Disordered gambling treatment programming has developed rapidly in the last 20-25 years in response to the need engendered by the proliferation of legal casinos. Research on treatment effectiveness has also expanded. One of the most important elements of good clinical practice is an up to date understanding of evidence-based practices. Research can inform practitioners of new modalities, and of refinements on current modalities. It can indicate training needs, and identify cost-effective methods of treatment that make best use of available resources. Treatment research also acts as an important reminder of the need to measure clients' progress and outcomes, and to adjust services to maximize their success.

The disordered gambling field benefits greatly from a robust exchange between clinical work and research. This paper will provide an overview of the current state of knowledge on disordered gambling treatment, and identify its gaps and limitations, particularly from the point of view of treatment providers.

Researchers have evaluated a number of approaches to disordered gambling treatment. These include cognitive-behavioural therapy, motivational interviewing, brief interventions, self-help, mindfulness meditation, family interventions, pharmacotherapy, online interventions, treatments specialized for women, and mutual aid. There are also studies comparing modalities, or combining them – an approach that is perhaps closer to what occurs in the real world.
There is an advantage to brief treatment when resources are limited, and when clients are unwilling to engage in more intensive forms of therapy. Brief treatments also provide researchers with a usefully circumscribed intervention that is easy to script and deliver. This form of intervention for disordered gambling includes a few main approaches: motivational interviewing (MI), self-help, brief therapist support by phone or in person, and personalized normalized feedback, as well as combinations of the above.

MI focuses on helping clients to explore and resolve ambivalence in order to move them toward change. Personalized normalized feedback involves providing a client with the results and interpretations of standardized assessment tools, with a particular focus on the areas in which their results diverge from the norm. This is often a single-session intervention. Self-help studies provide materials, such as worksheets and lesson plans, for clients to complete at home, often in combination with brief advice and phone support.

Wynn et al. (2014) in their review of disordered gambling treatment research find support for the efficacy of brief interventions over no treatment, and sometimes over longer treatment. Wynn and colleagues also note that motivational work via a therapist appears to be important in improving outcomes. Yakovenko and Hodgins (2016) also find the data supports brief treatment. They find that MI tends to be more consistently efficacious. “At present, brief treatments using motivational interviewing may be considered an evidence-based treatment for disordered gambling” (p. 301).

Motivational enhancement sessions have also been compared with CBT. Rash and Petry’s (2014) review cites several studies that compare two or more such active treatments with waitlist controls. Clients receiving active treatment do significantly better than those in the control group, but the active treatments frequently do not differ significantly from one another, or one study contradicts another, although when there is a difference, it tends to favour MI.

While brief treatments have clear advantages for research, it would be helpful to understand which clients can and cannot benefit from these interventions, and whether such services will be utilized when offered by regular treatment services. It seems likely that brief treatment would be more effective for individuals in the earlier stages of disordered gambling, with fewer concurrent disorders and more remaining resources and coping skills. However, such clients may be less motivated to access treatment when they are not paid as part of a treatment study. In studies on motivation for treatment-seeking, Suurvali et al. (2008) found that treatment seeking was associated with problem severity. Evans and Delfabbro (2005) found that most disordered gamblers sought help only as a last resort, when they were close to physical or psychological breakdown or financial ruin. However effective and wise early intervention may be, it must be accessed by clients in order to be useful.

Mindfulness training has increasingly been integrated into treatment for a number of disorders, including disordered gambling. The author’s personal experience indicates that the groups are particularly well-received by clients, who report benefits in self-awareness and self-regulation. Mindfulness-based interventions are intended to increase clients’ awareness of their physical, mental and emotional state, and accept them without judgement. The goal is to learn greater control over thoughts and feelings rather than be controlled by them. Wynn et al. (2014) lists...
some of the disorders for which there is research evidence of the effectiveness of mindfulness interventions. However, there have been few controlled studies on its benefits for disordered gambling. Toneatto et al. (2014) describes mindfulness as an ideal intervention for addressing the irrational beliefs and cognitive distortions that often accompany disordered gambling. In a pilot study, his group compared a combined CBT and mindfulness intervention with a waitlist control, and found a significantly reduced severity of gambling, urges and psychiatric symptoms at both the end of treatment and at three month follow up. Continued mindfulness practice was associated with significantly better clinical outcomes.

McIntosh et al. (2016) compared the effectiveness of mindfulness-based treatment to two versions of CBT. All three treatments led to large improvements in disordered gambling behaviour after seven sessions at post-treatment and at 3 and 6-month follow-up. They conclude that a brief mindfulness intervention may be a useful supplement to traditional CBT treatments. This promising area is understudied, however, and more research is needed.

