

## CHAPTER I

# Conceptual Foundations of Gambling Disorders

### TRUTH OR FICTION

After reading this chapter, you should be able to answer the following questions:

1. Gambling is a *new addiction* that first appeared in the twentieth century. True or False?
2. Gambling is primarily a compulsion, like perfectionism or excessive hand washing. True or False?
3. Problem gambling and pathological gambling are two separate and distinct disorders. True or False?
4. Most people with gambling problems lose control every single time they gamble. True or False?
5. Clinical difficulties involving gambling seem to be increasing. True or False?
6. True pathological gamblers develop problems regardless of wagering opportunities. True or False?
7. The treatment of pathological gambling is identical to that of other addictions. True or False?

Answers on p. 31.

## Introduction to Gambling

Gambling is the attempt to win something on the outcome of a game or event that depends on chance or luck. The purpose of this chapter is to educate professionals and clinicians about *pathological* and *problem* gambling. Gambling is not inherently pathological, immoral, or associated with any psychological problems. An overwhelming majority of people who choose to wager do so in moderation and without evident problems. There is no evidence that this majority is at any risk of developing the problems described in this chapter and throughout this book.

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However, in North America, approximately between 2 and 6 percent of the population has, or has had, gambling-related problems. Estimates vary according to the research methodology used. For example, researchers find different estimates depending on what time frame and frequency gambling is assessed (e.g., within the last month, within the last year, within a lifetime). Findings also are influenced by where they are obtained. For example, proximity to a gambling venue possibly contributes to the risk for developing a problem. However, this may be changing with the onset of additional wagering options, including those available on the Internet and growth in casinos across North America.

Although the behaviors involved in disordered gambling do not involve a specific substance of abuse, they facilitate a syndrome that is similar to the *classical* chemical, or other, addictions. Similarities include compulsion, loss of control, and continued use despite negative consequences. These are the “Three Cs of addiction” (Blume, 2005), and they are detailed in a later section. For people with a gambling dysfunction, the dependence, craving, and disruption to their lives are often as severe as in any addiction. What is confusing to family and others is that gambling does not involve a specific substance; consequently, the addiction to gambling seems (to them) less legitimate and understandable.

Not everyone with a gambling disorder demonstrates the stereotype of progressively severe impairments. In the world of gambling, what walks like a duck and quacks like a duck—may not be a duck at all. It is relevant to understand that, just because a person appears to meet the criteria of being a pathological or problem gambler, it does not always prove to be true. Some show patterns of periodic difficulties that may or may not be related to external events, such as life stressors; others “mature out,” gradually curtailing destructive gambling over months or years. The reasons for these varied patterns are not well understood. Still, others show more abrupt spontaneous remission that occurs when disordered gambling problems disappear without informal or formal treatment. The frequency of spontaneous remission is unknown, as are its definitive mechanisms.

Certain cultural, economic, racial, and ethnic groups may be at higher risk for developing gambling problems. The specific pathways for developing a gambling disorder are not necessarily the same in diverse groups or in any two people. Rather, gambling disorders may represent a common outcome or destination from a variety of different pathways.

The need for this book comes from the fact that many general therapists, counselors, and other mental health professionals now are encountering, or will soon encounter, someone with a gambling problem. Yet, gambling and gambling problems are not new. On the contrary, people have been gambling since recorded history, presumably even earlier. Betting on horses began almost as soon as these animals were domesticated. Ancient Chinese and Egyptian texts indicate that gambling was common, though excessive gambling was a concern. The Biblical book of Judges (Chapter 14) highlights the role that gambling played at ancient feasts and weddings, when Sampson apparently tried to pro-

voke warfare by wagering on who could solve a riddle (The Holy Bible). Many historical accounts discuss various forms of wagering that existed in Europe during the Dark Ages and during the Renaissance. During the sixteenth and seventeenth centuries, some of the seminal advances in the mathematics of probability and statistics were based on attempts to understand and capitalize on the odds afforded to gamblers.

In North America, the popularity of gambling has followed various periods of expansion that some observers have labeled *waves*. Undoubtedly, historians disagree about these exact time frames, and it is our belief that gambling expansion never completely ceased, even during its least popular periods. Some accounts suggest that the first wave began with colonization, where colonists gambled heavily, with the possible exception of the Puritans. Later, Scotch-Irish immigrants probably wagered even more frequently, primarily to fight the tedium of frontier life. The first race track was established on Long Island more than one hundred years before the Declaration of Independence. Playing the lottery became a voluntary tax and form of civic pride, as well as a universal form of amusement. All of the 13 original colonies had some form of lottery.

Many classic card games followed the Mississippi River up from New Orleans, blending French and Creole influences into the New World. These included poker, which had firmly developed a variety of different rules by the 1840s. The mystique of this game contributed to the American folklore of the prewar antebellum South and period of Western expansion. The *gentleman's game* of craps also originated in Europe and became popular in New Orleans, partly because it resisted *fixing*. Fixing displayed an ugly side to the romanticized notions of riverboat and frontier gambling. Violent sharks, thugs, and cons often attempted to rig whatever games were available. The solution for these players was often quick, vigilante justice.

Slaves may have turned to gambling as one of the few amusements that they could afford and conceal. Unfortunately, little is known about the folk gambling culture that developed during these conditions of oppression. Following the American Civil War, gambling popularity increased until the United States public became disgusted with recurrent lottery and race track corruption, beginning a period of rapid legal restrictions. This abruptly ended the first wave of North American gambling.

Some argue that the next wave of gambling in the United States, perhaps from the 1890s to the early part of the 1900s, was tied in part to advances in gambling technology. At the race track, the set starting gate and, particularly the tote board (or parimutuel machine), reduced the appearance of corruption. Tote boards feature odds that are constantly being updated. The public is basically betting against itself, with players trying to outsmart each other as they might in the stock exchange. No longer were odds set by various bookmakers, who were corrupt and might fix a race. Instead, all the money bet at a track was pooled together and divided according to odds set by the crowd's ever-changing choices. In the United

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States, this type of wagering smacked of the populism that a growing democracy liked. This led to the perception of fairness, though with many notorious exceptions and attempts to defraud the public, which continue on through today.

The mechanical slot machine, called the *fruit machine* in Britain, or one-armed bandit in some circles, was another innovation spawned from a renewed interest in legalized gambling. Invented in 1895 by Charles Fey, a locksmith and machinist in San Francisco, these amusement devices proved immensely popular and became a backbone of legal casinos in Nevada and later New Jersey and elsewhere. Nevada legalized most forms of gambling in 1931. The potential profitability of slot machines for the player increased when the mechanical reel was replaced with increasingly sophisticated electric and electronic variations. This eventually resorted in enormous revenue for slot machine owners, since so many more patrons played them, often for hours at a time.

The third wave began after the 1930s in the United States with the return of bingo and parimutuel betting, and on into the 1960s with the renewed popular-

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**IMAGINE THAT!**

The odds of being struck by lightning are 1 in 240,000. With slot machines, the odds of winning the top prize at maximum coin play ranges from 1 in 4,096 up to 1 in 33,554,000.

Source: British Columbia Partnership for Responsible Gambling (2004).

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**IMAGINE THAT!**

The profits from government gaming operations are almost \$13 billion nationally, but the costs of gambling addictions are not known. Some of these could be quantified, including medical care, policing, courts, prisons, social assistance, and business losses. However, no simple dollar figure can measure the devastation to the lives of those affected by pathological gambling.

Source: Canada Safety Council (2006).

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ization of state lotteries. Atlantic City saw gambling as a cure for a moribund economy and opened casinos in the late 1970s. This trend was followed with riverboat gambling, ostensibly for its romantic, quixotic appeal and attempt to restore rustbelt city economies. Native American casinos, often falling under less stringent regulation, became immensely popular and circumvented state law. Only two states, Utah and Hawaii, presently do not have some legalized form of gambling; however, this is now overshadowed by the ability to access Internet and cable or satellite television wagering.

In Canada, all gambling was made illegal by the Canadian Criminal Code of 1892. Still, there are many very colorful accounts of frontier gamblers that rival those on the Mississippi. Canadian gambling never really went away. It just moved *down the block* or out to the frontier. In 1969, the federal government began reducing its involvement with gambling, turning over regulation to provinces and territories, which accepted the expansion at varying paces. In 1985, provinces were allowed to oversee video slot machines and video lottery terminals. These have become immensely popular, very lucrative, and there is concern regarding their potential for causing

excessive gambling problems.

