A Psychodynamic Approach to the Treatment of Pathological Gambling: Part I. Achieving Abstinence

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A psychodynamic approach emphasizes the meaning and consequences of one's behavior. After a brief review of the literature, the authors present the first of a two-part model for psychodynamic psychotherapy with pathological gamblers. In this first phase, the immediate goal is abstinence, and five strategies for obtaining it are discussed. These consist of 1.) breaking through the denial 2.) confronting omnipotent defenses 3.) interrupting the chasing cycle 4.) identifying reasons for gambling, and 5.) motivating the patient to become an active participant in treatment. An argument is made for integrating a traditional psychodynamic approach with an addictions model.

INTRODUCTION

There have been few serious attempts (Rabow, Comess, Donovan, & Hollos, 1984; Rosenthal, 1987) to review the psychoanalytic literature on compulsive gambling, and to put it into perspective or give it its due. Yet, as Blaszczynski and McConaghy (1989) have

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observed, the conceptualization of compulsive gambling as a disease began around the turn of the century with the writings of the psychoanalysts. Furthermore, the contributions of Edmund Bergler to the newspapers and popular magazines of the 1950's were extremely valuable in raising public awareness of the disorder, and may have been an impetus for the founding of Gamblers Anonymous.

The work of these early psychoanalysts constitutes the most extensive body of individual case material available to us, yet it is largely ignored today, along with the theoretical discussions which accompany it. It is often dismissed in our contemporary literature by reductive one-liners, i.e., Freud equated gambling with masturbation, Bergler believed all gamblers wished to lose.

In reviewing this early literature, we are impressed with the ongoing debate, very similar to one that clinicians and researchers are having today, between analysts who viewed pathological gambling as an addiction, and those who regarded it as an obsessive-compulsive disorder. Freud thought it was an addiction, and placed it in a triad with alcoholism and drug addiction.

A number of these early authors, dating back to Simmel in 1920, emphasized the narcissistic fantasies, involving grandiosity and a sense of entitlement, pseudo-independence, and the need to deny feelings of smallness and helplessness. Other psychoanalysts (Greenson, 1947; Galdston, 1960) describe early and severe deprivation from the parents, with the gambler then turning to fate or to Lady Luck for the love, acceptance, and approval he or she had been denied. Several (Greenson, 1947; Comess, 1960; Niederland, 1967) saw compulsive gambling as an attempt to ward off a severe or impending depression. Boyd & Bolen (1970) viewed it as a manic defense against helplessness and depression secondary to loss.

Bergler (1958) is known for his formulation of the gambler's masochism, the "unconscious wish to lose," but his work contains a number of important ideas, most notably that the act of gambling reactivates megalomanic fantasies of omnipotence. For the pathological gambler, according to Bergler (p. 18), there is an unconscious "rebellion against logic, intelligence, moderation, morality, and renunciation."

A score of analysts have reported aspects of Freud's classic formulation, usually of an extremely competitive, love-hate relationship between the male gambler and his father, with a need for approval, and

feelings that one can never be good enough. Still others have emphasized the erotization of tension and fear (Von Hattingberg, 1914), the central role of omnipotence (Simmel, 1920; Greenson, 1947; Lindner, 1950), and problems in parental identification (Weissman, 1963; Boyd & Bolen, 1970). In fact, these early pioneers have anticipated most of our current formulations.[1]

Psychoanalysis is out of favor today, as the mental health field has moved toward quicker, often biologically based methods of treatment. However, there is a second, perhaps equally important reason why this potentially valuable body of data and knowledge has been "thrown out with the bath water." It has to do with our close affinity to a twelve-step program derived from Alcoholics Anonymous, and specifically our efforts to legitimize pathological gambling by emphasizing similarities with the addictions of substance ingestion.

A number of influential therapists in the alcoholism field have taken a strong position against insight-oriented or psychodynamic psychotherapy during the first few years of recovery. Vaillant (1981, 1993), for example, thinks psychotherapy useless in treating the alcoholic or chemically addicted individual. Bean-Bayog (1986), meanwhile, divides psychotherapy for addicted individuals into three phases: (a) achieving abstinence (b) maintaining abstinence and early recovery, and (c) advanced recovery. According to her schema, the second or relapse prevention phase involves supportive psychotherapy that assists in avoiding drug substitution, unhealthy relationships, and the defenses of denial and rationalization. It is only in the third phase, which may take two years to reach, that one should begin to address deep-seated family issues, strong emotions, or engage in conventional uncovering psychodynamic psychotherapy. This is also the position expressed by Zimberg (1985), Wallace (1985), and Kaufman (1989).

