

## CHAPTER 6

# DICE THERAPY

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Brief intervention dominates the addictions field in New Zealand. This is a result of the dismantling of inpatient services in favour of the more cost effective market-driven options. Motivational interviewing and cognitive behavioural therapy meet the unit-cost analysis criteria of the funding providers, and research suggests that for many consumers of addictions services brief intervention can be effective (Miller & Rollnick, 2002). Personally, I believe that many pathological gamblers need more than a quick fix for their problem behaviour, which for many is partially driven by instant gratification. As a worker in the addictions field I need to provide the best possible therapy, given the uncontrollable variables that I operate under. Brief intervention can still be comprehensive and long-term focused if the client can be *sold* on the idea that ongoing self-help therapy is in their best interests. Albert Ellis, the founder of REBT (Rational Emotive Behavioural Therapy), who considers himself to be the grandfather of brief intervention (Ellis, 1996), suggests that being a good salesperson is important for those of us in the behaviour change business (A. Ellis, personal communication, 27 March 2002). Engaging the client and building rapport and trust needs to be established before a counsellor can focus on socialising the client into the type of therapy on offer. When a client feels safe, fully informed and respected, they are more likely to be real and honest with themselves and the therapist. When these conditions are met, the client is more likely to fully engage themselves as an *active* participant in therapy.

Ciarrocchi (2002) suggests that the gambling field is where the alcohol and drug field was 30 years ago with regards to research. As there is to date no 'best way' to work with the problem gambler, it may be useful to apply some of what is known about addictions in general to the problem gambling population. Ciarrocchi (2002) devotes the first chapter in his

book *Counselling Problem Gamblers* to the 20% difference between clients who have an addiction to gambling and those addicted to substances. If Ciarrocchi's assertions are correct, this implies that there is an 80% similarity between the two populations. It may in fact be impossible to establish what is the best way to deal with an individual client with a particular issue at a specific time in their life. We do not have the luxury of waiting for the results of current research. According to Bellringer (1999), there are numerous ways to provide effective intervention to problem gamblers. "What is appropriate will depend on the age, personality and circumstances of the individual, the reasons why the gambler wishes to address their dependency, and the availability of treatment" (Bellringer, 1999, p.106).

Ciarrocchi (2002) proposes that, as a way of intervening, the cognitive behavioural paradigm is very effective. Indeed, many commentators suggest that the CBT (Cognitive Behavioural Therapy) approach has a lot to offer the gambling field (Sullivan, 2000a; Ciarrocchi, 2002; Blaszczynski 1998; Grant & Kim, 2003). Krumboltz (1998) opines that CBT is the learning approach to therapy, and that the therapist often adopts a coaching style. The educational aspect of CBT means that the whole therapy process is transparent and that the clients can be encouraged to discover for themselves how the addictive behaviour may have become problematic. According to Lazarus (1989, 2000), a key task of therapy is to fill in missing information and to correct misinformation. It is important, however, that the uniqueness of the individual is captured with an accurate conceptualisation (Beck, 1995). This conceptualisation needs to evolve as the client and therapist gain more understanding of what is required from the therapy. By brainstorming potential evidence-based problem solving strategies – in partnership with the client – the CBT approach can almost immediately recruit the client into a co-therapist role.

It is beyond the scope of this discussion to provide an exhaustive therapy blueprint. However, when designing a programme for working with problem gamblers, my proposed DICE (Deliberate-Intensive-Comprehensive-Empowering) acronym may be useful.

### **Deliberate**

According to the *Oxford Dictionary* (Thompson, 1995) being deliberate implies behaving purposefully and intentionally, after full consideration. When the problem gambler has given full consideration to the costs and

benefits of their behaviour, he or she needs to become an active and deliberate participant in the change process. That is, of course, if the decision is for change. One of the fundamental tasks in brief intervention is to encourage the client to work towards their life goals, and as the therapist cannot *make* the client change, there is a need to accept that unless the client's goal is towards change therapy should only provide feedback and support. If the client does choose to abstain or cut down on the problem gambling, the therapist can walk alongside them, but it is the client who needs to be deliberate and do *whatever* it takes. The client who is ready, willing and able (Miller & Rollnick, 2002) to deliberately change their gambling behaviour is more likely to succeed.

