Pathological gamblers are prone to leave treatment early and often display low levels of motivation within treatment. Use of brief treatments that emphasize reducing client ambivalence through motivational techniques may help increase the likelihood of treatment compliance. This case study describes a 5-session treatment of pathological gambling using a brief and motivationally focused cognitive-behavioral guided self-change (GSC) approach. The 36-year-old gambler in this study was treated for pathological gambling. At 1-month and 6-month follow-ups, the individual evidenced significant improvement in symptoms of pathological gambling. The client also showed considerable reductions in gambling behaviors including number of gambling episodes, length of time spent gambling, and amount of money wagered. These results support use of the GSC approach in treating pathological gamblers.

Keywords: problem gambling; brief treatment; guided self-change; cognitive-behavioral

1 Theoretical and Research Basis

During the past 30 years, there has been a dramatic increase in the availability of legalized gambling in the United States. As many as 82% of American adults have gambled in the past year, and 23% of adults appear to gamble at least weekly (Welte, Barnes, Wieczorek, Tidwell, & Parker, 2002). Accompanying proliferation of gambling is an increasing awareness of the occurrence of gambling-related problems. Gambling has been argued to exist on a continuum from those who experience no problems to those who meet diagnostic criteria for pathological gambling. Between 4% and 7% of adults appear to experience significant gambling-related problems, and another 1% to 2% of the population warrant a diagnosis of pathological gambling (National Research Council, 1999; Shaffer, Hall, & Vander Bilt, 1999).

Pathological gambling has the potential to negatively affect many areas of an individual’s life: financial, familial, legal, psychological, and physical (M. W. Abbott & Volberg, 1999; Boreham, Dickerson, & Harley, 1996; Dickerson et al., 1995; National Opinion Research Center, 1999). One problem shared by nearly all pathological gamblers is serious financial debt (e.g., Hodgins & el-Guebaly, 2000; Ladouceur, Boisvert, & Dumont, 1994; Stinchfield & Winters, 1996). Ladouceur, Boisvert, et al.’s (1994) study of pathological gamblers revealed that 62% borrowed substantial amounts of money, 20% engaged in illegal activity, 28% filed for bankruptcy, and 30% held considerable debt. Pathological gambling also affects
the gambler’s family and community, resulting in societal costs (Wynne & Shaffer, 2003). Theft, embezzlement, absenteeism from work, and pawning belongings of family members are all associated with pathological gambling (Ladouceur, Dube, & Bujold, 1994; Lesieur, 1998; Lorenz & Yaffee, 1986; Thompson, Gazel, & Rickman, 1996).

A variety of treatment strategies has been applied to pathological gambling including behavioral, cognitive, cognitive-behavioral, pharmacological, self-help, and 12-step approaches, but little work has been done to explore brief treatments (for a review, see Toneatto & Ladouceur, 2003). Examination of reviews of psychological treatments for pathological gambling generated three conclusions (Petry & Armentano, 1999; Stinchfield & Winters, 2001; Toneatto & Ladouceur, 2003; Winters & Kushner, 2003). First, pathological gambling responds to psychological treatment. Cognitive-behavioral interventions, in particular, have shown promise for modifying gambling behavior. Second, brief outpatient treatments have been successful with other addictive behaviors and show promise for treatment of pathological gambling. Third, positive change from psychological treatment is not limited to abstinence outcomes but may include the significant reduction of gambling behaviors to more normal or functional levels. These conclusions, coupled with the finding that close to 50% of gamblers who seek treatment drop out before completion (Ladouceur et al., 2001; Ladouceur, Sylvain, Boutin, & Doucet, 2002), suggest that a brief motivationally based and cognitive-behaviorally oriented intervention might be useful in igniting change and maintaining treatment participation.

One of the most empirically supported brief cognitive-behavioral treatments is guided self-change (GSC), with seven clinical trials supporting its efficacy (M. B. Sobell, Breslin, & Sobell, 1998). Since the first clinical trial with problem drinkers (M. B. Sobell, Sobell, & Gavin, 1995), this treatment has been contrasted positively with medication (Sellers et al., 1994), validated cross-culturally (Ayala, Echeverria, Sobell, & Sobell, 1997, 1998), used effectively with adolescents (Breslin, Li, Sdao-Jarvie, Tupper, & Ittig-Deland, 2002; Gil, Wagner, & Tubman, 2004), expanded to include social support (M. B. Sobell, Sobell, & Leo, 2000), and used in group and individual formats with alcohol and drug abusers (L. C. Sobell, Sobell, Brown, & Cleland, 1995) and with those with bulimia nervosa (Thiels, 2005; Thiels, Schmidt, Treasure, Garthe, & Troop, 1998).

GSC has been shown to be effective in treating individuals with both moderate and severe drinking problems (Breslin et al., 2002; M. B. Sobell, Sobell, & Gavin, 1995) across different settings (Sellers et al., 1994; Sellers, Higgins, Tomkins, Romach, & Toneatto, 1991; M. B. Sobell et al., 1990; M. B. Sobell & Sobell, 1990, 1993). Effectiveness of brief treatments for more severely dependent drinkers has been replicated in a number of studies (Edwards & Taylor, 1994; Project MATCH Research Group, 1997, 1998; M. B. Sobell et al., 1998). Despite expectation that serious problems require lengthier, more intense treatment, these studies found that response to treatment was unrelated to treatment length, regardless of problem severity.

