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Application of Cognitive-Behavioral Therapeutic Techniques in the Treatment of Gambling Disorder: A Case Study

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Abstract: This case report describes a 37-year-old male with severe gambling disorder (meets 7/9 DSM-5 criteria) involving sports betting and slot machines, with major psychosocial consequences including debt, occupational decline, family conflict, isolation, nightmares, and suicidal ideation. Psychometric assessment indicated pathological gambling, high irrational gambling beliefs, high situational risk, severe depression and moderate–severe anxiety. Etiological factors included early familial normalization of betting, competitive orientation, an initial win reinforcing cognitive distortions (illusory control), social comparison, and progressive escalation after abstinence periods. Treatment comprised a 12-session Cognitive Behavioral Therapy program (including two couple sessions) emphasizing psychoeducation on dopaminergic reward mechanisms, decisional-balance, Stages of Change, cognitive restructuring, ABC formulation of craving, coping skills, relapse-prevention planning, social-skills training and self-esteem enhancement. Initial barriers (limited insight; reluctance to self-monitor; disclosure hesitancy) were overcome. Outcomes: completed program without relapse, marked reduction in anxiety and depression, improved understanding of relapse mechanisms, and restored family engagement. The report highlights Cognitive Behavioral Therapy as first-line intervention for gambling disorder and underscores the role of patient engagement, family support, and early intervention in prognosis.

Keywords: irrational beliefs; relapse prevention; cognitive distortions

1. Introduction

Over the past two decades there has been a rapid increase in the legalization and accessibility of gambling. In Romania more than 10,000 casinos, gaming halls and betting shops operate, frequented by approximately 1.5 million people, and online gambling has been legalized since 2015. A public opinion survey conducted by INSOMAR in 2000 across 40 counties and Bucharest found that 63% of respondents had participated in prize contests or gambling activities, and among those who had not yet gambled, 23% reported an intention to do so in the future. Consequently, the population's increased exposure — both to a wide variety of gambling modalities and to an expanding array of venues — has been associated over the last two decades with a rise in deviant behaviours related to compulsive gambling.

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The cognitive perspective is a prominent, often dominant, approach to understanding human behaviour, grounded in the premise that mental processes play a determining role in cognition, emotion and behaviour. With respect to pathological gambling, cognitive theory posits that problem gamblers are guided by irrational, erroneous or false beliefs about chance, probability and random events.

Traditional research within the cognitive paradigm indicates that individuals with pathological gambling exhibit difficulties applying the principle of event independence and in accurately evaluating random outcomes, particularly when financial motivation is present. Analysis and clarification of the role of cognitive dimensions — together with their clinical implications and underlying substrates — are essential both for the development of effective preventive strategies and for the optimization of diagnostic processes and therapeutic interventions.

Cognitive–behavioural intervention for gambling disorder focuses on: (1) identifying irrational cognitions associated with gambling situations; (2) assessing the contribution of these cognitions to the maintenance of problematic behaviour; (3) generating alternative interpretations of the same situations; (4) empirically testing those alternatives; and (5) evaluating the resulting behavioural and emotional responses. In the initial phase of treatment, implementation of stimulus‑control strategies — including restriction of financial access to gambling resources — is recommended as a means of achieving an immediate reduction in problematic behaviour, with control subsequently being transferred gradually to the patient as part of the therapeutic process.

2. Case Presentation

2.1. Case History

2.1.1. Presenting Patient

Marian, male, 37 years old, employed as a car dealer, married for seven years, father of two children. He resides with his wife and children in an apartment purchased by his parents.

2.1.2. Chief Complaints

In 2019, following a gambling episode with substantial losses, Marian disclosed suicidal ideation to his wife. He refused psychiatric consultation, asserting that he was “not insane” and would not go to a psychiatric hospital. Marian meets criteria for pathological gambling, primarily involving sports betting and slot machines. His principal treatment goals are cessation of gambling and preservation of his family relationship; his wife issued an ultimatum: “If you gamble again, I will take the children and leave.”

2.1.3. History of Present Illness

Marian’s first gambling experience occurred five years prior, when a friend took him to a betting shop and he placed a small bet (10 lei) on football matches. The ticket won, yielding 600 lei; the unexpected win generated strong positive affect and he spent the winnings on a family meal. Shortly thereafter irrational cognitions emerged (e.g., “If I have a bet like this each week, I could live without my salary”). Over subsequent weeks he increased stake sizes (to 20–50 lei), believing larger bets would produce larger wins.

