CHAPTER EIGHT

From Twelve Steps to First Steps: An Integrative Approach to Care Pathways for Gambling Disorder

Wayne Skinner, David Brown

Four main frameworks shape our current understanding of gambling problems and how to address them. These have emerged additively over a relatively short time, starting in the mid-twentieth century. The first comes from the personal experience of people with severe gambling problems and their recovery through mutual aid membership in Gamblers Anonymous (GA) and practicing the Twelve Steps. The second framework offers a medicalized view of addiction as a disease that can be diagnosed and treated by health care professionals. The third sees problem gambling as an addictive behaviour that occurs on a continuum that includes mild, moderate, and severe disorders. The fourth focuses on complexity and the higher likelihood for people with gambling problems to have other co-occurring physical and mental health problems. Most interventive approaches to gambling disorders fall within one or more of these frameworks.

While many people with gambling problems recover 'on their own' without a mutual aid organization like GA or professional counselling and support (Toneatto, 2013), those concerned about their gambling behaviour and its consequences need access to formal health care services with timely and effective care pathways that lead to improved, healthier functioning. This chapter describes how these four frameworks offer distinct approaches to addressing gambling disorder and how these frameworks converge around a point of commonality. Each requires a first step: to

effectively engage people with gambling problems in a pathway of care that leads to change and recovery.

How we understand and address gambling problems (and all addictive behaviours) therapeutically is the product of less than century of research and practice. The anthropological and historical record shows that gambling has been endemic in human societies across time and place (Gabriel, 1996; Schwartz, 2006), implying that problems related to gambling also have a long history. Outside of moral and social censure, the emergence of formalized interventive approaches to help people with gambling problems and other addictive behaviours is very recent. Before the advent of mutual aid groups through the establishment of Alcoholics Anonymous (AA) and the Twelve Steps approach in the 1930s, there was little on offer to help people suffering from the harms of alcohol or any other addictive behaviour (Humphreys, 2004; Kurtz, 2010; White, 2014).

Gamblers Anonymous emerged two decades later in the 1950s, providing the first guiding framework on how gambling problems should be understood and approached. The limits of the GA approach and the gaps it exposed opened the space for the three other frameworks to emerge additively. As each new framework emerged, it did not displace earlier ones. Instead, it added a new layer of knowledge and practice. Much like an archeological dig reveals layers of activity that emerged over time, in this layered history of how we have come to understand and respond to gambling disorders, each layer makes its own positive contribution, and also reveals its own limits and gaps. Those limits and gaps open the way for subsequent frameworks to develop, shaping the more comprehensive understanding of gambling disorders as addictive behaviours that we have today.

Each of the four frameworks describes a 'healing journey' for people with gambling disorders to take when they seek help for gambling problems, and the 'care pathways' needed to walk it (Jesseman et al., 2014). Each framework can be summarized through a defining statement from the perspective of the person seeking help:

- The *Gamblers Anonymous* framework: "I have acknowledged to myself and others that I am a gambling addict. We are striving together toward recovery through abstinence."
- The *Medicalized framework*: "I have been diagnosed as having the disease of gambling addiction. I am striving to better manage this chronic disease through abstinence under the guidance of a health care practitioner."
- The *Behavioural Addiction* framework: "I have been assessed as living with a gambling disorder. I am learning to reduce or stop my gambling and lessen its harms with the support of a therapist."
- The *Concurrent Disorders* framework: "I have been assessed as living with a problem gambling disorder plus other challenging co-occurring disorders. I am striving to reduce or stop gambling and mitigate the concurrent harms with the support of therapists and other health care providers."

The first of these is the original GA framework that opened the interventive space for helping people with gambling problems, while the latter three are formal treatments offered by health care professionals. Together, they represent diverse approaches to helping people with gambling problems, potentially antagonist (as history shows), potentially reconcilable (as we propose here).

The Gamblers Anonymous Framework

The history of approaches to addressing gambling problems is both long and short. The long story is a historical and sociological one that has seen gambling itself, regardless of gambling problems and harms, as a moral failing. Most religious traditions caution against, disapprove of, or outright forbid gambling, and most people in most societies have seen problem gambling as a character failing or moral weakness. The shorter, modern story sees gambling as a common human behaviour and gambling problems as a related mental health disorder. Until GA and the recognition of pathological gambling as a disorder in its own right, conventional therapeutic perspectives viewed it as a sign or a symptom of deeper psychological conditions that needed to be overcome to abate their compulsion to gamble (Gamblers Anonymous, 1984; Schwartz, 2006; Ferentzy & Skinner, 2006; Ferentzy et al, 2009; Ferentzy & Turner, 2012; White, 2014).

It took people whose lives were most severely disrupted by gambling to identify and challenge the inadequacies of that approach and look for another pathway. As with AA, a small group of people (mostly men at that time) came to see their gambling issues as a chronic compulsive addiction that was out of their personal control and could not be cured. However, they also came to believe that they could learn to stay abstinent through peer support and the practice of the Twelve Steps through active participation in GA and return to healthy functioning. Since its first meeting in the US in 1957, GA has grown to be an international fellowship (Browne, 1991; Gamblers Anonymous, n.d.; Ferentzy & Turner, 2012).

