

'Bringing Torn Lives Together Again': Effects of the First Congruence Couple Therapy Training Application to Clients in Pathological Gambling

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ABSTRACT Counsellors (N=21) receiving their first training in Congruence Couple Therapy (CCT) applied CCT to 1–2 pathological gamblers (N=24) and their spouses conjointly at their Ontario treatment settings. Gamblers' and spouses' pre–post quantitative results indicated statistically significant reduction of gambling urges and behaviours and improvement in spousal relationship. However, contrary to hypothesis, spouses experienced a significant decrease in overall life satisfaction, specifically in the area of regrets, from pre-to post-treatment. Ratings of CCT by clients and counsellors indicated high satisfaction of CCT's effectiveness. Qualitative data based on client and counsellor sources substantiated quantitative findings and further revealed clinical changes in four key dimensions addressed by CCT: intrapsychic, interpersonal, intergenerational and universal–spiritual. Quantitative results are limited by absence of a control group and low sample size, but are compensated by a solid base of qualitative findings. Mixed methods yielded promising preliminary results of CCT's effectiveness in gambling behaviour and symptom reduction and in improved spousal relationship.

Introduction

Evidence-based treatment models are built on a programmatic evolution of iterative cycles of development, refinement and validation (Sexton et al., 2003; Szapocznik and Williams, 2000). To establish evidence to guide treatment choices that best serve our clients, we need models with an explicitly articulated theoretical framework and set of interventions, applied to a specific clinical problem within a specific context (Sexton et al., 2003). It is also necessary to ensure that clinicians are properly trained in the model, thus adhering to the knowledge and skills the model exemplifies. Moreover, very limited scientific research examines the relationship between quality of counsellor training and client treatment outcomes, an important but overlooked area that has implications for both the science of training and the outcomes for clients (Shaffer and Costikyan, 2002).

A first counsellors' training programme on a new couple therapy model for pathological gambling, Congruence Couple Therapy (CCT) was launched and evaluated in 2004–06 with two cycles of counsellor training. Evaluation demonstrated that training outcomes for those who participated were statistically significant and positive (Lee et al., 2006, 2008). An important unique feature of the training was the inclusion of an application of CCT by counsellor trainees to couples at their respective sites supported by group teleconference consultations with the trainer over a period of 12 weeks after a 4-day residential workshop. Preliminary evidence of CCT's effectiveness based on single group

pre–post client outcomes triangulating qualitative reports from clients and counsellors was obtained.

Congruence Couple Therapy

Congruence Couple Therapy (CCT), extending and further conceptualizing Virginia Satir's founding work in family therapy (Satir et al., 1991), employs humanistic and systems tenets that view a person as an interactive dynamic of intrapsychic, interpersonal, intergenerational and universal–spiritual multi-dimensional wholeness (Lee, 2002a, 2002b, 2008). Structured as a compact systemic 12-session couple therapy programme for pathological gamblers and their spouses (Lee, 2002c, 2008), CCT works towards reconnection and congruence within and among the four human dimensions. It is posited that increased congruence reduces gambling compulsion as an outlet for disowned and disconnected parts of self (Lee, 2002c, 2008). As such, CCT addresses issues commonly identified among problem gamblers, namely, their social isolation (Wiebe et al., 2001), low self-esteem (Rockloff and Dyer, 2006), history of childhood trauma (Brockman, 2001, Petry and Steinberg, 2005, Lee, 2002c), poor coping abilities (McCormick, 1994), marital distress (Ciarrocchi and Hohmann, 1989) and symptoms of depression and anxiety (Toneatto and Skinner, 2000). It reaches into the root system of pathological gambling, healing the person as a systemic whole and not just focusing on gambling behaviours. The aggregate client results from two training cycles are reported below.

Method

The evaluation of client outcomes represents one level of the entire controlled counsellors' training evaluation (Lee et al., 2006) that proceeded upon the approval of the University of Ottawa Research Ethics Board.

A mixed methods evaluation was used to assess CCT's effects on client outcomes, combining quantitative and qualitative data and analysis from three sources with five sets of data --- (1) pathological gamblers and their spouses: (a) pre-and post-CCT sessions on measures of gambling urges and activities, couple relationship and life satisfaction; and (b) clients' ratings and reports of their satisfaction and experience of CCT; (2) counsellor trainees: (a) reports and summaries of their application of CCT with their clients; and (b) counsellors assessment of CCT; and (3) trainer: teleconference consultation notes, observations and transcripts. Quantitative and qualitative data were analysed separately; the former statistically, the latter thematically. Results from quantitative and qualitative data were triangulated through comparison and synthesis. The use of mixed methods was especially important in adding confidence to our interpretations of the client outcomes in light of an uncontrolled sample. Qualitative findings also allowed us to understand better the CCT process.

