of abuse, neglect, and maltreatment by the nuclear or extended family, especially in childhood (Courtois & Ford, 2016; Terr, 1991). Trauma is an intricate topic that goes beyond PTSD and its definitions. Complex trauma expands the notion of trauma and its impacts on people's lives, as it takes into consideration relational disruption (Courtois & Ford, 2016). According to Courtois and Ford (2016), complex trauma seems to be more prevalent than expected and it presents a higher chance for the development of PTSD, especially if it involves interpersonal violation. Therefore, it is important to go beyond individuals and their symptoms and explore the effects of trauma in interpersonal relationships.

According to van der Kolk (2005), most childhood trauma, including abuse and neglect, starts at home, where parents are responsible for the maltreatment of their own children. The Child Maltreatment report revealed that approximately 75% of victims were neglected, 18% were physically abused, 6% suffered psychological maltreatment, and 9% were sexually abused (U.S. Department of Health and Human Services [USDHHS], 2017). In approximately 78% of the cases, the parent was the perpetrator of the maltreatment (USDHHS, 2017).

Unlike isolated cases of trauma, which can lead to behavioural and biological responses (such as PTSD), chronic maltreatment and repeated traumatization have significant developmental consequences that affect individuals through adulthood (van der Kolk, 2005). Complex trauma is related to difficulty with self-regulation and interpersonal connection (Cook et al., 2005). Van der Kolk (2005) explained this with John Bowlby's (1969) attachment theory. Early childhood experiences shape individuals'

ways of relating to others through “internalization of affective and cognitive characteristics of their primary relationships” (van der Kolk, p. 204), which Bowlby (1969) called “internal working models”. As early experiences happen while the brain is developing, social interactions and neural development are intimately linked (van der Kolk, 2005). Pearlman and Courtois (2005) pointed out that relationship problems seem to be more complicated for individuals with a history of cumulative childhood trauma (including interpersonal violence, neglect, or abuse), especially when it involves their primary caregivers. Consequently, individuals who were exposed to prolonged interpersonal trauma have psychological disturbances that are not considered under the PTSD diagnosis, such as impairments related to attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook et al., 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Complex trauma has lifelong consequences for individuals, such as psychiatric and addictive disorders and family problems, which put them at risk for further trauma and cumulative impairments (Cook et al., 2005).

Trauma and Addictions

Individuals with PTSD have a higher chance of developing addiction problems (APA, 2013; Bailey & Stewart, 2014; Sacks et al., 2008). Research shows a high prevalence of trauma in populations with substance abuse problems (Giordano et al., 2016). According to Brady, Kileen, Brewerton, and Lucerini (2000), substance use disorder (SUD) is one of the most common psychiatric disorders that is comorbid with PTSD. Brady et al. (2000) stated that researches estimate that 30 to 60% of individuals who seek treatment for SUD have a diagnosis of PTSD in their lifetime. In a study of 402

men and women in residential treatments for SUDs and mental health problems, Wu, Schairer, Dellor, and Grella (2010) found that 95% of the individuals reported one or more childhood traumatic events. Additionally, Simpson and Miller (2002) mentioned that childhood sexual abuse (CSA) is twice as common in women being treated for a SUD, compared to women from the general population.

Some authors suggested different ways in which trauma and substance abuse may be related. One of the reasons for this association is that people who have suffered trauma have the tendency to self-medicate for PTSD symptoms with psychoactive substances (Briere & Scott, 2013; van den Brink, 2015). Further, individuals with substance abuse problems are more likely to be exposed to traumatic experiences (Briere & Scott, 2013; van den Brink, 2015). Lastly, substance use can exacerbate PTSD symptoms, even though researchers have shown that it is more common for PTSD to precede SUD (Briere & Scott, 2013; van den Brink, 2015). In addition, Liebschutz, Savestsky, Saitz, Lloyd-Travaglini, and Samet (2002) found that people with interpersonal trauma have higher risk for substance abuse, which can lead to more interpersonal trauma. Consequently, trauma and addiction can be understood as a self-perpetuating cycle.

Gambling and Trauma

There is evidence for a relationship between trauma and PG (Lee & Awosoga, 2015; Petry & Steinberg, 2005). Kourgiantakis, Saint-Jacques, and Tremblay (2013) highlighted two concepts that explain problematic gambling behaviours, *pathological* and *problematic* gambling. Pathological gambling is a mental health diagnosis described in the DSM-IV as an impulse disorder, which is characterized by “persistent and recurrent maladaptive gambling behaviour” (APA, 2000, p. 671). Problem gambling, on the other

hand, is defined as a “gambling behaviour that creates negative consequences for the gambler, others in his or her social network, or for the community” (Ferris & Wynne, 2001, p. 8). According to Kourgiantakis et al. (2013), the definition of problem gambling considers the gambler’s context, as it includes individual’s functioning and its impacts on his/her family and community. Researchers have shown a co-occurrence of problem gambling with other addictions and mental health issues (Kourgiantakis et al., 2013). Petry, Stinson, and Grant (2005) reported that pathological gamblers often had other addiction problems and mental health disorders, such as alcohol use disorder (73.2%), drug abuse problems (38.1%), dependence on nicotine (60.4%), anxiety disorder (41.3%), mood disorders (49.6%), and personality disorders (68.8%). Kessler et al. (2008) corroborated Petry et al.’s findings, observing that a high number of individuals with pathological gambling also met the criteria for other mental health conditions, such as bipolar disorder, panic disorder, and SUD.

High rates of childhood trauma and maltreatment have been reported among pathological gamblers, including childhood abuse and neglect (Felsher, Derevensky, & Gupta, 2010; Hodgins et al., 2010; Petry & Steinberg, 2005; Poole et al., 2017). Poole et al. (2017) highlighted the cumulative impact of ACE on problem gambling. In a study with 33 individuals, Grant and Kim (2002) found high rates of neglectful parenting among individuals with pathological gambling. In a more recent study, Villalta, Arevalo, Valdeperez, Pascual, and de los Cobos (2015) noted their findings did not confirm Grant and Kim’ neglectful hypothesis. However, Villalta et al. (2015) results still showed pathological gamblers perceived their parents as less caring. In a systematic review, Lane

et al. (2016) reported the majority of articles reviewed showed a significant association between historical childhood maltreatment and subsequent problem gambling.

Lee and Awosoga (2015) also reported a history of traumatic events among gamblers, such as emotional abuse, and death or abandonment by significant others, sexual abuse and assault, witnessing a life-threatening event, and separation from their closest adults before the age of 18. Interestingly, these authors also found that the partners of problem gamblers shared a comparable, but slightly lower, extent of trauma history. Even though the literature shows an association between trauma and PG, in a study with women, Nixon et al. (2013) stated that there is not enough evidence to demonstrate *how* trauma is related to the development and progression of gambling problems.

Trauma, Addictions, and Couples' Relationships

Trauma and Couples Relationships

Considering the interpersonal effects of trauma mentioned previously, it is important to address the effects of trauma in couples' relationships. According to Goff et al. (2014), the literature had been mostly focused on the individual who suffered trauma and his/her symptoms. Only recently have researchers been paying more attention to the systemic impacts of trauma on couples and family relationships (Goff et al., 2014). The literature shows higher rates of divorce among individuals with PTSD, especially among military couples (Monson, Taft & Fredman, 2009; Pukay-Martin et al., 2016). According to Pukay-Martin et al. (2016), some PTSD symptoms that affect intimate relationships include avoidance and emotional numbing, which are considered primary factors for relationship dysfunction and impaired intimacy; avoidance affects couples'

engagement in pleasant activities, while emotional numbing creates difficulty sharing emotions, empathy, and closeness, which affects emotional and physical closeness. Moreover, intimate partner aggression has been associated with PTSD, in which the individual with trauma is more likely to be the perpetrator (Pukay-Martin et al., 2016; Taft, Watkins, Stafford, Street, & Monson, 2011). Additionally, Fredman, Vorstenbosch, Wagner, Macdonald, and Monson (2014) suggested that partner accommodation, characterized by partners' change in behaviour in response to the survivor, could contribute to avoidance and PTSD symptoms. Partner accommodation was also related to both partner and survivor symptoms of depression, increased anger, and lower relationship satisfaction (Fredman et al., 2014).

Alcohol abuse and other comorbidities are mediators in the relationship between aggressive behaviours and PTSD (Pukay-Martin et al., 2016). In a study with Vietnam veterans, Taft, Pless, Stalans, Koenen, and King (2005) compared rates of partner violence among individuals with PTSD, finding that aggressive behaviour towards a partner was associated with greater symptoms of depression, substance abuse, lower levels of marital adjustment, and more exposure to atrocities. In another study with Vietnam veterans, Savarese, Suvak, King, and King (2001) showed an association between quantity of alcohol consumption, PTSD hyperarousal symptoms, and aggression, including psychological and physical abuse; higher levels of alcohol instigated more violence. In addition, Blount et al. (2015) asserted that PTSD symptoms create distress in relationships, and simultaneously, the distress in the relationship reinforces the PTSD symptoms.

Traumatic experiences may also affect relationships through secondary/vicarious trauma. The theory of Secondary Traumatic Stress considers that individuals' stresses are communicable and can "infect" other people around them, especially those with close and emotional contact with the survivor (Henry et al., 2011). In other words, people can present their own stress responses to others' traumatic experience, through a process of internalization of the victim's trauma symptoms (Henry et al., 2011). In a study of war veterans from Iraq and Afghanistan, Goff, Crow, Reisbig, and Hamilton (2009) indicated that soldiers' traumatic stress symptoms, especially avoidance, can affect and predict trauma symptoms in the partner. Regarding partners' symptoms, Solomon and colleagues found that veterans' wives experienced somatization, depression, and anxiety were associated with their husbands' PTSD and combat stress reaction (as cited in Goff et al., 2009).

Regarding the research on trauma and couples, Taft et al. (2011) stated that the literature has been interested in exploring intimate and family problems of those with trauma history, and in developing interventions for these individuals and their intimate relationship problems. However, according to Cowlshaw, Evans, Suomi, and Rodgers (2014), most of the studies that link PTSD and family dysfunction are focused on veterans. They also mentioned that there is a small number of studies that address other types of trauma, and that there is a need for a better understanding of the impact of PTSD in long-term relationship problems. Clearly, there is a need for further research on couples with trauma history.

Addictions and Couples Relationships

Research has also shown the impact of addiction on couples' relationships. Fals-Stewart et al. (2004) stated that "the causal connections between substance use and relationship discord are complex and reciprocal" (p. 31). In a study with 217 couples, Fals-Stewart et al. (1999) found that couples with substance abuse problems reported significant levels of relationship dissatisfaction, maladaptive ways to deal with conflicts, and several attempts to divorce. Conversely, relationship problems have been associated with increased substance abuse problems and relapses (Maisto, O'Farrell, Connors, McKay, & Pelcovits, 1988). Holway, Umberson, and Thomeer (2017) have also shown the impact of partners on each other's psychological distress.

Regarding the impact of gambling on couples' relationships, Kourgiantakis et al. (2013) highlighted three key findings in a literature review: partners' lack of awareness and understanding of PG; the individual, familial, and social consequences of PG experienced by partners; and partners' coping skills to deal with the impact of gambling. Partners' lack of awareness and understanding of gambling mentioned in the studies were related to not knowing about the PG and its severity (Corney & Davis, 2010; Patford, 2009; Tepperman, Korn, & Reynolds, 2006). Additionally, PG strained couples' relationships, especially due to loss of trust, dishonesty, and loss of hope in the relationship (Corney & Davis, 2010; Dickson, James, & Kippen, 2005; Patford, 2009; Tepperman et al., 2006). Regarding couples' communication about gambling, Tepperman et al. (2006) mentioned that gamblers avoided talking about gambling and conversations about it escalated to heated arguments.

Patford (2009) mentioned partner's feelings of diminished quality of life, which were related not only to financial insecurity but also to partners' emotional distress. Partners experienced feelings of "anxiety, depression, fear, anger, resentment, regret, sadness, despair, frustration, uncertainty, guilt, and numbness" (Patford, p. 183). Gambler's absence, loss of time spent with partner, and neglect of family responsibilities were also sources of distress on couples' relationships (Patford, 2009; Tepperman et al., 2006). Tepperman et al. (2006) and Dickson et al. (2005) also reported the impact of gambling on partners' emotional health.

In a case study series, Lee (2014) identified couples' five circuits of interactions, which describe couples' communication patterns and their connection with PG. According to Lee, couples already had fault-lines in their relationship before the onset of the PG. These fault-lines were characterized by a limited range of communication, couples' patterns of over-functioning and under-functioning in their relationship, couples' disconnection from each other, and emotional and physical abuse. The onset of gambling was associated with times of stress, such as life transitions, losses, setbacks, and lack of coping mechanisms. Pathological gambling increases relationship distress and exacerbates initial fault-lines in the couple relationship, which leads to the gambler's relapse (Lee, 2014). Thus, this process illustrates what Lee described as "self-perpetuating cycles of couple distress in systemic interaction with pathological gambling development and relapse" (p. 1).

Overall, studies have shown PG's adverse effects on couple and family functioning. In a study with 95 pathological gamblers and 91 control individuals, Black, Shaw, McCormick, and Allen (2012) evaluated and compared participants' marital and

family variables and indicators of childhood maltreatment. In order to assess family functioning, the Family Assessment Device (FAD) instrument (Epstein, Baldwin, & Bishop, 1983) was used, with subscales that evaluate families' problem solving abilities, communication, roles, affective responsiveness and involvement, and behaviour control. Black et al. (2012) revealed that pathological gamblers and their families had worse family functioning than the controls, in all subscales. Additionally, Black et al. showed that pathological gamblers were more likely to divorce and report childhood maltreatment, with verbal and emotional abuse the most prevalent forms of abuse. Dowling, Smith, and Thomas (2009) also reported significant dysfunction in couples and family relationships of pathological gamblers.

Trauma, Addictions, and Couples Therapy

Trauma and Couples Therapy

According to Oseland et al. (2016), conventionally, trauma treatment has been focused on individual treatments with different cognitive-behavioral models, including cognitive processing therapy (CPT) (Monson et al. 2006; Resick & Schnicke, 1992), prolonged exposure, and trauma-focused cognitive behavioural therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006). In a meta-analysis, Ehring et al. (2014) evaluated the efficacy of individual and group PTSD treatments for adults with history of childhood abuse.

Despite the dominant focus on individual treatment approaches, interpersonal consequences of trauma are clear, especially in couples' relationships. According to Herman (2015), "the core experiences of psychological trauma are disempowerment and disconnection from others" (p. 133). Therefore, Herman highlighted the importance of

the creation of new connections in trauma recovery. “Recovery can take place only within the context of relationships; it cannot occur in isolation” (Herman, 2015, p.133). Researchers have suggested that social support, including a strong bond in marital relationship, as a positive effect on trauma survivors (Herman, 2015; Matsakis, 2004; Oselan et al., 2016; van der Kolk, 2007).

According to Riggs, Monson, Glynn, and Canterino (2009), in the trauma treatment, couples and family therapy have mostly focused on either a systemic treatment approach, or a supportive treatment approach. Within the systemic approach, the goal is to diminish the systemic impact of trauma, rather than reducing individuals’ particular symptoms. Consequently, the success of the treatment is based on the enhancement of family functioning, through better communication and reduced conflicts. On the other hand, the goal of supportive treatment approach is to promote education of family members and support for the trauma survivor (Riggs et al., 2009). Although these approaches have different goals, Riggs et al. (2009) also highlighted that they are not mutually exclusive, and that in some programs they might overlap.

In their literature review, Riggs et al. (2009) mentioned a few studies, including several behavioural and cognitive models, including Cognitive-Behavioral Couple Therapy (CBCT) (Monson, Schnurr, Stevens, & Guthrie, 2004), Emotionally Focused Couple therapy (EFCT) (Johnson, 2005), as well as courses and support programs. Riggs et al. also mentioned that regardless of these models, there were limited studies on couple and family therapies in trauma treatment. Additionally, empirical research had small samples with no control groups, and was mostly focused on veterans and their partners (Riggs et al.).

According to Pukay-Martin et al. (2016), research has shown “bidirectional association between PTSD symptoms and intimate relationship functioning” (p. 37). Some couples’ relationship interactions may cause PTSD symptoms to sustain or even worsen (Monson, Fredman, & Dekel; as cited in Pukay-Martin et al., 2016). Conversely, some PTSD symptoms, such as avoidance and emotional numbing, may affect individuals’ engagement with others and impair intimacy (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Renshaw & Caska, 2012). Considering this, Pukay-Martin et al. highlighted the importance of couples’ therapy for PTSD treatment. In their literature review, Pukay-Martin et al. (2016) discussed some couple-based therapies for trauma with empirical evidence, such as Cognitive-Behavioral Conjoint therapy (CBCT) for PTSD (Monson & Fredman, 2012), Structured Approach Therapy (SAT; Sautter, Glynn, Thompson, Franklin, & Han, 2009), and Emotionally Focused Therapy (EFT; Johnson, 2005). According to these authors, CBCT for PTSD is one of the most established treatments, considering its empirical evidence within a wide variety of the population (Pukay-Martin et al.).

CBCT for PTSD. According to Monson and Fredman (2012), most PTSD treatments were individual-focused. Thus, CBCT for PTSD was created in recognition of the nature interpersonal trauma and the associated consequences, as well as the power of intimate relationships in improving PTSD. CBCT for PTSD is considered a stand-alone treatment, in which the goal is to alleviate PTSD symptoms and improve couples’ relationship functioning (Monson & Fredman, 2012). This model consists of 15 sessions that are structured in three sequential phases: “rationale for treatment and education about PTSD and relationships” (phase 1), “satisfaction enhancement and undermining

avoidance” (phase 2), and “making meaning of the trauma and end of therapy” (phase 3) (Monson & Fredman, p. 17). In phase 1, the therapist focusses on giving clients the treatment’s rationale, doing psychoeducation on PTSD and relationship difficulties, and creating safety. In phase 2, therapist and clients discuss the role of avoidance on PTSD and relationship problems, and work on communication skills which are practiced in every session in order to help the couple become more aware of how their own thoughts influence their feelings and behaviours, and to help them become aware of and share those feelings. (Monson & Fredman). Each session of phase 2 focuses on a different skill, such as listening and approaching (session 3), sharing feelings (session 4), sharing thoughts (session 5), identifying and modifying maladaptive thoughts that sustain both PTSD and relationship problems (session 6), and developing problem-solving and decision-making skills related to how couples are going to diminish the role of PTSD in their relationship (session 7). Finally, in phase 3, clients utilize their new skills to explore and challenge their beliefs related to the trauma and its impacts on PTSD symptoms and their relationship, including trust, control, and emotional and physical closeness. In this final phase, therapist and clients also discuss the potential posttraumatic growth and review the improvements made in therapy (Monson & Fredman).

EFCT. EFCT model is an attachment-based model that emphasizes reprocessing emotional responses related to attachment behaviour (Johnson, 2004). In EFCT, therapists work with clients at the intrapsychic and interpersonal/systemic levels. The intrapsychic work consists of experiential techniques and expanding the emotional experience. The interpersonal work is based on identifying and reframing couples’ patterns of interactions (Johnson; as cited in Johnson & Williams-Keeler, 1998).

Therapists then observe clients' negative cycles of interaction based on emotional attachment, such as pursue/withdraw and blame/defend, and works on restructuring those key emotions and clients' interaction in the therapy sessions (MacIntosh & Johnson, 2008). By facilitating these new cycles and behaviours, therapists help clients process and integrate the traumatic experience (MacIntosh & Johnson, 2008). Considering this, MacIntosh and Johnson (2008) argue that EFCT "is particularly suited to couples facing trauma as it deals directly with affect regulation and assists couples in obtaining social support, which, when blocked, is linked to challenges in recovering from trauma" (p. 301).

According to Johnson (2005), in EFCT the therapist looks at how trauma interferes with couples' negative interactions and hinders the positive and healing interactions. Johnson (2005) described the model's tasks based on the three stages described by McCann and Pearlman (as cited in Johnson, 2005): the stabilization (stage 1); reconstructing the bond between partners (stage 2); and integration (stage 3). In stage one, the therapist focuses on creating safety in therapy and on identifying clients' negative interactional cycles and their emotional responses, and how trauma is embedded in it. The therapist relates these emotional responses to clients' unmet attachment needs and attachment fears. In stage two, the therapist focuses on reorganizing clients' emotional experiences and revising their sense of self, and restructures couples' interactions to promote trust and security in the relationship. Finally, in stage three, the therapist works with integration in three levels: clients' self-definition, clients' resilience to the trauma, and their relationship definition. Clients are able to attain integration by

“reflecting, affirming, and heightening new positive interactions” and by creating empowering narratives of their process of change in therapy (Johnson, 2005, p.108).

SAT. Sautter et al. (2009) described the SAT model as a couple-based approach that targets PTSD avoidance symptoms, which include avoidance of feelings and thoughts related to the trauma event, its external reminders, and emotional numbing symptoms. According to Sautter, Armelie, Glynn, and Wielt (2011), SAT’s interventions are structured based on the stress inoculation framework (Meichenbaum; as cited in Sautter et al., 2011), which focuses on helping clients develop coping skills related to past stressful experiences and also buffering stressful experiences in the future. Thus, SAT involves three phases: educational; skills training; and application phases. The educational phase is similar to CBCT for PTSD model, in which the therapist gives clients psychoeducation about PTSD and its impacts on couples’ relationships, as well as an overview of the model. In the skills training phase, the therapist focuses on building skills related to empathic communication and emotion regulation, which will help clients coping with the effects of PTSD. Finally, within the application phase, the therapist helps clients apply their skills through behavioural activation (Jacobson, Martell, & Dimidjian, 2001), in which they identify and engage in positive activities to reinforce positive experiences, and dyadic exposure.

When comparing SAT with CBCT for PTSD, Sautter, Glynn, Arseneau, Cretu, and Yufik (2014) stated that both models have extensive work with psychoeducation while managing avoidance behaviours and enhancing couples’ communication skills. However, the difference between the models is that SAT is more focused on trauma-related affects that impact couples’ relationships and on interventions related to emotion

regulation skills (Sautter et al., 2014). Initial studies on the SAT model have focused on combat veterans and their partners, and have shown positive results in reducing PTSD and relationship distress (Sautter et al., 2011; Sautter et al., 2014; Sautter, Glynn, Cretu, Senturk, & Vaught, 2015).

Overall, couples' therapy is important in helping individuals not only with relationship problems, but also at an individual level, by promoting the development and improvement of positive coping skills (Johnson, 2005). According to Johnson (2005), within the couple and family therapeutic model, therapists must help create new, positive connections. Cowlshaw et al. (2014) emphasized evidence of a relationship between PTSD symptoms and family difficulties, as well as research limitations on understanding the efficacy of couples' therapy for individuals with PTSD. Cowlshaw et al. (2014) mentioned most interventions focus on veterans and their families, with few studies on other types of trauma, such as sexual and physical abuse.

Addictions and Couples Therapy

Regarding the treatment of addictions within the context of couples' therapy, authors have emphasized the importance of involving the family in treatment of substance-use disorders (O'Farrel & Clements, 2012; Meis et al., 2012; Schumm, O'Farrell, Kahler, Murphy, & Muchowski, 2014). Moreover, Nelson and Sullivan (2007) stated that the inclusion of the partner seem to improve treatment outcomes. According to Ruff et al. (2010), O'Farrell, Falst-Stewart, and colleagues' Behavioural Couples Therapy (BCT) is "the most evidence-based relational approach to the treatment of substance abuse" (p. 440). Fletcher (2013) also highlighted in her systematic review the high number of studies attributed to O'Farrell and colleagues, and BCT. Sherrell and Gutierrez

(2014) stated that despite evidence, family treatment modalities are still underused.

Sherrell and Gutierrez (2014) reviewed three potential counseling strategies for working with addicted couples, namely, BCT, Congruence Couples Therapy (CCT), and EFT.

BCT. According to O'Farrell and Fals-Stewart (2006), the BCT is a 12-20 weekly session model for individuals with substance-using problems and their partners. BCT's main goal is to support individuals' abstinence and improve relationship functioning. At the beginning of the treatment, the therapist focuses on diminishing couples' conflict related to substance abuse. The therapist and clients establish a Recovery Contract, which specifies behaviours for both individuals to reduce distrust and conflict related to substance use and to reward abstinence. Then, the therapist focuses on interventions that help clients engage in positive activities and improve their communication skills (O'Farrell & Fals-Stewart). Finally, the therapist helps clients make plans for continuing recovery, which includes strategies to prevent and minimize relapse (O'Farrell & Fals-Stewart).

EFT in Addiction Treatment. In 2011, Landau-North, Johnson, and Dalglish proposed an extension of EFT, an attachment-informed model, to treat couples with addiction problems. Landau-North et al. considered addiction an attachment issue. In this context, addiction is not only an escape from negative emotions, but is also "seeking pleasurable mood-enhancing experience" (p. 197). Thus, individuals with addiction problems rely on the substance use as an "emotional defense and regulator" in their everyday life (Landau-North et al., p. 197). Considering this, EFT's goal is to help individuals replace the addiction with an emotional connection, as a healthy alternative to self-regulate. In secure attachment, individuals can turn to each other and find resilient

ways of coping with the world (Landau-North et al). Landau-North et al. proposed the implementation of EFT for treatment of addiction in three stages. In stage one, the therapist validates the need for emotional safety and frames addiction as part of couple's negative interaction patterns, as a cause and consequence of relationship distress. Once these negative cycles of interaction are identified, in stage two, the therapist explores deeper emotions and links them to addictive behaviours. The addiction is then explored in terms of attachment needs and fears. Still in stage two, the therapist helps clients create positive interactions, and the relationship is framed as an antidote to addiction. Finally, in stage three, the therapist encourage couples to create a story about their relationship distress, how it is related to the addiction, and how they are repairing their relationship. The couple also sets up a plan to deal with relapse (Landau-North et al.).

Recently, Fletcher and MacIntosh (2018) published a series of case studies in which they explored EFT in the context of addiction. The authors highlighted the needs for ongoing psychoeducation about addictions in therapy and adapting this model for highly traumatized clients. According to Fletcher and MacIntosh, the EFT's theoretical extension to treat individuals with addiction did not include the trauma aspect, and it might be "too destabilizing" for individuals with trauma history (p. 338). Finally, the researchers also noted that an adaptation to this EFT extension should be done to address how therapists should address and integrate relapses in therapy.

Gambling and Couples Therapy

Considering the impact of childhood experiences on PG, researchers have highlighted the importance of assessing and addressing childhood traumas, along with other psychological and addictive problems, in its treatment (Felsher et al., 2010; Poole et

al., 2017). However, according to Bertrand et al. (2008), individual treatment is still the main treatment for PG. In their critical review, Bertrand et al. reviewed some couple therapies for gambling found in the literature and proposed the Adapted Couple Therapy (ACT) model. The most recent models that Bertrand et al. mentioned in their study were CCT (2017) and, and Ciarrochi's (2002) behavioural-based model.

Ciarrochi's model. Ciarrochi (2002) adapted Jacobson and Christensen's integrative behavioral couple therapy (IBCT) to the treatment of PG (as cited in Ciarrochi, 2002). Ciarrochi (2002) acknowledged the limitations of behavioural models and the need to work with intimate relationships. Thus, his model seeks to support couples in their desire to quit gambling through task-oriented goals, such as creating environmental controls, working with financial recovery and possible legal issues, and creating space for the gamblers' partners to ask questions, give feedback on behaviour, and receive emotional support. It also helps clients in healing relationship wounds, restoring their intimacy, and emphasizing tolerance and acceptance to deal with the harms caused by the disorder (Ciarrochi).

ACT. Bertrand et al. (2008) developed another cognitive-based model for couples in which one of the partners has PG, which is offered along with individual-based treatment. In order to start ACT, the gambler must be abstinent from their main type of game and/or not going to the place they gamble for at least two weeks. One of the most important factors of this model is "optimal management" of gambling symptoms, which includes helping couples analyze gambling behaviours ("triggers-behaviour-consequences") (Bertrand et al., p. 403). To do this, the therapist helps gamblers create a strategy to maintain abstinence and prevent relapse, as well as support their spouses on

creating strategies that encourage abstinence for their partners. Additionally, the therapist should also assist spouses in addressing some of their own needs (e.g., social support, sources of leisure). Regarding the couple dimension, ACT works on clients' caring behaviours for one another, couples' communication and problem solving skills, and their concept of intimacy and affect expression (Bertrand et al.). This way, Bertrand et al. believed that ACT can help clients reliving personal distress related to the addiction and conflicts, and improve their happiness.

Congruence Couple Therapy (CCT)

Congruence Couple Therapy (CCT) is a relatively new approach to treatment. It was developed by Dr. Bonnie Lee (2017) and is based on the work of Virginia Satir (1991), a pioneer in family therapy. The CCT model offers a conceptualization and integration of Satir's ideas, and creates a structured framework and a manualized application for treatment of couples with addiction, thus extending the work of Satir. According to Lee (2009), CCT brings "a philosophical and conceptual grounding, as well as clinical structure and specificity to what was implicit and intuitive in Satir" (p. 46).

This therapy model is integrative and holistic, and considers congruence as consisting of four A's: attending; awareness; acknowledgment; and alignment. These are meant to bring authenticity and wholeness of being in the world (Lee, 2009). More specifically, *attending* refers to the openness of the individual in experiencing the world; *awareness* is the ability to notice one's inner and outer experience; *acknowledgement* is the ability to acknowledge one's experience without judgment; and *alignment* is matching one's inner experience with its outward expression (Lee, 2009). Moreover,

congruence means to say what you mean and match nonverbal cues with words, while being aware of and acknowledging of both self and other.