Gambling disorders have serious effects on family relationships and functioning. Kourgiantakis et al. (2013) conducted a comprehensive literature review and found that spouses and other family members experienced loss of trust, emotional distress (including fear, anger, loss of safety and security, guilt, despair, and uncertainty), financial difficulties, marital dissatisfaction and conflict, stress, parenting problems, physical and mental health impacts and isolation. Disordered gambling also had negative effects on family and couple functioning. Children experienced a loss of safety, stability and security through poor, absent or abusive parenting, and material impacts that affected their wellbeing. They were more likely to suffer from depression symptoms and conduct problems. Impacts like loss of trust and safety, conflict, anger and relationship breakdown continue long after the gambling ceases. Active conflict and loss of support at home greatly complicate recovery. Family members struggle with complex emotional and material losses and pressures. The home that should be a safe haven often becomes a source of stress. Unless these issues are addressed by treating the family as a whole, recovery can be a slow and uncertain process.

The above literature review found evidence that family involvement improved treatment retention and outcomes, for both the individual with the gambling disorder and for the family. An increase in coping skills in family members was associated with less severe gambling consequences and lower levels of gambling (Kourgiantakis et al. 2013).

Jiménez-Murcia et al. (2016) compared treatment outcomes for 675 male gambling disordered clients whose concerned significant others (CSO) did or did not attend treatment with them. Involvement of a CSO was associated with significantly higher treatment attendance and reduced dropout, lower rates of relapse and better adherence to treatment guidelines. Hazell and Leslie (2015) conducted a rapid evidence assessment of the gambling and substance abuse literature and found that better treatment outcomes for older adults were associated with family involvement in treatment.

In a qualitative treatment study that strongly encouraged family involvement, Kourgiantakis et al. (2017) examined outcomes as well as factors that facilitated or acted as barriers to family involvement. Family treatment attendance was associated with better outcomes, as well as more positive individual and family functioning. Facilitating factors for family involvement proved to be open and effective communication, family and professional support, and good coping skills. Barriers were family conflict, isolation, and mental health and/or substance use concerns. These findings suggest that higher functioning, better-resourced and less damaged families are more likely to engage in treatment together, and to profit from it. Those who fail to engage appear to need help the most, but struggle with too many problems to use it effectively. The authors suggest that such families “may require more integrated addiction and mental health services and for some families, mental health or substance use may need to be addressed before [problem gambling].”

The importance of family treatment has been largely overlooked in both clinical and research settings. Further work in this area is urgently called for.

Medication trials for the treatment of disordered gambling have so far produced mixed results (Yakovenko and Hodgins 2016). Trials have been carried out with SSRIs, mood stabilizers, dopaminergic medications, opioid...
antagonists such as Naltrexone, and glutamatergic medications. Early medication trials did not differentiate in their inclusion criteria by their subjects’ concurrent disorders, which are as high as 75 percent in this population (Dowling et al. 2015). Testing a single medication on subjects who may have untreated concurrent disorders as various as major depression and Attention Deficit Disorder is unlikely to produce a clear result. As a starting point, pharmacotherapy should address a client's specific concurrent disorders. Genetic vulnerability also needs to be taken into account. A family history of alcoholism is significantly associated with a positive response to Naltrexone (Grant et al. 2008).

Studies in recent years have been more likely to address the question of what medications may be helpful for which conditions. Grant et al. (2014) carried out a systematic review of pharmacotherapy studies, and found support for the efficacy of opioid antagonists and glutamatergic agents, especially for subjects who experienced strong urges to gamble. Another review study by Pettoruso et al. (2014) confirmed the utility of targeting the glutamatergic system, in particular to address cravings, impulsivity and cognitive inflexibility.

Given the heterogeneous nature of disordered gamblers, it is crucial for any medication trials to take concurrent disorders into consideration. As the following section indicates, such research is only beginning.

### Addressing Concurrent Disorders

According to a review by Dowling et al. (2016), evidence-based treatment recommendations for concurrent gambling and other disorders are relatively few. Only 21 studies were found that conducted post-hoc analyses to explore the influence of psychiatric disorders on treatment outcomes. These indicated some efficacy of current treatments for such clients, and little harm. The authors found only six randomized control trials that evaluated treatment targeted to psychiatric subgroups. Two focused on concurrent substance use, and found support for modified dialectical behaviour therapy as well as a combination of CBT and naltrexone. Other research, not surprisingly, found that including disorder-appropriate medication was effective (e.g. lithium for concurrent bipolar disorder). Dowling and colleagues suggested a number of ways in which future research could evaluate effective treatment for these sub-groups. It would also be helpful to learn whether dropout from treatment is associated with specific traits such as impulsivity.

### Online Interventions

Yakovenko and Hodgins (2014) describe a recent surge in web-based or web-assisted treatment studies, and see this as an emerging and promising approach to disordered gambling intervention. Various brief treatment protocols were involved in the studies examined, including CBT and MI, delivered through online self-help modules, sometimes supplemented by limited therapist contacts. Positive results were obtained in some studies, but not all.