Like AA and the other Twelve Step organizations that began to emerge, GA did not eschew formal treatment, nor did it fail to recognize that people with gambling problems have other troubles. As members engaged in mutual aid, it became their personal experience that GA and the

Twelve Steps were the bases of their recovery. At that time (and still in some places even today), there were no specialized treatment options for gambling problems nor was pathological gambling recognized diagnostically as addictive behaviour. For many people in many communities, availability, and access to treatment services for problem gambling and other addiction problems were limited, and this remains the case in many places today (Browne, 1991; Humphrey, 2004; Ferentzy & Turner, 2012). Those drawn to GA found that the explanatory message of the Twelve Step framework and the availability of peer support resonated with them at deeply personal levels (Ferentzy et al., 2014).

Loss of control is a core element in the Twelve Step worldview. The appeal and power of GA and its kindred Twelve Step organizations rests on the self-recognition that "we don't just have a problem; we are addicts." The first step is to admit powerlessness over gambling and that it has made life unmanageable. The condition is seen as progressive: it will only get worse if not addressed, and the only way to do that is through life-long abstinence, lived one day at a time—anything short of that is relapse (GA, n.d.; Browne, 1991; Ferentzy & Skinner, 2003; Ferentzy et al., 2006B).

Being an addict becomes a core element of a GA member's identity, an admission that is terrifying and liberating simultaneously. The recovery language in the Twelve Steps switches from 'me' to 'we'—from a self-centred vocabulary to one that is plural and collective (Ferentzy et al., 2006A; Kurtz & Ketchum, 2009; Humphreys, 2007; McGrath et al., 2018). It both names the problem, identifies the solution and points to the way to get there: We accept that we are addicts; we can manage this by abstaining from the addictive behaviour; we can recover by participating in the fellowship of GA groups; we can progress on the lifelong journey of recovery by following

the Twelve Steps and the mutual aid and peer support of other recovering gambling addicts (Gamblers Anonymous, 1984; Strobbe et al., 2010; Schuler et al., 2016).

Note that GA is not a treatment program for gambling disorders. Rather, it understands itself to be a peer-based mutual aid organization for people who self-identify as compulsive or addicted gamblers. Its services are free, and it only accepts financial support from its members (Gamblers Anonymous, 1984). Unfortunately, it is often characterized as a treatment approach, especially by health care professionals and researchers. Along with AA and other Twelve Step organizations, GA has no complaint about its members seeking help from health care providers with expertise in addiction and mental health but see it as additive or supplementary to what they offer, not a replacement. Over time, evidence has grown suggesting people in mutual aid pathways like GA and AA have comparable outcomes to those in formal treatment, and higher rates of sustained abstinence (Brown, 1993; Humpherys, 2004; Ferentzy et al., 2014; Kelly et al., 2014; Schuler et al., 2016).

The Medicalized Framework

Whereas in GA the person themself identifies that they are a gambling addict, the medical framework requires a physician or other authorized health professional to diagnose it as a disorder qualifying for appropriate interventive care. Diagnosis confers benefits by formally verifying that the person has an objective illness, but simultaneously carries a risk of labelling and stigma. Advocates of the medical approach argue this development improves the social perception of the person with gambling problems as a medically ill person who merits help, rather than just someone with a personal failing. Worth noting is that the regimen of care moves from the peer-based model of GA to a formal system of medical experts who have the authority to diagnose illness and

prescribe treatments for them, and to determine whether someone has recovered (Leshner, 1997; Freimuth, 2010; Starbrook, 2012; Wilcox, 2021).

First seen as a psychiatric problem of impulse control, and more recently as addictive behaviour, gambling disorders today have achieved the status of a mental health condition with diagnostic criteria and an interventive trajectory. In the 1970s, the addiction treatment system—already using referral to Twelve Steps programs in its treatment and aftercare of substance use disorders—began to include people with gambling problems in its orbit of interest, and incorporated GA participation into its framework. The disease model of gambling addiction proposes that something is biologically wrong with the person that puts them at risk of losing control of their gambling behaviour. The approach incorporates Twelve Step principles, calling on the person with a gambling problem to recognize it, admit it, take responsibility for it, and take up the lifelong practice of abstinence and Twelve Step work. At the same time, it takes on authority for diagnosing and treating it as a medical condition. This American disease model continues to form the basis for much of the addiction treatment services provided in North America and other developed countries (Custer, 1984; Blume, 1986; Blaszczynski & McConaghy, 1989; Humphreys & Moos, 2007; White, 2014; Rusk et al., 2016).

While GA has remained constant and faithfully committed to the Twelve Step model and its traditions, the medical view of gambling disorders has changed over the past several decades (Blaszczynski & Nower, 2002; Schafer & Korn, 2002; Ferentzy & Turner, 2014). Until recently, the Diagnostic and Statistics Manual (DSM) of the American Psychiatric Association (APA) did not classify pathological gambling as an addictive disorder, and when it was added to the DSM-III as a diagnosis in 1980 it was described as an impulse control disorder. It was not until DSM-5 that gambling disorders were included in a new category called “Substance-related and addictive

disorders," of which gambling disorders are the only condition not related to substance use (i.e., behavioural disorder) to be included (APA, 2013; Potenza et al., 2019).

The DSM-5 formalized the view of problematic gambling as a disorder, with addiction replacing compulsion as the governing concept in understanding and symptomizing gambling pathology. The disease model of addictive disorders still provides the overarching framework for understanding and treating gambling disorders, and referral to GA for Twelve Steps work and ongoing mutual aid remains integral to that approach (Custer, 1984; Rush et al., 2014).

