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COGNITIVE-BEHAVIORAL THERAPY IN PATHOLOGICAL GAMBLING; A CASE ANALYSIS

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Abstract

The paper describes a cognitive-behavioral intervention in the case of a 29 year-old patient brought to therapy by his mother and girlfriend due to excessive gambling, (roulette and slot machine games). The patient was diagnosed with pathological gambling, meeting 9 of 10 DSM-IV-TR criteria for this diagnosis. Also, he scored very high (18) on the 20-questions questionnaire of Gamblers Anonymous (USA). His case was approached by a two-fold intervention: (1) medication: Trileptal (Oxcarbazepine) in a dosage of 3x1 tb/day (1 tablet=300 mg), for 6 months and (2) cognitive-behavioral therapy (CBT) over 20 sessions, delivered in a 1 session/week format for the first 3 months, followed by 1 session every other week, and by 1 monthly session towards the end. The CBT package comprised hypnosis and self-hypnosis techniques and REBT techniques. The evolution of the case was favorable.

Keywords: pathological gambling, cognitive-behavioral therapy

Pathological gambling is characterized by impulse discontrol associated with compulsivity, manifested by gambling behavior leading to adaptation problems in personal, family, school and/or professional life. The onset of the disorder is during adolescence. The addiction circumscribes behavioral changes such as the need to increase gambling stake to satisfy pleasure seeking, resistance associated with irritability and anxiety, gambling urge and problem avoidance through gambling (Petry, 2001; Hollander, Buchalter & DeCaria, 2000).

Recent approaches debate the conceptualization of pathological gambling as non-pharmacological addiction (Comings et al., 1996, Lupu, 2007) or obsessive-compulsive disorder (Blanco et al., 2001). The first model is supported by the comorbidity of pathological gambling with various pharmacological addictions (Saiz-Ruiz et al., 2001), as well as with genetic and central

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neuromediation changes which would correlate to pathological gambling and other types of addiction of the reward deficiency syndrome (Blum et al., 1996; Bergh et al., 1997).

The alternative approach claims that pathological gambling is similar to obsessive-compulsive disorder, gamblers scoring very high on impulsivity and obsessionality measures (Blaszczynski, 1999). Gambling addicts are dependent on the pleasure and hope provided by winning. They spend an increasing time gambling up to the moment of total loss of control. In other words, they are real addicts, but without substance use.

If we consider gambling from a pleasure-seeking perspective, it can be observed that money do not necessarily represent the main reason for gambling, since most compulsive gamblers end up losing large amounts of money. Only 8% of gamblers say that they play for the sake of money, as compared to 50% who state that they play for excitement and pleasure, therefore ascertaining the fact that the arousal is the main reward for continued gambling or wagering. Hypothetical bets or low stake bets are less attractive for real gamblers. Thus, the more they bet, the more the arousal increases, making them persist gambling. This assumption is supported by arousal theories (Griffiths, 2003).

From the point of view of cognitive theories, gamblers believe or expect winning against all odds. Hence these theories solve the gambling paradox according to which people, in their attempt to win large amounts of money, engage in activities which make it possible to actually lose money. Therefore, in terms of understanding the main motivation for gambling, gaining large amounts of money could be regarded as being the main reason that people gamble for.

Research indicates that cognitive factors play a key role in the development and maintenance of problem gambling. Specifically, the erroneous connection of random/unrelated events seems to be the most important cognitive bias that gamblers have. They try various strategies and believe that their skills would help them win (Ladouceur et al., 1998). Studies performed to highlight the importance of cognitive biases in gambling indicate that 75% of the perceptions a person has when gambling are wrong (Langer, 1975). Many pathological gamblers remember important winnings during their first gambling experiences. An individual absorbed by gambling loses from sight its hazardous dimension and concentrates on the possibility of controlling and influencing the game into his/her favor.

The process of becoming a pathological gambler is a lengthy one, starting in adolescence or even childhood, and comprises four stages. There is an initial period of winnings in the "career" of a pathological gambler, unlucky enough to win several times over, symbolizing power and social acceptance. Once they start gaining money, they become very generous, making presents to friends and taking them out. Obviously, sooner or later, they start losing money. Besides the pleasure of winning, they are convinced they are in control of the game, and assign losses to external conditions (Ladouceur et al., 1993).

They are in denial, convinced of the possibility of regaining their “former mood”. They do not have a clear understanding of what is going on, returning to gambling in order to “recover” and win the lost money back. This leads them to making further loans, selling goods, and perpetrating crimes, with the aim of financing gambling activities. It must be made clear that gamblers do not necessarily have a personality disorder, and that their behavior does not have, in essence, an antisocial aim. On the contrary, they are convinced that the money they get by lying or theft will be returned. They become anxious, obsessed with gambling and depressive. This stage usually lasts for 5 to 15 years. In the end, they enter the despair stage; in a final attempt, they appeal to a person in their entourage to grant them a large loan. They become euphoric again, convinced that luck would be on their side once more, but they usually end up losing everything and are left with no solutions (Ladouceur et al., 1993).

