

Chapter 30

Introduction to the Treatment of Problem Gambling

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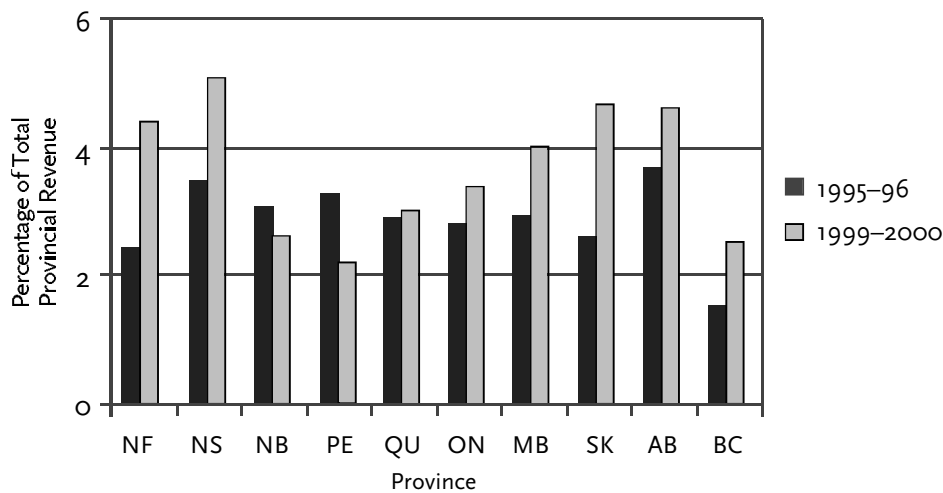
Information, training and research on problem gambling has been increasingly available in the last few years, in response to the rapid expansion of legalized gambling and consequent concerns about problematic gambling behaviour. There is now a large and growing body of information and experience for new practitioners to access. This chapter introduces the assessment and treatment of people with gambling problems. Although substance use counsellors will find a great deal that is familiar, and will have a head start in this area, there are significant differences in working with this population.

GAMBLING IN A SOCIETAL CONTEXT

There has been a remarkable proliferation of legal gambling opportunities around the world in recent years, representing an increasing source of revenue for governments and charities. The first commercial casino in Canada opened in Winnipeg in 1984. Since then, over 50 permanent casinos have been added. By 2000, there were 44 permanent horse racetracks and about 60,000 video lottery terminals (VLTs) and slot machines in Canada (Korn, 2000). From 1992 to 2000, net gambling revenues from casinos increased by 573 per cent, and revenue from VLTs and slots increased by 1,369 per cent (Azmir, 2001). There have also been expanding opportunities for bingo, off-track betting, Internet gambling and many other games of chance.

Governments' reasons for expansion in this area become very clear when revenues are examined. The Province of Ontario anticipates net earnings from gambling of \$2.3 billion in 2002–03, representing about 3.5 per cent of total revenues (Ontario Ministry of Finance Quarterly Update, September 2002). Across Canada, the proportion of provincial revenues coming from gambling have on average increased considerably (see Figure 30-1). Provincially run gambling across Canada, consisting of commercial casinos, VLTs and lotteries, produced gross revenues in 2000 of \$9.04 billion. The average net loss per Canadian adult was \$394.26 (Azmier 2001).

FIGURE 30-1
Gambling Revenue As a Percentage of Provincial Source Revenue



Source: Canadian Centre on Substance Abuse (1997); Azmier (2001). Used by permission.

In addition to government revenues, advantages cited for increased gambling include job creation, economic expansion, increased tourism, support for Aboriginal communities, prevention of illegal gambling, and enhanced revenues for charities. Ontario, for instance, guarantees \$100 million of gambling revenue to charities annually through the Ontario Trillium Foundation.

Gambling as a pastime is now far more accepted than it was a decade or two ago, and attracts a broader portion of the population. For instance, a trip to the casino is now a commonplace and respectable outing for women or seniors. Lottery tickets, illegal prior to the Olympic lottery held in 1970, are now a normal part of everyday life. Eighty-three per cent of Ontario adults engaged in some form of gambling in the past year, according to a 2001 study (Wiebe et al., 2001). Gambling is now highly

accessible, not just in casinos or racetracks, but also in convenience stores, by phone and on the Internet. In many parts of Canada, VLTs are or have been available in bars and corner stores. Gambling advertising is also ubiquitous, and its messages further normalize gambling behaviour.

Messages from the gambling industry do not typically include the real odds of winning. It is probably a rare gambler who thoroughly understands the odds and makes his or her bets consistent with that knowledge. Cognitive distortions associated with problem gambling will be discussed later in this chapter. However, mistaken beliefs about gambling are part of the current social fabric. For instance, in a survey by the Consumer Federation of America (1999), 27 per cent of respondents believed their best plan for financing their retirement was through lottery winnings rather than through saving and investing.

There is some movement to balance the weight of explicit and implicit pro-gambling messages. All provinces provide funding to promote responsible gambling and to support prevention, research and treatment. For instance, in Ontario 2 per cent of slot machine revenues are earmarked for this purpose. Such initiatives include training for casino staff, self-exclusion programs, 24-hour helplines, prevention packages for youth, and treatment services.

Along with the upswing in gambling opportunities has come an increase in the number of people seeking treatment for problem gambling. Callers to the Ontario Problem Gambling Helpline seeking treatment resources increased by 49 per cent between 1998 and 2002 (Ontario Problem Gambling Helpline statistics, 2003). A 2001 survey on gambling and problem gambling in Ontario found that 3.8 per cent of individuals 18 years or older reported moderate or severe gambling problems (Wiebe et al., 2001). This translates into about 340,000 Ontarians with such problems. Another 9.6 per cent report minor problems with gambling that indicate some risk. Studies consistently find that levels of problem gambling in youth are about double those of adults (AADAC, 2000; Shaffer et al., 1999).

The downside to gambling expansion can be found in damage to individuals, families and communities affected by problem gambling. Excessive gambling affects people's finances, employment, relationships, and physical and mental health, and these effects can range from mild to extreme. The results may include chronic poor levels of functioning, bankruptcy, job loss, legal trouble, family breakups or child neglect. A gambling problem generally affects a number of people in a widening circle of stress and loss.

DEFINITIONS AND GUIDELINES

Game Characteristics and Their Impact

Gambling involves wagering something of value on the result of an event whose outcome is uncertain. In essence it is a game played with probabilities; the person who correctly predicts the outcome wins something valuable from the one who does not. Games differ along a number of dimensions. In order to understand problem gambling, it is necessary to know some characteristics of the games, and how these characteristics affect the player.

One parameter of games is whether their outcomes can be predicted at all through skilled or knowledgeable play. For instance, bingo, slot machines and lottery tickets all have random outcomes; you cannot predict what will happen based on what has happened in the past. On the other hand, horse racing and sports betting involve some knowledge or skill; it is possible to increase the odds of winning through a greater understanding of the game. However, there is still so much randomness in these activities that it is almost impossible to predict outcomes well enough to win consistently. Also, betting venues make money by ensuring that the odds are with the house.

Whatever the type of gambling, people tend to search for patterns in the outcomes in order to predict what will happen the next time. These attempts can range from intensive research on game factors to superstitious beliefs about lucky days of the week. Such beliefs are given credibility by the fact that wins occur relatively frequently, even though overall losses are greater than wins. The longer a person gambles, the more money he or she is likely to lose. However, wins provide intermittent reinforcement which, as any behaviourist knows, is one of the best ways to ensure that a behaviour continues.

Another set of game characteristics has to do with how quickly a bet and outcome are completed, and how soon the next bet can be made. The old weekly lotteries gave a long break between the bet and the result. Now corner stores are filled with instant-win tickets. Horse racing used to offer only as many chances to bet as there were races in that location on that day. Off-track betting venues now allow continuous wagering on races all over the world. Slot machines and VLTs can complete a betting cycle in seconds. The quicker the betting cycle, the more potentially addictive the behaviour becomes (see Schwarz, 1984, for a discussion of schedules of reinforcement as they affect learning behaviour).

The literature has tended in the past to divide games into “action” and “escape” types, and the people playing them at problematic levels as “action” and “escape” gamblers. These two types tended to be associated with males and females respectively. There is some truth to this division. Interactive, higher-stakes games with a skill component tend to attract people who are looking for challenge and an adrenaline rush.

Solitary, smaller-stakes random games such as slot machines are often preferred by people who want to get away from the stresses in their lives. However, there are many overlaps in both the game characteristics and in the motivations of the people who play them. For example, an escape game may be approached with excitement or with pseudo-scientific research, while an action game may be engaged in out of a desire to escape unpleasant feelings. When gambling becomes a problem, motivations will likely change; the initial enjoyment of play may become a desire to win, and then to win back losses. In the end some people play chiefly to avoid thinking about the destructive effects of their gambling.