The disease model incorporates mutual aid via the Twelve Steps into its interventive framework. It remains the hegemonic approach to addiction theory and treatment, the one that fits most widespread beliefs about addictive behaviour and how it needs to be treated. On their own, GA and other Twelve Step organizations have flourished as stand-alone interventions for addiction. The hallmarks of these two founding narratives are severity, loss of control, and disease. They offer care pathways for people seeking help because of the seriousness of their gambling problem. With the DSM-5 came a third discourse describing addictive disorders as occurring along a continuum from mild, to moderate, to severe. This development provided a lens for looking beyond the most severe gambling disorders to a widened spectrum that includes people with mild to moderate gambling problems (Barber, 2012; APA, 2013; Griffiths, 2006).

The Behavioural Addiction Framework

The field of addiction treatment has expanded significantly since the 1980s, becoming more diverse, and being shaped and reshaped as research and scientific evidence have challenged policymakers and practitioners to broaden their views of addiction. As a result, new approaches to understanding and helping people with gambling problems have emerged, offering pathways that

are conceptually and practically different from the disease and severity-based narratives. Some see these new narratives as opposing and contesting the established view of gambling disorders, while others suggest these developments are additive to what came before, contributing more scope and options to how addictive behaviours are understood and addressed (Blaszczynski & Nower, 2002; Mechon et al., 2018; Skinner et al., 2014).

The GA and the disease model narratives see pathological gambling as a binary condition that a person either had or did not have, while the emerging dimensional approach recognizes that a population has people with varying degrees of addiction. Gambling problems are not necessarily progressive: some resolve even serious ones without formal help or GA membership. People engaging in behaviour with addictive potential, be it gambling or substance use, could be located along a continuum of severity. Now a much larger range of gambling problems could be identified in the population, most of whom would not identify as addicts or meet the older diagnostic threshold of pathological or compulsive gambling. They might see themselves as having a problem with gambling, but they are not likely to see that lifelong abstinence is the only goal or to view themselves as addicted (Littman-Sharp, 2017; Miller et al., 2019; Pickering et al., 2020; GREO, 2020).

The past several decades have seen the advance of research-based evidence shape interventions for people with addiction problems at points all along the continuum from severe to mild. Compared to other addictive disorders, gambling treatment research has in many ways lagged in this regard, even as gambling has expanded dramatically worldwide. Funding for gambling research and treatment in various jurisdictions that have legalized gambling, while adding significant revenue to government coffers, has been in no way proportional (Orford, 2020). With these developments, gambling problems and other harms to individuals, families and

communities have become more apparent, as has public awareness of them. This awareness reframes gambling problems as not just the troubles of a small percentage of 'pathological gamblers' (using DSM-IV language), but as wide-reaching issues. It also opens the possibility of approaches to prevention and early identification of gambling problems (Smith et al., 2010; Yakovenko & Hodgins, 2016; Littman-Sharp, 2017; Pickering et al., 2020).

Harm reduction perspectives appear to stand in stark opposition to the abstinence approaches at the heart of the Twelve Step and disease model approaches (Miller et al., 2020; Skinner et al., 2019; GREO, 2020). Growing evidence points to the efficacy of brief treatments and other less intense interventions, particularly for clients with mild or moderate gambling problems. These approaches are radically different from the established disease model interventive methods, expanding treatment goals from total abstinence as the only option to choosing moderation and control of gambling behaviour. Treatment then focuses on reducing symptoms, urges to gamble, frequency, and other psycho-social markers such as stress and overall functioning. From this point of view, having gambling problems does not always require lifelong abstinence or the prescriptive direction to enroll in GA for continued recovery support (Hodgins et al., 2007; Yakevenko & Hodgins, 2016; Littman-Sharp, 2017).

While it can be said that CBT approaches have been the most thoroughly researched, most addiction treatments tend to produce comparable results in clinical trials. The classic study in the addiction field, Project MATCH (Project MATCH, 1997), compared CBT with Motivational Enhancement Therapy (MET) and Facilitated Twelve Step (FTS). This was the first randomized control study comparing a Twelve Steps approach with conventional treatments. Participants showed strong outcomes in each condition, results that held over a 3-year follow-up, with no significant differences between them. This research and later studies have resulted in belated

respect for mutual aid and the Twelve Steps approach among researchers. However, a key distinction here is that the FTS was delivered by professional therapists as a formal treatment in this study, whereas GA is a peer fellowship which does not rely on professionals but radically insists on mutual aid as the guiding principle (Gamblers Anonymous, 1984; Potenza et al., 2019; Kelly et al., 2020).

Gambling Disorder is the only behavioural addiction in DSM-5. The International Classification of Diseases (ICD), the WHO diagnostic manual, recently added gaming disorder to its diagnostic list of addictive disorders. With more research support, it appears only a matter of time before internet addiction and technology use disorders are also added. Moreover, this broadening mental health lens sets the stage for the fourth key framework shaping our understanding of problem gambling (APA, 2013; Ali, 2021).

The Co-Occurring Disorder Framework

An emerging fourth perspective further deepens our understanding of gambling problems—particularly the likelihood that they will present with clinical complexity. People seeking help for gambling disorder tend to have other problems that need to be addressed separately—substance use being a common example. There are also higher rates of mental health issues, most commonly mood and anxiety disorders and/or attention deficit disorders. There is also higher likelihood of physical health problems. Thus, clients who seek help or are referred to treatment for gambling disorder, particularly severe cases, tend to have other issues that are actively affecting their wellbeing and their ability to respond effectively to treatments, especially those targeted on specific issues without an effective understanding of the whole person (Shaffer

& Korn 2002; Korman et al., 2008; Rash et al., 2016; Skinner et al., 2018; Potenza et al., 2019; GREO, 2020).

