

Motivational Interviewing To Help A Person Change Their Substance Abuse Use

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Why This Topic Is Chosen

The reason for choosing this topic is that some people develop severe forms of dependence – from alcohol, drugs, and gambling. They cannot be dealt with independently, so you have to go to specialized rehabilitation centres, where specialists apply different methods in the work of the residents, which are aimed at enabling the dependent to overcome the addiction and return to normal life. One such technique is motivational interviewing in the treatment of drug addiction and alcoholism.

What You Hoped To Learn From The Readings

This system is good because, as a result of communication with a psychologist, individually and in a group, it allows:

- to recognize and acknowledge to oneself and society the existence of dependence as a problem;
- to realize the need for a course of rehabilitation since the dependent can not cope independently;
- to develop a desire to undergo treatment;
- Rehabilitated in society – in the family, in the circle of friends, at work;
- To overcome dependence on the psychological level, we need to understand that it was dependence that led to the fact that life had fallen into decay.

The motive is the reason that a person commits one or another act or action. Motivation, in turn, is a specially designed system of motives that provokes a person's accomplishments or their absence. Motivational interviewing is based on the construction of logical chains such as motive-action and action-motive. This technique uses the identification of cause-effect relationships and helps the resident realize that changing the direction of motives can also change the consequences. The main point in applying the method of motivational interviewing is the complete adoption of a dependent person as a patient. In addition, he is offered assistance and is not considered in the expert's assessment of his "bad or good" actions, but on the other hand, a person independently draws conclusions about his life and gives them an adequate assessment. This is achieved by an unobtrusive style of counseling, by asking open questions that do not involve "yes or no" answers, the expert also does not give advice, criticize or condemn a resident's decision. Only clarifications and

clarification of situations, both for themselves and for the client, return, and thereby “mirror” the actions of the resident. What enables an addicted person to clearly see their responsibility in certain situations?

Motivational interviewing in the treatment of drug addiction and alcoholism is effective both independently and in conjunction with other treatment methods. It is used to rehabilitate patients with various kinds of addictions. Our Rehabilitation Center “Restoration” will provide specialized assistance that may be required by your family or friends. We have neurologists and psychologists with the highest qualifications. They develop an individual and group rehabilitation scheme for each patient. The technique allows the patient to come to an understanding of the need to abandon the substances that contributed to the fact that he lost his job, friends, and family or was close to them. An important factor in the course of treatment is the participation of relatives and friends and the support of the dependent.

SUMMARY. In the article, the goals, tasks, tactics and specifics of the initial diagnostic and motivational interview conducted by a clinical (medical) psychologist with patients who turned for help because of problems with gambling are considered.

Keywords: pathological gamblers, initial interview, diagnostics, motivational counselling.

Introduction

Pathological predisposition to gambling is a new and generally insufficiently developed problem of Russian psychiatry and narcology (Zaitsev, 2000). It is known that players are much more likely than the population to have various mental illnesses (affective and anxiety disorders, symptoms of chemical dependence, OCD, attention deficit hyperactivity disorder (history) and personality disorder (Black, Moyer, 1998, Crockford, El -Guebaly, 1998, Cunningham-Williams et al., 1998, Grant, Potenza, 2003, Ibanez, Blanco, Donahue, Lesieur, Pérez de Castro, Fernández-Piqueras, Sáiz-Ruiz, 2001. These patients have a marked tendency to commit unlawful actions to further fund their participation in the games (Thompson, Gazel, Rickman, 1996). , individuals dependent on the game have a high risk of suicidal attempts (Grant, Potenza, 2003; Frank, Lester, Wexler, 1991). Apparently, the formation of addiction to games for some subjects was a kind of test that revealed their premorbid vulnerability.

The behaviour of patients caused by the disorder of drives poses a threat to themselves, their families and to society as a whole. In this regard, timely diagnosis of both the underlying and associated disorders (disorders), overcoming pessimism and resistance, and increasing motivation to receive effective and effective care are needed. A primary motivational interview conducted by a clinical psychologist can help a patient realize the presence of a painful disorder and help him to form a motivation for further treatment and change his problem behaviour.

Tasks Of The Consultation

The functions and tasks of a medical psychologist are: independent implementation of patients' admission, necessary psychodiagnostic, psychocorrectional, rehabilitation and psycho-preventive measures. The experience of conducting the initial diagnostic and motivational interview was obtained in the course of work in the Center for the Treatment and Prevention of Gambling Addiction at ND No. 12 in the UZ of the South-Western Administrative District of Moscow and the Rehabilitation program "Outside the Game" (Avtonomov, 2008).

Our practice shows that, in most cases, patients suffering from pathological gambling are not aware of the seriousness of their problems and the severity of their existing psychopathology. They avoid contact with doctors and do not seek help from a psychiatrist. Feeling frightened and distrustful, they are more willing to contact a medical psychologist than with a doctor in an anonymous outpatient clinic. We believe that such a meeting is the first step on the path leading to the players' awareness of their difficulties, the true reasons for their occurrence and the receipt of qualified assistance.

We proceed from the hypothesis that the motivation of the patient (and not his relatives, colleagues and/or the clinical psychologist himself) is a fundamentally important and decisive condition for obtaining effective and effective help.

Thus, the tasks of the primary consultation are:

1. Identification of complaints and clarification of the client's subjective assessment of his condition.
2. Diagnosis of the client's presence of signs of a pathological addiction to gambling.
3. Collection of information about personal life, clarification of family and social history.
4. Collection of a psychiatric history with special emphasis on the diagnosis of concomitant mental pathology and personality disorders.
5. Collection of narcological anamnesis.
6. Evaluation of antisocial activity and suicidal risk.
7. Evaluation of the scope and scale of the current crisis, which forced the client to seek help.
8. Assessment of the consequences (interpersonal, financial, social, legal, etc.), losses, calls and actual threats that are hanging over the client.
9. Identify expectations from the meeting and assess motivation to change problem behaviour.
10. Carrying out a motivational intervention.
11. Conclusion of the psychotherapeutic contract and/or discussion of the client's further steps to get effective help.

Introduction

The first contact usually takes place in two ways – the client addresses “gravity” directly to the medical institution or pre-calls and arranges for a meeting by phone. A telephone call can be received by an employee who works in the registry and informs the time and order of admission from the specialist.

If a psychologist approaches the phone during the conversation, the client gets the opportunity to state his problem and ask questions of interest to him. The psychologist can, in turn, confirm his willingness to provide assistance and invite the client to come to a full-time consultation. The specialist reports the address, a convenient way to get to the meeting point, and the duration of the time allocated for the consultation.

The psychologist should avoid long conversations. The conversation should be concise, clear, unambiguous and to the point. Of course, one should not give unrealistic promises or any guarantees.

A very important point: based on our experience of consulting the players, only every second of the enrolled customers comes to the first meeting with a specialist. We paid attention to the following fact: the more time passes from the moment of recording, the less likely that the player will come to a meeting with a psychologist.

As a rule, customers who call by phone express their intention to come to the consultation immediately or are ready to wait for their turn not more than one and a half to two hours. Many of them are very disappointed that they can not “come and talk” at any time convenient for them. The need to reckon with reality (“Really what is resisting” (Jaspers, 1997), to meet with frustration, for many of them is simply unbearable. Some of the players quite sincerely believe that the expert is a priori glad to meet with them and eagerly awaits their appearance in the And if they did deign to pay him a visit, then he (the psychologist or the doctor) should “enter their position” and “go to their meeting.” Sometimes, for the sake of persuasiveness, a player intending to come to consultation is already on the phone from the very beginning. It is necessary to manipulate a specialist into seeking time convenient for him, talking about the “extremely urgent need for a meeting” or about her “special importance” for his future fate, often referring to the fact that at other times he is “very busy”.