A couple of further points should be made about the games. First, private games or bets are somewhat different in that there is no “house edge”; odds are potentially equal. While this does not prevent problems from developing, playing against friends tends to limit the financial damage. Second, some activities, such as stock market trading, can be defined as gambling under certain conditions. These include rapid trading rather than investment over the longer term, an excessive focus on the behaviour and a preference for high-risk, high-yield trades.

Problem versus Non-problem Gambling

Clearly not all gambling leads to problems. Most people gamble safely, either for entertainment, to socialize or to try their skill or luck. They limit their time and spending to what they can afford, see their losses as the cost of the entertainment, see their wins as due to chance rather than ability and have many activities besides gambling to meet their needs.

The level of gambling involvement may be seen on a continuum:

No gambling □ casual social gambling □ serious social gambling □ risky gambling □
 problem gambling □ pathological gambling

These are not discrete categories but possible points along a range of involvement. People who engage in serious social gambling may enjoy their game more than other activities, and may dedicate considerable time to it, but not to the point where it damages their relationships or other pursuits. Problem gambling varies in intensity, from mild to severe. The term “pathological gambling” arises from medical models, and is generally used to identify the most severe gambling problems.

Professional gamblers are missing from the list above. Such individuals do exist, but are unlikely to come to the attention of counsellors. Gambling for the sake of income must be done as a business, in an orderly fashion, without emotional involvement. Margins tend to be low, so considerable self-discipline is needed. Many people seeking treatment say that, after a series of wins, they began to think of themselves as professional gamblers; so this persona, although rare in fact, is important to consider when dealing with the belief systems that underlie problem gambling.

DSM-IV Criteria

The following are the criteria for pathological gambling from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000):

- A. Persistent and 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 behaviour is not better accounted for by a manic episode.

Some additional common indicators of problem gambling are:

- spending more time and money on gambling than the person can afford
- experiencing health problems, including stress and anxiety, due to gambling
- attempting to use gambling as a source of income
- borrowing money to gamble or cover losses
- believing a system of gambling will produce wins.

Several instruments aside from the *DSM-IV* can be used to help identify a gambling problem. They include the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987), the Canadian Problem Gambling Index (CPGI; Ferris & Wynne, 2001) and short screens developed by the Alberta Alcohol and Drug Abuse Commission (AADAC, n.d.) and Turner & Horbay (1998). There are also screens specifically for adolescents. References to these instruments can be found at the end of the chapter (Shaffer et al., 1994; Winters et al., 1993).

Gambling problems may emerge in the course of other kinds of treatment, but they often remain hidden unless specific questions are asked. Unless all clients are screened, clinicians will likely ask only if they suspect that such a problem exists. The following is a list of indicators that might suggest a gambling problem. Some may be reported by family members. If several of these issues emerge in the course of treatment, screening is advisable.

FIGURE 30-2

Warning Signs That May Indicate a Gambling Problem

IN ADULTS

MONEY

- Financial problems exist despite an adequate income.
- Debts are building up.
- Money has gone missing from a bank account or wallet, or valuables have disappeared.
- There is a lot of borrowing, cash advances, living off credit cards, etc.
- A person takes a second job, but there is no change in his or her finances.
- RRSPs, insurance plans, etc., have been cashed in or allowed to lapse.
- A person obtains money illegally.

BEHAVIOUR

The person:

- avoids family functions or other social events
- neglects responsibilities or makes excuses
- drops other leisure activities to focus on gambling
- arrives late for work or other commitments
- disappears for large blocks of time
- spends a lot of time on sports statistics, racing forms or phone calls.

RELATIONSHIPS

The person:

- withdraws from family and friends
- appears preoccupied
- appears deceptive or secretive about his or her behaviour, particularly around money
- seems edgy, reactive or defensive
- changes sleep, eating or sexual relationship patterns.

IN ADOLESCENTS

The young person:

- can't account for missing money
- skips school
- borrows or steals money from friends or family
- sometimes has large amounts of unexplained cash
- has a fake ID, casino entry card, or racetrack or ProLine receipts among belongings
- is preoccupied with video arcades, Internet gambling sites or day trading
- has left a trail of Internet visits or credit card charges to gambling sites.

UNDERSTANDING PROBLEM GAMBLING

Similarities to and Differences from Substance Use

Problem gambling is similar in many ways to problem substance use. The two behaviours serve many of the same purposes, including escape (sometimes to the point of dissociation), excitement, pleasure and socialization. Those affected have similar subjective experiences of preoccupation, craving, tolerance and loss of control. There are overlaps in the neurobiology associated with each disorder (Comings et al., 1996), and evidence exists of common genetic factors (Slutske et al., 2000). In addition, substance use and problem gambling both affect a person's functioning: individuals are subject to depression, low self-esteem, anxiety and chronic stress, as well as family, legal, employment and financial problems. In both cases, the negative consequences tend to lead to more of the behaviour, creating similar cycles of addiction. Both groups tend to become the focus of attention in their families, and to take on childlike, irresponsible roles there. In both cases, models among families and peers influence the person's behaviour, and the impact on relationships of substance use and problem gambling is alike in many ways. Both sets of families suffer high rates of dysfunction, as well as serious consequences for children (for some effects on children, see Darbyshire, 2001). Most importantly, similar strategies work well with both groups.

Despite these many similarities, problem gambling has some unique features. It is a disorder that relates in large measure to belief systems and cognitive distortions, which are associated with the random schedule of reinforcement mentioned above. An estimated 50 per cent of people with gambling problems have had a big win early in their gambling history (Turner & Liu, 1999). Although gambling includes an effect of adrenaline, perhaps endorphins and other neurotransmitters, and sometimes a subjective experience of withdrawal, the physiological impact is minimal compared with that of substance use.

People with gambling problems are generally healthier and more clear-headed than those with substance use problems. They are more likely to be employed, and on average they are higher functioning. However, their financial problems are usually more severe. No matter how much a person spends on alcohol or other drugs, he or she cannot spend as much as a person can gamble in a single night, or even a single bet. Because the problem is much easier to hide than is substance use, people with gambling problems are often able to build up huge levels of debt. Money trouble is the issue that brings the problem to light in most cases. Although illegal behaviour is common in both disorders, problem gambling is more likely to lead to financial crimes (Meyer & Stadler, 1999). Consequences for families are particularly severe, including the chronic fear and uncertainty that go with devastating financial loss and the hidden nature of the problem.

Although relapse is common in both disorders, only in gambling is it possible to encounter relapse as a winning experience. People with gambling problems can be difficult to keep in treatment when they win. And although individuals are vulnerable to both disorders for many of the same reasons, there are additional precursors for problem gambling. For instance, many people with gambling problems come from families that place a high value on money and material wealth. They may be particularly business-oriented, and perceive gambling as an investment. Interestingly, the persistence and determination that is so effective elsewhere in the lives of such entrepreneurial people tends also to be applied to their gambling, with disastrous results.

The Pathways Model

Many stereotypes exist about problem gambling, but there is no “typical problem gambler.” People with gambling problems do have many common experiences. But their backgrounds, needs and personalities vary enormously, and so a single treatment modality will not work for everyone. One useful approach to understanding etiology is Blaszczynski’s pathways model (2000), which identifies three major routes to gambling problems. It divides people with gambling problems into three general types: “normal,” emotionally vulnerable, and those with biologically based impulsivity.

People in the first group, essentially healthy before their problems begin, are described as falling victim to circumstances such as easy access to gambling, poor judgment and misunderstanding of the odds. Such symptoms as preoccupation, anxiety or depression are results, rather than causes, of their gambling. These people are high-functioning and have many resources. They tend to respond quickly to fairly minimal treatment, and are more likely to successfully reduce (rather than stop) their gambling, if this is their choice.

Those in the second group are predisposed to a gambling problem through a history of precursors such as addiction or mental health problems, including trauma, anxiety and depression. They gamble to escape from negative moods. These people are also affected by the same triggers—such as easy access and misunderstanding the odds—as those in the “normal” group. Given their vulnerability, abstinence is generally the most realistic goal for people in this group.

The third group comprises people with a biologically based tendency to impulsive behaviour. For instance, attention-deficit/hyperactivity disorder is one very common precursor to problem gambling; research suggests that as many as 20 per cent of those with gambling problems have ADHD (Specker et al., 1995). Such people are likely to have a number of concurrent problems, such as substance use, poor school or work performance, emotional lability, chronic boredom and inadequate social skills. Gambling provides exciting stimulation and an apparent chance to excel. The same precursors that affect people in the first two groups also apply here. These people are generally poor candidates for the goal of reduced gambling.

The pathways typology is a good reflection of clinical experience, and suggests that individuals require differential treatment based on their particular etiology.