Each of the key dimensions of human functioning - biological, psychological, and social - provides care pathways to recovery, usually involving steps and stages of change over a sustained period. Effectively understanding the complex problems of people with gambling disorders and other mental and physical health challenges is advanced by taking a multi-focal, integrated biopsychosocial approach. The biopsychosocial plus (BPS+) approach includes two additional dimensions, culture, and spirituality, to help understand a person's journey into problem gambling and other health issues and highlight potential pathways to recovery. Including a spirituality dimension points to the power of mutual aid and participation in GA, as well as other positive communities with strong value bases. While there are limits to the scope of practice and skill for every health care professional, as well as what can be offered in a GA fellowship, it is essential to see the client's needs and goals in ways that keep each of these whole persons, BSP+ care pathways open (Griffiths, & Delfabbro, 2001; Skinner and Herie, 2014; DiClemente, 2018).

Programs that focus on problem gambling and addictive behaviours can be reluctant or even opposed to offering care to someone with co-occurring disorders. They may fear they will end up 'stuck' with someone whose needs they cannot meet or presume the person cannot get the best out of their services. It may be convenient for a program to exclude someone with a higher level of need than average, but it creates a predicament for the person seeking help. As much as they need access to resources and supports, clients with complexity (who seek help more often than people with less severe problems) are less likely to become engaged in treatment and more likely not to complete treatment when they do. The problem in such a case is less that the client has complex problems and more that they seek help in complicated systems where the parts are

not well connected and are difficult to access (Meuser, 2003; Smith et al., 2010; Jesseman et al, 2014; Huneke et al., 2021).

Practical collaborative care needs a structural basis, not just the good intentions of help seekers and frontline workers trying to connect across disconnected systems. The problem extends beyond how helpers in the system work with clients to the interconnections negotiated and maintained between services within the health care system. That more significant problem goes beyond the approaches explored here. Nevertheless, it suggests a good starting point for thinking about how care pathways for the healing journeys of people with gambling and other problems. A sympathetic and complementary alignment of these four frameworks would be more valuable than the detached, and at times oppositional stance they have taken towards one another (Meuser, 2003; Jesseman et al., 2014).

First Steps: An Integrative, Person-Centred, Engagement-Focused Approach

There is strong evidence in the literature that the ability to engage a person in care is more important than what we do in treatment in terms of any technique or method. Indeed, there is evidence that the client's perception is more predictive of therapeutic success than the care provider's (Moyers & Miller, 2013; Miller & Moyers, 2020). Connecting and engaging with the person seeking help is the first step in all four of the addiction narratives described. Indeed, engagement continues to be the first step in any further moment of interaction, not just at the beginning but along a person's healing journey. What will draw some to a care pathway and keeps them connected is very much a function of how the person seeking help experiences the people they encounter along the way. Interpersonal engagement creates processes that involve, in one form or another, compassionate dialogue between the person seeking help and the people in the

helping milieu in which they find themselves. That, the evidence suggests, is the most active ingredient in recovery and change (Miller & Moyers, 2020).

Engagement can be achieved in several ways. For example, in GA, a person's 'buy-in' depends on whether they see themselves as having a gambling addiction that they cannot control. Without accepting that premise, it will be harder for them to decide they need to belong to a community of people with severe gambling problems. On the other hand, finding such a community can be a life-altering event for someone feeling their life is out of control because of compulsive gambling. It puts them into contact with others in the same predicament, offers a clear goal, a process for restoring their lives to a more normal level of functioning, and peer support that can be accessed day and night. We still do not know enough about the processes in GA and Twelve Steps fellowships in general to understand the operative factors. Its very nature and the principle of anonymity make it a challenging domain to research using the approaches that have shown us so much about formal therapies and interventions. Still, there is enough that we can learn from the participants' self-reports that engagement and empathic connection are hallmarks of their experience (Ferentzy et al., 2005; Ferentzy et al, 2009; Schuler et al., 2016; Mackay et al., 2015; McGrath et al., 2018).

The disease model emerged in the recovery space that Twelve Steps and mutual aid had opened, while also incorporating the tenets of the Twelve Steps and the vital role of peer support in ongoing recovery. The authority of the doctor and the medical gaze allows a diagnosis to be made and treatment to be prescribed, thereby establishing gambling disorder and other addictive behaviours as valid illnesses that can be treated medically. This framework also permits a confrontational approach, given its assumptions about the nature of addiction as a disease characterized by denial. In that and other ways, the disease model's mindset and language are

different than in the other three narrative approaches. The literature suggests that confrontational approaches are less effective than empathic ones. The question is how to help the people for whom these approaches failed. That points to the need for a pluralistic approach to finding care pathways for gambling disorders, not just those for people whose problems are extreme, who self-identify as gambling addicts, and who accept the medicalized narrative of what is wrong with them and how to treat it (Miller et al., 2019; Miller & Moyers, 2021).

The evidence suggests that the key to effective treatment for addictive disorders, including problem gambling, cannot be found in any one method of intervention. Well-developed therapies delivered by competent clinicians with ongoing supervision are all likely to be effective to about the same degree. Project MATCH (1997) and many other psychotherapy trials prove the near equivalence of most mature therapy approaches. The research on therapy factors makes the point that the empathic skills of the helper are more critical in determining whether people will start, be retained, and complete a program of therapy. The literature shows that people who complete therapy have better outcomes than those who do not (Hubbard, Craddock, & Anderson, 2003). But again, all of this is relative: it does not mean that everyone who finishes succeeds or that everyone who does not finish fails. Someone who did not get the result they needed through the intervention with the most empirical support might do better in a treatment program with less evidence to support it (Norcross & Wampold, 2011; Miller et al., 2019; Barkham & Lambert, 2021).

