CHAPTER THREE

From Engagement to Treatment, Recovery, and Beyond For People Seeking Help For Their Gambling-Related Problems

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This chapter focuses on the importance of engagement, assessment, and evidence-based treatments for people seeking help for gambling-related problems, and on understanding how relapse happens. It has been written for mental health professionals with a background in evidence-based practice, including Cognitive Behaviour Therapy (CBT) (Beck & Beck, 2011) and Motivational Interviewing (MI; Hettema et al., 2005). This treatment approach has been developed from the latest gambling literature and evidence-based practices, proffering a best-practice model for service delivery.

People struggling with gambling harm experience significant stigma, shame, and guilt (Hing et al., 2015), causing emotional distress that can make reaching out for help difficult. This chapter will discuss the importance of effectively engaging the client at the assessment stage to reduce this distress—but not eliminate it, because some distress will keep them mindful of the seriousness of their situation and motivate them toward engagement and treatment (Oakes et al., 2020). A key focus is for the gambling assessment and treatment to progress at a pace that allows the gambler to gradually acknowledge harms without reinforcing unhelpful self-pathologising narratives that obstruct change and have been shown to improve treatment retention and outcomes. We will discuss the importance of behavioural interventions such as exposure therapy with the aim of extinguishing the gamblers' urges to gamble, which are critical in reducing relapse and reshaping

maladaptive coping patterns. The use of cognitive therapies using Bayesian principles (Hoffrage et al., 2002) helps to correct erroneous beliefs that lead to the resumption of gambling despite its harms. This incorporates positive psychology approaches (Slade, 2010) based on the following

- mindfulness (de Lisle et al., 2012)
- increased self-awareness, acceptance, compassion
- identification of harmful stuck points
- internal dialogue
- harmful narratives (Resnick et al., 2006)

that act to improve prospects of long-term recovery.

The impact of comorbid mental health issues and associated risk and needs assessment to guide parallel evidenced-based treatment is discussed, including how to recognise and manage associated mental health comorbidity (particularly depression) to enhance prospects of sustainable long-term recovery. The CBT scientist-practitioner model approach utilises client-centred engagement and shared case conceptualisation (Rogers & Wood, 1974).

Defining Gambling Disorder and Harms

Gambling involves the risk of something of value, such as in a voluntary agreement between at least two parties to exchange an item of value based on the outcome of an uncertain event (Blaszczynski et al, 1999).

Gambling Disorder (GD) is associated with an inability to limit money or time spent gambling, resulting in adverse consequences for the gambler, as well as their partners, family, friends, employers, work colleagues, and the broader community (WHO, 1993).

Gambling Problems are a severe public health problem (Productivity Commission, 2010) affecting the welfare of gamblers who experience harms including depression, anxiety, suicidal ideation,

and dissociation (Delfabbro, 2007). A significant proportion of gamblers relapse, usually resulting in uncontrolled gambling with many damaging consequences across various aspects of daily life functioning (Oakes et al., 2012; Hodgins et al., 2002; Thygesen & Hodgins, 2003). This can cause the gambler significant distress, often due to significant financial losses, relationship breakdowns, employers, family members or friends becoming aware of their problem, and a sense of hitting 'rock bottom' (Evans & Delfabbro, 2005; Hodgins et al., 2009).

The Nature of Distress and its Role in Gambling

Regardless of the negative consequences it causes for them, their significant others and the broader community, those with problem gambling behavioursoften continue to gamble and/or relapse, unable to stop this vicious cycle of harm. Learning from the devastation of a gambling relapse and escaping the cycle is challenging for the gambler because gathering the motivation needed to change can be overwhelming, and repeated relapse becomes a way to avoid despair, reinforcing the same cycle.

With the support and use of evidence-based approaches (Oakes et al., 2020), the gambler can begin to tolerate this despair, recognise it as a passing state and start to learn from the harms of their behaviours. At this time, motivational enhancement strategies can help the client to identify, explore, and resolve any ambivalence, provide hope and foster a commitment to meaningful positive change through treatment (Miller, 1983).

