**Challenges in the implementation of manualized couple treatment for pathological gamblers in eight specialized centers: clinicians’ perspectives.**

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CONTEXT

Despite significant consequences for the well-being of couples and family members that can arise from gambling problems, treatments in this area are largely based on an individual approach (Tremblay et al., 2018). Our team developed Integrative Couple Treatment for Pathological Gambling (ICT-PG) (Tremblay et al., 2015) and led a real-life randomized controlled trial (RCT) in eight public specialized addiction treatment facilities in Québec (Canada) to evaluate its effectiveness. Quality-assurance in the implementation of the treatment model is crucial in order to optimize its potential effects. The efficacy of cognitive-behavioral couple therapies is supported by many RCTs. Effectiveness studies, although less numerous, have shown that despite smaller effect sizes, this type of treatment can be successfully implemented in practice settings (Fisher, Baucom and Cohen, 2016). Since gambling therapists are generally poorly trained in couple and family approaches, implementing ICT-PG in real-life setting constitutes a challenge. While clinicians are central to the process of implementing couple interventions, their perspectives are rarely taken into account. Yet as Johnson (2013) points out, the practitioners involved in couple therapy research hold unique expertise given that the quality of their clinical observations can advance this field of study and guide researchers to undertake work of greater clinical relevance.

OBJECTIVE

The aim of this paper is to understand various challenges in the implementation of manualized couple treatment for pathological gamblers, from the perspective of clinicians.

METHOD

This qualitative descriptive study is part of a larger RCT conducted in real-life settings and involving a total of 39 clinicians. Funded for a total of 8 years, the RCT was undertaken in two phases in order to recruit the number of participants required to verify the effectiveness of the ICT-PG model. Some clinicians from the first phase of implementation maintained their involvement during the second phase. Of these, a total of 18 clinicians participated in focus groups for this study, including 5 who participated in two different focus groups, one during in each phase of the study. Participants were solicited during day-long knowledge-transfer activities organized by the project and were invited to be part of a focus group held at lunchtime. No monetary compensation was offered. Prior to the start of the focus group, researchers obtained free and informed consent from participants who were asked to sign a consent form to this effect that was approved by a university research ethics committee. A total of 11 clinicians participated in two focus groups held in 2014, and a total of 12 participated, in two focus groups held in 2017 (including 5 participants who participated in 2014 and 2017 focus groups). The 18 participants in this study came from six of the nine addiction n centres involved in the RCT. These participants received between 30 and 99 hours of supervision during implementation of the model. The focus groups were audio recorded and lasted between 75 and 95 minutes. Clinicians’ perspectives were explored with respect to various topics: motivation to engage in the RCT; initial expectations and fears; clinical relevance of the couple therapy model; facilitating factors and obstacles to study participation; and training and supervision. Based upon the detailed notes and the audiotapes, a thematic analysis was done and the results were discussed by the research team.

RESULTS

When clinicians discussed their initial motivations for becoming involved in the research project, they emphasized having a strong interest in the research based on a very positive view of the clinical relevance of the ICT-GP model and expectations that the project would be beneficial to their own professional practice. They were unanimous in the view that clinical skill development was a key factor that made them enthusiastic to participate since various ways to improve their practice were made available through the research: training, regular clinical supervision, and access to relevant clinical tools (intervention manual, questionnaires). These benefits were all the more significant given their concerns about gaps in the health and social services system that limited their access to relevant training and clinical supervision. Involvement in the research project was also motivated by a favorable view of the ICT-PG model. Indeed, there was consensus with regard to the high clinical relevance of the model. According to participants, this clinical relevance resulted from the fact that ICT-PG:

* makes it possible to work on the partner’s strategies that contribute to the maintenance of the addiction or that conversely are beneficial to the gambler’s recovery;
* fosters support from the partner to manage the gambler’s budget;
* promotes treatment retention;
* provides to the therapist with a more complete picture of the gambler's difficulties;
* promotes the partner’s well-being by working on life balance, communication skills, and the quality of the couple’s relationship;
* guides the partner to provide adequate support to the gambler on a daily basis
* allows the couple to develop a shared view of their difficulties based on a better understanding of gambling addiction;
* takes the couple into account as a protective factor: fear of losing the relationship can lead the gambler to stop gambling.

Nonetheless, clinicians noted that the use of couple therapy could create clinical challenges in certain clinical situations. Thus, when partners experience high levels of anger and psychological distress, clinicians are of the view that couple therapy may be less appropriate because partners may require greater or different clinical attention to their needs. In complex clinical cases, when multiple needs are identified for both gamblers and their partners, it may be difficult to stay focused on gambling. Another challenge is to engage both members of a couple in therapy, particularly when one person is suspicious about or uninterested in the provision of couple treatment. Clinicians pointed out that individual sessions could be initially offered to address these fears and needs so as to eventually encourage a person to engage in a couple treatment modality. They also noted the importance of respecting a person’s freedom to choose and of providing various options.

In addition, although participants clearly showed great interest in the implementation of ICT-PG, they also pointed out challenges and obstacles to using this model on an organizational level. In particular, ICT-PG is time consuming and may be difficult to integrate with other clinical responsibilities. The preparation of couple sessions and paperwork related to the research were the main issues that participants identified. As well, randomization made it difficult to predict the number of couples who would be assigned to the couple modality in each study centre. Participants pointed out that this had repercussions for some clinicians who were required to be involved in a long-term supervision process without themselves having active clinical cases. In these situations, staying motivated to participate in training and supervision became difficult. Moreover, couples were available mainly in the evening and this led to scheduling issues for clinicians who had to work a greater number of evening hours. Also, participants found that the video recording of sessions and of supervision with colleagues could create anxiety and be intimidating. At the same time, they found the use of video to support training and supervision to be highly relevant.

Participants also identified organizational factors that facilitated ICT-PG implementation. The quality of training and supervision was central to their satisfaction with being involved in the research, and also to the quality of model implementation. Participants emphasized that they appreciated the support they received from colleagues and liked the co-development process based on the sharing of each person’s expertise. The modality of regular, small-group supervision was well received. In addition, access to a clear and structured clinical manual was seen to facilitate to the implementation process, especially since the manual was also designed to enable a certain degree of flexibility. Clinicians appreciated being able to direct the sequence of the clinical activities according to the needs of the couple and their clinical judgment. They also appreciated the structured exercises described in the manual such as those dealing with communication and the follow-up questionnaires on the alliance, gambling cravings, and marital satisfaction.

Finally, analysis of comments from clinicians who participated in the focus groups makes it clear that they consider their involvement in ICT-PG research to be challenging experience that was also relevant and satisfying. This professional experience has had an impact on their practice. Some clinicians now use couple therapy as part of their practice. Some use monitoring and clinical tools. However, participants also highlighted the need for planning to ensure a sustainable model. In their view, a number of strategies must be put in place to ensure the sustainability of the implementation of ICT-PG within their institution, including ongoing supervision, co-development, having a resource person in each of the centres to provide support, and more training videos. Some also emphasized their need for supervision because it is essential to support the development of couple intervention skills, based on a perception that this treatment modality is both relevant and challenging to implement.

CONCLUSION

In sum, significant investment by clinicians and organizations, particularly in training and supervision processes, are crucial to the success of ICT-PG implementation. According to clinicians, this type of investment was largely seen to be beneficial to clinicians themselves and to the quality of care offered to problem gamblers and their partners.

**References**

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