Because the primary focus of the CCT training evaluation was on the counsellors' learning outcomes, we did not use a control group for the clients so as not to place an added burden on the trainees and their organizations. To limit ethical concerns for treatment organizations and their clients, client data and demographics collected were

kept to the core essentials for this study.

Counsellors' Profiles

Details of the counsellors' profiles were reported with the training outcomes (Lee et al., 2008). Evaluation of training revealed that there was no significant relationship between training outcomes and counsellors' age, level of education and years of experience (Lee et al., 2008).

Recruitment of Couples

The sample of client couples was based on a convenience sampling of clients available at the time of CCT application at the respective organizations. Application to two different couples would give trainees an opportunity to compare and contrast variations when CCT was applied, thus extending their learning. Five trainees recruited two couples and 14 recruited one couple in their treatment settings following the 4-day CCT workshop.

Inclusion and exclusion criteria for recruitment of couples for CCT application were deliberately kept to a minimum for the following reasons: (1) trainees selected couples based on their individual clinical judgment in conjunction with their self-assessment of their own comfort and competence levels in providing CCT; (2) the clientele best suited for CCT was still under research, so no definitive exclusion criteria were imposed. Inclusion criteria included intent of continuing a committed relationship and for the gambling client to have met DSM-IV criteria for pathological gambling in the absence of intimate partner violence based on clients' self-reports.

Recruitment Rate

Recruitment rate was 60% based on the number of couples approached and the number of couples who consented to participate. Couples who did not participate had scheduling difficulties (23%), had an unwilling or unmotivated spouse (38%), and other unstated and stated reasons such as legal problems and other priorities (38%).

Client Demographics

Twenty-four couples took part in the study. Of the gamblers, 75% were male, and 25% female. The majority of the clients (76%) were 40 years of age and older. The mean number of years the clients had been married was 20. Of all the clients, 71% of the pathological gamblers and 38% of their spouses had received previous problem gambling-related counselling. In addition, 43% had had previous couple counselling not necessarily in relation to gambling problems. Only 29% of clients in this study were new intakes. Of the gamblers, 58% reported not gambling upon entry into the study and 33% reported gambling occasionally. During the study, 21% of the gamblers experienced a crisis such as job loss, hospitalization and suicide ideation.

Evaluation Instruments

An array of instruments was used to collect data on CCT application to clients during the training. Data were collected from gamblers and their spouses and from counsellors. They represent a mixture of quantitative and qualitative data that brought multiple perspectives and depth to understand the effects of CCT application.

1. Gambling symptom assessment scale (G-SAS)

The G-SAS (Kim et al., 2001) is a 12-item self-rating scale designed to assess the change of gambling symptoms during the past week. The G-SAS assesses gambling symptoms in the past week on the variables of interest in this study: gambling urges, thoughts and preoccupation, control, emotional distress and adverse personal consequences as a result of gambling. Total scores range from 0 to 48, with severity ratings categorized as follows: 8–20 (mild), 21–30 (moderate), 31–40 (severe) and over 40 (extreme). Test–retest reliability showed good correlation ($n = 58$; $r = 0.70$), with Cronbach's $\alpha = 0.89$. Convergent validity compared favourably with another gambling index over a 10 week period ($n = 48$; $r = 0.68$ to 0.82).

2. Satisfaction with life scale (SWLS)

The SWLS (Diener et al., 1985) is a global measure of life satisfaction based on conscious cognitive judgments of one's life. It consists of one factor under the general construct of subjective well-being. The scale has five items rated on a Likert scale and takes only one minute to complete. It was selected for its brevity and measurement of well-being and not pathology. Responses are summed to create a total score. The SWLS reports a coefficient alpha of 0.87 for the scale and a two-month test–retest stability coefficient of 0.82. Moderately strong correlations with other subjective well-being scales have been demonstrated ($n = 176$, $r = 0.59$ to 0.68). Convergent validity is demonstrated by a significant degree of agreement between self-reports and peer reports ($n = 38$, $r = 0.81$) (Pavot et al., 1991).

