STUDY PROTOCOL

The Effect of Self Stigma Tailored Cognitive Behavioral Therapy on Gambling Disorder

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Contents

1. Study Overview

The primary aim of this study is to evaluate the effectiveness of the psychotherapy method used in the research by comparing the severity of self-stigmatizing thoughts and gambling severity between pre-test and post-test measurements among adults diagnosed with Gambling Disorder who receive standard addiction treatment (control group) and those who receive cognitive-behavioral psychotherapy adapted to self-stigma in Gambling Disorder (SSCBT) in addition to standard addiction treatment (intervention group).

The secondary aim of the study is to assess the sustainability of the intervention's effect one month after the intervention. This will be done by comparing the difference between follow-up and post-test scores of self-stigmatizing thought severity and gambling severity among intervention group and control group.

The final aim of the study is to investigate whether the decrease in self-stigmatization severity, influenced by the intervention, mediates the reduction in gambling severity.

2. Objectives

H1: There is a significant decrease in the Self-Stigma Scale (SSS) scores of individuals diagnosed with Gambling Disorder following the CBT-based intervention adapted for self-stigma.

H2: There is a significant decrease in the South Oaks Gambling Screen (SOGS) scores of individuals diagnosed with Gambling Disorder following the CBT intervention adapted to address self-stigma.

H3: There is a significant decrease in the SSS follow-up scores one month after the CBT intervention, compared to pre-intervention scores, in individuals diagnosed with

H4: There is a significant decrease in the SOGS follow-up scores one month after the CBT intervention, compared to pre-intervention scores, in individuals diagnosed with Gambling Disorder.

H5: There is a significant difference in SSS score changes over time between individuals diagnosed with Gambling Disorder who received standard treatment only and those who received standard treatment plus CBT-based self-stigma intervention.

H6: There is a significant difference in SOGS score changes over time between individuals diagnosed with Gambling Disorder who received standard treatment only and those who received standard treatment plus CBT-based self-stigma intervention.

3. Study Design

Stratified randomized controlled trial

Participants were stratified based on their Self-Stigma Scale scores using the SPSS software, and within each stratum, they were randomly assigned to the intervention and control groups. To prevent selection bias, random assignment to groups was conducted by an independent researcher. The researcher who implemented the intervention had no influence or bias regarding the assignment of participants to the experimental or control groups.

Assessment Interview:

During the assessment interview, the following steps were conducted:

(1) Participants were provided with detailed information about the study.

(2) They were informed about the measurements to be conducted and the timeline of data collection.

(3) Participants were told that they would be randomly assigned to one of two groups via a computer program and that one of these groups would be placed on a waitlist.

(4) Informed consent forms tailored to both the intervention and control groups were signed and a copy was given to the participants.

(5) All data collection instruments were administered to evaluate participant eligibility and obtain baseline data (t0).

(6) Participants were informed that they would be contacted again regarding their group assignment, and the interview was concluded.

Randomization:

After the pre measurement interviews, participants who met the inclusion criteria based on the data collected were identified. Each participant was assigned a case number.

After randomization:

(1) Participants in the intervention group were contacted, informed of their group assignment, and scheduled for their first therapy session.

(2) Participants in the control group were informed that they were placed on the waitlist.

(3) Participants who were found ineligible based on exclusion criteria were informed that they could not participate in the study.

SSCBT Intervention:

Participants in the intervention group received SSCBT, in accordance with the study protocol. Sessions were held weekly, lasting 50 minutes each. The intervention consisted of four sessions completed over approximately four weeks per participant.

Participants who attended only one, two, or three sessions were considered to have not completed the intervention. Those who completed the intervention but did not participate in the follow-up session were also considered dropouts.

Post-Test and Follow-Up Assessments:

The **Self-Stigma Scale (SSS)** and the **South Oaks Gambling Screen (SOGS)** were used at post-test and follow-up stages. Post-test assessments (t1) were conducted one month after the start of the intervention (i.e., the date of the first therapy session). Follow-up assessments (t2) were conducted approximately one month after the post-test.

4. Methods

Study Protocol Summary

1. Participants fill out the informed consent form and case report form.
2. Baseline Scores: Pre-test measurements (Self Stigma Scale & South Oaks Gambling Screen) are taken before SSCBT
3. Intervention
4. Post-test (Self Stigma Scale & South Oaks Gambling Screen) measurements are taken after intervention.

5. Follow up (Self Stigma Scale & South Oaks Gambling Screen) measurements are taken 1 months after the end of the intervention.

Intervention Plan

Session 1: Psychoeducation 1

- Addressing Gambling Disorder from a bio-psycho-social perspective.
- Explaining the concepts of social stigma and self-stigma.
- Providing information on Cognitive Behavioral Therapy (CBT).
- Presenting the cognitive-behavioral model related to self-stigmatization in individuals with Gambling Disorder.
- Exploring the impact of emotions and cognitive distortions.

Materials:

Operant learning model of Gambling Disorder, progressive model of stigma, progressive model of self-stigma, bio-psycho-social CBT model.

Session 2: Psychoeducation 2

- Examining self-stigmatizing thoughts and their impact on behaviors.
- Identifying automatic thoughts relevant to the individual's criteria using cognitive techniques.
- Introducing cognitive awareness and the foundations of cognitive restructuring through evidence examination techniques.

Materials:

Emotion-thought-behavior connection, thought and emotion analysis, evidence vs. counter-evidence example and practice, thought-emotion reevaluation.

Session 3: Psychoeducation 3

- Aligning behaviors with personal values.
- Addressing cognitive restructuring and behavior change goals.
- Enhancing the individual's self-awareness.

Materials:

Values model, reminder summary, vicious cycle diagram.

Session 4: Psychoeducation 4

- Interaction of emotions, thoughts, and behaviors.
- Increasing awareness of personal life and experiences.
- Discussing foresight and preventive strategies.
- Relapse prevention strategies and termination.

Materials:

Integrated summary of addiction and self-stigma, example triggering thoughts, relapse prevention form.

Homework Assignments

Homework is a method used in CBT interventions to reinforce the therapeutic process. The goal is to help participants internalize the intervention by engaging with assigned tasks between sessions. These assignments remain with the participant and serve as a summary of the therapeutic process.

- Homework 1: Problem List – Aims to assess the participant’s current awareness of the issue at hand.
- Homework 2: A-B-C (Illustrated)- Aims to realize and recognize one’s emotions and thoughts in specific situation.

- Homework 3: New Book, Old Book – Encourages the participant to explore their emotions, thoughts, and alternatives.

- Homework 4: Behavioral Experiment Form – Provides an opportunity for the participant to identify and work on personal cognitions during the cognitive restructuring process.

- Homework 5: Relapse Prevention Form – Helps participants document new experiences and serves as a reminder of session content for cognitive restructuring purposes.

STUDY PROTOCOL DETAILS

Measurement Tools

- ***Self Stigma Scale***

The Self-Stigmatization Scale is a measurement tool that enables individuals to identify their perspectives regarding their illness or a specific condition, as well as the self-directed stigmas they apply. The scale was originally developed in English in 2010 by Mak and Cheung to assess and evaluate self-stigmatization levels in individuals with mental disorders. It was adapted into Turkish in 2019 by Emelnur Ulusoy.

The scale consists of three subdimensions—cognitive (19 items), affective (14 items), and behavioral (6 items)—with a total of 39 items. The cognitive subscale includes items 1, 2, 4, 5, 6, 10, 11, 12, 13, 18, 21, 26, 27, 29, 30, 31, 34, 35, and 38; the affective subscale includes items 3, 8, 15, 16, 17, 22, 23, 24, 25, 28, 32, 33, 37, and 39; and the behavioral subscale includes items 7, 9, 14, 19, 20, and 36. The items are rated on a 4-point Likert scale. The total score that can be obtained from the scale ranges from 39 to 156.

Mak and Cheung, the developers of the scale, noted that no cut-off score is used in evaluation; instead, the midpoint of the total score (78) is taken as a reference. In the Turkish adaptation of the scale, a total score of 72 or higher out of a maximum of 144 is considered to indicate a high level of perceived self-stigmatization (Ulusoy & Ulus, 2022). In the context of our study, the internal consistency of the scale was tested based on the pre-test data collected from participants (n=26) to determine whether the scale had

an adequate level of reliability. While the original 39-item version of the scale had a Cronbach's alpha coefficient of .89, the Turkish-adapted version used in this study, which was reduced to 36 items, yielded an alpha coefficient of .88. When the subscales of the instrument were examined separately, the Cronbach's alpha values were found to be .78 for the cognitive subscale, .83 for the affective subscale, and .76 for the behavioral subscale. These results indicate that both the overall scale and its subscales demonstrated an adequate level of reliability within the research sample. Permission for the use of the scale was obtained from Emelnur Ulusoy via email on September 13, 2023.

- ***South Oaks Gambling Screen***

The South Oaks Gambling Screen – Turkish Version (SOGS-T) is a 19-item self-report scale used to screen for Gambling Disorder (GD) and assess its severity. The SOGS-T is designed to evaluate individuals' gambling habits and the social, financial, and psychological problems resulting from these behaviors. The scale consists of "yes" or "no" response items, with some items formatted as multiple choice. Each "yes" response is scored as one point. Evaluation is based on the total score obtained from the scale.

Originally developed by Lesieur and Blume (1987), the scale was adapted into Turkish by Duvarcı and Varan (2001). The scale is scored between 0 and 19 points. A total score of 5 or more indicates possible GD, while a score of 8 or more suggests probable GD. The Cronbach's alpha coefficient of the scale was found to be 0.85. No special permission is required for the use of the scale.

Intervention Details

Cognitive Behavioral Therapy Adapted to Self-Stigmatization Perception in Gambling Disorder:

When creating the four-session therapy model, Albert Ellis's REBT, Aaron T. Beck's CBT, and Donald Meichenbaum's Cognitive Behavioral Modification (CBM) were utilized under the umbrella of CBT.

