

# Psychodynamic psychotherapy and the treatment of pathological gambling

## Psicoterapia psicodinâmica e o tratamento do jogo patológico

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### Abstract

**Objective:** The search for empirically based treatments for pathological gambling is in its infancy, with relatively few clinical trials and an absence of naturalistic studies. Treatment retention of gamblers has been a problem; cognitive-behavioral treatment and pharmacotherapy studies report especially high dropout rates. Psychodynamic approaches, with their emphasis on the therapeutic relationship, and the meaning of the patient's self-destructive and seemingly irrational behaviors, and on obstacles to self-forgiveness, might improve outcome. **Method:** After a description of psychodynamic psychotherapy, the literature on both short-term and longer therapies is reviewed regarding their efficacy for a variety of disorders. With regard to pathological gambling, the author summarizes the early (1914-1970) psychoanalytic literature then reviews the more recent psychodynamic psychotherapy literature on pathological gambling. **Results:** A review of the recent psychodynamic psychotherapy literature on pathological gambling failed to disclose a single randomized controlled study of treatment efficacy or effectiveness. However, there are eight positive outcome studies described as multi-modal eclectic; half of those seem to utilize psychodynamic approaches. Two of the more successful programs are described. **Conclusions:** A review of the outcomes literature for psychodynamic psychotherapy demonstrates efficacy for a variety of disorders sufficient to justify a clinical trial for pathological gambling. Short-term psychodynamic psychotherapy, with its focus on core issues, may be particularly applicable to the pathological gambler's need to avoid or escape intolerable affects and problems. Longer therapies may be needed to modify an avoidant coping style and defenses.

**Descriptors:** Pathological gambling; Psychodynamic psychotherapy; Multimodal, treatment; Dynamic formulation; Treatment effectiveness

### Resumo

**Objetivo:** A busca por tratamentos com base empírica para o jogo patológico está em sua infância, havendo relativamente poucos ensaios clínicos e uma ausência de estudos naturalísticos. A adesão dos jogadores ao tratamento tem sido um problema, sendo que o tratamento cognitivo-comportamental e os estudos farmacoterápicos relatam índices particularmente altos de abandono. As abordagens psicodinâmicas, com sua ênfase na relação terapêutica e no significado dos comportamentos autodestrutivos e aparentemente irracionais, e nos obstáculos à capacidade de se perdoar, poderiam melhorar o desfecho. **Método:** Após uma descrição da psicoterapia psicodinâmica, foi feita uma revisão da literatura que investigou a eficácia de tratamentos psicoterápicos de curto e longo prazo para uma série de transtornos. Com relação ao jogo patológico, foi feito um resumo da literatura psicanalítica inicial (1914-1970) e a seguir foi revisada a literatura mais recente sobre a utilização da psicoterapia psicodinâmica no jogo patológico. **Resultados:** A pesquisa da literatura recente sobre psicoterapia psicodinâmica não revelou nenhum estudo controlado aleatorizado sobre a eficácia ou efetividade desse tratamento. No entanto, há oito estudos com desfechos positivos descritos como ecléticos multimodais; a metade destes parece utilizar abordagens psicodinâmicas. São descritos dois programas entre os que obtiveram maior êxito. **Conclusões:** Uma observação sobre os desfechos mais gerais da psicoterapia psicodinâmica na literatura demonstra eficácia suficiente para uma variedade de transtornos que justificam um ensaio clínico sobre o jogo patológico. A psicoterapia psicodinâmica de curto prazo, com seu foco em questões nucleares, pode ser particularmente aplicável à necessidade dos jogadores patológicos de evitar ou escapar de efeitos e problemas intoleráveis. Terapias de mais longo prazo podem ser necessárias para modificar um padrão evitativo de comportamento e defesas psicodinâmicas.

**Descritores:** Jogo patológico; Psicoterapia psicodinâmica; Terapia combinada; Formulação dinâmica; Resultado de tratamento

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## Introduction

Psychodynamic treatments and approaches assume that each of us has an inner life that is important in understanding our outer life, and that both are the product of our personal histories, including the meanings we attribute to what has or may happen to us. Psychodynamic psychotherapy (PDPT) is akin to detective work; it seeks out motives and tries to read between the lines of human behavior. It looks for repetitive patterns; uses present relationships to shed light on the past; pays attention to the irrational and unspoken.

Until recently, PDPT was reputedly the most widely practiced form of psychotherapy in the United States.<sup>1</sup> However, efficacy and effectiveness studies for psychodynamic therapies have trailed far behind those for cognitive behavioral (CBT) and pharmacological treatments.<sup>1</sup> CBT and pharmacotherapy may lend themselves more easily to manual-based therapy, short-term trials, and random assignment. However, PDPT, and its parent, psychoanalysis, have at least until recently stubbornly resisted evidenced-based review. Some believe psychoanalytic therapies incompatible with scientific inquiry; others press the need for research and have been developing instruments and methods for collecting and analyzing data.<sup>2</sup>

The present review was undertaken to assess the contribution of PDPT to the treatment of pathological gambling (PG). The empirically based treatment of PG is in its infancy, with relatively few clinical trials, and major differences of opinion about how to classify and conceptualize the disorder. Treatment retention of PGs has been a problem: CBT and pharmacotherapy studies report dropout rates of 43 to 80%.<sup>3</sup> I will begin with a definition and description of PDPT. If we are to understand what works in treatment, we need to start by clarifying what it is that we actually do. I then present several examples from the PDPT outcomes literature, demonstrating that there are efficacy studies for a variety of disorders, in order to make the case for additional research on PG.

