

Gambling Accountability and Transparency Study Treatment Results

Vanessa Lopez Viets, Ph.D.
The University of New Mexico
Center on Alcoholism, Substance Abuse and Addictions

Overview of the Prevalence and Treatment Literature

Prevalence of Problem Gambling

A recent meta-analysis of epidemiological studies provided past-year prevalence estimates of 2.8% for problem gambling and 1.14% for pathological gambling among U.S. adults (Shaffer, Hall, & Vander Bilt, 1999). The need for effective treatment of problem gambling is particularly acute in New Mexico. With the relatively recent opening of casinos, New Mexico has experienced an increase in gambling problems. Combined prevalence rates of past year problem and pathological gambling among New Mexico adults range from 1.3 % to 3.9 % (Starling, Blankenship, May, & Woodall, 2008; Volberg & Bernhard, 2006). Moreover, an additional 6.4 % of New Mexico adults are at-risk gamblers (Volberg & Bernhard, 2006). Still more permissive laws in recent years made video-slot machine gambling even more widely available. These actions will further compound the already high prevalence of problem and pathological gambling within the multicultural population of New Mexico. Despite the increasing numbers of problem and pathological gamblers, evidence-based treatment services are virtually absent in New Mexico.

Survey studies suggest a tremendous disparity in gambling prevalence and related problems in relation to ethnicity. Latinos, for example, have been found to gamble more frequently and problematically than non-Latino Whites (Lesieur et al., 1991; Stinchfield, Cassuto, Winters, & Latimer, 1997). These findings hold true across survey studies conducted in New Mexico, such that a significantly higher percentage of Latinos as well as Native Americans were more likely to report problem and pathological gambling than non-Latino Whites (Starling et al., 2008; Volberg & Bernhard, 2006).

Treatment Outcome Research

Relative to the literature for many other disorders, gambling intervention research is still in its infancy. Nevertheless, the evidence to date provides reason for optimism in the development of efficacious interventions for individuals afflicted with gambling problems. Reviews of the treatment outcome literature concluded that in general, problem gambling can be treated with considerable success (Blaszczynski & Silove, 1995; Lopez Viets, 1998; Lopez Viets & Miller, 1997). Cognitive and behavioral approaches emerged as having particularly well-documented outcomes, with about two-thirds of clients having shown improvement on average.

Cognitive-Behavioral Studies. One well-designed cognitive-behavioral study was conducted by Echeburúa, Báez, and Fernández-Montalvo (1994a), who compared three treatment modalities and a wait-list control group within a sample of 64 persons having a

pathological gambling diagnosis. The individual therapy condition consisted of six 1-hour sessions with gradual in vivo exposure, response prevention, and stimulus control. For the group therapy condition, clients met once a week for 6 weeks also, and focused on cognitive restructuring, social support, and problem solving skills training. A combined treatment group received both individual and group components. Finally, a wait-list control was utilized for comparative purposes. Dependent variables measured included: frequency of gambling incidents per week, the amount spent per week on gambling, the total time in minutes of gambling activity per week, perceptions of problem severity, and depression score. At 6 months, all three treated groups showed a significantly greater reduction in frequency of gambling, problem severity, and depression than the wait-list control. Moreover, a significantly higher proportion of participants in the individual modality remained totally abstinent from gambling, compared to the combined and control groups.

A small randomized trial of cognitive-behavioral treatment also yielded promising results (Sylvain, Ladouceur, & Boisvert, 1997). Twenty-nine men meeting DSM criteria for pathological gambling were randomly assigned to either a wait-list control or cognitive-behavioral treatment administered on an individual basis that included four components: cognitive correction of gambling beliefs, problem-solving, social skills training, and relapse prevention. Of the treated individuals, 86% were no longer considered active pathological gamblers at follow-up. The treatment group showed (and maintained at 6- and 12-month follow-ups) significantly better outcomes than the control group on South Oaks Gambling Screen (SOGS) score, perception of control, frequency of gambling, desire to gamble, and number of DSM criteria met.

Most recently, Petry and colleagues (2006) developed a well-controlled, empirical trial that randomized participants to Gamblers Anonymous (GA) referral, GA referral plus a cognitive-behavioral workbook, or GA referral plus individual cognitive-behavioral therapy. These researchers found that participants receiving individual cognitive-behavioral therapy made the most clinical gains. A higher percentage of these individuals were classified as recovered or improved. In general, number of treatment sessions completed was positively associated with gambling abstinence.

Brief Interventions. As in the treatment of all addictive behaviors, gambling treatment dropout is a substantial impediment to successful outcome. Attrition rates among problem gamblers in treatment can be as high as 70%, with 40% leaving treatment after only 3-4 hours of service (Moore & Carlson, 1998). To date, gambling treatment programs have done little to measure or address initial motivation for change, an issue that has received considerable attention in research and treatment for other addictive behaviors.

Motivational interviewing (MI) is a brief clinical method specifically designed to enhance motivation for change in addictive behaviors. MI seeks to resolve the ambivalence that many individuals have about their addictive behaviors, through a collaborative examination of the consequences of an addiction against client goals and values (Miller & Rollnick, 1991). Consistent with this approach, evidence from the gambling field demonstrates that a significant proportion of former gamblers say that they resolved their addiction because of the incompatibility between their gambling and desired self-image (Hodgins & el-Guebaly, 2000).

MI has been found in controlled clinical trials to trigger reductions in alcohol (Allsop, Saunders, Phillips, & Carr, 1997; Bien, Miller, & Boroughs, 1993; Bosari & Carey, 2000; Brown & Miller, 1993; Marlatt et al., 1998; Miller, Benefield, & Tonigan, 1993; Senft, Polen, Freeborn, & Hollis, 1997), heroin (Saunders, Wilkinson, & Phillips, 1995), and marijuana use (Stephens, Roffman, & Curtin, 2000). The average effect size of MI has been large (Noonan & Moyers, 1997), with a doubling, on average, of abstinence rates in studies with alcohol dependent clients. Hence, MI appears very effective in promoting various health behaviors.

Hodgins and colleagues (2001) conducted a well-designed investigation in which 102 problem gamblers (52% females) were randomly assigned to one of three conditions: (a) a self-help workbook, (b) a combination of a telephone MI and a self-help workbook, and (c) a wait-list control. They found that individuals who received the combined MI and workbook condition showed better treatment outcomes (e.g., reductions in frequency, time, and money spent on gambling) than gamblers in the other two conditions. These results were maintained at the 24-month follow-up assessment (Hodgins, Currie, el-Guebaly, & Peden, 2004), strongly supporting the additive efficacy of MI.