Some form of legally sanctioned gambling is now available in all ten provinces, with casino gambling now available in many provinces as well.

In legal circles, the words *gamble* and *gambling* sometimes are used for the activities that run afoul of applicable criminal laws, and the more innocent sounding *gaming* is employed for activity specifically legalized by state or federal regulations. The most rapidly expanding form of gambling or gaming is available in some areas on the Internet. A new law in the United States, HR4411, prohibits gambling over phone lines; the debate is whether or not this means the Internet as well. In the United States, there is a movement of prohibition on Internet gambling, while for the rest of the world, it is extremely profitable for the site owners who peddle the sites. However, this unregulated Internet market still does not come close to the volume of money gambled through illegal person-to-person sports wagering at bars and through *bookies*, *agents*, *contacts*, or people with other such monikers. By some accounts, this illegal industry may amount to twice the size of the entire legal gaming market.

## Definitions of Problem and Pathological Gambling

The terms *problem* and *pathological* gambling often are used interchangeably. This is not quite accurate, as counselors soon discover in their encounters with the variety of gambling disorders that exist. The formal diagnosis of a gambling disorder is *Pathological Gambling* and it is defined by the current edition of the *Diagnostic and Statistical Manual—Fourth Edition, Text Revised (DSM-IV-TR; American Psychiatric Association, 2000)*. To receive this diagnosis, a person must meet five of the ten criteria listed in Table 1.1.

The *DSM-IV-TR* classifies this disorder as an “Impulse-Control Disorder Not Elsewhere Classified” (APA, 2000, p. 613). Similar disorders, according to the *DSM-IV-TR*, include kleptomania and trichotomania (hair pulling). Gambling is not listed as an “addictive disorder.” The *DSM-IV-TR* does not classify any disorders as “addictive” or “nonaddictive” per se, but it does classify chemical dependencies based on their degrees of severity. To date, there is just one level of severity for pathological gambling in the *DSM-IV-TR*.

## Definitional Distinctions

Many clinicians use the term *problem gamblers* to describe people who meet some (e.g., three of the criteria), but not the minimum five criteria that obtains the *DSM-IV-TR* diagnosis for pathological gambling. This also has become popular with researchers and will be discussed later regarding classification schemas. To avoid repetition, we may use more generic phrases, such as *impaired gambler* or *aberrant gambler* to refer to people with gambling disorders of any type, unless we need to designate between specific levels of severity. Recently, the prolific gambling researcher Nancy Petry (2005a) has suggested the term *disordered gambler* for people who meet *some* or *all* of the criteria for a *DSM-IV-TR* diagnosis. Often, this will be a useful term.

**Table 1.1:** Criteria for Pathological Gambling

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1. Is preoccupied with gambling (e.g., 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 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 to escape problems or relieve a dysphoric mood (e.g., helplessness, guilt, anxiety, depression)
  6. After gambling loss, often returns to “get even” (i.e., “chasing” one’s losses)
  7. Lies to family members, therapist, or others to conceal the extent of gambling involvement
  8. Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
  9. Has jeopardized or lost a significant relationship, job, educational or career opportunity because of gambling
  10. Relies on others to provide money to relieve a desperate financial situation caused by gambling
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Source: Reproduced by permission, American Psychiatric Association, 2000.

The terms *compulsive gambling* and *compulsive gambler* are older and were made popular by early researchers and the self-help group known as Gamblers Anonymous (GA). In general, these terms will be avoided because they are easily confused with unrelated psychiatric conditions, such as *Obsessive Compulsive Disorder* or *Obsessive Compulsive Personality Disorder*.

There are clinicians, often those involved in self-help groups, who emphasize the subjective nature of diagnosing gambling problems. They state that the *DSM-IV-TR* reiterates that subjective complaints are important in ascertaining whether a person has a gambling problem. It is not the specific number of criteria that a person does or does not have that make a diagnosis; it is whether or not the person *believes* a gambling problem exists. This is not a misconception about aberrant gambling, but rather a different way to view the problem that offers strengths and weaknesses. It originates from the *Disease Model* of addiction, which is well-ingrained in North American addiction treatment, especially in the United States.

Chapter 2 discusses other diagnostic lists, such as the 20 Questions of Gamblers Anonymous (GA). Although unscientifically derived, meeting criteria from these screening tools frequently assists people in rethinking their current gambling behaviors and in accepting a treatment plan. By formal criteria, these people are classified in most cases as “sub clinical,” yet it can hardly be said they are living free of gambling problems. Petry (2005a) has noted that, with the present definition provided by the *DSM-IV-TR*, these people would have to get worse before receiving a diagnosis making them eligible to receive treatment. As professional care providers, this does not make sense as it is ascribing that a client must deteriorate before we are allowed to intervene. This goes against everything we understand about how to treat mental health problems. Many clinicians agree that it is a misunderstanding of the nature of addiction to deny people treatment because they miss one or two of the required *DSM-IV-TR* criteria. From our perspective, there are obvious benefits and economic savings to early intervention and prevention versus waiting for problems to worsen before intervening.

Some researchers and practitioners state that gambling cannot be a *true* addiction because it does not involve any specific substances that are ingested, such as alcohol, nicotine, or heroin. Many others, including most treatment providers in the field of pathological gambling, believe that this difference is semantic and trivial (Grant & Potenza, 2005). We believe gambling is a real, addictive disorder that can paralyze a person as much as any drug can. The use of mnemonic of the Three Cs of Addiction—Feelings of *Compulsion*, *Loss of Control*, and *Continued Use, Despite Consequences*—is an effective strategy for assessing the frequency, duration, and intensity of addictive behaviors such as gambling, drugs, alcohol, work, sex, Internet, and so forth.

## **An Introduction to the Three Cs of Problem and Pathological Gambling**

The first “C,” *Compulsion*, involves an intense desire to irrationally gamble once a cue is present or a specific thought regarding gambling is triggered. A compulsion is an uncontrollable behavior sparked by an irrational idea, called an *obsession*. While these urges are not identical to the compulsions seen in anxiety disorders (such as *DSM-IV-TR* Obsessive Compulsive Disorder), they share similar overwhelming internal feelings that seem coercive and inescapable. They are seemingly *beyond reasonableness*. Anniversaries, various moods, physical events, people, places, practically anything can serve as powerful cues for eliciting an incapacitating need to gamble in people with a gambling-related disorder.

Sylvia, a lawyer for a large firm, who played video poker for several hours a night, phrased this well when she said, “Imagine resisting the hardest thing, like laughing when you are tickled, or worse, maybe sneezing when you need to. My compulsion to gamble was worse than that. It was a behavior that I just couldn’t resist.”

Some clinicians and researchers believe that the pivotal point in the development of any addiction is *Loss of Control*, the second of the three Cs. For the gambler, this involves an inability to *reliably* control or moderate wagering frequency or amount. *It is important to realize that this loss of control is not necessarily evident every time a disordered gambler places a bet.* However, once wagering has begun, the pathological gambler cannot be certain of the ability to show restraint. On some occasions, a pathological gambler may be able to wager in a limited fashion, adhering to a preset monetary limit. Based on the gambler's history, the probability of following this restraint is questionable and may not be very high. As the wife of a pathological gambler stated, "He doesn't spend the car payment every time he goes gambling. But he does it enough that I am scared to death."

Some argue that loss of control involves yet another C, *chasing*. As it is referred to in literature, chasing actually has two distinct purposes or meanings for the gambler. First, it is the process of betting more money for financial recouping. This is usually a variety of what is known as the Martingale system, developed in the eighteenth century. Many gamblers develop pathological patterns when they begin increasing their wagers to make up for previous gambling losses (Petry, 2005a). The Martingale guarantees failure. The mathematics show that making up for previous losses only is possible in the long run if the gambler has an unlimited bankroll and the bookmaker or casino has no limit on the size of bets it accepts. What inevitably happens is that the gambler goes tragically *bust* or broke, like Ben, a 19-year old college student in New York who owed over \$130,000 to bookies from chasing his losses. This occurred after only 6 months of gambling, trying to recoup his initial losses.

