Psychological Treatment of Slot Machine Pathological Gambling

A Case Study

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Abstract: In this article, treatment with stimulus control, exposure, and relapse prevention of a patient affected by pathological gambling is described. The patient, a 47-year-old woman, was suffering from this disorder for 5 years. Treatment consisted of nine individual sessions (five sessions of stimulus control and exposure and four sessions of relapse prevention) in a period of 10 weeks. At the end of 1-year follow-up, the patient was much improved, without gambling behavior or associated symptoms, as well as with a greater overall adaptation. Implications of this case for clinical research and practice are discussed.

Keywords: pathological gambling, stimulus control, exposure, relapse prevention, treatment.

1 THEORETICAL AND RESEARCH BASIS

Pathological gambling is a behavioral disorder that was first classified as a nosological entity with specific diagnostic criteria in *DSM-III* (American Psychiatric Association, 1980). Currently, pathological gambling is categorized in *DSM-IV* (American Psychiatric Association, 1994) as an impulse control disorder. It is a behavioral addiction characterized by emotional dependence on gambling and by a chronic and progressive failure in resisting the impulse to gamble. As a consequence, important alterations occur in the family, social, working, and personal environments of pathological gamblers, which negatively interfere with normal functioning in daily life. At the same time, other associated clinical problems include depression, increased risk of suicide, and drug/alcohol abuse (Báez, Echeburúa, & Fernández-Montalvo, 1994; McCormick & Ramírez, 1988).

Pathological gambling is a disorder of great social relevance. On the basis of epidemiological studies in Spain (Becoña, 1993; Irurita, 1996; Legarda, Babio, & Abreu,

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1992), the prevalence rate ranges between 1% and 3% of the population, with an additional 3% to 4% of individuals at risk. Those figures are similar to those obtained in other countries (cf. Bland, Newman, Orn, & Stebelsky, 1993; Volberg & Steadman, 1988, 1989). The main therapeutic demand in our environment comes from the slot machine gamblers (Fernández-Montalvo & Echeburúa, 1997).

From a clinical point of view, the therapeutic objective in the treatment of pathological gambling, as in other addictive disorders (Echeburúa & Báez, 1994), is abstinence. As far as the effectiveness of therapy is concerned, there have been few controlled studies. Furthermore, most of the studies refer generally to combinations of techniques in which the effective component cannot be always isolated (Blaszczynski, 1985, 1993).

However, three lines of research can be delineated in the treatment of pathological gambling: imaginal desensitization—a variant of systematic desensitization—designed to cope with the psycophysiological hyperactivation (cf. Blaszczynski, McConaghy, & Frankova, 1991; McConaghy, Armstrong, Blaszczynski, & Allcock, 1983, 1988); cognitive restructuring—justified by the high number of cognitive distortions being present in the gamblers (cf. Sylvain & Ladouceur, 1997); and finally, in vivo exposure with response prevention and stimulus control—designed to face the craving for gambling and to increase expectations of self-effectiveness regarding the capacity to gambling (Echeburúa, Báez, & Fernández-Montalvo, 1996; Echeburúa, Fernández-Montalvo, & Báez, 2000). Results obtained with these techniques have been satisfactory in assessments carried out following treatment. In some cases, even a rate of 100% abstinence has been reached (cf. Echeburúa et al., 1996). However, as happens in other addictions, a substantial percentage of individuals (around one third of total) relapse in the first months after therapy. Therefore, relapse prevention is the main challenge for the treatment of addictive disorders (Echeburúa, Fernández-Montalvo, & Báez, 2001).

2 CASE PRESENTATION

The main goal of this article is to describe the psychological treatment of a woman affected by slot machine pathological gambling. The first phase of treatment consisted of stimulus control and in vivo exposure with response prevention, which, according to some previous studies (Echeburúa et al., 1996, 2000), seems to be the most adequate treatment for the initial cessation of this kind of problem. In the second phase, a strategy to maintain abstinence from gambling in the long term was implemented.

The specific focus of this case, which has been treated in a controlled clinical trial (Echeburúa et al., 2000), is related to the gender of the patient—there are few studies of women in the field of therapy of pathological gambling—and to the focus of treatment: behavioral techniques for immediate abstinence and cognitive techniques for relapse prevention.