Despite accumulating losses, he minimized risks (“I’ll place another bet; I’m not using my money, I’m using winnings”). He later met Robert, the friend who initially introduced him to betting; Robert showed Marian a recent substantial win (17,000 lei), attributing it to careful study of teams (“I analyzed all the teams, it had to come out”). This reinforced an illusion of control over outcomes. Marian began spending increasing amounts of time (up to four hours daily) studying teams and strategies, reporting neglect of

eating and routine activities. Nevertheless, his returns remained modest and losses accumulated. A competitive dynamic with Robert developed, accompanied by envy and resentment.

Gambling behavior began to adversely affect occupational performance (declining sales) and family involvement. When his wife became aware of his gambling she urged professional help; he refused, believing he could stop on his own. He then maintained six months' abstinence but subsequently resumed betting with small stakes. After an initial win, he gambled 200 lei on slot machines and won 1,200 lei, which precipitated a paranoid-style interpretation ("They think I haven't been here for a while so they let me win to keep me coming back").

Escalation followed: larger, more aggressive gambling, indebtedness to private lenders, and a bank loan of 35,000 lei. With mounting losses he adopted avoidant behaviours toward his family, isolated himself in a room, and experienced nightmares about losing his home and family ("I dream the bank comes and takes the house"). His wife discovered a notice indicating missed loan payments; confronted, he admitted the problem and agreed to seek professional help. They contacted PROSALVITA, a prevention and addiction assistance program.

2.1.4. Social and Personal History

Youngest child in the family: one older brother (by 2 years) and one older sister (by 4 years). Close relationship with his father, who enjoyed fishing; mother was frequently occupied maintaining the family real-estate business. Gambling (sporting bets) occurred socially in his extended family (uncle a football fan who organized family bets). He completed a marketing degree in Bucharest and lived in his sister's apartment during studies. Occupational history: six years as a distributor for Coca‑Cola, then employed as a car dealer. Met his current wife at a company event; reports immediate attraction and subsequent marriage. Gambling escalated after two years of marriage following peer initiation; periods of abstinence were followed by progressively more aggressive gambling on higher stakes (indicative of progressive, degenerative course). Behavioral consequences included social isolation, depressive and anxiety symptoms, and recurring nightmares centered on debt and loss of home/family. Following disclosure by his wife, the couple sought specialist help.

2.1.5. Medical History. No medical conditions reported that would influence treatment.

2.1.6. Mental Status at Assessment. Oriented in time and space. Mood anxious and depressed.

2.2. Diagnostic Assessment

Meets 7 of 9 DSM‑5 diagnostic criteria for gambling disorder.

Psychometric results:

- South Oaks Gambling Screen (SOGS): score 18 — "probable pathological gambler."

- Problem Gambling Severity Index (PGSI): score 20 — severe gambling disorder with negative consequences and possible loss of control.

- Gambling‑related Irrational Beliefs Scale: score 21.

- Inventory of Gambling Situations: score 78 — denotes high risk for pathological gambling.

- Beck Depression Inventory (BDI): score 42 — severe depression.

- Beck Anxiety Inventory (BAI): score 35 — moderate‑to‑severe anxiety.

2.3. Case Conceptualization — Cognitive‑Behavioural Perspective

2.3.1. Etiological Factors

Early family normalization and social valuation of sports betting likely contributed to development of beliefs about the acceptability and normality of gambling. A competitive orientation and limited adaptive analytic strategies fostered a dysfunctional competitive gambling style that became problematic. The initial winning event likely acted as a trigger for cognitive distortions (e.g., "If you study teams you cannot lose" — illusion of influencing outcomes; "I am a fan so I know how to bet" — illusory control), which were reinforced by repetitive gambling behavior. Social comparison and envy of peers' wins likely exacerbated loss of control.

2.3.2. Current Cognitive and Behavioural Assessment

Cognitively, a prominent problem is illusion of control and belief in the possibility of influencing chance outcomes. Emotionally, the patient experiences anxiety after losses and avoids family contact, with envy toward others' wins that may reflect a need for social affirmation. Behaviorally, pursuit of losses led to maladaptive strategies (borrowing, bank loan) to fund further gambling. Despite negative consequences, gambling persisted.

2.3.3. Longitudinal Cognitive‑Behavioural Formulation

Longstanding exposure to familial betting practices and a dysfunctional competitive orientation fostered development of three central schemas:

1) Competence schema: "If I inform myself correctly, it is easy to win" — evaluated by self‑worth tied to success ("If I don't win, I'm not good enough").