An earlier contribution reviewed the psychodynamic literature on PG.<sup>4</sup> While contributions from that literature will be summarized, our focus here will be on more recent studies, and especially how PDPT has been subsumed into multimodal, eclectic treatment programs, often without being identified as such. Two of the more influential programs will be discussed in order to illustrate their use of psychoanalytic principles and methods.

Experiences gained through supervision, workshops, and consultations have convinced me that 1) good therapists are more alike than different, regardless of theoretical orientation, and that 2) there is a discrepancy between what therapists do in the privacy of their offices, and what they say or think that they do. Furthermore, apparently minor process parameters of care may be far more important in determining outcome than entire standardized treatment packages.<sup>1</sup> In studies comparing CBT with short-term psychodynamic psychotherapy (STPP), Ablon and Jones found that positive outcomes for either therapy correlated with the use of techniques and strategies that were prototypically psychodynamic.<sup>5</sup> The authors note that what is presumed to be a cognitive behavioral treatment may actually contain significant psychodynamic ingredients or vice versa, and that these interventions may be among the active ingredients in the therapy process. In a later study, the authors compared CBT with interpersonal psychotherapy.<sup>6</sup> Despite the use of detailed manuals and procedures for ensuring adherence, there was again substantial overlap and borrowing of process and technique. This time both forms of therapy

adhered more to the CBT prototype, which additionally correlated more favorably with outcome. The findings again demonstrate the need to study the therapy process along with outcome. Ultimately, we are asking a four-fold question: which kinds of treatment are effective, and for which gamblers; and in which ways are they effective; and through which kinds of mechanisms?

## What is psychodynamic psychotherapy?

Psychodynamic approaches are based on certain assumptions: that what people say and do has meaning, although it may be outside of conscious awareness; that there are patterns to one's behavior, and these repetitive patterns can be discerned from the individual's life narrative, and observed in the therapeutic relationship; and that although these behaviors become fixed, they can change with insight and understanding.

Psychodynamic psychotherapy utilizes seven types of interventions or techniques that differentiate it from other types of therapy:<sup>7</sup>

- 1) A focus on affect and expression of the patient's emotions;
- 2) Exploration of the patient's attempts to avoid topics or engage in activities that hinder the progress of therapy (avoidance, resistance);
- 3) Identification of patterns in the patient's actions, thoughts, feelings, experiences, and relationships;
- 4) An emphasis on past relationships;
- 5) A focus on interpersonal experiences;
- 6) An emphasis on the therapeutic relationship;
- 7) An exploration of wishes, fantasies, and dreams.

Dreams, according to Freud, represent the "royal road to the unconscious".<sup>8</sup> While contemporary PDPT tends to focus more on their manifest imagery and metaphorical meanings, the usefulness of dreams is indisputable.<sup>9</sup> They may serve as early warning signals of acting-out, including slips or a full return to gambling. Other changes may also present initially in dreams: "Often, the initial indication of a significant decision, change toward healthier behavior, or readiness to terminate treatment may be signaled in dreams" (p. 224).<sup>9</sup>

Transference, in which the individual relates to the therapist based on past experiences with parents or significant others, and the here-and-now collaboration between therapist and patient, together make up the therapeutic alliance. This constitutes the most effective tool in the armamentarium for change.<sup>10</sup> The therapist attempts to create a safe environment by being consistent, non-judgmental, and supportive. In turn, patients are encouraged to be curious about themselves, and especially about their seemingly irrational behaviors, and to express their fears and intolerable affects in the environment of the therapist's office, where these affects can be contained.

The therapist brings certain skills to the relationship. First is the ability to be empathic, to put oneself into the other's place in order to be aware of the patient's distress and shifting states of mind. Second is the ability to maintain (free-floating) attention, to listen for conscious and unconscious meaning while tolerating periods of uncertainty and not knowing. Third is the ability to be self-reflective, to be able to interact with the patient while simultaneously observing the interaction, reflecting on it, and using one's self-reflection to modify and guide future interactions. Further complicating the therapeutic relationship is that not all patient-therapist dyads constitute a "good fit"; until recently, this was not something that could be objectified or measured.

## 1. The psychodynamic formulation

An important component of the psychodynamic approach, and one that remains applicable even when the patient is in some other kind of therapy, is the psychodynamic formulation.<sup>11</sup> This is a statement of the patient's central issues and conflicts; it attempts to explain their role in the present situation; and predict how they will affect treatment and the therapeutic relationship. According to Perry et al., the psychodynamic formulation begins by addressing the question of "why this particular patient presents with this diagnosis and these particular problems at this particular time".<sup>11</sup> They also emphasize the importance of including a description of non-psychodynamic factors.

The psychodynamic formulation will be modified over time as one gets additional information and circumstances change. It need not be lengthy or all-inclusive, but there is general agreement that it needs to be in writing. The process of writing it helps to clarify what is essential, and serves as a kind of blueprint or game plan, to keep one on course when the therapy gets difficult. The incompleteness of the original formulation should stimulate the therapist's curiosity, while its speculative nature will result in hypotheses to be tested and modified.

The formulation helps the therapist accept the inevitable complexities and limited knowledge inherent in every clinical situation, and therefore to be more accepting of his or her limitations.<sup>11</sup> Therapists can also be more tolerant and accepting of their patient's pathology. When the patient's behavior in treatment is seen as a manifestation of their individual dynamics, and as characteristic problems that can be predicted and understood, the therapist can be more objective, non-judgmental, and empathic, and there is a strengthening of the therapeutic alliance.