Many pathological gamblers think of suicide (De Caria, 1996). According to DSM-IV-TR (2003), 20% of gamblers attempt suicide. Ladouceur compares the evolution of gambling with cancer, commencing slowly and obscurely, without making its presence felt, then suddenly becoming very aggressive (Ladouceur et al., 1993).

Among the pathological gambling treatment options used in Romania we mention:

1. Use of SSRI (Fluvoxamine, Clomipramine, Prozac);
2. Use of mood stabilizers (Carbamazepine);
3. Individual and group cognitive-behavioral therapies (including the rational-emotive and behavioral therapy);
4. Family counseling;
5. Marital counseling;
6. Psychological counseling (Lupu et al., 2007).

Ladouceur and colleagues, based on their extensive experience in the field, recommend cognitive-behavioral therapy in the case of pathological gambling, in a format combining individual and group therapy (Ladouceur et al., 1993). According to cited authors, therapy should comprise five stages:

1. Information on gambling;
2. Correction of erroneous beliefs on the possibility of control over the game;
3. Problem solving training to manage the gambling problem;
4. Social skills training;
5. Relapse prevention.

The majority of therapists believe that the most important stage of the entire process is the period of abstinence and fight against the psychological addiction to gambling.

Patients are then informed on the possibility of relapse to excessive gambling after a certain period of time. The therapist must give the gambler

information on recognizing risk situations, and encourage him/her by pointing out that relapses are not irreparable mistakes, but rather than surmountable difficulties.

Ladouceur (1994) conducted a study regarding the efficiency of the cognitive-behavioral therapy for gambling adolescents. The results indicated significant improvements in the case of all subjects enrolled in the study, who remained abstinent at 1, 4 and 6 months follow-up. Another study, carried out in Canada by Sylvain and colleagues (1997), on 29 males meeting DSM-III criteria for pathological gambling, identified significant positive changes following cognitive-behavioral therapy. The results were maintained at 6 and 12 months follow-up. As in other cases of addictive disorders, early intervention is very important in pathological gambling, followed by the suggestion of continuing with group interventions such as attending "Gamblers Anonymous".

If cognitive factors play a key role in the development and maintenance of problem gambling, the confrontation and correction of these problems should reduce or eliminate the problem behavior. Hence, it is hypothesized that if the erroneously perceived relations between random events appearing during gambling are corrected, a significant reduction in gambling behavior will follow.

The main component of therapy is based on the theoretical understanding of the cognition and behavior characteristic of gambling and comprises approximately 20 therapy sessions, of 60-90 minutes each, delivered in a two weekly sessions format (Ladouceur et al., 1998, 2003). The correction of the client's erroneous conception regarding randomness is essential (Sylvain et al., 1997).

CASE STUDY

"George", aged 29, male, a private entrepreneur, was brought to therapy by his mother and girlfriend, due to excessive gambling: slot machine games and roulette. Although he had been gambling since he was 15, things had worsened over time and had become critical during the last two years when "George" incurred large debts amounting to approximately 60.000 Euro.

He was extremely passionate about roulette, so much so that he sometimes spent over 24 hours in the casino. He was also superstitious, betting the same numbers all over again, as they had earned him money in the very beginning.

Similar to what has been described in other pathological gamblers, "George" borrowed large amounts of money, initially from friends, then from strangers, including usurers. The moment the gambler turns to usurers for money is critical, on the one hand because it means that he/she has lost credit with his friends, and on the other hand, because usurers practice high interests that further complicate things. The larger his losses were, the more debts increased, "George" being tempted to play roulette more and more so as to re-balance his financial

situation and to recover losses. He described with fascination the environment in the casino, which was a source of real pleasure. He also said that when he was betting small amounts, up to 60-80€, he felt practically no pleasure. Pleasure emerged when the stake rose to more than 300€. The largest amount he had won in one gambling session, of almost 10 hours, was of approximately 80000 €. Unfortunately, instead of being used to cover his debts, the money was spent on roulette and on “treats” he offered to regular customers of the place he went to rather frequently.

During the initial assessment “George” scored very high (18) on the 20-questions questionnaire of Gamblers Anonymous (USA) and met 9 of the 10 DSM-IV-TR criteria for pathological gambling.

His case was approached by a two-fold intervention: (1) medication: Trileptal (Oxcarbazepine) in a dosage of 3x1 tb/day (1 tablet=300 mg), for 6 months and (2) cognitive-behavioral therapy (CBT) over 20 sessions, delivered in a 1 session/week format for the first 3 months, followed by 1 session every other week, and by 1 monthly session towards the end. From the very beginning the advantages and disadvantages of continued gambling were put in balance.

The single advantage of gambling was the state of well-being it induced, “George” being fascinated by the environment. On the other hand, he mentioned the following disadvantages: increase of debts, impaired professional life, impaired relationships with parents and friends, being labeled a “gambler”.

