Problem Gambling: Taking Chances

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Background

From the rattling of divination sticks to the clatter of hucklebone dice, games of chance have been practised by humans since prehistory (Grunfeld, Zangeneh, & Diakoloukas, 2008; Reith, 1999). Gambling behavior as a form of play (Smith & Abt, 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, 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; McComb, Lee & Sprenkle, 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 (Pietrzak & Petry, 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. 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, Dumlao, & Farrell, 1998; Petry, Armentano, Kuoch, Norinth, & 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." However,

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

A. Persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:

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)
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 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 dependency, 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 gambling, 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, Cottler, Compton, & Spitznagel, 1998; Rush, Bassani, Urbanoski, & Castel, 2008). Major depression and mood disorders, anxiety disorders, obsessive-compulsive disorder, personality disorders (Boughton & Falenchuk, 2007; Zimmerman, Chelminski, & Young, 2006), and attention deficit disorder (Nower & Blaszczynski, 2006) have been associated with pathological gambling. The link between pathological gambling and adverse childhood experiences and trauma has received increasing attention in recent years (Kausch, Rugle, & Rowland, 2006; Lee, 2002; Petry & Steinberg, 2005).

Assessment Tools

One of the most commonly used DSM-based assessment instruments is the South Oaks Gambling Screen or SOGS (Lesieur & Blume, 1987). Gamblers are asked about their gambling behavior in lifetime and past 12 month timeframes, including types and frequency of gambling and the largest sum of money they have lost in a day, thus revealing the extent of spending related to gambling. Gambling debts and their sources are also assessed by the SOGS. More recently, the Canadian Problem Gambling Index or CPGI (Ferris & Wynne, 2001) was developed to provide a meaningful measure of problem gambling with further indicators of the social and environmental context of problem gambling. Like the SOGS, the CPGI overlaps with DSM criteria for assessment.

The Gambling Symptom Assessment Scale or G-SAS (Kim, Grant, Adson, & Shin, 2001) is a useful tool for assessing past-week gambling behavior. 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 (Weinstock, 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. Erroneous 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 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; Petry, 2005).

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 (Ladouceur et al., 2002). Referrals to financial advisors to help couples develop a plan to pay off debt, consider declaration of bankruptcy and to get back on track financially are recommended. A high percentage of calls for help is initiated by concerned significant others (Hodgins, Shead, & Makarchuk, 2007). Strategies for engaging the absent partner are important and should be developed, barring contraindications such as recurrent domestic violence (Lee, 2009a). Increased marital distress (Abbott, Cramer & Sherrets, 1995; Hodgins et al.; Lorenz & Yaffee, 1986), and separation or divorce (National Gambling Impact Study Commission, 1999; Tepperman, Korn & Reynolds, 2006), are common sequelae.

The relationship between couple distress and problem gambling is complex. There is evidence that couple difficulties and "fault-lines" in communication existed prior to pathological gambling, which in turn exacerbate couple distress in recursive cycles (Lee, 2009b). Therefore, the therapist needs to assess and observe not only the couple relationship impacted by the gambling, but also inquire into the history of the couple relationship — level of trust, intimacy and communication and how problems were dealt with before the gambling onset (Lee, 2009b). Such inquiry provides an understanding of the couple's pervasive patterns and communication impasses. Couple communication breakdowns often reflect family-of-origin patterns, and the fact that childhood maltreatment in the form of abuse, neglect, loss and abandonment are over-represented among pathological gamblers (Lee, 2002; Kausch et al., 2006; Petry & Steinberg, 2005) and potentially among their partners (Lee, 2002). Therefore, obtaining a family-of-origin history of communication patterns, traumatic events, and their impacts on current individual and couple functioning should be illuminating. Adult relationship traumas could also intensify the couple's reactions to the gambling repercussions (Lee, 2009b). A history of addictions and problem gambling in the family-of-origin is common 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 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 programs" may mean seeing spouses in groups separate from the gamblers. Conjoint sessions are lacking, although they have the benefit of allowing the clinician to observe 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 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 (Afifi, 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; Lorenz & Shuttlesworth, 1983). Spouses experience loss of trust, a sense of betrayal and being left with the burden of responsibilities (Dickson-Swift, James, & Kippen, 2005). The HITS Scale (Sherin, Sinacore, Li, Zitter, & Shakil, 1998) is a screening tool for identifying the frequency and type of domestic violence that could be present 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 peace-makers (Lesieur & Rothschild, 1989; Shaw, Forbush, Schlinder, Rosenman, & Black, 2007). Adolescent children are at increased risk of depressive feelings, adjustment and conduct problems, as well as gambling and substance use problems (Jacobs, Marston, Singer, et al., 1989; Vitaro, Wanner, Brendgen, & 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 lever the therapeutic process in a positive direction. In effect, all aspects of a problem are linked and interwoven.

