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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 huckleberry dice, games of chance have been practiced by humans since prehistory (Graufeld, Zangeneh, & Diakoloukas, 2008; Reith, 1999). Gambling behavior as a form of play (Smith & Abar, 1984), has evolved into what is now a multibillion-dollar industry fueled by capitalistic 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 form of legalized gambling is found in every province and territory in Canada (Statistics Canada, 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, 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; Haber & Zuckerman, 1994). Ethnic minority groups, notably Native Americans (Volkberg, 1994; Wardman, el-Guebaly, & Hodgins, 2001) and Asian immigrants (Blaszczynski, Huynh, Dumlos, & Farrell, 1998; Perry, Armentano, Kusche, 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 economic stressors, 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 (MacCallum & 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. Problem gambling and hence are at higher risk for adverse consequences (Shaffer, 2003).

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” (Steckel & Rishi-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; McCurdy, Lee & Spreenkle, 2009). On average, at least seven other people are said to be affected by each problem gambler’s behavior (Productivity 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 (MacCallum & Blaszczynski, 2003).

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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>
</tr>
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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>
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<tr>
<td>2. needs to gamble with increasing amounts of money in order to achieve the desired excitement</td>
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<tr>
<td>3. has repeated unsuccessful efforts to control, cut back, or stop gambling</td>
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<tr>
<td>4. is restless or irritable when attempting to cut down or stop gambling</td>
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<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>
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<tr>
<td>6. after losing money gambling, often returns another day to get even (“chasing” one’s losses)</td>
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<tr>
<td>7. lies to family members, therapist, or others to conceal the extent of involvement with gambling</td>
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<tr>
<td>8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling</td>
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<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 lack of funds due to gambling</td>
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B. The gambling behavior is not better accounted for by a Manic Episode.

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.” However,

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| 2. needs to gamble with increasing amounts of money in order to achieve the desired excitement |
| 3. has repeated unsuccessful efforts to control, cut back, or stop gambling |
| 4. is restless or irritable when attempting to cut down or stop gambling |
| 5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression) |
| 6. after losing money gambling, often returns another day to get even (“chasing” one’s losses) |
| 7. lies to family members, therapist, or others to conceal the extent of involvement with gambling |
| 8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling |
| 9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling |
| 10. relies on others to provide money to relieve a desperate financial situation caused by gambling |

B. The gambling behavior is not better accounted for by a Manic Episode.
an assessment is always more than just 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 a “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 other addictions, pathological gambling behavior is not better accounted for by a manic or depressive episode. This is provided that the gambling behavior is not better accounted for by a manic episode. Therefore, the therapist needs to ask about the history of the gamblers. Conjoint sessions are very important. What is commonly called “family programs” may mean therapeutic alliance with both partners and containing the volatility in couple sessions are integral to therapeutic process and require systematic skills. Engaging the resistant 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; Korman et al., 2008). Physical and verbal abuse by both gamblers and spouses could occur (Gerritzen et al., 1999, Lee, 2009b; Lesieur & Blume, 1991). Anger, guilt, isolation, helplessness and depression as well as physical symptoms have been reported by spouses of problem gamblers (Hodgins, Shead, & Makarchuk, 2007; Lorenz & Shuttsworth, 1983). Spouses experience loss of trust, a sense of betrayal and being left with the burden of responsibilities (Dickson- Swift, James, & Kippen, 2005). The FTPC (LeBlanc, Kippen, Zitter, & Shakil, 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, sense of home, as well as material and relational security (Darbyshire, Oster & Carrig, 2001). They are caught in family stress and triangles and become family scapegoats or peacemakers (Lesieur & Rutschild, 1989; Shaw, Forbush, Schleider, Rosenblatt, & Black, 2007). Adolescent children are at increased risk of depressive feelings, adjustment and conduct problems, as well as gambling and substance abuse problems (Jablonski, Marston, Singer, et al., 1989, Vitaro, Wanner, Benden, & 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 capitalizing on the client’s readiness to change in relation to each target area, e.g. gambling, couple relationships, parenting, mental health, the therapist can capitalize on the goal that represents the client’s greatest readiness and motivation to change and design a therapy plan that is more responsive and positive in direction. In effect, all aspects of a problem are linked and interwoven.
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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 lost $15,000 of her retirement funds and is looking for other pleasurable activities. Fearing 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 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 others. 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 others. As a result, 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.