The congruence model was developed based on five cornerstones in therapeutic traditions, which are systemic, humanistic, existential, experiential, and social constructionist. The *systemic* tradition considers that “nothing exists in isolation” (Lee, 2009, p. 47). Consequently, there is a focus on relationship patterns and how they affect the whole. For the *humanistic* tradition, it is important to recognize the human potential in the process of growth and healing. Meanwhile, *existentialism* accepts the limits of human existence, and considers the importance of choice and responsibility. The *experiential* tradition emphasizes the “bodily inner experience” and “felt sense” by focusing on the present (Lee, 2009, p. 48). Lastly, the *social constructionist* tradition focuses on how shared narratives, beliefs, values, and practices construct one’s social reality (Lee, 2009). CCT is an integrative model in terms of its therapeutic underpinnings, and also in its four-dimensional system. This system is composed of the intrapsychic, interpersonal, intergenerational, and universal-spiritual dimensions, which are inter-related and mutually influential (Lee, 2009; 2015; 2017). Figure 2 illustrates these four dimensions and their connections (Lee, 2009).

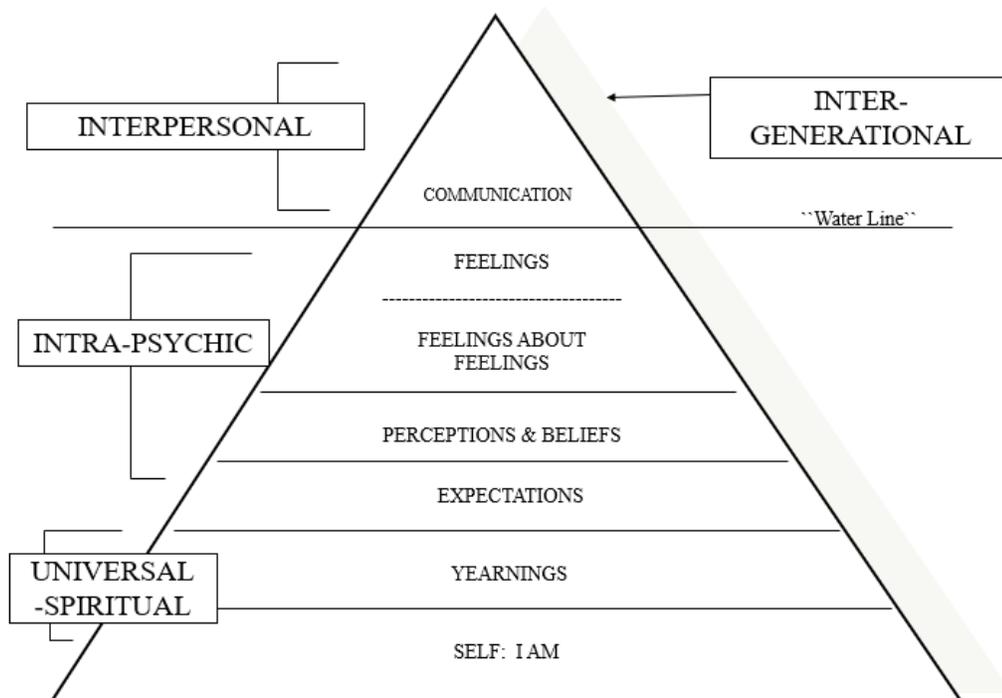


Figure 2. The Iceberg: Four Interrelated Human Dimensions (Lee, 2009; reproduced with permission¹)

The **interpersonal dimension** is the communication based on the individual’s interactions with others and the world (Lee, 2009). Lee (2017) highlighted the importance of communication and considers it the “key tool” for interaction and relationship success. Lee (2017) created what she called “Communication Postures” elaborating on and extending Satir’s (1991) communication stances to describe the different types of communication among individuals. These communication postures are presented and depicted in Figure 3.

¹ Reproduced with permission from Springer Nature: International Journal of Mental Health and Addiction *Congruence Couple Therapy for Pathological Gambling*, Bonnie K. Lee, 2007.

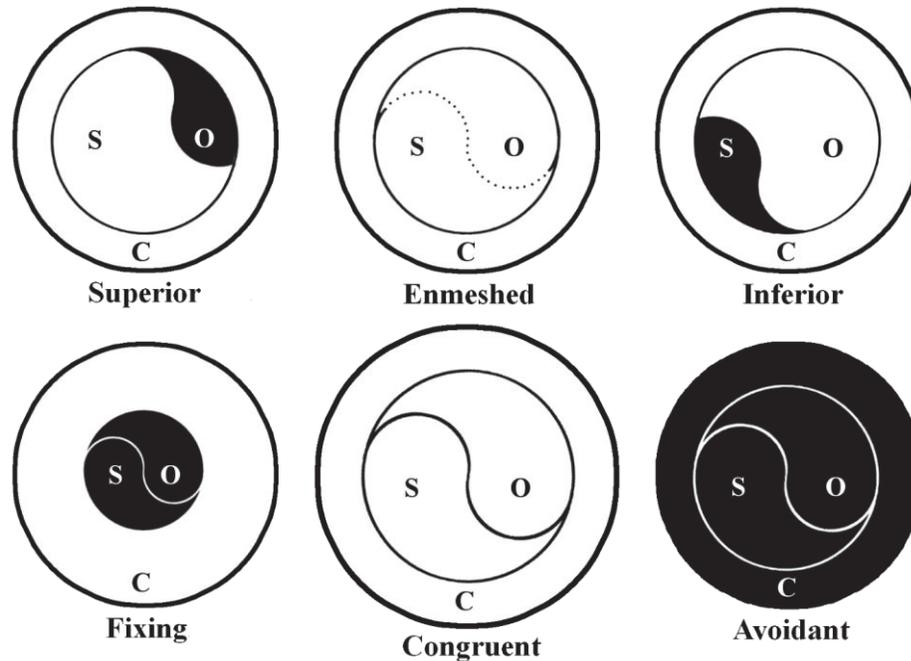


Figure 3. Communication Postures (Lee, 2017; reproduced with permission²)

According to Lee (2017), the **congruent posture** is characterized by congruent communication, which means awareness and acknowledgment of one’s self, other and the context. Relationship problems can be resolved, because one is able to express what is felt and experienced, while being open to hearing and acknowledging what the other experiences. In the **superior posture**, one individual has power over the other. Communication is mainly based on criticism, blame, punishment, and abuse. On the contrary, there is the **inferior posture**, in which the individual seeks approval and acceptance in deferring to the other and suppressing the self. In this case, the person is in the position of being submissive and pleasant to the other but losing oneself. **Enmeshed posture** refers to individuals’ difficulties standing on their own. These “individuals find strength and energy by merging or identifying with another person” (Lee, 2017, p. 27).

² Reprinted with permission from OpenHeart Couple & Family Therapy, Inc.: *Congruence Couple Therapy: Concept & Method Workbook*, Bonnie K. Lee, 2017

The fixing posture describes people who are focused on problem-solving and do not find meaning in connecting with others. Finally, the **avoidant posture** is the most distressed posture because the individual loses self, other, and the context of living and withdraws from connections and awareness. According to the Lee (2017), addiction is an example of this posture, because the person disconnects themselves from their relationships and environment.

The **intrapsychic dimension** is characterized by the individual's inner experiences, which are expressed by perceptions, expectations, feelings, and beliefs. An individual's interactions with other and with the world are influenced by his/her inner experiences. These experiences are closely related to the **intergenerational dimension**, which brings to awareness the familial influence in an individual's values, beliefs, and behaviours. Thus, individuals are able to gain better self-awareness through an understanding of their own past patterns and their influence in present functioning. Hence, congruence requires that a person connect the past and the present with awareness and choice. Finally, there is the **universal-spiritual dimension**. This dimension refers to a shared humanity, with universal yearnings and aspirations. This includes the need for humans to belong and feel connected, experience physical and emotional safety, and enjoy a sense of worth and respect (Lee, 2009; Lee, 2017).

Even though this is a new approach to couples therapy, an earlier study showed strong acceptance of the model from counsellors and clients, with positive results in improving couple relationships and reducing gambling symptoms (Lee & Rovers, 2008). A more recent pilot randomized controlled trial showed similar findings of significant improvement in couples' mental distress, family functioning, couple relationship, and

reduction in gambling symptoms (Lee & Awosoga, 2015). According to Lee and Awosoga (2015), the rate of retention for the treatment was 89% at the end of the study. Additionally, couples' satisfaction was reported in five categories: gambling symptoms, self-awareness, awareness of spouse and communication, congruence and self-worth, and awareness of family of origin influences (Lee & Awosoga, 2015).

Summary

The literature review expanded the notion of trauma as PTSD symptoms to the concept of complex trauma, which more aptly captures the longer term, relational effects of trauma. The literature also highlighted the connection between trauma and addictions, and its impact on individuals at the intrapersonal and interpersonal levels. However, the literature shows that the primary treatment for trauma and addictions is still focused on individual types of treatment. There also seems to be limited treatment options for couples, and there is a paucity of treatment models that are *not* cognitive behaviourally based. Thus, the present research seeks to understand how CCT as a humanistic and integrative systemic model helps couples struggling with both trauma and addictions.

CHAPTER 3. METHODOLOGY

In this chapter I discuss the methods used in the present study, including its philosophical stance. Because this study involved secondary data analysis, I describe in this section relevant aspects of the previous randomized controlled trial (RCT) (Lee & Awosoga, 2015), and provide details of the data collection and analysis. Finally, I discuss the ethical considerations, trustworthiness, as well as my role as a researcher in the reflexivity section.

Philosophical Stance

According to Creswell and Poth (2017), it is extremely important that researchers reflect on their philosophical worldview, which is closely related to the research design. Interpretative frameworks have been defined as the researcher's paradigms, beliefs, and theoretical orientations that could influence the study. Creswell and Poth (2017) describes four different paradigmatic interpretative frameworks: post-positivism, social constructivism, transformation, and postmodern.

As the researcher, I identified myself and my work within the social constructivist paradigm. According to this paradigm, individuals want to understand the world they live in and give subjective meanings to their experiences (Creswell & Poth, 2017). Considering that each person holds multiple meanings and complex views, the researcher's goal is to organize and present an understanding of participants' experiences. The researcher relies on the interactions of the participants to grasp the meaning of their experiences. Thus, researchers within this paradigm usually focus on "processes of interaction among individuals" (Creswell & Poth, 2017. p. 24). Additionally, in social constructivism, the researcher identifies and acknowledges his/her own background,

experiences, position in the study, and how they shape his/her interpretation (Creswell & Poth, 2017). Social constructivism is important to the present study as I am looking at individuals' experiences and interactions within the context of therapy, in order to understand how the therapist and the couple create meanings in the way that the CCT model works with trauma and addiction. My reflections as a researcher are presented in the reflexivity section.

Qualitative Research

The present study uses a qualitative design focusing on human experiences and social problems in their natural contexts. That means the researcher analyzes the data in the situation where participants experience the issue that is being studied (Creswell, 2014). According to Maxwell (2013), the intellectual goals of qualitative research are to: (a) understand the participants' meaning of events and experiences; (b) understand the particularities of the context in which individuals are involved, and how they are influenced by this context; (c) understand the process of the events, instead of focusing on the outcomes; and (d) identify unexpected events. Thus, qualitative researchers are interested on *how* things happen and what the *processes* are (Maxwell, 2013). Qualitative design can have multiple sources of data, such as "interviews, observations, documents, and audiovisual information," which are usually collected by the researcher (Creswell, 2014, p. 185). Researchers are the key instruments in qualitative research, because they interpret the data through their own observations and examinations of documents and processes (Creswell, 2014). The present study is interested on understanding the process of CCT through analysis based on transcripts from therapy sessions.

Qualitative Secondary Data Analysis

Secondary analysis has been defined as the “re-use of pre-existing qualitative data derived from previous research studies” (Heaton, 2008, p. 34). According to Heaton (2008) the two main purposes of secondary analysis are to address “new or additional research questions” or to corroborate previous research findings (p. 35). Irwin (2013) discussed the ethical aspects of secondary data analysis, especially regarding the ethical risks for participants. In order to address this concern, the author suggested making statements in informed consent the possibility of using the data for other research and teaching purposes (Irwin, 2013). Another challenge for using secondary data is that researchers are not part of the data collection. In this case, researchers need to have strategies that help them to understand the context of the data collection, such as contact with primary researchers or research team, and access to available literature and archived resources on the primary project (Irwin, 2013). Despite the challenges, Irwin (2013) stated that when the researcher understands the context of the data, they can be valuable. Secondary analysis can stimulate new questions and new opportunities for inquiry, and it could be a helpful source for research (Irwin).

The present study is a secondary research analysis of qualitative data, which were collected in a pilot randomized controlled trial (RCT) study conducted from 2009 to 2011. On this primary study, Lee and Awosoga’s (2015) goal was to evaluate the viability and practicality of a full randomized controlled trial of using a model of couple therapy, CCT, for the treatment of problem gambling. Additionally, the authors compared couples who went through the CCT treatment with control couples who received a non-specified and minimal treatment (Lee & Awosoga, 2015). The data for this study were

quantitatively analyzed, and published by Lee and Awosoga in 2015. The present study focuses on the qualitative aspect of the primary study, through the development of two case studies of couples with PG who participated in the CCT sessions. Therefore, the present study poses a new research question to the primary data. In order to address the concerns related to secondary analysis mentioned above, I accessed materials related to the primary research, such as the original research proposal (Lee & Solowoniuk, 2008), research report (Lee & Awosoga, 2012), and a peer-reviewed journal publication (Lee & Awosoga, 2015). Additionally, I participated in a five-day CCT training and sat in on weekly teleconferences with counsellors who were applying the model in a recent and similar expanded RCT research, which helped me to become more familiar with the context of the research and CCT sessions.

Case Study

Considering the different qualitative designs and the complexity of the topic of analysing the treatment of trauma and addictions in couple therapy, I select the case study design as the most suitable study design. That is because cases studies allowed me to analyse in-depth the therapeutic process as a whole. The case study approach explores real-life experiences of a single or multiple cases over time, with detailed and in-depth analysis (Creswell & Poth, 2017; Yin, 2014). Yin (2014) mentioned that case studies are relevant for “how” and “why” research questions, which are focused on events that the researcher cannot control. The present research uses the case study method to explore how CCT works with trauma and pathological gambling in the context of couples therapy. Through transcripts of therapy sessions, the goal is to describe how the model helped clients presenting with both trauma and addiction.

McLeod (2010) highlighted the importance of working with case studies in counselling and psychotherapy. According to McLeod, case studies are a way of creating evidence and discussing the possible values of a new treatment approach, and addressing critical issues that are relevant for practice. Case studies may be able to show and compare the evolution in clients' therapy sessions and offer interpretations of the therapeutic process, but they are not able to prove what caused the change or a good outcome (McLeod).

This study used the case study method consisting of two cases of couples in CCT sessions. Considering two cases for analysis is useful when the researcher wants to show different perspectives of the issue; it also allows comparison between cases (Creswell & Poth, 2017). When thinking about case studies, it is important to have a clear definition and delimitation of the case (Creswell & Poth, 2017). Regarding the present study, the data collection for both cases was in the same context and timeframe of a research study. Some outcome measures were used for the selection of the cases that were analysed. Further information regarding data collection and selection will be discussed in a following section.

The analytical strategy for this study is to first describe each case, then provide the themes that emerged in each one, and finally provide the common themes that cut across both cases. Creswell and Poth (2017) called these processes "within-case analysis" and "cross-case analysis." In this approach, the focus is on arriving at several key issues or themes. Different from quantitative studies, the goal of case studies is not necessarily to generalize the findings in a population. Instead, it seeks a better and in-depth understanding of the complexity of the case (Creswell & Poth, 2017). The present study

seeks an in-depth analysis of two couples with histories of trauma and addictions who underwent CCT. Consequently, it is not possible to generalize CCT's work with two cases. However, it is possible to provide detailed information on how the model worked with these two couples and initiate discussion regarding the model of CCT.

The report of the case studies will give enough information to enable the reader to become familiar with the case and its context. In order to do that, vignettes from the sessions in both cases will be provided to help the reader better understand each theme. Additionally, at the end of each theme, a summary will highlight the most important ideas. Creswell and Poth (2017) emphasized this idea by stating that the report need to be built with the readers in mind. To aid understanding, I have created a description of the issue that allows the reader to follow the my interpretations (Creswell & Poth, 2017). A closing summary allows me provide a conclusion and emphasize the complexity and the particularity of the cases (Creswell & Poth, 2017).

Data Collection and Case Selection

It is important to highlight some relevant aspects related to the data collection of the primary study. In the pilot RCT, a total of 15 couples were recruited from two differences provinces in Canada who met the following inclusion criteria: diagnosis of pathological gambling disorder for one or both spouses based on the DSM-IV criteria (APA, 2000), gambling activity in the previous two months, age of 18 years or older, and couples identifying themselves as being in a committed relationship (Lee & Awosoga, 2015). For the exclusion criteria, participants who had suicidal ideation or attempts and/or psychotic symptoms within the previous months, who engaged in or were victims of intimate partner violence, who received another treatment during the period of the

study, or who were involved with “loan sharks” were excluded from the study. From these 15 couples, 8 were randomly placed in the CCT treatment group, and the other 7 couples were randomly placed in the control group, in which couples received treatment-as-usual (individual counselling, group counselling, or non-CCT couple counselling) (Lee & Awosoga, 2015).

Lee and Awosoga (2015) collected quantitative data regarding participants’ gambling symptoms (Gambling Symptoms Assessment Scale, G-SAS), mental health (Brief Symptom Inventory, BSI), quality of couples’ relationship (Dyadic Adjustment Scale, DAS), and individuals’ systemic functioning (Systemic Functioning, STIC). Participants responded to these instruments at three points in time: before starting CCT sessions (Pre), after completing the 12 weekly sessions (Post), and at a 20-week follow-up session (Follow-up). In addition, Lee and Awosoga (2015) collected data on demographics, client satisfaction, and screening for trauma exposure or witnessing trauma using the Traumatic Events Screening Inventory Adult Screen (TESI-AS). Regarding the qualitative data, the researchers recorded twelve weekly sessions of CCT and the follow-up session for each couple, which were then transcribed with pseudonyms.

Case Selection

The material for this secondary qualitative analysis was drawn from two cases from this sample through purposeful sampling. According to Patton (2014), the purposeful sampling technique is broadly used in qualitative research, because it allows researchers to identify and select “information-rich cases whose study will illuminate the questions under study” (Patton, 2014, p. 264). In case studies, purposeful sampling allows the research to align the case selection to the research question (Patton, 2014).

Considering that the purpose of the present study is to describe how CCT sessions worked with couples in addressing trauma and addiction, I selected couples with the best progress in therapy because it could illustrate the couples who responded optimally to the use of the model. Thus, the case selection of the present study was based on the analysis of clients' progress in therapy.

Considering the difficulty in combining the analysis of results based on all the different instruments used in the primary research mentioned above, the present study based the case selection only on the analysis of results of the Dyadic Adjustment Scale (Spanier, 1976) as the main indicator of couple's progress in therapy. That is because DAS is the one instrument in which both spouses (gambler and partner) are evaluating a common area of functioning, namely, the quality of their relationship. Although the primary study utilized the TESI-AS (Ford, Hawke, Alessi, Ledgerwood, & Petry, 2007) to assess clients' history of trauma, the instrument is based only on self-reported traumatic events. In its 18-item questions on specific types of traumatic events, TESI-AS can give more detailed information about *what* traumatic events that participants experienced, but it does not give more in-depth information on *how* the individuals were affected by trauma. Additionally, TESI-AS is a historical instrument based on participants' retrospective report.

The DAS is a 32-item instrument that seeks to measure the quality of relationships, including any type of committed relationship. This instrument is organized under four subscales: dyadic consensus; dyadic satisfaction; dyadic cohesion; and affectional expression (Lee & Solowoniuk, 2008; Spanier, 1976). Lee and Awosoga (2012) analysed clients' changes in pre, post and follow-up, by comparing the means of

their scores on DAS using the Friedman’s Test (See Appendix A). The interest in looking at couples with the best progress in therapy is because the present study also seeks to better understand *how* CCT might have helped couples dealing with trauma and addictions.

Procedure. The Friedman Test provided statistical analysis of each participant’s changes on scores over time, by comparing means of pre, post, and follow up treatment scores. Lee and Awosoga (2012) presented DAS scores for each participant (gambler and partner) for all couples that were part of the study (7 couples in the control group, and 8 couples in the CCT group).

To select the two couples for the present study, first, I disregarded all couples that were in the control group, because they did not receive CCT treatment. Second, I disregarded couples in which one of the partners did not have statistically significant change in DAS scores, because I am interested in couples in which both partners showed significant change in their relationship satisfaction. Tables 1 and 2 illustrate, respectively, gamblers and partners who showed significant on DAS scores in pre, post, and follow-up treatment:

Table 1. Gamblers’ scores on DAS scale (Lee & Awosoga, 2012)

Participant	Pre		Post		Follow-Up		Friedman Test Stat	SIG.
	Mean	SD	Mean	SD	Mean	SD		
A (B1MG)	2.69	1.091	3.66	1.096	3.47	1.344	36.024	0.000*
B (B2FG)	3.34	1.359	3.03	1.282	3.69	1.256	11.241	0.004*
C (B3MG)	2.78	1.099	2.78	1.099	3.16	1.194	11.924	0.003*
D (C1FG)	2.22	1.211	2.91	1.279	2.81	1.091	10.571	0.005*

Note: *significant change in scores at $P < 0.05$

Table 2. Partners' scores on DAS scale (Lee & Awosoga, 2012)

Participant	Pre		Post		Follow-Up		Friedman Test Stat	SIG.
	Mean	SD	Mean	SD	Mean	SD		
A (B1FS)	3.06	1.134	3.72	1.170	3.84	1.167	26.964	0.000*
B (B2MS)	3.41	1.241	3.44	1.413	3.91	1.058	10.630	0.005*
C (B3FS)	2.72	1.250	3.06	1.268	3.03	1.332	8.704	0.013*
D (C1MS)	1.91	1.146	2.25	1.047	2.03	0.999	7.412	0.025*

Note: *significant change in scores at $P < 0.05$

By comparing participants' mean differences at the three time points (pre, post, and follow-up), it is noted that each participant had a different progression across the three points. For example, gambler A showed improvement from pre and post, but a slight decline from post to follow-up. On the other hand, gambler B showed decline from pre and post, but improvement from post and follow-up. Therefore, I decided to choose the two cases based on the overall mean of their scores. Participants' overall average are illustrated in Tables 3 and 4 below:

Table 3. Gamblers' Overall Score on DAS (Lee & Awosoga, 2012)

Participant	Treatment Scores (<i>mean</i>)			Overall Average
	Pre	Post	Follow- Up	
A (B1MG)	2.69	3.66	3.47	3.27*
B (B2FG)	3.34	3.03	3.69	3.35*
C (B3MG)	2.78	2.78	3.16	2.91
D (C1FG)	2.22	2.91	2.81	2.65

Note: *higher average scores

Table 4. Partners' Overall Score on DAS (Lee & Awosoga, 2012)

Participant	Treatment Scores (<i>mean</i>)			Overall Average
	Pre	Post	Follow-Up	
A (B1FS)	3.06	3.72	3.84	3.54*
B (B2MS)	3.41	3.44	3.91	3.59*
C (B3FS)	2.72	3.06	3.03	2.94
D (C1MS)	1.91	2.25	2.03	2.06

Note: *higher average scores

Both gamblers and partners from cases A and B had the highest average scores. Thus, Case A and Case B were selected for analysis in this study.

Ethical Considerations

Because this research project is a secondary analysis of a completed study and the data were already collected, there is no need for an informed consent form. During the data collection, the main researcher, Dr. Bonnie Lee, included in the consent form that the material could be used for research by graduate students under her supervision (Appendix B). In order to access the transcripts of the sessions for secondary analysis, a confidentiality form was signed (Appendix C).

Another ethical aspect of this case study is to disguise and remove identifiable information of the participants. The participants' identities are protected by using pseudonyms as well as by removing any other specific information that might identify them. The digital documents were protected with passwords and saved on a USB, which was also protected with a password, and backed up on my desktop computer in my office at the university campus.

Data Analysis

Thematic Analysis

Thematic analysis was the method used for the data analysis in this study. According to Braun and Clarke (2006), thematic analysis makes it possible for researchers to identify, analyze, organize, and report patterns in the data. Themes are relevant and meaningful aspects of the data that are related to the research question(s), and which appear repeatedly in the data set. There are two ways of identifying themes, inductive and deductive. In the inductive way, or 'bottom up' approach, the data are

coded without a pre-existing framework. In the deductive way, the ‘top down’ or ‘theoretical’ approach, coding is based on the researcher’s theoretical interest and on the engagement of the literature review to guide the analysis (Braun & Clarke, 2006). Nowell, Norris, White, and Moules (2017) highlighted the flexibility of thematic analysis, which makes it suitable for complex data. Thematic analysis helps researchers to summarize the main aspects of a large data set and, at the same, provides a rich and detailed explanation of the data. Additionally, this method allows the researcher to highlight both similarities and differences within the data (Nowell et al., 2017).

According to Braun and Clark (2006), the analytical process in thematic analysis is not linear. Instead, it is characterized by “a constant moving back and forward” between the codes and the data (Braun & Clark, 2006, p. 86). Braun and Clark described six steps of the thematic analysis. The first step is for the researcher to *get familiar with the data* through active readings and by looking for possible meanings and patterns. Then, the researcher *generates initial codes* by giving full and equal attention to the whole data, and identifying interesting aspects of the raw data. After generating codes, the researcher should *search for themes* within those codes and organize them into possible themes. The researcher should then *review the themes* through the process of “checking if the themes work in relation to the coded extracts and the entire data set” (p. 87). After refining the themes, the researcher *defines and names the themes*, by identifying and describing the central meaning of each theme and the relationships among them. The final step is for the researcher to *produce the report*, which consists of the final analysis and explanation of the story that comes from the data, which includes giving the reader evidence through examples from the data.

Although thematic analysis is a method that can be used in a variety of theoretical perspectives (Braun & Clarke, 2006), it nonetheless is informed by an epistemological position. As discussed earlier, the epistemological position for this thematic analysis is based on social constructivism (Creswell & Poth, 2017). Social constructivism facilitates an in-depth analysis of the contexts of CCT sessions, and the identification of themes that illustrate the therapist's interactions with the clients for the treatment of trauma and addictions.

Procedures. The data analysis started with familiarization of the transcripts of the CCT sessions. Case A (Antonio and Amanda) had transcripts of 12 sessions and a follow-up session, and Case B (Barb and Bob) had 9 sessions and a follow-up. Although there were two sessions missing for case B, I proceeded with the analysis because the existing 10 sessions still provided in-depth information about the case, especially because the missing sessions were not from the beginning or end of the therapy. This initial phase of analysis was done in word document, in which I added comments and initial coding. Then, I re-read and coded the data in NVivo 11 software (QRS International, 2015). This stage of the analysis involved multiple readings of the data and reviewing of the codes. This procedure continued until major codes were grouped into themes. Finally, after describing those themes, each of them were revised. Although I had CCT as a framework, the themes emerged inductively from the data.

Reflexivity

According to Maxwell (2013), “the researcher *is* the instrument of the research” (p. 45). Traditionally, researchers’ “identity” and “background” were considered bias which it should be removed from the study (p. 44). However, Maxwell argued that

researchers' knowledge, research background, and personal experiences can be valuable for the research. Thus, reflexivity is important in qualitative research. Creswell (2014) defined reflexivity as the process in which the researchers reflect on their personal experiences and background, as well as on their role in the research. This process not only allows the researcher to identify possible biases, but also to reflect on how his/her own experiences might shape the study (Creswell, 2014).

Beginning when I was a nursing student, I have been interested in understanding patients' experiences in illness. Because of my curiosity, I conducted qualitative research as an undergraduate thesis that involved exploring women's experiences with their own health issues, and examining mothers' experience of their children's hospitalization. My interest in mental health also grew in university course that offered me experience and practice with clients in mental health services, which included individualized nursing consultations based on psychoanalytic theory.

During my exchange program in Canada from Brazil, I deepened my knowledge in the mental health area by taking courses on: Loss, Grief and Bereavement; Family Life Cycle in Addiction; Introduction in Addiction Studies; Contemporary Issues on Mental Health; and Basic Concepts in Psychology. In preparation for my Masters research, I took additional courses and training in Individual Counselling, Traumatized Population and Addictions, and a 5-day CCT training offered to addiction counsellors. Additionally, I participated in weekly teleconferences with addictions counsellors and members of the research team investigating the use of the CCT model in another research study.

These courses, training, and research experiences helped me to become familiar with couple counselling using the CCT model in addictions, which informed my research

in the secondary analysis of CCT cases for my thesis. However, I would still consider my research as bringing an outsider perspective to the CCT research because even though I have theoretical knowledge, I am not a clinical counsellor or therapist. This position allows me greater objectivity to notice different elements of the model that are not necessarily related to the theoretical aspects of the model.

Trustworthiness

When planning academic research, it is essential to think about ways to ensure quality. In qualitative research, experts refer to trustworthiness and authenticity. Trustworthiness is based on: credibility; transferability; dependability; and confirmability (Bryman, Bell, & Teevan, 2012; Lincoln & Guba, 1985), which can also be applied to thematic analysis (Nowell et al. 2017).

- *Credibility* refers to confidence that the data and research process appropriately address the focus of the research (Lincoln & Guba, 1985; Polit & Beck, 2018). According to Connelly (2016), researchers can establish credibility through “prolonged engagement with participants, persistent observation if appropriate to the study, peer-debriefing, member-checking, and reflective journaling” (p. 435). Additionally, Shelton (2004) also suggested that providing a thick description of the research report can also ensure credibility, along with a statement of researcher’s background, including qualifications and experiences.
- *Transferability* “refers to the generalizability of inquiry” (Tobin & Begley, 2004, p. 392). In qualitative research, transferability refers to the applicability and/or how the research and its findings can be useful to others in different settings (Polit & Beck, 2018). In this case, qualitative researchers should provide a thick

description of the study allows the reader to judge its transferability (Lincoln & Guba, 1985; Nowell et al., 2017).

