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A cognitive-behavioral analysis of Gamblers Anonymous

Tony Toneatto

Centre for Addiction and Mental Health, Toronto. E-mail:
tony_toneatto@camh.net

For correspondence: Tony Toneatto, PhD, Clinical Research Department,
Centre for Addiction and Mental Health, 33 Russell St., Toronto, Canada
M5S 2S1. Phone 416-535-8501 ext. 6828, fax 416-595-6399, email
tony_toneatto@camh.net

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Tony Toneatto (PhD, clinical psychology, McGill University) is a senior scientist in the Clinical Research Department at CAMH. He holds a cross-appointment in the Departments of Psychiatry and Public Health Sciences at the University of Toronto and is also a registered clinical psychologist in Ontario. His research interests include the psychology and treatment of problem gambling, psychiatric comorbidity and addictions, and mindfulness meditation.

Abstract

Cognitive-behavioral therapy is often placed in opposition to twelve-step approaches in the treatment of addictions. While the former is accompanied by considerable empirical support and tend to be relatively brief and symptom-focused, twelve-step approaches are often more widely available, accessible without cost and can provide long-term, ongoing support. Very few studies have

directly compared these approaches in the treatment of problem gambling. The purpose of this article is to briefly examine the twelve steps of Gamblers Anonymous (GA) and show their essential comparability to concepts and strategies commonly found in cognitive-behavioral therapy (CBT). The striking similarities in intention and process between these two approaches are shown for each of the 12 steps despite their differences in their conceptual and linguistic framework. The result of this analysis is to encourage integration of these complementary approaches based on the common ingredients of therapeutic change rather than on ideologically-based differences.

The Complementary Nature of CBT and GA

Although rarely studied empirically (Petry, 2005), the twelve-step program (TSP) defining the recovery process within Gamblers Anonymous (GA) is frequently juxtaposed against more scientifically-evaluated approaches such as cognitive-behavior therapy (CBT). While the twelve-step approach may differ from CBT in many ways (i.e., the relevance of scientific research, acceptable treatment goals, the centrality of spirituality; see [McCrary, 1994](#) for an excellent comparative analysis of Alcoholics Anonymous and behavior therapy) these differences may mask important core similarities between these two approaches to recovery from pathological gambling. Although the efficacy of GA remains generally unsubstantiated, this self-help modality frequently remains the only treatment option available in many communities, is free of cost, and continues to be a central component of most residential treatment programs and an important element of aftercare. Correlational data have shown that GA affiliation is associated with better gambling outcomes even if they are engaged in concurrent professional treatment ([Hodgins, Peden, & Cassidy, 2002](#); [Petry, Ammerman et al., 2006](#)). The available evidence, in fact, suggests that these approaches may be of relatively equal effectiveness ([Project MATCH research group, 1996](#); [Wells, Peterson, Gaine, Hawkins, & Catalano, 1994](#); [Ouimette, Finney & Moos, 1997](#)) and likely share common treatment elements ([McCrary, 1994](#)).

An emphasis on the complementary nature of these two approaches may serve to integrate them more effectively in the treatment of problem gambling. The purpose of this article is to briefly highlight the essential comparability and compatibility of TSP and CBT in the treatment of problem gambling by demonstrating how each step of the GA program resembles conceptualizations and therapeutic interventions commonly advocated in CBT for problem gambling. Following each Step, a translation into terminology and concepts more familiar with CBT is presented.

Step 1 (GA)

We admitted we were powerless over gambling- that our lives had become unmanageable.

Step 1 (CBT)

We realized that our belief that we could control or predict gambling outcomes was illusory and that uncritical belief in this illusion had led to severe gambling-related problems in all of the important areas of our lives.

Step 1 describes the insight, awareness or realization that gambling-related negative consequences have outweighed the positive consequences to the point where gambling is no longer justifiable or tolerable. CBT, as a common treatment of addictions, often attempts to strengthen the commitment to change by explicitly exploring the positive and negative consequences of engaging in, and stopping, the addictive behavior ([Sobell & Sobell, 1993](#)). The awareness that gambling has become very harmful to one's core values (or conditioned reinforcements) and must be interrupted leads to a cognitive re-appraisal of gambling, which can be gradual ('I think I better do something about my gambling') or sudden ('That's it. I'm not gambling anymore'). Step 1 additionally indicates that the gambler has disconfirmed the core cognitive distortion common to problem gamblers, the illusion of control, eliminating the self-deceptions, attributional biases, rationalizations and other cognitive distortions that might otherwise sustain continued gambling ([Langer, 1983](#); [Gaboury & Ladouceur, 1989](#); [Toneatto, Blitz-Miller, Calderwood, Dragonetti, & Tsanos, 1997](#)). It is an act of radical self-honesty or veridical self-perception without which further therapeutic progress would be difficult.