3. Dyadic adjustment scale (DAS)

The DAS (Spanier, 1976) measures the quality of marital relationships and can be used for any committed relationship. It is a 32-item measure with four subscales: consensus, satisfaction, cohesion and affectional expression. The total score can range between 0 and 151, with higher scores indicating better adjustment to one's relationship. Cronbach's alpha is 0.96, indicating high scale reliability. Validity of content (relevancy, consistency and appropriateness of wording) has been established by independent evaluators. Testing for criterion validity found a significant difference of $p < 0.001$ between married persons with mean total scores of 114.8 ($n = 218$) and divorced persons with mean total scores of 70.7 ($n = 94$). The DAS correlates highly with another marital adjustment scale ($r = 0.86$ for married persons and 0.88 for divorced persons), indicating good construct validity.

4. Client satisfaction questionnaire

This is a one-page questionnaire with five items that take less than 15 minutes for clients to complete (Lee et al., 2006). Clients rate their overall satisfaction with CCT on a Likert scale (1 = highly dissatisfied; 7 = highly satisfied). Additionally, four open-ended questions asked participants (gamblers and spouses) to list (1) what was most helpful; (2) how they benefited from CCT; (3) ideas, words and concepts they associated with their experience of this model; and (4) any additional comments. Results were analyzed for mean rating on overall satisfaction. Short answers were analyzed qualitatively by content, key words and thematic categories.

5. Client recruitment summary

The purpose of the client recruitment summary (Lee et al., 2006) is to assess the appropriateness and risks of the couples that trainees recruited for CCT. Trainees were asked to list the criteria they used to select the couples for CCT. It requires counsellor trainees to practise deliberate assessments of the risks and benefits in selecting couples for a new treatment.

6. Teleconference audiotapes and notes

The weekly teleconference consultations with the trainer were audio-taped. An observer/note-taker was present during each of the sessions noting the counselling and consultation process and main points of each teleconference. Teleconference notes consisted of a session summary, main topics, issues raised by trainee, clients' responses to interventions, trainers' interventions, emerging issues, future training issues and CCT components counsellors applied (Lee et al., 2006). Written transcripts of selected sessions were completed to aid analysis.

7. Intervention summary

At the end of training, trainees were asked to provide a one to two page summary of the interventions they used with their couples in the course of their counselling and clients' responses to these interventions. This serves as an overall adherence monitor (Lee et al., 2006).

8. Workshop and training questionnaires

Two satisfaction questionnaires of 18 items and 39 self-rated items on a 7-point Likert Scale (1 = strongly disagree, 7 = strongly agree) on areas of the entire training, including the application to clients were administered to counsellors after workshop and after the application phase. A section for comments is included in both questionnaires. Each questionnaire takes approximately 20 minutes to complete.

9. Workshop focus group and training focus group interview schedules

Two focus groups, one after the workshop and the other after the client application inquire into trainees' experience and assessment of their (1) CCT training; (2) application of CCT; (3) participation in the research study; (4) spinoffs; (5) metaphors of training experience; and (6) personal and professional growth. Probes were given for each section to encourage participants to discuss specific areas of their experience. Focus group duration was approximately 1 hour in groups of 4–5 participants.

Results

Engagement and Retention

Using the definition of engagement as the percentage of clients who initiated treatment and who attended more than one visit within 30 days of the initiation of care (McLellan et al., 2007), the engagement rate of clients in this CCT study was 100%. Retention rate is hereby defined as the number of clients who remained in treatment until its completion, with the maximum number of sessions ranging from 8 to 12 depending on when counsellors were successful in recruiting their clients within a 12-week time-frame. Some counsellors only had eight sessions with their couples because of their delayed recruitment and the limits of the 12-week application period posed by project's timeline. The mean number of sessions attended by couples was 8 (range 1–12) with a retention rate of 96%. Two trainees were not able to find suitable clients during the training period but still participated in the weekly teleconference consultations, thus receiving the same dosage of training as the rest.

Client Termination Status

Trainees reported that 42% of their couples fully achieved their goals collaboratively defined with their counsellor within the time-frame of the study, 54% met their goals in part and 4% achieved their goals minimally. Upon termination of CCT application, 42% of couples had no further counselling plans with their counsellor, 54% elected to continue counselling with their counsellor as a couple beyond the research study and 17% desired to continue individually, in some cases in addition to couple counselling.

Client Quantitative Outcomes

Tables 1 and 2 display the means, standard deviations and statistical significance of change scores for gamblers and spouses on (1) gambling urges and behaviours; (2) satisfaction with life; and (3) marital relationship before and after CCT treatment based on three measures described below. Missing data were due to some counsellors' failure to send in clients' data. Our protocol only allowed three reminders. Outcomes were based on statistically analysis of total changes scores for each of the instruments.