We believe that one should not passively pass on the occasion of clients. If the specialist has the opportunity to take the player during the time period when he can do it, then this possibility should be used. If there is no such possibility, then one should not make compromises and artificially look for additional opportunities. Do not cancel or transfer other pre-recorded clients for the sake of the first-time caller of the primary customer.

Sometimes, some not-very-experienced specialists are “guided” by the arguments of the players and their insistent requests “to make an exception for them, etc.”. However, the result of such a policy

leaves much to be desired. “Having found the time” and “going to a meeting” for such a client, having received from him counter assurances that he is “already on his way” and “now will be”, the specialist can waste all the time and the client will not reach the threshold of the consulting office. The psychologist, unwittingly, turns out to be one of those many people from the player’s environment who, guided by their own good intentions and sincerely wishing to help them, were, in fact, deceived and deceived.

Of course, according to our experience, if a client wants to come to a consultation soon after a phone call, it increases the chances that he will not change his mind and still get to a specialist. However, this does not guarantee that he will come, even if the player swore on the phone that “it will not be applied” and “will definitely come”, etc.

It is also necessary to know that often, customers who call to agree on the time of reception are in acute crisis after another game breakdown and a major loss or are under strong pressure from third parties. Some players call, coming out directly from the casino, and their emotional state is not stable, and their behaviour is highly impulsive.

The specialist needs to know that some players are registered for a consultation with a view to “spreading straw” – only in order to then tell their relatives, colleagues or superiors that they “took their heads” and already “went to be treated”, etc. That is, only to demonstrate the “seriousness” of their intentions and to neutralize counterclaims of third parties – finally begin to be treated and seek help from a psychologist or a doctor.

It happens that the player insists on the urgent need for a meeting, and the psychologist can not accept him at the time he is counting on. It is often useful for a psychologist to ask the player by phone when asking for an alternative time of reception: “How long does the problem exist, because of which you want help?” Usually, when answering this question, players say that the problem has existed for several years and sometimes a whole decade. The psychologist can say in response the following: “If I understand correctly, the problem with gambling has existed for you for so many years. What do you think about meeting and discussing what you are worried about so much tomorrow? ” Thanks to this formulation of the question, the client, seized by the idea called “urgently needs to do something”, gets an opportunity to look more calmly and adequately at your situation. Ideally, with the help of a specialist, a player can understand that for a problem that exists for many years and one to two days, there is nothing to decide. And also to realize the fact that he, knowing full well about the existence of his gambling problem for a long time, did not make the slightest effort to solve it.

We also noticed that if the client signed up for the morning hours, the probability that he will come to a consultation on our statistics is about 10%. Many clients re-write after a while (from several days to six months) and then again do not come to a consultation. Such actions (and subsequent inaction) can be performed several times before the client crosses the threshold of the consulting room.

Of all those who came to the first meeting, about every second player was late for it. The delay time ranges from 5 to 30 minutes. Moreover, the majority of those who are late are sure that the time for

consultations will be extended for them. Of course, they (the players) were late, not through fault of their own, but road traffic jams, traffic police employees, and unexpected difficulties arose in finding a meeting place (by the way, game clubs, including illegal ones, the client finds without problems) and other circumstances “force majeure”.

Start A Consultation

The first step in advising clients who have turned to gambling problems is acquaintance and establishing boundaries (McWilliams, 1998, Pathopsychology, Psychoanalytic Approach: Theory and Clinic, 2008; Fenichel, 2004). The specialist invites the client to go into the office and points to the chair where he can sit. Further, the psychologist appears himself and asks the client about what he wants to be called, reminding him that the information he will receive will not be disclosed and is confidential.

When introducing themselves, most players call their real names. Of course, the patient should be referred to as “You”, even if he says that you can address him as “You”. The specialist should avoid unnecessary familiarity and maintain a reasonable distance.

Establishing boundaries when dealing with pathological gamblers is extremely important. A player is a person without clear boundaries, and he tries to organize his life in his own way. If a person has no boundaries, he will inevitably violate the boundaries of other people. The psychologist should establish clear spatial (arrangement in the office, distance) and time limits of the meeting, clearly speaking, how much time is at his disposal. The recommended time for an initial consultation is 90 minutes. If the client is late, he is informed that the time of his consultation will be reduced to the minutes corresponding to his delays. The responsibility of a specialist is that his words correspond to his actions. The psychologist should plan the conversation, taking into account the real remaining time, and complete it at a predetermined time. We believe that it is better to appoint a new time for additional re-consultation than to go beyond the agreed and allotted time.

Here are the most characteristic erroneous expectations, intentions, approaches, actions, omissions and delusions to which a specialist can be exposed:

1. The psychologist demonstrates his joy and satisfaction only because the patient came to him for a consultation.
2. The psychologist really wants to please the patient and put him to him.
3. The psychologist expects that the patient came of his own free will, highly motivated and ready for change.
4. The psychologist is afraid to offend or somehow hurt the patient. The psychologist believes that the patient (who was often in such life alterations, which psychologists can not imagine and himself) is fragile, like a glass Christmas tree toy, and that he is a psychologist, can somehow hurt his questions.

5. The psychologist passively goes on about the patient.
6. The psychologist tries insincerely to encourage and reassure the patient. (Phrases: “Do not despair!” Or “Everything will be fine!” Are banal and inappropriate.)
7. The psychologist tries to actively console and pacify the patient to smooth out “acute angles”.
8. The psychologist is trying to give early advice to the patient in the guise of recommendations.
9. The psychologist avoids an active confrontation with the hostility and self-destructiveness of the patient.
10. The psychologist allows himself to laugh after the patient (the so-called “Hilarious laughter”) when the client, laughing and smiling, with a cheerful expression on his face, tells about what woes, losses and misfortunes fell to his lot.

Note. If the psychologist cannot restrain himself (sometimes it is really difficult to do) and laughs with the patient, then the psychologist can say: “I take my laughter back and apologize to you; what you told me was not for you at that moment ridiculous. ” If a specialist sees that a patient is trying to seduce him into laughing with him over his suffering, then the psychologist can imperatively declare: “It was not funny for you! I will not laugh at your misfortune! ”

1. The psychologist avoids asking awkward questions, even if he feels that the answers to them are important to him.
2. The psychologist agrees that the patient’s main problem is financial and debt.
3. The psychologist, sincerely astonished, after hearing the patient’s story about the magnitude of his debts and/or about the lost sums, begins to act as a financial adviser or a lawyer.
4. The psychologist agrees with the patient’s version of his motives, namely, that he (the patient) is playing gambling to pay off his debts.
5. The psychologist shares the patient’s confidence that all of his problems will be solved in the event of the repayment of all debts.
6. The psychologist agrees with the patient’s version that when he has no money, he functions adequately mentally and emotionally and does not have any signs of frustration.
7. The psychologist refuses to express his doubt and mistrust to the patient, even when he clearly feels that he is not informed, rudely distorts the facts and their significance, and is lying and frankly misleading.
8. The psychologist is passive, renounces his power and allows the patient to lead the counselling process.
9. The psychologist allows the patient to determine the end time of the session. (The psychologist has the exclusive right to determine the end time of the session.) The patient begins the session by the fact of his coming to the consulting room.

