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What are Critical Gambling Studies?

A Critical Review of the Scholarly Discourse on Gambling Disorder Treatment: Part 1

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Abstract: This article presents a comprehensive review of the scholarly discourse on psychological and relational approaches to gambling disorder treatment. The article focuses on the "what" of knowledge production and treatment delivery by systematizing information on the types of scholarly articles that have been published in the English language; the treatment approaches that have been researched and discussed in the Anglophone literature; and the context of knowledge production over the past 50 years. The review includes 445 articles that present the findings of case studies and evaluations of disordered gambling interventions (k = 231), descriptive research (k = 49), meta-analyses (k = 10), and literature reviews and descriptions of novel approaches (k = 155). The findings show that Cognitive Behavioral Therapy (CBT), together with its constituent approaches, was the most discussed and researched approach to gambling disorder treatment in the period between late 1960s and the first half of 2019, covered by about 60% of the articles. Motivational Interviewing approaches were discussed in over one-fifth of the articles, whereas psychoanalytic and psychodynamic approaches accounted for under 10% of the articles. Roughly three-quarters of articles included in the review were published in North American and international journals. Our discussion situates these trends in critical discourses of the medicalization of mental health, dominance of Western mental health frameworks, and the politics of knowledge production.

Keywords: Gambling disorder treatment, problem gambling treatment, disordered gambling treatment

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Introduction

The literature on psychological and relational approaches to gambling disorder treatment has grown significantly over the past 50 years, particularly once pathological gambling was included in the psychiatric nomenclature in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in the 1980s (Hayer et al., 2018; Shaffer et al., 2006; Shaffer & Martin, 2011). This growing body of knowledge reflects the emergence of gambling disorder (GD) treatment as a professional field, committed to developing and delivering specialized care. Professional discourses on disordered gambling have become increasingly medicalized over time, as reflected by what is accepted as credible evidence of effective treatment (e.g., case studies vs. randomized controlled trials) and standards for how knowledge is produced and disseminated. These trends have favored those in more powerful countries and positions with greater resources in the creation and reification of what is considered "best practices" (Shaffer et al., 2006).

In this article, we present a comprehensive review of the scholarly discourse on psychological and relational approaches to GD treatment. Our goal is not to quantify treatment effects (as is the case in meta-analyses), to summarize the evidence, or to synthesize the knowledge on gambling disorder treatment; rather, our goal is to characterize the scholarly discourse on GD treatment. Using a broad lens, we include in our study not only evaluation research but also literature reviews and descriptions of new treatment approaches, which allows for a well-rounded characterization of the Anglophone, peer-reviewed literature over the past 50 years.

We reviewed this body of literature to answer the following questions: What is the trajectory of the scholarly literature on psychological and relational approaches to GD treatment? What treatment

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approaches have been privileged? And how and where has knowledge that has been accepted for publication been produced? Answers to these questions provide the basis for our discussion, which examines the politics of knowledge production and dissemination in gambling treatment research and literature.

Related Literature Reviews

In 2013 the term *pathological gambling* was replaced with the term *gambling disorder* in the DSM-5. In this article, we use *gambling disorder* to refer to what has been variously labeled across the literature as pathological gambling, problem gambling, or disordered gambling (APA, 2013). We recognize that those who gamble problematically, and some who seek treatment, may not meet DSM-5 criteria for GD; however, this distinction is not consistently made in the literature, and therefore, not emphasized in this research.

In our review of the literature, we found no studies that focused specifically on the scholarly discourse of psychological and relational approaches to GD treatment; in other words, there were no studies of the broad strokes of what has been published on the topic of GD across time and place. Studies of discourse trends can be found, however, related to various treatment topics across mental health disciplines (e.g., McDowell & Jeris, 2004; Kosutic & McDowell, 2008).

While not directed at capturing treatment discourse per se, systemic reviews and meta-analyses of GD treatment reflect important trends in the field. For example, Cowlishaw and colleagues (2012) conducted a systemic review and meta-analysis of randomized controlled trials of psychological therapies to investigate the effectiveness of Cognitive Behavior Therapy (CBT), Motivational Interviewing (MI), integrative therapies, and other psychological therapies to determine their efficacy and durability of therapy effects in relation to control conditions. Searching for studies published from 1980 onwards, Cowlishaw and colleagues identified and reviewed fourteen studies, which were published between 1983 and 2011. Nine studies found that CBT interventions had beneficial effects in reducing gambling symptom severity, financial losses from gambling, and the frequency in gambling behavior, 0 to 3 months post-treatment. Three studies of MI therapy found some benefits in reducing gambling frequency; however, more studies were needed to draw more definite conclusions. Two studies looked at integrative treatment approaches (motivational enhancement therapy and a condensed CBT approach), and one study investigated other psychological therapies (Twelve-Step Facilitated Group Therapy), though there was insufficient data to evaluate treatment effectiveness. The authors concluded that their investigation provided support for CBT's effectiveness in reducing gambling behaviors and other symptoms related to gambling, immediately following therapy, though the durability of these therapeutic gains remains unknown.

