PSYCHOTERAPIA 2 (185) 2018
pages: 47–62

Emilia Rutkowska[1], Bernadeta Lelonek-Kuleta[2]

ROBERT LADOUCEUR'S COGNITIVE-BEHAVIOURAL CONCEPTION OF THERAPY FOR PATHOLOGICAL GAMBLERS

[1]University of Szczecin, Institute of Psychology, Department of Personality Psychology

[2]John Paul II Catholic University of Lublin, Institute of Family Studies and Social Work,

Department of Public Health

pathological gambling
cognitive-behavioural psychotherapy

Summary

The aim of this paper is to present a model of psychotherapy for people diagnosed with pathological gambling, which was developed by Robert Ladouceur within the cognitive-behavioural approach. The main premise of this model is addressing patients' erroneous beliefs, as well as providing them with behavioural strategies that they can use to avoid situations conducive to gambling. The presented model can be applied to either individual or group therapy. There are recommendations provided for each of them concerning the course and content of the individual sessions. The paper also presents a short case study showing the use of this approach in the therapy of a patient with a pathological gambling problem.

Introduction

The term 'gambling' is used as a synonym for betting and games played for money with an inherent element of chance, risk and randomness [1]. Therefore, gambling is inseparably connected with risk. The outcome of a gambling game depends on chance, which means that there is no way of predicting or influencing the game's outcome. Playing gambling games involves spending money, but it also offers an opportunity to win money. The financial aspect is extremely important, and the prospect of a possible win encourages people to play [2, 3]. Unfortunately, due to the nature of gambling, players often lose their money. Some people lose very large amounts without being able to control their losses. In such cases, the negative aspect of gambling is exposed, which is pathological gambling, or – colloquially speaking – addiction to gambling.

Pathological gambling is a mental health disorder that has been included in the international DSM and ICD classifications of mental disorders. It was first defined in 1980 in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), where it was included in the group of habit and impulse control disorders. In the 2013 version of the DSM classification, it was included in the category of substance-related and addictive disorders for the first time. It was classified in the subcategory of non-substance-related disorders as a 'gambling disorder' [4]. The following nine of the ten diagnostic criteria from the previous editions of DSM were retained:

- preoccupation with gambling (e.g., reliving past gambling experiences, planning the next venture, etc.);
- gambling with increasing amounts of money in order to achieve the desired level of excitement;

- repeated unsuccessful efforts to control, cut back, or stop gambling;
- restlessness or irritation when attempting to cut down or stop gambling;
- treating gambling as a way of escaping from problems or relieving a dysphoric mood (feelings of helplessness, guilt, anxiety, depression, etc.);
- after losing money gambling, often returning another day to get even;
- lying to family members, the therapist or others to conceal the extent of one's involvement with gambling;
- jeopardizing or losing significant relationships, job, or educational or career opportunity because of gambling;
- relying on others to provide money to relieve desperate financial situations caused by gambling [5].

The criterion about committing illegal acts to finance gambling has been removed. It is worth emphasizing that pathological gambling has been included in the category of addictive disorders as the only one among the now broadly understood 'behavioural addictions'. It should also be noted that, due to a relatively long research tradition [6-8], it is one of the best-known "isms" (e.g. workaholism, shopaholism, etc.).

Development of pathological gambling

One of the first clinician-researchers studying pathological gambling was Robert Custer, who wrote many papers on the diagnosis of this disorder and opened the first gambling treatment clinic in Brecksville, Ohio [9]. According to him, there are four phases in the development of pathological gambling:

1. the winning phase,
2. the losing phase,
3. the desperation phase,
4. the hopelessness phase.

In the first phase, people discover gambling, which is very often associated with the initial big win, i.e. winning a relatively large amount of money in the game. This event is a source of a lot of strong, positive emotions and faith in subsequent wins. It triggers a desire to continue gambling, which makes it a consciously sought-after form of entertainment. Carrying on gambling inevitably involves more and more frequent losses that a person tries to recoup by gambling increasingly more money. One of the characteristics of this phase is "chasing losses".

In the second phase, the gambler begins to lie to the family to hide their activities, they continue to gamble and still believe in winning despite suffering successive losses. At the third stage, the problems caused by gambling are so serious that the gambler begins to experience them in various aspects of life – they lose their job, their relations with relatives deteriorate, they have serious financial problems. All this translates into their emotional state and makes them experience strong psychological stress, but they paradoxically continue to believe in winning. Feeling embarrassed and worried, they keep at a distance from other people

and shut themselves away in their own world dominated by problems related to gambling. In the fourth phase – hopelessness – they lose faith in the possibility to quickly improve their situation, they feel overwhelmed by difficulties and unable to overcome them. At this stage, the gambler may seek help, feeling that they have nothing more to lose (so far, they believed in gambling and were not ready to give it up). However, they may also look for an escape in psychoactive substances or try to take their own life, which is a particularly serious threat in this phase [10].

