BRIEF PSYCHODYNAMIC PSYCHOTHERAPY AS A TREATMENT FOR PROBLEM GAMBLING (BPPPG)

A Clinician's Guidebook

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Gambler's Help
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LIST OF ABBREVIATIONS

BBCH	Bentleigh Bayside Community Health
BPPPG	Brief Psychodynamic Psychotherapy for Problem Gambling
CBT	Cognitive Behavioural Therapy
DIT	Dynamic Interpersonal Therapy
GHS	Gamblers Help Southern
VRGF	Victorian Responsible Gambling Foundation
IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Clinical Excellence (UK)
NHS	National Health Service (UK)
RCT	Randomised Control Trial
LTPP	Long Term Psychodynamic Psychotherapy
STPP	Short Term Psychodynamic Psychotherapy

TRANSPARENCY DECLARATION

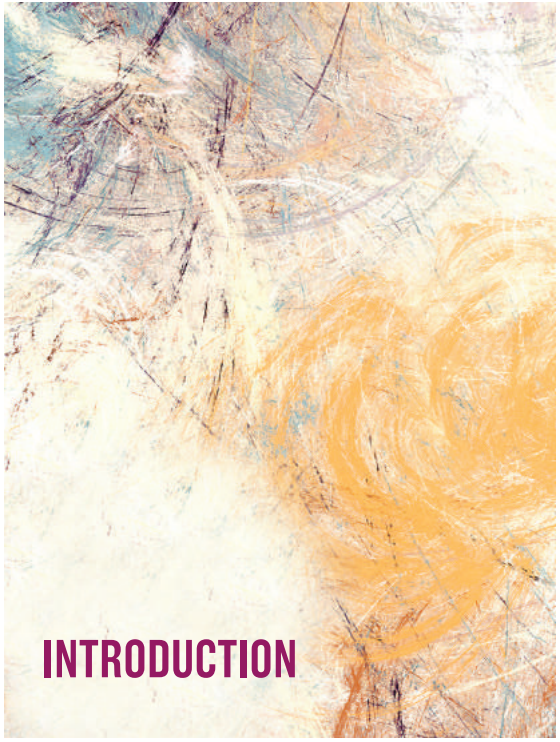
GHS is a programme of BBCH. GHS receives funding from VRGF to provide clinical and operational services to problem gamblers within the three catchment areas of Bayside (City of Port Philip, City of Stonnington, City of Glen Eira, City of Bayside and City of Kingston), Frankston & The Mornington Peninsula (City of Frankston, Mornington Peninsula-Shire) and the South East (City of Greater Dandenong, Cardinia-Shire and the City of Casey). The total population for the three catchments is just under 1.5 million.

GHS submits service plans to VRGF each year, for the coming year. Service plans are based on most current demographic data and seek to target the most at-risk individuals and families in its three catchments, from gambling associated behaviours

GHS's clinical services and model of care are independent from VRGF, state or federal government and industry alignment.

The three GHS clinicians, and professional consultant, involved in this project and the production of this guide declare no personal stake in the funding of GHS and no personal beliefs or views which may prejudice the outcomes of this project.

TC has spoken at a national (Australia New Zealand Addictions Conference, 2015) and international (4th Annual Asia-Pacific Problem Gambling & Addictions Conference, 2015) conference on problem gambling related harms. Attendance at these conferences was funded by GHS's annual service fund, from VRGF.

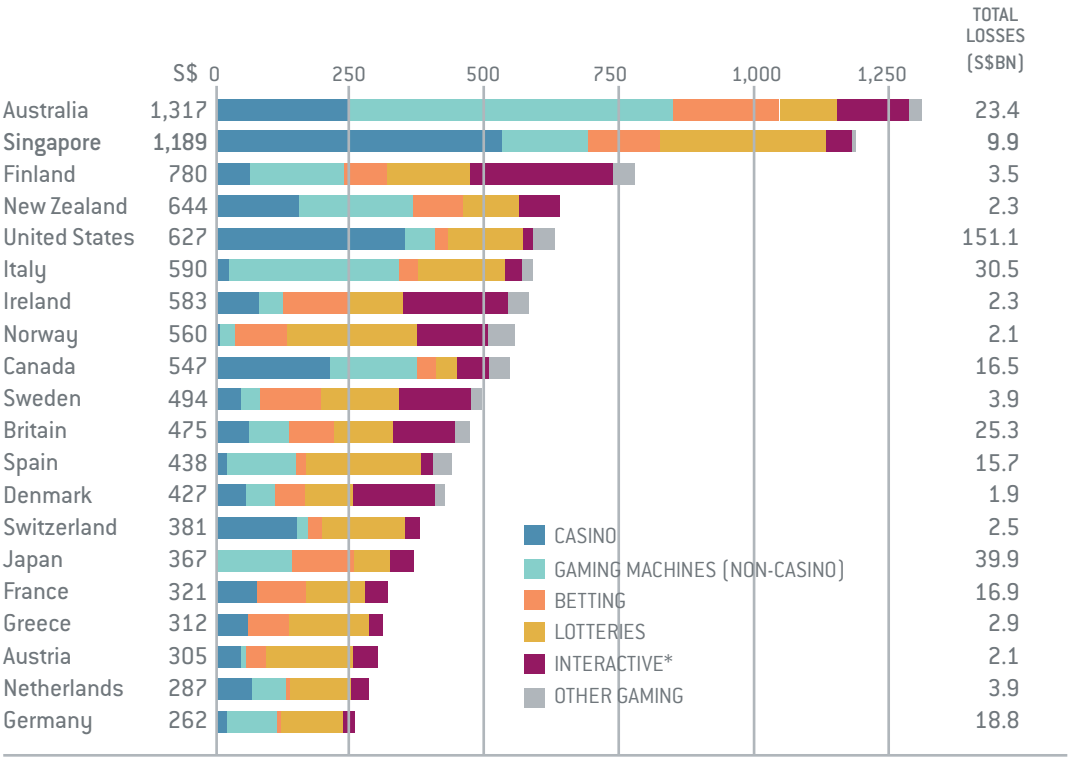


PROBLEM GAMBLING & GAMBLERS HELP SOUTHERN

According to most recent statistics (see fig. 1, below) Australia has the worst gambling problem in the world. With almost $1300 lost for every adult in Australia, the scale of the problem is fast approaching epidemic proportions.

GHS is the largest provider of problem gambling services in Australia and delivered, in 2014/15, just over 12,000 hours of therapeutic counselling and treatment to problem gamblers, their families and affected others.

Global Gambling: Average Loss per Resident Adult in 2013



* COMPUTER, MOBILE PHONE OR INTERACTIVE TV. SOURCE: H2 GAMBLING CAPITAL
(source: http://www.todayonline.com/singapore/sporeans-remain-second-biggest-gamblers-world)

The fact (http://www.problemgambling.gov.au/facts/) that for every problem gambler between five and ten other individuals are affected, coupled with the scale of the losses, places GHS at the centre of the current Australian epidemic.

CURRENT TREATMENTS FOR PROBLEM GAMBLING

With approximately 250 counselling and psychotherapy treatment modalities currently available there are numerous options for the treatment of problem gambling.

Many problem gambling services use cognitive and behaviourally-focused treatment modalities, such as Cognitive Behaviour Therapy, Neuro-Linguistic Programming, Cognitive Analytical Therapy and others.

The recent inclusion of problem gambling into the DSM-IV (American Diagnostic & Statistical Manual of Mental Disorders) as a behavioural addiction would suggest, from the terminology, that behavioural treatment approaches may be useful.

While this is certainly the case (and this guide is not intended to compile a case for or against one form of treatment over another) GHS believes that each client who presents does so with a specific history, capacity for change and set of needs. With this in mind GHS has adopted a model of care which allows for some flexibility, on the part of the clinician, as to which treatment approach to use given the assessment of client needs and patterns of behavior.

This is outlined, below.

GHS Model of Care

The GHS clinical model of care is based on NHS England's "Sustainable Care Models" (NHS England, 2014). The diagram (fig.1), below, depicts the underpinning values of this model.