Problem Development

Eric gambled occasionally with his wife and friends. When he was laid off at work, having time on his hands, he decided to visit a casino. He won the equivalent of a week's salary playing blackjack, and went home exultant. In the next two weeks he visited the casino four times, on two occasions winning several hundred dollars. He began gambling several times a week. When his wife, Anna, expressed concern, he began to conceal his trips. Eric continued to have some wins, but his net losses were depleting their savings. When Anna tried to withdraw money from their joint account and found it empty, she confronted Eric. He confessed to gambling "a bit too much," and promised to cut back and start looking more seriously for work. However, within a week he was back at the casino, betting his entire unemployment cheque. Although eventually he found a new job, the family continued to have to struggle almost entirely on Anna's salary. Eric's occasional wins paid some bills, but more and more frequently any wins were simply gambled away, and he would leave the casino with barely enough to get home. Eric visited the casino so frequently that he was often unavailable to his family. Within a year the couple was on the verge of separation.

To an outside observer, Eric's apparently irrational behaviour might seem baffling. A person with a gambling problem may lose money over and over again, and yet go back repeatedly to lose more. Typically the frequency, the bet size and the duration of gambling episodes increase over time. Negative consequences multiply, and still the person appears to seek a different outcome from the same behaviour.

Blaszczynski would describe Eric as a "pathway two gambler": he is depressed and escapes from unpleasant realities by gambling, and is also triggered by easy access (lots of free time) and a misunderstanding of the odds. Let's look at the experience from Eric's point of view.

Worried about unemployment and his family's finances, and feeling depressed and inadequate, Eric is delighted by his unexpected success at the casino. The experience is far more pleasant and rewarding than his job hunt, and apparently far more lucrative. When twice more he leaves with more money than he arrived with, Eric feels even more powerful and successful, and his view that gambling is easy money is confirmed.

Blackjack players who use care and a knowledge of the game can minimize their losses, leaving the house with an edge of about 3 per cent. Eric's initial wins are not unusual; given the small house edge, outcomes often fluctuate fairly broadly. However, over time even the best players will lose to the house. At the point where Eric

might acquire an understanding of these odds, he is already deeply engaged in the belief that he can make money by gambling. The initial wins have been so salient, particularly in combination with his unhappiness and feelings of failure elsewhere, that later losses seem only a temporary aberration on the road to more wins.

Once Eric's losses reach a certain point, the need to win his money back becomes imperative, and it becomes harder and harder to give up on the large amounts already invested. His belief that he will eventually come out a winner justifies his spending, all the concealment and the expenditure of time. Nonetheless, his self-esteem outside the casino inevitably takes a beating, increasing the contrast between his depressing life and the thrill of winning.

Not all people with gambling problems progress in similar ways. Men tend to begin gambling earlier, in their teens, and generally progress more gradually into serious problems. Women tend to start gambling later, in their thirties or forties, progressing much more quickly to problem levels (probably because on average they have less money to spend). Some gambling problems fluctuate in severity, depending on such factors as the person's circumstances, income and employment, and the availability of gambling venues.

A wish to win money is not always the focus of gambling, at least initially. While many people with gambling problems seek a "big win," others are motivated chiefly by the potential for escape in playing for hours on end, or simply by enjoyment of the game. For such people, interest in money centres on having enough to keep playing. But even when money is not the initial motivator, as losses mount people may become increasingly preoccupied with the need to win in order to resolve financial problems.

Turner et al. (2003) examined the characteristics and early gambling experiences of people with and without gambling problems, to determine differences that might act as precursors to the development of problems. They found five basic risk factors:

- a big early win
- susceptibility to boredom
- a poor understanding of randomness
- a tendency to use escape as a way of coping
- a stressful life with a lack of support and direction around the time that gambling began.

Impulsivity and interpersonal anxiety also correlated with problem gambling, and those with gambling problems were more likely to have started when a new opportunity to gamble presented itself. The more of these factors that were present, the more likely a person was to have a gambling problem.

Turner also identified some factors that reduced the risk of problem gambling, including:

- financial security
- supportive friends
- having hopes and dreams for the future
- doing well at work

- using support rather than escape to cope
- knowledge of randomness
- the setting of limits on betting.

These findings fit well with Blaszczynski's model: they identify situational and cognitive factors, factors relating to pre-existing poor coping, and links to biologically based precursors such as impulsivity.

Cognitive Distortions

Turner's finding of a relationship between problem gambling and a poor understanding of random events is particularly relevant to treatment approaches. Some practitioners emphasize cognitive approaches almost exclusively, seeing problem gambling as a disorder of thinking (Ladouceur & Walker, 1998). In fact, incorrect assumptions about the odds are very common among gamblers in general, whether or not their gambling is problematic. Such misperceptions are encouraged by misleading game characteristics. For instance, slot machines can give the appearance that the player has some control, whereas the outcome is actually determined by a random number program.

However, people with gambling problems are significantly more likely to have skewed beliefs about their chances of winning. Toneatto (2001) describes a variety of cognitive distortions to which such people are prone, including superstitions, attributional biases (e.g., attributing wins to skill rather than to chance) and beliefs in control over luck. He notes that those with gambling problems tend to overrate their own gambling skills, and to selectively remember wins rather than losses. The classic "gambler's fallacy" is the belief that results will even out—that a series of losses means that one is "due" for a win.

"Random" does not mean "evenly distributed"; in fact, randomness includes streaks that look decidedly non-random. Thus it is perfectly possible for someone to win consistently by chance for some time, and then to lose for some time, again by chance. People with gambling problems tend to ascribe the winning streak to some special attribute of their own, and the losing streak to unlikely chance or circumstances. The core of cognitive distortions is the belief that one can predict or control the outcome of events that are completely or largely unpredictable.

Concurrent Disorders

GAMBLING AND SUBSTANCE USE

Research suggests that problem gambling and problem substance use co-occur at rates much higher than chance. Grant et al. (2002) cite studies reporting alcohol use disorders in 19 to 48 per cent of clinical samples of those with gambling problems. A

literature review by Griffiths et al. (2002) notes that between 7 per cent and 19 per cent of adults with substance use problems also had gambling problems. Griffiths also finds high levels of co-occurrence in studies of adolescents.

Given these figures, clients who misuse substances need to be screened for gambling problems. If the two problems are concurrent, they clearly exacerbate each other. Impaired judgment and impulsivity due to substance use may dramatically increase gambling losses, while financial, work and family difficulties stemming from gambling problems will likely worsen the circumstances triggering substance use. Treatment priorities will depend on the client and on the severity of each issue. However, identifying and assessing gambling problems will not always lead to an interest in treatment. Clients who use substances often have a number of serious problems, and may see any gambling concern as well down their list of priorities. Aftercare is often a good time to focus on the gambling issue; at that point the client may be under less stress, and may also be at particular risk of increasing other problem behaviours to substitute for the missing substance.

This risk is substantiated by the large number of people entering treatment for gambling problems who report a past history of substance use. Many mention that they turned to gambling because they thought it would be a safer alternative. Therefore education and prevention for clients with substance use problems is highly recommended.

GAMBLING AND OTHER PROCESS ADDICTIONS

Gambling can be described as a process addiction. Peele (1980) theorizes that any experience can be addictive if is powerful and absorbing enough to detract from other involvements. If an activity reduces negative feelings and/or increases positive ones, while impairing self-esteem and the ability to cope, the activity will tend to increase in a worsening spiral. Excessive shopping, work, video game play and Internet use are other common process addictions. Some sexual behaviours also come under this heading, and clinical observations and research on problem gambling suggest it co-occurs quite frequently with sexual addictions (Taber, 1985; Boughton & Brewster, 2002). In fact, past or current experience with other process addictions is quite common among those with gambling problems.

Problem gambling almost by definition includes trouble managing money. Some of those affected live on as little as possible so they have more to gamble with, but many are impulsive spenders. In Boughton & Brewster's (2002) study of women with gambling problems, 24 per cent identify a current problem with compulsive shopping, while 43 per cent say they had such a problem in the past.

The Internet is, of course, connected with gambling because of burgeoning online betting opportunities. Numerous other Internet activities, such as chat groups, pornography searches and fantasy games, tend to eat up many hours, stretching far into the night—similar in some ways to gambling all night. Note that casinos are among the very few recreation centres that are open 24 hours a day; people with gambling problems often take advantage of this opportunity. Behaviours that go on

for many hours and interfere with sleep may have some common results. For example, long-term sleep loss has been related to poor judgment and depression, as well as many health problems (Dement & Vaughan, 1999); and isolation is inevitable for someone who spends most of his or her day gambling and/or on-line.