Typology of pathological gamblers

Although all pathological gamblers follow the same path to developing their addiction, they cannot be reduced to a "common denominator". There are many studies that allow us to understand the psychological profile of a gambler [11–14]. Alex Blaszczynski's typology of gamblers seems particularly interesting and close to clinical observations [15]. He distinguishes three types of gamblers, i.e. the normal gambler, the biologically vulnerable gambler, and the emotionally vulnerable gambler. The first type of gamblers is characterised by the lack of psychopathological symptoms preceding the gambling addiction. Such symptoms may appear in connection with the addiction. The development of addiction in this type of gamblers is often accompanied by social factors (e.g. their friends are also gambling) and making mistakes in estimating the probability of winning due to cognitive biases. Given the least serious nature of their disorder, such gamblers tend to achieve the best results in therapy and show the greatest motivation to change.

The second type of gamblers exhibit mental health disorders prior to the development of the gambling addiction. They could have had traumatic experiences in the past that made them more emotionally vulnerable. Gambling may be a way for them to escape such difficult experiences. In their therapy, the other disorders should be addressed first, which should include developing the patient's life competences and coping skills. The third group are people who have neurological problems with concomitant antisocial disorders. Their EEG graph resembles that of children with attention deficit. These gamblers started their gambling "career" very early and they often have other behavioural disorders, criminal tendencies, addictions, etc. They make the least progress in therapy due to the lack of willingness to change their behaviour. Therefore, treatment should include building their motivation and, due to the neurological basis of their disorders, it should be supplemented by pharmacological treatment. According to Blaszczynski, the prerequisite for addiction is the presence of games (ecological factor), which overlaps with psychological predispositions. He maintains that, in each case, addiction develops by means of conditioning [15].

Epidemiology

In Poland, there is still a shortage of nationwide studies on the scale of behavioural addictions, including pathological gambling. Research carried out in 2011–2012 shows, however, that nearly fifty thousand people in Poland are addicted to gambling, and two hundred thousand are at risk of developing this

addiction, including especially people under 34 years of age. In addition, nearly a quarter of people over 15 years of age in Poland played for money during the year preceding the research [16].

In terms of worldwide statistics, it is estimated that about 1–2.5% of society are pathological gamblers [17–19]. Some sources also indicate a much greater intensity of the problem in particular parts of the world, such as the state of Mississippi in the USA (4.7%) [20] or Alberta in Canada (8.6%) [21].

Therapy for pathological gambling

Although the problem of gambling affects from 1% to 2% of the population [17–19], no attempts have been made for a long time to develop a special therapy program for people with a pathological gambling problem. Therapies for so-called ‘behavioural addictions’ were dominated by the treatment model used in aid programs for people addicted to psychoactive substances: alcohol and drugs. It was usually a group therapy model related to the concept of a therapeutic community, or the Minnesota Model. Patients with a pathological gambling problem were often placed in groups for people with an alcohol or drug addiction, and their problems were addressed using similar assumptions and therapy methods as is the case of patients addicted to chemical substances [16, 22, 23]. Currently, several types of therapeutic measures are implemented with respect to people with a gambling problem. They include: psychodynamic therapy, family therapy, self-help group therapy (Gamblers Anonymous), behavioural therapy, and cognitive-behavioural therapy [24].The psychodynamic therapy for gamblers focuses on the search for the main intrapsychic conflict underlying maladaptive behaviours and on the analysis of the function and significance of the symptom, i.e. engagement in gambling. In addition, psychodynamic therapists concentrate also on helping the patient deal with shame and the feeling of guilt, which are related to the consequences of gambling they are facing, and on the analysis of defence mechanisms used by gamblers, such as avoidance, acting out, rationalization, minimization [24, 25]. When working with patients with a gambling problem, family therapy under the systemic approach is also used. The systemic approach assumes that a family is a whole, not a sum of parts, so any change in one of its members entails a change in the whole system. Thus, the pathological gambling problem of one of the family members affects and changes the way the whole family functions. For this reason, in family therapy, it is assumed that changing the patterns of intra-family interactions – reducing the intensity of conflicts and tensions – helps to change the behaviour of the gambler. In addition, family is used in the work with gamblers as a source of confrontation and support for the person with a gambling problem [24, 26].Treatment measures for people with a gambling problem also include Gamblers Anonymous self-help groups, whose philosophy and support program are based on the popular Alcoholics Anonymous recovery program. The main therapeutic factors in these groups are structure and support. The most important recommendations for members of Gamblers Anonymous groups are that the person with a gambling problem: (1) participates in as many meetings of self-help groups as possible, (2) refrains from gambling, even in situations where gambling does not involve winning money, (3) focuses on the “here and now”, with the intention not to gamble on that day, (4) interacts with other people in the group to get support [23, 24]. Behavioural therapists have also undertaken