The other use of the term is the attempt to *out wager* the habituation and tedium that accompany the grind of chronic gambling. Often, a financially solvent disordered gambler finds that it takes a greater amount to experience the excitement of an earlier time. Gambling is no longer fun. He or she *chases* that first big success by gambling progressively larger amounts. This also leads to quick financial devastation.

Periods of successful chasing are invariably followed by financial irresponsibility. For example, a windfall from an unlikely payout may be immediately wagered again, despite the fact that the gambler has many creditors. No one, it seems, can chase successfully and then walk away. Don, a securities professional, noted, "My trading was so crazy that I was losing money all over the place. Then, I'd score something through just plain luck. Rather than quit and pay my mortgage, I was overcome with the thought that this was going to be my day. I'd lose everything that I had earned, and then some. I went through thousands of dollars like this."

The final C in this mnemonic is a pattern of continued gambling despite *Consequences*. For the disordered gambler, gambling continues despite financial and legal problems, shame, scorn from social systems, and many other tangible costs. While the pathological gambler may or may not be in *denial*, the gambler is aware



that there are consequences to the behavior. This is what makes the behavior so hard to understand. The gambler may fluctuate between promising to change *tomorrow* and being unable to limit wagering once it has begun or when responding to cues. The individual is usually on a downward spiral of depression, stress, family alienation, and financial and personal ruin. In this mental state, this individual is at risk of serious felonious behavior and/or suicide. Sometimes the progression downward is slow; at other times, and for reasons that are not clear, it may occur rapidly. For Ben, discussed previously, he continued to borrow from his mother's credit cards in the belief that one day he would make enough money to cancel out his year of losses. He did not and was imprisoned.

For some who reach this stage, there is a reluctant awareness that gambling, in the long run, is certainly a losing proposition. They no longer can fool themselves into believing that luck will bail them out. By now they realize that gambling is a game of chance first, and skill second—if at all. Even with this realization, they still continue to irrationally wager. Sometimes pathological gamblers will admit that even severe losing is better than not wagering at all.

As mentioned, it is this final C that is so difficult for the outsider to understand, but at the same time lets others realize that the gambler is not simply acting immorally or selfishly. Aberrant gamblers act recklessly and foolishly. They behave in self-defeating ways that simply seem *crazy*. They may lose their job, lie to loved ones, rob, steal, and occasionally even kill in order to continue wagering. It is no wonder that *loss of control* seems to be a reasonable description for people in the end stages of extreme, pathological wagering.

## Myths versus Facts about Problem and Pathological Gambling

The following are some of the most pervasive myths that surround pathological gambling. No clinician or family member can hope to understand pathological gambling until these myths are recognized as untruths or part truths. Our colleagues wish these came from our imaginations or distant memories; but, unfortunately, they came from *recent, angry* telephone calls, letters, emails, or classroom discussions. See if you can find the patterns of extremes represented in the viewpoints that are expressed.

1. Myth: "Gambling is a relatively new problem that is due to contemporary problems of lax morals, social evil, or modern greediness."  
Fact: History records many colorful accounts of people risking something of value for the hope of gain.
2. Myth: "Gambling is evil—it is invariably harmful and turns everyone who undertakes it into someone less honorable or at least someone who does not live up to his or her potential."

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Fact: Based on the number of people who pursue gambling without ever developing noticeable problems, this is simply not true. Over 80 percent of North Americans over age 18 have wagered; almost 60 percent of North Americans have done so in the past year (Taylor, Funk, & Craighill, 2006). For an overwhelming majority, gambling is a pleasant, social activity, often with costs that are no greater than those of other amusements, such as ball games, movies, concerts, or hobbies.

3. Myth: "Pathological gambling is a victimless activity. All this talk about 'treatment and intervention' is just a fancy way to invent more problems for you wealthy professionals to solve."

Fact: Criminal activity, disruption of the family and other social units, and the cost to society from unsecured debt and squandered life opportunities are all caused by pathological gambling. Many victims of problem gambling often are silent. They may be family members, including children, who can comment little about the ways in which gambling affects their lives. By one account, each pathological gambler negatively impacts six to eight people. While these numbers probably cannot be accurately calculated, it is clear that disordered gambling is more than just a personal, victimless matter.

4. Myth: "Gambling is someone else's problem, not mine.... Gambling does not affect 'nice people,' religious people.... It is basically a problem that weak people acquire through selfish behavior. Face it—it is basically a fancy word for a moral problem."

Fact: Problem and pathological gambling can affect anyone who wagers as well as the individual's family, friends, and members of social institutions who do not wager.

5. Myth: "Gambling is a choice, or a result of a lack of willpower. People with true moral character or deep spiritual values do not develop problems from gambling and, if they do, can change their behavior through their effort and willpower."

Fact: As previously stated, while the initial decision to engage in gambling or other risky activities may involve moral elements, once a pattern of problematic gambling is established it is outside of the individual's volitional control. Treatment providers believe that no one solves the problem through willpower. If resolution and fortitude could solve the problem, then no one would request treatment. Counselors or therapists could simply provide feedback, give advice, and watch the positive results. How easy life would be! However, most researchers and clinicians believe that, by the time a pattern of pathological wagering is established, talk of morality, character, and values is usually of little help to the gambler and his or her family.

6. Myth: "Once people develop pathological gambling, they are basically without hope, as Freud and other psychoanalysts seemed to imply. Basically, it is best just to cut your losses with such people, not even wasting any resources on treatment."

Fact: Treatment for gambling can work. Millions have recovered from gambling disorders and millions more will, if they understand that treatment and recovery are possible. Data from controlled studies now demonstrate that very substantial change is possible. One purpose of this book is to assist the mental health professional, health care professional, clergy person, or other important provider in understanding what works in gambling treatment. Another purpose is to remind professionals and family that change is not necessarily speedy or easy.

7. Myth: “So, my kid has a gambling problem. I’ll just do what my dad did for me. I’ll make him go outside and get the biggest stick he can find and if that stick isn’t big enough, I’ll make him get a bigger one. Then, I’ll beat it out of him.”

Fact: Sorry, that approach does not work at all—ever.

8. Myth: “Addictions are not preventable. Since they are diseases, you have to let them develop and *then* you treat them. This means that if a person shows signs of having a gambling problem, the person has no choice but to ‘bottom out,’ just like an alcoholic without insight.”

Fact: The course of many diseases, even chronic ones, may be arrested. For example, the direction and damage of hypertension can take an entirely different course if treated aggressively. The belief that a disease has to reach extremely damaging proportions before it can be treated shows a misunderstanding of the concept of *disease* and thus confuses the notion of treatment with that of insight, which was once purportedly necessary for recovery from addiction. Surprisingly, this view remains common in gambling recovery, perhaps as much as it was 20 years ago in the alcohol or other drug fields.

The bottom line: No one believes you have to have a stroke in order to treat your high blood pressure. You do not have to start losing teeth to learn to brush and floss. At one time, perhaps people needed to experience addiction to make efforts to avoid it, but most practitioners no longer believe that initial insight is necessary for the successful treatment of addiction.

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**IMAGINE THAT!**

“There are two kinds of gamblers: The losers and the pathological liars.”

Source: Graffiti on a hallway, Iowa Casino.

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## Transient versus Chronic Problems

Another prevalent myth is that everyone who develops gambling problems develops them in the same ways. In a sense, this myth is a response to the gambler prototypes from the mid-twentieth century, much as our stereotype of drug dependence is based on heroin users during the 1940s and 1950s. Many of us pigeonhole pathological gamblers as down-and-out horse players or perhaps *degenerate* card players hiding in smoky rooms or back alleys. We may envision an older, white male, having spent many years arriving at his unfortunate station in life.

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For some, the progression from an occasional gambler to a dysfunctional one may follow this stereotypical path. For others, the progression is speedy, more direct, and frankly, catastrophic. Some paths may meander, encircling like an errant planet that ultimately gets caught in the orbit of its target. There is now emerging evidence that gambling problems that occur in a subgroup of women seem to follow this more rapid developmental course (Petry, 2005a).

In some situations, disordered gambling will reach a plateau of frequency and intensity. In still other situations, no easily discernable patterns are present. Heavy, problematic, and even blatantly pathological gambling may stabilize or decrease. It may fluctuate wildly between extremes. Other cases seem to recur through time, following a pattern that is strikingly similar to depression or bipolar disorder, which will be discussed further in the next section.

