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Problem Gambling: Taking Chances

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Problem Gambling: Taking Chances
Bonnie K. Lee, PhD

Background
From the rattling of divination sticks to the clatter of hucklebone dice, games of chance have been practised by humans since prehistory (Grunfeld, 2006). Gambling behavior as a form of play (Smith & Abe, 1984), has evolved into what is now a multibillion-dollar industry fueled by capitalism, appetites, tourism and technology worldwide. Casinos have become part of the landscape. Electronic gambling machines, Internet gambling, and the ubiquitous lure of lotteries are a part of 21st century culture. Legalized gambling is now found in every state in the United States except Hawaii and Utah (American Gaming Association, 2009). Some States except Hawaii and Utah (American Gaming Association, 2009) is now found in every state in the United States except Hawaii and Utah (American Gaming Association, 2009). From the rattling of divination sticks to the clatter of hucklebone dice, games of chance have been practised by humans since prehistory (Grunfeld, 2006). Gambling behavior as a form of play (Smith & Abe, 1984), has evolved into what is now a multibillion-dollar industry fueled by capitalism, appetites, tourism and technology worldwide. Casinos have become part of the landscape. Electronic gambling machines, Internet gambling, and the ubiquitous lure of lotteries are a part of 21st century culture. Legalized gambling is now found in every state in the United States except Hawaii and Utah (American Gaming Association, 2009). Some States except Hawaii and Utah (American Gaming Association, 2009). Some States except Hawaii and Utah (American Gaming Association, 2009).

Gambling is defined as staking something of value upon a game or event with an uncertain outcome based on luck or chance. Social acceptance of gambling and its accessibility have increased the risk for problem outcomes (Gerstein, Murphy, Toce, Hoffman, Palmer, Johnson, 1999). Although it has been argued that gambling and casinos can act as a catalyst for economic growth with spinoffs in social benefits (Shaffer & Korn, 2002), at the same time, gambling also poses a public health and mental health concern (Shaffer & Korn, 2002). Hence, marriage and family therapists need to be alerted to symptoms of problematic gambling and its impact on couples and families, and to the types of therapies available, especially empirically supported forms of treatment.

Problem and Pathological Gambling
Gambling exists along a dynamic continuum from social, recreational gambling to problem and pathological gambling. Problem gambling is a term commonly used to describe a range of gambling behaviors that result in negative consequences for the gambler, family and friends. Approximately 3-4% of the adult population in North America gamble excessively, and 1-2% of the population experience serious recurrent disruptions of their personal, family and vocational lives that fit with the diagnosis of “pathological gambling” (Stucki & Rihs-Middel, 2007).

Problem gambling needs to be viewed as a family problem because it has adverse consequences, not only for gamblers but for spouses, children and extended family members (Grant, Kalischuk, Nowatzki, Cardwell, Klein, & Solowoniuk, 2006, McCollum, Lee & Spenkle, 2009). On average, at least seven other people are said to be affected by each problem gambler’s behavior (Proactivity Commission, 1999), with fallout ranging from enormous financial and family pressures, relationship breakdown, and domestic violence. Compared to the general population, problem gamblers are more likely to report legal issues, crime and incarceration (Potenza et al., 2000), impaired physical and mental health (Pierrat & Perry, 2005), and suicide attempts (McCallum & Blaszczynski, 2003). Adolescents and college students show markedly higher rates of problematic gambling than the general population (Shaffer & Hall, 2001). Older adults are also considered a population that is potentially vulnerable to problem gambling (Shaffer, LaBrie, LaPlante, Nelson, & Stanton, 2004) with their increased leisure, personal losses and loneliness. In fact, Gerstein et al. (1999) found that the most dramatic rise in lifetime gambling was found in those over age 65. Traditionally, men have gambled more than women and are more likely to develop gambling problems, but more recently, disordered gambling rates among women have increased and are now comparable to men’s (Hing & Breen, 2001; Hrabá & Lee, 1996). Ethnic minority groups, notably Native Americans (Volberg, 1994, Wardman, el-Guebaly, & Hodgins, 2001) and Asian immigrants (Blaszczynski, Hayth, Dumlao, & Farrell, 1998; Perry, Armentano, Knoch, Norinith, & Smith, 2003) have been found in several studies to have a higher prevalence of gambling-related problems and are at greater risk for gambling problems than the general population. Social determinants such as social and cultural marginalization, trauma history, and socio-economic stresses need to be considered in understanding this over-representation (Yanicki, Gregory, & Lee, 2010). Gamblers of lower socio-economic status spend a higher proportion of their personal income on gambling and hence are at higher risk for adverse consequences (Shaffer, 2003).

