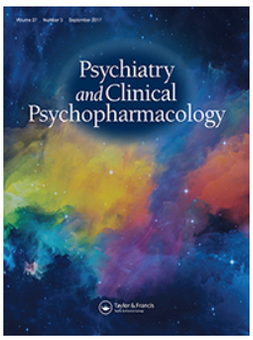

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CASE REPORT

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Cognitive behavioural therapy with pharmacotherapy for pathological gambling patient: case report

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ABSTRACT

Pathological Gambling (PG) is a persistent, recurrent, problematic gambling behaviour, leading to clinically significant impairment or distress. Literature studies regarding pharmacotherapy for PG treatment are complicated. Successful and promising results have been obtained with Cognitive Behavioural Therapy (CBT) and pharmacotherapy. In the treatment period with CBT, individual model for gambling behaviour was established and focused on automatic thoughts. Cognitive restructuring was performed and behavioural interventions were used. Also, a relapse prevention plan was devised. The treatment period and effect with pharmacotherapy and CBT of a patient suffering from PG and comorbid depression are discussed in this case report.

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Cognitive behaviour therapy; depression; pathological gambling; pharmacotherapy; gambling disorder; treatment protocol

Introduction

Pathological Gambling (PG) is a persistent, recurrent, problematic gambling behaviour, leading to clinically significant impairment or distress [1]. PG patients frequently resort to psychiatry clinics with depression or anxiety disorder complaints, and they do not mention their gambling problems [2]. It has been reported that especially high levels of depressive symptoms increase the possibility of gambling behaviour [2,3]. Besides, suicide attempt is high in PG patients [4]. Early diagnosis and treatment of depression comorbidity decrease recurrence rate [5]. There have been psychological interventions(Cognitive Behavioural Therapy (CBT), family therapy, gamblers anonymous) and pharmacological interventions (SSRIs, Mood Stabilizers, Antipsychotic Drugs, and Naltrexone) among the treatment strategies of PG [6–9]. Nevertheless, there is no standard treatment model for PG [10–12]. Since PG is not a homogeneous disorder, individual planning is required for its evaluation and treatment period [11]. Comorbid psychiatric disorder has been the guide for selecting the drug treatment [11,13]). In addition, there are also studies showing that pharmacotherapy has no different effects than placebo [3,10]. Successful and promising results are obtained with CBT and pharmacotherapy [6,9,14,15]. Only a limited number of cases were shared in a few journals about PG in Turkish population [11,12,16] Therefore, there is no standard treatment model for PG, this study aims to publish for literature a case that achieved successful results with Duloxetine treatment and simple CBT techniques in the treatment of PG in the practice of psychiatry. Also, there are no PG case reports in literature, where Duloxetine and CBT treatments are applied. In this case report, the treatment period and the effects of pharmacotherapy and CBT on a patient suffering from PG and comorbid depression are discussed.

Case

The patient was a 32-year old, university graduate, unemployed man, who was married, with one child. He visited our clinic after a suicide attempt with complaints of unhappiness, not being able to enjoy life, insomnia, family problems, continuous and uncontrolled online football betting, and not being able to stop betting although he wanted to. In his history, there were no psychiatric/medical disorders and there were no previous suicide attempts. In the assessment session, the patient was diagnosed with "Pathological gambling" and "major depressive disorder" in accordance with DSM 5. Beck's Depression Inventory (BDI), Gambling Symptom Assessment Scale (GSAS), and South Oaks Gambling Screen scores were 31, 45, and 11, respectively. The treatment of the patient was planned as Duloxetine 60 mg/daily and CBT.

During the first three sessions of psychotherapy treatment, suicidal thoughts, and depressive symptoms were considered in detail. The formulation was realized

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by redefining his current situation, treatment goals were determined, and the patient was informed about the treatment. An activity chart for behavioural activation was provided. The first sessions for suicidal thoughts were composed of five components; chain analysis, security plan, psycho-education, developing reasons for living and hoping, and clinical formulation. In this period, suicidal thoughts were handled by using frame (describing the frames in the film of the suicide attempt) and execution metaphor [17].

