Effective Strategies
for Treating Those with the Illness
of Pathological Gambling

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ABSTRACT. Gambling and its related problems have been around for centuries. As the technology of gambling has changed, so have the consequences facing our society. Pathological gambling is a very real problem facing all age, gender and socioeconomic groups in our society.

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The identification, assessment and treatment of those diagnosed with the disease of pathological gambling is a relatively new phenomenon. With research, professionals have greatly increased their knowledge regarding the complexities in treating pathological gamblers. With its inclusion in the Diagnostic and Statistical Manual, pathological gambling has gained professional relevance. Using the limited current research, we will examine the societal impact of pathological gambling along with effective strategies for treating those with the illness. Specific focus on the spectrum of gambling typologies, prevalence and interventions will be discussed to enhance professional understanding. doi:10.1300/J384v01n03_04
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INTRODUCTION

The disease of chemical dependency (i.e., signs and symptoms, consequences, treatment, etc.) is well documented. Less has been documented regarding gambling addiction, specifically the uses of a group format when working with those individuals diagnosed with this addiction. The purpose of this paper is to examine the uses of a group format, not only in professional settings but also in the Twelve Step community, as well describe methods used in a treatment center treating chemical dependency and process addictions (including gambling, Internet, shopping/spending, sex, and food addictions, as well as chronic pain with addiction). In order to better understand the uses of group and treatment of pathological gamblers, an initial overview will be given regarding gambling, Gamblers Anonymous and Gam-Anon, as well as the different types of gamblers and special gambling populations. In this article, the terms “compulsive gambling” and “pathological gambling” will be used interchangeably.

IMPACT OF COMPULSIVE GAMBLING

Webster’s Dictionary (1988) defines Gambling as: “(1. a) to play a game for money or property; (b) to bet on an uncertain outcome; (2) to stake something on a contingency; take a chance.” According to Gamblers Anonymous (www.GamblersAnonymous.org), Gambling for the compulsive gambler is defined as follows: “Any betting or wagering, for self or others, whether for money or not, no matter how slight or insignificant, where the outcome is uncertain or depends upon chance or ‘skill’ constitutes gambling.” According to William Eadington at the University of Nevada, Reno (2005), commercial gaming in America in 2004 earned $78.6 billion (not counting Internet gaming); the total in 1982 was $10.2 billion.

According to the National Council on Problem Gambling (2006):
- Approximately 85% of adults in the United States have gambled at least once in their lives; at least 60% gambled one time in the past year.
- Approximately 1% of the US adult population (2 million) meets criteria for Pathological Gambling in a year.
- Another 2-3% (4.8 million) of US adults qualify as problem gamblers (not meeting full criteria for pathological gambling but still exhibiting problematic gambling behaviors).
- 48 states and the District of Columbia have at least some form of legalized gambling.

Problem and Pathological Gamblers in the United States cost society approximately $5 billion a year in reduced productivity and social service utilization (including job loss, unemployment benefits, welfare benefits, poor health [physical and mental], and gambling treatment), as well as an additional $40 billion in lifetime costs for bankruptcy, arrests, imprisonment, legal fees, etc. However, this does not take into account family costs such as divorce, domestic violence, abuse, and/or suicide to name a few (NORC, 1999). What also needs to be considered in this cost are the consequences of drug and alcohol dependence. The rates of drug and alcohol dependence for gamblers versus non-gamblers are as follows: non-gamblers average 1.1% yet pathological gamblers average 20% in the United States (NORC, 1999).

Another important piece to be mindful of when working with compulsive gamblers is the increased risk for suicide. Approximately 20% of all Pathological Gamblers report they have attempted suicide (NCPF, 2006). Another study by Newman and Thompson in 2003 showed pathological gamblers are four times as likely to have attempted suicide as non-pathological gamblers (The Wager, 2003). Given the seriousness of this issue and the astounding figures, it is important to assess for suicide as well as any other co-morbid conditions (such as
depression) when working with pathological gamblers. This topic will be discussed in more detail later in this paper.