Others stress that alcoholism is the primary disease; the goal in treating it is abstinence. "It is important for the therapist to constantly stress the fact that alcohol and drug use is the primary problem" (Mann, 1991, p. 1207). Although family dynamics, interpersonal problems, sexual and intimacy issues, etc. will be raised, "a grave mistake is to confuse patients with these problems rather than focusing on the primary problem of alcoholism/drug addiction." According to Cocores (1991), the addict frequently brings up these other problems for the express purpose of manipulating the therapist away from drug and alcohol addiction issues.

While we understand the authors' wish to emphasize abstinence, such statements make us uncomfortable. Confrontation, clarification, and interpretation play an important role early in therapy and one should not underestimate the patient's capacity to make use of insight in a constructive manner. Furthermore, the therapist has to deal with what the patient brings up, and not communicate, directly or by omission, that intense feelings, histories of trauma, relationship problems or family dynamics are off limits. To do so confirms the patient's belief 1.) that painful reality can and should be avoided, and 2.) that the associated affects are intolerable, and he or she was right in trying to escape from them. It also conveys the false impression that gambling is an isolated aspect of their lives.

It should be noted that not all clinicians share the beliefs of Vaillant and the others. Khantzian (1981) and Shaffer (in press), in particular among contemporary writers, emphasize the value of psychodynamic psychotherapy in the treatment of the addictive disorders. According to Shaffer, "psychodynamically oriented psychotherapy is arguably the best strategy for helping patients determine what substance abuse *does for* them and what it *means to* them." It is our contention that unless patients understand what they are running from, periods of abstinence will not be sustained. Hence we are suggesting not either psychodynamic, insight-oriented psychotherapy, or strictly addiction-focused supportive therapy, but an integration. The therapist creates a therapeutic ally by stimulating the patient's curiosity about the meaning and consequences of their behavior. We also believe that such therapy begins with the very first contact with the patient.

Psychodynamic psychotherapy, both individually and in a group setting, has a formidable role to play in the treatment of the pathological gambler. It is entirely compatible with other therapies (supportive, cognitive-behavioral, pharmacological, twelve-step), and in fact, a combined approach is often most effective. A future task will be to see which therapies, or combinations of therapy, work best with subtypes of gamblers. Presently, however, there is a tremendous gap in the literature, between those psychoanalytic pioneers and today. What is a contemporary psychodynamic approach to the pathological gambler? There is an absence of such descriptions in the literature. The ensuing discussion, with clinical examples, and the accompanying article on transference and countertransference (Rugle and Rosenthal, this issue) will convey a sense of the various techniques and approaches subsumed

under psychodynamic psychotherapy. Future contributions will address treatment outcome, prognostic factors, and different approaches for subtypes of gamblers.

PHASE ONE: ACHIEVING ABSTINENCE

Psychodynamic approaches are unfortunately often associated with the stereotype of the "silent analyst," and we have all heard patients complain about previous therapists who "never said anything." Pathological gamblers are an impulsive group of people, with particular insecurities and fears of being judged; they often have difficulties with uncertainty, and an over-reliance on the opinions of others. They require a directive and knowledgeable therapist who communicates an understanding of their problem.

Being supportive and non-judgmental is not enough. In order to achieve and maintain abstinence, they need a therapist who will slow them down at times, confront them with the consequences of their behavior, call attention to gaps and inconsistencies in their story, anticipate problems, and suggest better ways of coping. One can be confrontational without being overly critical or cruel. The therapist is usually on safe ground if he or she reflects on the why of what the patient is saying or doing, and interprets its defensive function first (Rosenthal, 1986).

The very fact of the patient coming for treatment more often than not represents an enormous failure for them. Some were coerced or blackmailed into it. Others, although propelled by inner pain or the desperation of their situation, had second thoughts immediately upon making the appointment. They feel guilty and ashamed, and while one might not always empathize with their discomfort (they are often very good at masking it), the very fact that they need our help is evidence of their humiliation.

Taber (1985) offers an excellent description of the pathological gambler's ambivalence. On the one hand, they fear treatment will turn out to be just one more failure in their lives. At the same time, they fear its success, that deceptions will be unmasked, changes imposed on them, and that they will have to give up the one comfort in their lives, their gambling. The relationship with the therapist will often be viewed as adversarial (Rosenthal, 1986). The therapist should not take the

patient's hostility any more personally than he or she does their idealization.