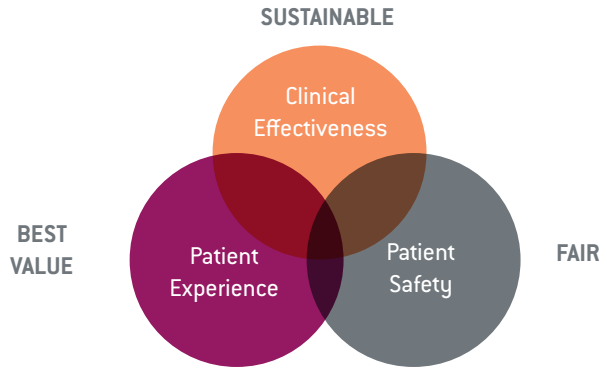
The elements can be described as follows:

- Effective care: The right evidence-based intervention and sound care that is delivered at the right time in the right place.
- Positive experience: People are treated with compassion, respect and dignity and care is tailored to their needs.
- Safe care: People are protected from physical, psychological or emotional harm.

Supported by:

- Best value: Based on sound evidence of value for money for outcomes achieved.
- Fair: Ensures equity in the distribution of resources and delivery of services.
- Sustainable: Delivered within environmental limits and building on social value.

Figure 1



GHS is committed to this vision as a key goal of our clinical model of care. The importance of delivering the best quality services, in an environment where resources are increasingly scarce, means sustainability must be a central component to our model of care. This entails awareness, at an organisational and individual clinician-level, of best practice, the efficacy of individual treatment approaches, clinical expertise and sustainable and flexible practice in treatment planning.

Enhancing health outcomes is the cornerstone of every health service. GHS proposes that reaching this goal is achieved by adopting the principles of Fair, Best Value & Sustainability, above.

GHS clinicians are skilled in a variety of treatment approaches, all evidence based. One of these is the psychodynamic model. This model itself incorporates a variety of approaches (such as psychoanalytic, attachment-based and mentalisation therapies).

One of these, Dynamic Interpersonal Therapy, represents a starting point for GHS's BPPPG.

Dynamic Interpersonal Therapy – An Acknowledgement

DIT emerged as a response to the UK-based National Institute for Health & Clinical Excellence's (NICE) initiative on Improving Access to Psychological Therapies (IAPT), in 2008.

DIT was developed by Peter Fonagy, Alessandra Lemma and Mary Target as a brief (16 weekly sessions) psychodynamic psychotherapy for depression and anxiety. The psychoanalytic/dynamic approaches with the best empirical evidence were used to develop DIT and it has been adopted by the UK National Health Service (NHS) as a manualized, semi-structured treatment.

One of the key goals of DIT is to facilitate the understanding between current symptoms and the client's relationships. It does this by helping the client identify a specific repetitive pattern in their relationships, the origin of which can often be found in their early years.

This pattern is then used to give meaning to the current symptoms, and relationships. The goal is to develop a capacity to better manage relationships and thereby reduce associated stress, depression and anxiety.

Using this as a general framework, this guide suggests that this therapeutic approach can be adapted to the treatment of problem gambling.

This guide, and its authors, would like to express acknowledgement to DIT, and its authors (Lemma, Target, Fonagy, 2011), in the development of BPPPG.

WHY THE NEED FOR BRIEF PSYCHODYNAMIC PSYCHOTHERAPY IN PROBLEM GAMBLING

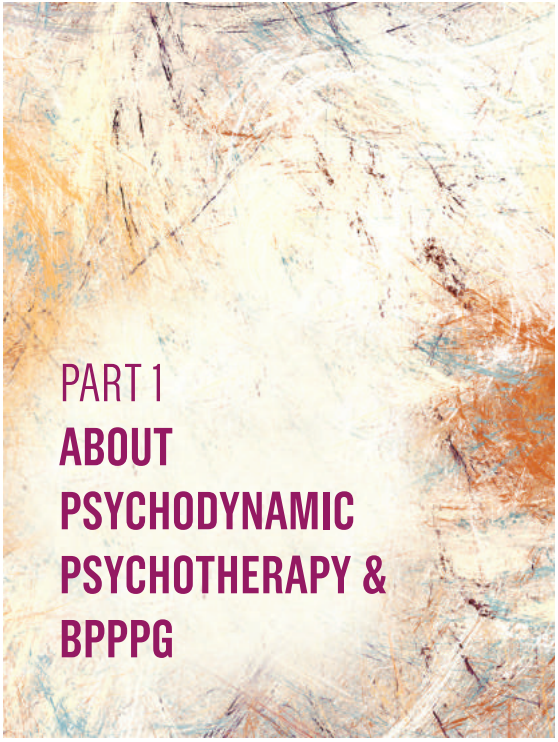
The mean number of therapeutic counselling sessions attended at GHS is one. This does not preclude the fact that many clients have been attending ongoing, weekly therapy for a number of weeks, months, even years. However, with such a low mean number of sessions, there is clearly an issue of retention in problem gambling counselling.

There are other useful and well researched studies which suggest reasons why this particular cohort may struggle to stay in therapy. This is not the purpose of this guide.

GHS believes that this low mean number of sessions, in addition to the finite resources available to problem gambling treatment services, deserves acknowledgment and response.

An overwhelmingly high number of clients who present at GHS do so with current interpersonal problems, historical attachments and relationship difficulties (often complicated by trauma, neglect and/or abuse) and depression/anxiety, in addition to problem gambling behaviours.

Consequently we believe there is a clear need for a therapeutic approach which addresses interpersonal and problem gambling issues within a time-limited framework. The aim is to address the issue of retention by adopting a goal-driven therapy that focuses on ending, thus reducing the potential stress, which client's report, at committing to open-ended therapy.



PART 1 ABOUT PSYCHODYNAMIC PSYCHOTHERAPY & BPPPG

THE EVIDENCE BASE

There is a commonly held misconception that psychodynamic psychotherapy is not an evidence based therapy. This has been, in part, due to the historical reluctance to engage in research, in the field of psychoanalysis (the "parent" of psychodynamic theory).

There has also been suggestion (Gaskin, 2012) that a high proportion of therapists, who do not identify as working psychodynamically, may use techniques which are identical to, or originate in, the psychodynamic school (such as countertransference, the therapeutic alliance or working with defences). This may have an impact on the reporting, in RCT's, on specifically psychodynamic techniques.

However there have now been a number of clinical trials conducted (see Gerber et al, 2011 and Shedler, 2009) which demonstrate psychodynamic psychotherapy to be superior to treatment as usual and at least equivalent to other psychotherapies (such as CBT) for depression and anxiety, somatic disorders, some personality disorders, eating disorders, PTSD and some substance-misuse disorders.

Initially RCT's were conducted mainly in long term psychodynamic psychotherapy (Leichsenring, Rabung, 2011). The results found LTPP to be "superior to less intensive forms of psychotherapy in complex mental disorders" (ibid.), but suggested further trials.

The RCT's of short term psychodynamic psychotherapy have found similar results (Driessena et al 2010), with the inclusion that patients have reported benefits increasing once leaving therapy.

Both LTPP and STPP trials have satisfied the American Psychological Association Division 12 standards to be included in future DSM publications as an empirically validated form of treatment (Gaskin, 2012).

Contraindications & Assessment

Considerable thought has been given to the process of assessment and contraindications for BPPPG.

GHS utilises a central intake system whereby all referrals, from several sources (Gamblers Helpline, self-referral, Dept. of Corrections, family member etc.), go through an intake and

assessment process. Clients are then referred on to a counsellor who best fits their presentation and is most convenient for them, geographically.

For example, GHS has several clinicians who specialise in working with couples. If a couple present for intake who live in Springvale they could be offered the option of seeing a counsellor in Dandenong or, if they require out-of-hours sessions, East Bentleigh.

The process for assessment for BPPPG has been different. Assessment for suitability for BPPG has not been done at the initial intake assessment. Preparatory discussion has taken place with GHS intake to identify some of the signs that a client may be suitable for BPPPG. These may be (but are not limited to);

- A capacity to think psychologically – does the client want to know more about themselves, are they interested in attending to their history, can they make connections between their history and their current presenting problem?
- An explicit willingness to commit to regular therapy.
- Previous experience of therapy.
- The capacity to verbalise ideas about what they want to change and how they hope that change might come about.
- A capacity for self-reflection – will the client continue to explore aspects of themselves and their behaviours after a question has been answered?
- Use of imagination and recognition of internal world – is the client able to symbolise, perhaps using "it's as if" statements or metaphors, and accept the discrepancy between external reality and how the world seems to them?