**HISTORY OF COMPULSIVE GAMBLING**

Given the scope and impact compulsive gambling has on not only the individual but also family, friends, and society, one may be curious to know how gambling originated in the United States. It is important to discuss the history because it is not just a phenomenon that happened overnight. Gambling has been present in some form in virtually all cultures throughout time. Some of the earliest evidence comes from ancient Egyptian murals. Greeks and Romans also placed bets on the turn of a chariot wheel. Playing cards originated in China, came to Europe through Spain and reached America with Columbus (NORC, 1999).

There are three phases of legalized gambling in the United States. The first phase is characterized by risk taking. Americans like the concept of “risking everything a person has to go for his or her dream.” This may include leaving everything behind to start over. Lotteries were important in early American history in financing Jamestown Colony and the Continental Army. They were also frequently used to finance paving streets and to build churches. During the second phase (post-Civil War), Southern states turned to the lottery to help rebuild the south after the Civil War. Lotteries were seen not as a movement toward recreation, but rather as a way to generate revenue. Beginning in the 1870s, most forms of gambling and all lotteries were banned after a scandal in the Louisiana lottery (which operated nationally) because of fraud in the government consisting of bribery of state and federal officials. Gambling throughout the states diminished until 1964 when the State of New Hampshire developed the first legal state lottery (in order to raise money for schooling) (NORC, 1999).

In the third phase of gambling in the United States, Nevada re-legalized gambling in 1931 but not as a major source of revenue (as that came from marriages and divorce). In 1945, Las Vegas built “the Strip” which coincided with the end of World War II. This allowed Americans to mingle with Hollywood stars who came to Las Vegas for entertainment. In 1976, New Jersey legalized casino gambling in Atlantic City as a way to increase employment. The first casino in New Jersey opened in 1978 (recouping its investment in just ten months). Gambling riverboats entered existence in 1991 in Iowa and Illinois with widespread expansion throughout the Midwest so that by 1998 there were over 40 Riverboats in Illinois, Indiana, Missouri, Iowa, and nearly 50 in Louisiana and Mississippi (NORC 1999). The first Internet wager was accepted in 1995. One study showed that Internet Gambling grew as an industry from $445.4 million in 1997 to $919.1 million in 1998 (NORC, 1999). Currently, there are only two states without gambling (casino or lottery): Hawaii and Utah. There are 41 states that offer state lotteries (OAGAA, 2005).

With the expansion of gambling over time comes not only entertainment but also concerns. Overall, most people are able to engage in gambling behavior for social/entertainment purposes, experiencing no negative consequences. However, there are those people who suffer consequences for their gambling when they lose control and end up engaging in problem or even pathological gambling behavior. This is where professional and Twelve-Step groups are available to offer assistance and support.

**GAMBLERS ANONYMOUS**

In January 1957, two men began to meet regularly to discuss their troubled histories due to their gambling behaviors. After several months of meeting, they realized neither one had returned to their gambling behaviors during this time. They decided in order to continue this positive journey, they needed to bring about certain character changes within themselves, using spiritual principals other addictions had used as a guide. “The word spiritual can be said to describe those characteristics of the human mind that represent the highest and finest qualities such as kindness, generosity, honesty and humility” (www.GamblersAnonymous.org). They also decided that in order to prevent relapse, they would need to carry their message to other gamblers. As a result, the first Gamblers Anonymous (GA) group met Friday, September 13, 1957, in Los Angeles, California (Gamblers Anonymous, 1984, p. 190). GA continues to grow today.

In most cases, when someone struggling with pathological gambling attends his/her first GA meeting, he/she needs to be prepared to read and answer the 20 Questions. The chairperson of the GA meeting will keep track of the prospective member’s number of “yes” answers. The 20 Questions can be found on the Gambler’s Anonymous website (www.GamblersAnonymous.org). Most compulsive gamblers will answer “yes” to at least seven of these questions (Gamblers Anonymous, 1984,
The chairperson of GA will then welcome the individual as a prospective member of Gambler’s Anonymous. Gamblers Anonymous groups are similar to other Twelve-step meetings such as Alcoholics Anonymous (AA) with some key differences. GA meetings are typically longer, usually lasting 1.5-2 hours compared with one hour for AA meetings. There are also fewer GA meetings across the country. Because of this, the meetings are harder to access in more rural areas, there are fewer females (therefore harder for females to find a sponsor), and fewer times available to attend meetings. GA meetings also have more cross talk, that is, asking someone questions after they talk as well as giving feedback on what they shared. In GA, sharing is called “therapy.” This format is not typical at other Twelve-Step meetings. GA meetings also historically had fewer Step meetings.

