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PROBLEM GAMBLING: TREATMENT STRATEGIES AND RATIONALE FOR THE USE OF HYPNOSIS AS A TREATMENT ADJUNCT

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Research into gambling behaviour and its treatment has undergone considerable growth in Australia in recent years with the rapid introduction of many new, highly accessible forms of gambling. The clinical characteristics and prevalence of serious gambling disorders have been investigated and DSM-IV (1994) includes Pathological Gambling as a form of impulse-control disorder. At the same time, relatively little is known about the prevalence of problem gambling in our community. This paper describes what is known about pathological and problem gamblers and discusses treatment strategies for problem gambling. These include imaginal desensitisation and cognitive restructuring, using hypnosis as an adjunct.

The study and treatment of gambling is relatively new in Australia, commencing with the landmark research of Dickerson (1984) and Blaszczynski and his associates (Blaszczynski, 1993; Blaszczynski & McConaghy, 1989, 1992; Blaszczynski, McConaghy, & Frankova, 1991a, 1991b). Research is continuing with the work of the Addiction Research Institute in Victoria (1995) and treatment centres in other states of Australia. This upsurge of interest, research

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research and developments in treatment for problem gambling has developed with the widespread introduction of new forms of gambling in most Australian states in recent years.

The literature on gambling uses different terminology to describe the nature of problem gambling behaviour. Such terms as "addictive" (Dickerson, 1984), "compulsive" (Bergler, 1957), "excessive" (Greenson, 1947), and "problem" (Coman, Burrows, Singer, & Singer, 1996) have been used to describe gambling behaviour that is considered unhealthy for the individual. In this paper, the term "pathological" will be used to describe the gambling characterised by the behaviours and sequelae detailed in the Diagnostic and Statistical Manual of the American Psychiatric Association [APA] (DSM-IV, 1994). The term "problem gambling" will be used to describe problematic gambling behaviour not fitting the criteria in DSM-IV.

Pathological gambling is recognised as a mental disorder by the APA (DSM-IV, 1994), characterised by chronic and irresistible impulses to gamble, with consequent gambling compromises and disruptions to family, personal, and vocational pursuits in at least three of the following:

1. Restlessness and irritability when attempting to cut down or stop gambling.
2. Gambling to escape from problems or relieve depressed mood.
3. Gambling to recover losses from previous gambling episodes.
4. Lying to family members or others to conceal gambling extent.
5. Committing illegal acts such as forgery, fraud, embezzlement, or income tax evasion to obtain money for gambling.
6. Jeopardising family or spouse relationships due to gambling.
7. Jeopardising job, educational, or career opportunities due to gambling.
8. Relying on others to provide money to relieve a desperate financial situation. (DSM-IV, 1994, p. 618)

Problem and pathological gambling can be distinguished from social and professional gambling. Social gambling typically occurs with friends or colleagues and lasts for a limited period of time, with predetermined acceptable losses. In professional gambling, the individual limits risk and operates with firm control over his or her behaviour. The pathological gambler is preoccupied with gambling, thinking about past gambling experiences and planning future activities. The individual seeks action and excitement, but increasingly larger bets are required to produce the desired level of excitement. When restrained from gambling, the individual may become restless and irritable and, over time, social relationships become strained and the individual may resort to antisocial behaviour to gain the funds needed to maintain the long-term chase to regain lost expenditure (DSM-IV, 1994).

We apply the term "pathological gambler" to the individual who engages in chronic gambling behaviour patterns described above. Some individuals can experience problems associated with their gambling behaviour, such as short-

term attempts to regain lost expenditure (called short-term behaviour by DSM-IV [1994]) and loss of control when in a gambling situation. These individuals do not meet the criteria for Pathological Gambling under DSM-IV but may well be considered "problem" gamblers. For treatment purposes, gambling behaviour is conceptualised as a continuum from controlled, through "problem" to the more serious notion of "pathological" gambling.

Pathological gambling has many similarities with addictive behaviour and while there are also similarities between obsessive-compulsive disorder (OCD) and pathological gambling, the latter is characterised by an element of choice not present in addictive disorders and OCD.

The prevalence of pathological gambling in the Australian community has not been clearly established. DSM-IV suggests a prevalence rate of 1–3% of the adult population. The current incidence of problem gambling in Australia is becoming clearer through projects undertaken by the Australian Institute for Gambling Research on a state-by-state basis. Recent research in Victoria conducted on behalf of the Victorian Casino and Gaming Authority (VCGA) suggests that problem gamblers make up 3% of the gambling population (VCGA, 1995) while some clinical experts suggest the percentage of problem gamblers to the adult population is 1% (Allcock, 1996).