Not all of these signs need to be present but a client who presents at intake and is unwilling, or incapable, of accepting that there may be a connection between previous experience of relationships and current ones may not be suitable for BPPPG. Similarly a client who cannot allow for any link between symptom relief (the cessation of gambling) and increased self-awareness may be unsuitable for BPPPG.

These signs of readiness can therefore be used to identify contraindications. They will not necessarily be evident at the intake stage but if there is some indication that a client may be able to tolerate psychodynamic psychotherapy one of the three clinicians participating in the project will be contacted.

That clinician will then arrange to meet with the client for a preliminary session. During that session the clinician will determine the client's potential readiness for BPPPG (see Key Competencies section). The clinician will then suggest the use of BPPPG to the client and, often, suggest that the client need not make an immediate decision on whether to take up the treatment.

At the second meeting the clinician will check in with the client to ascertain their thinking about the commitment to BPPPG.

The 12 Session Model

The decision to use a 12 session model was loosely based on the DIT model, identified by the following process;

Sessions 1-3	Identification of at least one key pattern or issue in the client's life, other than problem gambling, which the client recognises may impact on the presenting problem; client history reported; goals agreed; ending discussed.
Sessions 4-9	Work on identified pattern and how it is experienced in the therapeutic relationship.
Sessions 10-12	Ending Phase: revisit original goals and identified pattern; focus on experience of ending.

Throughout the therapy clients are asked to complete a client session evaluation form (appendix 1). This can be done between sessions, before sessions or during sessions; the individual clinician can suggest the most convenient method in discussion with the client.

The theme of ending is raised at the beginning of the therapy and referred to throughout (see *Key Competencies – Working With Endings*, below).

The client is made aware at the beginning of their 12 sessions that they can be offered further sessions, either with their BPPPG therapist or another GHS clinician, should they request this. However it is made clear that in order to avail themselves of this option they will need to re-present to GHS intake, as the 12 session treatment is separate and distinct.

KEY COMPETENCIES OF BPPPG

Basic Therapeutic Competencies:

These basic therapeutic skills are those required to carry out any psychological therapy and are not specifically associated to psychodynamic psychotherapy. They include, but are not limited to;

- the capacity to develop a therapeutic alliance with a client;
- the understanding that all clients are different and require acceptance as individuals;
- the need to adhere to ethical guidelines and frameworks;
- a capacity to use the supervisory relationship to identify the client's material and separate this from the therapist's own response;
- understanding of at least one modality of therapy;
- the ability to identify and clearly express an assessment of the client's needs – this can be done through history-taking, the client's expressed motivation, risk assessment and/or a formal intake or preliminary assessment;
- ability to identify, with the client, what issues need to be addressed and the time frame in which both will work towards this. This must be agreed with the client to achieve the maximum meaning for them.

Psychodynamic Competencies:

These are defined in greater details below but include those competencies which are specific to the provision of a psychodynamic treatment. While there are many schools of psychodynamic theory and practice (see *Key Psychodynamic Schools of Thought* section, below) there are generic competencies which are evident across them. These will differ from non-psychodynamic competencies primarily in their focus on the role of and attention paid to the unconscious, which is given greater privilege in psychodynamic theory than any other concept, except transference.

The interpretation of the transference, which is sometimes more predominant in longer term psychodynamic treatment, will also form part of this short term model.

Basic psychodynamic competencies include;

- knowledge of the basic principles of psychodynamic theory, including;
- a capacity to formulate for the client – this includes an understanding of the developmental origins of a client's issues, what unconscious conflict this may give rise to (eg. gambling), how the client seeks to avoid this (their defences and gambling behaviours) and what problems this may present for the client in their relationships with others (including their relationship to gambling);
- an ability to maintain a psychodynamic framework for the client (such as adhering to the same session time/day and room) and the ability to think with the client about their response to any changes to these boundaries;

- attendance to the unconscious communication of the client – this can be through encouraging the expression of dreams, fantasies or wishes with the therapist will then paying particular attention to recurring themes, words or ideas which can offer access to the client's internal world. While the therapist must of course attend to what the client is telling them, on a conscious level, they must also be able to listen to what the client may be trying to communicate from 'below the surface'. This competency also includes the ability to know when to remain silent so as to facilitate the expression of free associations.
- ability to work with transference and counter-transference and to use these tools as a way to sensitively show the client how difficulties in the therapeutic relationship may mirror those in the client's personal life.

Working with defences

All humans operate with defence mechanisms. These are necessary to protect us from whatever psychological or existential threat we may perceive. Where brief psychodynamic psychotherapy differs slightly from some other forms of psychotherapy is the importance it places in the existence of defences.

The therapist will make it clear to the client that they know there are good reasons for them retaining their defences. This is often one of the most alarming things for a client to hear; that their defence (perhaps their very gambling behaviour) is actually performing a function for them. Otherwise, why would they hold on to it?

Defences can perform many functions for us. A defence against hunger is eating, while a defence against physical injury is bleeding. In the same way psychic defences can also protect us. Someone who has experienced verbal, physical or sexual abuse might defend against situations where this might happen again by sabotaging attempts by others to seek intimacy. Similarly someone who has been ignored or disregarded in an earlier relationship may defend against the therapist having the opportunity to repeat this by offering little enthusiasm for the therapy, frequently missing sessions or staying silent.

When Freud first thought about defences he suggested that whatever is being defended against usually finds a way out. This gave rise to his idea of the 'return of the repressed' (Freud, 1896). The notion that we repress unpleasant, intolerable or painful memories or experiences, only for them to find expression in a form of behaviour, relational preference or some other form of acting out is now widely accepted as a psychological mechanism.

Those defences which protect the client against more deep-rooted and painful experiences cannot simply be confronted head-on. The potential here is for the defence to be strengthened by attack. The defence unconsciously communicates to us, "you see, I told you this would happen, that's why you need me".

The therapist must determine which defences are allowing the client to participate in treatment and which are preventing progress. If the reason for the defence can be identified, firstly be the therapist, and then gently discussed, the possibility is that a way can be found to give more life to test out the current validity of and attend to the anxieties which lie below the defence.

Common Defences:

- Projection – when the client attributes their thoughts or feelings to the other.

  For example, a client is angry with their partner for catching them gambling and asking that they see a counsellor. The client denies this anger at the partner but instead suggests that the partner is the angry one and describes this to their counsellor.

- Regression – reverting to more infantile, less age-appropriate behaviour.

  For example, the same client as above, when caught gambling, begins to cry, not out of

remorse for their actions, but in an, often, unconscious attempt to elicit sympathy from their partner, the way a child may do from the mother.

- Rationalisation – creation of a false but plausible excuse in order to explain a way of behaving.

  For example, the gambling client tells themselves that if they weren't putting money into the poker machine someone else would be so they may as well keep on going.

- Displacement – the re-direction of thoughts or feelings from their source onto another.

  For example, the client is caught gambling by their partner and experiences anger at this. Instead of directing this anger at themselves they go to work the next day and unjustifiably discipline a colleague for an unrelated matter.

There are, of course, many more defences. What is important, in BPPPG, is that the therapist recognises which are there to simply allow the client to function normally and which are there to enable the client to avoid engaging with some part of themselves which they have shut off and which seeks expression through gambling.

"No Memory, No Desire"

In BPPPG the therapist is urged to strive for what is unknown, what is not yet believed to be or apprehended. This can develop a sense of change and evolution.

This section refers to the theories of Wilfred Bion, a British psychiatrist and psychoanalyst who was largely responsible for developing group psychotherapy and contributed to Object-Relations Theory.

The relevance of Bion's thinking to BPPPG is his suggestion that the therapist "abandon memory and desire" (Bion, 1967) when in the consulting room. Bion believed that memory could not be considered an accurate record of fact because he felt it was always bound to be influenced by unconscious forces.

