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Adapted Couple Therapy (ACT) for Pathological Gamblers: A Promising Avenue

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Abstract The study of the effectiveness of treatment for pathological gambling constitutes a field that is still largely unexplored. To date, the models assessed primarily target the individual and include little or no involvement of the family circle. Yet, the deleterious effects of gambling on loved ones and especially spouses are well recognized. Further, the addition of a couple modality to individual treatment has been shown to be effective on many levels in the treatment of *substances use disorders*. This article therefore proposes a critical review of (1) the literature providing a better understanding of the complex interactions between the couple relationship and pathological gambling, (2) studies on the effects of couple therapies on gamblers and their partners. We then present the therapeutic model developed by our team of clinician-researchers in collaboration with actors from Québec clinical settings: *Adapted Couple Therapy (ACT) for pathological gamblers*. In the Québec context, this model will serve as a complement to an individual cognitive-behavioral treatment model that has been proven effective and is employed throughout the Canadian province. The assessment of couple therapies could reveal avenues of solutions to better assist pathological gamblers who tend to drop-out of treatment and relapse.

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Introduction

The treatment of pathological gambling remains a relatively recent and unexplored field of study (Ledgerwood and Petry 2006). While many studies document the effectiveness of cognitive-behavioral therapy for pathological gamblers (for a review, see Petry 2005; Toneatto and Ladouceur 2003; Toneatto and Millar 2004), no specific therapeutic modality has been assessed by at least two teams of independent researchers (Toneatto and Millar 2004). High treatment drop-out rates and abundant relapses seem to indicate that other therapeutic strategies might be able to contribute to the gamblers' recovery. Indeed, some studies show that nearly a third of pathological gamblers drop-out before the end of treatment (Ladouceur et al. 2001; Stinchfield and Winters 2001). In a longitudinal Canadian study, only 8% out of a sample of pathological gamblers who had recently stopped gambling remained totally abstinent for 1 year (Hodgins and el-Guebaly 2004). A meta-analysis of 22 studies demonstrates that the number of therapy sessions is positively related to positive outcome of psychological treatments for pathological gambling (Pallesen et al. 2005). However, in that field, there are limited and inconsistent evidence about the specific variables predicting therapeutic success and drop-out (Daughters et al. 2003; Melville et al. 2007). Researchers who compared abstinent and relapsed gamblers among 75 GA members suggested that social support may have a significant impact on gambling abstinence (Oei and Gordon 2008). In the same vein, a study on 50 pathological gamblers reveals that having a supportive environment predicts treatment continuation (Grant et al. 2004). As a result of these observations, several authors recommend the development and assessment of different models of gambling treatment based on the specific characteristics of diverse clinical sub-groups (Toneatto and Ladouceur 2003; Toneatto and Millar 2004; Petry 2005).

Pathological gamblers who live as couples experience significant couple problems (Hodgins et al. 2007; Lorenz and Yaffee 1988, 1989). Several authors have underlined the devastating effects pathological gambling may have on those close to the gambler (Kalischuk et al. 2006). It is estimated that eight to ten individuals close to the gambler will be directly effected (Lobsinger and Beckett 1996). Of those individuals, either family members or friends of pathological gamblers, spouses are the ones most affected, primarily in the form of personal distress (Hodgins et al. 2007). Numerous conclusions of studies, clinical publications, and literature reviews conducted in the field of substance dependency in particular underline the important role spouses may play in their partners' recovery (Ciarrocchi 2002; Christensen and Jacobson 2000; Gottman and DeClaire 2001; Jacobson and Christensen 1996; O'Farrell and Fals-Stewart 2006; Steinberg 1993; Tremblay et al. 2005; Wildman 1989; Wright et al. 2008a). Yet, the predominant model for helping gamblers continues to be individual treatment that does not target the social environment, nor does it targets the couple and its interactions at all.

This article therefore proposes to present a critical review of (1) literature offering a better understanding of the complex interactions that may exist between the couple relationship and pathological gambling, and (2) studies on the effects of couple therapy on pathological gamblers and their partners. Given that very few researchers have explored these questions, the results of studies conducted with people struggling with alcohol- or drug-related problems are also presented in order to enrich our reflection. We will end by

presenting *Adapted Couple Therapy (ACT) for pathological gamblers*, a promising therapeutic model we have developed not only on the basis of the scientific literature, but in collaboration with actors in Québec's clinical settings.