Table 1. Gamblers' Outcomes

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

* significant change $p < 0.05$

Table 2. Spouses' Outcomes

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

G-SAS

At baseline, gamblers, on average, scored in the mild range of symptom severity in terms of craving, preoccupation, and hours spent gambling, with scores ranging from mild to extreme (0–41). A significant decrease in severity symptoms was found after treatment with scores ranging from 0 to 24 within the mild to moderate range. G-SAS scores were normally distributed for gamblers. Paired values were available for 16 out of 24 cases. Missing values were not replaced. A repeated measures t-test was conducted to determine whether participation in CCT over 8–12 weeks decreased the G-SAS scores of gamblers before CCT ($M = 15.87$, $SD = 10.20$) compared to after CCT ($M = 9.94$, $SD = 6.55$). Results indicated a significantly decreased value of symptoms of gambling urges and activities immediately after CCT had ended, $t(15) = 2.60$, $p = 0.02$ (2-tailed).

SWLS

Gamblers. SWLS scores were normally distributed for gamblers. Paired values were available for 19 out of 24 cases. A repeated measures t-test was conducted to determine whether participation in CCT over 8–12 weeks increased the SWLS scores of gamblers prior to CCT ($M = 22.95$, $SD = 8.71$; slightly satisfied) compared to immediately after CCT ($M = 21.63$, $SD = 6.49$; slightly satisfied). Results indicated non-significant change in the value of life satisfaction immediately after CCT had ended, $t(18) = 0.88$, $p = 0.39$ (2-tailed).

Spouses. SWLS scores were normally distributed for spouses. Paired values were available for 16 out of 24 cases. Missing values were not replaced. A repeated measures t-test was conducted to determine whether participation in CCT over 8–12 weeks increased the SWLS scores of spouses prior to CCT ($M = 28.12$, $SD = 7.10$; satisfied) compared to immediately after CCT ($M = 24.00$, $SD = 6.64$; slightly satisfied). Results indicated a significantly decreased value of spouses' life satisfaction immediately after CCT had ended, $t(15) = 3.15$, $p = 0.01$ (2-tailed).

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

DAS

For both gamblers and spouses, the DAS pre-treatment scores were slightly under 100, below the normal range for married couples. These scores rose significantly to Gamblers. DAS scores were normally distributed for gamblers. Paired values were available for 14 out of 24 cases. Missing values were not replaced because of their large numbers. A repeated measures t-test was conducted to determine whether participation in CCT over 8–12 weeks increased the DAS scores of gamblers prior to CCT ($M = 98.28$, $SD = 18.35$) compared to after CCT ($M = 105.86$, $SD = 20.37$) immediately after treatment had ended. Results indicated a significantly increased value of dyadic adjustment immediately after CCT had ended, $t(13) = -2.49$, $p = 0.03$ (2-tailed).

Spouses. DAS scores were normally distributed for spouses. Paired values were available for 13 out of 24 cases. Missing values were not replaced because of their large numbers. A repeated measures t-test was conducted to determine whether participation in CCT over 8–12 weeks increased the DAS scores of gamblers prior to CCT ($M = 99.07$, $SD = 25.83$) compared to after CCT ($M = 112.85$, $SD = 17.50$) immediately after treatment had ended. Results indicated a significantly increased value of dyadic adjustment immediately after CCT had ended, $t(12) = -2.56$, $p = 0.03$ (2-tailed).

Client Satisfaction

The mean client overall satisfaction rating of CCT was 6.3 out of 7 based on a return rate of 65%. The mean rating indicated a high level of satisfaction that was substantiated by client comments analyzed in thematic categories with quotes presented in Table 3.

Clients' reports of their experience with CCT accorded with the aims of CCT and the dimensions of its interventions, namely, in achieving shifts in intrapsychic, interpersonal and intergenerational areas. The universal–spiritual dimension, though less explicitly described, is reflected in their heightened self-esteem, mutual understanding, enhanced

intimacy, hopefulness and peace that can be gleaned from their descriptions. Counsellors' attributes highlighted by clients fit in with a humanistic values orientation and the counsellor's ability to maintain an alliance with both partners' with the counsellors' 'neutral', non-blaming stance. CCT processes cited as helpful were the engagement of couples in setting realistic, achievable goals, the work on couple communication, the linking of communication to family of origin patterns and self-awareness, and relating of these factors to gambling. Notable also was the healing of the breach and hurts in the couple's relationship, which was not only restored, but enhanced, thus providing them with a strengthened couple support system.