2) Control/responsibility schema: "If I win one bet per week, I won't need my salary" — evaluated by belief that attention equals effortless monetary gain.

3) Catastrophic outcome schema: "I must recover the money or the bank will take my house" — leading to catastrophic beliefs about homelessness if debts remain unpaid.

2.3.4. Strengths and positive resources. Patient shows interest in technology, continuous self‑improvement, literature and travel. He is motivated to cease gambling and to refocus on family life.

2.3.5. Working hypothesis. Gambling disorder developed on the basis of distorted beliefs about gambling, an exaggerated competitive disposition, and insufficient accurate knowledge about gambling addiction. Cognitive distortions about control and predictability of chance outcomes, together with anxiety about losses and concealment of the problem, maintained gambling behaviour as an attempted solution to financial and interpersonal stress.

2.4 Treatment Plan — Cognitive Approach

2.4.1. Problem List

- Inability to stop gambling.
- Guilt related to accumulated debts.
- Fear of losing housing.
- Fear of marital separation.

- Low self‑esteem and poor assertiveness.

2.4.2. Therapeutic Goals

- Cessation of gambling and psychoeducation regarding neurobiological reward mechanisms (dopaminergic system) underlying gambling urges.

- Reduction of cognitive distortions that precipitate relapse.

- Decrease in anxiety and depressive symptomatology.

- Development of social skills.

- Improvement of self‑esteem.

- Promotion of personal development.

2.4.3. Intervention Planning and Techniques

Therapy planning

The initial phase of the treatment plan targeted cessation of gambling behavior and psychoeducation on the brain's reward system—specifically the dopaminergic pathways—alongside reduction of gambling ‑related cognitive distortions and attenuation of affective states that may precipitate relapse. A relapse ‑prevention plan was also developed.

To promote cessation, the decisional‑balance technique was employed to increase awareness of the short‑ and long‑term consequences of gambling. The Stages of Change model was integrated as an awareness tool to facilitate implementation of new functional behaviors.

Cognitive restructuring techniques were used to reduce automatic thoughts. Subsequent intervention focused on alleviating anxiety and depressive symptoms through cognitive restructuring methods aimed at modifying automatic thoughts and core beliefs.

Concurrently, we worked on identifying craving states and decoding the associated automatic thoughts, applying the ABC model (Thought–Emotion–Behavior) to enhance understanding. Emphasis was placed on developing new, functional adaptive coping mechanisms to maintain abstinence. Social skills training and self‑esteem enhancement were implemented to increase the patient's confidence and reduce relapse risk.

2.4.4. Techniques Employed:

- Decisional balance exercise to increase awareness of short‑ and long‑term consequences of gambling.

- Stages of change model (Prochaska & DiClemente) to facilitate behavioral change.

- Cognitive restructuring (Clark; Beck) to address automatic thoughts and core beliefs.

- Identification and decoding of craving states using ABC model (Antecedent–Belief–Consequence: Thought–Emotion–Behavior) and development of adaptive coping strategies to maintain abstinence.

- Social skills training and self‑esteem enhancement to reduce relapse risk.

2.4.5. Therapy Obstacles

Initial limited insight into the relationship between craving and relapse and reluctance to maintain an impulse journal; later compliance improved and monitoring became easier. Initial resistance to couple

participation due to reluctance to disclose full extent of debts; couple sessions focused on shared understanding of addiction mechanisms.

2.5. Outcomes and Follow-Up

Treatment comprised 12 sessions, including two couple therapy sessions. The first session involved both spouses to provide psychoeducation about addiction mechanisms; the second monitored implementation of functional behaviours. Marian completed the program without relapse, demonstrated improved understanding of loss of control and dopaminergic reactivation risk with renewed gambling, and showed marked reduction in anxiety and cessation of nightmares. Family involvement contributed positively to therapeutic outcomes.

3. Conclusions and Discussion

Cognitive-behavioural therapy integrates cognitive and behavioural techniques to identify and correct reasoning errors and maladaptive information-processing that sustain problematic gambling, while modifying resultant maladaptive behaviours and habits. CBT constitutes the first-line treatment for gambling disorder. Therapeutic objectives include correction of cognitive distortions, promotion of functional decision-making, regulation of neurobehavioural processes implicated in reward, and clarification of somatic and psychological responses associated with gambling. Interventions also target development of adaptive behavioural repertoires, enhancement of social skills, and implementation of relapse-prevention strategies.

This case underscores the importance of patient engagement in therapy and family support for favorable outcomes. Temporal factors, such as younger age and shorter disorder duration, may be associated with better therapeutic prognosis.

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