Literature Review

Pathological Gambling and Substance Use Disorders: Similarities

As we have previously mentioned, the results of studies on alcohol- and drug-related disorders may offer pertinent insight to guide our reflections, especially where little data on pathological gambling is available. Indeed, several parallels may be established between pathological gambling diagnoses and those of alcohol or drug abuse or dependency (Petry 2007). The concomitance of these diagnoses is well established in studies as much with the general public (el-Guebaly et al. 2006; Welte et al. 2001) as with clinical populations (Cunningham-Williams et al. 2000; Hall et al. 2000). Further, Petry (2007) points out that in addition to the etiological, neurobiological, and genetic aspects linking pathological gambling and psychoactive substance-related disorders, these diagnoses display several other similarities, notably in course and outcomes. It is therefore not surprising that several treatments developed in the field of gambling, such as *Gamblers Anonymous*, cognitive-behavioral therapies, and brief, motivational interviewing-based interventions, have numerous characteristics in common with treatments for substance addiction.

Couple Relationship and Addictions

Yet, while several substance addiction treatments involve a couple component, to date this aspect has received very little attention in the area of pathological gambling. Let us therefore examine what the literature reveals about the complex interactions between the couple relationship and pathological gambling.

Couple Relationship and Pathological Gambling

The Impact of Pathological Gambling on the Couple Relationship Pathological gamblers must typically deal with numerous consequences of their gambling habits, such as family, financial, and work problems as well as mental and physical health issues (Beaudoin and Cox 1999; Blaszczynski and Farrell 1998; Bergh and Kühlhorn 1994; Blaszczynski and McConaghy 1989; Ciarrocchi and Hohmann 1989; Evans and Delfabbro 2005; Griffiths et al. 1999; Ladouceur et al. 2004; Potenza et al. 2001; Shaffer and Korn 2002). Pathological gamblers are very preoccupied by their couple and family difficulties (Hodgins and el-Guebaly 2000). A study conducted with 233 pathological gamblers in treatment in Quebec, Canada, shows family and couple difficulties come first in terms of problems most frequently reported by gamblers themselves (Ladouceur et al. 2004). In fact, more than 53% of gamblers treated in out-patient clinics and 78% of gamblers treated in in-patient clinics consider gambling has had a significant impact on their couple and family life. The study conducted by Ciarrocchi and Hohmann (1989) with 193 hospitalized patients, including 67 men with diagnoses of pathological gambling, documents various difficulties pertaining to family environment. Pathological gamblers, like alcoholic men and women, display lower levels of family satisfaction, commitment, and support than control groups. Through the use of a valid instrument, the *Family Environment Scale* (Moos and Moos

1981), researchers have been able to establish that the family and couple relationship dysfunctions observed in the pathological gamblers are clinically significant.

Studies on the impact of gambling on gamblers' spouses provide a clear description of the crises, stress and disruption these families experience (Abbott et al. 1995; Dickson-Swift et al. 2005; Lorenz 1987; Lorenz and Yaffee 1988, 1989; Lorenz and Shuttlesworth 1983; McGurrin 1992). During in-depth one-on-one interviews conducted in the context of a qualitative study, five women and two men sharing their lives with pathological gamblers reported experiencing multiple difficulties. They explained how financial sacrifices, feelings of guilt, blame and anger, the loss of trust, and a sense of betrayal as well as the heavy burden of responsibilities they had to shoulder alone had undermined their relationships with the gamblers both in the short- and long-term (Dickson-Swift et al. 2005). Gamblers' spouses also mention experiencing communication problems, sexual dissatisfaction, and difficulty resolving conflicts. Further, recent studies have also used valid instruments to establish that partners of pathological gamblers exhibit high levels of psychological distress (Hodgins et al. 2007; Poirier-Arbour et al. 2007) and anger (Harvey et al. 2007), resulting notably from constant exposure to numerous sources of stress. Hodgins et al. (2007) specify that the higher levels of distress observed in spouses as compared to other individuals close to gamblers are linked in particular to the impact of multiple financial difficulties as well as to resentment and anger towards the gambler (Hodgins et al. 2007).

Other studies corroborate the high level of couple distress observed in both gamblers and their partners, although it is rarely measured in a valid manner with these populations (Harvey et al. 2007; Hodgins et al. 2007). In the study by Hodgins et al. (2007), the emotional consequences tied to gambling as reported by pathological gamblers' concerned significant others served as predictors of their degree of relationship satisfaction. In the study by Harvey et al. (2007), 58 couples in which one spouse was a pathological gambler exhibited a level of couple adjustment inferior to that of 40 couples from the general population. In fact, the level of couple adjustment in the gamblers' couples (Harvey et al. 2007), as measured with the *Dyadic Adjustment Scales* (Spanier 1976), surpassed well established clinical cut-off points (Wright et al. 2007). Also, a survey conducted by Lorenz and Yaffee (1989) with 151 couples recruited from *Gamblers Anonymous* conferences reveals that only 34% of gamblers and 19% of spouses say both partners are satisfied with their sexual relations *during the worst period of gambling*. These proportions climb to 69% and 53%, respectively when spouses rate their sex life during periods of abstinence from gambling. All of these data clearly demonstrate the clinical significance of the distress experienced by both partners in the couple. Despite of this, very few services are being offered to those couples.

