camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale
A publication of the Centre for Addiction and Mental Health

ISSN: 1494-5185

JOURNAL OF GAMBLING ISSUES

contents

issue 14 september 2005

intro

Conceptual challenges from pathological gambling
By Nigel E. Turner

research

Generational comparison among female pathological gamblers
By Andria M. Botzet

Interpreting prevalence estimates of pathological gambling: Implications for policy
By Blasé Gambino

"Double trouble": The lived experience of problem and pathological gambling in later life
By Gary Nixon, Jason Solowoniuk, Brad Hagen, & Robert J. Williams

Clients' perspectives of, and experiences with, selected Australian problem gambling services
By Alun C. Jackson & Shane A. Thomas

Youth gambling: A public health perspective
By Carmen Messerlian & Jeffrey L. Derevensky

Natural course of gambling disorders: Forty-month follow-up
By David C. Hodgins & Nicole Peden

clinical corner

The case of the sleepless slot-machine supplicant:
Bipolar disorder and pathological gambling
By Bruce Ballon

opinion

Can playing poker be good for you? Poker as a transferable skill
By Adrian Parke, Mark Griffiths, & Jonathan Parke

book review

Gambling problems in youth: Theoretical and applied perspectives
Reviewed by Keis Ohtsuka

book review

Suburban Xanadu: The casino resort on the Las Vegas Strip and beyond
Reviewed by William Thompson

conference proceedings review

Culture and the gambling phenomenon
Reviewed by Phil Lange

letters

submissions

links

archive

subscribe

Formerly the *Electronic Journal of Gambling Issues: eGambling* (*EJGI*)

PDF version of: This Article (68 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

intro

editorial

Conceptual challenges from pathological gambling

As a mental illness, pathological gambling has aspects that present us with several conceptual challenges. Ultimately, gambling pathologies can help illuminate the nature of the human mind, the concept of free will, and the logic of leisure.

Gambling is the act of risking the loss of something of value (usually money) on an uncertain outcome in the hope of winning something of greater value (usually money). More than 80% of the population of Ontario engages in some form of gambling (Room, Turner & Ialomiteanu, 1999; Turner, Wiebe, Falkowski-Ham, Kelly & Skinner, 2005). Similar levels of participation have been found in numerous countries throughout the world. Most people gamble as a means of entertainment; however, a relatively small proportion develop a clinically significant gambling pathology. Pathological gambling (PG), according to the DSM-IV (American Psychiatric Association, 2000), is an impulse-control disorder characterized by persistent and maladaptive gambling behaviours that have disruptive consequences for familial, occupational, and social pursuits. Researchers and clinicians also identify a less serious level of gambling-related disorder that is known as problem gambling. A meta-analysis by Shaffer et al. (1999) for North America reported the lifetime prevalence of PG in adults at 1.6%, with an additional 3.9% having a milder, sub-clinical level of gambling problems.

This editorial aims to explore some issues related to gambling that challenge our way of thinking about the world.

1) **Pathological gambling challenges our concept of addiction**. If pathological gambling is an addiction like drug or alcohol addiction, this forces us to turn our focus away from the chemistry of the "drug" per se and look more at its psychological effect. A gambling win is a powerfully rewarding experience, yet such an experience is not caused by a drug, but by an experience that is only pleasant because of the meaning it has for that person. For

example, suppose a dealer is pushing 10 chips towards you. If you had no understanding that black-and-yellow chips represented $100 each, you would not know that you had just won $1000. Nonetheless this psychological "addiction" can produce physiological symptoms of withdraw (Rosenthal & Lesieur, 1992). I believe we can gain a great deal of insight into the process of addiction by looking at the similarities and differences between various behaviours that we call addictions. For example, the fact that there are huge numbers of people who eat compulsively or who are addicted to smoking suggests that addiction is not a rare condition. Furthermore, although addictions are associated with increased risk of other addictions (e.g., gambling and smoking), yet many addicted people are selective in their addictions—that is, they may be addicted to gambling but not to drugs. Speaking from the point of view of a person who is overweight, I have a great deal of difficulty stopping when it comes to eating potato chips, but no difficulty at all stopping my consumption of sweet food, or alcohol, or gambling. Is this an addiction? My impulse control problem is very limited in scope (potato chips only, not poker chips). It is interesting that both smoking and excessive eating are associated with long term health problems, but relatively little short term harm (perhaps nausea or a stomach ache at worst). In contrast rarer “addictions” such as gambling and alcohol have a much greater potential for short term harm (e.g., loss of money, traffic accidents). Perhaps short-term harm is a factor that limits prevalence. A future area of research should be to look at similarities and differences in the nature of different addiction-like behaviours to gain insight into what is common and what is unique to each.

2) **Challenges to our notion of illness**. Gambling addictions are in essence brought upon oneself. The person is aware of what they are doing; they are not inebriated; there is no physiological harm done to oneself, and no brain damage to speak of. This awareness and apparent control over what one has done may explain the strong association between gambling and suicide. There are real changes to the reward system of the brain brought about by excessive gambling, but these changes are not really different from the sorts of changes found in other learning situations: learning to read and to drive create similar changes in brain function. Excessive gambling is an "illness" that causes no obvious physiological harm, but can lead to massive psychological and social harm. The stressful consequences of excess gambling, however, may lead to physiological harm.

3) **Challenges to our concept of free will**. How can free will be co-opted by a game? The same issue applies to drugs, but I think people are more comfortable talking about drugs as interfering with one' s brain because the drug is seen as an external agent that is ingested and acts upon the brain. With gambling it's the game that creates the problems. How? I have heard some people try to

explain machine gambling as a process of hypnotism caused by the spinning reels of a machine. But such an explanation does not account for addictions to betting on horses, dice, or poker or other card games, where there are no spinning reels to speak of. I suggest looking at gambling addiction as resulting from two modes of mental operation. One mode is the effortful processing that is used for novel situations, and the other involves automatic processes that are used to control familiar situations. Language comprehension provides a helpful analogy. We do not have time to ponder the nuances of every word, but have automatic processes for interpreting most sentences; however, we can resume control over the automatic processes when encountering novel words, strange syntax, or new information. Normally our brain takes care of most actions automatically; conscious thought is employed to conduct effortful thought processes only when the brain is unsure what to do. If you show someone the word "yellow" printed in red ink and ask what colour the word is written in, the word meaning is (usually) automatically retrieved and interferes with colour naming (the Stroop effect). In the case of automatic language processing, the effect is pretty usually harmless, even amusing. However, if highly ingrained gambling behaviour leads to an automatic process, it is difficult for the conscious brain—strongly conditioned to seek gambling—to override these pre-programmed behaviours. I believe that it is not until the behaviour has led to strong negative consequences (e.g., hitting bottom) resulting in competing drives that control reverts back to conscious thought for evaluation. Future research needs to examine the automation of gambling behaviours to determine how this process occurs, what can be done to prevent it, and what can be done to de-automatize the brain.

4) **Challenges of definition**. There are several problems with definitions. Gambling itself is not clearly defined. Is insurance (a small investment to protect against a large loss), for example, a form of gambling? Thirty percent of people in Ontario do not consider bingo to be a form of gambling (Turner et al., 2005). But the largest problem centres around the issue of the point at which pleasure-seeking becomes an addiction. Is pathological gambling an all-or-nothing disease or are there real intermediate levels of the pathology? This is not a simple problem. Surveys often identify people who appear to have an intermediate level of disordered gambling (e.g., a SOGS score of 3). Do these intermediate scores mean that problem gambling varies over a continuum? "Midway" scores could possibly be an artifact of inaccurate measurement rather than a true reflection of the nature of the phenomenon. It may simply be that we have not developed perfectly reliable and valid measurement techniques (nor will we ever). One particular source of error is the use of discrete yes/no questions in most assessment measures, because they (1) fail to take into account frequency of behaviour and (2) force the respondent to determine their own threshold of response. Do addictions vary on a continuum

or are they discrete conditions? We need to address this issue by developing better measures and by examining the nature of non-disordered gamblers.

5) **Challenges to our notion of responsibility**. If someone is addicted to gambling, are they responsible for their actions? Who is responsible for our actions in a casino? The idea of responsibility needs to be examined carefully. Interestingly, many gamblers do act in a responsible manner (e.g., they set limits; gamble with money they can afford to lose; Turner et al., 2005); however, the industry in general often does not act responsibly. Indeed the industry, driven by a single-minded focus on the short-term bottom line, often tries to encourage irresponsible play. I believe there is a shared responsibility. People need to take steps to protect themselves and seek out information about the risks of any activity they engage in. However, currently there is very little in the way of consumer-protection-oriented information available from the gambling industry. There is inadequate disclosure about the nature of the games and their addictive potential. Marketing practices are often not conducted in a socially responsible manner. In addition the industry often is in a position to be aware when people are harming themselves as a result of gambling, but does not regularly intervene. There are some signs that legal challenges and regulations may be moving the industry towards taking greater responsibility.

6) **Challenges to concepts of jurisdiction and ownership**. Who is in charge of gambling? Who is responsible for control? This issue will come to a crisis in the near future if Internet gambling begins to take a bite out of the casino and lottery profits. In Canada only the government or a charity can operate a casino or other gambling venue. By a weird twist of Canadian logic an arrangement that was intended to control gambling has been turned into one that promotes it. This situations has created a a conflict of interest in Canada over the balance of profit, regulation, and social justice. The situation is not really better in countries where casinos are privately owned because casinos provide tax revenue. Either way, huge profits have the potential power to corrupt. In either case the regulator is often at a conflict of interest. What will happen to regulation as we move towards greater globalization of gambling?

7) **Challenges to our notion of what is rational and what constitutes entertainment**. People choose to gamble even when they know it is a losing proposition. Taking drugs or alcohol in the face of potential consequences is similarly irrational. Some researchers have focused on the irrationality of gambling; however, gamblers often use logic to try to find an edge. Unfortunately most often the players lose anyway because the games offered either have no possible edge (slots, roulette, lotteries) or the edge is

relative to the other players' skills (poker, sports betting, games of skill). Although the systems that many gamblers come up with do not work in the long term, there is considerable logic employed in devising such systems (e.g., the Martingale system is logical, but based on faulty notions about random chance).

But even non-problem gambling is often viewed as irrational. In a recent paper Manson (2003) characterizes most gamblers as impulsive and poorly informed. Is it rational to buy a lottery ticket? The reality is that, for most people, wealth is unlikely to result from either buying the lottery ticket or not buying the lottery ticket. But gambling buys a dream. In the case of the non-problem gambler this dream might be thought of as rational if the pleasure they get from the dream is worth the cost. It's fun to gamble. The paradox of gambling is that people willingly (at least those who are not addicted to it) engage in an investment that has a negative expected value. Apparently the value of the fun or the risk makes up for the long-term expected losses (Wagenaar, 1988). Gambling does not have to be any more expensive than other hobbies. But we question the rationality of gambling because people play with money in the hope of winning. Leisure and entertainment in general can be thought of as financially irrational. If you spend money on a movie, there is no hope of winning back money. So which is more rational? A movie or a lottery ticket? Leisure activities are engaged in for pleasure; if you enjoy the movie or the gamble, you've gotten your money's worth. Gambling is therefore not an inherently irrational activity. Future research needs to explore non-problem gambling and its relationship to other forms of entertainment. Currently there is lot for research on the symptoms of pathological gambling, but very little on the psychology of healthy, non-disordered gambling.

Its fun to gamble, but it's not fun to lose one's life savings. Although we might be able to rationalize the behaviour of the non-addicted gambler, we cannot rationalize the behaviour of the addicted gambler. How can a behaviour that leads to such misery be so thrilling that a person could gamble away thousands of dollars? In the movie *Owning Mahowny* (for a review see Kassinove, 2004) , even after a great deal of stress and personal disaster, Mahowny's character still rates gambling as 100 out of 100 in terms of the most thrilling experience of his life. To what extent do people who have suffered such consequences of gambling continue to long for the thrill? At what point does pain drive out the pleasure?

8) **Challenges to the way we think about biology**. That gambling has a biological effect does not mean there is a biological cause. While gambling pathology has been linked to some genes and to a dysfunction of the reward system, the fact is that, like all other addictions, gambling is at least in part a learned disorder. The core central feature of gambling pathology is the experience of gambling

itself. Aspects of that experience crucially related to learning, such as big wins and intermittent reinforcement, go a long way to deepen our understanding of the disorder. Learning is a neurological process. Every time we learn something new the relative strength of different neural pathways is altered. An important area of future research is the study of the extent to which the brain is changed by the experience of gambling.

9) **Challenges to concepts of evolution**. Our brain has evolved the ability to become addicted. Our brain is designed to respond to salient stimuli, but in developing an addiction the brain goes well beyond merely learning. Why would a brain evolve the ability to acquire harmful habits, be they drugs, gambling, or smoking? It is obvious that gambling per se did not evolve, since there is no real natural equivalent of gambling. Thus there must be elements of gambling that borrow older, more primitive learning processes and co-opt them into an addiction. The evolutionary value of risk-taking perhaps explains the thrill that people get out of gambling, but not the addiction to it. I think it is reasonable to speculate that an addiction may co-opt some other mechanism in the brain. I would also suggest that the process in question that produces addictions might also be related either to the process by which bonds are developed between individuals or the process by which we learn which foods are safe to eat. Both mating and food preference are closely related to survival. They also are both known to lead to excessive behaviour in some individuals (e.g., stalking an ex-girlfriend, or overeating potato chips). Looking for the evolutionary purpose of the potential for addiction is an interesting area of future research that may also shed light on treatment.

My purpose in highlighting these challenges is to encourage the focus of gambling research to examine these issues more explicitly. Gambling problems are an interesting test case for our notions of free will, disease, addiction, and responsibility. In discussing these issues I hope that I can bring about a greater integration of ideas into this field of research and treatment so that gambling-related developments in genetics, neurology, psychology, sociology, and economics do not occur in isolation.

References

American Psychiatric Association. (2000).
Diagnostic and statistical manual of mental disorders. Washington, DC: Author.

Kassinove, J.I. (2004).
Owning Mahowny (2003): A gambler without emotion. *Journal of Gambling Issues*, Issue 11. Available at: http://www.camh.net/egambling/issue11/jgi_11_kassinove.html

Manson, N.A. (2003).
Probability on the casino floor. In G. Reith (Ed.), *Gambling: Who wins? Who loses?* (pp. 293–310). Amherst, NY: Prometheus Books.

Room, R., Turner, N.E., & Ialomiteanu, A. (1999).
Community effects of the opening of the Niagara Casino: A first report. *Addiction, 94,* 1449–1466.

Rosenthal, R. J., & Lesieur, H. R. (1992).
Self-reported withdrawal symptoms and pathological gambling. *The American Journal on Addictions, 1 (2)*, 150–154.

Shaffer, H. J., 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* (9), 1369–1376.

Turner, N.E., Wiebe, J., Falkowski-Ham, A., Kelly, J., & Skinner, W. (2005).
Public awareness of responsible gambling and gambling behaviours in Ontario. *International Gambling Studies, 5, 95-112.*

Wagenaar, W.A. (1988).
Paradoxes of gambling behavior. London: Lawrence Erlbaum Associates.

By Nigel E. Turner, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.

E-mail: Nigel_Turner@camh.net

For correspondence: Nigel Turner, PhD, Scientist, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Canada M5S 2S1. Phone (416) 535-8501 Ext. 6063, fax (416) 595-6899, e-mail: Nigel_Turner@camh.net.

Competing interests: None.

Contributors: NT thought of and wrote all content. He received feedback and suggestions from John Firth and the editorial board of the *Journal of Gambling Issues*.

*** *** ***

Statement of purpose

The Journal of Gambling Issues (JGI) offers an Internet-based forum for developments in gambling-related research, policy and treatment as well as personal accounts about gambling and gambling behaviour. Through publishing peer-reviewed articles about gambling as a social phenomenon and the prevention and treatment of gambling problems, it is our aim is to help make sense of how gambling affects us all.

The JGI is published by the Centre for Addiction and Mental Health and is fully funded by the Ontario Substance Abuse Bureau of the Ministry of Health and Long-Term Care. We welcome manuscripts submitted by researchers and clinicians, people involved in gambling as players, and family and friends of gamblers.

Ethics and accountability

The *Journal of Gambling Issues* is a member of the International Society of Addiction Journal Editors and supports the Farmington Consensus statement on ethical standards in publishing: http://www-users.york.ac.uk/~sjp22/isaje/farmington.htm

Editor
Phil Lange

Editorial Board

Bruce Ballon, **Peter Ferentzy**, **Nina Littman-Sharp**, **Robert Murray**, **Wayne Skinner**, **Tony Toneatto**, **Nigel E. Turner**, and **Martin Zack**, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Advisory Board

Peter Adams, Dept. of Psychiatry & Behavioural Science, University of Auckland, Auckland, New Zealand

Will Bennis, Max Planck Institute, Berlin, Germany

Alex Blaszczynski, School of Psychiatry, University of New South Wales, Sydney, New South Wales, Australia

Jeffrey L. Derevensky, International Center for Youth Gambling Problems and High-Risk Behaviors, Montreal, Quebec, Canada

Mark Griffiths, Psychology Division, Nottingham Trent University, Nottingham, U.K.

David C. Hodgins, Dept. of Psychology, University of Calgary, Calgary, Alberta, Canada

Edward Kwan, Independent practice, Hong Kong, China

Ray McNeil, Nova Scotia Department of Health, Halifax, Nova Scotia, Canada

Lia Nower, School of Social Welfare, University of Missouri-St. Louis, St. Louis, Misouri, U.S.A.

Nancy Petry, University of Connecticut Health Center, Farmington, Connecticut, U.S.A.

María Prieto, Dept. of Psychological Intervention, University P. Comillas, Madrid, Spain

Lusanda U.Z. Rataemane, National Gambling Board, Hatfield, Pretoria, South Africa

Gerda Reith, Dept. of Sociology, Anthropology and Applied Social Sciences, University of Glasgow, Glasgow, Scotland

Cesar A. Sanchez-Bello, Pathological Gambling Section of Latin-American Psychiatric Association, Isla de Margarita, Venezuela

Målfrid Todal, Division of Psychiatry, St. Olav's Hospital, Trondheim, Norway

Rachel A. Volberg, Gemini Research, Ltd., Northampton, Massachusetts, U.S.A.

Monica L. Zilberman, Institute of Psychiatry, University of São Paulo, São Paulo, Brazil

Reviewers

Peter Adams, Dept. of Psychiatry & Behavioural Science, University of Auckland, Auckland, New Zealand

Bruce Ballon, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Alex Blaszczynski, School of Psychiatry, University of New South Wales, Sydney, New South Wales, Australia

Linda Chamberlain, Denver, Colorado, U.S.A.

Gerry Cooper, Centre for Addiction and Mental Health, Sudbury, Ontario, Canada

Jeff Derevensky, Youth Gambling Research & Treatment Clinic, Dept of Educational and Counselling Psychology, McGill University, Montreal, Quebec, Canada

William Eadington, Institute for the Study of Gambling and Commercial Gaming, University of Nevada at Reno, Reno, Nevada, U.S.A.

Pat Erickson, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Jackie Ferris, Ferris Research, Toronto, Ontario, Canada

G. Ron Frisch, Problem Gambling Research Group, Dept of Psychology, University of Windsor, Ontario, Canada

Richard Govoni, Problem Gambling Research Group, Dept of Psychology, University of Windsor, Windsor, Ontario, Canada

Mark Griffiths, Psychology Division, Nottingham Trent University, Nottingham, U.K.

Rina Gupta, Youth Gambling Research & Treatment Clinic, Dept of Educational and Counselling Psychology, McGill University, Montreal, Quebec, Canada

David C. Hodgins, Addiction Centre, Foothills Medical Centre, Calgary, Alberta, Canada

Roger Horbay, Game Planit Interactive Corp., Toronto, Ontario, Canada

Alun C. Jackson, School of Social Work, University of Melbourne, Melbourne, New South Wales, Australia

Durand Jacobs, Loma Linda University Medical Center, Loma Linda, California, U.S.A.

Jeffrey Kassinove, Dept of Psychology, Monmouth University, West Long Branch, New Jersey, U.S.A.

David Korn, Dept. of Public Health Sciences, University of Toronto, Toronto, Ontario, Canada

Igor Kusyszyn, Dept. of Psychology, York University, Toronto, Ontario, Canada

Robert Ladouceur, École de Psychologie, Université Laval, Québec, Canada

Samuel Law, Baffin Regional Hospital, Iqaluit, Nunavut, Canada

Henry Lesieur, Dept of Psychiatry, Rhode Island Hospital, Providence, Rhode Island, U.S.A.

Vanessa López-Viets, Dept of Psychology, University of New Mexico, Albuquerque, New Mexico, U.S.A.

Ray MacNeil, Nova Scotia Department of Health, Halifax, Nova Scotia, Canada

Virginia McGowan, Addictions Counselling Program, The University of Lethbridge, Lethbridge, Alberta, Canada

Goldie Millar, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

María Prieto, Dept. of Psychological Intervention, University P. Comillas, Madrid, Spain

Gerda Reith, Dept. of Sociology and Anthropology, University of Glasgow, Glasgow, Scotland

Robin Room, Centre for Social Research on Alcohol and Drugs, University of Stockholm, Stockholm, Sweden

Lisa Root, The Niagara Alcohol and Drug Assessment Service, St. Catherines, Ontario, Canada

Richard J. Rosenthal, UCLA Gambling Studies Program, Los Angeles, California, U.S.A.

Loreen Rugle, Clinical and Research Services, Trimeridian, Inc., Carmel, Indiana, U.S.A.

Randy Stinchfield, University of Minnesota Medical School, St. Paul, Minnesota, U.S.A.

David Streiner, Baycrest Centre for Geriatric Care, Toronto, Ontario, Canada

William Thompson, Dept. of Public Administration, University of Nevada, Las Vegas, Nevada, U.S.A.

Marianna Toce-Gerstein, NORC at the University of Chicago, Washington, D.C., U.S.A.

Lisa Vig, Lutheran Social Services of North Dakota, Fargo, North Dakota, U.S.A.

Rachel Volberg, Gemini Research, Ltd., Northampton, Massachusetts, U.S.A.

Keith Whyte, National Council on Problem Gambling, Washington D.C., U.S.A.

Jamie Wiebe, Responsible Gambling Council (Ontario), Toronto, Ontario, Canada

Harold Wynne, Wynne Resources Ltd., Edmonton, Alberta, Canada

Martin Zack, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

Design Staff

Graphic designer: **Mara Korkola**, Centre for Addiction and Mental Health, Toronto, Ontario, Canada

issue 14 — september 2005

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (76 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 11 pages.]

Generational comparison among female pathological gamblers

Andria M. Botzet, University of Minnesota, Minneapolis, Minnesota, U.S.A.
E-mail: Botze003@umn.edu

Abstract

Research in gambling has only briefly examined age differences among problem gamblers, holding an anecdotal view that senior gamblers are more vulnerable to problem gambling. This study examines different generations of female gamblers, including their gambling habits and risk and protective factors. Approximately 450 female gamblers seeking treatment were surveyed and separated into five age groups for analysis. Results indicate that significant generational differences do not exist in areas such as gambling frequency or gambling debt; however, senior female pathological gamblers report starting to gamble at a significantly later age than their younger counterparts. Findings also suggest that senior women have a larger support network for their recovery, in contrast to common belief. Implications from this data may be useful to treatment providers in understanding and utilizing the assets more common to senior female pathological gamblers.

Introduction

Age differences among problem gamblers have been minimally examined by researchers, but senior gamblers are anecdotally more vulnerable to problem gambling due to their often limited income source and their decrease in social outlets. However, no thorough research has shown an increased amount of vulnerability for the elderly. A survey on Midwestern gambling attitudes by Abbott and Cramer (1993) found that many people, both gamblers and non-gamblers, view gambling as a benign recreational activity. This may be the case for seniors, who do not have as many recreational activities accessible to them, though the study did not specifically draw out age groups in the analysis. Other research

links pathological gambling to negative feelings such as boredom, loneliness, and social isolation (Trevorrow & Moore, 1998; Rich 1998). While the feelings of boredom, loneliness, and isolation may be related to the psychosocial consequences of aging, there is no clear relationship as to whether these feelings lead to pathological gambling, or if the gambling causes these feelings. These findings only suggest that senior citizens may be at increased risk for pathological gambling problems.

And what about gender differences? Much of the research on problem gambling is based on male, middle-aged and younger samples (Crisp et al., 2000; Mark & Lesieur, 1992). Yet the stereotypical portrait of casino gambling shows a little old lady playing bingo or sitting at the slot machines. Because women—old and young—seek treatment for their gambling problems, treatment providers need to understand how their therapeutic processes function within the female gender. This study examines the differences and commonalties of different generations of female gamblers, such as their gambling habits and risk and protective factors, including family history of problem gambling, substance use, psychosocial status, and perceived support networks.

Method

A sample of 460 women who were admitted to treatment at one of six state-supported gambling treatment programs between January 1992 and January 1996 participated in this study. A gambling treatment outcome monitoring system (GAMTOMS), developed by Stinchfield and Winters (2001), was administered at various stages of the gamblers' treatment experience. GAMTOMS consisted of four questionnaires, completed at various points along the recovery timeline: intake, discharge, 6-month follow-up, and 12-month follow-up. At admission to the treatment program, clients completed a 91-item Client Intake Questionnaire, which assessed domains of demographics, clinical history, gambling frequency, gambling problem severity (South Oaks Gambling Screen: SOGS), gambling-related financial and legal problems, gambling problem recognition, recovery attitude, substance use frequency, and psychosocial functioning. All participants scored five or higher on the SOGS, indicating pathological gambling behaviors.

The Client Discharge Questionnaire (63 items) was administered at the end of each gambler's primary treatment program, assessing gambling problem recognition, recovery attitude, treatment component helpfulness scale, client satisfaction, gambling frequency, and pre-treatment gambling-related legal problems (repeated from intake questionnaire).

Admission and discharge questionnaires were administered by staff at the various treatment programs. All recruiters were trained

in the recruitment of clients and the administration of assessment instruments. Before presenting the Client Intake Questionnaire, treatment program staff informed clients about the study by reading a standardized consent form and inviting them to participate. Those who agreed to participate signed and received a copy of the consent form. Program staff then administered the Intake Questionnaire, followed by the Discharge Questionnaire at the end of the client's discharge from primary treatment. Follow-up questionnaires were conducted by research staff via telephone at 6-month and 12-month intervals after discharge from primary treatment.

Results

Sample demographic characteristics are presented in Table 1. Ages ranged from 16 to 74 years old, with the mean age being 40.3 (standard deviation=10.4). For purposes of generational comparison, the sample was separated into five age groups: less than 21, ages 21–29, ages 30–39, ages 40–54, and ages 55 and older. The term *generation* in this study refers to a cohort of people who are generally at similar stages of life regarding the domains of career, family, and recreational/leisure time. Forty-five women comprised the oldest group, with only five women being in the youngest group. Group 2 (21–29-year-olds) included 59 women, group 3 (30–39–year-olds) had 163 women, and group 4 (ages 40–54) included 174 women. Fourteen women did not report their age and were thus eliminated from the analysis, making a final sample size of 446.

The oldest generation of women differed significantly from the other generations on most demographics, with the exception of race and education. More older women were married, as compared to the other age groups, and 9% had an annual income of $40,000 or more (a higher percentage than most of the other age groups, contrary to common belief).

Table 1
Sample demographics (446 women) *

Demographic characteristics	< 21 years n (%)	21-29 years n (%)	30-39 years n (%)	40-54 years n (%)	55 and older n (%)	***X*** 2 (sig)
Race:						28.28 (.10)
White/Caucasian	4 (80)	49 (83)	142 (87)	149 (86)	42 (93)	
African American	0 (0)	0 (0)	4 (3)	3 (2)	1 (2)	
American Indian	0 (0)	6 (10)	8 (5)	6 (3)	2 (4)	
Asian	1 (20)	4 (7)	3 (2)	4 (2)	0 (0)	
Other	0 (0)	0 (0)	0 (0)	4 (2)	0 (0)	
Unreported	0 (0)	0 (0)	6 (4)	8 (5)	0 (0)	

Education:						30.1 (.36)
< High school grad	2 (40)	6 (10)	13 (8)	10 (6)	9 (20)	
High school / GED	1 (20)	15 (25)	55 (34)	49 (28)	2 (27)	
Some college	2 (40)	18 (31)	37 (23)	43 (25)	9 (20)	
Vocational/Tech	0 (0)	8 (14)	25 (15)	24 (14)	8 (18)	
Associate degree	0 (0)	5 (9)	16 (10)	18 (10)	5 (11)	
Bachelor's degree	0 (0)	7 (12)	14 (9)	21 (12)	2 (4)	
Masters/Doctoral	0 (0)	0 (0)	2 (1)	7 (4)	0 (0)	
Unreported	0 (0)	0 (0)	1 (1)	2 (1)	0 (0)	
Annual income:						59.4 (.00)
< $20,000	5 (100)	47 (80)	96 (59)	94 (54)	31 (69)	
$20,000 to $40,000	0 (0)	9 (15)	51 (31)	53 (30)	9 (20)	
$40,000 or more	0 (0)	1 (2)	11 (7)	22 (13)	4 (9)	
Unreported	0 (0)	2 (3)	5 (3)	5 (3)	1 (2)	

*Note: some percentages may not equal 100 due to rounding

A comparison across generations was analyzed for several gambling-related variables at both pre-treatment and 12-month post-treatment intervals, and is summarized in Tables 2a and 2b. Analysis of variance was conducted for several variables; findings indicate that significant differences emerge between the generations on "SOGS score," "age at which you first gambled," and "age at which you started gambling regularly." Interestingly, all of the age groups reported regular gambling beginning shortly before the age group in which they fall (thus, within a few years before entering treatment). A possible interpretation is that pathological gambling progresses very rapidly from occasional or recreational gambling to pathological gambling, despite the age at which one starts gambling regularly.

Table 2b shows the frequency at which the women played the various games *weekly or more often*. Few significant differences emerge between the groups, with the exceptions of card playing and betting on games of skill. Slot machines were the most frequently played game among all but one age group, but note that bingo did not come in second for the older women, as legend has it! Lottery was the second most frequently played game in three of the five age groups.

Table 2a
Frequency and comparison of gambling variables across generations (pre-treatment)

Variables	< 21 years mean (sd)	21-29 years mean (sd)	30-39 years mean (sd)	40-54 years mean (sd)	55+ years mean (sd)	F (sig.)
SOGS score	8.4 (2.4)	10.6 (3.6)	10.6 (2.7)	10.5 (2.5)	9.2 (2.9)	2.47 (.04)
Current debt	$2,500 ($2,336)	$17,363 ($37,775)	$20,256 ($49,308)	$28,480 ($49,785)	$26,647 ($32,319)	1.15 (.33)
Age of 1st bet	5 (100) 0 (0) 0 (0) 0 (0)	47 (80) 9 (15) 1 (2) 2 (3)	96 (59) 51 (31) 11 (7) 5 (3)	94 (54) 53 (30) 22 (13) 5 (3)	31 (69) 9 (20) 4 (9) 1 (2)	59.4 (.00)
Age of regular gambling	18.2 (1.1)	21.8 (3.6)	29.6 (6.1)	39.3 (8.3)	51.9 (8.9)	152.46 (.00)

Table 2b
Gambling frequencies for games played weekly or more often (pre-treatment)

Variables	< 21 years n (%)	21-29 years n (%)	30-39 years n (%)	40-54 years n (%)	55+ years n (%)	X^2 (sig.)
Cards	3 (60)	25 (42)	32 (20)	28 (16)	10 (24)	22.0 (.00)
Horse/Dog racing	0 (0)	0 (0)	2 (1)	2 (1)	0 (0)	1.3 (.87)
Sporting events	0 (0)	4 (7)	6 (4)	3 (2)	3 (8)	5.3 (.26)
Dice games	0 (0)	1 (2)	4 (3)	1 (1)	2 (5)	4.2 (.38)
Lottery	1 (20)	17 (29)	67 (42)	68 (40)	19 (44)	4.6 (.33)
Bingo	1 (20)	11 (19)	37 (24)	40 (24)	11 (27)	1.0 (.90)
Slots/ Gambling machines	1 (20)	31 (53)	100 (63)	115 (67)	26 (59)	7.9 (.10)
Game of skill	0 (0)	8 (14)	4 (3)	5 (3)	0 (0)	17.3 (.00)
Pull tabs	1 (20)	16 (27)	52 (33)	45 (27)	12 (28)	2.1 (.71)
Game of choice *(mode presented)*	cards	slots	slots	slots	slots	48.1 (.00)

Tables 3a and 3b show gambling frequency and debt at a 12-month follow-up. Follow-ups were conducted via telephone, with varied response rates throughout the age groups. Both group 4 (ages 40–54) and group 5 (55+) had a 44% response rate to the follow-up. Group 1 (<21) had no responses out of the 5 possible

participants, group 2 (Ages 21–29) had 36% responding at the follow up, and group 3 (ages 30–39) had a 34% response rate.

The senior group reported a larger (but not significantly) post-treatment debt than the other age groups, yet their gambling frequency was not significantly different. This discrepancy might suggest that they were betting with larger amounts of money than the other age groups at post-treatment, or that they had not yet been able to pay off their previous debts.

Table 3a
Frequency and comparison of gambling debt across generations (post-treatment)

Variable	21-29 years mean (sd)	30-39 years mean (sd)	40-54 years mean (sd)	55+ years mean (sd)	F (sig.)
Current debt	$89 ($251)	$1303 ($2722)	$1315 ($4004)	$4269 ($7684)	2.48 (.06)

Table 3b
Gambling frequencies for games played weekly or more often (post-treatment) *

Variables	21-29 years n (%)	30-39 years n (%)	40-54 years n (%)	55+ years n (%)	***X*** (sig.)
Cards	0 (0)	2 (5)	1 (2)	1 (6)	4.3 (89)
Sporting events	1 (6)	0 (0)	0 (0)	0 (0)	10.04 (.12)
Dice games	1 (6)	0 (0)	0 (0)	0 (0)	19.17 (.02)
Lottery	0 (0)	3 (8)	7 (12)	3 (19)	10.91 (.54)
Bingo	0 (0)	2 (5)	3 (5)	1 (6)	14.38 (.28)
Slots/ Gambling machines	2 (12)	8 (20)	1 (22)	4 (22)	9.80 (.37)
Game of skill	1 (6)	0 (0)	0 (0)	0 (0)	9.97 (.13)
Pull tabs	0 (0)	3 (8)	3 (5)	2 (12)	10.82 (.29)

*Note: None of the women who were 21 and younger that initially participated were reached for a 12-month follow-up. Thus they are excluded from this analysis.

Tables 4a and 4b summarize risk and protective variables at pre-

treatment and post-treatment intervals. The older generation of women rated their relationships with family, friends, and a Higher Power significantly higher than the other generations at pre-treatment, but no differences were found at post-treatment. Slightly fewer older women reported having utilized mental health services or chemical dependency treatment in the past 12 months, when compared to the other generations, and a similar proportion of older women rated themselves higher on their emotional health. Physical health was really no different for older women compared to the younger cohorts at both time points, and there was no significant difference in parental history of problem gambling.