to develop the best treatment methods for people with a gambling problem, using theories of classical and operant conditioning. McConaughey, Armstrong, Blaszczynski and Allock [24] propose to work with gamblers using desensitization and guided imagery relaxation. During a therapy session, the patient imagines a gambling situation, which is likely to trigger a physical and emotional response in their body. The therapist can then propose breathing techniques and other relaxation techniques in order to bring the excitation to the optimal, desired level. Concepts of therapeutic work with gamblers have also been developed on the basis of the cognitive-behavioural approach. Professor Robert Ladouceur from the University of Laval in Canada, together with a team of fellow researchers, was one of the first to develop a comprehensive therapy program for people diagnosed with pathological gambling, which was based on the cognitive-behavioural approach [27]. So far, this approach has been successfully used in treating depression, anxiety disorders (generalized anxiety disorder, social anxiety disorder, panic disorder), psychoactive substance abuse, eating disorders, personality disorders, or in the treatment of psychoses [28], hence the idea to use it in therapies for gamblers as well. This approach assumes that therapeutic measures should focus on two main dimensions: (1) the behavioural dimension, which is associated with learning new behaviours, and (2) the cognitive dimension, involving the construction of new, more adaptive beliefs. The construction of new beliefs and alternative thoughts is connected with the hypothesis put forward by cognitive therapists that distorted, maladaptive thinking underlies all mental disorders, and that the patient's mental state can be improved by changing their way of thinking and helping them to develop a realistic view of reality, which in turn leads to changes in their emotional responses and behaviours. In most forms of therapy, "treatment is based on the cognitive model of a particular disorder and its application to the conceptualization or understanding of the problem of a given patient" [28, p. 3]. In the cognitive-behavioural approach, conceptualization of the problem in order to understand the patient usually consists in identifying the mechanisms in the sphere of thinking and behaviours that have led to the development of the disorder and contribute to the patient's current behavioural difficulties. However, this approach is not focused on the analysis of the past, but on the current way of thinking and behaviours [29].

The cognitive model of pathological gambling is based on the assumption that pathological gamblers develop specific cognitive disorders. To identify the core of cognitive distortions, the researchers studying pathological gambling used an experimental procedure based on the "loud thinking" technique. They observed people during gambling and asked them to speak their thoughts out loud. The experiment was recorded and the content of the statements made by the gamblers was then analysed by research teams [30–32]. On this basis, several types of cognitive distortions characteristic of gamblers have been distinguished [33], which are concerned with:

- the assessment of own skills and situations with respect to which pathological gamblers overestimate their ability to influence the outcome of random events and incorrectly assess the situation, thereby fostering the illusion of control,

- beliefs about having special personal characteristics that increase the probability of winning (e.g. the belief that "I'm lucky by nature", "fate is on my side", "winning is the answer to my prayers") or belief in superstition ("if I play with my left hand, I'll definitely win", etc.),
- selective memory – a person with a gambling problem focuses only on situations related to winning, completely ignoring losses and defeats or attributing them to random external factors,
- an erroneous perception of the probability of winning, misunderstanding the independence of plays, anticipating upcoming wins after a series of losses or hoping to win the money back, assessing losses as "near wins" ("because only one grape was missing", "because it was the number just next to mine") [30, 33, 34].

The identification of cognitive disorders specific to gamblers made it possible to develop a therapeutic program intended for people with a pathological gambling problem. The method of therapeutic work proposed by Ladouceur's team is one of the more coherent and comprehensive programs. They developed a concept of work with people who have a gambling problem, which can take the form of an individual or group therapy [30]. The uniqueness of Ladouceur's approach in comparison to other cognitive-behavioural approaches adopted in the work with gamblers is that, in his opinion, the most crucial misconception held by gamblers is the misunderstanding of the notion of randomness and confusing gambling with games of skill and competence.

Individual therapy for pathological gambling under Ladouceur's approach

Treatment schema

The program of individual therapy for pathological gambling proposed by Ladouceur's team consists of twelve to fifteen therapy sessions. The first two sessions, which are diagnostic in nature, are devoted to completing questionnaires by the patient, assessing the level of their motivation, setting therapeutic goals and conducting a diagnostic interview. If a serious disorder co-occurring with pathological gambling is diagnosed (e.g. depression, bipolar disorder, chemical dependence), the patient is referred to a specialist in order to treat this disorder first. The next eight to ten sessions are therapeutic in nature and conducted on the basis of the cognitive approach. During the first session of this part of the therapy, the patient analyses one gambling situation with the assistance of the therapist. Two subsequent sessions focus on working with the patient on defining the concepts of 'chance' and 'high-risk situation'. The aim of the next two is to discuss the phenomenon of cognitive bias with the patient. The final sessions of this part of the therapy are exercise sessions, during which the patient learns to work on their way of thinking about gambling. Depending on the patient's needs, there are three to five exercise sessions. The third series of sessions, which comprises one or two meetings, is concerned with relapse prevention. The last part consists in post-treatment assessment carried out during one session. The therapy concludes with three meetings that take place after the end of treatment: the first one is after three months, the second – after six months since the final assessment, and the third – one

year after the end of treatment. Their aim is to assess the patient's condition, continue constructive changes and preserve the effects of the treatment. The therapy schedule is presented in Table 1.

