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 (Granfeld, Zastinghe, & Diakoloukas, 2008; Reith, 1999). Gambling behavior as a form of play (Smith & Aber, 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 gaming 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, Tocce, 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; Hraba & Lee, 1996). Ethnic minority groups, notably Native Americans (Volberg, 1994, Wardman, el-Guebaly, & Hodgins, 2001) and Asian immigrants (Blaszczynski, Huynh, Dunlao, & Farrell, 1998; Perry, Armentano, Kusch, 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).

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” (Stark & Rihl-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; McComb, 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 (MacCalum & 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. 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 Gambling

<table>
<thead>
<tr>
<th>TABLE 1. DSM-IV (APA, 2000) CRITERIA: PATHOLOGICAL GAMBLING</th>
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<tr>
<td>A. Persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:</td>
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<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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<td>3. has repeated unsuccessful efforts to control, cut back, or stop gambling</td>
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<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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<td>6. after losing money gambling, often returns another day to get even (“chasing” one’s losses)</td>
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<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>
</tr>
<tr>
<td>9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling</td>
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<tr>
<td>10. relies on others to provide money to relieve a desperate need to gamble</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,
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 substance dependence, pathological gamblers exhibit signs of tolerance and withdrawal. These are captured on the DSM-IV-TR as preoccupation with gambling, need to gamble to relieve an adverse emotional state, and continuing to gamble despite harmful consequences or clergy. The Clinical Update: Problem Gambling (January 2010) provides 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 (Griffiths, Williams, Cottrell, Compton, & Spitznagel, 1998; Rush, Bassani, Urbanoski, & Castel, 2008). Major depression and mood disorders are also present in pathological gamblers (Steinberg, 2005). Cognitive Behavioral Assessment of the ten criteria must be met for a diagnosis. The DSM-IV-TR as preoccupation with gambling, need to gamble to relieve an adverse emotional state, and continuing to gamble despite harmful consequences or clergy. The Clinical Update: Problem Gambling (January 2010) provides that the gambling behavior is not better accounted for by a manic episode.

Couple Assessment
Family and couple problems are among the most common motives that lead problem gamblers to seek treatment, next to negative emotions and financial concerns (Lesieur et al., 2002). Referrals to couples counselors can help couples develop a plan to pay off debt, consider declaration of bankruptcy and to get gambling financial help. Cormier and Shin (2001) is a useful tool for assessing pathological gambling behaviors. The scale consists of 12 items that reflect frequency, intensity, and duration of gambling urges, and frequency and intensity of gambling thoughts and behaviors, and may be either self-administered or clinician-administered. A timeline follow-back procedure (G-TLFB, initially developed to assess alcohol consumption, has been applied to assess gambling behavior (Winston, Whelan, & Meyers, 2004). This interviewer-administered instrument uses calendar prompts to cue clients to remember the frequency and duration of their gambling. Results match those of other gambling screening instruments.

Cognitive Behavioral Assessment
The premise of cognitive behavioral therapy is that thoughts underlie behaviors and if we change the thoughts, we change the behavior. Erroineous thought patterns related to problem gambling include illusions of control in games of chance, superstitious and magical beliefs, selective memory of past wins over past losses, overestimating one’s abilities, and irrational interpretation of life events during a gambling session (Ladouceur, Sylvain, Boutin, & Doucet, 2002). Cognitions immediately prior to gambling are assessed to identify triggers. Cognitions during and after a gambling session are assessed for the sequence of erroneous thoughts related to gambling problems. Cognitive approaches are often integrated with behavioral approaches focusing on stimulus control; hence assessment would include obtaining information on money control, risky situations, triggers, social skills and ways of coping with stress (Jimenez-Murcia et al., 2007; Perry, 2005).

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 problem gambling (Lee, 2002; 2009b). At such times, couples could experience 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.

Because gamblers and partners often have poor coping and relational skills (Wood & Griffiths, 2007), assessing the couple’s cycle of communication and ways of handling stress and distress is important. What is commonly called “family program” is a mean for assessing spouses and how they separate from the gamblers. Conjunct sessions are lacking, although they have the benefit of allowing them to understand the couple interaction 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 requisite 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 (Gerstein 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; Lenzen & Shuttlesworth, 1983). Spouses experience loss of trust, a sense of betrayal and being left with the burden of responsibilities (Dickson-Swift, James, & Keppen, 2005). The Fifth Common (Shohry, Scheirer, 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, giving up 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 & Rothchild, 1989; Shaw, Forbush, Schmid, Rosen, & Black, 2007). Adolescent children are at increased risk of depressive feelings, adjustment and conduct problems, as well as gambling and substance abuse problems (Jacobs, Marston, Singer, et al., 1989; Vitaro, Wanner, Beendgen, & Tremblay, 2008).