GAMBLING AND MENTAL HEALTH PROBLEMS

The neurobiology of problem gambling has been the focus of increasing study (e.g., Comings et al., 1996; Carrasco et al., 1994). This research has linked levels of neurotransmitters, including dopamine and serotonin, to increased rates of problem gambling, and notes that these neurotransmitters are often implicated in impulse control disorders. Grant et al. (2003) summarize some promising pharmacological treatments that have been tried for people with gambling problems, including mood stabilizers, SSRIs and naltrexone. Some researchers theorize that problem gambling is one of an impulsive-compulsive spectrum of disorders (e.g., Hollander & Wong, 1995). "Compulsive gambling" is a common term, particularly in popular literature. It suggests a person with an irresistible compulsion to gamble. This usage tends to associate the behaviour with obsessive-compulsive disorder. However, the *DSM-IV* (APA, 2000) identifies problem gambling as an impulse control disorder. Obsessive-compulsive behaviours provide no pleasure, but are carried out to avoid anxiety. Gambling by contrast is a pleasurable activity; it is not until the point of complete desperation and disgust that people report gaining no pleasure from it.

In fact, attention-deficit/hyperactivity disorder, which affects impulse control and concentration, is far more common in those treated for problem gambling than is obsessive-compulsive disorder. As mentioned earlier, studies suggest that about 20 per cent of people with gambling problems have ADHD (Specker et al., 1995). Gambling provides the high level of stimulation they need in order to avoid boredom and depression, and also lends a sense of belonging and accomplishment that is often missing due to their poor functioning. The intense excitement of gambling, and the person's lack of impulse control, make self-restraint particularly difficult. Littman-Sharp and Jain (2000) describe the relationship of ADHD and problem gambling with depression and personality issues, and make suggestions for treatment.

Researchers have found higher rates of depression among those with gambling problems (e.g., McCormick et al., 1984; Cunningham-Williams et al., 1998). Becona et al. (1996) found a positive correlation between the severity of depression and that of pathological gambling. Both situationally caused and endogenous depressions are common in people with gambling problems. It is not surprising that someone who has put himself or herself into serious debt, along with other troubles, would feel depressed as a result; and a depressed mood in a gambling client does not necessarily indicate a major mood disorder. However, as represented by Blaszczynski's type two or emotionally vulnerable gambler, some people with endogenous depression use gambling to lift their mood. In some cases, gambling may be stressful enough to put a vulnerable individual into a depression that does not lift even when circumstances

improve. Such cases should be referred for psychiatric assessment, and if possible work should continue in collaboration with a psychiatrist.

In Boughton & Brewster's (2002) study on women with gambling problems, 63 per cent had visited a professional for help with depression, and 53 per cent had done so for an anxiety disorder. Again, some anxiety may be a result rather than a cause of gambling, and may relate to fears over money, threats to housing, pressure from creditors, etc. Physical symptoms of stress, such as stomach pain and insomnia, are very common. However, if the anxiety is persistent and predates the gambling, if there is a family history of anxiety disorders or if there are puzzling physical symptoms (Law, 2001), a referral should be made for a mental health assessment.

Personality disorders or related traits are also frequently found in those with gambling problems. Narcissistic personality traits are relatively common in clinical settings, often in conjunction with ADHD or other impulsivity problems. Some researchers have found high levels of antisocial personality disorder in this population (e.g. Blaszczynski & McConaghy, 1989). Once again, we must distinguish between causes and effects. People with gambling problems often behave selfishly or irresponsibly as they become caught up in a cycle of betting, chasing their losses and seeking more money to gamble. The behaviour is not always characteristic of the person, and it is sometimes the realization of how far they have strayed from their true personality and values that motivates people to seek treatment.

It is essential to carefully screen for suicidality. Between 4 per cent and 31 per cent of people with gambling problems report suicide attempts (Sullivan, 1994; Schwartz & Lindner, 1992). Rates of suicidal ideation cited in studies run as high as 70 per cent (Lesieur, 1998). Other studies have not found a significant link between problem gambling and suicidality (Cunningham-Williams et al., 1998), so the association is not entirely clear.

Certain characteristics appear to correlate with suicide risk. Frank et al. (1991) found that among people with gambling problems, those who were suicidal were significantly more likely than those without suicidality to have an early onset of problem gambling, severe "gambling addiction," serious relationship problems and a higher rate of problem substance use. A study by the Productivity Commission of Australia (1999) found that the rate of suicide attempts in problem gambling clients correlated with levels of debt, duration of gambling addiction and the amount of time spent in a diagnosed depression. The high rate of depression in people with gambling problems is probably enough to explain the high suicide risk.

Problem Gambling in Specific Populations

There is a growing body of work on the impact of gambling on specific populations, and the needs and characteristics of these groups. Only a few key issues are raised here; please consult the references for further reading.

WOMEN

Although there is considerable overlap between the experiences and needs of men and women with gambling problems, there are also some marked differences. As noted earlier, women tend to choose different games than men do. While men usually start gambling in their teens, women generally start later, in their thirties. Women often run into financial trouble far more quickly, probably because on average they have less money. Women with gambling problems have extremely high levels of past abuse and trauma, present life stressors and concurrent disorders (Boughton & Brewster, 2002). Women are more likely than men to use gambling as an escape from troubles, heavy responsibilities or stress.

One typical case is Patricia, a woman in her thirties who was under enormous stress, and had a great deal of responsibility at home and extremely high loads at work. She described her sojourns in front of the slot machines as “*her time*,” when no one could reach her or demand anything of her. This staid and law-abiding woman embezzled \$15,000 of her company’s money a little at a time, always intending to pay it back. When the theft came to light she was devastated by her behaviour and its consequences.

OLDER ADULTS

Older adults are less likely than the general population to have a gambling problem. However, when they do gamble excessively the consequences may be more severe, because there is often no opportunity to make up the lost money. Seniors are valued customers for gambling venues: they have plenty of time, and can be bused in from seniors’ centres and residences. For an older adult, a gambling venue can be very inviting; it provides a safe, often cheap outing among friendly people. However, seniors can be particularly vulnerable to developing a gambling problem, due to the loss of loved ones, loss of jobs and income, loss of health and resultant restriction in available activities.

Petry (2002) studied some differences between people with gambling problems in different age groups. One startling finding was the percentage of monthly income consumed by gambling. For older adults, this spending was far above their income, and older women spent on average two-and-a-half times their monthly income on gambling. Clearly the consequences of problem gambling for seniors can be very serious.

TABLE 30-1

**Median Amount Gambled in Past Month
As a Percentage of Monthly Income among
Those Seeking Treatment for Problem Gambling**

	AGE		
	18– 35	36– 55	56+
Men	94	67	187
Women	125	77	249

Source: From Petry (2002). Used by permission.

YOUTH

As mentioned earlier, youth typically have double or triple the level of problem gambling than does the adult population (AADAC, 2000; Shaffer et al., 1999). It is not clear whether the current youth cohort will continue to have higher rates of problem gambling in adulthood, perhaps due to the greater availability of legal gambling and its wide acceptance, or whether they will mature out of the problem.

Young people with gambling problems are predominantly male (Derevensky & Gupta, 1997), and the games of choice for underage bettors are card playing and sports betting. There is some evidence that youth with this problem also have difficulties in other areas (Gealt, 2002). Anecdotal evidence from adults with gambling problems suggests that the pattern often began their teens.

It is not easy to engage young people in treatment for problem gambling. Given the skills needed to work with youth, counsellors should probably be youth workers with additional skills in gambling counselling, rather than the reverse.

CULTURE

The relationship of problem gambling to culture is large and complex. Each ethnic or cultural group includes many subcultures, as well as generational differences, varying levels of acculturation, etc. In addition, each family has its own culture and beliefs, and its own preferences around seeking help. Thus it is not possible to make blanket statements about how to work on problem gambling with people from different communities. However, counsellors should explore cultural differences with clients, to understand the significance of these differences in relation to gambling. The importance of education on cultural competence for counsellors cannot be overemphasized (Gannam, 2001).

Gambling itself has different meanings and levels of acceptance in different cultures. For instance, some cultures and religions consider gambling to be a sin, while others use it in traditional and/or spiritual ways and still others regard certain levels of gambling as part of daily life. Cultures also differ as to, for example, who may gamble (for instance, according to age or gender), and what types of gambling and what gambling locations are considered acceptable. The family configuration—for

example, whether it is nuclear or extended, close or distant from their community, and what gender roles and hierarchy apply—will also influence how a problem is identified and how it can be addressed.

For those from other countries, experiences both before and after immigration need to be explored. Refugees may be more vulnerable to gambling problems because of traumatic experiences and current stress. Immigrants in general may be at risk because they have lost status or income, they must struggle to achieve financial stability and support their families, they are isolated from potential supports, they experience discrimination, or they have problems with acculturation.