Client-Therapist Relationship

This four-session adapted therapy model is designed based on psychoeducation, cognitive restructuring, and relapse prevention techniques. In the therapeutic process, the client-therapist relationship varies depending on the content and technique of the session, and a certain degree of role flexibility is adopted. The intervention process was created and prepared by the researcher who was trained in the field of Cognitive Behavioral Therapy and had experience in conducting individual sessions with this approach.

Session1: Psychoeducation

The first session primarily consists of psychoeducation. At the beginning of each session, a brief psychoeducational section related to the topic to be addressed is planned. Psychoeducation includes the educational aspect of the intervention. In this process, the therapist adopts the "teacher-student" role emphasized in Albert Ellis's Rational Emotive Behavioral Therapy (REBT) approach (Corey, 2015, p. 347). This approach aims to lay the groundwork for rational thinking patterns while strengthening the trust and collaborative relationship between the client and the therapist. According to Beck and Weishaar (1989), collaboration is one of the cornerstones of CBT and a fundamental building block of an effective therapeutic process.

Sessions 2 and 3: Cognitive Restructuring

In these sessions, cognitive restructuring exercises are conducted with the client. The client summarizes the previous session, sharing what they have learned, then submits the assigned homework to the therapist. After a brief psychoeducational segment, rational reevaluations and reinterpretations are made on the homework. Alternative thoughts tailored to the client's individual and cultural characteristics are developed.

During this process, the therapist adopts the Socratic dialogue approach emphasized in Beck's Cognitive Therapy (CT) model. The therapist’s attitude includes empathetic accompaniment, sincerity, and warmth, providing active guidance that facilitates the client’s self-discovery (Weishaar, 1993). This relational dynamic supports the client's development of internal awareness and the creation of alternative cognitive strategies.

Session 4: Relapse Prevention

The final session focuses on relapse prevention, which involves preparing for life situations that may trigger challenging emotions and thoughts. At this stage, Donald Meichenbaum's Cognitive Behavioral Modification (CBM) model is utilized. Throughout the session, the client engages in mental imagery exercises related to triggering life situations and develops positive future plans.

The planning process is structured based on the coping skills model of CBM and includes skill acquisition and rehearsal. During this phase, the therapist demonstrates a flexible attitude sensitive to the individual and cultural characteristics emphasized in Meichenbaum's CBM model (Corey, 2015, p. 373). The therapist's approach aims to strengthen the client's ability to cope with future challenges.

Session Content

Session 1

Introduction of the practitioner and participant, and mood state control.

Pre-test administration.

Session Goal: Psychoeducation

Psychoeducation topics:

a. The bio-psycho-social definition of Gambling Disorder (GD).

b. Introduction to the stigma process and self-stigmatization.

c. Introduction to Cognitive Behavioral Therapy (CBT).

1.a. Contrary to popular belief, GD is not a bad habit but rather a disease. Studies have defined it as a multifaceted disorder with biological, psychological, and social components (APA, 2021). As with any disease, in the case of GD, an individual will have difficulty overcoming the illness on their own without seeking professional help.

An example: "If I have a runny nose, I'm coughing, and my eyes are slightly red, what do you think is wrong with me?"

"Flu/cold."

"Even if you're not a doctor, I see that you made a quick deduction. What did you base this conclusion on?"

"Based on the symptoms you mentioned."
"The symptoms of the flu/cold are familiar to us and so obvious that we can make a quick judgment about who might have the disease. When we talk about an illness, we refer to defined, common symptoms. GD also has symptoms, just like a cold. However, we can't diagnose someone with GD as quickly as we can with a cold because the symptoms are not as visible. The symptoms of GD are mostly in our minds. There are certain cognitive processes, such as thought patterns, decision-making processes, and risk-taking behaviors, that manifest as symptoms (Grant et al., 2017). Just like with a cold, we observe the symptoms of GD, and experts in this area can create a treatment program to address these symptoms."

This explanation aims to increase the hope of individuals with GD regarding treatment and to support their self-compassion.
"There are biological processes involved in the emergence of GD, but psychological and social processes are also influential. Now, I want to talk about a learning model that affects this process. We have certain types of motivation that help us learn a behavior and then decide whether to continue that behavior (Czerny et al., 2008). Our motivation also determines how frequently the behavior we decide to continue will occur (Bozkurt, 2023, p. 127). In continuation of the definition, psychoeducation on behavior formation is carried out using Figure 1.

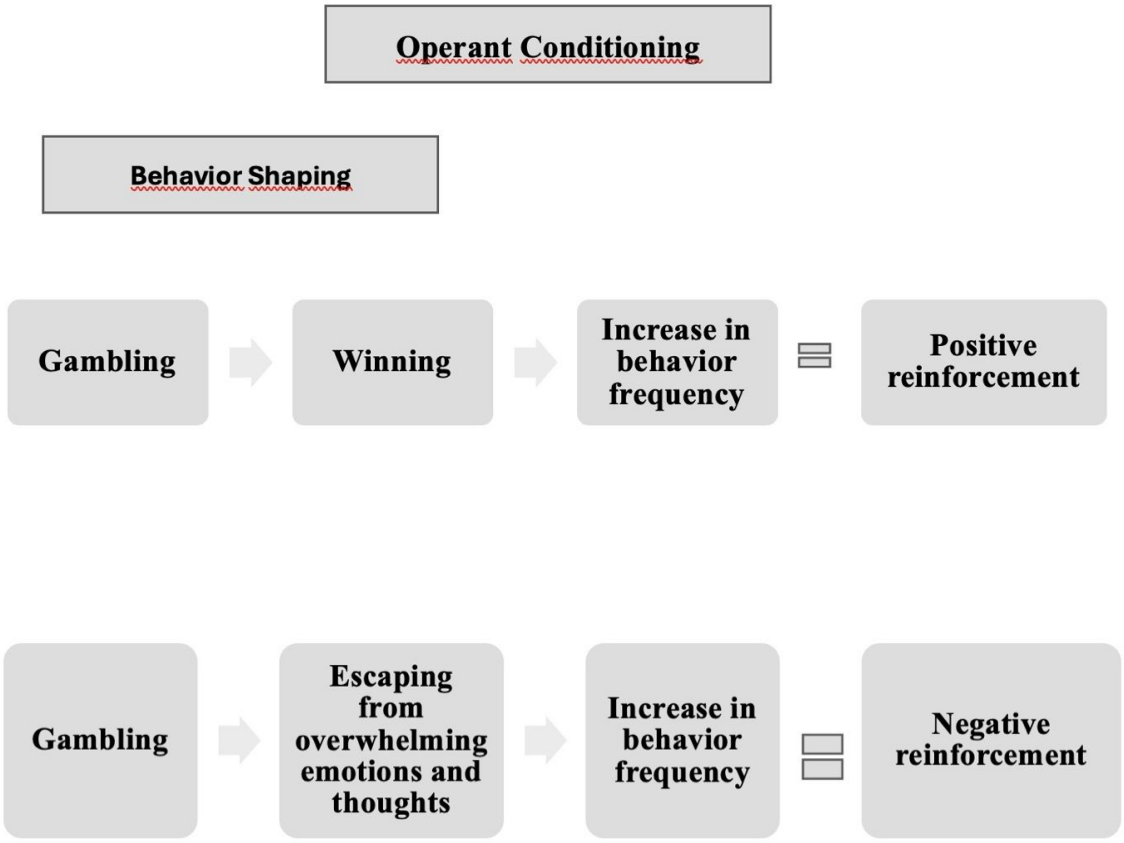


Figure 1. The Operant Learning Model of Gambling Disorder.

"When a behavior is exhibited and the person receives a desired, pleasurable outcome, they are motivated to continue that behavior and establish a frequency of behavior that aligns with their lifestyle. In the case of Gambling Disorder (GD), this could be seen as a reward gained from gambling.

However, our behaviors are not only motivated by rewards. When a person realizes that by engaging in a certain behavior, they can distance themselves from an undesirable or unpleasant situation, they may also be motivated to continue that behavior (Blaszczynski & Nower, 2002). In GD, this is the individual's attempt to distance themselves from boredom, negative thoughts, pessimistic expectations, self-judgment, or any other negativity in their surroundings (Nower et al., 2004; Gupta et al., 2004).

The compulsive processes lead to negative emotions. Our brain, evolved for survival, asks the question, "What made me happy?" in response to these stressful processes.

Addiction involves the activation of the dopaminergic pathways in the brain, specifically in the nucleus accumbens, which is highly active during pleasurable activities (Wanat et al., 2010). Brain imaging studies reveal that the nucleus accumbens is highly active during pleasurable activities, as indicated by its increased intensity and glowing on the scan. The mind records this activity. During distressing, stressful life events, the mind recalls that gambling was the activity that brought pleasure and resorts to this familiar route to experience the quickest relief (Riley, 2014). In our sessions, we will focus more on which negative emotions and thoughts the behavior is helping you avoid."

After defining operant learning motivated by negative reinforcement, the participant is invited to share their own experiences related to this concept. The model is personalized by adding the individual's own experiences to the created table. The participant is encouraged to analyze their experiences through a theoretical framework, facilitating understanding.

"What we are referring to here—the boredom, negative emotions, and negative thoughts the person wants to escape from—can arise or intensify depending on the way the individual evaluates themselves, their environment, and their future. These ways of evaluation are influenced by the socio-cultural structure we live in and our biographical stories."

1.b. Stigmatization. Using Figure 2, the concept is introduced to the participant in an interactive way.