One of the most important things the therapist can do for the pathological gambler is to help them understand what gambling means for them, not only its negative consequences and meanings, but what they get out of it as well. This is crucial to the first phase of therapy, where the task is both to achieve abstinence, and to help the patient become an active participant in his or her own treatment. What the therapist needs to communicate is that abstinence is essential for accessibility to further treatment.

The Excitement of Gambling

A good place to start is by asking the patient why he or she gambles, and what they like about it. Their initial response will most likely be to mention the "action" or "excitement" which gambling provides. You will probably have to repeat the question, and keep rephrasing it, to get a more specific, and meaningful, answer. One person's "action" is not another's. For some, what is exciting is the opportunity for a big win, or spectacular success. If you pursue this still further, perhaps asking what they would do with the money, you may learn that its importance lies in proving something to others. Many gamblers grow up feeling that nothing they do is ever good enough, that they can never do enough. As adults they carry with them a critical parent, telling them how inadequate they are. Winning a lot of money, they believe, would silence that critical parent, and impress other people: "See, look what I can do!" Winning, particularly a big win, means being favored by the gods or Lady Luck or the all-important Other. Basically, it means being loved.

Example: Mrs. A, who was a slot machine player, in an early session admitted with great embarrassment that at the moment when her machine pays off she has the distinct sensation of it pulsating or breathing. Since she had already indicated that she regarded the machine as masculine, it soon became obvious to us that this was her way of trying to elicit a response from her father who was not there for her when she was growing up. What she wanted, specifically, was the protection of this father who did not seem to notice that she was being sexually abused by her uncle.

She engaged in a variety of superstitious rituals all aimed at getting a response from the machine. When she didn't win, it meant that she had not done enough, and that she was not good enough to be loved. She would then have to put in more time, endure greater physical discomfort, and above all, spend more money, in order to demonstrate her worthiness. Particularly when she felt neglected by her husband she would go to the casino and play the slot machines.

There is a second group of gamblers, for whom it is not winning that is all important, but not losing. They will boast about the danger and about "living on the edge." It is the risk of getting hurt, and of losing everything, that is exciting for them. Rosenthal (1986) described this as omnipotent provocation, a kind of flirting with fate in order to prove one is in control. A classic example of this appears in the film, "The Gambler" (Chartoff & Winkler, 1974). In the climactic scene, the compulsive gambler-protagonist, a white, middle-aged college professor, walks the streets of Harlem, alone and at night, fully aware of the taunts and threats that follow him. He enters a bar and provokes a fight with a prostitute and her knife wielding pimp. After getting slashed, he staggers out, blood pouring from his face. In the final frame, he has stopped to look in a mirror, and while examining what will soon be a huge scar, he smiles. His expression says it all. He has gone to the edge, escaped with his life, and that, for him, is a big win.

Perhaps a third kind of excitement comes from the competition itself, and for these gamblers it is not so much the money that is important, as the matching of wits with one's opponent. We find, however, that while they initially describe the intellectual challenge of going head to head with a worthy opponent, what they are responding to viscerally is a battle to the death. Winning is everything.

Often the type of wager or pattern of play will offer a clue to the underlying fantasy. Some gamblers only play underdogs or sentimental favorites; others look to see streaks broken or continued. Mr. B, for example, had a propensity for situations in which the odds were against him. He developed elaborate economic theories, which he used in playing the commodities market. While growing up, he had felt totally overwhelmed by a very powerful and successful father. His fantasy was to avenge the humiliation, and prove his worthiness, by outsmarting the powers he assumed were controlling certain world

markets. He also went to Las Vegas, where his goal was nothing less than to "break the bank."

For others, the content of such fantasies may, initially at least, seem less important than the arousal. Strong sensations are craved, to counter feelings of emptiness or deadness. Some of these gamblers can not tolerate when their lives are going well, and have a need to manufacture crises in order to feel alive. One pathological gambler confided that she didn't think that she had ever even liked gambling, but viewed it more as a means to an end. Only when she was heavily in debt did her life become meaningful. She would work two and three jobs to pay off creditors and to keep from being evicted. At other times she felt empty and without direction.

Expectancies and Reasons for Gambling

There are six common expectancies or reasons pathological gamblers offer for why they gamble. These are more specific than the aforementioned desire for excitement. Pursuing them will shed light on important fantasies and core conflicts. The first, which we have already described, is the need for spectacular success. It is based on the need to demonstrate one's worth, and get the approval of others.