Table 4a
Risk and protective factors present at treatment intake

Variables	< 21 years n (%)	21-29 years n (%)	30-39 years n (%)	40-54 years n (%)	55+ years n (%)	F (sig)
Previous CD treatment	0 (0)	19 (32)	52 (33)	35 (20)	12 (27)	2.36 (.05)
Previous mental health treatment	1 (20)	34 (58)	94 (58)	101 (58)	22 (49)	1.06 (.38)
Family history of problem gambling	39 (60)	16 (27)	56 (34)	53 (30)	9 (21)	.88 (.48)
Good/ excellent Emotional health	1 (20)	9 (15)	14 (9)	19 (11)	7 (16)	2.35 (.05)
Good/ excellent physical health	2 (40)	22 (37)	50 (31)	63 (36)	19 (42)	.72 (.58)
Good/ excellent relationship w/family	3 (60)	19 (32)	64 (39)	84 (48)	28 (62)	5.10 (.00)
Good/ excellent relationship w/ friends	4 (80)	28 (47)	70 (43)	72 (41)	27 (60)	4.70 (.00)
Good/ excellent relationship with Higher Power	1 (20)	14 (24)	36 (22)	47 (27)	23 (51)	4.15 (.00)
Have friends to help me stay gambling free (agree/ strongly)	2 (40)	31 (53)	98 (60)	121 (70)	25 (56)	1.48 (.21)

Table 4b
Risk and protective factors present at 12-months post-treatment

Variables	21-29 years n (%)	30-39 years n (%)	40-54 years n (%)	55+ years n (%)	F (sig.)
Good/excellent emotional health	12 (57)	21 (38)	36 (47)	10 (50)	.70 (.55)
Good/excellent physical health	15 (71)	31 (56)	43 (57)	14 (70)	.45 (.72)
Good/excellent relationship w/family	18 (86)	42 (76)	57 (75)	14 (70)	.00 (1.00)
Good/excellent relationship w/ friends	20 (95)	41 (75)	66 (87)	18 (90)	.77 (.51)
Good/excellent relationship with Higher Power	15 (71)	32 (58)	48 (63)	14 (70)	1.09 (.35)
Have friends to help me stay gambling free (agree/strongly)	17 (81)	44 (80)	53 (70)	12 (60)	1.21 (.31)

Discussion

Results from this study indicate that the stereotypical view of the senior women's gambling habits is unwarranted. While significant differences emerged between the generations on income levels, the number of senior women reporting incomes in the upper income bracket was comparable with that in the other age groups. SOGS scores and gambling debt were also comparable with the other age groups at intake. However, the older women did have a nearly significant larger debt at post-treatment than the other age groups. Reasons for this are not known, but could be "left-over" debt (old debt that had not yet been paid). Senior female pathological gamblers report starting to gamble at a significantly later age than their younger counterparts, and they also started to gamble regularly at a later age. Women who are younger than 55 reported significantly poorer relationships with friends, family, and their Higher Power, when compared to the senior-aged women at pre-treatment, but these differences evened out at post-treatment. Variables that are often suggested as negatively impacting senior gambling, such as loneliness, social isolation, or poor relationships with family or friends do not appear to be identifying factors in senior pathological gambling; the senior women in this study do not rate themselves as any less emotionally or physically healthy, and in fact, report better family and friendship relationships when compared to their younger counterparts.

Differences in problem gambling behaviors and substance use frequency in this sample do not generally appear to be a function of age: the oldest generation in this sample showed no major differences from the other age groups. Implications of this data suggest that senior women are no more vulnerable or likely to experience the issues of problem gambling than other women. Rather, the older women are more equipped with assets such as strong relationships with their support networks, less family history of gambling problems, and better physical and emotional health as compared to many of the other age groups. This information is useful in understanding and personalizing treatment options according to the needs of female pathological gamblers, especially as the proportion of the elderly population increases and addictive disorders among the elderly grows as a public health concern. Treatment providers may benefit by utilizing the greater relationship assets that the senior women possess.

Admittedly, this sample can only be generalized to treatment populations, but since the women were recruited from various treatment sites, the diversity of the sample is broadened, representing a more varied group of treatment experiences. Further research needs to address the gender differences, as well as the generational differences, to see which differences, if any, are a function of gender. A larger sample of senior women would have been beneficial in this study, as would further investigation into the outcome measures of the population.

References

Abbott, D.A., & Cramer, S.L. (1993).
Gambling attitudes and participation: A Midwestern survey. *Journal of Gambling Studies, 9* (3), 247–263.

Crisp, B., Thomas, S.A., Jackson, A.C., Thomason, N., Smith, S., Borrell, J., et al. (2000).
Sex differences in the treatment needs and outcomes of problem gamblers. *Research on Social Work Practice, 10* (2), 229–242.

Mark , M.E. , & Lesieur, H. (1992).
A feminist critique of problem gambling research. *British Journal of Addiction, 87* (4), 549–565.

Rich, M. (1998).
Women who gamble. *Dissertation Abstracts International: Section B: the Physical Sciences and Engineering,58* (12-B).

Stinchfield, R., & Winters, K.C. (2001).
Outcome of Minnesota's gambling treatment programs. *Journal of Gambling Studies, 17* (3), 217–245.

Trevorrow, K., & Moore, S. (1998).
The association between loneliness, social isolation, and women's electronic gaming machine gambling. *Journal of Gambling Studies, 14* (3), 263–284.

This article was peer-reviewed. Submitted: September 12, 2002. Accepted: December 12, 2004.

For correspondence: Andria M. Botzet, MA, University of Minnesota, FUMC - F282/2A West 2450 Riverside Ave S., Minneapolis, MN 55454 U.S.A. Phone: (612)-273-9856, fax: (612)-273-9779, e-mail: Botze003@umn.edu

Competing interests: None declared.

Ethical approval: In 1992 by the University of Minnesota Institutional Review Board

Department of Human Services, State of Minnesota.

Funding: AB is employed at the University of Minnesota, Department of Psychiatry.

Andria Botzet completed her masters' degree in counseling psychology at the University of Minnesota in 1997. She then conducted crisis counseling for two years at a youth shelter while simultaneously working part-time at the U of MN in the Center for Adolescent Substance Abuse Research. For the past nine years she has remained at the Center for Adolescent Substance Abuse Research, conducting studies primarily on youth gambling, pathological gambling, and adolescent substance abuse.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (141 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 19 pages.]

Interpreting prevalence estimates of pathological gambling: Implications for policy

Blasé Gambino, Boston, Massachusetts, U.S.A.
E-mail: blasegambinophd@aol.com

Abstract

Some guidelines for interpreting prevalence estimates for the purpose of establishing the number of pathological gamblers in the community are presented. The analysis is based on the concept of the likelihood ratio, a recommended procedure for validating criteria for defining cases based on test scores. It is shown that the likelihood ratio can be employed with available estimates of prevalence to translate cut-off scores into positive predictive value. Those cut-off scores associated with high positive predictive values provide an empirical measure of confidence that those gamblers who meet or exceed the cut-off criterion are pathological gamblers. A potential limitation of the analysis is the possible specificity of results to the validation studies employed to compute likelihood ratios and to the specific estimates of prevalence used to determine positive predictive value. A recommendation is presented for obtaining study- or community-specific validation evidence. Key words**:** prevalence estimation, case-definitions, public policy, validity, likelihood ratios, sensitivity, specificity, predictive value

Introduction

Prevalence estimates of pathological gambling reflect choices and assumptions made by researchers (Gambino, 1997a). Choices include decision rules, such as the cut-off point used to define a case (Brenner & Gefeller, 1997; Dickerson et al., 1996) and the time period over which cases are to be defined, for example, six-months (Abbott & Volberg, 1991), past-year (Welte et al., 2001), or lifetime (Volberg, 1994). Assumptions include our confidence in the validity of the measurement systems that are employed to obtain estimates (e.g., Gambino, 1999a; Stinchfield, 2002, 2003).

On the surface, determining how many pathological gamblers there are in a community seems to be a straightforward task. Define who is or is not a pathological gambler, apply this "working" definition to a representative sample drawn from the population of interest, count how many meet the chosen definition, and divide by the number of eligible respondents. In practice the issue is complicated by the lack of consensus over the most appropriate means of defining a "case" in community surveys on pathological gambling (Abbott & Volberg, 1999; Dickerson, 1993; Dickerson & Volberg, 1996; Dickerson et al., 1996; Gambino, 1997a, 1999a; Poulin, 2002; Shaffer et al., 1997; Walker & Dickerson, 1996). An additional complication is the definition of "eligible respondents"; should non-gamblers be counted in that number or not (Shaffer et al., 1997)?

It has been observed that case-definition strategies are the "sine qua non" for most epidemiologic research (Zahner et al., 1995, p. 23). In the absence of a case-definition, the relevant events or states cannot be identified and counted, and prevalence or other measures of interest cannot be obtained. Agreement on some form of classification always entails some degree of arbitrariness. The convenience of using shared case-definitions to assign individuals into categories as cases and non-cases is fundamental to communication among researchers and clinicians (Rose & Barker, 1978). Its utility stems from the achievement of comparability among data sources and researchers; and, in addition, it permits the testing of etiologic and other hypotheses. Shared case-definitions also have implications for communicating with policy makers. A major task for researchers will be how to "calculate" and effectively "communicate" the implications of their findings, including the meaning of agreed-upon case-definitions to policy makers (Koplan et al., 1999, p. 1153).

A complicating factor in the interpretation of prevalence estimates is the lack of agreement on how to deal with the occurrence of diagnostic errors (Abbott & Volberg, 1999; Gambino, 1999a; Shaffer & Korn, 2002; Volberg, 1999). Given the expected lack of perfect discriminability of any definition (Kraemer, 1992; Zhou et al., 2002), any group classified as cases (positive test outcomes) will include some non-disordered individuals (false positives), and any group classified as non-cases (negative test outcomes) will include some who are truly disordered (false negatives). The basic question in the case of prevalence estimation is a simple one. Given the presence of errors, are sample prevalence estimates biased or unbiased (Shaffer et al., 1997)? Bias refers to whether sample estimates tend, on average, to overestimate (positive bias) or underestimate (negative bias) the true population prevalence (Gambino, 1997b).

Many of the proposed solutions are complicated and generally entail mathematical and statistical models (Gambino, 1997b, 1999a, 1999b; Garrett et al., 2002; Hui & Walter, 1980; Rogan & Gladen, 1978; Staquet et al., 1981). Available solutions have seldom been employed in studies of pathological gambling, although this is true for other medical and psychiatric disorders as well (Faraone & Tsuang, 1994). The failure to apply these procedures is generally conceded to be the perception that these models are viewed as too mathematically complex. The general focus of these models has been on obtaining precise estimates of error rates, although that is a simplification. An alternative solution is presented below.

Terms and definitions

There are four possible outcomes from testing a sample of respondents drawn from a specific population for the purposes of assessing the presence or absence of pathological gambling. These are presented in Table 1, where a, b, c, and d are, by

Table 1
Four possible outcomes of testing

	True status		
Test results	Pathological	Not pathological	Row totals
Positive	a = TP = P*Se*N	b = FP = (1 − P)*(1 − Sp)*N	a + b
Negative	c = FN = P*(1 − Se)*N	d = TN = (1 − Sp) *Sp*N	c + d
Column totals	a + c	b + d	N

P = prevalence Se = sensitivity Sp = specificity (a + b)/N = Pp = sample prevalence estimate

Adjustment for errors may be obtained as P = [(Pp − (1 - Sp)]/[Se − (1 - Sp)]

Number of pathological gamblers = a + c
Sensitivity = TP / (TP + FN) = a / (a + c)
Number of non-pathological gamblers = b + d
Specificity = TN / (TN + FP) = d / (b + d)
Number of positive tests = a + b
Positive Predictive Value = TP / (TP + FP) = a / (a + b)
Number of negative tests = c + d
Negative Predictive Value = TN / (TN + FN) = d / (c + d)

convention, labeled as true positives (TP), false positives (FP), false negatives (FN), and true negatives (TN), respectively. The terms positive (predicting presence of the disorder) and negative (predicting absence of the disorder) simply mean that the respondent met or did not meet the criterion for defining a case.

Table 1 also presents four measures of diagnostic accuracy. Diagnostic accuracy may be defined as the ability of a test to discriminate those with the disorder from those in whom the disorder is absent (Zhou et al., 2002). The four measures of diagnostic accuracy presented in Table 1 may be further distinguished by the labels test accuracy and predictive accuracy. Test accuracy is represented by sensitivity, defined as the proportion of those with the disorder with positive test results (true positives); and specificity, the proportion of those without the disorder with negative test results (true negatives). Predictive accuracy is represented by positive predictive value, the proportion of positive tests that are true positives, and negative predictive value, the proportion of negative tests that are true negatives.

These four measures are related but not identical since they are based on different denominators (Table 1). The primary distinction lies in the fact that sensitivity and specificity are independent of population prevalence, whereas positive and negative predictive value will change as a function of prevalence. In general, the positive (negative) predictive value of any instrument will be high (low) when applied to populations with high (low) prevalence rates. As prevalence decreases positive (negative) predictive value will decrease (increase). Technically, predictive values are known as specific rates since these are specific to the prevalence of the population being tested as well as the sensitivity and specificity of the test instrument employed.

Defining a useful case-definition

The minimal requirement for a suitable diagnostic or screening case-definition (Meehl & Rosen, 1955) is that it yields a higher percentage of positive findings among the truly disordered (its sensitivity) than among the truly non-disordered (its lack of specificity). Put simply, sensitivity (Se), the true positive rate of the test among pathological gamblers, must be greater than 1 – specificity (1 − Sp), the false positive rate of the test among non-pathological gamblers. The above requirement also implies each of the following relationships: Se + Sp > 1 and PPV > P where PPV = positive predictive value and P = true prevalence; NPV > 1 - P where NPV = negative predictive value and Se > Pp where Pp = the sample prevalence estimator (the observed proportion of positive outcomes identified as those respondents meeting criteria for caseness).

Current conventions for defining a case. The two most frequently employed instruments for conducting research on pathological gambling (Shaffer et al., 1997) are the SOGS (South Oaks Gambling Screen) (Lesieur & Blume, 1987), a 20-item instrument, and the current clinical definition accepted by the American Psychiatric Association, the DSM-IV, a 10-item test

(APA, 1994). The general convention for defining a case of pathological gambling adopted for both instruments is that those who respond positive to five or more of the clinical indicators incorporated in the instrument will be defined as cases of pathological gamblers. Those individuals who score less than five will be defined as not being cases of pathological gamblers. Scores that are less than five, but greater than zero, i.e., 1–4, have been given a variety of labels including problem, potential pathological, at-risk, and level-two gamblers (National Research Council, 1999). This varied nomenclature is another source of confusion in the literature on the estimation of prevalence (Poulin, 2002).

A second source of confusion is related to the number of items on the two instruments. The number of items on the SOGS relative to DSM-IV provides 10 additional opportunities to meet the recommended criterion of five or higher and, in part, may explain the higher levels of prevalence reported for the SOGS (Shaffer et al., 1997). A third source of difficulty flows from the expressions of dissatisfaction with both instruments. The net result of this dissatisfaction has been a continuing effort to develop and validate alternative instruments, mostly in the form of variants on both the SOGS and the DSM-IV (Shaffer & Korn, 2002).

In practice, some investigators have argued for a different cut-off point for defining a case. For example, Dickerson et al. (1996) have argued that for the SOGS the criterion should be set at 10 to reflect the average scores obtained from gamblers in treatment. Stinchfield (2003), employing discriminant analysis, a statistical procedure for separating those with from those without the disorder, has argued that a criterion score on DSM-IV of four or higher is a more accurate discriminator between the presence and absence of pathological gambling than the recommended criterion of five. What are the implications of raising or lowering criteria relative to the recommended convention of a criterion score of five or higher?

Setting the criterion bar for case ascertainment. If it is important to protect against false positives, the researcher may set stringent criteria, e.g., eight or higher, but this comes at the cost of an increased likelihood of false negatives. Protecting against false negatives by the use of less stringent criteria, e.g., three or higher, has the opposite effect. Now it is unlikely that many cases will be missed, but there is an increased probability that many of the presumptive diagnoses will represent false positives. The first strategy (stringent criteria) provides conservative estimates of prevalence; the latter strategy (less stringent criteria) results in liberal estimates (Gambino, 1997a). An important implication of raising and lowering the cut-off point is often overlooked. The use of a cut-off score to separate individuals into two categories, pathological or not pathological, is always arbitrary, as is the

implication that the disorder is dichotomous in nature. All that can be stated as factual is that once a cut-off has been set, then the following must be true: Those who score at or above the criterion can *only* be true positives or false positives. Those who score below the criterion can *only* be true negatives or false negatives. In practice, since pathological gambling is a construct and not in the realm of public scrutiny, the truth or falsity of these four labels can never be known with complete certainty.

Protecting against false positives, or against false negatives?
The decision to protect against false negative or false positive errors will be conditional on the goals of the decision-maker, and the severity of the consequences of making false positive or false negative errors. In the clinical setting, for example, the test outcome is not the sole source of evidence. A detailed history of the gambler is usually taken in addition to the application of one or more tests. The clinician is usually more concerned with false negatives than false positives. The clinician wants to avoid failing to identify a gambler in need of treatment or referral. In this case the use of a less stringent criterion score is recommended since it will minimize the number of false negatives and thus capture most of those who are pathological gamblers. These individuals may then be followed up with more intensive testing, referral to a specialist or the implementation of treatment.

If the goal is estimating the number of pathological gamblers in the community, it makes more sense to apply a strict criterion to protect against false positive errors (e.g., Dickerson et al., 1996). In view of the unknown, but likely low, levels of help-seeking (Productivity Commission, 1999), policy makers should plan for a conservative number of pathological gamblers expected to seek treatment.

It may also be argued that when researchers present estimates of pathological gambling to policy makers in the community, they should stress interval estimates, not point estimates. Interval estimates (Gambino, 1999b) are a more reasonable measure of the accuracy of prevalence estimates (McGrath, 1998), and are recommended by the American Psychological Association in their latest guidelines for statistical reporting (Wilkinson, 1999). An interval estimate provides a measure of the degree of confidence one has that the true prevalence value has been captured by the interval. This would enable researchers to more confidently communicate their findings to funding sources and other stakeholders. It may also be noted that those stakeholders unfamiliar with the technical requirements for computing confidence intervals are, in fact, quite familiar with the concept itself. This is the result of the frequent reporting in the media of survey or poll results in which the outcome (point estimate) is presented along with an estimate of the margin of error (confidence interval), and

researchers should take advantage of this equivalence to communicate the meaning of the confidence interval to stakeholders.

Setting the criterion for use by policy makers. Any decision by policy makers on the estimated number of pathological gamblers requires a rule for determining clinical or practical significance. The issue of clinical significance is a complex one (e.g., Spitzer, 1998) and the solution presented here is only one of several that may be applied. It has the advantage of being relatively simple to calculate and has a straightforward interpretation in terms of the likelihood or certainty of diagnosis. The technique is one recommended by clinical epidemiologists for making diagnostic decisions with confidence (Chu, 1999; Koch et al., 1995; Kraemer, 1992; Schmitz et al., 2000; Zhou et al., 2002). The application of this technique to the evaluation of prevalence estimates rests on the assumption that increasing score levels reflect increasing levels of severity. There is an increasing accumulation of evidence that severity is related to the likelihood that individuals will need or seek treatment (Productivity Commission, 1999). For example, in a recent national study of Australian gamblers, Tremayne et al. (2001) found that only 12.3% of those who scored between 5 to 9 on the SOGS reported seeking help whereas 54.3% of those who scored 10 or higher sought assistance.

The method entails the calculation of the likelihood ratio (LR) where, in general terms, the LR is defined as the probability that a test result (positive or negative) would be expected in a respondent with the disorder (pathological gambler) compared to the probability that the same result would be expected in a respondent without the disorder (non pathological gambler). The LR for positive test results is therefore defined as Se / (1 − Sp), and for negative test results as (1 − Se) / Sp.

The likelihood ratio for positive (negative) tests is an empirical estimate of the power of a score or range of scores to discriminate the pathological gambler who scores positive (negative) from the non-pathological gambler who scores positive (negative). In the analysis presented below, negative predictive value is ignored as well as the LR based on negative test outcomes since with a low base-rate disorder such as pathological gambling (Shaffer et al., 1997; Welte et al., 2001), most individuals will not be pathological gamblers and these measures have little utility in this setting. A detailed discussion of the usefulness of negative predictive value and the LR for negative tests is provided by McGee (2002), Schmitz et al. (2000) and Zhou et al. (2002).

Likelihood ratios for positive tests

Computation of the LR requires a set of individuals known to have

the disorder to be compared to a set of individuals known to be free of the disorder. In an ideal situation the identification of those with and those without the disorder requires the application of a gold standard (in theory, a gold standard is an errorless procedure; in practice it is that procedure considered the most accurate one available). Since gold standards do not currently exist for pathological gambling, gamblers in treatment served to define the presence of pathological gambling (sensitivity) and gamblers from the general population served to represent the absence of the disorder (1 − specificity). This is an acceptable procedure in the absence of a gold standard (Zhou et al., 2002). Although some in the general population sample may be false negatives while some gamblers in the treatment sample may be false positives, this approach is defensible since it assumes the results apply on average rather than to any specific individual (Schlesselman, 1982). There are additional problems associated with the use of the LR but these are shared with alternative methodologies. These problems have been described in more detail by Schmitz et al. (2000) and Zhou et al. (2002).

Results

The results of computing the LR are shown in Tables 2 and 3 for the SOGS and DSM-IV respectively, based on the validation data reported by Stinchfield (2002, 2003). Likelihood ratios were converted into post-test odds by use of the formula

Post-test odds = likelihood ratio (test odds) times pre-test odds, where pre-test odds = prevalence / (1 − prevalence).

Converting the result by use of post-test odds / (1 + post-test odds) results in positive predictive value. An example will be helpful. Table 2 shows that at scores of 5 or higher, Se = .985 and 1 − Sp = .017. The LR is computed as .985/.017 = 57.92 and, assuming prevalence = .019 (Welte et al., 2001), post-test odds are obtained as 57.92 times .(019/.981) = 1.1218. Positive predictive value is then obtained as 1.1218/2.1218 = .529.

Table 2
Likelihood ratios (LR) and positive predictive values (PPV) based on scores on SOGS[1]

Score on SOGS	Se	1 − Sp	LR	PPV
>0	1.000	.159	6.49	.112
>1	.996	.066	15.09	.226
>2	.991	.043	23.04	.309
>3	.988	.028	35.28	.407

>4	.985	.017	57.92	.529
>5	.976	.013	75.04	.593
>6	.948	.008	118.50	.697
>7	.893	.006	148.83	.743
>8	.841	.001	841	.942
>9	.765	.000	∞	1.00

[1] Se = sensitivity, based on responses of treatment sample (N = 327); 1 − Sp = 1 − Specificity, based on responses of general population sample (N = 845); LR = Likelihood Ratio = Se / (1 − Sp); PPV = post-test odds / (1 + post-test odds) where post-test odds = pre-test odds x LR. Pre-test odds were obtained as prevalence / (1 − prevalence) employing an estimated prevalence = .019 (Welte et al, 2001).

Table 3
Likelihood ratios (LR) and positive predictive values (PPV) based on scores on DSM-IV[2]

Score level	Se	1 − Sp	LR	PPV
> 0	.992	.044	22.55	.229
> 1	.978	.024	40.75	.350
> 2	.978	.014	69.86	.480
> 3	.969	.0075	129.20	.631
> 4	.949	.0038	249.74	.767
> 5	.914	.0000	∞	1.000

[2] Se = Sensitivity, based on responses of treatment sample (N = 257); 1 − Sp = 1 − specificity, based on responses of general population sample (N = 800); LR = Likelihood Ratio = Se / (1 − Sp); PPV = post-test odds / (1 + post-test odds) where post-test odds = pre-test odds x LR. Pre-test odds were obtained as prevalence / (1 − prevalence) employing an estimated prevalence = .013 (Welte et al, 2001).

The estimates of prevalence (see Tables 2–3) were obtained from the national study reported by Welte et al. (2001). A major advantage of using these estimates is that the same respondents were tested with both instruments, thus avoiding the possibility that differences in prevalence were a function of the distribution of risk factors, e.g., differences in gender, ethnicity, and co-morbidity that might occur if different samples were employed to estimate prevalence for each instrument.

The results indicate that the power to detect pathological gambling (positive predictive value) does not reach 90% until scores of nine or higher on the SOGS, and of six or higher on the DSM-IV. A recent analysis (Strong et al., 2003) using Rasch modeling (a method for obtaining equivalent measures) provides support for these results. These investigators found that scores of nine on the

SOGS were equivalent to scores of six on DSM-IV.

Discussion

The results reported in Tables 2 and 3 for positive predictive value reflect, in part, the specific choice of prevalence estimates. Other researchers might select a different set of prevalence estimates and reach a different set of recommendations (Shaffer et al., 1997). The results are interpretable as indicating that it is best to employ relatively strict criteria in order to reduce or eliminate the number of false positive results, since each false positive represents an added cost to any program for which resources might be allocated. The data in Tables 2 and 3 also demonstrate that the likelihood of a diagnosis of pathological gambling increases with increasing scores, thus supporting a view that gambling lies on a continuum of severity (Shaffer & Korn, 2002). The higher the score the more likely the result will represent a true positive outcome.

A related issue bears emphasis. The results are based on two validity studies and are specific to the instruments employed by Stinchfield (2002, 2003) and to the choice of prevalence estimates (Welte et al., 2001). This raises the important question of validity generalization (Murphy, 2003). Additional validation studies have been conducted and others are ongoing (e.g., Abbott & Volberg, 1992, 1996; Cunningham-Williams & Cottler, 2001; Fisher, 2000; Gerstein et al., 1999; Smith & Wynne, 2002; Stinchfield et al., 2001). It is unclear that the application of the LR based on other validation studies would lead to the same conclusions with respect to validating the cutoff criterion. In particular, the comparison of gamblers in treatment (on average the most severe cases) with gamblers from the general population (on average the least severe cases) is likely to result in higher–than-expected LRs than if Se and Sp were obtained from the population of interest. This is more of an issue if the use of the Se based on a clinical population is used for the purpose of estimating PPV for a non-clinical population, such as in the primary care setting (Zhou et al., 2002). It is possible to obtain measures of Se and Sp from samples from the general population, thus generalizing the procedure described here. This allows the prevalence researcher to avoid the need to conduct their own validation studies because they employed a different instrument or a variation on the instruments employed by Stinchfield (2002, 2003).

First, it must be kept in mind that validity does not refer to the test or instrument employed. Validity refers to the conclusions or inferences drawn from test scores (Rubin, 1988). The procedure described in the present analysis can be applied to any test if prevalence researchers employ independent validation criteria. Researchers routinely collect data that may serve as empirical validation criteria that are independent of the instrument employed.

For example, a question that is often asked is whether or how often in the past year the gambler lost more than $100? Those who respond yes to the criterion question can be treated as equivalent to the gamblers in treatment used in the Stinchfield studies and will serve to represent true positives. Those who respond no to the question can be treated as equivalent to the general population sample used by Stinchfield and will serve to estimate false positive rates at each score level. Other questions that are also independent of the instrument can be employed, providing additional sets of LRs. It is possible to combine these by simply multiplying the respective LRs, as long as these are independent for one, two or more criteria (Sackett et al., 1991). The resulting values for PPV can be expected to be high.

The final LR may then be multiplied by pre-test odds (prevalence odds) to determine post-test odds and the resulting positive predictive value obtained. Researchers who employ a different instrument from those used by Stinchfield or a variant of these do not have to conduct their own validation study. The use of one or more independent questions provides the data required to apply the LR procedure. Once the LR has been obtained, researchers need only decide on an acceptable estimate of prevalence. These may be obtained from those available in the literature. The researcher can also compare these results from those obtained by employing the observed sample prevalence rate. The procedure illustrated in the present analysis is therefore generalizable to other studies.

Conclusions

Policy recommendations should be based on practical (useful) and well-defined (validated) measures. Effective public health is heavily dependent on clear case-definitions that include criteria potentially categorized by the degree of certainty regarding diagnosis as "suspected" or "confirmed" (Teutsch, 1994). The present analysis indicates that when results based on scores of 10 or higher on the SOGS or six or higher on the DSM-IV are used, observers can assume with a high level of confidence that those identified as true positives are indeed pathological gamblers.

The LR and its translation into PPV is an increasingly popular methodology (Sackett et al., 1991). Researchers must develop improved measures of severity which are needed to help describe the etiology and natural history of gambling disorders (Gordis, 1996; Koeter et al., 2003; Winters et al., 1996). The data in Tables 2 and 3 demonstrate that as severity (as measured by increasing scores) increases the LR and PPV will correspondingly increase. A more relevant concern for researchers interested in policy decisions on allocation of resources is to develop better definitions of functional status and disability (Pincus et al., 1998; Spitzer,

1998). These measures may then be related to prognosis and will likely predict seeking help (Ustun & Rehm, 1998).

Current definitions should also be more strongly tied to accepted notions of clinical and social significance (Frances, 1998). Examples include: did you recently lose your job because of your gambling, does your gambling substantially interfere with important activities, how often does this occur, and what is the most recent incident? Either there are people who will benefit in terms of some non-trivial measure of quality of life if they reduce or stop their gambling or there are not. If there are, then we must decide if we wish to allocate scarce resources to help. That, in turn, requires consensus on a definition of who is a case in need of assistance?

Clearly more intensive and focused research will help to better clarify this important issue of who should be defined as a case and who should not. Future research can further refine these initial estimates, and address important issues such as taking into account the sample sizes needed to obtain sufficient power for testing hypotheses and ensuring the reliability of estimates. The question of robustness remains to be resolved. Can the present results be generalized to variants on the instruments employed here or not? In the interim, the procedures described above should serve as reasonable initial estimates.

It should be added that most errors will occur just below, at, or just above the selected cut-off value. Few researchers would argue strongly that those who score four on DSM-IV are in fact different from those who score five. Yet these individuals are generally treated differently and the researcher often behaves as though the distinction were real rather than arbitrary. All that can be known is that if the criterion is set at five then there are four possible outcomes with respect to a gambler who scores five and a gambler who scores four. The four outcomes are a) both pathological (true positive, false negative), b) neither are pathological (false positive, true negative), c) the first but not the second (true positive, true negative), or d) the second but not the first (false positive, false negative). The use of the LR or some similar procedure is applicable to any instrument, including those which may be developed prior to the adoption of a new definition for DSM-V, and thus provides a bridge between the old and the new. Those who employ current instruments and those who develop alternatives should collect and report evidence on sensitivity, specificity, as well as positive and negative predictive values, since the latter measures are much more relevant and meaningful to clinicians.

References

Abbott, M., & Volberg, R. (1991).
Gambling and problem gambling in New Zealand. Report on

phase one of the national survey (Research Series No. 12). Wellington, New Zealand: Department of Internal Affairs.

Abbott, M., & Volberg, R. (1992).
Frequent gamblers and problem gamblers in New Zealand (Research Series No. 14). Wellington, New Zealand: Department of Internal Affairs.

Abbott, M. W., & Volberg, R. A. (1996).
The New Zealand National Survey of problem and pathological gambling. *Journal of Gambling Studies, 12,* 143–160.

Abbott, M. W., & Volberg, R. A. (1999).
A reply to Gambino's "An epidemiologic note on verification bias": Implications for estimation of rates. *Journal of Gambling Studies, 15,* 233–242.

American Psychiatric Association. (1994).
Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Brenner, H., & Gefeller, O. (1997).
Variation of sensitivity, specificity, likelihood ratios and predictive values with disease prevalence. *Statistics in Medicine, 16,* 981 – 91.

Chu , K. (1999).
An introduction to sensitivity, specificity, predictive values and likelihood ratios. *Emergency Medicine, 11,* 175–181.

Cunningham-Williams, R. M., & Cottler, L. B. (2001).
The epidemiology of pathological gambling. *Seminars in Clinical Neuropsychiatry, 6,* 155–166.

Dickerson, M. (1993).
A preliminary exploration of a two-stage methodology in the assessment of the extent and degree of gambling-related problems in the Australian population. In W. R. Eadington & J. A. Cornelius (Eds.), *Gambling behavior and problem gambling* (pp.347–363). Reno, NV: University of Nevada, Reno.

Dickerson, M. G., Baron, E., Hong, S. M., & Cottrell, D. (1996).
Estimating the extent and degree of gambling related problems in the Australian population: A national survey. *Journal of Gambling Studies, 12,* 161 – 178.

Dickerson, M. G., & Volberg, R. A.
Preface/editorial for special issue. *Journal of Gambling Studies, 12,* 109 – 110.

Faraone, S. V., & Tsuang, M. T. (1994).
Measuring diagnostic accuracy in the absence of a "gold standard." *American Journal of Psychiatry, 151,* 650–657.

Fisher, S. (2000).
Measuring the prevalence of sector-specific problem gambling: A study of casino patrons. *Journal of Gambling Studies, 16,* 25–51.

Frances, A. (1998).
Problems in defining clinical significance in epidemiological studies. *Archives of General Psychiatry, 55,* 119.

Gambino, B. (1997a).
Method, method: Who's got the method? What can we KNOW about the number of compulsive gamblers? *Journal of Gambling Studies, 13,* 291 – 296.

Gambino, B. (1997b).
The correction for bias in prevalence estimation with screening tests. *Journal of Gambling Studies, 13,* 343 – 351.

Gambino, B. (1999a).
An epidemiologic note on verification bias: Implications for estimation of rates. *Journal of Gambling Studies, 15,* 223–232.

Gambino, B. (1999b).
Estimating confidence intervals and sampling proportions in two-stage prevalence designs. *Journal of Gambling Studies, 15,* 243–245.

Garrett, E. S., Eaton, W. W., & Zeger, S. (2002).
Methods for evaluating the performance of diagnostic tests in the absence of a gold standard: A latent class model approach. *Statistics in Medicine, 21,* 1289–1307.

Gerstein, D., Hoffman, J., Larison, C., Murphy, S., Palmer, A., Chuchro, L., et al. (1999).
Gambling impact and behavior study. Report to the National Gambling Impact Study Commission. National Opinion Research Center at the University of Chicago.

Gordis, L. (1996).
Epidemiology. Philadelphia: W.B. Saunders Co.

Hui, S. L., & Walter, S. D. (1980).
Estimating the error rates of diagnostic tests. *Biometrics, 36,* 67–71.

Koch, M., Capurso, L., & Llewelyn, H. (1995).
Analyzing the discriminating power of individual symptoms,

signs and test results. In H. Llewelyn & A. Hopkins (Eds.), *Analyzing how we reach clinical decisions* (pp. 51–67). London: Royal College of Physicians of London.

Koeter, M. J. W., de Fuentes-Merillas, L., Schippers, G. M., & van den Brink, W. (2003).
Severity of gambling addiction: Development of a new assessment instrument. *World Psychiatry, 2,* 6 (Supplement 1).

Koplan, J. P., Thacker, S. B., & Lezin, N. A. (1999).
Epidemiology in the 21st century: Calculation, communication, and intervention. *American Journal of Public Health, 89,* 1153–1155.

Kraemer, H. C. (1992).
Evaluating medical tests: Objective and quantitative guidelines. Newbury Park, CA: SAGE.

Lesieur, H. R., & Blume, S. B. (1987).
South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American Journal of Psychiatry, 144,* 1184–1188.

McGee, S. (2002).
Simplifying likelihood ratios. *Journal of General Internal Medicine, 17,* 646–649.

McGrath, R. E. (1998).
Significance testing: Is there something better? *American Psychologist, 53,* 796–797.

Meehl, P. E., & Rosen, A.
Antecedent probability and the efficiency of psychometric signs, patterns, or cutting scores. *Psychological Bulletin, 3,* 195–216.

Murphy, K. R. (Ed.). (2003).
Validity generalization: A critical review. Assessment Systems Corporation. Available at: http://www.assess.com

National Research Council (1999).
Pathological gambling: A critical review. Washington, DC: National Academy Press.

Pincus, H. A., Zarin, D. A., & First, M.
"Clinical significance" and DSM IV. *Archives of General Psychiatry, 55,* 1145.

Poulin, C. (2002).
An assessment of the validity and reliability of the SOGS-RA.

Journal of Gambling Studies, 18, 67–93.

Productivity Commission. (1999).
Australia's gambling industries (Report No. 10). Canberra, Australia: AusInfo.

Rogan, W. J., & Gladen, B. (1978).
Estimating prevalence from the results of a screening test. *American Journal of Epidemiology, 107,* 71–76.

Rose, G., & Barker, D. J. P. (1978).
What is a case? *British Medical Journal, 2,* 873–874.

Rubin, D. B. (1988).
Discussion. In H. Wainer & H. I. Braun (Eds.), *Test validity* (pp. 241–256). Hillsdale, NJ: Laurence Erlbaum.