The CBT model frequently used for impulse control disorders is composed of four components: 1-Cognitive restructuring for correcting dysfunctional beliefs, which lead to impulsive behaviour, 2-Development of problem-solving abilities for creating responses as alternative to stress, 3-Social skills training, 4-Relapse prevention by identification of high-risk conditions, and avoiding such conditions [18]. In the fourth session, gambling behaviour formulation was performed and focused on automatic thoughts such as "I will never be able to stop gambling" and "I will never have a happy life." Alternative and realistic thoughts were detected and studied. In the fifth session, long- and short-term advantages and disadvantages of gambling and stopping gambling were reviewed in order to provide motivation; it was indicated that he should monitor himself daily for gambling. After this session, which increases patient awareness, he was shown in the sixth session a comparison between his situation 5 years and 10 years later if he continued gambling and if he stopped gambling. In the seventh session, an individual model for gambling behaviour was established. The cycle, which is developed as; "thoughts related to gambling triggered due to the occurrence of a high-risk situation, first betting, gambling behaviour, encountering the same high-risk situation as a result of winning or losing the bet," was defined according to the model suggested by Ladouceur and Lachance [19]. Behavioural interventions were started for avoiding gambling behaviour, by defining high-risk situations in accordance with this model. New hobbies were found for the patient to distract him from gambling, and the patient was encouraged for these hobbies. The patient started the gym three times a week (min. 1 h) and a training course related to his occupation. In the eighth session, the formulation was repeated, and the bet he could remember the best was addressed. Cognitive restructuring was performed by determining the cognitive distortions of the patient such as overgeneralization, arbitrary inference, gambler's fallacy and illusion of control. In the ninth session, the development of problem-solving abilities was emphasized. A relapse prevention plan was devised and the other sessions mainly involved relapse prevention (It was established what to do in case of a slip or relapse. Strategies were discussed and developed to prevent slips or relapses).

The patient attended sessions of 50 min once a week for 12 weeks. The patient, who several times had tried to stop gambling on his own and could stop gambling only for 10 days, did not gamble for 3 months this time. He started working in a better position in his job, and there was a significant improvement in his family life at the end of 3 months. At the end of first month, it was observed that the suicidal thoughts of the patient disappeared and his depressive symptoms were decreased. BDI score decreased to 22 on the 4th week of treatment, and to 10 at the end of the 12th week; GSAS score decreased to 22 on the 4th week of treatment, and to 4 at the end of the 12th week. The patient continued maintenance interviews once a month for six months, and it was observed that he did not gamble during this period.

Discussion

In this case, the treatment of a patient suffering from PG and comorbid depression was presented. This case describes and provides an example of how the general principles of CBT techniques can be adapted on a patient. However, since the literature studies regarding the efficiency of antidepressant drugs for gambling behaviour are complicated, and due to promising results of cognitive behavioural approaches together with pharmacotherapy in recent years [6,10,11]. A recently published study reported that a combination of group CBT and antidepressants were found as the most effective intervention in maintaining the treatment of PG patients [9]. In the study, group CBT and any types of medications were associated with lower rate of dropouts. Also, group CBT was not better than individual CBT. In this present case, we would like to share the positive result achieved by pharmacotherapy, CBT, and administered methods.

Previous editions of DSM included PG in the impulse-control disorder category because of patients' preoccupation or compulsion to gamble. But in DSM 5, PG is covered under the title "addiction." Although the title was changed, the cognitive behavioural interventions were not changed, and the positive results obtained from administered methods with this evidence were based on CBT model. Nevertheless, this information needs to be verified in other cases diagnosed by DSM 5.

From a different point of view, PG was detected in 51 patients among 47,464 adverse effects reported to Food & Drug Administration [20] of patients using Duloxetine (only Cymbalta) between January 2004 and December 2012; in our study, we achieved a favourable response during the treatment with CBT and Duloxetine.

However, more researches performed on with more cases are required for determining the efficient treatment interventions for this disorder.

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Disclosure statement

No potential conflict of interest was reported by the authors.

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