Hoping to shed more light on the efficacy of disordered gambling treatments, Petry and colleagues (2017) completed a systematic review of randomized controlled trials for treatments of problem gambling. Twenty-one studies, published between 2001 and 2016, met inclusion criteria. Eleven of the 21 studies evaluated interventions that used multisession, in-person therapy that included CBT, MI, or a combination of both. The ten remaining studies employed one or fewer in-person sessions, using workbooks with cognitive and behavioral (CB) exercises alone or with MI and brief personalized feedback interventions. The authors concluded that while no single treatment was empirically validated for GD treatment, CB interventions had the greatest evidence of efficacy, regardless of the number of sessions or the use of self-directed approaches. Of the two studies that used stand-alone MI interventions, there was little evidence of reductions in gambling, highlighting a need to integrate CB interventions with these methods. Brief personalized feedback interventions demonstrated some benefits, but did not outperform control conditions of CB treatments. They concluded that brief interventions were most appropriate for individuals not seeking formalized gambling treatment and college students. The authors also found that measures used to assess gambling outcomes varied, making cross-study comparisons difficult. They concluded that the problem gambling field would benefit from agreeing on a single or composite index of improved outcomes.

Following this recommendation, Pickering and colleagues (2018) conducted a systematic, narrative review to identify the range of outcome variables and indices of recovery used to evaluate treatments. A search of six databases yielded 34 psychological and pharmacological treatment studies, with publications ranging from 2006 to 2019. Of the 34 articles, 25 utilized gambling-specific measures (e.g., gambling pathology and severity) and 36 non-gambling specific measures (e.g., depression, anxiety, wellbeing). The authors argued for a multi-dimensional conceptualization of recovery to be incorporated into a single, comprehensive measure to ensure uniform reporting across studies.

Maynard and colleagues (2018) completed a meta-analysis of studies with publications ranging from 1980 to 2014 on mindfulness-based interventions for gambling behavior and symptoms, gambling urges, and financial outcomes. After conducting a systematic review for interventions used for either problem or pathological gambling clients, thirteen studies met inclusion criteria. The criteria for articles for the meta-analysis included randomized or quasi-experimental designs in testing the effectiveness of mindfulness interventions. The authors found that mindfulness-based interventions including present-moment work, meditation, and relaxation skills, had positive and

significant effects on gambling behaviors and symptoms, providing building support in the utility of mindfulness-based interventions for GD.

Challet-Bouju and colleagues (2017) conducted two systematic reviews on cognitive remediation (CR) interventions with the first exploring the potential neurocognitive targets of CR interventions and the second looking at the efficacy of CR interventions for GD. The first systematic review yielded 50 studies, published from 1995 to 2006 and concluded that CR interventions for disordered gambling should focus on altering the triadic impulsive-reflective-interoceptive neurocognitive systems. The second systematic review yielded only one study that met eligibility; thus, no firm conclusions could be drawn. The authors argued that CR showed positive efficacy in working with other addictive disorders and that more research for CR interventions is needed for treating disordered gambling.

Positioning Ourselves

The research team and authors of this paper include scholars and practitioners from the fields of Counseling, Family Studies, and Marriage and Family Therapy. One of us was born and raised in Southeastern Europe and the other two grew up in the United States of America (USA). We share a commitment to social equity in mental and relational health. Our interests in gambling treatment literature emerged through clinical work and workforce development in this area.

Methods

We completed a comprehensive systematic review to identify published literature on psychological and relational approaches to GD treatment. We located peer-reviewed articles from (a) a systematic search of electronic databases and (b) hand searches of select peer-reviewed journals and reference sections of scoping literature reviews. We first searched electronic databases in May 2019 for articles published through April 2019. We conducted a second search of electronic databases in August 2019 for articles published between January and June of 2019. Our search strategy was developed in consultation with university research librarians and having reviewed previously published scoping reviews of the literature on disordered gambling (i.e., Maynard et al., 2018; Rodda et al., 2018; van der Maas et al., 2019). The following six electronic databases were searched: PsychNet, PubMed, SocINDEX, Psych and Behavioral Sciences (through Ebsco), Social Science Citation Index, and Academic Search Premier. Pre-defined terms related to gambling and treatment were used to locate the articles: (problem* OR pathology* OR disorder*) AND gambl* AND (treatment* OR intervention* OR program*OR outcome* OR evaluation* OR provider). The results of the searches were exported to SPSS software and duplicate records were identified using a combination of automated searches and manual reviews.