There is also evidence that some people experience nonrecurrent (single or very few) episodes of moderate or even extreme pathological gambling. For example, a 31-year-old business person attending a convention at a gambling resort wagered her checking account funds and “maxed out” her credit cards in 2 days. This was her first and only severe gambling experience. Five years later, she has not made any other bets and looks back on this episode with extraordinary regret and utter embarrassment. “I can’t believe it was me who was that stupid,” she recalls. However, little is known regarding people who engage in this process of an occasional gambling *fling* or one-time pathological wagering that they do not repeat.

Patterns may incorporate any of these features for reasons that are not understood. We can guess that particular pathways relate to wagering opportunities, a lack of social supports, an absence of social sanctions, erroneous cognitive beliefs regarding wagering, and possibly some personality factors. There is also growing evidence that genetic factors may be involved, particularly those that affect neurotransmitters including the noradrenergic, serotonergic, and dopaminergic systems.

### POINTS TO REMEMBER

Gambling is a real, addictive disorder that can paralyze a person as much as any drug or alcohol substance can.

- Pathways for developing problem or pathological gambling are diverse.
- The Three Cs of addiction are **C**ompulsion, **L**oss of **C**ontrol, and **C**ontinued Use Despite **C**onsequences and are an effective mnemonic device for assessing the frequency, duration, and intensity of addictive behavior, including disordered gambling.
- Treatment providers believe that no one solves a gambling problem through willpower.

## Spontaneous Remission and Maturing Out

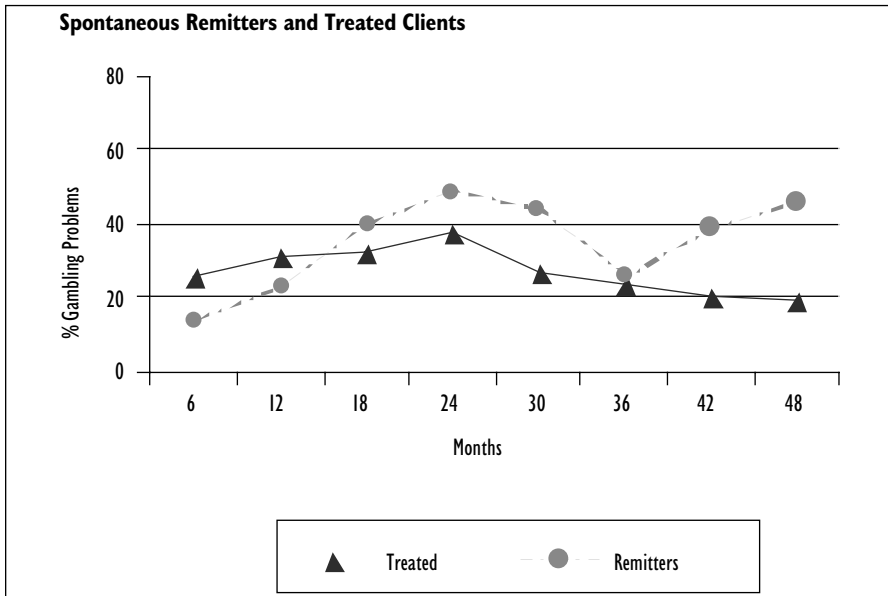
Another myth regarding pathological gambling is that once a person develops a gambling problem, the person will invariably have it for life in its full intensity. But, in fact, among those who develop a gambling problem, as many as 40 to 60 percent will demonstrate substantial clinical remission without professional or formal intervention. This number is approximately the same as with other addictions and the mechanisms involved are not known. People who follow this pattern are said to be *maturing out*. They will not meet the current criteria of pathological gambling, but do show evidence of having met the criteria in the past (Petry, 2005a).

No large studies have refuted this finding, which has been replicated with various groups, using different methodologies. This result should not be surprising, as many chronic disorders in mental health and also in medicine show patterns of spontaneous remission. Examples are anxiety, depression, and bipolar disorder in psychiatry. In internal medicine, they include lupus, hypertension, seizure disorders, and even allergies. These disorders may disappear, though often they recur with environmental triggers, sometimes increasing in severity.

It is not known whether pathological gambling that spontaneously remits is likely to return at a later time. This is illustrated in Figure 1.1, in which different groups of hypothetical people who mature out of addiction are *followed* for a number of years. Based on knowledge regarding alcohol and other drugs (AODs), it is likely that many cases of spontaneous remission will show a varied course and may return.

The concept of spontaneous remission rubs many counselors the wrong way. They may have experience with disordered gamblers who *plan* on maturing out, often when their bankrolls run dry. The counselor may have recalled being told, "I'll quit when I'm broke, but not before I'm old." Furthermore, spontaneous remission has been used by insurance companies and various legal authorities as an excuse for denying needed gambling treatment. These and other concerns leave some clinicians uneasy regarding discussions of spontaneous remission. Regardless, it does occur quite frequently and future research may use the experiences of people who show spontaneous remission as starting points for new treatment methods.

It is impossible for the clinician to know who will experience spontaneous recovery or a maturational healing, although the factors from research concerning other addictions include awareness that the addiction is problematic and the existence of positive spousal support. The relationship between negative life events and spontaneous remission is not clear. In one of the few studies, gamblers were more likely to quit when they viewed gambling as interfering with their views about themselves. The impetus was not necessarily one event, but the emotional reaction to a number of events. A reduction in negative life events and an increase in positive events seemed to facilitate self change or its maintenance.



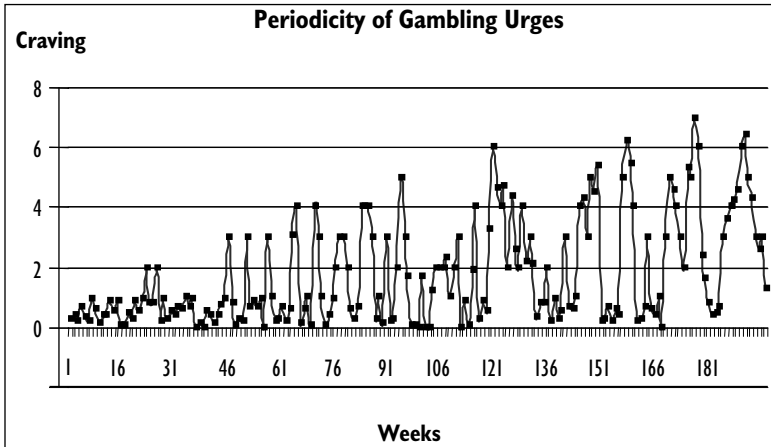
**Figure 1.1:** Percent of treated and spontaneously remitted clients with self-described gambling problems following initial gambling cessation.

From what we know about schizophrenia and affective disorders, such as bipolar disorder and depression, addictions that spontaneously remit indeed may be more likely to periodically return. There is evidence that many disorders show what is called *periodicity*, meaning they may be triggered by initial, extreme life stress, and then resolve in time often without treatment. However, once they are triggered, subsequent gambling occurrences are likely, and they are triggered by lower levels of stress or fewer environmental cues than before. As well, relapses tend to occur more frequently, more severely, and with less environmental precipitants. This is illustrated in Figure 1.2.

Because there are no clues or cues for whether a person will mature out or have a gambling problem for life, trained clinicians never count on spontaneous remission or maturing out as strategies for treatment. It is important for clinicians to understand that this can happen, but it should not shorten a well-thought-out treatment plan.

### **Clinical versus Nonclinical Populations: Why Some Gamblers Do Not Mature Out**

To state it simply, and to repeat a phrase that will become frustratingly common throughout this text, *we simply do not know* the answer. Attempts to determine why some gamblers spontaneously mature out or quit problematic gambling are hampered by a lack of studies in the scientific literature.



**Figure 1.2:** Periodicity of gambling urges in a client who spontaneously remitted from disordered gambling.

Despite the fragmented literature, some factors seem relevant. Understanding the real odds of winning and losing may discourage pathological gamblers from continuing this behavior (Benhsain, Taillefer, & Ladouceur, 2004). Many gamblers report that the realization that they were “suckers” was so offensive that they abandoned gambling altogether. As one pathological gambler stated, “When it occurred to me that you never beat the House, I was so disgusted that I had to quit. I am not that bad of a loser that I would be someone else’s sucker.”