The patient is a 47-year-old housewife, married for 25 years to a plumber with two daughters (23 and 20 years old) and one son (11 years old). The patient was suffering from pathological gambling for 5 years and sought treatment at the Pathological Gambling Center of Rentería (Spain) in March 1999.

3 PRESENTING COMPLAINTS

This patient plays the lottery (with an approximate weekly expenditure of $22) and plays slot machines (approximately $165 every week). She goes three times a week to the slot machine gallery at the hotel—never anywhere else—and spends around $54 each day, although she does recognize that on one occasion she even managed to lose $270. When she wins money, she does not leave the gambling area, but, instead, stays gambling longer until she loses everything. She only allows for $1, which she keeps in a separate pocket, for the bus trip back home.

She feels depressed and ashamed because she is forced to lie. When she gets back home, she usually finds people from her town on the bus and she no longer can think up an excuse for making the trips. Moreover, when she arrives back in her town, old friends are usually at a coffee shop near the bus stop, and when she is with them, she has to think up new excuses. She is totally despaired and can no longer take it and thinks nobody believes her any more. When she is very down, she often drinks too much, "to forget it all."

At home, the situation is not any better. She is very nervous and has difficulty sleeping. When she gets home, she does not like talking nor does she feel like doing any housework. Nobody in her family knows anything about her gambling, although she does think they suspect something. On one occasion she commented to them that she had a problem but did not dare tell them the truth. She has let the house run down and even her personal appearance. Moreover, her daughters confront her because it is not possible to talk to her. Her husband, who until recently has not worried about money at home, has begun to ask her to account for her spending. She is very desperate because she has spent all of her savings. Moreover, gambling has added up to become a $1,650 debt from a small personal loan that she can no longer meet. She has never stolen, but on some occasions has gone through the drawers in her daughters' rooms in search of money with which to gamble. Every night when she goes to bed, she thinks that she is not going to gamble the next day; however, she cannot help it. Her thoughts about gambling are continuous. The relationship with her husband is worsening. They have not had sexual relations for 2 months, because she feels incapable, and he has lost interest.

The patient insists that if her husband were to find out, he would file for divorce. She has come to the therapist's office ready to do anything she can to quit gambling because she can no longer cope with the situation she finds herself in, and she feels she is incapable of controlling it by herself.

4 HISTORY

The patient's gambling began approximately 10 years ago. At that time, she began to go out with her friends to horse races and bet small amounts. She never won very much but she does remember that she had a good time. At home, her husband did not know that she would go to the races, but she dreamed of hitting it big and giving him a nice surprise. Nevertheless, she never lost control with this kind of betting.

Soon afterward, she began to play football pools. She had never understood very much about football, but she read the papers carefully and, based on the standings of the team, she placed her bets. However, such gambling was to last for only a short time (around a year) because, according to her own words, she was never very "taken" by it.

Later on she took up buying lottery tickets. The weekly expenditure was around $22, which she continues to spend to date. However, although it is a relatively large amount (approximately $88 a month), she never got over it, but she did keep it under control.

The patient began to lost control playing slot machines. It all began 6 years ago. She was at a coffee shop waiting for a friend. While waiting, she saw how a man who was playing on a slot machine won a special prize. Ever since then, she got into the habit of spending the change from the price of coffee on slot machines. However, she became increasingly hooked and spent more and more time playing the slot machines.

As a result, she began to drift away from her friends. She preferred to be by herself so as not to be seen and to feel more at ease. At first, she would play slot machines in her hometown. However, she began to go to San Sebastian (the capital city). In this way, neighbors and people who knew her would not see her. In San Sebastian, she went to a gallery of slot machines at a well-known hotel. Since then, her behavior has grown progressively worse, and she has been spending increasing amounts of money. For example, on the same day that she came to the therapist's office for the first time, she had been gambling immediately before and wound up only with the money for a bus ticket back home.

Medical and psychological records of the patient are characteristic of a person with normal health who has not suffered any grave illness nor has undergone any operation. She never has received any psychiatric treatment before suffering from this disorder. There are also no previous psychopathological episodes or medical and/or psychological visits for this reason in the immediate family.

5 ASSESSMENT

Assessment measures were administered to the patient before beginning the initial treatment program. Three assessment sessions (1 hour each) were carried out, and the content of the therapy was explained to her. Following treatment, an assessment session

was carried out to evaluate therapeutic results—the main goal of this treatment was total abstinence of gambling. This assessment session also served as the preassessment for the relapse prevention program. The following evaluations, always in the format of a personal interview, took place when the relapse prevention program was completed and in the 1-, 3-, 6-, and 12-month follow-ups. All of the assessments were conducted by an experienced clinical psychologist.