A second reason for gambling has to do with rebelliousness and anger. Many compulsive gamblers turn to gambling when angry at someone. Such gambling is a way to thumb their noses or in fantasy punish the other. This is partly based on an assumption of gambling as deviant behavior, which they know their families and others look down upon. There is an anti-authority, to-hell-with-society aspect to this, which is part of its attraction. They feel they are breaking the rules, or getting away with something. On a deeper level, there are aggressive, and even murderous fantasies acted out through the gambling. A specific set of fantasies which occur frequently has to do with *turning the tables* (Rosenthal, 1981, 1986, 1989); what appear on first impression to be acts of generosity and philanthropy often contain these fantasies in which one's winnings are used to even the score and humiliate others.

A third reason for gambling, not unrelated to the first two, has to do with freedom from dependency. People who feel overly dependent, for approval or validation from others, look for substitute activities and objects which they can control. Despite its reputation for risk-taking, gambling is a rather predictable activity. You can win or lose, but it is

only money, and there is a rhythm, and rules, and an immediate responsiveness to it. The individual feels free from the merry-go-round of trying to court approval and being subject to the whim of others.

It is not unusual for money to be thought of as the route to independence. The belief is that if one could just win a certain amount of money, one could quit one's job, or get a divorce, or be independent of one's parents. Financial independence is equated and confused with emotional independence.

Example: Mrs. C was excessively dependent, and had never separated herself from a very successful, powerful and controlling father. Gambling was an activity unlike anything her rather proper and conservative family knew about. In fact, it disinhibited her. In the card room or casino she could be funny and gregarious, outgoing and assertive, even aggressive, everything she could not be normally.

Everything was terrific, except for winning and losing. If she lost, she felt guilty; it would mean her family would find out, and she would have to go to her parents for a bailout. Needless to say, she chased. Winning was equally problematic, however; it meant having money of her own. This was the reason she often gave for gambling, her desire for financial independence. To be independent, however, meant being disloyal. On some level she was aware that her father's needs came ahead of hers and that she was required to remain "daddy's little girl."

A fourth reason for why people gamble has to do with social acceptance. Many gamblers will mention the perks they received, and how important it was that the various casino employees remembered their name, lit their cigarette, or brought them a drink. They felt accepted and valued. Sometimes they will boast of the friendships they had with card room or race track personnel, or with their bookies.

Particularly important is their kinship with other gamblers. They will tell you how democratic gambling is. Sitting next to you at the card table may be a ditch-digger or the king of Spain but everyone is equal. All you need is the money to ante up, and you're included. That sense of belonging erases their feeling of alienation. Furthermore, one is judged solely by one's abilities as a card player. And when you win or lose, you know where you stand—there are no other demands or expectations of you.

Card clubs and race tracks, in particular, have a social milieu that is important for many gamblers. When Mrs. C stopped gambling she wanted to go to the card club to visit her friends there, and because it was the only place where she felt socially accepted. It is notable that the camaraderie stops short of intimacy. These people are your friends, she explained, they'll do anything for you, but only in the club and they never see each other outside of the club or get involved in each other's lives.

The fifth reason for gambling is as an escape from painful or intolerable affects. This is the self-medication hypothesis popularized by Khantzian (1985). When people who are depressed gamble, they may experience an increase in energy, or a release of endorphins. However one chooses to explain it, there seems to be a temporary antidepressant effect. The tremendous concentration and focus involved in gambling blots out awareness of outside problems, a kind of temporary amnesia, as the individual gets lost in the artificial world of play. High risk activities also serve to counter feelings of emptiness and deadness.

For those who are hyperactive (and many gamblers meet the diagnosis of Attention Deficit Hyperactivity Disorder), the intensity of gambling, at least initially, has a paradoxical effect; like cocaine or amphetamines, it slows them down, allowing them to concentrate, process affects, and feel normal (Rugle & Malamed, 1993). For the ADHD gambler, who has deficits in organizing and planning, gambling becomes a clear-cut win-lose principle around which to organize life. This, of course, ceases to work with time.

Gambling may also be used to prolong or intensify the manic phase of a bipolar disorder, to increase omnipotence, and disavow vulnerability, and to deny or eradicate feelings of helplessness, shame, or guilt.

The sixth and final reason for gambling is because of the competitiveness. Pathological gamblers are extremely competitive. There are several factors which contribute to this. Many of the gamblers grew up feeling unappreciated and neglected by their families. There was a need to excel in order to get attention. Athletics frequently offered such an opportunity. A number of the families put undue emphasis on achievement; concerns over material success and status were significant. The competitiveness, especially for male gamblers, often grew directly out of the relationship with the father. Frequently they were

taught to be competitive. Perseverance was particularly valued, although this same trait would later get them in trouble, when they would chase gambling losses.