Such expectations, actions and inaction are, in most cases, frankly anti-therapeutic and not useful. It’s surprising how widespread and often some psychologists use such approaches in counselling. The patient, in this case, can perceive the consultant as another simpleton, whom he fooled and rounded a finger, not worth his attention or his time.

For pathological players, in general, a passive position is typical for their own recovery. Many players take a passive-arrogant attitude towards a psychologist or a doctor. Their typical message without words: "Well, here I come, let's heal me." A visit to a specialist for the treatment of dependence is perceived by many in the manner of visiting a dentist. Players often believe that it's enough to go in and sit in a chair, and – the rest will be done by the expert himself. Hence, the frequency of requests and requests, hypnotize them, apply educational and restraining measures, "give the right attitude", "instil ideas about the harm of the game," etc. In the anamnesis, such players often have a history of seeking help from psychics, fortune-tellers, and sorceresses. Some tried to be treated by conspiracies, removed spoilage, the evil eye and/or resorted to methods of "placebo-mediated suggestion" carried out by doctors-narcologists called: "coding", "25 frames", etc. The effect of such procedures (which are essentially "transference healing" (Fenichel 2004) is usually short-lived and unstable, which, however, does not prevent patients from wanting to repeat it. This treatment method is beneficial to both parties because one side (doctors) easily earns money, and the second side – patients receive a kind of "indulgence" for the continuation of the game, following the logic: "I wanted to quit playing ("I'm good ") – I was treated by a specialist – I went to the casino to check the effectiveness of treatment – It turned out that I was ill-treated! – By I play it again ("I'm not guilty ").

Players hide from themselves their enjoyment obtained in the game and try to convince themselves and the psychologist that they play only solely for the sake of money and winnings. Particularly touching from the players' mouths are stories that they, they say, play only in order to "recoup", that is, to regain their own money spent earlier on the game. God forbid that they would be suspected of greed, greed, greed and desire to enrich themselves at another's expense! They are trying to expose themselves as people who have exclusively financial and debt problems, such as deceived depositors of a bank that has been bankrupted or those who have suffered through the fault of fraudsters.

Based on our experience, we believe that the starting point of understanding the problems of pathological players is the thesis that patients do not play for money. Money is an "entrance ticket", a pass to the world of pleasure and a way to at least somehow measure it. We believe that pathological players play for the sake of pleasure and to relieve tension (Avtonomov, 2010; Grant, Potenza, 2003). The anticipation of excitement, pleasure from the desire for pleasure from the game, gambling, and the gameplay for pathological players in itself becomes (is) a form and source of enjoyment.

The player is used to interacting with others by means of lies, pressure, manipulation and sycophancy. Accordingly, he almost inevitably reproduces his habitual treatment with other people in the session and with a psychologist. His behaviour in the consulting room can range from verbal aggression (behind which fear and vulnerability hide) to self-abasement with the call for salvation (behind which stands arrogance, arrogance and rejection of any real help).

The specialist should understand that he is always in contact with the player between the Scylla of a professional position (which the patient may perceive as rigid, rejecting or indifferent) and Charybdis of human empathy (which the patient may perceive as weakness and inappropriate "rescue"). The psychologist must possess knowledge and skillfully balance between these two extremes.

Further, after acquaintance and establishing clear temporal and spatial boundaries, the psychologist offers the patient free form to tell about the reason for his treatment (McWilliams, 1998, Pathopsychology, Psychoanalytic Approach: Theory and Clinic, 2008, Jacobson, Jacobson, 2007).

The question addressed to the patient may sound approximately as follows:

- What led you to a consultation?
- Tell me about the problem that led you to the consultation.
- What is the purpose of your visit to me?
- Whose idea was this to turn to us (to me) for help? “

The first part of the conversation is active listening and monitoring of the patient. The task of the specialist is to help the patient express freely all that he can and wants to say. Avoid leading questions or hurry the patient, he is given the opportunity to independently organize communication with a specialist in the manner and with the speed at which he is capable. During this speech, the specialist can track and assess the patient's ability to remember, think, understand and analyze (Pathological Psychology: The Psychoanalytic Approach: Theory and Clinic, 2008; Jacobson, Jacobson, 2007).

Usually, the primary diagnosis of a pathological tendency to gamble does not cause difficulties for the specialist. For patients themselves, their formal diagnosis, in many cases, is also not a mystery. Between the awareness of the problem and the first appeal to a specialist, according to our observations, several years pass. During this time, the patient is repeatedly convinced that he has a problem. Some patients, having entered the office, declare from the threshold that they have, say, “gambling”. The problem here is this: the absolute majority of patients who know that they are “gambling” do not know that gambling is a mental illness. Most patients, recognizing the presence of “gambling”, consider it a vice, a moral defect and a manifestation of their deep defectiveness. Even those patients who are familiar with the 12th Stepping Recovery Program, who went to the “Anonymous Players” group and heard that gambling is a disease, still feel dejected, vicious and criminal at heart. Perceiving what happens to them through the prism of morality and ethics, they inevitably find themselves in a dead end.

Using a moral paradigm, patients take on the role of a sinner and criminal. A criminal is a free person who is the author of his actions, fully responsible for his actions and commits them according to his evil will. The moral paradigm is the paradigm of sin and punishment (redemption). Igromaniya, according to this paradigm, is a sin, and players, according to the moral paradigm, are vicious natures who are able to control their behaviour but still make choices in favour of the game. Also, in the moral paradigm, pleasure and desire are emphasized. A player is a passionate person who makes a choice in favour of his vice. The treatment of gambling in such a paradigm, if we consider it very simply, is reduced to repentance, punishment, abstinence and correction. Strictly speaking, our patients are engaged in these practices, regardless of whether they are religious or not. They repent after another game, try to atone for their guilt, curse and call themselves the last words, punish themselves or

allow other people to punish them. As early as 1927, Professor Sigmund Freud drew attention to successively changing phases characteristic of the pathological gambler: The game – “repentance” – another game breakdown (Freud, 2004).

“Repentance” is a technical device (“reset conscience”) that prepares the ground for the next game failure. Such “repentance” has nothing to do with the true, original meaning of this word, meaning “change of thinking” and a radical change in the way of life. No real change in thinking occurs, and no conclusions are drawn. Out of perfect deeds, experience is not extracted; the way of life remains the same. After a loss, a pathological player experiences an orgy of self-flagellation, self-abasement and self-pity. Then comes a kind of “catharsis”, liberation and pathological gambler calms down and once again says to himself: “Now everything, I will not play anymore! I’m tied up! It was just a nightmare, and it will not happen again. I start to live anew, etc. “.

Some patients try to solve the problem by isolating themselves from the temptations of visiting monasteries, some fasting and depriving themselves of the usual pleasures, talking with clergymen, giving oaths no longer to play, etc. After that, usually, in a short time, they go again to play, and the cycle repeats. It is precisely the collapse of such co-management strategies that leads them to the office of a psychologist or a doctor.

The moral model of “sin” contrasts with the medical model of the disease. According to the medical paradigm, gambling is a mental illness, a frustration of drives. A pathological gambler is a sick person who is not free in his actions because, at times, he is in control of the disease. Here, it is important not to confuse unfreedom in actions with the concept of “insanity”, which refers to the legal paradigm. The concept of “insanity” is applicable in those cases when the behaviour resulting from a mental disorder, in itself, forms a component of the crime. A pathological gambler is unable to control his symptoms and needs treatment, not punishment. As the disorder progresses, the game becomes a necessity; dependence limits freedom and prevents adaptation and development of the individual.