Sackett, D. L., Haynes, R. B, Guyatt, G. H., & Tugwell, P. (1991).
Clinical epidemiology: A basic science for clinical medicine (2nd ed.). Boston: Little Brown.

Schlesselman, J. J. (1982).
Case-control studies. New York: Oxford University Press.

Schmitz, N., Kruse, J., & Tress, W. (2000).
Application of stratum-specific likelihood ratios in mental health screening. *Social Psychiatry & Psychiatric Epidemiology, 35,* 375–379.

Shaffer, H. J., Hall, M. N., & Vanderbilt, J. (1997, December 15).
Estimating the prevalence of disordered gambling behavior in the United States and Canada: A meta-analysis. *Harvard Medical School Division on Addictions*. Boston: Harvard College Fellows.

Shaffer, H. J., & Korn, D. A. (2002).
Gambling and related mental disorders: A public health analysis. *Annual Review of Public Health, 23,* 171 – 212.

Smith, G. J., & Wynne, H. J. (2002).
Measuring gambling and problem gambling in Alberta (Final Report). Prepared for the Alberta Gaming Research Institute.

Spitzer, R. L. (1998).
Diagnosis and need for treatment are not the same. *Archives of General Psychiatry, 55,* 120.

Staquet, M., Rozencweig, M., Lee, Y. J., & Muggia, F. M. (1981).
Methodology for the assessment of new dichotomous diagnostic tests. *Journal of Chronic Disease, 34,* 599–610.

Stinchfield, R. (2002).
Reliability, validity, and classification accuracy of the South

Oaks Gambling Screen (SOGS). *Addictive Behaviors, 27,* 1 – 19.

Stinchfield, R. (2003).
Reliability, validity, and classification accuracy of a measure of DSM-IV diagnostic criteria for pathological gambling. *American Journal of Psychiatry, 160,* 180–182.

Stinchfield, R., Govoni, R., & Frisch, G. R. (2001, November).
An evaluation of diagnostic criteria for pathological gambling (Final Report). Windsor, ON: University of Windsor.

Strong, D. R., Lesieur, H. R., Breen, R. B., Stinchfield, R., & Lejuez, C. W. (2003).
Using a Rasch model approach to examine the utility of the SOGS screen across pathological and nonpathological gamblers. *Addictive Behaviors, 28,* 1465–1472.

Teutsch, S. M. (1994).
Considerations in planning a surveillance system. In S. M. Teutsch & R. E. Churchill (Eds.), *Principles and practice of public health surveillance* (pp. 18–30). New York: Oxford University Press.

Tremayne, K., Masterman-Smith, H., & McMillen, J. (2001).
Survey of the nature and extent of gambling and problem gambling in the ACT. Sydney, Australia: Australian Institute for Gambling Research, University of Western Sydney.

Ustun, T. B., & Rehm, J. (1998).
Limitations of diagnostic paradigm: It doesn't explain "need." *Archives of General Psychiatry, 55,* 1145–1146.

Volberg, R. A. (1994).
The prevalence and demographics of pathological gamblers: Implications for public health. *American Journal of Public Health, 84,* 237–241.

Volberg, R. A. (1999).
Research methods in the epidemiology of pathological gambling: Development of the field and directions for the future. *Annuario de Psicologia, 30,* 33–46.

Walker, M. B., & Dickerson, M. G. (1996).
The prevalence of problem and pathological gambling: A critical analysis. *Journal of Gambling Studies, 12,* 233–249.

Welte, J. W., Barnes, G. M., Wieczorek, W. F., Tidwell, M., & Parker J. (2001).
Alcohol and gambling among U.S. adults: Prevalence, demographic patterns and comorbidity. *Journal of Studies on*

Alcohol, 62, 706–712.

Wilkinson, L. (1999).
Statistical methods in psychology journals: Guidelines and explanations. Task Force on Statistical Inference. *American Psychologist, 54,* 594–604.

Winters, K., Specker, S., & Stinchfield, R. (1997).
Diagnostic interview for gambling severity (DIGS). Minneapolis, MN: University of Minnesota Medical School.

Zahner, G. E. P., Hsieh, C., & Fleming, J. A. (1995).
Introduction to epidemiologic research methods. In M. T. Tsuang, M. Tohen, & G. E. P. Zahner (Eds.), *Textbook on psychiatric epidemiology* (pp. 23–54). New York: Wiley-Liss.

Zhou, X. H., Obuchowski, N. A., & McClish, D. K. (2002).
Statistical methods in diagnostic medicine. New York: John Wiley & Sons, Inc.

This article was peer-reviewed. Submitted: August 8, 2003. All URLs cited were available at the time of submission. Accepted: March 14, 2005.

For correspondence: Blasé Gambino, PhD, 10 Ellet Street, Boston, MA 02122 U.S.A., Telephone: 617-282-2560, e-mail: blasegambinophd@aol.com

Competing interests and funding: None declared.

Blasé Gambino (PhD, experimental psychology, University of Massachusetts at Amherst) currently serves on the editorial review board of the *Journal of Gambling Studies*. His publications include articles on mathematical models to eliminate bias in prevalence estimation research for single- and two-stage prevalence designs, as well as articles on the epidemiology of pathological gambling. Co-editor of *Compulsive Gambling: Theory, Research and Practice* (1989). His current interests are in the epidemiology of pathological gambling, latent structure, and taxometrics.

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (98 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 21 pages.]

"Double trouble": The lived experience of problem and pathological gambling in later life

Gary Nixon, Jason Solowoniuk, Brad Hagen, & Robert J. Williams, University of Lethbridge, Lethbridge, Alberta, Canada.
E-mail: gary.nixon@uleth.ca

Abstract

Objective: The objective of this phenomenological qualitative study was to explore the lived experience of older adults who engage in problem or pathological gambling.
Method and sample: Older adults who gambled were recruited and were administered two gambling screens to ensure that they met the criteria for problem or pathological gambling. Eleven problem-pathological gamblers were identified and contributed their narratives via in-depth interviews about their experiences of problem or pathological gambling.
Results: Several themes arising from the interviews were similar to patterns identified with younger gamblers, yet distinct patterns emerged. Some older gamblers gamble as an opportunity to break away and escape from traditional roles and go to extreme measures to continue their gambling while hiding it from significant others.
Conclusion: Despite research suggesting few seniors encounter problems with gambling, this qualitative study suggests that gambling can have devastating consequences. Older adults may have lessened ability and time to recover from these consequences or from hitting bottom. Key words: gambling, narrative, older adults, problem-pathological gambling, phenomenology, aged

Introduction

In recent years, older Canadians who gamble have increasingly caught the attention of the media due to a growing awareness of the tremendous market that seniors pose for the gaming industry. For example, a December 17, 2000, issue of the *Ottawa Citizen*

ran a typical story on seniors and gambling, stating, "With carefully pitched offers of free food, transportation and a cozy social environment, gambling is growing among seniors while gaming addictions trail not far behind." Similarly, an addictions counsellor was recently quoted in an on-line casino newsletter describing casinos as "a sea of grey" (Casino Gambling News, 2000). Indeed, many casinos are aggressively marketing gambling to seniors, realizing that seniors have increased time to engage in leisure activities and increasingly find gambling an enjoyable, social, and exciting pastime (Hope & Havir, 2000; McNeilly & Burke, 2000, 2001; Morgan Research, 1997; Munro, Cox-Bishop, McVey, & Munro, 2003; Savoye, 2001).

Recent studies support the perception that seniors are largely responsible for the upsurge in gambling and the number of legalized gambling venues. McNeilly and Burke (2001) reported that in 49 adult communities surveyed in the U.S., gambling ranked the highest among all social activities of older adults and 16% of seniors went on day trips to local gambling casinos on more than a monthly basis. A recent Canadian study (Hirsch, 2000) found that 67.8% of seniors polled had gambled within the previous year, and an Australian study (Morgan Research, 1997) found even higher rates, with 86% of older adults surveyed reporting gambling in the previous year.

Interestingly, these growing numbers of older gamblers appear to have different motivations for gambling than their younger counterparts. Hope and Havir's (2000) study of older adult gamblers revealed that the primary reason for gaming was not the gambling action. Instead, gambling for gambling's sake ranked as only the third reason, behind the pursuit of a pleasurable social activity (first reason) and the food (second reason) (Hope & Havir, 2000). In the same vein, a study of 478 older adult women conducted by Tarras, Singh, and Mouffakir (2000) found, through examination of this group's expenditures, that their casino visits are balanced between gambling and non-gambling activities such as eating. However, Bazargan, Bazargan, and Akanda (2000) also found that a small portion of older adults gamble because of stressful life situations such as change in residence, serious financial difficulties, marital separations, death of a spouse, and arguments with friends or significant others. In these incidences, the older adult's motivation to gamble is not so much the pleasurable social activity but the escape from current life stressors (McCown & Chamberlain, 2000).

Given that some older persons are gambling as an escape or to cope with stress, it is not surprising that some of them may encounter difficulties with problem or pathological gambling (Morgan Research, 1997; Wiebe, 2002). Yet, traditionally, the research literature has suggested that older persons show lower

rates of problem or pathological gambling than younger persons (National Research Council, 1999; Shaffer, Hall, and Vander Bilt, 1997). For example, in a recent Canadian study of 5000 older adults, the Addictions Foundation of Manitoba found that only 1.6% of the sample were gambling at problem levels, and a further 1.2% were gambling at probable pathological levels (Wiebe & Kolesar, 2000). These results are similar to an Alberta study, finding rates among seniors of problem gambling at 1.4% and of probable pathological gambling at 0.4% (Hirsch, 2000), and a U.S. study, finding rates among seniors of pathological gambling at 0.4% (National Research Opinion Center, 1999).

However, the delineation of older adults as problem-pathological gamblers is in its early infancy (Petry, 2002), and actual rates of problem and pathological gambling among seniors could be higher than the initial studies suggest. This is due not only to possible underreporting by seniors because of the potentially shameful aspects of gambling (Hirsch, 2000) but also to the fact that some of the questions on commonly used gambling screens (such as those related to work) do not always apply to older persons.

Furthermore, at least two studies have reported considerably higher rates of problem or pathological gambling among older adult gamblers: Bazargan et al. (2000) found that 17% of a sample of older gamblers were heavy or pathological gamblers and McNeilly & Burke (2000) found that 4.2% of 308 older adult gamblers were problem gamblers and 2.6% were probable pathological gamblers.

Relatively little is known about older gamblers who meet the criteria for problem or pathological gambling. In one of the few studies on older pathological gamblers, Petry (2002) found, not surprisingly, that older pathological gamblers had less problems with family obligations, marital problems, legal problems, and drug problems compared to their younger pathological gambling cohorts. Reflective of gender demographics in older persons is that female older adults made up the majority of the pathological gamblers in Petry's study and spent the most money and the highest percentage of their income gambling. Very interestingly, 89% of the female pathological older adult gamblers in Petry's study reported that they did not begin regular gambling until casinos became legalized in Connecticut (the study's location) in 1992.

In general, much research remains to be undertaken with respect to older adults experiencing difficulty with problem or pathological gambling. In particular, it has been noted (Hirsch, 2000; Munro et al., 2003) that there is a particular lack of *qualitative* research exploring the experience of problem and pathological gambling in later life. The purpose of this study is to address this gap by examining how and why seniors develop gambling problems and successfully recover from them.

Method

Research design

A phenomenological approach was utilized in order to understand older adults' lived experience of gambling. The aim of the phenomenological approach is to "understand a phenomenon by having the data speak for itself" (Osborne, 1990, p. 81), or, in this particular case, to understand, as intentional objects, the themes of gambling in the context of research participants' lived experiences (Heidegger, 1962; Osborne, 1990; Van Manen, 1984, 1990). Van Manen (1984) described phenomenological research as the study of lived experience in which the essence or nature of an experience has been adequately described in language so that the description reawakens or shows us the lived meaning or significance of the experience in a fuller or deeper manner. Van Manen (1984) saw actual phenomenological research as a dynamic interplay in which we turn to a phenomenon of serious interest, investigate the experience as we live it rather than as we conceptualize it, reflect on the essential themes that characterize the phenomenon, and, finally, describe the phenomenon.

Because the intent of the study was to understand older adults' experience of problem gambling, phenomenology, with its focus on the individual's subjective experience and perceptions and on the meaning of a phenomenon (Osborne, 1994; Tesch, 1990), seemed the ideal qualitative research methodological approach. While ethnography describes and analyzes practices and beliefs of cultures and communities (Mertens, 1998), this research attempted to illuminate the unique addictive processes and experiences of gambling in the lives of older adult individuals, given the possible life circumstances that separate older gamblers from other populations of gamblers, such as the loss of work life, the experience of boredom and social isolation, the loss of self-esteem, and a corresponding vulnerability to the attractions of casino life. Because phenomenology focuses on the conscious experience of the individual subject (Osborne, 1994), it is an ideal way to understand how people, despite their good intentions, fall into the addictive process of gambling. For example, as discussed later in the themes section, older adult problem gamblers can consciously attempt to win back losses by gambling more, oblivious to the fact that in most cases they are merely magnifying their losses. A phenomenological approach allows the subjective experience, self-talk, and meaning-making of this experience of chasing losses to be described and understood.

Rather than a schedule of interview research questions, a narrative method for interviewing was used to give a natural chronological story structure to the interview (Cochrane, 1985; 1986). In these

narratives, research participants described their lived experience of gambling starting from the beginning of their gambling careers and as they progressed over time. Key experiences and turning points were identified during the interview and participants were encouraged to expand on these themes. All qualitative interview transcripts (*N* = 11 problem-pathological gamblers) were analyzed using a phenomenological analysis of the themes of the lived experience of gambling (Osborne, 1990; Van Manen, 1990). Essential to this type of research is reflection on the essential themes that characterize the phenomenon (Osborne, 1990; Van Manen, 1984, 1990).

Participants

Older adult participants had to be at least 65 years of age and were recruited through ads in local newspapers, notices at casinos and senior centres, and information booths at casinos. Interested participants were offered $30 for their participation. Recruitment of problem-pathological gamblers proved to be difficult, probably largely due to some of the potential embarrassment and shame associated with identifying as a problem gambler.

Subjects were determined as being either problem or probable pathological gamblers through a combination of the results of the two gambling screens. After three months of recruiting subjects, a total of 24 participants agreed to participate in the study and the initial screening. In the end, a total of 11 participants met the screening criteria for problem or probable pathological gamblers and agreed to be interviewed. All participants were over 65, with 9 females and 2 males being interviewed.

Ethical considerations

The entire research protocol was reviewed and approved by a University Research Ethics Board, and participant confidentiality was assured by the use of pseudonym initials selected by the research participants for the transcription of interviews.

Data collection

Use of gambling screening tools

Two gambling screens were used with participants: the South Oaks Gambling Screen (SOGS) and the NORC DSM Screen for Gambling Problems (NODS). With the SOGS (Lesieur & Blume, 1987), a score of three to five represents problem gambling, and scores of five or more represent probable pathological gambling. Our participants all had scores of three or higher, with an average of 7.63. The NODS (Gerstein et al., 1999) was devised by the

National Opinion Research Center for the 1999 National Survey of Gambling Behavior. The NODS classifies respondents as low risk (gamblers with no adverse affects), at risk (gamblers meeting one or two of the criteria), problem (three or four of the criteria), and pathological (five or more criteria). Our 11 participants averaged 5.27 for the NODS "lifetime" score. The score for the last year was not used as a few of the older adults were now in recovery for their gambling addiction. However, all participants met the criteria for lifetime problem gambler with a score of three or more.

Table 1
Gambling screening scores by participant

Problem or probable pathological gamblers (*N* = 11)

Participants (m = male) (f = female)	SOGS (lifetime)	NORC-DSM-IV (lifetime)
1. H.J. (m)	5	5
2. P.L. (m)	4	4
3. M.A. (f)	8	3
4. C.F. (f)	3	3
5. O.L. (f)	12	7
6. B.B. (f)	14	11
7. C.A. (f)	4	3
8. M.M. (f)	9	5
9. T.L. (f)	6	6
10. P.M. (f)	8	7
11. S.J. (f)	11	4
Total mean scores	7.63	5.27

Phenomenological interviews

The 11 participants identified as being either problem or probable pathological gamblers participated in an in-depth audio-taped interview, lasting between 40 and 80 minutes, exploring their lived experience of gambling as seniors. As opposed to a predetermined schedule of research questions, a narrative method was used to give a natural chronological story structure to the interviews (Cochrane, 1985; 1986). Research participants were, however, invited to describe their lived experience of gambling from the beginning of their gambling, and the progression of their gambling over time, including pivotal events and turning points.

Results

Description of data analysis procedures

An analytical procedure outlined by Osborne (1990) was used to conduct the thematic analysis of the data. The researchers read and familiarized themselves with each interview transcription. Each research participant's interview was then reduced to simple paraphrases or surface themes. From these surface themes, higher-order clusters of themes were made within each interview. Following this, the researchers drew out the themes that were common across interviews to highlight the shared structures of the experience of gambling.

Interview themes

Escaping and being on your own

Casino and electronic gaming appeared in many cases to have provided older adults, particularly women, with the opportunity to go beyond the traditional roles of caring and sacrifice for others. For example, P.M. spoke of her gambling this way: "When you're here (gambling) … you're more or less on your own and nobody can control you—we always helped our kids a lot, so I didn't feel like I should just scrimp and save any more!" Another woman, T.L., described her gambling as a welcome relief from years of having to commit to her family: "I raised a family all by myself, done all these things … I've had to follow all these rules and I've had to commit myself, always, always, always, I'm not doing it any more, I am retired." Similarly, M.M. acknowledged, "You don't do it every day, but you do it occasionally, and I have to admit that it is fun to stay up until three … and be bad for change!"

Gambling appeared to provide an escape from the reality of current life problems for many seniors. T.L. explained this as follows:

> It's an escape, it's an escape, and I think a person has to make some changes to get out of that situation.… It's just been a nice escape for me, so even though it causes me grief at times it's an escape from reality .

M.M. reiterated this idea of gambling as an escape, even going so far as to call it her "fairy world" and "little hideaway." She explained why her gambling became so problematic for her in later life:

> I think that's the basic reason, is to get away from reality, just go to a fairy world.…Yeah, it's an escape, wherever your mind blanks out, you don't think about it. … That's it, your little hideaway, on that chair.

P.M. suffered the loss of her husband, and gambling became her avenue of escape:

> I went with him for about five years and then he died suddenly of an aneurysm. He was fifty-one, and then I guessed I was pretty depressed and lonely and you know, it was one place that you could just be away.

C.A. described how gambling could even help you forget about the physical losses associated with aging: "I know I'm losing in the long run … but I use it as a recreation vehicle.… I want to forget about my arthritis in my hands."

In addition to providing an escape, pathological gambling could also provide a way for seniors to isolate themselves when they feel depressed or solitary. C.F. described this well:

> I don't go there [the casino] to meet people; I don't go there because I know somebody there that's gambling, I don't do that. I just go there, just sit in a corner, just leave me alone, just don't talk to me, I want to be by myself.

Feeling good through a big win

Winning can be experienced by older pathological gamblers as a powerful ego-booster and keeps them addicted to gambling, as they try to recreate the magical feelings of the big win. O.L. described this magic :

> It's the sound, it's the carrying it, if I win big I put it in my pants pockets, not my purse and I go straight to my vehicle and ah, a couple of times, like you know, when I won that twenty-five hundred, I actually let some young supervisors walk me to my vehicle.

M.A. had a similar way of describing this: " I feel good … I generally don't win that much, but it's something wonderful now and then, where I have won four or five hundred dollars, that's great." C.A ., an older gentleman with gambling problems, described how these early big wins initially "hooked" him into gambling and began his problems:

> Well one day I just said "let's go to the casino," you know, just for the heck of it. I'd never been in there, and I'd walked by the stupid place for years and years without ever going in. So I went in, and won $1000! So I'm thinking by golly, and then a couple of weeks later I won $2700! So I figured I'm doing a bang-up job … and that's how it all started.

Experiencing a big win appears to both begin, and revitalize, the

gambling process for older pathological gamblers. H.J. describes her surprise with not only winning a large amount but *being* a winner:

> Well, they told me I got the big win for the day, so I got kind of excited. But then they told me "no—you got the big win for today—you're the only winner." I won ninety-four hundred dollars! I couldn't believe it!

Some older gamblers, however, had the insight to realize that such big wins could have a darker side—a side that kept drawing them back to gambling. As M.M. relayed, with a serious expression on her face, "I have occasionally won twenty-seven hundred from only playing three loonies, and I said, 'Oh my God, I shouldn't have done this … because now we'll be gambling again.'"

The emotional roller coaster ride

Older adult problem gamblers can get carried away by the gambling action—one moment they are up, the next they come hurtling down again. Due to the unpredictability of the gaming action, the problem gambler becomes caught in a veritable roller coaster ride of emotions. H.J. described his own gambling ups and downs : "In horse racing you are either down in the depths, because you had a bad day, or else you're exhilarated … there's hardly any in between." The highs of the roller coaster can indeed be sweet and exciting, as O.L. explains:

> In the casino it seems you can win or lose a lot more money, and I think it's the excitement in the casino, when you cash out it's the excitement of all the quarters or all the dollars falling in the pot.

However, older problem gamblers also described the dreaded lows that quickly follow the highs of the roller coaster ride of gambling. B.B. experienced it this way: "It's just such a big fast flip-flop … first, it's real excitement and then, BANG! ... real depression." T.L.'s experience with depression mirrors this: " You can quickly become very depressed and angry, all sorts of things and I'm too ashamed to admit to my family that I gamble as much as I do." Similarly, B.B. reported being in and out of depression, often voicing her anger and depression to the actual machines she was playing:

> You know, I was on so much medication, and it kept on getting worse . Eventually, however, in my case, I'd just get real mad. In my case, I've even started yelling at the machines! You know, " Why the hell aren't you paying me??!!" 'Cause you know, the machine next to me would be paying out.…

As gambling expenditures increase, the values and belief systems of the older gamblers become jeopardized, subsequently triggering guilt and self-loathing. M.A., for example, told how his gambling problems were in conflict with his Christian beliefs: "My son doesn't say much of anything about my gambling even though we're fairly close…. I might not sound like it, but I am a very strong Christian, so sometimes I have some guilty feelings there." Similarly, O.L. remarked how her behaviour was at odds with what she believed she should do:

> Later you're disappointed with yourself, because you work so hard to keep your bills paid up, then, your charge card is up, you know darn well that maybe the last two hundred dollars you spent on gambling should have went towards paying off that card.

Guilt, in turn, is accompanied in several pathological gamblers by chronic worrying and remorse. P.L. acknowledged this:

> After a while, I started sitting back and thought and thought for hours and hours, that probably this year, (kind of reason why I phoned you) is that, I maybe lost four thousand dollars this year—and all this finally started to really worry me.

P.M. also felt both guilty and worried about her gambling behaviours:

> You hate yourself; we always helped our kids so I shouldn't feel guilty because they're all well off…. So I shouldn't feel guilty but I do. I then start to really worry about what happens if something happens to one of them—and then I kick myself! I should have given each of them twenty thousand dollars at least. [Sigh] Instead, I pissed it all away.

Double trouble: Extended play to recoup losses or to keep winning

Participants spoke often of the intense chaos generated by attempts to recoup losses and remain in control of their lives. M.A. affirmed that chasing losses was intense:

> Sometimes when the machine doesn't win and I have some money left I go to the blackjack table and I am able to recover what I lost from the machine … instead of putting the money back in the bank, I will go back to another machine and see if I can make it talk—then you start getting in *double trouble* [emphasis].

T.L. was also seduced into chasing losses:

> You can lose five or six hundred dollars and you start thinking to yourself: "it *has* to pay out … it *has* to pay out. " Then you starting thinking that maybe you should just quit. But then another part of you kicks in and you start thinking, "No, no, no quitting now, pretty soon it will start paying!" Do you see how crazy it gets!?

O.L. descended into this same "craziness" to recoup her losses:

> There was nothing I needed to go home for … ah, I didn't have to, you know, prepare a meal, and I just wanted to win back my money…. That machine got my hundred dollars and I'm going to get it back! But pretty soon that machine's got two hundred dollars.

This urge to recover losses can become so pronounced that people may gamble for extended periods, with complete loss of any sense of time. M.M. acknowledged that this was the case for her: "Sometimes we are there from ten o'clock in the morning until three o'clock in the morning." Similarly, older problem gamblers could lose track of not only how much they were gambling during a day but even how much they were gambling during a week. As C.F. stated, "I'd kind of lose track of the days … like last week I think I went back for three days in a row because I am on a winning streak." M.A. also noted this:

> Sometimes I look at a month, and I'd realize I played seventeen times this month. Oh my God, I'll say, I'd better quit—look what I have done, I've lost at least seven hundred dollars this month … but of course, I couldn't quit.

With some participants, this "double trouble" of playing to recoup losses or keep winning led to unusual or obsessive behaviour. B.B. described this kind of behaviour with relation to the machines she would play:

> You didn't ever let anybody get your machine. You could leave it for minutes to get some money, but you had to *run* and get money … or sometimes you came back and somebody else got it [the VLT machine]. I would tell them that was my machine I just left, you don't take it! By the end of the night if I put a thousand dollars in it [the machine], and walked away and never got anything, you had to be back at ten o'clock in the morning, right when they opened, to get the same machine ... otherwise, somebody might get "my"

> money!

S.J. described similar thinking and behaviour:

> I got kind of crazy and kept thinking it [the VLT machine] was going to pay off, so I couldn't leave it for someone else . I'd wait and wait for it to pay out until I couldn't take it any more….I'd turn my chair backwards on it [the machine] and take my coins and run to the ladies' room and come back as fast as I could. Sometimes I just seem to be glued to it.

Attempting to regulate or cut back on gambling

Many problem gamblers in this study reported phases of trying to regulate or cut down their gambling. For example, one participant would occasionally keep track of the amount of gambling on a computer, while another used a notebook. M.A., in contrast, tried to develop a schedule:

> I would say other than a Wednesday night … I have been keeping to about twice on the weekend, maybe Saturday, Sunday afternoon, or Friday night, and Saturday afternoon, something like that.… I still go, and when you run into a streak of bad luck, that's when I cut down a bit, or say I'm only going to play regular cards, or I'll fold cards for awhile.

Yet such attempts to regulate gambling often seemed short-lived and often left the older problem gambler frustrated and yearning to play more. P.L. described it this way: "I have gone up to two or three weeks and completely stayed away, but then I get that big urge to play." O.L. had a similar experience:

> I don't have very many more years to sock a little bit away, ah, you know, then I get quite mad at myself and then I'll stay away for quite awhile, and then I'll say 'I've been good,' and before I know it, I'll be back.

Hiding, lying, borrowing, and stealing to continue gambling

Participants also described a process where, as their gambling became more and more out of control, they increased their efforts to hide their gambling from significant others. C.F. described her experience of this: "Sometimes right at ten o'clock I would need to go gamble, if I didn't have to work, I would lie to my husband, and tell him that I have to clean some more houses." P.M. also tried to hide her gambling from her daughter: "I would park beside the Salvation Army, and tell her and pretend that I am doing volunteer work there, but my daughter finally checked a couple of times."

One study participant, B.B., felt so burdened by her gambling behaviour that she went to extravagant means to conceal it from others:

> Like lots of times I would stay out, I would sleep in the car, until he (my husband) went to work and then I would go in the house to bed. 'Cause I was scared and this would go on for months, sometimes I would even drive around the country until he wasn't in the house when I would be there.… Many nights I slept in the car so I wouldn't have to face him about where I'd been.

Eventually, some participants had lost so much control of gambling expenditures that they would begin to borrow or steal to continue to chase "the big win." B.B. described how this happened to her:

> At first, I starting begging my kids, because even though they were going to school, they were also working part-time—so I asked them to lend me the money.… You know, that's something you just don't do—and we've been broke before but never did anything like this. Later on, I frauded the bank, and they were actually good to me!

M.M. also described problems with banks, who she claimed "never asked a thing," because she was a "nice little old lady." She put it this way:

> At first, you get a loan from the bank to cover it, and then before you know it you're in really big trouble.… Then you go mortgage the house you have paid off, and that's how I ended up where I am at now.

P.M. too, lost her house to pay for her gambling habit: " Well I sold my house, and the price of my house is gone.… I used to be pretty well off at one time."

Clinging to hope: "There's always that chance"

Even when they claimed they knew logically that their "chase" was hopeless, many participants described still clinging to the faint hope of winning the big jackpot. O.L . describes this:

> It's the, it's the chance, because they have a lot of um, what do they call those ah, they have big jackpots, there is three machines that are connected all over Alberta.… So you know, ah, I've seen that jackpot up to like, nine hundred and some thousand, ah, you know, so there's always the chance that you'll win, and I keep playing.

T.L. had also reached the hopelessness phase of his gambling, yet continued to wager more and more for that one final win that would "save" him:

> I keep going back.… I was just thinking, if I won that great big progressive thing, it was up to a hundred and seventy thousand the other day, and I thought if I could win that hundred and seventy thousand, I could pay off my debts, pay off my house, buy a new car, buy all new furniture.

Hitting bottom: Putting the brakes on gambling

For a few participants, a point came when the feverish gambling finally ended in a process of "hitting bottom" or "putting the brakes on." For participants, this process happened in different ways. For P.M., hitting bottom was simply having nowhere else to go for money: "Well when you run out of money you pretty well have to put the brakes on.… I realized I had no more to live on, and that I was in big trouble." For T.L., rock bottom also coincided with completely running out of money: "I didn't have enough money to pay the rent and so I went down to the bank and said, 'Has this cheque been cashed or has this cheque been cashed?'—but I knew the game was over." For B.B., hitting bottom was accompanied by a brush with suicide:

> I was feeling weird, feeling that I was so far in debt, I was having problems with the bank, I actually did let go of the wheel for five seconds and a semi was coming up … and I said to myself, 'wake up! … you won't waste your life because of this.'

Seeking help

Four study participants had actually sought help for their gambling problems. B.B. had seen an advertisement for a 1-800 gambling help number, and gathered the courage to both phone and tell her husband about her gambling: "… so I phoned the 1-800 number and they told me when the meetings were, so I sat down and told him , but I told him you need to come with me." C.F. also attested to how the first experience of seeking help was fraught with fear and anxiety:

> So my first meeting I was terrified, and I bawled more than anything. But you know, when I walked in there—and it was the most, I had the feeling—I felt like I knew some people in there really well, and they knew me.

Another older pathological gambler who got help by attending Gamblers Anonymous described a similar experience of his first

few meetings: " It was just not me in there, there are a lot of people out there like me, and if I was going to get help, I had to stick with it."

Other participants found Gamblers Anonymous less than helpful. T.L. explained her experience:

> I tried to go back to GA and it was the same thing, a personality thing…. You can phone the number, which is what I did about four years ago, I went to a couple of meetings, but I ah, found them like I said, it was so smoky and I found it degrading, let's put it that way.

Recovering from a gambling compulsion can be attempted in many ways: some try treatment, some try to control their gambling, others try Gamblers Anonymous, while others quit cold turkey. M.M. tried another avenue: "I went to a hypnotist, it cost me three hundred dollars, and I stayed away for eight months."

Discussion

Our findings, drawn from the lived experience of older adult problem and pathological gamblers, appear to be similar to previous research that suggests that there is a need for greater awareness and examination of the growing number of adults who venture into casinos (Bazargan et al., 2000; Fessler, 1996; Glazer, 1998; Gosker, 1999; Grant, Kim, & Brown, 2001; McNeilly & Burke, 2000, 2001; Morgan Research, 1997; Munro et al., 2003; Petry, 2002; Wiebe, 2002). This examination found that gaming is not always a risk-free pastime for older adult gamblers and that their behaviours not only posed financial risks but led to psychological and social dysfunction.

Through a phenomenological approach to understanding the lived experience of eleven representatives we compiled nine themes that appear to have manifested themselves during problem and pathological levels of gaming. One interesting theme, which many of the female gamblers verbalized, was that gambling was an avenue to break away from traditional and stereotypical roles. It appears that gambling began as a novelty for some older adults, but over a period of time this novelty, whereby one seeks to integrate oneself into a different lifestyle, ended up having serious social, psychological, and financial costs.

What we found particularly interesting was that older adult gamblers didn't deny having a gambling problem themselves but went to extravagant means to hide it from family and friends. Also interesting was the extent to which older adult gamblers experienced guilt and shame from concealing their gaming. Raised

during the Great Depression or shortly thereafter, the older adults in our study disclosed that they had been conditioned to hold saving money and being thrifty in great esteem.

Some similarities among our gambling themes have also been found in adult problem and pathological gambling studies, such as chasing losses, failed attempts to cut down or regulate gambling, binge gambling, gambling to escape current life stressors, entering into illegal acts to continue to gamble, and hitting bottom (McCown & Chamberlain, 2000; Mok & Hraba, 1991; National Research Center, 1991; Petry, 2002; Shaffer et al., 1997). In spite of these similarities, there is a stark difference between the older adult's ability to recover from hitting bottom and the resulting health complications, psychological and social impairment, and financial ruin that may follow. As well, older adults are a proud group of individuals whose merit in life is tied to a strong sense of self-reliance in an age where our society isolates and marginalizes them (McNeilly & Burke, 2000, 2001; Mok & Hraba, 1991). As a result, as evidenced by our research participants, when gambling ends and older adults hit rock bottom, they are reluctant to seek treatment and are left to deal with financial debt, social impairment, and psychological maladies by themselves, which only perpetuates their guilt, depression, and loneliness and sometimes leads to extreme behaviours such as fraud, theft, and even suicide attempts.

Overall, it appears that this new populace of problem-pathological older adult gamblers is a hybrid of sorts. This hybrid has characteristics of the younger problem-pathological gambler, yet it carries with it characteristics that may pose a greater threat to the older adult, such as a reluctance to seek help for problem gambling and having less time to recover from psychological, social, and financial ruin. Given that a greater percentage of the population is on the brink of retirement age, and as casino style gaming becomes more socially acceptable along with its increasing availability, it appears that this new hybrid of older adult problem gambler may continue to rise. Therefore, it is important that future research on gambling among older adults employ both phenomenological and quantitative approaches so that we can be better prepared to understand the detrimental influence that gambling has on older adults during and after problem-pathological gambling. It also seems important, given the vulnerability of older adults to problem gambling and their reluctance to seek help for their gambling addiction issues, that prevention programs be researched and implemented both for individuals on the brink of retirement age and for those already retired.

References

Bazargan, M., Bazargan, S., & Akanda, M. (2000).
Gambling habits among aged African Americans. *Clinical Gerontologist, 22* (3/4), 51–62.

Casino Gambling News (2000).
Retrieved January 31, 2004, from http://www.casinoworkz.com/gambling-news/2000/12/17/a-16416.php

Cochrane, L. (1985).
Position and the nature of personhood. Westport, CT: Greenwood Press.

Cochrane, L. (1986).
Portrait and story. Westport, CT: Greenwood Press.

Fessler, J.L. (1996).
Gambling away the golden years. *Wisconsin Medical Journal, 95* (9), 618–619.

Gerstein, D.R., Volberg, R.A., Toce, M.T., Harwood, H., Johnson, R.A., Buie, T., et al. (1999).
Gambling impact and behavior study: Report to the National Gambling Impact Study Commission. Chicago, IL: National Opinion Research Center at the University of Chicago.

Glazer, A. (1998).
Case report: Pathological gambling. *The Nurse Practitioner, 23* (9), 74–82.

Gosker, E. (1999).
The marketing of gambling to the elderly. *The Elderly Law Journal 7* (1), 185–216.

Grant, J.E., Kim, W.S., & Brown, E. (2001).
Characteristics of geriatric patients seeking medication treatment for pathological gambling disorder. *Journal of Geriatric Psychiatry and Neurology, 14* (3), 125–129.

Heidegger, M. (1962).
Being and time (J. Macquarie & E. Robinson, Transl.) London: SCM Press. (Original work published 1962.)

Hirsch, P. (2000).
Seniors and gambling: Exploring the issues. Edmonton, AB: Alberta Alcohol and Drug Abuse Commission.

Hope, J., & Havir, L. (2000).
You bet they're having fun! Older Americans and casino gambling. *Journal of Aging Studies, 16* (2), 177–197.