Example: Mr. D grew up believing that his father was ashamed of him, and that he was not good enough to be his father's son. His father regularly belittled him, while at the same time pushing him into sports, and "programming him" (his term) to be competitive. Their social life revolved around the country club, where he was regularly told that the day he could beat his father at golf, would be the day he'd be accepted as a man. So Mr. D played religiously, compulsively. "Since your score is cumulative," he explained, "if I started out poorly or messed up a hole, I would go back and start over. You can imagine how long it took me to complete eighteen holes." The connection with his gambling was obvious. Long after his father's death, he still kept going back, only now to the casino, trying to "get it right."

He explained that he had chased from the beginning of his gambling career. "Even when money wasn't important, when I could always go to my parents for more, so that it didn't even seem like it was my money I was gambling with. And it's not that I couldn't stand losing. *I couldn't stand not winning."*

Confronting Omnipotent Defenses

Omnipotence may be the most important concept for understanding the pathological gambler (Rosenthal, 1986). It has been defined as an illusion (some would say delusion) of power and control which defends against helplessness and other intolerable feelings. To feel omni-potent, literally meaning all-powerful, is the most basic of the self-deceptions, since it is experienced precisely at the moment one is most helpless and out of control. Omnipotence is borne out of desperation. For the gambler, it is "I will win, because I must." The greater the desperation, the greater the certainty.

Three types of omnipotence have been described: 1.) *omnipotence of thought,* in which one's thoughts are regarded as all-powerful. One will win because one has to. Wishing will make it so. 2.) *omnipotent action* (Rosenthal, 1981), where to do something, anything, is better than doing nothing. The alternative is helplessness or paralysis. Usually the action is destructive, and brings about the opposite effect from the one

intended. 3.) *omnipotent provocation* (Rosenthal, 1981) which involves a flirting with danger, and the risk of great loss, in order to prove one is powerful and in control. Such risks may involve a threat to life or limb, or the risk of getting caught at some illegal activity.

Gambling reinforces omnipotence. First of all, essential to the activity of gambling is the notion that one can predict the future. One is attempting to control the uncontrollable. Certain occurrences feed this sense of omnipotence. Custer (1982) has noted how disastrous a big win can be. It is as if reality has confirmed the existence of one's magical powers; expectations get raised, one *can* do anything. A bailout can have a similar effect. Believing that one has gotten away with something, one no longer feels bound by the rules. Losing heavily can produce a similar response. When payments are due, one becomes desperate, which in turn gives rise to the aforementioned sense of conviction. One will win, because one has to. Additional losses feed the desperation, adding to the vicious cycle. Finally, gambling offers the possibility of the improbable or seemingly impossible occurring. When the rules appear not to hold, one is no longer accountable (Rosenthal, 1986). The freedom one wins is a freedom from guilt.

Gambling offers an escape from intolerable situations and affects for people who believe such escape is possible. If the therapist can interpret its defensive function, and help the gambler face these "intolerable" experiences, then the need for escape dissolves, and problems can be dealt with directly. In the process, gambling will have lost something of its meaning and value.

The nature of these intolerable situations and affective states is frequently not difficult to uncover.[2] It may be as obvious as early parental death or divorce, a rivalry one couldn't win, the helplessness and unpredictability of living with an alcoholic parent, or intense shame over a congenital defect or developmental delay. Mr. E, for example, grew up in the shadow of an older brother who had died when he was still a child. Not only did his parents never stop mourning their obviously favored son, but every achievement by the patient would bring forth comments about what the brother might have accomplished if he had only lived. As the patient got older, every success was accompanied by depression, and he would often sabotage his career and relationships. It was not surprising that gambling, with its opportunity for spectacular success, became more and more meaningful.

Even when these traumas and intolerable feelings cannot be easily identified, confronting the omnipotent aspects of the gambling—the magical thinking, grandiosity, etc.—may be sufficiently deflationary to help the patient stop gambling, and advance the therapy.

Chasing, as an Early Motive for Relapse

An important part of the initial assessment is to inquire about chasing.[3] For many men in particular chasing has been a crucial part of the progression. During the course of the disorder they become increasingly intolerant of losses, and as shame, guilt, and depression worsen, they are increasingly desperate to win back what they lost. They take greater risks, abandon any reasonable gambling strategies, and become increasingly irrational in their thinking.

Although gamblers may cite practical reasons for their chasing, in our experience it is largely due to the patient's narcissistic entitlement, excessive competitiveness, or defenses against shame and guilt. Some gamblers believe that something is owed them, to make up for early deprivation and the "unfairness" of the hand fate dealt them. Others speak of getting back "their" money, as if some valued part of the self had been abducted. This goes beyond issues of self-esteem; what is threatened is their very existence. For the more competitive gambler, losing is simply inconceivable.

