Proposal for a cognitive model to the treatment of pathological gambling

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Abstract

Pathological gambling is a psychological disorder that usually begins as an enjoyable activity, but in time, some gamblers become addicted to gambling. The development of clinical strategies for the treatment of pathological gambling is in its early stages (Gooding & Tarrier, 2009; Korn & Schaffer, 2004). We propose a cognitive counseling model which is intended to assist practitioners with the assessment and treatment of pathological gambling. The proposed model reflects the findings of the literature review of the treatment of pathological gambling (Blaszczynsky, 2010; Coombs, 2004; Korn & Schaffer, 2004; Petry, 2005; Raylu & Oei, 2010; Toneatto & Millar, 2004).

Keywords: pathological gambling; impulse control; cognitive treatment.

1. Introduction

The large accessibility to gambling has led to an increase of the number of individuals who would be classified as pathological gamblers (Fong & Rosenthal, 2008).

Considering the negative consequences associated with pathological gambling, it is important that treatment models are available for the clinicians treating clients with such problems.

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The specific intent of the treatment is to minimize the harmful consequences of gambling, reduce the risks associated with gambling, cope effectively with negative mental states and satisfy need for entertainment (Korn & Schaffer, 2004).

2. Treatment models for pathological gambling

A systematic review and meta-analysis conducted in 2009 determined that CBT has a highly significant effect in reducing gambling behaviors (Gooding & Tarrier, 2009).

In the gambling literature we can find some cognitive behavioral models of problem gambling (Blaszczynski, 2010; Ledgerwood & Petry, 2005; Raylu & Oei, 2010).

Ledgerwood & Petry (2005) introduced a treatment model whose central component was to have the patient restructure his environment in ways that make gambling less likely. Patients are initially thought to identify gambling triggers and distorted cognitions about their gambling, than to understand how these cognitions contribute to gambling and to develop ways to cope with thoughts that lead to gambling behaviour.

Blaszczynski (2010) completed a self-help program for overcoming gambling, with 7 steps: working out your motivation to stop; monitoring your gambling; controlling your urge using a relaxation technique; controlling gambling-related cues: identifying irrational ideas; how to stop chasing losses; preventing relapses; learning how your family can help.

Raylu & Oei (2010) introduced a cognitive behavioral therapy program for problem gambling with four parts: assess the client’s problems and needs, to offer him psycho-education and motivate him to change disfunctional behaviors; provide the client with basic cognitive and behavioral self-management strategies in order to stabilize his compulsive gambling; teach the gambler some coping skills to help maintain positive changes in his gambling behavior and teach him strategies to maintain the therapeutic gains and prevent relapse.

3. The central ideas in CBT

The central idea of CBT is that there are thinking biases implicit in maintaining specific problematic emotions and behaviors. The clinician should make these thoughts more explicit and assist the client to find alternative, more useful ones.

CBT enable professionals to collaborate with the clients in order to help them in their recovery.

During the treatment, the clients learn some alternative cognitive behavioral coping skills which have an important role in reducing his gambling problem.

Most gamblers believe that they have some skills or ability to influence the outcome of a chance event. E.J. Langer (Blaszczynski, 2010) has called “illusion of control” the belief that a gambler can alter the outcome of a chance event. The gamblers tend to remember wins more than losses and attribute wins to their own ability. Their distorted cognitions may play a part at any stage of the gambling circle.

We can find also some others distorted cognitions as the gambler’s belief in his own luck or the belief that he has some special talents and knowledge that will help him win.

The clinician should correct these cognitions in order to overcome the pathological gambling.

4. Proposal for a Cognitive Model to the Treatment of Pathological Gambling

The goal of our model of therapy for pathological gambling is the total abstinence from gambling and the average duration of the treatment is six months.

The key tasks of the treatment are:
• assessment and formulation;
• psycho-education;
• cognitive restructuring
• problem-solving training;
• assertiveness skills training;
• relapse prevention.

The clinician have to start therapy indicating that most people gamble at some time in their life and for
the social gamblers, this is a pleasurable activity that can be combined with other life tasks. The gamblers
who consider this activity as a sin may be likely to resist more rational to potentially successful means of
therapy (Ladouceur, Sylvain, Boutin & Doucet, 2002).