The incidence of non-problematic gambling is significantly higher. Blaszczynski (1995) reported that 80–90% of people engage in social gambling, while between 24% and 39% of people engage in regular gambling, depending on the precise definition of the behaviour involved.

Two-thirds of pathological gamblers are male, but the remaining one-third females are seriously under-represented in treatment programmes (DSM-IV, 1994). What is particularly concerning in the Australian context is the relatively recent availability of many different forms of gambling and the potential for their abuse by the general public not educated in the reasonable use of these activities. This is one focus of attention for the Addiction Research Institute, a centre for research and counselling in problem and pathological gambling, whose interests include research into abuse of alcohol, tobacco, prescription, and non-prescription drugs and the range of treatment strategies for such abuse.

Males and females exhibit quite dissimilar gambling characteristics. Males commence gambling behaviour in early adolescence, whereas females commence in their mid-twenties to mid-thirties. Females who gamble are often depressed and gamble to escape. In a survey of gamblers, 24% reported they gamble for money, 46% to relieve boredom and/or depression, and 51% to relieve stress (Blaszczynski, 1995). While some few individuals become hooked on gambling from their first bet, for many there may be years of social gambling followed by an abrupt onset precipitated by greater exposure to gambling sources or a stressor which causes increased gambling behaviour. For many pathological gamblers there is a progression in the frequency of gambling, increases in the amount wagered, and increasing preoccupation with gambling (DSM-IV, 1994).

Despite the attention given to casinos in our capital cities, legal and illegal casinos account for less than 1% of problem gambling. Gambling on horses accounts for nearly 58% of problem gambling, followed by poker machines (32%), video machines (5.5%), and card games (3%) (Blaszczynski, 1995).

It is important to remember that many pathological gamblers have associated symptoms of anxiety and/or depression. Studies show that up to 75% of gamblers seeking help suffer from depression and 61% report suicidal ideation. Over 22% have made actual suicide attempts (Blaszczynski, 1995). Gamblers who focus their attention on low-skill gambling, such as electronic gaming machines, to relieve stress are more likely to be suffering from stress and anxiety. When depressed, gamblers utilise more skilled games to lift their depressed mood, with daydreams of winning. They may also engage in more social forms of gambling, such as card games, to enhance social interaction. Whatever the type of gambling utilised, the practitioner needs to take this into account when assessing the severity of disorder and selecting appropriate treatment strategies.

Gambling abuse may also be associated with alcohol and drug usage, which can act as a trigger for relapse. For example, an individual stops drinking, then goes to a club, gambles, becomes depressed, then relapses into drinking. Conversely, the reformed gambler may drink, the alcohol acts as a dis-inhibitor, so that s/he then relapses into gambling. Both problems need to be addressed simultaneously in treatment.

Together with substance abuse, pathological gambling is also frequently associated with criminal behaviour and personality disorder. In Blaszczynski and McConaghy's (1992) sample of 306 pathological gamblers, 68% admitted to gambling and non-gambling related criminal activity. Fifteen per cent of the sample met the criteria for antisocial personality disorder. DSM-IV (1994) reported similar associated features and disorders and also makes the point that loss of judgment and excessive gambling may characterise a manic episode. A diagnosis of mania would only apply if these manic-like features apply away from the gambling situation. Research has yet to be conducted to determine if such associated personality characteristics apply to problem gambling.

The presence of alcohol abuse, personality disorder, and criminal behaviours in other impulse disorders such as sexual addiction and paraphilias are predictors of poor response to treatment (Blaszczynski, 1993) and their presence needs to be carefully assessed when considering treatment strategies, especially hypnotherapy, for problem and pathological gambling.

AETIOLOGY OF PROBLEM AND PATHOLOGICAL GAMBLING

The aetiology of gambling disorders is not clearly understood. The theories which have been put forward include psychodynamic, behavioural, sociological, and addictive interpretations. A full analysis of these is beyond the scope of this paper.