Other gamblers, however, will stop chasing once they have been found out, and we learn that what fueled their gambling was the need to repay losses before a spouse or some significant other learned what they had been doing. In many cases, they projected their feelings of shame and guilt on to the other person, and were driven to keep gambling out of a need to conceal what they regarded as intolerable "weakness" or "failure." They frequently believed that their spouse would leave, or their family shun them, in short that they would be abandoned once their shameful secret was discovered. When this does not happen, and particularly when the family is supportive of treatment, they often experience enormous relief. They then can start dealing with issues of self-worth and relationship problems involving dependency and trust.

Some gamblers will continue to be unstable, and depending on the outcome of their last gambling episode, will be plagued by feelings of shame and guilt which will send them back into action. It is important

to pay close attention to these feelings, and how gambling is used to modify them. Pathological gamblers frequently believe that if they can win back what they lost, it not only erases the debt, but it is as if they had never gambled in the first place. Guilt is dealt with by the psychological defense mechanism of undoing. In a sense, two wrongs can make a right.

Shame, on the other hand, is not something that can be undone. However, gambling offers an escape from painful awareness. The intense concentration involved in gambling, which blots out memories of everyday life, offers a kind of primitive avoidance, and a hiding out from the eyes of the world. At the same time, the social acceptance of the casino or race track denies one is disapproved of or an outcast.

The emphasis on action, being outer directed and competitive, may counter feelings of weakness, impotence, and paralysis which are related to the experience of shame. This may be an adrenergic antidote to parasympathetic overload. Lewis (1987, p. 102) has noted that shame evokes a "rage reaction both at the self for being humiliated and at the other, who has been experienced as betraying, disapproving, or scornful. Humiliated fury is inevitably directed against the offending other, and retaliatory impulses are evoked to 'turn the tables' on the other."

Example: While in an inpatient program, Mr. F was seen in a conjoint session with his wife, who came from out of town to participate in his treatment. He was initially defensive, and tried to turn the tables so that it was she who felt put down and inadequate. He was alternately resentful, paranoid, and detached. However, as the session progressed he seemed to comprehend for the first time the degree to which he had hurt her by his gambling. After the session, he experienced over the next several hours a variety of physical symptoms which included palpitations, dizziness, blurred vision, uncomfortable changes in body temperature, and an upset stomach. He was unable to sit through a scheduled group meeting.

The only thing which brought relief was playing ping pong, which he did in a more ferocious and competitive manner than ever before. During the course of the afternoon he defeated everyone he played, including the best player on the unit, who had previously been unbeaten. Whether it was the intense physical activity, the competitiveness, or the aggressive and attacking manner with which he played, it

calmed him down. In discussing it afterwards, he volunteered that if he had not been in the hospital, his response to such physical and emotional discomfort would have been to go to the card club and play poker.

When seen by his therapist the next day, he was asked if he had ever experienced such acute physical distress before. His response was to describe a series of situations dating back to childhood when his inadequacies were exposed, and he felt shame and humiliation. These included being unprepared for a test at school, being ridiculed for his appearance, being challenged to a fight, and a time when his mother caught him masturbating. He described the ease with which he blushes, and the feelings of social ostracism which accompany present and past occurrences. His antidote was intense physical activity. However, going to the card room was greatly preferred over a visit to the gym because the former was associated with a sense of instantaneous and satisfying acceptance, while at the gym he knew no one, and worked out alone.

Confronting the Denial

Shaffer (in press) has emphasized the delay which exists between the patient's thoughts of quitting, and his or her resolution to do so. This can be shortened by helping the patient recognize that gambling is now exacerbating rather than diminishing problems. For example, if they gambled to relieve depression or to achieve a sense of control, they are now more depressed and more out of control.

As noted above, the course of the disorder includes not just a progression in the amounts wagered, or in the preoccupation with gambling, but in the intolerance of losing, and most important, in the guilt, shame and depression which accompanies losses and mounting reality problems. In breaking through the patient's denial, the therapist seeks to correct the minimization of these difficulties. Both the amount of gambling, and its consequences, need to be appraised realistically.