Other Interventions. Other approaches have not been properly tested with problem gamblers. Approaches such as psychodynamic and 12-Step ones may perhaps be useful with problem gamblers, but to date no well-controlled empirical research has been conducted with these types of interventions. Thus, it is difficult to determine whether or not they would be beneficial interventions for problem gambling. One intervention that has received some attention is eye movement desensitization and reprocessing (EMDR). EMDR was first developed for people with post-traumatic stress disorder. Unfortunately, the EMDR literature, including the one study that targeted problem gambling (Henry, 1996), is fraught with flaws. It is not supported by the literature as being efficacious in the treatment of problem gambling.

Overview of the Current Study

Little is known about the availability and level of practice for treatment of problem gambling behavior in New Mexico, even though the prevalence of gambling is prominent in the state. In order to determine the types of treatment services available for problem gambling in New Mexico, a survey was conducted by the Center on Alcoholism, Substance Abuse and Addictions (CASAA) at the University of New Mexico via a contract from the New Mexico Department of Health and ValueOptions. The purpose of the current study was to provide a comprehensive description of treatment services available in New Mexico for problem gambling in relation to the evidence base and any existing standards.

The New Mexico Council on Problem Gambling provided a list of currently certified therapists who provide treatment to problem gamblers. Out of a total of 58 therapists on the list, seven of these individuals had disconnected telephones and/or were no longer available (e.g., had moved out of the state of New Mexico). Thus, 51 therapists were contacted to participate in the study. Each therapist was sent via postal mail an introductory letter, a description of the project, and a University of New Mexico Institutional Review Board approved project consent form. The contents of the description explained that the study would involve being asked a series of questions by a member of the project research staff regarding problem gambling treatment

services. Additionally, therapists were told the interview would be recorded and take approximately 30 minutes to complete. They were also informed that the results would be reported in aggregate form.

Only the therapists who either mailed or faxed a signed copy of the consent form were contacted to participate in the study and were considered a study participant. A total of nineteen (from a pool of 51) certified problem gambling therapists participated in the study, for a 37% response rate. Despite persistent efforts, 13 therapists declined to participate and 19 others never responded (26% of the non-responders were from one agency). Fifty-eight percent of the participants were female and 42% were male. Approximately 53% of the surveyed therapists were in private practice while 47% saw patients with gambling problems at treatment agencies. These individuals were telephoned to schedule a face-to-face or a phone interview. Each of the consented participants were then contacted at the scheduled time and asked a series of questions regarding treatment of problem gambling in New Mexico. Most of the questions were open-ended. It is important to keep this information in consideration of the responses, because lack of endorsement of a particular item does not necessarily mean that the therapists do not carry out or disagree with the item. However, therapists did prioritize and vocalize certain items or themes. Also, sometimes therapists chose multiple responses; they were usually not limited to one response. What follows are the results of the interviews.

Results

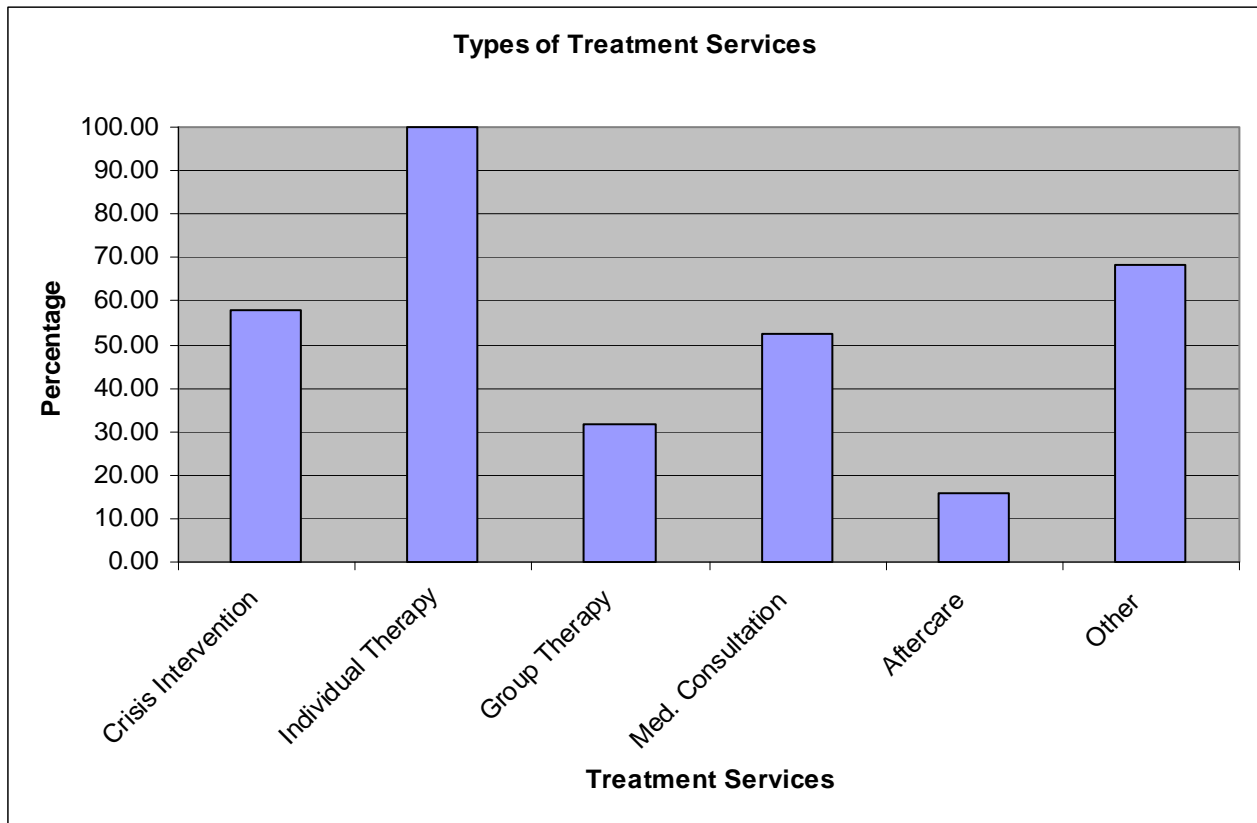
1. How quickly are patients seen once they have been referred?

Over half of the therapists saw patients within three days of the referral. Another 21% stated they saw patients within a week, and about 16% of the therapists said they saw patients in 2 weeks or more of the referral. One therapist who worked for an agency stated that this item was difficult to ascertain because it depended on patient and therapist factors such as individual schedules.

2. What kinds of treatment services are offered (e.g., crisis intervention, individual therapy, group therapy, medication consultation, aftercare, etc.)?