Table 1. **The schema of Ladouceur's therapy program for pathological gamblers**

Initial diagnosis 1. Questionnaires 2. Diagnostic interview and assessment of patient's motivation *(two sessions)*
Treatment – the cognitive dimension – Analysis of a gambling situation *(one session)* – Defining the concepts of 'chance' and 'high-risk situation' *(two sessions)* – Cognitive biases *(two sessions)* – "My turn" exercises *(three to five sessions)*
Relapse prevention *(one or two sessions)*
Post-treatment assessment *(one session)*
Assistance – meetings *(3, 6 and 12 months after the end of treatment)*

Adapted by Bernadeta Lelonek-Kuleta from Ladouceur et al., 2000, p. 10. [35]

The schema presented above is very general. Although it does not include any session devoted to behavioural therapy, according to Ladouceur its elements can also be used in the treatment. The author emphasizes, however, that in contrast to the cognitive dimension, which is crucial and necessary in the therapy, behavioural treatment is not obligatory and is undertaken in response to the needs of a particular patient [16].

Initial diagnosis

The aim of diagnostic sessions, apart from making a diagnosis, is to achieve some other goals as well, which include:

- making first contact with the patient and building a relationship based on trust,
- learning the patient's motivation to ask for help,
- setting therapeutic goals,
- identifying the nature of the patient's gambling behaviours and their way of understanding gambling,
- assessment of the patient's perception of their own effectiveness in dealing with high-risk situations and their sense of control over gambling,
- assessment of the consequences of gambling in various areas of the patient's life,
- ruling out other mental health disorders [27].

The initial diagnosis is based on the results of the questionnaires completed by the patient and a semi-structured diagnostic interview (*L'Entrevue diagnostique sur le jeu pathologique – révisée*). This process can be carried out in one of two ways. The first is by sending a set of questionnaires to the patient seeking help from a specialist, so that they can fill them in before the first session, when a diagnostic interview will be conducted. Alternatively, the patient may receive the questionnaires after the first session – diagnostic interview – to fill them in at home and discuss them with the therapist during the second diagnostic session. The order is not relevant, but it is important that the diagnosis is completed before starting any therapeutic intervention. The diagnostic interview comprises 45 questions regarding, e.g., the patient's motivation to seek consultation, the nature of gambling, its consequences, the patient's lifestyle, other addictions, sense of control over gambling, as well as diagnostic criteria for pathological gambling according to DSM-IV. Therapeutic goals are established before any work with the patient begins. Apart from abstinence, reduction of gambling can also be a goal of therapeutic work under Ladouceur's approach. What is important is that the goal is set by the patient themselves and that it is something that they personally strive to achieve and feel capable of achieving. Forcing the patient to abstain from gambling is detrimental to their motivation and may lead to discontinuation of therapy.

Treatment – the cognitive dimension

Cognitive therapy proceeds in precisely defined and ordered stages. A guide for therapists and a guide for patients have been developed for each of these stages. The guide for therapists contains guidelines on the goals specific to a given stage, its course and exercises recommended to the patient. It may also include additional explanations and clinical examples. The guide for patients also contains a brief description of the goals to be achieved at each stage of treatment, as well as a task to complete [38]. Individual sessions follow a similar pattern. At the beginning of each session, the therapist receives the exercise completed by the patient and talks to them about what happened since the last session in terms of the patient's gambling-related behaviour. Then, the therapist introduces and describes the next aspect of the therapy and discusses it with the patient. At the end, the patient is given another task from the guide concerning the issue addressed during the session.

Analysis of a gambling situation

The first therapeutic session is devoted to the analysis of a gambling situation. The aim of this session is to:

- identify the gambler's erroneous thoughts related to gambling – mainly their beliefs about winning and the tendency to try to predict the outcome of the game,
- discover the factors that trigger the desire to gamble, as well as the thoughts and emotions that accompany them,
- specify in detail the patient's own style of gambling,

- understand the reasons why the patient gambles and the reasons why they cannot stop doing it.

During the session, the patient is asked to recreate in their memory their last gambling experience and describe in minute detail their thoughts and emotions at that time. The "loud thinking" technique is used at this point, which involves reporting aloud all that was happening in the gambler's head during that situation.