- *Dependability* refers to the process of data collection and data analysis and its stability over time (Polit & Beck, 2018, p. 296). This addresses the concern of inconsistency of the data over time (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). According to Shenton (2004), dependability uses procedures that shows that the repetition of the research (in the same context, methods, and participants) would give similar results. Audit trails of process logs, peer-debriefing, and a detailed report are some examples of how to address dependability (Connelly, 2016; Shenton, 2004)
- *Confirmability* is comparable to objectivity. In qualitative research, it refers to generating findings that are clearly derived from the data, which requires the researchers to show how they reached the findings and conclusions (Nowell et al., 2017; Tobin & Begley, 2004). Confirmability is addressed through researchers' reflections on their beliefs behind the decisions made throughout the study, as well as the study's limitations (Shenton, 2004). Peer debriefing and detailed notes can also address confirmability (Connelly, 2016).

Regarding the trustworthiness of the present study, I provide readers a thick description of the cases, which allows them to make their own interpretation of the material. Additionally, I provide an extensive description of the methodological procedures, including the RCT study. I ensure the transparency of the research by clarifying my biases through a reflexivity process. I also chose to stay close to the data with “low-inference description” in the manner of a descriptive study (Sandelowski,

2000, p. 337; Sandelowski, 2010), which does not include an evaluation of the effectiveness of the model, nor does it rely heavily on a priori theoretical assumptions and interpretations. As discussed earlier, the thematic analysis adopted was inductive, from the bottom up, staying close to the data. I came up with the themes and conclusions independently. Thus, in order to prevent biases related to my relationship to my supervisor (CCT's author), I presented my thematization to my supervisor after having completed the entire analysis. Finally, peer debriefing and external auditing were emphasized by having a heterogeneous research committee, which included my thesis supervisor and other experts in qualitative research and counselling. During the analytical process, I had regular meetings with the committee members to discuss case selection and the emerging findings. Peer debriefing and external auditing processes are ways to review and question the findings (Bryman et al., 2012; Cohen & Crabtree, 2008; Creswell, 2014).

CHAPTER 4. FINDINGS

In this chapter, I describe themes emerging from case analysis conducted on transcripts of two couples in CCT sessions. I begin by briefly describing these cases to facilitate understanding of themes. Additionally, two tables show the distribution of themes throughout therapy sessions. These tables represent the flow of each theme within the sessions. I use short vignettes to present findings and illustrate relevant moments of therapy sessions. This allows a broader contextual understanding of the sessions.

Participants

Case A. Antonio and Amanda had been married for more than 10 years. The couple first came to therapy with difficulties in their relationship related to Antonio's gambling and substance use, with the goal to understand and help him end his addiction. Amanda's main complaints were related to lack of trust in her husband and his disconnection from the family. Antonio had a difficult and traumatic childhood, in which he experienced emotional neglect, abandonment by his father, as well as severe physical and emotional abuse. In therapy, the gambling client seemed highly avoidant of his past, evidenced by his difficulty in expressing his thoughts and feelings about it. Amanda also had issues with her family of origin (FOO), her father's gambling, and her parents' divorce, which contributed to her present relationship problems with Antonio. Amanda's anxieties related to her husband's behaviour and addiction became evident in the sessions.

Case B. Barb and Bob had been together for more than 10 years. Barb had been struggling with gambling for the past 13 years, but she also reported a long history of drug and alcohol abuse since early adulthood. She described herself as someone with an

“addictive personality.” Barb had experienced multiple deaths among family members during her lifetime, starting in childhood and continuing into adulthood. As a child, she grew up in an unstable and abusive family environment. This instability together with emotional abuse continued through her adulthood with her ex-husband. Barb was overwhelmed by the multiple deaths she had experienced in her family over the years, and came to the sessions wanting to deal with these “other parts of her life” besides her addictions. Bob mentioned his worries about the financial situation stemming from Barb’s gambling losses, and he avoided conflicts with Barb because of the fear of “making her gamble.” Bob did not report any history of trauma or addiction.

Themes

Five themes emerged from analysis of the couples’ therapy cases; two of the themes have sub-themes. These themes illustrate relevant aspects of CCT sessions working with trauma and addiction within the context of couples’ therapy. The first, **Building the Foundation for Couples Therapy: Therapeutic Alliance in CCT**, illustrates how the therapist worked with alliance and set the space for working with trauma and addictions in the first few sessions. Second, **Understanding Gambling Patterns and Building the Timeline of Addiction**, presents how the therapist tried to explore clients’ understanding of addiction, and how she navigated through gambling and other addiction patterns. Third, **Connecting Addiction with Life-Stressors, Trauma, and Childhood Wounding**, illustrates how the therapist gradually linked the addiction with clients’ life experiences, including life stressors and childhood trauma, and how those experiences link to their inner experiences. Fourth, **Exploring Trauma within the Context of Relationship** presents how the therapist explored trauma during sessions

through the exploration of the sub-themes *Family of Origin (FOO)* and *Intergenerational Trauma*, and by *Exploring the Effects of Trauma in Present Couple and Family Relationships*. Finally, the fifth theme, **Healing Trauma and Addictions through Reconnection with Self and Others**, addresses how CCT helped clients in their process of healing from trauma and addictions through *Reconnecting with FOO*, *Reconnecting with Partner and Children*, and *Healing through Self-Connection*. These themes reflect the multiple non-linear layers that arose from the analysis. Figure 4 illustrates how the themes appeared within the two cases.



Figure 4. The Four Elements in Working with Trauma and Addictions in CCT

This multi-layered process of the alliance creation, understanding the addiction, and exploring and connecting with trauma are inter-related processes. Healing through reconnection is the center of the process. In order to gain a better understanding of CCT's therapeutic process, I tracked the presentation of each theme over each session for both

cases. Tables 5 and 6 illustrate CCT’s iterative process. Even though the model had some set interventions at the beginning of therapy, for example, the exploration of client’s FOO and building their timeline of addiction, these aspects were continuously explored and deepened throughout subsequent sessions. The distribution of themes over the therapeutic process in both cases are illustrated in Tables 5 and 6.

Table 5. Theme Distribution: Case A

Themes		Sessions											
		1	2	3	4	5	6	7	8	9	10	11	12
1	Building the Foundation for Couples Therapy: Therapeutic Alliance in CCT	X	X	X	X	X	X	X	X	X	X	X	X
2	Understanding the Addiction and Building Addiction Timeline	X	X	X ¹		X			X			X	X
3	Connecting Addiction with Stressors, Trauma, and Childhood Wounding	X	X	X	X	X	X	X	X	X		X	X
4	Exploring Trauma within the Context of Relationships												
4.1	Exploring FOO Relationships and Intergenerational Trauma	X	X	X ²	X ³	X	X	X	X	X	X	X	X
4.2	Exploring Effects of Trauma and Addictions in Present Couple and Family Relationships	X	X	X	X	X	X	X	X	X		X	X
5	Healing from Trauma and Addictions through Re-Connection with Self and Other												
5.1	Reconnecting with FOO	X		X	X	X		X		X			X
5.2	Reconnecting with Partner and Children in the Present	X	X	X	X	X	X	X	X	X	X	X	X
5.3	Reconnecting with Self	X	X	X	X	X	X	X	X	X	X	X	X

Notes: X¹ Building timeline of addictions; X² Exploring Antonio’s FOO; X³ Exploring Amanda’s FOO.

Table 6. Theme Distribution: Case B

Themes		Sessions											
		1	2	3	4	5	6	7	8	9	10	11	12
1	Building the Foundation for Couples Therapy: Therapeutic Alliance in CCT	X	X	X	X	X	X	X	X	-	-	X	X
2	Understanding the Addiction and Building Addiction Timeline	X	X	X		X	X ¹		X	-	-	X	X
3	Connecting Addiction with Stressors, Trauma, and Childhood Wounding	X	X	X	X	X	X	X	X	-	-	X	X
4	Exploring Trauma within the Context of Relationships												
4.1	Exploring FOO Relationships and Intergenerational Trauma	X	X	X	X ²	X ³	X	X	X	-	-	X	X
4.2	Exploring Effects of Trauma and Addictions in Present Couple and Family Relationships	X	X	X	X	X	X	X	X	-	-	X	
5	Healing from Trauma and Addictions through Re-Connection with Self and Other												
5.1	Reconnecting with FOO	X	X	X	X	X		X		-	-	X	X
5.2	Reconnecting with Partner and Children in the Present	X	X	X	X	X	X	X	X	-	-	X	X
5.3	Reconnecting with Self	X	X	X	X	X	X	X	X	-	-	X	X

Notes: X¹ Building timeline of addictions; X² Exploring Bob’s FOO; X³ Exploring Barb’s FOO; Shaded columns are missing sessions.

Regarding the healing process observed within the two cases, the mechanisms of clients’ reconnection with themselves were also inter-related, with one facilitating the other, as illustrated in Figure 5 below.

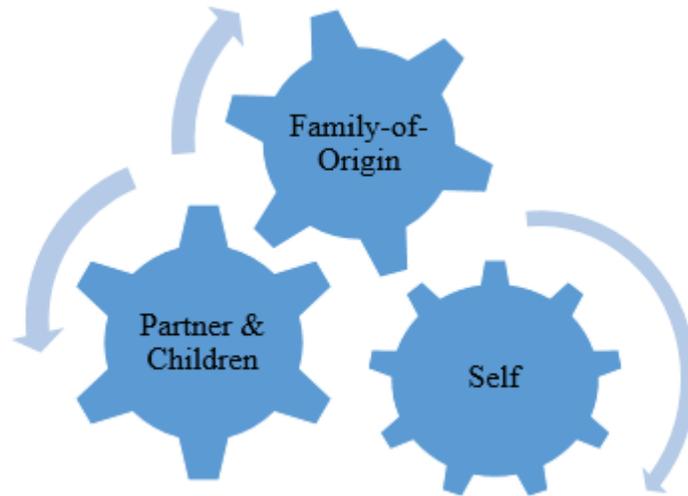


Figure 5. Healing Process through Reconnection

Theme 1. Building the Foundation for Couples Therapy: Therapeutic Alliance in CCT

Considering the complexity and sensitivity of the trauma and addictions treatment, it is important to highlight and describe how CCT set up the space to work these sensitive issues in the context of couples' therapy.

Case A: Antonio and Amanda

Therapeutic alliance refers to client-therapist relationship in therapy, which consists of three aspects: (1) therapist and clients' bond, which is based on understanding, comfort, respect, and trust; (2) therapist and clients' agreement on tasks and activities that will take place in sessions; and (3) therapist and clients' agreement on goals for the therapeutic process, which is related to specific areas for change (Bordin, 1979; Raue, Castonguay, & Goldfried, 1993)

In CCT, the therapist started building therapeutic alliance with clients by exploring clients' hopes and wishes for the sessions. In asking the clients about their hopes and wishes, the therapist begins setting an initial plan for the sessions, namely to

explore and understand what started Antonio's gambling, and to rebuild trust in the therapeutic relationship. By exploring clients' hopes and wishes, the therapist honours clients' intention in seeking therapy in a positive way, rather than focusing on the problem that brought them to therapy. The following vignette exemplifies this process.

Vignette 1 – Case A, Session 1

Therapist: For our first session I would like to find out what your hopes and wishes are for these sessions, what you hope to get out of these sessions. Then, we will do some exploring, maybe learn a little bit more about Antonio's gambling, and we will take it from there.

Amanda: Umm. I hope to get a better understanding of why Antonio gambles, and what the addiction of gambling is all about. And, I hope that I can learn to trust Antonio more than I do right now.

Therapist: So, your trust has been hurt because of his gambling?

Amanda: Maybe because of the lies he told while he was gambling.

Therapist: So, you want to gain an understanding of what brought him to gamble.

Even though the therapist mentioned Antonio's gambling, it was only intended as a starting point for their work in therapy. As the partner hoped to understand more about her husband's addiction, she also shared her frustration and broken trust, emphasizing Antonio's lies about the addiction. The therapist acknowledged her feelings of hurt caused by the gambling, while reframing and reinforcing the purpose of the therapy to understand why Antonio gambles. This way, the therapist tried not to focus on the gambling behaviour; instead she reframed Amanda's statements by highlighting the feeling related to the addiction. After briefly exploring Antonio's understanding and behaviours related to gambling, the therapist brought up information from questionnaires, which revealed stressful life events, such as Antonio's history of childhood abuse.

Vignette 2 – Case A, Session 1

Therapist: About the stressors. We may not go into all of that today. But, I did have a chance to go over your questionnaires, and it sounded like, Antonio you have had different events in life that were traumatic for you.

Amanda: Absolutely.

Antonio: Yeah.

Therapist: Yeah, and we will talk about that. We do not have to talk about it in the first session. But, you made a good point because with the car accident you nearly died. All that could bring back some of these old feelings that were buried way down from your childhood or from earlier life. (...) Maybe, in these 12 sessions would give you a chance to process some of that and find some new ways to deal with stress rather than running away from it. Being more aware of yourself. Then, you are connected with yourself and find ways to deal with all of that. (...) So, let's hear what you want to get out of these sessions (...).

Antonio: What I want to get out of these sessions? I guess I want to understand better some of the things that gets me there to gamble. I want to keep my marriage, probably even more than I want to understand why I gamble, or whatever. Umm, I do not know (...).

Therapist: What about learning how to appreciate yourself a bit more?

Antonio: Yeah, I guess that is all in that recovery. Coming to learn it, I guess.

This vignette illustrates how the therapist introduced the discussion of stressful events' impact in the client's life. By providing psychoeducation related to traumatic events, the therapist also set a plan about what will unfold in subsequent sessions. This way the therapist paced the disclosure of trauma and gave an idea of how therapeutic work progresses and deals with trauma and addictions, giving the clients a clear direction, and facilitating safety. Finally, the therapist explored Antonio's hopes and wishes, endeavouring to engage with both clients regarding their hopes and wishes for the therapeutic process.

Psychoeducation also came up in other sessions. For example, in session 3, the therapist started the session by giving clients an overview about how the model understands addiction and how it relates to individuals' experiences. In this process, the therapist tried to engage the clients in their understanding and perception of the issues. This could give the clients clarity about the process and facilitate their engagement. The following vignette illustrated that moment:

Vignette 3 – Case A, Session 3

Therapist: I will start the session by giving you a framework of how this model works. (...) (Therapist begins to illustrate on a board) So, I will draw two simple diagrams. At the heart of any addiction, including gambling, is disconnection. So, this is my theory okay? At the heart of any kind of healing, is reconnection. Okay? So, what is it that we have to connect? Or what is disconnected? What do you think?

Amanda: The self.

Therapist: Yes, Okay. So, if you are not aware of what you are thinking and feeling, or what your wishes or your human yearnings are... If you are not aware of, when you are sad or when you are overwhelmed, then you cannot do anything about it, right? So, first of all, we want to make that inner connection. So, in kind of academic jargon, we call it intra-psychic; that means what's inside. Okay? You know inside connection. But, in this system, it is disconnected. Would you say you are aware of what you are thinking and feeling, most of the time?

Antonio: I think so, most of the time.

Case B: Barb and Bob

In Barb and Bob's case, it seems like the therapist sensed client's high anxiety when they first came, so she began with the present moment by asking them what it was like for them to come in for couple counselling and their feelings about the therapy before getting into their hopes and wishes. This shows another relevant aspect in alliance, the therapist's ability to read clients' body language to acknowledge feelings in the moment to peel back the layers of emotions.

Vignette 4 – Case B, Session 1

Therapist: Welcome to our first session. How do you feel about coming to your first session?

Bob: Nervous.

Barb: Very nervous.

Therapist: Nervous? OK, let's talk about what you are nervous about.

Barb: Whatever we are gonna talk about.

Therapist: So, you do not know what's gonna come out, is that what you are nervous about?

Barb: Exactly, yes.

Therapist: I find that people generally know how much to say, and what they are comfortable with, and with the support here, I think you will be all right. It is a little scary, and it is little like a venture in to the unknown, eh?

Barb: Very much so, ya.

(Exploring client's previous experiences with therapy)

Therapist: What about you, Bob, what are you nervous about?

Bob: Oh, just what kind of questions you'll ask, how deep so you want to go into our personal lives. All that type of stuff.

Therapist: You can say what you feel comfortable with. You do not have to answer all my questions. Maybe, just say, "Well I am not prepared to answer that right now", or "I am a little nervous about that," (...) So, I think maybe the first lesson is you trust yourself, and your own pace and your comfort level. Take that as your guide. And I am not a big authority figure! So (laughs) feel free to say "no" and that is really important too.

Barb: To say no?

Therapist: Yes, to me.

In this process, the therapist acknowledged couple's feelings by repeating ("nervous") and naming ("scary") them, and tried to normalized their feelings, by saying that people tend to be nervous about the unknown. In this process, the therapist was trying to create a safe space in the session. She also tried to increased client's sense of safety by reinforcing client's control over the sessions and affirming Barb's ability to trust herself. This way, the therapist is also pacing the disclosure of stressful and traumatic events in the session. It is important to note that she engaged with both clients. After creating some safety in session, the therapist explored clients' hopes and wishes:

Vignette 5 – Case B, Session 1

Therapist: What are your hopes and wishes? You took this big step coming here today despite your fears. There is something really important that brought you here.

What do you hope to get out of these sessions even though it is a risk?

Barb: Because I am hoping it will help me to quit gambling and help other parts of my life.

Therapist: Yes. What other parts of your life?

Barb: To learn not to run – how to deal with my feelings.

Therapist: Yes. That is a very good goal, and we can certainly work on it here. Because gambling is one thing, but the rest of your life – that is big, right? It follows you; you cannot run away from yourself.

Barb: No, I find that to be so true – so I need to learn how to stand up and fight I guess.

Therapist: So, those are big statements, actually: stand up and fight. So true, and such honesty in that – and if you have to cry, you cry.

Therapist: Do not hold back: if you cry, you cry. Because, where else can you do that? (...) And breathing is important too. (Laughs)

Barb: I find that I stop myself from breathing a lot.

Therapist: OK, so let's all breathe. (Laughs) Deep breaths. So, what brought you here, Bob?

Bob: Actually, my wife brought me here. She talked me into coming here to see if we can get in to this program to help her quit gambling. Hopefully to find out why she does not want to quit or whatever it is so that is why I am here. Supporting my wife.

Therapist: Supporting your wife (...) that is a sign of how much you care about her and the relationship, right?

As shown in the vignette above, when exploring the client's hopes and wishes, the therapist also acknowledged client willingness and honesty in choosing to come to therapy. She focused on the client's strength. Instead of only focusing on addiction, the therapist reinforced client's openness to explore "other parts of her life" and validated her own statements, such as "stand up and fight." To balance her communication between the couple, the therapist also asked Bob about his hopes and wishes. Even though quitting gambling came up again; the therapist repeated and reinforced the positive intent of his wishes, which is to support his wife. This way, the therapist tried to begin the therapy process by promoting the couples' connection and alignment, acknowledging their nervousness, courage, and positive intent. The following vignette illustrates the beginning of session two, when the therapist was looking over forms that the clients filled out:

Vignette 6 – Case B, Session 2

Therapist: Are we in an agreement about how the therapy is going to be conducted?

Bob: You know, what I want to happen in therapy was... her gambling and stuff like that.

Hopefully, we are in an agreement that we can get something accomplished.

Therapist: About the gambling? Yeah...

Bob: Um-hum...

Therapist: And that is a very good question. With this model of therapy, we look at how you were impacted by all the losses you suffered; what your relationship here is like and how it can be helpful to you. By looking at some of these other things, my guess is her gambling will go down. What drives you to gamble do you think? So, we are going underground a little but to get to the root system .

The therapist noticed that Bob seemed to have the expectation that therapy target Barb's gambling behaviour directly. The therapist acknowledged his possible need to

understand how therapy works, and tried to clarify expectations about how they were going to help with the gambling. The therapist provided psychoeducation about the model. She gave an initial idea about how the model connects trauma and addictions, and how work with the relationships one has with oneself and with one's significant others could be helpful.

Summary

It is essential to build a trusting relationship with both partners to create a safe environment in the sessions, so the therapist is not perceived to be aligning with one over the other. At the beginning of therapy in both cases, the therapist tried to build a balanced therapeutic alliance with both partners by acknowledging their feelings, hopes, and wishes. In doing so, she tried to create a safe environment of trust and validation, with an emphasis on the clients' strengths, so as not to reinforce their existing shame and problem-focused views. By exploring client's hopes and wishes, the therapist gained an initial understanding of how clients see the addiction problem and couples' relationship, and set an initial plan for the following sessions. The unknown can raise anxiety in clients, so providing clarifications to clients' doubts and direction to subsequent sessions facilitated clients' engagement and feeling of safety in therapy. In different ways, the therapist worked with clients' presentations and emotions in setting the pace for exploring stressful and traumatic experiences that were brought up explicitly or implicitly in the first session. For example, in Case B, as clients seemed more anxious about the therapy, the therapist reaffirmed their control over sessions. The beginning of the therapeutic process is critical, and how the therapist responded to them gave a sense of the therapeutic process to come.

Theme 2. Understanding the Addiction and Building Addiction Timeline

Gambling was initially the main concern and the reason why the couple sought therapy. To align with couples' interest and motivation, the therapist explored clients' addiction behaviour and their understanding of it, although she gradually led the couple beyond the behaviour of addiction itself.

Case A: Antonio and Amanda

At the beginning of therapy, the therapist tried to explore client's understanding of the addiction. As they explored their hopes and wishes, Amanda brought up her frustration with Antonio's addiction (see Vignette 1). Then, the therapist inquired about the problem gambling timeline: its onset, escalation, and course. She also questioned about type of gambling and amount of money lost.

Vignette 7 – Case A, Session 1

Therapist: And has that been going on for many years? The gambling. How long has it been going on?

Antonio: Well, I have gambled over the years for sure, but it has definitely escalated here in the last I would say nine months, but probably really more in the last six months.

Therapist: And how do you understand that? What precipitated that?

Antonio: I do not know. I guess probably just the frequency, and the amount of money that I gambled.

Therapist: But what made it escalate?

Antonio: Oh, I do not know. That part, I guess I am not a hundred percent sure on...
(Inaudible mumble)

Therapist: So, how much money do you think you have lost?

This vignette illustrates how the therapist inquired about the Antonio's understanding of his addiction. This open-ended question was a way to learn the circumstances in which gambling occurred and whether there were any events precipitating it. Antonio appeared largely unaware of the precipitating factors and his own inner state in the onset and escalation of his gambling. Instead, he described his

addiction patterns, such as frequency and amount of money lost. Then, the therapist followed his train of thought and asked a few more questions to understand his gambling pattern, including the type of gambling.

Although the initial focus was on the PG, later in session three the therapist explored Antonio's other addictions.

Vignette 8 – Case A, Session 3

Therapist: (...) Alright? Maybe, just going back to what you said, Amanda. You said Antonio has always used drugs or substances. Tell me a little bit about that history.

Amanda: Be honest.

Antonio: Well...

Amanda: Since he was 12 years old.

Antonio: Well, I smoked marijuana.

Therapist: When?

Antonio: I do not know. How old are you in grade seven?

Amanda: Twelve (...).

Antonio: So, twelve. (...).

Therapist: So, you started marijuana.

Antonio: Yeah.

Therapist: Have you used it constantly?

Antonio: Yup.

Therapist: Like, all the way into your adult life?

Amanda: He does still?

Therapist: So, it is like a cigarette, right?

Antonio: Well, no...no. Not like... I do smoke. I smoke cigarettes, but that is... I guess I always say to my wife, people come home and have a drink at the end of the day, that is what I do at the end of the day.

Therapist: So, you do it every day?

Antonio: Yup.

Therapist: Do you still do it?

Antonio: Yes.

As noted above, the therapist started again with an open question about the client's history of addiction, to capture Antonio's perception and understanding of his addiction patterns. Then, the therapist started to delineate the client's history in using multiple substances, building a timeline of Antonio's addiction. Again, the therapist asked similar questions similar to the exploration of gambling, such as age, period of

time, duration, and frequency, in order to gain a better understanding of the client's addictive patterns.

Besides creating the addiction timeline, the therapist also explored and inquired about possible abstinence, urges, relapses, and ways of coping during the therapeutic process. Thus, as the therapy progressed, the therapist started to focus more on the changes in Antonio's gambling pattern. The following vignette illustrates one of those moments.

Vignette 9 – Case A, Session 8

Therapist: So, how are your urges about gambling?

Antonio: Really, my urges... that part is easy to me because work has been busier and picking up and... I just do not put myself in the situations to give myself the urge so... On one hand it, I guess it is easy to say it is easy but I mean – it is easy when you avoid it all together.

Therapist: Have you gambled at all since we started these sessions?

Antonio: No. It is a 110 days today. And, that is ... no, nothing. Nothing.

Therapist: Well, that is good for you. Are you worried about [the gambling]?

Antonio: Well, no. Right now, I am not. It is just that... no, I am not. (...) I do not have that urge but then again, I avoid a lot of those situations (...)

Therapist: Yes. But, you did something about them. To avoid having them come up.

Antonio: Yes. I guess. (...) I mean – I still, I still go to a bar. I still go into those situations yet I am not focused on it at all. I guess I am there just as much as maybe, you know, as I was before, yet, it is just a different mindset.

Therapist: A different mindset and how to take better care of yourself now.

Antonio: Yeah. Yeah. For sure.

Therapist: And Amanda. How worried are you about his gambling?

Amanda: Not as worried as I was before when I first came here because he – I think he is really taking a look at his past and seeing how it defined some of the choices that he is made.

Therapist: Yes. Yes.

Amanda: Yeah. So, I mean, he is making a conscious effort to do better. Like, he is – not just better gambling, just better all around.

Therapist: What changes have you found in him?

Amanda: We talked about this. (...) Yeah, like I found changes in him. And we were just talking and trying to figure it out. I think we were talking about how some of the changes have come because you felt like you had a weight lifted off your shoulder. (...)

Antonio: --well there was all that constant fears. (...)

As they were talking about his changed gambling patterns, the therapist brought awareness to the couple's present pattern of awareness of self and other, the changes in their relationship, and their reduced anxiety, which reinforces the possibility of sustained change for the client. As Antonio described his changes, the therapist acknowledged his efforts by making positive statements about his relationship with himself; how is taking care of himself, and taking responsibility to avoid risky situations. The vignette also illustrated how the therapist included the partner in the discussion. By asking Amanda about her worries, the therapist was not only not appreciating her perspective, but also possibly promoting her acknowledgment for Antonio. Thus, more than only exploring the changes in the addiction patterns, the therapist was linking the increased responsibility for the self, along with changes in their relationship to the positive impact on each other and on the addiction.

Case B: Barb and Bob

Compared to Antonio, Barb seemed more aware of her addiction. When stating her hopes and wishes (see vignette 5), Barb mentioned wanting to quit gambling, and explore other parts of her life. She showed increased awareness about her addiction patterns when the therapist directly inquired about it:

Vignette 10 – Case B, Session 1

Therapist: You have other addictions besides gambling, Barb?

Barb: I have had all kinds of addictions in my life. I was addicted to drugs; I was addicted to alcohol at one point. I am just a very addictive person. (Sounds very ashamed).

Therapist: How old were you when you were addicted to drugs?

Barb: Eighteen; nineteen. (Starts nervously flicking her nails)

Therapist: For how long?

Barb: Oh, three years, until just before I met Bob (...)

Even though Barb seemed nervous and ashamed, she was able to acknowledge her “addictive” personality, which could be a sign of her sense of hopelessness about

herself as if addiction was part of her make-up. Following up on the client's openness, the therapist asked more questions about her addiction, such as *"What kind of drugs?"*, *"You were able to get off it?"*, *"And you got off it with help or on your own?"*, *"And you were how old when you quit?"* During session 6, while working with the couple's relationship and communication patterns, they revisited the addiction timeline.

Addressing Bob, the therapist said:

Vignette 11 – Case B, Session 6

Therapist: Yeah. Actually, I found that pattern in a lot of couples that I work with, okay? I call it 'over-functioning.' Usually, in a relationship where there is the gambling problem there is often an over-functioning partner. Sometimes that person was doing that even before the gambling started. Like, taking over everything and doing everything until they are burnt out, exhausted, or they throw in the towel. That gets worse after the gambling because, as you say, you have to make sure that you look after the finances, pay the bills and all of that. But now you are rebalancing the relationship. Which is good. So, you are going to let yourself relax a little bit. (...)

Bob: We will give that a shot.

Therapist: And how are you with this? (Talking to Barb)

Barb: I am fine.

Therapist: So, there were circumstances that created that problem, right? And the circumstances are changing for the better. (...) Okay. And tell me a little bit about your drug use? Like, what are the other substances you used before?

The vignette illustrates how the therapist explored the impacts of addictions on couples' relationship. In doing that, the therapist also highlighted positive changes in this couple's communication and coping mechanisms, showing reciprocity of the changes on both partners as the gambling problem improves. Considering addiction impacts, the therapist revisited the addiction timeline to gain more clarity about Barb's lifelong addiction patterns. The following vignette illustrates some questions asked.

Vignette 12 – Case B, Session 6

Therapist: You quit before meeting Bob. And then, did you use anything after you met Bob?

Barb: Uh-uh.

Therapist: No? Okay. Then, the gambling started.

Barb: Um-hm. The drinking and the gambling.
Therapist: Okay.
Barb: So, I just went from one drug to another.
Therapist: Right. So, this is self-medication really ... because of the pain. So, when did you stop the drinking?
Barb: And that is why I was gambling.
Therapist: Yes. So, when did you stop the drinking?
(Big Pause)
Bob: Umm, how long ago was that you managed to break that?
Barb: After [family member] died.
Therapist: Okay. And would she get drunk?
Bob: Um-hm.
Therapist: Yes. And what would happen when she was drunk?
Bob: She would be argumentative. She just wanted to argue all the time.

This time, Bob is also engaged to the timeline of addiction, and together they discuss the years and events that happened at the time. This keeps the partner engaged in sessions and triangulates a third point of view for corroboration. Moreover, Bob was able to talk about how Barb's addiction impacted him. As noted in the analysis, the addiction timeline indicates how the client copes with pain, how long the pain has existed, and life situations and events that have aggravated the pain and overwhelmed the client.