As seen in Figure 1, every therapist indicated offering individual therapy to treat problem gamblers. Also, over half of the sample offered crisis intervention and medication consultation. About a third of the respondents indicated offering group therapy, and 16% of the therapists stated they offered aftercare services to patients. Over two-thirds of the therapists specified other services they offered including: acu-detox, acupuncture, couples and family therapy, recovery houses, and specialized tracks (e.g., co-occurring disorders tracks).

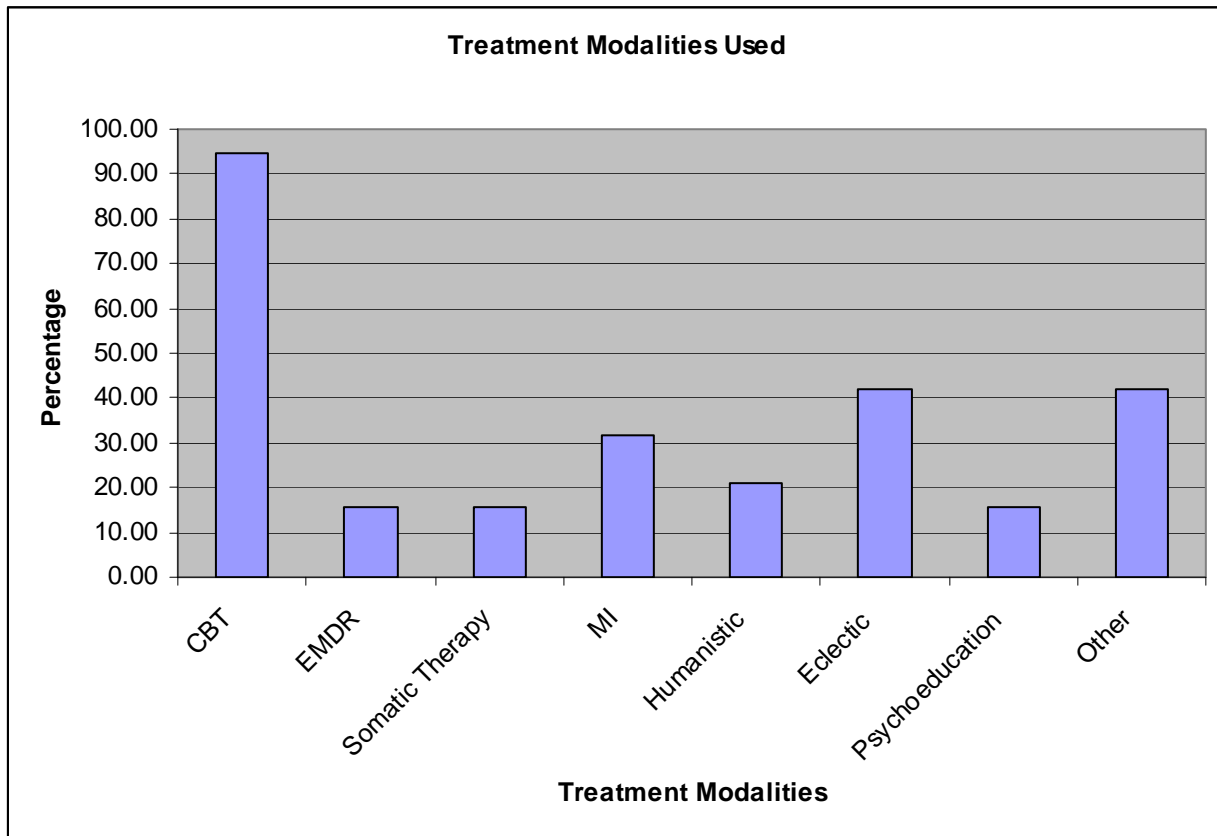
Figure 1. Types of treatment services offered by percentage of therapist responses.



3. What types of therapy modalities are used (e.g., cognitive-behavioral, pharmacotherapy, eclectic, etc)?

As shown in Figure 2, most of the therapists indicated they used cognitive-behavioral therapy (CBT) to treat patients with gambling problems. Almost half of the sample stated using an eclectic or mixed approach when treating patients. Approximately one-third of the sample used motivational interviewing (MI) techniques in working with problem gamblers. One therapist aptly described her use of MI by using the following analogy: “You view [the patient] as the one doing all of the work at the front of the canoe and you’re in the back kind of steering it. So if you see things that you want to try and incorporate, then gently introducing them and see if there’s energy going in that direction on [the patient’s] part, and if not then, well, okay.” Another 21% of therapists specified using a humanistic approach in their treatment. Other therapy modalities used by 16% of the therapists were eye movement desensitization and reprocessing (EMDR), psychoeducation, and somatic therapies. Finally, 42% of the respondents used techniques from other orientations or approaches including: psychodynamic approaches, psychospiritual approaches, reality therapy, relapse prevention, systemic approaches, and twelve-step approaches.

Figure 2. Types of therapy modalities used by percentage of therapist responses.



4. Are all patients provided with a standard treatment or are various treatment options available? If various options are available, what decision tree is used for treatment placement?

Only 16% of the surveyed therapists indicated using a standard treatment in their work with problem gamblers. Another 16% said they used both standard and customized approaches. In other words, the techniques or approaches they used were standard, but they customized treatment according to the individual patient. The majority of the therapists (68%) stated they customized their treatments. Treatment customization depended on patient background (e.g., demographics, past recovery), goals, likes, motivation, and needs (e.g., co-occurring disorders). As one therapist in favor of tailoring treatment stated: “I don’t use a cookie-cutter approach ‘cause I think everyone’s different and the stories people come in with are vastly different.”