Defining the concepts of 'chance' and 'high-risk situation'

The second stage of the therapy consists of two sessions, the aim of which is to:

- specify in detail the concept of chance together with the patient,
- make a distinction between games of skill and gambling games,
- sensitize the gambler to high-risk situations and their inner dialogues, as well as develop their ability to recognize them,
- make the gambler aware of the influence of their inner dialogues on the decisions they make with respect to gambling,
- explain to the gambler the relationship between their behaviour and excessive gambling.

At this stage, it is important to effectively sensitize the gambler to the concept of chance on the basis of the observation that the majority of compulsive gamblers misunderstand it, and thus their desire to gamble is intensifying. The correct understanding of chance is that the outcome of an event based on chance is impossible to predict or control. The results of misunderstanding the concept of chance include confusing gambling games with games of skills, which the player can improve and thus influence the game's outcome.

Cognitive biases

At the next stage, the gambler's erroneous thoughts regarding the estimation of the probability of winning are addressed. This issue is the main focus of two sessions, which aim to:

- provide the gambler with knowledge about various gambling "traps" so that they can become aware of their own erroneous thoughts,
- sow a seed of doubt in the gambler's mind regarding their beliefs about gambling.

In order to familiarize the patient with cognitive biases, the therapist provides them with a text describing this phenomenon. It is important to arouse in the gambler the belief that erroneous thoughts are the primary cause of the gambler's inability to manage their excessive gambling. When analysing the text, the therapist and the gambler return to the analysis of the gambling situation with special emphasis on the thoughts accompanying the game. Together, they discuss these thoughts, assessing the extent of their consistence with the definition of chance developed earlier.

"My turn" exercises

Most sessions (three to five) are devoted to the patient developing their own skills. At this stage, the patient needs to:

- learn to question their own erroneous thoughts,
- realize that they have the ability to decide whether to gamble or not – the purpose of the exercises is to teach them how to manage their own thoughts.

The goal is to reinforce the gambler's beliefs about the strong connection between their thoughts and gambling and that giving up gambling is their own choice. According to Ladouceur, this element is the essence of therapeutic activities, thanks to which the gambler changes their attitude from the adamant "I cannot stop gambling" to taking responsibility for their own "I decide not to gamble" behaviour.

Relapse prevention

The next stage of the therapy is relapse prevention. It comprises one or two sessions aimed at achieving the following goals:

- preparing the gambler for the opportunity to return to gambling,
- discussing returning to gambling (Has the gambler already experienced this? How did they handle it?, etc.)
- discussing the text "Emergency Measures" [36].

Ladouceur points out that the problem of relapses should be discussed throughout the therapy, practically since its start, because its purpose is to prevent the return to gambling. The patient's ability to control their gambling is strengthened and, at the same time, the therapist provides them with "emergency measures" to use in case of a situation, where they may feel an urge to return to gambling. They comprise tips and advice such as: "Stay calm" (with a description), "Review your efforts so far", "Analyse in detail the situation that made you return to gambling or increased your desire to gamble", "Ask for help".

At this stage, the therapist may also introduce behavioural interventions if they may be useful in treating a given gambler. In behavioural therapy, the goal is to identify situations that raise the risk of engaging in gambling for a particular patient and to develop a coping strategy to use in such situations to minimize this risk.

Post-treatment assessment

The last session serves as a summary of the therapy. The scope of the assessment includes all of the patient's achievements during the treatment, the nature of their gambling (if the goal was not abstinence), perception of their self-efficacy in relation to the risk of gambling, as well as their sense of control over their gambling. The final component of the assessment serves to evaluate the impact of the change of the gambling nature (if any) on different areas of the gambler's life – family, emotions, mental state, etc. A similar assessment is carried out also three, six and twelve months after the end of the treatment.

Group therapy for pathological gambling under Ladouceur's approach

As in the case of individual therapy, therapeutic work in groups conducted according to the cognitive-behavioural model under Ladouceur's approach involves modifying erroneous beliefs regarding the perception of interrelations between random events in a game. It is additionally supplemented with an analysis of various behavioural strategies that may help to avoid gambling [37, 38].

Group psychotherapy for people with a gambling problem is designed for 13 sessions taking place once a week. The first session is an introductory session, where information regarding the organization and principles of group work are discussed. Each subsequent session has a similar, specific structure. The session begins with the group participants discussing the task they were asked to complete over the week. The main part of the session is educational and consists in teaching the group participants about pathological gambling. Then the participants are encouraged to discuss the information provided in the educational part, referring to examples from their own lives. At the end of each meeting, participants receive a homework assignment to do during the week, which is then discussed at the next session.