The Impact of the Couple Relationship on Gambling Habits While researchers have stressed primarily the study of the consequences of pathological gambling, we know very little about the influence of couple interactions on individuals' gambling habits. A few studies, occasionally tinged with prejudice, identify different spousal behaviors that enable gambling, such as finding excuses or alibis for the gambler's absences from work, paying debts, avoiding discussions about gambling, taking on the gambler's responsibilities for negotiating with creditors, or assuming family responsibilities (Lorenz 1987; McGurrin 1992). Other authors stress that spouses may also contribute to pathological gamblers' relapses (Ledgerwood and Petry 2006; Lorenz 1989). Lorenz (1989) highlights the predominant role of couple conflicts and the couple relationship in explaining relapses, based on a qualitative study involving six spouses. Thus, in Lorenz's (1989) study, spouses report that their partners' efforts to change aroused difficult affects, like fear of rejection and fear

of sexual intimacy. Other spouses recognize that their partners' gambling problems entail certain secondary advantages, like filling *their need to be needed* and to receive sympathy and attention from others. Lorenz (1989) hypothesizes that these spouses are able to sabotage their partners' rehabilitation process to preserve the equilibrium of the couple system, as suggested by systemic theorists like Minuchin (1974). Lorenz's (1989) results also reveal that financial control exercised by the spouse is a factor liable to precipitate relapse. Even if the data, based on a limited sample, are interesting and consistent with clinical experience, the results cannot be generalized and must be interpreted cautiously.

In the same vein, an exploratory study conducted with six spouses of pathological gamblers in treatment suggests that a vicious circle often becomes entrenched in pathological gamblers' couple relationships, with gamblers feeling an increased need to gamble in reaction to the controlling behaviors of their significant others, who in turn try to exert even greater control in order to cope with the gambling problems, and so on (Tremblay and Brisson 2007). As Ledgerwood and Petry (2006) have pointed out, interpersonal conflicts, the quality of social support, and the attitudes of friends and family towards gambling are probable major elements in explaining the occurrence of relapses.

If they are able to hinder the rehabilitation process, spouses of pathological gamblers are also able to foster change in their partners. A Canadian study demonstrates that excessive gamblers who have stopped playing, on their own or with treatment, are very preoccupied by the impact of their gambling problems on those close to them, and consider family to be their major incentive, after financial and emotional pressures, to stop gambling (Hodgins and el-Guebaly 2004). However, studies on the roles partners of pathological gamblers may play in the latter's recovery are virtually non-existent.

Thus, despite the data available, the inter-influences of couple interactions and gambling habits continue to be poorly understood. Studies are largely based on small samples consisting essentially of men wrestling with gambling issues. Further, the use of valid instruments for measuring personal and couple distress and coping strategies is rare or non-existent. In addition, the mechanisms by which spouses may foster change in their partners' gambling habits as well as help prevent relapse are largely unknown. Other studies, particularly ones employing longitudinal designs, are necessary to arrive at more solid conclusions.

Couple Relationship and Substance Use Disorders

In contrast to the gambling field, there are numerous studies examining interactions between couple relationships and alcohol- and drug-related issues. Thus, a strong prevalence of couple difficulties has been noted in alcohol- and drug-addiction treatment center populations (for a review, see Marshal 2003). Couples coping with alcohol- or drug-related issues report lower couple adjustment levels than couples not dealing with this type of issue (Johns et al. 2007; Mudar et al. 2001; O'Farrell and Birchler 1987; Fals-Stewart et al. 1999). Further, a study on distressed couples undergoing couple therapy shows that such couples present more alcohol- or drug-issues compared to couples from the general population and for the vast majority report experiencing disagreements about substance use (Halford and Osgarby 1993).

Several correlational studies show that the more couples are faced with important alcohol problems, the less satisfied they are with their couple relationship (Dumka and Roosa 1995, 1993; Leonard and Roberts 1998; Leonard and Senchak 1993; Marshal 2003; O'Farrell and Birchler 1987). In fact, it seems that couple dissatisfaction intensifies primarily as a function of the negative consequences of alcohol consumption (Johns et al.