There is some support for the view that pathological gambling is an addiction, with similar sensations being reported by gamblers to those reported by those using drugs and alcohol (Dickerson, 1984; Horodecki, 1992; Murray, 1993; Schwartz & Lindner, 1992). For this reason, there has been a resultant placement of gambling treatment centres within abuse programmes conducted by drug and alcohol centres (Gambino & Cummings, 1989; Lesieur & Blume, 1991; Shaffer, 1989; Schwartz & Lindner, 1992). One difficulty in determining the causality of pathological gambling is the difficulty of cross-addiction of alcoholism and gambling, making causal relationships hard to determine. As Murray (1993) concludes, we do not know if gamblers can be divided into dichotomous groups of those who are pathological versus those who are not sick and those who lose control as gamblers, compared to those who do not lose control. Many researchers and clinicians are unhappy with the view of pathological gambling as an addiction. Walker (1989), for example, points out that the concept of addiction involves physiological processes that do not appear to be always present in cases of excessive gambling.

There is also some current pharmacological evidence to suggest that pathological gambling may also have a compulsivity dimension, similar to that in obsessive-compulsive disorders (Hollander, Frenkel, Decaria, Trungold, & Stein, 1992). Allcock and Grace (1988) argued that compulsive gamblers are neither impulsive nor sensation-seekers.

The problem of aetiology extends to understanding the nature and causality of problem gambling versus pathological gambling. We do know that the majority of people say they gamble to relieve stress and boredom but this does not explain why some individuals then go on to gamble excessively, to the point where the behaviour becomes problematic (in contrast to pathological). However, we have found one current behavioural interpretation helps us understand many of the phenomena associated with problem gambling; its causality; and treatment. This is McConaghy's Behaviour Completion Mechanism Model (Blaszczynski, 1993; McConaghy, 1980). McConaghy argued that, over time, as an individual gambles, the central nervous system habitualises the behaviour, from initial stimuli-provoking arousal through to completion of the gambling act. When the individual cannot complete the behaviour, either through his or her attempts at control or when prevented externally, the individual experiences noxious tension so aversive as to compel them to indulge in gambling behaviour to relieve the tension. The model has support from the evidence which shows that gamblers' attempts to control their behaviour induce feelings of tension, irritability, and depression, which are reduced when gambling behaviour is initiated. The reduction in physical and emotional tension acts as a negative reinforcer, while the excitement generated by gambling serves as a positive reinforcer. The gambler learns that tension generated by other stressors can be reduced by gambling, so that any negative emotional states of anger, frustration, or anxiety act as cues for further gambling (Blaszczynski, 1993; McConaghy, 1980).

TREATMENT FOR PROBLEM GAMBLING

A range of treatment approaches have been used in the treatment of pathological and problem gambling, often reflecting the aetiological approach of the therapist. Earlier this century, psychodynamic formulations dominated treatment interventions, but since that time, behavioural, cognitive-behavioural, psychopharmacological, and multi-faceted approaches have also been developed. Unfortunately, the treatment literature consists mainly of case study analyses and there have been few, if any, controlled studies reported in the literature. Thus, there is no clear or commonly agreed treatment programme available.

This section does not provide a full description or analysis of treatment approaches for pathological and problem gambling. For such a review, see Blaszczynski (1993), Knapp and Lech (1987), Murray (1993) and Walker (1993). Here we briefly review some current treatment methods that may be appropriate for problem gambling and then suggest an approach to individual treatment based upon the experience of the Addiction Research Institute and treatment centres elsewhere in Australia.

Aversive Treatment

One early form of treatment for pathological gambling was aversive therapy, in which gambling behaviour is paired with an electric shock or other noxious stimuli. There have been a limited number of controlled research studies into the use of such therapy reported in the literature, with most information coming from case studies and anecdotal evidence. A wide variety in actual techniques and schedules of reinforcement makes inter-study comparisons difficult, but Walker (1993) suggests a conservative success rate of about 23%.

The first use of aversive therapy for gambling was reported by Barker and Miller (1966), who treated a 34-year-old male with a 12-year history of excessive slot or poker machine play. They used randomly delivered electric shocks, totalling 672 during four 3-hour sessions of play on a machine set up in a hospital ward. The patient, following therapy, ceased gambling and did not resume play during a two-month follow-up. A number of other cases in which aversive therapy was successfully used were subsequently reported. In some cases, aversive therapy in the natural environment or with an actual machine was not available, so shock therapy was administered while gamblers watched a film of themselves gambling and viewed slides and heard an audio recording of themselves while at a gambling venue. Another strategy used was to pair a film of the client gambling with audio recordings of a spouse and therapist describing the negative consequences of excessive gambling. In some cases, up to 450 shocks were administered in 10 30-minute sessions.

When considering the use of aversive therapy for gambling or any other behavioural disorders, a number of ethical considerations, in addition to those normally present in a therapist/client relationship, must be taken into account.