Assessment
A variety of measures and instruments are available for the assessment of the severity of gambling and related problems, and for the diagnosis of “pathological gambling.”

Table 1. DSM-IV (APA, 2000) CRITERIA: PATHOLOGICAL GAMBLING

<table>
<thead>
<tr>
<th>A. Persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:</th>
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<tbody>
<tr>
<td>1. is preoccupied with gambling (e.g. preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)</td>
</tr>
<tr>
<td>2. needs to gamble with increasing amounts of money in order to achieve the desired excitement</td>
</tr>
<tr>
<td>3. has repeated unsuccessful efforts to control, cut back, or stop gambling</td>
</tr>
<tr>
<td>4. is restless or irritable when attempting to cut down or stop gambling</td>
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<tr>
<td>5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression)</td>
</tr>
<tr>
<td>6. after losing money gambling, often returns another day to get even (“chasing” one’s losses)</td>
</tr>
<tr>
<td>7. lies to family members, therapist, or others to conceal the extent of involvement with gambling</td>
</tr>
<tr>
<td>8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling</td>
</tr>
<tr>
<td>9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling</td>
</tr>
<tr>
<td>10. relies on others to provide money to relieve a desperate financial situation caused by gambling</td>
</tr>
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</table>

B. The gambling behavior is not better accounted for by a Manic Episode.
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an assessment is always more than test administration, so the following discussion hopes to assist practitioners in covering areas of inquiry and exploration in the clinical interview with individuals and couples.

Diagnosis
Pathological gambling is currently classified as an “impulse control disorder” in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). The ten criteria seen in Table 1 assess persistent and recurrent maladaptive gambling that interferes with personal, family or occupational functioning. Similar to cases of pathological dependence, pathological gamblers exhibit signs of tolerance and withdrawal. These are captured on the DSM-IV-TR as preoccupation with gambling, need to gamble with increasing amounts of money, repeated unsuccessful efforts to control or stop gambling, and restlessness or irritability when attempting to cut back or stop gambling. At least five of the ten criteria must be met for a diagnosis of pathological dependence. This provided that the gambling behavior is not better accounted for by a manic episode.

Concurrent Mental Health and Addiction Concerns
Screening for pathological gambling for clients with a history of mental illness or substance abuse is important since these issues commonly co-occur with gambling problems (Cunningham-Williams, Cortell, Compton, & Spitznagel, 1998; Rush, Bassini, Urbanosky, & Castel, 2008). Major depression and mood disorders are diagnosed in 63% of pathological gamblers (Lesieur & Blume, 1991). Anger, guilt, shame, and the need to escape reality are also common in pathological gamblers, as are pressure points that often set off the onset or escalation of gambling problems. Stages for change have been a valuable contribution to the treatment of pathological gambling and should be noted.

Family life cycle transitions (Carter & McGoldrick, 1989), losses, crises and setbacks in the gambler’s or couple’s life are pressure points that often set off the onset or escalation of gambling problems. Such crises could include overwhelming emotional and coping challenges that overtax their responsive capacity, especially if the couple lack awareness of themselves and their communication is limited in range and depth that pre-empt support and negotiations. Engagement of the partner can be a couple and family issue can get in the way.

Because gamblers and partners often have poor coping and relational skills (Wood & Griffiths, 2007), assessing the couple’s cycle of coping and ways of handling stress and distress is important. What is commonly called “family programs” may mean seeing spouses as separate from the gamblers. Conjoint sessions are lacking, although they have the benefit of allowing those who are affected by the gambling to interact and to assess their different perspectives on the issue systemically. Building a strong therapeutic alliance with both partners and containing the volatility in couple sessions are integral to therapeutic progress and require systemic skills. Engaging the hesitant partner to come in for conjoint therapy also requires some strategizing, as fear, trust and a lack of understanding of how pathological gambling is a couple and family issue can get in the way.