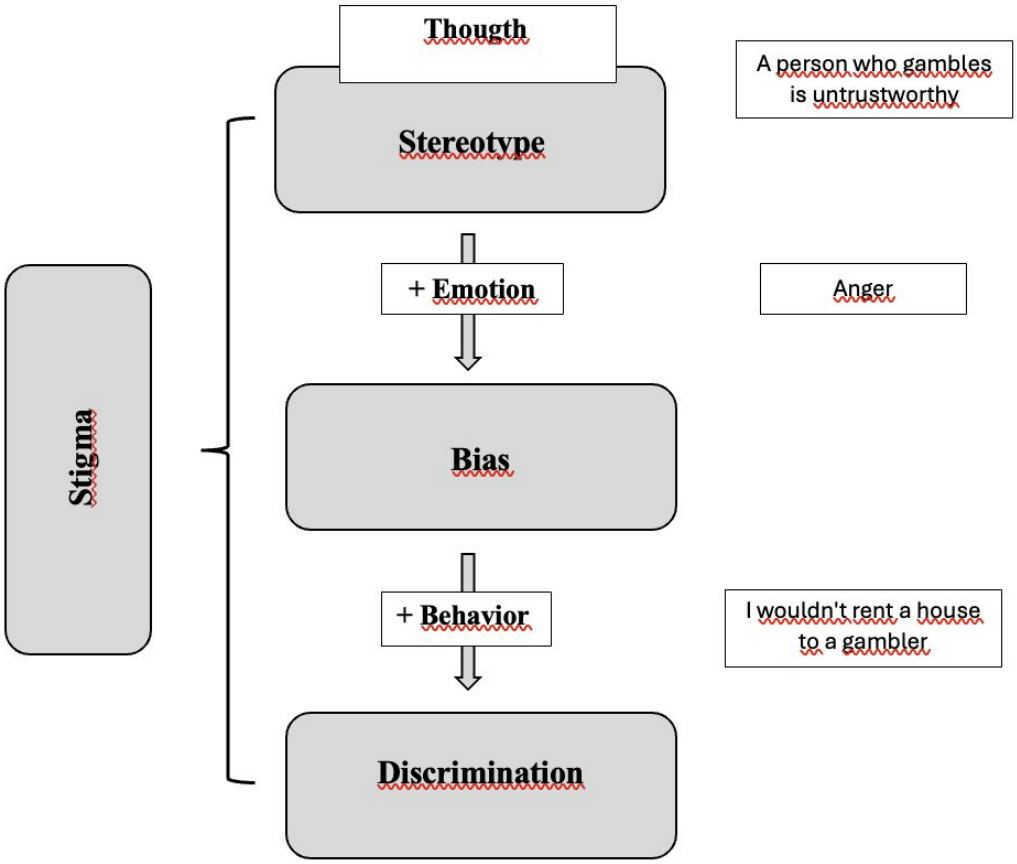


Figure 2. The Progressive Model of Stigmatization. (Created by the researcher, based on the work of Corrigan et al., 2011).

“We learn and adopt the perspectives of the society we grow up in, using them to create shortcuts in our lives. Let's take a look together at what kind of beliefs might exist in our unconscious societal processes regarding people who gamble, based on the table you see here.

Initially, what negative beliefs can you identify about people who gamble? Considering the societal perspective, how do you think people with Gambling Disorder (GD) are perceived?"

"Unreliable, unable to form a family... etc."

Since the most frequently stated stereotype by participants is "unreliable," we will continue with this example of the stereotype "unreliable."

"The societal conclusion that people who gamble are unreliable is a thought. If we add an emotional component to this thought, it transforms into a prejudice. What kind of emotion do you think is felt toward those who are considered unreliable?"

"Disappointment, anger, anxiety... etc."

Since the most frequent emotional response mentioned by participants is "anger," we will continue with the emotional response of "anger."

"After the thought that people who gamble are unreliable, if someone feels anger, they have now formed a prejudice. What kind of behavior do you think someone with such thoughts and emotions would exhibit towards a person diagnosed with GD?"

"They wouldn't want to engage, would keep their distance, would speak badly about them... etc."

"When behaviors motivated by prejudice start to be exhibited, we can talk about discrimination. When all these components come together, the process of stigmatization is complete. We made these definitions with your help, and I understand that you assume the thoughts, feelings, and behaviors you've identified towards people who gamble are widespread in society and your environment, is that correct?"

The aim is for participants to gain awareness of the concept of stigmatization by sharing their personal experiences with it. By discussing the destructive effects of stigmatization, the goal is to foster empathetic collaboration.

"The experience of stigmatization causes the individual to become indistinguishable from the stigmatized issue (Matthews, 2019, p. 19). For example, the term 'gambler' is a stigmatizing expression that creates the misconception that gambling is an inseparable part of the individual's character. In contrast, using 'a person with GD' separates the

person's character from the disorder. This usage emphasizes that the person is someone with a treatable diagnosis.

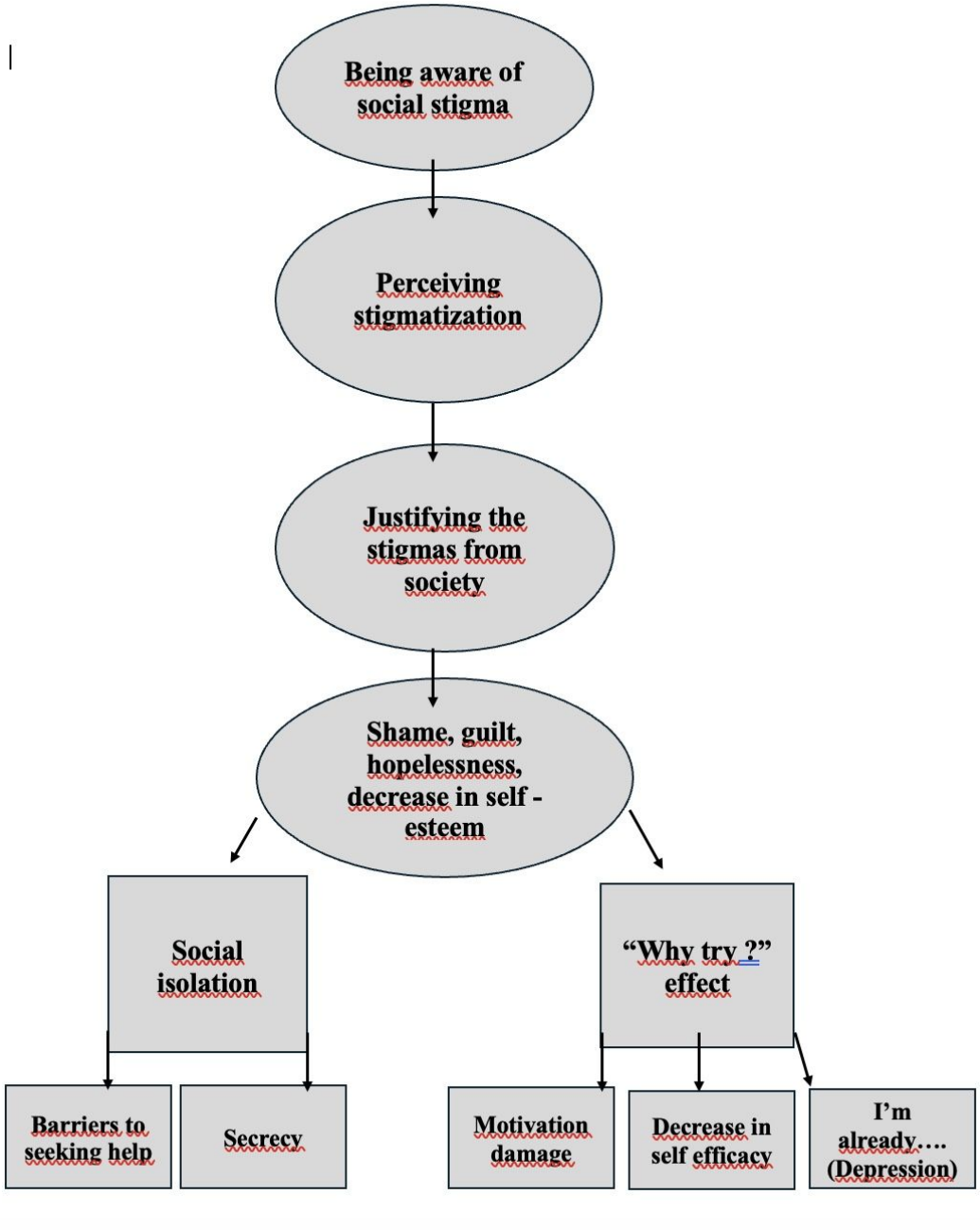


Figure 3. The Progressive Model of Self-Stigmatization (Adapted by the researcher from Corrigan et al., 2011).

1.c. Self-Stigma. "How do you relate to people who make you feel stigmatized? How do you manage your experience of stigma in your environment?"
"I distance myself; I leave, I try not to see them... etc."

"The experience of stigma leads individuals to emotionally challenging processes that are difficult to cope with (Horch & Hodgins, 2013; Corrigan et al., 2011). It often results in distancing from people and environments where the experience occurs, leading to feelings of exclusion (Prizeman ve ark., 2023). The individual becomes aware of society's stigmatizing attitudes and, upon recognizing themselves as part of the stigmatized group, begins to internalize these labels (Luoma, 2010). They evaluate the prevailing social stigmas and may start to accept some as valid (Corrigan et al., 2011). For example, 'People say that those who gamble is unreliable. I gamble, I lie, I borrow money and fail to repay it. Therefore, I must be unreliable too. People are right to think this way.' As a result of this process, the individual begins to self-stigmatize.

"One of the most significant challenges of self-stigmatization is that, while an individual may try to cope with external stigma by withdrawing from stigmatizing environments, they cannot escape the self-stigmatizing thoughts in their mind and continue to be exposed to them. The experience of self-stigmatization often leads to overwhelming emotional states such as shame, guilt, a desire to hide, decreased self-esteem, and hopelessness. Due to the persistent exposure to self-stigmatizing thoughts and distressing emotions, the individual's self-perception becomes increasingly negative, leading to social isolation (Atlam et al., 2024), secrecy (Luoma et al., 2007), barriers to help-seeking, and a lack of motivation to change, often expressed as 'Why try?effect' (Corrigan et al., 2009). This results in decreased self-efficacy, harm to motivation for change, and increased depressive symptoms.