The diagnosis of pathological gambling was made following *DSM-IV* diagnostic criteria. In addition, a structured interview on gambling history was carried out (45 minutes) in the first assessment, the objective of which was to gather data related to the beginning and subsequent development of this gambling problem.

The assessment tool, related directly to pathological gambling, was the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987). The SOGS is a screening questionnaire composed of 20 items that are related to gambling behavior, loss of control, the sources for obtaining money, and the emotions involved. The range is from 0 to 19 and the cutoff point, which serves to identify probable pathological gamblers, is 4 in the Spanish version of Echeburúa, Báez, Fernández-Montalvo, and Páez (1994). This tool is used only in the first assessment because it is not a test sensitive to therapeutic change (Echeburúa et al., 1996).

Some relevant information about dependent variables related to gambling also were gathered: amount of money, frequency, and time dedicated weekly to gambling on the average. The patient's perception of the seriousness of the frequency, time, and money invested in gambling also was evaluated, along with frequency of thoughts about gambling and the subjective need to gamble: this is referred to as the patient's subjective indicator. Scores for each variable vary from 0 (*nothing*) to 4 (*very much*) on a Likert-type scale, and the summed total ranged from 0 to 20. These same questions also were posed to the older daughter to help confirm patient self-report. This is referred to as the family member assessment.

In addition to gambling-related measures, other psychopathological indicators usually associated with gambling were evaluated: depression (Beck Depression Inventory [BDI]), anxiety (State Trait Anxiety Inventory [STAI]), and lack of adaptation to daily life (Inadaptation Scale [IS]). Assessment strategies were used that have been shown to be sensitive to therapeutic change.

The IS (Echeburúa & Corral, 1987) reflects the extent to which gambling affects different areas of daily life: work, social life, free time, marital adjustment, and family adjustment. This tool, with 6 items that range from 0 to 5 on a Likert-type scale, also is composed of a global scale, which reflects the degree of global inadaptation to daily life. The range of the total scale is from 0 to 30 (the higher the score, the greater the inadaptation). The version used in this study is described in Fernández-Montalvo and Echeburúa (1997).

The results of pretreatment assessment are shown in Table 1.

The socioeconomic level of the patient was lower-middle class. Gambling behavior was characterized as being frequent, entailing a considerable amount of money

TABLE 1
Results of Pretreatment Assessment

Gambling variables	
South Oaks Gambling Screen (SOGS) (range = 0-19)	11
Subjective indicator (range = 0-20)	16
Family assessment (range = 0-20)	16
Gambling frequency (days/week)	3
Money invested in gambling ($/week)	165
Time invested in gambling (hours/week)	6
Psychopathological variables	
Anxiety (STAI-S) (range = 0-60)	35
Depression (BDI) (range = 0-63)	29
Inadaptation (IS) (range = 0-30)	21

NOTE: STAI-S = State Trait Anxiety Inventory; BDI = Beck Depression Inventory; IS = Inadaptation Scale.

spent, and involving a substantial amount of time. Moreover, the patient was heavily in debt ($1,650).

From a psychopathological point of view, the patient was characterized as being anxious, with relevant depressive symptoms and with important negative consequences in daily life.

6 CASE CONCEPTUALIZATION

EXPLANATORY HYPOTHESIS AND MOTIVATION FOR TREATMENT

Following assessment, the therapist explained to the patient and her eldest daughter (who was going to act as a co-therapist) the characteristics of pathological gambling behavior, the mechanism for acquiring it, how it was being maintained in this case, the nature of the treatment, as well as the proposed therapeutic goal: total abstinence from gambling. This was the most suitable for a pathological gambler (Fernández-Montalvo & Echeburúa, 1997).

The first treatment session served to motivate the patient and was designed to ensure adherence to therapeutic prescriptions. The initial motivation in this case came from family pressure and the patient's immediate social surroundings. It was becoming increasingly difficult to hide her gambling problem, as she felt out of control.

As a way to get her actively involved in the treatment and to motivate her to change, it was suggested that the patient inform her husband and her elder daughters about the existing problem and her firm commitment to change. The therapist offered to talk to them later on to clear up any doubts and to give them any necessary support.