Clinicians should consult their professional organisations' code of ethics and professional conduct.

Self-Help Organisations

Gamblers Anonymous is the only self-help group which specifically provides a therapeutic regime for pathological and problem gamblers. Established in California in 1957, their treatment is based on the philosophy that pathological gambling is a progressive illness, which can only be arrested, not cured, by total abstinence. The programme utilises a 12-step recovery process, similar to that of Alcoholics Anonymous and relies heavily on sharing of common experiences in a supportive group environment.

Given that the organisation is not involved in systematic data collection determining programme evaluation and success, it is hard to establish the efficacy of the process. In a longitudinal study of Gamblers Anonymous in Britain, Brown (1985, 1987) conducted a retrospective analysis of meeting attendances from a number of GA meetings over a five-year period. Of 232 new members who attended during the period, 22% attended one meeting only and 69% had dropped out after attending fewer than 10 meetings. It is not known how many of these returned to gambling or how many began gambling again at a problem level. Eighteen per cent of new members during the period were still active with GA after two years. While this figure is not high, it should not be surprising, given that continued membership is dependent on total abstinence from gambling and the programme has a high spiritual orientation.

Little is known about which individuals are more likely to benefit from this programme, compared with other treatment modalities. The very limited studies of individuals most likely to gain from contact with Alcoholics Anonymous have suggested AA works most effectively for those individuals with a certain pattern of personal characteristics, including lower educational level and high need for authoritarianism, dependency, and sociability (Feist & Brannon, 1988). Notwithstanding, the limited available data suggest that people who do participate in the GA programme can benefit from the experience (Brown, 1985; Taber, McCormick, Russo, Adkins, & Ramirez, 1987). Anecdotal evidence from callers to G-Line, a telephone counselling and referral service for people affected by problem gambling run by the Addiction Research Institute in Victoria, suggests that many meetings are dominated by men who have long histories of gambling on horse and dog racing. Women report feeling highly uncomfortable attending such meetings and have discontinued attendance after only one session. Gamblers Anonymous will not run separate sessions for men and women, given their charter to provide help to all problem gamblers regardless of personal characteristics. However, the organisation is a dynamic one and groups close when memberships decline in one area and form when demand is generated in other geographic areas. Women callers to G-Line report feeling welcomed and helped by groups in which there is equal representation for men and women, or groups with a majority of women.

Minimal Intervention Programmes

The term "minimal intervention programme" was used by Dickerson, Hinchy, and Legg England (1990) to describe specially written self-help manuals for gamblers. These were designed in the absence of adequate community resources to help pathological and problem gamblers, and were based on the success of such manuals for a variety of problem areas. The manual included training in self-monitoring, analyses of gambling behaviour, goal and limit setting, self-reinforcement, and how to maintain long-term gains. A superficial study of the effectiveness of such an intervention (Dickerson et al., 1990) reported that most users maintained subjectively acceptable reductions in gambling behaviour at six-month follow-up. The Addiction Research Institute has prepared a similar manual (Coman et al., 1996). We have found that manuals of this kind work most effectively with clients who acknowledge their problematic gambling behaviour and who have good self-awareness and motivation to change.

Pharmacological Treatment

Several single and small case studies have reported the use of medication, primarily to block the reinforcing affective component of gambling behaviour.

Lithium carbonate was used by Moskowitz (1980) to treat a small group of three pathological gamblers but the study did not record success or failure over the unspecified follow-up. As indicated earlier, pathological gambling episodes can be symptomatic of a manic episode (DSM- IV, 1994), so it is not clear if the medication is operative for the pathology of gambling or cyclic affective disturbance.

Clomipramine, fluoxetine, and other serotonin re-uptake blockers have been used by several researchers, based on the belief that pathological gambling is related to the impulsivity dimension of obsessive-compulsive disorders, rather than being an addiction (Haller & Hinterhuber, 1994; Hollander et al., 1992). Results suggested a reduction in gambling behaviour over one-month follow-up, but, clearly much more research needs to be done to clarify these data and to determine if long-term reductions also apply. These medications have been used successfully in the treatment of other impulse-control disorders, including sexual paraphilic behaviours (Emmanuel, Lydiard, & Ballenger, 1991), compulsive non-paraphilic sexual addiction (Stein et al., 1992), trichotillomania (Winchel, Jones, Stanley, Molcho, & Stanley, 1992), kleptomania (McElroy, Keck, Pope, & Hudson, 1989), and bulimia (McElroy et al., 1989).