2007). Moreover, such consequences are associated with the deterioration of couple satisfaction for both members of the couple (Johns et al. 2007). Certain contradictory data, however, serve as a reminder of the complexity of the phenomenon. For example, a study by Kahler and colleagues (Kahler et al. 2003) shows greater severity of spousal alcohol problems to be associated with greater couple satisfaction. The concordance of substance use issues in a couple, i.e., when both spouses have problems of substance abuse (Fals-Stewart et al. 1999), constitutes the principal moderating variable explaining these results. Thus, for example, in a study by Fals-Stewart and his team (1999), couples in which both partners abuse drugs report higher satisfaction with their relationships than couples in which only one spouse abuses drugs or distressed couples undergoing couple therapy.

Some longitudinal studies provide a better understanding of how the quality of the couple relationship can predict alcohol- and drug-consumption and vice versa. Thus, studies conducted with clinical samples show that alcohol consumption can predict subsequent couple difficulties (Locke and Newcomb 2003; Zweben 1986). In addition, it has also been shown that the level of dyadic adjustment can provide long-term prediction of relapse in alcoholic men undergoing treatment (Maisto et al. 1998; O'Farrell et al. 1998). The results of a recent longitudinal study involving 1,675 individuals recruited from the US general population (Whisman et al. 2006) point into the same direction. Spouses who are dissatisfied with their couple relationship have a probability 3.7 times greater than satisfied spouses of presenting an alcohol-related issue 1 year later. A longitudinal study by Wilsnack et al. (1991) qualifies these results somewhat. The study shows that women married in 1981 who were problem drinkers were more likely in 1986 to have *reduced* their dependency symptoms if they were separated. This tendency was even stronger for marriages in 1981 characterized by frequent alcohol consumption on the part of the husband and/or by sexual dysfunction. Even though it is impossible to assert the clinical significance of these results, as suggested by the authors, it seems plausible that women may need to drink less to self medicate relational problems after a separation. However, it is otherwise presumable that some women may drink more after a separation to overcome this major stress.

These results clearly show that it is not possible to establish simple cause-and-effect relations between couple relationships on the one hand and alcohol-, drug-, or pathological gambling-related problems on the other. Nevertheless, as a whole these data permit us to conclude that couple relationship quality is a central dimension that must be considered in order to develop a good understanding of the evolution of substance abusers and pathological gamblers, as much in terms of the development and maintenance of the problems as of their consequences and the rehabilitation process.

Couple Therapy and Addictions

Couple Therapy for Pathological Gambling

In the same vein, Ciarrochi (2002) and Steinberg (1993) deplore the relative lack of attention paid to the couple dimension, on both clinical and empirical levels, in therapeutic models for the treatment of individuals with pathological gambling problems (Ciarrocchi 2002; Steinberg 1993). As a result, both authors have elaborated clinical guides, without however, assessing them. Treatment duration for both models is variable, depending on couples' needs. Couples in this type of treatment usually have weekly sessions.

Ciarrocchi (2002) adapted Jacobson and Christensen's (1996) integrative behavioral couple therapy (IBCT) for his model. The primary aim of this therapeutic model for

couples is to support pathological gamblers in quitting gambling, and to do so with the help of diverse strategies: developing environmental controls; restoring the couples' financial situation, managing eventual legal problems brought about by the pathological gambling behavior, permitting non-gambling partners to ask questions and give gamblers feedback about their behavior, provide gamblers' partners with emotional support. Beyond these task-oriented goals, the couple therapist must also help couples heal their wounds and reestablish a certain intimacy. Given the significant and painful impact of pathological gambling on the couple, Ciarrocchi favors the IBCT model due to its emphasis on the concepts of tolerance and acceptance. If each partner manages to feel accepted by the other, they will both only be more motivated to change. To foster a climate of tolerance and acceptance in the couple, central themes are explored, like trust, fairness, and self-esteem.

The model proposed by Steinberg (1993) is *Systemic Couples Therapy* (SCT) adapted to the problem of gambling. On a conceptual level, SCT focuses primarily on overcoming existing couple intimacy deficits so as to permit the couple relationship to recover. Specific themes also emerge from this model: multiple dependencies (comorbidities), finances, control and power, anger, sexuality, and relational intimacy. The multiple dependency-related issues represent as many barriers to intimacy between partners, and must therefore be the subject of numerous interventions during treatment. This model also provides for the use of other resources in parallel, such as for example the services of a sex therapist or financial advisor. The first steps in rebuilding the couple do not constitute fertile ground for the development of intimacy, the priority being simply to ensure the survival of the couple's union. On this level, the SCT model tends to prioritize reinforcing the bonds of trust between partners, bonds that have been severely strained by the gambling problem.