5. Do you refer patients to Gamblers Anonymous (GA), and if so, at what point in time?

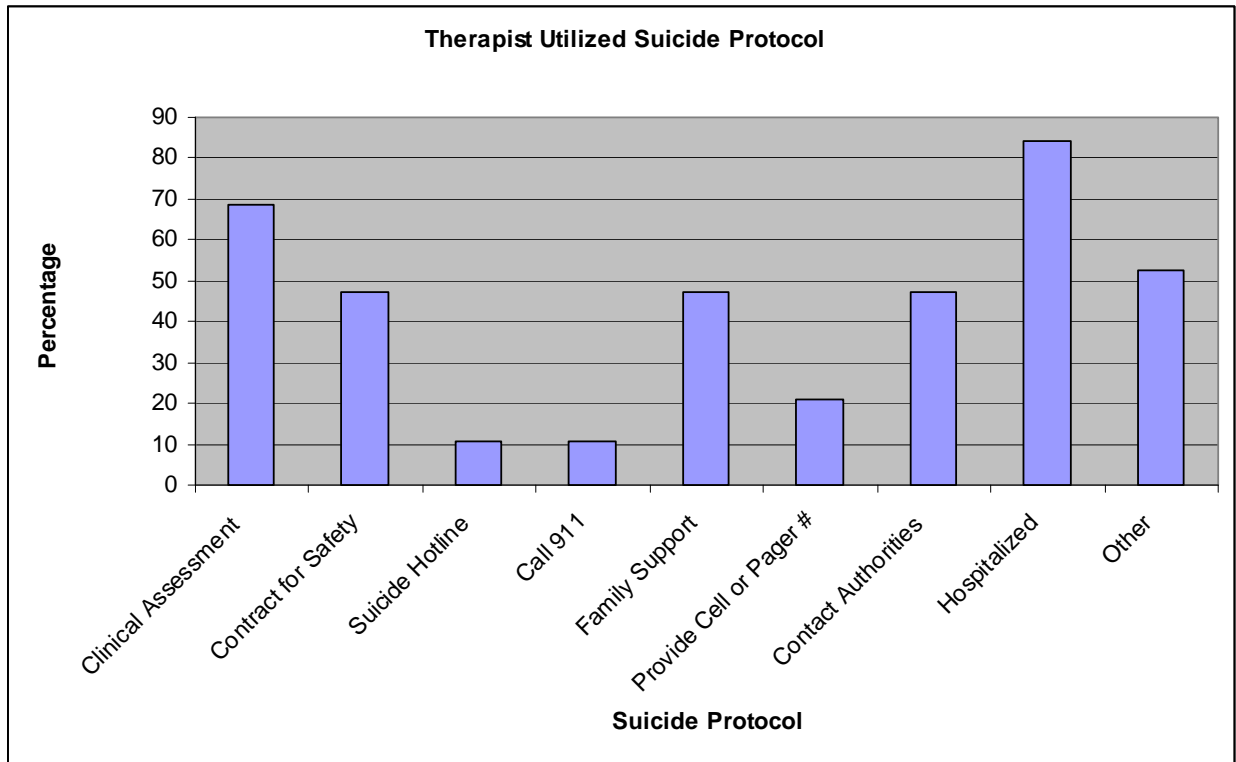
All therapists stated they refer their patients to GA, with most of them (58%) making the referral at the beginning of treatment, 32% making the referral during treatment, and 10% making the referral at the end or after treatment. Despite the high rate of referral to GA, however, 42% of

therapists expressed significant concerns regarding GA. A main concern related to GA was its lack of development in New Mexico, especially in rural parts. The meetings tend to be too small for individuals to feel anonymous. Moreover, there are purportedly few role models of recovery in GA, thereby instilling little confidence in the program and making it difficult to find a sponsor. GA can also be unreliable such that some groups seem to temporarily operate and then dissolve without notice. As one therapist attested to this phenomenon, "...one person will be in charge, and I don't know if they flake out or the group flakes out, but all of a sudden that number is no good anymore." One therapist emphasized that she does not refer patients to GA until after treatment because patients are told not to seek help outside of a higher power. Another therapist mentioned that many of his patients unsuccessfully tried GA, hence their seeking formal treatment. For these reasons and others (e.g., the group setting), therapists said that many patients resist going to GA even when the therapists encourage it. Nevertheless, some therapists stated that GA is a helpful resource for patients, because it provides them with a positive support system that can fill the void left by not gambling. In addition, one therapist mentioned that GA is a nice adjunct to treatment, because patients can work on issues that come up in GA while they are in treatment, and vice versa. For example, he said that Step 4 (i.e., taking a self-inventory) often brings up traumatic memories for patients, and they can discuss these issues with their therapists. Another therapist who was a proponent of GA mentioned using a flexible approach to enlist the cooperation of her patients to try GA: "A lot of [patients] are resistant, but I ask that they...make a commitment to do it five times, and then sometimes they are able to continue with it." Hence, although GA is a popular support system for people with gambling problems, therapists expressed mixed opinions about its helpfulness.

6. How do you deal with suicidal patients? What protocol do you use?

First and foremost, many therapists said they would assess patients who expressed suicidal ideation. More specifically, they would evaluate a patient's suicidal intent, plan, means, and past attempts. In terms of actions taken after the clinical evaluation, therapists indicated using a wide range of clinical options depending on the imminence of the suicidal threat. Most therapists (84%) stated they would hospitalize the patients if the situation called for such an action. Other more frequent responses included contracting for safety with patients, contacting the authorities, and obtaining support from trusted family members. Also, 21% of therapists said they provide patients with their cell phone number or a 24-hour pager number to use in an emergency. Other therapists said they preferred patients call 911 or a suicide hotline. Finally, other actions reported by therapists when dealing with suicidal patients included: taking tremendous measures to locate suicidal patients, making more frequent appointments with the patients, referring patients to a psychiatrist, conducting a follow-up visit with patients after hospital discharge, and obtaining increased supervision. Figure 3 shows a breakdown of the results.

Figure 3. Actions therapists take to treat suicidal patients by percentage of therapist responses.



A few therapists voiced concerns about some of the purported resources for suicidal patients. One therapist mentioned that some of his patients have not felt heard or connected when calling a particular suicide hotline: “They haven’t really helped [them] or they don’t understand or they’re not listening.” Another therapist said that the hospital to which she had referred her suicidal patients sent them away including an individual who had made a suicide attempt. Fortunately, these therapists reported taking additional measures to maintain the safety of their patients.

7. How do you deal with dual diagnosis (e.g., gambling and substance abuse)?

Many therapists said that dual diagnosis issues are very common among individuals with gambling problems. Surprisingly, however, only 16% of therapists reported conducting a comprehensive assessment to evaluate a patient’s clinical profile. With regard to treatment, most therapists (74%) stated that they treat the problems that are presenting. Thus, they endorsed using a comprehensive approach to address the disorders the patients manifest. Moreover, some therapists said they treat gambling like any other addiction given the similarities. A few therapists reported focusing on the gambling given their limited expertise to treat other major disorders. One therapist stated that she focused on depression, because she viewed gambling as a symptom of a depressive disorder.

8. How do organizations ensure that providers are adhering to treatment guidelines/standards, if any?

This item was only applicable to therapists working at treatment agencies (N=9). Most therapists (78%) stated their organizations use quality assurance measures (e.g., auditing of patient files) and provide them with weekly clinical supervision (56%). Other procedures that were mentioned included the use of standard operating procedures, therapist trainings, and the routine staffing of patients (i.e., discussion of patient needs, goals, etc.).