It should be remembered that the term "denial" was first used (Freud, 1927) to mean a disavowal of external reality. The example Freud offered was of a young man whose beloved father had died. The mechanism involved a splitting of the ego, so that the person both knew and did not know the truth. Selected perceptions are rejected, in

the service of avoiding pain. Inherent in maintaining the denial is the use of fantasy. The pathological gambler believes, in the face of evidence to the contrary, that he or she can gamble in a normal and controlled manner. Furthermore, they will ignore past losses, no matter how heavy or continuous, and believe they can win at gambling. This is sustained by a fantasied sense of invulnerability and specialness (Trunell & Holt, 1974).

Since the denial defends against the patient's pain, for them to give it up something of value must be offered in its place. This might include the experience of being understood, the possibility of forgiveness, and hope derived from the therapist's belief that pathological gambling is a treatable disorder. Today the meaning of "denial" has been expanded (Bean, 1981), to place an emphasis on the avoidance of inner reality, in the form of painful or intolerable affects, and it is regarded as a more complex mechanism, also involving minimization, rationalization, and projection. The therapist helps the patient accept personal responsibility. This is done in part by returning projections, for the gambler typically is blaming others—often the spouse, parents, and at some point the therapist. Essentially this is a paranoid defense against depressive anxieties. Helping the patient to accept these feelings of guilt and shame will enable them to accept personal responsibility.

Strengthening the Patient's Active Involvement

The pathological gambler's need for action, and activity-oriented solutions, is utilized in treatment by helping them become active participants in their own recovery. First of all, this involves a plan. What are they going to do? Frequently they believe they can stop gambling, not only on their own, but without any changes in lifestyle. The therapist will be more effective here not by imposing rules or conditions, but instead by using each disputed activity and option as an opportunity to address the patient's remaining denial.

Thus when the patient argues their right to read the sport section, or watch games on television, it is important to explore what is involved, and how it would strengthen or weaken their abstinence. There will be many practical issues to decide. Should they turn over control of family finances? Have access to credit cards, or their own paychecks? Be advised to quit the stock market? Give up season tickets for their

favorite professional team? Particularly when spouse or family members are present, questions such as these will lead to heated discussions.

Often, what the patient is arguing against, by refusing to consider the need for such changes, is acknowledgment of the seriousness of their problem. Responsibility is foisted onto others. The spouse, therapist, or Gamblers Anonymous is accused of telling them what they can and cannot do, treating them like a child, and they resent not being allowed to be themselves. Helping the patient clarify what they need to do, and why, is often an important turning point in recovery.

Similarly, the patient may initially refuse to attend Gamblers Anonymous, or say that they went once or twice and did not like it. It is important to take up the various evasions, rationalizations, and underlying fears of attending. We never force anyone to go, or make it a condition of treatment, but will aggressively pursue resistances to participation.

Active involvement in Gamblers Anonymous complements the process and goals of psychotherapy. For example, the brilliant first step of GA, which acknowledges helplessness over gambling, involves a giving up of omnipotence. For gamblers who have based much of their lives on the importance of winning, this idea of surrender is anathema. As gambling (and chasing) has been a defense against feeling beaten and defeated, the idea of surrendering control brings out feelings of annihilation. Psychotherapy can not only help the gambler understand the meaning of gambling in his or her life, but to understand their resistance to aspects of the recovery program such as surrender and powerlessness.

Early in treatment, going to GA will help patients reduce the guilt and especially the shame they are experiencing. By speaking at meetings, they practice being more open and accessible. Most gamblers have problems with intimacy, particularly around issues of trust and dependency, and a relationship with an abstract higher power, or with a group of peers, is often much easier than a relationship with the therapist, or with family members. However, it is interesting to see that some patients can tell the therapist things which they could never discuss with their sponsor or at a meeting, and for others, the reverse is true. The therapist is involved in a triadic relationship, and needs to be sensitive to the patient's differential valuation of GA and therapy as it pertains to shifts in the transference (Rugle and Rosenthal, this issue).

There are very few patients who can not go to GA. Those with severe social phobia come to mind, and some who are too paranoid. Some patients with borderline features will experience the closeness of the group as "too-closeness," and they fear loss of identity and engulfment. Attendance should be a goal of the treatment, and as they progress they will find it easier to participate. The important thing is not to assume that the patient's avoidance of GA is synonymous with their resistance to quit gambling.

It is crucial for the therapist not to rush the patient, but to remember what he or she knows about timing and tact. It is also important to follow up their attendance, as one would with all the gamblers under one's care, by inquiring about their level of involvement, how they feel about going, and whether they are identifying or not. Some patients can go to Gamblers Anonymous, but have difficulty identifying. This is particularly true for women, very young gamblers, and ethnic minorities. Gamblers who grew up with gambling problems in the family, or with an alcoholic parent, may have particular difficulty feeling comfortable in a 12-step program, and may need to recall early memories of parental use and its consequences before they can themselves meaningfully participate. This would be a clear indication for intensive, uncovering psychotherapy at the onset of treatment.