The few studies to have assessed couple treatment with pathological gamblers, although based on very small samples (less than 10 couples) and exploratory in nature, have nevertheless documented the favorable effects of this type of intervention (Boyd and Bolen 1970; Lee 2002). Lee (2002) has developed the *Congruence Couple Therapy* (CCT) model based on the work of family therapist Virginia Satir (1983, 1991, 1994). Her integrative, multi-dimensional model, based on a systemic approach, is centered on the concept of congruence. This concept is defined "as alignment, communication, and flow between different parts of a system" (Lee 2002). Congruence is assessed according to four dimensions: interpersonal, interpsychic, universal-spiritual, and intergenerational. For example, the therapist fosters the development of spouses' understanding of their communication behaviors in connection with their family learning. Also, the therapist attempts to promote acceptance and validation of the partner's needs and experience. CCT seeks to initiate structural changes in the couple system so as to obtain more durable results, as much with respect to gambling habits as to communication in the couple. To achieve these objectives, the couple attends 12 weekly couple sessions over a 3-month period. Lee's (2002) results document the positive effects of CCT on couple's satisfaction and satisfaction with regards to life in general. Moreover, all participants maintained abstinence 4 months after treatment. Unfortunately, the study has a limited sample size and does not provide long-term follow-ups. Therefore, it is not possible to evaluate the stability of therapeutic change.

Boyd and Bolen (1970) assessed the effects of a psychoanalytic marital group therapy model with nine pathological gamblers and their spouses. Eight couples completed couple treatment, with the eight gamblers successfully quitting problem gambling. The authors note that gambling is so often an integral part of the couple dynamic that quitting gambling in the context of individual therapy alone may result in separation. According to them,

gamblers' fear of separation may explain the high drop-out rate for individual treatment. Again, the small sample size and the absence of long-term follow-ups are limiting the conclusions that may be formulated.

While it may not be possible to establish conclusively the effectiveness of couple therapy for pathological gambling, the results of these few exploratory studies are encouraging. However, in our opinion, one shortcoming of these therapeutic models is that they do not refer to couple models developed for substance abusers, which have already been shown to be effective. In particular, these couple therapies for alcohol- and drug-addicted individuals (1) are based on cognitive-behavioral models; (2) are offered as a complement to individual treatment for the addict; (3) from the offset include modalities for generating a shared understanding of the issue while committing both partners to a contract promoting abstinence; and (4) more recently, integrate components tied to motivational approaches (see Miller et al. 2002) for better consideration of the ambivalence to change characteristic of individuals wrestling with addictive behaviors.

Couple Therapy for Substance Use Disorders

The clinical pertinence and effectiveness of couple intervention with couples in which the male partner abuses alcohol and/or drugs are well documented, especially with respect to Behavioral Couples Therapy (BCT). O'Farrell and Fals-Stewart (2003), based on the results of 17 controlled studies, conclude that BCT is more effective than individual treatment at achieving abstinence and improving relationship functioning.

BCT, as described by O'Farrell (1993) in his Project CALM, is comprised of five modules that are presented in a set order to groups of couples over the course of 10 sessions. Each 2 h session covers various aspects: (1) alcohol consumption and couple interactions related to alcohol, (2) behaviors that demonstrate concern for the other ("caring behavior"), (3) Sharing moments of pleasure and recreation together, (4) communication, and (5) problem-solving skills. This type of therapy, a complement to individual treatment, proves more effective than individual therapy alone, as much with respect to the rehabilitation of the alcoholic- or drug-abusing male as to the way the couple operates (for reviews, see O'Farrell and Fals-Stewart 2006; St-Jacques and Nadeau 2008; Tremblay et al. 2005). The results of a few recent studies also support the effectiveness of BCT for couples in which the female partner is an alcoholic (Fals-Stewart et al. 2006) or abuses drugs (Winters et al. 2002). However, the superiority of BCT over individual therapy is not clearly demonstrated at the 2 years follow-up (O'Farrell et al. 1992). Despite the fact that spouses of the BCT group were still more satisfied about their couple than spouses from the control group at the 2 years follow-up, it was not the case for the alcoholic husbands (O'Farrell et al. 1992). Adding 15 couple's sessions targeting relapse prevention was proven effective to enhance marital adjustment and to promote abstinence at the 30 months follow-up (O'Farrell 1993). It is still a challenge of addiction treatments to maintain therapeutic success over time regardless of which therapeutic modality is being considered.

The model developed by McCrady's team, *Alcohol Behavior Couple Therapy* (ABCT) (Epstein and McCrady 2002; McCrady and Epstein 1995) differs from O'Farrell's, notably in terms of its greater flexibility regarding duration and objectives, based on the individualized assessment of each of the couples met. The authors have also integrated *motivational interviewing* (Miller et al. 2002) strategies into their approach. They assess the individual's level of motivation, using specific strategies to deal with lack of motivation including, among others, a non-confrontational style (Epstein and McCrady 2002).

