



Single-session interventions for problem gambling may be as effective as longer treatments: Results of a randomized control trial



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ABSTRACT

Empirically supported treatments for problem gambling tend to be multimodal combining cognitive, behavior and motivational interventions. Since problem gamblers often prefer briefer treatments it is important that interventions adopt strategies that are optimally effective. In this study, 99 community-recruited problem gamblers (74% male, mean age: 47.5 years) were randomized to *one of four* treatments: *six* sessions of cognitive therapy, behavior therapy, and motivational therapy or a single-session intervention. The sample was followed up for 12 months post-treatment. In both the Intent-to-Treat and Completer statistical analyses, no significant group differences on key gambling variables (i.e., frequency, expenditures, severity) were found. All *four* treatments showed significant improvement as a result of treatment that endured throughout the follow-up period. These results, although preliminary, suggest that very brief, single-session interventions may be as effective as longer treatments.

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1. Introduction

With rates of pathological gambling hovering about 1% (Shaffer & Hall, 2001) the need for efficacious treatments remains a priority. Several reviews of the controlled treatment literature have shown cognitive/behavioral treatment (CBT) approaches to be supported with the best empirical evidence (Ashley & Boehlke, 2012; Petry, 2005; Petry et al., 2006; Hodgins & Holub, 2007; Toneatto & Millar, 2004; Korn & Shaffer, 2004). The better designed cognitive-behavioral studies have obtained long-term improvements in gambling of between 50% and 75% (e.g., Echeburua, Baez, & Fernandez-Montalvo, 1996; Sylvain, Ladouceur, & Bosivert, 1997; Ladouceur et al., 2001; Ladouceur et al., 2003).

In recent years brief treatments for problem gambling emphasizing motivational interventions have also emerged. Wulfert, Blanchard, Friedenberg, and Martell (2006) reported that combining motivational interventions with CBT reduced drop-out rates. However, Petry, Weinstock, Ledgerwood, and Morasco (2008) found mixed results for the efficacy of combined motivational intervention-CBT treatment for gambling compared to brief advice or assessment control. Hodgins, Currie, and el-Guebaly (2001) showed that a motivational intervention enhanced the efficacy of a self-help manual compared to the manual alone group up to *two* years later (although there were no group differences at *one*-year post-treatment).

Very brief interventions, often delivered within *one* session, may be as effective as longer treatments (e.g., McCambridge & Strang, 2004;

Chick, Ritson, Connaughton, Stewart, & Chick, 1988; Larimer et al., 2012). Dickerson, Hinchey, and England (1990) and Hodgins et al. (2001) have shown that CBT-based self-help manuals can produce significant reductions in gambling behavior. Diskin and Hodgins (2009) demonstrated a greater effect on gambling behavior of a *one*-session motivational interview compared to a control interview *one*-year post-intervention. Larimer et al. (2012), in a college sample of at-risk problem gamblers 10% of whom met criteria for DSM-IV pathological gambling found that a 60–90 minute, motivational-interviewing based intervention was as effective as a *six*-week cognitive-behavioral intervention on measures of gambling frequency and DSM symptoms.

Most efficacious treatments for problem gambling tend to be multimodal combining cognitive, behavioral, and motivational interventions. As a result it is difficult to evaluate which class of interventions are the most effective in effecting clinical change (e.g., Blaszczynski & Silove, 1995; Walker, 1992). This can be a serious impediment in the formulation of optimally effective treatment for problem gambling given the brief duration of contact between problem gamblers and the treatment system (Rush & Moxam, 2001; Cunningham, 2005) and generally high attrition rates among gamblers in treatment (Wulfert et al., 2006). To maximize the impact of treatment and reduce the risk of non-compliance, drop-out and relapse, treatments should strive to include only those interventions that have been empirically supported. For example, neither Echeburua et al. (1996) nor Toneatto and Gunaratne (2009) found that the addition of cognitive therapy to be differentially more effective than either behavioral treatment or a combined cognitive-behavioral treatment. In addition, several other non-cognitive approaches to gambling treatment have also been shown to be ineffective (cf. Korn & Shaffer, 2004).

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The purpose of the present study was to directly compare relatively homogeneous treatments for problem gambling based on modalities shown to be the most empirically effective (i.e., cognitive, behavioral, motivational). By testing the relative efficacy of cohesive, narrowly-defined clinical interventions, an empirical approach to maximizing the efficacy of problem gambling treatment can be developed.

2. Method

2.1. Participants

Participants were recruited from the Greater Toronto area through classified advertisements placed in local newspapers seeking individuals with a gambling problem and who were interested in treatment. Potential participants were initially screened over the phone to determine eligibility (i.e., at least one DSM-IV symptom for pathological gambling in the previous year and were not concurrently receiving any additional treatment for problem gambling). Exclusion criteria included any severe psychiatric or psychosocial crisis (e.g., suicidality, psychosis, and homelessness) requiring immediate attention. Participants were included in the study if they were interested in treatment for problem gambling and not currently receiving gambling treatment elsewhere. Ineligible participants were referred to the appropriate treatment services (e.g., Problem Gambling Service and Emergency Department). The study received approval by the Research Ethics Board of the Centre for Addiction and Mental Health (CAMH). All participants completed an informed consent.