Gambling has a special place in some First Nations cultures. Traditionally, certain games have spiritual meanings for the group as a whole. Aboriginal people are more likely to say they gamble to spend time with friends and family. The losses sustained by Aboriginal communities through residential schools, dislocation, poverty, trauma and racism all increase people's vulnerability to addictive disorders. A study by the Ontario Federation of Indian Friendship Centres (2000) found very high levels of problem gambling in Aboriginal respondents. For First Nations cultures, the family is made up of the whole community. For this reason, it is preferable to deal with problem gambling on a community level, rather than in terms of the individual or the immediate family.

Cultures vary in the ways people feel comfortable seeking help (e.g., within or outside the cultural group; through a doctor, family member or religious leader). Language alone can create serious barriers in counselling; access to professional cultural interpreters is essential in a multicultural society. Partnerships with ethnically specific treatment providers are one approach to providing linguistically and culturally appropriate service.

TREATMENT

The interventions discussed in this chapter are largely cognitive-behavioural. This umbrella covers many therapeutic approaches, including:

- change-stage matching
- motivational interviewing
- brief solution-focused counselling
- identifying and increasing skills for coping with high-risk situations
- cognitive restructuring.

Formats include individual or group counselling educational sessions, and family and marital therapy. The best choice depends on the client's needs and on what the agency can offer. Cognitive-behavioural techniques are widely used in Canada and elsewhere, and are increasingly accepted in the United States. Blaszczynski (1998), based in Australia, has published an excellent handbook on cognitive-behavioural approaches to problem gambling. Toneatto & Ladouceur (2003), in reviewing research on gambling treatment, found that cognitive-behavioural interventions

appear to have the most empirical support. These techniques, with suitable adaptations, are useful for clients of all three pathways, but emotionally vulnerable clients (type two) and those with biologically based impulsivity (type three) may need additional interventions such as medication or psychotherapy.

Because cognitive-behavioural techniques are probably familiar to many readers, and are covered in detail elsewhere in this book (see index), the focus here will be on how elements of the technique are applied to problem gambling.

Assessment

When a client presents with a gambling problem, assessment focuses on largely the same areas that would be explored for substance use disorders:

- precipitating factors that brought the person into treatment
- current levels of functioning
- the person's relationships and work situation
- his or her legal situation
- physical and mental health history and any current problems
- past treatment
- crisis issues (including the potential for self-harm or harm to others)
- goals for treatment
- motivation levels.

Clients should be screened for substance use, both past and current. The specifics of the person's gambling history and behaviour should be explored in some detail, including the types of gambling he or she engages in; the location, frequency and amount of time spent; whether he or she gambles with companions; and typical patterns of play. Counsellors need to understand when gambling became a problem and why, and what the person's current triggers are. Financial issues should also be explored, including how much the person owes and to whom, and the level of arrears on bills and payments. In addition, a family history of mental health, substance use and problem gambling is often very revealing.

If there is any question as to whether a person has a gambling problem, one of the screens mentioned earlier should be used to help clarify the issues. Counsellors may choose to give each new client a comprehensive addiction and mental health screening. Note however that people with gambling problems often arrive in crisis, and many are impatient. There may be only a narrow window of opportunity to work with the client, and if response is not rapid this opportunity may be lost. An immediate supportive contact focused on the client's presenting problems will engage the client and raise the likelihood of his or her return. More comprehensive assessment can take place over subsequent sessions. It is helpful for agencies to have a counsellor available to screen and engage new clients as they call.

People in crisis due to gambling problems (along with their families) may need financial help including income support, as well as the help of credit counsellors, lawyers, psychiatrists, distress lines, food banks and shelters, among others. Case

management at this stage includes setting short-term, manageable goals and giving concrete advice. Clients will be tempted to use any money that comes their way to gamble, in order to escape distress and give them the hope of an 11th-hour rescue. Even funds they obtain with great effort to help them out of a crisis—say, to avoid eviction—are at risk. Thus counsellors should advise clients to arrange for any such money to go through someone else's hands. It is often advisable to bring in the family at this stage, as they also need advice on how to handle the crisis in a way that will not lead to further trouble later. For instance, bailouts, co-signing loans or paying off creditors all tend to be counterproductive. More on the family's role will be found later in the chapter.

Stages of Change and Motivational Interviewing

The stages of change model (Prochaska & DiClemente, 1998) is as appropriate to problem gambling as it is to substance use (for a detailed description of the model, see Chapter 2). However, motivation to change often fluctuates even more in those with gambling problems, because of their experience of winning, or of seeing or hearing about wins. For instance, at one group session a new member described a \$40,000 slot machine win, and his subsequent rapid loss of that money and \$80,000 more that didn't belong to him. The story of the win brought on intense urges to gamble in the rest of the group; the story of the devastating losses and legal problems hardly had an impact.

Cognitive distortions will also affect motivation. For example, if people believe that although they lose on the horses, they are especially knowledgeable about football, they will tend to revert to the precontemplation stage during football season.

When clients are in the action stage, they may be so only in relation to a portion of the problem. For instance, credit counsellors are used to people with gambling problems identifying difficulties with money, rather than with gambling. Sometimes work, family, health or legal pressures are the prime motivators for a person to enter treatment. In this case, the client may still be in contemplation regarding the gambling itself, but may be willing to deal with the related issues; there may be some impact on the gambling in the process.

Motivational interviewing can provide a balanced viewpoint and a reality check (see Chapter 2 for a detailed discussion of motivational interviewing). The techniques for addressing cognitive distortions are valuable in this regard; they are touched on below. Just as it is important for people with substance use problems to identify how much they consume, it is vital for those with gambling problems to be clear about how much they spend. The counsellor should clarify and write down the figures as they go: income, amounts gambled, frequency of gambling, specific debts, etc. Clients are often vague on these points and may initially avoid such questions, but there is no better eye-opener than the realization that one is spending 90 per cent of one's

income on gambling. Debts to family and friends are often barely mentioned or readily dismissed; if the people involved are not pressing for their money, the client may set aside these debts as unimportant or even non-existent. Bringing the impact of such debts back into focus can help motivate the person. The often extensive and debilitating effects of gambling on other parts of the person's life should also be explored. It goes without saying that the counsellor needs to remain non-judgmental in this work; his or her role is to clarify the facts and to let those facts speak for themselves.

Motivational interviewing is in some cases continued as needed during treatment: as the client's stage of change fluctuates, or as different issues emerge. People often need to remind themselves why they entered problem gambling treatment in the first place. For instance, clients who abstain from gambling and begin to accumulate money in the bank are likely to have urges to return to gambling.

One of the common presentations related to motivation arises with clients who acknowledge a problem but see no way out. They are already convinced that gambling has been extremely harmful, but are so mired in debt and other troubles that continuing to chase a win seems like their only hope. Some people who have been deceitful or dishonest can achieve real change only by making the terrifying choice to "come clean." By continuing to gamble, juggling their finances and so on, they have struggled to avoid the inevitable: loss of relationships, trust, status or employment. They may be subject to criminal prosecution. The more successful they have been at concealment, and/or the higher their original status in their family or community, the harder they find the choice to be honest. In such cases the client needs support, good information about the likely consequences of coming clean, and the assurance that people can and do get through such problems. The support of others with gambling problems is helpful in this regard. If the person has unrealistically pessimistic beliefs about the outcome of disclosing his or her difficulties, this should be addressed with cognitive therapy techniques. But complete reassurance is not possible. The person's spouse may indeed feel this is the last straw and leave. The employer may in fact prosecute. Counsellors can offer their belief in the client's ability to survive such eventualities, and can gently inform the person that if his or her gambling continues, such outcomes are inevitable in any case.

Goal Setting

People with gambling problems often hope to return to normal levels of gambling rather than having to give it up altogether. Whether or not this is realistic depends on many factors (see Table 30-2).

TABLE 30-2

Criteria for Considering Reduction vs. Abstinence Goals

	REDUCTION	ABSTINENCE
Stage of problem	early	later
Level of gambling problems as indicated by DSM-IV/SOGS	low	high
Concurrent disorders	no serious ones, especially before onset of problem gambling	significant ones (e.g., substance use, depression, impulsivity)
Goals	realistic (e.g., a small weekly budget for lottery tickets)	unrealistic (e.g., "I'll get my money back and then I'll quit.")
Reasons for gambling	appropriate (e.g., to socialize, to have fun)	inappropriate (e.g., to win, to avoid problems)
Supports and coping strategies	good	poor
Ability to tolerate some further losses	adequate	poor
Family able to accept further gambling	yes	no

Some gambling clients seem able to continue with a form of gambling that has never caused them trouble; usually this is their weekly lottery ticket. Others manage to restrict their gambling in other ways. A reduction goal may be a route to abstinence, or an end in itself. In either case, an initial period of abstinence is advisable in order to restore a healthier range of activities and to put gambling in perspective.