Based on what we know about alcoholism and drug addiction, we may surmise that opportunities for gambling and cultural acceptance both play an undeniable role in whether a person matures out of problem wagering. Just as alcohol availability increases the likelihood of alcohol dependence, the availability of a gambling venue increases the likelihood that a borderline problem will become more encompassing. People who live near a casino are more than twice as likely as others to develop gambling problems. As mentioned, this may be becoming less relevant since virtually every Internet-connected computer in North America and Europe has access to legalized or semi-legalized wagering. Gambling opportunities are literally only clicks away. Cable and satellite television also offer gaming or horse racing channels dedicated to providing hundreds of wagering opportunities in a short time span.

We also can hypothesize that an early age of onset is associated with more serious problems. If research in other addictions is an indication, the earlier people start and the greater their opportunity to participate, the more likely they are to develop a gambling problem. Furthermore, they will probably have a worse prognosis. This is made even worse if their social conditions in life, such as absence of education, life skills, and opportunities, make them particularly vulnerable (Tims, Leukefeld, & Platt, 2001). This is of special concern because evi-

dence suggests that poorer and younger people are gambling at a higher rate than in previous generations. More research is needed in this area.

## Risk Factors for Gambling Disorders

We know little about the risk factors for developing severe pathological gambling (Ladouceur & Shaffer, 2005) due to the sparse attention paid to general gambling problems compared to other addictions. However, we may speculate, with reasonable certainty, that research from other addiction areas and laboratory studies may be applicable to people with gambling problems of various ranges.

### Exposure, History, Attitudes, and Expectancies

Wagering is rewarded on a variable ratio of reward. This aspect of conditioning probably accounts for part of the explanation of why pathological gambling is addictive (Weatherly, Sauter, & King, 2004). Anecdotal accounts and some researchers suggest that people who *score big* or experience a windfall profit early in their gambling histories may be at particularly high risk. One casino manager said recently that he believes half of the people who experience a “very large financial gain” will “give it back to us” within a year. While some researchers dispute this, a general consensus is that a big win may act to bias a person’s cognitions and emotions toward the belief that gambling is a predictable process that affords the player the opportunity to score consistently huge payoffs.

Recently, clinicians have seen other risk factors for acquisition of problem gambling, such as a person’s total hours of Internet exposure and participation in risky financial transactions. New venues for wagering are developing almost yearly and often cannot be anticipated. For example, some high school students have gone beyond wagering on college sports and now bet on the outcome of local high school matches. Professionals involved with high schools must be vigilant to assess youths at risk of developing gambling problems.

Irrational expectations regarding pay-offs are risk factors for at least a subset of gamblers (Benhsain et al., 2004; Walker, 1992). Presumably they include a strong belief in luck, in the possibility of beating games of chance, or that games of chance show detectable patterns. People with gambling problems, especially with pathological gambling, expect to win in the long run, sometimes even in the short run. Often, these expectations seem to resist normal extinction mechanisms and become pathological, defying usual behavioral and cognitive theories that apply to others. Promising treatments that have strong empirical support focus on changing these irrational expectations (Toneatto & Millar, 2004).

Some people are more apt to develop a gambling problem when they consider gambling an illicit or forbidden activity. This may explain why sometimes the most intense gambling occurs among people with the deepest sentiments against



it, such as deeply religious people who are in a state of rebellion against social or religious figures. Furthermore, the excitement associated with the lack of inhibition is increased in people who consider gambling *bad* or *evil*. When excessive wagering is seen as simply unhealthy, perhaps a bit like eating potato chips, it may lose some of the luster associated with its apparent tawdriness and then may become less tempting.

### Personality Variables

The classic work of Custer and Milt (1985) identified two major types of gamblers—Action gamblers and Relief gamblers. These are useful models, though *models do not typically encompass every condition* and serve more as useful guides or maps. A clinician who tries to pigeonhole someone into a model may not understand fully the function of models.

*Action gamblers*, the majority of whom until recently were male, appear to be motivated by the positive reinforcing qualities of gambling-related arousal. While gambling, they usually experience intense excitement, a euphoric *rush* while winning, self importance, and feelings of omnipotence and power. Furthermore, they may often demonstrate, or appear to demonstrate, a reckless disregard for their losses. It is believed that the action gambler usually needs to bet more and more frequently in order to maintain the rewarding experiences.

*Relief gamblers* wager primarily for distraction, rather than for thrills or to enhance their egos. In other words, they are thought to be seeking negative reinforcement or a reduction in anxiety, depressive rumination, and other dysphoric states. However, gambling (like alcohol, commonly abused drugs, and other life distracters) is an exceedingly unreliable and costly mood-altering method. Its frequent failures result in increased use. When abused, it results in more anxiety and depression, causing a vicious circle.

### Blaszczynski's Types

More than 60 years of research suggests that many personality factors may be a risk for some forms of disordered gambling. The prolific gambling researcher Alex Blaszczynski and his associates (Steel & Blaszczynski, 1996) have argued that there are four *personality types* at risk for developing the most severe pathological gambling problems.

The first type is essentially *no discernable type*, meaning those who have no substantial personality factor that contributes to their pathology. They are *normal* people who become exposed to excessive gambling perhaps through a large win or lifestyle factors. They may live near a casino or may be involved in the

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#### IMAGINE THAT!

“My church makes a lot of money off of those Las Vegas nights. The idea is to make it as glitzy and really almost as sinful as possible, without sinning, if you know what I mean. I don’t know that we will be doing it again, though. The last time we had one of those ‘Casino Nights’ one of the card dealers got into a fight with one of the players about cheating. It got that violent over *imaginary money*.”

Source: Southern Church  
Pastor, now minus two church  
members.

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gaming industry. Regardless of having no apparent predisposition, they develop severe gambling problems that cause personality-related behaviors.

A second type is composed of people who have serious preexisting *neurotic* spectrum disorders or other psychiatric conditions. An example might be a person who has anxiety or depression and gambles as a result of these conditions. This group likely corresponds to the relief gambler described earlier. In the language of many personality theorists, these people probably have a high degree of trait neuroticism, a personality characteristic that is related to emotionality and negative affect. An example is a person who gambles in response to the loneliness following the separation from a spouse.

A third type may have specific *biological vulnerabilities* to gambling and perhaps to other addictions as well. These people are highly impulsive and appear to have a strong biological component and difficulty regulating their moods. Perhaps they gamble as a form of mood regulation. A current theory is that they have abnormalities involving the neurotransmitter dopamine, causing reward deficits that will be discussed in later chapters. A radio commentator recently described these gamblers as “addicted to the action” because the action “makes them calm” and indeed they seem to be. They tend to enjoy taking chances and learn more slowly from their mistakes than others.

A fourth type is composed of people with *antisocial personality traits* that do not condition to signals of punishment in the way that the rest of us do. There is certainly some overlap between groups three and four. Groups two, three, and four are not mutually exclusive. It is possible for someone to have temperamental or intrapsychic variables or predispositions that propel the person to excessive gambling. That same person, quite independently, might have problems with various neurotransmitters or neurohormonal regulatory or reward systems. This might make people more addiction prone to a variety of stimuli and substances, not just gambling.

### **Specific Contradictory Personality Variables**

A number of often contradictory personality factors are considered related to pathological gambling (Aasved, 2002). Some of the disparity in the literature may be due to the fact that subtypes of gamblers were included in the studies. Table 1.2 shows some personality variables that have been cited in research or clinical literature that are associated with gambling problems. Many of these traits are controversial and have not been replicated in other studies. Still, clients often find them useful in self-evaluating risk and self discovery.

It is clear that many types of personalities gamble excessively. Many personality extremes can be stretched into the hypothetical *gambling personality*. Not surprisingly, there is no single type of personality highly correlated with gambling problems, although personality may be a cofactor in the development of the disorder.