2.2. Assessment

2.2.1. Baseline

Eligible participants were invited to CAMH, a large, urban, treatment and research facility located in downtown Toronto to participate in a baseline assessment. Lack of availability of psychometrically robust measures of problem gambling and gambling behavior at the time that this study was designed required the development of study-specific questionnaires. In the 30 days prior to the baseline assessment gambling frequency and expenditures were assessed using single-item questions (i.e., “*In the past 30 days, estimate on how many days you gambled*”; “*In the past 30 days, estimate how much money you bet*”). The severity of problem gambling (past year) was assessed using a checklist based on the DSM-IV criteria for pathological gambling given the absence of psychometrically-validated diagnostic measures at the time that the study was developed and conducted (Stinchfield, 2003). The history of psychiatric (e.g., “*Have you ever been treated by a psychiatrist*”) and gambling treatment (e.g., “*Have you ever attended Gamblers Anonymous*”) was also assessed using study-specific questions. With only about one-third of the sample reporting being married or common-law, collateral informants to corroborate participant self-report were not recruited.

2.2.2. Post-treatment

Following treatment participants completed measures of gambling frequency and expenditures for the previous 30 days prior to the final session. In the case of the Minimal Intervention (MI), the post-treatment assessment occurred 30 days following the intervention to ensure a comparable post-treatment period for all 4 groups.

2.2.3. 12-Month follow-up

Measures of gambling frequency and expenditures in the 30 days prior to the follow-up assessment, identical in form to the baseline and post-treatment measures, were administered. Past year DSM-IV criteria for pathological gambling as well as current ratings of confidence in controlling gambling, resisting gambling urges, desire to gamble, and treatment efficacy were also administered in a face-to-face interview (e.g., “*On a scale between 1 and 100, how strong would you*

rate your desire to gamble at the present time?”). In addition, participants rated their satisfaction with the specific treatment, the program, treatment length, and overall helpfulness of the program (e.g., “*On a scale between 1 and 100, how satisfied were you with the length of the treatment?*”). Intermediate follow-up (i.e., 3 or 6 months post-treatment) were not included as the specific interest in the study was in durable treatment outcomes. Recovery from addictive behavior is highly variable especially in the months of post-treatment. Assessment of treatment outcomes during such vicissitudes serves only to confuse questions about the efficacy of treatment. A one-year follow-up provides a superior evaluation of the relative efficacy of the four treatments included in this study.

2.3. Treatments

Following the baseline assessment participants were randomly assigned by the study coordinator to one of four groups using a random numbers table.

2.3.1. Cognitive therapy (CT)

The cognitive intervention was based on a treatment model influenced by Ladouceur et al. (2001) and Toneatto (1999, 2002) that focused on the identification and cognitive restructuring of key gambling-related distortions. The goal of the CT was to assist the client in becoming aware of the distorted beliefs and attitudes held about gambling outcomes and weaken the gambler's core belief of the predictability or controllability of such gambling outcomes. Key interventions included (i) awareness-raising of gambling-related beliefs about the predictability and controllability of gambling outcomes, (ii) introduction of doubt about gambling-related distortions, (iii) collaborative empiricism between the therapist and client to evaluate the validity of gambling beliefs, (iv) rational evaluation of the plausibility of distorted beliefs, and (v) metacognitive interventions (e.g., challenging the degree of confidence in the veridicality of one's own beliefs).

2.3.2. Behavior therapy (BT)

The behavioral intervention focused exclusively on action-oriented strategies designed to achieve four specific goals: (i) stimulus control (i.e., avoiding gambling venues, socializing with other gamblers, and gambling-related stimuli); (ii) coping with urges (i.e., develop effective responses to temptations and cravings); (iii) increasing behavioral reinforcement (i.e., resuming gambling-free lifestyle, engaging in activities incompatible with gambling, planning leisure activities) and strengthening social reinforcement (i.e., resumption of supportive social relationships, repairing damaged relationships, socializing with non-gamblers).

2.3.3. Motivational therapy (MT)

The motivational intervention, largely based on Miller and Rollnick's (1992) stage of change model, assumed that behavioral changes are facilitated by the proper motivational state. Therapeutic interventions were tailored to the individuals' stage of change with the goal of strengthening the commitment to action and moving the individual towards the maintenance stage of change. Components of the MT included the resolution of ambivalence about modifying gambling behavior (e.g., intention to resume gambling later), clarification of core values (e.g., healthy relationships and financial responsibility), awareness of gambling consequences, and decisional balance analysis (e.g., pros and cons of both stopping and continuing to gamble).

The CT, BT and MT treatments each consisted of 6, one-hour, sessions and were individually administered on a quasi-weekly basis over an 8 to 10 week period. No objective measure of treatment fidelity was used in this study. However, to enhance treatment fidelity therapists were instructed to adhere closely to the key principles defining each treatment (e.g., refrain treating cognitive distortions directly using interventions consistent with CT if the participant had been randomized to the

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