Motivational Interviewing (MI) provides several important strategies for the therapist to master when working with the problem gambler (Miller & Rollnick, 1991). An important aspect of MI is working with the trans-theoretical model of change (DiClemente & Prochaska, 1998). This model looks at change as a process, incorporating pre-contemplation, contemplation, determination, action, maintenance and relapse stages. Cognitive Behavioural Therapy and MI are potentially very compatible components of an integrated brief intervention package. Ciarrocchi (2002) suggests that the therapist using CBT *as a way of intervening* needs to be motivational as a *way of being*. This I believe, is a call for the Cognitive Behavioural camp to recognise the importance of integrating Rogerian principles – as incorporated in the motivational interviewing approach presented by Miller and Rollnick (2002). These principles include being non-judgmental, having unconditional positive regard for the client, practicing empathy, and supporting self-efficacy. Employing the evidence-based strategies that have come from CBT research – in a motivationally enhancing style – makes therapeutic sense. The basic principles that underlie Motivational Interviewing – expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance and supporting self-efficacy – (Miller & Rollnick, 1991) integrate well with a structured CBT intervention plan. The various therapeutic tasks specific to the stages of change also need to be understood (Miller & Rollnick, 2002). Indeed, the client who is in the pre-contemplation stage about their gambling will not see it as a problem. This individual (who has no problem) is unlikely to actively engage in a purposive and deliberate problem-solving programme. This client can perhaps be conceptualised as someone who has a high level of motivation to *not* change. The therapist

in this case needs to focus on building rapport and providing information. As the client is encouraged to give full consideration to the effects of their gambling behaviour, they may be provoked into thinking about change and thereby progressing into the contemplation stage and beyond. Providing information in a motivational enhancement style can help the client personalise the risks of their behaviour and make them more open to the possibility of change. If the client can see benefits in changing their behaviour it is more likely that they will engage in some deliberate course of action to change.

### **Intensive**

Deeply ingrained behaviours will not respond to low intensity measures. The notion of intensive care in the hospital setting is well understood, and this picture may be useful to keep in mind. Problem gambling programmes need to consider the gravity of the potential problems facing their clients, and to recognise the need for urgency and intensity. The high incidence of suicide attempts and ideation amongst problem gamblers is well documented (Sullivan, 2003), and the enormous financial and social costs to significant others and society as a whole has also been recognised. The client who has recognised that gambling has become problematic needs to be encouraged to *do whatever it takes* to change. This often includes handing over their financial control and access to *all* funds. Taking full responsibility for the change *process* is an important aspect of the CBT approach. Paradoxically, this may mean (at least temporarily) giving some responsibility to others when it comes to managing money. Although brief interventions consist of fewer sessions, the *level* of intensity of the work that the client does to facilitate change may well determine the success or failure of the therapy. Naturally, the therapist is also encouraged to take some responsibility for the efficacy of the intervention and to help the client prevent slips becoming full-blown relapses (Jarvis, Tebbutt, & Mattick, 1995).

A big part of the CBT-oriented programme is based on cognitive restructuring (Beck, 1995). Challenging automatic thoughts that encourage the problem gambling, and changing the intermediate and core beliefs that support the pathological behaviour, requires intense focus and adherence to strategies designed to combat them. The so-called 'hot cognitions' need to be challenged and replaced by cognitions that support wellness. Ellis (1996) has asserted that only vigorous disputing of self-

sabotaging thoughts and emotions will assist long-term behaviour change. Again, by integrating a motivational way of being with the client, the therapist can gently help enhance the client's level of commitment to *intensively* engage in the type of therapy that is required. Any half-hearted disputing of such cognitions as "I cannot stop/cut down gambling"; "Staying stopped must not be this hard"; "Life shouldn't be this dull without gambling"; "I have proved to myself that I can stop so I can't actually have a real problem"; and "Because I have a problem with gambling I am no good as a person," will set the scene for returning to the old behaviours. The client may benefit from looking at the intensity and commitment that they had put into their gambling, as a measure of what level of intensity may be required to *not* gamble problematically. The level of intense commitment and action needs to occur across all of the factors that are identified in a holistic programme.