**Table 1.2:** Personality Characteristics Purportedly Causally Related to Gambling

Assertiveness	Conformity
Boredom proneness	Easily entertained personalities
Disagreeableness	Agreeableness
Need for interpersonal intimacy: High	Need for interpersonal intimacy: Low
Extraversion	Introversion
Female-ness	Male-ness
Gullibility	Paranoia
Magical Thinking	Concreteness
Generosity	Selfishness
Narcissism	Desire for Anonymity
Aggressiveness	Passivity
Need for achievement: High	Need for achievement: Low
Type A personality traits	Type B personality traits
Assertive personality traits	Avoidant and compliant traits
Need for rejection	Need for acceptance
Neuroticism	Excessive Stability
Sensation seeking	Passivity
Rebelliousness	Conformity
Need for acceptance: High	Self-punishment
Need for power: High	Need for power: Low
Manic subclinical traits	Depressive subclinical traits

Opposite and exclusive personality traits may relate to different types of gambling and when a person is likely to gamble during the life cycle. For example, extraverts may be at risk during specific periods and enjoy games in which they can be seen winning or losing. Introverts, on the other hand, may be less likely to enjoy flashier aspects of casinos but may develop gambling problems from other wagering opportunities.

Research now shows that major personality traits, as broadly measured, are relatively stable throughout much of life. Some of these broad personality variables are related to addictive disorders, such as high impulsivity. Others may make people more likely to become addicted following specific situations, such as high levels of trait neuroticism, which may interact with uncontrollable life stress.

Most clinicians are aware of the importance of personality in acquiring and maintaining addictive behaviors; however, they do not find it useful to directly treat an *addictive personality*. It is unlikely that one single addictive personality exists, despite what the media and popular accounts proclaim. Researchers and clinicians now understand that it is far more efficient to change extreme addictive behavior than it is to change personality traits. On the other hand, when their clients talk about having addictive personalities, clinicians help the clients use these insights to foster behavioral changes.

### **Comorbid Psychiatric Disorders**

There are several well-recognized comorbid, or co-occurring, psychiatric disorders that are important risk factors for pathological gambling. These also are called comorbidities (Winters & Kushner, 2003). Based on the summary of existing literature, disordered gamblers are more likely than the general population to have the co-occurring or comorbid disorders listed in Table 1.3.

These disorders, and the diagnostic confusion that they generate, are discussed more fully in Chapter 2. Additional chapters will highlight the problems of comorbidity in treatment management and compliance.

### **Biology and Genetic Factors**

Most researchers, and practically everyone who has recovered from a serious gambling problem, believe that the brains of gamblers work differently than those of others—but how? Some researchers believe that the underlying pathology of aberrant gambling is related to a reduced sensitivity of the brain's *reward system* (Reuter et al., 2005). This may be acquired through life experiences, may be based on genetic factors, or may be a combination of the two. Early experience might alter the ability of the reward system to function adequately and predispose a person to developing a gambling problem. There is increasing evidence from other addictions that, once specific brain mechanisms are overstimulated, it is unlikely that they will return to their balanced state prior to addiction (Kelley & Berridge, 2002).

Mounting evidence suggests that pathological gamblers show deficits in a specific portion of the brain associated with *deficits in impulse control*, especially under conditions of excitement. Essentially, they fail to show an adequate ability to inhibit or stop responses, even under conditions of losses. These people do not avoid punishment as well as the rest of us. It is easy to see how they might be more likely to continue gambling, despite serious financial setbacks.

**Table 1.3:** Co-occurring Disorders with Problem and Pathological Gambling

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Alexithymia (inability to describe emotions)
Antisocial Personality Disorder
Anxiety Disorders
Attention-Deficit Disorder
Avoidant Personality Disorder
Bipolar Disorder
Borderline Personality Disorder
Dependent Personality
Depression
Dyslexia and Other Learning Disabilities
Impulse Control Disorders Other than Gambling
Narcissistic Personality Disorder
Other Addictive Disorders
Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Various Communication Disorders

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*Source: From Winters and Kushner (2003), Petry (2005), and other sources.*

Several neurotransmitters have been implicated in disordered gambling. These include serotonin, norepinephrine, dopamine, and beta endorphins (Aasved, 2004). Fiorillo (2004) reviews the somewhat controversial nature of dopamine. Dopamine appears to be a major neurotransmitter involved with pleasure. It also appears to be released under conditions of uncertainty, a relatively novel finding that has been verified on a cellular level. Fiorillo notes, “If dopamine is increased by reward uncertainty and it is reinforcing, then it seems likely that it would contribute to the reinforcing and potentially addictive contribute of gambling, which is defined by reward uncertainty” (p. 123).

There is now data suggesting substantial genetic influence in pathological gambling (Potenza, Xian, Shah, Scherrer, & Eisen, 2005). Care needs to be taken in interpreting the findings of these studies, which were conducted on middle-aged men. However, they are congruent with the notion that differences in

reward sensitivity may underline gambling addiction. Certainly, the picture is much more complex than anyone presently imagines. The next few years should produce important breakthroughs.

### **Coexisting Addictive Disorders**

The *DSM-IV-TR* has proven to be a reliable tool in defining addictive disorders up to a certain point. For example, in drug addictions, the *DSM-IV-TR* can provide criteria to classify between abuse and dependency. It also provides the criteria needed to obtain a pathological gambling diagnosis. But nowhere is there a definition for sex, work, alcohol, buying, or food addiction (which is different than eating disorders). Statistically, a person with any addictive disorder, such as alcohol, has a higher chance of becoming addicted to gambling or another addictive disorder. As this field grows, there will be more research linking prevalence of gambling to drug addictions.

### **Epidemiology of At-Risk Populations**

Despite common stereotypes, disordered gamblers can be male or female, teen, young adult, middle-aged, and older people. Aberrant gamblers are found among the poor and the wealthy. Every race and religion is included; every ethnicity or nationality is at risk.

Historically, the poor and people who are socially or economically disenfranchised have been more likely to develop gambling problems. This trend remains, and gambling among the most disenfranchised appears to be growing at an alarming pace. Statistically, Black and Asian people are more likely to become disordered gamblers, even controlling for economic factors (Welte, Barnes, Wiczorek, & Tidwell, 2004). The reasons for these patterns are not clear, but may relate to a cultural tolerance of gambling due to a history of economic deprivation, or because these groups had few other leisure options, such as oppressed people in the slavery period.

Because pathological gambling once took years to develop, gambling was believed to be a problem primarily for middle-aged people. However, gambling is increasing fastest among the young and the elderly, and there is evidence that pathological gambling is increasing fast in these groups as well.

During the last 10 years, elderly people have been recognized as being at particularly high risk for gambling problems. Many are addicted to such harmless pastimes as church-related bingo. Occasional gaming-industry marketing approaches target elderly patrons all too successfully. Because elderly people have limited leisure opportunities, they are at higher risk for financial devastation.

Studies suggest rates of disordered gambling may be from 7 to 12 percent for high school students. Many students are gambling much earlier and more frequently than their peers from a generation ago. Research finds above 80 percent of high school students admit to some history of gambling and about 14 percent

## TESTING YOUR KNOWLEDGE



1. Rates of gambling in the North American population appear to be between \_\_\_\_\_ and \_\_\_\_\_.
2. Rates for younger people tend to be \_\_\_\_\_ than those of older people.
3. The *DSM-IV-TR* classifies gambling as a Disorder of \_\_\_\_\_.
4. Gamblers Anonymous prefers to use the term \_\_\_\_\_.
5. The term \_\_\_\_\_ is often used for cases of gambling disorders that are not as severe as those that have the full pathological symptoms.

Answers on page 31.

state that they have gambled on school property. High-stakes poker is now a highly popular cable television show for high school-aged people; and participation in games such as Texas Hold 'em has become a national craze. For some students in late high school and early college, gambling with peers is the only organized source of socialization.

In the college years, students may be at particularly high risk for exposure to new and particularly dangerous wagering opportunities. Outfitted with a credit card, which is often necessary for college transition, these students often are tempted to participate in sports wagering or other Internet gambling. Advertisements for these wagering opportunities are commonly encountered where students visit. To uninformed individuals, who do not realize that their gambling odds may be incredibly poor, the attraction can be overwhelming.

Student athletes and people that work closely with them may be particularly vulnerable for developing wagering problems. As more people wager on college sports, there may be pressure for these athletes to fix games or small parts of games. This can be done very subtly. For example, some bookmakers accept wagers on how many strikes must be thrown before the first base on balls is recorded in a specific game. It is exactly this type of athletic performance that is easy to unobtrusively manipulate, and officials are appropriately wary. Still, occasional accounts that appear in the media suggest that the problem is not necessarily under control.

Today, with rapid play video terminals and Internet wagering, many younger people are showing an affect that has been labeled *telescoping*. This occurs when a person advances rapidly through stages of gambling that once developed more slowly. As previously mentioned, some authors believe that women also are more likely to experience these telescoping tendencies.