Gamblers who are still financially or professionally successful not only have difficulty identifying, but often feel extremely guilty when hearing the stories of those who are out of work or struggling to survive. They feel they cannot tell their story without stimulating envy, and the problem is compounded when, as sometimes happens, other members seek favors from them. Gamblers who do not experience any urges or cravings to gamble also often feel out of place. The therapist should remember that these feelings can change, and the patient's relationship with GA, like the relationship with the therapist, is a dynamic one.

The more active the gambler's participation, the more they will get out of it. We encourage going to meetings and taking part, getting a sponsor, working the steps, developing a supportive network with the members, and "giving back" by helping others. In fact, we regard Gamblers Anonymous as a 24 hour-a-day program, based upon a striving for honesty and responsibility. Crucial to an active working of such a program is a healthy reverence for the laws of cause and effect. In other words, we are responsible for our actions.

A fundamental principle of the self-help programs is the idea of taking things one day at a time, or if that isn't manageable, breaking it down into shorter intervals. If one assumes a choice to be made every fifteen minutes, there are repeated opportunities to feel better, and strengthen recovery. When the gambler makes wrong choices, which are defined as those hurtful to self or others, he or she feels worse and moves closer to relapse. Conceptualizing it this concretely seems to be helpful to patients.

Psychodynamic psychotherapy is based on the idea that what the patient says and does is meaningful, and that the causal connections can be discovered. Thus, there is a linkage between past and present, thoughts and feelings, fantasies and behavior. Becoming an active participant in therapy means being curious about oneself and about the choices one makes.

Finally, an active program involves a need to develop new and healthy activities to replace those that are being given up. Physical exercise is extremely important, particularly for those who are hyperactive or depressed. With regard to the other activities, only the individual can decide what they will be. The patient is empowered as he or she develops internal controls and gives up patterns of learned helplessness.

SUMMARY

Psychotherapy which is solely supportive has two drawbacks. First, it communicates to the patient that they should not deal with their past traumas and that they need to avoid uncomfortable feelings and conflicts. This just reinforces what they had been trying, unsuccessfully, to do with their gambling. Second, allowing the patient to continue in their destructive pattern, particularly if not talked about, only serves to increase guilt, and make the patient less available. It may also appear to the patient that the therapist is colluding with their addictive personality, and has abdicated his or her role. Other patients will merely feel contempt at the therapist's stupidity. In either case, the treatment becomes worthless.

We advocate a balance between pushing the patient to look at their emotional vulnerabilities and connections between past events and current addictive behavior, and their capacity to tolerate stressful

emotions and painful memories. In this initial phase, the therapist should help the patient identify negative affective states that have been relieved by gambling. There is increasing awareness, not only of harmful consequences, but of gambling's defensive function, for example to deny helplessness or dependency. It is important for the therapist to be active, and to share with the patient his or her understanding of the gambler's problems, both those which preceded the gambling, and those exacerbated by it.

In summary, we recommend an integration between traditional psychodynamic psychotherapy and an addictions model. The therapist should not get caught up in theoretical warfare, waged between those who view pathological gambling (and the disorders of substance dependence) as the sole focus of treatment, and those who view it as symptomatic of other problems. That it is both is one of the many paradoxes the acceptance of which will make us better therapists.

NOTES

1. More recently, analysts have been investigating deficiencies in self-regulation, as they pertain to gambling and other addictive disorders (Krystal and Raskin, 1970; Wurmser, 1974; Khantzian, 1981; Schore, 1991; in press; Ulman & Paul, in press). Others, like Meltzer (1966) and Chasseguet-Smirgel (1974), have explored the addict's withdrawal into an alternative or substitute world.
2. Vaillant (1981) believes that alcoholics reorder traumatic events to justify their drinking. In our experience, this fictionalization or re-creation of one's history is true to some extent for all patients, not just addicts. The focus of the patient's re-creation may be significant, and provide a key to understanding central themes in the patient's pathology. Patients may be particularly revealing in these first sessions.
3. Due to spacial considerations, we have not discussed the assessment process, which includes a careful gambling history, looking at factors which hasten progression; the presence of periods of abstinence, and previous attempts to cut down or stop; prior experiences with treatment and self-help groups; areas of the patient's life which have been affected; current reality problems, and the support or lack of it by family,

friends and employer; a close look at addictive patterns, and co-morbid disorders.

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