### **Comprehensive**

As well as the need for an all-inclusive assessment process, the problem gambling intervention programme needs to be comprehensive. A holistic approach, one that contextualises the 'target problem behaviour' in the client's idiosyncratic world, sets the scene for long-term behaviour change. Bespoke therapy, which refers to the idea that the therapy be tailor-made to suit the client (Lazarus, 1998), as opposed to formula therapy, is to be encouraged at all times. The therapist is therefore encouraged to avoid fitting the client into a course of therapy. It is the therapy programme that needs to be adapted to suit the client. This often calls for a great deal of integration of strategies and skills. Lazarus (1989, 2000), with his BASIC ID framework, offers a useful clinical tool to integrate therapeutic strategies. Lazarus asserts that wild eclecticism is to be avoided at all costs, and that multi-modal therapy – NOT multi-muddle – is to be encouraged. The BASIC ID (Behaviour, Affect, Sensations, Imagery, Cognitions, Interpersonal relations, and Drugs and lifestyle issues) acronym, central to Lazarus's multi-modal therapy approach (1989, 2000), enables the therapist to conceptualise the gambling behaviour in a comprehensive manner. Most CBT programmes are tri-modal in nature, focusing on the cognitions, affect and behaviour. The BASIC ID framework extends the therapeutic focus further by adding *imagery* (e.g. how does the gambler picture themselves and what fantasies do they have about gambling?), *sensations* (e.g. what physical sensations such as sweating, palpitations,

headaches, tensions, etc. does the individual experience around the gambling behaviour?), *interpersonal relations* (e.g. how does the problem gambling impact on significant others in the gambler's life?), and *drugs and lifestyle* (e.g. does the gambler self-medicate or use prescription drugs? Are there exercise, diet, or sleep issues?). By using the BASIC ID framework the therapist and client can discuss the accompanying factors associated either directly or indirectly with the problematic gambling. This may lead to a more comprehensive assessment process covering all of the potential co-existing disorders that have been associated with problem gambling.

By placing the problem gambling within a wider context and completing a rigorous assessment process, the therapist and client may also get a sense of the level of 'organicity' that may be involved in the gambling behaviour. Albert Ellis (1992) suggests that addictive behaviours can be viewed at three basic levels. The first level consists of low frustration tolerance (LFT). Here the problem gambler needs to increase their level of tolerance for frustration and learn to become more comfortable about feeling uncomfortable. Once this skill is mastered, Ellis suggests the client will be able to put up with the discomfort of stopping gambling or cutting down on gambling. The second level is the obsessive-compulsive level of addiction. Here the severity of the behaviour may also include the LFT, but is characterised by the obsession with gambling and an inability to easily resist the compulsion to engage in it. The third level of addiction suggests that there is an organic component to the problem (LFT and OCD issues are also likely) and that perhaps due to genetic predisposition or neuro-adaptation the brain of the problem gambler is to some extent impaired. The efficacy of pharmacological intervention gives salience to this notion of an 'organic' gambler. Grant and Kim (2003) offer some evidence of the usefulness of such prescription drugs as Naltrexone, in conjunction with CBT, when working with problem gamblers. The client is also likely to benefit from medication for the depression and anxiety that often accompanies the problem gambling. As the growing literature on the co-morbidity rates amongst problem gambling illustrates (Sullivan, 2003), the need for ongoing comprehensive assessment and treatment cannot be overstated.

## Empowering

Coaching the problem gambler to become their own therapist needs to be accomplished if brief intervention is to be effective long-term. This vital component of a structured psycho-educational programme can to some extent 'future proof' the brief intervention process and increase the client's sense of self-efficacy. Taking control of their therapy ultimately empowers the individual. This may be especially so for the client who meets their needs for power and control with gambling (Glasser, 1999). Finding other behaviours that have some intrinsic value may help fill any existential gap left by terminating the problematic gambling behaviour. It is important that the therapist and client search for what may be idiosyncratic substitutes for the gambling behaviour. Socratic questioning techniques may facilitate this process (Beck, 1995).