"Furthermore, this process reinforces negative reinforcement mechanisms, as described in operant conditioning (Şekil 1), where the individual engages in gambling behavior as a means of escaping negative experiences (Weatherly & Cookman, 2014). Once self-stigmatization emerges as a consequence of gambling disorder (GD), it becomes one of the maintaining factors, playing an active role in the individual's life.

"Do any of these emotions feel familiar to you? Do you find yourself experiencing these emotions in your daily life? How often and how intensely do you feel them?"

Following this explanation, the question aims to encourage participants to share their own experiences, reflect on memories, and develop awareness of the emotions they have felt and the moments in which self-stigmatization was active. All participants reported experiencing emotional responses such as shame, guilt, and decreased self-esteem.

1.d. Cognitive Behavioral Therapy.

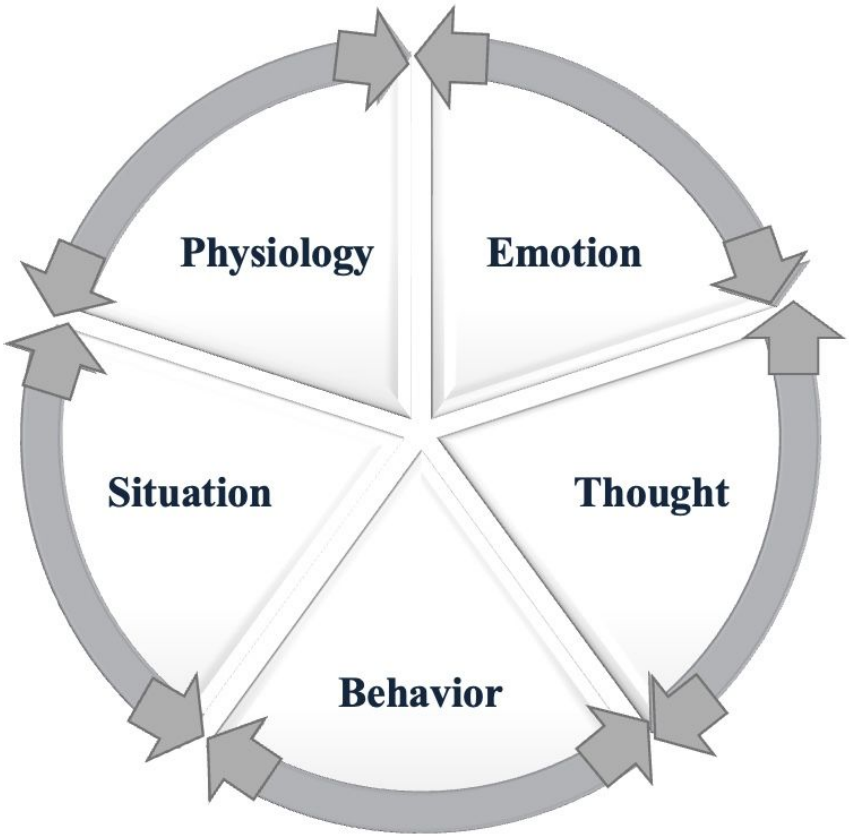


Figure 4. Conveying the Cognitive Behavioral Therapy Model from a Biopsychosocial Perspective (Özdel et al., 2021).

Within the scope of our study, we will examine the stigmatizing thoughts and their effects that emerge as a result of the activation of self-stigmatization perception, based on the cognitive-behavioral therapy (CBT) approach. As seen in the circular diagram (Şekil 4), the components of physiology, emotion, thought, behavior, and situation interact bidirectionally, forming a continuous cycle in human life. If we are talking about change, we must observe changes in these components. This change should be planned systematically, step by step. Initially, it makes sense to target a component that we have control over.

"Is it within your power to change your physiological responses according to your goals and intentions?"
"No."
"Can you snap your fingers and change the situation you are in?"
"No."
"Are you capable of instantly replacing distressing emotions with supportive ones?"
"No."
"Can you eliminate your distressing thoughts simply by deciding not to think them anymore?"
"No."
"But is it within your control to change, reduce, or manage a behavior?"
"Yes."
"Then, in our initial phase, our goal in addressing the negative experience of self-stigmatization perception will begin with the behavioral component."

The Function of Homework (Corey, 2015, pp. 343-386):

The concept of homework, which is inherent in cognitive-behavioral therapy, is introduced, emphasizing that assignments related to session content will be planned at the end of each session. Participants are encouraged to complete their assignments before the next session. Homework serves to ensure that self-stigmatization perception is not only focused on during the 60-minute weekly sessions but remains an active part of the participants' awareness throughout the four-week process. This helps integrate session topics into daily life, encouraging active engagement in the therapeutic process.

Session 1 – Homework 1: Illustrated Thought Record Form (Figure 5)

This form has been obtained from the website of the "Association for Cognitive Behavioral Psychotherapies." Due to the nature of self-stigmatization, guilt and shame emotions are often triggered. This homework aims to support participants' awareness through in vivo applications. Guilt and shame are treated as signals, functioning as an alert system. Participants are instructed to recognize when these emotions are triggered and, at that moment, direct their attention to identifying the specific self-related thought that is active. They are then asked to record these thoughts.

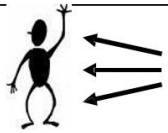
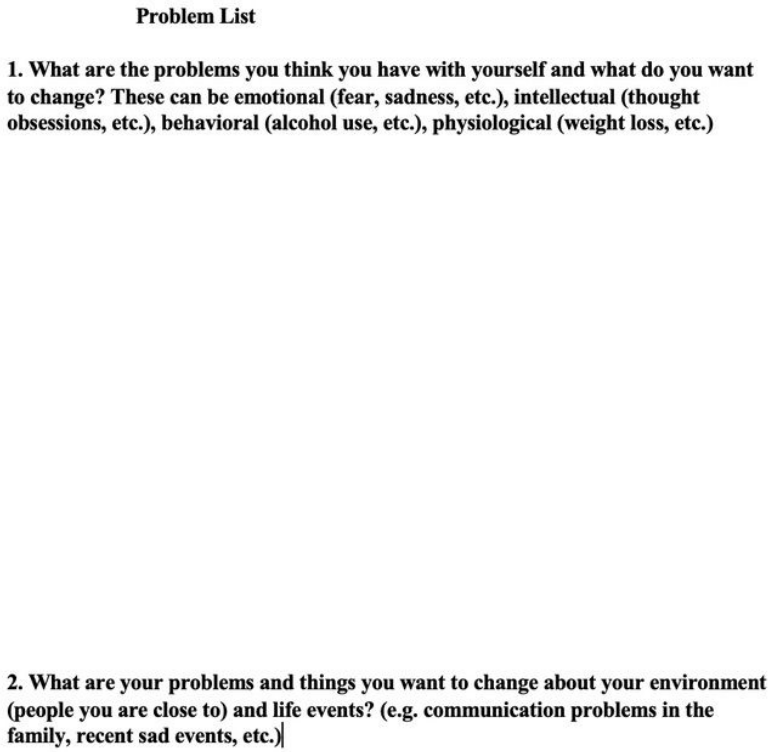
 What was happening around me?	 How was I feeling?	 What was I thinking?	 What was I doing?	Did it work?	 What else could I do?

Figure 5. A-B-C (Illustrated), Association for Cognitive Behavioral Psychotherapies, 2024.

1.e. Session 1 – Homework 2: Problem List (Figure 6).

This form is taken from the website of the "Association for Cognitive Behavioral Psychotherapies." The goal is for the participant to think about and write down their change goals, making the key areas they wish to intervene in for life goals that align with their values clear to themselves.



Problem List

1. What are the problems you think you have with yourself and what do you want to change? These can be emotional (fear, sadness, etc.), intellectual (thought obsessions, etc.), behavioral (alcohol use, etc.), physiological (weight loss, etc.)

2. What are your problems and things you want to change about your environment (people you are close to) and life events? (e.g. communication problems in the family, recent sad events, etc.)

Figure 6. Goal Setting Form II, Association for Cognitive Behavioral Psychotherapies, 2024.

Session 2

Session Goal: Cognitive Restructuring

Cognitive restructuring aims to discover the dysfunctional automatic thoughts that affect an individual's life and to question and reduce belief in these thoughts through the evidence examination technique (Dryden, 2002). Beginning to question dysfunctional automatic thoughts allows for the possibility of replacing them with functional thoughts in later sessions.

At the beginning of the session, the homework discussed in the previous week is reviewed. Since the homework provides examples from the participant's personal life, it helps personalize the session content. The examples from the thought record form (Figure 5) will highlight the thoughts that will form the basis for cognitive restructuring techniques. Before discussing the homework, psychoeducation materials supported by visuals are provided to explain how emotions are formed (Figure 7). Then, attention is brought back to the cycle discussed in Session 1, and the examination of thoughts in the context of the cyclical relationship (Figure 4) between emotion, thought, behavior, and physiology is explained. The reciprocal interactions between thoughts and emotions, as well as the motivational tasks of generating behavior, are defined. Events and situations are discussed in their raw form, devoid of emotion and thought.

Events and situations are addressed as they are—stripped of emotions and thoughts. The interaction between emotion, thought, and behavior is discussed through a case example, which is visualized and presented using the material in Figure 7.