This is evident when we often confuse client's histories or previous session material with another. Often, when we think about why this has taken place, we find similarities in the two, or more, clients we have confused. On further examination we may find that we are also enmeshed in the confusion – perhaps we have unconsciously replaced one client with another because we favour one, find one 'easier' to be with or identify with one in some way.

Of course the possibility exists that we simply have so many clients to see that we have forgotten the last session or an important aspect of their lives.

However the potential remains for us to have become unconsciously involved in their narrative and this is what Bion wanted us to guard against.

In much the same way, desire can operate as a blockage to truth. Bion believed that memory and desire;

> *"…deal, respectively, with sense impressions of what is supposed to have happened and sense impressions of what has not yet happened."*
>
> *(ibid)*

Bion is telling us that each session is unique and, while we may believe that we 'know' about the client, in some certain and concrete way, we do not. This is because every time a client comes to the session they are bringing a new version of themselves.

This does not mean that we urge ourselves to forget important themes or empirical details about a client's past relationships or history.

When we cling to what believed 'facts' we have of our client we are entering into their fixed defensive structure. This allows for no change and change is why the client comes to therapy.

Formulating Interpretations

Page 22 makes reference to transference interpretations and the 'transference triangle'. This triangle is a key tool when formulating interpretations, at any time, but especially in BPPPG.

We will use the example, below, to formulate an interpretation.

Client: I'm not sure there's any point in talking about why I gamble.
Therapist: Or perhaps you're not sure there's any point in talking to me about why you gamble?
Client: Well I know that talking can help but there's no point with me, I'll probably never stop.
Therapist: But then you keep coming to your sessions, why is that I wonder.

This is relatively early in the treatment, at session four. The client is articulating their ambivalence. On the one hand they feel there's "no point" in talking but, on the other, they "know that talking can help".

We all know that empathy is vital when working as a therapist. An empathic response to the client above might be to link some of their statements together and say, "There's a part of you that's not sure if talking to me will help, another which thinks there might be something in this for you and yet another which perhaps doesn't believe you can get better".

This simple linking describes elements of the client's thinking that they are mostly conscious of. The seemingly conflicting feelings they are expressing are verbalized, all together, by the therapist.

But this is not a transference interpretation in BPPPG.

An interpretation will go a step further than this, illuminating thoughts or feelings which are not conscious or which the client is only half aware of.

The example above is a link between sentences which the client themselves has made known. These sentences are usually joined up, follow one another or something obvious, like theme, in common.

In order to formulate an interpretation with this client more needs to be known about them. This is because the formulation of an interpretation involves linking ideas, sentences, thoughts which do not seem obviously connected.

This allows those thoughts or feelings which are bubbling away under the surface to be made available to the client's conscious mind.

For example with the client above they had already talked about the fact that their partner "forced' them to come to counselling because they had been caught gambling. They also repeatedly used negative language when describing themselves; "I'm no good at talking", "That was another relationship I messed up", "I've never been good enough for them".

With this in mind the following interpretation was possible to formulate;

Therapist: I'm wondering if your resistance to talking is about a concern that I will catch you out and I might find someone who doesn't deserve to get better.
Client: Yes, that's it, I don't deserve it.
Therapist: So perhaps it's ok to acknowledge that this might leave you feeling angry because it's possible you feel the same about your partner finding out and about not feeling good enough.
Client: I do feel angry at her. She exposed me.

The client's feelings of vulnerability at being caught gambling are triggered by their feelings of vulnerability at being seen, fully, by their therapist as someone worthless. But the worthlessness existed before the gambling, was a function of another interpersonal relationship - with a parent,

and were being experienced in new relationships; with their partner, therapist etc.

If we use the transference triangle (*page 22*) it tells us that a good interpretation can include all three sides; the past, present and therapeutic relationship. Sometimes, particularly early on in the therapy, making reference to the therapeutic relationship may not be possible or desirable.

However, it is worthwhile trying out an interpretation as early as the first session as this will give the therapist an idea of the client's capacity to think about themselves.

Interpretations can be powerful tools, when thought about carefully and formulated in the way described above.

Working with Endings

One of the key reasons for developing BPPPG is to give the client, and the therapist, the opportunity to work with a planned ending. Often this has not been possible, for either.

At GHS clinicians rarely experience a 'good ending'. This term refers to an ending which has been planned by both therapist and client, explicitly talked about, agreed upon and enacted. In talking about a planned ending many difficult thoughts and feelings can arise.

Much has been written about breaks and endings in psychodynamic literature, and in many other modes of therapy (see Ingram, 2003, Murdin, 1994 and Salzberger-Wittenberg, 2013). The focus is usually on the painful associations which may of us have experienced when thinking about endings; the loss of a loved one, the termination of a role or relationship or the end of ourselves – death. Whatever way we conceive of endings most people try to avoid them; even thinking or talking about them.

This is part of the reason why so few therapists experience a planned ending with a client. So why develop a treatment plan with ending as its focal point if thinking about endings, let alone going through them, is so painful?

Whatever modality of therapy we adhere to there must be at least some respect for 'truth' in what we do. If therapy is a search for truth – personal truth through self-realisation, acknowledgment of the truth of our own behaviours or other, more elusive truths – and the only truth about which we can be sure is that everything ends, then surely we should engage with what an ending means? To avoid thinking about ending is to avoid truth.

Working with endings in BPPPG may represent the same process as in other modes of therapy. But with BPPPG the therapist is telling the client, from the very first session, "This, like all things, will end and we need to talk about that".

The therapist will raise the issue of ending at the start, encourage the client to think and talk about their associations to endings and plan the ending together.

The experience of ending, what may have been one of the most remarkable relationships someone has experienced, needs to be referenced. The therapist's countertransference feelings coming up to the ending should be acknowledged and, if appropriate, made available to the client. The client may feel alone in their feelings of loss and being made aware that this experience can be difficult for the therapist too could alleviate that sense of loss.

The focus on ending in BPPPG pays respect to the often-cited goal of clients that they want to be seen. Naming the discomfort of an ending can serve as an acknowledgement of previous losses and rebuttals.

KEY CONCEPTS OF BPPPG

Transference

The term transference is perhaps one of the most widely used but poorly defined in the psychological lexicon. Certainly, when used in the psychodynamic sense, the term is very commonly misused, and is often employed to refer to any kind of transferal of feelings between client and therapist. This use of the term would move it closer to the definition of projection than transference.

Part of the problem in using and defining transference is that so much has been written about it. From the 'father' of psychodynamics, Sigmund Freud, we learned about the existence of transference as a phenomena. But Freud very much downplayed the importance of it as a component of treatment. He described it thus;

> *"What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician." (Freud, 1905)*

So the idea was formed that, in therapy, a part of the client is experienced by them in their therapist. This is not a conscious process and this is why Freud, and many other psychodynamic writers use the term 'phantasy' and not fantasy. The 'ph' denotes that it is an unconscious fantasy.

If we apply this to present day therapy, and to BPPPG in particular, the centrality of the concept of transference has increased.

What is perhaps important to note is that BPPPG is not inventing a new concept here. It is using an interpersonal dynamic process which takes place between individuals every day, in almost every relational transaction.

This is what psychologists might call 'set'.

For example we might find ourselves reacting particularly strongly to a new colleague at work. On closer inspection of our own behavior we might feel strongly inclined to want to please this individual, but for no easily discernable reason. When we interact more with them it may transpire that certain character traits, or idiosyncrasies, might subtly remind us a relationship from our earlier years (perhaps a demanding sibling or needy parent).

This phenomenon can be intensified when we are unwell. Most of us are familiar with the inclination to revert to more juvenile behavior when feeling ill.

Stress can also be seen as an illness and there are few marriages or long term interpersonal relationships in which the words, "I am not your mother", or "Don't speak to me like a child", do not feature. These are examples of transference.

The table, below, shows the links between attachment patterns and the threats associated. These attachment relationships and protective responses highlight many of the threats which activate defences.