The first step in helping is engagement: the person seeking help feels that they have an effective connection with the people they encounter in the care pathway with whom they are involved. Therapists with lower empathy have less success engaging and helping people seeking help, while more empathic ones are more successful, regardless of treatment approach. Put most

bluntly, relationship and connection matter (Barkham & Lambert, 2021; Moyers & Miller, 2013; Miller & Moyers, 202l).

The First Steps approach to helping people with gambling problems, no matter what kind of care pathway the helper works in, emphasizes engagement as a necessary condition for effective care. Care becomes less about convincing or prescribing what the person seeking help needs to do and more about helping them find the care pathway they are most willing to take. That involves keeping all four narratives alive and the care pathways they provide open. It asks that we deepen our understanding of not just *what* is done in each care pathway, but *how* it helps (Skinner & Herie, 2014).

The First Steps approach sees factors that are often discounted as soft and secondary and moves them from the background to the foreground (Skinner & Brown, 2022). The ability to connect opens processes of compassionate dialogue that result in the person seeking help feeling heard and understood. This forms the foundation for engagement, action, and change. Keeping care pathway options open sets the stage for a dialogue about what action or decision the person seeking help will make. As humbling as it may be for therapists and other helpers, there is ample evidence that people with gambling problems can change without formal help or joining GA. Furthermore, many people experience levels of complexity and severity for which single specialized providers cannot help them adequately; they are better served by collaborative and integrated care (Dowling & Cosic, 2011; Dowling et al., 2015; Skinner et al., 2018; Miller et al., 2019).

Rather than seeing Twelve Steps recovery and formal addiction treatments as incompatible or at odds, it is better—and more evidence-based—to adopt an integrative and pluralistic perspective. The First Steps approach respects each care pathway in terms its strengths and

limitations and works to improve and expand the options available for people who seeking change and recovery. Each of the four frameworks offer complementary resources and open distinctive care pathways for people with addiction problems (Humphreys & Ribisl, K., 1999; Humphreys, 2004; Jesseman et al., 2014).

First Steps is based on the values and principles of person-centred care. People seeking help have options and make choices. Helping change happen requires interventive models and practical skills that are informed and guided by an adequate understanding of the whole orbit of choices a person can make. People seeking help for gambling problems are best served when they can find and access the care pathways that are best for them. Change as an open and evolving process often requires different types of help and support at different times (Skinner & Brown, 2022).

People with gambling problems who seek help have a more comprehensive range of care pathways today than ever before. Interventive approaches to gambling disorders can now be measured, evaluated, and compared. Based on addiction research findings, efforts are made to define best practices in treating gambling disorders—though there may be some hubris in using the term 'best,' because even the most well supported interventions have only moderate effect sizes (Miller et al., 2021). Still, there is merit in exploring better and worse practices, and there is a growing research literature to help do that.

Extensive international research for the past several decades points dramatically to the therapeutic relationship as the most important determinant of treatment outcomes. The empathic skills of the helper, along with the ability of the helper and help-seeker to form an effective working alliance, predict therapy outcomes more than the interventive approach being used. These findings do not dismiss the importance of other factors, including expectancy, treatment method and client

factors, but they spotlight the helping relationship and empathic connection as the most important ingredient in the process of therapeutic change (Asay & Lambert, 1999; Norcross & Wampold, 2010; Miller & Moyers, 2020).

From Twelve Steps to First Steps and Beyond

The four master narratives described here, when taken together, provide the opportunity for an integrative and pluralistic view of how people can recovery from gambling disorders. First, GA opened the door to the good news that people working together in mutual aid groups and following the Twelve Steps could successfully address their severe gambling disorders. Second, the disease model moved gambling problems from a shameful moral failing to a health condition that can be medically understood and treated. Aligned with the Twelve Steps worldview in support of abstinence and recovery, it added access to health care services, especially for early recovery and relapse, to stabilize and help clients learn new skills.

Third, gambling disorders came to be understood as not just an either/or condition, but as existing along a continuum from mild to extreme severity. Effective treatment approaches have emerged, often modelled on the treatment of substance use disorders, but including care pathways that are briefer and less intense than the traditional disease model. These methods are effective for people in the mild or moderate range, but also for people with higher degrees of severity. This challenges narrowly prescriptive treatments to adopt a model of behavioural addiction that emphasizes client goal choices and collaborative decision-making. Abstinence, even when it is seen as the ‘gold standard,’ belongs within a larger public health paradigm of harm reduction and health promotion.

The fourth narrative is about complexity: people who seek help for gambling problems are at higher risk of having other problems, including other addictive behaviours, mental health challenges and physical health issues. Financial hardship, emotional crisis, and interpersonal distress are often precipitating factors in the lives of people seeking gambling treatment. Change and recovery might start with stopping or minimizing the harms related to gambling but needs to include a wider spectrum of outcomes.

Together, these four narratives gathered into an integrative framework call for a BPS+ approach that offers an understanding of the factors that have led to gambling problems and provides a comprehensive approach to the diverse care pathways that help people change and recover. This perspective recognizes the interplay of neurobiology, physical well-being, mental health, social factors, cultural context, and spirituality in shaping recovery.