Typically, the first sessions focus on the use of psychoactive substances, while greater attention is progressively devoted to the way the couple functions.

In addition, the study by McCrady and colleagues on couples in BCT allows for validation of the conceptual framework (McCrady et al. 2002). In this study, the intensity of the alcoholic spouses' alcohol consumption 6 months after treatment is predicted by their degree of couple happiness at the end of treatment, and by the quality of their couple relationship at the beginning of treatment (McCrady et al. 2002). Further, less intense alcohol consumption during treatment is predicted by greater spousal use of problem-solving strategies and social support seeking as well as less use of self-criticism, magical thinking, and avoidance (McCrady et al. 2002).

Additional modelization attempts to document the variables that explain and/or predict change must be carried out. In particular, Moos (2007) suggests that social control and behavior economics theories could help chart the interactions between couple satisfaction and substance abuse during and following BCT. For example, social control theory enables us to understand how partners' positive attachment bonds, combined with their presence during therapy sessions, incite the reduction of deviant behaviors. As for the behavior economics model, it encourages taking part in pleasant activities without alcohol and drugs and as a couple (leaving less time for consumption activities), which increases couple satisfaction, in turn reinforcing the couple's attachment bond. A better understanding of the connection between substance abuse and couple satisfaction would allow for the improvement of BCTs with this clientele.

It appears to us that these reflections might also be used to guide our efforts in developing more effective therapeutic modalities for pathological gamblers taking into account personal and couple distress experienced as much by gamblers as by their spouses.

The demonstration of the effectiveness of behavioral couple therapy (BCT) for alcohol- and drug-related disorders provides validation of its conceptual framework and supports the pertinence of exploring the use of BCT to improve intervention for pathological gamblers. Moreover, there is a consensus about the effectiveness of couple therapy for couples with an « identified patient » who is depressive or anxious for example (Epstein and Beaucom 2002; Wright et al. 2008a).

Adapted Couple Therapy (ACT) for Pathological Gamblers: A Promising Avenue

Together, the above studies suggest the adaptation of cognitive-BCT, whose effectiveness has been repeatedly demonstrated in over 20 clinical studies (see Wright et al. 2008b), as a promising avenue for the treatment of pathological gambling. They also indicate that it is necessary to consider the couple relationship, where one exists, in any therapeutic effort targeting pathological gambling, for at least two reasons: (1) to support and encourage the gambler's rehabilitation process; (2) to take into account and relieve the personal and couple distress experienced not only by gamblers but also by their spouses.

We have therefore developed ACT for pathological gamblers based on four sources: (1) BCT for couples in which the male spouse is alcoholic (O'Farrell and Fals-Stewart 2006); (2) the work on integrative BCT with significantly and chronically distressed couples, some of these couples characterized by an "identified patient" (i.e., depression, violence, anxiety) (Christensen et al. 2004; Jacobson and Christensen 1996; Wright et al. 2008c); (3) our own clinical experience, and (4) feedback from counselors in substance abuse treatment centers in Québec, Canada, permitting us to adapt our model to their clinical context.

ACT was conceived in such a manner as to be offered to couples in which one of the spouses has a gambling problem and is currently in treatment. In the Québec context, this model is therefore destined to serve as an addition to an individual cognitive-behavioral treatment model that has been proven effective (Sylvain et al. 1997) and is employed throughout this Canadian province. The most important target of change of this cognitive-behavioral individual treatment is to correct the gambler's erroneous cognitions concerning randomness. Research has demonstrated that this goal should be included in any gambling treatment regardless of theoretical perspective (Ladouceur et al. 2000). Besides, there is universal agreement that in couples where there is an identified patient (IP), couple therapy is an essential complement, although insufficient on its own, for the majority of couples with comorbid pathological gambling, substance abuse, and couple violence issues (Snyder and Whisman 2003; Wright et al. 2008a).

ACT was developed to be offered over eight typically takes place over eight to 12 meetings, but the duration is determined by level of achievement of objectives rather than time, as recommended by Christensen and collaborators (2004) as well as Wright et al. (2008c). It may be useful to propose a smaller number of sessions at the beginning in order to avoid a high proportion of gamblers refusing the program when perceived as too intense. For example, the couple may be offered to participate in two or three sessions aiming to provide feedback about their situation and to explore their expectancies as well as the pertinence to continue or not the couple therapy. Also, the fact that gamblers can choose among different treatment modalities, for example individual therapy only or a combined approach integrating a couple component, may increase in itself the motivation of gamblers to engage in a form of treatment. Finally, ACT is designed to be offered to one couple at a time rather than as part of a group. With a view to encouraging the model's implementation in Québec treatment centers, we consider this format to be easier for professionals to master while also maximizing the possibility of offering individualized and thus potentially more effective services. This format is also better suited to the numerous regional centers serving large territories for which setting up couples groups proves practically impossible.