These results do suggest that, among the impulse-control disorders, pathological gambling may have a compulsive dimension comparable to that of obsessive-compulsive disorders.

Cognitive Strategies

Treatment interventions for problem or pathological gambling frequently utilise cognitive strategies, to help clients understand their thoughts in relation to gambling and in restructuring cognitions. A number of specific cognitive techniques can be used.

Cognitive Restructuring Many problem gamblers exhibit irrational beliefs and superstitions about gambling activity. An important focus for any treatment programme, then, should be an analysis of the beliefs and ritualistic behaviours, self-talk and talk to the gambling tool in which the client engages.

Players of card games at casinos can be observed to knock the table when being dealt a card or abide by self-generated rules about doubling, or taking cards. Electronic gaming machine players sometimes have favourite machines. Regardless of whether the machine is a favourite or not, they will often engage in self-talk, such as: "This machine is going to be good to me today" or "I haven't won for a while. I deserve to win today" or "This machine feels lucky to me." Players will also talk to the machine as if it were a person: "Why didn't you pay me that time?" or "Thank you" when a payout is made. Gamblers can also engage in rituals; rituals about the number of coins to insert prior to play; whether to allow credits to accumulate or be returned; the strength of handle pull or button push; and the number of lines or coins played per game. It will be necessary for the therapist to thoroughly examine the gambler's thoughts immediately prior to, during, and after a gambling session.

Once the range of irrational or superstitious beliefs and behaviours have been identified, then cognitive restructuring can occur. This will involve challenging the client to recognise the beliefs and behaviours as irrational and to replace them with ones which are more reasonable. Rational emotive therapy would be a useful tool at this stage.

Imaginal Desensitisation McConaghy and his colleagues have successfully used imaginal desensitisation to treat pathological gambling (McConaghy, Armstrong, Blaszczynski, & Allcock, 1983; McConaghy, Blaszczynski, & Frankova, 1991). Using this procedure, the client undergoes 14 sessions, administered in three 20-minute sessions each day over five days, with each session separated by no more than two hours. The client relaxes in a quiet room, is then given a series of four scenes in which they are stimulated to gamble but do not do so, and asked to visualise themselves performing the behaviour described in the scene. After relaxing for 20 seconds, the client is asked to visualise the next scene in the sequence until the scene is completed. They then blank their mind prior to the next scene being introduced. Two of the four scenes are:

> *You are going home from work and know your wife is away. You decide to go to the club and put a few dollars through the slot machines. You are about to put a coin in, but you feel bored. You leave without gambling.*

You have had a trying day where nothing has gone right for you. You feel tense and angry. On the way home, you decide to drive to the betting shop to place a few bets. As you are walking toward the entrance you start to feel bored with the idea of spending your time gambling. You decide not to enter, but return home to your wife.

The rationale behind this technique lies in the fact that gambling behaviour is associated with high levels of excitement and arousal, causing higher and more aversive levels of tension if not completed when stimulated. Imaginal desensitisation acts by training the client to feel relaxed rather than aroused in response to cues for the compulsive feelings that would normally cause him or her to engage in gambling behaviour. This rationale is reinforced by the finding that, unlike uncontrolled gamblers, the subjects in the Blaszczynski et al. (1991a) study who reported control, or cessation, of gambling at follow-up, showed normal levels of trait anxiety and neuroticism. They had learnt control over their gambling compulsion and the aversive tension normally felt with their previously uncontrolled gambling response.

Thought Stopping Thought stopping is a common technique used by therapists to help clients change their behaviour and is one which may be used to good effect with problem gamblers. Many gamblers report feeling irresistible urges to gamble and describe gambling venues as magnets which draw them in. In therapy, the client is instructed to monitor the impulses to gamble. When a thought regarding gambling is generated, one or more of a variety of thought-stopping techniques or thought-replacement techniques can be instigated. A common thought stopping technique is to flick an elastic band worn around the wrist to stop the gambling thought and then replace the thought with a previously rehearsed alternative.

Behavioural Strategies — In Vivo Desensitisation

When using in vivo desensitisation for the treatment of problem gambling, the therapist accompanies the client to the gambling venue. The client is allowed to experience all the normal stimuli associated with gambling but not allowed to place a bet. The aim is to ensure that the client becomes desensitised to the stimuli and learn that s/he can experience them without gambling. Programmes utilising this technique can involve a concentrated strategy, incorporating daily sessions over seven to ten days (Blaszczynski, 1988) or a more lengthy approach involving a greater number of sessions over a period of months (Greenberg & Rankin, 1982)

An analysis of treatment outcomes for the above programmes suggests that, on its own, in vivo desensitisation is not very effective, with between 10% and 30% of participants reporting abstinence or controlled gambling at follow-up of nine months. Walker (1993) suggested this low success rate applies because full extinction of the gambling behaviour and associated excitement is unlikely to

occur within such a short period of treatment. An over-learned behaviour such as gambling may take months or years of such trials to completely decondition some clients.