Client Engagement

Few people experiencing gambling harm voluntarily seek treatment, and of these about half will drop out or prematurely terminate the program before finishing treatment (Melville et al.,

2007; Ronzitti etal., 2017). When they do seek help, it is usually crisis-motivated rather than a deeper recognition of the problem (Evans & Delfabbro, 2005). Encouraging treatment engagement is therefore essential to reduce, resolve or prevent associated harms to the individual, their families, and society (Pulford et al., 2009). The counsellor must consider that the shame and stigma associated with gambling problems are strong deterrents to disclosure, help-seeking (Hing et al., 2015), and treatment engagement. The gambler may fear judgment shame and/or stigma from attending counselling (Hing et al., 2015), so these must be addressed early in the help-seeking process so that people are comfortable seeking help before they reach a crisis and continue to engage with treatment (Brown & Russell, 2020).

When gambling is triggered by distress, the therapeutic process of exploring its negative consequences may make the gambler feel increasingly distressed and overwhelmed. This suggests that a comprehensive assessment during the first appointment may be too confronting because experiencing high levels of distress during the therapeutic process is not conducive to persistence in treatment. Reducing acute distress should be an immediate priority to ensure clients are in a stronger position to think clearly about their help-seeking options and can take on new information.

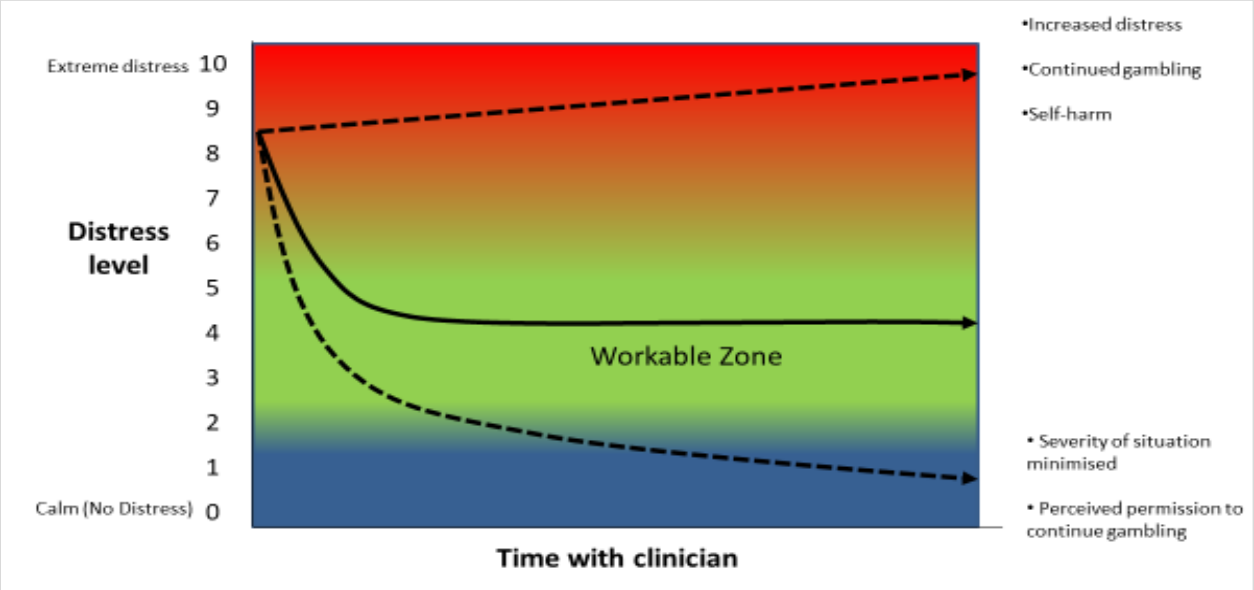
A Rogerian approach is ideal for facilitating engagement in the therapeutic process, with the clinician demonstrating unconditional positive regard for their clients' wellbeing, helping them understand their situation and treatment needs, and demonstrating deep and genuine concern. This empathetic approach can minimise the shame and stigma the client may be experiencing and make talking about the problem more comfortable for them. Reflecting on the clients' emotions and issues is essential for them to feel validated, accepted, understood, and ready to engage in the therapeutic process (Rogers & Wood, 1974). This approach may take several sessions but is a critical part of the initial engagement process. It is important to reduce the level of distress enough

that the client can engage and benefit from treatment, but without eliminating it so that they remain mindful and focused on the seriousness of the situation and need to change (Oakes et al., 2020).