Screening for domestic violence is recommended, as problem gamblers have shown higher risks of intimate partner violence (Affi, Brownridge, MacMillan, & Sareen, 2009; Nower, Lesieur, & Zettler, 1998) as being a couple and family issue can get in the way. Spouses report loss of trust, a sense of betrayal and being left with the burden of responsibilities (Dickson-Swift, James, & Kippen, 2005). The HITS竹 (Heimer, Itururua, Shover, & Blak, 2007) and ZETTO (Zettler, Shover, & Blak, 1998) is a screening tool for identifying the frequency and type of domestic violence that could be presented to allow the clinician to assess for appropriateness of couple therapy. The Dyadic Adjustment Scale (Spanier, 1976) is useful in gauging the degree of couple distress and cohesion as a baseline for comparison as therapy progresses.

Family Assessment
Children of pathological gamblers experience a theme of “pervasive loss” affecting their physical and existential well-being with loss of trust, one by one, as well as material and relational security (Darbyshire, Oster, & Carrig, 2001). They are caught in family stress and triangles and become family scapegoats or peace-makers (Lesieur & Rotherchild, 1989; Shaw, Forbush, Schindler, Rosenfield, & Blake, 2007). Adolescent children are at increased risk of depressive feelings, adjustment and conduct problems, as well as gambling and substance abuse problems (Jacobs, Marsot, Singer, et al., 1989; Vitato, Wanner, Btegen, & Tremblay, 2008). Stages of Change

The “stages of change” model (Prochaska & DiClemente, 1983) has been a valuable contribution to working with addictions and other client changes. Clients’ readiness to change is assessed in terms of six stages: (1) pre-contemplation; (2) contemplation; (3) preparation; (4) action; (5) maintenance; and (6) relapse. At each stage, clients focus on specific tasks that will lead them to the next stage of change. By noting the client’s readiness to change in relation to each target area, e.g. gambling, couple relationship, parenting, mental health, the therapist can capitalize on the goal that represents the client’s greatest readiness and motivation to change. The motivational interviewing approach emphasizes the client’s positive direction. In effect, all aspects of a problem are linked and interwoven.
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Treatment

Most problem gamblers do not seek or receive treatment despite its availability (National Research Council, 1999; Perry & Armentano, 1999). At the lower end of problem gambling severity, many gamblers recover without self-help or formal treatment interventions (Hodgins, & el-Guebaly, 2000). For those who seek formal treatment, gambling problems that range along a continuum of severity respond to a range of therapies and treatment modalities offered in clinical settings.

Individual and Group Approaches

Brief therapy models such as motivational interviewing (Miller & Rollnick, 1991) utilize open-ended questions, affirmations, reflective listening, and summaries to support client’s self-efficacy. Questions open up the discrepancy between positive and negative consequences of problem gambling. Clients can come to realize the payoffs of problem gambling and how these may need to be compensated for by other alternatives; they also come to appreciate what benefits can be anticipated on stopping/reducing gambling behavior. The goals of brief intervention include instilling hope, increasing awareness of risky habits, offering feedback, and obtaining information about the client’s healthier behavior patterns. Psycho-education and client-centered interviewing raise awareness of factors that may be contributing to problem gambling (e.g., family history; habitual ways of dealing with stress and boredom). Brief interventions consisting of one to two sessions are valued for their cost-effectiveness and for the purpose of engaging the gambler and opening up the potential for change. Once engaged, continuing therapy is much easier and the drop-out rate is substantially lower (Wulfert, Blanchard, Fresenbend, & Martell, 2006). Treatment dropout rates average around 31% (Melville, Casey, & Kavanagh, 2007). Motivational interviewing is an empirically supported method to engage the clients in weighing the costs-benefits of problem gambling and empowering the client to reach a decision for change. (Hodgins & Makarchuk, 2002; Robson, Edwards, Smith, & Colman, 2002).