AN APPROACH TO TREATMENT FOR PROBLEM GAMBLING

The treatment approach described below has been developed from our experience with problem gamblers treated by the Addiction Research Institute and other centres in Australia.

Desired Treatment Outcome

In determining an approach to treatment, the clinician's first goal is to establish whether controlled gambling or abstinence is the treatment outcome. Much of the available literature in treatment programmes for pathological and problem gambling asserts that abstinence is the desired treatment outcome. This view has developed from the impact of the Gamblers Anonymous approach to treatment, espousing the philosophy that gambling is a disease and that participation in any form of gambling would invariably lead to loss of control and resumption of the individual's pathological habits (Blaszczynski, 1993). The argument that abstinence should be the only appropriate treatment outcome comes also from the view of pathological gambling as a form of addictive behaviour While pathological gambling does share features in common with addictive disorders, its classification as an impulse-control disorder in DSM-IV (1994) does suggest that abstinence as a sine qua non for success in therapy may not be warranted.

We also argue that abstinence as a treatment goal may fail to take into account significant improvement in gambling behaviour and other areas of functioning for the individual receiving treatment. These include:

1. The client stops problem or pathological gambling in its primary form, but continues to participate in other benign gambling behaviours (Blaszczynski, 1993).
2. The client may continue to gamble in a reduced manner in the primary gambling form, but may show significant improvement in other areas. These may include improved social and interpersonal functioning, reduced urge to gamble and consequent reduced frequency of gambling behaviour, and ability to control gambling urges when indulging in gambling activity (Blackman, Simone, & Thoms, 1989; Blaszczynski, 1985; Taber et al., 1987).

For many clients, the possibility of a relapse when the treatment outcome is abstinence, may constitute failure of treatment. This may reduce willingness and motivation to engage in therapy in the first place and will certainly reduce motivation to continue in therapy should a relapse occur. On the other hand, setting controlled gambling as the preferred treatment outcome means that clients may continue to regard themselves as having successfully undertaken

treatment, despite lapses. We find also that the prospect of controlled gambling brings people to therapy much sooner than they might otherwise contemplate, with its desirable goal of helping the individual to control an otherwise unpleasant and intrusive preoccupation. As Blaszczynski (1993) noted, the option of controlled gambling as a treatment outcome of choice also lowers treatment rejection and attrition for gamblers who find complete cessation difficult or unacceptable.

At the commencement of therapy, therefore, it is important to discuss with the client their preferred treatment outcome and to formulate a mutually agreeable objective to treatment before proceeding.

Treatment Approach

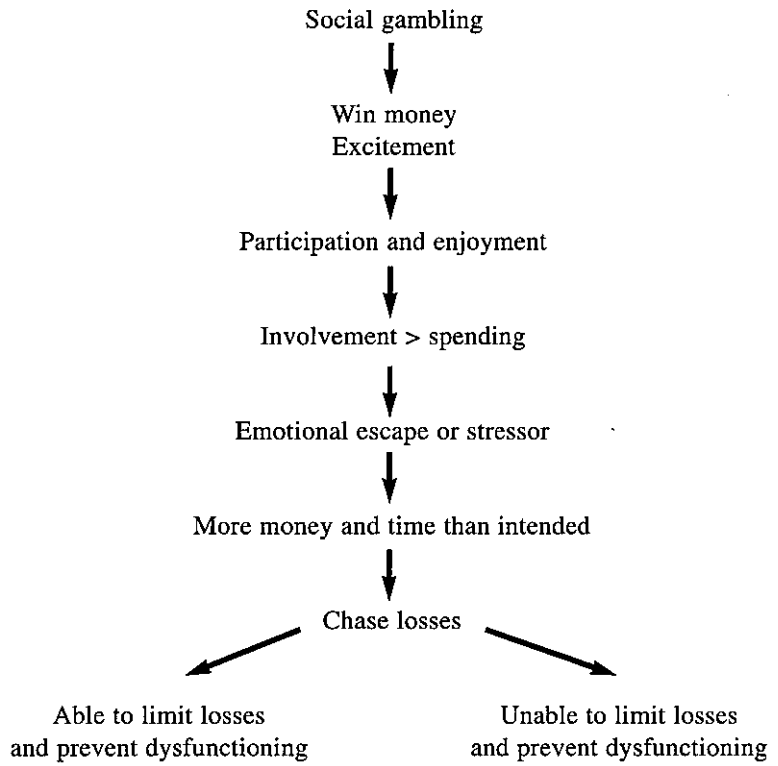
We suggest the following approach to counselling and treatment for problem gambling, using a range of behavioural, cognitive, and possible hypnotherapeutic techniques. It is important to begin with an understanding of the client's motivation for gambling, why social gambling changed to problem gambling, and why the client has presented at this time. Figure 1 suggests how some emotional factor or stressor may cause social gambling to become problematic.