Following a removal of duplicate records, the dataset containing bibliographic information and abstracts was exported to Microsoft Excel, and titles and abstracts were screened for relevance. Two reviewers checked each record and then convened to compare their decisions, with a third reviewer weighing in on disparate codes. Records were coded as "not relevant" if they covered obviously unrelated topics such as oral health and medicine; if they centered on gaming and other behavioral addictions; and if they focused on pharmacological treatment of problem gambling without a psychological or relational component. In the next step, full text was obtained for articles that were coded as potentially relevant; each of these articles was reviewed and independently screened for relevance by at least two reviewers. Separately-reached screening decisions were compared and discrepancies were resolved through discussion until consensus was reached. Articles were coded as relevant for this review if they were published in the English language and if they involved literature reviews, descriptions of new approaches, meta-analyses, evaluation research, case studies, and descriptive research pertaining to psychological and relational treatment of problem gambling. Articles were excluded if they described prevention interventions; public health interventions; study protocols; instrument development research; prevalence research; methodological research; descriptive research without a section on implications for treatment; interventions that involved pharmacological treatment without a psychological component; interventions completed in samples that did not include problem gamblers; and commentaries, errata, and book reviews.

We then developed a coding sheet in a sample of ten articles and tested it in a separate sample of ten articles. Discrepancies in coding decisions were discussed by all members of the team, and the resulting decisions were used to make adjustments to the coding sheet. Following an additional test run, we finalized the coding sheet to include fields pertaining to bibliographic information; article type (see Table 2); treatment model (see Table 3); and sample description for evaluation research (country of the target population and listing of the country in article abstract).

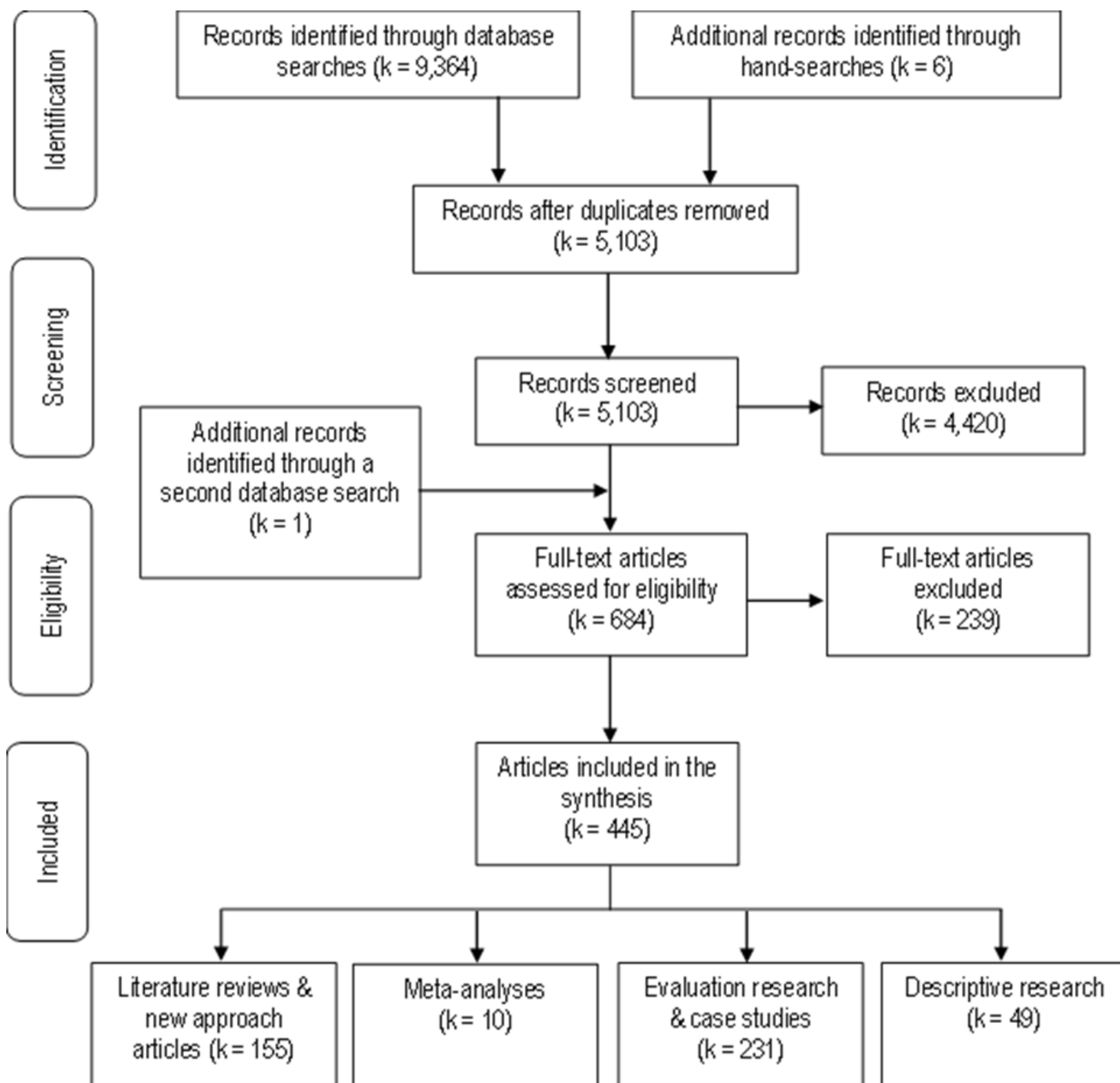
The remaining articles were split up and coded by two reviewers, who frequently conferred with each other about the coding process. Additionally, after each set of 100 independently-coded articles, the two reviewers double-coded ten articles and compared their codes in an effort to prevent drift and to maintain consistency in coding decisions. Toward the conclusion of the coding process, we decided to add several new fields (variables) to the coding sheet. All three of us coded the additional fields, while also checking the extant fields and raising for discussion any questionable codes. Differences in opinion were resolved through a joint review of full text. Lastly, one member of our team consulted journal websites and reviewed scope, aims,