Step 1 also acknowledges the ambivalence inherent in any addictive behavior and how the resolution of such ambivalence is the necessary and critical first step in the recovery process ([Miller & Rollnick, 1991](#)). Although influenced by multiple negative consequences (interpersonal problems, financial problems, health problems), a decision to stop gambling, for it to endure, must ultimately remain an individual one and not primarily a reaction to external influences (e.g., to satisfy a spouse). Finally, Step 1 acknowledges that willpower is insufficient to make real change. Individual efforts need to be accompanied by other sources of support (GA group, family, friends) and transcendental values (e.g., desire for happiness, spiritual transformation, highest self), a realization that directly leads to Step 2.

Step 2 (GA)

Came to believe that a Power greater than ourselves could restore us to a normal way of thinking and living.

Step 2 (CBT)

We realized that values and motivations of greatest meaning or reward value to me, more important than those governing our gambling behavior, would guide us to healthier thought and behavior.

Step 3 (GA)

Made a decision to turn our will and our lives over to the care of this Power of our own understanding.

Step 3 (CBT)

We decided to behave according to the higher-order values and motivations of greatest meaning to me.

Steps 2 and 3 acknowledge the importance of transcendence in recovery, in becoming responsive and available to influences that go beyond solely the immediate needs of the self. The concept of transcendence is often discussed within CBT in the context of values, motivations, or high-order reinforcers that govern behavior. An individual who has experienced the cognitive change associated with Step 1 is often motivated by the clear awareness that continued gambling poses a serious threat to a fundamental value, reinforcement or reward held by the individual. Unfortunately, it is often the case that a gambler's core values must be threatened before they develop the resolve to avoid further damage by addressing the gambling behaviour. Interventions often attempt to raise awareness of the impact of continued problem gambling on these higher-order values. While the transcendental value may certainly be the spiritual one often associated with the Twelve-Step Programs, many other values may form the basis of such transcendence. For example, family, self-esteem, health, honesty, financial health, belief in an actualized or higher self, the search for peace or tranquility are just a few of the important goals which may have become seriously threatened by continued gambling and which contribute to the cognitive re-appraisal signified in Step 1. By becoming aware of the transcendental aspect of recovery, that one is making this change in order to preserve or regain relationships, meanings, and values which are of high significance than the gambling behavior, the gambler remains committed to change and less susceptible or vulnerable to proximal gambling-related triggers and other stimuli which might otherwise interfere with the recovery process. Note that transcendent values of a lower order or in some way inauthentic (e.g., to appease others) may not be effective motivators in high-risk situations. For many gamblers, their first awareness of the transcendental aspect of recovery (their Higher Power) is their attachment to their recovery group.

Since the commitment exemplified in Step 1 often arises within the context of an intense psychological crisis induced by the accumulation of gambling-related (often financial) consequences, it can be short-lived once the crisis has faded unless the

individual has a valid motivation to continue to address the gambling problem. Remaining aware of such transcendental values may also guard the newly recovered gambler against acting impulsively to satisfy desires for sensation, excitement, fun, or money. Individuals who lack any meaningful source of transcendence (e.g., lack of spiritual beliefs, no family, dysfunctional self-esteem) may have particular difficulty in remaining committed to recovery and stabilizing the cognitive appraisal described in Step 1, especially under the demands of treatment. For example, a gambler who has no meaningful interpersonal relationships may find it difficult to maintain their recovery if such relationships serve as their primary transcendental value.

Steps 2 and 3 advance the work described in Step 1 by making the individual aware of the positive and prosocial core cognitive schemas which inform the individuals' view of their self, other people and their environment ([Beck, Wright, Newman, & Liese, 1993](#)). Identifying these core schemas is critical to developing a firm motivational basis to tolerate the often-difficult personal work that the recovery process may entail. Since it is possible that the recovering gambler may not always be aware of which values and core schemas are actually healthy or may even focus on values that are dysfunctional in the long-term (e.g., to appease others) it is very helpful to engage the support of individuals who may provide the necessary feedback (e.g., GA group, therapist) to ensure that this process leads to the identification of suitable values and meanings.

An important aspect of these two steps is the willingness to accept new ways of thinking or believing. The individual acknowledges that their habitual way of thinking and perceiving may not be most helpful and that more adaptive approaches must be adopted. One aspect to this transformation is the willingness to accept help from source outside oneself, a key element in the successful application of the next 2 steps.