The BPS+ dimensions are not separate threads but interrelated so that the interplay among the dimensions shapes the development and persistence of gambling and other problems. The BPS+ approach not only untangles the factors that lead to gambling disorders, but weaves together the diverse ways people can change and recover. Optimally, people seeking help for gambling disorders are welcomed and understood in their complex wholeness. Ideally, resources that support healing and recovery need to include pathways that weave together the biological, psychological, social, cultural, spiritual, and other dimensions through which change occurs. Our own recent experience in working collaboratively with program leaders and clinicians to create a person-centred approach to clients seeking help for gambling and technology use disorders has brought the interpersonal engagement of client and counsellor to the foreground of initial contacts for people seeking care, with a focus on the client feel heard and understood by the counsellor. This then sets the stage for goal setting that is not prescriptive but based on choices that include access

to care pathways that are based on all four frameworks described here. We call this approach 'First Steps', not just because they are about the initial connection between client and counsellor, but because these factors, the evidence shows, when kept in the foreground. This is especially important for the person seeking help who have more severe and complex problems, more likely to identify with a GA approach and to be eligible for services for people with co-occurring disorders (Brown & Skinner, 2022; Skinner & Brown, 2022b).

Engagement begins and sustains the healing journey in well-conceived care pathways that are helpful for people with gambling problems. The ability of the helper to connect with and dialogue compassionately with a person seeking help is how engagement happens. Empathy matters more than any method or technique. The therapeutic relationship is the most important factor in how change happens—seeing the person seeking help not as an object to be treated but as a subject who is the principal author of the story of their healing journey. Compassionate dialogue is skillful activity.

Notably, the Twelve Steps approach begins with a first step that centres on engagement. Welcoming and engaging people to join them in being committed to and hopeful about doing some of the most challenging work they will ever have, opening a care pathway that leads to a healing journey. From Twelve Steps and GA, started in the 1950s and sustained by an active and committed membership over decades to today, where it is one of four core narratives that guide our understanding and care of people with gambling problems, evidence and experience converge to show that the first step of compassionate engagement opens caring pathways that lead to change, healing, and recovery.

References

Ali, Y. A. (2021). Behavioral addictions: the substance of "non-substance related addictive disorders." *International Journal of Emergency Mental Health and Human Resilience*, *23*(1), 1–6.

APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders,* (5th ed.). American Psychiatric Association.

Barber, J. P., Muran, J. C., McCarthy, K. S., & Keefe, R. J. (2013). Research on psychodynamic therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 443-494). New York, NY: John Wiley & Sons, Inc.

Barber, M. E. (2012). Recovery as the new medical model for psychiatry. *Psychiatric Services*, *63*(3), 277–279.

Barkham, M., & Lambert, M. (2021) The efficacy and effectiveness of psychological therapies. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), Bergin *and Garfield's handbook of psychotherapy and behavior change*. New York, NY: John Wiley & Sons.

Blaszczynski, A. P., & McConaghy, N. (1989). The medical model of pathological gambling: Current shortcomings. *Journal of Gambling Behavior*, *5*(1), 42–52.

Blaszczynski, A., Nower, L. (2002). A pathways model of problem and pathological gambling. *Addiction*, *97*(5), 487–499. https://doi.org/10.1046/j.1360-0443.2002.00015.x

Blume, S. B. (1988). Compulsive gambling and the medical model. *Journal of Gambling Studies, 3*, 237–247. https://doi.org/10.1007/BF01019883

Brown, D. & Skinner, W. (2022). *First Steps: a guide for people concerned about their gambling.* Toronto, CAMH.

Brown, R. I. F. (1993). Some contributions of the study of gambling to the study of other addictions. In W. R. Eadington & J. A. Cornelius (eds.), *Gambling Behavior and Problem Gambling* (pp. 241–272). University of Nevada, Reno.

Browne, B. R. (1991). The selective adaptation of the Alcoholics Anonymous program by Gamblers Anonymous. *Journal of Gambling Studies,* 7, 187–206.

DiClemente, C. (2018). *Addiction and Change: How addictions develop and addicted people recover* (2nd ed.). New York: NY: Guilford Press.

Dowling, N. A., & Cosic, S. (2011). Client engagement characteristics associated with problem gambling treatment outcomes. *International Journal of Mental Health and Addiction*, *9*(6), 656–671. https://doi.org/10.1007/s10899-016-9599-5

Dowling, N. A., Cowlishaw, S., Jackson, A. C., Merkouris, S. S., Francis, K. L., & Christensen, D. R. (2015). Prevalence of psychiatric co-morbidity in treatment-seeking problem gamblers: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry*, *49*(6), 519–539.

Dowling, N. A., Cowlishaw, S., Jackson, A. C., Merkouris, S. S., Francis, K. L., & Christensen, D. R. (2015). The prevalence of comorbid personality disorders in treatment-seeking problem gamblers: A systematic review and meta-analysis. *Journal of Personality Disorders*, *29*(6), 735.

Ferentzy, P., & Skinner, W. (2003). Gamblers Anonymous: a critical review of the literature. *The Electronic Journal of Gambling Issues*, 9. http://dx.doi.org/10.4309/jgi.2003.9.9

Ferentzy, P., Skinner, W. (2006). Mutual Aid: An annotated bibliography. Journal of Gambling Issues, #17, August.

Ferentzy, P., Skinner, W. & Antze, P. (2004). *Exploring mutual aid pathways to recovery from gambling problems*. Report: Ontario Problem Gambling Research Centre.