The medical model draws attention to hereditary predisposition, organic changes, concomitant mental illnesses and psychological addiction. The pathological tendency to gamble can arise in a person, regardless of his religious views and the height of his moral standards. It is not possible to cure by means of “repentance”; therefore, in case of the development of the disease, “repentance” becomes a necessary part of the addiction illness. Precisely, thanks to “repentance”, there is a reboot of conscience, which prepares the ground for a new game breakdown.

We are convinced that solemn oaths, fasts, prayers, vows, training of willpower, and self-punishment are the means of avoiding the solution of the problem, the haughty arrogance of the sick person and raising his collapsed self-esteem. They give the player only a temporary illusion that he can control the appearance of the symptoms of his illness by his own forces. According to the medical view, the pathological gambler is not responsible for the fact that he is sick, but he is responsible for his recovery from his illness. He does not control the symptoms of his illness, the main of which is the appearance, regardless of his will, of an addictive attraction. But the patient is powerful over how he

treats his symptoms, with what he does if he does.

An experienced clinical psychologist, listening attentively and observing the patient, his behaviour and the way he organizes communication without resorting to special diagnostic techniques, can get, in most general terms, information about:

- Appearance of the patient. Including information about age and its correspondence to biological age, physique, weight, and height. Presence of scars, traces of injuries, surgical operations, self-harm, and traces from intravenous injections. Tattoos, their quality of performance, location and content of the images depicted. Dental states; clothes and her condition. Presence of accessories and ornaments. Manners hold and behave.
- Motor sphere and gesticulation. Pose, coordination, gait, restlessness, tics, hyperkinesis, compulsions, agitation or stiffness.
- Mimicry. Living, poor, sorrowful, ingratiating, etc.
- Expression of face and eyes. Uncomplicated, frozen, tense, sad, arrogant, contemptuous, wary or deliberately theatrical.
- The patient's speech. The voice is quiet, loud, hoarse, etc. Silence, pause, interruption of the speech of a psychologist, the total density of discourse. Rigidity, spontaneity, tonality, speed, volume, the presence of speech defects, such as stammering, etc.
- Cognitive sphere. which includes:
 1. a) Specific content of thoughts. Suicidal and self-blaming thoughts, ideas of greatness, paranoid ideas and relationship ideas. Delusional, overvalued and obsessive designs, phobias.
 2. b) The process and pace of thinking. Associative series, speed, rate of flow of thought processes and smoothness of flow, their adequacy. Consistency, amorphousness and the presence of signs of "blockage of thoughts" (sperrunga).
 3. c) Motivational aspect of thinking. Purposefulness, versatility, slippage, thoroughness, reasoning.
 4. d) The semantic sphere. Adequacy/inadequacy of meanings, paralogism, pseudo-abstraction.
 5. e) The level of intelligence and erudition in the most general terms. High, medium, low. How flexible or rigid is the patient's thinking? Is the patient able to perceive new ideas?

Note. In case of suspicion of the psychologist for the presence of delirium, it is necessary to clarify the structure of delusion, its central theme, the degree of development and the power of involvement. How delusional the idea (the idea) dominates in the mind of the patient and disturbs the process of thinking, and how the social life of the patient has been reconstructed under its influence.

If the psychologist suspects the presence of ideas of greatness, it should be clarified on what, in the patient's opinion, conviction is based on his superiority (whether on knowledge, on special abilities of foresight, on intuition, on origin, on being chosen, etc.) and how it manifests itself in a conversation with a psychologist.

In case of suspicion of the psychologist for the presence of paranoid ideas, which are manifested in

alertness, mistrust, vigilance and conviction in the presence of conspiracy and in the hostile attitude of others. It is necessary to clarify the degree of hostility and danger to the behaviour of the patient toward others, which can be manifested in irritability, active or passive aggression, hostility, disrespect and indignation.

- Affective state. The general level of emotional development, stability/instability of affect, its adequacy, strength, and duration. How patient is sensitive to external stimuli, stimuli and how much it is able to arbitrarily control their emotions. Interest in life events and events, general emotional involvement. Animation, joy in the eyes, smile, expression of bliss when talking about the game. How the patient reacts to the words and silence of the psychologist.
- Memory status. How easily recalls the events and dates of her biography, which selectively forgets, remembers the name of the psychologist, etc.
- Attention. Ability to concentrate and switch, distractibility, exhaustion of attention.
- How the patient is adapted to reality. Is it inclined to escape from reality (suicidal and addictive behaviour), opposition to reality (antisocial and antisocial behaviour) or ignoring reality (infertile fantasies, autism).
- Criticism of the disease and condition. What is the internal picture of the disease and the internal picture of health if it is formed in the patient? Awareness of the disease: does the patient understand that pathological involvement in gambling is a mental illness?
- The idea of health and recovery: how does one imagine his own recovery? By what signs will he understand that he is getting better? By what changes in his behaviour does he believe that the people around him will understand that he has begun to recover?
- The locus of control. External or internal.
- Leading relationship vector. To people, against people, from people.
- Dominant defence mechanisms of personality. Primitive protection: isolation, negation, omnipotence, introjection, projection, splitting. Higher protections: isolation of affect, repression, intellectualization, moralization, rationalization, destruction of what was done, turning against oneself and shifting. Also, about the redundancy or weakness of the protection and the rigidity of their application.
- Perception of the psychologist-consultant. Typical are the two extremes: "Magical Rescuer" and "Potentially dangerous pursuer". Or, in general, adequate perception.
- Motivation for change. Motivation for change is absent; motivation is external / controlled, and motivation is internal/autonomous.

A few words about the discourse of the patient: usually, the patient prepares his speech in advance, and the duration of this message he pre-rehearsed takes from a few seconds to several tens of minutes. Probably, this patient repeatedly spoke to himself on the way to the consulting office. We believe that everything that the patient has prepared does not matter how much in this story of lies and self-deception or truth serves him as a defence. The question here is how strongly and rigidly the patient is ready to stick to his narrative. Some patients say almost non-stop to avoid dialogue with the psychologist, and others feel so paralyzed with shame and fear that they can not connect two words, and all their rehearsed speech immediately falls apart. Other patients are relieved of their

experiences, talking about themselves in the second and even in the third person, so that the psychologist has a feeling that they seem to tell a story about someone else or recount a previously seen film or a read book. Some begin by diagnosing themselves, saying that they have gambling, and then look inquiringly at the psychologist's reaction as if waiting for him to confirm their hypothesis or praise for insight. In any case, at the initial stage of the interview, it is much more important for the psychologist to pay attention to how the patient speaks and not what he says (McWilliams, 1998, Pathopsychology, Psychoanalytic Approach: Theory and Clinic, 2008).

In the first part of the conversation, the patient has the opportunity to state the main complaints and tell about the reasons that led him to seek help. In the transition from the first part to the second, the psychologist can realize, summarizing what he heard from the patient. It is useful to use the words of the patient, sounded earlier in his speech. The psychologist, as it were, draws a line under the patient's speech, linking the anxieties, fears and hopes of the patient (McWilliams, 1998). For example, a psychologist can tell a patient:

- "As far as I understand you, the reason that prompted you to seek advice is anxiety and anxiety because you lost control of the game."
- "If I understand you correctly, then you came here because you feel that something is going wrong with you recently, and this is due to your active participation in gambling."
- "You mentioned today that despite the problems that gambling brought into your life, you were not able to refuse them, and this dealt a blow to your self-esteem and self-esteem."