Finding new knowledge about the possible aetiology of the gambling behaviour and knowledge on how to overcome this behaviour may also give the client a sense of power and achievement. It is important for the therapist to respect the client who finds it important to hand the problem over to a higher power of their understanding. It takes a lot of courage for individuals to share with their therapist and others that they have been unable to 'do it alone.' Feeding back to the client that it takes a lot of strength to admit to one's weakness can enhance the client's self-acceptance. Paradoxically, for some clients this can be quite self-empowering. According to Ellis (1996), the client who does not unconditionally accept themselves – despite their poor behaviour – will have little reason to change.

Beck's (1995) concept of core beliefs and Ellis' (1996) notion of underlying philosophies point to the need to address deeply held self-defeating beliefs. Often clients, through childhood and subsequent events, develop destructive core beliefs and philosophies. These deeply-seated beliefs need to be challenged and replaced with beliefs that support well-being. Whether the client gambles to escape or for excitement, long-term behaviour change is unlikely if the client continues to hold on to the self-sabotaging and disempowering beliefs that support gambling. The client who is identified as meeting the DSM-IV criteria for pathological gambling may therefore first need to look at breaking down any belief that they do not have the strength or ability to change. This 'I have a weakness for thinking that I am not strong' belief, I have found to be common across all addictive behaviours. It makes sense, therefore, that

any brief intervention programme also asks the basic question “does the client have the skills to complete the tasks of therapy?” The client who is ready willing and *unable* needs to be identified and treated accordingly. This inability may well be a genuine lack of *skill-power* to accompany the will-power that they may have. If that is the case, then the therapy needs to address the educational needs of this client before assuming that they can be an active participant in the therapy. It may also be the case that the client is in the contemplation stage with regards to the gambling behaviour, but pre-contemplative about engaging in an intensive, possibly painful, journey of discovery and recovery. The learning aspect of CBT may reignite feelings of despair and inadequacy that resulted from negative educational experiences. The idea of having to learn to behave differently, unlearn old behaviours, and do homework assignments may to some clients be re-traumatising. It is vital, therefore, that the therapist can ‘sell’ the idea that self-help therapy is empowering and that just because the education system may have failed the client in the past does not mean that they will be unable to participate in CBT. Holding on to the notion that they have no power can only reinforce the belief system that supports the gambling behaviour.

## Conclusion

Brief intervention is the norm in the gambling field in New Zealand, and for the majority of clients these programmes offer useful strategies to meet client goals. ‘Brief’ does not have to mean that the therapy is shallow and narrow in focus. I have argued that a successful brief intervention programme needs to be structured and tailor-made to suit the idiosyncratic needs of the individual. The programme needs to be **deliberate**, **intensive**, **comprehensive** and **empowering**. It is paramount that the client be successfully socialised into the educational and self-help aspect of this approach. Recognising the way that problem gambling behaviour impacts on the client and their significant others, and exploring the *function of the dysfunction* helps the client to see the adverse consequences of the gambling. In partnership with an empathic therapist the client may begin to experiment with ways to counteract their self-sabotaging behaviours. Learning to unconditionally accept themselves as fallible human beings, despite their poor behaviour, needs to be a primary focus of therapy. If the client can reach the stage where they will do *whatever it takes* to realistically modify their behaviour – and transfer the skills learned in



therapy to ongoing self-development – it is likely that self-efficacy will grow. Alas, for some clients – perhaps those who Ellis (1992) describes as ‘organic’ – more long-term intervention will be required. With this group of clients the CBT may need to focus more on accepting that there may be biological aspects around their difficulty in controlling their impulsive behaviour. If the addiction funding providers themselves could be therapised out of their own problem of instant gratification, they may see the sense in offering more long-term therapy for the significant minority of clients who need more than brief intervention.