9. Are you aware of evidence-based practices and/or best practices that are accepted by experts in the field?

The majority of the therapists (84%) surveyed indicated they were aware of best practices in the field of gambling. The few who had limited knowledge of these best practices expressed interest in more training. They drew from various knowledge bases to supplement their treatment of problem gambling (e.g., treatment resources related to addictions, the Internet, and information from conferences).

10. If so, is the treatment provided consistent with treatment standards, best practices and/or evidence-based practice?

Most therapists (74%) stated they do use best practices when treating problem gamblers. When questioned to specify the best practices used, some therapists (36%) mentioned cognitive-behavioral therapy. Other specific techniques reported included: relapse prevention, somatic treatments, and techniques from the field of substance abuse. Others mentioned using the techniques and assessments they have picked up from conferences and trainings, but they did not specify the tools used. Some therapists stated working on specific issues as a best practice including: financial, family, and women's issues (e.g., grief and loss). Finally, some therapists emphasized the importance of certification and well-documented treatment plans when conducting clinical work.

11. What pre-treatment data are collected (e.g., gambling, substance abuse, and other disorders)?

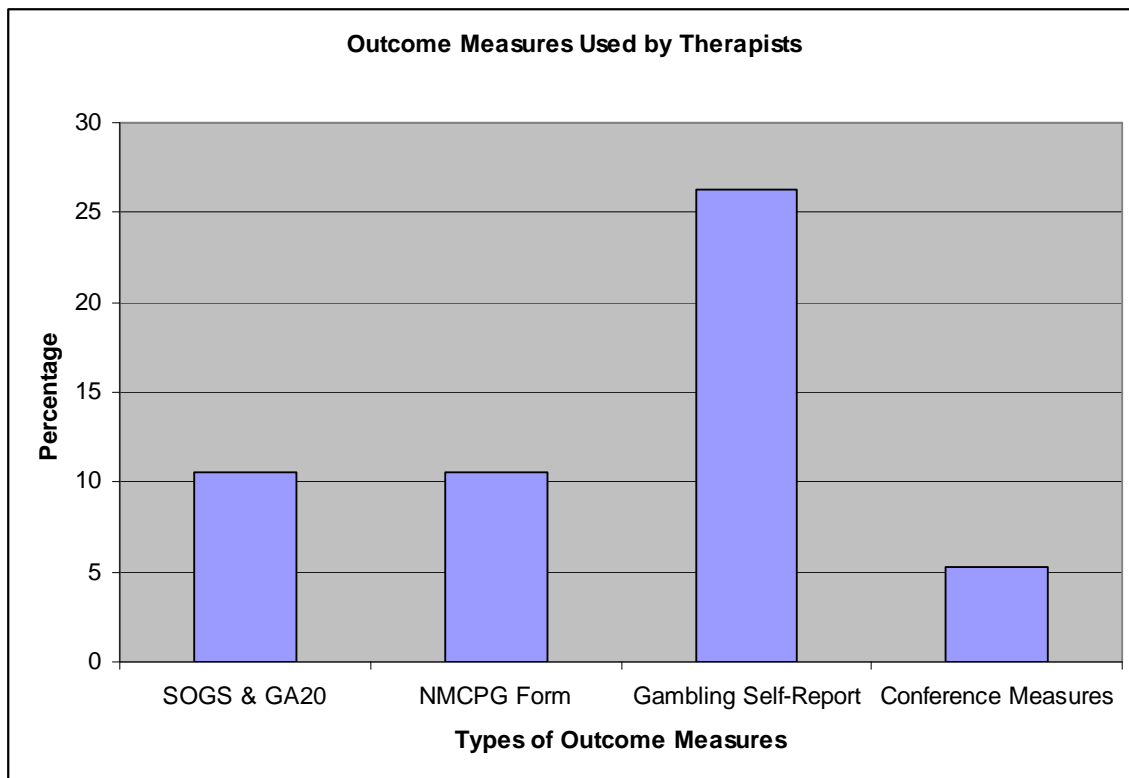
At intake therapists reported gathering a variety of information about their patients. Several therapists (53%) stated they conduct a biopsychosocial assessment which includes treatment history, family history, social matters, etc. Also, many therapists (53%) said they ask patients about their gambling and other mental health disorders. Others (47%) reported inquiring about substance use. A few therapists stated using formal assessments including the South Oaks Gambling Screen (SOGS), the Gamblers Anonymous 20 Questions (GA20), DSMIV criteria, a mini mental status exam, the Beck Depression Inventory, the Addiction Severity Index, and the Substance Abuse Subtle Screening Inventory. Also, a handful of therapists mentioned questioning patients about their debts and finances, domestic violence, issues of grief and loss,

religious beliefs, criminal history, and patient strengths. One therapist stated she used a timeline to gather important information about a patient's life.

12. What outcome measures are used? Are treatment drop-outs followed up?

Outcome measures assess patients at different points in time to see how they have progressed in treatment. Many respondents reported finding it difficult to follow up patients to assess their gambling behaviors at different points in time because of the high attrition rate. One therapist said he was “soft on measures,” but was very interested in learning more about them. Thus, few therapists stated they use gambling outcome measures (see Figure 4). Approximately 10% of respondents said they use the SOGS or the GA20. However, these are screening tools for gambling problems. They are not good outcome measures, because they do not provide a measure of intensity or frequency of gambling. Also, about 10% of therapists reported using a follow-up form developed by the NMCPG. Some of the items that were described on this form included the number of treatment sessions attended by patients, number of relapses, length of abstinence, etc. However, very few of the certified therapists reported using it. About a quarter of the therapists stated using patient self-report, but few named the specific gambling behaviors about which they would inquire. Finally, one therapist reported using measures obtained at a conference, but could not recall the names of these items.

Figure 4. Gambling measures used to describe patient outcomes by percentage of therapist responses.



Over half of the sample stated that treatment drop-outs are followed up, mostly in the form of a phone call for a missed session. Opinions varied on the extent of the follow-up with patients who have dropped out of treatment from one follow-up phone call after a missed appointment to regular and persistent follow-up.

13. Is there collateral verification?

The majority of the respondents (74%) stated that they do obtain information from significant others to verify the patient's self-report. However, these therapists stated that they informally acquire this information. For example, when family members accompany patients to their treatment sessions, they often do not hesitate to disclose the extent of the patient's gambling problems. Or, if therapists offer group sessions, sometimes the patient's peers will tell the therapists the true nature of the patient's gambling.

Others said that it was difficult to obtain this information, because sometimes gamblers were very secretive about their gambling and its subsequent treatment, so significant others were unaware of the problem. One therapist said that when family members "tattled" on patients, this action harmed the therapeutic process. Another therapist was vehemently opposed to asking significant others about the extent of a patient's gambling: "I would consider that to be an invasion of their privacy." At any rate, therapists need to obtain a patient's consent if they want collateral verification about an individual's gambling.

