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Empirically supported treatment for pathological gamblers

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Session III: Critical issues in treatment

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*(Introduction.)***Ken Winters**: We're now going to tackle treatment approaches that are usually focused on the more intensive or longer-term approaches and models. And we're going to start with Dr. Ladouceur, who's a professor in the Department of Psychology at Laval University in Québec City.

Dr. Ladouceur is one of the most prolific researchers in the field. It does help if you're in Canada, though. Those Canadians do get the money to do the research. *(Laughter.)* But, we get the benefit as well. So here's Dr. Ladouceur.

Robert Ladouceur: Thank you, Ken. And thank you to the Council for the nice invitation, and I'm quite honored to be with you to discuss important treatment issues for problem gamblers. When we got the guidelines for this symposium, which my colleague, David, did not tell you, not only did they suggest, but they *imposed*, that we have only five minutes and only five slides to be presented. Ken just told us that now we have fifteen minutes, so he said that to solve that problem, just speak more slowly. *(Laughter.)*

Ken Winters: I'm the moderator.

Robert Ladouceur: I have another solution: I'll make a regular speech, five minutes in English and the other five minutes in French, because I come from Canada. *(Laughter.)*

Well, let me start with a citation that struck me.

A couple of months ago, I was in a symposium and Peter Nathan started his talk by saying that, “Gambling has a long history but a short past.”

I thought that was very interesting because we often compare the knowledge we have in our field with the knowledge we have with substance abuse or alcohol or anxiety disorder or depression. Well, the story is quite the opposite. The majority of the controlled studies in the field have been conducted over the last decade or so.

We often forget this. Our past is quite recent: not only our knowledge about gambling in general, but our knowledge about the efficacy of our treatment procedures.

Fundamental research increases our knowledge and improves our understanding of what's going on in the mind or in the life of the gambler and so helps us to develop more effective ways to help problem gamblers. That's our goal. This is why, I guess, we attend conferences such as this one.

The first question that we should ask is, are the treatments we use effective?

Let me adopt the perspective of a scientist for the next five minutes. We all know that the efficacy of a treatment can be evaluated in many ways. Yet such a task is difficult to conduct.

What are the best measures to use? What is the goal of the treatment? Is it abstinence? Is it controlled gambling? Is it increasing the quality of life of our clients? What else?

Many criteria can be used to assess the efficacy of our treatment. But, recently, the American Psychological Association has recommended that, when they are available, we should use empirically validated procedures.

Let me give you some information about what is empirically validated treatment. For, in general, an empirically validated treatment is a treatment that we should use, if available, for any particular disorder. For example, if you have a patient with panic disorder in your office, what is the best treatment to use? In physical medicine, if you suffer from diabetes, what is the best treatment? You expect your doctor to give you the best available treatment or medicine.

If your doctor is an old doctor who says, “My clinical experience tells me that this is the best treatment for you. This is what I recommend,” how would you react? For from a scientific perspective, it may not be the best available treatment.

So what is empirically validated treatment? Do we have empirically validated treatments to help problem gamblers?

Here are some defining criteria to establish such treatment:

1. I. At least two good between-group design experiments demonstrate efficacy in one or more of the following ways:
    1. A. Superior (statistically significantly so) to pill or psychological placebo or to another treatment.
    2. B. Equivalent to an already established treatment in experiments with adequate sample sizes.
    OR
2. II. A large series of single-case design studies demonstrating efficacy. These studies must have:
    1. A. Used good experimental design and
    2. Compared the intervention to another treatment as in I.A.
3. III. Experiments must be conducted with treatment manuals.
4. IV. Characteristics of the client samples must be clearly specified.
5. V. Effects must have been demonstrated by at least two different investigators or investigating teams.

The first criterion means a treatment group should provide better results than a control group. It should be superior, from a statistical standpoint, to either a pill or a placebo.

Another criterion is that experiments must be conducted with a treatment manual.

Using a manual doesn't mean that the therapist will act as a robot, or in a mechanical way. Quite the opposite. A manual is a guideline for the therapist who can be creative in doing therapy.

The other criterion is to specify the characteristics of the sample.