When people experiencing gambling harm find the courage to seek help, it is essential to use this window of opportunity to encourage them to critically examine their problematic behaviours. Therefore, the assessment process needs to progress in a manner that allows them to gradually acknowledge the harms associated with their behaviour until they are emotionally stabilised, allowing them to engage fully in the therapeutic process (Oakes et al., 2020). As shown in Figure 1, the aim is to sufficiently reduce the clients' distress level to remain in the 'workable' or optimal zone (Oakes et al., 2020).

Figure 1

Potential Changes in Distress Level Based on Counsellor Response



A mental health, risk, and service needs assessment is essential for all gamblers presenting for help, as many suffer from depression or other negative affective states. A comprehensive assessment should include the identification of comorbidities to facilitate the development of a holistic case conceptualisation and treatment plan that addresses triggers of harmful behaviours and relapse, and barriers to long-term recovery. Once clients begin treatment, clinicians need to foster adherence and retention (Melville et al., 2007), because gamblers have been found to habitually reschedule, cancel, or fail to attend sessions (Toneatto, 2005). Behaviour change can take time, as can be seen in the example of alcohol addicts who need long-term support to deal with their issues (Humphreys & Tucker, 2002).

Problem gambling behaviours also significantly impact family members and carers, so educating and involving these significant others as appropriate will improve their understanding, resilience, and capacity to support and assist in maintaining the client's treatment. Involving the family or significant other in the treatment process is valuable to help them understand the treatment approach and their role in supporting the gambler with financial and emotional management. However, it is important to consider the impact of gambling on significant others, spouses, and intimate partners, as it often causes additional intra- and interpersonal distress (Hodgins et al., 2007).

Understanding the relationship between problem gambling behaviours, family impacts, family coping, and family violence is important for treatment and relapse prevention. Screening for family violence is essential when offering family-based approaches (Suomi et al., 2013). It can be beneficial to encourage affected others to seek personal support and resources to help them understand and process any unresolved issues regarding the gambler’s behaviours and impact on their lives.

Initial Engagement, Self-Analysis & Assessment

Traditional top-down treatment models involve expert clinical assessment to diagnose gambling-related problems, often with a pejorative label that can be distressing, counterproductive, and destructive, removing a sense of personal capacity, responsibility, and agency to alter or change their behaviours. In this formulation, the individual is reduced to, and defined in terms of, their pathology. For example, a review of workforce development needs in drug and alcohol addiction (Allsop & Helfgott 2002) found skill and knowledge deficits in drug specialist staff, which should be addressed to better respond to the problem. The authors highlighted that knowledge and skill development strategies must be available to ensure these workers have high-level skills and external credibility.

These therapeutic approaches rely on experts to administer or deliver external interventions, which although sometimes effective in the short term, do little to alter the underlying individual psychological factors. Expert models emphasise recognition that an external locus of control and lack of personal responsibility serve to reinforce feelings of worthlessness, helplessness, and hopelessness, and contribute to gambling harm and higher relapse rates.

Early treatment models espoused the virtues of expert psychodynamic approaches documented in Bergler (1958), behaviourist-driven approaches such as aversive conditioning (Seager, 1970), or inpatient treatment programs (Russo et al., 1984; Morefield et al., 2014). Research on these types of programs frequently lacked controls and demonstrated high relapse rates. They failed to recognise psychological drivers beyond operant and classical conditioning, having not learned from decades of unsuccessful behaviour modification experimentation. These

behavioural approaches achieved short-term change in a controlled environment, but participants failed to generalise and maintain these gains in the real world, leading to relapse.

We believe this is primarily a consequence of the failure to treat the whole person, restore their agency or self-efficacy, and adequately address the underlying psychological factors and treat comorbidities such as substance misuse, depression, trauma, and suicidality. Doing so requires incorporating empirically supported treatments like CBT that promote personal responsibility and an internal locus of control. These are client-centred approaches based on the scientist–practitioner model whereby the therapist, in collaboration with the person experiencing harm, teaches effective strategies and skills that increase self-efficacy, functioning, capacity, and individual agency to promote longer-term sustainable gains and recovery.