ACT begins when the crisis situation, usually characterized by the gambler's request for treatment, has been resolved. From the beginning of their first individual sessions, gamblers receive support in settling the financial crisis with which gamblers and their partners are most frequently faced, thus ensuring a minimum framework of security for the couple's basic needs, a condition necessary to the beginning of ACT. For the same reasons, pathological gamblers must show they have completely stopped playing the principal type of game related to their difficulties and/or that they have stopped returning to the specific locations associated with it for at least 2 weeks.

To encourage couple engagement in this modality of treatment, the principles of motivational interviewing (Miller et al. 2002) are particularly helpful. Indeed, this stage is very important given the resistance of pathological gamblers who often try to hide their gambling habits from those close to them. Spouses often feel exhausted and angry and may consider it unjust that they must invest in such a therapeutic process when the pathological gambling problem is not their responsibility. Thus, interventions that draw on motivational approaches, which are non-confrontational and based on humanist principles, may be useful. These facilitate exploration of the individual's ambivalence towards a given change while encouraging resolution of the ambivalence through the development of a motivation intrinsic to the change. ACT thus includes a component focused on engagement in treatment. Gamblers and their spouses may be invited to explore the pros and cons of becoming involved in this modality of treatment and to express their fears. The counselor's role

consists first of validating their feelings while at the same time reassuring them and facilitating the identification of the specific needs of each partner as well as common needs that may be met through couple therapy. For example, pathological gamblers may be motivated to find solutions so that their spouses are less critical and controlling of them, while spouses suffering from a rift that has widened over the years between them and the gamblers may be motivated to rebuild bridges of communication. Both may express suffering related to their perpetual conflicts and wish for a truce. This process may permit the couple to commit themselves to a rehabilitation process so as to support not only the gambler's abstinence but also the improvement of their personal and couple well-being.

ACT includes two phases that may overlap in time. The first involves all the steps taken as a couple to ensure optimal management of the IP's symptoms, the pathological gambling problem. This objective also overlaps with those of the individual process, but is treated differently in couple therapy. For this reason, we believe it is advisable to inform the couple in the first couple session of these a priori assumptions of ACT: (1) there is an IP, but there are also couple problems, some of which preceded the comorbid problem while others have arisen since, (2) the circular cause-and-effect nature of individual and couple problems, although responsibility for problematic symptoms, such as the pathological gambling, still clearly rests on the shoulders of the IP. In keeping with the principles of integrative BCT, the counselor should encourage the couple's development of an empathetic, shared vision of the problem, i.e., pathological gambling and its repercussions. An increased capacity for empathy in each of the spouses towards the other fosters acceptance and tolerance of one another's differences, essential therapeutic ingredients emphasized in both integrative BCT and our model (ACT).

This initial phase also implies assisting the couple in conducting a functional analysis of the gambler's gambling behaviors (trigger-behaviors-consequences). Based on this analysis, precise, individualized avenues of solutions may be established in order to: (1) help gamblers adopt strategies to sustain their abstinence and prevent a relapse, (2) help spouses implement strategies to encourage abstinence from gambling in their partners and to avoid behaviors that may, even if unintentionally and frequently based on good intentions, contribute to a relapse or increase in gambling behaviors (e.g. control by checking spouse's comings and goings, criticizing past gambling habits, protecting gambling spouse from negative consequences of gambling), (3) assist spouses in implementing strategies to help them focus on their own needs and adopt a certain distance towards the gambler's difficulties (e.g. exploring social support, sources of pleasure and recreation, establishing limits in certain areas where expectations/responsibilities are high, exploring the need to use specific help services). During this phase, a special attention is given to gamblers' and spouses' irrational cognitions concerning gambling. Essential components of this phase include the explanations given about the relation between erroneous cognitions and the gambling behaviors as well as correcting those beliefs. It facilitates the adoption of a common vision for the two spouses on the gambling problem.

In addition, the couple recovery contract proposed in the BCT substance abuse model (Fals-Stewart et al. 1996) is used at this stage in an adapted form. Couples draw up verbal agreements establishing that (1) the gamblers and their partners must discuss the status of abstinence from gambling at a predetermined time and frequency, (2) during these discussions, the gamblers must commit to remaining abstinent for the predetermined period until the next discussion, (3) the gamblers' partners must recognize their spouses' abstinence in a positive manner contingent on abstinence. In addition to fostering support for abstinence in the gambler's partner as well as meeting the loved one's need to be kept appraised of the situation in order to feel reassured, it also provides a structure for

interactions concerning gambling and permits the reduction of anxiety related to a moment both partners usually dread. The couple's investment in the prevention of relapse and the gambler's rehabilitation process as well as the partner's experience during the process thus always remain in the foreground at each session.