GSC was specifically designed and tailored to help modify addictive behaviors (for a description of the treatment guidelines, see M. B. Sobell et al., 1998; M. B. Sobell & Sobell, 1993). Based on L. C. Sobell et al.’s (1996) research on natural recovery, GSC attempts to stimulate the individual’s own natural recovery and self-change process. The treatment uses what has become known as a motivational interviewing (MI) style of client-therapist interaction (Miller & Rollnick, 2002). MI style can be described as a directive and
client-centered counseling style that is designed to enhance motivation for change in addictive behaviors, blending principles drawn from motivational psychology, client-centered therapy (Rogers, 1959), and the processes of change in natural recovery from addiction (Prochaska & DiClemente, 1982, 1986). Client motivation is viewed as a fluid state that ebbs and flows during treatment and can be influenced through interaction with the therapist. Ambivalence is considered normal, constituting an important obstacle to creating and maintaining change, which can be resolved through a flexible alliance between client and therapist. In this way, the MI style is especially useful in delivering the GSC therapy in a manner tailored to clients’ fluctuating motivational state as they move through treatment. A therapist using the MI style partners with the client through the principles of empathic listening, rolling with resistance instead of attacking the resistance, heightening the awareness of discrepancies between behavior and goals, and supporting self-efficacy and optimism. This treatment process works to increase addicted clients’ motivation to change and encourage use of individual strengths and resources to help solve problems.

GSC embraces a harm-reduction perspective for the treatment of addictive behaviors. Within this perspective, an overarching goal is to decrease the damage caused by the behavior without necessarily requiring complete abstinence. Commitment and motivation to create change that reduces harm are more important than the specific goal (Marlatt, 1998). Flexibility in this approach allows the treatment to be tailored to individual’s needs and expectations. Consistent with Bandura and Cervone’s (1986) social cognitive theory and evidence that people active in their own decision-making processes will perform better, the GSC approach encourages clients’ involvement in determining and enacting their own goals for change. In fact, programs that require abstinence may actually deter prospective participants (M. B. Sobell & Sobell, 1993). As such, GSC offers an alternative that may appeal to some individuals.

The guided self-change for gambling (GSCG) treatment was developed using the GSC treatment for alcohol abuse as a foundation. Modifications to the program were made to address differences between gambling and substance use that have been identified in the literature (Herscovitch, 1999; National Research Council, 1999). Specifically, the assessment battery was modified to include a thorough assessment of gambling behaviors, the feedback process was geared toward those gambling behaviors, and the analysis of antecedents and consequences was expanded to focus on gambling-related cognitive distortions (Ladouceur, Sylvain, Letarte, Giroux, & Jacques, 1998) and gambling-related financial problems (D. A. Abbott, Cramer, & Sherrets, 1995). The present case study is an exploration of the effectiveness of the GSCG program in treating an individual who met diagnostic criteria for pathological gambling.

### 2 Case Introduction

This case describes the treatment of Joel, a 36-year-old Caucasian male who was married for 7 years and had an 18-month-old son. He had an MBA in marketing and worked as a salesman with responsibility for a wide geographic region. His job kept him on the road for much of the week and provided the opportunity to gamble. Joel gambled primarily on sporting events but also enjoyed playing blackjack when his travels took him near a casino. Joel also liked to consume alcohol while he gambled.
3 Presenting Complaints

Joel reported that he was experiencing a variety of financial, relational, and personal problems related to his gambling. He stated that he had lost a substantial amount of money because of his wagering and as a result was having difficulties paying his bills. Because of his losses, Joel and his family had to move in with his wife’s parents until they could develop greater financial stability.

Joel also reported that he was concerned about his relationship with his wife, especially following the birth of their son. He had kept the extent of his gambling hidden from his wife and as a result felt guilt and disappointment. He was concerned that the gambling was beginning to erode what had previously been a very positive and supportive relationship. Joel further described feeling increasingly worried and anxious about his gambling and was spending more and more time thinking about gambling. This resulted in periodic difficulties focusing on his job and failing to complete his work to his own satisfaction. Joel felt that this constant state of worry was taking a toll on his health.

4 History

Joel recalled as a youth when he saw his father gambling regularly on sporting events, although he did not remember him ever specifically discussing gambling with him. His perception growing up was that gambling and sports went hand in hand. Joel began placing bets on sports during his senior year of college, learning by watching his fraternity brothers gamble. Initially, Joel played for the comradery and excitement. His bets were small, took little of his time, and never caused any concern. However, during the past 10 years, he steadily increased the time and money spent gambling. Joel stated that he had probably lost $100,000 gambling during his lifetime. Before entering treatment, Joel had never tried to stop gambling, although he made several failed attempts to limit his wagering. He also noted that family and job demands had periodically made gambling impossible for 3- or 4-month periods.