Case Example

Cindy has been feeling depressed after the death of her brother and her gambling problems began when the casino opened in town. Her gambling increased to the point where she now meets all ten of the DSM criteria for pathological gambling. She has exhausted her retirement funds and kept this a secret from her husband Rob until she was charged for defrauding her employer. Unlike substance abuse, gambling problems can be better hidden which makes its discovery more sudden and devastating. Cindy was under house arrest while her husband took control of the family finances and kept a close eye on her use of the Internet and other activities. Resentful of being “treated like a child” and berated by Rob for her crime, Cindy bottled up her shame and resentment while feeling she was given no credit for her efforts. This eventually led to her relapse. “What’s the point,” she thought, “I have tried so hard to make other people happy all my life, now is my turn to have some fun.” After her arrest, Cindy received a few individual counseling sessions focused on modifying her erroneous cognitions regarding her chances of winning at casino games. She also attended Gamblers Anonymous (GA) and felt less alone in her struggles in fellowship with other gamblers. GA gave her a place to talk about the twists and turns of her recovery, something she was not able to do at home. The couple therapist at the agency coaches Cindy in approaching Rob to see if he might be willing to try a few conjoint couple sessions. The therapist balances hearing and validating each of Cindy’s and Rob’s perspectives and concerns. Fears, anger, and hurt expressed from both sides are acknowledged in a non-blaming way. Patterns of the couple’s communication are pointed out to them – how Cindy tends to placate and hide her feelings because of her fear of rejection and Rob’s self-preoccupation, dismissiveness and oblivious to Cindy’s ongoing distress and loneliness. The therapist helps the couple see that the impasses in interaction they have in the present reopen the hurts and unresolved issues they suffered in their respective families of origin. With new clarity and awareness of themselves and their past, the couple rehearse new patterns of congruent communication with each other, and learn to acknowledge themselves and their partner. Through these conjoint sessions, Cindy and Rob gain a deeper understanding and respect for each other that heal the breach in their relationship. They recognize problem gambling as a symptom of a prolonged and profound disconnection they have with themselves and each other with influences from their family-of-origin. Less ashamed and alone, Cindy’s urges to go back to the casino have drastically reduced. When she has the odd relapse, she and Rob are able to talk in order understand what happened, and to strategize ways to pre-empt the possibility of a future episode. She and Rob have started renovating their house and are planning a vacation together for the first time in 8 years.

Cognitive-behavioral approaches may involve recording the number of gambling and non-gambling days in a month, rewarding the non-gambling days, noting times for greater risks for gambling and restructuring these times to prevent access to gambling, and looking for other pleasurable activities (Petry, 2005). Cognitive interventions include exploring thoughts that occurred before, during and after the client’s last gambling session, and challenging faulty thoughts and beliefs (Ladouceur et al., 2002). Problem gamblers are educated on the difference between chance and skill in gambling, and a primary focus is to increase awareness of the insatiable and unstoppable nature of most gambling games (where outcomes are entirely random). Exercises are set up to increase gamblers’ awareness of their own thoughts and behaviors and to help them control their losses. Maintaining healthy thought patterns, finding strategies to support abstinence, and being aware of risks of relapse are part of a cognitive–behavioral program. Cognitive-behavioral therapy has often been conducted in group treatment with comparable results to individual treatments at 3 months (Ladouceur et al., 2003; Gooding & Tarrier, 2009).

Psycho-dynamic and psychoanalytic approaches view problem gambling as arising from and motivated by internal conflicts and unconscious forces and its understanding of “compulsive gambling” held sway in the 1950s and 1960s (Hodgins & Holub, 2007). Delivered in individualized or group format, psychotherapy aims to increase the clients’ insight into the unconscious drives and id impulses behind the gambling behavior and helps the clients resolve unconscious conflicts to reduce the compulsion to gamble. Requirements for longer-term treatment and client propensity for high-level verbalization of psychological insights may be barriers to clinical application of formalized psychodynamic therapies. Psychoanalytic approaches are not standardized depending on the orientation of the therapist, hence difficult for controlled outcome studies.

Although medications specific to the treatment of problem gambling have not been approved (Hodgins & Holub, 2007), a small body of research exists to demonstrate the treatment effectiveness of some pharmacologicals (e.g., selective serotonin re-uptake inhibitors; opioid agonists; mood stabilizers) that reduce difficulties with anxiety, depression symptoms (Grant, Williams, & Kim, 2006; Pallesen et al., 2007). Problems of medication research are side effects, lack of treatment compliance, and high treatment drop-out rates (Hodgins & Holub, 2007).

Couple Approaches

Despite the fact that problem gambling takes a toll on the gambler as well as the partner and the couple relationship, relatively little attention has been given to couple treatment models until recently (Bertrand, Dufoeur, Wright, & Lasnier, 2008; McBee, Lee, & Sprenkle, 2009).