Preparedness for CCT Application

Counsellors considered themselves at a moderate level of preparedness in applying CCT to couples based their knowledge and skills after the workshop ($M = 5.6$ on a 7 point scale, $SD = 0.9$). Their self-assessed readiness to implement CCT after the trial application increased ($M = 5.9$, $SD = 0.7$). The level of reported preparedness corroborated with the counsellors' desire to obtain further training, especially in areas of working with the intergenerational and spiritual dimensions as voiced in the focus groups. Of counsellors, 94% indicated plans to obtain further supervision to work with couples.

Counsellors' Assessments of Client Outcomes

Counsellors rated the positive impact of CCT application clients as 6.6 out of 7 ($SD = 0.5$), equivalent in both cycles of training and application. Their quantitative ratings accorded well with their descriptive reports from the teleconference transcripts and focus groups. Pseudonyms are used in reference to clients. Client outcomes observed and reported by counsellors fell into the following thematic categories:

Increased awareness of self: Self-awareness pertains to the intrapsychic dimension of inner connectedness to one's thoughts, feelings, and expectations. For example, a counsellor's observed that her client 'was able to figure out that he is cranky when he comes home from work He realized he needs some time to unwind after work and he was able to communicate that to her.' When the client was self-aware, he was able to reveal his inner experience to his spouse.

Increased awareness of spouse: Problems arise when clients fail to recognize that their spouse are feeling persons with a history all of their own. Symbolic representation helps to externalize inner constructs for new perception. One counsellor reported: 'I really think the sculpting (with objects) was huge for them ... visually to watch him see where Jill put herself in relation to not only him, meaning up on the shelf, just where she put her whole family and everyone in her life, and visually to see his expression on that and the absolute realization that "I just, I didn't know she felt that way!"'

Table 3. Client Satisfaction with CCT

Categories	Impact on Gambler	Impact on Spouse
Gambling	- <i>'allowed me to see the reasons for my gambling and how I can improve'</i> - <i>"gambling is no longer all-consuming: other things to do"</i>	- <i>'my therapist gave me some insight into my partner's urges and reasons for gambling'</i>
Self Awareness	- <i>'heightened my awareness of issues'</i> - <i>'I have a clearer understanding of my gambling motivations'</i>	- <i>'allow me to understand our personalities, discuss my emotions, and understand each other'</i>
Awareness and Understanding of Spouse	- <i>'easier to see both sides of things'</i> - <i>"effects of gambling on loved ones"</i>	- <i>'insight into my partner's urges and reasons for gambling'</i>
Couple Communication	- <i>'I can set the communication patterns or styles'</i> - <i>'same page, going forward, caring and sharing, communicate'</i> - <i>'understand how my partner feels instead of thinking wrongly how he feels'</i>	- <i>'not having negative feelings without talking them over to each other'</i> - <i>'my husband talks more with feeling and is trying to know me better, so I am not so afraid to voice my feelings and concerns'</i>
Family of Origin	- <i>'how my family is still impacting my life now'</i>	- <i>'understand by looking at family history why we behave and react the way we do'</i>
Healing from Losses and Hurts	- <i>'overcome the hurts and losses'</i> - <i>'counsellor assisted with spouse's feelings'</i>	- <i>'the counsellor took time to listen and drew out the true feelings we kept in ourselves, so we were able to show more and to listen to each other'</i>
Couple Intimacy and Mutual Support	- <i>'I now have a support system'</i> - <i>'my wife and I are extremely happy with our new-found respect for each other's emotions and concerns'</i>	- <i>'two together can help each other'</i> - <i>'building and sustaining relationships'</i> - <i>'we have learned how to talk with each other and try to find out the problem to fix it'</i>
Counsellor's Attributes	<i>'patient', 'listening', 'paraphrasing', 'non-judgmental', 'understanding', 'neutral'</i>	<i>'insightful', 'good analysis', 'perceptive', 'respectful', 'compassionate'</i>
CCT Structure and Process	- <i>'setting potentially achievable goals as a couple'</i> - <i>'walls coming down'</i> - <i>'honest', 'helpful', 'free'</i>	- <i>'wanting us to communicate and check our goals as we went along'</i> - <i>'open', 'calming', 'hope', 'very beneficial'</i>
Overall Satisfaction of CCT	- <i>'I am very pleased with this therapy model.'</i> - <i>'Good assistance to overcome addiction.'</i> - <i>'We started CCT a bit late in the game. I believe we would have benefited even more had we started in the beginning.'</i>	- <i>'This has been a great experience, talking through experiences and feelings with my partner present.'</i> - <i>'Bringing torn lives together again.'</i>

Couple communication: 'Their biggest change that they've been able to work on is their communication to each other ... and she's even recognizing where she'll say something and as soon as it's out of her mouth she'll say "wait a minute, I need to rephrase that"' was a common observation. Counsellors helped couples shift from limiting communication stances such as blaming or avoidance to open, congruent communication. This went beyond the mechanics of words to congruence when words matched affect: 'His tone of voice ... you could really pick up the anger, even when he might have been trying to give her a compliment it had a bit of an edge to it ... and it's much softer now.'