ACTIVATION OF THE ATTACHMENT SYSTEM

Attachement feelings and behaviour are evoked by different kinds of threat to four kinds of attachement bonds

Attachment Bond	Nature of Threat/Protective Response
1. The pair-bond relationship (partnet)	Protection of relationship
2. Parent to childre	Protection of the other
3. Transference relationships to helpers	Evoked by threats to self
4. Persistent childlike attachment to parents	Loss of relationship

A more widely used definition of transference, and one which BPPPG applies is;

"The experiencing of feelings, drives, attitudes, fantasies and defences toward a person in the present, which do not befit that person but are a repetition of reactionso riginating in regard to significant persons of early child-hood, unconsciously displaced onto figures in the present. The two outstanding characteristics of a trans-ference reaction are: it is a repetition and it is inappropriate."

(Greenson, 1967)

In psychodynamic psychotherapy this is a key tool with which the therapist can gain access to seminal relationship templates which the client reuses in the session.

The therapist does this by making transference interpretations.

Transference Interpretations

Interpretations are the central tool in the armory of almost all therapies. Different therapeutic modalities will use them in different ways.

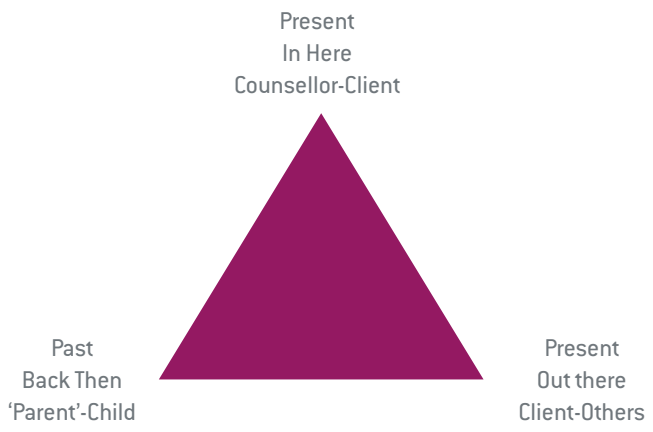
For example a cognitive interpretation may highlight to the client how their current behavior differs from their preferred behavior, or from the behavior which they wish to exhibit.

In psychodynamic psychotherapy a transference interpretation will make a link between three ongoing (so, dynamic) relationships. These are:

1. The relationship between client and therapist (the present);
2. The relationships between the client and significant others in their life which they are reporting to the therapist (this is also present and could be the client's relationship with gambling);
3. The relationship between the client and the key person from their past.

This can be conceptualised as a triangle, below. The therapist, when making a transference interpretation, can think of each side of the triangle as a dynamic, or active, interpersonal process. Drawing attention to how a client's current attitude towards them (the therapist) seems similar to how they report their feelings about a current relationship (e.g. gambling, partner etc.) and making the link to a previously acknowledged relationship from childhood can be powerful.

Figure 2



However it can also be the case that the client cannot, or will not, allow this interpretation. Often psychodynamic psychotherapists have to choose very carefully when and how to use this tool.

For this reason, and for the purposes of this guide, BPPPG suggests that therapists ask the following questions when considering formulating a transference interpretation;

1. Who is speaking (is it the client or an internal voice belonging to a significant person from their past/current relationships)?
2. What are they saying (thinking between the words, is there more meaning than just the surface meaning)?
3. Why are they telling me this now?

An example of a transference interpretation, from BPPPG, follows. This is from a client who presented for BPPPG and completed the full 12 sessions. The client endured a traumatic loss, of a parent, early in childhood, and this formed much of the therapeutic work. The linking of the three sides of the triangle means this is a transference interpretation because it took into account the client's past (loss of the parent), present (their debilitating gambling losses) and the relationship with the therapist (the planned end of the therapy).

Countertransference

There are times when all of us, clinicians or otherwise, feel deeply moved by an interaction with another or experience intense feelings about an other. These subjective feelings are called countertransference, in psychodynamic theory.
However, because this happens almost all the time it is useful to distinguish what we mean as countertransference, for the purposes of BPPPG.

This can be done by separating them into two distinct categories.

The first is the personal, subjective experiences which belong to the therapist and could perhaps be triggered by any number of different experiences.

For example, on first meeting a new client the therapist is strongly reminded of their own brother. Their relationship with their brother was characterised by feelings of inadequacy and conflict. The therapist then begins feeling they will be unable to help this client and reacts in a combative way to the client's suggestion that they feel unheard and the therapy progresses, if at all, in a contentious manner.

This is an example of an unresolved conflict within the therapist being permitted to enter the therapy. It is for this reason that personal psychodynamic psychotherapy is often advised while training as a therapist.

However, in this example, the therapist could react in a different way. Assuming they are relatively well adjusted and able to tolerate the anxieties and frustrations inherent in their own internal world, the therapist can choose not to act on these feelings of inadequacy and conflict. These may indeed have characterised some of their own personal relationships but because the therapists unconscious understands that of the clients (Heiman, 1950) they are able to use this material to shed some light on their client's current communications.

This second form of countertransference is what we mean by the term in BPPPG. The clinician is asked to use the feelings about the client, which naturally arise, but not act on them. The feelings should be thought about; whose are they, where do they come from, what do I know about my client which resonates with these feelings?

These questions will percolate in the mind of the therapist until they illuminate some aspect of the client which the client cannot tolerate and is unconsciously asking their therapist to know about for them.

In the same way a mother will take those feelings which her infant is unable to bear – helplessness, hunger, pain, fear of abandonment – understand them, as not her own, and translate them into comfort, food, succor and reliability.

So a therapist will recognise the feelings of inadequacy and conflict, reflect on them and return them to the client in a form they can use, and tolerate. The therapist might directly name those feelings if they feel the client has the capacity to cope with this.

If not the therapist might say something like, "perhaps you feel that I won't be able to hear you and give you what you need", or, "maybe it's difficult to imagine a relationship which doesn't feel like a contest".

In BPPPG the therapist is encouraged to dwell on their countertransference, mull it over and try to identify if it feels like a natural reaction of theirs. Ignoring the feelings we have for the client can shut down a wealth of clues and information about they are trying to tell us.

Unconscious Defences

BPPPG recognises that defences are vital to keeping us together (as discussed above, page 14). However many of the defensive structures which our clients bring to sessions are being operated at an unconscious level. That is to say, the gambler, who destroys all potential to financially support himself or his family by losing all of their money, does not consciously wish to destroy. However that is not to say that there is not an unconscious wish to destroy family as a defense against their own painful experience of what family means to them.

This example of an unconscious defence is not as uncommon as may first appear and may resonate with clinicians working with addiction.

There can be as many unconscious defences as problem gamblers themselves. What is important, for BPPPG, is that the therapist is able to recognise what is operating as a defence and find a way to make it conscious to the client.

BPPPG conceives unconscious defences like this;

- Memories and desires never go away but reside in the unconscious;
- They are hidden but active, influencing behaviour;
- Their custodians are unconscious defences;
- When the desire becomes too strong, or the memory resurfaces, the resulting tension (anxiety) is the battle between custodian and urge;
- When the urge wins we cat out (gamble);
- When the defence wins the urge seeks expression elsewhere.

If we think of gambling as the urge, BPPPG encourages the therapist to use their countertransference feelings, and what the client is telling them, to make links between the memory/desire, the gambling behaviour and the resultant anxiety.

One of the key goals of BPPPG, and psychodynamic therapy in general, is to allow the client greater access to the reasons why they gamble, without focusing too much on the gambling itself.

Unconscious defences allow the client to justify gambling to themselves. In this sense they represent a process which the client knows about but cannot think about. This is the role of the BPPPG therapist; to help the client think the unthought known (Bollas, 1986).

OTHER PSYCHODYNAMIC TREATMENTS FOR PROBLEM GAMBLERS

By far the most thoroughly researched and long running psychodynamic treatment program for problem gamblers is the UCLA Gambling Studies Program at the Semel Institute for Neuroscience and Human Behaviours, in Los Angeles.

This is run by Dr. Richard Rosenthal, a Los Angeles based psychiatrist and psychoanalyst. Dr. Rosenthal has written extensively on problem gambling and was instrumental in the inclusion of problem gambling in the DSM-IV.