Joel primarily bet on sports but occasionally played blackjack in the casinos. He also reported betting intermittently while playing golf. A typical gambling session for Joel involved a day of sports betting, usually on NFL football when it was in season but also on other sporting events during the year. He would spend the preceding week reading about upcoming games and preparing his bets. On Sunday, he studied the newspaper and finalized his strategy for the day. He would then call his bookie and place a series of bets totaling $500 to $1,000. The remainder of the day was spent watching games, sometimes with a group of friends. He reported drinking heavily during these episodes. Although he set financial limits, Joel was rarely able to keep to these limits and engaged in what is called “chasing” (gambling more frequently or with more money to try to recover his losses). Joel stated that he got “pumped-up” while gambling, that it was exciting, “a rush,” and that he enjoyed the competition. Joel seemed proud that he had earned a reputation among his friends as a successful gambler and that he was the one to seek out for betting advice. Joel reported, “Sunday mornings I’d get dozens of phone calls looking for tips on the day’s games and it felt great.” This appeared to reinforce his positive view of himself as a gambler and
validate his gambling activities. Joel also expressed some apprehension that changing his gambling might lead to losing his group of friends.

Joel reported that his health had suffered because of his gambling. He felt he was more tense and anxious, had less energy, suffered from headaches, and often had difficulty sleeping. He also stated that because of the time spent either preparing to gamble or actually gambling, he was exercising less and eating more poorly than he would have liked. Joel had no major past or present physical problems and reported that he went to the doctor for yearly checkups. Joel indicated that 3 years ago he sought treatment for what he described as a chronic inability to maintain attention. At that time Joel was given a diagnosis of attention deficit/hyperactivity disorder (ADHD). Joel has taken medication for this ever since, and he stated that the ADHD was greatly improved and rarely a concern.

5 Assessment

Completed during the first treatment session, assessment included a semistructured interview to collect a gambling history and basic demographic information and a series of self-report and behavioral assessment instruments. The instruments were chosen for their ability to identify and monitor target behaviors, provide insight to inform treatment, and evaluate treatment effects. These fell into four categories: diagnostic, gambling behaviors, mediators of change, and contextual factors.

Diagnostic evaluation. As the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987) is known to overidentify pathological gamblers (Cox, Enns, & Michaud, 2004) and the DSM-IV subscale of the Massachusetts Adolescent Gambling Screen (MAGS; Shaffer, LaBrie, Scanlan, & Cummings, 1994) is known to underidentify pathological gamblers (Weinstock, Whelan, Meyers, & McCausland, 2005), both were used to assess diagnostic status. Joel’s score of 10 on the SOGS indicated that his gambling symptoms were consistent with the pathological gambling diagnosis. This was supported by Joel’s score of 6 on the DSM-IV subscale of the MAGS. The research on this measure supports that those scoring above 4 meet diagnostic criteria.

Gambling behaviors. To assess gambling behavior, Joel completed the Gambling Timeline Followback (G-TLFB; Weinstock, Whelan, & Meyers, 2004). The G-TLFB is an individually administered calendar, with U.S. holidays noted, in which participants retrospectively report their gambling behavior for the past 6-months. Information collected on the calendar includes frequency, type of game played, duration, intent, risk, win or loss, and number of standard alcoholic drinks consumed while gambling. Timeline followback (TLFB) is a widely used behavioral assessment methodology with a long history in assessing drinking behaviors (M. B. Sobell & Sobell, 2000). The advantage of the TLFB method lies in collecting information on specific behaviors without relying on individual interpretation of the behavior. Although some bias may exist in the assessment of behaviors, the G-TLFB has been shown to be highly consistent with collateral report (e.g., Hodgins & Makarchuk, 2003). Instructions for the G-TLFB encouraged the use of recall strategies such as recording key dates (e.g., birthdays, anniversaries, paydays), periods of black and
white days (i.e., heavy gambling periods and abstinent periods), and patterned gambling (e.g., regular Thursday afternoon trips to casino with friends, weekly lottery ticket purchases). Use of appointment books as memory aids, if the participant had them, was encouraged. Several examples were provided, and then the experimenter assisted the participant in recording the most recent gambling episode on the G-TLFB. During the past 6 months, Joel had gambled 63 times, spending 168 hours and wagering more than $67,000. This information was later provided to Joel in the form of personalized feedback in the second session of treatment.

Mediators of change. As motivating self-change is the foundation of this treatment approach, it is important to assess factors that influence the client’s abilities to change. The Gamblers’ Beliefs Questionnaire (GBQ; Steenbergh, Meyers, May, & Whelan, 2002) is a 21-item self-report instrument that measures gamblers’ cognitive distortions. Joel’s score indicated a moderate level of gambling-related irrational thinking. He described a number of gambling-related cognitive distortions including chasing behaviors and illusions of control over the outcome of the game that influenced the manner in which he gambled. The Gambling Self-Efficacy Questionnaire (GSEQ; May, Whelan, Steenbergh, & Meyers, 2003) is a 16-question self-report instrument that assesses perceived self-efficacy to control gambling behavior in a variety of high-risk situations. Joel’s score of 80 indicated a moderate level of self-efficacy to control his gambling. The therapist later used this information to help identify triggers for gambling episodes and potential high-risk situations. To assess readiness for change, Joel was provided a Stages of Change questionnaire (Prochaska & DiClemente, 1986) adapted for gambling. Joel indicated he was in the action stage and thus was determined to change his gambling behaviors.