In the first session, it is necessary to establish the client's form(s) of gambling. Check if it is consistently the same form of gambling activity, or if the client utilises several different forms of gambling. Pay particular attention to the client's description of any emotional or stressful events that were experienced immediately prior to the emergence of problem gambling. Blaszczynski (1993) argues that most clients will be unable to clearly separate their transition from controlled to uncontrolled gambling. He suggests this occurs because the client will exhibit denial of the problem in its early stages and the problem behaviour may well have had a gradual onset. Clinicians may find it appropriate to use a standard scale for the assessment of the client's gambling problem, such as the South Oaks Gambling Questionnaire (Lesieur & Blume, 1987).

It is also necessary in the early stages of therapy to assess if the client's gambling problem is related to psychiatric disturbance, criminal activity, personality disorder, or substance abuse. As part of the client's investigation, many clinicians utilise a battery of psychological tests, including measures of anxiety (State-Trait Anxiety Inventory; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), depression (typically the Beck Depression Inventory; Beck, 1993), presenting symptomatology (Symptom Checklist-90; [SCL-90]; Derogatis, 1977), and sensation-seeking behaviour (Zuckerman's Sensation Seeking Scale; Zuckerman, 1978).

In the second session, take a full personal and family history, focusing on the gambling habits of both parents and grandparents of the client. Fully explore the client's alcohol consumption, smoking habit, and use of legal and illicit drugs.

Figure 1 Process of Developing Problem Gambling (after Blaszczynski, 1995)



If any of these are also problems for the client, they need to be treated concurrently with the gambling problem. If the client has entered therapy to offset criminal prosecution, this secondary motivation will interfere with treatment and will reduce motivation to remain in treatment once the threat of criminal prosecution has passed. Treatment for the gambling behaviour should, if practical, not commence until legal action has been completed.

Stress to the client that improvement will be slow, but gradual. Research suggests that it may take up to 10 sessions for any demonstrable improvement in emotional control over gambling impulsivity (Blaszczynski, 1995). The therapist and client need to establish the aim of therapy: whether abstinence or controlled gambling is the desired outcome to treatment. Some clinicians argue strongly that it is important to cut off the gambler's access to all sources of money and to discourage all forms of gambling. However, as we have suggested earlier, the desired treatment outcome may be controlled gambling, rather than complete cessation.

Hypnosis

Hypnosis can be a valuable adjunct to treatment for problem gambling and can be introduced early in therapy. It is vital to assess contra-indications to the use of hypnosis, especially co-existent depression, personality disorder, or criminal intent or activity.

There is practically no reference in research or clinical literature to the use of hypnosis in the treatment of gambling problems. However, our belief that hypnosis should be considered as a part of therapy is based on its proven efficacy in the treatment of compulsive and habit disorders, anxiety disorders, and addictive disorders (Burrows & Dennerstein, 1988; Evans, 1995; Hammond, 1990). There are also many clinical and experimental reports of the use of hypnosis in heightening the efficacy of desensitisation, imagery, cognitive-behavioural, and cognitive therapies (Burrows & Stanley, 1995; Hammond, 1990). Hypnotherapeutic techniques are also useful for ego-strengthening and increasing self-esteem (Stanton, 1993).

Early in therapy, it is appropriate to begin utilising imaginal desensitisation with the client, with or without hypnosis. Earlier, we reported two of the guided imagery scenes used by McConaghy et al. (1991), but these can be varied to suit the particular client. To do this, get the client to outline in detail the steps involved in their gambling behaviour. Break these up into their components. Teach the client progressive muscle relaxation or self-hypnosis. While relaxed or in trance, describe the gambling scenes to the client — asking them to visualise the sensory, cognitive, and emotional states associated with each, while, at the same time, remaining relaxed. Then ask them to change the cognition by, for example, visualising the horse (wheel, cards, etc.) losing, visualising oneself not wanting to bet, throwing the betting slip away, and walking away with money in pocket — still fully relaxed.