and editorial board descriptions to retrieve information on professional audience (gambling treatment providers, addiction specialists, family therapists, psychologists, psychiatrists, social workers, health care providers, mental health professionals not specified, multidisciplinary, and other); part of the world in which a journal was based (US/Canada, Australia/New Zealand, UK, Europe, International, and other); and the year in which a journal was started. Codings of all articles were stored in an electronic database, and data analyses were conducted using SPSS Version 25.0 (IBM Corp, 2017). There was no funding for this systematic review.

Results

A visual depiction of the search and selection process is presented in Figure 1. Electronic database searches resulted in 9,364 records. Additionally, six articles were identified through hand searches of journals and reference sections of scoping literature reviews. An identification of duplicate entries resulted in a removal of 4267 records. The remaining 5,103 records were screened for relevance based on titles and abstracts. Full text was retrieved for 684 articles that were marked as potentially relevant, and full text reviews resulted in a removal of 239 articles, including one article that was withdrawn but remains indexed in electronic databases. The final sample included 445 articles, 231 of which were case studies and evaluations of gambling disorder treatment interventions; 49 of which were descriptive research studies with subsections on implications for disordered gambling treatment; 10 of which were meta-analyses; and 155 of which were literature reviews and descriptions of new approaches.

Figure 1. Process for Determining Articles for Inclusion



Literature Development Over Time

Peer-reviewed, anglophone literature on disordered gambling treatment was characterized by a marked increase in publications over a 50-year period under study. Following a slow start in the 1960s and 1970s, the number of articles grew sharply in the late 1980s and remained steady in the 1990s at an average of about 24 articles per each five-year period. This number nearly doubled to 42 articles in the early 2000s, and doubled again to 99 articles in the period between 2005 and 2009. Following a small decline in the subsequent five-year period (i.e., between 2010 and 2014), the number of articles increased 30% in the period between 2015 and the first half of 2019, during which 129 articles on GD treatment were published.

As with articles, the number of journals containing titles on gambling disorder treatment increased significantly during the period under study. Starting with only four journals in the late 1960s, the number of journals grew steadily, reaching a plateau of about 58-59 journals per each five-year period between 2010 and the first half of 2019.

A broader lens punctuates the turn of the 21st century as a period of marked growth. Between the 1960s and 1999, a total of 85 articles were published in the English language across 39 journals. The number of both articles and journals nearly doubled in the first decade of the 21st century to 141 articles across 70 journals. Despite a slowdown in growth in the subsequent decade, increases in the number of both articles and journals continued. Namely, the number of articles rose over 50% and the number of journals rose over 40% in the period between 2010 and the first half of 2019.

Knowledge Production: World Regions and Target Audiences

Over half of articles on disordered gambling treatment (54%) were published in North American journals and a quarter (25%) were published in international journals. The remaining articles were published in journals based in the United Kingdom (6.5%), other European countries (6.7%), Australia and New Zealand (5.6%), and other parts of the world (2.2%). Close to a third of articles were published in journals whose target audience was gambling treatment providers (32%); this was followed by psychologists (16%), multidisciplinary audiences (15%), psychiatrists (14%), mental health professionals (11%), health care providers (5%), and other professionals (7%) such as addiction specialists, family therapists, family counselors, social workers, and hypnotists.