Contextual factors. The Dyadic Adjustment Scale (DAS; Spanier, 1976) was provided to assess Joel’s feelings about his relationship with his spouse. His 114 score on this instrument revealed that Joel was generally happy with his marital relationship and committed to making it work. Lastly, Joel completed the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993) and scored 10, indicating that he was likely to experience problems from drinking if he continued to drink at current levels. It was noted from the G-TLFB that Joel frequently drank while gambling, and thus alcohol may have played a role in maintaining his gambling.

6 Case Conceptualization

The therapist conceptualized Joel’s gambling problems within the GSCG framework. This intervention is designed to be applicable to the majority of clients who present with gambling problems and, through use of the MI style, flexible to the needs of the individual. By presenting individualized feedback of assessment information, allowing the client to set and revisit treatment goals at each session, and working toward identifying and developing discrepancies between current and preferred behavior, the intervention is adapted specifically to the client. Treatment focuses on stimulating self-change through the analysis of the pros and cons of change, functional analysis of problem gambling, and problem-solving.
activities to guide replacement of gambling with alternative behaviors. This model assumes that clients possess different levels of motivation to both enter into and be engaged in treatment, and an important component of the intervention is helping clients resolve evolving ambivalence as change occurs.

Joel’s decision to enter treatment came after a significant loss playing casino blackjack. This loss made Joel “question what he was doing with his life.” He was particularly concerned about the negative effect that gambling may have had on his relationship with his wife and son. But Joel had also begun to notice that gambling was affecting his work, financial situation, and health. From the initial intake interview and assessment materials, the therapist concluded that Joel was motivated to receive treatment and attend therapy sessions but simultaneously unsure that he could enact the changes he voiced. Joel’s extensive history of gambling made him both dubious that he could reduce gambling and uncertain that this was what he actually wanted. For example, on one hand, Joel was beginning to question the role of gambling within his life, in particular wondering how he could maintain his gambling while “trying to be a good father.” On the other hand, Joel was reluctant to give up gambling as it served as an escape from the stresses in his life and provided the “rush” he valued. Also of concern was the fact that Joel was often in high-risk gambling situations, either with friends who gambled or in casinos when he traveled on business. At the same time, Joel was clearly competent and appeared to be a dedicated and hard worker. He was deeply concerned about improving his relationship with his family and recognized them as being a valuable means of support. The therapist concluded that for Joel to be successful in modifying his gambling, he needed to increase his sense of self-efficacy to control his gambling and his motivation to make the changes desired.

The GSCG treatment uses a number of strategies to encourage behavioral change beginning with asking clients to identify discrepancies between their current behavior and their desired behavior. Individuals often realize that their gambling results in negative consequences but do not have a perspective on the lasting effects. To help identify discrepancies, the client may be asked to identify the positive aspects of gambling, a question many never fully consider. This is intended to help the client recognize that there are attributes of gambling that are valued and that would likely be missed when removed. This is then balanced by asking the client to describe negative aspects of gambling. By voicing discrepancies between the positive and negative sides of gambling, the client is stimulated to recognize his or her state of ambivalence. Once in this state, the client can often better visualize the discrepancy between current and ideal behavior. Thus, clients begin treatment with a running start toward evaluating their gambling and potentially seeing the value of change in their life (M. B. Sobell & Sobell, 1993).

The next step in enhancing client motivation is presenting information obtained in the assessment phase to the client in the form of individualized feedback. This is unique in that it is often the first time that clients see the intensity of their gambling behavior and how it relates to other aspects of their lives. This is not intended to make clients feel guilty about past behaviors but to help them make an informed decision regarding their gambling. Presented in a factual and nonjudgmental manner, the therapist hopes to gently lead clients to understand the discrepancies between their behaviors, thus helping them become increasingly motivated. Once clients begin to evaluate the role of gambling in their lives, they are asked to develop a specific goal for treatment. In identifying their own goals, the
clients become involved in the treatment process and in enacting change. As changes in goals are likely to occur during treatment (Adamson & Sellman, 2001; Hodgins, Currie, & el-Guebaly, 2001), the clients are asked each week to reconsider their goals.

To help promote movement toward implementing change, clients are asked to complete a functional analysis of gambling episodes. The therapist asks the clients to carefully detail and review situations that have triggered gambling and then to examine specific long- and short-term consequences of the behaviors. The role of irrational thoughts, especially illusion of control, must be considered here. The clients are also encouraged to generate options for potential alternative behaviors. This problem-solving exercise is intended to help foster a sense of self-efficacy in the clients’ ability to change gambling behaviors. Here the clients are also learning new skills for replacing and implementing behavior change.