The therapist also explored clients' changes in addiction patterns throughout sessions. In Barb's case, relapses occurred during therapy. The therapist then not only explored the gambling and urges, but also the situations and responses that led the relapses. They discussed relapses during sessions 6 and 8.

Vignette 13 - Case B, Session 6

Therapist: Have you gone back gambling at all? In the last while? Like, since you have started these sessions.
Barb: Mm-hmm.
Therapist: In the last week or two?
Barb: In the last... not in the last couple.
Therapist: Yeah, okay. So, you have gone back like initially after you started these sessions and then you kind of phased out more?
Barb: Yeah, I am trying to be more aware of it.
Therapist: So, what would drive you to go to the machines?
Barb: Like some of this drives me crazy.

Therapist: What?

Barb: This therapy, this whatever...

Therapist: Yeah. So, when you think about the therapy you, you want to go the machines?

Barb: When I just think about how I am and who I am.

Therapist: What about who you are?

Barb: Like you were saying, the train of thought...

Therapist: Yeah

Barb: My thought goes to depressing things. It does not go to uh...

Therapist: Let's catch some of these 'depressing things.' What are they?

As the client mentioned the relapse, the therapist tried to elucidate what was happening that prompted Barb's relapse. Barb mentioned that things brought up in therapy led her to view herself in a negative light, considering her past substance abuse and relationship with her children. She might have felt ashamed of it and therapy led her to face some "depressing things"; issues she had not been able to come to terms with. The conversation showed the therapist's attempt to link the relapse to distressing thoughts brought up in therapy, and used the relapse as an opportunity to raise more self-awareness for Barb.

Summary

In both cases, clients came in with the main goal of "quitting" and "understanding" the gambling. Since the first session, the therapist tried to explore clients' broader perception and understanding of addiction for both Antonio and Barb. However, the clients responded quite differently. Antonio was focused more on the gambling patterns and behaviours by relating to "frequency" and "amount of money," whereas Barb mentioned negative thoughts about herself and low self-esteem, as she related the gambling to the "rotten person" she is. These open-ended questions allowed the therapist to explore the clients' understanding of their own addictions and could have helped to plan subsequent interventions.

In both cases, the therapist did most of the exploration of the addiction in the beginning phase. The therapist built the timeline of their addiction with the clients, attempting to increase clients' awareness about their history with addictions, including possible precipitators. As the therapy progressed, the therapist checked in about urges and relapses to identify possible changes, improvements, and factors that could have helped clients to make change. It is important that, when talking about the addiction, the therapist did not only focus on the client, but also invited partners to share their perspective and for corroboration. By doing that, the therapist was able to explore possible effects of the addiction on partners and on the couple's relationship. More than just gathering addiction pattern information, the therapist tried to check for clients' understanding and brought awareness regarding their addiction and helping them see their addiction as more than "bad behaviour."

Theme 3. Connecting Addiction with Stressors, Trauma, and Childhood Wounding

As illustrated by previous vignettes, the therapist explored clients' understanding about their gambling from the beginning of therapy. More than inquiring about symptoms and behaviours of PG (such as urges, frequency of casino visits, games played, and money lost), the therapist asked about clients' understanding of the gambling: "*How do you understand your gambling? What precipitated that? But what made it escalate?*" and "*What is the reason? What drives you to go gambling do you think?*" (see Vignettes 6 and 7). These questions could foster an attitude of curiosity and prompt attention and awareness, which demonstrate CCT's effort to go beyond the behaviour of addiction to potential life event associations (such as trauma and pressure points), and the client's intrapsychic experiences.

Case A: Antonio and Amanda

In the first few sessions, it seemed hard for Antonio to engage in and elaborate about his understanding of addiction (see Vignettes 1 and 7). The picture seemed opaque for him. However, within the first session, the therapist already attempted to bring awareness to the link between stressful events/trauma and addictions when she was exploring the addiction patterns and escalation. The following vignette exemplifies one of these moments in which the therapist tried to create these links:

Vignette 14 – Case A, Session 1

Therapist: Usually, we find people have this change in pattern or habits around the time gambling is escalating, like a time of life transitions. Do you see anything around that?

Antonio: Uhhh (tilts head back thinking).

Therapist: Maybe an anniversary or something.

Antonio: No, I do not think so.

Therapist: Or a setback or something?

Antonio: What? (looks at Amanda)

Amanda: I think it was my accident. I think that has a lot to do with it.

Antonio: Well yeah, the reason that got me started with drugs was... she was in an accident a couple years ago now. Umm... basically to the point where she was pretty much bed-ridden at one point.

Therapist: So, it was quite a serious accident.

Antonio: So, I was basically stepping in and taking over you everything, which was a total role reversal because she did the majority of that... It was pretty tough to do my job and travel because I had to stay home, and make sure the kids got to school, and dinner...

Therapist: So, the stress piled up?

The vignette shows a moment in which the therapist tried to link the escalation of the gambling with a stressful life event. This was the first time the clients linked the addiction to a pressure point or traumatic event in therapy. Antonio seemed oblivious to the impact of stressors in their lives. The spouse played a co-construction role in facilitating the linkage of stressful events, internal pressure, and turmoil and the addiction as a form of escape or self-medication, as in this case when Antonio seemed to articulate

the inner stress he went through related to his wife's major accident. Also in this first session, the therapist tried to help clients in increasing their awareness to factors that "drive" the addiction, *"That is what we want to try to understand a little bit more here. Like, what's driving this, right?"* At that moment, the therapist raised information from Antonio's responses to the study's questionnaire and traumatic experiences she noted there. This way, the therapist was already setting the intention work with traumatic experiences and to link those experiences with coping mechanisms and addictions. *"Maybe, in these 12 sessions, it would give you a chance to process some of that and find some new ways to deal with stress rather than running away from it."*

This initial session is a good example of what happens in future sessions. However, from the transcripts, Antonio seemed highly unaware and avoidant of his own story and inner experience. The therapist continued to gradually work with Antonio's awareness and acknowledgement of his own distress. For example, at session 2, as the therapist inquired *"I am kind of curious Antonio, when you went to gamble. What would drive you to gamble? (...) Have you noticed what you said to yourself when you go?"* Here, the therapist tried to explore Antonio's awareness about his thoughts when he went gambling. In this session, the therapist recapped some stressful events the clients mentioned in the first session, and tried to explore more about how those events could be related to gambling. The following vignette illustrates the moment in which the therapist alluded to the implication of the recent trauma of the car accident and the incapacitation of his wife with earlier life trauma when he had to face overwhelming events on his own.

Vignette 15 – Case A, Session 2

Therapist: So, how do you think you handled it? Like, I mean, there was definitely stress, right?

Antonio: Yeah, well, I think at the same time I did it alright. I did not get into some of the problems we have had until later on. (...) Up until then, I think I handled it pretty good. I got the kids to school and...

Therapist: And then what happened, what were you saying to yourself when you started gambling more?

Antonio: Well even that came later. I guess, first I got started on the drugs. That would have lasted whatever, a few months. That came up...

Amanda: That would have been over a year after my accident.

Antonio: Yeah. Like, that is weird.

Therapist: Were you saying maybe, I have worked hard enough, you know, I need a break now?

Antonio: I do not know I am trying to think back now. I do not know... (Inaudible)...back then, I guess at the start of the year we were definitely starting to drift apart or...

Thus, during session 2 it is noticeable how the therapist is gradually trying to increase the client's awareness and to build the connections between addictions and trauma, and their impact on his feelings at the time. In this section, the therapist tried to frame the gambling as Antonio's coping mechanism, checking to see if it was because he needed "a break" from all the changes and stresses that happened after the accident. In doing so, the therapist was able to acknowledge the client's feelings of needing relief to help deal with possible guilt related to the gambling.

In session 3, they went deeper in exploring the addiction in relation to childhood events and trauma. The therapist tried to explain the concept of disconnection in the model, "*If you are not aware of what you are thinking and feeling, or what your wishes and human yearnings are (...)*". In that context, she also described addiction as disconnection, "*At the heart of any addiction, including gambling, is disconnection.*" Then, the therapist linked this disconnection to childhood trauma, as illustrated in the following vignette:

Vignette 16 – Case A, Session 3

Therapist: Maybe, there is also disconnection inside. The reason I say that is, there are some really painful things that happened when you were a child, Antonio. It is really hard to touch those things, because it is like holding your hand to the fire. You don't want to hold it there too long. Whether it is sadness, or disappointment, or helplessness, or vulnerability, or all that, right, it is a sensitive area. We call that the inter-generational. What happened before could influence how connected you are today, because when a person has to distance themselves from what is inside, from here (pointing to heart), that translates into today too. That is very understandable because if a child is feeling overwhelmed and hurting and there is nobody for a child to go to, you might as well just stuff it, right? Because, what can you do about it?

The therapist made a connection between trauma and addictions, often stemming from early childhood painful experiences. In this vignette, the therapist tried to bring awareness to the effects of trauma on the individual. Pain and overwhelming feelings related to the past trauma, such as disappointment, helplessness, and vulnerability in early life maybe too difficult for a child to handle, and can shape an individual's ability to connect with himself and with others as adults. The inability to acknowledge and process the hurt leads to a disconnection with self. The therapist explained the meaning of disconnection and put it as the "heart of any addiction."

Still in session 3, after they explored Antonio's FOO and past relationships, the therapist went deeper in relating the trauma to the client's low self-worth, as she brought up the possibility of his low self-esteem being related to blame he received from his mom and step-dad. Antonio's father also left the family when he was very young, adding to his sense of abandonment and rejection, as well as unworthiness. The therapist explained,

My guess is with his mother and being blamed by his step-father, he kind of internalizes it and starts to feel I am not a good father, I am really not that good a person. The self-esteem goes down that way. But he's been taking that here, and the father disappearing could be a sign of rejection, so 'there's something wrong with me that my father did not even want to talk to me, or that my father left and pretended that he did not know me.' So, there is a lot of internalized messages there, like being blamed.

Emotional abuse, neglect, loss, and abandonment all might have led to low self-worth as a child. This shows that the understanding of a client's history might help them to make the connection between addictions, trauma, and what is carried forward into the present.

Considering Antonio's apparent difficulty in connecting trauma and addictions, the therapist tried to explore possible changes with his formulation of the gambling problem, and its connection with trauma and feelings about himself, which happened in multiple sessions (sessions 6, 8, 11). A vignette from session 11 illustrates an example of how the therapist revisited Antonio's understanding of addictions:

Vignette 17 – Case A, Session 11

Therapist: But what I meant was – what got you to start gambling in the first place? What is your understanding of that?

Antonio: Oh! I do not know. I guess I always – I always did something, some gambling so I mean that... you know, I do not know –

Therapist: Can you link that to what you suffered in childhood and how you felt about yourself. Like, how you manage stress or pressure. Can you link all of that together?

Antonio: Well... (Pause). I mean it definitely was my... you know, whether it was an escape or... I guess something that I did on my own and no doubt... Definitely, when I was on the road, it was kind of my thing to go and hide and just get away from people, I guess.

Therapist: And then of course it was the car crash and all the stress around that.

Antonio: Yeah, I mean it was somewhat...you know, it started out as an escape and it escalated into, you know, desperation. It just – I guess –

Therapist: So, how does that link to what you suffered in childhood?

Antonio: I do not know.

Therapist: You know, your biological father and then this –

Antonio: -- to link it all together? I do not know –

Therapist: - your stepfather....

Antonio: I guess at the time, I wasn't really thinking that that –

Therapist: -- Most people do not go that far back. But these are the connections we've tried to make here. Like, how did that kind of childhood shape the way you felt about yourself and how you deal with difficult situations? And, how you get support?

Antonio: Hmm. Well, I guess as far as difficult situations probably, you know, whether I avoided them or just um –

Therapist: -- and why would you avoid them?

Antonio: Just because they are difficult.

Therapist: And, they were unsolvable, right? For a child, right?

Antonio: Yeah. Some of it, for sure.

Therapist: How does that affect how you deal with situations?

Antonio: (Big pause). I do not know, I guess... I do not know. When it is my own personal situations, I probably – I just kept owing things, and kept putting things off.

In this scenario, Antonio and the therapist were exploring how the gambling was related to his distancing from himself and his feelings about himself. The therapist attempts to link his childhood experience of loss, abandonment, and abuse to his inability to deal with some personal situations when feelings are involved. The therapist alludes to the sense of “insolvability” of it all for a child and how that sense of helplessness and paralysis could influence how he deals with certain situations today. This change in perspective and consequences for the self are key in CCT. At the end of the therapy, Antonio was able to see how his addictions served as an escape and a place to hide from people. This shows Antonio’s increased awareness of how childhood trauma relates to present addiction, which could possibly lead to a greater degree of self-compassion.

Case B: Barb and Bob

The connection between trauma and addiction happened differently for Barb and Bob, because since the beginning the client seemed more awareness of her gambling and how it was related to her feelings about herself. In session 1 (Vignette 5), Barb mentioned wanting help to “quit gambling” and with “other parts of her life.” During this first session, Barb mentioned some of her losses and her guilt and self-blame, which gave the therapist the opportunity to make some initial links between her history of trauma and addiction. This situation is illustrated in the vignette bellow:

Vignette 18 – Case B, Session 1

Therapist: Ya. So, lots of tragedies. Lots of tragedies. So, breathe. Yes. And to know how much grief you hold inside with all those losses.

Barb: It is a lot. (Choked up.)

Therapist: Yes. So, no wonder you run away. (Pause) It is OK to cry. Tears are good for you. Has these anti-stress hormones. The body is very self-healing, actually.

Bob: (Chuckles.)

Barb: Trying.

Therapist: Mhmm. I can see why you might run away because there are all these strong emotions and you do not know how to deal with them. What else do you do, right? You either run, or you self-medicate. And addiction is a kind of self-medication.

Barb: Ya to try to forget, but it does not go away.

After hearing some of her losses and feelings related to them, the therapist acknowledged Barb's feelings, as well as her difficulty dealing with them. The therapist linked the pattern of running away to addictions, naming it "self-medication". Like Antonio and Amanda's case, the therapist described past events without labeling them as trauma. Instead the therapist used the words "tragedies," "grief," and "losses," which are words that could help the client relate in a human way.

In their second session, the therapist also provided psychoeducation about the model, when she spoke about the links between trauma and addictions (see Vignette 6). At that moment, they discussed more about Barb's gambling, which led to the following situation:

Vignette 19 – Case B, Session 2

Therapist: What drives you to gamble do you think?

Barb: Just the hours I do not have to think about other things.

Therapist: What things?

Barb: The rotten person I am.

Therapist: So, it is hard to be with yourself.

Barb: Exactly. Exactly.

Therapist: It is the relationship with yourself inside, and you need to run away from it. Then, you go gambling. So, this is exactly what I mean. Here, we would like to look at that relationship and if we can change it, rather than tying you up so you do not go gambling.

Similarly to case A, the therapist tried to explore Barb's understanding of her addiction, by asking what drives her to go gambling. Differently from Antonio, Barb's response seemed more aware of how gambling is rooted at a deeper level within the self and with her low self-worth, as she described herself as a "rotten person." The therapist observed to Barb her difficulty in being with herself, and framed the gambling as a way of "running away" when she did not know how to deal with deep feelings inside of her. Thus, this section reinforced CCT's approach to addiction, not in "fixing" the behaviour, but in going "underground" to work through past traumatic experiences and their effects on the individual.

Another relevant moment for building those connections between trauma and addictions was while working on Barb's timeline of addictions (see Vignettes 11 and 12). As mentioned previously, during that process they connected the client's addiction patterns to some of her losses.

Vignette 20 – Case B, Session 6

Therapist: So, this is all very understandable. You see it all from here. And when did it get worse.

Bob: I suppose after (brother) died it got worse.

Barb: Um-hm.

Bob: The gambling part anyway. The drinking...wasn't too bad compared with the gambling.

Therapist: Yes. Barb, is that true? Did you find it got worse after your brother died?

Barb: Um-hm. Yup.

Therapist: Um-hm. So, it all has to do with that emotional mess. And all the pain and the loss.

Barb: And I cannot deal with it.

Therapist: Yes. And with that degree of loss, not many people cannot deal with it on their own. So, you are doing well. You have that spark still and that drive for life, for a better life.

This vignette illustrates how both clients and the therapist were relating Barb's losses of many significant others in her life with her addictions and, in this case, with the

escalation of gambling. Again, instead of referring to the losses as trauma, the therapist referred to her feelings related to her losses, “emotional mess” (said by Barb previously) and “pain.” It is important to note that the therapist not only acknowledged Barb’s feelings and her difficulties to deal with them, but also raised her awareness of her “drive for life” and her efforts in seeking help. Different from Antonio, with whom the therapist worked at a more cognitive level, with Barb she was able to work at a more emotional level and at the level of her worth and spirit. Barb received from the therapist the acknowledgment and understanding of her turmoil that she could have failed to receive from anyone up to this point. Towards the end of the therapy, in sessions 11 and 12, the therapist also tried to explore Barb’s and Bob’s change in understanding the addiction.

The following vignette illustrates one of those moments:

Vignette 21 – Case B, Session 11

Therapist: Because (working on traumatic experiences) is sort of an indirect route – most spouses are more keen on getting their spouse to stop gambling. And then all the troubles will go away.

Bob: -- but she had more problems than just gambling though in her life.

Therapist: Yes.

Bob: What she was running from. Dealing with all the deaths and everything, that kind of stuff...they just haunted her.

Therapist: And did you know that that was a part of it? When you first came?

Bob: Not really. I just thought she—she just got an addiction to gambling. But maybe it had something to do with her running away from all the – the troubles that happened in her lifetime. Which is a possibility. She could put that to rest.

Therapist: So, as we went along, you kind of connected the dots?

Bob: Um-hm.

Therapist: Yeah. That is good. You are patient and a smart guy. It is good though. What you said about why working on the couple relationship helps the gambling.

Barb: I can honestly say that I think that these therapy sessions have honestly helped me...to, umm...to realize that the gambling is not all about me... that all those other issues were part of it. I did not realize that – all that was a part of it.

Therapist: Good for you.

Barb: So it does not bother me as much as when I tried to quit before. I have a little more insight to what makes me tick.

Therapist: Like, you mean, before you thought you had an addiction. Gambling was the problem. But now you could see what fed into it.

Barb: Yes. Exactly. Exactly.

Therapist: That is good.

Barb: It was not really that I have to go gambling. I just have to learn how to deal with my emotions as far as all that other garbage goes.

Therapist: So, it is about you and being connected with yourself.

Barb: Exactly.

As the therapist and the couple review the therapeutic process, the therapist checks in with Bob about his understanding of the connection between trauma, addictions, and the work in couple therapy. This is because he seemed to question the process at the beginning of the therapy. This section is important because it also shows Bob's and Barb's new understanding of her addiction and trauma. The therapist acknowledged their insight, and reinforced the connection between Barb's addiction and the dire life circumstances as precipitating factors, as well as her relationship with herself.

Summary

The process of connecting addictions to trauma was not completed in one session. It was a complex and progressive process and happened gradually over the sessions. As the therapist had more information about clients' past traumas, she was able to make ongoing connections between those events, the client's inner experiences and feelings, and the client's addictive behaviours. The therapist not only acknowledged the traumatic nature of the events, but acknowledged the client by naming the client's feelings, such as "pain," "sadness," "disappointments," "helplessness," "hurt," "loss," and "self-criticism." The therapist made emotional connections by exploring the consequences of trauma to the client's addiction as a way of dealing with her unbearable pain, shame, and guilt. Disconnection is at the heart of any addiction. The therapist raised awareness of links between external stressors and trauma, and inner distress and addiction.

Through both cases, it was possible to see how this process can vary depending on client's awareness, openness, readiness, and processing style. In Antonio's case, the therapist needed to revisit multiple times the client's understanding of his addiction by asking about it to help him make the cognitive re-framing. However, with Barb who was able since the beginning to relate her addictions to her feelings about herself, the therapist worked at a more emotional and spiritual level. This difference in clients' awareness was also clear on their last sessions when the therapist revisited understanding about trauma and addiction. Antonio still needed more guidance from the therapist to understand his emotions. On the other hand, Barb and Bob were both able to state their understanding of the gambling in light of Barb past traumas.

Theme 4. Exploring Trauma within the Context of Relationships

CCT looks at addiction intending to uncover traumas and stressors leading and related to them. Both cases revealed traumas related to childhood events, including abuse, abandonment, emotional neglect, and losses. Considering the relevance of childhood events and their impact on clients' present lives, the therapist dedicated a substantial amount of time to exploring clients' FOO, allowing the therapist to not only gain more understanding about the nature and effect of the trauma, but also to understand the context of the relationships and communication patterns at the time, including their effects on the couples' present family dynamics and relationships.

Theme 4.1. Exploring FOO Relationships and Intergenerational Trauma

Case A: Antonio and Amanda

The FOO topic came up over the course of multiple sessions (see Tables 1 and 2), and even the clients themselves brought up it up. Already in their first session, Amanda

mentioned Antonio's relationship with his father, *"You said something. I do not even know if you remember saying it, 'I am a loser just like my old man was,'"* as they were discussing their goals for therapy. The spouse commented on Antonio's low self-esteem, and how he compared himself to his father due to their similar gambling problems. As the session continued, the therapist further explored Antonio's relationship with his father, *"So, you were not in touch for many years?"* This allowed the therapist to have an initial idea of Antonio's FOO and to identify his feelings of abandonment and neglect, as the client complained about his father showing up only for special occasions.

But when [older son] was born, we tried to reach out, and we actually went over to his house a couple times. And then, it just died from there. I just said 'You got to make some effort or whatever.' We got his answer: we never heard from him.

Then, after having an initial understanding about their relationship and his feelings about it, the therapist explored Antonio's willingness to reconnect with his father:

Maybe learning some more communication skills to talk about what is hard to talk about. You may be able to reach out to him. Who knows? Who knows? When you were little, you did not know how to reach out to him. I would like to hear more as these sessions go on about what kind of background he came out of, and what kind of a person he is.

Also, it shows how the therapist slowly tapped into the client's FOO and his feelings about it, and how she set up an intention to go deeper into the exploration of his past, including his parents' background, even though Antonio still seemed highly resistant to reconnecting with his father, carrying a sense of deep disappointment.

"Myself, I do not want to. I am pretty much to the point where I do not care. I have a father, and that is her dad. I do not know him. I do not know him, really."

Sessions 2 and 3 explored more deeply Antonio's FOO, as the therapist asked about coping mechanisms and support during childhood, "*So, as a child if something painful happened to you, or something bad happened to you, what did you do with it?*" and "*Were there people you could go to? Or run to?*" Then, the therapist inquired directly about Antonio's FOO with an open-ended question, "*Tell me about the environment you grew up in.*" As Antonio mentioned his parents' divorce, his mother's remarriage, and the abusive relationship with his stepfather, Antonio brought up his childhood abuse, "*No, it was I mean, whatever our time with him. It was.... I was in lots of trouble. Whatever. I was in lots of trouble at that time. Whatever. I was beaten as a kid.*" Even though it seemed difficult for Antonio to talk about his past, he ended up mentioning his abuse. Then, the therapist gained a better understanding of the extent and severity of the physical and emotional abuse, as the Antonio described his stepfather's violence towards him.

The therapist also used brief questions to explore the family dynamics and the abuse family members suffered. This provided the "lay of the land" for future exploration. Still regarding possible traumatic situations and addictions, the therapist explored Antonio's parents' FOO, and their history of addiction to understand its effects on family dynamics. Going into the parents' history allows the therapist and client to contextualize parents' lives and how they came to be what they were. Antonio brought up his mother's family dynamics and her moving away from them. After gaining some clarity about how his mom grew up, the therapist continued to explore his relationship with her, as noted below:

Vignette 22 – Case A, Session 3

Therapist: So, she was pretty much on her own.

Amanda and Antonio: Mhmm.

Therapist: And what three adjectives would you use to describe her? And we'll ask your view later Amanda.

Antonio: I would say, strong, capable, loving.

Therapist: Loving? Is she still living?

Antonio: Yeah.

Therapist: And do you see her often?

Antonio: Yeah.

Therapist: So, you are close to her.

Antonio: Yeah. Somewhat, I guess.

Therapist: I am curious, why do you say 'somewhat'?

Antonio: Well, I do not know, it is just... I do not know why I said that.

Therapist: So, pause for a minute, and do a scan inside. That is important, that is a good skill.

Antonio: I guess I am close, but not close like her mother and her. (Motions to Amanda)

Therapist: So, does that mean you do not talk about everything?

Antonio: Definitely not.

Therapist: Definitely not. You love each other, but it is kind of unspoken?

Antonio: Well no, I mean I tell I love her and everything like that.

Therapist: It is not like you share your feelings and thoughts, or your troubles?

Antonio: Not all the time. I mean yeah, not completely open, no.

Therapist: Yeah. So, in a way now you know where this interpersonal disconnect comes from, right? You really did not quite have that openness in your family.

Antonio: Yeah, no.

The therapist identified familial communication patterns and intergenerational history that exerted an impact on Antonio's mother. The therapist pointed out his mother's disconnection from her family, and after exploring their closeness, she highlighted the family's pattern of interpersonal disconnection. This exercise of describing his mother with three words could possibly help both the therapist and the client to gain more understanding about his family's relationships and how they might have an impact on his present relationship with Amanda.

The therapist also explored Antonio father's FOO, "*Let's learn a little bit about your dad. How did he grow up? What do you know about that?*" Even though Antonio

said that he did not know “*a whole lot*” because of the lack of communication, he still brought in some elements of his grandparents and their history of intergenerational traumas. The culture in which the father grew up, and the war trauma his grandparents suffered provided insight into some of the strains and unprocessed trauma that could have curtailed communication and closeness. In this exploration of the FOO, the therapist was able to identify familial communication patterns:

Vignette 23 – Case A, Session 3

Therapist: So, my guess is they probably did not talk too much about their traumatic experience.

Antonio: No. Well...I never...

Amanda: Maybe to peers.

Antonio: I never had much interaction.

Therapist: In some cultures, where there is trauma or pain you do not talk about it.

Antonio: Yeah.

Therapist: If you do not talk about it, then you are not opening up a can of worms. You do not have to feel it and you pretend it never happened.

The therapist helped the clients identify some factors related to his grandparents’ collective traumatic experiences, losses, and social marginalization. She highlighted the familial pattern of avoiding talking about pain and traumas, and the consequences of not sharing. Then, the therapist connected this with Antonio’s lack of communication and isolation from his family. As they were building his father’s family map or genogram, the therapist asked Antonio to describe his father in three words. However, Antonio struggled, saying “*I do not have three words for him. It is hard to. Like, I do not know him.*”

The topic of FOO appeared in subsequent sessions as well. The therapist eventually used some of the information from his FOO and childhood trauma to understand Antonio’s communication patterns and his perceptions about himself. For example, in session 7, as they discussed Antonio’s and Amanda’s conflict, the therapist

identified Antonio's lack of self-acknowledgement and self-appreciation in dealing with a stressful situation. *"But give yourself that appreciation. Probably, you had so little appreciation when you were growing up. Did you get any appreciation or acknowledgement? As you grew up?"*

Vignette 24 – Case A, Session 7

Therapist: And what about acknowledgment – like not from your biological dad?

Antonio: No.

Therapist: No? Then, your step-dad?

Antonio: None whatsoever.

Therapist: Never. Never acknowledged. Never appreciated.

This vignette is an example of how the counsellor explored the client's connection with FOO, and how it might have helped him understand how he relates to himself in the present. The lack of acknowledgement and appreciation in his childhood could lead to a lack of connection with himself in the present.

Although it would be expected to focus sessions on the client with the addiction, the therapist also explored Amanda's FOO. The therapist started by asking *"So, Amanda, tell me a little bit about how you were in your family."* In this process, they also explored her closeness to family members, *"Who are you closest to in your family? Tell me more about being close?"* Amanda then brought up her parents' divorce, which she had previously mentioned as a traumatic situation for her and Antonio, considering that Antonio considers her dad a father figure. The therapist also asked for the three-word descriptions of both of Amanda's parents, and explored their communication patterns.

Vignette 25 – Case A, Session 4

Therapist: What would you say is their communication pattern over the years that you have observed?

Amanda: My parents?

Therapist: Yes.

Amanda: This might be why I get some of my scariness about our communication patterns. They are the same... my dad was one of those people that his business,

like – Antonio would not want to tell me about losing a customer, because he knew it would bug me. He was the same thing with my mother. So, I mean, I think that is where some of my scariness with our communication comes from is that – if he can hide the (drug use) from me and if he can hide the gambling from me, what else could he hide from me?

Therapist: Okay. So, hiding.

Amanda: Yeah, I would rather, I mean, would I be upset that he lost a client? Yes, but my worry would be about him. I understand that, yes, financially it is going to affect us, but for us to have that communication where he goes “You know what? This is what happened to me today.”

Therapist: And that takes away some of the closeness, right?

Amanda: Yeah, absolutely. To me, it does.

Therapist: Yes, and then you do not become as much of a partner to support him and to deal with stress, maybe the drug use, or gambling maybe it is soothing for him to have these relationships. If he has things on his mind that he cannot talk about here to relieve the stress and the burden.

Amanda: Yes. I would say that is 100% on the nose. That is why it bothers me with our communication patterns. It is the hiding, the lying, the cheating – all of that.

This vignette illustrates how the exploration of her parents’ communication helped increase both the clients’ and the therapist’s understanding of Amanda’s anxieties and insecurities when Antonio does not share his troubles with her. The therapist related her parents’ relationship to Amanda’s current relationship with Antonio. Additionally, the client also made the parallel between her father’s and Antonio’s patterns of “lying and hiding.” To help Amanda understanding these patterns, the therapist framed the addictions as ways of self-soothing, which could be changed through partner support and better communication.