During the 50-year period under study, 445 articles on disordered gambling treatment were published across 163 journals. A listing of journals that included at least ten titles on gambling disorder treatment is presented in Table 1. Together, these seven journals published over 40% of articles in this study. What is more, one of them—*Journal of Gambling Studies* (formerly known as *Journal of Gambling Behavior*)—published close to a quarter of all articles. The six other journals listed in Table 1 published anywhere between 2.2% and 4.9% of articles each. Two additional considerations about journals are worth noting. First, all but one journal showed growth over time in the number of articles they published on GD treatment. Second, three of the seven journals listed in Table 1 were relatively new, having been established in the early 2000s

Table 1. Count of Articles over Time: By Journal (k = 445)

	Year Started	Article Count by Decade					Total	
		1966-1979	1980-1989	1990-1999	2000-2009	2010-2019	*k*	%
Journal of Gambling Studies	1985	–	15	22	27	36	100	22.5
International Journal of Mental Health and Addiction	2006	–	–	–	7	15	22	4.9
International Gambling Studies	2001	–	–	–	5	13	18	4.0
Journal of Gambling Issues	2000	–	–	–	5	10	15	3.4
Addictive Behaviors	1975	–	–	1	2	7	10	2.2
Journal of Consulting and Clinical Psychology	1937	–	–	1	6	3	10	2.2
Psychology of Addictive Behaviors	1987	–	–	–	4	6	10	2.2

Article Characteristics Over Time

Over half of articles under review (51.9%) were evaluation studies. This included randomized controlled trials (RCTs), quasi-experimental studies, outcome evaluations without a comparison group, process evaluations, and case studies. The remaining articles included descriptive studies with explicitly articulated, and labeled, implications for disordered gambling treatment, meta-analyses, literature reviews, and descriptions of new approaches to gambling disorder treatment. There was growth over time in all but one of these article types. Namely, articles describing new treatment approaches increased each decade through 2009, followed by a decline in the second decade of the 21st century. By contrast, articles describing outcome evaluations without a comparison group nearly tripled and RCTs almost doubled over the last two decades. Lastly, it is worth noting that, as evidence from evaluations with a comparison group started to accumulate, initial meta-analyses on disordered gambling treatment were published at the turn of the 21st century.

Treatment Approaches Over Time

While the number of published articles on disordered gambling treatment has increased substantially over time, growth has been largely limited to describing and evaluating a few related approaches: CBT, cognitive therapy (CT), behavioral therapy (BT), and motivational interviewing and motivational enhancement therapy (MI/MET). CBT was, by far, the most commonly-discussed approach, with mention in close to half (45%) of all articles. CBT emerged in the 1990s and quickly established a strong footing in the GD treatment literature. Its share of over one-fifth of articles in the 1990s more than doubled to over half (53%) of all articles published in the 2000s and 2010s.

Either CBT or its constituent components—Cognitive Therapy (CT) and Behavioral Therapy (BT)—were discussed in over 60% of articles published during the 50-year period under study. As stand-alone approaches, however, CT and BT were considerably less well represented in the literature. Namely, CT was discussed in 13% and BT in 24% of all articles. CT emerged at around the same time as CBT and initially occupied a slightly larger proportion of the literature than CBT (26% vs. 22%, respectively). Over time, however, CT declined in prominence and was significantly outpaced by CBT. In the 2000s, CT was discussed in 18% of articles, and in the 2010s, in 10% of articles.

BT—broadly defined to include any approaches so labeled, stimulus control and in vivo exposure interventions, aversion therapy, and imaginal desensitization—was present in some of the earliest literature on disordered gambling treatment, dating back to the 1960s. As the literature expanded in the 1980s, so did interest in BT, with coverage in close to one-third (31%) of articles. BT's share of the literature grew in the 1990s, followed by a sharp decline in the subsequent decades. Fewer than one-quarter (23%) of articles in the 2000s and under 20% of articles in the 2010s discussed BT.

MI/MET have been reviewed or studied in conjunction with other treatment approaches, most notably CBT, CT, and BT; as stand-alone approaches to GD treatment; and, as both adjunctive and stand-alone treatments. What is more, over 80% of articles that discussed MI/MET also included CBT, CT, or BT. MI/MET was introduced to the literature on gambling disorder treatment in the late 1990s, and it continued expanding its reach over time. Over one-fifth (23%) of articles between 2000 and 2009 and nearly three out of ten (29%) articles published between 2010 and the first half of 2019 discussed MI/MET.

Like MI/MET, mindfulness approaches have been studied both in conjunction with CBT, CT, and BT and as stand-alone treatments). And, as with MI/MET, there was considerable overlap between articles that discussed mindfulness and those that discussed CBT, CT, and BT. Namely, all but one article on mindfulness in GD treatment also covered CBT, CT, or BT. As newcomers to the field of gambling disorder treatment, mindfulness and the associated approaches—namely, dialectical behavior therapy (DBT) and acceptance commitment therapy (ACT; de Lisle et al., 2012)—occupied a small share of the literature, with twelve, five, and five articles, respectively. That said, each of these approaches has shown potential in initial outcome research.