The therapist anticipated that this aspect of treatment might be particularly difficult for Joel as the majority of his gambling was around sports, one of his passions in life. As such, the therapist knew it was particularly important to be alert for alternative behaviors that might be effective options for Joel.

A final step in promoting and maintaining motivation and self-efficacy is preparing the clients for potential relapse. The clients describe potential high-risk situations that they may encounter and, using the skills they have learned in previous sessions, develop strategies for handling these situations. Second, the clients are presented with the Marlatt’s (1985) concept of the abstinence violation effect (AVE). The AVE takes place after a slip or lapse by the client which is then interpreted as a personal failure and loss of control. This interpretation typically leads to a resumption of the undesirable behavior. The client is encouraged to manage the AVE by (a) interrupting relapses as soon as possible, (b) evaluating relapses as potential learning experiences, and (c) not attributing relapses to personal failures but instead to situational factors that can be addressed successfully in the future. As Joel reported several 1- to 3-month periods of abstinence from gambling in his history, the therapist was concerned about his potential for relapse and planned to address this accordingly.

7 Course of Treatment and Assessment of Progress

Joel was treated using the five-phase GSCG treatment protocol in which participants carefully examine their gambling, make choices about change, set treatment goals, and then implement a problem-solving strategy based on a functional analysis to realize the goals that they set. Throughout all phases of the intervention, a MI style is used to maximize the client’s motivation and sense of self-efficacy. Homework assignments help reinforce the focus of each session and promote preparation for the upcoming session. GSCG treatment is designed to be delivered in five weekly sessions, but the phases can be delivered over an extended period if necessary. Missed and rescheduled appointments are seen as reflections of ambivalence, and the therapist’s response is to help the client generate motivation. The initial assessment session was 2 hours long, and all other sessions were approximately 1 hour in length. At the beginning of each session, the therapist assessed Joel’s mood and queried him regarding his ability to maintain his treatment goal. If relevant, the therapist collected information about gambling episodes since the past session, including triggers, thoughts prior to gambling, and money and time spent during each episode.
Session 1—Assessment. Joel completed the assessment battery and brief semistructured interview previously described. The therapist then asked him to complete a brief decisional balance exercise, identifying the positives and negatives of gambling. Within this exercise, Joel began to gain awareness of his gambling behavior and identify the reasons behind maintenance of these behaviors. He identified a number of positive reasons for gambling including feelings of thrill and excitement, immediate stress release and escape, being challenged, and having the opportunity to spend time with friends. He also identified negative consequences such as increased stress and worry, fights with his wife, loss of money, health problems, and disappointment in himself. At the end of the session, the therapist presented Joel with two homework assignments. The first was a reading intended to help the client understand and manage potential slips and lapses in a more productive manner. Joel was encouraged to approach lapses as opportunities to learn from his mistakes. The second homework was a more extensive decisional balance exercise for Joel to complete between sessions that required careful consideration of the pros and cons of modifying his gambling behavior. At the close of the session, he was encouraged to think about the information provided and was given an explanation of how this information would be used in future sessions. Joel stated that he wanted to abstain from gambling until the next session. Within this and the next session, the therapist attempted to increase Joel’s motivation for change by identifying from the interview and assessment information discrepancies between his current and ideal behavior. Between the two sessions, the therapist examined the results from the assessment and prepared the personalized feedback packet.

Session 2—Feedback. Joel had not gambled since the last session, and he was upbeat about having abstained. However, he expressed concern about several strong urges to bet on sporting events he had watched on television. Joel remarked, “I’m not sure I’ll be able to resist betting when the playoffs start. It was hard enough already!” Staying within his goal and managing urges were always viewed as opportunities to increase his self-efficacy through praise and motivating statements (e.g., “Sounds like you did a great job resisting those temptations!”). After discussing events of the past week, Joel was provided with individualized feedback based on the information obtained during the assessment phase. This personalized feedback was intended to help him recognize his high-risk behavior and to evaluate the extent gambling had affected his life. A key element to this feedback phase is the use of information from the 6-month G-TLFB to create a very detailed picture of the individual’s recent gambling patterns. This includes descriptions and illustrations of amounts intended to wager, amounts actually wagered, time spent gambling, weekly and monthly gambling patterns, and normative information. Table 1 provides a summary of Joel’s personalized feedback form. This information was framed with questions that Joe was asked to consider, for example, in regard to time spent gambling, “What are some other things that you could have done with that time? Does the amount of time you spent gambling as compared to doing other things reflect your priorities? What is important to you?” This information provided the therapist with the opportunity to contrast Joel’s previous gambling behavior with his current goals and priorities and help motivate him to move toward these goals. The therapist would frequently revisit this in subsequent sessions, asking Joel to consider if his gambling choices were consistent with his goals. In response to the feedback, Joel described feeling overwhelmed and stated that “he felt nauseous.” Joel
continued, “I’ve never really realized the extent of time and money that I’ve been spending on gambling. This just makes it seem so much more real.”