## 2. Short-term psychodynamic psychotherapy

It is useful to distinguish more classical or traditional PDPT from short-term PDPT. The former is open-ended and typically long-term. The therapist is less directive, allowing the patient to bring up whatever seems important or meaningful to them; underlying issues or reasons for seeking treatment may not become apparent until well into therapy. The whole person is the subject of treatment, their character, defenses, values, etc., and less so the presenting complaint or initial diagnosis. Transferences are analyzed as the relationship between patient and therapist goes through a number of changes and permutations.

Short-term psychodynamic psychotherapy (STPP), on the other hand, is usually time-limited, consisting of 16-30 sessions, conducted on a once or twice-weekly basis.<sup>12</sup> The therapist is relatively active, and fosters the development of a therapeutic alliance and positive transference. STPP focuses on specific conflicts or themes that are formulated early in therapy. The psychodynamic formulation is conceptualized most simply in terms of a formative or critical life event and the coping skills or defenses used to deal with it<sup>10</sup> or as a core conflictual relationship theme (CCRT).<sup>13</sup> Attention is paid to the setting of achievable goals, adhering to the tasks at hand, and on issues involving termination. STPP would naturally lend itself much more readily to manual-based treatments and research on outcome.

### Efficacy and effectiveness of psychodynamic psychotherapy

#### 1. Short-term psychodynamic psychotherapy

Leichsenring, Rabung, and Leibling did a meta-analysis of studies of STPP conducted between 1970 and 2004.<sup>12</sup> Their rigorous inclusion criteria included randomized control trials, use of

manualized therapy with treatment integrity ensured, therapists experienced with or specifically trained in STPP, the treatment of patients with specific psychiatric disorders, reliable and valid diagnostic measures, and data necessary to calculate effect sizes. Based on the seventeen studies that fulfilled their criteria, they found that STPP yielded significant and large pre-post treatment effect sizes for target problems, general psychiatric symptoms, and social functioning. They concluded that STPP proved to be an efficacious treatment of psychiatric disorders, but that further research was needed on specific disorders, including a study to determine the active ingredients of STPP, and studies of its effectiveness.<sup>12,14</sup>

The study corroborated the results of previous meta-analyses.<sup>14</sup> Notably, it utilized a different database, and only a small number of the studies included previously were able to meet the more rigorous inclusion criteria here. The effects of STPP proved stable and even tended to increase with follow-up, thus replicating earlier findings. The conclusion that STPP was superior to both treatment as usual and wait-list conditions, and at least as beneficial as other forms of psychotherapy such as CBT, was based on studies of depression, social phobia, posttraumatic stress disorder, anorexia and bulimia nervosa, and borderline and cluster C personality disorders. The one kind of chemical dependence included was cocaine dependence; there were no studies of PG or of any other behavioral addictions or impulse control disorders.

Among the seventeen studies included in the meta-analysis, different models of STPP were being used, although most frequently those of Shapiro and Firth, Horowitz, Davanloo, and Luborsky.<sup>14</sup> Leichsenring wonders whether different models of STPP are sufficiently similar to be lumped together. If so, empirical evidence for one model would also be valid for the others. On the other hand, how the models might differ among themselves raises questions for further research. Comparing prototypic sessions would help identify factors characterizing the different forms of STPP. And finally, Leichsenring<sup>14</sup> admits that even with adherence to a treatment manual, there may be considerable differences in the underlying interpersonal processes, and as other researchers have noted,<sup>15,16</sup> it is these processes that may be most significantly related to outcome. For example, Crits-Cristoph and Mintz found that different therapists applying the same form of manualized therapy differed with regard to its efficacy.<sup>17</sup>

#### 2. Long-term psychodynamic psychotherapy

As one might expect, there are few studies of long term PDPT. Methodological problems have been reviewed by Gunderson and Gabbard.<sup>18</sup> There are problems with randomization to alternative methods of care: patients not given their treatment of choice will drop out. Suitable matched control groups are difficult to recruit. Unexpected and uncontrolled for variables such as illness, life events, axis I disorders, and medication changes are frequent over the long course of treatment. Cost of a long follow-up would be prohibitive.

Nevertheless, there are two studies worth mentioning. The Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPP)<sup>19-21</sup> followed 756 persons who received national insurance-funded treatment for up to three years in psychoanalysis or psychoanalytic

psychotherapy. Outcome was assessed in terms of symptoms, social relations, morale or existential attitude, general health, health care utilization, and working capacity, as measured by qualitative interviews, self-report inventories, questionnaires, and official records. At the end of treatment, those in four or five times a week psychoanalysis had similar outcomes to those who received once or twice weekly psychotherapy. During the follow-up period, however, the analytic patients continued to improve, while those in psychotherapy did not. By the end of the follow-up period, the scores for the analytic patients were almost indistinguishable from those obtained from a non-clinical Swedish sample.

The German Psychoanalytic Association conducted a follow-up of psychoanalytic treatments conducted between 1990 and 1993.<sup>22,23</sup> A representative sample (n = 401) of all patients who terminated treatment with members of their analytic association was followed up. Between 70 and 80% of the patients achieved good and stable psychic changes when contacted an average of 6.5 years after the end of treatment. This was according to the patients themselves, their analysts, independent analytic and non-psychoanalytic experts, and questionnaires suitable for this kind of outcome study. Patients also reported fewer days of sick leave during the seven years posttreatment, and in addition to this kind of indirect financial benefit, was their continued subjective valuation of the treatment experience.