Congruence couple therapy (CCT) and community reinforcement and family training (CRAFT) are two other newcomers to the field, having been introduced to the literature in the 2000s. Unlike most other approaches to GD treatment, CCT and CRAFT include concerned significant others in case conceptualization and interventions. Although they had a relatively small presence in the literature during the period under study—with eight and five articles, respectively—these approaches promised to take the field of gambling disorder treatment in new directions. In contrast, representatives of a longstanding tradition to treatment are psychoanalytic and psychodynamic approaches, which have had a small but consistent showing in the literature since the 1960s. Following an uptake of interest in the 1980s and the 1990s, these approaches have declined in prominence, with coverage in fewer than 5% of articles in the 2010s.

Lastly, several other professionally-delivered treatments were discussed in the literature. Some of these include reflective team couples therapy (Garrido-Fernández et al., 2011), Seeking Safety Therapy for gambling disorder and PTSD (Najavits et al., 2013), *Ngā Pou Wāhine* intervention (Morrison & Wilson, 2015), and *Let's Talk About Children* intervention (von Doussa et al., 2017). Additionally, it is important to acknowledge

twelve-step approaches, which have had a small but steady presence in the literature since the 1980s. Close to one-fifth (19%) of all articles on gambling disorder treatment included mention of twelve-step programs, in conjunction with professionally-delivered treatments, as stand-alone approaches, or both.

Treatment Approaches in Evaluation Research

CBT was the most common approach in evaluation research, included in close to half of all evaluation studies, and notably, over half of RCTs, quasi-experimental studies, and outcome evaluations. Next in frequency were motivational approaches, which were studied in over one-third of RCTs, one-fifth of quasi-experimental studies, and over 10% of outcome evaluations. Other commonly studied approaches included BT, which accounted for one-fifth (20%) of evaluation studies, and CT, which was studied in 8% of evaluation studies. The remaining approaches (i.e., mindfulness, DBT, ACT, CCT, CRAFT, and psychoanalytic and psychodynamic approaches) were studied in fewer than 5% of evaluation research articles, as Table 2 shows. Notably, three of the four commonly studied approaches—that is, CBT, BT, and MI/MET—saw growth over time in the number of research articles (Figure 2). CT, by contrast, remained stagnant, with an average of six research articles per decade

Figure 2. Count of Evaluation Research Articles Over Time: By Select Treatment Approaches

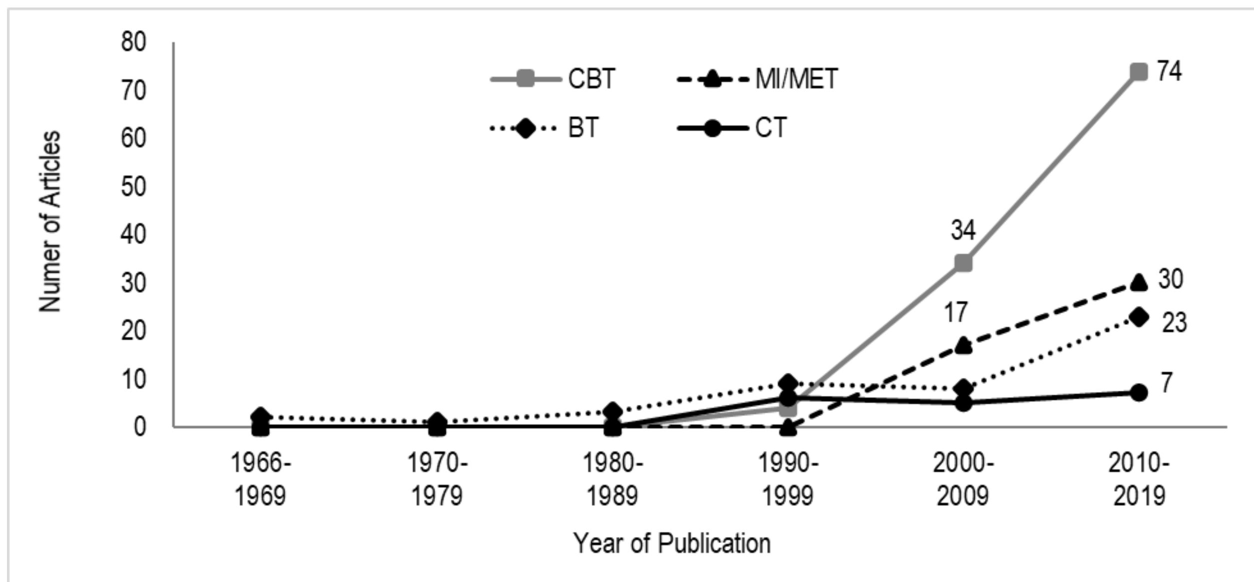


Table 2. Count of Evaluation Research Articles: By Treatment Approach and by Evaluation Design (k=231)