Middle Of The Consultation

The second part of the conversation is the collection of information about the patient (Kernberg, 1998; McWilliams, 2001; Pathopsychology, Psychoanalytic Approach: Theory and Clinic, 2008; Jacobson, Jacobson, 2007). The psychologist takes an active position in the conversation, asking questions of interest to him. The principle here is very simple: if the psychologist does not ask, then most likely, he will never know. We justify our choice of questions by covering the main areas of the patient's life based on numerous published studies that have revealed the most characteristic and common psychopathological syndromes, comorbid diseases and conditions. And also, the most characteristic of pathological players are characterological (personality) disorders.

The specialist should remember that the comorbidity of the pathological predisposition to gambling with other mental disorders, according to M. Ibanez et al. (2001) is 62.3%. So, the expert should know that the pathological attraction to gambling is most often combined with:

- Affective disorders. The prevalence of depressive disorders ranges from 50 to 75% (Cunningham-Williams RM et al., 1998; Becona E. et al., 1996) [9, 11]. Hypomanic and manic 38 to 8%, respectively (McCormick et al, 1984). The specialist should know that in about 2/3 of the patients, the manifestation of the depressive episode preceded the formation of a pathological

attraction to the game. According to Grant JE and Potenza MN (2004), pathological players are characterized by a combination of dysthymia and episodes of deep depression. Patients used gambling as an antidepressant to cope with dysthymia, feeling the excitement, excitement and joy of victory arising from gambling. Then, as the inclusion in the game progresses and the subsequent loss, the patient experiences a depressive episode in connection with the financial, interpersonal and professional problems resulting from the loss.

- Abuse/dependence on alcohol and psychoactive substances, both current and in history. In 66.4%, pathological players throughout life were diagnosed with substance abuse (including alcohol) or dependence syndrome (Kausch, 2003).
- Obsessive-compulsive disorder. Prevalence ranges from 1 to 20% (Grant et al, 2004).
- Anxiety disorder (usually social anxiety disorder). Prevalence ranges from 9 to 46% (Grant, Potenza, 2004).
- Attention Deficit Disorder with Hyperactivity. According to Black DW, Moyer T. (1998), up to 40% of patients had a history of this disorder).
- Anti-social and borderline personality disorder. According to Cunningham-Williams RM et al, (1998), 42% of pathological gamblers have a personality disorder.
- High suicidal readiness and suicidal attempts in the anamnesis. According to Frank ML et al. (1991), Petry NM et al. (2002), and Thompson WN et al. (1996), suicidal thoughts are recognized in 32 to 70% of patients. At 13 – 40% of pathological players, there are suicidal attempts in the anamnesis.

Next, we list the main aspects that an expert can affect during a conversation [1 – 8]. Their number is redundant and not at all necessary, so all the questions we have to ask should be asked, and all of them need to get a detailed answer. We offer an approximate map of the survey and recall that “a map is not a territory”.

- Demographic data. Biological age, place of birth, parents’ origin, education. Was he called into the army, whether he participated in hostilities. Whence came (for non-indigenous residents), when and for what purpose? Did you change places (and how often)? Profession, speciality, work. Family status, marriages, divorces, and long-term, meaningful relationships.
- Social anamnesis. Where and with whom lives, their own or rented accommodation. Works or studies how long the work/service takes and what the schedule is. Relations with superiors, colleagues and subordinates. Does it have access to working money, is there the possibility of additional earnings both legal and illegal. Is there still an opportunity to take out loans and/or mortgaged property? Relation to religion, a typical pastime, a hobby. Presence/absence of friends and characterization of the patient’s environment. Do they gamble and/or talk about gaming topics? Abuse alcohol and/or psychoactive substances. Is the environment conducive to the game of gambling and drunkenness? Whether the surrounding people provoke the next game break, talking with him or with him on the game topic and/or trusting the patient with large amounts of money and valuables.
- Actual problems. According to the patient, his main difficulties are concluded and how he understands the reasons for their appearance. How the patient now assesses his life situation.

What worries him most? What feelings he encounters cause him the greatest anxiety. And such an important question, shedding light on the patient's motivation and object relations: "Who recommended you to come to a consultation?"

- **Family history.** Includes information about the father and mother of their age, profession, place of work, and social status. Whether they are alive or not, the reasons and time of death, if they are dead, are married or divorced. Continue to live together or not. What is the state of their health, both mental and physical? There was either alcoholism, suicidal attempts, game addiction, mental illness or episodes of antisocial behaviour among either of them or the next of kin. Have there been any family violence, including sexual abuse and/or neglect of parental responsibilities? Parent education and their nature. How the patient thinks about whether he was a desired child or not. How he was treated and brought up. In his opinion, his parents had expectations and hopes for him. What are the relationships of parents with each other, and who dominates the relationship? Do they know about the patient's problem, how they treated the patient before the game, and how they are treated now? On which of the parents or next of kin, according to the patient, he is more like. Does the patient know who he was named after? Brief information about siblings: how many brothers and sisters, place of the patient among them (birth order). What kind of relationship with siblings, how did their fate and life develop, and what are their problems, difficulties and successes?
- **Features of the patient's development.** How his childhood and adolescence proceeded, what difficulties he encountered, how he studied, and how he spent his free time. Was the patient as a child restless, disinhibited and hyperactive. Whether it was difficult to concentrate and whether the school performance suffered because of this. Was he reckless in dangerous situations, whether he had rashly disobeyed social rules, interrupted his studies, ran away from school, or was unable to carry out what he had begun to the end? How he interacted with parents, teachers, peers and friends. Were there any destructive and self-destructive patterns and problems in the transition years (with food, play, alcohol, drugs, risk, sex, suicidal thoughts and attempts)? Whether there were episodes of cruel treatment of animals.
- **Wife (spouse).** Information about age, education, physical and mental health, character. From whom proceeded the initiative of marriage (marriage). When, where and how the marriage took place? Who was present at it? What were the relations of the members of the parents' families? Does the spouse remind one of the patient's parents? How did the relationship develop in marriage? What significant events have occurred since the marriage: travel, illness, the birth of children, death, job change, etc? What changes have occurred in connection with the game? How the game affected the patient's wife. How the family interacts with the current problem. How the situation can develop according to the worst-case scenario. How else can the patient aggravate the problem? What are the positive aspects of the problem? Is the patient being reproached for his past games and breaking promises he made earlier, thereby provoking a new breakdown? Who leads the family budget, and who owns the money? Do they continue to trust money and values? Are there extramarital, stable relationships and/or casual connections from one side or the other?
- **Sexual sphere.** Does the patient notice changes in the sexual sphere in connection with

participation in gambling? Does the patient use the game to suppress/replace his sexuality? Or vice versa, is gambling potentiating his (her) sexuality? Is sexually excited during the game, in the case of a win or, conversely, in the event of a loss, does he seek solace in sex? Does the patient enter into extramarital affairs in order to avoid feelings of loneliness or because he can not tolerate intimacy in a pair and strive to organize a love triangle?