“George” was most often tempted to gamble during weekends, especially when he had amounts of money exceeding 150€. He also noticed that when together with his girlfriend, he was less interested in gambling. Therefore, “George” asked her to keep him company everywhere he went, both for work, which involved frequent traveling by car, as well as outside working hours. At the beginning of therapy, this was useful in helping him diminish his gambling impulse. At a later point in the intervention, “George” was advised to travel by himself when work required and to try to control his impulsive behavior by himself. This step was implemented after the client was thought a self-control technique, similar to the Ronen model (1997), which was initially applied to children and adolescents suffering from nocturnal enuresis. Therapy consisted of 5 stages, each directed to gaining self-control over the maladaptive behavior. The stages were as follows:

1. Changing maladaptive beliefs/cognitions.
2. Understanding the problem.
3. Increasing internal stimuli perception.
4. Developing self-control.
5. Removing the problem.

At the same time, the three-step breathing technique was introduced and the ideas of gradually giving up gambling and exercising self-control under all circumstances were implemented under self-hypnosis (Lupu, 2003). Bellow, we

Clinical Forum Section

present the “scenario” of a hetero-hypnosis session, whereby the patient was taught a self- hypnosis technique.

Hypnotic induction was performed using the Jacobson method of progressive muscle relaxation, preceded by the three step breathing technique, which had been introduced in a previous session. Each of the three steps of the breathing technique lasted 4 seconds:

I. Forced maximal inhaling;

II.The Valsalva maneuver - blocking the breathing, with the increase of intra-thoracic and intra-abdominal pressure;

III. Forced exhaling.

To deepen the trance and to implement the therapeutic suggestions, the “blackboard exercise” was used:

„Imagine a blackboard... take a white chalk and slowly, slowly write... in the centre of the blackboard, the letter “A”, in uppercase... contemplate it... and relax...; then, take a yellow sponge, soaked with the water in a blue bucket, squeeze it hard... and gently, gently erase...the blackboard ... and relax even more ...even more ...; then take the chalk again and slowly write in the centre of the black board the letter “B” in uppercase...etc (the same procedure was used with all letters, from A to Z)...take the sponge again and erase the blackboard completely...then, take the chalk and write on the blackboard the following words, one under the other, in uppercase:

<p>SICKNESS</p> <p>IMPULSIVITY</p> <p>LACK OF CONTROL</p> <p>ROULETTE</p> <p>MISTRUST</p> <p>ANXIETY</p>
--

Take the sponge ... squeeze it...and by a gentle movement ...slowly...erase them and relax even more ...even more ...; now, please write on the blackboard, in uppercase, the following words, which shall permanently remain there:

<p>HEALTH</p> <p>SELFCONTROL</p> <p>SILENCE</p> <p>SUCCESS...</p> <p>WITH GOD’S HELP I WILL</p> <p>SUCCEED, I WILL SUCCEED I WILL SUCCEED</p>
--

You will see that if you do this exercise every night before going to bed, preceded by the three-step breathing exercise, you will relax more and more, and the impulse to play roulette will gradually, gradually diminish, until it disappears. Also, when you will feel a strong urge to gamble, all you have to do is practice the three-step breathing exercise and the impulse will diminish considerably...”.

“George” practiced this self-hypnosis exercise and noticed a considerable improvement of the symptoms.

Thus, after two months of therapy, he scored 6 on the Gamblers Anonymous questionnaire. During a four months interval, he only experienced three relapses: he played slot machines twice and gambled amounts of up to 30€, and played roulette once, wagering 85€, a sensibly smaller amount than the ones engaged before beginning therapy.

“George” was explained the difficulty of total abstinence (which was in fact the goal of therapy) and a special attention was given to relapse prevention. After each relapse, he experienced strong feelings of guilt, as he had made the commitment to his mother, partner and therapist that he would never gamble again. Rational-emotive and cognitive behavioral (REBT) techniques were employed in his case; the client was presented the A-B-C-D-E model of Ellis (1994), and thought to identify and challenge irrational cognitions and dysfunctional emotions (including guilt) and to replace them with rational cognitions, generating functional negative emotions (i.e., remorse in this particular situation) (Ellis et al., 1997). He was advised to practice the model at home, and suggested to read Windy Dryden’s book called “Overcoming guilt”. This book, by the well-known and experienced REBT psychologist and psychotherapist, is written in an accessible manner, comprising questions and answers, that help clients change their guilt-producing attitudes, stop trying to self-improve and start enjoying life (Dryden, 1999).

“George” was receptive to all therapeutic indications. He was a client with good intellectual abilities (I.Q. =110) and highly motivated for change, as his girlfriend conditioned marriage upon him quitting gambling.

After significant progress in improving self-control was observed, sessions were reduced to one every two weeks, and then to one monthly meeting, after “George” was explained the importance of staying in touch with the therapist in order to maintain abstinence and prevent relapses. Fortunately, there were no relapses, and the evolution of the case was favorable even one year after initiating therapy.

CONCLUSIONS

Cognitive-behavioral intervention associated with Oxcarbazepine-type medication proved efficient in this case of pathological gambling, in a 29 years

old client, as gambling abstinence was maintained even at one year after therapy initiation.

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