Couple Behavioral-Cognitive Models.

Behavioral-cognitive models for couples treatment have been adapted from such models for substance abuse disorders. Ciarrocchi (2002) adapted integrative behavioral couple therapy (Jacobsen & Christensen, 1996) to provide a self-regulation manual for individuals and couples. Strategies are directed towards task-oriented goals, such as developing environmental controls, restoring the couple’s financial situation, managing legal problems, and permitting partners to ask questions and give feedback to gamblers. The approach favors tolerance and acceptance to motivate change and create a climate to explore trust, fairness and self-esteem (Ciarrocchi, 2002).

More recently, Adapted Couple Therapy (Bertrand et al., 2008) is proposed as a promising adjunct to individual cognitive behavioral therapy that corrects the gambler’s erroneous cognitions concerning random environmental controls to clinical Couple Therapy commences only after the crisis situation is resolved and the financial crisis is settled. The model subscribes to the gambler being the identified patient and that the responsibility of the pathological gambling “rests on the shoulders of the IP” (Bertrand et al., 2008, p. 403). The therapy begins with a functional analysis of the gambler’s gambling behavior, to identify the presence of trigger-treatment effectiveness of some pharmacologicals (e.g., selective serotonin re-uptake inhibitors; opioid agonists; mood stabilizers) that reduce difficulties with anxiety, depression symptoms (Grant, Williams, & Kim, 2006; Pallesen et al., 2007). Problems of medication research are side effects, lack of treatment compliance, and high treatment drop-out rates (Hodgins & Holub, 2007).

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the gambler’s abstinence in a positive manner. Inclusion of couple work such as the demonstration of caring behaviors, sharing pleasure and expression for affection, constructive anger therapy and problem-solving skills. This model has not been empirically validated.

Conjoint Humanistic Integrative Model. Conjoint Couple Therapy (CCT) was developed as a short-term, integrative, humanistic model for working with pathological gamblers and spouses conjointly (Lee, 2002, 2009a). Designed around the concept of congruence, CCT provides a clear therapy structure conjoinly (Lee, 2002; 2009a). Designed developed as a short-term, integrative, not been empirically validated.


National Council on Problem Gambling: www.pathologics.org. The mission of the National Council on Problem Gambling is to increase public awareness of pathological gambling, ensure the widespread availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and education.

National Problem Gambling Helpline: 1-800-522-4700 (U.S.) Confidential-Native-247

Gamblers Anonymous (International) http://www.gamblersanonymous.org Gamblers Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from a gambling problem.

Gam-Anon (International) www.gam-anon.org The self-help organization of Gam-Anon provides assistance for the spouse, family or close friends of compulsive gamblers.


Hodgins, D. C., & Federman, E. J. (2001). The Alberta Association of Marriage and Family Therapists. Lee has been the principal researcher and trainer in a research program since 2001 in the development and application of Congruence Couple Therapy, a systemic relationship model for the healing of pathological gambling, which she is now extending to other families. Lee works in bringing together training, practice and research in service of human growth and healing.

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References


Author.


Lee, B. K. (2009). Congruence Couple Therapy is safe and acknowledged to be a safe drug treatment for gambling problems (Lee, 2009b).


Relapse and Maintenance

Similar to other addictions, relapse rates among pathological gamblers are high, and can be as high as 75% (Hodgins, Currie, el-Guebaly & Diskin, 2007). Pathological gambling, is a complex multi-factorial disorder that can be influenced by a variety of factors including lack of control, relapse and maintenance. The major factors that contribute to relapse are: severity of gambling, duration of gambling, and lack of support from family and friends.

Behavioral self-management programs, such as Gamblers Anonymous and other self-help organizations, have been shown to be effective in reducing relapse rates (Dunton, 2007). These programs provide individuals with tools and strategies to manage their gambling behavior, including setting limits, keeping track of gambling activity, and seeking support from others who have experienced similar issues.

Problem Gambling: The impact of gambling on individuals and families

Gambling can have a significant impact on individuals and families. It can lead to financial problems, relationship issues, and even legal and health problems. Research has shown that problem gambling can lead to increased risk of suicide, domestic violence, and physical and mental health problems (Hodgins, 2009). The impact of gambling on families can be significant, and it is important for family members to seek help and support in dealing with this issue.

Resources for Practitioners


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