Step 4 (GA)

Made a searching and fearless moral and financial inventory of ourselves.

Step 4 (CBT)

We thoroughly assessed the negative consequences of our gambling addiction on all aspects of our functioning, especially our relationships with others, to ourselves, and our finances.

Step 5 (GA)

Admitted to ourselves and to another human being the exact nature of our wrongs.

Step 5 (CBT)

We accepted the results of this self-assessment and engaged in a collaborative relationship with a therapist with whom we could share and discuss these findings and receive appropriate and accurate feedback and support. Steps 4 and 5 reflect the importance of a thorough assessment of the effects of gambling on various life domains. Such an assessment not only serves as a potent source of motivation (e.g., guarding against relapse, minimizing the seriousness of the crisis, identifying the negative consequences of gambling) but also specifies the exact areas of functioning that will require behavioral change (e.g., improved interpersonal relationships, money management). This important awareness-raising exercise serves to identify and prioritize the changes that may need to be made. CBT excels in the assessment of the behaviors, interpersonal relationships, and cognitions necessary to properly conceptualize a clinical problem and developing an adequate treatment plan ([Beck, 1995](#); [Sobell & Sobell, 1993](#)). The assessment of the impact of gambling upon oneself and others, both significant (e.g., family, friends) and less significant (e.g., employers, bank managers, utilities) others, critically informs the treatment plan within CBT or the recovery process within TSP. This cognitive and behavioral assessment requires both honesty to oneself and others (i.e., the information gathered must be reliable and valid) and a genuine desire (i.e., the motivation should be intrinsic rather than extrinsic) to extend the insights identified in Steps 1 through 3. This process may sometimes be aided by significant others who can contribute to the assessment.

Step 5 also explicitly indicates the need to share with others the analysis of the consequences of problem gambling. The role of the therapist within CBT, and of other GA members within TSP, is paramount insofar as these relationships may be one of the few remaining human interactions for the recovering gambler where there is acceptance, empathy, support, and understanding. If the client is attending group therapy, other members can also act as the recipients of this shared communication. It is within this safe communication that the recovering gambler is encouraged to become fully aware of the consequences of gambling assessed in Step 4 without fear of censure, attack, criticism or ridicule. The presence of a significant other in the recovery process (e.g., therapist, Higher Power, GA members, GA sponsor) with whom this communication takes place also acts as a source of feedback, clarification, elaboration, and support but can also prevent self-deception by pointing out inconsistencies, maladaptive thinking or erroneous conclusions. Thus, the therapist or GA member also serves as a mirror to provide the gambler veridical feedback regarding the impact of problem gambling on the individual's life. Such communication also prevents the gambler from excessive self-condemnation or self-derogatory attitudes that may impede recovery and assist the maintenance of the correct attitude that will facilitate recovery. Thus, discussing the results of this assessment process produces a more complete and accurate understanding of where the gambler will need to focus to help maintain their recovery.

Finally, Steps 4 and 5 encourage the gambler to develop humility, a rational understanding of one's limits, powers and intelligence, the lack of which may have fuelled the cognitive context of the problematic gambling behavior and also prevented the awareness of the consequences that have subsequently accumulated. The test for humility arrives when one must share the results of the self-assessment with someone else. While it is easy at times to admit to oneself the negative impact of gambling, it takes an additional measure of motivation, self-understanding and seriousness to then verbalize these matters with another. It is in this attitudinal transformation from self-interested arrogance and denial to admission, surrender, and humility wherein the power of these two steps lie.

Step 6 (GA)

Were entirely ready to have these defects of character removed.

Step 6 (CBT)

We were motivated and prepared to modify our habitual and automatic maladaptive interpersonal behaviors.

Step 7 (GA)

Humbly asked God (of our understanding) to remove our shortcomings.

Step 7 (CBT)

We worked in collaboration with a therapist whom we acknowledge has the expertise to guide us in modifying inadequate and dysfunctional patterns of behavior.