The South Australian Intensive Gambling Help Service Treatment Approach

PsychMed has run the South Australian Intensive Gambling Help Service (SAIGHS) on behalf of the local government for seven years. A key component of the treatment provided by SAIGHS is reducing and ultimately eliminating gambling urges through graded exposure. The main approach is to help clients recover from their gambling-related problems using best practice models of care. Once clients complete a course of evidence-based treatment, they can feel confident to re-engage in a meaningful and purposeful life without the ongoing harms associated with gambling. Clients committed to the treatment program have consistently reported that they no longer experience gambling urges and can make rational decisions about their gambling behaviours.

Because the SAIGHS treatment model takes into consideration the connection between mental health (e.g., trauma, suicidality) and gambling (Manning et al., 2020), each client registered

for the SAIGHS program is assessed by our clinical team using a comprehensive psychological assessment to identify any underlying mental health issues or substance-related comorbidities.

Figure 2 illustrates the SAIGHS engagement process described in Figure 1 which is aimed at reducing client distress when a client seeks help to ensure they feel comfortable and supported to engage in the assessment of their gambling-related issues.

Figure 2

Initial Engagement Process

Most clients who seek help at our service have some degree of suicidal ideation. These clients present as extremely distressed, so our team takes time to stabilise them and provide them with hope for recovery to bring them to a point where they feel able to engage in treatment. They were usually also referred to our Suicide Intervention Program for Suicide-Attempters (SIPS), a suicide prevention Australia (SPA) accredited program (ASSIP, Michel & Gysin-Maillart, 2015) providing brief, structured, CBT-informed, and client-centred interventions for those who have recently attempted suicide or are in a suicidal crisis.

Our clients also often present with significant trauma symptoms, either related to past events or more recent gambling-related trauma (e.g., financial difficulties, loss of role or relationships). These clients are offered access to our Cognitive Processing Therapy (CPT) group,

a structured program designed to help reduce trauma symptoms, improve social function and capacity, and facilitate long-term recovery from gambling harms (Resnick et al., 2014).

These programs are delivered by accredited and trained clinicians who receive regular supervision.

We use an evidence-based gambling treatment model that emphasises the importance of the following:

- Client motivation and engagement.
- Reducing shame, guilt, and negative self-labelling.
- Normalising and contextualising distress, acceptance of thoughts and feelings, recognising harmful self-labelling and metacognitive thoughts associated with ruminative cycles (Meichenbaum et al., 2007; Wells, 2004).
- Promoting individual agency, responsibility, and factors within our control, such as present and future behaviours.
- A client-centred approach, assisting people in identifying specific, measurable, and realistic therapeutic goals, the focus of change, and how to objectively measure it.
- Utilising motivational interviewing techniques to enhance motivation to change, reduce gambling harms, increase personal awareness of values, and achieve balanced short-term goals across many life domains.
- Functional behavioural analysis of gambling behaviours and identification of the underlying psychological factors and comorbidities that sustain barriers to long-term recovery.
- Providing psychoeducation around comorbidities and perpetuating factors such as erroneous gambling beliefs, dissociative states, and autonomic arousal behind gambling

urges associated with operant and classical conditioning. Psychoeducation is a systematic, didactic, and psychotherapeutic intervention to inform clients and significant others about a psychiatric disorder. The aim is to enable their ability to cope with the illness using a teaching method adjusted to the disorder with the objectives to clarify identity, promote empowerment, and change attitudes and behaviour (Bonsack et al., 2015).