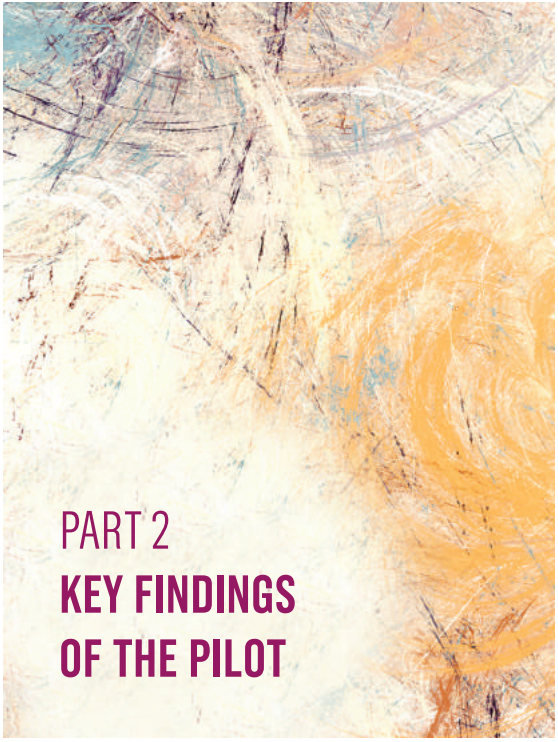
He runs one of the only residential psychodynamic treatment facilities for problem gamblers in the world. The program offers once and twice weekly short term psychodynamic psychotherapy for problem gambling over a 4-6 month period. It is well researched and the evidence suggests that the psychodynamic model works well with this cohort.

In Australia there are no known psychodynamic-only treatment services for problem gambling. In fact, despite the majority of the problem gambling case material and initial theorizing having come from early to mid-twentieth century psychodynamic clinicians, there are very few services which offer psychodynamic treatments.

This may be, in part, to the symptomatic in-fighting which characterised the various psychodynamic schools of thought, from Freud, to Klein and the British School. The perception of an elitist, intelligentsia prescribing nothing but their own mode of treatment is outdated and false.

What BPPPG suggests could not be further from this exclusive notion. The suggestion of this guide is that the clinician uses those aspects of psychodynamic psychotherapy which best fit with their training and the individual client.

The number of sessions has suggested, to us and to the clients who have completed, that this does some way to addressing the failure of problem gambling treatment services to retain clients. That is why we suggest that this is an effective component of treatment. The specific therapeutic techniques employed can be chosen from the psychodynamic ones outlined here, or in conjunction with them, others from other disciplines.



PART 2

KEY FINDINGS OF THE PILOT

ADOPTING PSYCHODYNAMIC PSYCHOTHERAPY IN PROBLEM GAMBLING COUNSELLING

As addressed, at the start of this guide, psychodynamic psychotherapy has not traditionally been the treatment of choice for problem gambling or what are termed behavioural addictions.
The clinician's experiences, and the client session evaluations, which have arisen from this project have suggested that, in fact, there is a place for this kind of work with problem gambling clients.

The purpose of this guide is not to debunk other forms of therapeutic treatment but to address the low number of sessions attended by problem gamblers.

The use of the client session evaluations has provided evidence which suggests that a relatively high number (36%) of problem gamblers are willing to remain in treatment when a clearly defined number of sessions is offered.

However, we believe that this is not the only reason for the retention rate. The specific use of some of the therapeutic tools, outlined in Part 1, have played a part also, we feel. This is clear from the fact that of the eight clients who completed the twelve sessions all were treated with psychodynamic psychotherapy. This was made clear in the ongoing clinical supervision sessions.

This is not to suggest that other factors have not played, perhaps, a significant role in the clients' experiences of being able to know more about their gambling.

There is also the issue of further testing and larger sample sizes.

A final point which needs to be raised is the issue of relevance. Psychodynamic psychotherapy, whether practiced in a set number of sessions or open-endedly, cannot be adopted by all services.

There are various reasons for this; training, conflicting models of care, agency structure and catchment/demographic or simply a therapeutic orientation which will not allow for its use.

What this guide suggests though is that aspects of psychodynamic theory can be adopted, perhaps are already being adopted, for the good of the client.

For a full analytical account of the results of the project please see the report document, which also includes the client session evaluation forms.

Clinician's Experiences of the Model

LYNNE

The project has provided a wonderful opportunity to work collaboratively in a learning environment for the benefit and best outcome of clients.

I have caused to reflect on my practice - and the impact of the therapeutic setting; on myself and the client – and the importance of the relationship between client and myself – highlighting the need for me to be aware of my own internal states so that I can convey the unknown thought – the transference/counter-transference – thus making the unknown, known.

The project has highlighted the significance for me, of developing a stronger sense of the narrative of the person and being more focused on how this reveals the early attachment experience.

Expanding upon the foregoing, the therapist needs to be receptive to the client's unconscious communication, in a way that could be considered a mimicry of that between a mother and her baby. This will generally utilise expression of the client's internal states via verbal representation - meaning the client inspires some action within the part of the therapist, which the therapist can then convey to the client; so putting things to the client in a way in which the client can relate to.

The project has allowed me to articulate various ways of working with a client, that previously have been at an intuitive level – such as developing a relationship with the client where the client feels free to entrust him/herself to (me) the therapist which means the therapist can acknowledge and work in an honest and respectful way with the client's defences.

Working in such a way sees the therapist (me) observing such defences and being able to raise them with the client, with a view to having the client explore their internal states. Assisting the client to feel 'at home' within him/herself can potentially reveal what has previously been hidden; so again, making the unknown, known.

Why Clients Have Been Excluded

A number of clients were excluded based on their state of mental health at presentation. Such mental health may have proved complex and/or requiring long-term therapy, or perhaps I was too protective of clients, which I shall speak of later. Additionally some clients were not willing to commit to weekly sessions, preferring just to see 'how things go'. This may be interpreted as clients only considering or committing to change. Ostensibly some clients may have been in a more contemplative stage – recognising the problem, but not quite ready to actually make the change.

It could be argued that in some way, clients self-excluded from the project. The notion of committing appeared difficult for some, even though they were given the opportunity to set their own end date together with the option of re-presenting, so as to continue with therapy.

Moreover some clients wished to have 3 weekly or monthly sessions, those clients generally being someone who is an affected other; with occasional clients who were highly defended, with the potential to experience difficulty in fully engaging in the process of therapy, ie. not being able to feel 'at home' within oneself.

Life events also impacted on weekly attendance, for example, clients were asked to work, felt unwell, had family matters such as pregnancies, car breakdowns, or hospitalization to attend to.

Of interest is my experience that some clients expected to be provided with a few practical strategies in the hope that they will no longer gamble. A quick fix, as it were.

Many clients are seemingly unaware that there are underlying factors that contribute to their propensity to gamble, instead expressing that gambling is just a habit.

Clients are frequently unprepared for the notion of exploring such factors and the expectation they will be doing some work in session, which means active participation - reflecting and awakening dormant parts of the self, previously locked within. This concept can be perceived, by the client, as being fraught with danger – experiencing the pain of being known.

To some degree I felt protective towards some clients, questioning whether it was wise to provide short term therapy; would the gap at ending the 12 weeks of therapy prove to be difficult in re-engaging to the same degree. Additionally, that 'inner sense' (experience) informed me that a client would not continue to engage after perhaps 3-4 sessions.

The protectiveness may have been fear projected from the client which, in hindsight, I could have used as a therapeutic tool – in the counter-transference – so raises questions, such as how the client relates to me and what feelings are triggered in me? Who am I likely to represent for the client? These could have received more of a focus when considering the client's initial narrative.

There was also a consideration of the number of new clients compared with existing clients. There were not a large number of new clients over the past 6 months, but perhaps if the project were ongoing more clients may have engaged, particularly with the current plan of raising the service profile.

How May The Project Succeed And How Could It Improve?

It's important that conversations around this modality continue, so as to build upon and share the knowledge that continues to be gleaned through working on the project.

Other counsellors could be encouraged to consider this theoretical perspective as an addition to their skill base, as well as familiarising themselves in working with a brief form of therapy.

The project can essentially be considered a work in progress with new insights being proffered through the experience of working with clients in a brief dynamic interpersonal therapy and through dialoguing during group discussion and with the consultant.