Family of origin: Reconnecting with childhood experiences entailed both emotional release and insight: 'He's had a couple of releases ... after sessions, though ... crying and sobbing at home and realizing that he's really carrying a lot of his past with him ... how hard that's been for him.' For another gambler, her insight was 'I'm very much like my dad, so although I haven't chosen alcohol as a way of coping, I just chose something different, but it was really for the same reasons.'

Couple intimacy and mutual support: For a troubled client to 'feel comfortable enough to go talk to his partner about what's going on gives him the feeling of the safety net ...' was a big step. In addition to support that comes from safety and congruence, couples expanded their communication to show appreciation that nurtures their relationship: 'They look at each other a lot with this wonderful smile ... they're just truly appreciative of one another ... he's actually allowing the ... gentle side of him to show' Better relationship leads to better teamwork on the practicalities of life: 'his words were "we tend to be working as team much better, both for the good situations and the bad"'

Self-esteem and self-compassion: A greater honouring of self and acceptance of one's fallibility raises self-esteem: 'finding a better way to be more congruent with themselves ... less critical of themselves'. Understanding of one's history and inner experience leads to greater self-compassion: 'when they see the reason how they became the person they came from a broader view ... it enhances a kind of compassion in themselves'.

Universal-spiritual human yearnings: A counsellor observed how hope and trust in the process of life brought vivid change to her client: 'just increasing her hopefulness and real sense of like "I'm going to be ok." ... to experience that with her, really underscored for me how powerful that universal-spiritual dimension can be for some clients'.

Spin-offs at work and with children: Communication and self-changes spilled over into work relationships: 'He feels he's been communicating better with his coworkers ... with some of his coworkers that he didn't really get along with before and he's finding that a lot of times what he was hearing isn't what they meant at all.' Positive effects with children were observed: 'The relationship with the children has improved ... they've even noticed how the daughter communicates and responds to them ... with less friction because there's less choppy answers, and you know, huffing and puffing and demands.'

Gambling: Communication and spousal support helped gamblers cope with problems resulting in reduced gambling frequency and urges: 'Purely being able to talk things out

and work as a couple and not against one another ... and reducing the stressors ... reduced the gambling.' Gamblers' awareness of their triggers and reduced stress also contributed to gambling reduction: 'And finances were another trigger ... when she felt that things were getting tight financially she would go and gamble; but now that they're talking more, and they're able to plan things out, and she feels comfortable checking in with him about what's going on with finances, and he's less angry so he's not freaking out so much when abillcomes in ... so then again that reduced the one trigger for her.'

Similar to the clients' self-reports, the counsellors noticed not only a restoration but an enhancement of couple relationships which improved their overall quality of life. Gambling ceased being a pre-occupation.

Counsellors' Assessment of CCT

Counsellors highlighted the structure and experiential fluidity of their experience of CCT, its room for creativity in the unfolding of the therapeutic process, CCT's positive energy and focus, its impact on pathological gambling and its potential applicability to other fields.

CCT structure: Counsellors found CCT focused and structured but at the same time flexible, making room for their own clinical judgement and process: 'It's focused and it's ... specific. You can go and use different tools and you don't have to use all the tools and interventions in the model because you can pick and choose what might be most appropriate. But it is very focused and on track.' Though 'very structured and to-the-to the point, and it was very, um, keeping it in the here and now and dealing with what was going on now ... rather than getting caught up in a lot of the historical stuff.' As a process, experiential model, 'there's a lot of room for counsellors to use their own creativity within the structure, even to blend it in with their own style ... it's not a cookbook ...'.

CCT process: Counsellors commented on how CCT allowed them to interrelate gambling with spousal relationship patterns and other issues of the gambler's life: 'CCT didn't just focus on the gambling behaviour—it went beyond the gambling behaviour, but then we were able to relate that back'. Using CCT interventions, 'it's allowed people to go a little deeper and look at what's going on in their relationship patterns ... that correlate with their gambling'. It became apparent to some counsellors that CCT shifted processes and not it was not an attempt to change 'content': 'It's really helped me move from content to process, so helping clients focus on the process of what's happening ... slowing it down, and looking at the ingredients of the process ... so I found some of the ideas and skill of this model very helpful.'