One advantage of online treatment is its easy availability, particularly via online gambling sites. There is also the potential to attract disordered gamblers who are at an early stage, and/or are unwilling to seek face-to-face treatment. The downside of such recruitment may be the inclusion of individuals who are not truly invested in making changes to their gambling behaviour. Luquiens et al. (2015, cited in Yakovenko and Hodgins 2014), who recruited 1109 moderately at-risk poker players from an online poker site, found the rate of dropouts to be particularly high; outcome measures were not significant. It would be important to understand what motivates pre-crisis disordered gamblers to seek and remain in treatment.

Casey et al. (2017) compared a six week internet-based CBT intervention with a waitlist control and an active comparison condition consisting of monitoring, feedback, and support. The CBT condition produced significantly greater effects on measures relating to gambling urges, cognitions, stress, and life satisfaction, and the gains were stable after twelve months.

One disadvantage to the above treatments may be the loss of group input. Boughton et al. (2016), in a small pilot project, addressed this deficiency for female clients by including clinician-facilitated group support through use of teleconferencing technology. The group met online for support and discussion based on the treatment workbook. Participants reported improvements in mood, coping and other variables. This approach appears to have good potential value for clients with limited access to treatment, who require the support and input that group therapy can provide. It was a small study, however, and did not look at gambling behaviour outcomes.
Research and clinical experience have long since established that women with addictions have different profiles than men, and do better when they receive services that address their specific needs (e.g. Covington, 2002, Poole et al. 2014). Similar findings have emerged regarding women with gambling disorders. These women report much higher levels of depression and anxiety, substance and other behavioural addictions and trauma history than the general female population (Boughton and Falenchuk 2008). In a review of the literature concerning clinical characteristics of female pathological gamblers compared to males, Wenzel and Dahl (2008) found that women were significantly more likely to gamble to escape problems than men, and to suffer from anxiety and mood disorders. The authors also found a consensus that treatment for women should focus on emotional needs.

Piquette-Tomei (2008) analyzed interviews with members of a women-only group for problematic gambling, with regard to what aspects of treatment they found helpful. There was a strong consensus that a women’s group provided more safety and acceptance than a mixed group, more sharing and opportunities to speak, and an experience of being understood that the participants had not found in groups with both men and women. Boughton et al. (2016), mentioned in the previous section, developed an innovative women-only group via teleconferencing, utilizing a workbook designed specifically to address the needs and issues of women with gambling disorders. The workbook included elements of evidence-based trauma treatment and emotion regulation material. Clients’ evaluation of the workbook and the group were positive.

The research on disordered gambling treatment aimed at women and other specific population is very limited. More study is required.

Gamblers Anonymous (GA) is a twelve-step fellowship, which has been available since the 1950s for those struggling with disordered gambling. However, there is little research evidence on the effectiveness of GA. A scoping review of the literature (Schuler et al. 2016) found only three such studies published between 2002 and 2015, all of which used GA as a control condition. The studies found significantly better outcomes in the conditions receiving formal treatment. Results were described as mixed; in one case differences became less clear on long-term follow up, and in another, questions were raised about whether more frequent GA attendance would have led to better results. There was also some indication that continued GA attendance at follow up was associated with better outcomes. Still, the research evidence does not appear to support GA as a standalone treatment. Rash and Petry (2014) note that client engagement in GA tends to be low, even when clinicians recommend attendance.

The current state of knowledge indicates that a number of practices are either well-supported or promising for disordered gambling. Cognitive-behavioural therapy, motivational interviewing, mindfulness, brief and online interventions, treatments, pharmacotherapy, women-and family-focused treatments have all shown evidence of effectiveness. Mutual aid, while not well-supported, may have value as an adjunct to professional treatment.

Application of the data surveyed here to real-world clients and treatment services is subject to some limitations, however. Research samples do not tend to fully reflect treatment samples. For instance, many studies using CBT screen out clients with comorbidities (Tolchard 2016), even though concurrent disorders are extremely prevalent in this population. Complexity is the rule rather than the exception. Current best practices include attending to that complexity, rather than focusing on single issues. Clients who are easy to treat will respond to most types of therapy. Far more research is needed to understand what works for clients with concurrent gambling and substance or psychiatric disorders. Effective treatments for other sub-populations, such as women and minorities, also need more attention.

Researchers and therapists have both tended to avoid addressing the complex context of clients’ family relationships. Damaged family dynamics are left to fester and threaten recovery, and the family’s potential as a powerful force for change is not utilized. This is a very important area for further study.

Overall, gambling treatment research is a dynamic and growing field that has supplied clinicians with an excellent groundwork of best practices. The focus is
beginning to widen to include complexity and the needs of subgroups.

About the Author

Nina Littman-Sharp was the manager of the Problem Gambling Service at the Centre for Addiction and Mental Health from 1998 to 2016. She writes and presents on topics including problem gambling, behavioural addictions, gambling and couples counselling, and gambling and fatigue. She co-authored the Inventory of Gambling Situations, a relapse risk instrument. Nina developed a network of diverse ethno-cultural treatment providers, in order to raise community capacity to address problem gambling in multiple languages. She is currently in private practice.

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