## Gender Differences

In the past, men were more likely to develop gambling problems; however, now many authors argue that genders have achieved parity. History shows that women are more likely to be relief gamblers, while men are more likely to be action gamblers. It is not clear whether these trends will continue.

Clinical cases and self-help literature suggest that many female problem and pathological gamblers may have a number of psychological and social burdens that male gamblers do not. These are listed in Table 1.4.

It is likely that gender differences and their relationship between the two types of problem and pathological gambling styles will disappear in the next generation or two. There is already some evidence that women are rapidly becoming more action gamblers; and as many as one half of men who seek help for gambling appear to be relief gamblers. Since the development of a specific type of gambling disorder may relate to the opportunities that a person can access, it may be that women have more access to relief-oriented games.

**Table 1.4:** Purported Characteristics of Female Problem and Pathological Gamblers

- 
- Gambling becomes a problem later in life, frequently after women reach age 30.
  - Gambling problems are more likely to occur when women reach the “empty nest phase” when their children leave.
  - Gambling problems are presumed to occur more often following a divorce.
  - Women are presumed to gamble at games that are entirely luck based, compared to those that involve a minimal degree of skill.
  - In the past, women tended to be very quiet about gambling, compared to men, who tended to boast.
  - Women often show more irregular wagering patterns—weeks of intensity, followed by months or years of quietude, with a return to intensity.
  - Women were often observed to be more in a “fugue state” while gambling, appearing numb to their surroundings.
  - Self-help literature states women with gambling problems tend to avoid confrontation.
  - It is believed that gambling is harder on children if the mother has the problem.
  - Some authors believe that women may reach a point of desperation sooner, following a much more rapid declining path after their initial wagering experiences.
  - Self-help groups often claim that women have a difficult time in early recovery because of overwhelming shame and guilt.
  - Some self-help proponents believe that women are more likely to relapse.
-



## Gambling, the Family, and Multicultural Considerations

Presently, it is not clear how families affect problem or pathological gambling or related behaviors. Practitioners often note that dysfunctional families tolerate or actually encourage problem gambling by another member. Many family therapists see these *Identified Patients* (IPs) as scapegoats or metaphors for problems of other members in the family system. While this perspective has not generated the clinical enthusiasm that it has in other areas of addiction, it is often useful, especially where families seem to assist or enable relapses (Federman, Drebing, & Krebs, 2000). Clinical impression suggests that, where there is a gambling-related disorder, many families show a tendency toward a specific type of dysfunctioning. They are simultaneously crisis prone and treatment resistant. They are in need of intervention, but seem to work hard to avoid making interventions successful.

As is the case with alcohol, some clinicians note that families that model gambling moderation (rather than total abstinence) are likely to produce children without gambling problems. From a sociological perspective, social gambling can be taught in the family context the way social drinking can be reinforced by a family's values. But there is no guarantee that these social gamblers will not evolve into problem gamblers regardless of the reinforcement and support.

The meaning attached to gambling and abusive gambling may differ in diverse cultures. In some Asian cultures, gambling is commonly accepted and may even be necessary for daily business dealings. Gambling abuses may or may not be tolerated, however, and subcultures run the gamut of being permissive to extraordinarily restrictive. Practitioners need to be careful to avoid stereotypes based on limited experiences of people in Western settings.

Most fundamentalist Islamic countries detest gambling, though this moral condemnation does not seem to have slowed the progression of pathological gambling in many people of this background. Sub-Saharan African and European descendents do not seem to show any particular pattern. Gambling rates seem to vary by country and historic period. Other groups, such as the dwellers of southern Louisiana, have had a colorful past that has often involved abuse of gambling and excessive alcohol.

The role of religion needs to be considered carefully by professionals. Historically, the more *Protestant* a person, family, or origin group is, the greater the tendency to regard gambling as morally aberrant. However, in many cases, this morality can cause a person to engage in periodic binges that may increase the severity of gambling problems. Binge gambling, like binge drinking, seems especially high among people with conservative backgrounds, who are temporarily in a location where they feel that they will not be detected.

Usually, a trained counselor who is sensitive is able to ask about a person's religious beliefs and how these beliefs might have influenced the individual's

gambling patterns. Religious values may be an untapped source of strength that assists in motivating a client to change. Regardless, this is a sensitive topic to explore and must be dealt with gently when opportunities arise for exploration and discussion.

## **What the Future Holds for the Treatment of This Disorder**

The field of gambling treatment has become more outcome oriented. At the same time, when professionals are beginning to gain recognition as being autonomous, techniques are being systematized and subjected to empirical critiquing. The days when a specific treatment approach is used simply because popular clinicians advocate them will be gone. Similarly, clinicians who require clients to undergo a specific treatment simply because it worked for the specific clinicians or their peers will be seen as atavistic—relics of the past.

The treatment of gambling disorders will also move more toward a truly *biopsychosocial model*. The clinical and scientific community has often given lip service to the concept that gambling addiction is multicausal and is related to constructs from biology, psychology, and social interaction. What this means in practice, however, is that researchers and clinicians emphasize the variables that are most in their range, experience, and professional licensing to change. This is an example of the old adage of “If you have a hammer, the world is a nail.” For example, psychiatrists *naturally* gravitate to biological orientations toward gambling, such as models that emphasize serotonergic or dopaminergic imbalances. Psychologists tend to emphasize learning and the cognitive aspects of the acquisition of gambling behavior. Social workers and family therapists tend to emphasize the interaction of family units, especially couples.

In other addictions, sadly, there is a further tendency to further fragment fields by the subspecialty of the practitioner. For example, nurses working in sexual addiction may read separate journals and have separate theories than family therapists working in sexual addiction. This is most prominent where addiction research is most advanced—alcohol. This trend may be beginning in gambling treatment, but practitioners and researchers can stop it cold.

Perhaps in 10 years, this fragmented, segmented approach to gambling research and treatment will be avoided. It is possible that gambling research and treatment may escape the splintering by profession that other addictions have experienced. Only time will tell, but there is reason to be hopeful.

## **Where the Field Is Going**

The treatment for gambling disorders is now where alcohol was 30 or 40 years ago. There are many more questions than answers. Seven years ago, when we

wrote a book for clinicians who wanted to learn about pathological gambling, there was clearly an insufficient number of studies. It was questionable whether pathological gambling was a disorder that the average clinician would ever encounter. The demand for treatment was primarily inpatient, unlike today, where comparatively few people are treated in this intensive of a modality.

In the past 10 years, academics in the field have learned more, and researchers want the therapeutic community to pay attention to what they have found. We now have some idea of what works, at least some of the time. Clinicians want better treatment based on data, not charisma or authority. To paraphrase the late Robert Coombs, "Addictionology is at last becoming a profession" (personal communication, April 15, 2004).

In many cases, briefer treatments appear to be very effective. A major concern over the next 10 years will be in determining for whom brief treatments are an appropriate intervention. Emphasis may be on interfacing formal aspects of brief treatment with Gamblers Anonymous.

Undoubtedly, there will be greater work on the subtypologies of pathological gamblers. Research has largely been retrospective and suffers from the deficits inherent in that design. Furthermore, there will be more research linking theories of abnormal behavior to these subtypes, and biological differences will undoubtedly loom boldly in these findings.

The field will pay attention to the growing number of Internet gamblers. In 2003, worldwide Internet gambling made revenues of \$5.7 billion, and it is expected to reach approximately \$16.9 billion by 2009 (Groover, 2005). Kearney (2005) reports that, between 2002 and 2003, there was an increase of 42 percent in the revenues obtained through Internet gambling; Internet gambling is not expensive to obtain, transportation is not involved, and there are basically no usage charges. The rise of Internet gambling brings an increase in youths gambling, gambling problems, and criminal activity. Individuals who previously could not gamble due to age, disabilities, and societal positions, now can gamble anonymously on the Internet. Furthermore, Internet gambling increases the opportunity for some types of fraud, such as credit card fraud. Participation in Internet gambling also could increase an individual's engagement in other forms of gambling.

Furthermore, as more *average citizens* become involved in the stock market, this form of investing will likely result in expanded opportunities for pathological gambling. The tendency of young people to gamble at apparently higher frequencies will need more attention, and researchers need to determine whether prevention of gambling in this age group can help prevent the development of other disorders. Research also will be aimed at determining what works for which type of high-risk group, such as the elderly, certain ethnic groups, and women.