What My Difficulties Were

- Feelings of uncertainty around the project in terms of working within the framework of 12 sessions;
- Uncertainty around how to 'create' an ending;
- Clients I have deemed suitable for the project being referred at a later stage so too late for inclusion within the project.

Wonderings – What Has Surfaced?

The differences in the client groups – with Paul seeing more 'tradies' – me seeing more females and older people – is perhaps a consideration in accounting for why some people only attend 1-2 appointments.

Did the project somehow remind me of private clients having to be seen for a short period and then completed? Did I feel a pressure to work within constrained time? Perhaps more consideration needs to be given to what can be worked on within the time frame – the notion of setting the goals.

What Could Have Been Done Differently

For my part more thought needs to be put into a consideration of the tension between inviting all new clients to consider the 12 week option and allowing them to make the decision. Rather than me having 'removed it', as an option – alongside me actually making the decision as to whether a client may potentially be considered for the project.

PAUL

I have a dilemma.

So much has happened in the process of participating in this project that it feels impossible to process it all, let alone write about it. Since this was our first attempt at running such a project and time and resources were in short supply.

Much of what we learned was developed on the run although all members of the project team had some prior experience or training in psychanalytic/psychodynamic therapy. There remains for me many unanswered questions and unprocessed experiences.

This may at least in part be a counter-transference response or identification with the people I worked with, my clients. I came to see them as having been exposed to so much in their lives, particularly during important developmental years, that their ability to process these experiences became overwhelmed. I came to see this project as an attempt to create some sort of space or environment in which this impairment could start to be repaired.

It was typical of clients to be incapable of thinking between sessions, at least in the beginning.

I often asked clients in their second session whether anything had come up for them after their first; usually nothing had. It was common for clients to forget previous sessions and I also found it difficult to remember and frequently found myself feeling blank whenever I sat down to write notes.

One client returned his session rating scale every week without fail but it was never filled out. We learned that he could never remember sessions outside the room, but could always recall his last session when he arrived for his next.

It seemed he needed help to know about himself, someone who could genuinely be there for him and that this was his central complaint right through his therapy. In the beginning he thought that he would need six sessions and that this would be enough. He managed to attend eleven.

Another client reported, after several sessions, that she noticed things arising for her after each of her visits, sometimes painful things, but also sometimes things that made her feel warm and comfortable inside.

At one point I took some leave and there was a break in the therapy and she noticed that during the break nothing had arisen for her at all and this distressed her.

We came to realise that not only did she need her weekly sessions to stimulate the blocked thoughts and feelings, but that she also wanted this. She learned that she did not need to do anything in particular with these experiences other than to know about them and to ride them out. Gradually she learned that she did not need to gamble when she had feelings or thoughts that she found disturbing. Her capacity to block thoughts diminished and she grew less fearful.

I think this is how the project worked; the creation of some space with another in which to think and allow things to arise without the other becoming so disturbed by them that they had to respond defensively.

I think some clients thought that they wanted this but when they tried it they found that they didn't, and pulled out early. I think some clients thought that they didn't need this but when they tried it they found that it worked for them. And I think some clients wanted this, and could have used the space successfully, but their relationships outside of the counselling room were so disruptive that it was made impossible for them.

I learned that it was very important to attend to breaks in therapy and to create space to talk about how this may or may not be impacting on the clients work.

I learned that it was very important to talk to clients about the idea of ending, right at the

beginning and to negotiate with them how they saw their therapy progressing and then finally coming to an end.

I noticed that some clients whom I thought would choose open ended, long term therapy actually chose to work for twelve weeks, while some clients I thought would choose twelve weeks of therapy chose something more open ended.

Keeping sessions to the same day and time each week was important, even using the same room. I learned to look for the impacts that changing any of these things had and to discuss them with the client, and consider these changes as potentially important and so did they.

I learned at the start of every session to remind the client (and myself) about the session number. This avoided shocks for both of us, kept the end in mind all the time and enabled us to track the end effects of the therapy.

This usually seemed to occur somewhere around session nine. I noticed my own anxiety at approaching endings and my wonderings about whether the client would be ok after the therapy finished. I learned that this was a very useful thing to share and it seemed to give the client permission to talk about their experiences too.

At times I noticed myself feeling anxious about whether a client would attend a session. I found it was useful to raise this in some way with the client, and always found that they too had thought about not coming that day, and were grateful to have the opportunity to talk about this.

At times I found myself feeling overwhelmed by the impact of my clients. I learned that it was very useful to find a way to let them know that I knew just how much they had gone through and what they were trying to deal with. I found that I didn't need to have solutions but it was useful to make space in order to talk about what could and could not be done.

Acknowledging limits was also important.

Every client who completed twelve sessions felt like a major achievement, for them and also for me. It felt like twelve sessions was long enough to not only achieve something real but also for both client and therapist to know about what had been achieved.

Every client who completed twelve sessions experienced a reduction in the frequency and intensity of their gambling. Clients who did not complete twelve sessions may also have achieved something but it seemed harder to know. There was always a feeling of things left undone or of goals yet to be achieved and it was important to create space to talk about this.

I came to understand what a gamble it was for clients to come to therapy in the first place and how much courage it takes. It is never known from the outset whether anything will be achieved with a particular client and they often wanted reassurance that this would occur.

They often asked questions like "Have you been able to help anyone else?" or "Do you think it is possible for me too change?" While I also wanted to reassure them, I found that it could be useful to acknowledge what it took for them to come here, their fear and trepidation upon entering into an uncertain relationship that could leave them feeling worse off, better off or just the same.

For the therapist too, I think therapy is a gamble. We expose ourselves to what the client brings and we don't know in advance what exactly that might be. We don't know how we are going to be impacted by the client work or whether we will be able to manage it.

A supportive environment is vital, with appropriate calm spaces to facilitate reflection, quality supervision and a great team. It is my view that it would not be possible to do this work with high case-loads.

Like my clients I think that I have learned a lot.

How to approach endings and breaks, or rather that endings and breaks do need to be approached, especially with this client group.

In particular, I have a new appreciation of just how powerful the impacts of this client work can be on the therapist and how useful this is if it can find its way back into the therapy.

I am now talking to every client about how they would like their therapy to end and I am often doing this right near the beginning. I am continuing to offer Brief Psychodynamic Psychotherapy to my clients as an option. There are some clients whom I think would not be good candidates but I think it is a good idea to raise it with them anyway and give them the right of refusal rather than to decide on their behalf. I am still surprised by who takes it up and who does not.

Also like my clients, there are things I still need to learn. There is scope for another project after this one, and possibly another one after that. As with the client work there were things left undone or not achieved. There is more to be processed and written about than I have time for. There are things that we could have tracked but did not, people whom we could have involved in the project but were not able to.

It could be useful to develop a session rating scale or counter-transference journal for therapists.

There is more we could learn about the long term benefits (or otherwise) for those who participate and there is room to develop clearer assessment and procedural guidelines.

Using psychodynamic psychotherapy with other approaches or tools

As stated throughout this guide, and in the GHS Model of Care, the use of some of the psychodynamic interventions detailed here is not mutually exclusive with other therapeutic modalities.

As is widely recognised the most important factor in any successful therapeutic treatment is the establishment and maintenance of a working relationship. This is also the case for BPPPG. What may differ slightly with this modality is that adoption of some of the tools inherent in BPPPG, such as active use of the countertransference or recognition and work with the defences, may assist a therapist where the establishment of a working relationship has been problematic.

However BPPPG in particular, and psychodynamic psychotherapy in general can benefit greatly from the therapeutic techniques employed in ACT, Mindfulness, Attachment and Trauma based psychotherapies a many more.

In fact the key aspect pf BPPPG in which we argue its efficacy lies is borrowed from another therapeutic modality; time-limited therapy. Brief therapy originated in the 1960's and quickly established itself as a mode of therapy which could be measured, although the effectiveness of the actual mechanisms which work continue to be debated.

This guide is intended to be used in tandem with existing therapeutic practices, such as those outlined in the GHS Model of Care.