Ferentzy, P., Skinner, W. & Antze, P. (2004). Gender Differences in Gamblers Anonymous. *International Journal of Self Help and Self Care*, 2(4), 271-280. http://dx.doi.org/10.2190/4A25-MBXK-81UX-JLVA

Ferentzy, P., Skinner, W., & Antze, P. (2006A). Rediscovering the Twelve Steps: recent changes in gamblers anonymous. *Journal of Groups in Addiction and Recovery*, 1(3–4), 59–74. https://psycnet.apa.org/doi/10.1300/J384v01n03_05

Ferentzy, P., Skinner, W., & Antze, P. (2006B). Recovery in Gamblers Anonymous. *Journal of Gambling Issues,* 17. http://dx.doi.org/10.4309/jgi.2006.17.6

Ferentzy, P., Skinner, W., & Antze, P. (2009). Gamblers Anonymous and the 12 steps: How an informal society has altered a recovery process in accordance with the special needs of problem gamblers. *Journal of Gambling Issues, 23*, 42–65.

Ferentzy, P., & Turner, N. E. (2012). Morals, medicine, metaphors, and the history of the disease model of problem gambling. *Journal of Gambling Issues*, 27, 1–27. https://doi.org/10.4309/jgi.2012.27.4

Ferentzy, P., Skinner, W., & Antze, P. (2014). Understanding Gamblers Anonymous – a practitioner's guide. In D. C. S. Richard, A. Blaszczynski, L. Nower (eds.), *the Wiley-Blackwell handbook of disordered gambling.* Oxford, UK: John Wiley & Sons.

Freimuth, M. (2010). The "new look" in addiction assessment: Implications for medical education. *Annals of Behavioral Science and Medical Education*, *16*(1), 30–34.

Gabriel, K. (1995). *Gambler Way: Indian gaming in mythology, history and archaeology.* Denver, CO: Bower House.

Gamblers Anonymous (n.d.). *About Us*. Retrieved August 15, 2022, from https://www.gamblersanonymous.org/ga/content/about-us

Gamblers Anonymous (1984*). Sharing Recovery Through Alcoholics Anonymous*. Los Angeles: Gamblers Anonymous Publishing.

GREO. (2020). *Effective treatment and support for problem gambling.* Gambling Research Exchange Ontario. Report prepared for the Gambling Commission, Birmingham, UK. https://doi.org/10.33684/2020.005

Griffiths, M., & Delfabbro, P. (2001). The biopsychosocial approach to gambling: contextual factors in research and clinical interventions. *Journal of Gambling Issues, 5*(1). https://doi.org/10.4309/jgi.2001.5.1

Griffiths, M. (2006). An overview of pathological gambling. In T. G. Plante (Ed.), *Mental disorders of the new millennium: Behavioral issues* (pp. 73–98). Praeger Publishers/Greenwood Publishing Group.

Hubbard, R. L., Craddock, S. G., & Anderson, J. (2003). Overview of 5-year followup outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of Substance Abuse Treatment*, *25*(3), 125–134.

Hodgins, D. C., Currie, S. R., el-Guebaly, N., & Diskin, K. M. et al. (2007). Does providing extended relapse prevention bibliotherapy to problem gamblers improve outcome? *Journal of Gambling Studies, 23*, 41–54. https://doi.org/10.1007/s10899-006-9045-1

Huneke, N. T. M., Chamberlain, S. R., Baldwin, D. S., & Grant, J. E. (2021). Diverse predictors of treatment response to active medication and placebo in gambling disorder. *Journal of Psychiatric Research, 144*, 96–101. https://doi.org/10.1016/j.jpsychires.2021.09.053

Humphreys, K. (2004). *Circles of Recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge Press.

Humphreys, K., & Moos, R. H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: two-year clinical and utilization outcomes. *Alcohol Clinical & Experimental Research,* 31, 64–68.

Humphreys, K., & Ribisl, K. M. (1999). The case for a partnership with self-help groups. *Public Health Reports,* 114, 322–329.

Jesseman, R., Brown, D., & Skinner, W. (2014). Care pathways for healing journeys: toward an integrated system of services and supports. In M. Herie & W. Skinner (eds), *Fundamentals of Addiction: a practical guide for counsellors.* Toronto: Centre for Addiction and Mental Health.

Kelly, J., Humphrey, K, & Yeterian, J. (2014). Mutual aid groups. In M. Herie & W. Skinner (eds), *Fundamentals of Addiction: a practical guide for counsellors.* Toronto, ON: CAMH.

Kelly, J. F., Abry, A., Ferri, M., & Humphreys, K. (2020). Alcoholics anonymous and 12-Step Facilitation Treatments for Alcohol Use Disorder: A distillation of a 2020 Cochrane Review for clinicians and policy makers. *Alcohol and Alcoholism, 6,* 641–651.

Korman, L., Collins, J., Littman-Sharp, N., Skinner, W., McMain, S., & Mercado, V. (2008) Randomized control trial of an integrated therapy for comorbid anger and gambling. *Psychotherapy Research, 18*(4), 454–465.

Kurtz, E. (1991). *Not-God: a history of alcoholics anonymous*. Center City, MN: Hazelden Educational Services.

Leshner, A. (1997). Addiction is a brain disease, and it matters. *Science*, *278*(5335), 45–47. https://doi.org/10.1126/science.278.5335.45. PMID: 9311924

Littman-Sharp, N. (2017). *Treatment for disordered gambling: current evidence and recommendations*. Gambling Research Exchange Ontario (GREO). https://www.greo.ca/Modules/EvidenceCentre/files/Littman-Sharp_(2017)_Treatment_for_Disordered_Gambling.pdf

Mackay, T. L., Petermann, L., Hurrell, C., & Hodgins, D. (2015). Knowledge translation in gambling research: A scoping review. *International Gambling Studies*, *15*(2), 179–195. https://doi.org/10.1080/14459795.2014.1003575

McGrath, D. S., Kim, H. S., Hodgins, D. C., Novitsky, C., & Tavares, H. (2018). Who are the anonymous? Involvement and predictors of gamblers anonymous attendance among disordered gamblers presenting for treatment. *Journal of Gambling Studies*, *34*(4), 1423–1434.