Case B: Barb and Bob

In Barb and Bob’s case, the exploration of FOO was also done gradually for Barb over the sessions. In the first session, the client brought in her losses related to members of her FOO. In the second session, the therapist revisited the FOO topic as they were talking about the couple’s communication pattern and Barb’s tendency to self-blame and feel intimidated. The therapist related these patterns and feelings to past experiences, as

she asked Barb “*Did people blame you for everything?*”, “*Who else have you been intimidated by?*” and “*Throughout your life is there one person who really sees you and appreciates you and treasures you?*” This exemplifies how, over the sessions, the FOO topic would come up eventually as an attempt to bring awareness and understand the client’s present relationship with herself and her communication patterns.

Barb’s past with her FOO revealed relevant traumatic experiences. Some of her losses of family members and an abusive relationship with her ex-husband happened later in life and have greatly impacted her. During session 3, they explored her past trauma related to the abusive marital relationship, communication patterns, and her self-blame over some of their conflicts. The following vignette illustrates a moment after they were discussing some of their conflicts as a couple, and some of what she considered her mistakes in their relationship:

Vignette 26 – Case B, Session 3

Therapist: How was he [ex-husband] like? (...) Was he abusive?

Barb: No. Not physically, no.

Therapist: Emotionally, like verbally?

Barb: Pretty much.

Therapist: Mhmm. So, that must have eroded you too. Over the years.

Barb: Oh, yes! (Pause.) I did things I would have never done! (Wiping tears.)

Therapist: So those were difficult years and you lost some of yourself in there. Your esteem; (Pause) your confidence. Your faith in life. (Pause)

Barb: It was not pretty.

Therapist: That is why maybe there is a part of you, when Bob raises his voice or gets angry, you get a little shaky inside (Pause).

Barb: But it has nothing to do with him (...) my whole thing has nothing to do with him.

Therapist: Right. You did not deserve any of that from (ex-husband).

Barb: I do not know, did I? Sometimes I wonder. (Long pause) Had I not made that first mistake... (Pause, looking defeated).

As illustrated in the vignette, therapist tried to explore more about Barb’s ex-husband’s communication patterns and abuse towards the client. Then, the therapist highlights their impact on Barb’s relationship with herself and possibly with Bob, when

he raises his voice. That was an attempt to show the client how past relationships could have an effect in the present. However, as Barb has been showing increased awareness, she was able to differentiate Bob from her ex-husband, which the therapist re-affirmed (“*Right*”) and tried to shift Barb’s feelings of self-blame by highlighting that she was non-deserving of abuse.

Considering Barb’s convoluted past, in session 5, the therapist revisited her FOO by helping to build a timeline of her losses, which she experienced through her childhood and adult life. In this exercise, the client and therapist collaboratively recapped Barb’s losses and other stressful events, such as her divorce and move, putting them into perspective in chronological order, externalized visually on paper.

Vignette 27 – Case B, Session 5

Therapist: Actually, I may like to have Barb draw a picture. (...) Draw a picture of a timeline and some of your losses. That is a tough one. But let’s just draw a timeline... (Draws a line.)

Bob: That was easy.

Barb: Yeah, I could have done that! (Laughs)

Therapist: Now, would you like to draw some of the losses you have experienced in your life?

Barb: I do not know!

Therapist: Maybe put your age down, and the year.

Barb: I do not know how to do a timeline, (therapist)!

Therapist: OK, so let’s start with zero, when you were born.

Barb: OK.

Bob: So, when you father died.

Therapist: Right, and that is when your father died.

Barb: Yeah.

Therapist: OK. So, you can just write, “father died.”

As they followed this process, Barb wrote down all the losses, the years, and causes of deaths of multiple family members. At the end, the therapist explored Barb’s feelings as she looked at the picture, and Barb responded with a laugh “*A lot of people died.*” This process of externalization and rendering her losses visually couple possibly

help Barb to alleviate some of the internal burden she carried, as well as brought order and clarity to these tragic events in her life. The paper served as a container for these events. As they discussed her timeline and ways that she coped with those events, Barb revealed more instabilities from her past, including abuse and troubled communication patterns. Thus, creating a timeline also gave the therapist other insights about Barb's childhood:

Vignette 28 – Case B, Session 5

Therapist: So, what comments do you have, Bob, looking at this history?

Barb: Mumble-jumble?

Bob: It is a mess.

Therapist: It is a mess?

Bob: (Laugh.) She is an orphan. (Look at each other, laugh.) (Pause.) Had a hard life. Lots of different fathers. Or step-fathers, whatever you want to call them.

Barb: It was normal to me.

Therapist: Mhmm. (Pause.) No wonder she finds it hard to trust, you know.

Barb: I guess back in here there was a lot of whatever. Because my oldest brother was a drug addict. My dad and him got in fistfights.

Therapist: Mhmm. So, there was fighting here. Right?

Barb: Oh yes. My mom and my dad fought like crazy! (Laugh.)

Therapist: And your dad had alcohol problems, right?

Barb: So did my mother.

Therapist: Oh really? All right. So lots of instability.

This vignette illustrates how the therapist also involved Bob in the session.

Through this process, the therapist was trying to raise the client's awareness and helping her process her difficult history. In fact, Bob's perception helped to highlight Barb's troubled past. Barb then elucidated more about the chaotic family dynamics and poor communication patterns, such as her parent's fights, their addictions, and the complicated and abusive relationships with her stepfathers. This process allowed the therapist to understand Barb's perception of her past, as the client stated the normality of these instabilities.

As they briefly explored her relationship with her mom, the therapist was able to note another pattern in Barb's FOO. Although Barb valued her relationship with her mom, *"My mom was a great mom. My mom and I were very close,"* she also mentioned her mom's history of loss and abuse in her childhood, *"But my mom lived the same kind of life I lived. Her whole childhood was pretty much the same thing!"* The therapist then highlighted the intergenerational history of pain, but in the light of change, *"Maybe, very little of that had been acknowledged. So, you are going to break that pattern, you are going to break that cycle by acknowledging yourself."*

Like Case A, the therapist explored the partner's FOO. In session 4, they started exploring Bob's FOO, *"I thought it might be a good idea to focus on Bob a little bit today. Like, his family, since we are on that topic. So, tell us about your family. How many brothers and sisters do you have?"* After grasping an overall idea about Bob's family map, siblings and parents' heritage, the therapist asked the client for three words to describe his father. Then, they talked about his father's "strictness" and their communication at the time:

Vignette 29 – Case B, Session 4

Therapist: Yeah, so you are closer now. What was relationship like with him when you were younger?

Bob: He was tough on me.

Therapist: But you were the first boy, right?

Bob: Umhm.

Therapist: Was there conflict or just distant?

Bob: What do you mean?

Therapist: You know, conflicts would be you butt heads...

Bob: Oh yeah. We butt heads all the time when I was younger.

Therapist: And how do you think that affected you?

Bob: It probably made me tougher I suppose. Not as easy going. Things have to be done right I suppose.

The therapist tried to explore Bob's father's strictness, by exploring their relationship more. This allowed the therapist to understand Bob's past communication patterns with his father, and the possible impacts on him. In fact, the therapist tried to explore Bob's own perception and awareness of effects of their past conflicts. The therapist expanded the exploration of Bob's past relationships in his FOO by asking him about three words to describe his mom and about their closeness, "*Were you closer to her growing up? What brought you closer to her?*" Although the client did not show history of trauma in his childhood, the therapist still inquired about his parents' relationship with each other.

Vignette 30 – Case B, Session 4

Therapist: And how well did your Mom and Dad get along?

Bob: Oh they fought like cats and dogs. They still do. [Laughs].

Therapist: And how do they fight? Was there a more domineering one or not? Or were they pretty equal.

Bob: I guess my Dad was probably domineering I would think.

Therapist: But when you were growing up was he domineering? Or you do not remember?

When exploring Bob's parents relationships and conflicts, the therapist also tried to explore Bob's perceptions about conflicts. The therapist took Bob's description of his parent's relationship and used it to normalize differences in relationship ("*people can argue and still stay together*"). This was important, considering Bob and Barb's avoidance of conflict, which will be discussed in the following theme.

Summary

This subtheme highlights the importance of exploring clients' past. For the most part, exploring FOO allowed the therapist to gain better understanding of the adverse childhood experiences or trauma, familial context, and their impact on the present life. The therapist also looks into the positive relationships and possible resources, to uncover

the clients' strengths and spirit. It is also important to notice how the exploration of FOO also include the parents' FOO, which allowed the therapist to identify intergenerational traumas and communication patterns. This also might help the client understand what made the parents the way they were.

It is also notable that the exploration of FOO might happen during multiple sessions, but as the therapy progressed the exploration and understanding of FOO went deeper. There was usually one session dedicated for deep exploration of FOO for each partner. The therapist also adapted the way she explored FOO to the client's history, especially for Barb. Considering Barb's significant history of multiple tragic losses, she invited Barb to externalize all her losses over time by building a timeline.

Theme 4.2 Exploring Effects of Trauma and Addictions in Present Couple and Family Relationships

The therapist explored FOO communication patterns intending to understand its consequences for the client's present communication patterns in the couple relationship. Because communication patterns learned in childhood are replicated in the couple's relationship, it is important to explore family and couples' dynamics when trauma is involved.

Case A: Antonio and Amanda

The first vignettes illustrated how the initial sessions were important to understand the effects of gambling on the couple's relationship, especially on Amanda's loss of trust (see Vignette 1). However, looking at the effects of gambling on the partner was not the only purpose of the sessions. In the therapy process, the therapist used the FOO history and past traumas to understand couple's communication problems, which

happened in different sessions. The vignette above from session 4 illustrates a moment when they were talking about Antonio's increased connection with Amanda, and how she used that moment to further explore their communication:

Vignette 31 – Case A, Session 4

Therapist: That was a fantastic improvement, yes. So, you are telling Antonio that he is paying more attention. How does that affect you? When he pays more attention or he is more present?

Amanda: I feel more appreciated (...) I want us to be more connected, and working together as a team. When Antonio is communicating to me that way, I do feel that we are moving a step toward that.

Therapist: Feeling connected to someone is a universal need. I think some hurts from the past came from losing that connection. You with your dad. And maybe, to an extent with your mom, because she was wrapped up with her own problems, right? Then, of course, there was a violation of relationship, what your stepfather did. So, it was disconnection, disconnection, disconnection.

Amanda: And I think that might be some of the reasons he is turned to...the behaviours that happened after my accident. Because he has said that he felt like he lost me. Like who I was. We have always been really connected.

Therapist: That is what I was going to ask. Like, what was your relationship like before the accident? Could you talk about things then? With each other?

The therapist linked Antonio's childhood experiences and previous disconnections to his relationship with Amanda. The therapist was interested in understanding more about communication patterns before Amanda's accident, which was previously mentioned as a traumatic event leading to Antonio's addiction. Although they both mentioned having a good relationship before the accident, Amanda still mentioned their difficulty in communication about finances, which she related to their differences in background. Amanda seemed aware of influences from the past in present relationships. Besides making these connections with past patterns, the therapist also brought the clients' present communication pattern to their awareness:

Vignette 32 – Case A, Session 4

Therapist: Okay. I just want to make an observation here. Amanda, sometimes I notice when Antonio wants to come in the conversation...

Amanda: Um-hm.

Therapist: And you have a train of thought, right? That is fine. I am not saying you do not talk, right? But just notice some of the cues that he gives, that he wants to talk. Maybe he is a little more hesitant?

Amanda: Um-hm.

Therapist: So, when he is trying to come in, you might want to kind of wrap up your thought and go back to him and say, "So, you wanted to say something?" That is opening up a space. To make the relationship a little more balanced.

Amanda: Okay.

After observing clients' communication patterns for a few sessions, the therapist noted a moment where Amanda was leading the conversation as an opportunity to delineate this pattern to them. By doing that, the therapist increase their awareness, which facilitates change. The therapist also suggested ways to help them balance their communication. Later on the same session, the therapist took their example to refer to the model's communication postures, "*You (Amanda) said when you were upset and you would put it out, he would try to fix it. How did he try to fix it?*" Here, the therapist pointed out Antonio's tendency to "fix" things rather than tending to Amanda's emotions, and tried to learn more about how he usually does that. Another example of this past and present connection happened in session 8, as Antonio mentioned his expectation of being "booted out" by Amanda because of his addictions. The therapist linked that to Antonio's past history of neglect and abuse, "*Because your step-father would have done that. You are used to punishment. So, it is not surprising that you expected that, right?*"

The exploration of communication patterns did not happened in only one session. In session 5, as they were exploring the couple's conflict and lack of communication related to Antonio's work, the therapist promoted a role-play between the couple. This allowed her to notice again some problems in their communication pattern,

So, it is good that you are able to talk about what fault-lines were. So, Antonio, he would hide, keep to himself, when there is a problem, when there is stress.

(Drawing) Maybe, if he spoke about it, Amanda would react, get anxious, and that would cause him to hide. And go back to the old cycle.

The therapist took their present communication about a stressor to exemplify their fault-lines in the cycle of incongruent communication, by highlighting Amanda's anxieties and Antonio's avoidance.

Besides the effects on the relationship with the partner, it is important to note how Antonio's childhood trauma also had an impact on his relationship with his whole family, especially with one of his sons. That first came up during session 2, as they were exploring the impact of Antonio's childhood abuse:

Vignette 33 – Case A, Session 2

Therapist: So, lot about punishment [referring to Antonio's past upbringing]

Antonio: Yes.

Therapist: And what do you think that does to you?

Antonio: What it does to me, well one hand it is you know, it is been hard, like I've definitely butted heads with my son on a lot of different things.

The therapist's open-ended question gave Antonio space to reflect on the impact of his past in other relationships, as he brought up his troubled relationship with his son. After that, the conflictual situation with the son came up in the sessions multiple times, and eventually the therapist directly commented on how his childhood trauma could have an impact on this present relationship. The following vignette illustrates a moment that they discussed couple's conflict related to Antonio's relationship with their son and the therapist brought up Antonio's past:

Vignette 34 – Case A, Session 7

Therapist: (...) On the other hand, you acknowledge that maybe you and your son have had a bit of history and a set of disappointments that still hurt inside of you.

Antonio: Yes.

Therapist: Yeah. Yeah. Somehow, maybe that part needs to be acknowledged and taken care of. In terms of the set of feelings that belong to you. That needs to be looked at. Regardless of whether it is justified or not.

Antonio: Yeah, no matter what the situation is or whether it is justified or not, yeah.

Therapist: Yes, but there is a store of disappointment. I hear a lot of disappointments in your relationship with your father – or fathers. The step one and the biological one. Then, now with your son. Those feelings belong to you and they need to be processed and looked at.

Antonio: Yeah (Curtly).

Therapist: Yes. And Amanda, because she comes from a different background, she has a different history and maybe different expectations of your son, so she gets protective.

This section illustrates how the therapist pointed out the similarities between past and present disappointments. The therapist linked Antonio's history of disappointments with his fathers, with his present feelings of disappointments and frustration with his son. Thus, the therapist highlighted the importance of being aware, owning, and processing those feelings in order to improve his relationship with his son. As they try to work on Antonio and his son's relationship, the therapist highlighted the couple's difference in background and hence their different relationships with their son.

In different moments throughout the sessions, Amanda's emotions and reactions to Antonio's history of abuse caught the therapist's attention, "*Amanda, you are really upset.*" As the therapist noted those moments, she gave the partner space to express herself and acknowledged her feelings, "*You feel for them.*" The following vignette illustrates another moment like this:

Vignette 35 – Case A, Session 9

Therapist: And Amanda what was it like for you? To witness that?

Amanda: Hmmm. Sometimes it makes me sad for Antonio that – I do not know.

Although he does not like to say it – I think maybe why he... does not think his opinions matter and, that was the way that his stepfather treated him and the way that his fathers abandoned him. Because there is no other word for it.

Therapist: So, it made you sad....

Amanda: It makes me sad that he has to feel that way, because I love him and I do not want him to feel sad.

Therapist: So, let him feel that, because that is actually the natural reaction to that kind of experience, right?

Amanda: Yeah.

Therapist: So, he will feel sad...

Amanda cried over Antonio's description of childhood experiences which showed her deep empathy for his pain. The therapist helped her name feelings. However, the therapist also acknowledged Antonio's experiences and normalized his feelings for her. This segment illustrates the therapist's attempt to help the couple differentiate from each other, while allowing for the empathy from others that allow us to heal.

Case B: Barb and Bob

In Barb and Bob's case, the therapist also explored the effects of addiction and trauma on the relationship, asking Bob *"How does Barb's gambling affect you?"* Besides giving the partner space to express his feelings about Barb's gambling, the therapist also asked about his worries about her, *"Do you worry about her? In what way? What do you worry about her?"* By doing that, the therapist was able to learn more about how their relationship is affected not only by the gambling, but also through Barb's pattern of running away and low self-worth, as Bob said *"I worry that she's gambling when I am not there. Worry that she wants to run away or hurt herself because she's mad at herself for gambling or whatever. That type of thing."*

As the therapist learned more about Barb's past and traumas, she was able to identify some aspects of their communication that could have been affected by those experiences. In session 2, Barb mentioned feeling intimidated by Bob, *"But when he gets mad, he gets mad...He is very intimidating."* At that moment the therapist inquired into Barb's past relationships in which she might have felt intimidated (*"Who else have you been intimidated by?"*). The therapist then linked past and present relationships as they discussed the stepfather's violence towards her brothers:

Vignette 36 – Case B, Session 2

Therapist: Did he hit them with weapons?

Barb: No, his hand. He did not need a weapon. His hand was big enough.

Therapist: So, that was scary for you as a child to witness. Maybe that is why Bob gets a little scary for you when he gets loud. Did you know about that? (Barb' foot has slowed tapping temporarily at this point.)

Bob: Mhmm. She has basically told me everything about her life at one point or other.

Therapist: So, there is a vulnerability, you know, the little girl who did not feel safe, who suffered tragedies, sudden losses.

The therapist acknowledged and named Barb's feelings, and also how Bob's raised voice could make her feel intimidated and unsafe. This observation could also help Bob to understand the impact of his actions on Barb. Again, the therapist noted the same pattern during the following session, as they were discussing her abusive relationship with her ex-husband. *"That is is why maybe there is a part of you, when Bob raises his voice or gets angry, you get a little shaky inside"* (see Vignette 26). Thus, this shows how the therapist tried to explore patterns through Barb's life and possible effects in her present relationships.

Besides making these connections to understand the possible impacts of Barb's experiences on their communication patterns, the therapist also tried to identify and describe their present communication style. The following vignette illustrates one of those moments:

Vignette 37 – Case B, Session 2

Therapist: (...) So, I think I understood how maybe you find yourself in a bind. You walk on eggshells because you do not want to do anything that is going to make her gamble some more, so... if you are not happy with something, you have to keep it in, because you do not want to upset her, which that would lead to gambling. Is that true?

Bob: Yeah, pretty much. That is probably why we do not fight too much.

Therapist: Exactly, but that is not too comfortable. If you are not happy about something, you keep it in, and you cannot be yourself and speak your mind freely, how you feel... It is like being in a relationship, but having your hands tied all the time...

Bob: Yes, you just stay in agreement all the time. Probably why we do not fight too much.

This vignette illustrates how the therapist acknowledged Bob's position and then asked more questions to gain a better understanding of Bob's avoidance of conflicts. She also pointed out how differences are normal in couples. The therapist then went on to explore Barb's perception about their communication patterns: *"Did you know he felt that way, Barb? That is how he's been feeling? How do you feel about that?"* So, the therapist also tried to gain Barb's perception of the situation and their communication, which also could help Bob to know what was going on inside of Barb. In the following sessions, they identified Barb's need for self-protection:

Vignette 38 – Case B, Session 4

Therapist: You have been hurt so much you have to protect yourself. And I think we all have these protections, it is not just you. You look at how people function in the world. Who is going to give you their heart on a platter? But with him and with people you are close to, maybe start lowering your guard a little bit and see what happens.

Barb: It is not that easy.

Therapist: It is not. There is a risk.

Barb: It is not that easy because I have been doing it for so long I suppose. It is my only way of protecting myself.

Therapist: So, what are you protecting?

Barb: My feelings.

Therapist: Yes, protect your feelings.

Bob: Just one feeling.

Barb: Rejection.

Therapist: Rejection. Who have you been rejected by?

Barb: Oh, okay well maybe not rejection. Loss.

The therapist validated Barb's need for self-protection, but also tried explore Barb's awareness of the pattern and its origin and connection with her past. Together they ended up linking her need for self-protection with her past losses. In session 5, they were able to identify another pattern, as Barb referred to her chaotic life *"Chaos is all I've ever known."* The client was even able to make further associations herself and added *"So, if*

my life is not a chaos, then I am lost,” which she further linked to her relationship with

Bob:

Vignette 39 – Case B, Session 5

Barb: Well, I suppose that is where our relationship comes in, because it is normal and I am not used to normal.

Therapist: You mean, this relationship is normal and you do not know how to handle it.

Barb: And I run from it because I do not know what to do with it, even though it is 15 years later.

Therapist: So, what have not you done in this relationship?

Barb: I do not know. I try to create chaos so that I know what to do with it, I suppose.

Therapist: You mean like the gambling and all that?

Barb: Mhmm. I think that could be a very good...

Therapist: Mhmm. So, you are still running, actually. All that in the past, but you are still running.

Barb: It is the only thing I know how to do.

The vignette illustrates how the client might have gained more awareness about her familiarity with chaos. It shows how the therapist guided her in that reflection and linked the gambling with the chaos. Thus, together Vignettes 36, 38, and 39 show an example of the progressive work in therapy, and how Barb gained insight into herself, her fears and how she functions in her relationship with Bob.

Similar to Case A, the therapist also noted how past trauma not only affected the couple’s relationship, but also the family dynamics and Barb’s communication with her children. In session 2, Barb related her own father’s death to her children’s loss of their father, and her guilt around what happened, *“I suppose that hits home for me because my dad died, so I knew how they felt. So, I babied them and he (Bob) disciplined them, because I felt guilty.”* Similarly, in session 3, Barb showed her hurt because of the difference in Barb and Bob’s relationship with her children. The vignette below illustrates how the therapist explored the issue:

Vignette 40 – Case B, Session 3

Therapist: (Pause) Um, so tell me what you heard.

Barb: It hurts me when he talks about my kids and stuff...

Therapist: What did he say about them?

Barb: No, not that there's anything wrong with it; it is all truth!

Therapist: No, no, but...

Barb: It is all stuff I have to deal with... (Pause) But as close as he is with my kids, it kind of hurts. Me... because they're closer with him than they are with me... which hurts.

Therapist: OK. And what makes you think they're closer with him than they are with you?

Barb: Because they are! He is. He's very close with my children.

Therapist: Did you know that before we were in these sessions together?

Barb: Yeah (...)

Again, this illustrates how Barb's past trauma affects her perception of herself as an inadequate mother because of her past addictions and decisions, and her current emotional instability. In the session, she was able to disclose her jealousy and misgivings about not being the go-to person for the children. The therapist asked for specifics that led Barb to this perception. The therapist also explored the effects of trauma when she asked Bob how he felt as Barb mentioned her losses:

Vignette 41 – Case B, Session 1

Therapist: So, what are you feeling right now Bob, just hearing this?

Bob: Just reliving everything that happened over the past sixteen years with her mom dying and ex-husband dying and brother dying, and dealing with the kids with their father dying.

Therapist: You were part of all that?

Bob: Mhmm. Yes, we went through hell for a while with the kids after their father died.
(...)

Barb: (Wiping tears quietly.)

Bob: Yup.

Therapist: So, you were part of all that too even though you just came into the picture.

Bob: Yup, and the kids not knowing who I was really yet... did not want nothing to do with me when their father died. I tried to help them.

Therapist: So, that was hard for you. You were rejected.

Bob: You are not my father; I do not have to listen to you, all that kind of stuff.

By engaging Bob to the session, the therapist was able to give Barb time to be with herself, and explore Bob's perspective about her history with trauma, especially

because he also experienced some of those events. This way, the therapist brought attention to the effects of trauma for him and his relationship with Barb's children, by acknowledging his difficult position and the rejection he felt. The therapist expanded the context of the trauma by exploring its impact on the partner and including Bob's perceptions and feelings about it.

Summary

This theme illustrates how the therapist tried to link past relationships, traumas, and addictions to the clients' present relationship with each other and family. Many of the consequences of trauma might be displayed in the current couple's and family's communication patterns, even though they are not aware of that. Moreover, the therapist also attempted to help clients to identify their communication problems, like patterns of avoidance and anxieties. In both cases, it was possible to see how the therapist explored the consequences of the trauma for the non-addicted partner as well. The effects of trauma touch the lives of significant others, spouses, and children. Although Bob did not show signs of distress with Barb's description of her traumas, the therapist still gave him space to talk about experiences with the children after her ex-husband passed away. Because the therapist explored both past and present relationships, it showed that, within these two cases, CCT focused on exploring and understanding the impact of trauma on relationships, rather than its symptoms.

Theme 5. Healing from Trauma and Addictions through Re-Connection with Self and Other

As noted in previous themes, the therapist tried raising clients' awareness about the complexity of their own history and its connection with addiction. This theme

illustrates the healing process within these two cases, as CCT attempts to promote interpersonal and self-reconnection.

Theme 5.1 Reconnecting with FOO

In both cases, clients' traumas were related to past relationships. Consequently, in order to facilitate their healing process, the therapist tried to promote clients' reconnection with their past.

Case A: Antonio and Amanda

In Antonio and Amanda's case, one of the most challenging relationships was Antonio's relationship with his father because of the abandonment and neglect. This was the main relationship that needed work. Still in early sessions, the therapist tried to give Antonio another perception about his father, as noted below:

Vignette 42 – Case A, Session 1

Therapist: Like, I mean did he not try, or did you not try [to connect]?

Antonio: Well I actually, well, I tried.

Amanda: He tried. His sister still tries.

Antonio: He just did not respond.

Therapist: Maybe he did not know how, right? What do you say to your son whom you left?

Antonio: My understanding was that his new wife says this is your family now, and those people are not your family.

Therapist: I see, but he came to those big occasions (*like wedding? Or graduation?*).

Antonio: Yeah, he did.

Therapist: So, the actions spoke? (...)

Antonio: I guess, but it was like... you (his father) come out for a day. (...) I guess, at the time I thought it was great and it was nice that he was there. But in the end, big deal, you just come out for the event (...)

As the therapist explored Antonio's relationship with his father, Antonio seemed frustrated about trying to reach out to him. The therapist tried to help Antonio gain another perspective about his father, and his possible feelings of guilt and shame for leaving his family. She tried to highlight the dad's efforts to be present in important

occasions. Later, in session 5, after gaining more clarity about the relationship, the therapist promoted Antonio's connection with his father through role-play, "*What if you were to practice? Do a rehearsal? What would it be like if you spoke to him now?*" However, Antonio seemed determined to not practice communication with him, "*I wouldn't. At least with him, anyway. I am done.*" Although Antonio seemed resistant in connecting with his dad, the therapist tried to help him open up to possible changes. In session 12, as Antonio mentioned his father's attempt to contact his son and his feelings of uncertainty about the situation, the therapist said "*Well, maybe he is a different person today.*"

Another way to promote reconnection with FOO was through Antonio's relationship with his mother. As mentioned previously, the therapist asked for three adjectives to describe his mother (see Vignette 22). This exercise not only elucidated family dynamics, but also helped reinforce the client's connection with a parent, because of a positive relationship with her, as he described her as "*strong, capable, loving.*" As they continued to explore their relationship, the therapist asked:

Vignette 43 – Case A, Session 3

Therapist: So, how did she support you?

Antonio: She worked three job and did whatever she had to.

Therapist: So, she worked hard?

Antonio: Oh, yeah definitely. She did basically whatever she had to do to pay the bills and keep myself and my sister fed and clothed.

Therapist: So, you know about that, like being a provider.

Antonio: Definitely, yeah.

Therapist: And you know about hard work and will and determination, survival.

Antonio: Yeah, definitely.

Therapist: So, breathe, and say yeah. That is all part of your heritage.

As noted above, the therapist highlighted Antonio's additional positive characteristics that his and his mother have in common, such as "provider" and

“determination.” The therapist linked the client’s attributes to his mother, emphasizing their positive characteristics to show the positive legacy. This was an important moment of reconnection with Antonio’s FOO, considering that Antonio’s mother was one of the only positive relationships from his childhood with which he seemed willing to reconnect. The therapist further explored this moment of reconnection by asking the client about his feelings as they talked about his mother, *“How do you feel about that, as you talk about her?”* Antonio showed his connection with his mom by saying, *“I feel good. I learned a lot from her. She kind of taught me to look after yourself.”*

Case B: Barb and Bob

In Barb’s case, the work with reconnection was more elaborate, considering her history and seemed willingness to reconnect with people she had lost. Throughout the therapy, there were moments in which the therapist tried engaging Barb in direct communication with her relatives.

In session 3, the therapist helped Barb speak to her ex-husband about her feelings related to his passing, *“You said you were angry at (ex-husband) for dying. Why do not you tell him that too? Whether you can see him or not. Tell him what angers you about that.”* This lead Barb to mention her anger about him *“hurting his children.”* In response to Barb’s anger, the therapist brought awareness to the feeling of despair her ex-husband must have felt. She also tried helping Barb have compassion and empathy for her ex-husband’s feelings at that time, as they had similar addictive behaviours, *“Maybe you do understand something about that despair that drove him to do that. He was irresponsible and he was in despair.”* By facilitating this conversation with her ex-husband, the

therapist tried helping Barb to voice her anger towards her ex-husband rather than turning it against herself.

The following vignette illustrates another moment in which they relate Barb's feelings about herself, and guilt related to her "nervous breakdown," to her traumatic experiences:

Vignette 44 – Case B, Session 5

Barb: I had a nervous breakdown. I was not there for everyone! I guess I am easier on other people than I am on myself.

Therapist: Why do you beat up on yourself? That is crazy. Maybe, there is some anger there, but you have to find the right targets for that and it probably is not yourself. I think there are two pieces. One is to acknowledge yourself, and then the other piece is to say goodbye to some of these people. You can tell all the suffering caused ruptures in relationships. All our suffering is really relational. To heal that, it is important to say what you have not said. Say the truth, and the truth heals. I think you have spoken to (ex-husband) a couple of sessions ago. Who would you like to speak to today? Your dad, or your mom, or your brother?