Steps 6 and 7 acknowledge that addressing the results of the self-assessment identified in Steps 4 and 5 require an ongoing readiness and continued effort to change and that such change may frequently require the help of others (e.g., God, therapist, family). Even problem gamblers who prefer to recover without the assistance of therapy, a reliance on a transcendental value will still be at work (e.g., health, higher self, being the best one can be, happiness). An important function of steps 6 and 7 is the fostering of an attitude of openness to the help and guidance (within TSP) or treatment (within CBT), which is a necessary component in resolving the problems facing the gambler. Step 6 also signifies the acceptance of responsibility for the gambling-related problems by identifying specific interpersonal behaviors and habitual and automatic ways of thinking, feeling and behaving (i.e., character defects) that have contributed to the development of the gambling problem (e.g., anger, arrogance, egotism, intolerance). Steps 6 and 7 begin the important work of re-establishing healthy relationships with others that have likely been severely strained or damaged as a result of gambling. However, it

is acknowledged that it is not usually possible to re-establish these relationships without also modifying one's own interpersonal behavior and identifying and correcting character defects that may have contributed to the development of the gambling problem.

Step 7, within the context of CBT, requires the establishment of a good working alliance, an important mediator of therapeutic change, between therapist and client ([Beck & Emery, 1985](#); [Miller & Rollnick, 1991](#)). Treatment may frequently include the involvement of significant others, or the provision of therapy within a group format, a standard approach within TSP. The inclusion of humility in Step 7 signifies the individual's willingness to accept support (i.e., from higher Power, therapist, GA sponsor), which would not be possible if the individual believed that such support was unnecessary or impossible. Excessive pride, social isolation, or the damaging effects of intense emotions such as depression, despair or anger can present obstacles to benefiting from others who may genuinely care for the gambler, which may include friends, family, the therapist or spiritual forces. The acknowledgement that help may be needed (Step 7) does not signify the surrender of responsibility within the TSP (any more than receiving treatment from a therapist or physician is a surrender of responsibility within formal psychological or medical treatment systems) but a reflection of the individuals' preparedness to address the gambling problem and improve their behavioral, cognitive, and emotional functioning by taking advantage of the expertise and experienced support available to them. Finally, Steps 6 and 7 acknowledge that stopping the gambling problem is not equivalent to recovery. Without addressing the highly-learned, dysfunctional and habitual interpersonal and intrapersonal behaviors associated with the gambling problem, the risk of relapse remains high. Thus, these two steps are the beginning of the relapse prevention process as well.

Step 8 (GA)

Made a list of all persons we had harmed and became willing to make amends to them all.

Step 8 (CBT)

We became aware of the negative impact of our gambling on others and were prepared to take responsibility for improving these relationships.

Step 9 (GA)

Made direct amends to such people wherever possible except when to do so would injure them or others.

Step 9 (CBT)

Where possible and free of negative consequences to others, we made concrete changes in our relationships with individuals who may have been harmed by our gambling.

Steps 8 and 9 continue the work of Steps 6 and 7 on the repair and re-establishment of interpersonal relationships damaged through gambling, an important outcome of a successful recovery. Steps 8 and 9 are the behavioral or active component of this aspect of recovery whereas Steps 6 and 7 represent the cognitive or intellectual analysis of the gambler's interpersonal behavior. This process includes the empathic identification and awareness of feelings significant others may have about the individual's gambling, (e.g., anger, depression, rejection) as well as the gambler's own depression, despair, guilt, shame. Successful completion of these steps may require the development of empathic skills, learning to sacrifice self-needs, modifying maladaptive interpersonal behaviors, and the adoption of more effective coping skills to deal with the gambling triggers. It often requires putting the needs of those who have been damaged by the gambling behavior ahead of the gamblers'. In some cases, social skills training, assertiveness training and other interpersonal skill development may be necessary. When relationships have been irretrievably ruptured (e.g., separation, divorce, bankruptcy) the necessity of mourning the loss of the relationship and processing the emotional after-effects is critical.

The insights made in Steps 1 through 3, the awareness and assessment of the consequences of gambling achieved in Steps 4 and 5, and the readiness to change expressed in Steps 6 and 7, culminate in Steps 8 and 9 in the difficult work of actually modifying one's relationship with others begins. Since many problem gamblers have character pathology ([Blaszczynski, & Steel, 1998](#); [Rosenthal, 1986](#)), this work may require considerable time, guidance and input from the therapist, other GA members, GA sponsor and other patients (if group treatment is the modality) since such maladaptive behaviors are often highly automatized and resistant to modification without the assistance of others. Depending on the gambler's intrapersonal strengths, resources and willingness, this phase of recovery can be prolonged. Within CBT this may necessitate participation in a long-term group or treatment specifically designed for individuals with character pathology. The successful result of this process is the development of a healthy social support network which becomes available to help the former gambler cope with urges, temptations or any other stimuli associated with gambling. The development of healthier, authentic interpersonal relationships also forms an important component of an alternative lifestyle incompatible with gambling and protection against relapse. Perhaps the most significant implication of these two steps is the resumption of non-manipulative relationships between the recovering gambler and significant others which is modeled in the relationship between the gambler and the therapist or GA sponsor / member.