- Children. Number, sex, age, problems and joys. Were they desirable or not? What are their relations with them now? Does their education and education deal with “yes” then, how and how? Which of the children, in his opinion, is similar to him, and what is the similarity? How the game affected the relationship with children.
- Affective sphere. It is necessary to examine both the past and the present and take into account the duration, strength and combination of symptoms. Clinically significant if the duration of symptoms of mania is equal to or exceeds one week, accompanied by significant disruption of functioning and is not associated with the use of surfactants. For depressive symptoms, the duration of the presence of symptoms for two or more weeks is clinically significant, the absence of a connection with somatic disease, the abuse of surfactants and the loss experienced. It is necessary to find out whether in the past the patient had a decrease in mood or, conversely, a sharp increase in mood, expansiveness and irritability. Inhibition or increased motor activity. Drowsiness, insomnia, or decreased need for sleep. Was there a loss of a sense of pleasure and interest, fatigue, and energy or unrestrained activity and the difficulty of bringing it to completion. Was there a loss or weight gain, a decrease in concentration of attention. Was there a perception of a “shortened future,” depression and pessimism, or a sense of unlimited possibilities and an optimism that ignores reality? Did the patient experience a decrease in self-esteem and level of claims, guilt, and permanent suicidal thoughts, or did he have a sense of omnipotence, bombast, arrogance and ideas of greatness? Objectively, here and now there is a slowing of thinking, speech, movement, or vice versa, there is a flight of ideas, jumps of thoughts and agitation.
- Game history. The first experience of the game is the main types of games in which the patient plays. Who served as a guide to the world of the game, and what is the progression of involvement in the game? Is there a loss of control over the game, money, or time? Does the patient have the inability to interrupt the game by the effort of will, a sense of guilt after excess, secrecy, playing a debt, obsessive desire to “recoup”, or skipping work because of the game? What is the frequency of the game over the past year, and when the patient played the last time? Presence of game debts and how much they are commensurate with incomes. Does the patient have a change in personality and way of life, change in value orientations, or are there any signs of dependence? What areas of the patient’s life suffer from the game: personal, financial, interpersonal, professional and social? What are typical trigger situations? What (who) most often, in his opinion, provokes another game breakdown?
- Previous attempts to stop playing and the history of treatment (if it was). This point is important because patients tend to repeat and reproduce with each new psychologist and therapist old behavioural stereotypes. What decisions about his participation in gambling did the patient make? What goals and objectives did you set yourself? Has he tried to reduce the extent of his

involvement in gambling in the past? I tried to stop playing on my own, and what happened? What strategies did you use to achieve this goal? What was the success? Something went wrong? With the problems he faced, abstaining from the game. Why, as he thinks, did he not achieve his goal? What prevented him; was this obstacle external or internal? Did he ask for help about his problems with the game? Was this professional help or not? Did you receive outpatient or inpatient care? What, in his opinion, was the treatment, and how did he react to it? Has it stopped receiving assistance ahead of schedule or “broken” during its provision? Did he try to solve the problem by moving and voluntarily isolating himself from temptations? What happened after he returned home? What methods of self-restraint and self-punishment are used? What other methods of treatment know, but believes that they will not help him or do not fit. What other methods of treatment know but have not yet tried but are ready to try? What conclusions did he learn from his previous attempts to stop playing or take the game under control?

- **Narcological anamnesis.** Includes information on the use of any psychoactive substances (legal and illegal), including alcohol. Age of the beginning of the use, quantity, frequency, methods of reception, duration, dynamics, signs of abuse and dependence. Did the patient ever have a problem with alcohol or drug addiction? Did the patient use surfactants and/or alcohol last year? If not, are there any special reasons why he did not use alcohol and surfactant? Has the patient ever tried to reduce the amount (or frequency) of alcohol and/or surfactant use? Annoyed or angry when someone criticizes his drunkenness? Does the patient feel guilty about eating? Did the patient ever have to start the morning with the intake of alcohol or surfactant to regain his normalcy? Did someone call the patient an “alcoholic” or a “drug addict” (even if he categorically disagreed with this)? Were there problems in the past due to alcohol and/or surfactant use? What impact has the use of alcohol and/or surfactant on life, work, career, family and health? Was the patient aggressive and dangerous to others in a state of intoxication? Did he cause self-harm and trauma? Have there been memory disorders after use? Were there episodes of drunken drunkenness and/or withdrawal syndrome? Did he seek medical help because of this? Whether Was it treated for any dependence? When, where, by what method and how many times? How did you relate to the recommendations of a specialist? What was the effectiveness of the treatment? Was he pleased with the results? Does the patient note the connection between the use (or refusal) of alcohol and/or surfactant with the game? Did alcohol and/or surfactants use “self-medication” from gambling (or vice versa)? Aggravated or decayed the craving for the game after eating? Date of the last use of alcohol or surfactant. Medications taken by the patient or dietary supplements.
- **Antisocial actions.** Did the patient commit a crime in order to obtain money to finance the game? Was he going to commit crimes to pay off debts that arose because of the game? If yes, how often in the last year? Were these property crimes (theft, embezzlement, forgery) or crimes against the individual (looting, robbery, etc.)? Was the patient under investigation, arrested, imprisoned or subjected to criminal prosecution? Did you feel a sense of remorse and remorse after committing antisocial actions? Did he really (by actions) atone for his guilt? Which patient has drawn conclusions from his antisocial behaviour and consequences?

- Suicidal mood. You should also explore the past as well as the present. The patient should be asked directly: Did he think about the desirability of dying? Were there any thoughts of self-harm? Did he think about killing himself? Are thoughts of suicide related to the game (with problems due to the game)? Did he ever try to kill himself? What thought stopped at the last moment? Or when, where, how did he commit a suicidal attempt, and what were the consequences of his actions? When did he think about suicide for the last time? It should be determined whether the patient has a right here and now thoughts of suicide. Does he have a specific plan for implementing suicidal intent? Did the patient think about killing someone else (or instead of himself)? What can help the patient to stop and stay alive? And does he, in his opinion, need hospitalization right now?
- Motivation for change and treatment. For the study of motivation, you can ask the following questions: When did you first get the idea that your participation in gambling is becoming a problem? How much time passed after a clear realization that you need to stop playing? Why did you ask for help only now? What happened? What made you come to the consultation? What was the last straw for you? Do you have support from others? Whose idea was it to come today for a consultation? Who convinced you that you need help? Who was the initiator of today's meeting? Who was looking for information about the methods of care and treatment facilities for you? What specific actions did you take to come here? What do you expect from our meeting? What do you think is wrong with you? What help do you expect, and what help do you want to receive?

Completion

The patient can be asked: "Is there something else important that I should (could) ask you but did not ask?" "Are there any other questions that are important for you that have not been touched?" (Kernberg, 2000; McWilliams, 2001).

We believe that the motivation of the patient is the decisive component for recovery, and it is more important than the formal diagnosis. The diagnosis is not within the competence of a medical psychologist. The diagnosis is made by the doctor. Nevertheless, the medical psychologist can inform the patient about his understanding of what is happening to the patient in the clinical sense if he believes that this is necessary to enhance his motivation. The task of the psychologist at the initial stage is to motivate the patient to meet with a doctor to receive a variety of qualified care, which includes psychopharmacotherapy and participation in specialized rehabilitation programs. The psychologist can generalize his impressions to inform the patient about his vision of the problem and propose a possible action plan that includes alternative options.