Barb: I am mad at my brother! For being a jerk!

Therapist: OK, so that is important. So, tell him how he is a jerk.

Barb: He is a jerk! He left his kids! Took the easy way out.

Therapist: So, "you"; can you say it in "you." "You took the easy way out! And you dumped everybody!" Get your anger out there. You can be angry.

Barb: And left everybody to deal with it.

Therapist: Yes, that is awfully selfish.

Barb: And it hurt.

Therapist: It hurts.

Barb: It hurts his kids. And he should know.

Therapist: It probably got to be too much for him too.

Barb: It did. Exactly. Obviously, he was hurting.

Therapist: Yes. So, with that you can have a little compassion for him.

Barb: I have a lot for him.

In this session, the therapist linked her low self-esteem and anger towards herself to ruptures in past relationships, which could be healed through honest and truthful communication. Regarding the loss of her brother, the therapist acknowledged the client's anger and hurt, and encouraged direct and honest communication with him. At the same time, the therapist evoked compassion for him. Barb was able to voice feeling

hurt related to his death, and show her compassion for him as well. They continued to discuss the circumstances related to her brother's passing and how Barb was alone to deal with the consequences. While enacting a dialogue with her brother, the therapist prompted Barb to say, "*So, tell him that you are only a human being too, and that you had your own responsibilities.*" Thus, the therapist highlighted the importance of direct communication with people to help heal feelings about herself. This could have helped the client to heal from past relationships in the present, promoting reconnection.

In session 7, as they briefly revisited Barb's role-play with her ex-husband and brother, Barb valued the exercise, saying "*See, that role playing is just (laughter). It feels good.*" The therapist then reaffirmed her humanity and that "*It all ends in love. We become human.*" This shows how role-play was used to help the client transform feelings of sadness, guilt, and anger into feelings of love. The therapist then invited the client to finish her goodbyes by talking with her father:

Vignette 45 – Case B, Session 7

Therapist: So, what kinds of feelings do you have when you think of me? (talking as if she was her father)

Barb: I just want to cry.

Therapist: Cry a little then. A little is good. (Big pause). Have you cried when you thought of me?

Barb: I do. I wonder what my life would have been like had he not died. My whole world might have changed.

Therapist: ...is there anything you want to say to your dad?

Barb: I do love you, even though I cannot remember you. And it does not mean I do not love you.

Therapist: You are a loving daughter, and a sensitive one.

Barb: Too sensitive. That is a part of my problem.

Therapist: Well, you are well mad, but – there is just too much hard knocks and you just kind of have to steel yourself. But being sensitive is good. It makes you human.

In this role-play, they had the opportunity to recap some of Barb's memories and feelings related to her father. The therapist also promoted reconnection by acknowledging

Barb, as if she was her father, to bring a sense of closeness. At the end, she tried to help Barb move on from her losses and enjoy her present life,

You have a good life now. I am happy to see that. You have a good companion, who knows how to be a good father. So, let yourself enjoy that. Are you willing to let yourself enjoy that?

Finally, the short role-play with Barb's mom gave the client a chance to express her love for her, "What do you want to say to you mom?" Barb got emotional as she mentioned her feelings for her mother. The therapist reinforced their connection, "Yes. She has been important to you. You had an important relationship. You love her and you miss her. She hears that. Do you think she knows that?" At the end of the therapy, In order to consolidate Barb's connections with her FOO, at the final session the therapist revisited her relationships and her perception about them by asking what Barb thought they would say to her about how she was doing in the present and her growth. This process might have helped Barb express her feelings for them once again, and the therapist to reaffirm their connection,

There's such a connection, right? You still have with these people you love, even though they're not here. And what you do today, who you are today, affects them. You know, the past and the present. It kind of flows together.

Summary

This theme, *Reconnecting with FOO*, illustrates how the therapist worked with clients to promote reconnection with their past relationships, adapting each case. In Case A, the therapist was not able to engage Antonio with role-play, but she still tried to give him a different perception about his childhood trauma and relationship with his father. Also, the therapist promoted Antonio's reconnection with his mom by using his present descriptors and feelings about her, and by highlighting some positive traits they share. On

the other hand, in Case B, the process of reconnection was more elaborate. Over multiple sessions, the therapist used role-plays to connect Barb with people she had lost and speak directly to them. The goal of the intervention was to offer the opportunity to communicate congruently with people she had lost, especially the ones related to the client's trauma and pain. This process might have helped her to express feelings that were true to her, deal with "unfinished conversations," and say her goodbyes.

The overall idea of this process is that the therapist and client are not necessarily reconstructing the trauma memory, but are adding a new perception to what happened and to one's relationship with the significant other, which could have helped clients to alter their feelings attached to that experience, such as frustration, anger, and guilt. Moreover, the counsellor guided them through an increased awareness of the other in the situation, evoking empathy and compassion for them. This process could be seen as an opportunity to help clients heal past traumas and relationships in the present, differentiate the past from the present, and move on from the cycle of trauma. The therapist helped promote clients' self-connection, self-definition, and their capacity for change.

Theme 5.2 Reconnecting with Partner and Children in the Present

Considering the effects of trauma and addictions on each client's present relationship with partner and family, the therapist also dedicated time to work with clients in promoting present reconnection with the spouse and other family members.

Case A: Antonio and Amanda

Since the first sessions, the therapist made statements to reinforce the couple's positive feelings for each other, such as *"And you care about him very much," "I hear that both of you really care about each other and this marriage," "(...) there is such love*

there, loyalty, and commitment.” The therapist also invited the clients for direct communication of appreciation for each other throughout the sessions. The following vignette illustrates one of these moments:

Vignette 46 – Case A, Session 1

Therapist: Amanda, you said that you love him for who he is. Can you tell him what you love about him, because I have a sense that sometimes Antonio does not know how beautiful he is as a person. From what I could hear, he felt a little unworthy and that he deserved to be punished. So, tell him what you see in him that he might not see in himself.

Amanda: He is a kind, I cannot say open heart, but he is a kind person. He has always been very supportive of anything I wanted to do. He has always been there for both me and the kids.

Therapist: Tell it to him directly.

Amanda: You are someone that I can laugh with and have fun. I just feel like we are connected on a different level (starts crying). Like we are not just husband and wife, like we are best, we are best friends.

Therapist: Sounds like you are soul-mates and you both have good hearts.

As noted above, the therapist helped Amanda to express her feelings of appreciation for Antonio. This was especially important during the first session, because it helped to add positivity and reinforce the couple’s connection as they started the challenging process of therapy.

Previous themes showed how past traumas and addictions can affect couple relationships through incongruent communication patterns. Besides bringing awareness to problematic patterns, the therapist helped the clients find ways to improve their communication. For example, as they finished session 3, Antonio mentioned his desire to be more open about his need and to reconnect with Amanda:

Vignette 47 – Case A, Session 3

Therapist: Excellent, asking for help, making requests. That is a very important one. Maybe, showing appreciation that could be another one. So, we will expand the range of your communication.

Amanda: I just wish that between us we could have more open and honest communication. Also, less blaming on my part.

Therapist: And maybe, Antonio could say, “You have spoken for 5 minutes, let me have 5 minutes.” So, you can claim your talking space too.

The therapist then mentioned the importance of making requests and showing appreciation. She also modeled for Antonio how to make a request for space and balance in their communication. Along with the requests, the therapist invited the clients to practice asking questions. The vignette below illustrates a moment that the therapist guided the couple’s communication about a conflict related to Antonio’s work:

Vignette 48 – Case A, Session 5

Therapist: One thing in working with couples is – especially couples with problems – is there is limited range and depth to the communication. One way (to expand communication) is asking questions. Do not jump to conclusions yet. So, be curious, “How did that happen?” Be a detective. Okay. So, go ahead Amanda.

Amanda: So, how did that happen?

Antonio: If I knew how it happened, I would have solved it before it happened.

Amanda: What were they not happy with?

Antonio: I do not know.

Therapist: Good. More detective work.

The therapist invited Amanda to be “curious” instead of jumping to conclusions, as a way to deepen their communication, and acknowledged her efforts. By practicing requests and questions, the therapist was trying to help Amanda open space for Antonio in their communication. Paraphrasing was another practical way of dealing with clients’ old communication patterns:

Vignette 49 – Case A, Session 5

Therapist: Okay. Let’s practice doing that paraphrase to end our session today. What did you hear from each other the communication that you had. Just paraphrase one thing, “I hear that... .”

Amanda: I would like it if Antonio went first.

Therapist: Yes, I think it is good if Antonio goes first. So, what did you hear from Amanda?

Antonio: What did I hear? Well, that is easy. I know you are stressed about (inaudible) and, what can I do to help you not be stressed about this?

Therapist: That is a good question. And, what did you hear? What would help her not to stress?

Antonio: Umm (Nervous chuckle) what can I do to help you? You are obviously stressed about your budget.

Starting with Antonio was way to help him practice changing his communication pattern of avoidance, and coming in the conversation. The therapist acknowledged his engagement and efforts, and guided him to be more direct.

To deepen their connection the therapist reinforced the importance of acknowledgement, because it touches clients at a deeper level. As noted in the beginning of the vignette, the therapist mentioned the importance of appreciation in communication. Practicing acknowledgement and appreciation for the partner were an exercise the therapist included for improvement in communication. Given Antonio's way of avoiding and fixing problems, they explored the importance of acknowledgement:

Vignette 50 – Case A, Session 4

Therapist: That is his model, right? Growing up. I mean, that is the way it is, you just have to pull yourself up by your bootstraps and keep going, right?

Amanda: Yeah.

Therapist: And you are saying, maybe what a human being really needs is for somebody to acknowledge the feeling first.

Amanda: Yeah.

Therapist: And so, it is a bad day for you, and you find it harder to get going. You need a little bit of encouragement. Good for you for trying to get up. So, there is that acknowledgement that you are going to practice giving to each other because some things cannot be fixed.

Antonio: Um-hm.

Amanda: No.

Therapist: But once you acknowledge them, somehow there is a soothing with that acknowledgment.

More than only working with communication strategies (making requests, asking questions, and paraphrasing), the therapist went deeper and helped the clients notice and acknowledge each other's feelings, especially when dealing with stressful situations. The therapist reinforced this idea in the following session, as they again discussed Antonio's lack of communication about his challenges in his business.

Vignette 51 – Case A, Session 5

Therapist: I think it is really good that Antonio could give you that feedback, and that you are changing through these sessions too.

Amanda: Um-hm!

Therapist: You recognize you have some anxiety and especially when it is over situations you cannot control. You have also suffered, a pretty brutal accident...Life-threatening. That is totally understandable with the 'PTSD' (which she was diagnosed with). But now, you're healing and you're to encourage him to come to you, maybe? First of all, maybe soothe him. Say, "That is really tough and that is upsetting for you." I think both of you have come to appreciate how the consoling, the comforting, the soothing, bring down the stress. Then knowing you have a partner who works along with you, that brings down the stress, right? And you can deal with whichever situation is out there.

This vignette illustrates how the therapist brought up elements that are important to the couple's relationship, such as sharing, feedback, and comforting. Amanda's default style seemed to be telling Antonio what to do. The therapist acknowledged their difficulty in communication, and suggested changes in their communication by raising awareness of what they have been doing that created distance rather than closeness. The therapist showed the clients how to acknowledge each other's feelings and how to give comfort. In fact, in the same session the therapist also highlighted the need to deal with emotions, instead of solving problems,

And sometimes, it is dealing with emotions, rather than solving the problem. If you get comforted, if there is soothing, if there is appreciation. Somehow, it is not as big of a problem.

The therapist extended to communicating and connecting in Antonio's relationship with his son. As mentioned in previous themes (see Vignettes 33 and 34), trauma also affected the client's relationship with his son. The therapist not only helped promote reconnection with the partner, but also with his son. During session 6, as they discussed Antonio's frustrations with his son, the therapist made suggestions for change in their communication, "*Is there a chance for you to sneak in some appreciation for him?*"

Or asking him questions, instead of giving advice? What can you tell him that is positive and affirming? Yes, make requests of him too.” She invited the client to a role-play:

Vignette 52 – Case A, Session 6

Therapist: Just give me an idea of how that conversation goes. Can you role-play a little bit?

Amanda: Yes.

Therapist: Okay, Amanda. You start. You are (the son).

Amanda: So, dad, what do you want me to do?

Antonio: Well, just, it is pretty simple. We do not always, or ask you to do very much, need take out the garbage, you need mow the lawn –

Therapist: Okay. ... Can you say something to acknowledge him first? What has he improved in? So, acknowledging. Do that acknowledging piece.

Antonio: What has he improved in?

Therapist: Yeah. Maybe he has made an effort or “I see that you did this...” Find something. [laughter]

Antonio: Well, that is my problem.

Amanda: He just went out and got a full-time job.

Antonio: Yeah, he just – yes.

Therapist: Okay, so give him the credit for that. How do you put it into words?

Antonio: Well, I am going to tell him, he went out and got a full-time job and that is great. That is awesome.

Although the therapist made suggestions about how Antonio could communicate with his son, the client started the role-play with complaints and directions for his son.

The therapist interrupted him to help him improve his communication by adding acknowledgment first. Amanda helped him identify one acknowledgment for their son, and the therapist guided him through the process to put that into words. As Amanda noticed his difficulties through his body language, the therapist helped him identify his feelings towards his son’s accomplishments and to communicate it convincingly to him, *“Let’s try it again here. To practice with more confidence. Look at him and say it. Do you really mean it? Are you quite proud that he went out to get a job?”*

Again, this illustrates the importance of role-play in the session. Because although the therapist said how important acknowledgement is for their communication, it could

be hard for the client to do it. The therapist guided the client through the communication and made suggestions for improvement. Furthermore, the therapist motivated both clients to extend this change in communication within the family system:

So, building relationship through appreciation. Can you do that at the dinner table? Finding the positive. At the dinner, you try to find some acknowledgment for each person, 'Wow, that dish was really terrific!' Show some appreciation to start a different culture going. Let's see what happens. How about if we try that this week? You are going mend some of these broken limbs in the relationship.

The therapist suggested further practice at home, then linked the change and healing of the present communication with his son with healing from past relationships, as she added, *"When you mend those relationships, you are mending a lot from your past."*

Considering Antonio's resistance in reconnecting with his father, the therapist tried to heal that relationship through reconnecting with his son. In changing their communication pattern, the therapist was trying to help Antonio change his past pattern of disconnection with family. Healing present relationships helps the client to heal from past relationships. In fact, the therapist brought up this idea in the beginning of therapy, *"We cannot undo the past, but we can do in the present and in the future, we undo the bindings of the past, so we are no longer in the grip of the past."* After learning more about Antonio's communication patterns and relationship difficulties, she added at the end *"You might have lost a father, but you may have gained a son. So, that balances the equation."*

Regarding this idea of healing from the past in the present, it was important for the therapist to differentiate some similar patterns and situations. Although the therapist noted similar patterns of difficulties in Antonio's communication with his father and his

son, she also differentiated them and the two relationships, *“Because you are the father for instance”* and *“But (son) is different. (Son) is not your father.”* By doing that, the therapist reaffirmed the possibility of moving from a pattern and healing the relationship with his son.

Case B: Barb and Bob

With Barb and Bob, the therapist also reaffirmed the partners’ feelings for each other, while working with alliance. The therapist affirmed Bob’s goal of “supporting” his wife, and translated that into his caring for Barb, *“That is a sign of how much you care about her and the relationship, right?”* (see Vignette 5). As the therapist also explored the effects of the gambling for Bob, she shifted the focus to his worries about her, *“Do you worry about her? In what way? What do you worry about?”* That could help clients feel acknowledged and move from complaints about gambling to owning their feelings of care and worry about the partner. This might have allowed husband and wife to hear each other and know how their actions affect the other person.

Similar to Case A, traumatic experiences affected both couple and family relationships. One reason for Barb and Bob’s conflict was his relationship with her children. Barb mentioned feeling hurt because *“they are closer with him.”* That possibly fed into Barb’s low self-esteem as a mom and guilt for not being available because of her addiction and mental health problems. In order to reconnect the couple and the family, the therapist worked on the couple’s communication about family dynamics. The therapist paraphrased to clarify their perception about their relationship. *“It seems to me that they are close to you and her, but it sounds like they have a different relationship with you (Bob) and a different relationship with you (Barb). Yes, but different does not*

necessarily mean better or more or less.” The following vignette illustrates how the therapist facilitates Barb and Bob’s communication:

Vignette 53 – Case B, Session 3

Barb: He makes it well known that they relate more to him than they do to me.

Therapist: Makes it known to whom?

Barb: To everyone! That he is the one.

Therapist: So, that hurts.

Barb: Yeah, it hurts! Of course, it hurts.

Therapist: OK. (Pause.) OK. (Pause, then to Bob) Did *you* know that that hurts her when you say that?

Bob: Yeah, probably. It probably would hurt her, even though I do not mean to hurt her, but... They are her kids, not my kids. I have a close relationship with them and that probably bothers her.

Therapist: Close, but not necessarily closer, right?

Bob: No.

Therapist: It is just different.

Bob: Yes. I am the stable one. They can count on me if they need something, where at certain times when she was gambling and stuff, she was not able to do it

Therapist: Yes. So, let’s see what we do about communication here. Feedback is so important. First, maybe you did not have any idea when you make these statements how Barb hears it, and how much it really hurts her. So, now we have this feedback. You might not have known that, but knowing that now, what would you do with that information?

Bob: Uh, maybe re-word it, I suppose, or something like that? I am not sure how...

Therapist: How about like, “The kids relate differently to you than they do to me.” Like, “We have a different relationship with the kids. And I am close to them and they are close to you too, for different reasons,” so it is not like a “better than” or “more than” because how do you weigh that anyway?

Bob: Well, that is true.

Therapist: We all need acknowledgement. Where is the acknowledgement for Barb? (Turns to Barb) What you have done for your kids and the choices you made?

This vignette exemplifies how the therapist guided couples towards more congruent communication. First, she brought awareness to Barb’s feelings and to Bob’s incongruent communication. The therapist also talked about the importance of feedback and the meaning Barb made out of what he said. Then, she helped Bob reframe his thoughts. Finally, the therapist affirmed the importance of acknowledgment in the relationship, and invited the clients to acknowledge Barb as a mother. This section then

illustrates key elements observed during CCT sessions in work with couples' reconnection. Besides working on communication, through awareness, paraphrasing, and feedback, the therapist tried to promote deeper connection by helping clients to be true to their feelings and express it through acknowledgement. It also shows how congruent communication between the couple can foster reconnection within the larger family unit, by reaffirming and valuing the possible different ways in which they relate to each other. This way they could also foster Barb's healing and self-connection as a mother, and facilitate her connection with her children. Another way that helped clients to emotionally reconnect with each other was through appreciation, which is illustrated below:

Vignette 54 – Case B, Session 4

Therapist: Maybe just practice here. Tell Bob how much he means to you. What you appreciate about him. Go and look at him and tell him that without the edge.

Barb: (Laughs). Without the edge. (Looking down). I appreciate that he loves my kids...

Therapist: Tell him directly. I appreciate you.

Barb: That you love my kids as your own. I appreciate that you tolerate me (Laughs). I know, I am not easy to live with. I love the fact that you love me, and you show it all the time.

Bob: I try to show it. Sometimes I may not, especially when we argue.

Barb: Yeah, but we have to learn to argue, not just snap and walk away.

In guiding clients through appreciation, the therapist reinforced the need for direct communication. Barb was able to express her appreciation and love for Bob, and he was able to respond with his caring and worries about hurting each other's feelings. This shows how the appreciation exercise led the clients to identify the need to change their pattern of avoidance and, consequently, reconnect. Still in this session, the couple brought up their conflict related to finances and household situations. The therapist then guided their communication through requests, *"Okay Barb, make a request. What is it that you are asking for? Make it straight. Make your request, instead of saying what's not*

there.” The therapist kept coaching and balancing their communication, “*So, let him respond. Go ahead, so how do you respond to her request?*” This situation brought up the importance of turning complaints into requests, as noted by the therapist “*You have every right to make requests. ‘I would like to have...’, rather than a complaint. Because a complaint comes from something you want that you are not getting.*”

The therapist also checked in for possible changes in communication patterns.

The vignette below illustrates a moment in which they explored communication about Barb’s relapse:

Vignette 55 – Case B, Session 8

Therapist: How did you handle it differently this time? When he showed you the bill?

What’s different from the way you --

Barb: -- well, I asked him questions. Instead of going separate ways and saying nothing.

Therapist: So, what did you ask?

Barb: He took it and he needed to be by himself, but he did not tell me that. He just disappeared. So, I thought he was really angry at me and wouldn’t talk to me. But I realized that he needs his space, but I just wish he would have said something instead of going downstairs to watch TV. Because I thought he left.

Therapist: Right. How was that for you?

Barb: It was not good.

Therapist: So, it is good that you are telling him now, “I wish you would tell me that you needed some time to process all that.”

In exploring Barb’s relapse, the therapist tried focusing on changes about their interactions and how Barb felt about it. The therapist also acknowledged Barb’s efforts to reach out to Bob, and modeled the communication. This way, the therapist possibly gave hope for the clients to improve and create a new communication pattern. At the end of therapy, she affirmed positive changes and could have helped them change their perception about conflicts and disagreements, “*Sometimes the issue is not the disagreement, but how you do the disagreement, right? Not to be afraid of saying it, and to make it work in a way that respects yourself and the other person.*” Helping clients

improve communication facilitated them to get in touch with and express their own feelings, which deepens their connection and respect of each other.

Considering Barb's remorse and guilt over her inadequacy as a parent, the therapist used role plays to encourage her congruent communication with her children (sessions 2 and 12). In session 2, the therapist first modeled for her, "*Tell them what good judgment you had, what you saw in Bob, and how Bob has been a good father to them. You may say, "I am a woman of insight. I saw the gem in him. It turned out to be right. So, I make good judgments."* However, it still seemed difficult to for to engage, so the therapist tried to help her be more direct "*Tell your children that, directly.*" In session 12, the therapist revisited communication with her children, "*What would you say to your children, now? About those parts of your life (referring to her history with addictions)?*" Barb mentioned that she already started a conversation with her daughter about it and their relationship. The client also mentioned her willingness to talk individually to each of her children. Considering that, the therapist invited the client to practice that conversation in session:

Vignette 56 – Case B, Session 12

Therapist: What would you say to your children, now? About those parts of your life?
(Referring to her history with addictions).

Barb: I will just explain to them where I came from. Why I made the choices I made.
Why I did the things that I did.

Therapist: Yes, yes. Want to have a little rehearsal here?

Barb: No. I am comfortable with it. (Chuckling.) I know exactly what I am going to say.
But it has to be spontaneous, right? It is not like you can set up a role and say –

Therapist: - I am just curious what you might say.

Barb: Well, I'll just explain that I am sorry for the way you guys were raised but obviously your father and I were caught up in the drugs. They know that I love them. I made bad choices, but that I loved them.

Therapist: Yes. And you have made some good choices too.

Barb: They learned a lot of from him. We just taught them different things. Which is what makes a family, right?

Therapist: That is beautiful. So, it is not like, who is the better parent. That is a huge change from session two.

Barb seemed confident in her intent to talk with her children about her past.

However, the therapist saw the importance of practicing and provided encouragement and validation of Barb's increased connection with her family. Finally, another way to connect them as family was to help Barb differentiate her story from her children's story of loss, and her appreciation of Bob as a father to her children, "*You did not get to enjoy your dad as a child but seeing what your children have [with Bob], you may be happy for them and maybe then, being happy for them, you are kind of getting a piece of that, through the backdoor.*" In other words, the therapist brought up the idea that having Bob as a father for her children could help Barb heal from the loss of her father. Like in Case A, the therapist tried to help the client to heal from past in present relationships.

Summary

This theme, *Reconnecting with Partner and Children*, illustrates how the therapist used present relationships to help clients healing from past traumas, by helping clients to change their communication patterns. Besides bringing awareness to clients' communication patterns, the therapist helped clients by including some elements to that communication, such as making requests, asking questions, and paraphrasing. Thus, communication was a tool to promote clients' reconnection by deepening the range of their communication. To go deeper in the reconnection with family, the therapist guided clients through acknowledgment and appreciation of the partner. By doing that, the therapist might have helped clients notice and express their feelings for their loved ones.

As noted above, interpersonal connection was crucial for healing from trauma and addictions in the CCT process. In Case B, the therapist reaffirmed the importance of connection with others in healing from addiction:

The biggest antidote to addiction is connectedness with other people; that is what the research found. When a person feels connected to the community, friends, family, they are less prone to mental health problems or addiction.

The counsellor uses the present moment to alter past communication patterns through role plays and reconnection with present family members. This use of present relationships was especially important in cases where the client did not seem to be able to reconnect with his/her past. In Case A, Antonio resisted working through his feelings and reconnecting with his father, so the therapist focused on his reconnection with his son, saying: “*When you mend those relationships (with your children), you are mending a lot from your past*” and “*You are the father for instance.*” Something similar happened in Case B, as the therapist helped Barb differentiate her father’s death from her children’s father death, and to valuing Bob’s relationship with the children. This shows the systemic effect of the model, which is not limited to the couple, but crosses generations.

Theme 5.3 Reconnecting with Self

Reconnection with partner and family through congruent communication requires each individual be true to him/herself, which is self-connection. This theme describes elements from CCT sessions that facilitated the client’s reconnection with the self.

Case A: Antonio and Amanda

At the most superficial level, the therapist tried to bring awareness to patterns. The vignette below illustrated one of the moments the therapist explored Antonio’s coping mechanisms.

Vignette 57 – Case A, Session 2

Therapist: Do you reach out to talk to people very much? (Directed to Antonio).

Antonio: It is pretty rare.

Therapist: So, how do you handle stress?

Antonio: It is just like I tell my wife, I just keep it in the little ball of hate I have down inside. (Amanda starts giggling)

Therapist: You have “a little ball of hate”?

Antonio: Oh sure, you know, does not everybody?

Therapist: Show us where it is.

Antonio: Maybe it is not a little ball of hate, it is just a little ball of life, I do not know. I do not know, it is somewhere in there.

Therapist: Okay, so take a moment and be quiet, until you find it, that is really important. Where do you think it lodges? Let's just give him a minute.

Antonio: Where does I think it lodges? I do not know. I guess maybe in the pit of my stomach, I do not know.

Therapist: Okay. Breathe... breathe... breathe... and close your eyes if you like. Let's just see if you can locate it. (silence). So, you keep everything inside...and you kind of go to that little ball of hate, and it is in your stomach somewhere...

Antonio: I do not know, maybe it moves around from my head to my stomach. I do not know.

Therapist: It moves around, eh? So, what is in that little ball of hate? This is just getting interesting. Yeah, let us hear it.

Antonio: I do not know, I guess it is just life, it is just what I have had to deal with, I do not know. That is how it has always been, keeping it to myself.

Therapist: As a child, if something painful happened to you, or something bad happened to you, what did you do with it?

Antonio: Not a whole lot I guess.

The therapist tried to explore Antonio's coping mechanisms, including his ability and willingness to reach out to people. Antonio then mentioned his “little ball of hate,” which could be linked to his pattern of distancing himself from feelings and pain. However, he seemed to be able to speak about and identify ways of dealing with feeling the “little ball of hate.” This vignette shows the how the therapist slowly guided the client to greater self-awareness at his pace, which was an experiential exercise. The therapist also inquired about his childhood again, to bring awareness to his patterns of “keeping it to himself.” The following vignette illustrates another moment in which they explored

Antonio's history with trauma, his feelings, and the familial pattern of not talking about it (see Vignette 23).

Vignette 58 – Case A, Session 3

Therapist: If you do not talk about it (referring to traumatic experiences), then you are not opening a can of worms. You do not have to feel it, and you pretend it never happened.

Antonio & Amanda: Mhmm

Therapist: But you know the effects are still felt, right?

Antonio: Absolutely, yeah.

Therapist: It is the same thing here, if you do not talk about it, you keep it to yourself; you become isolated from your children.

Antonio: Yeah.

Therapist: How are you feeling as we talk about this?

Antonio: I feel good.

Therapist: Sad?

Antonio: No...not really sad. I just...

Therapist: I feel sad.

Antonio: Yeah, well, I do not think I really feel sad. That was what happened.

The therapist tried to help Antonio note that the effects from traumatic experiences were felt despite people's efforts to not talk about them. Moreover, she highlighted the possible similarities of Antonio's and his family's patterns in dealing with the trauma. The therapist then tried to focus more on the client's feelings, and tried to connect him to possible feelings of sadness over his family's trauma. The therapist showed another way of dealing with emotions, by naming them. In fact, in an earlier session, the therapist discussed the importance of naming feelings in self-connection,

If you cannot name things then you cannot connect with it and you cannot deal with it directly, right? So, here we are going to do some practicing of naming things. Whether it is something you are feeling now or trying to understand what went on there. So, it is really reconnecting with yourself that way.

Besides helping clients become more aware of their feelings and experiencing them, the therapist also helped deepen their self-connection through self-compassion and self-acknowledgement. Through the sessions, the therapist asked questions to guide

Antonio in his self-reflection, such as “*So, what would you say to appreciate yourself in that situation (referring to Amanda’s car accident)? In terms of how you did your best to cope? So, this is connecting with your own spiritual resources.*” The therapist also helped

Antonio voice self-appreciation:

Vignette 59 – Case A, Session 4

Therapist: So, what does that say about you as a person? Seeing that you did all of that, and you are capable.

Antonio: Well, just, you know...I do not know. It is just the family first idea and umm, you know, I knew it was the right thing to do as far as that goes.

Therapist: Um-hm...what does that say about you as a person. Can you say “*I am...*” Maybe two sentences starting with that. (Big pause.) You said “*kind of a family kind of idea*”, but that is kind of distancing an idea. Can we now put it in personal terms? “*I am...*” Take some ownership for yourself, and for who you are. (Big pause.) Declare it. (Pause.)