The two studies make a case for intensive long-term treatment and for long-term follow-up. A smaller (n = 53), naturalistic study of PDPT conducted for a minimum of three years found long-term improvement in defensive functioning, which predicted improvement in depressive, anxiety, and personality symptoms.<sup>24</sup>

### 3. Additional predictors of outcome

Based on their analyses of data from several studies of intensive PDPT, as well as a short-term collaborative study of major depression, Blatt et al. have concluded that evaluation of therapeutic progress must go beyond symptom reduction as primary outcome measure, and should include the assessment of decreased vulnerability to stress, the development of improved coping strategies and defenses, and a maturation of self and object representations.<sup>25</sup> The authors contend that these changes in personality organization and structure are essential for dealing with most forms of psychopathology if symptomatic improvement is to be sustained and significant relapses avoided.

Blatt et al. also concluded that therapeutic outcome is determined, not by type of treatment provided as guided by manuals, but "by the therapist's ability to appreciate the nature of the patient's disturbances and personality organization, an understanding that is essential for establishing a therapeutic relationship that enables the patient to feel trust and confidence in the therapist and to participate actively in the treatment process" (p. 538).<sup>25</sup> They found that the quality of the therapeutic relationship, established as early as the second session, was the better predictor of treatment success.<sup>25</sup>

Crits-Christoph and Mintz demonstrated that individual therapists applying the same form of therapy differed with regard to efficacy.<sup>17</sup> Even when adhering to a treatment manual, there may be significant interpersonal differences, and these may be determining the outcome.<sup>15,16</sup> In addition to differences between therapists is the fit between therapist and patient. Some therapists are better with some kinds of patients and

with some kinds of disorders. Experience with the treatment of one kind of addiction, for example, may not translate into empathy, interest or ability in treating another kind of addiction.

### Pathological gambling

#### 1. Early (pre-1970) psychoanalytic theories and case reports

The psychoanalytic literature on PG has already been extensively reviewed.<sup>4</sup> Notably, among the early analysts was an ongoing debate, not dissimilar from today's, about whether to categorize disordered gambling as an addiction or as an impulsive or compulsive disorder. In addition to interesting theoretical discussions, one finds a wealth of clinical material, with detailed histories and specific examples of what went on in treatment.

A number of these early authors emphasized narcissistic fantasies involving grandiosity and a sense of entitlement, pseudo-independence, and a need to deny feelings of smallness and helplessness.<sup>4</sup> Others described early parental deprivation, with the gambler turning to fate or Lady Luck for the love, acceptance, and approval they believed they had been denied. [Recently Grant and Kim compared PGs with normal controls, and confirmed significant parental neglect in the gamblers].<sup>26</sup> Several analysts saw compulsive gambling as an attempt to ward off a severe or impending depression, or as a manic defense against helplessness and depression secondary to loss.

According to Stekel, the gambler was continually challenging fate.<sup>27</sup> The game was an oracle for him; if he won, his secret wish for love, power, etc. would be granted. This idea was frequently repeated in the gambling literature. Stekel, as others did after him, referred to the *language* of gambling in order to show its sexual and aggressive gratifications, as well as its exhibitionistic features. Freud emphasized the extremely competitive, love-hate relationship between the male gambler and his father, with a need for approval and feelings that one can never be good enough.<sup>28</sup>

It was not for money that the gambler gambled, Freud explained, but for the gambling itself, what we would today refer to as "the action." In fact, he noted, the gambler may gamble in order to lose.<sup>28</sup> There were several reasons for this, rooted in the young man's ambivalence toward his father. Losing could be a way to punish oneself, to expiate guilt, but it could also be a way to gain love and acceptance (i.e. suffering = love). Freud's theory of masochism underwent at least three major revisions (Rosenthal, Masochism and pathological gambling, submitted); it was part of his life long attempt to understand deliberately self-destructive behavior.

After Freud, Bergler's writings were the most influential,<sup>4</sup> and he is generally credited with popularizing this idea of the gambler gambling in order to lose. According to his theory,<sup>29</sup> the pathological gambler was in rebellion against the authority of the parents and the reality principle they introduced. The ensuing guilt about this rebellion created the need for self-punishment. Behind the gambler's pseudo-aggression was a craving for defeat and rejection. Compulsive gamblers, according to Bergler, were involved in an adversarial relationship with the world. Their opponents at the poker table, the dealer in the casino, the roulette wheel or stock exchange, were all identified with the refusing mother or rejecting father.

While a number of analysts found confirmation for Freud's classic formulation, others emphasized the erotization of tension and fear, the central role of omnipotence, deficits in self-regulation, and the role of early parental identifications.<sup>4</sup> Between 1920 and 1970, we find many individual case reports



of gamblers successfully treated by psychoanalysis.<sup>4</sup> The only attempt at a systematic approach was Bergler's.<sup>29</sup> He also is the only one to report results of a case series. Of the approximately two hundred compulsive gamblers referred to him, sixty stayed for treatment and more than half, according to Bergler, were cured. The latter consisted of more than mere cessation of gambling, but required the patient to give up all self-destructive thinking.

Bergler's treatments lasted for a year, a year and a half at most, although we do not know how often patients were seen, and whether it was face to face or on the analyst's couch. He does mention working with dreams and analyzing the transference, but his examples from sessions illustrate his typical confrontational style of challenging the gamblers' beliefs and omnipotent defenses. He seems very knowledgeable about the various schemes and self-deceptions. Bergler's challenging, argumentative style fits in very well with his perception of how his gambler patients viewed the world, that is, as adversarial. Hence his very technique would heighten and intensify their transference reactions.