14. What are the outcomes based on the data collected?

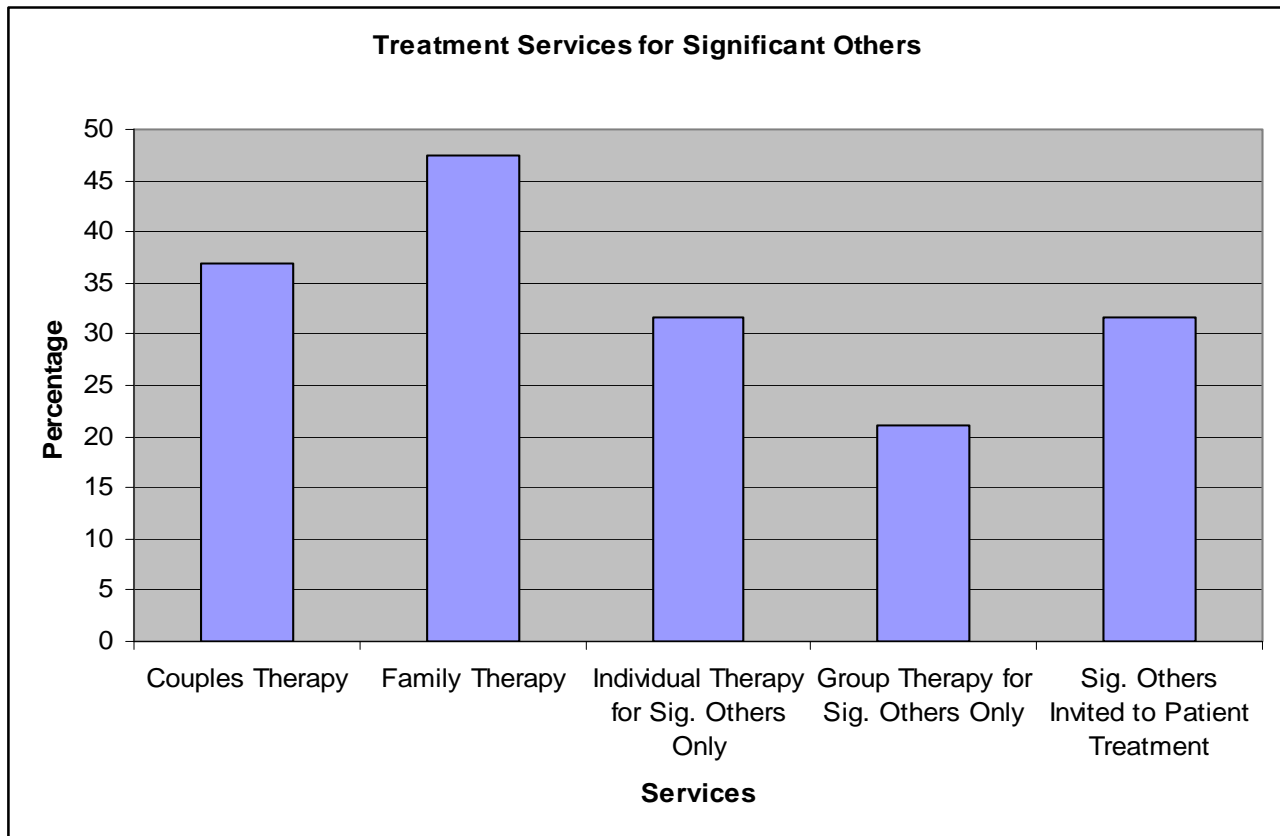
Most of the therapists surveyed do not obtain outcome data. One individual stated that they do not collect data on gambling at her agency for a few reasons: "We do not have any means of doing this [collecting outcome data]. We have a low percentage of our community who has a problem with gambling because of the poverty. There are bingo players...this hurts budgets quite a bit, but it is not socially recognized as a problem." Hence, the purported lack of identified problem gamblers in the community may be indeed due to the low prevalence or the acceptance of gambling. However, without the proper screening and assessment tools it is difficult to discern whether or not some treatment providers are missing diagnosing gambling problems. The few (27%) that do collect this information, look for decreased gambling activity and money spent on gambling and progress toward treatment goals. A couple of the therapists mentioned using the NMCPG's follow-up treatment form which consists of treatment objectives and progress.

15. What services are provided to significant others?

Almost 50% of the respondents reported providing family therapy and 37% said they provided couples therapy. Thirty-two percent of the therapists indicated they invite significant others to attend the patient's treatment sessions. However, some therapists reported that this arrangement was problematic because either the gambler did not want his family members to know the extent

of the gambling problem, or family members were so hurt, angry, and exasperated with the gambler that they wanted nothing to do with the individual. One therapist noting the complexity of the family issues stated: "It's wonderful if their families can support them and be there as long as they don't come to tattle. Because that...hurts the relationship and it usually will affect [the gambler's] attendance. They have enough shame as it is." Some respondents reported that they provide services to family members affected by the patient's gambling even if the patient was not in treatment. One therapist expressed her appreciation of the availability of the Treatment Fund to family members of problem gamblers. Approximately 32% of therapists provided individual therapy to these family members or significant others, and 21% reported providing supportive group therapy to significant others of gamblers and people with other addictions. Finally, other services that were available to significant others included domestic violence groups, financial counseling, psychoeducation, and referrals to appropriate services. The above information is illustrated in Figure 5.

Figure 5. Services for significant others and percentage of therapist responses.



16. In what languages is treatment offered? How do organizations ensure that providers are competent and fluent?

Approximately half of the study sample reported providing treatment in both English and Spanish. Another 37% of therapists said they provide therapy in English only. Therapists from one agency reported having the resources to provide services in English, Spanish, and certain Native/Pueblo dialects, if necessary. To ensure linguistic competence, some organizations use current Spanish-speaking therapists to conduct employment interviews of new Spanish-speaking therapists. Others hire people whose first language is Spanish. Some therapists said they rely on the clinician's awareness of his/her linguistic ability to conduct therapy in another language. One participant reported receiving complaints from patients when they do not get a therapist who can effectively communicate with them. Another individual said that language competency is not ensured at her organization.