Techniques For Motivational Interviews

So, going back to the first meeting, some difficulties arose with the specialist when the patient came

under strong pressure from outside. Sometimes, such patients, in fact, lack the motivation not only for rehabilitation and treatment but also for counselling (conversation). They are literally led by the hand, by their alarmed relatives. They are the initiators of the meeting and believe that the task of the psychologist is to persuade and educate the patient or, even in more severe cases, to cure him without his (patient's) desire. Of course, in this life scenario, the patient perceives the psychologist in the transfer as an ally pursuing his parental figure. That is, he actively dissimulates, lies, misinforms and avoids attempts to explore what is happening to him. Speaking psychoanalytic language demonstrates all the signs of psychopathic and paranoid transference (Kernberg, 1998, 2000). In this case, to work with such a patient at an initial consultation, the psychologist can use a specific technique. The essence of this technique is that the psychologist takes a meta-position in relation to the patient and the person interested in his treatment. The psychologist refuses to join the figures pressing on the patient and builds his conversation as much as possible non-invasively and neutrally. For this, he mainly uses open-ended questions formulated through a third party (Ahola, Furman, 2000). They are formulated at first sight somewhat strange, but nevertheless, thanks to them, a psychologist can bypass the patient's resistance.

A sample list of questions:

1. Whose idea was that you came here today?
2. Why do you think Ms. A. is interested in our meeting?
3. What is the main concern of Ms. A. in your behaviour?
4. What do you think is wrong in Ms. A.'s opinion?
5. What do you think you should stop doing so that Ms. A. left you alone?
6. What do you think you should do to have Ms. A. leave you alone?
7. What specific changes do you expect from Ms. A.?
8. What do you think Mrs A. expects from our meeting?
9. What, in the opinion of Mrs. A., could this meeting be useful to you?
10. The answers to which questions, in Mrs. A.'s opinion, you received today?

Thanks to this formulation of the question, many patients go in contact with a psychologist. Moreover, thanks to these formulations, patients begin to occupy the position of another person, as if looking at themselves from the outside. We are convinced that the active position of the psychologist only strengthens the resistance of the patient; moreover, even before the meeting with the psychologist, the patient was preparing for a defensive reflection of the attacks. When these attacks fail, his "self-fulfilling" prophecy is not realized in practice; the patient is at a loss. In some cases, he can come in contact with his inner psychic reality, with his anxieties and try to share them with a psychologist. If this does not happen, then at least the patient will have a different, more realistic and positive image of the psychologist than the one who was before the meeting. This can facilitate contact in the future when the patient is ready.

Another way of dealing with patients who come not on their own will is to give them information about gambling as a disease. The psychologist can tell about the disease, its characteristic signs,

symptoms, dynamics and flow. In some cases, it is possible to demonstrate appropriate medical literature or a classification of diseases to patients. Talk should be as neutral as possible and not try to convince the patient of anything. If the patient says that all the above is not treated, the psychologist can say that he is very happy for the patient. And suddenly, if he realizes for himself that something is wrong with him, then he can ask for help when he sees fit.

The psychologist should clearly understand that it is not at all necessary that all patients who come to his office are ill with gambling. The patient can be the bearer of a family symptom, be the so-called "identified patient". Family members can projectively place their own psychopathological symptoms and problems in the patient (it's exclusively about adolescent patients) and then solemnly insist that a psychologist or doctor treat him.

Returning to motivational counselling, the problem lies in the fact that in the case of a patient developing a pathological tendency to gambling, it happens that A.N. Leontiev is defined as "shifting the motive to the goal." The game itself and the altered state of consciousness that accompanies it, as well as all-powerful fantasies about the big win, become independent motivating motives.

Motivation is a fundamental mental phenomenon. Motivation is not the same as the concept of "causality," but it is the driving force of the individual. Motivation is a system of sustainable motives that determine the behaviour and selectivity of relationships (Miller, Rollnick, 1991). The patient's motivation for treatment and rehabilitation is an important and crucial component of recovery. The motivational approach is based on the following theses (Miller, Rollnick, 1991, 1999):

1. The motivation of the client is the key to change.
2. Motivation is a multidimensional phenomenon.
3. Motivation is not static, on the contrary it is dynamic and changeable.
4. Motivation depends on social interactions.
5. Motivation can vary.
6. Motivation depends on the style of the psychologist (doctor).
7. The task of the psychologist (doctor) is to identify and increase motivation.

The purpose of the motivational interview is to maintain and strengthen the motivation to change their problem behaviour. The motive itself can not be formed; it can only be updated and supported. Motivational counselling is a clinical style for awakening one's own inner motivation for change (Miller, Rollnick, 1991, 1999). This goal is achieved through a non-confrontational way of interaction, avoiding the patient's resistance. Motivational counselling has the advantage over the traditional approach, which is based on informing patients about the adverse consequences that their dependent behaviour brings and the advantages of a healthy, independent lifestyle (Miller, Rollnick, 1991, 1999; Miller, Tonigan, 1996).

Such tactics usually only strengthen resistance in patients, encouraging them to argue with a psychologist or a doctor and bring counterarguments, and not necessarily out loud. More often occurs, as in Krylov's famous fable: "And Vaska listens, but eats."

Miller and S. Rollnick (1999) cite the principles of motivational interviewing: the formulation “FRAMES”

F – feedback – provide feedback on behaviour;

R – responsibility – reinforce the patient’s sense of responsibility for behaviour change;

A – advice – give advice on behaviour change;

M – menu – discuss the menu of possible options for changing behaviour;

E – empathy – express empathy towards the patient;

S – self-efficacy – support the self-efficacy of the patient (Miller, Rollnick, 1999).

The motivational approach is not to force patients to do what they do not intend to do. The patients themselves often try to involve the psychologist in the game long described by the transactional analysts – “Yes, but”. The purpose of this game is to declare a problem and consistently reject any proposed assistance and any options for a possible solution to the problem.

Motivational conversation emphasizes the contradiction between the behaviour of the patient and his goals and values (Miller, Rollnick, 1991, 1999). The psychologist gives the patient the opportunity to review them and realistically assess their situation. By developing empathy and avoiding condemnation and confrontation, the psychologist contributes to the actualization of an ambivalent attitude to the problem, supporting the patient’s internal reserves.

Motivational interview is based on the theory of cognitive dissonance (Miller, Rollnick, 1991, 1999). The phrase “cognitive dissonance” comes from English terms: “cognition” – knowledge and “dissonance” – inconsistency, disagreement. Cognitive dissonance is a state characterized by a clash in the mind of an individual of conflicting knowledge, beliefs, and behaviour. When such a clash occurs, and intentions mismatch with each other, the subject has a need to reduce them to a common denominator. The clash of two cognitions relative to one object is subjectively experienced as discomfort. Traditionally, it is believed that people tend to maintain harmony as a desired internal state and minimize tension. If there is a contradiction between what a person knows and what he does, then this person tries to somehow explain himself to this contradiction. The presence of dissonance leads to actions aimed at reducing it. The ways in which the subject copes with dissonance are diverse and specific to each individual person.

Some players simply avoid contacting information related to one of the elements that is in conflict with the other. If dissonance arises between two elements, for example, between the desire to stop playing and the desire to continue playing, then this dissonance can be eliminated by changing one of these elements. One way to change this view of the contradiction is not as a contradiction in order to again achieve a state of internal cognitive coherence. Another way is to actually change your behaviour. But patients, in the majority, prefer not to face the choice of one or the other. After all, the choice always involves giving up one of the alternatives. Instead, they “choose” to reduce dissonance

through self-deception, rationalizing the contradiction. Another way is a global decrease and a reduction in perception. Patients “attack” their own psychic apparatus of awareness-perception, which connects them with reality. Some players tell us that their life goes like a dream, in a fog and confusion. And the only idea, the guiding star, illuminating their way, is the thought: “Where else can I get money?”.