Although Bergler describes how his patients' lives changed as a result of treatment, there is no reported attempt at posttreatment follow-up. This is particularly unfortunate as the approach practiced both by him and the more classic analysts mentioned earlier was designed to address the meaning and purpose of gambling for the individual, challenge their defenses, and bring about character changes that should have made a return to gambling less likely.

## 2. Multimodal, eclectic and integrated approaches

In the contemporary literature, there are no randomized controlled studies of PGs treated psychodynamically, despite the continued use of this type of treatment and its contribution to other types of treatment. Psychodynamic approaches are often subsumed under multimodal eclectic treatments. There are eight published outcome studies for gambling treatment programs self-described as multimodal.<sup>30-32</sup> Abstinence, reduced or controlled gambling is reported in two thirds of cases treated, with significant improvement in depression, family relationships, financial status, and general quality of life.

While there is frequently no specific information on what is meant by individual or group therapy, psychodynamic approaches may be discovered. For example, Blackman et al. mention that individual treatment focused on the "underlying dynamics" that caused the gambling problem.<sup>33</sup> Several of the other programs have described their individual and group approaches elsewhere. For example, a central component of the inpatient program at South Oaks Hospital in Amityville, New York, has been the involvement of the gambler's family. Heineman conducted educational sessions, family therapy, conjoint therapy, combined groups, parent groups, and aftercare programs for family members.<sup>34</sup> She emphasizes the importance of understanding family dynamics, including parental expectations, secrets, covert approval of the gambler's antisocial behavior, splitting, competitiveness, feelings of guilt, and fears of rejection on the part of family members that lead to enabling behaviors or otherwise work against recovery.

Started in 1972, the inpatient gambling treatment program at the Brecksville, Ohio Veterans Administration Hospital is the oldest gambling specific treatment program in the world. It has now treated more than 2,500 pathological gamblers. Outcome studies by Russo et al.<sup>35</sup> and Taber et al.<sup>36</sup> showed that of those located for six month follow-up, 55% had

remained abstinent and reported significant improvement both on psychological measures and quality of life. Forty-five of the 66 patients from the second study were located for twelve-month follow-up.<sup>37</sup> Fifty-five percent were abstinent and had been for the full twelve months since leaving the program. Prior to treatment, patients had averaged more than 18 years of pathological gambling with longest period of abstinence being, on average, less than 11 months. Findings are even more significant when one considers the requirement of total abstinence used for measuring treatment success. In all three studies, patients who achieved abstinence after one or a few episodes, or who significantly reduced but did not stop gambling, were not considered successful outcomes. It is also noteworthy that most of the patients were from out of state and, after completing their thirty-day inpatient stay, had returned to communities where aftercare and even Gamblers Anonymous were less than optimally available.

The current director of the Brecksville program, Loreen Rugle, prefers to describe its multimodal program as "integrated" rather than "eclectic." Her choice of terms suggests the endorsement of a broader approach and deliberate assimilation of different methods, techniques, and theories, rather than the absence of a theoretical orientation or "eclecticism by default".<sup>38</sup> According to a description of the program prepared by Rugle:

"The Brecksville program utilizes a largely psychodynamic approach to enhance patients' self-awareness and facilitate behavioral change. Patients engage in a process of self-exploration to understand the role and meaning of gambling in their lives; they look at patterns of avoidance and begin to recognize vulnerabilities for addictive behavior. Essential for this to occur is a safe and supportive environment that offers them empathy, structure, clear and consistent limit setting. Major components of the program include:

- 1) Individual and group psychotherapy, with an emphasis on recognition of one's needs and feelings; identification of defenses that interfere with honesty; and an emphasis on relationships, especially as one learns to give and receive support. Gambling is viewed in the context of the individual's life, as both attempted solution and contributor to core problems;

- 2) More structured educational groups that provide assertiveness training, problem solving and enhancement of coping skills, and specific relapse prevention strategies such as identification of gambling triggers, tools for dealing with cravings, money management, cost benefit behavior analysis, and values clarification;

- 3) Twelve step facilitation groups that help patients understand and utilize Gamblers Anonymous; a peer counselor leads these groups on the process and goals of recovery, on working the individual steps, and the role of sponsorship.

- 4) Marital and family counseling, which includes family and significant others either in person or via conference call, serves to corroborate specifics of the gambling and important aspects of the history; evaluates the patient's support system, while engaging others in treatment and discharge planning; addresses questions and concerns; and facilitates more open communication;

- 5) While the first four components have been present from the program's inception, mindfulness groups have been recently added. These are based on stress management and meditation techniques, and are intended to further develop self-awareness, reduce impulsivity, and teach self-soothing techniques that assist affect tolerance and regulation.

While it is extremely difficult to know which experiences are most beneficial, a key element of the Brecksville program

(and the one most often cited by former patients) has been the written autobiography that each patient prepares and then reads in the dynamic therapy group. It allows them to begin looking at the purpose and meaning of gambling in their life, and they become more aware of intra- and interpersonal vulnerabilities that contribute to the development and maintenance of their gambling behavior. It also encourages awareness and expression of feelings, including those that the patient had been trying to avoid or escape through gambling, those feelings enhanced by gambling, and those that are a consequence of their gambling. Presenting the autobiography to the group helps them develop more meaningful and supportive relationships, encourages honesty, and, through the completion of this challenging and often most difficult task, enhances their self-esteem" (Rugle, unpublished manuscript).