	Article Count by Research Design					Total	
	RCT	Quasi-Exper.	Outcome Eval.	Process Eval.	Case Study	*k*	%
CBT	38	10	45	4	15	112	48.5
CT	8	1	3	1	5	18	7.8
BT	14	2	15	4	11	46	19.9
MI/MET	26	4	11	2	4	47	20.3
MIND	2	0	2	0	3	7	3.0
DBT	1	0	1	0	0	2	0.9
ACT	1	0	1	0	0	2	0.9
CCT	1	0	1	2	0	4	1.7
CRAFT	3	0	0	0	0	3	1.3
PSYANAL	0	0	0	0	1	1	0.4
Other	25	8	32	16	13	94	40.7
Total*	70	18	85	23	35	231	100.0

Note: CBT = cognitive behavioral therapy; BT = behavioral therapy; CT = cognitive therapy; MI/MET = motivational interviewing/ motivational enhancement therapy; MIND = mindfulness-based therapy; DBT = dialectical behavior therapy; ACT = acceptance commitment therapy; CCT = congruence couple therapy; CRAFT = community reinforcement and family training. PSYANAL = psychoanalytic and psychodynamic approaches. Other = other approaches, eclectic approaches, and not specified approaches. RCT = randomized-controlled trial; Quasi-exper. = quasi-experimental evaluation design; outcome eval. = outcome evaluation without a comparison group; process eval. = process evaluation; case study = single or multiple case studies. *Columns do not add up to totals because a number of articles discussed or studied multiple treatment approaches.

Countries in Evaluation Research

Participants from Australia, Canada, and the USA were best represented in evaluation research, with inclusion in close to one-fifth of evaluation research articles each. Additionally, Spain (8%) and the Nordic countries (6%) were relatively well represented, whereas participants from Asian countries, Germany, United Kingdom, New Zealand, and other countries were included in under 5% of evaluation research articles. The country of the target population was not specified in over 10% of articles. It is also interesting to note that the country was specified in the abstracts of a large majority of studies from Asian countries and New Zealand; about half of studies from Australia; and close to 40% of studies from the Nordic countries and Germany. In contrast, the country was specified in under one-third of abstracts from the United Kingdom, fewer than one-fifth of abstracts from Canada and the United States, and under 5% of abstracts from Spain.

Table 3 shows the distribution of evaluation research articles by the country of the target population and four of the most discussed treatment approaches (i.e., CBT, BT, CT, and MI/MET). Over one-fifth of studies of CBT were conducted with samples from Canada. This was followed by the USA, Australia, Spain, and Nordic countries; the remaining countries comprised fewer than 5% of articles on CBT. CT and BT were studied most in samples of participants from Australia and Canada. Lastly, most studies of motivational approaches were conducted with samples from the United States, followed by Canada and the Nordic countries.

Table 3. Count of Evaluation Research Articles: By Country of Target Population and by Treatment Approach (k = 231)

	CBT		CT		BT		MI/MET	
	k	%	*k*	%	*k*	%	*k*	%
Australia	18	16.1	4	22.2	16	34.8	2	4.3
Canada	23	20.5	3	16.7	7	15.2	12	25.5
United States	21	18.8	2	11.1	4	8.7	17	36.2
Spain	16	14.3	1	5.5	5	10.9	3	6.4
Nordic countries	9	8.0	0	--	1	2.2	6	12.8
Asian countries	5	4.5	0	--	1	2.2	0	--
Germany	3	2.7	1	5.5	1	2.2	0	--
United Kingdom	3	2.7	1	5.5	1	2.2	0	--
New Zealand	1	0.9	0	--	0	--	1	2.1
Other countries	3	2.7	1	5.5	2	4.3	1	2.1
Country not specified	10	8.9	5	27.8	8	17.4	5	10.6
Total	112	100.0	18	100.0	46	100.0	47	100.0

Note: CBT = cognitive behavioral therapy; BT = behavioral therapy; CT = cognitive therapy; MI/MET = motivational interviewing/motivational enhancement therapy.

Discussion

The systematic evaluation of models used in GD treatment is to be applauded. Rigorous appraisal of outcomes helps ensure the field moves toward establishing best practices. There are, however, some potential unintended consequences of this focus, particularly when it is limited to describing and evaluating a narrow set of related approaches. As noted by Brophy and Savy (2011), modernist, manualized approaches can be "at odds with the professional needs of mental health workers…given the messiness and uncertainties inherent in working with service users whose individual problems require flexible approaches tailored from a broad and evolving practice-base" (p. 229). Evidence-based practices that are demonstrated as effective via RCTs remain the gold standard regardless of critiques of their design and/or suggestions that the use of a medical model is reductive and misplaced in the practice of psychotherapy (McPherson et al., 2020; Tasca et al., 2018).