And, finally, the effects must have been demonstrated by at least two different teams of investigators.

Well, in a paper that my colleague and friend, Tony Toneatto, published about a year and a half ago on reviewing treatment outcome studies, we came across about a dozen, or a few more, controlled trials in psychological treatment.

I'm not including drug treatment. All the treatments used a cognitive behavioral approach. There were mainly three. We could classify these studies in three clusters.

There was one on cognitive and behavior therapy that probably some of you know about, on our work at Laval.

There was the imaginal desensitization research conducted by the Sydney group, led by Alex Blaszczynski.

And there's the cognitive behavior therapy and the stimulus control component by the Spanish group, mainly by Enrique Echeburúa in the Basque Country in Spain.

In the majority of these studies, the treatment group had better results than the control group.

Well, that's good news.

Now, the question is, can we assume that these treatments are empirically supported?

We can conclude that they are effective. But if we use all the criteria suggested by the American Psychological Association, unfortunately we cannot conclude from the results of these clinical trials that they are empirically validated.

The good news is that we are very close to that status. And I think that's very important, taking into consideration that these studies have been conducted only over the last 10 years.

So what can we conclude? Well, I'd like to make four comments as a wrap-up.

1. 1. Although we have effective treatments to help pathological gamblers, we still don't know exactly how these therapies work.
2. 2. We need to move away from the uniformity myth. All pathological gamblers surely do not fit into one model. We need to pay more attention to the different types of problem gamblers and to adapt our therapeutic interventions to each type. The three pathways identified by Blaszczynski are surely a great start to adapting our treatment to the individual.
3. 3. There are many trials going on now with drug therapy. Jon will talk about this in few minutes. Let me simply raise the question of the efficacy of combined therapy. Is drug therapy effective in comparison with psychological therapy? Is combined treatment effective? If so, for what kind of pathological gamblers?
4. 4. And finally, what is the goal of our treatment? Is abstinence the only goal? Is controlled gambling a better avenue for some problem gamblers? At Laval University, in Québec City, Canada, we are now conducting a clinical trial on this topic.

What are the preliminary results? Interestingly, many gamblers enrolled in our trial clearly indicated that they would not have enrolled in treatment if the goal was abstinence. Secondly, some gamblers have shifted their goals in going from control to abstinence.

Let me end my talk by flashing out a very important issue. As mentioned by Alex in his talk at lunchtime, we strongly need to revisit the construct of pathological

gambling.

And I think we've been underestimating the importance of this aspect. Essentially, we need to identify the main defining features of pathological gambling. We have put too much emphasis on the negative consequences to assess problem gambling. The majority of the instruments, the DSM, the SOGS, the CPGI, the 20 questions of the GA, the majority of the criteria we use, refer to negative consequences. Let's have a closer look at the construct of impaired control. We may open new avenues that will tell us more about this disorder.

Thank you very much for your attention.

Ken Winters: Would anyone like to offer a question?

Robert Ladouceur: It has to be a good one.

Ken Winters: Yeah, by the way, there's a chair over there for people who don't ask good ones. You have to sit in that.

Are there ways that you can envision, then, further tailoring cognitive and behavioral therapy to address your core construct of impaired control? In other words, do you feel like you haven't yet maximized the targeting of that construct?

Robert Ladouceur: Well, here we get into the content of what we do and I would certainly not say that cognitive modification is the only active element in the treatment of pathological gamblers. I think we would all agree.

It's one of the major ones, and I think it should be there, not only to help gamblers at the moment, but to prevent relapse. So what are we doing when we do cognitive therapy?

The first thing is to increase gamblers' awareness of the erroneous perceptions they've been maintaining for many years. Once they're aware of their erroneous perceptions, we try to modify them by creating dissonance in the way they think.

In this process, the individuals are increasing their level of awareness; they can identify an illusion of control and many other cognitive biases. Many of these cognitive biases refer to the basic notion that they do not consider the gambling activity as chance, but as a game of skill.

The illusion is in trying to control what is uncontrollable. Impaired control as a defining feature has a lot of implications for cognitive and behavior therapy. I think it was a fairly good question, Ken. *(Laughter.)*

Ken Winters: You're too kind.