With this feedback in mind, Joel was then asked to declare a treatment outcome goal of abstinence or moderated gambling. Joel formulated a moderation goal for his gambling in which he would stop all casino gambling and all sports betting except for the occasional small

<table>
<thead>
<tr>
<th>Measured Gambling Behavior</th>
<th>Text Presented to Client</th>
<th>Questions Presented to Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount intended to gamble over 6-month period</td>
<td>Over the course of 6 months, you gambled 65 times and intended to wager $33,000. This is approximately 46% of your total reported income for this period.</td>
<td>What are some other things that you could have done with your money?</td>
</tr>
<tr>
<td>Amount actually wagered over 6-month period</td>
<td>Over the course of 6 months, you gambled 65 times and actually wagered $68,640. This is approximately 95% of your total reported income for this period. Over the past 6 months, you wagered $35,640 more than you intended. You wagered what you intended on 34 of 65 gambling episodes during the past 6 months.</td>
<td>Compare the amount you intended to gamble with the money you actually risked gambling. What are your impressions of this comparison?</td>
</tr>
<tr>
<td>Time spent gambling over 6-month period</td>
<td>Over the past 6 months, you have gambled approximately 168 hours, which translates into 7 days.</td>
<td>What are some other things that you could have done with that time? Does the amount of time you spent gambling as compared to doing other things reflect your priorities? What's important to you?</td>
</tr>
<tr>
<td>Amount won or lost gambling over 6-month period</td>
<td>Your gambling losses for the past 6 months totaled approximately $17,420, which translates into approximately 96% of your total reported income for this period. If you had a job paying just $7 an hour, you would have earned $1,176. Instead, you lost $104 per hour gambling.</td>
<td>You told me about priorities. Does the way you spend money reflect your priorities in life? If someone were to view how you spent your money, would they get an accurate picture of those priorities?</td>
</tr>
<tr>
<td>Where does your gambling fit in?</td>
<td>You scored 10 out of possible 20 points on the South Oaks Gambling Screen. A score of 5 or greater is indicative of a potential pathological gambler. A pathological gambling is someone who can experience serious problems from gambling.</td>
<td>About 1% of the adult population scores 5 or above. What do you think about this?</td>
</tr>
</tbody>
</table>
bets he placed when he played golf. Joel limited his golf bets to twice a month and $5 a game. Initially, this seemed potentially problematic, and the therapist asked Joel to consider how well this fit into his goals and priorities. Joel felt that gambling on golf was different from his other gambling as he had always played for fun and had never bet out of control. At the conclusion of the session, Joel was provided with a homework assignment to complete before the next session. In this assignment, Joel was asked to conduct a functional analysis of his gambling episodes to identify antecedents and resulting short- and long-term consequences.

Session 3—Triggers and consequences. At the beginning of this session, Joel reported that he had gambled while playing golf, wagering a total of $5 since the previous session. He noted that aside from this, he had few urges to gamble even while watching sports. The therapist then inquired as to whether the goal that Joel had formally established in the last session was still valid or if it needed to be modified. Joel remained comfortable with his moderation goal. Reconsidering and revisiting treatment goals helps the client realize he or she is responsible for the change process and that it may evolve over time as needed. Joel was next asked to present the functional analysis of his problematic gambling situations that he had worked through for the week’s homework. The purpose of this exercise was to help Joel identify antecedents and consequences of problematic gambling episodes to understand the function of gambling in his life and to develop strategies for identifying high-risk situations. Joel reported five antecedents that had led to gambling: a need for stimulation and desire to compete, getting into arguments with his wife, receiving phone calls for gambling advice, drinking alcohol, and socializing with a group of friends who spent a lot of time gambling. He then described short- and long-term consequences of these behaviors. Short-term consequences included being able to escape from stresses in his life, a feeling of excitement and thrill in the moment, and being admired by his friends. Long-term consequences involved losing the respect of others, causing financial stress for his family, and damage to his relationship with his wife. The therapist explored this information at length with Joel to develop a thorough understanding of the situations, cognitions and behaviors that maintained Joel’s gambling, and inhibited changes in his gambling. At the end of the session, Joel was provided with the homework assignment for the next session. Joel was asked to take the antecedents he had identified in the previous homework and develop a list of three alternatives for each. He was then asked to describe the likely consequences of these actions.

Session 4—Alternatives. Once again, Joel reported wagering while playing golf but staying within his limits. Joel was positive about his progress, stating that he felt like he was beginning to see the benefits of reducing his gambling. These included feeling more financially secure, getting more work done, and having significantly fewer arguments with his wife. Joel also reported still feeling comfortable with his goal statement. The fourth session involved identifying and implementing alternatives to problematic gambling. Joel was encouraged to identify beneficial alternatives for responding to his identified antecedents of problematic gambling and to develop and initiate detailed plans for implementing these alternatives. By identifying high-risk situations and then creating alternatives when these situations arise, the client learns to use personal strengths and resources to develop alternatives and, hopefully, learns to manage future problem situations. Joel described alternatives to his need for excitement and stimulation such as working out, playing sports with his friends, and spending time with his family and young son. The therapist discussed plans for implementing
these alternatives. Joel recognized that these alternatives were unlikely to provide the same level of intense stimulation as gambling but believed that these would be acceptable alternatives. At the conclusion of the session, he was provided with the homework for the final session, which asked him to identify potential high-risk situations and develop plans for handling these situations.