The patient was seen as an impulsive and emotionally unstable person. Her slide into gambling was gradual, going from one kind of game to another until she was faced with her uncontrollable gambling urge with slot machines. At first, gambling was of a

merely social and recreative nature; she gambled with her friends to pass the time away. However, the casual observation of how a slot machine player won a jackpot led her to have expectations that in this way she too could win a jackpot. She began to bet more often. Her previous gambling habit was already considerable and she preferred to do it alone. However, she did meet sporadically with three gamblers, who were recent acquaintances. In fact, she gradually withdrew from her prior circle of friends and dedicated more and more time to gambling. Within a short period of time, the only thing that was exciting to her was being in front of a slot machine. The discriminative stimuli that triggered off gambling behavior increased gradually until she totally lost control.

The treatment plan, as well as its overall guidelines, was explained to the patient and her daughter. It was emphasized that the only way to overcome the addiction was by controlling the stimuli, with the help of regular exposure to slot machines, without actually playing. The tasks were initially to be troublesome, but the therapist, in order to motivate the patient, proposed to her that the program would be gradual. He would teach her some skills to confront such initial discomfort and be at her disposition should anything negative happen. Likewise, he was going to draw up a subsequent plan to prevent any relapses.

TREATMENT SELECTION

The therapist who carried out the assessment and treatment of the patient is a clinical psychologist with 6 years of experience in cognitive-behavioral treatment of pathological gambling. The treatment, including assessment, lasted for 3 months (three assessment sessions and nine weekly therapeutic sessions). The therapeutic techniques used were as follows.

Stimulus control and gradual in vivo exposure with response prevention. Stimulus control refers basically to maintaining control of money (not taking money or credit cards with her, except what is strictly necessary; reporting all expenses to a relative; managing income, etc.) and to avoiding situations or routes of risk as well as gambling friends. As treatment advanced, control of stimuli was gradually faded, except the avoidance of gambling friends.

Gradual in vivo exposure with response prevention forced the patient to experience the desire to gamble and to learn how to resist this desire in a gradually more self-controlled manner. The aim of systematic exposure to cues and situations of risk was to make these cues lose their power to induce urges and gambling behavior. The exposure task took place 6 days a week for a minimum time of 15 to 20 minutes. The patient could not drink alcohol or use other drugs during the exposure tasks. These techniques are presented in Table 2.

The aforementioned two techniques were used sequentially in an individual therapy format. Stimulus control can stop gambling behavior, but if planned exposure is not carried out, probability of relapse in the relatively near future is greater. A detailed diary

TABLE 2
Characteristics of Exposure in Pathological Gambling

Exposure	*Characteristic*
First week	The co-therapist (a relative or a close friend) is together with the patient when she is exposed to a slot machine.
	Patient does not take any money.
Second week	The co-therapist goes with the patient to the locale of gambling but stays out waiting for her when she is carrying out exposure. The patient takes only some coins to pay for a soft drink.
Third week	The co-therapist stays at home when the patient goes to her locale of gambling for exposure. If the patient is in a jam, she can phone the co-therapist.
	The patient takes a restricted amount of money.
Fourth week	The co-therapist does not take part any longer in the exposure task. Patient can take money without any restriction.

of the sessions, along with the corresponding homework, is included in Fernández-Montalvo and Echeburúa (1997).

Relapse prevention. The first goal of this program was to train the patient to identify high-risk situations for relapse; the second goal was to provide her adequate strategies for coping with problematic situations. In this way, the patient learned to identify and discriminate risk situations that could lead to an initial lapse in gambling. The usual high-risk situations considered were social pressure, negative emotional states (e.g., anxiety, depression, and anger), and interpersonal conflicts. These three situations were the main risk factors for relapse (cf. Marlatt & Gordon, 1985).

However, the program also included confrontation of the patient with specific high-risk situations, as well as an educational intervention about some factors that would specifically contribute to relapse in pathological gamblers (Fernández-Montalvo, Echeburúa, & Báez, 1999): alcohol abuse, irrational expectations about gambling, lack of financial planning, lack of pleasure in activities, and so on. Finally, an individualized exposure program for high-risk situations was developed and carried out. The goal of exposure was to practice confrontation strategies in a systematic way to increase self-efficacy expectations.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

COURSE OF TREATMENT

Stimulus Control

The first treatment session was dedicated to organizing stimulus control. The patient's eldest daughter was chosen as a co-therapist, who at the outset was surprised at the seriousness of her mother's problem. However, she clearly could perceive that some-

thing was happening to her mother. In this way, the daughter gained control of the money (credit cards, pocket money, etc.), and the patient only received just the money for daily shopping. Nevertheless, the patient later had to account for all of the money she had spent from shopping receipts. On the other hand, the patient was told not to loiter in bars with slot machines and to avoid contact with friends who gambled.