Perhaps with gambling disorders, we have finally learned from our treatment errors in other addictions. First, we have learned that prevention is more impor-

tant than expensive, after-the-fact treatment. As discussed in many sources (e.g., Coombs & Howatt, 2005), mental health prevention can be divided into three levels for comparison. Primary prevention is directed toward preventing the initial occurrence of a gambling disorder, by limiting either gambling opportunities or other methods that limit development of exposure to risk factors. Secondary prevention seeks to arrest or retard existing gambling problems and their effects before they become unmanageable. Tertiary prevention seeks to reduce the occurrences of gambling relapses in people who are committed to treatment. Greater emphasis will be placed on primary and secondary prevention and in understanding the transitioning between low-risk and high-risk gambling.

Bornstein and Miller (2006) report video games as being more harmful than any other form of media because of their interactive involvement. Video games have been associated with substance abuse, poor school performance, low activity, and gambling. We are concerned about the possible breeding ground for future gamblers to which the video game industry may be contributing. Today this industry is collectively bigger than the movie industry, which has been around much longer. We have no clinical evidence, just years of clinical experience that suggests gambling problems will continue to increase because of the Internet infrastructure and video game training arenas providing young people adventure and escape from the real world. Both are prime drivers for adult gambling addictions. We encourage and promote the idea that video games, the Internet, and other sources of electronic entertainment be monitored by parents closely.

Emphasis also will be less on traditional gambling treatment modeled after substance abuse treatment, and more on that which is modeled after relapse prevention (Toneatto & Millar, 2004). People for whom gambling abstinence is not an appropriate goal, or for those who choose not to pursue abstinence, methods of harm reduction will become more common. Harm reduction is a policy or program directed toward decreasing the adverse health, social, and economic consequences of gambling without requiring abstinence (although abstinence can be one of the strategies). Whether it is possible to use harm-reduction techniques to divert people who are on a trajectory toward high-risk gambling activities is not known and is beyond the scope of this book.

Ultimately, the greater goal will be beyond gambling cessation to one of health promotion—the process of enabling people to increase control over and to improve their health.

## Summing Up

There are similarities and distinctions between gambling and other addictive disorders. Those with anger and a lack of empathy toward people with addictions often become blatantly antagonistic toward people specifically with gambling disorders. Through progress in treatment, most of us have some understanding of how drug or alcohol addiction can cause devastation, and there are now fewer

**POINTS TO REMEMBER**

Despite common stereotypes, disordered gamblers can be male, female, teen, middle-aged, elderly, rich or poor, and any ethnicity or nationality; although, historically, the poor and socially or economically disenfranchised have been more susceptible to developing gambling problems.

- Some reports suggest that younger adults are having more problems with gambling than older adults.
- Video games have been associated with substance abuse, poor school performance, low activity, and gambling.
- The meaning attached to gambling and abusive gambling differs across cultures, families, and religions.
- Treatment for gambling disorders is effective for the majority of people with problems.

stigmas associated with alcohol and drug addictions. In contrast, gambling-related disorders are more likely to be viewed as a personal Achilles' heel or a great wrongdoing. If others do see problem or pathological gambling as a legitimate addiction, they are likely to see it as beyond treatment, “utterly beyond the worst of hopeless” as a probation officer recently said. One possible reason is that there are fewer public examples of recovered pathological gamblers who are leading successful lives, in contrast to recovered alcohol or drug-addicted people. A number of common myths have impeded understanding and treatment of problem and pathological gambling. These include the idea that excessive gambling is a moral failure or personal weakness.

Furthermore, gambling problems may be acute or chronic and vary in severity. Many personality variables, psychiatric conditions, and cultural factors, perhaps genetics as well, influence the development of disordered gambling. Perhaps even sheer accident—dare we say chance?—also plays a role.

There is definitive evidence that treatment for gambling disorders is effective. During the next few years, more scientifically based treatment will combine with successful mechanisms of prevention to boost the effectiveness of interventions.

## Key Terms

**Mature out.** Gradually curtailing destructive behavior over months or years.

**Spontaneous remission.** Disordered gambling problems disappear without informal or formal treatment.

**Pathological gambler.** The formal diagnosis of a gambling disorder as defined by the current edition of the *Diagnostic and Statistical Manual—Fourth Edition, Text Revised (DSM-IV-TR)*. To receive this diagnosis, a person must meet five of the ten criteria as indicated in Table 1.1.

**Problem gambler.** People who meet some (e.g., three of the criteria), but not the minimum five criteria that obtains the *DSM-IV-TR* diagnosis for pathological gambling.

**Disordered gambler.** A general term used to describe anyone with a gambling disorder.

**Compulsion.** An uncontrollable behavior sparked by an irrational idea, called an *obsession*, having overwhelming internal feelings that seem coercive and inescapable.

**Chasing.** First, it is the process of betting more money for financial recouping. Another use of the term is the attempt to *out wager* the habituation and tedium that accompany the grind of chronic gambling

**Action gambler.** A person that appears to be motivated by the positive reinforcing qualities of gambling-related arousal.

**Relief gambler.** A person who wagers primarily for distraction, rather than for thrills or to enhance his or her ego.

**Comorbid.** Co-occurring.

## Recommended Reading

For an excellent summary and breakdown of the three Waves, see Roger Dunstan (1997) at <http://www.library.ca.gov/CRB/97/03/Chapt2.html>.

One of the best resources available for summarizing findings regarding risks of developing problem and pathological gambling is available at the web page of the Ontario Problem Gambling Research Centre (OPGRC): <http://www.gamblingresearch.org/contentdetail.sz?cid=2007>. This is presented as a model that is constantly being updated, in response to new findings regarding biological, psychological and social influences in development of aberrant wagering. It is particularly useful to researchers, as it links present findings to questions of immediate interest.

Bob Wildman's e-review contains over 8,000 citations directly relevant to gambling. It is a very readable and entertaining narrative that highlights everything from the history of gambling to contemporary theories. It is free and Dr. Wildman writes like a gifted science writer. You can access it at the web page of the OPGRC at <http://www.gamblingresearch.org/ewildman.sz>.

While it is not quite the "Latest Addiction on the Internet" as they claim, [Addictionsearch.com](http://www.addictionsearch.com) (<http://www.addictionsearch.com>) is a great resource for summaries of many recent findings for a variety of pharmacological and non-pharmacological addictions; counselors or therapists may find yourselves spending hours following the links listed there. Warning Sign posted: the information is so good it may be "Addicting to the Interested."

*The Addiction Counselor's Desk Reference* by Coombs and Howatt (2005) is a volume written by the editors of this series. This book, which is also available as an electronic e-book, is an immensely practical guide book for all kinds of information you might want to know about addiction in your daily practice. Moreover, and for our purposes, it has an outstanding set of tools for intakes, treatment planning, and client action plans. This book is *highly recommended* as a time saver and as a rich source of practical ideas and summaries of pertinent theoretical information. Get it today!

*This Must Be Hell: A Look at Pathological Gambling* by Humphrey (2000) includes brief accounts of the lives of pathological gamblers—very useful for clinicians, gamblers, and their families.

*Born to Lose: Memoirs of a Compulsive Gambler* by Lee (2005) is a very honest, straightforward account of how a very bright man with a great deal of talent developed an immense gambling addiction. This is a great book for people who might have a gambling problem, their families, and for therapists as well.

*Pathological Gambling: Etiology, Comorbidity, and Treatment* by Petry (2005b) is the most current, comprehensive scholarly review of pathological gambling by a noted researcher, who has a talent for asking questions that practitioners need answered. This is also a user-friendly treatment guide filled with resources for the clinician. Clinicians can adopt the cognitive behavioral program that she recommends with very little revisions. The book includes 35 pages of handouts for her scripted interventions. If you treat one gambler, at any time in your professional career, you must have this book.

#### TESTING YOUR KNOWLEDGE

### ANSWERS

1. 2 percent and 6 percent 2. Higher 3. Impulse control 4. Compulsive gambling 5. Problem gambling

#### TRUTH OR FICTION

### QUIZ ANSWERS

1. False 2. False 3. False 4. False 5. True 6. False 7. False