Brief solution-focused counselling techniques (e.g., Berg & Miller, 1992) can be used to develop reasonable goals, and to emphasize positives and a sense of progress, particularly when clients are feeling trapped and despondent. For instance, scaling questions can be used to ask the client what level he or she is at in terms of an identified problem, from one (worst) to 10 (best). The counsellor then asks what it would take to raise the client one point on the scale. This dialogue points to both long- and short-term goals. Brief solution-focused techniques tend to emphasize a client's strengths and abilities, and to focus on solutions rather than problems.

However, some gambling clients are overly optimistic; they focus on the short term and fail to plan realistically for anything beyond the immediate future. In this case an emphasis on positives is likely to feed into the client's prevailing overconfidence, which was part of the problem to begin with. The counsellor's role then is to provide realistic feedback, and to emphasize careful planning, the client's cheerful assurances notwithstanding. In all cases the counsellor needs to help the client achieve a balance: confidence based on a realistic assessment of skills, resources and supports. For a more detailed discussion of behaviour change and relapse prevention tools for problem gamblers, see Littman-Sharp (2001).

Identification of Triggers

Like people with substance use difficulties, those with gambling problems need to know what triggers their urges in order to learn how to cope. Gambling triggers may resemble those of other addictions, particularly when they relate to positive or negative emotions, relationships and social pressure. However, some triggers are unique to gambling. For instance, the vast majority of people with gambling problems are triggered by the availability of money or credit. Financial pressure is another common issue. Belief systems about gambling and the ability to win are also central. Also, gambling tends to lead to more gambling as the person wins and wants to win more, or loses and tries to win the money back.

A functional analysis of problem gambling reveals a wide variety of individual patterns. People gamble to have hope, to relieve pain, to cope with loss, to feel smart or accepted. Gambling provides entertainment, a predictable environment, a sense of freedom, the thrill of winning stress relief. As with any addictive behaviour, the consequences tend to become causes as the gambling cycle repeats.

Personal triggers can be determined through interviews, self-monitoring or group brainstorming. It helps in such brainstorming to divide triggers into events, thoughts and feelings. Following a gambling incident, from the first decision to gamble through to the final consequence, provides a great deal of information on triggers. The Inventory of Gambling Situations (Littman-Sharp & Turner, 2001) is a 63-item questionnaire for identifying high-risk situations. It is based on the Inventory of Drinking Situations (Annis et al., 1982). Validation research on the inventory has identified 10 subscales of high-risk situations within four overall groupings (see Table 30-3).

TABLE 30-3

Inventory of Gambling Situations Subscales

<p>1. Negative affect situations Negative emotions Conflict with others</p>	<p>3. Positive affect situations Pleasant emotions Social pressure Need for excitement</p>
<p>2. Temptation situations Urges and temptations Testing personal control</p>	<p>4. Gambling cycle situations Worry about debts Winning and chasing losses Confidence in skill</p>

Clients commonly have multiple triggers, and the longer they have been gambling, the more likely this is to be true. Combinations of triggers are more likely to lead to relapse than are single triggers. For instance, someone trying to abstain may succumb if he or she simultaneously is depressed, gets unexpected money and hears about a supposed new winning system.

In identifying gambling triggers, we are seeking the antecedent of the *decision* to gamble, not of the gambling itself. Decisions are often made well before the first bet is placed, and once made are very hard to reverse.

While major triggers are obviously a key concern, less frequent triggers also need special attention, because they may take the person by surprise. For instance, resistance to gambling that is well established at home may dissolve on a work trip. The client may also need to be prepared for periodic triggers such as sports seasons or holidays.

Coping Strategies

Once specific triggers are identified, specific strategies must be developed to cope with them. As with triggers, it is helpful to divide these into behavioural, cognitive and affective strategies. Clients may tend to prefer only one or two of these types, for instance to focus on self-talk but to take no action, or to operate on impulse and action but to avoid thinking situations through. Again, the counsellor's role is to promote balance. The counsellor may need to focus on the client's faulty beliefs and misunderstandings about the odds of winning. Techniques for this are touched on below.

If the client is struggling with urges, detailed advance planning is very important. What route will the person take to avoid passing by the casino? Which bills will he or she pay first? What newspaper does not contain sports results? What will the person do on the weekend instead of playing bingo? The client will need to find ways to fill the large amounts of time that gambling has taken up, preferably in a way that meets at least some of the needs that gambling fulfilled. The person's plans should include small and frequent rewards for sticking to goals.

Most people with gambling problems need to avoid handling money, at least for a time. Counsellors should encourage clients to request their family's help in this regard; most families are relieved to take this on. The person's access to cash and credit should be reduced, but he or she should still be responsible for helping to manage bills, make financial plans and take on other family financial responsibilities. Relieving the person of all responsibilities would reinforce a childlike role rather than encouraging adult behaviour.

Another way to reduce access to gambling is self-exclusion. Most casinos allow this option, which involves a legal agreement to stay out of the casino for a specified period of time, with penalties if the person is found on the premises. In Ontario this involves a ban on entry to all casinos and slot facilities in the province. At present the person must go to a casino to arrange self-exclusion, and so he or she should be encouraged to take along a supportive friend or family member to ensure there is no relapse.

Self-exclusion is a very effective behavioural strategy for motivated and essentially law-abiding clients who are looking for reinforcement of their effort to avoid casinos. It is less effective for anyone inclined to evade the restriction. Canadian casinos are

beginning to consider facial recognition and other technologies, but currently casinos are not able to prevent access by determined gamblers. Whether or how to enforce self-exclusion is an ongoing issue for the gambling industry, faced with media concern and a number of lawsuits. The provinces handle this issue in various ways. The contract used in Ontario states that self-exclusion is voluntary, and that the industry is not obligated to enforce it. There is no requirement prior to re-entry, once the contracted period is up. In contrast, Manitoba has introduced mandatory psychoeducational programs for self-excluders who wish to return to the casinos. These programs are a promising intervention for a vulnerable population.

Continued self-awareness and planning are necessary to avoid relapse. Clients need to catch warning signs early and deal with them promptly, before their habitual, over-learned patterns of behaviour take over. One of the tasks of counselling is to anticipate what events might lead to relapse and to prepare a list of more positive alternative responses.

Cognitive Restructuring

As mentioned earlier, faulty beliefs contribute to problem gambling. Toneatto (2001) describes cognitive therapy techniques that aim to correct beliefs based on such errors in thinking. The core belief of many people with gambling problems is that they can, through special knowledge or personal attributes, predict the outcome of games that are in fact not predictable. The person selectively recalls evidence that supports these beliefs, and discards contrary evidence. Instead of looking at results over time (i.e., heavy losses), he or she tends to take note of short-term wins that confirm existing beliefs.

People with gambling problems are not always aware of the beliefs and attitudes on which they base their decisions. To bring these underlying assumptions to the surface, the counsellor asks how the client makes betting decisions, and asks the client to explain his or her beliefs in some detail. For instance, the counsellor may ask, "If you win when you are watching the game on TV, how does that work? How is a game in another city affected by the fact that you are watching?" Just bringing these beliefs to a conscious level can raise doubts in the client's mind, and make it possible for the client to challenge his or her own thinking. Counsellors can educate clients about the games, their odds and what randomness means. Note, however, that it is not effective to argue about the characteristics of games that the client probably knows better than the counsellor. It is generally not productive to get caught up in the minutiae of why the person's "system" won't work, especially if the person is strongly invested in his or her belief system. What does work is asking how effective the person's strategy has been over time.

Related Issues

Counselling may uncover other issues that relate in various ways to the gambling. Some of these issues can be dealt with in the problem gambling treatment, while others may require referral.

Gambling clients generally struggle with serious relationship problems. The stress of juggling finances, keeping secrets and dealing with consequences often takes up so much of their time and energy that they have difficulty broadening their focus to include the impact on those around them. If possible, the family should be invited to join some or all of the counselling sessions. If anger and recriminations threaten to take over, it is sometimes better to give family members the chance to vent separately, before the family is seen together. More on family issues can be found below.

The client's finances need to be examined in detail and managed appropriately, to avoid the risk of relapse. If the counsellor has the relevant skills, he or she can give advice and help with budgeting; otherwise a referral to a credit counsellor is advisable. For this work to be effective, all debts and income must be revealed and the family must be involved in the process. Dealing with finances can be a very painful step for all concerned, and one that clients may take time to face.

Clients may be dealing with the legal consequences of criminal behaviour. Generally this is non-violent financial crime such as fraud, theft or embezzlement. Such clients may be referred by the legal system. Although mandated, it is not unusual for them to be highly motivated, particularly if this is their first experience of being charged; such clients are often shocked at the extremes to which their gambling has led them.

Those seeking treatment may also be involved in evictions, private suits, wrongful dismissal cases, negotiations with Revenue Canada, separation and divorce, and many other legal wrangles. Most legal issues should be referred to a lawyer. Clients who are destitute due to gambling may need to turn to Legal Aid or free legal clinics. Some lawyers will provide 30 minutes of free initial consultation. Such processes tend to move slowly, and these entanglements add greatly to clients' stress levels.