Each of the group therapy sessions is devoted to a particular subject, which include: (1) gains and losses resulting from gambling, (2) the concept of chance, the illusion of control and interdependence of plays, (3) the distinction between an excessive gambler and a pathological gambler and the phases of the development of a gambling addiction, (4) discussion of the determinants and origin of pathological gambling, (5) a list of situations that increase the risk of gambling, (6) behavioural strategies to avoid gambling, (7) thoughts and beliefs conducive to gambling, (8) constructive thoughts which serve as an alternative to automatic thoughts conducive to gambling, (9) difficulties in adopting alternative beliefs and behaviours, (10) analysis of risk factors that may lead to gambling relapses, (11) re-analysis of cognitive biases conducive to gambling (illusion of control, interdependence of plays, superstitions, etc.), (12) relapse analysis: warning signs, prevention strategies.

The last (thirteenth) therapy session is devoted to summarizing changes in the therapy. It also includes a revision of the information analysed so far.

Example of the application of Robert Ladouceur's approach to working with a patient – a case study

In this section, we present an example of using Ladouceur's cognitive-behavioural approach in a therapy for a patient with an alcohol addiction and a pathological gambling problem.

The patient is 45 years old, married, has two adult children and lives with his family. He has vocational secondary education, has been unemployed for three years and is supported financially by his wife. He has had a problem with alcohol for around 15 years, and with gambling for 10 years, according to his claims. About a month before coming to the clinic, he completed an inpatient therapeutic program for people addicted to alcohol. The therapy for pathological gambling began at an advanced stage of the work on his alcohol addiction. According to the interview conducted with the patient, he played mainly gaming machines. As a result, he had considerable debts, but his family repaid them. His parents sold valuable family heirlooms and

his wife took two loans, which she has not repaid yet. He does not have any close friends – he says that his friends left because he borrowed money from them to gamble and still has not paid them back.

The cognitive component of the therapy was concerned with the analysis of a gambling situation recreated by the patient and the identification of his erroneous beliefs. During the session, the patient identified the following automatic thoughts and beliefs related to playing the machines: "It's my machine, I know it, I know how to play to win", "I lost a large amount of money today, the machine must start paying out soon", "I won many times, I'll win again for sure", "I must often stroke my machine, then I'm sure it'll let me win". After identifying inner dialogues associated with gambling, the focus of the session was to induce cognitive dissonance in the patient on the basis of the belief: "It's my machine, I know it, I know how to play to win". The therapist referred to what the patient had said by paraphrasing his statement: "I understand that there are situations when you play on your machine and you win?" Then he started a dialogue with the patient by asking the following questions: "Do other machines sometimes pay out anything?", "Does it happen that your machine does not pay out?", "Have the other machines that you played not paid out?". During the dialogue with the patient, the notions of randomness of games and chance were introduced and discussed, and then alternative beliefs were formulated together with the patient with respect to the following statement: "No matter which machine you play, sometimes you win and sometimes you lose, but it's based on random probability". The cycle of therapeutic dialogue concerned with inducing dissonance in relation to the concepts of chance and randomness of games was repeated with the patient several times during subsequent sessions with respect to the other identified beliefs.

The behavioural component of the therapy involved compiling together with the patient a list of strategies that could be useful to him in reducing the likelihood of engaging in gambling. The patient decided that the following strategies would be useful to him: "I will not carry more than PLN 10 in cash", "I will cancel my ATM card, I want only my wife to have access to our money", "I will tell my wife where I played, ask her to go there and say that I self-excluded because I have a gambling problem", "I will participate regularly in AA meetings", "I will work on building new relationships with people".

Working on the issue of gambling based on Ladouceur's model took the therapist and the patient 9 sessions. The discussed therapeutic work was part of a broader therapeutic process involving work on the prevention of addiction relapses, which also included gambling-related issues. The subsequent work with the patient also focused on his behaviour patterns that made it difficult for him to function satisfactorily in family relationships, social interactions and professional roles.

Conclusions

In this paper, we have presented the main premises and methods of individual and group therapy for people with a pathological gambling problem, which have been successfully used by Ladouceur and his colleagues in Canada for many years. There are many empirical studies on the therapeutic program based on his idea, which show its usefulness in working with people diagnosed with pathological gambling [35, 37,

38]. The effectiveness of this approach was analysed in terms of the effectiveness of individual therapy [39] and group therapy [38], as well as particular therapeutic techniques [40].

As far as individual therapy for gamblers based on the discussed approach is concerned, Toneatto and Ladouceur's literature review [39] shows that 85% of patients who completed treatment based on this model did not meet the criteria for pathological gambling after the treatment, and these effects lasted for at least one year after the end of the treatment.

Researchers at the University of Laval in Canada also studied the effectiveness of Ladouceur's approach in group therapy for people with a pathological gambling problem [38]. The study compared two groups of participants of a group therapy and people who were waiting for the start of treatment. The results of the study showed that 88% of the treated gamblers no longer met the DSM-IV criteria for pathological gambling, compared to 20% of the control group. Moreover, the effects of the therapy were relatively stable, as demonstrated by follow-up evaluations carried out 6, 12 and 24 months after the end of the treatment.