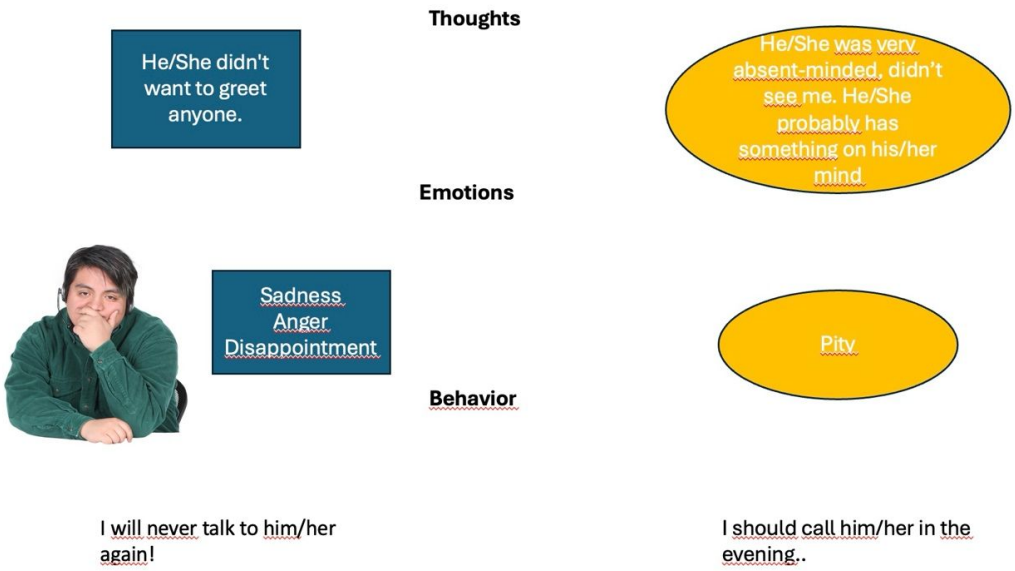


Figure 7. Explanation of the connection between emotion, thought, and behavior. Özdel, (2023). Cognitive Behavioral Therapy Training [Created by the researcher using a CBT training visual].

For example, “You are walking down the street and notice someone you know walking towards you. Then, you both walk past each other without greeting.” When we describe what happened without interpreting it, it is referred to as the “raw event.” Now, let's add a thought to this event: "See, they didn't want to greet me." What kind of emotional response would you expect if you interpret the situation with this thought?" Answers typically include anger, frustration, and sadness. "As you can see in this hypothetical example, when I describe the event without any interpretation, no emotional response arises. However, once we add a thought, we can talk about strong emotions." Based on this thought and these emotions, how would you behave towards this person? Answers included, "I would ignore them, I wouldn’t pick up their calls."

Let's talk about a different thought for the same event. If the thought “Poor thing, they didn’t even see me, they were so distracted” is considered, what kind of emotional response would you expect? Responses generally include concern, worry, and pity. "What would the behavioral response be to these thoughts and emotions?" The responses

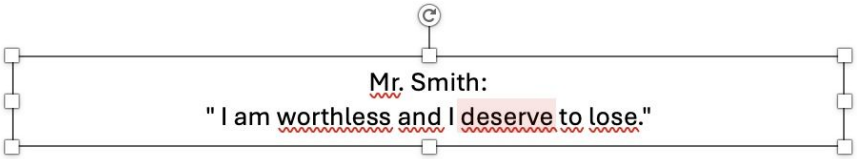
included, "I would call them in the evening, ask how they're doing." Similar responses were gathered.

In this example, attention is drawn to the behavioral outcome. It is explained that even though the raw event remains unchanged, the way it is interpreted alters the dominant emotional response and the resulting behavioral reaction. The participant's three experiences, brought in through the homework, are simplified to "raw events," and it becomes clear how strongly the thoughts related to guilt and shame, which were the focus of the homework, appear in these experiences. The self-stigmatizing thoughts that the participant identifies by directing their attention to their thoughts during moments of guilt and shame over a week are simplified to make them easier to analyze (Figure 8).

HOT THOUGHTS	
SIMPLIFICATION (IF NECESSARY)	
THE EMOTION IT MAKES AND THE INTENSITY OF THE EMOTION (0-10)	
STRENGTH OF BELIEF IN THIS THOUGHT (0%-100%)	

Figure 8. Thought and Emotion Analysis. Adapted from Akkoyunlu and Türkçapar (2012).

For example, a heavy thought such as *"Even if I stop gambling, my mother/spouse and those around me will still think I am gambling and will not stop talking about me as a gambler."* is simplified to *"Even if I quit, no one will believe me."* for analysis. Using this method, three thoughts identified by the participant throughout the week are also simplified and examined. For each identified thought, the participant is asked to rate the distress it causes on a scale of 1 to 10 (e.g., 10/10) and to evaluate their belief in the thought on a scale of 0 to 100 (e.g., 90%). The "evidence review" technique is then applied to all three thoughts (Figure 9).



EVİDENCE FOR	AGAİNST
I lost a lot of money and couldn't make up for my mistakes.	There are things in my life that I do well. Times when I am successful at my job and in my social relationships.
I lied to my family and loved ones and lost their trust.	My loved ones don't say I'm a bad person, they try to support me.
I lose control of myself when I gamble, which shows that I am a truly weak person.	People make mistakes and that doesn't mean they are worthless; I can strive to improve myself too.

Figure 9. Example of Evidence and Counter-Evidence. Dönmez (2023). Cognitive Behavioral Therapy Training [Created by the researcher using a CBT training visual].

In the *evidence review* technique, the participant is asked to list experiences in their life that support the given thought (Akkoyunlu & Türkçapar, 2013). While listing the evidence, assumptions, interpretations, and feelings are not considered valid evidence; instead, the participant is expected to describe actual events. For example, *"Even though I am not gambling, my mother said, 'You've been looking at your phone a lot—are you gambling again?'"* or *"While we were talking, my spouse said, 'You want to quit now, but tomorrow you'll want to gamble again.'"*

In the next step, the participant is asked to generate counter-evidence for the same thought. Similar to the first part, concrete behaviors and experiences are preferred, and even the smallest counter-evidence is noted without omission (Figure 10). If the participant struggles to generate counter-evidence, they are encouraged to imagine themselves as a lawyer in a courtroom who must find evidence to win the case, even if

they do not personally believe in it (Akkoyunlu & Türkçapar, 2013). A sample list is provided to clarify the process (Figure 9).

AUTOMATIC THOUGHT SENTENCE:

EVIDENCE FOR	AGAINST
ENVIRONMENTAL EVIDENCE THAT CAUSES ME TO THINK AND FEEL THIS WAY	NON-ENVIRONMENTAL EVIDENCE THAT CAUSES ME TO THINK AND FEEL THIS WAY (ACTUALLY…)

Figure 10. Evidence and Counter-Evidence Application. Created by the researcher based on Akkoyunlu and Türkçapar (2012).

Examples of counter-evidence may include experiences such as: “I am not giving up. There was a time when I didn’t gamble for a month, and gradually, people’s attitudes toward me changed. I spent more time with my friends, and they noticed that I had quit. I received positive feedback. I was able to set aside money to pay off my debts. My mother tried to support me and constantly praised me. My spouse and I even went out for dinner one evening.”

The collected evidence and counter-evidence for the examined thought are then evaluated. The outcome is discussed objectively by considering both the number and quality of the supporting and opposing pieces of evidence (Figure 10).

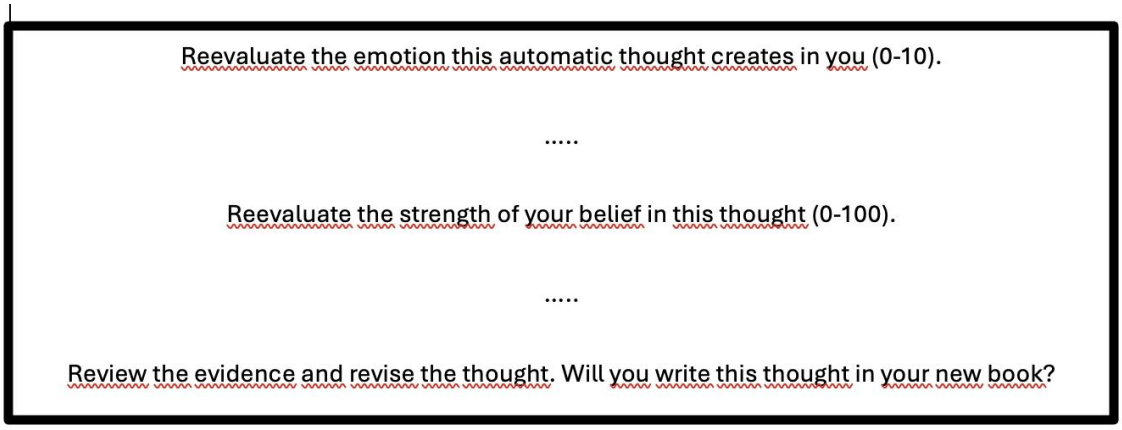


Figure 11. Thought and Emotion Reassessment. Created by the researcher based on Akkoyunlu and Türkçapar (2012).

The participant’s initial distress level and belief percentage regarding the thought are reassessed, and any changes are recorded (Figure 11). Attention is drawn once again to the power of the thought in generating and intensifying emotions, using a personalized example tailored to the participant’s life.

Assignment 2: "New Book/Old Book" Worksheet (Figure 12). – At the beginning of the session, the stigmatizing thoughts discussed are written in the *Old Book* section of the worksheet. In the *New Book* section, the participant is asked whether they want to keep these thoughts or not. For each thought they do not wish to keep, they are tasked with

writing an alternative thought in the *New Book* section by the next session. The first cognitive restructuring session is then concluded.

OLD BOOK	NEW BOOK

Figure 12. Old Book – New Book Exercise. Dönmez (2023). Cognitive Behavioral Therapy Training [Training Visual].

Session 3

Session Objective: Cognitive Restructuring / Behavioral Adjustment

The *New Book/Old Book* assignment from the second session is reviewed. This exercise helps reinforce the participant's motivation by encouraging them to develop alternative thoughts aligned with their personal values (Figure 12).

Psychoeducation: Values.

Values are a dynamic process that begins to develop in early childhood through the interaction of various internal and external factors and continues throughout life. They are a set of fundamental beliefs and principles that define what is considered good, right, important, and desirable by individuals, groups, or societies (Yazıcı, 2014). Values serve as internal guides that influence thoughts, behaviors, and decisions, extending from individual identity to societal norms (Schwartz, 2009).