Another example of a multimodal, integrated approach with a similar psychodynamic orientation was described by Gupta and Derevensky.<sup>39</sup> At the time of their publication, the McGill University Research and Treatment Clinic had successfully treated 35 of 36 adolescent boys who presented with serious to severe gambling problems. Patients were followed for at least a year after terminating treatment. Not only were all but the one abstinent from gambling, none were experiencing problems with other addictive or compulsive behaviors. While the authors acknowledge the absence of matching controls, they also emphasize that their measures for treatment success included not just gambling abstinence, but return to or improvement in school or work, improved peer and family relationships, and an absence of depressive symptomatology or delinquent behavior.

Their treatment approach was predicated upon the belief that the gambling served as an unsuccessful solution to underlying problems. Rather than viewing gambling as a vehicle for making money, their adolescent gamblers thought of money as the means to continue gambling. Patients were seen exclusively in individual therapy, typically on a weekly basis, but could be seen more frequently at the discretion of the therapist. The boys were all given a pager or cell phone number that they could use for emergency contact between sessions. Treatment consisted of between 20-50 sessions.

The components of treatment, as spelled out by Gupta and Derevensky,<sup>39</sup> consist of:

1) An emphasis on the therapeutic relationship. The authors mention a non-judgmental attitude on the part of the therapist, the importance of honesty, and the need to establish trust;

2) Specific therapeutic goals. These will differ, depending upon the needs of the individual. They will also change during the course of therapy. For example, some gamblers will initially want to try controlled gambling; others may have committed to abstinence prior to beginning treatment. Similarly, some patients present with significant depression; others have pressing legal, health-related, or other reality-based problems;

3) Identification of underlying issues. Gambling is typically used to escape one's problems. This may be associated with poor coping skills, feelings of helplessness, or a lack of support from family and friends;

4) Acceptance of the problem. This would include both acceptance of the gambling as a problem and acceptance of the underlying problem. It might include a willingness to make significant changes in one's life;

5) Need to improve coping skills, and to develop more mature defenses;

6) Treatment not viewed as successful or complete until (a) underlying problems have been resolved, and (b) coping/problem solving skills are improved.

This last item is crucial for the authors, who emphasize that unless these goals are met, cessation of gambling will be temporary or may result in other addictive and self-destructive behaviors.

There is a striking similarity between these programs, although Brecksville utilizes a team approach while McGill relies more on a single therapist working individually. The case presentation by Gupta and Derevensky is offered in sufficient detail to illustrate how much one can learn from a good history of the present illness, and how one's awareness of underlying issues can be used to incorporate seemingly diverse treatment modalities into a sensitively integrated whole-person approach.<sup>39</sup>

The patient was an 18-year-old boy whose father died after a difficult and prolonged illness four years earlier. The patient had started gambling at 13, at approximately the time when his father's illness first required hospitalization. While watching the sporting events on which he had wagered, he could forget his father's illness and his belief that the family was "falling apart." He spent time in the company of other sports betters; their common purpose gave him a sense of belonging, and constituted for him a new family. It was an exciting one, in contrast with the one at the hospital. When his father died, his gambling escalated. Family members were unavailable to him, as they were consumed by their own grief. His mother, in particular, was and has remained depressed. The patient's guilt and shame about his gambling alienated and isolated him even further.

The therapist's approach focused first on helping the patient understand the meaning and motivations for gambling. He came to appreciate how he had used gambling to avoid his feelings about his father's illness and death. In particular, the excitement of gambling served to distract him, and created an illusion of something meaningful while helping to self-medicate his painful feelings.

Secondly, although most likely concurrently, the patient was encouraged to record his daily gambling behavior, in order to establish a baseline and then to decrease his gambling. Not only did his record keeping foster a habit of self-observation and self-reflection, but as he decreased his gambling it created a sense of mastery and self-control.

Third, he addressed with his therapist the cognitive distortions about gambling. These centered on the illusion of control in relation to both sports betting and his gambling on slot machines. He acknowledged having always been aware on some deeper level of the irrationality of these beliefs. They may have been related to his desperate need for control at a time in his life when he felt so overwhelmed, helpless, and out of control.

In psychotherapy he now addressed his feelings about his father's death, including his anger both at his father for dying and at his family for not being there for him. When depression emerged two months into the therapy, he was placed on antidepressant medication. One is tempted to second-guess the reasons for using medication and whether the patient could have grieved his losses without it, but on this point the reader does not have sufficient information.

The patient's response to his father's illness had been consistent with his typical pattern of avoidance. He regularly kept his feelings to himself, and did not know how to

communicate his need for help, which added to his feeling of being alone. Since this pattern was repeated in his relationship with his girlfriend, the therapist worked on developing these skills through role-playing exercises within the session. After the patient could better communicate with his girlfriend, he then tackled the task of reconnecting with his family. Individual family members were invited to a therapy session where the patient apologized for his past actions, attempted to explain his behavior and feelings, and expressed his desire to earn back their trust and respect.

Rebuilding his social support network was considered a critical part of therapy. He began a repayment schedule and confronted his debtors. Each of these situations was utilized in therapy to help him develop new and more adaptive coping strategies. He regularly brought stressors and daily problems into therapy sessions, and developed confidence in himself as he learned to deal with them. From the very first session, he had been encouraged to get at least a part-time job. During the course of therapy, he considered going back to school and the possibility of turning a satisfying new activity (cooking) into a career. As he extended his involvement with the community, he maintained his connection with the therapist.