For the second stage, which concentrates on couple dimensions as in the model by O'Farrell (1993) and colleagues, ACT focuses on four elements: (1) the capacity to care about the well-being of one's partner (*caring behaviors*), (2) the concept of shared pleasure, intimacy, and the expression of affection, (3) communication in the couple, including constructive anger and frustration management in particular, and (4) problem-solving skills. Where pertinent, gambling repercussions for the family and parenting skills issues are also examined.

The strategies used are also inspired by the integrative BCT model (Jacobson and Christensen 1996), and are therefore not limited to skill teaching and interventions targeting the modification of the cognitions that maintain dissatisfying couple interactions. Central themes are explored with the couple based on its particular dynamic. Intimacy, power, conflict and anger management are examples of the issues couples may struggle with repeatedly. Therapeutic strategies, inspired by IBCT, are structured around four types of clinical exchanges with the couple: examination of the fundamental differences between them; anticipation of an upcoming stressful event; a recent critical event that illustrates the difficulties of managing the different styles of both partner; and a recent event they have succeeded in managing constructively (Wright et al. 2008c). A second group of strategies is also used to encourage tolerance of the other's differences, including identification of problem behaviors and of their potentially positive components as well as the development in both partners of the ability to take care of their own needs themselves (Wright et al. 2008a, b, c).

Conclusion

We believe that the addition of ACT to individual cognitive-behavioral therapy for pathological gamblers is likely to result in numerous positive consequences: (1) improvement effectiveness of individual treatment with regards to pathological gamblers' gambling habits, (2) relief of personal distress resulting from the consequences of pathological gambling and couple conflicts, as much in pathological gamblers as in their spouses, and (3) improved couple happiness for both partners. We can equally formulate the hypothesis that taking the partner's personal and couple distress into account in the treatment of pathological gambling is likely to provide increased protection of children in certain situations, as the latter suffer not only from parents' gambling problems, but also from couple conflicts that erupt in the household. Furthermore, the addition of a couple component to the treatment of pathological gambling also facilitates access to the gambler's family system. Issues of substance abuse, violence and mental health may thus be better identified and suitable services may be provided to gamblers, their partners or children, if need be.

However, we are obliged to note that it is currently impossible to verify these hypotheses due to the dearth of studies examining couple dimensions in relation to pathological gambling and its treatment. Indeed, it should be remembered that couple adjustment for couples in which one of the spouses is a pathological gambler is only rarely measured with validated instruments. Further, longitudinal studies on interactions between conjugal adjustment and pathological gambling are non-existent. As for evaluative studies

targeting couple treatment of pathological gambling, these are rare and exploratory in nature, conducted with extremely small samples. It should nevertheless be pointed out that several descriptive quantitative and qualitative studies have documented the couple problems of pathological gamblers and their significant others as well as the ensuing personal distress. As well, the favorable results of exploratory studies on the impact of couple therapy in pathological gambling are encouraging.

Furthermore, the clinical pertinence and effectiveness of couple intervention with couples in which the male spouse abuses alcohol and/or drugs are well documented, particularly with regards to BCT. The superiority of treatments that include a couple component in comparison with other treatment modalities points to the importance of using the powerful lever of the couple system. There is no longer any doubt that substance addiction can create couple distress or that the quality of the couple relationship can have an influence on substance abuse and the rehabilitation of the alcoholic or drug addict. The results of studies documenting the connection between the couple relationship and pathological gambling as well as the effectiveness of couple therapies for gamblers tend to be similar to the data collected for alcoholics and drug addicts.

All of these observations underscore the importance of conducting studies to develop a better understanding of the complex interactions between the couple relationship and pathological gambling. Longitudinal designs and the use of validated instruments are essential. Furthermore, effectiveness studies of couple therapies must aim for greater specificity: when and under what conditions, will particular types of couple therapy be effective (Snyder et al. 2006)? More precisely, it would appear highly pertinent in the field of pathological gambling to develop and assess models of couple therapy for gamblers and their partners. The processes through which this therapeutic modality may influence the gambler's rehabilitation process and the couple's level of well-being and happiness should also be highlighted. The use of mixed protocols, combining qualitative and quantitative methods, would allow for a better understanding. Despite the limited empirical data available, the evidence of the personal distress experienced by pathological gamblers' loved ones as well as of the couple conflicts characteristic of their unions call into question the predominance of the individual treatment model for pathological gambling on a clinical level. In our opinion, the implementation of couple therapy as a supplement to individual therapy is not only pertinent, but desirable.

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