

Pathological gambling: understanding relapses and dropouts

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Abstract

There is little available information on the factors that influence relapses and dropouts during therapy for pathological gambling (PG). The aim of this study was to determine socio-demographic, clinical, personality, and psychopathological predictors of relapse and dropout in a sample of pathological gamblers seeking treatment. A total of 566 consecutive outpatients diagnosed with PG according to *DSM-IV-TR* criteria were included. All patients underwent an individualized cognitive–behavioral treatment program. We analyzed predictors of relapse during 6 months of treatment and during the subsequent 6 months of follow-up, and predictors of dropout over the entire therapeutic program. Eighty patients (14.1%) experienced at least one relapse during the entire follow-up of the study: 50 (8.8%) within the treatment period and 12 (2.1%) during the subsequent 6-month follow-up period. The main predictors of relapse were single marital status, spending less than 100 euros/week on gambling, active gambling behavior at treatment inclusion, and high scores on the TCI-R Harm Avoidance personality dimension. One hundred fifty-seven patients (27.8%) missed 3 or more therapeutic sessions over the entire therapeutic program. The main predictors of dropout were single marital status, younger age, and high scores on the TCI-R Novelty Seeking personality dimension. The presence of these factors at inclusion should be taken into account by physicians dealing with PG patients.

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1. Introduction

There is evidence that cognitive–behavioral treatment is the most effective intervention for treating pathological gambling (PG) [1–3]. In a meta-analysis including 1434 subjects in 22 articles, Pallesen et al. [4] concluded that psychological interventions for PG were more effective than no treatment and yielded favorable short- and long-term outcomes. Although individuals who begin therapy for PG may find considerable relief of symptoms, relapses and lack of adherence to treatment have been noted in many patients

in two systematic reviews [5,6]. However, both reviews mentioned that few studies have directly examined relapses or dropouts, and those that have, include small samples.

Studies focused on PG relapses have reported differing results. Some authors have cited dissatisfaction with treatment, alcohol consumption, and high levels of neuroticism as the main factors related to relapse [7]. Others have additionally mentioned psychopathological distress as predictive of relapse [8,9]. Hodgins and el-Guebaly [10] concluded that optimism to make money, a need for more money, free time, boredom, negative mood, the desire to socialize, and excitement-seeking were factors contributing to relapses. All these factors have been described in retrospective studies, and there are no reports investigating relapses over a lengthy follow-up.

During PG treatment, patients often re-schedule, cancel, or fail to attend sessions, and some may ultimately drop out of treatment [5]. Although several studies have investigated

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the influences associated with dropout, the available results do not provide robust empirical evidence to identify the main factors with certainty [11]. Some authors have described a role for neuroticism [7], impulsivity [12,13], and sensation-seeking [14,15]. Melville et al. [5] reported a relationship of dropping out with age at gambling onset and poor coping with stressful situations. Jiménez-Murcia et al. [16] found no link between age at onset and a poor response to treatment (dropout or relapse), but in another study by the same group, a positive association between shorter duration of the disorder and treatment dropout was evident [14]. Issues such as motivation and adherence to treatment are core aspects of the therapeutic prognosis in PG patients [2,17–19]. Given the variability of these results, additional work is needed.

Most studies that have attempted to analyze relapses and dropouts in PG are based on small samples or have explored specific clinical and psychopathological variables. The aim of this study was to determine predictors of relapse and dropout in a large sample of pathological gamblers attending a dedicated PG unit. In addition, the time to the first relapse was investigated over an extended follow-up period.

2. Methods

2.1. Subjects

The study population was derived from a prospective single-center registry of consecutive outpatients attended at a publicly-funded Pathological Gambling and Behavioral Addictions Unit with a catchment population of 1.5 million inhabitants and universal access. Most patients are referred from primary care physicians within the public healthcare system. The study period was from October 2005 to January 2012. We included all patients diagnosed with PG according to the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (Text Revision) (DSM-IV-TR)* [20]. Patients consulting at the Unit for any other behavioral addiction (compulsive buying, internet addiction, sex addiction) were excluded.

The study was carried out in accordance with the latest version of the Declaration of Helsinki (WMA, 2008). The Research Ethics Committee of Consorci Sanitari de Terrassa approved the study, and informed consent was obtained from all participants.

2.2. Procedures

After receiving the diagnosis of PG, all participants completed a semi-structured interview and were entered in a therapeutic program involving individualized outpatient cognitive-behavioral therapy for PG, aimed at achieving abstinence from gambling. The interview and treatment were applied by a clinical psychologist with more than 10 years' experience in the diagnosis and treatment of PG. In the first session, we collected socio-demographic and clinical data, and information about gambling behavior and personality traits.

Treatment was protocolled, and the main techniques used were psychoeducation, motivational interviewing, stimulus control, cognitive restructuring (understanding the concept of chance, detecting and modifying perceptions and misconceptions that players have in relation to the game), and relapse prevention. Treatment lasted for 6 months and consisted of individual 40-minute sessions on a weekly or biweekly basis and after this period, patients began a 6-month follow-up period with monthly visits. Subsequently, a later follow-up phase involving 3 follow-up visits at 3, 9, and 21 months was scheduled. Patients who did not achieve abstinence were considered to be in partial remission, and prolongation of these periods was decided, extending the therapeutic protocol. At each scheduled visit, the therapist recorded attendance to the treatment session, whether the patient had gambled on previous days, and the amount of money spent on gambling.

2.3. Aims and outcome definitions

The aim of the study was to determine predictors of relapse during the 6 months of PG therapy and the subsequent 6 months of follow-up, and predictors of dropout over the entire therapeutic protocol. In addition, the time to the first relapse and the relapse pattern were investigated over the extended follow-up period using a survival analysis.

For the purposes of the study, gambling events were divided into two categories: *lapse* and *relapse*. *Lapse* was defined as an isolated episode of gambling associated with mild negative consequences on the patients' economy and family. *Relapse* was defined as more than two episodes of gambling documented at two consecutive visits or one gambling episode that showed no sense of control, with loss of control defined as total expenditure higher than that of 1 week of gambling prior to entering therapy [6,7]. In the present study, we analyzed the predictive factors related to relapses.

Based on the fact that poor adherence to treatment is common in PG patients and missing a single treatment session could be due to many reasons [5,17], *dropout* was established when 3 or more sessions had been missed without previous notification.

2.4. Predictors

Predictors of relapse and dropout were selected based on the findings of published research [5,6]. These were categorized into three blocks—socio-demographic and clinical factors, gambling behavior, and personality traits—and recorded during the first session.

2.4.1. Socio-demographic and clinical factors

The socio-demographic data included age, sex, employment status, marital status, and years of education. The clinical data comprised other psychiatric comorbidities, use/abuse of illegal substances, and family history of gambling, and were assessed according to *DSM-IV-TR* criteria [20].

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