The research conducted by Ladouceur's team [41] also compared the effectiveness of cognitive and behavioural techniques in the treatment of people with a pathological gambling problem. The results of the study have shown that both the techniques aimed at changing the patient's beliefs and those aimed at changing their behaviour have similar effectiveness in the work with patients with a pathological gambling problem.

In light of the above, it seems that Ladouceur's therapy program is an effective tool and can be used in whole or in parts when working with people with a gambling problem, also in Poland. A significant advantage of this approach is its short-term nature. The patient's main personality mechanisms do not have to be addressed at the initial stage of therapy, so the focus can be placed on the primary problem instead, i.e. gambling. This approach provides the therapist with an effective and reliable step-by-step scenario; however, as in the case of all therapeutic approaches, it also has some limitations. First of all, the patient must be able to scrutinize their own thoughts and subliminal assumptions. This first barrier can be insurmountable for some patients. In addition, the approach assumes a high level of the patient's involvement in the therapeutic process and their regular work on the assigned tasks, which are the basis of the effectiveness of the therapy. Some patients with addictions do not even try to complete these assignments, which may inhibit the therapeutic process. The cognitive approach helps to deal with distressing symptoms but it does not address their underlying causes. Due to these limitations, the discussed tools should be used in a flexible manner and adapted to the situation of a particular patient.

References

1. Słownik Języka Polskiego online [Online Polish Language Dictionary]. www.sjp.pl, accessed: 21.02.2014.
2. Act of 19 November 2009 on Gambling Games. Journal of Laws of 2009, no. 201, item 1540.
3. Ministry of Finance. Informacja o realizacji ustawy o grach losowych w 2012 roku [Information on the implementation of the Act on games of chance in 2012]. Warsaw, 2013.

4. DSM-5 Table of Contents. Washington, DC: American Psychiatric Association. www.DSM5.org, accessed: 18.02.2014.
5. Diagnostic and statistical manual of mental disorders. DSM-IV. Washington, DC: American Psychiatric Association, 1995.
6. Freud S. Dostojewski und die Vatertötung [Dostoevsky and Parricide]. Munich: Hrsg. von René Fülöp-Millerund Fritz Eckstein, 1928.
7. Bergler E. On the psychology of the gambler. American Imago, 1936; 22: 409–441.
8. Fenichel O. The psychoanalytic theory of neurosis. New York: W.W. Norton & Co. Inc.; 1945.
9. Padwa H, Cunningham J. Addiction: A reference encyclopedia. Santa Barbara, CA: ABC–CLIO; 2010.
10. Lesieur HR, Custer RL. Pathological gambling: Roots, phases, and treatment. Ann. Am. Acad. Polit. Soc. Sci. 1984; 474(146): 146–156. SAGE Publications: http://ann.sagepub.com, accessed: 20.11.2007.
11. Chevalier S, Hamel D, Ladouceur R, Jacques Ch, Allard D, Sévigny S. Comportements de jeu et jeu pathologique selon le type de jeu au Québec en 2002 [Gambling behaviour and pathological gambling according to the type of gambling in Quebec in 2002]. Montreal and Quebec: National Institute of Public Health of Quebec and the Laval University; 2004. www.inspq.qc.ca, accessed: 17.03.2006.
12. Lelonek-Kuleta B. Psychospołeczne korelaty uzależnień od gier hazardowych [Psychosocial correlates of addiction to gambling]. Lublin: John Paul II Catholic University of Lublin; 2012.
13. Minet S, Meijas S, Druine C, Somers W, Hoffmann E, Servais L, et al. Du plaisir du jeu à la souffrance. Une enquête sur le jeu et la dépendance au jeu [From the pleasure of the game to the suffering. An investigation into gambling and gambling addiction]. Brussels: Free University of Brussels, Institute of Sociology, Centre for Psycho-Sociology of Opinion; 2004. www.ulb.ac.be/soco/creatic, accessed: 17.12.2005.
14. Ogińska-Bulik N. Uzależnienie od czynności. Mit czy rzeczywistość? [Addiction to activities. Myth or reality?] Warsaw: Difin; 2010.
15. Blaszczynski A, Nower L. A pathways model of problem and pathological gambling. Addict. 2002; 97(5): 487–499.
16. Moskalewicz J, Badora B, Gwiazda M, Herrmann M, Kalka J. Oszacowanie rozpowszechnienia oraz identyfikacja czynników ryzyka i czynników chroniących: hazardu, w tym hazardu problemowego (patologicznego) oraz innych uzależnień behawioralnych [Estimation of prevalence and identification of risk factors and protective factors concerning gambling, including problem (pathological) gambling and other behavioural addictions]. Warsaw: CBOS; 2012.
17. Cunningham-Williams RM, Cottler LB. The epidemiology of pathological gambling. Sem.Clin. Neuropsychiatry 2001; 6(3): 155–166.
18. Welte JB, Barnes GM, Wieczorek WF, Tidwell MC, Parker J. Gambling participation in the US – Results from a national survey. J.Gambl. Stud. 2002; 18: 313–337.
19. Williams RJ, Volberg RA, Stevens RMG. The population prevalence of problem gambling: Methodological influences, standardized rates, jurisdictional differences and worldwide trends. Report prepared for the Ontario Problem Gambling Research Centre and the Ontario Ministry of Health and Long Term Care; 2012. http://hdl.handle.net/10133/3068, accessed: 15.02.2014.