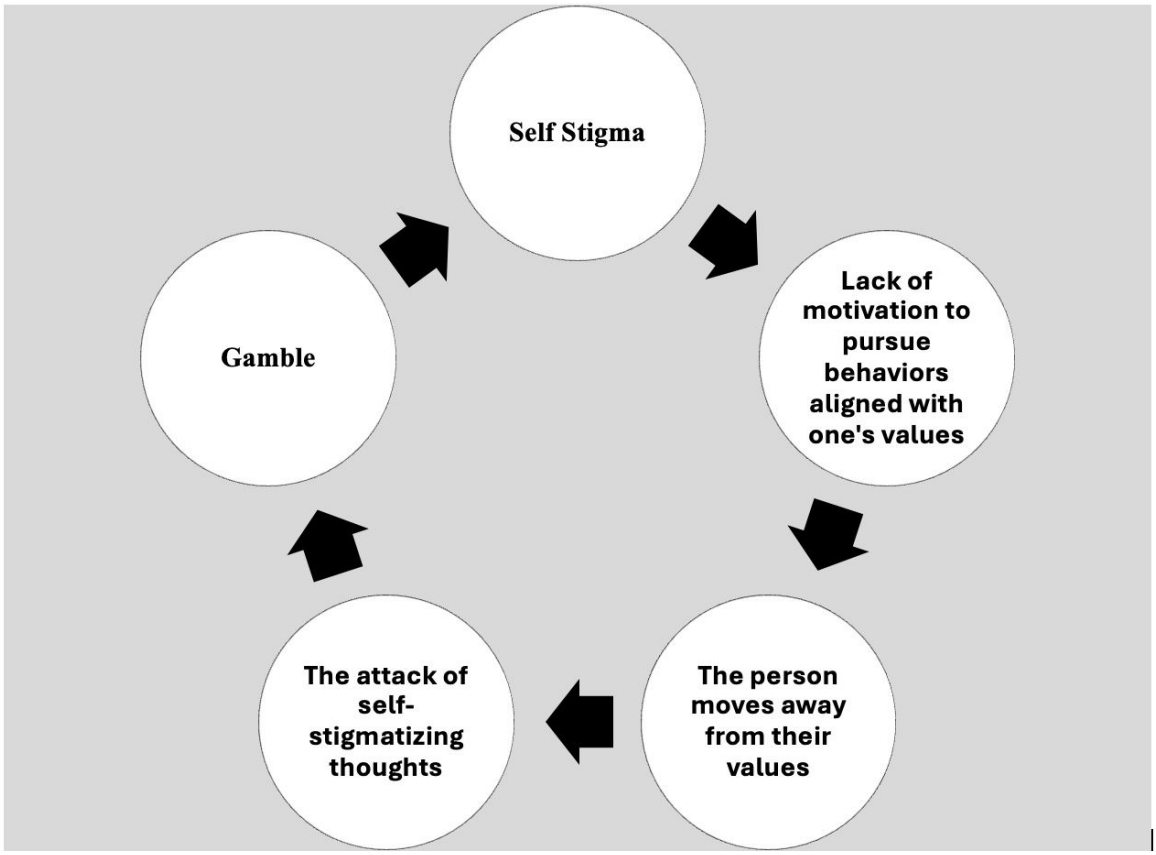


Figure 13. Values Model.

The relationship between gambling disorder, the values of the individual, and self-stigma is discussed in Figure 13. As a result of Behavioral Addiction, self-stigmatizing thoughts lead individuals away from the motivation to pursue life goals that align with their values (Corrigan et al., 2009). The material and emotional resources that would help the individual pursue goals in line with their values are exhausted or harmed in the gambling process, causing their lifestyle to automatically drift away from these goals. When an individual starts doing things that contradict their values and begins living a life that no longer aligns with their values, they develop various negative thoughts and emotions about themselves and once again become subject to the attack of self-stigmatizing thoughts. The more the individual feels they have strayed from their values, the more intense the self-stigmatizing thoughts are likely to become (Corrigan & Kleinlein, 2005; Norman et al., 2008).

The intrusive thoughts related to the person's detachment from their values, such as "I'm not doing what I know is right," "I'll lose my reputation," "I am a failure and inadequate," "I no longer recognize myself," trigger feelings of guilt, shame, loss of self-esteem, inner conflict, alienation, dissatisfaction, unhappiness, self-criticism, depression, anxiety, and a sense of disconnection (Atlam et al., 2024). This can have deep effects on the individual's self-perception and mood.

The increase in inner conflict, harsh self-criticism, and experiences of disconnection resulting from behaviors and lifestyle that contradict one's values can lead to mental health issues such as depression and anxiety in the long term. By the end of this process, the individual may feel pessimistic, hopeless, and anxious. Struggling to cope with these overwhelming emotions and thoughts, the individual may turn back to gambling, which is recorded in their mind as a pleasurable activity (Figure 13). This leads back to the starting point and perpetuates the vicious cycle (Figure 14).

As a result of Behavioral Addiction, the self-stigmatization perception becomes one of the factors that sustain the addiction.

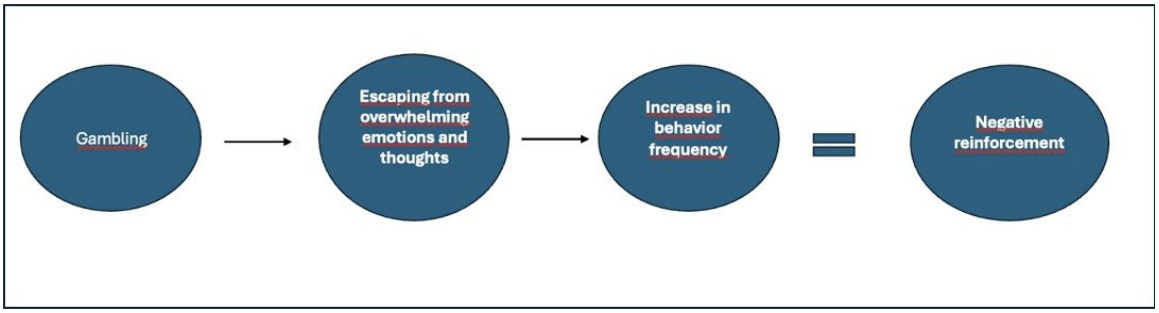


Figure 14. Reminder Summary.

The factors that lead to a lifestyle and evaluation style disconnected from the individual's values due to their behavioral addiction, and that sustain the perception of self-stigmatization, are examined using the vicious cycle flower (Figure 15a). Immediately afterward, the current behaviors that support a life aligned with their values, as well as potential behavioral changes, are explored using a second cycle flower. At the end of the session, the participant is given the value-consistent cycle flower (Figure 15b) for further reflection.

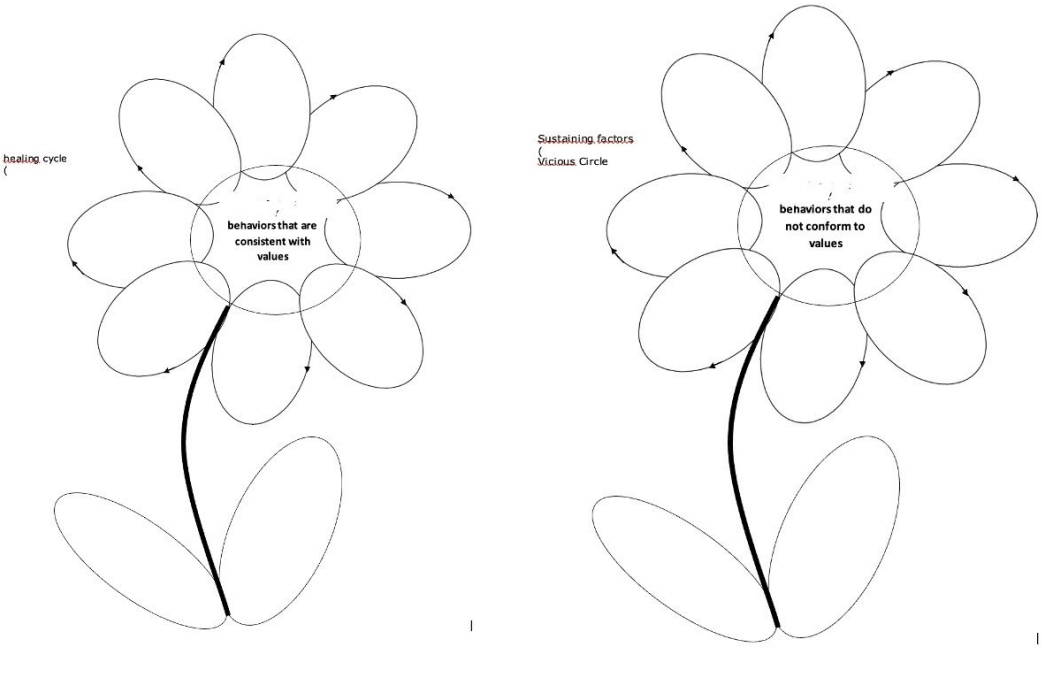
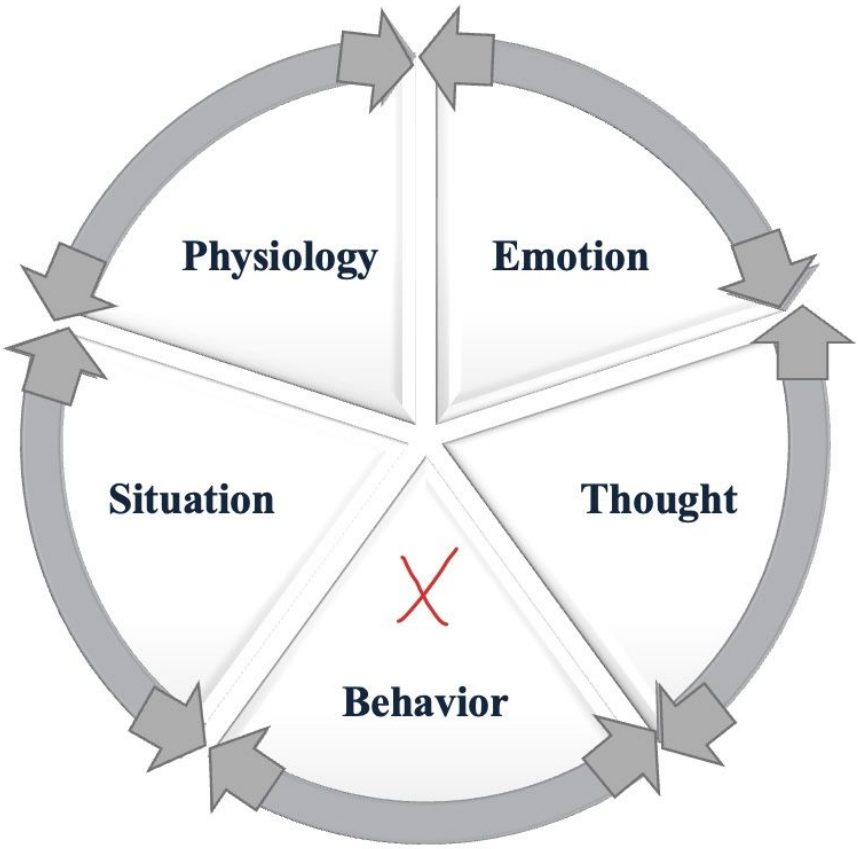