Overall impact: 'In both my cases, CCT had tremendous impact ... gambling has a huge ripple effect, with communication, with trust, with respect and self-esteem. I think that's (self-esteem) a huge one with gamblers', observed one counsellor with regard to CCT's holistic approach. CCT's focus on clients' strengths, hopes and dreams brought energy for change and growth: 'Our clients are on a self-fulfilling prophecy that everything will

go negative. They forget about positive aspects, hope, dreams. This model really works on picking out their potentials and finding hope in changing their situation.' Some saw CCT's potential going beyond the gambling field, because it works with a person and his/her family system: 'It could be of great benefit to the whole problem gambling field. I think it could be a great benefit to the mental health sector, to family and children services ... so not just problem gambling.'

Adherence

Adherence to CCT protocol of interventions was monitored through weekly counsellors' self-reports of their session-by-session progress with their clients in group consultation teleconferences. Adherence was also assessed based on the counsellors' summary of interventions at the end of treatment. No audiotapes of sessions were used for this study to limit ethical concerns for the organizations and their clients. Based on an analysis of teleconference notes, teleconference transcripts and counsellors' reports, not every counsellor used all the tools and interventions in the repertoire of CCT with each couple; this depended on the requirements of the case. The most commonly used CCT interventions were: (1) reframing blame into hopes and wishes; (2) building a strong balanced alliance with the couple; (3) collaborative goal-setting; (4) shifting couple communication; (5) encouraging mutual appreciation between the spouses; and (6) family mapping. Inconsistently applied interventions included: (1) linking gambling urges and activities to intrapsychic and marital factors; (2) working with clients' pain; and (3) universal-spiritual affirmations and meditations. Adherence was assessed to be moderately high based on counsellors' weekly reports and their summary of interventions.

Summary of Evidence on CCT Effectiveness on Gamblers and Spouses

In summary, clients' and counsellors' ratings and reports indicated a clear attainment of the improved functioning in the four dimensions and areas targeted by CCT framework and interventions (Table 4).

Some areas of client improvement correspond with items covered on the standardized quantitative measures which showed similar improvement. Compared to the quantitative data, the qualitative data were more comprehensive and detailed in capturing richness of experience that allowed us to compare client outcomes with the objectives of CCT. Results of the SWLS showed significantly decreased life satisfaction of spouses immediately after CCT, which is thought-provoking. Other than the SWLS, combined qualitative and quantitative findings indicated a reduction of the severity of gambling urges and activities, significantly improved self-awareness and self-esteem, enhanced spousal relationship and mutual support. Increased hopefulness, compassion and awareness of the impact of family of origin experiences were also evident. These changes not only affected their marital relationships but appeared to have transferred to other family, social and work relationships leading to an overall improved quality of life.

Limitations

These quantitative findings are limited by the relatively low sample size, moderate return rates, missing data and the lack of a control group. Validity and reliability issues compromised by these factors were compensated by a solid set of qualitative data from multiple client, counsellor and trainer sources to substantiate and complement the quantitative data. The convergence of these different findings lent confidence to our findings and interpretations of CCT's effects on clients.

Another confounding factor in assessing the client outcomes is that some clients had individual, group and couple counselling for their pathological gambling prior to CCT. Sampling was based on convenience. For these reasons, the generalizability of the results of CCT must be moderated.

Adherence was assessed based on counsellors' self-reports and written summaries of their interventions. Video and audio-taped sessions would yield considerably more quantifiable and superior assessment in future studies.

Table 4. Summary of Evidence

Dimension	Areas of Improvement	Clients' Report	Counsellors' Assessment	Quantitative Outcome
Gambling	Increased awareness of triggers to gamble	✓	✓	ND
	Reduced urges and activities	✓	✓	✓
Intrapsychic	Awareness of self	✓	✓	ND
	Self-esteem and connection with self	✓	✓	✓
Interpersonal	Awareness of spouse	✓	✓	✓
	Deepened mutual understanding	✓	✓	✓
	Improved communication	✓	✓	✓
	Improved relationships at work, with children and extended family	✓	✓	ND
Intergenerational	Insight into impact of family of origin on self and behaviours	✓	✓	ND
	Emotional release of childhood pain	✓	✓	ND
Universal-spiritual	Increased appreciation of self worth, worth of spouse, and compassion	✓	✓	ND
	Hope	✓	✓	ND

✓ = Improvement noted; ND = No data

Additional measures of gambling could have given more gambling information and served as concurrent validation of findings on G-SAS.