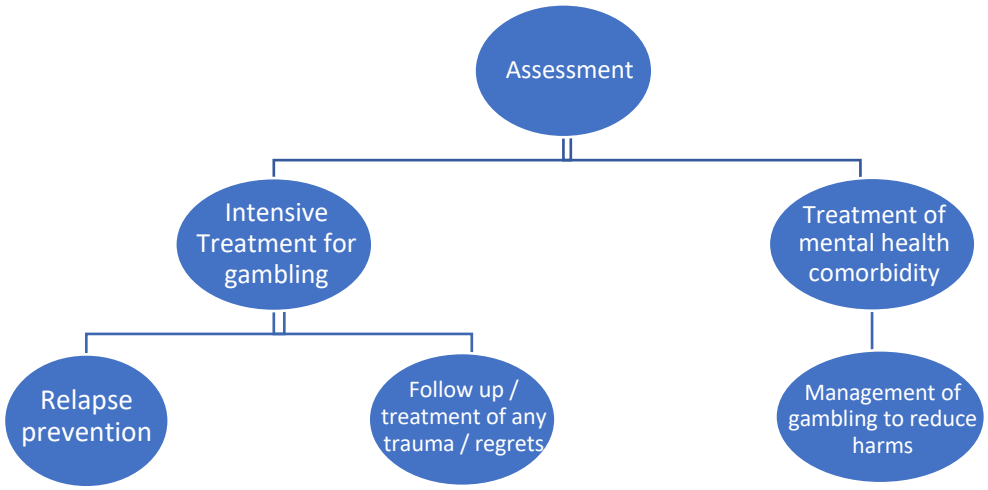
- Utilising evidence-based treatment approaches and a scientist–practitioner framework to address irrational beliefs and behaviours through systematic desensitisation.
- Providing cognitive processing therapy (CPT) to reduce symptoms associated with past trauma that act as ongoing triggers of gambling relapse (Resick, et al, 2006). It is a manualised therapy based on CBT that provides skills to handle distressing thoughts and regain control of one's life (Tran et al., 2016). In comparison, CBT is about the interplay between how thoughts, feelings, and actions affect each other with the aim of changing unhelpful and unhealthy ways of thinking, feeling, and behaving (Hawton et al.,1989).

Figure 3 illustrates the client's flow through the program after assessment. If gambling is the main issue, the client enters the gambling treatment program and then progresses to the relapse prevention component, which includes the options of attendance at a treatment support group. This open treatment support group option provides clients with peer support as they progress through treatment, and after treatment as required. Some clients benefit from the psychoeducation provided in this group program which teaches skills to manage life stressors and reintegrate into society. Once the client completes treatment, they are placed into a follow-up program, usually at three, six-, and twelve months post-treatment. Some clients will also receive additional support at this time for any post-treatment adjustment and regrets as they enter a new life without gambling.

After the assessment, some are treated for a related comorbidity which may present as their main problem. During this time, the clinician works with them to first reduce the gambling harms they may be experiencing. This may include strategies to ensure their finances and assets are safe before the treatment of their gambling-related problems. Once addressed, the clients are then transitioned to the gambling treatment program.

Figure 3

Client Flow-Through Treatment



After addressing mental health co-morbidity, clients are transitioned to the gambling treatment program, ensuring a comprehensive and integrated approach to their care.

Graded Exposure Therapy

Cue exposure techniques have been used with several addictive behaviour problems, including nicotine, alcohol and drug dependence, and eating disorders. The underlying mechanism involved in cue exposure is the unreinforced exposure to repeated cues, which is associated with the extinction of responses, the facilitation of increased self-efficacy, and the minimisation of positive outcome expectancies such as erroneous beliefs about winning money when gambling. Since relapse is triggered in specific high-risk situations that often elicit adverse emotional reactions, cue exposure programs may be improved by presenting these cues in a high-risk situation (Marlatt, 1990).

Exposure therapy in gambling treatment uses exposure to gambling triggers and response prevention to achieve the habituation of the gambling urge. It aims to break the two-way maintenance relationship between gambling and triggers such as money, gambling paraphernalia, boredom, isolation, relationship problems, and financial difficulties (Oakes et al., 2008).

After completing treatment and extinguishing the gambling urge, clients should no longer rely on avoidance strategies. The client will then achieve mastery over their urge to gamble and return to a healthy lifestyle without the need to be vigilant to the dangers of relapse. Cognitive restructuring for erroneous gambling-related beliefs and negative thoughts is used to supplement the exposure therapy once the urge to gamble has subsided.