Figure 15. Figure 15a. Vicious Cycle Flower, Association of Cognitive Behavioral Psychotherapies, 2024 (Adapted). Figure 15b. Value-Consistent Cycle Flower *(Adapted by the researcher).*

At the end of the session, it is reminded that the intervention's power for the targeted change in thoughts and emotions lies in behaviors, and the cycle used in the first session is revisited.



Moving away from self-stigmatizing thoughts and the distressing emotions they create is possible by distancing oneself from maintaining behaviors. At the end of the 3rd session, the individual gathers examples from their own life related to maintaining behaviors and behaviors that guide them toward living according to their values and prepares a behavioral experiment for the homework at the end of the session. This is expected to activate a decision-making process based on their experiences to determine which behaviors to maintain in life.

Homework 3: Behavior Experiment (Figure 16)

	PREDICTION What did you assume would happen?	BEHAVIORAL EXPERIMENT	WHAT ACTUALLY HAPPENED? How was it in accordance with predictions? (0-10)	DID IT WORK? (0-100)
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Figure 16. Behavioral Experiment. Cognitive Behavioral Psychotherapies Association, 2024 (Adapted).

For the behavioral experiment to be implemented, an example behavioral experiment that aligns with the individual's values in the areas they aim to change, based on the "goal list" homework given in Week 1, is planned together. Change is not easy. Before the behavioral experiment is conducted, predictions about how the individual will feel and think are discussed, and the intensity of the predicted emotions and thoughts is rated on a scale from 0 to 10. After the behavioral experiment is completed, the validity of these predictions is reconsidered. After the individual carries out the behavioral experiment, the impact on their self-stigmatizing thoughts is evaluated in the "Did it work?" section. Scoring in this area is done on a scale of 0-100, and attention is drawn to the effective parts.

Session 4

Goal: Relapse Prevention

Psychoeducation: The Contribution of Self-Stigmatization Perception to Relapse

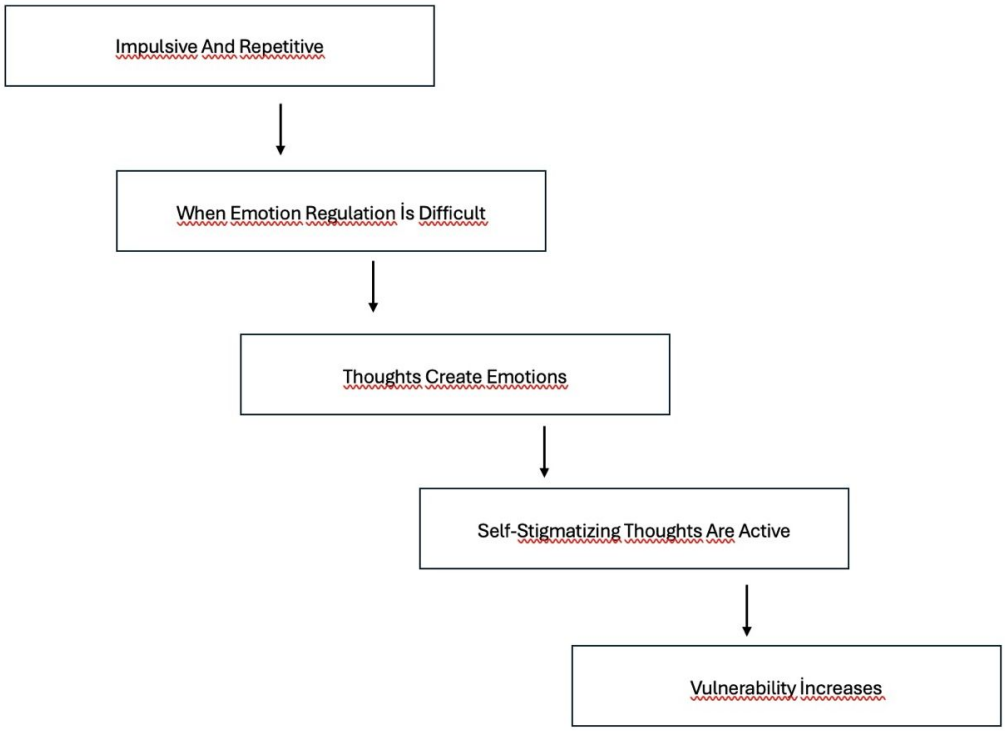


Figure 17. Integrative Summary of the Nature of Addiction and Self-Stigmatization.

A summary of the relationship between addiction and self-stigma is illustrated in Figure 17. Addiction is a disease that follows a pattern of recovery and relapse. Addiction is a brain disease. Certain regions in the brain are responsible for reward and pleasure systems. Like other addictions, gambling is a disease in which a person struggles to maintain control once they start, and it is impulsive and repetitive in nature (Potenza et al., 2019). Just like alcohol and substances activate the brain's reward mechanism, gambling also activates it in a similar way (Darçın et al., Noyan, 2023, p. 50). Resisting impulsive urges becomes more difficult in processes where emotion regulation is challenging. During periods when overwhelming emotions take over, the repetitive nature of addiction is more likely to emerge. The strongest factor triggering overwhelming emotions is the thoughts that arise along with the individual's perception, interpretation, and evaluation of life events. As one of the symptoms of Gambling Disorder (GD), the increased effectiveness of cognitive distortions exposes the individual to self-stigmatizing thoughts. With the presence of overwhelming emotions, which are difficult to regulate,

accompanying self-stigmatizing thoughts, the individual's vulnerability increases, making them more susceptible to impulsive urges. This vulnerability, combined with the repetitive nature of addiction, may lead the person to face relapse.

This cycle is examined within the context of factors in the participant's life that could lead to potential risks in the future. This examination is carried out using the Cognitive Behavioral Psychotherapies Association's "Relapse Prevention" form (Figure 18).

Self-stigmatizing thoughts can either be weakened or reinforced by making inferences about what significant others in the environment may think (a cognitive distortion called "mind reading"). In the first stage of the relapse prevention phase, possible mind-reading thoughts are listed as examples, and the participant is asked to choose those that seem familiar. The current belief about these selected thoughts is rated on a scale from 0 to 10. Afterward, the participant is asked to consider whether these thoughts align with the belief that the money won from gambling was acquired in a manner consistent with their and significant others' values, and to rate this belief on a scale of 0 to 10. These thoughts are then used in the relapse prevention form to identify high-risk situations and triggers, which are marked as potential triggers. The reevaluation of these thoughts is expected to provide cognitive restructuring regarding the outcomes of gambling disorder while also helping the individual to recall the values of both themselves and the significant others in their life.

Example Trigger Thoughts:

1. "If I make money, people will love me again."
2. "If I buy a house or car, my family will respect me again."
3. "If I make enough money, everything will get better."
4. "People around me expect me to make money."
5. "If I become rich, people will speak well of me."
6. "If I don't achieve great success, no one will value me."
7. "I need to make a lot of money to forgive myself."
8. "If I don't make money, my friends will distance themselves from me."

9. "I must make money to prove I've overcome my gambling addiction."
10. "If I am financially successful, my relationship with my family will improve."
11. "People will only take me seriously once I am rich."
12. "To gain respect in society, I need to have money."

Relapse Prevention

What did I learn?
Which ones were the most useful?
How can I make sure I don't go backwards?
What are high risk situations? **What events/situations/triggers make me more vulnerable?**
What are the signs? **Thoughts / feelings / behaviors**

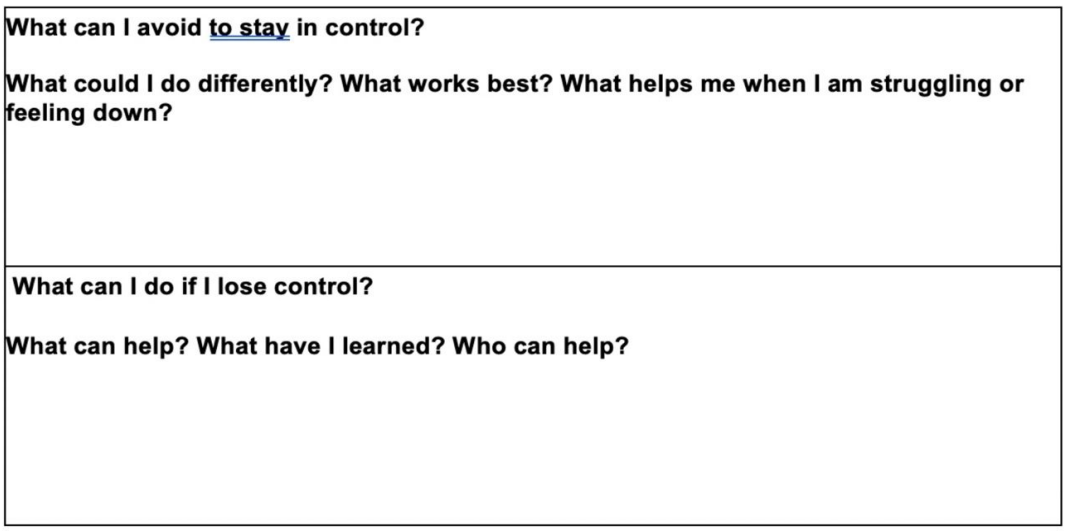


Figure 18. Relapse Prevention Form, Association for Cognitive Behavioral Psychotherapies, 2024.