As presented by the authors<sup>39</sup> the case beautifully illustrates how each modality was used to further the goals of treatment as initially formulated psychodynamically. Understanding the meaning of gambling for this particular patient, its defensive purpose, the underlying issues, his avoidant coping strategies, repetitive behavior patterns, and the nature of his relationships, informed the entire therapy and led to its successful outcome.

### 3. An integrated psychodynamic addictions based approach

Rosenthal and Rugle integrate a traditional psychodynamic approach with an addictions based model.<sup>40</sup> Understanding the positive aspects of gambling, in other words what the individual gets out of it, clarifies its defensive and adaptive purpose. Central to this approach is the belief that gambling, and the fantasies associated with it, is a way to avoid, compensate for or negate intolerable affects. These unbearable feelings may be rooted in the past or may be secondary to some current reality based problem that is perceived by the gambler as unsolvable. Not to address this early in treatment, in the authors' experience, may foster the patient's belief that these problems are intolerable and that they were right to avoid them.

This is not to say that abstinence isn't crucial in order for the patient to be emotionally available for the work of therapy. Rugle and Rosenthal explore the various power games that may occur between patient and therapist, and the consequences of the patient continuing to gamble, keeping secrets or lying, and then feeling smarter than the therapist or that they have gotten away with something.<sup>41</sup> Shifts in the transference or countertransference may call attention to whatever is being avoided. Focusing on the patient's feelings of guilt, shame, and helplessness, and the vicissitudes of those feelings, is central to Rosenthal and Rugle's method of treatment.<sup>40</sup> For example, chasing, in their experience, is frequently an irrational way to negate feelings of guilt. Some gamblers believe that by winning back what they had lost, it is not only the debt that is erased, but that it is as if they had never gambled in the first place. This is the psychological defense mechanism of undoing. In a sense, two wrongs can make a right. Similarly, guilt may be used as a defense against

shame. Doing something, such as gambling, with its emphasis on action, may serve to counter the sense of weakness, helplessness, and paralysis that is associated with shame.<sup>42</sup> The guilty individual feels he or she has done something bad; the individual living in shame feels he or she is bad.

And finally, an important part of therapy is self-forgiveness. Many gamblers stop gambling, even put together significant periods of abstinence, without ever forgiving themselves. The process of self-forgiveness begins by being able to put one's behavior in the past:<sup>42</sup> "I used to do such-and-such, but I don't do it any more." Rosenthal has described covert forms of gambling, and ways of "staying in action" that interfere with the ability to say this. Intractable guilt on the part of the patient can have several causes, but is frequently due to behaviors in the present that have remained outside of awareness or escaped the purview of the therapy.<sup>43</sup>

Taking responsibility for the choices one makes, and addressing the consequences of one's behavior, is central to the development of self-esteem. By fostering curiosity in the patient about the meaning of their behavior, and encouraging self-reflection, they should be less likely to engage in impulsive or self-destructive behaviors in the future. While we lack systematic outcome studies of pathological gamblers treated psychodynamically, studies cited above for other disorders treated by PDPT (especially when of one to three years' duration), document long-term changes in defensive organization and coping styles.

### Conclusions

There are no randomized controlled trials of PDPT for pathological gambling. Prior to 1970, there were a number of single case histories of gamblers treated successfully by psychoanalysis and PDPT. Dynamics focused on the role of omnipotent defenses against helplessness and depression; competitiveness with authority figures; shame, guilt, and issues involving loss of control.<sup>4</sup> There is a series of gamblers treated by a single therapist,<sup>29</sup> with clearly defined criteria for success, but with no follow-up posttreatment. Although a psychoanalyst by training, Bergler's success seems related to his unique style of confrontation, in which he challenged his patients' omnipotent defenses, their patterns of self-deception, and irrational thinking. A more recent paper on transference and counter-transference reactions<sup>41</sup> acknowledges the importance of the therapeutic relationship and describes some of the common and problematic interactions and their affect on the treatment of PG.

In the contemporary literature, we find PDPT subsumed under multimodal, eclectic and integrated approaches, with approximately half a dozen studies attesting to its efficacy. Unfortunately, in multimodal, eclectic programs it is even more difficult than when examining simpler programs to appreciate what therapists are actually doing and, in those instances of successful treatment, what it is that may be making the difference. Toward this end, I assembled a more detailed description of two of the more successful programs.

After reviewing their theoretical assumptions, Gupta and Derevensky presented a case history illustrating how the initial formulation of a young gambler's core issues could be used in a multimodal, integrated way to achieve the goals of treatment.<sup>39</sup> The authors emphasize that, in their experience, unless underlying problems are resolved, and the patient's coping/problem solving skills improved, gambling cessation will be temporary and the individual will remain at risk for other

addictive and self-destructive behaviors. This conclusion is similar to one reached by Blatt et al. in their review of the PDPT literature for other disorders.<sup>25</sup>

There are a number of studies showing that, across a spectrum of disorders, STPP is at least as effective as other types of treatment, and that therapy of longer duration may be more successful in bringing about longstanding or permanent changes in defensive functioning. When STPP is modified for a specific clinical problem, it is far more likely to be effective.<sup>1</sup> PG, and the other impulse control disorders, may readily lend themselves to STPP. Given these factors, and the continued use of psychodynamic approaches for treating PG, empirically solid outcome studies are needed.