Although the focus of the examples provided in this chapter is related to Electronic Gaming Machines, this process can be used for all types of gambling. The clinician works closely with the client to establish their hierarchy of triggers for the graded exposure. Before the commencement of the hierarchy, the clinician must first ensure the client cannot access money to gamble. Then the client is taught to allow any urges that arise to subside. These are often the product of emotional

triggers that once identified, can be discussed with the clinician. Cognitive therapy helps the client identify and challenge negative thought processes that trigger the urge to gamble. This technique is done separately from exposure therapy, whilst self-instructional cognitive approaches can enhance its efficacy.

Habituation of the urge is based on the four principles of graded exposure with response prevention:

1. Repeated: The task is repeated daily as homework.
2. Graded: The exposure task is graded to a level that the client feels comfortable to sit with until the urge passes. Eventually, the tasks become more difficult but manageable as the client progresses through treatment. These tasks are repeated daily.
3. Focused: During the exposure task, the client must remain focused on gambling-related thoughts like “I would be lucky today,” “I have spare money to gamble with,” or “this is my favourite/lucky machine.”
4. Prolonged: During each task, the client is asked to prolong their urge by thinking about gambling until the urge completely subsides, without distraction from these thoughts.

The client works closely with their clinician to determine when they have progressed through the stepwise grading of triggers to a point where they feel comfortable sitting alone in a gambling venue with a small amount of money in the gambling machine. The client is educated that they can regrade the task if it feels too overwhelming.

Clients are asked to record their tasks and urges so the clinician can review them to ensure each of the four principles of exposure has been followed. Once habituated to the task, the client progresses to the next one with the clinician’s help. On occasion, the clinician may accompany

them during the live tasks to the gambling venues to ensure they stay confident and adhere to the principles of exposure.

The following is an example of a stepwise graded exposure plan for a client with a focus on Electronic Gaming Machines:

- A black-and-white image of a favourite gambling machine.
- A coloured image of machine, providing increased realism.
- Recorded music and sound effects of a gambling environment with gambling machines, including the jingles that represent winning.
- Videos of different gambling machines winning, evoking a classical conditioned response.
- Imaginal exposure consists of the client being asked to remember a specific gambling situation and describe the scenario in considerable or progressively increasing detail, evoking all five senses. This process is completed in a graded manner where the client slowly engages in self-observation of their gambling behaviours. Some clients can experience urges, while others are more emotionally reactive. The tasks are repeated until the scenario becomes less stimulating to the client. This process can also moderate steps and create an effective hierarchy of exposure exercises.

In live exposure, the client enters a real-world gambling situation and remains until their urges subside completely. The client is asked to:

1. Visit the hotel parking lot without money.
2. Visit the hotel venue without money.
3. Visit the hotel /casino without money.
4. Sit at a gambling machine without money.
5. Visit an ATM and withdraw a small amount of cash.

6. Sit in the venue with a small amount of money.
7. Sit in front of a gambling machine with a small amount of money.
8. Put a small amount of money in the gambling machine but not use it, and then remove it once the urge has passed, having resisted any urge to gamble.

Grading gambling cues allows the subject to habituate to tasks one at a time until their end-of-treatment goal is achieved. Each new task usually takes five to seven days of repeated daily exposure for habituation to occur. These tasks are performed at least five times a week, each usually lasting between 30 minutes and one hour. This time reduces as habituation to the task is achieved (Oakes et al., 2008).

A critical aspect of client-centred, evidence-based practice involves assisting people to identify what they wish to change and how to objectively measure and monitor that change. The case conceptualisation should include examination of presenting, predisposing, precipitating, perpetuating, and protective factors. Using a scientist-practitioner approach engages the person experiencing harm and develops their confidence, personal control, and agency by monitoring how effectively the interventions manage symptoms through their journey to recovery.

Cognitive behavioural therapies and their key components include psychoeducation, motivational techniques, thought challenging, exploring the evidence for and against harmful thoughts, and exploring cognitive distortions, heuristics, and erroneous gambling beliefs. Metacognitive and mindfulness techniques, self-instructional and constructive narrative techniques can be used to augment the effectiveness of exposure, whilst other behavioural interventions such as relaxation training and cognitive interventions (e.g., self-talk, constructive narrative, dialectical behavioural, acceptance and commitment therapeutic approaches) can be used to increase self-awareness, personal agency and enhance capacity for emotional regulation.