CBT and related treatments (i.e., BT and CT) proved to be most frequently studied followed by MI/MET and mindfulness approaches that are stand-alone or integrated into other treatment models. This trend is in keeping with the promise of CBT as an effective approach to treating gambling disorder (Abbott, 2019). At the same time, CBT may be limited as a stand-alone treatment that can meet all of the complex needs of those in GD treatment. CBT's straight-forward theoretical framework, targeted goals, well-developed interventions, and manualized treatment protocols lend themselves well to systematic evaluation and randomized controlled trials. This may skew the investigation of what works toward CBT in an era in which claims of treatment effectiveness must be scientifically substantiated (Rasmusen, 2018). The concern is not about the use of CBT in gambling disorder treatment. Rather it is about the relative absence of other models in the evaluation literature and the lack of new and innovative approaches. One of the standout exceptions to this is the development and systematic evaluation of CCT as a systemic treatment for gambling disorder (Lee & Awosoga, 2015). Other exceptions include research on the use in GD treatment of DBT (Christensen et al., 2013), ACT (Nastally & Dixon, 2012) and CRAFT (Nayoski & Hodgins, 2016). While DBT and ACT are considered third wave CBT, this was a common distinction found in the literature as a means to differentiate the mindfulness aspects of those treatment modalities. An additional concern about the potential over reliance on evidence-based models is that including only what has and/or can be scientifically evaluated fails to capture the wisdom or "evidence" gathered in everyday clinical and healing practices around the globe (Brophy & Savy, 2011). Likewise, the definition and measurement of treatment outcomes varies considerably across studies (Pickering et al., 2018) and the literature lacks a clear, systematic focus on harm reduction versus abstinence.

It is important to notice what is missing in the literature on GD treatment. Notably, while there is increasing attention to diversity (Abbott, 2019),

culturally responsive disordered gambling treatment appears to be lagging compared to the more robust focus on culture, diversity, and equity in related disciplines (e.g., social work, marriage and family therapy, counseling). This review revealed some recent literature that focused on sociocultural factors (Richard et al., 2017), treatment for culturally diverse older adults (Luo & Ferguson, 2017), and the cultural adaption of CBT (Okuda et al., 2009). Several articles targeted treatment of specific populations, noting how these populations differ from Western groups, such as; Chinese in Hong Kong (Wong et al., 2015), Arab Australians (Mazbouh-Moussa & Ohtsuka, 2017), Asian Americans (Fong & Tsuan, 2007; Kim, 2012), Chinese Canadians (Papineau, 2005), Greek and Vietnamese Australians (Chui & O'Connor, 2006), and Asians (Raylu et al., 2013). These authors collectively argued the importance, when relying on Western designed treatments, of tailoring their fit for non-Western clients. It is perhaps self-evident that effective treatment of GD worldwide requires culturally appropriate treatments to emerge from around the globe. The most striking example of developing a non-Western, culturally centered approach in this review was an article on the development and implementation of a Māori culturally-based approach to the treatment of disordered gambling (Morrison & Wilson, 2015).

The dominance of Western-based treatments is also reflected by which countries are represented in the literature. This review is skewed by the fact that only articles written in English were included; however, there is a preponderance of evidence that most of the literature on GD treatment has originated in the Western world. Again, over half of the articles in this review were published in North American journals. When articles published in other Western countries are added to this total (i.e., the United Kingdom, European Countries, Australia and New Zealand) the percentage jumps to 73%.

Conclusion

A systematic review of the past 50 years of literature provides a retrospective view that can help shape the future of disordered gambling treatment. This body of knowledge has largely mirrored trends in dominant Western mental health, including the specialization and medicalization of mental health practices. The majority of GD treatment literature focuses on the individual, reflecting a Western modernist view of "disease" and "healing" as being a primarily individual phenomenon that can be measured, predicted and controlled. Medicalization of mental health is reflected by the increasing prevalence over time of evidence-based practices, particularly when effectiveness has been demonstrated through RCTs.

It is likely that GD treatment researchers and clinicians will continue to develop and test the effectiveness of promising CBT, MI/ME, and MI interventions. It is also likely, given the trajectory of this body of literature, that aspects of various treatment models will be combined to create greater flexibility and responsiveness to the wide variety of client needs. This includes flexibility in treatment goals (e.g., harm reduction vs. abstinence), increased use of technology, and greater availability of home-based interventions. We explore more of the "how" of GD treatment in the second part of this article.

Our hope is that the focus on establishing evidence-based models through repeated evaluation will not deter from exploring innovative, gambling specific treatment frameworks. We echo the call for knowledge to be produced and culturally responsive treatments developed by and for non-dominant cultural groups. This includes careful consideration of the outpacing of literature coming from Western countries to avoid colonization and/or to avoid promoting the use of approaches not optimally effective for non-Western populations. Finally, we applaud the growing depth and breadth of producing and disseminating knowledge on GD treatment and encourage efforts to continuously work toward improving treatment outcomes for those who directly struggle with gambling as well as their families and concerned others.

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