Any identified mental health problems may also require the help of experts. As mentioned earlier, some of the most common concurrent problems for people with gambling difficulties are depression, anxiety and impulsivity. A history should attempt to determine whether these symptoms predated the gambling problem. If not, it may resolve the issue to get the gambling and its results under control. Good psychiatric consultants with knowledge of problem gambling are invaluable when working with this population.

Self-Help

Gamblers Anonymous and Gam-Anon provide help and inspiration to many people with gambling problems (GA), and to their family members (Gam-Anon). It is help-

ful to hear from others who have been through the same experience and have found a way forward. Many clients benefit from a combination of professional counselling and self-help. These groups offer a great deal of wisdom, support and a program that addresses real issues facing those with gambling problems.

GA and Gam-Anon do not suit everyone, however. They adhere to a disease model and label, which act as a barrier to those unwilling to accept them; such people may not agree that they have a problem if that problem is represented as a disease. The two groups insist on total abstinence as the only viable goal, and do not distinguish between different levels of problems. They focus on spirituality, which does not fit well for many people. Historically, GA groups have been male-dominated and have not been as comfortable for women. Although there are attempts to alter this bias, research shows that women tend to do better in women-only groups. Another risk of self-help groups is that while messages from members may be wise and helpful, they may also reflect misunderstandings, bias or the individual's own troubled state.

Clients can be encouraged to try these groups and see how they respond to them. When self-helps groups work for a person, they provide support in many ways that professionals cannot, just as professionals provide services not available through self-help.

HELPING THE FAMILY

Counsellors should not underestimate the impact of problem gambling on the family, and the importance of family and community in treatment. Gambling treatment services should include family members as clients, whether or not the person with the gambling problem attends.

Family members are often more severely affected than the gambler by the financial stresses and resultant insecurity and loss. Spouses typically feel enraged, helpless, depressed and deeply fearful of the future. They may be desperately worried about meeting the needs of dependent children, humiliated by debts to other family members, harassed by creditors and a sense that all responsibilities are on their shoulders, and struggling with the loss of expectations for the future and with loss of the spousal relationship they thought they had. They are often isolated from supports because they feel they must keep "family business" within the family. Depending on the extent to which the gambling has been hidden, spouses may be coping with sudden and devastating losses of homes and security. The person who gambles, in his or her attempts to conceal the gambling, may over time have projected blame on to the spouse, damaging the relationship and the spouse's self-esteem. The effect of lying on trust in the relationship is insidious and extremely damaging.

In initial meetings, spouses need to have their feelings validated, and to be reassured that their reactions are a normal response to abnormal circumstances. They need to examine and process past hurts. Most need very much to have an honest

conversation with their spouse, and to hear at least that the person regrets what he or she has done. They need to get onto firmer ground by learning all the facts, however upsetting. Any further concealment is very frightening, and will prevent real recovery in the relationship.

The person with the gambling problem, meanwhile, is struggling to overcome shame, loss of respect, and long habits of avoidance and concealment. A long process is sometimes needed before the person is ready to reveal everything. Some people, particularly characteristic optimists, prefer to think in the short term, and do not understand their spouse's need to process the past. If they have stopped gambling recently, they may see this as a sufficient answer to all the spouse's concerns. Such a person often needs some initial time and space to address immediate practical problems, increase his or her sense of self-efficacy, and reduce stress. The spouse's strong emotions are often more than the client can handle without becoming defensive and inflicting more pain.

Clearly the needs of the couple tend to clash. The counsellor's role is to validate both sets of needs and to help the couple reach agreements so that at least some needs of each person can be met. One useful technique is for the couple to process the past for a specified period each week, perhaps in the counsellor's office, and to agree that those issues will not be mentioned outside that time. The couple can also work to support each other's needs. For example, the person with a gambling problem can help ease the spouse's anxiety by being open about financial matters, while the spouse helps by joining his or her partner in relaxing leisure activities; or the client takes on more family responsibilities and the spouse offers positive feedback when these responsibilities are handled well.

A central issue in families is the distortion of roles: gamblers often act as and are treated as difficult adolescents, and spouses take on corresponding parental roles. The counsellor needs to address these imbalances and to help restore adult-to-adult communication between the couple. Communication skills training can be a helpful technique in this regard.

Other family members are also gravely affected by problem gambling. Elderly parents may lose their home in trying to rescue their children; young children may suffer stress, dislocation or neglect; and adults may worry about their parents' ability to remain independent, or may watch their siblings' lives and families deteriorate. All these people need help in meeting their unique needs. Adult family members need to decide what they can and cannot control, and what they can and cannot handle from the person with the gambling problem. They need to learn to respect their own needs and look after themselves and their children, rather than centring their lives on the gambling.

The issue of bailouts comes up frequently. A real concern is that bailing out the person may allow him or her to continue gambling. However, it is not always realistic for the family to withhold all financial aid; in some cultures it is close to impossible. Counsellors need to work with each family to find out what actions they can live with.

Some choose to help, but without letting the money go through the gambler's hands. Some insist the person gets treatment before they will help. Others offer help only to the person's spouse and children.

Sometimes reframing will help the family pull back and allow the person to face the consequences of his or her actions. For example, the counsellor may suggest that a good mother's job is not only to support her children, but also to let them learn from their mistakes so they will grow up strong and independent.

There are some good self-help manuals for family members of those with gambling problems, including *Behind the 8-Ball: A Guide for Families of Gamblers* (Berman & Siegel, 1992) and *Don't Leave It to Chance: A Guide for Families of Problem Gamblers* (Federman et al., 2000). As discussed earlier, some family members also benefit from the support of others like themselves at Gam-Anon meetings. Counselling services often hold groups for family members.

CONCLUSION

Reported prevalence rates for problem gambling suggest that between 640,000 and one million Canadians have multiple gambling problems (Azmier, 2001). The families of these people also suffer greatly. The number of people affected points to the need for treatment, prevention and research.

Working with people with gambling problems is both challenging and fascinating. The similarities to problem substance use mean that counsellors can use many of their existing skills, while the differences provide new and stimulating learning. At present, information and ideas about problem gambling are expanding exponentially. This is an emerging field, with new practices, new research and new approaches appearing constantly. This chapter touches only briefly on some of the knowledge and techniques available, and should be used as a starting point for learning, rather than a blueprint.

REFERENCES

Alberta Alcohol and Drug Abuse Commission. (2000). Proceedings of the Interprovincial Think Tank on Youth and Gambling. Edmonton, AB: author.

Alberta Alcohol and Drug Abuse Commission. (n.d.). AADAC Gambling Screen. Available: www.calgaryhealthregion.ca/familymedicine/tools/aadac_gambling_screen.pdf.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington, DC: author.

Annis, H.M. (1982). *Inventory of Drinking Situations (IDS – 100)*. Toronto: Addiction Research Foundation.

Azmier, J.A. (2001). *Gambling in Canada 2001: An Overview*. Calgary, AB: Canada West Foundation.

Becona, E., Del Carmen Lorenzo, M. & Fuentes, M.J. (1996). Pathological gambling and depression. *Psychological Reports*, 78, 635–640.

Berg, I.K. & Miller, S.D. (1992). *Working with the Problem Drinker: A Solution-Focused Approach*. New York: W.W. Norton.

Berman, L. & Siegel, M.E. (1992). *Behind the 8-Ball: A Guide for Families of Gamblers*. Toronto: Simon and Schuster.

Blaszczynski, A. (1998). *Overcoming Compulsive Gambling: A Self-Help Guide Using Cognitive Behavioural Techniques*. London, England: Robinson.

Blaszczynski, A. (2000). Pathways to pathological gambling: Identifying typologies. *eGambling: Electronic Journal of Gambling Issues*, 1. Available: www.camh.net/egambling/issue1/feature/index.html.

Blaszczynski, A. & McConaghy, N. (1989). Anxiety and/or depression in the pathogenesis of addictive gambling. *The International Journal of the Addictions*, 24, 337–350.

Boughton, R. & Brewster, J. (2002). *Voices of Women Who Gamble in Ontario: A Survey of Women's Gambling—Barriers to Treatment and Treatment Service Needs*. Toronto: Ministry of Health and Long Term Care.

Canadian Centre on Substance Abuse (1997). Gambling: A multi-billion-dollar industry. In *Gambling in Canada—A Report by the National Council of Welfare* (chap. 1). Available: www.ccsa.ca/plweb/cgi/fastweb.exe?getdoc+view1+General+672+1++gambling%20in%20canada.

Carrasco, J.L., Saiz-Ruiz, J., Hollander, E., Cesar, J. & Lopez-Ibor, J.J. (1994). Low platelet monoamine oxidase activity in pathological gambling. *Acta Psychiatrica Scandinavica*, 90, 427–431.