Discussion

Although randomized controlled trials (RCT) are regarded by many scientists as the 'gold standard' in demonstrating the efficacy of a particular treatment, other preliminary evidence serves as important indicators towards the merit of future investment in obtaining RCT evidence. Types of relevant evidence at the earlier stages of building an evidence-based model include: case studies (Davidson and Spring, 2006; Qureshi, 2004), observational data (Davidson and Spring, 2006); user reported experience and satisfaction (Caron-Flinterman et al., 2005; Grypdonck, 2006; Towle, 2006); practitioners' reports and assessments (Davidson, 2006; Malterud, 2001); single group pre-post outcomes, and pilot studies with small samples. Qualitative data in mixed methods are valuable as evidence (Hanson et al., 2005; Jack, 2006; Malterud, 2001), especially in the early stages of a model development. In this study, mixed methods observations and results from three sources, namely, clients, counsellors, and trainer, suggest promise for this new model of couple therapy for pathological gambling.

What did we learn that could help us in planning future controlled and efficacy studies? First, keeping in mind the limitations of an uncontrolled study, we learned that this first CCT training was sufficiently effective to produce some statistically and clinically significant client outcomes within 8–12 sessions. The treatment was administered by a group of counsellors newly trained in CCT with a mature background in terms of their age and experience in counselling (Lee et al., 2008). It was also a group who professed an existing compatible humanistic orientation as that of CCT working with organizational support (Lee et al., 2008). It would be of interest to monitor in future training which counsellors' attributes and organizational factors have a bearing on their training outcomes and related client outcomes.

The significantly decreased life satisfaction reported by spouses on the Satisfaction with Life Scale was contrary to hypothesis. We surmise that the SWLS as a generic instrument that interpreted regret as lower life satisfaction may not be best suited for pre-post clinical purposes. Despite SWLS's stable psychometric properties, it does not measure all aspects of life satisfaction and well-being, and hence is best complemented by other well-being measures (Pavot and Diener, 1993). It is also possible that at 8–12 weeks post-treatment, clients, in particular the spouses, had not fully accepted and come to terms with the pain and losses of pathological gambling and were still working through these issues. Longitudinal follow-up studies would be of interest. Moreover, the impact of pathological gambling on spouses and their treatment outcomes have not been well studied hence warranting greater research attention.

Qualitative findings tell us that gambling changes came about in relation to gamblers' and spouses' increased self and other awareness, family of origin work, and a spirituality of hope and compassion. The couple relationship not only improved but was enhanced to allow partners to find in each other a source of practical and emotional support and solace

in times of stress and distress. The changes some clients experienced spilled over into other domains of their lives as improved work and parenting relationships. Qualitative data collected from client and counsellor sources were especially important in identifying and understanding the experience and process in the change domains. Categories emerging from clients' and counsellors' reports allowed us to ascertain that client outcomes matched closely with CCT treatment objectives, areas that were not readily assessed in quantitative measures at this time. In future, quantitative instruments that align closely with the dependent variables in the intrapsychic, interpersonal, intergenerational and spiritual dimensions would yield a stronger set of triangulated findings.

Counsellors' reports and the empirical evaluation of their CCT skills and interventions (Lee et al., 2008) indicated that counsellors' average level of preparedness and expertise in CCT was moderate at the end of CCT training. Counsellors were provided with a CCT Self-Assessment Tool to monitor their practice with a new intervention (Lee et al., 2006). With close guidance and monitoring of adherence, this level of counsellor preparedness yielded observable client outcomes. High engagement and retention rates may be in part attributable to prior therapeutic alliances of the counsellors with their clients. However, they could also be associated with the counsellors' non-blaming approach to balancing couples' concerns, collaborative realistic goal-setting, humanistic counsellors' attributes, structured and focused here-and-now interventions, and the introduction of hope and a positive focus early on in the therapeutic process, all elements cited as important in the CCT counselling process by both clients and counsellors. Because engagement and retention rates in treatment are found to be related to drug treatment outcomes (Fiorentine et al., 1999; Simpson, 2004) and are therefore commonly used as indicators of treatment quality (McLellan et al., 2007), factors contributing to high engagement and retention rates in CCT should be further studied.

The overall findings of counsellors' training outcomes and client outcomes were summarized in an executive summary and member-checked with counsellors and organizations and obtained their corroboration (Lee et al., 2006). Keeping in mind its limitations, findings in this first CCT application during training set a milestone in the continued evolution of CCT for pathological gamblers. The initial promise of these mixed methods findings points us in the direction of further studies to understand CCT's mechanisms and its efficacy with pathological gamblers in randomized controlled trials.

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