Likewise, a list of pending debts was drawn up and a realistic plan to pay them back was established, strengthening the patient's responsibility to pay them. In this way, the patient reached an agreement with her creditors, with the express request that they should never lend her any money on any other occasion.

Stimulus Control and Gradual In Vivo Exposure With Response Prevention

In the second session, the patient came to the office with renewed hope. She had managed to fulfill all therapeutic prescriptions and, for the first time in a long while, had spent one whole week without gambling. Such headway was later confirmed by the co-therapist. To that end, with the goal of reinforcing the period of abstinence achieved, it was decided to continue with stimulus control along the same lines as in the previous session. In this session, an exposure technique was begun, and it was explained both to the patient and the co-therapist what type of corresponding tasks were to be carried out in the first week of exposure (see Table 2). The patient had to enumerate exposure tasks carried out on a record sheet.

In the third session, the patient continued to avoid gambling and did not present any problem with exposure tasks. Nevertheless, during this week there was a slight worsening in her mood. It was noted that the patient, after giving up her gambling, had many free hours on her hands that she previously had dedicated to gambling and now did not know what to do with that time. Indeed, she spent the whole afternoon watching television and, as a result, her negative mood, as well as her thoughts on gambling, increased. Thus, a list of possible reinforcing and alternative activities to replace gambling was drawn up (to go for walks with friends, get exercise, sewing, attending a computer science class, etc.), with the goal that the patient should do them, thereby limiting risk of relapse.

Concurrently, stimulus control began to be faded. The patient now received a fixed sum of money as a weekly shopping allowance, with the goal of strengthening her responsibility in administering the allotted money. Nevertheless, it was still necessary for all of the expenditure to be accounted for by the co-therapist, and the patient was not allowed to be in contact with her gambling friends. Likewise, the exposure program corresponding to the second week was continued (see Table 2).

In the fourth and fifth sessions, gradual fading of stimulus control was continued due to the fact that the patient was feeling better and avoided gambling. Also, she had begun swimming at the municipal swimming pool during her free hours and felt more relaxed. She continued with exposure tasks (corresponding to weeks 3 and 4, respectively) with an ever-increasing amount of money at her disposal. When the patient com-

pleted the entire exposure program without any considerable discomfort, it was deemed to have ended.

Relapse Prevention

In the subsequent sessions (from sixth to ninth), after undergoing a midtreatment evaluation, treatment directed to relapse prevention was initiated, this time without the co-therapist. In these sessions, coping skills to deal with main risk situations were provided: bad mood, interpersonal difficulties, social pressure, alcoholic drinks, money management, and so forth.

In the sixth session, main situations in which a relapse could occur were identified, as well as the patient's skills to cope with them adequately. Likewise, there was a training session in relaxing techniques, with the goal of preventing the high level of anxiety from turning into a situation that could lead to relapse.

In the seventh session, dedicated to interpersonal problems, the patient was taught how to cope with usual difficulties in everyday life. Likewise, the patient was informed about risk of excessive drinking for relapse in pathological gambling, but counseling was sufficient and a specific training program for controlled drinking was not required.

Session eight was dedicated to dealing with social pressure. The patient was trained in an assertive way to refuse invitations for gambling, as well as strategies to deal with this situation by using appropriate social skills. At this point, the patient was at increased risk for relapse because she had paid up her gambling debts (Fernández-Montalvo et al., 1999). Therefore, being able to refuse given her access to additional money was critical.

Finally, in session nine, the patient was prepared to cope with negative emotional states. Specifically, a cognitive intervention to restructure irrational thoughts related to negative mood was implemented. Special emphasis was placed on putting into practice fun and social activities to restart a satisfactory everyday lifestyle.

ASSESSMENT OF PROGRESS

In this study, therapeutic success was defined as total abstinence from gambling. Concurrently, mood improved everyday life. Table 3 documents progress at different points in the treatment.