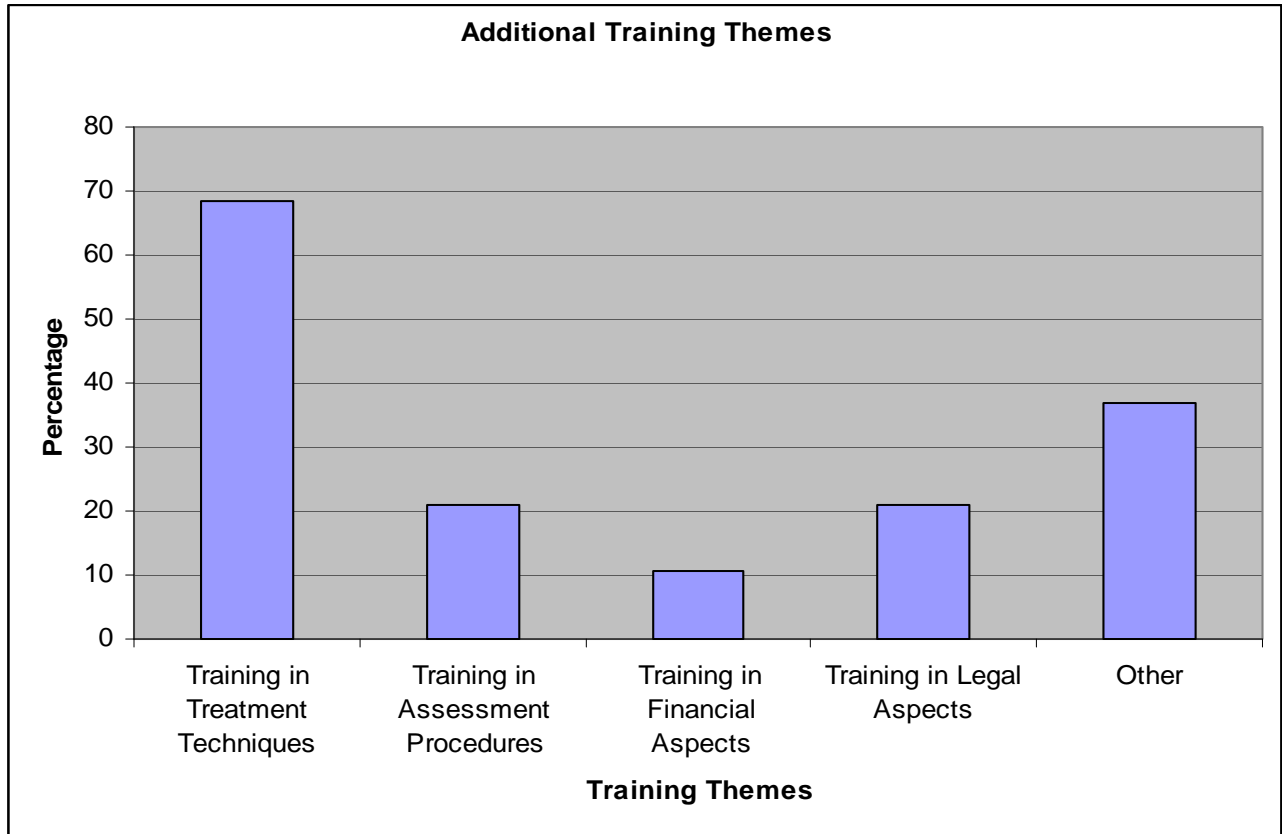
Some therapists also discussed the importance of cultural competence when working with patients from non-White backgrounds. For example, one organization uses a curriculum that is specifically tailored to Latino patients: "...it emphasizes religious tradition, the making of meals, and family." One Spanish-speaking therapist mentioned she uses outside resources such as churches to aid Latino patients in their recovery from addictions.

17. What additional training would you like in your work with problem gamblers?

Figure 6 describes the training preferences the therapists vocalized. A majority of them stated they would like to receive training in treatment techniques targeting people with gambling problems. Moreover, many of these therapists stated that they would like to learn the mechanisms or the "how to" of these techniques. A couple therapists recommended having smaller conferences, so that the participants could partake in experiential groups to practice the techniques. One therapist found this idea of experiential groups particularly appealing, because as she described: "Sitting in a room for hours on end watching a projector, I turn into this fidgety adolescent." Treatment methods specified by therapists included: best and promising practices, cognitive and behavioral approaches, motivational interviewing, stress reduction, EMDR, and alternative methods such as those incorporating non-Western cultural and spiritual traditions. Therapists also expressed interest in different treatment formats such as group, couples, and family therapy. A few therapists also mentioned a desire to receive training in assessment procedures in the field of gambling. In addition, a few said they would like more training in the financial aspects associated with problem gambling to increase their ability to help patients. One treatment provider, in particular, highlighted the need for therapists to address financial issues with gamblers: "...we're only going to deal with three-fourths of the reality, or half the reality because that's where my comfort zone is. I just think [therapists] need to be more pragmatic...they don't spend as much time, especially because they don't have the training, but you can't ignore [the financial part] because it's always an issue." Another significant proportion of therapists stated that some of their patients experienced legal problems because of their criminal activity to fund their gambling habit. Hence, some therapists proposed to learn more about their patients' legal problems, the court system, and the options that are available to patients. Other topics of training interest included: the brain function of gamblers in comparison

to people with other addictions; issues of comorbidity; approaches addressing the high relapse rate; medications; issues of grief and loss; methods addressing ways to work with gamblers at different motivational stages; criminal behavior; and updated statistics on the prevalence of gambling. Also, one therapist said she would like trainers to follow up with therapists to see how their use of the newly learned techniques is faring.

Figure 6. Areas of interest for future training by percentage of therapist responses.



Conclusions and Recommendations

In sum, this study provided a description of current treatment services that are available to people with gambling problems. Of positive note, many therapists reported seeing patients soon after a referral and providing them with a broad range of services including individual therapy, crisis intervention, medication consultation, and group therapy. Also, most therapists said they used cognitive-behavioral therapy in their work, which to date is a treatment modality that has received the most empirical support in the field of problem gambling. Other encouraging findings included the level of care therapists reported using with suicidal patients, the treatment options for significant others of gamblers, and the availability of Spanish-speaking therapists. On the other hand, the limitations that were noted included the use of therapy modalities with limited efficacy (e.g., EMDR) and the deficiencies in clinical assessment and outcome evaluation of gambling and other disorders.

As previously mentioned, this was a descriptive study and not one that evaluated the efficacy of current treatment practices. The effectiveness of different clinical approaches with problem gamblers can be examined in the future. While cognitive-behavioral techniques are considered most effective in the treatment of gambling problems, these need to be formally evaluated in the state of New Mexico. In general, most gambling treatment outcome research has been conducted with White males, and further examination of evidence-based interventions is needed to determine the relevance of these approaches to other groups. This consideration is especially important in New Mexico, in which approximately half of the population is comprised of Native Americans and Latinos. Unfortunately, Native Americans and Latinos are disproportionately afflicted with problem gambling (Starling, Blankenship, May, & Woodall, 2008; Volberg & Bernhard, 2006), thereby underscoring the need to make efficacious treatment available to these groups.