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 help or formal treatment interventions (National Research Council, 1999; Petry & Mischke, 2002), a decision for change. (Hodgins & Makarchuk, 2002; Robson, Edwards, Smith, & Colman, 2002).

Clinical and Social Work Overview

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 (Perry, 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 impulsivity and addictive 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 psycholinguistic 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. Psycho-dynamic 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 pharmaceuticals (e.g., selective serotonin re-uptake inhibitors; opiod agonists; mood stabilizers) that reduce urges to gamble, anxiety, and affective symptoms (Grant, Williams, & Kim, 2006; Pallesen et al., 2007). Problems of medication research are side effects, lack of treatment compliance, 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, Dufour, Wright, & Lassiter, 2008; McComb, Lee, & Spenkohl, 2009). Couple Behavioral-Cognitive Models. Behavioral-cognitive models for couples treatment have been adapted from such models for substance abuse disorders. Ciarciochi (2002) adapted integrative behavioral couple therapy (Johnson & 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 (Ciarciochi, 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 outcomes and barriers to clinical Adapted 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 II” (Bertrand et al., 2008, p. 403). The therapy begins with a functional analysis of the gambler’s gambling behavior, to identify the occurrence of triggering behaviors and consequences. Analysis of this chain of events leads to strategies to sustain abstinence and prevent relapse. Spouses are helped to avoid behaviors that could undermine these goals, sometimes unintentionally through control and checking on the spouse, and through criticism, and protecting the spouse from negative consequences. Spouses are encouraged to look after their own needs and explore social support, to set limits, and to use specific help services. A couple recovery contract establishes that the couple discuss at predetermined intervals the status of the gambler’s abstinence. From gambling, secure commitments from the gambler to maintain abstinence, and requires the spouse’s recognition of
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the gambler’s abstinence in a positive manner. The intervention include couple work such as the demonstration of caring behaviors, sharing pleasure and expression for affection, constructive anger anger and healthy 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 approach for working with pathological gamblers and spouses conjointly (Lee, 2002, 2009a). Designed around the concept of conjoint, CCT promotes the development of a healthy couple work for couples along four dimensions (Lee, 2002, 2009a). Rather than targeting the behavior of gambling, the aim is to reduce or end problem gambling through addressing underlying systemic connections (Lee, 2002, 2009a,b). Pathological gambling is viewed as a symptom of a distressed system, delineated in “five circuits” of couple interactions (Lee, 2002, 2009a,b). Separation of the self is the first stage, followed by (2) powerlessness; (3) accommodation; (4) separation, and (5) deflection, with the fifth circuit, congruence, interrupting the recursive cycles to bring about reconciliation and healing hence displacing gambling behaviors and variables. Couple communication often lack depth and openness prior to pathological gambling. Inability and escalation of pathological gambling is set off by pressure points of life transition and setbacks overwhelming the adaptive capacity of the gambler who cannot turn to his/her spouse. Gambling becomes a way of finding solace, relief or a boost to one’s capacity of the gambler who cannot turn to the task of biological true systemic couple therapy options into the arena of problem gambling treatment.

Resources for Practitioners


National Council on Problem Gambling (U.S.) www.nogambling.org The mission of the National Council on Problem Gambling is to increase public awareness of pathological gambling, ensure the availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and intervention. National Problem Gambling Helpline 1-800-522-4700 (U.S.) Confidential-Nationwide-24/7

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.

Journal of Gambling Issues www.camh.net/jgaming A refereed journal on gambling research, treatment, research experience, and policy people with gambling with gambling.

Responsible Gambling Council (Canada) www.responsiblegaming.org/en/help This non-profit organization provides useful information, audio and video resources on problem gambling and to support responsible gambling.

Problem Gambling (Canada) www.problemgambling.ca An online community supported by the Centre for Addiction and Mental Health (CAMH). This website presents information about problem gambling for individuals concerned about their own, or someone else’s gambling. Problem Gambling.ca also provides an online space for professionals to exchange knowledge and resources about problem gambling.

Youth Gambling (Canada) www.youthgambling.ca The Centre addresses knowledge on youth gambling and risk-taking behaviors. Information for adolescents and parents are available on this site.

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