20. Shaffer HJ, Korn DA. Gambling and related mental disorders: A public health analysis. Ann. Rev. Publ. Health 2002; 23: 171–212.
21. Le jeux de hasard au Canada. Rapport du Conseil National du bien-être social [Gambling in Canada. Report of the National Council of Welfare]; 1996. http://www.ccsa.ca/ccsa, accessed: 16.04.2006.
22. Mellibruda J. Psychologiczna problematyka uzależnień od alkoholu i narkotyków [Psychological issues in addiction to alcohol and drugs]. In: J. Strelau (ed.), Psychologia. Podręcznik akademicki. T. 3 [Psychology. Academic Handbook. Vol. 3]. Gdańsk: GWP. 2005; 691–710.
23. Pindiur A. Życie wolne od hazardu. Wskazówki dla terapeuty [A life free of gambling. Guidelines for the therapist]. In: B. Woronowicz (ed.) Hazard. Historia, zagrożenia i drogi wyjścia [Gambling. The history, threats and the ways out]. Poznań: Media rodzina. 2012; 121–168.
24. Fong, T. Types of psychotherapy for pathological gamblers. Psychiatry (Edgmont), 2005;2(5): 32–39.
25. Abadi M. Psychoanalysis of gambling. Rev.Psicoanal. 1964; 21: 366–373.
26. Goldenberg H, Goldenberg I. Terapia rodzin [Family therapy]. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego, 2006.
27. Ladouceur R, Lachance S. Overcoming pathological gambling. Therapist guide. Oxford: Oxford University Press, 2007.
28. Beck J. Terapia poznawcza. Podstawy i zagadnienia szczegółowe [Cognitive therapy: Basics and beyond]. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego, 2005.
29. Popiel L, Prągłowska E. Psychoterapia poznawczo-behawioralna [Cognitive-behavioral psychotherapy]. Warsaw: Wydawnictwo Paradygmat, 2008.
30. Ladouceur R, Sylvain C, Boutin C, Doucet C. Understanding and treating the pathological gambler. Ontario: John Wiley & Sons; 2002.
31. Petry NM. Pathological gambling: Etiology, comorbidity and treatment. Washington, DC: American Psychiatric Association, 2005.
32. Toneatto T. Cognitive therapy for problem gambling. Cogn.Beh.Pract. 2002; 9: 191–199.
33. Riscwood D, Blaszczynski A, Delfabbro P, Dowling N, Heading K. The psychology of gambling. In: https://www.psychology.org.au/Assets/Files/APS-Gambling-Paper-2010.pdf; 2010, accessed: 4.01.2018
34. Joukhador J, Blaszczynski A, MacCallum F. Superstitious beliefs in gambling among problem and social gamblers: Preliminary data. J. Gambl. Stud. 2004; 20: 171–180.
35. Ladouceur R, Boutin C, Doucet C, Lachance S, Sylvain C. Programme d'évaluation et de traitement des joueurs excessifs [Evaluation and treatment program for excessive gamblers]. Québec: Centre pour la prévention et le traitement du jeu; 2000.
36. Ladouceur R, Lachance S. Overcoming your pathological gambling: Workbook (Treatments That Work). London: Oxford University Press, 2006.
37. Ladouceur R, Sylvain C, Letarte H, Giroux I, Jacques Ch. Cognitive treatment of pathological gamblers. Beh. Res. Ther. 1998: 36: 1111–1119.
38. Ladouceur R, Sylvain C, Boutin C, Lachance S, Doucet C. Group therapy for pathological gamblers: A cognitive approach. Beh. Res. Ther. 2003, 41: 587–596.

39. Toneatto T, Ladouceur R. Treatment of pathological gambling: A critical review of the literature. Psychol.Addict.Beh. 2003, 17 (4): 284–292.
40. Harvey P, Smith D, Battersby M, Harvey P, Pols R, Ladouceur R. Two-group randomized, parallel trial of cognitive and exposure therapies for problem gambling: A research protocol, BMJ OPEN 2013, 3(6), 9p.
41. Smith D, Battersby M, Harvey P, Pols R, Ladouceur R. Cognitive versus exposure therapy for problem gambling: Randomised controlled trial. Beh.Res.Ther. 2015, 69: 100–110.

E-mail address: emiliapsycholog@gmail.com