Antonio: I do not know what the right word is. I just....

Therapist: ‘I’ something. Can you say, “*I am a loving person and I go through all things for my family*” or something like that, whatever fits.

Antonio: I am, I am a caring person and –

Therapist: Yes. So, say it again.

Antonio: I am a caring person.

Therapist: Okay. So, declare. Say it confidently.

Antonio: I am a caring person.

Therapist: Yes. How does it feel to say that?

Antonio: Feels okay. (inaudible) I do not know, just....

Therapist: Say it again then. Get used to it. (...) Now, close your eyes and say that.

Antonio: I am a caring person.

Therapist: Yes. You are. You are a caring person.

Antonio: It is just weird.

Besides modeling for the client, the therapist then helped Antonio to see the importance of making direct statements and taking ownership of himself. Through these declarations, the therapist also promoted self-acknowledgement and self-appreciation. The repetition of self-affirmative statements could possibly intensify Antonio’s affect and connection with the statement, so it is not just rote. As they did this exercise, Amanda got emotional, and as the therapist explored her feelings she said “*it is good to hear him talk like that,*” which could be a way for Amanda to acknowledge Antonio. This illustrates how

powerful it can be to promote self-connection in the context of couples' therapy, and how self-connection can facilitate interpersonal connection as well. Over the sessions, the therapist kept motivating clients, including Amanda, to make more "I am" statements and self-affirmations. As Amanda expressed her vulnerabilities in her relationship with Antonio, the therapist encouraged her to "self-soothe," and invited her to practice self-affirmations, "*Can you make three statements of self-affirmation, Amanda?*" Thus, it also shows how the therapist identified both of the clients' difficulties, and made space for individual work for both of them.

Finally, another important moment noted in their sessions was the therapist's effort to differentiate present from past patterns. Considering that the therapist and client himself noted similar patterns between Antonio and his father, in the healing process it was also important to differentiate them. This happened as they discussed Antonio's conflicts with his son:

Vignette 60 – Case A, Session 2

Therapist: That is very commendable that you did not repeat that pattern (*of abuse*).

Amanda: And I have always thought so too.

Antonio: So, yeah, that is last thing I ever wanted to do...

Therapist: You need to give yourself a message of appreciation.

Antonio: Oh yeah, and I have told him (*referring to his son*) before, you need to appreciate too, boy. Because he has no clue, you know.

Therapist: I think it is really commendable, Antonio, that you did not have really good role models, and yet, you knew what wasn't good, and you did not want to repeat it. I can hear how you restrained yourself.

Antonio: Oh, believe me, it took restraint.

Therapist: Yeah, there was self-control. A lot of self-control and a lot of conscious choices, rather than giving into your impulses. So, for the most part you have done really well as a father.

Amanda: He is done extraordinarily well for a father.

Therapist: Yes, so tell him that.

Although the therapist explored the FOO to identify similar patterns between past and present, she also highlighted the interruption of the cycle of abuse and trauma in the

family. Bringing attention to the difference between past and present could be important to the clients to know that they can create something different today that would lead to a different future. It also reinforced Antonio's belief in himself for change, which the therapist did by asking him to appreciate himself. Again, inviting the partner's appreciation for Antonio could have reinforced this new way for Antonio to view himself.

Case B: Barb and Bob

In Barb and Bob's case the therapist explored Barb's coping mechanisms. With the client's timeline of losses, the therapist inquired about her possible resources, "*Maybe we should draw another line in terms of your resources, how you dealt with all that. How do you think you coped?*" However, Barb mentioned not being able to identify her coping mechanisms, which could be an indication of her lack of resources at the time, "*I do not know. I do not remember. I do not have a clue.*"

Throughout the sessions, Bob seemed to understand Barb's gambling as a coping mechanism for her past trauma and losses, and tried to help her find a hobby, "*You just need to sit down and figure out what kind hobby you... so, that keeps you interested.*" The therapist valued Bob's point, but also reaffirmed Barb's need to heal her relationship with herself, "*So, the hobbies, that is a good idea. And the other piece, your very inside that you need to take care of is what do not you like about yourself.*" The therapist then brought up again Barb's need to improve her self-talk,

The first thing is to catch 'what messages am I giving myself?' When your mood starts going down, there is something bad you are saying to yourself. We point fingers at ourselves all the time. So, just take a deep breath, and say 'how can I say something positive?'

Here, the therapist reaffirms the need for self-awareness and self-care through positive thoughts. The therapist also used the “I am” exercise with Barb to increase her awareness about her feelings:

Vignette 61 – Case B, Session 2

Therapist: If you were to tell your kids three things so they would understand you better, what would you say? Start with “I” “I am,” or “I felt” so that they could understand you better.

Barb: I felt guilty...I felt angry...I felt scared.

Therapist: ... Let’s start with angry. What were you angry about?

Barb: (Ex-husband) dying, doing that to his kids. I felt very angry. (Crying.)

Therapist: Yes. That is good. You are angry at something he did. It has nothing to do with you. Good. What is that other statement?

Barb: I felt scared.

Therapist: Mhmm. About?

Barb: Scared whether I did the right thing for them.

Therapist: So, you were scared. Say, “That took courage.”

Barb: It took courage.

Therapist: And that took courage from deep inside because it was a decision that could affect so many people and you took charge of that and made that decision; that’s courage, and not knowing the outcome but just trusting your own judgment, your own instincts. That is courage.

Barb: But was that selfishness on my part?

Therapist: Depends on what you choose to believe. If you choose life, you will say it took courage. If you choose guilt, you will say I was so selfish. So, what do you choose to believe?

Barb: Courage.

By asking Barb for “I am” statements, the therapist tried to help the client become aware, name, and acknowledge her feelings. The therapist also tried to help Barb change her perception about herself, by choosing positive feelings that were true to her, like “courage” instead of “scared.” As it followed, the therapist added an experiential exercise and encouraged Barb to notice the “shakiness” in her body, as Barb was shaking her foot, *“Ask your foot. What are you nervous about? The minute you pay attention to it, instead of ignoring it or running away, it calms down.”* This highlighted the importance of noticing and acknowledging feelings and sensations in the body, to calm it down,

“acknowledgment just brings everything to peace.” The therapist invited Barb to acknowledge herself in other sessions, as illustrated in the following vignette:

Vignette 62 – Case B, Session 5

Therapist: (...) Let’s see if you can give yourself a word of acknowledgement.

Barb: I am not as bad as I feel sometimes.

Therapist: Good. Can you frame it in the positive now?

Barb: I am not a bad person.

Therapist: No, you are not. Can you say, “I am a good person”?

Barb: I am a good person.

Therapist: Yes.

Barb: I do not hurt people intentionally. I do not!

Therapist: Yes. You are a good person. You do not hurt people intentionally. Even when you had a nervous breakdown, it was not intentional. It was just too much.

Considering Barb’s pattern of self-blame and guilt, it was important to guide her to self-acknowledgement. The therapist noted her negative self-talk and encouraged her to be more positive and see the goodness in herself. In session 6, the therapist worked again with Barb’s negative thoughts about herself, but also tried to challenge those thoughts, *“Let’s just make three statements. How are you an awful person? Let’s see if we can challenge each of those things.”* As they challenged her negative thoughts, the therapist also acknowledged Barb’s self-awareness about her gambling,

This is good because you have insight now. Before you would not know why (referring to her gambling), ‘I just spent all my money.’ Now you know, ‘When I was an emotional mess and when I get negative.’ That is insight, you are already going beyond that. That is insightful. It is not just spending the money but now you know why. So, you are already moving forward.

Thus, the therapist modeled to Barb how to go beyond the negative and be more aware of her thoughts. The therapist also acknowledged her increased awareness and her moving forward. Thus, the therapist tried to explore Barb’s changes through the sessions, which was especially important in the last session:

Vignette 63 – Case B, Session 12

Therapist: How do you feel about being in the last session?

Barb: A little sad because we will not get to meet with you anymore. But good. It has done me a lot of good. I am really glad I have gone through it.

Therapist: Okay. That took a lot of courage.

Barb: That I completed the whole thing, without running away.

Therapist: How were you able to do that?

Barb: Just talking to you. Being able to talk and say it out loud.

Therapist: Yes, yes. In doing that you acknowledge yourself, right? And what you were living. Instead of running away from yourself.

Barb: Right. Yes, really looking at things and my reaction to things.

Therapist: Well that is huge. Just that pattern all together.

Barb: I am proud of myself.

Therapist: And self-affirmation, yes. That is amazing. You are proud of yourself.

Considering Barb's old pattern of low self-esteem, the therapist acknowledged her self-affirmations and changes in pattern. Still regarding the changes in pattern, in this case there were also moments in which the therapist differentiated Barb from her past.

The vignette below illustrates a discussion of Barb's FOO and childhood trauma:

Vignette 64 – Case B, Session 5

Therapist: Mhmm. So, there was fighting here. Right? (referring to her FOO)

Barb: Oh yeah. My mom and my dad fought like crazy! (Laugh.)

Therapist: And your dad had alcohol problems, right?

Barb: So did my mother.

Therapist: Oh really? All right. So, lots of instability.

Barb: Oh yeah.

Therapist: So, in a way you have done really well, coming out of that background! Yeah.

Barb: (Laugh.)

Therapist: And being able to stay in a relationship. Because you did not really have much stability there or permanence or models of good relationships.

Barb: No, not one I can think of.

Therapist: How do you feel when you talk about that?

Barb: I do not know! It was life to me.

The therapist acknowledged the FOO's instabilities, but also attempted to help the client to differentiate herself from the past, by reaffirming Barb's stability in her relationship with Bob. The therapist also tried to connect Barb to her feelings about her past. As they continued, Barb mentioned the similarities between her and her mother's traumatic experiences, and the therapist responded by differentiating Barb from her past

and reaffirming her ability to break that pattern “*Yes. So, you are going to break the pattern now, actually. Yes, that is a big job. `You are going to break that cycle by acknowledging yourself.*” The therapist tried to empower the client to change the past pattern of trauma by reconnecting and acknowledging herself in the present.

Summary

Reconnection was noted as the main element in the process of healing from trauma and addictions. The previous themes discussed the importance of interpersonal reconnection. However, interpersonal connection through congruent communication also entails self-connection. That is because congruent communication allows the individual to express and acknowledge his or her own feelings. This last theme, *Reconnecting with the Self*, illustrates how the therapist also made space in the sessions for individual work as well. The therapist guided the clients through self-awareness, self-appreciation, and self-acknowledgement, leading to an alignment of the inner awareness and feelings and the outer expression through congruent communication. Although in CCT the therapist looks for familial patterns of communication, it was important to note that she also tried to differentiate clients from their past trauma, in an attempt to give them hope.

CHAPTER 5. DISCUSSION

In this chapter, I address how the CCT model works with addiction, integrates trauma during treatment, and which aspects of CCT are used in treatment. Then, I discuss the healing mechanism observed within the two cases. Because CCT is a recent model, originally developed for the treatment of gambling problems, I discuss some of the similarities and differences between CCT and other models. Finally, I present the study contributions and limitations, and recommendations for future research.

Addiction, Trauma, and Couples Therapy

Problem Gambling and Other Addictions.

The Congruence Couple Therapy model was developed to treat problem gambling (PG) and couples' distress (Lee, 2009). Despite the negative consequences of PG for the partners of gamblers, existing treatments have been highly focused on individual interventions (Kourgiantakis et al., 2013; Tremblay et al., 2018). Kourgiantakis et al. (2013) noted there is limited research regarding the inclusion of family in PG treatment. Additionally, psychotherapies for PG have been mainly focused on cognitive and behavioural approaches (Cowlshaw et al., 2012).

Bertrand et al. (2008) reviewed couple therapy models for treatment of PG, such as CCT and Ciarrochi's (2002) cognitive based model, and proposed the Adapted Couple Therapy (ACT). Although ACT and Ciarrochi's models consider the importance of couples' relationships and intimacy in the PG treatment, they are still cognitive-behavioural models and highly focused on managing gambling addiction and behaviours. CCT then offers a different perspective to couples struggling with PG, as it includes the gamblers and their partner in an integrative and multi-dimensional approach (Lee, 2017).

Through my case analysis, I note that clients first come to therapy focused on fixing the gambling behaviour, but the therapist gradually changes their perception of gambling as a problem to viewing it as a consequence of their painful, and often traumatic, life experiences. This corroborates with the existential and systemic aspects of CCT (Lee, 2017). Since the beginning of the CCT treatment, the therapist frames clients' addictions as a consequence of traumatic experiences and acknowledges the clients' limitations in integrating their past and its impact on the present, which aligns with the CCT existential perspective. Thus, this study shows how CCT did not focus just on eliminating the gambling behaviour, but instead worked with a broader understanding of addictions and their underlying factors.

Regarding the involvement of the partner in the sessions, this study shows how CCT acknowledges the centrality of the couple relationship, and gives the couple space to share their frustrations and needs and to make mutual changes. At the same time, as the therapist explores the clients' changes in gambling patterns, she also helps the partners to describe and acknowledge those changes co-constructively, which validates the gamblers' efforts. This illustrates CCT's systemic pillar (Lee, 2017), as it recognizes the impact that each partner has on the other, and on the addiction. Some models of couple therapy for SUD and PG, like BCT and ACT, include the partner in the treatment process as a way to support individuals' abstinence (Bertrand et al., 2008; O'Farrell & Fals-Stewart, 2006). However, in CCT the therapist does not only focus on enlisting partners to reinforce abstinence, but uses the therapeutic process to help couples develop mutual empathy, congruence communication, self and other awareness, thus changing their

perception and communication with each other with self-compassion and understanding for themselves.

Johnson's (2005) Emotionally Focused Therapy (EFT) model has been studied in the trauma treatment for couples, based on the idea that a loving and supportive bond between partners is crucial in the healing process of trauma (Greenman & Johnson, 2012). Recently, Fletcher and MacIntosh (2018) published a case study in which they investigated the application of EFT in the context of addictions, based on the Landau-North et al. (2011) theoretical extension of EFT. As EFT is strongly based on attachment theory, this theoretical extension suggests that addiction is also an attachment issue. Therefore, its treatment is based on helping couples to create healthy relationships, which will help clients to move away from addiction as a self-regulation strategy (Landau-North et al.).

EFT and CCT are different from the cognitive-behavioural models, as they do not focus on treating clients' addiction symptoms; rather, the models' primary focus is on enhancing couples' relationships as a protective factor to addiction. Although EFT had already addressed trauma within the model, Fletcher and MacIntosh (2018) mentioned that this "theoretical extension did not address how to treat or adapt the model for highly traumatized individuals" (p. 337). Fletcher and MacIntosh also mentioned the need for adaptation for this extension to include the client's history of trauma and psychoeducation about addictions. Consequently, CCT differs from EFT as it incorporates traumatic experiences as a core issue leading to addiction; they are integrated into the process of addiction treatment.

Crockford and el-Guebaly (1993) mentioned that studies show that 25 to 63% of individuals with PG also have SUD at some point. Hodgins, Peden, and Cassidy (2005) confirmed the elevated rates of lifetime substance use in individuals with PG, with 73% using alcohol and 48% using other substances. The literature has stated that behavioural and substance addictions are conceptually and etiologically related (Wong & Hodgins, 2014). Despite similarities between behavioural and substance abuse addictions, Rush, Urbanoski, Bassani, Castel, and Wild (2010) noted that therapists and treatment programs do not offer integrated interventions. Consequently, another difference between CCT and the other models is that CCT can address this poly-addiction aspect of addiction, as it works on the underlying problems of communication and emotional regulation patterns beyond gambling. This demonstrates CCT's holistic and integrative approach as it covers deep structures and patterns of addiction that are not usually addressed in other models. As noted in my results, CCT is an integrative model that looks at clients from multiple perspectives to give clarity on their experiences with addictions and connections with trauma.

CCT was created to treat addictions, but a key difference from other models is that it explores clients' addictive history with their trauma history, communication, emotion regulation, and coping patterns. Focusing on addiction, the clients' history and couples' relationship brings to the surface the underlying story beneath the addiction and helps the client understand the impact of their experiences and trauma on their addiction. In fact, the literature have shown a high prevalence of childhood trauma among gamblers (Felsher et al., 2010; Hodgins et al., 2010; Petry & Steinberg, 2005; Poole et al., 2017), and has suggested assessing and addressing these issues, as well as other addictive

problems in PG treatment (Felsher et al., 2010; Poole et al., 2017). As illustrated in the present study, CCT is able to explore and link clients' childhood traumas to present struggles with addiction.

Trauma in Addiction Treatment

This study shows how the linkage of trauma and addiction is central in the model. Even though the therapist explores clients' addiction patterns, it is noticeable that the addiction and its manifested behaviours or symptoms cannot be the sole focus of treatment. Beginning with clients' initial understanding of addictions, the therapist uses addiction patterns and timelines to raise clients' awareness to how addiction links with "pressure points" and traumatic experiences. This illustrates how CCT goes beyond addiction patterns and recognizes the need for addressing clients' underlying intergenerational, interpersonal, intrapsychic, and universal-spiritual problems contributing to PG that cannot be ignored (Lee, 2009). In fact, Lee (2002a, 2009) proposes to "make inroads into healing the depth of woundings and traumatic history of pathological gamblers." As Petry and Steinberg (2005) analyzed gamblers' history of childhood maltreatment, they suggested the need to address these issues in the treatment of PG.

The study findings support that CCT is a humanistic, integrative, and systemic model (Lee, 2009), and as such, does not only focus on changing symptoms and behaviours, but works with the whole person in relationships by exploring clients' different traumatic and stressful life events influencing current patterns of communication and behaviours, and integrating them into awareness and new choices. According to the present analysis, the model broadly frames addiction as a symptom of unresolved trauma.

To reinforce its integrative, existential, humanistic, and systemic view, Lee (2017) described addiction as “an extreme form of alienation from self, others, one’s history and one’s spiritual nature” (p. 14). CCT considers addiction to be a deep disconnection in individuals’ four-dimensional system (intrapsychic, interpersonal, universal-spiritual, and intergenerational), rather than a “personality flaw” (Lee, 2017, p. 59). In the present study, the therapist brings up disconnection as a consequence of the interpersonal trauma and broken past and present relationships (intergenerational and interpersonal dimensions), which manifests as lack of communication, awareness, acknowledgment, and appreciation for others and themselves. This is intrinsically related to the clients’ self-disconnection (intrapsychic and universal-spiritual dimensions), as the trauma also creates a lack of awareness and acknowledgement of their own needs and feelings. According to Lee, this understanding of addiction as a disconnection related to trauma “reduces shame and restores self-worth,” rather than viewing addiction as a character flaw, which helps clients increase their sense of worth and prevent relapse (p. 59). Thus, the model sees addiction through a trauma and relational lens, where something that overwhelm clients integrity, and that is why healing from addiction is intrinsically related to healing from traumas.

Although the literature shows evidence for the co-occurrence of trauma and addictions (Driessen et al., 2008; Giordano et al., 2016; Mills, Teeson, Ross, & Peters, 2006; Petrakis, Rosenheck, & Desai, 2011), treatments for concurrent PTSD and addictions are still in an emerging stage (Flanagan, Korte, Killen, & Black, 2016). Najavits and Hien (2013) described complex trauma, PTSD, and SUD as “parts of a prism,” in which these conditions are “different lenses from which to see into clients’

often tragic past” (p. 433). The field has seen these conditions as distinct entities because of its formal diagnostics, but trauma and addictions are closely related in clients’ everyday life experiences. The linkages between PTSD and SUD have only recently received more attention (Najavits & Hien, 2013).

In both cases analyzed in the present study, clients reveal histories of adverse childhood experiences (ACE) of parental neglect and abandonment, divorce, abuse, and deaths. Some studies have indicated a possible relationship between PG and childhood adversity/ACE, in which individuals with history of ACE are more likely to report problem gambling later in life (Afifi, Brownridge, MacMillan, & Sareen, 2010; Felsher, Deevensky, & Gupta, 2010; Hodgins et al., 2010; Poole et al., 2017). In a literature review in which Lane et al. (2016) analyzed the relationship between childhood maltreatment and PG in adulthood, the authors reported that the majority of studies included in the review revealed a significant relationship between the two factors. Some authors then have suggested this multidimensional perspective in order to create a more effective strategy in the treatment of ACE and /or childhood trauma and PG (Felsher et al., 2010; Poole et al., 2017). Thus, the two cases analyzed in the present study illustrate that CCT makes an important contribution as an innovative treatment model that can integrate the work with PG, its comorbidity with other addictions, and ACE.

According to Back, Waldrop, and Brady (2009), clinicians found that treating co-occurring SUD and PTSD is significantly more challenging than treating each condition separately. The authors mentioned that one of the most common challenges of the concurrent treatment of PTSD and SUD is integrating treatment components to address symptoms of both conditions. Some of the questions that came out of the study were

related to safety issues, especially in case of clients' relapse and the continuity with the trauma work (Back et al.).

In my research, I note that the first step in creating space to facilitate the healing process of trauma and addictions is a strong alliance and alignment with both clients and their partners. According to Friedlander et al. (2011), alliance in couples therapy is challenging because of the different and interrelated alliances that are developing at the same time, which are also influenced by clients' previous family dynamics. As mentioned before, in CCT, couples first come to sessions expecting treatment for the PG; the therapist aligns with the clients' concerns by listening to both of their expectations, hopes, and wishes. The therapist also provides information about the framework she uses, which considers addiction to be a consequence of traumatic experiences. This process addresses what Bordin (1979) refers to as task and goal agreements, as they help clients and the therapist and client to set the goals for therapy together and their intention to work with both trauma and addiction. Additionally, the therapist gives clients control over the sessions by following their presentation and working with trauma issues as they arise, instead of imposing a rigid set of interventions during the sessions. Throughout the sessions, the therapist acknowledges both clients' feelings and experiences continuously. This way, the therapist enhances clients' feelings of respect and trust, facilitating their bond, which is another concept highlighted by Bordin. Herman (2015) have also highlighted the importance of helping a client with a trauma history to restore their sense of control, especially in a therapeutic relationship.

Hien, Cohen, Miele, Litt, and Capstick (2004) stated that a common belief regarding the PTSD assessment in early stages of treatment is that it may impair the

progression of addiction treatment, by making it harder to achieve and maintain abstinence. Regarding the complex PTSD treatment, Busuttil (2009) also suggested addressing self-harming behaviours, including substance abuse, in the stabilization phase and prior to the trauma treatment. On the other hand, there are researchers who support the immediate integration of trauma in to the addiction treatment, to help clients alleviate trauma suffering sooner, and because trauma related symptoms may cause relapse and dropout (Brown, Recupero, & Stout, 1995; Ouimette, Ahrens, Moos, & Finney, 1997; Triffleman, Carrol, & Kellog, 1999). Hien et al. (2004) reported that two cognitive-behavioural treatments helped women in decreasing both their PTSD and SUD symptoms. CCT offers a flexible and fluid approach to trauma and addictions, because both issues are addressed together with no rigid set of pre-determined timing interventions, as manifested in the couple's interactions and in relation to the discussion of addictions, which also facilitates clients' safety in therapy. This graduated flexibility also differentiates CCT from other approaches that combine SUD and PTSD treatments, such as Substance Dependence PTSD Therapy (SDPT) (Triffleman et al., 1999), which strongly recommends abstinence before addressing trauma, and suggests that SUD should be addressed first.

Recent literature reviews on co-occurring treatment for trauma and addictions refer to studies that mostly focused on PTSD and SUD based on individual and group approaches (Flanagan et al., 2016; Roberts, Roberts, Jones, & Bisson, 2015; Torchalla, Nosen, Rostam, & Allen, 2012; van Dam, Vedel, & Ehring, 2012). Most of those concurrent treatments are CBT-based (Roberts et al., 2015). However, in their literature review, Flanagan et al. (2016) cited one preliminary finding of a couple therapy model,

the Couple Treatment for Alcohol Use Disorder for Posttraumatic Stress Disorder (CTAP) (Schumm, Monson, O'Farrell, Gustin, & Chard, 2015).

According to Schumm et al. (2015), the CTAP model combines two empirically supported cognitive-behavioural based models, the Cognitive-Behavioural Conjoint Therapy (CBCT) for PTSD (Monson & Fredman, 2012) and the Behavioural Couples therapy (BCT) for Alcohol Use Disorder (AUD) (O'Farrell & Fals-Stewart, 2006). This a 15-session based model, in which the goal is to diminish alcohol use and PTSD symptoms while helping couples to improve their relationship (Schumm et al., 2015). In their uncontrolled trial study, Schumm et al. (2015) reported preliminary results that support the CTAP as treatment to lessen co-occurring alcohol abuse and PTSD symptoms, but they stated that further research is needed. Although the CTAP addresses clients' emotions and avoidance related to PTSD and addiction, the model seems more focused on cognitions. The focus on cognitions differentiates CTAP from the CCT model, which has the systemic and experiential traditions as a foundation, and sees the individuals through their interpersonal, intrapsychic, spiritual, and intergenerational dimensions with a strong emphasis on shifting perceptions and meaning-making.

CTAP and EFT for addictions showed the importance of addressing trauma and addictions combined within the couples' therapy modality, which supports the CCT approach illustrated in this study. CCT brings new perspective to the work with both conditions of trauma and addiction. As illustrated in the present study, CCT is not focused on reducing addiction and PTSD symptoms, instead addressing the underlying issue: clients' experiences in the form of complex trauma that affected their emotion regulation and relationships. As noted in the two case studies, in CCT, the therapist links

trauma and addictions, and considers how past traumatic experiences still affect clients in the present in their couple relationship. Consequently, different from the CTAP and EFT, facilitating couples' reconnection is a way to help clients heal and transcend their past trauma and addictions.

Working with Trauma through Present and Past Contexts of Relationships

Najavits and Hien (2013) mentioned the difference in present-focused and past-focused trauma treatments in the field. According to Najavits (2014), past-focused approaches addresses the painful traumatic memories and related emotions, and present-focused approaches focuses on “encompassing coping skills and psychoeducation” (Najavits, 2014, p. 282). Najavits and Hien (2013) noted that “trauma-focused” is often used to describe exposed-based models, and “non-trauma-focused” describes present-focused models.

CCT considers it necessary to address the root of addiction and individuals' wounds caused by a traumatic history (Lee, 2017). The model progressively creates linkages between trauma and addictions over the course of therapy. My results, together with the definitions of present and past-focused approaches mentioned above (Najavits & Hien, 2013), indicate that CCT is a combination of present and past-focused models. My study shows that even though the therapist created space for clients to describe and explore the impact of their trauma through a gradually deepening process conducted over a series of sessions, the focus was on gaining clarity on the contexts of clients' past and present relationships, including clients' relationships with themselves. The past-focused aspect is related to the exploration of *intergenerational dimension* (Lee, 2017), which allows the therapist and clients to understand the nature and impact of their childhood

trauma, and the environment and relationships in which the client grew up. When appropriate, the therapist also explores how clients' parents grew up, which expands the understanding of the continuity of their FOO experiences and their present relationships. The therapist then notes patterns and describes those relationships in terms of communication postures, connecting patterns repeated from past to present relationships. Consequently, the present-focused aspect of CCT is not only related to psychoeducation and coping skills, but also to the exploration of clients' present relationships with their partner and children. This resonates with Lee's (2017) idea about how the "present can change the past" (p. 78). Lee highlights that the effects of traumatic experiences can be addressed by creating "new patterns of thinking, feelings, and communicating" in the present (p. 78) to correct dysfunctional patterns shaped by the past.

Working with the past in light of the present illustrates CCT's approach to clients' trauma and addictions in four dimensions: (1) intrapsychic; (2) universal-spiritual; (3) interpersonal; and (4) intergenerational (Lee, 2017). My analysis shows that the therapist explores the *intergenerational dimension* to gain more understanding about clients' past significant relationships. With deeper understanding about these difficult relationships from the past, the therapist works on identifying and changing present relationships and communication patterns in the *interpersonal dimension*. Finally, the therapist addresses the traumatic and addiction experiences at the *intrapsychic* and *universal dimensions*, which consider the individual and his or her own emotional experiences and beliefs about the self. Moving back and forth between these dimensions, the therapist gains more understanding of the consequences of trauma for the individual and his/her pain and unmet human needs behind the addiction. Recently, Lee defined human universal needs

by the “CSWs,” which stand for connection, safety, and worth (p. 36). In addition, Lee stated that “urges to use a substance or engage in harmful behaviour usually have underlying fantasies and wishes of unmet need and unexpressed emotions” (Lee, p. 36).

Thus, clients’ reconnection in CCT is based on the model’s definition of congruence, which is operationalized by the four A’s: attention, awareness, acknowledgment and alignment (Lee, 2017). This study shows how the therapist brings attention and awareness to clients’ present relationship with themselves and their families, and how it is affected by past relationships, trauma, and addictions. Building on attention and awareness, the therapist adds alignment in the work with the clients, as she guides them to express feelings that are true to themselves regarding their past and present experiences. Finally, this study also shows how the therapist invites clients to acknowledge themselves (“I am” exercise) and their partners and family members.

This study posits that CCT approaches trauma by using the lens of communication to look into clients’ past and present relationships with themselves and others. Considering five communication postures (superior, enmeshed, inferior, fixing, and avoidant), the therapist is able to identify clients’ ways of relating with themselves and with others in their lifetime (Lee, 2017). Lee (2017) highlighted that in stressful situations, individuals will likely use “automatic ways of communication” which are “learned in early life” (p. 24).

By looking at intrapersonal and interpersonal relationships, the CCT model converges with Herman’s (2015) concept of trauma as “violation of human connection” (p. 54). According to Herman, relational damage can be a primary effect of traumatic events, considering that those events have consequences “not only on the psychological

structures of the self but also on the systems of attachment and meaning that link individual and community” (p. 51). In other words, traumatic experiences damage individuals’ sense of safety in the world and positive sense of self. In early developmental stages, such as childhood and adolescence, Herman stated the importance of individuals’ “secure sense of connection with caring people as the foundation for personality development” (p. 52). If this connection is broken/damaged (“shattered”), the individual also loses a sense of self (Herman, 2015, p. 52). Hence CCT addresses more than the symptoms of PTSD, but the more pervasive consequences of complex trauma, which is aligned with van der Kolk’s (2005) idea of developmental consequences of trauma.