McLellan, A., Lewis. D., O'Brien, C., & Kleber, H. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*(13), 16891695.

Menchon, J., Mestre-Bach, G., Steward, T., Fernández-Aranda, F., & Jiménez-Murcia, S. (2018). An overview of gambling disorder: from treatment approaches to risk factors. *F1000Research*, *7*, 434. https://doi.org/10.12688/f1000research.12784.1

Mueser, K. T. (Ed.). (2003). *Integrated treatment for dual disorders: A guide to effective practice*. Guilford Press.

Miller, W. R., Forcehimes, A. A., & Zweben, A. (2019). *Treating addiction: A guide for professionals*. Guilford Publications.

Miller, W. R., & Moyers, T. B. (2021). *Effective psychotherapists*. Guilford Publications.

Moyers, T., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, *27*(3), 878.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98–102. https://doi.org/10.1037/a0022161

Orford, J. (2020). *The gambling establishment: challenging the power of the modern gambling industry and its allies.* United Kingdom: Routledge.

Penfold, K., & Ogden, J. (2021). Exploring the experience of Gamblers Anonymous meetings during COVID-19: A qualitative study. *Current Psychology.* Advance online publication. https://doi.org/10.1007/s12144-021-02089-5

Pickering, D., Spoelma, M. J., Dawczyk, A., Gainsbury, S. M., & Blaszczynski, A. (2020). What does it mean to recover from a gambling disorder? Perspectives of gambling help service users. *Addiction Research & Theory*, *28*(2), 132–143.

Potenza, M. N., Balodis, I. M., Derevensky, J., . . . & Yip, S. W. (2019). Gambling disorder. *Nature Reviews Disease Primers, 5*, 51. https://doi.org/10.1038/s41572-019-0099-7

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *JSA, 58*, 7–29.

Rash, C., Weinstock, J., & Van Patten, R. (2016). A review of gambling disorder and substance use disorders. *Substance Abuse and Rehabilitation, 17*(7), 3–13. https://doi.org/10.2147/SAR.S83460

Shaffer, H. J., & Korn, D. A. (2002). Gambling and related mental disorders: a public health analysis. *Annual Review of Public Health, 23*, 171–212.

Schuler, A., Ferentzy, P., Turner, N. E., Skinner, W., McIsaac, K. E., Ziegler, C. P., & Matheson, F. I. (2016). Gamblers Anonymous as a recovery pathway: a scoping review. *Journal of Gambling Studies*, *32*(4), 1261–1278. http://dx.doi.org/10.1007/s10899-016-9596-8

Schwartz, D. (2006). *Roll the bones: the history of gambling.* New York, NY: Gotham.

Skinner, W. J. W., Littman-Sharp, N., Leslie, J., Ferentzy, P., Zaheer, S., Smit Quosai, T., . . . & McCready, J. (2018). Best practices for the treatment of older adult problem gamblers. *Journal of Gambling Issues*, 39, 166–203. https://doi.org/10.4309/jgi.2018.39.6

Skinner, W., & Brown, D. (2022a). *First Steps: Compassionate dialogue for complex problems*. Presentation at the 15th World Conference on Person-Centred and Experiential Psychotherapy and Counselling. Copenhagen: August 2022.

Skinner, W & Brown, D. (2022b). *First Steps: Program guide for therapists*. Toronto: CAMH.

Skinner, W., & Herie, M. (2014). BioPsychoSocial Plus: a practical approach to addiction and recovery. In M. Herie, & W. Skinner (eds), *Fundamentals of addiction: a practical guide for counsellors*. Toronto, ON: Centre for Addiction and Mental Health.

Smith, D., Harvey, P., Battersby, M., Pols, R., Oakes, J., & Baigent, M. (2010). Treatment outcomes and predictors of drop out for problem gamblers in South Australia: a cohort study. *Australian & New Zealand Journal of Psychiatry, 44*(10), 911–920. https://doi.org/10.3109/00048674.2010.493502

Stanbrook, M. B. (2012). Addiction is a disease: we must change our attitudes toward addicts. *CMAJ, 184*(2), 155. https://doi.org/10.1503/cmaj.111957

Strobbe, S., & Kurtz, E. (2012). Narratives for recovery: personal stories in the 'Big Book' of Alcoholics Anonymous. *Journal of Groups in Addiction & Recovery*, 7(1), 29–52. https://doi.org/10.1080/1556035X.2012.632320

Toneatto, T. (2013). Natural recovery. *Principles of Addiction*, *1*, 133-139.

White, W. (2014). *Slaying the Dragon: the history of addiction treatment and recovery in America* (2nd Ed.). Bloomington, IL: Chestnut Health Systems.

Wilcox, S. (2021). A genealogical analysis of the medical model of problem gambling. *Critical Gambling Studies*, *2*(1), 97–107. https://doi.org/10.29173/cgs72

Yakovenko, I., & Hodgins, D. C. (2016). Latest developments in treatment for disordered gambling: review and critical evaluation of outcome studies. *Current Addiction Reports, 3*(3), 299–306. https://doi.org/10.1007/s40429-016-0110-2