Another issue worthy of attention is the high attrition rate in the treatment of problem gamblers. Many therapists expressed their concern and their desire to learn more about maintaining patients in treatment. One method that was used by some therapists in the current study and that has been widely studied in the field of addictions is motivational interviewing (MI). MI helps patients explore the discrepancy between their life goals and their addictive behaviors while supporting self-efficacy (Miller & Rollnick, 1991). Recent research supports the efficacy of MI with problem gamblers (Hodgins et. al, 2004). MI can be studied with problem gamblers in New Mexico to determine its efficacy in attenuating the high drop-out rate.

By maintaining more patients in treatment, more opportunities will arise to assess them at different points in time. At a minimum, therapists should ask patients about the frequency of their gambling, the length of each gambling episode, and the money spent on each gambling activity (Walker et al., 2006). Assessments such as the SOGS or the GA20 are good screening tools, but they do not provide sufficient information about a patient's gambling frequency or intensity. More careful assessment is not only needed of gambling, but also of other disorders. Dual diagnoses are common among patients with gambling problems. These disorders should be carefully assessed to determine the interplay of symptoms and diseases to best treat patients.

This study can be used as a springboard for further research in the treatment and the assessment of problem gambling. A well-controlled clinical trial that examines treatment interventions for problem gamblers is needed in New Mexico. Given the prevalence of problem gambling in New Mexico and the diverse population, further development and understanding of the most efficacious treatments would be beneficial.

References

Allsop, S., Saunders, B., Phillips, M., & Carr, A. (1997). A trial of relapse prevention with severely dependent male problem drinkers. *Addiction, 92*, 61-74.

Bien, T. H., Miller, W. R., & Boroughs, J.M. (1993). Motivational interviewing with alcohol outpatients. *Behavioral Psychotherapy, 21*, 347-356.

Blaszczynski, A., & Silove, D. (1995). Cognitive and behavioral therapies for pathological gambling. *Journal of Gambling Studies, 11*, 195-220.

Bosari, B., & Carey, K. B. (2000). Effects of a brief motivational intervention with college student drinkers. *Journal of Consulting and Clinical Psychology, 68*, 728-733.

Brown, J. M., & Miller W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors, 7*, 211-218.

Echeburúa, E., Báez, C., & Fernández-Montalvo, J. (1994). Efectividad diferencial de diversas modalidades terapéuticas en el tratamiento psicológico del juego patológico: Un estudio experimental. *Análisis y Modificación de Conducta, 20*, 617-643.

Henry, S. L. (1996). Pathological gambling: Etiologic considerations and treatment efficacy of eye movement desensitization/reprocessing. *Journal of Gambling Studies, 12*, 395-405.

Hodgins, D. C., Currie, S. R., & el-Guebaly, N. (2001). Motivational enhancement and self-help treatments for problem gambling. *Journal of Consulting and Clinical Psychology, 69*, 50-57.

Hodgins, D. C., Currie, S., el-Guebaly, N., & Peden, N. (2004). Brief motivational treatment for problem gambling: A 24-month follow-up. *Psychology of Addictive Behaviors, 18*, 293-296.

Hodgins, D. C., & el-Guebaly, N. (2000). Natural and treatment-assisted recovery from gambling problems: A comparison of resolved and active gamblers. *Addiction, 95*, 777-789.

Lesieur, H. R., Cross, J., Frank, M., Welch, M., White, C. M., Rubenstein, G., Moseley, K., & Mark, M. (1991). Gambling and pathological gambling among university students. *Addictive Behaviors, 16*, 517-527.

Lopez Viets, V. C. (1998). Treating pathological gambling. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed, pp. 259-270). New York: Plenum Press.

Lopez Viets, V. C., & Miller, W. R. (1997). Treatment approaches for pathological gamblers. *Clinical Psychology Review, 17*, 689-702.

Marlatt, G. A., Baer, J. S., Kivlahan, D. R., Dimeff, L. A., Larimer, M. E., Quigley, L. A., Somers, J. M., & Williams, R. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. *Journal of Consulting and Clinical Psychology, 66*, 604-615.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*, 455-461.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Moore, T. L., & Carlson, M. J. (1998). Video poker and the new pathological gambler. *The Counselor, 16*, 13-16.

Noonan, W. C., & Moyers, T.B. (1997). Motivational interviewing: A review. *Journal of Substance Misuse, 2*, 8-16.

Petry, N. M., Ammerman, Y., Bohl, J., Doersch, A., Gay, H., Kadden, R., Molina, C., & Steinberg, K. (2006). Cognitive-behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology, 74*, 555-567.

Saunders, B., Wilkinson, C., & Phillips, M. (1995). The impact of a brief motivational intervention with opiate users attending a methadone programme. *Addiction, 90*, 415-424.

Senft, R. A., Polen, M. R., Freeborn, D. K., & Hollis, J. F. (1997). Brief intervention in a primary care setting for hazardous drinkers. *American Journal of Preventive Medicine, 13*, 464-470.

Shaffer, H. J., Hall, M. N., & Vander Bilt, J. (1999). Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health, 89*, 1369-1376.

Starling, R., Blankenship, J., May, P., & Woodall, G. (2008). Problem gambling in New Mexico: 1996 and 1998. *International Journal of Mental Health and Addiction*.

Stephens, R. S., Roffman, R. A., & Curtin, L. (2000). Comparison of extended versus brief treatments for marijuana use. *Journal of Consulting and Clinical Psychology, 68*, 898-908.

Stinchfield, R., Cassuto, N., Winters, K., & Latimer, W. (1997). Prevalence of gambling among Minnesota public school students in 1992 and 1995. *Journal of Gambling Studies, 13*, 25-48.

Sylvain, C., Ladouceur, R., Boisvert, J. (1997). Cognitive and behavioral treatment of pathological gambling: A controlled study. *Journal of Consulting and Clinical Psychology, 65*, 727-732.

Volberg, R. A., & Bernhard, B. (2006). *The 2006 study of gambling and problem gambling in New Mexico*. Report to the Responsible Gaming Association.

Walker, M., Toneatto, T., Potenza, M. N., Petry, N., Ladouceur, R., Hodgins, D. C., el-Guebaly, N., Echeburúa, E., & Blaszczynski, A. (2005). A framework for reporting outcomes in problem gambling treatment research: The Banff, Alberta Consensus. *Addiction, 101*, 504-511