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.

McCown, W.G., & Chamberlain, L.L. (2000).
Best possible odds: Contemporary treatment strategies for gambling disorders. New York : John Wiley & Sons, Inc.

McNeilly, D.P., & Burke W.J. (2000).
Late life gambling: The attitudes and behaviors of older adults . *Journal of Gambling Studies, 16* (4), 393–415.

McNeilly, D.P., & Burke, W.J. (2001).
Casino gambling as a social activity of older adults. *International Journal of Aging and Human Development, 52* (1), 19–28.

Mertens, D. (1998).
Research methods in education and psychology. Thousand Oaks , CA: SAGE.

Mok, W.P., & Hraba, J. (1991).
Age and gambling behavior: A declining and shifting pattern. *Journal of Gambling Studies, 7,* 313–335.

Morgan Research (1997, September).
Report on older people and gambling. Melbourne, Australia: Victorian Casino and Gaming Authority.

Munro, B., Cox-Bishop, M., McVey, W., & Munro, G. (2003).
Seniors who gamble: A summary review of the literature. Edmonton, AB: The Alberta Gaming Research Institute

National Research Council (1999).
Pathological gambling: A critical review. Washington, D.C.: National Academy Press.

National Research Opinion Center (1999).
Gambling impact and behaviors study. Chicago: University of Chicago.

Osborne, J. (1990).
Some basic existential phenomenological research methodology for counsellors. *Canadian Journal of Counselling, 24* (2), 79–91.

Osborne, J. (1994).
Some similarities and differences among phenomenological and other methods of psychological qualitative research. *Canadian Psychology, 35* (2), 167–189.

Petry , N.M. (2002).

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

Savoye, G. (2001).
Growth of retiree gambling raises stakes. *The Christian Science Monitor, 93,* 3.

Shaffer, H.J., Hall, M.N., & Vander Bilt, J. (1997).
Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health, 89* (9), 1369–1376.

Tarras, J., Singh, A.J., & Moufakkir, O. (2000).
The profile and motivations of elderly women gamblers. *Gambling Review and Research Journal, 5* (1), 33–36.

Tesch, R. (1990).
Qualitative research analysis types and software tools. New York: Falmer.

Van Manen, M. (1984).
Practicing phenomenological writing. *Journal of Phenomenology and Pedagogy, 2,* 36–49.

Van Manen, M. (1990).
Researching lived experience: Human sciences for an action sensitive pedagogy. London, ON: The Althouse Press.

Wiebe, J. (2002).
Gambling behavior and factors associated with problem gambling among older adults. Unpublished doctoral dissertation, University of Manitoba, Canada.

Wiebe, J., & Kolesar, G. (2000).
Senior gambling prevalence study. Winnipeg, MA: Addictions Foundation of Manitoba.

For correspondence: Gary Nixon, PhD, School of Health Sciences, University of Lethbridge, 4401 University Drive, Lethbridge, AB, T1K 3M4 Canada. Phone: (403) 329-2644, fax: (403) 329-2668, e-mail: gary.nixon@uleth.ca

Contributors: GN conceived the study. GN, BH, and RW contributed to the design of the study. GN and JS conducted the research interviews and thematic analysis. JS transcribed the interviews. GN and JS wrote the first draft. RW provided gambling screen literature and consultation. GN, JS, and BH were involved in writing the final draft.

Competing Interests: None declared.

Ethics approval: The University of Lethbridge Human Subjects Research Committee gave Human Subjects Research Approval for the research project "Seniors and gambling: Towards a better understanding" on December 10, 2001.

Funding: We gratefully acknowledge direct funding for this project provided by the Alberta Gaming Research Institute. GN and BH are employed as faculty members with the School of Health Sciences, University of Lethbridge. RW is employed as the Alberta Gaming Research Node Coordinator at the School of Health Sciences, University of Lethbridge.

Gary Nixon, PhD, is an associate professor in the School of Health Sciences and Addictions Counselling program coordinator. Gary is a counselling psychologist with interests in existential, transpersonal, and developmental approaches to counselling and psychotherapy. His research and publications in addictions lie in the areas of seniors, second stage recovery, quantum change, ego-transcendence, narrative therapy, and phenomenological-hermeneutics. E-mail: Gary.nixon@uleth.ca

Jason Solowoniuk, BHSc, is a masters student in the Counselling Psychology program at the University of Lethbridge. He has a special interest in psychoanalytic and object-relations approaches to psychotherapy as well as phenomenological-hermeneutics. He is currently conducting research on gambling archetypes for his masters thesis as well as being involved with a number of other gambling research projects. E-mail: Jason.solowoniuk@uleth.ca

Brad Hagen, RN, PhD, is currently an associate professor in the School of Health Sciences, where he teaches in both the Nursing and the Addictions Counselling programs. Brad's current clinical and research interests lie in the broad areas of mental health and gerontology, and he has recently been involved in a variety of research projects investigating the use of psychotropic medications in nursing homes, problem gambling among seniors, advanced practice nursing, and family care-giving with frail elders, among others. When not working, Brad enjoys the mountains of southern Alberta and northern Montana—hiking, climbing, and avoiding ticks and grizzly bears. E-mail: Brad.hagen@uleth.ca

Robert Williams, PhD, is a professor in the School of Health Sciences at the University of Lethbridge. He is a clinical psychologist by training and was the regional psychologist for Manitoba Health and Family Services (Thompson region) from 1986 to 1996. From 1996 to 2001, he was both a clinician and a researcher at the Addiction Centre, Foothills Medical Centre, in Calgary, Alberta. In January 2001, Dr. Williams accepted a faculty position at the University of Lethbridge. He has published in the areas of seasonal affective disorder, fetal alcohol syndrome,

adolescent addictions, and problem gambling. His current research mandate is the study of gambling. E-mail: Robert.williams@uleth.ca

issue 14 — september 2005

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (129 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 31 pages.]

Clients' perspectives of, and experiences with, selected Australian problem gambling services

Alun C. Jackson, The University of Melbourne and University of Melbourne/La Trobe University Gambling Research Program, Melbourne, Victoria, Australia.
E-mail: aluncj@unimelb.edu.au

Shane A. Thomas, The University of Melbourne and University of Melbourne/La Trobe University Gambling Research Program, Melbourne, Victoria, Australia.

Abstract

Although there continues to be interest in documenting the evidence base for problem gambling interventions, little has been published on service users' perspectives on services provided to them. To gain a greater understanding of this issue, group interviews were held with present and past users of two services in Victoria, Australia—the government-funded state-wide Gambler's Help program and the privately funded self-help Free Yourself Program. Service users articulated a range of views about factors leading to the propensity to gamble, causes of problem gambling, the action that they would take to protect problem gamblers, the effectiveness of self-exclusion from venues, the features of a good problem gambling counselling service, unhelpful service characteristics, and the issue of abstinence or control as desired endpoints of intervention. Key words: problem gambling services, client perspective, service design

Introduction

Although there is continuing interest in documenting the evidence base for problem gambling interventions (National Centre for Education and Training on Addiction, 2000; Blaszczynski, 1993; Petry & Armentano, 1999; Lopez Viets & Miller, 1997; Oakley-Browne, Adams, & Mobberly, 2001), little has been published on

clients' perspectives on what makes for an effective problem gambling service, although this would be generally acknowledged, we believe, as important information for program planners and evaluators to have. Unfortunately, even when clients' views of services are sought, they too often come from a narrow "satisfaction" perspective, without adequate recognition of the conceptual and methodological problems that attach to the concept of satisfaction (Pekarik & Wolff, 1996; Forbes, 1996; La Sala, 1997).

This paper presents data from two focus groups held with clients of Gambler's Help, a state-wide problem gambling counselling service, and one with clients of Free Yourself, a self-help organisation in Melbourne, Australia.

Problem gambling service models

The approach taken to treating gambling-related problems at the level of the individual and family is determined by the view taken of the causes of problem gambling. Broadly speaking, there are three main schools of thought that have dominated discussion about the causes and consequent required treatment of problem gambling: the medical model, the behavioural model, and the cognitive model (Petry & Armentano, 1999).

The medical model sees problem gambling as an addiction akin to alcohol and substance dependence, as a compulsion, or as an impulse-control disorder, each of which must be treated by interventions appropriate for an illness, with the goal being abstinence from all gambling (Hollander, Buchalter, & De Caria, 2000; Bianco, Moreyra, Nunes, Saiz-Ruiz, & Ibanez, 2001; Wedgeworth, 1998).

The behavioural model, on the other hand, interprets problem gambling as a learned behaviour, motivated and/or reinforced by the personal experiences and social context of the gambler. As with any other problem of behaviour, the treatment focus is on unlearning bad habits and learning how to minimise the harm arising from gambling through controlled gambling (Petry & Roll, 2001). Abstinence, although theoretically consistent with this approach, is not usually specified as an endpoint. Cognitive theories of gambling suggest that problem gambling behaviours are maintained by irrational beliefs and attitudes about gambling.

Theories of gambling behaviour cover the realm of biological, sociological, and psychological perspectives. Most theories, however, have focused on only one aspect of gambling behaviour. More recently, there has been a move towards taking an eclectic approach to explaining the development, maintenance, and

persistence of gambling behaviour (Blaszczynski & Silove, 1995). This eclecticism, in turn, is increasingly reflected in problem gambling intervention models.

There is now a broad range of interventions in use, as well as a growing number of multimodal treatment programs that utilise a range of different therapeutic techniques and strategies. Treatment programs are increasingly developing a client-centred orientation in that the needs of the client are the focus of treatment, "not the models and methods of the helper" (Egan, 1994). This paradigm shift reflects an appreciation of the multifaceted nature of problem gambling behaviour.

To date, a great deal of the treatment literature has described clinical trials of various methods of intervention or efficacy studies, which in a lot of cases have not been systematically translated into treatment programs (Blaszczynski & Silove, 1995). Furthermore, of those established treatment programs that are described in the published literature, very few are accompanied by controlled effectiveness studies (Jackson, Thomas, & Blaszczynski, 2003).

The study undertaken by the U.S. National Gambling Impact Study Commission (1999) supports this. They concluded that few studies exist that measure the effectiveness of different treatment methods, and those that do exist "lack a clear conceptual model and specification of outcome criteria, fail to report compliance and attrition rates, offer little description of actual treatment involved or measures to maintain treatment fidelity by the counsellors, and provide inadequate length of follow-up" (National Gambling Impact Study Commission, 1999, pp. 4–15).

In attempting to make judgements about what constitutes best practice from a programmatic perspective, we need to recognise that the problem gambling treatment literature has also been dominated by theoretical and nonempirical studies, weakening the possibility of generalisation to different populations (Ciarrocchi & Richardson, 1989) or different sites of service delivery. As pointed out by Blaszczynski (1993), problems associated with sample selection have also restricted the ability to generalise across specific subgroups of gamblers.

Evaluating the appropriateness of various treatment programs—for whom, at what level of problem intensity, for what type of problems, for what types of gamblers, in what mode of service delivery—is further complicated by the fact that there are "no internationally established models of best practice in existence" (Elliott Stanford and Associates, 1998).

Although there is a growing number of reviews of best practice in

problem gambling services (National Centre for Education and Training on Addiction, 2000; el-Guebaly & Hodgins, 2000; Jackson, Thomas, & Blaszczynski, 2003), there are few reported studies that explicitly address the views of clients of problem gambling services on what constitutes good practice and that draw attention to the frames of reference that these clients use to explain gambling behaviours and interventions. This paper is an attempt to make a contribution to this area.

Problem gambling services used by these clients

As noted earlier, the people interviewed for this study used the Gambler's Help program and the Free Yourself Program. The Victorian government implemented and developed a Problem Gambling Services Strategy from 1993, primarily through the Department of Human Services. Through the strategy, two sorts of services were established:

- problem gambling counselling services, including those that are integrated with financial counselling services, and
- a range of counselling and support services addressing family issues which may have arisen as a result of problem gambling through the establishment of state-wide family skills and regional family resource centres.

The strategy comprised a number of important and interrelated components as well as the counselling services. These included the appointment of gaming liaison and community education officers in each Department of Human Services region; a range of community education initiatives and media campaigns; a free, 24-hour telephone counselling and referral service; and a social research and evaluation program to provide information regarding problem gambling in the community and inform appropriate service responses.

Developments in the service model in recent years have seen a rebranding of the original BreakEven Problem Gambling Counselling Service as Gambler's Help and the G-Line telephone counselling service as Gambler's Helpline. Financial counselling was integrated into the Problem Gambling Services Strategy in 2000–2002, while discretionary funds were introduced in 1999–2000 and fully implemented by 2000–2001. The Gambler's Help services have been extensively reviewed and documented (Jackson, Thomas, Thomason, Borrell, Crisp, Enderby, et al., 2000; Jackson, Thomas, Thomason, Borrell, Crisp, Ho, et al., 2000; Thomas & Jackson, 2001). A variety of theoretical models underpin the delivery of counselling services within Gambler's Help as the counsellors within the service choose which approach they will take

with clients and how they will design client interventions. In a study by Jackson, Holt, Thomas, and Crisp (2003), the range of counselling and intervention approaches used in Gambler's Help is described and indeed the variety of approaches used served as a stimulus for the development of a tool designed to document the tasks undertaken as part of the counselling function. Thus, there is no single approach taken in Gambler's Help, but there are service standards and funding and service agreements in place that serve to ensure that minimum standards of professional practice are observed in the delivery of services. The service is free to all users as the Victorian Government funds all the Gambler's Help services.

Free Yourself, the self-help program included in the study, is described by its creator (Byrne, 1999) as a positive, holistic, proactive, and effective approach to helping people deal with problem gambling. The program is based on an addictions framework with an abstinence goal and aims to provide strategies that people can use "in the moment" when the urge to gamble threatens to become overpowering.

Based on neurolinguistic programming, a major strategy taught in the program is for people to learn to become aware of the "split" that occurs when a person develops a gambling problem, with one part wanting to give up the behaviour while the other part wants to continue the behaviour. The Free Yourself Program places a lot of emphasis on how to win what is described as an "internal war" that takes place before the person engages in the gambling behaviour. The use of specific language patterns is designed to help people take back control of the part of themselves that does not want to stop gambling. As a holistic intervention, the Free Yourself Program also incorporates the positive effects of diet, exercise, and meditation or prayer, as well as exercises to strengthen what the program describes as the "willpower muscle."

The program was designed by Gabriela Byrne, following over four years of problematic poker machine play, which had lead to employment, financial, and relationship problems, as well as suicidal ideation. She developed the program following her use of a range of conventional therapy approaches such as Gamblers Anonymous, counselling, and hypnotherapy in an attempt to create a total lifestyle-based intervention. The program includes

- individual sessions with a facilitator qualified in the Free Yourself Program;
- group support sessions, providing support for people using the Free Yourself Program;
- telephone counselling, supplemented with the Free Yourself

Program workbook;

- the Free Yourself Program workshop, involving a seminar held over four weeks (two hours per week) teaching the Free Yourself Program strategies to people directly or indirectly affected by problem gambling;

- the Free Yourself Program Facilitator Training (four-hour) Workshop.

After the four-week workshop, participants are encouraged to start a new group. In addition to training people who have directly experienced gambling-related problems, the facilitator workshop is designed to integrate the program into existing interventions and is thought to be suitable for psychologists, social workers, psychotherapists, ministers, family lawyers, medical practitioners, youth workers, etc., who are involved in helping people with a gambling-related problem.

In addition, the program has established a restaurant and entertainment facility in a suburb of Melbourne to provide a supportive alternative venue for those not wishing to use venues with gambling facilities.

Methods

Group interviews were carried out at Gambler's Help offices and at the Free Yourself offices, with a total of 19 people in three groups, with members including, in the case of the Gambler's Help clientele, people attending established group work sessions, and in the case of the Free Yourself clientele, people who responded to an invitation to join the discussion group. The Free Yourself group was formed by the Free Yourself Program on the basis of invitations to program participants chosen to reflect the diversity of clients of this service. Similarly, one of the eighteen Gambler's Help services servicing a large urban and rural fringe catchment area recruited two groups of clients and ex-clients to participate in the focus group discussions. Once again, the participants were chosen to reflect the diversity of clients of this service.

Interview questions used to guide discussion in the groups were as follows:

- What do you think affects a person's wish to gamble?

- What would make someone go from being a regular gambler to being a problem gambler?

- If you ran things, what would you do to better protect problem gamblers?
- Do you have experience of self-exclusion, and does it work?
- What are the features of a good problem gambling service?
- Do current problem gambling services give you what you need?
- Is the aim of your involvement with a problem gambling program abstinence or controlled gambling?

Qualitative data in the form of detailed information provided by clients of Gambler's Help and the Free Yourself Program in the three group discussions were formed into categories and analysed thematically (Cresswell, 1994). According to Patton (1990), there are two ways to represent the patterns emerging from analysis of such data. First, the analyst can use the categories developed and articulated by the people studied to organise the presentation of particular themes. Second, the analyst may also become aware of categories or patterns for which the people studied did not have labels or terms, and the analyst may develop terms to describe these inductively generated categories. In this study, broad categories were suggested by the structure and purpose of the group interviews, while subthemes emerged from the data.

From detailed reading of the group interview transcripts, themes were identified until a point was reached where no new categories of behaviour could be identified. This is akin to the theoretical saturation of Glaser and Strauss (1967). The following themes and subthemes emerged with, inevitably, some overlap between them:

- propensity to gamble;
- causes of problem gambling:
    - heredity or family background,
    - personality type,
    - early wins,
    - escape,
    - issues for women;

- actions clients would take to protect problem gamblers:
    - leisure- and entertainment-based strategies,
    - venue-based strategies,
    - elimination of gambling advertising,
    - advertising gambling help services;
- self-exclusion;
- features of a good problem gambling service:
    - availability of group work as an intervention,
    - a range of demand-driven services,
    - staffing,
    - interventions, particularly early intervention,
    - residential option;
- service elements found to be unhelpful;
    - waiting times to see counsellors,
    - seeming irrelevance of explanations;
- abstinence or control.

These themes are discussed in more detail below.

Propensity to gamble

In discussing their propensity to gamble, some participants expressed their enthusiasm for the excitement associated with the act of gambling:

> Some people just love it. They love the adrenalin rush.

Others described the act of gambling as involving an escape from the circumstances of everyday life:

> I just love it because I love turning off from the world.
>
> You blank everything out.

Some participants described their participation in gambling as being precipitated by crises or difficulties in other areas of life:

> It wasn't really the money for me; it was crisis sort of for me. At the time I was seeing a girl and pretty involved and stuff and so when you're pretty involved you tend to let friends drift away a little bit so when I broke up with her my friends were sort of a bit distant and it was like, "Where do I go; what do I do?" and I just sort of went to the club. So it was somewhere to drink and stuff and I put a few coins in and then...
>
> Maybe you get a crisis and something happens and bang you play it to get through the crisis.

For others, propensity to gamble was a function of a complex array of reasons, such as boredom and desire to escape from anxiety or problems of loneliness. Some of these reasons were purely instrumental (but unrealistic):

> Trying to gain wealth to cover bills and that you think you can make up extra money.
>
> Get rich quick.

Causes of problem gambling

Participants offered a range of reasons why people may develop gambling problems. These reasons included the issue of *heredity or family background*:

> I grew up with it: family—mother, father, grandmother, uncle. You lived it and breathed it. It is hereditary in some people. I will go to my grave believing in that.

Although there was quite a lot of disagreement about *the role of personality* in causing problem gambling, and whether such a thing as an addictive personality existed and explained problem gambling for some people, one male problem gambler was in no doubt about the validity of this sort of explanation:

> Well honestly in my situation I think that looking back at myself I am a compulsive person in a lot of regards. When I play sport I am full at it when I work I am full at it and it was a matter of time when I was introduced to gambling that I took the same attitude that I had with my work and my normal life and I just went at it full ball. And it is different to your work because it is devastating because financially it ruins you. In my case I believe it

> my compulsive attitude towards when I pursue something I like I am full on.

Another member of this group commented about the addictive potential of gambling:

> You get hooked. It is the love of getting hooked. It's a stupid thing but it is reality for some people.

Early wins and also large wins were cited by some participants as a cause of subsequent problematic play:

> I used to work in the railways and I used to watch everyone else put fifty dollars, and it used to make me sick and I'm thinking, "Oh they're crazy," but I put five dollars in one day and all of a sudden I won fifty dollars. This was about twelve years ago.… That's what got me—how easy is this; everybody can do it, you don't have to work again.
>
> That's what happened to me too. I won four hundred dollars and I was hooked—boom just like that.
>
> I know when I had this first big win I got such an adrenaline rush and I had all these people standing around me this machine went for forty-five minutes.

Gambling to escape as a feature of problem gambling rather than routine gambling was mentioned by other clients:

> In my case it wasn't money like it is different I felt like it distracted me from the world out there and I basically wanted that feeling again because I won big at times and it was never enough you know if I won big I wanted more and I wanted more of that feeling. I felt like I was like a drug addict wanting a fix that's how I felt.
>
> That's what takes over after a while though isn't it you know the initial win might be the thing that starts you going um but then it is lots of other things take over, you know, especially I live by myself just me and the dog and it's boredom you having a lousy day lots of things happen in my life. I went through lots of grief issues. It's a great way of hiding; it's a great way of having company that you don't have to talk to anybody if you don't want to.
>
> So you know there's a lot of aspects to it you know that gradually take over and then it becomes a miserable

> existence because you keep going. It's horrible.

A number of clients noted that *gambling venues being a safe place for women* may encourage them to go there rather than other entertainment venues:

> It's a safe place to go for women. You could have sort of stayed in a public bar but for us it wouldn't have been quite safe.

> When I was growing up I was told that women never went to pubs alone and this particular night changed everything—the night we went from bingo to the pokies machine. I thought, "Oh you can come to hotels without having a man; oh that's wonderful," and that's what set it off for me.

> You know guys don't latch on to you like if you go to a public bar and you have a drink on your own. Can you imagine—they pounce! It's great no one talks to you but I feel really sad for women cause women haven't really got places to go on your own whereas a guy can go to a pub and just mix in and talk crap to other blokes but women...

Actions clients would take to protect problem gamblers

When asked what they would do to protect problem gamblers if "they ran things," the participants suggested a range of strategies. These included *leisure- and entertainment-based strategies*, including provision of better youth services and provision of entertainment venues with a larger range of leisure opportunities:

> I think that the whole attitude towards entertainment should change and … we need to look at it and say, "Hey we need entertainment venues. People don't want to do another arts and craft class, you know; we want to have fun but we've got to go somewhere where it is safe," and look at really changing the attitude of venues and emphasise the ones that have no pokies. Make them advertise … that women are welcome you know we have live music at lunch time you know things like that would make a difference.

Venue-based strategies included banning all gaming venues, reducing the number of venues, getting rid of all electronic gaming machines (EGMs) in venues, removing automatic teller machines (ATMs) from venues, restricting opening hours, removing note acceptors, reducing the number of lines and credits that can be

played on an EGM, slowing the rate of play on machines, and training venue staff to identify problem gamblers and remove them:

> A lot of the staff who work at the casinos probably know who the problem gamblers are. I don't know if they know all of them but I think they should know some of them. In a way there has got to be some way. I know it is just the first step if people who have a problem with gambling don't have complete access to these places until they have somehow dealt with their problems.

A variant of venue-based strategy mentioned by a small number of people with on-course track-based gambling problems was simply to reduce the opportunity to gamble by reducing the number of race meetings held.

Other suggestions included better practices regarding provision of cheques for paying winnings:

> If you have a large win and you are waiting on a cheque they will take up to twenty-five minutes for that cheque and in that twenty-five minutes you can lose half of what is on that cheque. Because they say they have got to go out to the safe and get a chequebook and wait for the manager to come in and pay you so in that delay you have had a rush from a high win so you keep playing on another machine and you can give up to half of it back. So that is a ploy that they are using to get half their money back. Because to me you walk out to the safe and collect the chequebook and write the cheque it doesn't take twenty minutes.
>
> Sometimes you can't get it until the next day.

Clients were, by and large, cynical about the possibility of meaningful regulatory change aimed at limiting gambling opportunity, the time spent in venues, and money spent, because of the reliance on gambling taxation by the state government:

> But you would never convince the government because they are getting about twenty percent every week.
>
> They don't want to know because they are getting so much kickback from it all.
>
> They will never be banned.
>
> They say people should give up cigarettes but the government is never going to cut it out completely; they

> get too much revenue.

Reduction or elimination of gambling advertising was mentioned as a strategy, already shown to be effective in other areas such as tobacco:

> I don't think they should advertise it at all. And we talk about the Quit campaign for cigarettes—I am a smoker. Okay, that is my personal belief and if I want to do it it is my business but I honestly believe. You are not allowed to advertise cigarette smoking on TV, newspapers; it is supposed to be our big health problem we have got but as we spoke about before they are never going to ban it because the government make too much money out of it. And honestly I certainly believe and as someone said before we are all here for the same reason, we have all got a gambling problem whether it be big, small, or otherwise. I think it is irrelevant to what someone has lost or won or whatever. I just think they shouldn't be able to advertise it.

Advertising of counselling services was mentioned, particularly with materials available in restrooms as in HIV and other blood-borne disease materials:

> And what I was saying too is maybe, you know, when that lady left her child in a car [at a venue] and it died and now on the back of each toilet door it says you can't leave children unattended. That's great but what if they had like, five forms of different gambling cards and brochures. When they have a gambling card [advertising a problem gambling service] it's normally near the gambling counter where you get your money and you feel like a right goose, "Oh I'll have twenty dollars of ones," and trying to grab the card with fifteen people behind you. That's pretty embarrassing stuff so if you had them in the toilet—all five on the back of the doors.

Group participants also suggested providing more advertising to encourage people to seek help early:

> There was one brilliant ad on television about a young apprentice kid who started gambling when he was 18 and all his mates were going out and he wouldn't go with them and he lost all his money and then he started stealing money from his workmates. That was a great ad; that was brilliant.

> If there is to be any advertising or forewarning it has got to be harsh it has got to be similar to the TAC [Transport Accident Commission] ads—graphic. And the fact is I remember watching a show in America about where they took in these problem juveniles into prisons and they exposed them to life-sentenced prisoners and these kids come out and they changed their mindset straight away because these blokes in there were in for triple murders, rape, this and that and they said, "Look you come in here and you will be my little boy and you won't like it." The same thing with gambling … Expose us to someone that says, "Listen this is the stark reality and don't joke around with it. This is what is going to happen to you."

Self-exclusion

There was considerable doubt expressed as to the worth of *self-exclusion* from gambling venues by participants:

> I self-excluded myself for the very first time in six months from half a dozen but then I found my little car could travel further. So then when that time was up I would go up and got to a wider area. I self-excluded myself three times over a period of eighteen months.

> Well there was two times that I have been into a place purposely. They didn't recognise me. They didn't notice. But there was one occasion where they did recognise me. They said, "Oh I am sorry I thought the self-exclusion stopped last week."

> I self-excluded a long time ago from the [venue] but that had zero effect. I went back hundreds of times after that and I didn't really care ... There was a very low chance of being caught.

> They did actual research on this they had someone that was excluded from eight venues and they took the person to the eight venues and on seven out of eight there were no questions asked.

Interestingly, a number of clients suggested that because of perceived problems with enforcement, the deterrent value of self-exclusion was primarily psychological, and its appeal was a matter of personality:

> Well I kind of took it that um ah as a deterrent. Even though you could go and do it I said to myself I am

banned. Psychological.

[Q: Did you try to get in?]

No I haven't.

It is a personality thing. It wouldn't be right for me.

Features of a good problem gambling service

Not surprisingly, many of the group participants, having experienced Gambler's Help, Gamblers Anonymous, and other programs such as Free Yourself, had strong opinions on what features they wished to see in a problem gambling service, drawing on their positive and negative experiences of these services.

Group work and contact with other problem gamblers through this group experience and in individual counselling was highlighted by a number of participants:

Being involved in a group and a one-on-one service. Being able to come to the group and being an equal with everyone.

We are all here for the same reason.

Oh I think being around people that are like you they have the same problems as yourself.

They don't judge you.

You don't judge them but you worry about them in a caring way.

And talking about it and understanding and you are not on your own.

I think the most important thing you see new people come into the group and it is always the same story and it doesn't change. It doesn't get far off track but that central way of thinking how they were all introduced and the kick start and then the habit so and when you see new people come in after you have been here for six months or six years it is all the same situation.… I will be damned if I want to sit around for many more years doing this but I really appreciate the effect that I get from these groups because of the fact that that reinforces each time.

Many of the Free Yourself participants noted the benefits of working in a "therapeutic/commercial" restaurant and "alternative space" enterprise:

> It is just the spirit of the whole thing and the people that you are working with have the same problem as you. We just love to work together we have a lot of fun.
>
> But it is good because there are days when I have come in and I feel like.... They know here I am either talking my head off or I am quiet. And usually when I am quiet I am either mad or I have just been to the pokies the day before or something and I have come in and just blown X amount of dollars and then I come in and say, "I went to the pokies last night." And they are not like nongamblers, "I don't get it. I think you are an idiot." But these guys say, "How are you doing now? Do you want to talk about it? Do you want to have a coffee? Do you want to keep busy? I know what it is like." A big hug you feel all safe and you can open up.
>
> We know they are not judging.
>
> Yeah there is no pointing and judging.

It was noted by some clients that a useful service was one that provided *a range of services to meet changing demand and acute demand*, particularly citing the usefulness of the Gambler's Helpline:

> You have got the helpline which gives you 24 hour access. And sometimes that is good in the middle of the night or late at night. Odd hours when you are not counsellors are available it has been good [sic].
>
> I rang the 1-800 number last week and last Monday no Sunday last week and the girl who answered the phone spoke to me for over half an hour. I found it pretty encouraging because at the time I was pretty low and pretty flat because my problem has just come to a head in just the last week and I found it was really good. I came here today on a one-on-one session this morning and I found it very draining when I left. I was fine when I was going through it and I went out and sat in my car for ten minutes before I could drive away and I felt absolutely drained. And I just think it is really great that this is available to people and I find the 1-800 number was really good for me last week. I rang them on Sunday and also again on Monday. I found them really

> good.

Other clients thought that the extension of this idea to incorporate 24-hour one-on-one counselling would be useful:

> I personally think the 1-800 number is great a lot of things happen late at night. You can't tell me there is no money out there a lot of people put a lot of money into gambling there should be a one-on-one 24 hours a day seven days a week. That you could go somewhere and speak to someone face to face if you didn't want to speak to [the Helpline]. Sometimes I can't get on the phone late at night because I have got my husband in the other room. Because we are not good I can't do it. I have that problem when I am at the beach sitting by myself and it would be good to talk to someone. Instead of going to a venue or going to the beach and thinking stupid things I think it would be good to have a 24 hour service one on one and you can't say that the money isn't there.

Another suggestion, following the establishment of a counselling service at Crown Casino, was extending this idea into the community:

> And also having these at the venues would be fantastic too. Having a counselling person at the larger venues. It might not be feasible for all of them, but if you were there and you suddenly realised it was getting out of hand you could actually go and see a counsellor.

Participants had strong views on who should *staff* the problem gambling services:

> It's got to be someone who's been there.
>
> There's absolutely no doubt about it 'cause they know how you tick; they know how you think; they know your next step right before you even know it and that's the best thing about Free Yourself. Gabby [Gabriela Byrne] has been there so she knows your next step. She's one step ahead of you all the time and to me that's the most important thing.

Although we understand this sentiment, it is obviously impractical to ensure that problem gambling services are staffed by people who have experienced problem gambling firsthand. What we understand people to be saying is that they expect counsellors to know the cognitive, affective, and behavioural aspects of problem

gambling and to respond sensitively to their clients with respect for the meaning of lapse and relapse and for the struggle to change.

Clients endorsed a multimodal approach to the provision of *interventions*, again, in some cases emphasising the relevance of training or experience of counselling staff:

> I think that the ideal service would sort of combine a lot of approaches to find out like an initial interview stage. I really think it would be great to have a lot of people who have been there done that to get that rapport going. But, I mean, where we're lacking here is in general that there are underlying issues that they are not trained to deal with, you know, and I believe to work together with professionals to be able to combine the academic approaches with self-help's passionate support—I think that's where an ideal service would go to.

Group members, as seen in the quote above, endorsed a service model that addresses those issues that many see made them vulnerable to gambling in the first place but also returned to the question of counsellor competence:

> It could also be like one of the things like you just said, you know, the night before your husband's funeral ... so there was grief involved there. With me there was grief issues involved. You can't cope anymore. I lost five family members in three years and enough was enough so it [EGM venue] was a great place to bury myself.
>
> So I think probably most people would agree. I mean, that's pre-gambling. I mean that's something I guess you feel you would want to address; have an opportunity to do that. So I guess that's where a professional counsellor type person could be of use, couldn't they?
>
> And it has to be a very well checked out person because a friend of mine has just gone through a horrendous experience with a counsellor so you have to be able to have a person that has a good reputation and is associated with the counselling academy and all the rest of it; not somebody that does a few courses and hangs up a shingle.

Other clients noted their preference for continuity of staff and the ability of staff to work with individuals with gambling problems as well as other family members, either singly or conjointly.

A small number of group participants argued strongly for the establishment of a *residential treatment facility* (there is no publicly funded residential program for problem gamblers in the study jurisdiction at present):

> All these services—come for half an hour, come for an hour, and stuff like that you know. I am not at rock bottom at the moment but some people are at rock bottom and plenty of people don't even come to these groups. We have an addiction and that is why we are here and maybe we need to look at these services needing to be expanded into like we've got for drug rehabilitation. You go for three weeks' or a month's time; you go into a centre and you spend your time and you face the problem. You are not put into temptation. You know even in three weeks, like you feel good. You feel great. Three weeks I haven't had to hit the pub but the temptation is right in front of you. And maybe we need to look at programs that are a month-long program, in-house, staying somewhere in like an addiction.
>
> But as I see it I think you need to be able to do when you do decide that you need help. I think you need to get it pretty quick.
>
> It is also to the point where, alright, if you did have those programs there would be so many wait lists for those too I am sure. But I am just saying if you did have those programs on offer to go and live in … I know when I hit the bottom rung you have got the support of some of your friends and you haven't got the support of some of them. It is a real mix of who you have got the support from. But you need that support professionally as well.

Service elements found to be unhelpful

A number of group participants were concerned with identifying service elements that they found unhelpful. These included, in contrast to those who were very positive about the Helpline, the perceived failure of the Gambler's Helpline on some occasions to offer appropriate assistance:

> Get someone on there who has some idea of what they are talking about and don't go, "Well you've got to figure out why you gamble. Would you like to speak to a counsellor?" Well if I knew why I gambled I wouldn't go out and gamble again and there I am thinking I'm going

> to get sympathy and some sort of help and she's going, "Why do you gamble? You've got to figure what's missing in your life and you filled it in with gambling." Oh, there we go. How easy is that? Obviously I'm missing [deceased husband] so therefore knowing that, I won't gamble.
>
> I was really annoyed because I'd just spent a thousand dollars I was in tears and this lady on the phone I think had obviously had no idea.

It would seem that for some of these clients Gambler's Helpline was seen as a crisis line and not simply a means to receive counselling through a different modality, that is, by telephone rather than face-to-face. We have commented elsewhere (Jackson, Thomas, Thomason, Borrell, Crisp, Enderby, et al., 2000) on the need to clarify the purpose of telephone help lines, and, if these clients' views are representative of the expectations that many people have of Gambler's Helpline, then it is clear that such a clarification still needs to be made and sold to the intended clients of such a service.

There was concern about *waiting times to see counsellors*, with clients believing Gambler's Help should be an "on-demand" service:

> But I had a counsellor, a local counsellor, and I used to have to ring him and beg for an interview. I mean he didn't make an appointment to say come back and where we'll talk more about it and to see how you are going. He left it with me and said, "Ring me when you need me," and when I tried to get him he couldn't see me for a month.