Session 5—Relapse prevention. Joel arrived to this session in positive spirits, eager to describe the events since his previous appointment. He related having been able to maintain his goal despite a weekend trip out of town to a bachelor party during which he and his friends visited several casinos. Joel described having had no urges to gamble while he was there. “It felt great, I was able to stand there and watch my friends playing without wanting to join in myself,” Joel remarked. The therapist then asked, “Really? You didn’t want to gamble at all? How were you able to do that?” Joel continued, “Well, I just kept thinking that I’d have to tell my wife that I had gambled . . . . I’d probably lose all my money . . . . I’d really let myself down . . . . It just wasn’t worth it.” The therapist continued, “So despite this trigger, your thoughts were on the long-term consequences?” “Yeah, I just couldn’t help thinking that I’ve come too far to quit now,” Joel stated. The therapist then used this as an opportunity to discuss whether or not the alternative behaviors developed in the previous session had worked for Joel. He stated that he had been able to practice his alternatives (especially spending more time with his wife and son) and that he did not need to come up with additional ones.

The session continued focusing on helping Joel maintain the gains he had seen through treatment by preparing him for potential relapse. In this session, two components of relapse prevention were presented. The first is identification of high-risk situations in which the client might be prone to relapse and the development of plans to deal with these situations based on the information and skills obtained in previous sessions. The second is a review of the AVE, originally presented in the first homework. The client is encouraged to recognize that lapses may occur, and, although unfortunate, they are opportunities to learn.

In his homework, Joel identified two future high-risk situations and developed plans for managing these situations. He was particularly concerned about the upcoming Super Bowl and planned to minimize the risk by enjoying the game with family and friends who do not gamble. He also felt it was important to clarify to his wife that this may be a difficult time and that he might need her assistance. The second situation Joel identified was being around his “old gambling buddies.” He decided the best way to address this was to relate his concerns about gambling and limit his contact with this group. The therapist then presented the AVE with the client and discussed how he might interpret a potential slip. Joel was encouraged to use the knowledge and skills developed during sessions to manage upcoming situations in a positive manner. Joel was scheduled to come back for follow-up and booster sessions at 1- and 6-month intervals.

8 Complicating Factors

Joel unexpectedly canceled and rescheduled several sessions early in treatment, reporting that he was out of town on business. This generated some concern that his motivation
to complete treatment may have decreased or that he was ambivalent to change. When Joel did return, the therapist responded to this concern for potential dropout by encouraging his self-efficacy and optimism by highlighting the positive steps he had taken. This was also an opportunity to inquire about barriers to change that had not been recognized and to make provisions for these barriers if found.

A second complication was Joel’s desire to continue betting while playing golf. Although his self-determined treatment goal stated that he would greatly restrict this betting, it was initially unclear how well Joel would be able to maintain this goal after cutting out all other forms of gambling. There was concern that he could begin betting more and more on golf as a substitute for his other forms of gambling. Thus, it was important for the therapist to understand the role that this gambling had for the client. It became apparent to the therapist and client that the landscape of sports betting was quite different from that of betting while playing golf. Specifically, the client had to physically perform while playing, he was already doing something he greatly enjoyed, alcohol was not involved, and he had a history of maintaining control in this environment. This was an example of how specific goal statements aided in helping the client better conceptualize his self-determined treatment objective and enabled him to track the changes that had occurred. In the end, this appeared to help bolster Joel’s self-confidence as he was able to maintain a goal of controlled gambling in the golf setting while eliminating gambling in all other settings.

9 Follow-Up

The client was contacted to participate in relapse prevention booster sessions at 1-month and 6-month intervals. During these sessions, he completed a packet of self-report instruments that included the G-TLFB, GBQ, GSEQ, AUDIT, and DAS and versions of the SOGS and MAGS DSM-IV subscale modified to reflect a 6-month follow-up period instead of lifetime. At follow-up, gambling behaviors since the previous session were reviewed and discussed, positive changes realized since beginning treatment were emphasized to promote self-efficacy and motivation, and relapse prevention was revisited. Notable decreases were observed in Joel’s gambling behavior (see Table 2). At 1-month follow-up, Joel no longer met criteria for pathological gambling according to scores on the SOGS and MAGS DSM-IV subscale instruments. Joel’s gambling was reduced from 10.5 episodes a month to a single episode. He also went from gambling 28 hours and risking $11,307 a month to less than $2 and less than 1 hour a month. He also showed reductions in gambling-related cognitive distortions, increased confidence in his ability to control gambling, and higher satisfaction with his marital relationship. These reductions were maintained and, in most cases, improved at 6-month follow-up.

During the 6 months following treatment, Joel experienced few if any of the symptoms that had previously caused intense distress in his life. He reported decreased stress, increased satisfaction in his relationships, and a more hopeful outlook. Joel stated that he rarely argued with his wife and relished the time he was able to spend with his son. He was also performing much more effectively at work and was in line for a promotion. Joel had been presented with a number of high-risk situations during this time and had been successful
in controlling his gambling. This had a dramatic positive impact on his self-confidence. Joel also reported that he felt he had been drinking less since beginning treatment, although this reduction was never a specific goal of treatment. This was echoed in a slightly lower score on the AUDIT. It is worth noting that Joel maintained his treatment goal of moderation during the 6-month period and at follow-up and remained confident that he would keep up his moderated gambling goal.