It is useful to audiotape the imaginal desensitisation sessions and to ask the client to listen to the tape twice a day, five days a week. The aim of this re-exposure is to help the client visualise the controlled scenes without the tape, a process which can take up to four weeks. At this point in treatment, it is useful to commence cognitive therapy, to challenge the client's beliefs about gambling and to eliminate cognitive distortions that are reinforcing the gambling behaviour.

The most common cognitive distortions gambling clients share are that gambling is financially viable; that one can extract oneself when one wants to; and that the money lost is rightfully theirs, so that gambling should continue until it has been reclaimed. Ask the client to indicate their biggest win when gambling and to estimate their overall loss. Not only will the client have to challenge some of their beliefs, but will also have to accept their losses and other negative outcomes from gambling.

The hypnotic trance can be used to help clients challenge their beliefs, helping the therapist to suggest new, more appropriate beliefs and cognitions.

One suggestion found useful by therapists is that gambling subsidises the club, other people, and the community, and is there as entertainment. Few gamblers like the idea that they are subsidising other people and that, as a form of entertainment for which they pay, they are unlikely to get their money back. Suggest that, the next time they think of gambling, the client should think of benefits going to other people. Another cognitive strategy is to ask the client to calculate the amount of money they invest per day, week, month, and year on gambling. Many clients claim their financial problems are the result of daily living costs, not their gambling behaviour.

As the client develops control over their gambling behaviour, it is necessary to begin helping them substitute new behaviours to replace the gambling. These alternate behaviours should be comparable in excitement to gambling for the client, accessible, and able to be carried out at any time of the day, without anyone else being needed. If the client is married, it may also be appropriate to discuss putting time into relationships with spouse and children.

For those clients who report gambling to relieve boredom, help them to develop new strategies to fill in their time in different ways.

It will also be useful to discuss with the client the likelihood of relapses, depending upon what was set as the goal of therapy earlier in treatment. The therapist should have discussed with the client the fact that improvement may occur in many areas of the client's life, without full abstinence from gambling and that, even if relapses do occur, we know that this does not lead invariably to a resumption in problem or pathological gambling habits (Blaszczynski et al., 1991b). It may also be possible that the client has switched from a previous problem gambling behaviour to other more benign forms of gambling, which will constitute success from treatment.

Treatment programmes have to be tailored to the individual needs of each client. It may also be necessary to develop strategies for other specific factors which have contributed to the gambling problem. These strategies may include:

1. Stimulus control techniques, to help the client effectively avoid or deal with exposure to gambling cues or contact with other gamblers.
2. Stress management techniques, coping skills training, relaxation training, and/or self-hypnosis, to help the client deal with life stresses and their resultant anxiety.
3. Hypnosis to help the client build up their self-esteem, sense of self-worth, and ego-strength. We find that many clients have a negative self-worth as a result of feeling out of control when gambling.
4. Marital therapy to help the client and spouse deal with the loss of trust and increased suspiciousness that may have occurred as a result of the gambling behaviour. There may be anger and resentment on the part of the spouse for the financial strain that gambling may have imposed on the relationship. Many cases of pathological gambling have been associated with physical and emotional abuse of spouse and family, which will also

have to be addressed in therapy.

5. It may be useful to discuss pharmacological adjuncts to treatment. Antidepressants can be useful when the client exhibits dysphoric mood. Serotonin re-uptake inhibitors may also be of assistance in reducing a client's compulsive urge to engage in gambling behaviour.
6. The client may be usefully referred to Gamblers Anonymous, as an ongoing support after therapy has been concluded. As indicated earlier, the research data suggest that GA can be of assistance to help gamblers resist relapses. The gambler's spouse may usefully be referred to Gam-Anon, to help deal not only with the spouse's behaviour, but to understand and deal with their own emotional difficulties.

Treatment of pathological gambling is known to be a long-term process, with some gamblers relapsing well after 18 months of gambling-free behaviour. Given the current lack of controlled research, we do not know if problem gamblers exhibit similar long-term relapse problems, but the possibility of long-term relapses need to be discussed as part of treatment.

Treatment strategies to help clients with pathological and problem gambling problems have been poorly researched and it is only now that the individual and social issues associated with gambling are being addressed in a systematic and controlled manner.

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