In discussion of specific interventions, there was a view expressed by some people about the *seeming irrelevance of explanations about the odds of winning*:

> Gamblers Help, okay? In the end I threw my hands in the air and I thought, "What help am I getting?" All he gave me was a list of figures like, you know. My mind was racing, "How am I going to cope?" I didn't want to look at all these figures. I mean yes they had bearing on it but I wanted him to talk to me to try to find out what I was doing. I didn't get that help. Then I went to Gamblers Anonymous and that was even worse!

Abstinence or controlled gambling

Most members of the groups suggested that *abstinence* was the goal of their help-seeking:

> I want to give it up totally.
>
> Go in there and not want to do it.
>
> I don't think you can keep it under control. Your addiction is there or the problem as you might call it. You couldn't go back and just put five dollars in.
>
> As far as the pokies are concerned I don't think I could possibly go a little bit and not worry about it taking over. I have never heard of anyone with problems just going a little bit and having it under control.

A small number, however, thought that while abstinence might be the ultimate goal, *controlled gambling* was a possible and desirable intervention goal:

> When I was gambling I didn't have any plan about it. I was thinking that you had to give up altogether. But I think that sometimes some people can probably do it with a strategy. They can control it. I think it is possible to do that.
>
> I know that I could go to a venue now and know that I could put money in and I don't think it would bother me in the slightest. But I don't want to. I have just lost the whole thing about it.
>
> I mean, even bingo! I love bingo and I say I am never going to give up bingo but I haven't been this year. But I know that I can go; I have a choice but it is not like, "No I can't go." I have a choice, and I really learned from doing the program that I have a choice. In what I can do and what I want to do. My real choices. If I chose to go to bingo I will go. It is not going to rule my whole life and my family's life if I go to bingo a couple of times a year.
>
> Oh it has been at least three months since I gambled last but it hasn't been much of a problem in the last two months roughly. I mean I have gambled but it hasn't been an obsession to the same extent that it was before although I have gambled too much. But I guess the actual difference it has made to my life is the fairly obvious thing to say, I suppose, is that gambling can easily become the worst problem. I know in my life I have got a few problems but gambling easy becomes

> the worst and by not gambling in the last few months and by it not being the kind of obsessional problem it's been the last couple of years, I guess it means I have got one less problem in life and it also allows me to focus more on other things.

Others suggested that a mixed strategy of control and abstinence was also possible:

> To try and give up the addiction you have got but not give up gambling. Because Tattslotto can be classed as gambling and I still play Tattslotto so what I want to give up and have so far succeeded in is horse racing.
>
> My problem was the pokies but at the same time I was probably a bit out of control with the horses as well. I have been able to just cut that back anyway. I used to go up every Saturday and have bets all over the joint and things like that I only bet now in the Spring carnival.

The consequences of not beating their problem gambling

As part of the discussion on abstinence and control, a number of group participants made the case strongly for why it was worth it to them to give up gambling:

> Can I say just quickly for me it is pretty simple? It is cutthroat because if I keep going I destroy my relationship, I destroy myself financially, I lose respect in the workplace which means I am no longer employable—I have become unemployable because the word gets around.
>
> I think when you gamble you become a "gonna." I am gonna do this and I am gonna do that and it just got to the stage, and I feel almost angry talking about it; there was so many things that I wanted to do by this stage that I haven't done and I guess there is anger. There is the shame of what I have done but also the anger that yeah I was going to do this that and the other. I don't think that it has gone but it is still there.

Discussion

This study has demonstrated the richness of data, readily available from service users, which may be used both as a quality assurance measure in terms of perceived impact of interventions and as a guide to determining whether the program design, in terms of the service model, theory of problem causation, and theory of

intervention, is understood and endorsed by the service users. However, it is acknowledged that the participant numbers in this study were modest and, although they were chosen by the services as being representative of their client groups, it is certainly the case that they were not randomly selected. Although there are many issues raised by the study, we wish to highlight three elements: the broad issue of what clients believe makes for a good problem gambling service, the use of regulatory strategies such as self-exclusion, and the issue of controlled gambling.

What makes for a good problem gambling service?

One of the main issues raised in the group discussions of what makes a good problem gambling service is that it be demand driven and be seen as relevant to client needs. The ability to see a counsellor for individual sessions at a time determined by the client was seen as a prerequisite for a service to be considered accessible. Many participants endorsed the notion of a multimodal approach to interventions, although in this cohort, there seemed to be little support for cognitive-only interventions, which some participants saw as mistakenly assuming that their problem gambling behaviour was a product of faulty thinking or knowledge. Rather, they were aware that there were multiple and complex pathways into gambling (Blaszczynski, 2002) and that problem gambling services should be able to work with precursor issues such as bereavement, loss, and change as well as what they saw as symptomatic gambling behaviour.

Another issue was the presence in the Gambler's Help service of people who had experienced gambling problems themselves. We have already noted that it is impractical to staff problem gambling services solely with people who have experienced gambling problems firsthand. Perhaps this issue could be addressed by the use of a peer education or peer counselling approach. For example, groups could be jointly led by a problem gambling counsellor and a person with direct personal experience of the problem.

The use of regulatory strategies: The case of self-exclusion

A recent review of self-exclusion programs in Victoria (O'Neil et al., 2003), the jurisdiction in which the clients in this study have predominantly gambled, noted the Productivity Commission's (1999) view that even within the limitations of existing self-exclusion programs, they are, overall, a useful adjunct to responsible gambling policies. O'Neil et al. concluded, along with Nowatzki & Williams (2002) and Ladouceur et al. (2000), that when properly implemented, self-exclusion can be valuable in helping to curb problem gambling:

In behavioural terms, self-exclusion can be a valuable tool because, by preventing the commencement of a session (theoretically), it is preventing engagement with gambling cues that could easily become a temptation to return to old gambling patterns. Again, a critical determinant of effectiveness is the ability/success in prevention of commencement. (O'Neil et al, 2003, p. 35)

O'Neil et al.'s (2003) study concurs with the clients in the present study in their assessment of self-exclusion programs that while they appeal to some and may be useful in efforts to maintain abstinence, their potential seems to be undermined by implementation design issues and the problems associated with enforcing bans from multiple venues rather than the single-venue casinos reported in the literature. The wide availability of gambling venues and opportunities poses significant challenges to self-exclusion of determined individuals.

Controlled gambling

Although self-exclusion is based on an abstinence model, and many of the clients in this study endorsed an addiction/abstinence model of gambling, a number of clients supported the concept of controlled gambling or a mixed abstinence/control strategy to address their gambling behaviour, particularly where this involved multiple forms of gambling, or what we might term 'polygambling.' It is important to note, if this treatment goal of control were to be adopted, that Rankin (1982) and others (Greenberg & Rankin, 1982; Baucum, 1985; Blaszczynski, 1988) have questioned the validity of regarding episodes of relapse as indicative of treatment failure without adequately taking into account frequency or intensity of gambling characteristic of such relapse episodes. Individualised and nuanced endpoints have to be the norm in this approach.

Perhaps contrary to expectation, controlled gambling does not appear to increase the probability of relapse into uncontrolled gambling. This was demonstrated in an Australian treatment outcome study on 63 of 120 pathological gamblers on whom data were successfully obtained. Blaszczynski, McConaghy, and Frankova (1991) classified eighteen abstinent gamblers into two groups; those reporting complete abstinence and those abstinent with intermittent relapse episodes over the follow-up period. Relapse was defined as an episode of, or period of, excessive gambling accompanied by a subjective sense of loss of control. The mean number of reported relapses was 1.89. Prolonged periods of abstinence were regained after lapses. Results indicated that both groups improved significantly on posttreatment psychological and sociodemographic measures and did not differ from each other. Russo, Taber, McCormick, and Ramirez (1984) similarly found 21% of their sample who reported abstinence in the

month preceding the follow-up interview had earlier experienced gambling lapses without resurgence of pathological gambling behaviour patterns. Lapses may be beneficial in enhancing the learning process of identifying and subsequently coping with or avoiding situational and emotional determinants leading to gambling relapse (Blaszczynski et al., 1991).

Rosecrance (1989) has expressed a somewhat different view of controlled gambling and rejected the medical model of gambling in favour of the notion that problem gambling was the expression of poor gambling strategies in play. He offered an interesting and highly innovative alternative to clinical management, a controlled gambling treatment program, which placed reliance on active gamblers in the mode of peer counsellors. The primary aim of his approach was to replace defective with sensible gambling strategies learnt through exposure to those tactics employed by experienced gamblers. While no empirical evaluation of such an approach has been undertaken, Rosecrance went on to provide anecdotal evidence of its efficacy.

Given this limited evidence base and its apparent appeal to some clients in this study, it would be good to see some methodologically sound controlled gambling intervention studies undertaken in a variety of service settings such as Gambler's Help as well as in the more clinically oriented inpatient and outpatient settings.

Conclusion

This study of service users' perspectives of their experiences and expectations of two Australian problem gambling intervention programs has indicated that such service users are able to articulate a wide range of views relating to the aetiology of problem gambling, including issues such as trigger factors in the progression from social gambling to problem gambling. In addition, these service users have presented a number of challenges to service providers:

- Can agencies offer both control and abstinence as goals to accommodate the varied expectations and desires of problem gambling clients?

- How can problem gambling counsellors solicit trust and confidence in them by clients without gaining legitimacy by having directly experienced problem gambling themselves? This is obviously not an issue unique to this clientele (it is common in health and human services), but this desire has been strongly expressed by these groups of service users.

- How can gambling-specific counselling services work with

other service providers, if possible, to provide early intervention when people are showing early signs of vulnerability to gambling problems occasioned by other life events such as loss and bereavement?

Although it is based on modest participant numbers, the present study shows the benefits of obtaining consumer feedback on problem gambling services. It does, however, need wider replication with larger systematically chosen study samples. It would also be interesting to extend the focus from the present study of evaluation of experiences of existing programs to wider issues, such as why and how service users choose to seek help and then which programs to access to obtain that assistance.

References

Baucum, D. (1985).
Arguments for self-controlled gambling as an alternative to abstention. In W.R. Eadington (Ed.), *The gambling studies: Proceedings of the sixth national conference on gambling and risk taking* (Vol. 5, pp. 199–204). Reno, NV: University of Nevada, Reno.

Bianco, C., Moreyra, P., Nunes, E.V., Saiz-Ruiz, J., & Ibanez, A. (2001).
Pathological gambling: addiction or compulsion? *Seminars in Clinical Neuropsychiatry, 6* (3), 167–176.

Blaszczynski, A.P. (1988).
Clinical studies in pathological gambling: Is controlled gambling an acceptable treatment outcome? Unpublished doctoral dissertation, University of New South Wales, Australia.

Blaszczynski, A.P. (1993).
Juego patologico: una revision de los tratamientos. *Psicologia Conductual, 1*, 409–440.

Blaszczynski, A.P. (2002).
Pathways to pathological gambling: Identifying typologies. *Journal of Gambling Issues: eGambling,* Issue 1, 14pp. Available: http://www.camh.net/egambling/issue1/feature/

Blaszczynski, A.P., McConaghy, N., & Frankova, A. (1991).
A comparison of relapsed and non-relapsed abstinent pathological gamblers following behavioural treatment. *British Journal of Addiction, 86* (b), 1485–1489.

Blaszczynski, A.P., & Silove, D. (1995).
Cognitive and behavioural therapies for pathological

gambling. *Journal of Gambling Studies, 11* (2), 195–220.

Byrne, G. (1999).
Free Yourself Program: A way out of the gambling trap. Melbourne: Gabriella Byrne.

Ciarrocchi, J., & Richardson, R. (1989).
Profile of compulsive gamblers in treatment: Update and comparisons. *Journal of Gambling Behaviour, 5* (1), 53–64.

Cresswell, J.W. (1994).
Research design: Qualitative and quantitative approaches. Thousand Oaks, CA: Sage Publications.

Egan, G. (1994).
The skilled helper. A problem management approach to helping (5th ed.). Pacific Grove, CA: Brooks/Cole.

el-Guebaly, N., & Hodgins, D. (2000).
Pathological gambling: The biopsychological variables and their management—Interim report. Edmonton, AB: Alberta Gaming Research Institute.

Elliot Stanford & Associates. (1998).
Evaluation of the gamblers rehabilitation fund final report. Adelaide: Department of Human Services.

Forbes, D. (1996).
Clarification of the constructs of satisfaction and dissatisfaction with home care. *Public Health Nursing, 13* (6), 377–385.

Glaser, B., and Strauss, A. (1967).
The discovery of grounded theory. Chicago: Aldine.

Greenberg, D., & Rankin, H. (1982).
Compulsive gamblers in treatment. *British Journal of Psychiatry, 140*, 364–366.

Hollander E., Buchalter A.J., & De Caria, C.M. (2000).
Pathological gambling. *Psychiatric Clinics of North America, 23* (3), 629–642.

Jackson, A.C., Holt, T.A., Thomas, S.A., & Crisp, B.R. (2003).
Development of an instrument for the analysis of problem gambling counselling practice. *International Gambling Studies, 3* (1), 67–87.

Jackson, A.C., Thomas, S.A., & Blaszczynski, A. (2003).
Best practice in problem gambling services. Melbourne: Gambling Research Panel.

Jackson, A.C., Thomas, S.A., Thomason, N., Borrell, J., Crisp,

B.R., Enderby, K., et al. (2000).
Longitudinal evaluation of the effectiveness of problem gambling counselling services, community education strategies and information products—Volume 1: Service design and access. Melbourne: Victorian Department of Human Services. Available: http://www.problemgambling.vic.gov.au

Jackson, A.C., Thomas, S.A., Thomason, N., Borrell, J., Crisp, B.R., Ho, W., et al. (2000).
Longitudinal evaluation of the effectiveness of problem gambling counselling services, community education strategies and information products—Volume 2: Counselling interventions. Melbourne: Victorian Department of Human Services. Available: http://www.problemgambling.vic.gov.au

La Sala, M. (1997).
Client satisfaction: Consideration of correlates and response bias. Families in society. *The Journal of Contemporary Human Services, Jan./Feb.*, 54–64.

Ladouceur, R., Jacques, C., Giroux, I., Ferland, F., & Leblond, J. (2000).
Analysis of a casino's self-exclusion program. *Journal of Gambling Studies, 16* (4), 453–60.

Lopez Viets, V.C., & Miller, W.R. (1997).
Treatment approaches for pathological gamblers. *Clinical Psychology Review, 17* (7), 689–702.

National Centre for Education and Training on Addiction (NCETA) (2000).
Current 'best practice' interventions for gambling problems: A theoretical and empirical review. Melbourne: Victorian Department of Human Services.

National Gambling Impact Study Commission (1999).
(Chairman, Kay C. James) Washington D.C. Available: http://www.ngisc.gov/reports/fullrpt.html

Nowatzki, N., & Williams, R.J., (2002).
Casino self-exclusion programmes: A review of issues. *International Gambling Studies, 2*, 3–25.

O'Neil, N., Whetton, S., Dolman, B., Herbert, M., Giannopoulos, V., O'Neil, D., et al. (2003).
Evaluation of self-exclusion programs. Melbourne: Gambling Research Panel.

Oakley-Browne, M.A., Adams, P., & Mobberly, P.M. (2001).
Interventions for pathological gambling. *Cochrane Database of Systematic Reviews*, Issue 4. In *The Cochrane Library*, 4,

2001. Oxford: Update Software. Abstract available: http://www.cochranelibrary.com/Abs/ab001521.htm

Patton, M.Q. (1990).
Qualitative evaluation and research method. London: Sage Publications.

Pekarik, G., & Wolff, C.B. (1996).
Relationship of satisfaction to symptom change, follow-up adjustment, and clinical significance. *Professional Psychology: Research and Practice, 27*, 202–208.

Petry, N.M., & Armentano, C. (1999).
Prevalence, assessment, and treatment of pathological gambling: A review. *Psychiatric Services, 50* (8), 1021–1027.

Petry, N., & Roll, J. (2001).
A behavioral approach to understanding and treating pathological gambling. *Seminars in Clinical Neuropsychiatry, 6* (3), 177–183.

Productivity Commission (1999).
Australia's Gambling Industries. Report No. 10. Canberra: AusInfo.

Rankin, H. (1982).
Control rather than abstinence as a goal in the treatment of excessive gambling. *Behaviour Research Therapy, 20*, 185–187.

Rosecrance, J. (1989).
Controlled gambling: A promising future. In H.J. Shaffer, S.A. Stein, B. Gambino, & T.N. Cummings (Eds.), *Compulsive gambling: Theory, research and practice* (pp. 147–160). Lexington, MA: Lexington Books.

Russo, A.M., Taber, J.I., McCormick, R.A., & Ramirez, L.F. (1984).
An outcome study of an inpatient treatment program for pathological gamblers. *Hospital and Community Psychiatry, 35* (8), 823–827.

Thomas, S.A., & Jackson, A.C. (2001).
Longitudinal evaluation of the effectiveness of problem gambling counselling services, community education strategies and information products—Volume 6: Project discussion paper. Melbourne: Victorian Department of Human Services. Available: http://www.problemgambling.vic.gov.au

Wedgeworth, R. (1998).
The reification of the 'pathological' gambler: An analysis of gambling treatment and the application of the medical model

to problem gambling. *Perspectives in Psychiatric Care, 34* (2), 5–13.

This article was peer-reviewed. Submitted: March 12, 2003. All URLs were active at the time of submission. Accepted: May 27, 2005.

For correspondence: Professor Alun C. Jackson, PhD, School of Social Work, The University of Melbourne, Victoria, 3010, Australia. Phone: 613 8344 9402; fax: 61 3 9347 2496; e-mail: aluncj@unimelb.edu.au

Contributors: AJ and ST were the principal investigators on the research program from which this paper was derived. They conceived the study, carried out searches and extracted data. They jointly wrote the initial and final drafts of the paper.

Competing interests: None declared.

Ethics approval: Data collection and analysis was carried out as part of a publicly tendered research project awarded by the Victorian Gambling Research Panel, and ethics approval was deemed by the GRP to be not needed.

Funding: This project was funded by the Community Support Fund, a hotel electronic gaming machine tax, administered by an independent board through a grant to the Gambling Research Panel, which commissioned this research through a public tender process. The grant was administered through Melbourne Enterprise International.

Alun C. Jackson, PhD, is professor of social work at the University of Melbourne; Co-Director of the University of Melbourne /La Trobe University Gambling Research Program; adjunct professor in Public Health, La Trobe University; a fellow of the Murdoch Children's Research Institute, and a fellow of the Centre on Behavioural Health, University of Hong Kong. He has been involved in the design and direction of many large-scale research programs including: an evaluation of the Victorian Gambler's Help service, an assessment of the health and mental health effects of gambling on women, an analysis of best practice in treatments, a study of the impact of gambling on children and adolescents, a review of prevalence measures, and the design of practice standards. He has also worked with the Australian Institute for Gambling Research on a range of studies with state governments relating to prevalence, service design and the design of industry-specific and whole of industry responsible gambling policies. E - mail: aluncj@unimelb.edu.au

Shane A. Thomas, PhD, is professor in the School of Public Health at La Trobe University, co-director of the University of Melbourne /La Trobe University Gambling Research Program and is a director of Thomas and Associates. He has been involved in the design and direction of many large-scale research programs including an evaluation of the Victorian Gambler's Help service, an assessment of the impacts of gambling on specific cultural groups; an analysis of best practice in treatments; a study of the impact of gambling on children and adolescents; a review of prevalence measures; and the design of practice standards. The author of Introduction to research in the health sciences, and Clinical decision making for nurses and health care professionals, Professor Thomas is an international authority in research and evaluation methodology and in particular the development and validation of measurement tools. E-mail: ShaneThomas@bigpond.com

issue 14 — september 2005

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI.* To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (149 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 20 pages.]

Youth gambling: A public health perspective

Carmen Messerlian & Jeffrey L. Derevensky, McGill University, Montreal, Quebec, Canada. E-mail: carmen.messerlian@mcgill.ca

Abstract

Over the last decade research in the area of youth gambling has led to a better understanding of the risk factors, trajectories and problems associated with this behaviour. At the same time, governments have begun to recognize the importance of youth gambling and have offered to support research and treatment programs. Yet, public health and prevention in the realm of youth gambling has only recently drawn the attention of researchers and health professionals. Early work by Korn and Shaffer (1999) set the groundwork for a public health approach to gambling. This paper attempts to apply health promotion theory to youth gambling and describes a conceptual framework and model. Strategies focus on addressing risk and protective factors through community mobilization, health communication, and policy development. It is anticipated that this paper will provide future directions and serve as a starting point for addressing youth gambling issues from this new perspective.

Introduction

The study of gambling and gambling-related problems among youth has become increasingly important to researchers and health professionals alike. Although research in the field of gambling is still in its infancy, work over the last decade suggests that youth gambling problems are a serious concern, with more young people gambling today than ever before. However, only recently has gambling emerged as a significant public health issue (Korn & Shaffer, 1999) despite the growing trend and the associated negative health, psychological, social, financial, and personal consequences. There is concern that without a concerted focus on

understanding and preventing problems among those most vulnerable, the burden of problem gambling among youth will persist.

With the continuous expansion of the gambling industry worldwide, more gambling opportunities and types of gambling exist today than in the past. With this increased exposure, more adolescents, already prone to risk-taking, have been tempted by the lure of excitement, entertainment, and potential financial gain associated with gambling. Research from North America and internationally suggests that approximately 80% of adolescents have participated in some form of gambling during their lifetime (see reviews by the National Research Council, 1999, and meta-analysis by Shaffer & Hall, 1996). While there has been some debate over the prevalence of problem gambling in youth (for a complete discussion of the methodological issues surrounding youth gambling see Derevensky & Gupta, 2004, and Derevensky, Gupta, & Winters, 2003), considerable research supports the claim that approximately 4%–8% of adolescents between 12 and 17 years of age gamble at a pathological level, and another 10%–15% are at risk of developing a serious problem (Derevensky & Gupta, 2004; Derevensky et al., 2003; Hardoon & Derevensky, 2002; Jacobs, 2000; National Research Council, 1999).

The consequences faced by youth with gambling problems are widespread and have an impact on psychological, behavioural, social, legal, academic, and family/interpersonal domains. Delinquency and criminal behaviour, poor academic performance, early school dropout, disrupted family and peer relationships, suicide, and other mental health outcomes such as anxiety and depression have been associated with gambling problems in adolescents (Derevensky & Gupta, 2004). Youth gambling problems, therefore, affect not only individuals, but families, communities, and health services as well as society at large (Crockford & el-Guebaly, 1998; Korn, 2000).

Movement towards public health

While governments worldwide have embraced the revenues associated with gambling, concern over the growing burden of gambling to individuals and society has stimulated discussion of gambling as a social and public health policy issue (Wynne, 1997). Early work by Korn and Shaffer (1999) laid the foundation for a public health approach to gambling problems in the general population. They discussed the growth of the gambling industry and the concomitant increase in gambling problems. Korn and Shaffer highlighted the importance of creating awareness among health professionals; suggested a public health framework that examines the issue from a population health, health promotion, and

human ecology perspective; and proposed an agenda to strengthen policy, research, and practice. They further argued the need to assess and document the social costs and possible benefits of the impact of gambling upon communities.

More recently, Shaffer (2003) has outlined four guiding principles underlying a public health perspective suggesting that: (1) empirically based scientific research act as the foundation for any public health action; (2) public health knowledge be derived from population-based observations; (3) health initiatives be proactive and include both primary and secondary prevention; and (4) public health models be unbiased and consider both the costs and potential benefits. Others have argued that traditional gambling paradigms that frame gambling as an act of individual freedom and merely a form of recreation fail to recognize the social and economic impact of gambling (Korn, Gibbons, & Azmier, 2003). Korn and his colleagues assert that public policy on social issues is very much influenced and directed by the way in which it is framed. They maintain that a public health perspective is best suited to address policy issues, as it accounts for the multitude of factors involved in gambling; as such, this approach allows for a more complete debate on the issues. However, they caution that moving toward a public health approach may be difficult as there are a number of barriers to embracing this paradigm, including the fact that existing frameworks are currently nested within well-established political and corporate interests.

From Think Tank and beyond

The idea of developing a public health agenda prompted the Second International Think Tank on Youth Gambling, sponsored jointly by the International Centre for Youth Gambling Problems and High-Risk Behaviors, McGill University, and the Division on Addictions, Harvard Medical School, and held in Montreal in 2001. Sixty-three delegates—representing researchers, treatment providers, prevention specialists, government, and the industry—from nine countries gathered to identify and prioritize critical issues needed to address the development of an international public health approach toward youth gambling. Participants identified several key issues that were most critical to responding to youth gambling from a public health perspective. They also recommended action steps for each of the issues identified.

Definitions

Delegates initially agreed that the key terms of any discussion of problem gambling among youth should be carefully defined from an international perspective. They also noted that there was difficulty in engaging in dialogue on youth gambling when the definition of *youth* varies broadly between cultures. Further, there was

agreement that the term *problem* is commonly used in association with youth gambling; however, there existed little empirical knowledge of the nature or extent of problems that were derived from youth gambling. As well, the group concluded that the definition of problem varied depending on the framework. For example, adopting a medical model rather than a public health model alters the definition significantly. Delegates remained concerned that the term *gambling* needed to be defined more explicitly, as different forms of gambling were thought to have different connotations and perceived risks. For example, government-sanctioned, legal, and regulated gambling may differ from social gambling occurring in a home environment. They urged the need to consider all these factors when formulating a definition of gambling. Participants strongly agreed that little is known about what constitutes *normal* or *responsible* gambling among youth, and the language of normality influences and affects definitions of abnormal or disordered gambling. Overall, participants agreed that in order to formulate a consistent dialogue across cultures, some consensus over terminology, nomenclature and language was necessary.

Raising Awareness
Delegates further emphasized the lack of awareness of youth gambling problems as a public health issue and the limited sense of responsibility among individuals, organizations, professionals, decision makers, the public at large, and youth themselves. They recommended that carefully planned and empirically sound public awareness campaigns be implemented.

Funding
Think Tank delegates noted that available funding for research was limited. There existed a need to identify appropriate sources of international funding required to achieve the goals of an international public health initiative, and that such sources be sustainable over a period of time. Participants also agreed that an international governance structure be established, and they highlighted the importance of creating a future agenda and ways of disseminating information and research.

Youth Involvement
Participants perceived that the success of developing a public health agenda required the engagement of youth in the process. They noted that programs developed with input from young people are more likely to be effective, and that this process helps facilitate commitment among youth.

More Research
Lastly, participants felt strongly that considerably more scientific research was needed in several areas in order to support the development of an international public health agenda on youth

gambling. These areas included: (1) the psychological, physiological, familial, societal, and cultural factors associated with problem gambling; (2) common risk and resiliency factors linking gambling with other addictive and high-risk behaviours; (3) the gap between youth and adult prevalence data of gambling problems; (4) the effects of gambling advertising upon youth; (5) the impact of increased accessibility of all forms of gambling upon youth gambling behaviour in general and disordered gambling in particular; 6) the impact of new technologies upon youth gambling; and (7) the need for facilitating empirically-based research on therapeutic and prevention programs.

Significant progress has been made in several areas since the Think Tank gathering, most notably in new areas of research (see Derevensky & Gupta, 2004, for our current knowledge concerning youth gambling and gambling-related problems). As well, several ongoing studies are being conducted at the International Centre for Youth Gambling Problems at McGill University. A recent study examined the relationship between several risk and protective factors associated with problem gambling, substance abuse and other risk behaviours among 11- to 19-year-olds. Specifically, this research examined the relationship between family cohesion, school connectedness, coping, achievement motivation, and mentor relationships, and the development of health-compromising outcomes, namely, gambling, substance abuse, and multiple risk-taking behaviours (Dickson, Derevensky, & Gupta, 2003). Another study, presently in the data analysis phase, is investigating risk and resiliency factors, and cultural issues related to youth gambling among 12- to 17-year-olds.

The proliferation of on-line gambling poses a new problem for youth (Messerlian, Byrne, & Derevensky, 2004). Research by Griffiths and Wood (2000) has highlighted the ease with which gambling Web sites may be accessed by young people as well as the visually enticing aspects of Internet gambling. Given the paucity of research in the area of new technologies, the Centre is presently conducting an exploratory study examining Internet gambling practices among youth.

While there are some methodological issues involved in the measurement of pathological gambling in youth, a recent paper by Derevensky et al. (2003) explored these issues and acknowledged the need for more rigorous research and more refined measurement instruments and screening tools. They further argued that the field must move quickly to resolve nomenclature and definition concerns. Currently, a national effort in Canada is underway to develop new adolescent screening tools to help better identify youth gambling problems.

The Centre is also involved in a study examining the ease of

gambling access, proximity of gambling opportunities to schools, and the risk of gambling problems among high-schools students in Quebec. Dr. David Korn from the University of Toronto, through funding from the Ontario Problem Gambling Research Centre, is currently examining the effects of gambling advertising on youth. As well, a recent review of the literature examined the efficacy of using media-based programs as prevention initiatives (Byrne, Dickson, Derevensky, Gupta, & Lussier, 2003). There have been very few studies that have empirically and systematically evaluated treatment programs, primarily due to the limited number of youth who present for therapy for gambling problems (Gupta & Derevensky, 2004; Hardoon, Derevensky & Gupta, 2003). Additional research is needed in all of these areas in order to better understand the risks to youth, and the development of effective prevention (Derevensky, Gupta, Dickson, & Deguire, 2001) and treatment programs (Gupta & Derevensky,2004; Rugle, Derevensky, Gupta, Winters, & Stinchfield, 2001).

Other developments have been made in the area of awareness since the Think Tank. In 2003, the National Council on Problem Gambling sponsored an inaugural National Problem Gambling Awareness Week in collaboration with the Association of Problem Gambling Service Administrators, and local organizations throughout the United States. Each state was involved in implementing its own state-wide campaign titled "Hope and Help" which aimed to increase public and professional awareness of problem gambling issues and the availability of services to assist those affected by problem gambling behaviours. The Ontario Ministry of Health in Canada also recently funded a provincial campaign titled "Within Limits." Campaigns were tailored to the needs of each community and included information brochures, local newspaper inserts, posters, and awareness booths displayed at malls. The Responsible Gambling Council of Ontario is charged with evaluating this awareness initiative and hopes to disseminate the campaign to more communities in 2005.

Some action has also been taken in developing an international governance structure through contact with the World Health Organization (WHO). Given the barriers to penetrating such a large organization, the McGill International Centre has recently developed significant collaboration with the Pan American Health Organization, the Americas' office of the WHO, as an initial starting point. This partnership stimulated the formation of a Task Force of researchers and clinicians from North and South America. The Task Force's objective is to examine and address high-risk behaviour among Latin American youth.

With the hope of understanding the "teen" perspective on gambling, several groups have developed Web sites with the assistance and collaboration of adolescents. In Canada,

"youthbet.net" was created with input by youth; teens form part of the committee that oversees the implementation of the program. Similarly, in the U.S. "wannabet.org" has been very successful in engaging youth in the development of a Web site and other prevention initiatives. Employing a junior editor and several youth advisors on their team, these youth are responsible for the illustration of characters, writing of articles, and designing of the online and paper-based magazine. Involving youth in the development and implementation of programs is slowly becoming part of on overall approach to prevention.

A public health framework for youth

A public health framework incorporates a multi-dimensional perspective, recognizes the individual and social determinants, draws upon health promotion principles and applies population-based models. Several proposed theories and models as they relate to youth gambling are highlighted in the following sections (for a fuller account see Messerlian, Derevensky, & Gupta, 2005).

It is now well accepted that the degree of potential consequences of problem gambling in youth, similar to adults, can be measured along a continuum of gambling risk (Korn & Shaffer, 1999; Messerlian et al., 2005). Individuals who gamble infrequently, or in a low-risk manner, have few, if any, negative outcomes. At this level, Korn and Shaffer (1999) suggest that some people derive a degree of pleasure, enjoyment, or benefit. Healthy gambling encompasses informed choices concerning the probability of winning, pleasurable gambling experiences in low-risk situations, controlled gambling (the ability to set and adhere to appropriate limits) and understanding the potential risks involved in excessive gambling (Derevensky, Gupta, Messerlian, & Gillespie, 2004).

As gambling escalates and one moves along the continuum of gambling risk, the negative outcomes begin to outweigh any potential benefits. As a result, adolescent gamblers begin experiencing a wide array of impaired personal, health, financial, and social consequences. The at-risk gambler, while not meeting all the criteria for pathological gambling, is nevertheless experiencing a number of gambling-related problems. This group remains at greater risk than the low-risk social gambler but is considerably better off than those with significant gambling problems (sometimes referred to as pathological gamblers, probable pathological gamblers, disordered gamblers, compulsive gamblers, or Level III gamblers). Youth on this end of the continuum, who gamble at the pathological level, meet established diagnostic criteria and are in need of therapeutic treatment. A public health model incorporates a range of prevention and harm reduction strategies as well as treatment interventions targeted at

different levels of risk.

The Youth Gambling Prevention Model (Messerlian et al., 2005) (see Figure 1) illustrates this continuum, as well as primary, secondary, and tertiary prevention intervention points, related prevention objectives at each level of risk, and the recommended health promotion strategies required to achieve the objectives. This model is unique in that it delineates two trajectories; the risk continuum and the prevention pathway. The latter moves in the opposite direction and aims to reverse the risk at every level along the continuum; strategies aim to impede the progression at each stage along the range of risk. The model also links clusters of health promotion strategies to prevention objectives, however, the authors suggest tailoring and implementing each strategy to the specific needs of communities or groups.

In addition, Messerlian et al. (2005) have applied an ecological health promotion model to youth gambling and maintain that problem gambling is governed by a complex set of interrelating factors, causes, and determinants: biological, familial, behavioural, social, and environmental. An ecological approach to health behaviour views gambling behaviour from multiple perspectives. Originally proposed by McLeroy, Bibeau, Steckler, and Glanz (1988), an ecological health promotion model focuses on addressing health behaviour from both an individual and socio-environmental level; strategies are directed at shifting intrapersonal, interpersonal, institutional, community, and public policy factors. It is the interaction of these five factors that determines one's predisposition to developing a gambling-related problem (Jacobs, 1986). An ecological perspective on gambling emphasizes moving beyond offering problem gamblers treatment and counselling; instead, interventions work at modifying all five levels within this multi-dimensional model.

Intrapersonal and *interpersonal* level factors have been the focus of considerable research, treatment, and prevention programs in the past. There is extensive research outlining the many intrapersonal risk factors, as well as the effects of parents, peers, and family on the acquisition, development, and maintenance of gambling problems (for a review of the substantial empirical research outlining risk factors and correlates see Derevensky & Gupta, 2004). However, more research is needed to better understand the role of community factors such as civil/local organizations, social norms, socio-economic variables, and the media in shaping social identity, norms, values, beliefs and behaviours regarding gambling. The aetiology of gambling behaviour and gambling problems, although still not fully understood, includes the interaction of biological, psychosocial, and environmental factors.

Institutional structures, regulations, and policies can either promote

or hinder health behaviour and outcomes. The gambling industry's policies/practices concerning the development of products and venues, their promotion and sale, and the enforcement of existing legal statutes prohibiting access to minors remain important determinants of gambling participation and behaviour. Yet, there is evidence that retailers and venue operators fail to properly enforce such statutes (Derevensky & Gupta, 2001). Furthermore, some school practices may unwittingly be promoting gambling through fundraising activities including lottery/raffle draws and casino nights, and through permitting card playing within schools. These institutional factors can be viewed as targets for change; they can be challenged and modified to help create healthy organizational culture and practices.

Public policy factors related to gambling intersect a number of different policy domains including the social, educational, health, economic, legislative and judicial. Governments around the world continue to control and regulate gambling in a manner that promotes and sustains economic benefits. Governments have sought various means to bolster the economy, reduce deficits, and increase revenues (Campbell & Smith, 1998). Changes in the level of economic security have resulted in governments becoming dependent upon revenues generated by the gambling industry, and governments are now reluctant to change regulations in favour of progressive public health policies. Applying political economy theories to gambling, Sauer (2001) maintains that gambling expansion has been driven by the need for larger governments to generate greater revenue. Legislation on advertising and promotion, laws regulating minimum age-requirements and their enforcement, provision of programs for harm minimization, fiscal measures, and regulation of the availability of products are examples of public policy initiatives that can influence the social environment and minimize unhealthy behaviour. Clearly, however, policies need to balance public health interests with the economic gains to governments and the industry.