Step 10 (GA)

Continued to take personal inventory and when we were wrong promptly admitted it.

Step 10 (CBT)

We continued to self-monitor our thoughts and behavior and immediately corrected maladaptive beliefs and behaviors that we become aware of.

Step 11 (GA)

Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for the knowledge of His will for us and the power to carry that out.

Step 11 (CBT)

We remained aware of, and endeavored to think and behave as consistently as possible with, our highest motivations and values.

Steps 10 and 11 stress the importance of ongoing self-awareness and self-monitoring, reflection, and self-analysis in order to minimize the influence of cognitive distortions, erroneous perceptions, conditioned responses, or emotional reactions on long-term recovery. Step 10 is comparable to relapse prevention common in the CBT of addictive behaviors (Dimeff & Marlatt, 2000). Psychological vigilance is as important in ensuring a stable long-term recovery as the behavioral changes described in the preceding steps. Consistent ongoing cognitive assessment makes available to memory the consequences associated with the decision to initially stop gambling and hinders the fading of memory that may weaken the commitment to recovery ([Miller & Brown, 1991](#)). Similar techniques are common to TSP. Step 10 also suggests that regular self-monitoring behavior (both overt and covert) is a potent means of rapidly becoming aware when any aspect of our behavior is a potential risk factor for relapse and should thus elicit immediate remediation or correction (e.g., contemplating a visit to Las Vegas, indulging anger).

Step 11 further stresses that recovery should be guided by the most positive and healthiest motivations defined in earlier Steps. For example, a recovering gambler who has committed themselves to developing honest and authentic relationships with people will not only develop an excellent means of avoiding a relapse to gambling but will experience benefits in others areas of their life which will further sustain recovery. Step 11 thus appeals to the need for the individual to strengthen the healthiest and most adaptive aspects of their functioning. To adhere to these higher values requires specific actions that are consistent with the value and thus a

powerful bulwark against the influence of harmful influences on behavior.

Step 12 (GA)

Having made an effort to practice these principles in all our affairs, we tried to carry this message to other compulsive gamblers.

Step 12 (CBT)

Once we were certain that the cognitive and behavioral changes we had made were stable, we acted as a role model for other problem gamblers.

Step 12 is the final outcome of a successful therapy insofar of recovery as the recovered gambler is now in a position to also actually help others with gambling or other problems, whether formally (as counselors) or informally (as role models). It represents the mastery of dysfunctional behavior and attitudes and their transformation into prosocial and effective interpersonal and intrapersonal functioning. Only through repeated practice and rehearsal of the adaptive ways of thinking, feeling and behaving and continuous self-assessment to ensure that any threats to recovery are rapidly addressed can the changes that have been made become a well-learned, permanent and resilient part of one's day-to-day functioning. This Step also exposes the former gambler to powerful social reinforcements that can further strengthen and maintain long-term recovery from problem gambling. As a role model, the recovered gambler continues to strengthen their own recovery through continual rehearsal of functional living as well as becoming a potent source of reinforcement for other gamblers in recovery (whether in a therapy or GA group). This Step also stresses the importance of integrating the changes that one has made during the recovery process into all areas of functioning and to be on guard against any aspects of the self that remains vulnerable to the temptations and dangers of gambling and that may serve as a portal for it's reoccurrence.

Summary

As this analysis has demonstrated, the goals, processes, and outcomes of both the TSP and CBT with respect to pathological gambling are highly similar, comparable and complementary. Consequently, there would appear to be few obstacles in combining elements of both approaches in helping the gambler ([McCrary, 1994](#)). Perceived differences between TSP and CBT, such as the adherence to an abstinence goal, the role of spirituality or the causes of addiction, are less central to the change processes common to both approaches. The use of the group approach to treatment favored by the TSP appears to be consistent with the growing literature of the effectiveness of this modality in CBT. While some of the concepts employed in TSP appear alien to practitioners of CBT, they reflect

different traditions rather than underlying different concepts. For example, higher Power corresponds to highest values or motivational variables, powerless over gambling corresponds to insight that control over gambling outcomes is an illusory belief, turning our lives over to the higher Power corresponds to increasing the influence of higher values and ideals in the control of behavior, and so on. Since clients often do not have ideological preferences when seeking treatment but are interested in receiving the most effective treatment, it is important that practitioners of CBT consider the potential contribution of twelve-step approaches to assist their clients (especially in the long-term).

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