Calming these escalated physiological and emotional states when people are experiencing dissociation helps to engage parasympathetic responses and restore rationality in decision-making, planning, and judgment (i.e., capacities associated with the frontal and prefrontal cortices of the brain). These techniques can and should be equally applied to underlying comorbid psychological conditions that initiate, maintain, or contribute to relapse risk. They assist by equipping people with strategies, building skills, increased self-efficacy, hope, and a pathway to long-term recovery.

Remission

The DSM 5 describes the following criteria for remission of gambling disorder:

In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but less than 12 months.

In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for 12 months or longer American Psychiatric Association. (2013).).

Relapse Prevention

It is essential to incorporate relapse prevention strategies throughout therapy, specifically equipping the client with techniques to maintain their behavioural change and reduce the likelihood of a lapse. The goal of relapse prevention is for the client to identify risky situations, improve their ability to cope with them (Echeburúa et al., 2001), and build a sense of self-efficacy (Marlatt & Gordon, 1985).

Clients often experience gambling urges following treatment, usually associated with emotional triggers or access to large amounts of money. The clinician must work alongside the

client to develop an understanding of their individual environmental and emotional factors that make them vulnerable to a lapse or relapse.

For example, ensuring clients have a money management plan until they can handle money independently will prevent further financial damage. This decision must be made with the treating therapist and significant others involved in managing their finances.

CBT Techniques for Relapse Prevention

A critical component of relapse prevention is to educate clients on the theoretical grounding of the behavioural framework for recovery (for example, the role of operant and classical conditioning and how triggers out of the blue can lead to unexpected urges to engage in previous maladaptive cognitive, emotional, and behavioural reactions). Teaching the client to use imagery and cognitive diffusion techniques can be beneficial. Urge-surfing is one example where the client is introduced to the metaphor of an urge being a wave that rises and subsides onto a beach, which helps them to understand if they can resist an urge to gamble as it starts to increase, the urge will pass in time (Marlatt & Gordon, 1980, 1985).

The client should be confident to apply exposure techniques to all urges experienced after treatment using the same methods they have mastered during the treatment. When an urge has subsided, the client is encouraged to engage in critical thought and challenge the erroneous beliefs that may have triggered the urge. Client perceptions also need to be addressed, such as when the client attributes a setback as a failure. These automatic thoughts can lead to guilt and other negative emotions that are high-risk triggers for relapse.

As part of relapse prevention, the client will eventually eliminate these spontaneous urges with repeated exposure to residual triggers and cognitive challenges of associated thoughts.

Post-Treatment Adjustment and Regret

Clients often experience regret after recovering from a gambling related problem, dissociating focus of cognitions from the present to the past by ruminating on past choices and consequences. Stress associated with financial losses, relationship discord, loneliness, and perceived overdependence on others appears to engender regrets about past omissions, lost time and opportunities, and can cause or exacerbate depressive symptoms (Choi & Jun 2009) and other negative emotional states.

People who lack insight and self-awareness often cannot adequately identify when regrets and rumination have moved from functional reflection and problem-solving to dysfunctional, stuck, and destructive narratives. Developing greater self-awareness strategies and skills, using self-acceptance and compassion, metacognitive and mindfulness techniques to facilitate greater control over the focus of their thoughts will decrease dysregulation of cognitive and emotional states associated with recurrent thoughts about failure. These clients need to learn to adapt internally to regrettable past behaviours by adjusting their perceptions associated with their regret (Wrosch & Heckhausen, 2002). If not addressed, the distress associated with persistent regret may increase vulnerability to relapse out of a misguided desire to recover past financial losses.

The client may therefore need to be assessed for trauma associated with their losses and gambling behaviours. CPT is an ideal approach for those in long-term recovery who had previously used gambling to escape negative emotions, and who describe much trauma associated with the aftermath of their gambling. Combining these approaches with constructive narrative perspective approaches can build resilience and improve relapse prevention (Meichenbaum, 2014).

Psychoeducation

Other techniques include role-plays in which the client can practice gambling refusal skills with the clinician to prepare them to respond quickly and effectively to peer pressure. Developing ways to effectively cope with stress and negative emotions are essential lifestyle changes for clients. For example, activities including relaxation, exercise, social events, attention to self-care, and time alone are not helpful to avoid gambling temptations per se but can replace the time spent gambling previously and improve the overall quality of life. Maintaining a healthy and balanced lifestyle with stress management strategies in place is essential for relapse prevention.