Moving from levels of action to goals, a public health approach to youth gambling must work at establishing and realizing overall goals in order to guide action along the spectrum of issues. Denormalization, protection, prevention, and harm reduction have been applied to a public health and youth gambling framework (Messerlian et al., 2005) and together describe the aims of an overall approach.

Denormalization aims to implement strategies that encourage society to question and assess underage gambling. Not unlike the strategies used in tobacco prevention, denormalization can include drawing attention to the marketing strategies employed by the gambling industry, influencing social norms and attitudes on youth gambling, promoting realistic and accurate knowledge about

gambling, and challenging current myths and misconceptions among youth and the general public.

Society has a shared responsibility to protect children and adolescents from potentially harmful activities such as access to and exposure to gambling. This goal as applied to youth gambling should aim to protect youth from exposure to gambling products and promotion through effective institutional policy and government legislation, and reduce the accessibility and availability of all forms of gambling to underage youth. Further, efforts to protect youth from the direct and indirect marketing and advertising of gambling products and venues is required.

Prevention efforts should be targeted at the primary, secondary, and tertiary levels. While much of the focus has been on tertiary prevention, or treatment-based interventions, primary and secondary prevention reach larger numbers of youth, and have potential for a much broader impact. Prevention objectives should aim to increase knowledge and awareness of the risks of gambling among youth, professionals, and the general public; promote informed decision-making in individuals and families; increase the early identification and treatment of youth experiencing gambling problems or at risk of developing them; help youth develop effective problem-solving, coping, and social skills required for healthy adolescent development; and minimize the harm of gambling problems in youth, their families, and communities.

Harm Reduction is an approach to prevention that is directed at reducing the problem behaviour. In general, harm-reduction strategies target youth already gambling and those at risk. Harm-reduction objectives should reduce the risk of developing a gambling problem among youth who gamble in an at-risk manner, and decrease the potential negative consequences of gambling among youth without necessarily making abstinence a goal (see Dickson et al., 2003, for a discussion of the harm minimization approach as applied to youth gambling).

Strategies for public health action

Raising awareness and increasing knowledge of the risk and consequences of underage gambling among adolescents, parents, school personnel, health professionals, and the general public are important initial steps in primary prevention and may help achieve denormalization goals. Evidence suggests that professionals, parents, and the general public fail to view gambling among youth as a serious problem (Derevensky, Gupta, Hardoon, Dickson, & Deguire, 2003). Implementing health promotion strategies such as health education in schools and health communication within communities can help improve the level of public awareness and

knowledge of the hazards of gambling in a young population.

Health communication campaigns have been one of the most widely used vehicles in educating the public about risk behaviours (Brown & Walsh-Childers, 1994). By disseminating persuasive information on unhealthy behaviours to the public and portraying it as an important public issue, mass communication strategies have the potential to influence social norms and attitudes regarding that behaviour (Byrne et al., 2003; Yanovitzky & Stryker, 2001).

Effective public health action is most often formulated with an appreciation of the history of each community, and is appropriate within the local context (e.g., approaches in North America may differ from those in Australia). Strategies that seek to educate and empower communities may help bring gambling issues to the forefront of the public policy agenda. Tones's model of health promotion proposes that community health education helps set the public health agenda and raises critical consciousness of health issues (Tones, 1993; Tones, Tilford, & Robinson, 1990). This critical consciousness raising may empower and enable individuals and groups to be more active in community health issues. Furthermore, involving community groups in the development of programs and the policy-making process may help mobilize action and may create pressure and support for policy changes. However, these measures are effective only when they form part of an integrated approach, which includes healthy public policy (Tones, 1993).

Organizational development can include working with health services in order to develop or improve the delivery of treatment and prevention care to youth, partnering with the education system/schools in order to implement school-based prevention programs, and forming a collaboration with the gambling industry itself. The latter approach includes, but is not limited to, developing policies and programs offering information to retailers on legal liabilities, and on the importance of enforcing the legal age, all of which help increase barriers for underage youth trying to gamble. Furthermore, strategies that advocate for the development of global industry standards regulating the promotion and marketing of gambling products and venues in light of research suggesting that youth are adversely affected by advertising tactics (Griffiths, 1999, 2003; Felsher, Derevensky, & Gupta, 2004) would be another example of effective organizational development within the gambling industry.

Policy development approaches focus on the social and political factors that facilitate or impede behavioural choice, aiming to remove structural barriers to health-protective action and constructing barriers to risk-taking (Campbell, Wood, & Kelly, 1999). Policy measures that create supportive environments can

be effective in that they enable youth to change their own behaviour rather than persuading them to change (Tawil, Verster & O'Reilly, 1995). For example, the age of onset of gambling behaviour represents a significant risk factor; the younger the age of initiation the greater the risk of developing a gambling-related problem (Gupta & Derevensky, 1997, 1998; Jacobs, 2000; Wynne, Smith, & Jacobs, 1996). Increasing the age of first exposure to gambling participation by limiting the accessibility and availability of gambling products, venues, and activities, and raising the legal age, are important regulatory policy development issues. However, most importantly, without the development of policies that cultivate environments supportive of behaviour change, education programs at any level will likely not be effective (Campbell et al., 1999).

Responsible social policy

The expansion of gambling is a global phenomenon. The rise of new and existing forms of gambling will continue to grow worldwide, given the lucrative revenues generated for government coffers and for the industry itself. However, the proliferation of the industry and of its ensuing profits has not been without reproach. Anti-lobbying and public-interest groups have tried, albeit mostly unsuccessfully, to curtail the growth of gambling venues in communities and limit the development of new forms of gambling. Others, mainly public health professionals and social scientists, have argued for a more careful examination of the costs and consequences of gambling expansion and for weighing this with any potential economic or social benefits (Korn & Shaffer, 1999; Henriksson, 2001). Gambling has therefore become an exceedingly contentious social policy issue throughout the world [see reports for the U.S. National Gambling Impact Commission (NORC, 1999), Canada West Foundation (Azmier, 2000), Canadian Tax Foundation Report (Vaillancourt & Roy, 2000), The U.K. Gambling Review Report (2001), the Australian Productivity Commission Report (1999), National Centre for the Study of Gambling, South Africa Report (Collins & Barr, 2001)].

Social policies, however, are often established by default, and gambling policy seems to be based upon a harm reduction model rather than abstinence or prohibition (see Dickson et al., 2003, for a comprehensive discussion). Effective social policy needs to be reflective of the existing ideological, social and political context from which it is derived, while concurrently directive of future impact and changes. Policy makers and legislators are urged to adopt a multidimensional perspective, and given the strong interdependence that exists between social, physical, interpersonal, cognitive, environmental, and psychological domains, they must incorporate all these elements (Cowen & Durlak, 2000). Furthermore, social policy should reflect the determinants of health and the link between individuals and

communities. This would translate into policies that indirectly target the individual through changes at the social and environmental determinants levels. These efforts can be achieved through the development of both programmatic and regulatory policies.

As the gambling industry continues to burgeon, the adoption of formal laws and regulations governing this expansion, and the establishment of regulatory bodies to monitor the enforcement of such laws as well as assess the impact of gambling upon society, remain important policy initiatives. The aim of such regulatory policies is to reduce the risk of gambling to youth by restricting access to products and services. However, policies that aim to deter youth from participating in gambling by increasing the minimum-age requirements and the price of products are only effective if there is widespread adherence and enforcement of such policies and statutes. This enforcement is contingent upon the acceptance of the implemented regulations within the community which is affected by the perceived severity of gambling problems among youth in general (Derevensky, Gupta, Messerlian, & Gillespie, 2004). A lack of awareness among retailers regarding laws and penalties, and among the public on the seriousness of gambling problems, may in fact partly account for the ease with which underage youth purchase lottery tickets in spite of legal prohibitions (Felsher et al., 2004). In addition, enforcement is problematic in countries such as Canada: the government bodies charged with the responsibility associated with a duty-of-care are often simultaneously directly or indirectly responsible for maintaining increases in revenues (Derevensky et al., 2004).

Other key policy considerations include those that contribute to the prevention of gambling problems in youth through funding commitments, and through the implementation and institutionalization of prevention practices (Pentz, 2000). Examples of programmatic policies include community education and development, training of health services professionals and the development of resources for prevention and treatment, and industry education programs targeting retailers and venue operators, all of which aim to create supportive environments as well as enhance the skills of individuals.

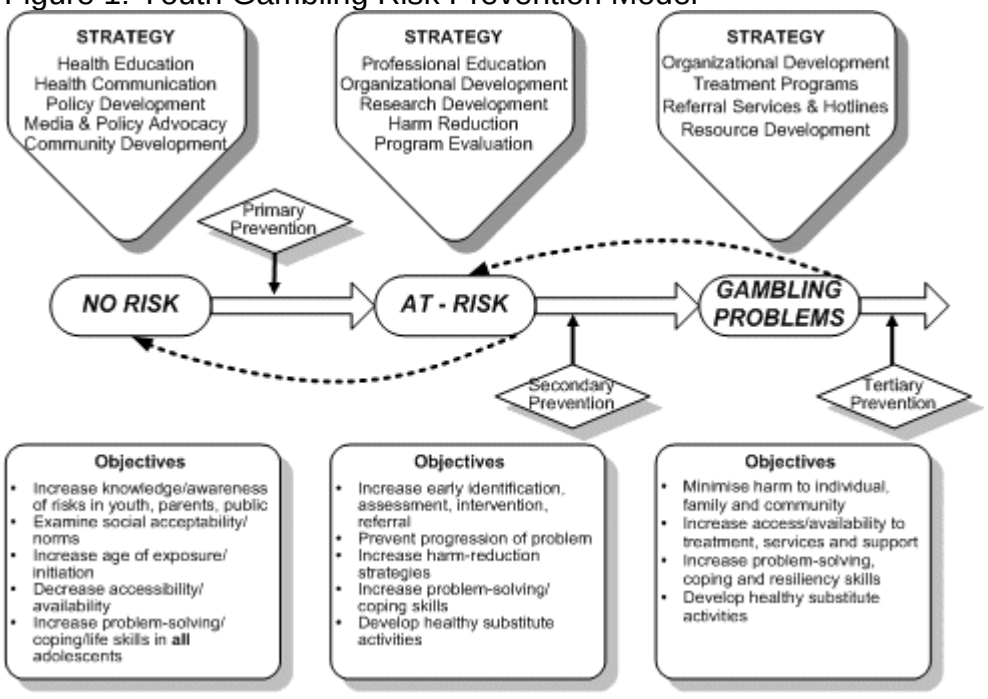
Conclusions

Since the Second International Think Tank on Youth Gambling Issues, a significant amount of research has been conducted to better understand the risk factors, trajectories, and problems associated with excessive youth gambling behaviour. While not universal, governments and the industry throughout the world have come to understand the importance of this issue and are beginning to provide greater funding for research, prevention, and treatment.

The public health model and framework described in this paper has attempted to apply health promotion and prevention theory to youth gambling. Very few strategies recommended have yet to be implemented or empirically evaluated for effectiveness. It is anticipated that this paper will provide gambling and public health professionals some direction for further work in this area and serve as a starting point for addressing youth gambling issues from this new lens. As more public health strategies become implemented, the model and theories outlined can be tested and assessed for their applicability to youth gambling.

With the increase in gaming technology and the expansion of the gambling industry, opportunities for gambling participation are abundant. This, coupled with the associated rise in the number of youth who gamble, creates the need to find effective best practices for the prevention and treatment of gambling problems. At the same time, there needs to be a greater public awareness that youth are not immune to gambling problems. Collaborative efforts between researchers, treatment providers, prevention specialists, and legislators will ultimately lead to more effective public health intervention and social policies.

Figure 1: Youth Gambling Risk Prevention Model



References

Azmier, J. (2000).
Gambling in Canada: Triumph, tragedy, or tradeoff. Canadian gambling behaviour and attitudes. Calgary, AB: Canada West Foundation.

Brown, J.D., & Walsh-Childers, K. (1994).
Effects of media on personal and public health. In J. Bryant & D. Zillmann (Eds.), *Media effects: Advances in theory and research* (pp. 389–415). Hillsdale, NJ: Lawrence Erlbaum.

Byrne, A., Dickson, L., Derevensky, J., Gupta, R., & Lussier, I. (2003).
An examination of social marketing campaigns for the prevention of youth problem gambling. Report prepared for the Ontario Problem Gambling Research Centre, Ontario.

Campbell, C. S., & Smith, G. J. (1998).
Canadian gambling trends and public policy issues. In J. Frey (Ed.), *Gambling: Socioeconomic impacts and public policy* (pp. 22–35). Thousand Oaks, CA: SAGE.

Campbell, C., Wood, R., & Kelly, M. (1999).
Social capital and health. London, U.K.: Health Education Authority.

Collins, P., & Barr, G. (2001).
Gambling and problem gambling in South Africa: A national study. National Center for the Study of Gambling, South Africa.

Cowen, E. L., & Durlak, J. A. (2000).
Social policy and prevention in mental health. *Development and Psychopathology*, 12, 815–834.

Crockford, D. N., & el-Guebaly, N. (1998).
Psychiatric comorbidity in pathological gambling: A critical review. *Canadian Journal of Psychiatry—Revue Canadienne de Psychiatrie, 43*, 43–50.

Derevensky, J., & Gupta, R. (Eds.). (2004).
Gambling problems in youth: Theoretical and applied perspectives. New York: Kluwer Academic/Plenum Publishers.

Derevensky, J., & Gupta, R. (2004).
Adolescents with gambling problems: A review of our current knowledge. *The Electronic Journal of Gambling Issues: eGambling, 10*, 119–140. Available: http://www.camh.net/egambling/archive/pdf/EJGI-issue10/EJGI-Issue10-derevensky-gupta.pdf

Derevensky, J., & Gupta, R. (2001).
Le problème de jeu touche aussi les jeunes. *Psychologie Quebec, 18* (6), 23–27.

Derevensky, J., Gupta, R., Dickson, L., & Deguire, A-E. (2001).
Prevention efforts toward minimizing gambling problems.

Paper prepared for the National Council on Problem Gambling, Center for Mental Health Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), Washington, DC.

Derevensky, J., Gupta, R., Hardoon, K., Dickson, L., & Deguire, A.-E. (2003).
Youth gambling: Some social policy issues. In G. Reith (Ed.), *For fun or profit? The controversies of the expansion of gambling* (pp. 239–257). New York: Prometheus Books.

Derevensky, J., Gupta, R., Messerlian, C., & Gillespie, M. (2004).
Youth gambling problems: A need for responsible social policy. In J. Derevensky & R. Gupta (Eds.), *Gambling problems in youth: Theoretical and applied perspectives*. New York: Kluwer Academic/Plenum Publishers.

Derevensky, J., Gupta, R., & Winters, K. (2003).
Prevalence rates of youth gambling problems: Are the current rates inflated? *Journal of Gambling Studies, 19*, 405–425.

Dickson, L., Derevensky, J., & Gupta, R. (2003).
Youth gambling problems: The identification of risk and protective factors. Report prepared for the Ontario Problem Gambling Research Centre, Ontario.

Felsher, J. R., Derevensky, J., & Gupta, R. (2004).
Lottery playing amongst youth: Implications for prevention and social policy. *Journal of Gambling Studies, 20*, 127–153.

Griffiths, M. D. (2003, September).
Does gambling advertising contribute to problem gambling? Paper presented to the World Lottery Association Conference, London, England.

Griffiths, M. (1999).
Gambling technologies: Prospects for problem gambling. *Journal of Gambling Studies, 15*, 265–284.

Griffiths, M., & Wood, R. (2000).
Risk factors in adolescence: The case of gambling, videogame playing, and the Internet. *Journal of Gambling Studies, 16*, 199–225.

Gupta, R., & Derevensky, J. (2004).
A treatment approach for adolescents with gambling problems. In J. Derevensky & R. Gupta (Eds.), *Gambling problems in youth: Theoretical and applied perspectives*. New York: Kluwer Academic/Plenum Publishers.

Gupta, R., & Derevensky, J. (1998).

Adolescent gambling behaviour: A prevalence study and examination of the correlates associated with excessive gambling. *Journal of Gambling Studies, 14*, 319–345.

Gupta, R., & Derevensky, J. L. (1997).
Familial and social influences on juvenile gambling behaviour. *Journal of Gambling Studies, 13*, 179–192.

Hardoon, K., & Derevensky, J. (2002).
Child and adolescent gambling behaviour: Our current knowledge. *Clinical Child Psychology and Psychiatry, 7*, 263–281.

Hardoon, K., Derevensky, J., & Gupta, R. (2003).
Empirical vs. perceived measures of gambling severity: Why adolescents don't present themselves for treatment. *Addictive Behavior, 28*, 1–14.

Henriksson, L., E., (2001).
Gambling in Canada: Some insights for cost-benefit analysis. *Managerial & Decision Economics, 22*, 113.

Jacobs, D. F. (2000).
Juvenile gambling in North America: An analysis of long term trends and future prospects. *Journal of Gambling Studies, 16*, 119–152.

Jacobs, D. F. (1986).
A general theory of addictions: A new theoretical model. *Journal of Gambling Behavior, 2*, 15–31.

Korn, D. (2000).
Expansion of gambling in Canada: Implications for health and social policy. *Canadian Medical Association Journal, 163*, 61–64.

Korn, D., Gibbons, R., & Azimer, J. (2003).
Framing public policy towards a public health paradigm for gambling. *Journal of Gambling Studies, 19*, 235–256.

Korn, D., & Shaffer, H. (1999).
Gambling and the health of the public: Adopting a public health perspective. *Journal of Gambling Studies, 15*, 289–365.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988).
An ecological perspective on health promotion programs. *Health Education Quarterly, 15*, 351–377.

Messerlian, C., Byrne, A., & Derevensky, J. (2004).
Gambling, youth and the Internet: Should we be concerned? *Canadian Child and Adolescent Psychiatry Review, 13* (1), 3–

6.

Messerlian, C., Derevensky, J., & Gupta, R. (2005).
Youth gambling problems: A public health framework. *Health Promotion International. 20*(1), 69-79.

National Opinion Research Center. (1999).
Gambling impact and behavior study: Report to the National Gambling Impact Study Commission. Chicago, IL: National Opinion Research Center at the University of Chicago.

National Research Council. (1999).
Pathological gambling: A critical review. Washington, DC: National Academy Press.

Pentz, M. A. (2000).
Institutionalizing community-based prevention through policy change. *Journal of Community Psychology, 28*, 257–270.

Rugle, L., Derevensky, J., Gupta, R., Winters, K., & Stinchfield, R. (2001).
The treatment of problem and pathological gamblers. Report prepared for the National Council for Problem Gambling, Center for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), Washington, DC.

Sauer, R. D. (2001).
The political economy of gambling regulation. *Managerial and Decision Economics, 22*, 5–15.

Shaffer, H. (2003).
A public health perspective on gambling: The four principles. Report prepared for the American Gaming Association Responsible Gaming Lecture Series, Chicago, IL.

Shaffer, H. J., & Hall, M. M. (1996).
Estimating the prevalence of adolescent gambling disorders: A quantitative synthesis and guide toward standard gambling nomenclature. *Journal of Gambling Studies, 12*, 193–214.

Tawil O., Verster A., & O'Reilly, K. (1995).
Enabling approaches for HIV/AIDS prevention: Can we modify the environment and minimize the risk? *AIDS, 9*, 1299–306.

Tones, K. (1993).
Changing theory and practice: trends in methods, strategies and settings in health education. *Health Education Journal, 52*, 126–139.

Tones, K., Tilford, S., & Robinson, Y. (1990).

Health education: Effectiveness and efficiency. London: Chapman and Hall.

Vaillancourt, F., & Roy, A. (2000).
Gambling and governments in Canada, 1969–1998: How much? Who pays? What payoff? (Special studies in taxation and public finance, No. 2). Toronto, ON: Canadian Tax Foundation.

Wynne, H.J. (1997).
Gambling as a public health issue. Paper presented at the Canadian Foundation on Compulsive Gambling Annual Conference, Toronto, ON.

Wynne, H., Smith, G., & Jacobs, D. (1996).
Adolescent gambling and problem gambling in Alberta (Report prepared for the Alberta Alcohol and Drug Abuse Commission). Edmonton, AB: Wynne Resources Ltd.

Yanovitzky, I., & Stryker, J. (2001).
Mass media, social norms, and health promotion efforts: A longitudinal study of media effects on youth binge drinking. *Communication Research*, 2, 208–239.

This article was peer-reviewed. Submitted June 3, 2004. All URLs cited were available at the time of submission. Accepted: November 30, 2004.

For correspondence: Carmen Messerlian, MSc., McGill University, 3724 McTavish Street, Montreal, Quebec, Canada H3A 1Y2. Phone: (514)-398-4438, fax: (514)-398-3401, URL: www.youthgambling.com. e-mail: carmen.messerlian@mcgill.ca

Contributors. CM wrote, researched and implemented the conceptual layout of the paper. JD assisted with the conceptualization and direction of the paper and provided ongoing editorial feedback.

Competing interests: None declared.

Ethical approval: None required.

Funding: No specific funding is linked to this paper.

Carmen Messerlian is director of program development and communications at the International Centre for Youth Gambling Problems and High-Risk Behaviors at McGill University. Carmen obtained her Master of Science degree in public health from the London School of Hygiene and Tropical Medicine in England.

Bringing experience in public health, she has been instrumental in developing and applying health promotion models and theories to youth gambling and has presented her work at national and international conferences.

Jeffrey L. Derevensky, PhD, is a professor in the School/Applied Child Psychology, Department of Educational and Counselling Psychology at McGill University. He is associate professor, Department of Psychiatry; and associate professor, Department of Community Dentistry at McGill University. He is a clinical consultant to numerous hospitals, school boards, government agencies, and corporations. He has served on many government committees and has performed consultative services for SAMHSA, NIMH, NRC, and the NCPG. Dr. Derevensky has published widely, is on the editorial board of several journals and is a contributing editor of Wellplace (www.wellplace.com). He is a member of the National Centre for Gambling Studies, University of Alberta; National Network on Gambling Issues and Research, Canadian Centre on Substance Abuse; Centre d'Excellence, Université Laval; and is an International Associate of the Centre for the Study of the Social Impact of Gambling, University of Plymouth, England.

issue 14 — september 2005

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (123 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

research

[This article prints out to about 15 pages.]

Natural course of gambling disorders: Forty-month follow-up

David C. Hodgins & Nicole Peden, University of Calgary, Calgary, Alberta, Canada.
E-mail: dhodgins@ucalgary.ca

Abstract

The natural course of gambling disorders was examined in 40 active pathological gamblers following a three-and-a-half-year period. The majority who reported intentions to quit or reduce gambling made a serious change attempt; however, at follow-up most were gambling problematically. Emotional and financial factors were important precipitants of attempts to quit as well as reasons for relapse. A substantial number experienced a depressive episode or substance use disorder during the follow-up period. A number reported quitting drinking and smoking concurrent with quitting gambling. Less than half had treatment for their gambling problem during the follow-up interval. The few participants who were currently gambling but no longer experiencing gambling problems reported less serious gambling problems initially. In contrast, the successfully abstinent group reported more gambling problems initially. This study provides important directions for future research. Abstinence may be more feasible for individuals experiencing more serious problems, whereas non-abstinent goals may be realistic for individuals with fewer negative consequences. Keywords: natural course, recovery, relapse, change process

Introduction

Little is known about the natural course of gambling disorders (Nathan, 2003). From the traditional addiction perspective, pathological gambling is viewed as a progressive and chronic disorder with progression arrested only with formal treatment involvement and abstinence (American Psychiatric Association, 2000; National Research Council, 1999). On the other hand, stable,

non-abstinent outcomes (controlled gambling) from gambling disorders have been described (Blaszczynski, McConaghy, & Frankova, 1991). In that study, a group of 63 pathological gamblers who participated in abstinence-oriented behavioural treatment were re-assessed two to nine years post-treatment. At the follow-up, 28% were classified as abstinent, 33% as continuing to gamble problematically and 38% as controlled gamblers with no impaired control of gambling and no adverse financial consequences. The controlled and abstinent participants were similar in terms of their psychosocial functioning and, not surprisingly, were much better functioning than the uncontrolled subjects.

In the Blaszczynski follow-up study, controlled gamblers reported less treatment and Gamblers Anonymous involvement during the follow-up interval than the abstinent and uncontrolled gamblers. Non-treatment-assisted recoveries have been reported in other studies of pathological gamblers (Hodgins & el-Guebaly, 2000; Hodgins, Wynne, & Makarchuk, 1999).

Shaffer has suggested that gambling disorders are dynamic, with people moving in and out of problematic involvement over time (Shaffer & Hall, 2001). In a prospective study of casino employees, who are a group at high risk of gambling disorders, Shaffer and Hall observed those with the most serious problems were most likely to shift to a less serious problem over the course of a 12-month follow-up as opposed to showing maintenance or progression of the disorder (Shaffer & Hall, 2002). Similarly, a study of the natural history of gambling disorders in a cohort of students from ages 18 to 29 showed that, although the aggregate prevalence rates over 11 years were relatively stable, gambling problems at the individual level were transitory and episodic rather than chronic and enduring (Slutske, Jackson, & Sher, 2003). Abbott and colleagues (1999) reported a seven-year follow-up of participants in a New Zealand general population study. Of the 35 disordered gamblers at baseline, 66% were non-problematic at follow-up. Most recently, a one-year follow-up of pathological scratch card gamblers in Holland also revealed that the problem had low stability (DeFuentes-Merillas, Koeter, Schippers, & van den Brink, 2004).

A popular heuristic describing the stages and processes of change over time is the transtheoretical model developed by Prochaska and colleagues (Prochaska, DiClemente, & Norcross, 1992). According to this model, an individual facing a behaviour change, such as confronting a gambling disorder, moves through a series of stages including precontemplation, contemplation, preparation, action, relapse, and maintenance. Progression through the stages is not necessarily linear and relapse into the original behaviour, and possibly a return to the precontemplation stage, is common.

Processes of change have been identified that serve to move the person through the stages. For example, movement from contemplation to preparation and action for most behaviours is associated with cognitive-experiential processes such as consciousness raising (e.g., seeking information), dramatic relief (e.g., feeling frightened by seriousness of the problem), self-re-evaluation (e.g., feeling ashamed about the problem), social-liberation (e.g., noticing public awareness campaigns), and environmental re-evaluation (e.g., realizing that the problem hurt other people) (Prochaska et al., 1992). In gamblers, the most frequently used processes were self-re-evaluation, environmental re-evaluation, dramatic relief, and self-liberation. The least used processes were reinforcement management and social liberation (Hodgins, 2001). These results, however, were based upon retrospective reports from a group of recovered gamblers. Longitudinal studies of the recovery process have not been reported.

The present study followed a group of active pathological gamblers for a three-and-a-half-year period. Participants were originally recruited for a study of natural and treatment-assisted change (Hodgins & el-Guebaly, 2000). The participants in the present report were recruited as an "active problem gambling" control group (n = 63) for the initial study for comparison with a group of recovered gamblers. Because a relatively small sample was available the data for this follow-up are analyzed mainly in a descriptive fashion with the goal of catalyzing further research with larger samples. In particular, we were interested in changes in gambling behaviour and the process individuals used in making changes. Did individuals have plans to reduce gambling when they initially participated? If so, did they follow through, and how did they do it?

Method

Participants

Participants were recruited through media advertisements searching for people with existing gambling problems who were not currently in treatment or attending a self-help group. Inclusion criteria for the initial study were a South Oaks Gambling Screen (SOGS) score of five or greater, which indicates probable pathological gambling (Lesieur & Blume, 1991, see below), and willingness to provide the name of a collateral to verify gambling reports. Initial but not follow-up reports were confirmed by these collaterals (Hodgins & el-Guebaly, 2000).

Of the group of 63 active problem gamblers, 55 provided consent for a further follow-up during the original interview, and we

successfully interviewed 40. Two individuals were contacted but refused to participate and the other 13 could not be located. The mean follow-up period was 40.3 months (SD = 4.6) with a range of 33 to 49 months. A comparison of the followed sample (n = 40) to the not-followed sample (n = 23) showed that women were more likely to be followed than men (60% vs. 40%), $\chi 2(1, N = 63) = 5.1$, $p < .05$, and that those followed were less likely to have a lifetime diagnosis of alcohol dependence (22% vs. 52%) but more likely to have a lifetime diagnosis of alcohol abuse (20% vs. 0), $\chi 2(2, N = 63) = 8.7$, $p < .05$. There were no other differences in demographic or clinical variables.

Participants in the follow-up sample (60% female) had an average age of 42 years at the initial interview (SD = 9, range 21 to 66) and had a mean of 13 years of education (SD = 1, range 8 to 18). Full- or part-time employment was reported by 77% (includes one homemaker), with 18% unemployed and 5% disability. The sample included one Aboriginal man, with the remainder being Caucasian.

The mean age of onset of regular gambling (self-defined) was 29 years (SD = 13). The mean SOGS score was 13 (SD = 3, range 6 to 18), and 37 of the 40 (92%) met DSM-IV criteria for pathological gambling. The types of problem gambling were primarily video lottery terminals (VLTs, 55%), mixed games (casino and VLTs, 35%), casino games (5%), and bingo (5%).

Initial and follow-up interviews

The content domains of the Time 1 face-to-face interview included: demographics, gambling history and related problems, DSM-IV pathological gambling criteria, mood disorder and substance abuse diagnoses, smoking history, and readiness to change (Hodgins & el-Guebaly, 2000). At the Time 2 (follow-up) face-to-face interview, a timeline follow-back interview captured the number of days of gambling during the follow-up period, the amount of money won or lost on each occasion and any treatment sought over the follow-up. The retest reliability and validity of these types of data are generally good (Hodgins & Makarchuk, 2003). The mood and substance disorders modules of the Structured Clinical Interview for the DSM-IV (SCID) (First, Gibbon, Spitzer, & Williams, 2002) were re-administered. Participants who had made a serious attempt to reduce or quit gambling during the follow-up interval were asked to describe their goal and their strategies. Their reasons for resolution were recorded using a 15-item checklist as well as described on a number of dimensions (Hodgins & el-Guebaly, 2000). Participants who subsequently returned to gambling completed the Reasons for Gambling Questionnaire to describe the relapse precipitants (Hodgins, el-Guebaly, & Armstrong, 2001).

Measures

South Oaks Gambling Screen (Lesieur & Blume, 1987). The SOGS was used as a descriptive measure of gambling severity at Time 1. It is a widely used 20-item self-report questionnaire that assesses lifetime gambling-related difficulties. A score of 5 or greater indicates probable pathological gambling as validated against clinician ratings (Lesieur & Blume, 1987; Stinchfield, 2002).

Structured Clinical Interview for the DSM-IV (First et al., 2002). The SCID is a structured interview that examines the frequency and intensity of DSM-IV symptoms and provides Axis I diagnoses. The Mood and Substance Use modules were administered at Times 1 and 2. The SCID-IV format was used at Time 1 to determine whether participants met pathological gambling diagnostic criteria for their lifetime period of heaviest gambling (Hodgins & el-Guebaly, 2000). Interrater diagnostic agreement for the two interviewers and the first author of this paper across 12 audiotapes was 100%.

Stages of Change Algorithm (Prochaska at al., 1992). Readiness to change or stage of change was assessed at Time 1 and Time 2 by asking about intentions to quit or reduce gambling: pre-contemplation (not in the next six months), contemplation (in the next six months), and preparation (in the next month).

Reasons for Resolution Checklist (Hodgins & el-Guebaly, 2000). The participant was asked to describe the reasons for quitting gambling using a checklist of reasons, adapted from the categorizations of the open-ended responses from studies of the resolution of alcohol problems in a variety of populations (Cunningham, Sobell, Sobell, & Gaskin, 1994; Cunningham, Sobell, Sobell, & Kapur, 1995). The reasons (e.g., financial problems, emotional factors, family/children, etc.) were each rated on a five-point scale (not at all, slightly, moderately, considerably or extremely important).

Reasons for Gambling Questionnaire (Hodgins et al., 2001). The RGQ provides a list of 24 possible reasons for relapse to gambling that are rated on a 6-point scale with the anchors of not at all, moderately and extremely important (see Table 3). The items were originally modified from the Reasons for Drinking Questionnaire (Zywiak, Connors, Maisto, & Westerberg, 1996) but were refined and validated through feedback from problem gamblers (Hodgins et al., 2001).

Results

When initially interviewed at Time 1, 93.5% of the participants described themselves as in the preparation stage—planning to quit gambling in the next month but not actively doing so. Those

remaining were contemplators, reporting that they planned to quit in the next six months (3.3%), or precontemplators, not planning change in the next six months (3.3%). None were involved in treatment or self-help groups at that time.

At Time 2, participants were first asked whether or not they were "currently gambling". The majority described themselves as currently gambling (82.5%) and only 7 (17.5%) described themselves as not currently gambling. These two groups are described below.

Currently abstinent group

Two of the seven participants, both women experiencing problems with VLTs, had quit shortly after the initial interview and described quitting as a conscious decision. One, age 38, entered individual counselling and began attending Gamblers Anonymous (GA). The other, age 57, had no involvement in treatment, describing the process as "mind over matter." She also quit smoking at the same time. Time 1 SOGS scores were 14 and 13 respectively.

Two additional participants, also both women, reported lengthy periods of abstinence although they had not immediately stopped after the initial assessment. One woman, age 37, who had problems with bingo, VLTs, and horse races and a Time 1 SOGS score of 14, quit three months after the initial interview (three years ago). She also quit smoking and drinking alcohol at the same time and described her resolution as related to a religious conversion. Quitting gambling was not a conscious decision; it simply happened without her being aware of it. She did not participate in any gambling-related treatment but did enter a residential program for alcohol abuse.

The second woman, a problem VLT player, age 44, with a SOGS score of 16, quit 18 months before the follow-up interview. She described the process as a conscious decision related to accumulated financial problems. She attended GA twice but reported that family support and improved circumstances were factors that promoted her success. The final three participants who were not currently gambling quit more recently. One, a woman, age 33, with a Time 1 SOGS of 14, last gambled three months ago and gambled (VLTs) about three times in the past year before that. Her conscious goal was to quit completely and her strategy was to stay away from gambling locations and gambling friends. A reduction in gambling has led to a reduction in drinking. She reported no treatment involvement.

The remaining two abstinent participants were men. A 55-year-old man, who had problems with horse races, casino games and VLTs

and an initial SOGS of 17, had not gambled for two months. He reported a myriad of psychiatric and gambling treatments over the follow-up period but described his resolution as resulting from the loss of the desire to gamble. His strategy also involved staying away from gamblers and gambling locations. The other man, age 38, had not gambled for only four weeks and before that was gambling about twice per month. He shifted his gambling from bingo to VLT play over the follow-up period but described both as having caused problems. His Time 1 SOGS score was 16. He had read a self-help book but had no formal treatment.

Currently gambling group

Thirty-three participants (82.5%) described themselves as "currently gambling" at Time 2. Notably, five of these participants described themselves as no longer having a gambling problem. A 48-year-old woman denied that she ever had a problem although her gambling had "gotten out of hand" a few years prior. Her Time 1 SOGS score was 8 and she had reported problems with bingo, lottery, and scratch tickets. At Time 2, she was gambling between four to six times per month, losing a little more than she can afford, and was feeling that she should cut back. She had never had treatment. She also met the diagnostic criteria for alcohol dependence at the follow-up interview.

A second participant, age 36, who described himself as no longer having a gambling problem, quit gambling for a four-month period 1.5 years ago but has been gambling in a controlled manner for the past ten months (two days per month; about $300 on VLTs). He attended outpatient counselling and GA during his period of abstinence. He would like to cut back although he described himself as not experiencing any current problems. His initial SOGS score was 9.