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 naturally 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, Freidenberg, & Martell, 2006). Treatment dropout rate averages 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 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 impersonal and unpredictable 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).

Psychodynamic 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, psychodynamic therapy 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. Psychodynamic 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; opioid agonists; mood stabilizers) that reduce urges to gamble, anxiety, and compulsive 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, Dufour, Wright, & Lasnier, 2008; McComb, 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 (Jacobson & 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 randomness. 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 IP" (Bertrand et al., 2008, p. 403). The therapy begins with a functional analysis of the gambler's gambling behavior, to identify the sequence of trigger-behaviors-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, secures commitment from the gambler to maintain abstinence, and requires the spouse's recognition of

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 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 oblivion 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 old. 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.

the gambler's abstinence in a positive manner. Other elements in ACT include couple work such as the demonstration of caring behaviors, sharing pleasure and expression for affection, constructive anger and frustration management, and problem-solving skills. This model has not been empirically validated.

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 clear therapy structure for working with 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 disconnections (Lee, 2009a, 2009b). Pathological gambling is viewed as a symptom of a distressed system, delineated in "five circuits" of couple interactions (Lee, 2009b). Within these five circuits are the four recursive circuits of escalating couple distress: (1) fault-lines; (2) pressure points; (3) exacerbation; and (4) relapse, with the fifth circuit, congruence, interrupting the recursive cycles to bring about reconnection and healing hence displacing gambling urges and behaviors. Couple communication often lack depth and openness prior to pathological gambling. Onset 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 is a way of finding solace, relief or a 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 by CCT (Lee, 2009b). Congruence is defined as awareness, attention, acknowledgment, and alignment of four dimensions of being: intrapsychic, interpersonal, intergenerational, and universal-spiritual (Lee, 2009a). Living congruently breaks individual isolation and reduces relationship distress commonly experienced by pathological gamblers and their spouses. Congruence Couple Therapy is generally conducted in blocks of 12 sessions and places emphasis on generating hope, developing realistic goals collaboratively, reframing blame, and building on the foundation of a strong therapeutic alliance with both partners. As interpersonal and intrapsychic experiences intertwine, CCT facilitates self awareness translated into congruent communication. Conversely, respectful communication that is safe and acknowledging invites 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 problem gambling 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 & Diskin, 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 bringing true systemic couple therapy options into the arena of problem gambling treatment. ■

Resources for Practitioners

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National Council on Problem Gambling (U.S.)
www.ncpgambling.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-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/egambling
An on-line publication on gambling research, treatment, policy and people's experience with gambling.

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

ProblemGambling.ca (Canada)
www.problemgambling.ca
An online community supported by the Centre for Addiction and Mental Health (CAMH). 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 space for professionals to exchange knowledge and resources about problem gambling.

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

Bonnie Lee, PhD, assistant professor in the Faculty of Health Sciences, Addictions Counselling Program, University of Lethbridge, is an AAMFT Clinical Member and Approved Supervisor, and board member with the Alberta Association of Marriage and Family Therapy. 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 addictions. Lee works in bringing together training, practice and research in service of human growth and healing.

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