Providing a daily activity schedule during treatment can help the client to develop meaningful activities that give a sense of satisfaction. These include activities with friends to improve their social networks, time to schedule homework tasks, relaxation, exercise programs to suit the client's lifestyle, and regular activities such as housework and gardening.

Seven Steps to Address a Client's Lapse / Relapse

If a client experiences a lapse or relapse after having achieved some level of recovery, there are seven steps the clinician should take to address it:

1. Conduct an ongoing risk and service needs assessment.
2. Work with the client to reduce their distress.
3. Review and normalise the lapse in detail and identify the associated triggers and cognitions to help bring constructive pro-recovery explanations to events.
4. Assist them to develop a set of effective coping strategies and support people in similar situations: the "Learning from Lapses approach."
5. Assist them in resuming graded exposure therapy where they feel comfortable extinguishing any reinstated urges.

6. Put money management back in place until they feel comfortable having small amounts of cash/credit on hand.
7. Provide a few booster sessions to ensure they feel ready to be placed back in regular treatment or follow-up.

Cash Management

As treatment progresses, the clinician should review the client's confidence in having small amounts of cash or a limited credit card with the client. However, at this stage, the client should be discouraged from managing their finances independently due to the heightened risk of relapse.

Financial independence should be discussed after treatment is completed during the follow-up sessions. As money begins to have value to the client, they will feel more confident to handle small amounts of cash/credit with the slow reintroduction of access to money in consultation with the clinician.

Outcome Measures

Collecting progress monitoring data is essential to evaluate the client's response to the therapy and, if necessary, revise the treatment to improve it (Persons & Hong 2016).

Outcome measures need to evaluate treatment success with respect to several domains of the client's life. These measures must be multidimensional, considering the client's physical, mental, and social well-being (Pickering et al., 2018).

Several outcome measures are used to evaluate the SAIGHS intervention, taken at baseline, six weeks into treatment, completion, and at one, three, six, and 12-month follow-ups. Examples include:

- The Problem Gambling Severity Index (PGSI): a nine-item self-report instrument designed to measure a single problem gambling construct (Ferris & Wynne, 2001) Given its background and theoretical underpinnings, it is suited for use with a general population. It is a relatively brief, clear, and straightforward instrument with adequate psychometric properties (Holtgraves, 2009). The Problem Gambling Severity Index (PGSI) is used to assess gambling severity at the client's intake into the SAIGHS program."
- The Gambling Symptom Assessment Scale (G-SAS). The G-SAS is reliable and valid in assessing symptom severity and changes in gambling symptoms during treatment and asks for average symptoms during the past seven days (Kim, et al., 2009).
- The Kessler 10 (K10): a widely used and well-validated screening tool measuring current psychological distress (Kessler et al., 2002).
- SMART goals: developed through a client-centred approach to assist the client in identifying and clarifying issues impacting their life and develop concise goal statements that are specific, measurable, achievable, realistic, and timely (Matre et al., 2013). Traditional behavioural approaches recommend developing a specific problem statement and asking clients to rate how much the problem interferes with their daily life and the clinician explains the benefits of implementing this change. The appropriate measures will vary but should reflect clinical best practices and include one for symptom severity related to the psychological issue of concern (e.g., PCL-5 for trauma symptom reduction, BHS for suicidality risk, BDI-II for Depressive symptoms, BAI for anxiety symptoms).

Conclusion

We have outlined the importance of engaging with clients with gambling harms so that they continue to participate in treatment and the ongoing harms are reduced for them, their significant others, and the community. Furthermore, when a gambler reaches out for help, there may be only one opportunity to engage them with professional treatment, so it is critical to invest the time needed to ensure they feel supported, reduce their distress, and provide them with hope. This will ensure the potential for recovery if they complete the treatment and follow-ups. However, recovery can be complex for many clients due to comorbid mental health issues, post-treatment regret, and destructive narratives that can hamper long-term recovery. Therefore, care providers treating people experiencing gambling harm must have adequate skills and supervision to address these issues appropriately.

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