The remaining three participants who reported that gambling was not currently a problem at Time 2 acknowledged that VLT play had been a problem previously when they gambled more heavily. None reported ever having quit gambling and all gamble occasionally (i.e., once every few months). Two of the three did not have any treatment for either gambling or mental health problems and one attended GA and outpatient counselling. Time 1 SOGS scores were 9, 10, and 10. One reported that her gambling decreased when she stopped using cocaine (she was cocaine dependent at the initial interview) and the other two, both men, consciously cut back on gambling because of major financial problems.

The remaining 28 participants (70%) were currently gambling and described themselves as having a current gambling problem at Time 2. The mean Time 1 SOGS score for this group was 12.4 (SD = 2.8). The majority (24) had gambled in the past two weeks. The

mean number of days of gambling per month during the follow-up interval ranged from 8.1 (SD = 7.6) to 10.6 (SD = 10.0), and paired t-tests revealed no statistically significant changes over time.

Table 1 displays information about participant functioning over the follow-up interval and Table 2 displays current psychiatric functioning at Time 2. Less than half had had treatment for their gambling problem during the follow-up interval. A substantial number experienced a depressive episode or alcohol or other drug use disorders during the follow-up period, as assessed by the SCID. At Time 2, 22 participants (79%) indicated that they planned to reduce or quit gambling in the next month (preparation stage), 3 participants (11%) in the next six months (contemplation), and 3 participants (11%) did not plan to change in the next six months (precontemplation). Most had the goal of quitting the types of gambling that had caused problems (43%) and 21% wanted to quit all types of gambling. Cutting back on gambling was the goal for 29%, and 7% were unsure.

Table 1
Functioning over the follow-up period

		N	%
Treatment for gambling problems	No	16	57
	Minimal	4	14
	Yes	8	29
Treatment for mental health problems	No	18	64
	Minimal	2	7
	Yes	8	29
Depressive episode[1]		14	50
Manic episode[1]		0	0
Alcohol dependence/abuse		7	25
Other drug dependence/abuse		3	11
Quit smoking		2	7

[1]n = 27

Table 2
Functioning at Time 2 assessment

		N	%
Lifetime Mood Disorder[1]	None	8	30
	MDD	17	63
	Bipolar II	2	7
Current Mood Disorder[1]	None	18	67
	MDD	8	30
	Bipolar II	1	4
Lifetime Alcohol Diagnosis	None	14	50

	Abuse	8	29
	Dependence	6	21
Current Alcohol Diagnosis	None	22	79
	Abuse	0	0
	Dependence	4	14
	Dependence –early partial	2	7
Lifetime Drug Diagnosis	None	19	68
	Abuse	4	14
	Dependence	5	18
Current Drug Diagnosis	None	25	89
	Abuse	2	7
	Dependence	1	4
Current Smoker		22	79

[1]n = 27
Note. Current refers to past month. MDD = Major depressive disorder.

Previous change attempts

Of the 28 participants who were currently gambling and reporting a gambling problem, 17 reported a serious attempt to either quit (71%) or reduce their gambling (29%) during the follow-up period. The majority described the decision as completely conscious (59%), and the most frequently cited reasons for the change attempt, based upon the 15-item Reasons for Resolution checklist, were financial problems (88%), emotional factors (88%), hitting rock bottom (53%), problems with spouse (53%), family/children (47%), and humiliating event (47%).

Participants were also asked to describe their reasons for relapsing back into gambling. The mean ratings on the Reasons for Gambling Questionnaire items are displayed in Table 3. The most important reasons were to escape from thoughts or feelings, wanting to win, and not caring any more.

Table 3
Mean ratings on Reason for Relapse questionnaire items (N = 17)

Reason for relapse	M	SD
escape from thoughts or feelings	4.0	1.5
wanted to win	3.5	1.5
didn't care anymore	3.4	2.0
felt bored	3.2	1.7
felt anxious or tense	3.0	1.7
felt tempted to gamble out of the blue	2.9	1.9
felt pressured by financial debts	2.8	1.9

felt angry/frustrated with self	2.7	1.8
felt angry/frustrated because of relationship	2.6	1.9
needed to win back past losses	2.6	1.9
felt sad	2.5	1.6
had opportunity and had to give in	2.5	1.5
felt lucky	2.3	1.8
in situation where in habit of gambling	2.2	1.9
wanted to see what would happen	2.1	2.0
felt worried/tense because of relationship	2.0	1.9
felt others were being critical	1.9	1.7
felt physically uncomfortable, wanting to gamble	1.8	1.5
felt in a good mood	1.6	1.5
opportunity to gamble happened out of the blue	1.4	1.5
felt physically ill or in pain	1.2	1.5
someone invited me	1.0	1.7
saw others	1.0	1.5
having a good time	0.9	1.6

Note. Rated on 0 to 5 point scale – "not at all important" to "extremely important."

Discussion

A majority of this sample of problem gamblers, who had acknowledged a gambling problem and had reported the intention to quit or reduce their gambling, made a serious change attempt during the subsequent three-and-a-half-year period. Only 11 (28% of those interviewed) reported no attempt to change. However, despite their efforts at change, relatively few were free of problems at the follow-up assessment—only 7 (17.5%) were not currently gambling and 5 were gambling but not reporting problems (12.5%).

The small group of individuals who reported continuing to gamble but without problems is notable. This group reported infrequent gambling compared to the problematic group. Clearly, gambling is not a major focus of their leisure time. Compared to the other participants, it appears that they generally had less serious gambling problems initially, as assessed by the SOGS. Non-abstinent goals and outcomes may be more realistic for individuals with fewer negative consequences, as has been found for people with alcohol problems (Klingemann et al., 2001; Monti, Rohsenow, Colby, & Abrahms, 1995).

Consistent with this possibility, the successfully abstinent group, by comparison, had the highest SOGS scores. Abstinence may be a more feasible goal for those with more severe problems (Hodgins, Leigh, Milne, & Gerrish, 1997; Hodgins, Peden, & Cassidy, 2003). The successfully abstinent group did not necessarily recover

through treatment or GA involvement. Three of the seven attended treatment and one additional participant entered a residential alcohol treatment program. A number of the participants, in fact, reported quitting drinking and smoking concurrent with quitting gambling. Again, these results are similar to findings in the alcohol treatment area, where it is increasingly recognized that tackling tobacco at the same time as alcohol is an effective strategy (Monti et al., 1995).

Comorbid depression and substance use disorders including smoking were highly prevalent in the sample. About half the sample of those continuing to gamble problematically experienced a depressive episode during the follow-up interval. Overall, 70% met the DSM-IV criteria for a lifetime mood disorder, and 34% had a current mood disorder at the follow-up assessment. Previous longitudinal research suggests an association between a positive mood disorder history and poorer outcome from gambling disorders (Hodgins et al., 1997; Hodgins et al., 2003).

The implications of a comorbid substance abuse problem are less clear from previous research. In the group of continuing problematic gamblers, 25% experienced problematic alcohol use, 11% other drug use, and 79% were smokers during the follow-up interval. Only two individuals in this group quit smoking during this interval. Untangling the association between these disorders is an important future research direction (Hodgins et al., 2003).

Although ultimately they were not successful, over half of continuing problematic gamblers made an attempt at change during the follow-up interval. The descriptions of the precipitants of these attempts were similar to descriptions obtained from successful quitters (Hodgins, Makarchuk, el-Guebaly, & Peden, 2002), with most indicating emotional and financial factors as important. These same factors were also cited as the reasons for relapse. We have previously noted that the most frequent reasons for relapse, wanting to win and wanting to escape from feelings, parallel clinical observations about subtypes of problem gamblers, the thrill-seekers and the escape gambler (Hodgins & el-Guebaly, 2004).

One of the limitations of this study is the follow-up rate and sample size. Only 73% of those who agreed to be contacted for a follow-up were successfully located and interviewed. Women and individuals who were not alcohol dependent were more likely to be interviewed. Otherwise this follow-up sample appeared similar to the group not interviewed. More frequent contact with the participants may have improved the follow-up rate. More frequent assessments would also minimize memory problems and increase the accuracy of the reporting. Re-assessment of severity of gambling problems at regular intervals, using the SOGS or DSM-IV

criteria, would also be informative. In the current study, these measures were only administered at Time 1.

The sample size limited the analysis to descriptive statistics and, therefore, generalizations need to be made cautiously. Nonetheless the results do provide directions for further work. The importance of understanding the implications for the high prevalence of comorbid disorders and their impact on outcome is underscored. In addition, the course of gambling disorders needs further study. We did not observe in this group of self-acknowledged problem gamblers that their problems were transitory, as observed in a general population sample (e.g., Slutske et al., 2003). It appears that our sample had generally more severe problems than the previous general population samples and may, therefore, have been less likely to transition as readily back to non-problem gambling. Participants were likely to begin the study in the preparation stage of change and to end the study in the same stage. That is not to say that the status quo was maintained—in contrast, most participants moved into action and through relapse stages. A small group, as well, reported stable non-abstinent outcomes. Understanding the dynamic nature of the course of gambling disorders is important.

References

Abbott, M. W., Williams, M., & Volberg, R. (1999).
Seven years on: A follow-up study of frequent and problem gamblers living in the community. Wellington, New Zealand: Department of Internal Affairs.

American Psychiatric Association (2000).
Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.

Blaszczynski, A., McConaghy, N., & Frankova, A. (1991).
Control versus abstinence in the treatment of pathological gambling: A two to nine year follow-up. *British Journal of Addiction, 86*, 299–306.

Cunningham, J. A., Sobell, L. C., Sobell, M. B., & Kapur, G. (1995).
Resolution from alcohol problems with and without treatment: Reasons for change. *Journal of Substance Abuse, 7*, 365–372.

Cunningham, J. A., Sobell, L. C., Sobell, M. B., & Gaskin, J. G. (1994).
Alcohol and drug abusers' reasons for seeking treatment. *Addictive Behaviors, 19*, 691–696.

DeFuentes, L., Koeter, M. W. J., Schippers, G. M., & van den

Brink, W. (2004).
Temporal stability of pathological scratchcard gambling among adult scratchcard buyers two years later. *Addiction, 99*, 117–127.

First, M. B., Gibbon, M., Spitzer, R. L., & Williams, J. B. (2002).
User's guide for the structured clinical interview for DSM-IV-TR axis 1 disorders (research version). New York: Biometrics Research.

Hodgins, D. C. (2001).
Processes of changing gambling behaviour. *Addictive Behaviors, 26*, 121–128.

Hodgins, D. C., & el-Guebaly, N. (2000).
Natural and treatment-assisted recovery from gambling problems: A comparison of resolved and active gamblers. *Addiction, 95*, 777–789.

Hodgins, D. C., & el-Guebaly, N. (2004).
Retrospective and prospective reports of precipitants to relapse in pathological gambling. *Journal of Consulting and Clinical Psychology, 72*, 72–80.

Hodgins, D. C., el-Guebaly, N., & Armstrong, S. (2001).
Critical dimensions of relapse in pathological gambling. Calgary, AB: Author.

Hodgins, D. C., Leigh, G., Milne, R., & Gerrish, R. (1997).
Drinking goal selection in behavioural self-management treatment of chronic alcoholics. *Addictive Behaviors, 22*, 247–255.

Hodgins, D. C., Makarchuk, K., el-Guebaly, N., & Peden, N. (2002).
Why problem gamblers quit gambling: A comparison of methods and samples. *Addiction Theory and Research, 10*, 203–218.

Hodgins, D. C., Peden, N., & Cassidy, E. (in press).
The association between comorbidity and outcome in pathological gambling: A prospective follow-up of recent quitters. *Journal of Gambling Studies*.

Hodgins, D. C., Wynne, H., & Makarchuk, K. (1999).
Pathways to recovery from gambling problems: Follow-up from a general population survey. *Journal of Gambling Studies, 15*, 93–104.

Klingemann, H., Sobell, L., Barker, J., Blomqvist, J., Cloud, W., Ellinstad, T., et al. (2001).
Promoting self-change from problem substance use.

Dordrecht, the Netherlands: Kluwer Academic.

Lesieur, H., & Blume, S. (1991).
The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American Journal of Psychiatry, 144*, 1184–1188.

Monti, P. M., Rohsenow, D. J., Colby, S. M., & Abrahms, D. B. (1995).
Smoking among alcoholics during and after treatment: Implications for models, treatment strategies, and policy. In J. B. Fertig & J. P. Allen (Eds.), *Alcohol and tobacco: From basic science to clinical practice* (pp. 187–206). Washington, DC: National Institutes of Health.

Nathan, P. E. (2003).
The role of natural recovery in alcoholism and pathological gambling. *Journal of Gambling Studies, 19*, 279–286.

National Research Council (1999).
Pathological gambling. A critical review. Washington, DC: National Academy Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992).
In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102–1114.

Shaffer, H. J., & Hall, M. N. (2001).
Updating and refining prevalence estimates of disordered gambling behaviour in the United States and Canada. *Canadian Journal of Public Health, 92*, 168–172.

Slutske, W., Jackson, K. M., & Sher, K. J. (2003).
The natural history of problem gambling. *Journal of Abnormal Psychology, 112*, 263–274.

Zywiak, W. H., Connors, G. J., Maisto, S. A., & Westerberg, V. S. (1996).
Relapse research and the Reasons for Drinking Questionnaire: A factor analysis of Marlatt's relapse taxonomy. *Addiction, 91* (supplement), 121–130.

This article was peer-reviewed. Submitted: August 10, 2004. All URLs were active at the time of submission. Accepted: September 3, 2004.

For correspondence: David Hodgins, PhD, Department of Psychology, University of Calgary, 2500 University Dr. N.W., Calgary, AB, T2N 1N4 Canada. Phone: (403) 220-3371, fax: (403) 210-9500, e-mail: dhodgins@ucalgary.ca

Contributors. DH was responsible for research conceptualization and design, NP for data collection, and both shared in analyses and preparation of the manuscript.

Competing interests: None declared.

Ethics approval: The University of Calgary Conjoint Faculties Research Ethics Board approved the research project "Influence of substance dependence and mood disorders on outcome from pathological gambling" on October 31, 2002.

Funding: This project was funded in part by the Alberta Gaming Research Institute and the Alberta Heritage Foundation for Medical Research.

David Hodgins, PhD, CPsych., is currently a professor, Department of Psychology, University of Calgary, and is the University of Calgary coordinator for the Alberta Gaming Research Institute.

Nicole Peden, MSc., is a PhD candidate in clinical psychology at the University of Calgary.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (72 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

clinical corner

[This article prints out to about 12 pages.]

Clinical corner

Welcome to the first case presentation in the **Clinical corner**. This new offering from the *Journal of Gambling Issues* focuses on difficult situations that clinicians face when dealing with individuals suffering from pathological gambling. Sample composite cases will be presented to illustrate important points in conceptualizing how concurrent mental health factors interplay with the symptoms of pathological gambling. In some cases, the focus will be on a clinical condition, such as attention deficit hyperactivity disorder, or a therapeutic approach, such as mindfulness therapy. We invite readers to e-mail the editor (Phil_Lange@camh.net) to suggest future topics or to submit a clinical case for publication. The case below can be used as a template for submissions. All cases and materials presented in this section are peer reviewed.

The case of the sleepless slot-machine supplicant: Bipolar disorder and pathological gambling

Bruce Ballon, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.
E-mail: Bruce_Ballon@camh.net

Case presentation

Ms. S is a 44-year-old Caucasian woman, married for twelve years with no children. She finished high school and took a year of college courses. She is a homemaker, although she used to do clerical work until she married. She is supported by her husband's income. She has had no legal problems in her past. She currently owes $11,000 in gambling debts she has kept secret from her husband. Ms. S has been gambling on slot machines for the last five years, starting when a casino opened near her home. In the last two years, because Ms. S reported spending sprees, staying up all night, agitation, mood instability, and depression, her family doctor thought she might have bipolar disorder. She consulted with a psychiatrist who also

thought this was the case, and she was started on a variety of mood stabilizing, antipsychotic, and antidepressant medications. She quickly developed a variety of side effects from them and so she wanted to know if she really needed all these medications. The medications also did not seem to have any impact on her moods or gambling behaviours.

When asked to explain her symptoms in further detail, Ms. S described staying up for one to two days at a time without sleep when absorbed in gambling on slot machines. Her spending sprees were all in the pursuit of getting tokens to play the slots. She denied spending money on items such as fancy clothes, extravagant phone bills, or food. Her mood instability connected to all the stresses of financial debt, ongoing difficulties keeping the debt secret from her husband, and concerns about what she was doing with her life. Her moods were never so low that she ever felt the urge to self-harm (i.e., to cut herself, etc.) or to contemplate suicide. Her appetite has remained unchanged through the last few years.

Ms. S's early history includes a chaotic family upbringing. She had difficulty with relationships, often failing to develop close intimacy. She married her husband to get away from her family, but for her this relationship also seemed to lack intimacy. She felt cut off from the world and alone. She says she started gambling to "escape" and feel alive. She denied any problematic substance use history. Family history was negative for bipolar or other mental health or addiction issues.

Recent blood work done by her family doctor demonstrated normal blood and electrolyte indices. Her thyroid functions were also normal. A urine toxicology screen was negative for substances of abuse (e.g., amphetamines, cocaine, etc.).

- What aspects of this case make you concerned over the diagnosis of bipolar disorder?
- What additional information do you need to determine what the problem is?
- What further complications could arise if her diagnosis is inaccurate?

Bipolar disorders

Bipolar disorder (BP), previously known as manic-depressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. The prevalence rate is ~1.2%, e.g., three million adults in North America alone. The

condition usually develops in late adolescence or early adulthood, but there are variant forms that begin in early childhood or later in life (Hales, Yudofsky, & Talbott, 1999).

The symptoms are often not recognized ("just a wild guy/gal"), and people may suffer for years before the disorder is properly diagnosed and treated. They are often misdiagnosed as suffering from attention deficit hyperactivity disorder (ADHD), substance use disorders (SUD), and personality disorders (PD) such as borderline personality disorder (BPD) (Hirschfeld, 2001). In addition, conditions such as substance use, trauma (and resultant post-traumatic stress disorders (PTSD)), and mood disorders often coexist with people suffering from BP (Hales, Yudofsky, & Talbott, 1999).

Bipolar disorder is a chronic illness that must be carefully managed throughout a person's life. There is no single cause for the condition and scientists speculate that a genetic basis combines with multifactorial vulnerabilities for the condition to manifest. Brain imaging tests have shown slight abnormalities in only some people with the condition and this supports the contention that BP represents a heterogeneous group of conditions (Soares, Mann, 1997).

People with the condition may alternate between "manic episodes" (ME) and "major depressive episodes" (MDE). This is called "Bipolar I." Some people have only mild forms of mania—i.e., they manifest symptoms, but these are not severe enough to interfere with their functioning in life. Such manifestations are called "hypomanic episodes"; having them with alternating episodes of MDE is classified as "Bipolar II." Then there are people who manifest sub-clinical depressive episodes with hypomanic episodes, and this is called "cyclothymia." People who have at least four episodes (manic or depressive) in a year are classified as "rapid cycling." In fact, the normal course of the illness is that the frequency and intensity of episodes increase as time goes on. As this occurs, sometimes people can develop "mixed" episodes where they have symptoms of mania and depression simultaneously (e.g., they are both full of energy and suicidal) (American Psychiatric Association Diagnostic and Statistical Manual-IV-TR, 2000).

Some episodes are so intense that people can develop psychotic features (i.e., hallucinations and delusions) or even catatonic features (abnormal movement states) during the episode's course. Sometimes episodes can be triggered by the stress of childbirth and arise in the postpartum period as well (APA DSM-IV-TR, 2000).

The classic DSM-IV-TR symptoms and signs of a manic episode

are listed in Table 1 and of a major depressive episode in Table 2

Table 1
Manic episode DSM-IV-TR criteria

A) A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)
B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   1) inflated self-esteem or grandiosity
   2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   3) more talkative than usual or pressure to keep talking
   4) flight of ideas or subjective experience that thoughts are racing
   5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   6) increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation
   7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C) The symptoms do not meet criteria for a Mixed Episode
D) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features
E) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism)

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I disorder

Table 2
Major depressive episode DSM IV TR criteria

A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
4) insomnia or hypersomnia nearly every day
5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6) fatigue or loss of energy nearly every day
7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B) The symptoms do not meet criteria for a Mixed Episode

C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation,

psychotic symptoms, or psychomotor retardation

Table 3
Pathological gambling DSM IV TR criteria

A) Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
   1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
   2) needs to gamble with increasing amounts of money in order to achieve the desired excitement
   3) has repeated unsuccessful efforts to control, cut back, or stop gambling
   4) is restless or irritable when attempting to cut down or stop gambling
   5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
   6) after losing money gambling, often returns another day to get even ("chasing" one's losses)
   7) lies to family members, therapist, or others to conceal the extent of involvement with gambling
   8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
   9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
   10) relies on others to provide money to relieve a desperate financial situation caused by gambling

B) The gambling behavior is not better accounted for by a Manic Episode

"Mimicry" of bipolar disorder by pathological gambling

Interestingly, according to the DSM IV-TR, one of the exclusion criteria for making the diagnosis of pathological gambling (PG) (see Table 3) is that the behaviours are not "better accounted for by a Manic Episode" (i.e., the gambling is only a small manifestation in the overall plethora of behaviours being manifested by someone in the throes of mania).

Another thing to consider is that pathological gambling often co-occurs with other mental health and addiction issues. According to recent studies, BP is not very common compared to ADHD, SUD,

and PD (Specker, et al., 1996; Petry, 2000).

As well, behaviours (and their consequences) arising from PG can "mimic" other mental health issues, e.g., staying up all night to indulge in gambling, committing illegal acts such as stealing for money to gamble, spending their money only on gambling, emotional reaction to losses, dealing with relationships that are impacted by the gambling, and other problems. Often this may lead to depressive symptoms and, for those vulnerable, a major depressive episode. When gambling problems are treated usually many "psychiatric" symptoms vanish as well. If the symptoms do not resolve, or they get worse, then it becomes clear that there is a co-occurring/underlying psychiatric condition to be dealt with.

So, what are the possibilities in this case?

Possibility 1. Gambling behaviours in the context of bipolar disorder

If this were the case, we would expect Ms. S to have behaviours consistent with mania beyond just gambling. Gambling would most likely be merely one of the pleasurable activities someone would pursue while "high"—e.g., sex, spending sprees on all sorts of items, recreational drug use, running up telephone bills. The gambling would be just part of the many goal-directed activities engaged in, combined with poor judgment. Ms. S would demonstrate a grandiosity not just about her skills as a "great gambler" but about a great number of other things as well. You would also expect Ms. S to be in an energized state, needing little sleep for at least a week whether she was in the casino or not. Pressured speech (rapid, continuous, hard to interrupt) and flights of ideas (rapid shifting between usually related thoughts) occur in a manic state and not in pathological gambling. Similarly, a person does not develop psychotic symptoms if she is only engaging in pathological gambling! The clinician needs to get an understanding of the person's behaviours, signs, and symptoms inside and outside the gambling context.

Possibility 2. Pathological gambling disorder alone

How can this condition end up mimicking bipolar disorder? As mentioned already, people may be "driven" to gamble by many factors, but often they are releasing various neurochemicals (which give them pleasure and energy) during the act of gambling. This is why people can stay up for long periods of time—but eventually "crash" into exhaustion. They usually can't go a full week of being energized like someone in a manic state. Also, the "spending spree" is like in other addictions—the money is going into the pursuit of their gambling and very little else. This is not really a

spending spree, then, but just part of the typical behaviour of pathological gambling. The gambler's affects and moods can be variable but are usually reactive to situations, e.g., feeling joyous while playing, ecstatic when winning, anxious when losing, depressed when in debt. In fact, one criterion for pathological gambling is "becoming restless and irritable" (see Table 3) when trying to cut down the behaviour. These shifting moods are not sustained abnormal mood states as described above in bipolar disorder. However, someone under enough stress and with the right amount of genetic vulnerability could develop a major depressive episode. The clinician needs to look at all mental health issues and behaviours and see if they always manifest within or due to the gambling behaviours, or are occurring outside of them as well. If the former, the behaviours can all be explained purely by a pathological gambling disorder.

Possibility 3. Combined bipolar and pathological gambling disorders

Of course, there is the possibility that both are occurring at the same time. There are a few ways this could look, including:

a. *Starting with a pathological gambling disorder*. Pathological gambling behaviours are ongoing but there are discrete episodes of hypomania, mania, or major depression occurring when a history is carefully taken. It could be during these episodes that the gambling behaviour worsens, but other symptoms of bipolar disorder are also present.

b. *Starting with a manic episode*. A person with the potential for gambling difficulties enters into a manic episode, and takes up gambling as part of the illness. Once the episode begins to decrease in intensity, the person continues to gamble. If the person starts to slip towards a major depressive episode, he or she may increase the gambling behaviour as a way to self-medicate their mood (a method which is usually doomed to failure).

c. *Starting with a major depressive episode*. The person starting to develop a depressive episode begins to "treat" him- or herself with the "highs" of gambling and develops the pathological gambling disorder due to a vulnerability to that condition. The gambling continues but worsens when a manic episode arrives.

The key again is taking a careful longitudinal history of the different symptoms to see how they match up temporally.

Possibility 4. None of the above

Although it is beyond the scope of this article to go into in detail, bipolar disorder diagnoses are sometimes misdiagnoses of ADHD, BPD, SUD, and trauma-related conditions. Medical conditions such as hyperthyroidism can create equivalent manic behaviours. In Ms. S's case above, there seems to be no history of learning problems or difficulties at school or attention problems (although this makes ADHD merely unlikely, but does not rule it out), and no overt trauma history (although emotional trauma may have occurred in her upbringing). Self-reported history and urine toxicology screen are negative (although, for example, cocaine can be undetectable a few days after use unless you use the proper lab tests), and her thyroid levels are normal. For simplicity in this article, let us go along with the working hypothesis that all these possibilities have been ruled out for now (although a good clinician always keeps fall-back hypotheses!).

What do we need to know?

So, to get the proper context to understand what is going on, the clinician needs to know at least the following:

- Behaviours inside and outside the gambling environment
- Onset and pattern of gambling and psychiatric symptoms, and how they relate to each other temporally (it helps to draw this out as a chart). This chronology of symptoms can include developmental history, periods of abstinence, etc.
- Addiction conditions (either ruled out or, if present, put into the temporal relationship chart)
- Medical conditions (either ruled out or, if present, put into the temporal relationship chart)
- Medication use—is it helping with any of the symptoms?
- General functioning in the following domains:
    - School/Vocational functioning
    - Family functioning
    - Social/Peer relationships
    - Leisure activities
- Family history of mental health issues, e.g., mood disorders, anxiety disorders, gambling problems, addiction problems, etc.

The case revisited

Based on the information on the case, and assuming there are no underlying issues of ADHD, trauma, or addiction, etc., most of Ms. S's behaviours can be explained by the pathological gambling condition alone. There are likely some interpersonal issues that predate the gambling problem and may have originally led her to use gambling as a self-soothing, maladaptive coping mechanism, but further history would be required to solidify this theory. Although she is currently suffering from some mild depression, it does not appear to be a major depressive episode. Thus the medication she is taking may be unneeded. Cognitive behavioural therapy (CBT) can address gambling and depressive cognitions simultaneously. If the mood symptoms remain or worsen, then one can consider re-examining the situation to see if Ms. S has developed a MDE and could benefit from combined CBT and/or medication treatment.

Final thoughts

Context is key. Symptoms don't exist in a vacuum.

It often takes time to truly unravel a diagnosis, especially when many conditions have overlapping symptoms.

Being misdiagnosed with bipolar disorder when instead the condition is pathological gambling has serious implications:

- The person has to live with the "label" and all the consequences that go with it
- Would-be parents must consider the possibility of having children who inherit a psychiatric condition
- The person must maintain a certain lifestyle to prevent triggering an episode (i.e., going to bed on time, etc.)
- The pathological gambling often can be overlooked and "lumped" into being only a manifestation of a manic episode, and thus the person does not receive the proper treatment for PG
- The person may be put on medications which can cause unwanted side-effects and possible long-term problems induced by the medication
- This also speaks to the question of whether most mental health clinicians are aware of the presentation and manifestation of pathological gambling to help prevent misdiagnosing BP

References

American Psychiatric Association. (2000).
Diagnostic and statistical manual of mental disorders (Rev. 4th ed.). Washington, DC: Author.

Hales, R.E., Yudofsky, S.C., & Talbott, J.A. (Eds.). (1999).
The American Psychiatric Press textbook of psychiatry (3d ed.). Washington, D.C.: American Psychiatric Press.

Hershfeld, R. (2001).
Bipolar spectrum disorder: Improving its recognition and diagnosis. *Journal of Clinical Psychiatry, 62* (Suppl. 14), 5–9.

Petry, N. (2001).
Psychiatric symptoms in problem gambling, and impulsiveness. *Drug and Alcohol Dependence, 63*, 29–38.

Soares, J.C., & Mann, J.J. (1997).
The anatomy of mood disorders—review of structural neuroimaging studies. *Biological Psychiatry, 41* (1): 86–106.

Specker, S., Carlson, G., Edmonso, K., Johnson, P., & Marcotte, M. (1996).
Psychopathology in pathological gamblers seeking treatment. *Journal of Gambling Studies, 12*, 67–81.

This article was peer reviewed. Submitted: February 16, 2005. Accepted: April 19, 2005.

For correspondence: Bruce Ballon, BSc. MD FRCP(C), Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario M5S 2S1 Canada. E-mail: Bruce_Ballon@camh.net.

Competing interests: None declared.

Ethical approval: Not required.

Funding: Not relevant.

Bruce Ballon (BSc. MD FRCP(C)) is a psychiatrist at the Centre for Addiction and Mental Health, as well as an assistant professor for the University of Toronto's Faculty of Medicine, assistant professor of psychiatry, and addiction psychiatry education coordinator, University of Toronto. He is a clinical education specialist and consulting psychiatrist to the problem gambling, youth addiction, and concurrent disorder services at the Centre for Addiction and Mental Health. His training includes a BSc. (genetics), MD (psychiatry specialist degree and two fellowships: child and

adolescent psychiatry, and addiction psychiatry). Dr. Ballon has received numerous awards for his work in psychotherapy, education, the humanities, and for his writing. He has special interest in different forms of media and their relationship with addiction and mental health issues. He has designed a variety of novel psycho-educational and therapy initiatives involving the use of film, television, the Internet, creative writing, and art.

issue 14 — september 2005

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI.* To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (57 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

opinion

[This article prints out to about seven pages.]

Can playing poker be good for you? Poker as a transferable skill

Adrian Parke, Mark Griffiths, & Jonathan Parke,
Nottingham Trent University, United Kingdom.
E-mail: mark.griffiths@ntu.ac.uk

Introduction

In late 2004, we were approached by an on-line gaming company to examine the skills involved in playing poker (both on- and off-line) and to assess to what extent the skills involved had any transferability to real-life situations. This provided an interesting challenge and we would like to share our speculations (as there was little in the way of empirical research to utilise).

Poker savoir-faire

Much of poker's appeal is due to the fact that, unlike many other forms of gambling, the scope to influence the outcome is vast. Put simply, it is primarily a game of skill. Although some of the necessary skills can be inherent (such as emotional intelligence, i.e., the ability to process emotional information, particularly as it involves the perception, assimilation, understanding, and management of emotion), many of the more idiosyncratic skills are only acquired through experience. As a result, successful poker players will always seek to improve by being critical of their own play and assimilating a behavioural repertoire of opponents' playing styles. Some sense of humility is required.

Successful poker players must show consistent voracity (i.e., greed). Profitable players need to view the game as a financial exchange rather than a social entertainment activity. This includes micromanagement of their "stack." In other words, they should not play loosely simply because they have the chip lead. They shouldn't differentiate pots based on the level of action or entertainment value. A "pot won is a pot won" and each one is important. Poker is a zero sum game—the pot won must not be

graded only by how much it increases the player's stack, but by how it affects the chip position with the opponents. A stack is primarily built by consistently grinding out small wins rather than by making erratic, high-risk plays.

Another skill that experienced poker players acquire is to realise their boundaries. This is applicable to several areas. Firstly, they must choose a game which suits their bankroll. Put simply, they should not play at a table where they are forced to play their blinds based on pot odds. Secondly, they should play at a level where they can keep their head above water (i.e., players should walk before they can run). A cheaper way to gain experience from the experienced players rather than "sitting" with them is to simply observe the profitable players at the high-stakes table. The final parameter is for players to know when they are beaten. Conceding defeat in a battle does not equate to losing a war. The war in poker consists of hundreds of battles. For players to use all of their "ammunition" in a battle they are unlikely to win is bad strategy.

Control

At a fundamental level, what separates good (professional) gamblers and novice or problem gamblers is the factor of self-control. The general rule of thumb for players is to avoid becoming emotionally involved in the game. Inducing emotional (rather than logical) reactions from gamblers is what makes the gambling industry so profitable. By remaining unemotional, players can protect themselves from recklessly chasing losses and avoid going on "tilt." On-line gamblers are particularly at risk from engaging in chasing losses for the simple reason that they have 24-hour access and are constantly subjected to temptation. Furthermore, they often lack a "social safety net" to give objective appraisals.

There are ways to avoid becoming emotionally engaged. These include reflective "time-outs" and having an objective attribution of outcomes. Reflective time-outs equate to playing slowly and making gambling decisions with accrued knowledge (i.e., knowledge of probability and of opponents). It is advisable after a "bad beat" for players to be disciplined enough to sit out one or two hands to regain composure before playing again. Extending the concept further, it is probably wise after a particularly ineffectual session to suspend play for an elongated time-out. Reckless and unintelligent play by knowledgeable players emerges from not being able to deal with frustration appropriately.

Determining objective attributions of outcomes involves players having an external locus of control when assessing the cards they have, and an internal locus of control regarding what they do with the cards available to them. The mantra of poker players is, "You

can only play the hand you were dealt." All players will experience streaks of desirable and poor hands, and it is how players respond to these streaks which will determine their success. It is very easy for players to become frustrated while in a negative streak. It is also easy in a positive streak to become narcissistic and complacent. It is the knowledgeable player who understands probability and who realises that over a continuous playing period streaks (both positive and negative) are inevitable and transient.

On-line poker playing

On-line poker and off-line poker are not synonymous. A very useful tool in poker is to "read" players through their body language and their verbalisations. In on-line poker, gamblers are denied this advantage, so they must seek to manipulate opponents by the tools at their disposal. The key is to take a weakness (i.e., not being able to physically see other players) and turn it into an advantage (i.e., using this nontransparency). On-line poker permits gamblers to create a false identity. Gamblers could portray themselves as young attractive novice female players when in fact they are actually very experienced recognised professionals. The key to a "hustle" or manipulating other players in poker is for gamblers to project a character and hide their identity. Essentially, it is about *representing* a façade, whether for one hand or the whole game. Gamblers can adopt any "character" they wish to suit any game in which they engage. Perhaps in the case of playing with novices it may be profitable for gamblers to portray themselves as experienced professionals in order to intimidate players into submission.

Using the Internet relay chat band provided, gamblers may find it easier to develop their personas. The tone and pitch of what gamblers say is not revealed in text, so fundamentally they are acting with their most unemotional "poker face." Put simply, they can exude confidence as they go all in on a bluff, when in reality their hands might be shaking and they may be sweating. The key to winning is inducing emotional reactions from other players. With knowledge of their opponents, it is possible for gamblers to "tailor" interactions to induce the desired response.

On-line social interaction at the poker table is not confined to adversarial chastising. It is possible to develop amiable relationships between players. On-line poker—particularly at low-stakes tables—is often more about entertainment than profit. In poker, it is not necessary to reveal your hand if nobody calls (i.e., pays to see it). Without seeing cards it is more difficult to understand player behaviour. However, at more sociable tables, people will reveal what they had to opposing players, if for nothing else than to indulge the observers. Creating false "alliances" is a

way for gamblers to ascertain more information about their opponents and improve their ability to "read" them.

Poker and transferable skills

Poker—both on- and off-line—requires many skills and abilities. Below are some of the traits and skills we speculate are needed to be a successful poker player and the characteristics needed to be a good poker player. We argue that all of these can be utilised in other contexts to bring about success in other areas of peoples' lives, particularly in the areas of employability and future success within that job.