The questions "What have I learned?" and "Which were the most beneficial?" on the worksheet remain unanswered. Instead, participants respond to the questions "How can I prevent relapse?", "What are my high-risk situations?", and "What are the warning signs?" to enhance awareness of risk factors in their lives and to recognize early signs before entering a progressive relapse process.

The question "What should I avoid to maintain control?" encourages individuals to identify high-risk environments, situations, or behaviors and take responsibility for their choices. Additionally, the question "What can I do if I lose control?" is answered to emphasize that experiencing a slip does not inevitably lead to a downward spiral; instead, it reinforces the idea that there is always an option to regain control.

The continuation of the worksheet is included in this form so that participants can keep it with them and record their experiences until the follow-up session scheduled for one month later.

When deterioration occurs…

How do I interpret this?

What events/triggers caused this regression? How did I react to them? What did I think? What did I feel?

What did I learn from this?

Was this a very risky situation? Where things I would describe as difficult? What helped and what didn't?

Afterwards, what could I have done differently?

When I feel…. or think…., what could I do instead of what I did?

In the event of a relapse, the individual is asked to answer the questions “How can I interpret this?”, “What have I learned from this?”, and “What could I have done differently afterward?” with the aim of determining their perspective on the experience and fostering a constructive evaluation of their situation.

The questions “What have I learned?” and “Which insights were the most beneficial?”—if not answered immediately—are assigned as a reflective task for the participant to consider and write about until the follow-up session one month later. This approach aims to reinforce the topics covered during the sessions, ensuring that the individual continues to engage with them even in the absence of ongoing meetings.

5. Statistical Analysis Plan

The normality of continuous variables was assessed using the Skewness-Kurtosis test and the Shapiro-Wilk test. Data obtained from pre-measurements, post-measurements, and follow-up measurements were analyzed using appropriate parametric tests to evaluate whether differences in self-stigmatization perception and gambling severity between the experimental and control groups were statistically significant.

For continuous variables that followed a normal distribution, descriptive statistics were reported as mean and standard deviation, while categorical variables were presented as frequency and percentage. The Mixed Design ANOVA was used to compare dependent variables across different time points between groups. To assess the changes in dependent variables over time, the interaction term (independent variable *time*) was included in the Repeated Measures ANOVA.

The assumptions for variance analysis were checked, and no violations of these assumptions were found. Descriptive information about participants in the experimental and control groups, along with the statistical results from the analyses, were presented in tables. A significance level of $p < 0.05$ was considered statistically significant.

Statistical calculations were performed using STATA (version 13.0) and SPSS (version 25) statistical software. Hayes' Process was employed to test the mediation hypothesis,

with a 95% confidence interval and a p-value < 0.05 considered significant.

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9. Informed Consent Form

INFORMED CONSENT FORM

PLEASE READ CAREFULLY!

You are being invited to participate in this study. Before deciding whether to take part, it is important that you understand the purpose of the study and make your decision freely after reviewing this information. Please read this information sheet carefully and feel free to ask any questions you may have."

What is the name of this study?

The name of this study is *"Examining the Effectiveness of Cognitive Behavioral Therapy Adapted to Self-Stigmatization Perception in Individuals Diagnosed with Gambling Disorder."*

What is the purpose of this study?

The aim of this research is to understand how the perception of self-stigmatization experienced by individuals struggling with gambling disorder may hinder their treatment adherence, through a four-session customized cognitive behavioral therapy model. Additionally, the study aims to analyze the effectiveness of this model in reducing self-stigmatization perception among individuals diagnosed with gambling disorder.

What tools will be used in this study?

In this study, a demographic information form, the Self-Stigmatization Scale, and the South Oaks Gambling Screen will be used as pre-tests for both the experimental and control groups. A four-session cognitive behavioral therapy model, designed to address self-stigmatization perception in gambling disorder, will be implemented with volunteers assigned to the experimental group. Homework materials supporting cognitive and behavioral restructuring will be used after each session. These materials were obtained from the website of the Cognitive Behavioral Therapies Association. The content of the psychotherapy to be applied to the experimental group and the homework assignments after each session are as follows:

Session 1: Gambling Disorder from a bio-psycho-social perspective, stigma and self-stigma, CBT introduction, cognitive-behavioral model of self-stigmatization, impact of emotions and cognitive distortions.

Materials: Operant learning model, stigma and self-stigma models, bio-psycho-social CBT model.

Homework 1: Problem List – Aims to assess the participant's current awareness of the issue at hand.

Homework 2: A-B-C (Illustrated)- Aims to realize and recognize one's emotions and thoughts in specific situation.

Session 2: Self-stigmatizing thoughts and behaviors, identifying automatic thoughts with cognitive techniques, cognitive awareness, and restructuring with evidence examination.

Materials: Emotion-thought-behavior link, thought analysis, evidence vs. counter-evidence practice.

Homework 3: New Book, Old Book – Encourages the participant to explore their emotions, thoughts, and alternatives.

Session 3: Aligning behaviors with values, cognitive restructuring, behavior change, and self-awareness.

Materials: Values model, reminder summary, vicious cycle diagram.

Homework 4: Behavioral Experiment Form – *Provides an opportunity for the participant to identify and work on personal cognitions during the cognitive restructuring process.*

Session 4: Emotion-thought-behavior interaction, personal awareness, prevention strategies, relapse prevention, termination.

Materials: Addiction and self-stigma summary, trigger thoughts, relapse prevention form.

Homework 5: Relapse Prevention Form – Helps participants document new experiences and serves as a reminder of session content for cognitive restructuring purposes.

Volunteer's Initials	Researcher's initials

What is the probability of random assignment to different treatment groups?

The probability of being randomly assigned to the research groups is 50%. Participants will not be assigned to the groups by the researchers. The assignments will be determined based on the order in which patients apply for treatment.

How much time will it take?

The duration of the standard treatment provided at the outpatient clinic is determined by the outpatient doctor. The total duration of the research is 2 months. The psychotherapy sessions will be completed within a total of 4 weeks. One month after the final session, all participants will only be asked to complete the research scales.

What is the estimated number of volunteers expected to participate in the study?

A total of 32 participants are expected to take part in the study.

What will happen to the biological materials taken from you, and where will the analyses be conducted? (If the analyses are to be performed abroad, please explain where the biological materials will be sent.)

No biological materials will be collected from you as part of this study.

What is expected from you? What are your responsibilities?

What is expected from you in this study is:

1) To participate in the 4-session cognitive-behavioral psychotherapy experimental application adapted to the standard treatment provided at the outpatient clinic and the perceived self-stigmatization in gambling disorder,
2) To complete the forms provided by the researcher at three different intervals under the guidance of the researcher.

What will you gain by participating in the study?

It is anticipated that the psychotherapy schema planned to be applied to the volunteer as part of this research will be beneficial in developing a functional coping strategy for managing self-stigmatization perceptions and will contribute to the improvement of individual well-being and increased participation in social life. By participating in this study, you will be able to contribute to the scientific literature on the issue that is the focus of this research. The psychotherapy method to be applied in this research is a new treatment method whose effectiveness is being investigated in this field. If the psychotherapy method proves to be effective, you will be informed about the existence of a new approach that can help you manage your issue. Upon request, you will be informed of the research results after the study is completed.

What situations would require the termination of your participation in the study?

There are no specific situations that would require the termination of your participation in the study. Participation in the study is voluntary, and you have the right to withdraw from the study at any time, with or without providing a reason.

Could participation in the study cause you any harm?

Participation in the study does not pose any risk to you. Any potential situations that may arise during the study will be thoroughly explained to you by the researcher.

What are the alternative methods available to you?

There are no alternative methods applied within the scope of this study. No methods will be applied without your knowledge.

Volunteer's Initials	Researcher's initials

Will I receive any payment for participating in this study?

You will not receive any payment for participating in this study.

Will I have to pay any fees for participating in this study?

No fees will be charged to you for participating in this study. Any tests, physical examinations, or other research-related expenses will not be charged to you or any institution or organization under your insurance coverage.

Confidentiality of Information:

Personal data such as your identity, age, gender, family history, as well as health data including psychiatric and medical diagnoses, current and past treatment information will remain confidential and will only be used for scientific purposes. Even in the event of publication of the research results, your identity will remain anonymous.

Contact Information of the Study Supervisor:

1- Name: Asoc. Prof. DR. Umut Kirli

Accessible phone number: 0 232 390 1618

Affiliation: Ege University

2- Name: Ayça ÇINAROĞLU ASAR

Accessible phone number: 0 543 530 86 83

Affiliation: Ege University

Consent to Participate in the Study:

I have read and heard the information above, which must be provided to the volunteer before the research begins. I have asked all the questions that came to my mind to the researcher, and I fully understand all the explanations made to me, both in writing and verbally. I was given enough time to decide whether or not I want to participate in the study. Under these conditions, I give permission to the research supervisor to review, transfer, and process my medical information, and I voluntarily accept the invitation to participate in this study without any coercion or pressure. I am aware that I am participating in this research voluntarily and that I can withdraw from the study at any time, with or without justification. By signing this form, I acknowledge that I will not lose the rights granted to me by local laws. In the context of the clinical research, I give my explicit consent to the collection, processing, sharing as indicated in the consent form, and anonymization of all personal data, including my personal health information, for use in scientific studies.

I understand that a signed and dated copy of the informed consent form will be given to me.

Participant		Sign
Name & Surname		
Date		
The qualified researcher who provided the information about the study and is part of the research team is:		Sign
Name & Surname	Psyc. Ayça ÇINAROĞLU ASAR	
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