### 1. Future directions

Multimodal, eclectic or integrated, gambling specific programs, which have played such an important role in the treatment of PG, offer a special opportunity for collecting data. There is a need for more outcome studies, but with longer follow-ups, and with more information on what programs actually provide: their theoretical assumptions, structure, and the nature of their interventions. What actually takes place in individual and group therapy sessions? Pre and posttesting could address questions about what happens in treatment. For example, do patients retain information from the educational components of the program? Are there changes in defenses/coping mechanisms? What about the quality of the gambler's relationships, their self-esteem, moral and spiritual values? Which of these changes correlate or are causal with gambling abstinence? What happens long-term?

As Leichsenring and others have cautioned, the findings that emerge from efficacy studies conducted within the strictures of the randomized clinical trial model cannot be directly transferred to routine naturalistic clinical practice.<sup>14</sup> For one thing, clinical trials typically exclude comorbid conditions in order to focus on homogeneous populations. In the case of PG, comorbidity is the norm rather than the exception. Naturalistic studies keep exclusion criteria to the minimum in order to better reflect the clinical population. The two types of study designs (randomized controlled versus naturalistic) lead to different intended applications;<sup>44</sup> therefore they are not in competition with each other, and there is a need for both.

Naturalistic studies also differ in other respects. Routine practice usually involves combination treatments, and titrates those treatments to patient response. Naturalistic studies of psychotherapy have consistently found a dose-response relationship, in that longer treatments (1-2 years) are more effective than briefer treatments.<sup>45-47</sup> Is this true for PG, or is there an optimal dose with regard to frequency and length of treatment? How long a follow-up would one need? Naturalistic studies can address a variety of interesting research questions, and can also serve to generate hypotheses that can then be tested under more rigorous conditions. As Westen et al. correctly observed, most of the major clinical innovations in the field of psychiatry have come from clinical practice.<sup>47</sup>

With regard to PG, there is a lack of naturalistic treatment studies. What kinds of gamblers are being seen by individual clinicians in the community? How and when do gamblers get to treatment? How are reality factors, such as health insurance, the patient's financial situation, distance from the therapist's office, work and school related time constraints, medical problems, affecting the affordability and practicality of

treatment? How does comorbidity affect treatment, and how is the therapist dealing with it? When is medication being used, and with what results? Does the therapist utilize psychodynamic approaches, either as PDPT or mixed with other techniques? How do they deal with the gamblers' families? With Gamblers Anonymous? And finally, what treatment differences are there between those clinicians with specialized gambling training and those without?

According to Kazdin, our current approach to outcomes research has it backwards. He believes treatment research should begin by identifying the *key dysfunctions* associated with a disorder and empirically demonstrate them clinically.<sup>48</sup> A proposed treatment method would need to be conceptually linked to the hypothesized dysfunction. Only then could a manualized treatment be developed and tested. In two additional steps, process-outcome studies could then be implemented to establish key treatment components and necessary treatment length, and finally, one could look at factors that promote or undermine the effectiveness of the treatment.

With regard to pathological gambling, certain key dysfunctions have been described. One that may be particularly promising has to do with the gambler's use of avoidant coping strategies and defenses. Gambling is typically turned to in an attempt to avoid or escape some intolerable affect or situation. Among psychoanalysts, intolerable affect is also referred to as *unbearable affect*. There is also a developing literature on what has been named *experiential avoidance*.<sup>49</sup> Experiential avoidance has been described in relation to several impulse control disorders, including compulsive and high-risk sexual behaviors<sup>50</sup> and trichotillomania.<sup>51</sup> There are now a number of instruments for measuring avoidant strategies and coping styles; affect intensity, control, and regulation; one's subjective experience of emotions; and also boredom proneness and susceptibility.

As has been frequently observed in the gambling literature, there is a need for subtyping. Blaszczynski and Nower's<sup>52</sup> three pathways model shows some promise, but it has not been applied, much less tested, clinically. While STPP may work as well as other forms of treatment, this still leaves unanswered the question of which gamblers it might work best for, and whether modifications would make it more or less suitable for specific types of gamblers.

Several of the claims attributed to PDPT need to be tested. Does the quality of the therapeutic relationship, measured as early as the second session,<sup>25</sup> predict treatment success? Does PDPT strengthen defenses and coping mechanisms in a way that protects against relapses long term? This would be more significant if we knew that PG was a chronic, life-long disorder, similar to our conception of alcoholism, rather than a more acute disorder, like cocaine dependence. Longitudinal studies are necessary, but again, the possibility of subtypes (one acute, the other chronic) exists.

And finally, a central claim attributed to psychodynamic approaches, namely that understanding the meaning of one's self-destructive, seemingly irrational behavior (specifically, why one gambles), can be important in getting one to stop, needs to be empirically tested. Gamblers Anonymous rejects the idea, yet it has been important to clinicians, as exemplified in a number of the above-cited examples. The identification of core issues and conflicts may allow the patient to start facing those intolerable affects and situations and not feel the need to escape. Understanding why one did what one did also helps considerably in beginning to forgive oneself.



How useful is it to identify core issues and conflicts early in the treatment of PG? And how easily can they be identified? Research might support the importance of the psychodynamic formulation, regardless of treatment subsequently utilized. Additionally, it would address the all-important question of whether abstinence from gambling was a sufficient treatment goal, or whether the therapeutic focus should be on the gambler's underlying problem(s), or, a third possibility, on the need to develop healthier, more mature defenses/coping mechanisms.

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