### 10 Treatment Implications of the Case

This case study illustrates the potential efficacy of the GSCG approach in treating pathological gambling. Principles of GSC (M. B. Sobell & Sobell, 1998) appear to facilitate immediate and long-term change in pathological gamblers in a brief treatment intervention. Joel was able to decrease his gambling behaviors and meaningfully reduce the symptoms that were causing distress in his life. Joel also experienced an increased sense of self-efficacy, an improved relationship with his wife, and a decrease in alcohol consumption. He reported that he had learned problem-solving skills for approaching difficulties within his life and felt confident in his abilities to generate alternative behaviors using these skills.

This case also demonstrates that a controlled gambling or moderation goal is a feasible alternative to abstinence. In this situation, the client appeared to benefit from the flexibility allowed by choosing his own goal for treatment. Although the client responded to treatment as expected based on the theoretical approach of GSCG, we do not fully understand the changes observed in gambling behaviors. We cannot rule out the contribution of other therapeutic or historic variables or specifically identify the extent to which treatment components affected the outcome. A longer follow-up period will be necessary to determine if the effects of the treatment are long lasting.

### Table 2

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Pretreatment</th>
<th>1-Month Follow-Up</th>
<th>6-Month Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOGS</td>
<td>10</td>
<td>—^a</td>
<td>2^b</td>
</tr>
<tr>
<td>MAGS–DSM-IV subscale</td>
<td>6</td>
<td>—^a</td>
<td>0^b</td>
</tr>
<tr>
<td>AUDIT</td>
<td>8</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>GBQ</td>
<td>45</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>GSEQ</td>
<td>80.00</td>
<td>86.25</td>
<td>93.75</td>
</tr>
<tr>
<td>DAS</td>
<td>114</td>
<td>115</td>
<td>120</td>
</tr>
<tr>
<td>Number of gambling episodes per month</td>
<td>21</td>
<td>2</td>
<td>&lt; 2</td>
</tr>
<tr>
<td>Total amount wagered per month</td>
<td>$11,307.00</td>
<td>$10.00</td>
<td>$1.50</td>
</tr>
<tr>
<td>Time spent gambling per month</td>
<td>168 hours</td>
<td>1 hour</td>
<td>&lt; 1 hour</td>
</tr>
</tbody>
</table>

Note: SOGS = South Oaks Gambling Screen; MAGS–DSM-IV subscale = Massachusetts Adolescent Gambling Screen–DSM-IV subscale; AUDIT = Alcohol Use Disorders Identification Test; GBQ = Gamblers’ Beliefs Questionnaire; GSEQ = Gambling Self-Efficacy Questionnaire; DAS = Dyadic Adjustment Scale.

a. SOGS and MAGS DSM-IV are not given at 1-month follow-up.

b. SOGS and MAGS DSM-IV subscale instruments were modified to reflect previous 6-month gambling behaviors.
11 Recommendations to Clinicians and Students

Knowing that pathological gamblers are prone to drop out of treatment and often display low levels of motivation for maintaining treatment, clinicians and students should consider the qualities of GSCG that may help to counter these potential obstructions. Within the GSCG approach, motivation is viewed as a dynamic state that therapists can manipulate to help move clients from a state of ambivalence to a point where they are ready to change. Using the MI principles of empathic listening, rolling with resistance, creating discrepancies, and supporting self-efficacy and the exercises from the GSC treatment, the therapist attempts to encourage clients to recognize a personal desire to implement change and their ability to create change from within. Thus, clients become empowered to explore and resolve their ambivalence without encountering resistance from the therapist. Changing motivational states is aided by allowing individuals to select their own goals and being active in the decision-making process. Finally, adopting a harm-reduction approach in which the goal is to minimize harm to the individual without necessarily requiring abstinence permits flexibility within treatment, which may alleviate initial resistance to change and help prevent attrition. Ideally, these motivational qualities provide an atmosphere in which clients are encouraged and rewarded for their efforts.

References


**Damon Lipinski**, MA, is a clinical psychology doctoral student at the University of Memphis. His interests include the assessment and treatment of pathological gambling and comorbid alcohol and gambling problems, the effects of alcohol consumption on gambling behavior, and sport psychology. He also serves as a therapist in the Gambling Clinic.

**James P. Whelan**, PhD, is an associate professor, the director of clinical training at the University of Memphis, and co-director of the Gambling Clinic. His research and clinical interests include the efficacy for psychological treatments, problem gambling and gambling behavior, and sport and exercise psychology.

**Andrew W. Meyers**, PhD, is a professor of psychology and the vice-provost for research at the University of Memphis. He also serves as co-director of the Gambling Clinic. He has published more than 140 publications in the areas of self-regulation, gambling, smoking, eating disorders, exercise, and sport.