This idea is especially important in the cases analyzed in the present study, because both clients have a history of childhood trauma (abuse, neglect, and loss) leading to relationship difficulties. I noted that CCT works with complex trauma that may or may not have PTSD symptoms, similar to what Courtois and Ford (2016) described as “complex traumatic stressors” (p. 10). Complex trauma is related to the exposure to interpersonal forms of trauma, which are often chronic and damage individuals’ self-integrity, personal development, and capacity for healthy relationships with others (Courtois & Ford). My study shows that, when referring to the past traumatic experience, the therapist mostly used clients’ feelings related to the events, such as “pain,” “sadness,” “disappointment,” “helplessness,” “hurt,” and “loss,” instead of labeling their experience as trauma. This shows how in both cases CCT did not focus solely on PTSD symptoms, but on clients’ felt experiences and the consequences of trauma on their present relationships with themselves and others.

Regarding the stigma of mental health issues, Corrigan and Watson (2002) have described two aspects of stigma: public and self-stigma. According to the authors, public stigma are the stereotypes, prejudice, and discrimination towards individuals with mental illnesses. In self-stigma, individuals become aware of and internalize the public stigma, which leads to diminished self-esteem and self-efficacy. Thus, by identifying and naming clients' emotions related to the trauma, the therapist connects with clients at an emotional level and avoids the stigmatization in labelling trauma and PTSD. Furthermore, the linkage between trauma and addictions also help diminish the stigma related to the addiction. That is because of the shame of addiction issues from clients seeing themselves as "failing in effective agency and not living up to their own normative standards" (Matthews, Dwyer, & Snoek, 2017, p. 275). Thus, as CCT connects trauma and addiction, it helps to shift clients' view of themselves as a failure to exercising self-compassion on themselves for having survived the traumatic experiences they have gone through.

Healing from Trauma and Addictions through Relationships

Considering the relational context of trauma and the cycle of couples' distress with addictions, CCT brings a relational perspective of healing from trauma and addictions within the two cases analyzed in my study. Traditionally, cognitive models focus on identifying and treating complex trauma by helping clients manage or alleviate trauma symptoms (Mahoney & Markel, 2016). In couples therapy, CBCT for PTSD seeks to enhance intimate relationships to "treat PTSD and its comorbid symptoms" (Monson et al., 2012, p. 700). According to these authors, the model involves exercises

that help clients “increase skill acquisition and use,” including communication and conflict management skills (p. 703).

Different from CBCT for PTSD, Johnson’s (2005) EFT takes into consideration the interpersonal effects of trauma, which she considers essential to address in couples therapy by helping clients create a “safe haven” in their relationship (p. 5). EFT combines social support and attachment theory to help clients dealing with psychological distress, such as PTSD. According to Greenman and Johnson (2012) the creation of a loving and supportive bond between partners is essential in the process of healing from trauma. Johnson and Williams-Keeler (1998) mentioned that EFT works at the intrapsychic and interpersonal level. The main purpose of EFT is to raise client awareness of negative interaction patterns and to create new patterns based on secure emotional connections (Greenman & Johnson); however, it does not go into the intergenerational dimension. Therefore it appears to be a predominantly present-focused model.

This study highlights differences between CCT and the two models mentioned above. In CCT, couples’ relationships were central to therapy, not only in alleviating addiction symptoms. Changing communication patterns is central to interrupting a repetition of past patterns that were shaped by trauma. Although EFT reinforces the importance of work with the interpersonal aspect of trauma, it differs from CCT because it works in the present relationship. My study illustrates how CCT works with clients’ past and present relationships in tandem. It brings the intergenerational influences into conscious awareness and invites clients’ choices to communicate differently with their present family members. The intergenerational dimension is an important dimension to CCT to deeply understand the current impact of past traumatic relationships and to

differentiate past and present contexts, thereby changing the clients' perception of self and other to be freed from their painful past. Again, this illustrates CCT's systemic and social constructionist tenets (Lee, 2017), as it acknowledges the impact of past relationships in shaping clients' present beliefs and reality.

My case analyses show that in CCT, the therapist works with the interpersonal and intrapsychic dimensions, especially through clients acknowledgement and appreciation for each other and of themselves. In CCT theory, the interpersonal dimension is especially important because "communication is one of the most important ways in coping" (Lee, 2017, p. 24). More than a way of problem solving, communication is seen as a source of "empathy, comforting, and soothing," which can also help individuals in coping with stress (Lee, 2017, p. 24). Asking questions, turning complaints into requests, and paraphrasing were practical ways to facilitate congruent communication and deepen clients' connection. In congruent communication, the individual can express truthfully what he or she thinks and feels (Lee, 2017). CCT also seeks to expand the "range and depth" of communication, which Lee (2017) calls the Elastic Circle of Connection, inspired by Satir's Temperature Reading (Satir et al., 1991, pp. 309-316). This Elastic Circle of Connection includes areas that can help clients deepen their communication, such as "asking questions, self-disclosure, offering new information, making requests, sharing fear and worries, and celebrating achievements" (Lee, 2017, p. 60; Satir et al., 1991).

CCT addresses intergenerational effects not only in the past, but also in the present and future. The therapist not only changes the communication between the partners, but also expands this type of communication to the clients' children. Through

role plays, the therapist helps the clients to re-connect with their children and other family members through communication, especially regarding situations of conflict and misunderstanding. When it is possible, the therapist uses the sessions as a space to reconnect with the FOO, to help the client heal from past trauma. When the client is not willing to reconnect with FOO (as in the example of Case A), the therapist uses a present relationship with a child to reconnect and help the healing process issue from the present to past relationships. Changing present communication patterns can help clients heal from past relationships; as the therapist says in one of the sessions, “*When you mend those relationships [with your children], you’re mending a lot from your past.*” This resonates with Lee’s (2002b) definition of healing that involves integration and restoration of different dimensions, including elements of these dimensions that have been disrupted. Congruence is based on the notion of healing as reconnection that brings into harmony “elements in the intrapsychic, interpersonal and universal-spiritual dimensions of the person,” elements that have been separated but are now “brought into awareness and integration” (Lee, 2002b, pp. 75-76). In this new reality, individuals can express and reconnect with their true selves, with others, and with the spiritual essence of being in an interdependent unity (Lee, 2002b).

Thus, these two cases illustrate how CCT uses the present moment for reconnection with present and intergenerational relationships and to heal from past traumas. Regarding CCT’s tenets, this process of healing through relationships reaffirms the humanistic, systemic, and existentialism aspects of the model (Lee, 2017), as it recognizes clients’ individual limitations and losses, but still affirms their potential for growth and healing.

This idea of reconnection with others as part of healing from trauma has already been highlighted by Herman (2015), as she stated that “helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery” (p. 197). Herman reaffirmed that idea by saying that recovery does not happen in isolation, it happens in the context of relationships. Reconnection with others allows the individual to reconstruct psychological abilities, such as “trust, autonomy, initiative, competence, identity, and intimacy” (Erikson, as cited by Herman, 2015, p. 133), which were affected by the trauma (Herman, p. 133). From the analysis of the two cases, CCT’s approach to trauma and addiction brought healing to core aspects of self and one’s relationships through work based in the past and the present.

Addressing Self and Interpersonal Connection in Trauma

In the treatment of complex trauma, Courtois and Ford (2016) mentioned that “most often, couple therapy does not replace individual treatment, and the individual modality may provide important preparation or support for couple work; however, it is equally possible that couple therapy can facilitate stronger engagement in individual treatment” (Courtois and Ford, 2016, p. 215). This idea reaffirms the positive effects that couples’ therapy has at an individual level. The present study shows how CCT integrates the individual level of therapy within the couples’ modality.

During therapy, the therapist includes the intrapsychic dimension by helping clients to increase their self-awareness and highlighting the importance of self-acknowledgment and self-appreciation. The individual is mostly represented in CCT by the intrapsychic dimension, which refers to clients’ feelings, perceptions, expectations, and beliefs about themselves (Lee, 2017; Satir et al., 1991). Closely related to the

intrapsychic dimension, there is the universal-spiritual dimension, which is described by Lee (2017) as shared human “universal yearnings and aspirations,” which are “to belong, to be loved, accepted, and respected, to be seen and heard, and to live with meaning and purpose” (p. 36); in short, the yearning for meaning, connection, safety, and worth. In my analysis, I note that the therapist explores consequences of trauma for the self and the loss of connection to these universal-spiritual yearnings. To heal from trauma and addictions, the reconnection with the core self and honouring its yearnings is just as important as the reconnection with family.

Relational-Cultural Therapy (RCT) (Jordan, 2009) is yet another model that reaffirms the value of self-connection (Kress, Haiyasoso, Zoldan, Headly, & Trepal, 2018). The model takes into consideration that traumatized individuals might experience a sense of disconnection from others and from themselves, and the interpersonal disconnection might give individuals a false sense of safety from revictimization (Banks, 2006; Kress et al., 2018). RCT considers that by helping clients heal their relationship with themselves through self-empathy and awareness, therapists are also creating with them the foundation to interpersonal relationships (Kress et al., 2018). Also, RCT values exploring relational experiences that might be connected to interpersonal trauma (Kress et al., 2018). That is because, according to RCT, relational images influence how individuals conceptualize relationships and how they identify themselves (Jordan, 2009). RCT then sees connection with others and growth-fostering relationships as ways to help individuals healing (Jordan, 2009; Kress et al., 2018).

My study shows similarities between RCT and CCT, in the way both models relate the interpersonal trauma with disconnection from self and others, and how both

consider the exploration of past relational experiences important. Consequently, in both models, self-reconnection and interpersonal reconnection are important factors in healing from trauma. Regarding self-connection, both models highlight the need for individuals' self-awareness and self-empathy, as a way of reconnecting with others. The models differ in how this is done. RCT focuses on the therapeutic relationship between client and therapist (Banks, 2006; Jordan, 2009; Kress et al., 2018), and CCT focuses on couples' relationships. My study illustrates how the CCT therapist works with both interpersonal and self-connection, and how both of these factors work together to help individuals on their healing process.

Study's Contributions

My study contributes to the limited research on couple therapy for the treatment of trauma and gambling focusing on the CCT model. Treatments of trauma and addictions have been focused on cognitive-behavioural models. Thus, the present study brings a new understanding of the process of a humanistic-existential, systemic, and social constructionist in the treatment of these conditions. Although in the two analyzed cases CCT works with the couples to address the primary presenting gambling problem, both couples have recent and past history with other substance use. The descriptive nature of my study helps to illustrate the process of CCT for research purposes, but it would also benefit practitioners in the field who would like to learn how to work with other types of addiction, couples' relationships, and the impact of adverse childhood experiences in an integrated fashion. As most previous research on CCT was conducted by the developer of the model, my study is one of the first to provide an external perspective and analysis of it.

Study Limitations

As the study was based on secondary data analysis of transcripts, I was not able to experience the data collection and therapy sessions first-hand. My analysis was based only on transcripts and I was unable to include reflections on clients' and therapist's body language in their interactions, even though the transcripts included these observations. Had I been witness to the vividness of what transpired in the session through tone and non-verbal exchanges, my interpretations may have been enriched.

This study was based on a qualitative, case-analysis design. Although this study design allowed me to do an in-depth analysis of CCT sessions transcripts, it limits the generalizability of my findings. In this study, I analyzed cases of couples who showed significant improvement in their relationship satisfaction, according to the Dyadic Adjustment Scale, before and after the therapy. Couples who made lower levels of improvement may provide other insights into how CCT works with these couples and how they respond.

Considering the importance of the researcher in a qualitative study, it is important to acknowledge my background as a limitation to the present research. Although I have a mental health background in nursing, I am not an addictions counsellor or a couple therapist. Thus, this could be a limitation in terms of how I analyzed, described, and viewed the therapeutic process which could be different from that of a trained clinician. One other limitation is that the developer of the CCT model is my thesis supervisor which could potentially introduce a bias. To address this, I focused my study by staying close to the data in the transcript and simply describing the process I observed empirically without being constrained by the theory of CCT, until I developed my own

descriptive themes. I focused on the process of how the model works with trauma and addictions rather than analyzing its effectiveness. I only presented my thematization to my supervisor after having completed the entire analysis. In addition, I formed a supervisory committee, including a nurse and psychologist who are not associated with the model, and we held regular supervisory team meetings during my analytical process. The foregoing factors served as safeguards to offset any bias in my analysis that could have occurred.

Recommendations for Future Research

This is the first in-depth case study analysis on the CCT model and its approach to trauma and addiction. Consequently, more case studies are recommended to expand the knowledge about the process of CCT as integrative treatment model for these conditions. Although clients in both of my case studies had a history of other addictions, gambling was the only addiction at the time of treatment. Thus, it would be interesting to analyze the applicability of CCT to other types of addictions.

I also recommend that researchers with different backgrounds be involved in CCT research, to gather additional perspectives of the model. Additionally, case studies with other therapists applying the CCT model would help to understand the wider applicability of the model. I also recommend research that explores client and therapist experiences with the present model. This could enhance understanding of their perception of the application of the model, as well as improving the model to meet clients' needs. Finally, considering the impact of both trauma and addiction in couples' lives, and the lack of studies on integrated systemic co-occurring treatment of trauma and addiction in couple relationships, further research and models should address this challenging area for

treatment, and their outcomes for the addicted individuals themselves, the couples, and their intergenerational families.

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APPENDIX A: FRIEDMAN TEST REPORT
(from Lee and Awosoga, 2012)

Shaded rows = control
N=number of items answered on test

Significance levels * < 0.05
** < 0.01
*** < 0.001

SUMMARY FOR GAMBLERS
DAS (Dyadic Adjustment Scale)

CANDIDATE (N)	PRE-TREATMENT MEAN	PRE-TREATMENT SD	POST-TREATMENT MEAN	POST-TREATMENT SD	FOLLOW-UP MEAN	FOLLOW-UP SD	FRIEDMAN TEST STAT	SIG.	COMMENT
A1MG (31)	2.50	1.481	3.03	1.282	2.91	1.279	14.000	.001	***
A2MG (32)	2.41	1.160	3.19	1.148	3.31	1.330	23.403	.000	***
A3MG (30)	2.91	1.400	2.28	1.486	1.72	1.529	22.132	.000	***
B1MG (32)	2.69	1.091	3.66	1.096	3.47	1.344	36.024	.000	***
B2FG (30)	3.34	1.359	3.03	1.282	3.69	1.256	11.241	.004	**
B3MG (32)	2.78	1.099	2.78	1.099	3.16	1.194	11.924	.003	**
B4FG (32)	3.84	1.221	3.81	1.176	3.63	1.289	1.018	.601	
B5MG (32)	3.38	1.100	3.59	0.979	3.25	0.842	4.816	.090	
B6FG (32)	3.09	1.146	3.72	1.085	3.28	1.143	20.458	.000	***
B7FG (32)	2.69	1.230	3.47	1.270	3.63	1.040	28.065	.000	***
B8MG (32)	1.66	1.066	1.72	1.023	1.97	1.062	4.899	.086	
B9MG (32)	3.22	1.070	3.26	1.032	3.56	1.076	8.000	.018	*
C1FG (31)	2.22	1.211	2.91	1.279	2.81	1.091	10.571	.005	**
C3FG (28)	3.38	1.238	3.38	1.129	3.47	1.164	0.078	.962	
E1MG (32)	3.53	1.016	3.31	0.998	3.13	0.942	4.657	.097	

SUMMARY FOR SPOUSES

DAS

CANDIDATE (N)	PRE-TREATMENT MEAN	PRE-TREATMENT SD	POST-TREATMENT MEAN	POST-TREATMENT SD	FOLLOW-UP MEAN	FOLLOW-UP SD	FRIEDMAN TEST STAT	SIG.	COMMENT
A1FS (32)	2.28	1.198	2.91	1.058	2.81	1.091	13.743	.001	***
A2FS (31)	1.91	1.634	1.94	1.366	2.34	1.715	4.682	.096	
A3FS (32)	1.91	1.594	1.56	1.458	1.28	1.442	24.125	.000	***
B1FS (32)	3.06	1.134	3.72	1.170	3.84	1.167	26.964	.000	***
B2MS (31)	3.41	1.241	3.44	1.413	3.91	1.058	10.630	.005	**
B3FS (32)	2.72	1.250	3.06	1.268	3.03	1.332	8.704	.013	*
B4MS (32)	3.72	1.170	4.06	1.045	4.13	1.040	10.157	.006	**
B5FS (32)	3.66	1.125	3.56	1.014	3.28	1.054	7.373	.025	*
B6MS (32)	3.38	1.185	3.47	0.915	3.44	1.162	0.857	.651	
B7MGS (32)	2.69	1.176	3.25	1.016	3.41	1.073	27.114	.000	***
B8FS (32)	2.25	0.916	1.69	1.148	2.25	1.368	9.029	.011	*
B9FS (32)	3.38	1.212	3.53	1.704	3.66	1.096	7.378	.025	*
C1MS (32)	1.91	1.146	2.25	1.047	2.03	0.999	7.412	.025	*
C3MS (31)	3.41	1.241	3.09	1.058	3.59	0.911	5.114	.078	
E1FS (32)	3.19	1.091	3.50	0.984	3.09	1.027	8.324	.016	*

APPENDIX B: INFORMED CONSENT



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A PILOT RANDOMIZED CONTROLLED TRIAL OF CONGRUENCE COUPLE THERAPY FOR PATHOLOGICAL GAMBLING

CLIENT'S INFORMATION LETTER AND CONSENT FORM

You are invited to participate in a clinical trial research study of Congruence Couple Therapy consisting of 12 weekly couple therapy sessions, if you are randomly allocated to the treatment group.

This pilot clinical trial of Congruence Couple Therapy is led by Dr. Bonnie Lee, **Principal Investigator**, Assistant Professor in the School of Health Sciences, University of Lethbridge. She is a Registered Clinical Member in the Canadian Registry of Marriage and Family Therapists and a Clinical Member and Approved Supervisor of the American and Alberta Associations for Marriage and Family Therapy.

What is the Congruence Couple Therapy?

Congruence Couple Therapy (CCT) is a humanistic therapy model built on the pioneering family therapy contributions of Virginia Satir (1916-1988). It is a holistic model that draws on a person's psychological, marital-social, family of origin, and spiritual resources to create therapeutic change and to reduce the urges and activities associated with problem gambling. Intended outcomes are increased self-esteem and well-being, improved couple relationship, increased coping capacity for stress and distress, and reduced gambling urges and activities. This model was piloted with some promising preliminary results with 8 couples including one partner with pathological gambling by Dr. Bonnie Lee in a 2001-2002 study and with 24 couples in a 2004-2006 study.

What is the purpose of the study?

We are proposing a pilot study to serve as a prelude to a major study in a future proposal. Pilot studies help us justify the investment of resources in any large-scale randomized controlled study, to minimize risks and to increase its likelihood of its benefits to participants.

The goals of this study are:

1. To determine whether a full scale randomized controlled trial of Congruence Couple Therapy is feasible.
2. To determine what modifications and refinements are needed to the research and clinical protocols.

3. To obtain some preliminary outcomes on the efficacy of CCT and some factors influencing its outcomes.
4. To understand the factors that contribute to problem gambling and factors that contribute to its recovery.

How are you selected to participate in this study?

We are looking for couples in which:

- One partner presents the characteristics of pathological gambling according to clinical criteria.
- One partner having gambled in the past 2 months
- 18 years or older
- Both couple partners are committed to the couple relationship (self-definition)

For this study, we cannot accept participants who demonstrate:

- Current suicidal ideation
- Past month psychotic symptoms
- Recurring intimate partner violence
- Involvement with loan sharks

What will you be asked to do?

If you are randomly allocated by picking one of two envelopes to receive CCT, you will be asked to participate in the following tasks which would take approximately 20 hours of your time in the course of 5 months to:

1. Attend 12 sessions of couple counselling and 1 follow-up session where your counsellor will be incorporating the use of her knowledge in CCT. The treatment sessions will be held at _____ and have been scheduled for _____ (frequency) from _____ to _____.
2. Complete a set of clinical questionnaires *before* and *after* your couple therapy that are meant to capture information on: your demographic background, your gambling problem, your couple relationship, your mental health status, your coping strategies, your alliance with your research counsellor, factors that could have contributed to your/your spouse's gambling.
3. Complete an anonymous *Client Satisfaction Questionnaire* at the end of 12 and 20 weeks on the CCT counselling you received which you will drop in the mail to the research team.
3. Agree for your case to be discussed anonymously or with a pseudonym by your counsellor at weekly case consultation teleconferences with other counsellors and researchers on the project. This is to support your counsellor in providing you with the best possible counselling service.
4. Agree to have your counselling sessions audiotaped and videotaped by your counsellor for the purposes of clinical consultation, research, training materials, theses and publications.

5. Agree for the findings of the pooled questionnaire scores and quotes from your therapy sessions and questionnaires to be used in reports and publications ensuing from this study without disclosing your identity.

If you are selected to be in the control group, you will not receive the 12 sessions of CCT immediately. However, you will be contacted at week 3, 6, and 9 during a 12-week period by a researcher to maintain contact with you and to have you answer a few questions. You will be asked to come in at week 12 and 20 to complete some questionnaires.

If you receive other or “usual treatment” while in the control group, we ask that you let the researcher know the type of treatment, frequency and duration of the treatment you received during this period.

At the end of the 20th week, you can request for CCT or other treatment with the agency that provides the service closest to you.

Is my participation in the study voluntary?

Your taking part in this study is entirely voluntary. You may leave the study at any time and revoke in writing your consent to the research use of any of your clinical information. You will however inform the researchers of my decision to withdraw as early as possible. You may refuse to participate and refuse to answer questions without penalty. Your access to treatment services outside of the study will not be affected in any way whether you decide to complete the program or not.

Do I receive any compensation for participating in this study?

Yes. Each couple in the control group will receive a voucher for \$50 at the beginning of the study after the submission of the initial pre-test questionnaires.

Each treatment couple will receive a voucher for \$25 at the beginning of the study after the submission of the initial pre-test questionnaires.

Upon completion of the follow-up interview and questionnaires at week 20, all couples will receive a voucher for \$50.

Are there any costs involved?

No, except your transportation and parking to get to the study.

Are my records confidential?

Any clinical information will be anonymous and disguised to protect your anonymity by the researchers. Only a fake name and code will be used.

The partnering problem gambling agency will retain a copy of your records.

All researchers and participating counsellors will be bound by confidentiality in guarding the information discussed in teleconferences and on the audio and videotapes.

Your completed questionnaires will be submitted anonymously, identified only by a code number for pooled analysis. Quotes from your CCT sessions and questionnaires may be used in reports and publications, but again only anonymously.

As soon as your consent form is received, your consent and all other research documents will be kept in a locked and secured in an office in Health Sciences at the University of Lethbridge. Only the Principal Investigator, Co-Investigator, research team members and transcriptionists will have access to the research records, audio- and videotapes, and transcripts.

A limit to confidentiality applies when there is a threat of harm to yourself or another person or in cases of suspected child abuse or neglect or if the records are subpoenaed by law. Under such circumstances, confidentiality will have to be breached.

Your research counsellor will ask that you agree to a “no secrets policy” with regard to CCT. This means that information you disclose on the questionnaires or to the counsellor individually may be shared in the conjoint therapy sessions if deemed by the counsellor to be important to the effectiveness of the treatment.

How will the data be stored and for how long?

The University of Lethbridge will store the signed consent, audio and videotapes, questionnaires, and evaluation forms in a locked office. The raw data such as the audio and videotapes from the study will be kept for 10 years until 2020 and then destroyed.

The partnering agencies have agreed to follow the same agreement for retention and destruction of your records related to this research study.

Are there any risks in taking part in this study?

Since CCT deals with very personal issues, emotions may arise that are at times painful and difficult. The goal of the CCT is to help clients towards greater personal and interpersonal integration, including the enhanced ability to take responsibility for oneself and to make choices, to expand ways to cope with life’s challenges, and to improve the couple relationship.

However, no results from the treatment research can be guaranteed. As in all forms of psychological treatment/therapy research, there is the risk of negative outcomes. You are encouraged to ask questions about the nature of the procedures of the couple counselling at any time, and to inform the counsellor of the effects of different interventions on you and on your couple relationship.

Since CCT is a relatively new approach, there may be unknown and unforeseen risks when utilized by a counsellor who is being trained in the method.

If issues should arise that are beyond the scope, intensity, expertise or duration of the 12 couple therapy sessions, your counsellor will give you a list of community and professional resources for problem gambling, couple therapy and psychotherapy. If needed, you will be encouraged to contact your family doctor for referrals. You will be responsible for any fees for therapy or services outside of the 12 stipulated research sessions with Congruence Couple Therapy.

If you are randomized into the control group under conditions you cannot receive treatment for the 20-week period, you are free to withdraw from the study if you deem it necessary to obtain

treatment during this period. It is important for you to know that your well-being comes before any research requirements.

Are there any benefits in taking part in this study?

CCT is a model of couple treatment that focuses on the resources and strengths of individuals and couples. Your participation may help you progress towards the intended outcomes of the CCT, namely, increased self-esteem and well-being, improved couple relationship, increased coping capacity for stress and distress, and reduced gambling urges and activities.

Furthermore, you will be contributing to the research development of new best practices that can expand the treatment options for other problem gamblers and their spouses.

How will the results be used?

Pooled data, excerpts and quotes from therapy sessions and questionnaires may be used in the reports and publications. The Principal Researcher further seeks your consent to use your data from this study to answer other related research questions (secondary data analysis) that may emerge related to couple therapy and problem gambling, including the use of the data for potential theses by graduate students supervised by the Principal Researcher. However, your identity will be disguised and protected. Publications and conference presentations may be in the forms of papers, posters, manuals, journal articles, website information/ publications, theses and dissertations, training material including monographs, books, videos and DVDs using actors.

However, in all the instances listed above, your identity will remain anonymous and identifying details disguised.

At the completion of the study, you can access an executive summary of the study by contacting Dr. Bonnie Lee, Principal Investigator.

Questions:

If you have any questions or concerns, you can contact the **Principal Investigator** for this project, Bonnie K. Lee, PhD School of Health Sciences, Addictions Counselling Program University of Lethbridge, 4401 University Drive, Lethbridge, Alberta T1K 3M4, Canada.

Tel. 403-317-5047 Fax. 403-329-2668 E-mail: bonnie.lee@uleth.ca

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge, Tel. 403-329-2747.

If you decide to participate in this study, please complete the consent form on the next page.

Client's Consent to participate in

A PILOT RANDOMIZED CONTROLLED TRIAL OF CONGRUENCE COUPLE THERAPY FOR PATHOLOGICAL GAMBLING

Please **INITIAL** next to the items where you agree.

- I have read the Client's Information Letter on the study.
- I have had the opportunity to clarify my questions in regard to participation in this study and my questions have been answered to my satisfaction.
- I freely consent to taking part in this study with the terms outlined in the Client's Information Letter.
- I have received a copy of the Client's Information Letter and Consent Form to keep for my records.

I consent to.....

- Participate in CCT treatment OR participate in a comparison group without immediate treatment depending on chance allocation.
- Have my counselling sessions audiotaped and videotaped for research purposes.
- Allow audiotaped excerpts of my counselling sessions to be played by the counsellor for teleconference case consultations with other research counsellors.
- Complete and submit all research-related questionnaires either electronically or on paper to my research counsellor or the University of Lethbridge.
- Permit the University of Lethbridge's researchers and graduate students under the supervision of the Principal Researcher to release and disclose research findings including quotes for publications, reports, manuals, theses and dissertations, and future training materials that may ensue from this study, provided that any identifying information is removed or disguised.
- I know I am free to withdraw from the study at any time and, if I choose to withdraw, I can ask in writing that any data gathered from me be destroyed.

Participant's Name (Please Print) _____ Participant's Signature _____ Date _____

Research Counsellor's Signature: _____

Date: _____

University Researcher's Signature: _____

Date: _____

Please send consent form by regular mail or by fax to:

Bonnie K. Lee, Reg. MFT, Ph.D.

Assistant Professor

School of Health Sciences

Addictions Counselling Program

University of Lethbridge

Anderson Hall 111

4401 University Drive

Lethbridge, Alberta T1K 3M4

Canada

Tel. 403-317-5047

Fax. 403-329-2668

Participant's Address: _____

City: _____ Province: _____ Postal Code: _____

Phone No. (H) with area code: _____ (W – optional) _____

(cell) with area code: _____

E-mail: _____

Emergency contact person: _____

Contact person's telephone no. with area code:

(Home) _____ (Work) _____ (Cell) _____

Family physician _____

FOR RESEARCHERS ONLY

CODE _____

APPENDIX C: CONFIDENTIALITY FORM AGREEMENT

CONFIDENTIALITY AGREEMENT

**A PILOT RANDOMIZED CONTROLLED TRIAL OF CONGRUENCE COUPLE
THERAPY FOR PATHOLOGICAL GAMBLING**

I, **Jessica Bastardo Gaelzer**, M. Sc. Graduate Student in the Faculty of Health Sciences, agree to:

1. keep all the research information shared with me from the above project confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts, surveys) with anyone other than my Thesis Supervisor, except with permission for the components to be used in my thesis.
2. keep all research information in any form or format (e.g., disks, tapes, transcripts, surveys) secure and password protected while it is in my possession.
3. return all research information in any form or format (e.g., disks, tapes, transcripts, surveys) to my Thesis Supervisor when I have completed the research tasks.
4. after consulting with my Thesis Supervisor, erase or destroy all research information in any form or format regarding this research project that is not returnable to my Thesis Supervisor (e.g., information stored on computer hard drive, flash drives etc.).

Graduate Student

(print name)

(signature)

(date)

Thesis Supervisor

(print name)

(signature)

(date)