As can be seen in Table 3, stimulus control and in vivo exposure with response prevention contributed to total abstinence from gambling. Associated variables reflect improvement as well.

8 COMPLICATING FACTORS

In this case, the therapist could not have the patient's husband as co-therapist because he was not informed at all about his wife's illness and she did not dare to let him

TABLE 3
Results of Treatment

Variable	*Pretreatment*	*Intratreatment*	*Postreatment*	*1 Month*	*3 Months*	*6 Months*	*12 Months*
Subjective indicator	16	2	1	0	1	0	0
Family assessment	16	5	3	3	2	0	0
Gambling frequency	3	0	0	0	0	0	0
Money spent ($)	165	0	0	0	0	0	0
Time invested	6	0	0	0	0	0	0
Anxiety (STAI-S)	35	25	14	12	9	8	8
Depression (BDI)	29	15	8	6	4	4	4
Inadaptation (IS)	21	20	13	8	2	1	1

NOTE: STAI-S = State Trait Anxiety Inventory; BDI = Beck Depression Inventory; IS = Inadaptation Scale.

know, for fear of his divorcing her. Therefore, the patient's daughter, in spite of not being as adequate a potential co-therapist as the husband, was chosen as alternative co-therapist.

A complicating factor for the long-term improvement was the patient's poor repertoire of reinforcing behaviors alternative to gambling. It was difficult to involve the patient in other hobbies other than gambling in order to motivate her for everyday life and to prevent relapse.

9 FOLLOW-UP

Once treatment was completed with a program for relapse prevention, abstinence from gambling remained on course, and progressive improvement in associated variables was observed at the 1-year follow-up. In addition, the patient looked better, was concerned about her personal appearance, and was more diligent about household matters. The couple's relationship had improved and she had gone back to her former, nongambling friends.

10 TREATMENT IMPLICATIONS OF THE CASE

In this case, the cognitive-behavioral treatment of a woman diagnosed with pathological gambling disorder has been presented. As this addiction affects more men and as women are more reluctant to recognize the problem and search for therapeutic help, it is rare to find a scientific bibliography on descriptions of clinical treatment of women. The nature of the symptoms presented in this case includes the basic characteristics of pathological gambling behavior: loss of control, alteration of family and social life, incessant lying, personal negligence, and so forth.

The treatment of pathological gambling has, in the first instance, the goal of helping the patient achieve abstinence and get back in control of her life, and, second, to teach suitable strategies to cope with difficult situations where there is a risk of relapse. In this sense, exposure treatment, initially used in the field of anxiety disorders, has begun to be used recently in different clinical trials. As for addictive behavior in particular, results gained from this technique to cope with craving, used together with stimulus control, have been shown to be clearly encouraging in achieving the goal of abstinence. In the case presented, the patient achieved abstinence by applying these two techniques. Our results match those obtained in two previous studies from our group (Echeburúa et al., 1996, 2000). Therefore, the combination of these two techniques can be considered, at this time, a primary treatment of choice to achieve cessation of gambling behavior, as well as improvement in the associated variables.

In addition, application of a specific relapse prevention strategy is most useful to ensure maintenance of the positive results over the long run. There is the question of helping the patient identify the main situations where there could be a risk of relapse, of giving her more suitable strategies to confront the addiction, and, in the very end, to put to the test the strategies learned in the therapist's office by using controlled exposure in real-life situations where there might be a risk (Marlatt & Gordon, 1985). Relapse prevention strategies have been shown to be useful in the case of pathological gambling (Echeburúa et al., 2000).

In any case, from the point of view of cost and benefit, the program described is brief (only 12 hours of therapist-patient contact over a total period of 3 months), it is well structured, and has been shown to be effective over time.

11 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

Clinicians and students interested in the treatment of pathological gambling should consider the main following points:

1. Develop strategies of motivation for therapeutic change because this point may be more important than treatment in itself.
2. Use strict stimulus control in the first phase of therapy. In this way, the patient can avoid gambling and learn how to cope with high-risk situations.
3. Involve exposure, in the second phase of therapy, as the choice treatment to cope with craving and resist the desire to gamble.
4. Provide, after initial treatment, adequate strategies to cope with problematic situations to prevent relapse and to maintain therapeutic success in the long term.

Future research should concentrate on determining the specific weight of the components of this program.

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