TREATMENT EVALUATIONS

The feedback tool

It will come as little surprise to clinicians that the feedback tool employed in BPPPG is based on those developed by Scott Millar in the Feedback Informed Treatment model. This was developed by Scott Miller and Barry Duncan in the US, based on research they conducted which suggested that up to 50% of psychotherapy clients drop out of treatment before an agreed ending.

In particular they found that the more traditional methods of measuring a client's level of participation in the therapy and satisfaction with the therapist were cumbersome and outdated. Consequently they developed their Outcome Rating Scale.

Based on this BPPPG has developed a more simplistic Client Session Evaluation form, below.

BENTLEIGH BAYSIDE COMMUNITY HEALTH

Gambler's Help
gamblershelp.com.au

Gambler's Help Southern
(03) 9575 5353
gamblershelpsouthern.org.au

CLIENT SESSION EVALUATION

Client Name: **Session No:** **Date:**

1. In the past week I have felt that my gambling, and thoughts about gambling, have been difficult to control.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

2. In the past week I have felt closer to my friends and family and have felt more comfortable discussing problems and things I'm worried about with them.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

3. In the past week I have felt more connected to those I work/study with.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

4. In today's session I felt my therapist and I talked about the things I felt it most important we talk about.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

5. In today's session I felt that my therapist understood me.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

6. I've been becoming more aware of why I gamble.

   1 2 3 4 5 6 7 8 9 10

   Agree **Disagree**

   Score:

The focus of the evaluation period has been kept at one week as the treatment period and frequency is based on the client attending weekly sessions. Similarly the qualitative focus has remained on the client's family and social relationships, but with questions specifically related to gambling as parentheses, at the beginning and end. There are two questions which relate to the client's experience of the therapist, but without – we believe – asking the client to directly appraise the clinician's 'performance'.

How to use the feedback tool

The issue of how and when to use feedback tools in psychotherapy has been a hotly debated topic (see Robinson, 2009, Slade, Lambert, Harmon, Smart, Bailey, 2008, et al). Most of the evidence

seems to suggest (Duncan & Miller, 2015), however, that the person of the therapist is key to the success of the therapy.

With this in mind BPPPG will not prescribe a method for the use of the Client Session Evaluation tool, only that it is used.

In the course of the pilot the three participating therapists used the tool in different ways; asking the client to complete at the start of the session, at the end of the session, taking it home and returning the tool at the next session etc.

What has been key to the use of the tool has been the individual therapist making a clinical decision about how to ask the client to complete the tool (or even if to ask at that particular time). When asking the client to take the tool away and return at the start of the next session further client questions emerged. Do I return it to you? Do I return it in an envelope? If so, do I seal the envelope? Can I complete in front of you?

In all of these examples the focus on the psychodynamic specificity must be kept. This means that because it seems that almost of the client questions which arise here are around thoughts or feelings about what the therapist will think of them, this needs to be attended to.

This is where a less psychodynamic and more behavioural approach may differ. Even in the collection of the feedback the therapist is encouraged to think about their role in the process. When the client asks "Do I return it to you?" or "Can I complete it in front of you" they are implicitly asking about the nature and quality of the therapeutic relationship. "What will you think of me?" is perhaps what the client is asking.

In attending to these unconscious, or barely conscious, fantasies of what others think of them, and how their therapist might feel about them, the BPPPG therapist is allowing for unconscious communication with the client to be possible.

What does the feedback tell us?

As mentioned above, the project report outlines the formal evaluation. Based on the completion rate of participants (36%) we believe that this compares favourably to the statewide rate of completion of treatment across Gamblers Help providers (although data for this is yet to be made available). This represents a significant step if, as we believe, more participants in BPPPG complete their treatment than for standard, open-ended treatment.

The feedback also tells us that participants in BPPPG report increases in work and social connectedness, thoughts about their gambling and an appreciation of the reasons why they gamble.

There was also a gradual increase in client's feeling understood by their therapist and believing that they addressed the issues they wanted to address in the sessions.

We would suggest that if clients believe they addressed what they wanted to in session, and there was a marked increase in their understanding of the reasons why they gamble, there would appear to be a link between the two. This would lend credence to the principle of psychodynamic work in general, but BPPPG in particular, that there is an 'unthought known'; unconscious factors at work which, at the start of therapy, the client is not able to know about but, through the course of having their specifically identified issues attended to throughout the therapy they are able to know about in time.

This has been the experience of the therapists involved in the pilot and this is substantiated in the empirical evidence and also in the anecdotal evidence.

Another issue of note in the feedback is the is the seemingly direct relationship between use of the feedback tool and engagement in the therapy. All eight clients who completed their twelve sessions of treatment completed more feedback tools than the others.

Clients who completed the most feedback tools preferred to do them away from the session and return them in the next session. These clients also exhibited almost a sense of pride and ownership about 'their' feedback tools.

They described them in the following ways;

- "important"
- "helpful for me to track things"
- "I mustn't forget it"
- "simple and useful"

In those who completed there was little sense that clients felt inhibited by the use of the tool. In those who did not complete, even those who only attended a handful of sessions, there was a much lower level of commitment to using the forms, or even offering feedback about the forms.

There was one instance of a client who reported that she felt uncomfortable using the form and did not want to.

We believe that this suggests, perhaps, something which we may already have known; that client engagement in therapy is dependent on the particular therapist, how comfortable they are with different types of intervention and the relationship they have developed with the client.

If this is the case then why use the feedback tools?

We suggest that with such a low number of clients directly reporting negative reactions to the use of the tools and with a, relatively, high number of clients using them effectively, it can be argued that the tools do less harm than good.

As this corresponds to our model of care we believe that if we are to continue to offer BPPPG we will continue to use the feedback tools.

What have we learned?

The other issue which needs to be addressed is the small sample size used in this project. Although proportionately we believe BPPPG has enjoyed some success we are realistic in this appraisal and also suggest that this is only the beginning.

The modality requires significantly more testing with larger sample sizes and with different demographics of gamblers.

The issue of demographics is another learning from the pilot.

Our experience has been that in those areas where there has been a high reporting of non-attendance, or attendance at one session (for example, the more remote areas of the Mornington Peninsula), BPPPG works better.

With clients over the age of fifty-five BPPPG also seems to work better. But with couples and affected others there is little evidence to suggest any effectiveness for BPPPG.

This in itself could inform an entire research project but this is obviously not our intention, due to a scarcity of immediate resources.

However we believe that other Gamblers Help providers could draw further learnings from the use of BPPPG, due to the differing demographics each work with.

A mention must also be made of gaming and "problem gaming". This was a target demographic at the start of the pilot. No gaming clients have agreed to participate in BPPPG. Three were invited and all declined. Again the issue of sample size prevents any clear conclusions being drawn from this but we would suggest that the age of the cohort – all under the age of 20 – seemed to reduce their suitability for the pilot. All three stated that it was precisely because they were asked to commit for twelve sessions that they felt "overwhelmed" and put off.

The final point to note is how BPPPG has impacted on the GHS clinicians who participated (please see Clinicians Experiences, above). The most reported reaction to the pilot has been the capacity for BPPPG to open up the clinician to understanding their own response to their client, their countertransference.

We believe that this is a commonly ignored aspect of not only problem gambling counselling but of the counselling and helping professions in general. The widespread therapist burnout, which

is commonly reported but very seldom addressed, appears to be a symptom of a profession which offers substantial care, hope and empathy for its service users, but little, if any, to its practitioners.

BPPPG seems to allow for difficult feelings about our clients to not only be acknowledged but worked with and made part of the therapy. The expectation that we will 'like' every client we have and so want to do all we can to help them because of that, is naïve, at best, and dangerous, at worst.

The experience of BPPPG has allowed the participating therapists to see their clients as human, not as a conflation of pathologies or a problem gambling conundrum to be undone. Nor are we suggesting that this is how any therapist who has not experienced BPPPG sees their clients but perhaps as we all do, with any client, from time to time.

The development of empathy is therefore vital for any counsellor but perhaps the focus on empathy which only sees the positive aspects which can be attended to is misleading. Perhaps the development of empathy which also acknowledges the unwanted, ugly, destructive aspects, of the client and the therapist, is important too as it can drive honest engagement and preempt authentic response.

Isn't this why people come to therapy and why therapists train?

PART 3
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