The proposed frequency of the treatment is one session per week and each session should be structured
in the following way:
• agenda setting and recap of previous session;
• specific agenda items;
• session review and feedback;
• home exercises.

It is important to have an ending to therapy because it may contribute to a positive shift in the client’s
identity.

Clinicians consider there are two senses of recovery: recovery from gambling and recovery related to
wider social and personal opportunities, when clients are looking for positive things in their lives
(Mitcheson, Maslin, Meynen, Morrison, Hill, Wanigarante, 2010).

As no single treatment model can help any pathological gambler, it is important to complete an
individualized treatment plan for each client (Rizeanu, 2011).

4.1. Assessment and formulation

The assessment interview will help us to complete a case formulation of the client’s problems and the
treatment plan; we should use the South Oaks Gambling Screen, developed by Lesieur and Blume (Korn

We have to engage the client in treatment and enhance his motivation in order to undertake an
assessment. It is important to create a positive therapeutic environment, whereby motivation can be
enhanced and conditions for engaging in CBT are maximized.

The formulation should be revised according to emerging information, including what happens in
treatment; an assessment done in the right way will engage the client in the treatment. From a CBT
perspective we are aiming to understand three key things:
• what is the current gambling problem;
• how is this gambling behavior maintain;
• how did the problem develop.

Formulations focus on experiences, cognitions, emotions, physical sensations and behaviors of each
client. This formulation help client understand what led to his pathological gambling developing.

4.2. Psycho-education and introducing to ABCDE model

In this session we need to educate the client about the problem gambling and help him to understand
the developing and maintenance of his pathological gambling.
We should also introduce to client the Albert Ellis’ABCDE model (Dryden, DiGiuseppe, Neenan, 2003), where A stands for an external activating event, B stands for irrational beliefs and C stands for the emotional, behavioral and cognitive consequences of the client’s belief about A.

According to this model, people experience undesirable activating events (A), about which they have rational and irrational cognitions (B). The irrationals beliefs lead to dysfunctional consequences and clients need to dispute them (D) to assimilate more efficient (E) rationale beliefs.

Ellis points that, in order to change the irrational emotions, humans have the power of choice and the ability to identify, challenge and change the main irrational beliefs: demands about self, demands about others and demands about world (Dryden, DiGiuseppe, Neenan, 2003).

4.3. Cognitive restructuring

Cognitive restructuring for pathological gamblers reflects interventions that are directed toward changing unhealthy gambling behavior by correcting distorted thoughts, beliefs and attitudes about gambling (Korn & Schaffer, 2004).

At this stage we have to identify the client’s gambling-related beliefs and to integrate these into the individual formulation. The main distorted cognitions that are common among pathological gamblers are: illusion of control of gambling, predictive control, interpretive biases, gambling related expectances, perceived inability to stop gambling (Toneatto & Millar, 2004).

Than we should assist the client to challenge the gambling specific thinking errors and to generate rational self-statements, such as the following (Raylu & Oei, 2010):

- gambling outcomes are more determined by luck than skill;
- we can not control or predict the outcomes on gambling machines, which are determined by a computer using a randomized system;
- gambling outcomes are not related to previous outcomes;
- gambling machines are set in such a way that they pay less than they stake;
- structural factors related to gambling machines encourage continued gambling despite losses.

Working with beliefs about gambling is central to the treatments of pathological gambling. This process has three steps: defining and operationalising, evaluating and developing alternative control beliefs.

4.4. Problem-solving training

Teaching pathological gamblers basic problem solving skills, we help them to consider alternatives before engaging in gambling behavior.

The following steps are involved in problem solving training: identify the problem, identify all possible solutions, choose the best solution, prepare, carry out and review.

4.5. Assertiveness skills training

Being assertive means to express one’s personal rights without disrespecting other’s people’s rights and needs. There are several ways one can be more assertive: respect the basic human rights; deal with the negative emotions; challenge negative thinking; effective communication.
4.6. Relapse prevention

The client needs to be armed with strategies to minimize relapse and maintain treatment gains if this occurs. Having frank conversation about relapse prevention towards the end of therapy develops the idea of clients being their own therapists through reviewing what was learnt in therapy. A relapse does not mean the end of treatment, but an opportunity to help the client further understand his specific vulnerabilities.

Considering that each client is different and has different needs, the duration of the treatment program and the frequency of the sessions could vary, depending on the client (Rizeanu, 2011).

References