- **Critical evaluative skills**: The ability to appraise information and situations realistically, and to anticipate problems and difficulties, is vital in poker. To critically evaluate your playing decisions ("did I play that right?") and those of others is common. These are also essential skills in the workplace—particularly in management.

- **Numerical skills**: The ability to handle and interpret numerical and statistical information is an important skill in many areas of employability. In poker, there are many levels of numerical skill, such as the micromanagement of funds—every penny is important—or the cards themselves. Not many jobs require mathematical wiz-kids but many decision-making judgements can be based on the balance of probability or the ability to interpret data summaries.

- **Pragmatism skills**: The ability to make the best of a nonideal situation and to work within preset constraints is a valuable skill in poker. For example, players need to accept what they cannot change (their cards) and play with what they have. Pragmatism is an undervalued skill within the workplace—most probably because it is more of an inherent skill than something that is learned. Success in almost any job will require good use of pragmatism.

- **Interpersonal skills**: Knowledge of the mechanisms of social communication and the potential sources of interpersonal conflict can be the difference between a good and a great poker player. Being able to identify an opponent's "tell" can pay huge (financial) dividends. Having good interpersonal awareness is not the same as being socially skilled (although it contributes). Interpersonal skills contribute to emotional intelligence, i.e., how to respond to different people in different situations. Interpersonal awareness skills in the workplace can make a difference in understanding and dealing with interpersonal problems. They may also help in

telling whether colleagues are lying or trying to be economical with the truth.

- **Problem-solving skills**: The ability to identify different strategies and approaches is of great benefit when playing poker. Problem-solving skills in the workplace are extremely important to anyone wanting to be successful in their career, especially when they are tied in with pragmatism skills.

- **Goal orientation skills**: The ability to set goals and to formulate strategies to achieve those goals can be of benefit while playing poker. Being hungry and insatiable in the desire to achieve (i.e., winning) is a common characteristic of good poker players. Having goals gives people a purpose, which is very valuable in the workplace. It allows people to measure their success in some way, just as the poker player does when winning or losing.

- **Learning skills**: The ability to continuously learn and not rest on your laurels is a valuable skill in poker (as it is obviously in almost all areas of life). In poker, being humble enough to learn from those more experienced and to take others' expertise into future games is akin to other learning experiences in other environments—including the workplace. In poker, such learning can bring about objectivity. For instance, poker players should not act in haste but ponder and deliberate responses objectively. In essence, this is continuing professional development. It doesn't matter what walk of life you find yourself in—learning from others is paramount.

- **Higher-order analytic and strategic skills**: The ability to extract general principles from immediate or concrete situations and to formulate appropriate strategies can be very important while playing poker. For example, good poker players know not to let the cards get them frustrated or not to fight battles they can't win. There are clear parallels in the workplace, including office politics.

- **Flexibility skills**: The ability to adapt to any situation or to be opportunistic when a situation presents itself underlies skills in flexibility. In poker, adapting to your environment (e.g., who are you playing against, how big is your stack) comes with playing experience. The ability to look from several points of view is not something that can necessarily be taught but is certainly a valuable skill to an employer.

- **Face management/deception skills**: The ability to knowingly deceive someone is not normally seen as

desirable, but in poker it is all part of the game. Good acting ability is needed to demonstrate poker face, bluffs, etc. The telling of nonverbal white lies is important here. In some situations in the workplace, such skill will be of great importance. Telling white lies to keep face or to be diplomatic is a good example. There are also many situations that employers have to bluff in order to succeed (e.g., in giving a presentation to the board or being interviewed for a dream job). While such skills are not encouraged, they can certainly be of great benefit to the employee.

- **Self-awareness skills**: The ability to play to strengths and acknowledge weaknesses is a common trait in many walks of life. In poker, such skills can be very important. For example, skilful poker players remember that bad luck doesn't always last and good luck definitely doesn't last. Poker players also know that there is no room for apathy or complacency (in winning or losing streaks). In the workplace, self-awareness skills will help employees succeed in areas of strength and delegate in areas of weakness.

- **Self-control skills**: The ability to act with a cool head under pressure and to show the nerve and the mettle to cope under adversity is critical in good poker playing. Quite clearly, in the workplace, many team leaders and managers need such skills in order to get the most out of themselves and their teams. Such skills are also important in terms of stress management.

Many of these skills are transferable to other arenas and are the kinds of abilities and traits that will help people achieve in the workplace and aid promotion. Diplomatic use of white lies can aid employees in a variety of situations and can help smooth over (or disguise) mistakes and errors.

This article was not peer-reviewed. Submitted: October 1, 2004. Accepted: January 12, 2005.

For correspondence: Professor Mark Griffiths, International Gaming Research Unit, Psychology Division, Nottingham Trent University, Burton Street, Nottingham, NG1 4BU, U.K. Phone: 0115-8485528, fax: 0115-8486826, URL: http://ess.ntu.ac.uk/griffiths/, e-mail: mark.griffiths@ntu.ac.uk.

Contributors: AP and JP collaborated on the initial half of the article and MG wrote the last half.

Competing interests: None declared.

Mark Griffiths, PhD, is professor of gambling studies at the Nottingham Trent University. He is internationally known for his work into gambling and gaming addictions and was the first recipient of the John Rosecrance Research Prize for "Outstanding scholarly contributions to the field of gambling research" in 1994, winner if the 1998 CELEJ Prize for best paper on gambling, and 2003 winner of the International Excellence Award for "outstanding contributions to the prevention of problem gambling and the practice of responsible gambling." He has published over 150 refereed research papers, two books, numerous book chapters and over 350 other articles. In 2004 he was awarded the Joseph Lister Award for Social Sciences by the British Association for the Advancement of Science.

issue 14 — september 2005

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (43 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

review

[This article prints out to about six pages.]

book review

Gambling problems in youth: Theoretical and applied perspectives

By Jeffrey L. Derevensky & Rina Gupta. (Eds.). (2004). New York: Kluwer (264 pp.), ISBN: 0-306-48585-0 (hardcover).
Price (approx.): CAD$ 84.50 or USD$ 56.00.

Reviewed by Keis Ohtsuka, Victoria University, Melbourne, Victoria, Australia.
E-mail: keis.ohtsuka@vu.edu.au

Abstract

This collection of specialist papers on the current state of youth gambling research summarises the progress in youth problem gambling research in recent years. Theories on youth problem gambling have evolved to a point where research evidence once perceived as contradictory and subject to debate can be reconciled within a more general theoretical framework. Growing consensus makes possible a synthesis that can inform public policy.

Youth gambling is no longer a novelty. More than 20 years have passed since concerns were raised regarding the increased availability of legalised gambling in industrialised democracies. A generation of youth has since grown up in a gambling-friendly environment. Over this period, substantial research evidence on youth gambling has also been accumulated, enabling us to refine theories regarding the genesis, maintenance, and treatment of youth problem gambling.

This timely volume, edited by Jeffrey L. Derevensky and Rina Gupta (International Centre for Youth Gambling Problems and High-Risk Behaviors, McGill University) summarises the current state of youth gambling research. This book synthesises research findings on youth problem gambling with the aim of achieving a better overall understanding. It is encouraging that theories on youth problem gambling have evolved to a point where research

evidence that was once perceived as contradictory and subject to debate can be reconciled within a more general theoretical framework. In particular, what were once competing explanations for youth problem gambling (e.g., Jacobs's general model of addiction vs. the cognitive/behavioural model of youth gambling) are now increasingly understood as equally valid causal explanations for different types of problem gamblers. Growing consensus makes possible a synthesis that can inform public policy. Collective research efforts on youth problem gambling are making progress, although more work is ahead of us.

Jacobs (Chapter 1) provides an up-to-date general overview of youth problem gambling in North America. He warns that the increase in youth problem gambling may be a linear function of gambling availability. Given the lack of reliable predictive models, his prognosis is a starting point for further debate. One thing is clear: we need to monitor the prevalence of youth problem gambling, anticipate its increase, and allocate resources for assistance and treatment. The development of accurate demographic, psychological, and behavioural prediction models is also necessary.

In Chapter 2, Stinchfield discusses the risk and protective factors of youth problem gambling. Analysing demographic, behavioural, and psychological correlates, he conceptualises youth problem gambling as a subclass of youth deviant behaviours. Males who exhibit antisocial behaviour, smoke, drink alcohol, and use drugs, with a history of parental/familial gambling, school problems and failure, and peer deviance, are consistently subject to youth problem gambling. Stinchfield recommends careful appraisal of causal and predictor relationships between the risk and protective factors of youth problem gambling and research on their effectiveness in prediction. He also argues for the integration of youth problem gambling models with the more general model of adolescent risk-taking behaviour.

Depression, anxiety, and youth suicide often accompany youth problem gambling. Langhinrichsen-Rohling (Chapter 3) proposes an integrated model of the association between gambling and depression and suicidal behaviour in youth. However, she cautions that the same processes may not fully explain the occurrence of addiction in adolescents and the elderly, in males vs. females, or in people from different socioeconomic backgrounds. Winters, Arthur, Leitten, and Botzet (Chapter 4) propose three pathways to co-occurrence of substance abuse and problem gambling behaviour. They propose that youth problem gambling be defined as a subclass of addictive behaviours. Research evidence so far clearly shows that youth problem gambling should not be regarded as just a benign non-life-threatening truancy. It occurs with a wide range of youth deviance behaviours, including substance addiction, as well

as depression and anxiety leading to suicidal behaviour.

Grant, Chambers, and Potenza (Chapter 5) review the neurological aetiology of youth problem gambling and pharmacological treatment. This chapter is an informative introduction to readers who work with youth problem gamblers with emotional vulnerability and impulse control disorder. To treat this group of impulsivist youth problem gamblers, a team of psychologists and psychiatrists may need to coordinate psychological and pharmacological intervention. Youth embrace novel things and adapt easily to new technology. E-mail and Internet chat supplement the telephone in young people's need to get in touch with peers on regular basis. Some youth exhibit an excessive use of new technology, which may be classified as addiction. Griffiths and Wood (Chapter 6) discuss the relationship between technology, such as video game playing and Internet surfing, and youth gambling. Undoubtedly, behavioural addiction such as gambling shares many common features with similar types of behavioural addiction, such as excessive video game playing and Internet use. Along with the increased availability of new technology, the percentage of youth showing worrying signs of addiction to such technology would also increase. Another concern is that young people may misapply expertise in video games (skill-based activities) to gambling (chance-governed activity). Langer (1975) argues that misapplication of skill-based approaches to gambling contributes to the illusion of control beliefs and overoptimistic expectations of winning at gambling. Beliefs in the illusion of control are predictive of gambling frequency as well as of problem gambling (Moore & Ohtsuka, 1999).

Derevensky and Gupta (Chapter 7) review screening instruments of youth problem gambling. Most screening instruments are based on the DSM-III or IV definition of pathological gambling. They include a preoccupation with gambling, a lack of adequate control over one’s gambling behaviour, and an inability to stop gambling; guilt, withdrawal symptoms, and difficulties in one’s social life; and work/school failure. Differences exist in terms of sensitivity and in the rate of false positives. Perhaps the notion of a progressive disorder, multiple pathways to youth problem gambling, and a theoretical framework that regards problem gambling as a constellation of disorders need to be incorporated in order to accurately assess youth problem gambling. It is suggested that incorporating immediate feedback into screening instruments should maximise the effectiveness of youth education.

The Transtheoretical Model (TTM) of Intentional Behavior Change (DiClemente & Prochaska, 1998; Prochaska & DiClemente, 1994), originally developed as a model of smoking cessation, explains a wide range of individual behavioural change such as the recovery process from substance abuse, exercise, and weight control

(DiClemente, Delahanty, & Schlundt, Chapter 8). Five stages are required to effect any permanent behavioural change: precontemplation (not considering behavioural change), contemplation (seriously considering change), preparation (preparing to change), action (performing actual behavioural change), and maintenance (sustaining the behavioural change over time). TTM also advocates a focus on markers of change. As well as strengthening protective factors, cognitive-behavioural therapists working with youth need to ensure that their decision-balance is in favour of curtailing gambling and that their self-efficacy is strengthened to ensure successful treatment outcomes.

Gupta and Derevensky (Chapter 9) and Nower and Blaszczynski (Chapter 10) identify three groups of youth problem gamblers: (a) behaviourally conditioned problem gamblers, (b) emotionally vulnerable problem gamblers, and (c) antisocial impulsivist problem gamblers. Gambling initiation and maintenance mechanisms differ among the three groups—hence the need for different treatment plans for each group. A pathways approach to treatment is applicable to a wide continuum of youth problem gamblers—starting with behaviourally conditioned youth on one end of the spectrum, those with emotional vulnerability in the middle, and impulsive youth with emotional vulnerability on the extreme end of the scale.

The book concludes with chapters on prevention aimed at reducing gambling problems (Derevensky, Gupta, Dickson, & Deguire, Chapter 11) and socially responsible policy (Derevensky, Gupta, Messerlian, & Gillespie, Chapter 12). Empirical research on risk and protective factors as well as a more comprehensive theoretical framework identifying youth problem gambling in a general theory of youth deviance would facilitate multiple approaches to youth gambling reduction.

Socially responsible policy is arguably one of the least developed areas of youth gambling research. While our psychological and clinical understanding of youth problem gambling can be applied to alleviate existing problems, our knowledge can be equally useful in assisting socially responsible policy making: this is a proactive rather than a reactive policy.

We know considerably more about youth gambling initiation, maintenance, treatment, risk, and protective factors—be they psychological or demographic—than we did 10 years ago. We need more research on the role of gambling in society and within communities; on its impact upon the national economy, at both the macro and the micro levels; and on the meaning, function, and symbolic experience of gambling, as well as research on resilience, treatment efficacy, and preventive education. Examining the phenomenological experience and meaning of the addiction for the

individual helps us to understand the causes of underlying distress beyond the manifestations of problem gambling. The next challenge for researchers and policy makers, as well as for members of the general community, is to apply what we have learned through research directly to socially responsible policy making.

References

DiClemente, C.C., & Prochaska, J.O. (1998).
Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviour. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 3–24). New York: Plenum.

Langer, E. (1975).
The illusion of control, *Journal of Personality and Social Psychology, 32,* 311–328.

Moore, S.M., & Ohtsuka, K. (1999).
Beliefs about control over gambling among young people, and their relation to problem gambling. *Psychology of Addictive Behaviors, 13,* 339–347.

Prochaska, J.O., & DiClemente, C.C. (1994).
The transtheoretical approach: Crossing traditional boundaries of therapy. Malabar, FL: Kreiger.

This review was not peer-reviewed. Submitted: March 8, 2005.

For correspondence: Keis Ohtsuka, Victoria University, Melbourne, Victoria, Australia. E-mail: keis.ohtsuka@vu.edu.au

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (50 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

review

[This article prints out to about seven pages.]

book review

Suburban Xanadu: The casino resort on the Las Vegas Strip and beyond

By David G. Schwartz. (2003). New York: Routledge. ISBN 0-41593-557-1 (paperback). Price: (approx.) CAD$ 45.00 or USD$ 35.95.

Reviewed by William Thompson, University of Nevada at Las Vegas, Las Vegas, Nevada, U.S.A.
E-mail: wthompson@ccmail.nevada.edu

Suburban Xanadu offers the reader a history-packed volume on casino gambling in Las Vegas and other American venues. The book presents the material in an orderly, chronological manner that covers many topics that have been likewise presented in other volumes as well. Some very good material is new. *Suburban Xanadu* seeks to establish that casino gambling is a normal (e.g., healthy) American pursuit, and that casino operators and regulators have been able to keep the casino industry honest and above-board in almost all cases. It is a "point of view" analysis; however, it is presented as if it were a "factual" analysis. The book is generally well written, and very well documented, but the overall tone is not always convincing.

The author, David G. Schwartz, has written a book that is essentially an extension of his doctoral dissertation in history (2000). It is a great achievement when a newly credentialed scholar is able to have his dissertation accepted by a reputable publisher who then distributes it for consideration by the general public. Editors of books drawn from dissertations usually seek to extract and dispose of academic rigmarole such as theoretical frameworks and hypotheses, and propositions subject to formal testing. They also seek to minimize the use of academic jargon.

Here the editors would have done a service to the reader if they had insisted that the author actually give the reader such a "framework." He should have at least provided some guiding

themes and directions as a road map through the detail and the unfortunately heavy dose of academic jargon that remains. The book is crammed full of interesting information that is well worth reading in and of itself, but lacks the coherent sense of direction that is usually provided with academic methodology; the reading becomes tedious at times.

The book is replete with trendy academic words such as "paradigm" and "marginal" (whatever such words mean). This could be accepted as "part of the territory" if the main concept were more completely developed. That concept is, of course, "suburban." After completing the book, I am still at a loss as to what the author means by the term and how it relates to Las Vegas, Reno, Atlantic City, Tunica, or any other casino jurisdiction. There are references to the notion that the American population became to a great extent "suburban" after World War II. Yet precisely how this was tied to casino development is not adequately explained.

This reviewer suggests that "suburban" is not a proper descriptive term for Las Vegas at all. First, Las Vegas is a city, not a suburb. Second, the Las Vegas Strip—which is technically under political control of the Clark County government—is not now, nor ever was, a "suburb." The Strip was developed on open land—the term "rural" might be appropriate, but it was in fact "deserted" (more accurately, never previously occupied) desert land. Before casinos, no one ever lived by the Strip, and even afterwards no suburbanites lived by the Strip. There have never been single family (stand-alone) houses near the Strip. Indeed, apartments aplenty accompanied the development of Strip casinos, but they housed card dealers, room attendants, and cocktail waitresses—not suburban families. No Las Vegas school is located within walking distance of the Strip.

The customers of the Strip were Americans and tourists from foreign lands. They came from urban and rural areas, as well as from the suburbs of Detroit, Houston, London, and Tokyo. Whatever their demographics, to argue that qualities tied to "suburban" (as opposed to other) lifestyles dictated their desire to come to Las Vegas is a bit of a stretch.

That the Strip developed outside of the city of Las Vegas (but not in suburbs) is an historical accident. The city did not want to push its services southward beyond Sahara Avenue, and the casinos existing out on Highway 91 (now the Strip), forced to develop their own utilities, turned to the Clark County government for support. This was not the typical case of an American company leaving the central city and moving, for instance, from Chicago, Detroit, or Atlantic City to the suburbs. The Strip casino developers were never in the city.

The author seeks to explain why the Strip developed while the casinos of downtown did not do so to the same degree. However, the idea of suburbanization doesn't work as an explanation. The author does not cite the analysis by Eugene Moehring (1989) in his *Resort City in the Sunbelt: Las Vegas, 1930-1970* that is directly on target. Moehring explains that City interests (dominated by downtown casinos) did not want the Strip to be within Las Vegas city limits, and how the Strip casino interests afterwards won several major battles with the city, notably to have the convention center located near the Strip, and to have McCarran Airport built next to the Strip. Additionally, they influenced the placement of the Interstate Highway so that it would serve the Strip by funneling drive-in guests from California to the casino doors. The author also neglects to point out two other major factors in the growth of the Strip resorts: the advent of air conditioning, which enabled horizontal as well as vertical growth, and the coming of jet air travel, which allowed larger and faster aircraft that could fly above storm clouds.

These factors certainly grew Las Vegas more than any suburban mind-set that swept the nation in the latter decades of the 20th century.

The use of the word "suburb" also becomes a device for declaring that "Atlantic City" has been a rousing success. The author concedes that the city of Atlantic City has remained a dismal, decaying center of urban blight, but he dismisses the fact that the main purpose of having casinos was to bring urban development to *Atlantic City*, not to its suburbs. The growth of suburban economies around Atlantic City simply has not been the goal, and it has not done the trick. It is not a good basis for declaring the "success" of Atlantic City, anymore than one could say that the three casinos of Detroit have given the Motor City economic development because life is good in Bloomfield Hills.

The other "title concept" of "Xanadu" comes from a poem by Samuel Taylor Coleridge. "Xanadu" was the pleasure-dome for royalty in the mystery-shrouded city of Kubla (Coleridge's spelling) Kahn's 13th Century China . I would agree that it makes sense to call the big resort casinos of Las Vegas "Xanadus," but I am not sure why that is important to the intended message of the book. The author points out that the typical Las Vegas Strip resort is actually bigger than the fictional Coleridge "Xanadu," but what does it mean to say Las Vegas is "big"? The Luxor pyramid casino on the Strip is bigger that the Luxor pyramid in Egypt, the Monte Carlo Casino on the Strip could house all the casinos of Monaco under its roof, the entire village of Bellagio in the Italian Alps could fit inside the casino of that name on the Strip. O.K., Las Vegas is big.

The idea that the Mob involvement which did dominate early Strip

development was somehow internally honest and professional is advanced with an unconvincing story about Charles J. Hirsch. This gentleman was an accountant. He actually makes for a good side story—but it is a side story. Hirsch developed essential control concepts for accounting within casinos. In the latter Mob days of the late 1950s and 1960s, he conceptualized the notions of "handle," "drop," and "hold." (The drop is the amount of money the gambler brings to the casino and puts into play. The handle offers a consideration of the amounts of money gambled—and this includes money turnover, that is, money won by the player and then gambled again. The hold is the percentage of money that the player brought to the casino [drop], measured in chips sold to the player, minus the money the player takes away from the casino when he leaves.)

The author contends that integrity was present in the Mob-controlled casinos, because they were able to use the accounting methodologies developed by Hirsch. The story about Hirsch is new to this reader, and in and of itself it is an interesting story. However, I'd rate the reasoning behind the story as less than compelling, as the accountant developed his notions *after* the Mob secured its position in Las Vegas. Hirsch occupied lower-level casino positions until he became the controller at the Sands in 1970. What did the casinos do before Hirsch came along? Secondly, Hirsch's methods, while providing the casino with a tracking mechanism to ensure that players were not cheating them, did absolutely nothing to protect a player from a casino when the casino wished to cheat the player. Overall, it can be suggested that the casinos were happy to simply have the odds in their favor in honest games (when the players were losing). However, there are ample stories of casinos confronting high-roller players who were enjoying fabulous runs of good luck. The stories find the casinos replacing honest dealers with dishonest "mechanics," or changing decks of cards or dice, and then deliberately cheating players. The stories are simply too much a part of the fabric of the Las Vegas past to be brushed off with a story of good internal accounting at one (or more?) of the casinos.

Another story of the triumph of "good" is provided by a profile of William Harrah. It too lacks substance. Harrah was an innovator who introduced bus junkets between San Francisco and his casinos in Reno and near Lake Tahoe. I can see why an author from Atlantic City would choose to overlook this innovation, and instead concentrate on the fact that Harrah was a WASP, and therefore represented an exception to the supposed rule that casinos were all controlled by Jewish and Italian operators. But there were many other "non-Jewish non-Italians" involved in early casinos: Benny Binion, Sam Boyd, John Ascauga, Baron Hilton—amazingly, none of whom are mentioned in the book—as well as Kirk Kerkorian and Howard Hughes. Back to Harrah. He was by

most other accounts a dismal failure toward the end of his life, as he refused to modernize, or even keep his northern Nevada casinos in clean condition. His car collection and his collection of spouses de-energized his talents for casino management. Harrah's was saved by William Harrah's demise in 1977 and by the efforts of Mead Dixon, Michael Rose, and Phil Satre to take the company public and engineer an effective merger with Holiday Inn. Today's Harrah's is nothing at all like William Harrah's Harrah's.

As the title uses the word "suburban," it is somewhat disconcerting that the author has given less than a single page to the phenomenal growth of major casinos for locals (the Boyd, Coast, and Stations properties being the best examples) that has occurred in the new Summerlin and Green Valley neighborhoods that truly do epitomize the notion of "suburban."

The author seems to mix in the casino gambling of Las Vegas with casino gaming elsewhere as he draws his picture of a "nice," "wholesome" industry. He accepts the veracity of tribal studies that prove the beneficial nature of Native American casinos. Some dissent can be offered to these views.

The author also recognizes pathological gambling, but then dismisses it from serious consideration by accepting industry dogma that problem gambling cannot be accurately studied and described with numbers. Yet the industry itself (the American Gaming Association) has done so, concluding that 1.3% of adults are pathological gamblers, and a National Commission has also used survey research to attach dollar values to the costs imposed upon society by pathological gamblers. There is a growing body of research on compulsive gambling.

The value of the book is not in the opinions of the author but in the meticulous, well-documented scholarship used in drawing out a multitude of stories about activities tied to the emergence of Las Vegas as the leading resort city of the world. It is not a quick read, but it is a good read.

The author is a scholar in one very good sense of the word. He has labored hard and long to stuff his mind full of facts about his (and my) chosen topic of interest—gambling. Good things must be said for scholars who toil hard in the isolation of their own hand-to-eye-to-mind laboratories. Studying hard worked when we were students; it also works when we become professors. (It beats drinking coffee and discussing the *New York Times* with colleagues.)

My critique need not be considered negative. I highly recommend this book for its wonderful substantive content. Those interested in

the casino gambling industry would be wise to give attention to the work. This reader is quite happy that the author, a fellow professor at his university (the University of Nevada, Las Vegas), has now written a second book on gambling, and a third book is in the works. David Schwartz is becoming a leading scholar in the field of gambling studies.

References

Moehring, E. (1989).
Resort city in the Sunbelt: Las Vegas, 1930–1970. Reno, NV: University of Nevada Press.

Schwartz, D.G. (2000).
Suburban Xanadu: The casino resort on the Las Vegas Strip, 1945–1978. Unpublished doctoral dissertation, University of California, Los Angeles.

Submitted: May 25, 2005. This article was not peer-reviewed.

For correspondence: William N. Thompson, Department of Public Administration, University of Nevada–Las Vegas, Las Vegas, NV 89154-6026 U.S.A. Phone: (702)-895-3319, fax: (702)-895-1813, e-mail: wthompson@ccmail.nevada.edu

Competing interests: None declared.

William N. Thompson (PhD, University of Missouri–Columbia) is professor of public administration at the University of Nevada–Las Vegas. He is an active researcher on gambling topics. His books include: *Gambling in America: An Encyclopedia of History, Issues, and Society* (2001); *Native American Issues: A Reference Handbook* (1996); *Casino Customer Service* (1992, 1996, with Michelle Comeau); *International Casino Law* (1991, 1999, with Anthony Cabot); *The Last Resort: Success and Failure in Campaigns for Casinos* (1990, with John Dombrink). He has served as a consultant to public and private organizations including The National Gambling Impact Study Commission, The President's Commission on Organized Crime, The Detroit Casino Study Commission, Lotto Quebec, The Manitoba Lottery Commission, The Netherlands Board of Gambling, several Native American tribes with gaming facilities, and commercial casinos.

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net

PDF version of: This Article (45 KB) | This Issue (813 KB)

JOURNAL OF GAMBLING ISSUES

contents
intro
research
clinical corner
opinion
review
letters
submissions
links
archive
subscribe

review

[This article prints out to about six pages.]

conference proceedings review

Culture and the gambling phenomenon

Blaszczynski, A. (Ed.). (2001). *The proceedings of the 11th national conference of the National Association for Gambling Studies, Sydney, Australia*, pp. 1–461. ISBN: 0-9585358-5 X. Availability: nags@nags.org.au

Reviewed by Phil Lange, Centre for Addiction and Mental Health, Toronto, Ontario, Canada. E-mail: Phil_Lange@camh.net

Abstract

Forty-six papers on culture and gambling include many that advance the use of the culture concept in gambling studies. Some authors implicitly equate "culture" with minority group status, multi-ethnicity, and non-mainstream status. This review summarizes eight papers that offer original approaches to understanding gambling through the concept of culture.

Introduction

Among biopsychosocial and other popular models of gambling, cultural approaches are the poor little match girl; forgotten or barely noticed and left in the cold while the prosperous received wisdoms of popular positivist variables (SES, mental health problems, understanding probability) maintain their comfortable hegemony. There is much preaching to advocate use of the culture concept to study gambling, but little action. To scan the Internet using the search terms "culture" and "problem gambling" is to discover a whole exhortatory literature scolding us to notice and include culture in gambling research, yet seldom doing so beyond mentioning it. So an entire conference devoted to culture and gambling is welcome—if one has a tilt towards cultural explanations—and this volume of papers stands as a valuable record. This review will comment on some of the more interesting papers, and by implication suggest that there are many creative

ways by which we can include the concept of culture in gambling studies.

When Raymond Williams (1976) reminded us that the popular social science concepts we take for granted to study how society works are mostly recent constructions, often less than a century old, he included the culture concept among these johnny-come-lately Euro-North American concepts on which we rely. The academic concept of "culture" is prominent in anthropology, cultural geography, history, and on the fringes of psychology and sociology. While even I have been chided that anthropologists don't own culture, yet they and other academics with a history of a strong cultural approach can add rigour to such studies, just as behaviourists and cognitive psychologists can provide robust paradigms because they have gone beyond common sense understandings of the terms "behaviour" and "cognition." Eight conference papers from this volume can serve as exemplars among the many ways that culture can be used in gambling studies.

Richard Wooley in "The Art of Speculation: Rationality, Imagination and Emotion in the Experience of 'Serious Punting'" (pp. 417–425). (A "punter" is a bettor.) Wooley takes what could have been just a tick-off item—

"Are you a serious punter?" [ ] Yes [ ] No

—and instead, from lengthy interviews and genuine participant-observation with one punter, builds for us a data-rich life-world that demonstrates what is rational and logical in making a serious commitment to gambling on horses. With insight he builds the case that much of punting is speculation; a part of everyone's life. He also shows the value of a thorough analysis of even one person's gambling experiences.

Sharlene Wong in "Asian Problem Gambling—a Western Chinese Perspective" (pp. 411–416) uses reflexivity in a cultural analysis that both concerns an "Other" and reflects back to "Us" how mainstream culture constructs gambling and counselling. We begin the paper expecting an analysis of problem gambling among the "Other"—here, Chinese clients. But Wong astutely uses our everyday English terminologies to show us how the cultural aspects of Euro-North American conceptions of agency and responsibility create ethnocentric categories and processes. Wong develops an original analysis, for the concept of reflexivity makes us examine our selves and our research paradigms to evaluate how our experiences with gambling shape us, both professionally and personally. She skilfully builds herself into her reflexive analysis.

William N. Thompson, Carl Lutrin, and Asher Friedberg in "Political Culture and Gambling Policy: A Cross National Study" (pp. 378–390) offer a tantalizing view of theory in political science that illumines "political culture" as an independent variable—a novel scholarly venture. Such an approach, as in this detail-rich paper, when used across jurisdictions helps us to understand how and why gambling policies both diverge and converge in Israel, Great Britain, Nevada, and California.

Adrian Scarfe in "The Culture of Envy and the Problem Gambler" (pp. 335–339) analyzes an emotional response that some might call an "ethic of envy," manifested in an individual, yet that can present as one form of desiring among members of a community. (The reviewer notes that, wherever you may be from originally, a wide acquaintance of many other wholly different ways of life would likely convince you that some peoples are more envious than you are accustomed to, and others much less envious.) For Scarfe, many clients show a dynamic of envy of other people—of their success, their happiness, even their comfort and ease in the world—that leads to unhealthy thinking and dangerous lifestyles, and that sabotages recovery. Scarfe's evidence comes not from ethnographic research per se, but from the give-and-take of counselling sessions; a valuable contribution.

Mark Milic in "A Psycho-Semiotic Approach to the Analysis of Gambling in Popular Culture" (pp. 269–275) uses the current cultural approach of symbolic analysis. He shows us how the symbols manifest in gambling represent both surface and deep levels of meaning that "conceals, expresses, and meets (in a limited way) underlying social and individual needs" (p. 269). Readers who are open to Milic's mode of analysis—semiotics is not for everyone—will find a surprise in every paragraph.

Virginia McGowan, Lois Frank, Gary Nixon, and Misty Grimshaw in "Sacred and Secular Play in Gambling Among Blackfoot Peoples of Southwest Alberta" (pp. 241–255) develop, from autobiographies and interviews with members of this First Nation people of the Great Plains, the wisely limited goal of understanding the "meanings given to gambling by traditional and contemporary Blackfoot peoples" (p. 242). The rich results from thorough, open-ended interviews with five people are understandings of gambling in social and spiritual spheres that contrast markedly with western secular and psychological models. The section aptly titled "Ethnocentric epistemologies in gambling studies" includes an insight by a Blackfoot addictions counsellor about one taken-for-granted treatment concept and goal: "'recovery' of that which you never had (such as stable employment, property, parent-child relationships) is simply not possible for many colonial peoples" (p.249). A parallel analysis to this quote involves standard gambling measures and what appear to non-Aboriginal peoples as

common sense questions—yet they reveal the ethnocentric assumptions behind the questions and the (often) scripted answers.

Kate Earl and Richard Maidment in "Cultures Collide Law and Social Science: Mental Health Expert and Problem Gamblers in Court" (pp. 128–135) analyze two trial cases and how the differing epistemologies of law and psychology can either talk past each other or be mutually useful. The paper represents an early stage of what could be a valuable project.

Jennifer Borrell and Jacques Boulet in "Culture and the Prevention of Problem Gambling" (pp. 14–23) suggest a whole new reorientation to gambling studies by inserting a reconstruction of subjectivity as "a sense of culture, a sense of health as a social construct and as a social 'issue'" to approach questions like:

> "(1) What is the meaning of 'disorders' (like problem gambling) within various cultural groups [including dominant ones]. How are they generated and conceptualised… (2) How can community action focus on creating healthy communities, and (3) What would person-oriented prevention be within families and communities?"

Each of these eight papers moves beyond only mentioning culture as something good to study, or conflating culture and ethnicity, or defining culture as non-mainstream.

Where are the ethnographies? I should be clear that it is no fault of the conference organizers that ethnographies of gambling are scarce, for this fundamental source of cultural analysis is also rare among current gambling studies. A conference can only present research projects that were rewarded with funding. Yet an ethnographic approach, not as a brief behavioural record, but as a focused examination of the rich interplay of social constructions by many interests around a topic, can add much to our understanding. We already have the example of Henry R. Lesieur's *The Chase: Career of the Compulsive Gambler* (1977) that left the well-worn trail of popular variables for an ethnographic approach, and so elicited a key concept of enduring value, that of "the chase." Hayano (1982) researched poker players and also left us a valuable model. Some of these conference papers may represent beginnings in this tradition.

For a future conference? With some papers it was difficult to find the culture concept in use, and we accept that this is not the fault of the conference organizers, for they clearly stated that they wanted to be inclusive. Would a greater emphasis on culture yield a more

dedicated collection of papers? Perhaps an option for a future conference might be to require that each abstract submitted describe which culture concept will be used and how it is included in the paper. (There are many scholarly approaches to culture, all easily available. An author who cannot find and use at least one approach can hardly claim to understand the concept.) Even this minimal requirement would greatly increase the degree to which the accepted papers address culture in gambling studies.

References

Hayano, B.M. (1982).
Poker faces: The life and work of professional card players. Berkeley, CA: University of California Press.

Lesieur, H.R. (1977).
The chase: Career of the compulsive gambler. Rochester, VT: Schenkman.

Williams, R. (1976).
Keywords: A vocabulary of culture and society. London: Fontana.

This article was not peer-reviewed. Submitted: June 1, 2005.

For correspondence: Phil Lange, editor, *Journal of Gambling Issues*, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario M5S 2S1 Canada.
Phone: (416)-535-8501 ext. 6077, fax: (416)-595-6399, e-mail: Phil_Lange@camh.net

Competing interests: Phil Lange is editor of the *Journal of Gambling Issues*.

Phil Lange (MA, social anthropology, University of British Columbia) has carried out research and community development in Brazil, Nunavut, and Ontario.

issue 14 — september 2005

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

contents | intro | research | clinical corner | opinion | reviews

letters | archive | submissions | subscribe | links

Please note that these links will always point to the current issue of *JGI*. To navigate previous issues, use the sidebar links near the top of the page.

Copyright © 1999-2005 The Centre for Addiction and Mental Health

Editorial Contact: phil_lange@camh.net phil_lange@camh.net
Subscribe to our automated announcement list: gamble-on@lists.camh.net gamble-on@lists.camh.net
Unsubscribe: gamble-off@lists.camh.net