Comings, D.E., Rosenthal, R.J., Lesieur, H.R. & Rugle, L. (1996). A study of the dopamine D2 receptor gene in pathological gambling. *Pharmacogenetics*, 6, 223–234.

Consumer Federation of America. (1999). *New Study: Typical American Household Has Net Financial Assets of \$1,000*. Available: www.consumerfed.org/primerica2.pdf.

Cunningham-Williams, R.M., Cottler, L.B., Compton, W.M. III & Spitznagel, E.L. (1998). Taking chances: Problem gamblers and mental health disorders—Results from the St. Louis epidemiological catchment area study. *American Journal of Public Health*, 88(7), 1093–1096.

Darbyshire, P. (2001). The experience of pervasive loss: Children and young people living in a family where parental gambling is a problem. *Journal of Gambling Studies*, 17(1), 23–45.

- Dement, W.C. & Vaughan, C. (1999). *The Promise of Sleep*. New York: Dell.
- Derevensky, J.L. & Gupta, R. (1997, June). *Prevalence estimates of adolescent gambling: A comparison of the SOGS-RA, DSM-IV-J, and the GA 20 Questions*. Paper presented at the 10th International Conference on Gambling and Risk-Taking, Montreal.
- Federman, E.J., Drebing, C.E. & Krebs, C. (2000). *Don't Leave It to Chance: A Guide for Families of Problem Gamblers*. Oakland, CA: New Harbinger.
- Ferris, J. & Wynne, H. (2001). *The Canadian Problem Gambling Index: Final Report*. Available: www.ccsa.ca/docs/cpgi_final.htm#section3.
- Frank, M.L., Lester, D. & Wexler, A. (1991). Suicidal behaviour among members of Gamblers Anonymous. *Journal of Gambling Studies*, 7(3), 249–254.
- Gannam, V. (2001). Cultural background and problem gambling. In R.D. Murray (Ed.), *Helping the Problem Gambler*. Toronto: Centre for Addiction and Mental Health.
- Gealt, R. (2002). *Does juvenile gambling predict delinquency: Act vs. attitude*. Paper presented at the 16th Annual National Conference on Problem Gambling, Dallas.
- Grant, J.E., Kim, S.W. & Potenza, M.N. (2003). Advances in the pharmacological treatment of pathological gambling. *Journal of Gambling Studies*, 19(1), 85–109.
- Grant, J.E., Kushner, M.G. & Kim, S.W. (2002). Pathological gambling and alcohol use disorder. *Alcohol Research and Health*, 26(2), 143–150.
- Griffiths, M.D., Parke, J. & Wood, R.T.A. (2002). Excessive gambling and substance abuse: Is there a relationship? *Journal of Substance Abuse*, 7, 187–190.
- Hollander, E. & Wong, C.M. (1995). Obsessive-compulsive spectrum disorders. *Journal of Clinical Psychiatry*, 56(suppl. 4), 3–6.
- Korn, D.A. (2000). Expansion of gambling in Canada: Implications for health and social policy. *Canadian Medical Association Journal*, 163(1), 61–64.
- Ladouceur, R. & Walker, M. (1998). The cognitive approach to understanding and treating pathological gambling. In A.S. Bellack & M. Hersen (Eds.), *Comprehensive Clinical Psychology*. New York: Pergamon.
- Law, S. (2001). Special treatment issues: Concurrent disorders. In R.D. Murray (Ed.), *Helping the Problem Gambler*. Toronto: Centre for Addiction and Mental Health.
- Lesieur, H. (January 1998). Testimony to the National Gambling Impact Study Commission, Atlantic City, New Jersey, 22 January 1998.
- Lesieur, H.R. & Blume, S.B. (1987). The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American Journal of Psychiatry*, 144, 1184–1188.

Littman-Sharp, N. (2001). Teaching clients skills for change and relapse prevention. In R.D. Murray (Ed.), *Helping the Problem Gambler*. Toronto: Centre for Addiction and Mental Health.

Littman-Sharp, N. & Jain, U. (2000). Problem gambling and attention-deficit hyperactivity disorder. *eGambling: The Electronic Journal of Gambling Issues*, 2. Available: www.camh.net/egambling/issue2/clinic/.

Littman-Sharp, N. & Turner, N. (2001). *Inventory of gambling situations: Validation data on an instrument which identifies areas of risk for relapse*. Paper presented at the National Council on Problem Gambling Annual Conference, Seattle.

McCormick, R.A., Russo, A.M., Ramirez, L.F. & Taber, J.I. (1984). Affective disorders among pathological gamblers seeking treatment. *American Journal of Psychiatry*, 141(2), 215–218.

Meyer, G. & Stadler, M.A. (1999). Criminal behavior associated with pathological gambling. *Journal of Gambling Studies*, 15, 29–43.

Ontario Federation of Indian Friendship Centres (OFIFC). (2000). *Analysis Report on Friendship Centres Gambling Survey*.

Ontario Ministry of Finance Quarterly Update. (September 2002). Available: www.gov.on.ca/FIN/english/finances/2002/ofin022e.htm.

Ontario Problem Gambling Helpline statistics. (2003). Unpublished.

Peele, S. (1980). *The Addiction Experience*. Center City, MN: Hazelden. Modified from a two-part article that appeared in *Addictions* (Addiction Research Foundation), Summer 1977, 21–41; Fall 1977, 36–57. Available: www.peele.net/lib/addexp.html.

Petry, N.M. (2002). A comparison of young, middle-aged, and older adult treatment-seeking pathological gamblers. *The Gerontologist*, 42(1), 92–99.

Prochaska, J. & DiClemente, C. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviours. In W.R. Miller & N. Heather (eds.), *Treating Addictive Behaviors* (2nd ed.). New York, NY: Plenum Press.

Productivity Commission of Australia. (1999). The impacts of problem gambling. In *Australia's Gambling Industries: Inquiry Report* (chap. 7). Available: www.pc.gov.au/inquiry/gambling/finalreport/chapter07.pdf.

Schwartz, B. (1984). *Psychology of Learning Behavior*. New York: W.W. Norton.

Schwarz, J. & Lindner, A. (1992). Inpatient treatment of male pathological gamblers in Germany. *Journal of Gambling Studies*, 8(1), 93–109.

Shaffer, H., Hall, M.N. & Vander Bilt, J. (1999). Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health*, 89, 1369–1376.

- Shaffer, H., LaBrie, R., Scanlan, K.M. & Cummings, T.N. (1994). Pathological gambling among adolescents: Massachusetts Gambling Screen (MAGS). *Journal of Gambling Studies*, 10(4), 339–362.
- Slutske, W.S., Eisen, S., True, W.R., Lyons, M.J., Goldberg, J. & Tsuang, M. (2000). Common genetic vulnerability for pathological gambling and alcohol dependence in men. *Archives of General Psychiatry*, 57, 666–673.
- Specker, S.M., Carlson, G.A., Christenson, G.A. & Marcotte, M. (1995). Impulse control disorders and attention-deficit disorder in pathological gamblers. *Annals of Clinical Psychiatry*, 7(4), 175–179.
- Sullivan, S. (1994). Why compulsive gamblers are at high suicide risk. *Community Mental Health in New Zealand*, 8, 40–47.
- Taber, J.I. (1985). Pathological gambling: The initial screening interview. *Journal of Gambling Behavior*, 1(1), 23–34.
- Toneatto, T. (2001). Cognitive therapy for problem gambling. In R.D. Murray (Ed.), *Helping the Problem Gambler*. Toronto: Centre for Addiction and Mental Health.
- Toneatto, T. & Ladouceur, R. (2003). The treatment of pathological gambling: A critical review of the literature. *Psychology of Addictive Behaviors*, 17(4), 284–292.
- Turner, N. & Horbay, R. (1998). Centre for Addiction and Mental Health (CAMH) Gambling Screen. Unpublished.
- Turner, N., Littman-Sharp, N., Zangeneh, M. & Spence, W. (2003). Winners: Why do some develop gambling problems while others do not? Available: www.gamblingresearch.org/download.sz/winners%20Turner.pdf?docid=1521.
- Turner, N.E. & Liu, E. (1999). *The naive human concept of random events*. Paper presented at the 1999 Conference of the American Psychological Association, Boston.
- Wiebe, J., Single, E. & Falkowski-Ham, A. (2001). *Measuring Gambling and Problem Gambling in Ontario*. Canadian Centre on Substance Abuse. Available: www.responsiblegambling.org/articles/CPGI_report-Dec4.pdf.
- Winters, K.C., Stinchfield, R. & Fulkerson, J. (1993). Toward the development of an adolescent gambling problem severity scale. *Journal of Gambling Studies*, 9, 63–84.