Stages of Change
The “stages of change” model (Prochaska & DiClemente, 1983) has been a valuable contribution to working with additions 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. For example, if the client is not prepared to change the negative direction in the present, in all aspects of a problem are linked and interwoven.
Clinical Update: Problem Gambling

Treatment

Most problem gamblers do not seek or receive treatment despite its availability (National Research Council, 1999; Petry & 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 insulating 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, Freedens, & 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).

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 (e.g., family history; habitual ways of dealing with stress and boredom). Cognitive interventions include exploring thoughts that occurred during a period of time (e.g., selective serotonin re-uptake inhibitors; opioid agonists; mood stabilizers) that reduce preoccupation with the cessation of the gambling (e.g., family history; habitual ways of dealing with stress and boredom). Cognitive behavioral interventions are 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 effectiveness of some pharmacologicals (e.g., selective serotonin re-uptake inhibitors; opioid agonists; mood stabilizers) that reduce preoccupation with the cessation of the gambling. (Bertrand, et al., 2002). Problem gamblers are helped to do their best to change their way of thinking about the gambling (e.g., family history; habitual ways of dealing with stress and boredom). Cognitive behavioral therapy 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 used up all of 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 bottlenecked 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 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.

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Conjoint Humanistic Integrative Model. Congruence Couple Therapy (CCT) was developed as a short-term, integrative, humanistic systemic model for working with pathological gamblers and spouses conjointly (Lee, 2002, 2009a). Designed around the concept of congruence, CCT provides a framework for working with couples along four dimensions (Lee, 2002, 2009a).

Pathological gambling is viewed as a symptom of a distressed system, delineated in “five circuits” of couple interactions (Lee, 2002, 2009a). Similar to other addictions, relapse is thought to be facilitated by pressure points of life transition and emotional concerns are frequently cited reasons for relapse (Hodgins et al., 2007). From a systemic standpoint, pathological gambling is a way of finding solace, relief or boost to one’s self-esteem. The couple relationship further deteriorates in the aftermath of pathological gambling, precipitating relapse. Healing of the couple relationship and both partners through increased congruence is facilitated in blocks of 12 sessions and places emphasis on generating hope, developing realistic goals collaboratively, reinforcing blame, and building on the foundation of a strong therapeutic alliance with both partners. As interpersonal and intrapsychic experiences intertwine, CCT facilitates self-awareness transformed into conjoint communication. Conversely, respectful communication fosters safety and acknowledges greater self-awareness and disclosure. Intergenerational underpinnings to current couple patterns are brought to awareness prompting new choices in the present. A vital context is created for fulfillment of human yearnings and an affirmation of the positive qualities of the unique spirit and being of each person (Lee, 2009a, 2009b). Congruence Couple Therapy has been taught to a cohort of Canadian professionals and counsellors and has obtained promising empirical support for both its training and client outcomes (Lee, 2002; Lee & Rovers, 2008; Lee, Rovers, & MacLean, 2008).

Relapse and Maintenance. Similar to other addictions, relapse rates among pathological gamblers are high, and can be up to 75% (Hodgins, Currie, el-Guebaly & Dokin, 2007). Financial and emotional concerns are frequently cited reasons for relapse (Hodgins et al., 2007). From a systemic standpoint, unresolved relationship problems perpetuate the gambler’s distress, despite reduction or temporary abstinence of gambling (Lee, 2009b).

In contrast to directly treating the gambling behavior, an important consideration of conjoint systemic couple therapy is to bring clarity to interrupt underlying recurring difficult relationship patterns, past and present, that create distress and undermine adaptability. Improved relationship with self and one’s partner increases resiliency, so that a person can better respond to life’s challenges. Problem gambling as a symptom of personal and relationship distress then dissipates. Marriage and family therapists are poised to rise to the task of addressing true systemic couple therapy options into the arena of problem gambling treatment. ■

Resources for Practitioners


National Council on Problem Gambling (U.S.) www.preventgambling.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 treatment.

National Problem Gambling Helpline 1-800-522-4700 (U.S.) Confidential-Nationwide-24/7

Gamblers Anonymous (International) www.gamblersan.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.gamanon.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/gambling

A cutting-edge publication on research, treatment, research, experience and policy with gambling.

Responsible Gambling Counseling (Canada) www.responsibilizing.org/en/help

This non-profit organization provides useful information, audio and video resources on research and problem gambling and to support responsible gambling.

Problem Gambling.ca (Canada) www.problemgambling.ca

An online community supported by the Canadian Council on Addictions and Mental Health (CCAMH). This web site contains information about problem gambling for individuals concerned about their own or someone else's gambling. ProblemGambling.ca also provides an online service for professionals to exchange knowledge and resources about problem gambling.

Youth Gambling (Canada) www.youthgambling.com

The Centre advises knowledge on youth gambling and risk-taking behaviors. Information for adolescents and parents are available on this site.

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References