Another way to avoid cognitive dissonance is to occupy your mind with an erroneous (in terms of logic) idea formed by replacing causes and effects with places. Or violating the logical relationship of their actions with the consequences of their actions. In this case, for example, the player is convinced that he is playing “for the sake of money and winnings,” but he continues to play to “pay off debts.” At the same time, ignoring the fact that the money earned by him is spent on the game. As well as the money won as a result of the game, money also goes to continue its participation in further games. That is, “winnings” in no way solve its financial problems. The won money is not spent for other “non-playful” needs, as the pathological player pities them. In fact, when playing, a pathological gambler progressively worsens his financial state and periodically loses winnings, giving him only an opportunity to increase his time in the game and/or give the opportunity to play at larger bets. The motivation “I play to pay off debts” is the result of substituting the cause of an event with its consequence.

The psychologist can ask the question: “How did you get debts?” This question almost invariably puts the player on a dead end. An honest answer to it is the recognition of the fact that debts arose because of the patient’s involvement in gambling. The following judgment of the psychologist: “So, it seems that you think that you need to continue to play to pay off debts due to the game?” Often causes the player painful cognitive dissonance.

The purpose of the motivational interview is to intensify the patient’s contradictions regarding his desires and actions in order to stimulate a favourable attitude towards changing habitual behaviour. From the method of motivational interviewing (Miller, Rollnick, 1991), we use in our practice such elements as inductive questioning, active listening and regular use of summing up. We ask you to argue “for” and “against” the alternative course of action, avoid moralizing and evaluating, and also contribute to the formation and reinforcement of adaptive attitudes and behaviours (Miller, Rollnick, 1991).

An important part of the motivational intervention is that the patients themselves (and not the specialist who conducts the consultation) called arguments in favour of refusing the game. We suggest that patients themselves give arguments in favour of changes in their current situation and make a list of the problems that have arisen from the game. The psychologist, on the contrary, in some cases, can play the role of “devil’s advocate”, giving arguments in favour of continuing the game.

The specialist can suggest to the patient directly during the consultation to fill in a special table of arguments “for” and “against” the continuation of the game.

Table of arguments “for” and “against”.

Table 1.

Continue to play.		
No.	ARGUMENTS FOR”	ARGUMENTS AGAINST”
1		
2		
3		

Give up the game.		
No.	ARGUMENTS FOR”	ARGUMENTS AGAINST”
1		
2		
3		

Then, the results are necessarily discussed. In the course of this work, you can identify the motives, arguments and prerequisites for change. It is important to induce the patient to independently analyze his life situation. Working within the framework of the motivational approach, the psychologist should clarify the motivation of the patient to continue playing, and what is the motivation to abandon the game. And these opposites should be considered together.

Another option for this task is to offer a specialist to a patient on a sheet of paper to write “10 pluses” of gambling and then “10 cons”. In practice, patients usually write “10 minutes” with ease, without any problems and with enthusiasm. However, it is difficult to bring “10 pluses” or lead them very impersonally and formally. Some players state that there are no “pluses” at all. In this case, the psychologist can say something like this: “You claim that there are no advantages to the game. Based

on what you just told me about myself, I had a feeling of bewilderment. Then why did you gamble for so many years? ”

Motivational interview is designed to help patients, decide on participation in rehabilitation. It is based on respect for the choice that the patient makes and constructive self-confrontation. The psychologist can ask the patient to give arguments in favour of maintaining the existing status quo. He can ask the patient the question: “Why (for what) do you need to stop playing?”The patient immediately finds himself in an unusual role for himself because usually, everything happens exactly the opposite. Someone from his entourage gave him arguments in favour of abandoning the game, pursued, accused, blamed and shamed him, which encouraged the patient to strengthen their defensive manoeuvres. Now, he must prove to the psychologist himself that abandoning the game is important for him. With such a statement question, the patient himself has to give arguments in favour of the change. It is important for a psychologist to be able to ask open-ended questions, reflect, argue, select from a patient’s speech important motivators for him and return his own words to him.

Treatment is possible only after the recognition of the disease. Initially, the patient should be helped to recognize the presence of a painful disorder and help shape the motivation for change. Recognition of the disease (or refusal to recognize the disease) is the responsibility of the patient. The task of the psychologist is to give the patient information about the disease and not to convince him that he is ill. If the patient has not convinced his life that he has problems, and with this, he has to do something, then not even the most brilliant psychologist or doctor can do it.

The difference between the motivational interview and other approaches is that the main motivation work is carried out by the patient himself (Miller, Rollnick, 1991, 1999).

End Of Consultation

The psychologist should understand that the basis for proper relations between him and the patient is informed voluntary consent. This principle is the basis of the saying, which can be the motto of a specialist and a call to the patient: “We are three – you, I and the disease. Let’s unite to defeat the disease. ” The patient has the right to independent treatment of psycho-corrective intervention and rehabilitation. The patient has the right to receive information about:

1. Diagnosis (refers to the competence of the doctor).
2. The goals of the proposed treatment and psycho-correction.
3. Its possible consequences.
4. Possible reasonable alternative methods and approaches.
5. Forecast in case of rejection of the proposed treatment and rehabilitation.

The patient should not act with his eyes closed; he has the right to receive objective, unbiased information and explanations about his disease and its potential danger so that he can realize the need for treatment. This information includes information about the recurrent nature of pathological

gambling addiction, the recommended timing and the process of rehabilitation. On the need for follow-up actions aimed at prevention of disease breakdown and recurrence.

The patient is told the purpose of rehabilitation, namely, achieving a stable remission. By stable remission, we mean a remission lasting at least a year, with the desired result being the achievement, if possible, of lifelong remission. Another important goal of treatment is the prevention of the occurrence (or progression, if any) of parallel dependence, whether non-chemical (behavioural) or dependence on psychoactive substances, including alcohol.

Also, a psychologist can recommend a patient to consult a psychiatrist-psychiatrist expert in narcology and/or a psychotherapist.

A possible reasonable alternative to treatment is the offer to participate in self-help groups of the “Anonymous Players” community.

At the end of the meeting, the psychologist needs to achieve an empathic understanding of the problems, feelings and conditions with which the patient actually meets. Summarizing what has been heard, the psychologist can tell the patient:

- “You said that your family (professional, business) life is ruined because of your excessive involvement in gambling; you are worried and disturbed, and you want to put an end to it.”
- “Today, you told me that when you play, you lose control of your life. Because of the game, you start doing what you do not want and then feel guilty and ashamed. Previous attempts to take the game under control have not been successful, and you began to have suicidal thoughts that you were so scared that you decided to seek help. “
- “The rapid growth of your debts due to the game and the increasing pressure from the creditors made you doubt the idea that you will” recoup, “that is, solve the problems that have arisen from the game by making it even more involved in the game, which has led you to a sense of confusion and bewilderment. It seems that now you have become more open, in order to get information about possible alternative ways of solving your problems. “

Concluding the meeting, the psychologist sums up the results and suggests that the patient take the steps necessary to overcome the unfavourable situation that has developed for the patient. It will be useful if, in the end, the psychologist asks the patient: “What questions did you get during the meeting today?” The psychologist should be given the opportunity for the patient to make a decision about his further actions (or inaction) regarding the problem, because of which he came to the consultation. Also, it is advisable to briefly discuss the next steps of the patient regarding his situation.

In any case, the task of the psychologist is to enrich and expand the patient’s vision and understanding. The patient left the psychologist’s office not only to talk about the exciting topic but also so that he could look at his problem from another angle and from another angle. It is important that the patient not only receives an answer to the questions that concern him but also be able to ask

himself new questions that bring his understanding and awareness to a qualitatively new level.