Because of fewer GA meetings available, the clinician needs to strongly encourage the compulsive gambler to seek assistance and support from other Twelve-Step meetings such as AA and utilize their desire to stop drinking/using for today to be able to attend and participate in Closed Meetings. Compulsive Gamblers would rather not attend anything but GA; however because of fewer GA meetings and the high risk for relapse, it is imperative for the Compulsive Gambler to receive continued support of the 12-step program whether or not it is solely from GA. It is important to recommend that pathological gamblers abstain from all mood altering chemicals/behaviors in order to avoid the potential for cross-addiction (replacing one addiction with another). Sometimes it may also be helpful for females to obtain two sponsors—one for gambling (can be male if no females available) and one for step work (a female from another Twelve-Step program).

Some Gamblers Anonymous groups also offer Pressure Relief Groups. These meetings are held with the new GA member and his/her significant other to address areas causing pressure on them including financial, legal, employment, or family problems. GA and Gam-Anon members meet with the gambler and his/her significant other during these meetings. Most GA groups require 30-60 days from the last bet and having attended a minimum of three to four GA meetings to qualify for the Pressure Relief Group (Gamblers Anonymous, 1984, pp. 78-79). If these meetings are not available in the gambler’s area, there are alternatives that will be covered later in this paper when discussing treatment of the pathological gambler.

Gam-Anon is for spouses, families, or close friends of compulsive gamblers. “Gam-Anon’s purposes are three-fold: To learn acceptance and understanding of the gambling illness; to use the program and its problem-solving suggestions as aids in rebuilding our lives; and upon our own recovery, to give assistance to those who suffer” (www.gam-anon.org). As Gamblers Anonymous and Alcoholics Anonymous are similar, so are Gam-Anon and Al-Anon. The Gam-Anon program focuses on decreasing co-dependency issues by refusing to take responsibility for someone else’s behavior while at the same time taking ownership for one’s own behavior. The prevailing idea is, “The gambler will play as long as someone else will pay” (www.gam-anon.org). One key difference between GA/Gam-Anon and AA/Al-Anon is once a month GA and Gam-Anon has a joint meeting where they are able to come together and share issues and ideas and have fellowship.

In summary, GA and Gam-Anon both serve to assist pathological gamblers and their families by: providing a forum to help identify their problem(s); sharing ideas, concerns, feelings, etc., and receiving feedback on them; gaining a better understanding of pathological gambling; and potentially receiving relief from pressures (e.g., financial, legal, employment, or family problems).

**TYPES OF GAMBLERS**

In order to provide effective treatment for pathological gamblers, one must have an understanding of the particular characteristics that help define them. Discerning between compulsive versus non-compulsive gamblers is an important aspect of the assessment process. This section will identify the six types of gamblers with specific focus on the compulsive gambler as well as provide the criteria for pathological gambling. In addition, information on teens, seniors, females, and those suffering with dual diagnoses will be reviewed.

Custer and Milt (1985) identified six types of gamblers:

1. The professional gambler
2. The antisocial personality gambler
3. The casual social gambler
4. The serious social gambler
5. The “relief-and-escape” gambler
6. The compulsive gambler

The first five aforementioned gamblers do not meet criteria for pathological gambling. This paper is specifically focusing on compulsive gambling.
Compulsive gamblers are addicted to gambling (Custer and Milt, 1985) (i.e., they meet criteria for pathological gambling based on the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association). Pathological gamblers cannot stop gambling even though they may think they can. This type of gambler has experienced or will experience extreme negative consequences as a result of his or her gambling. "It may, at the beginning, occupy only a minor role in his life, but then it becomes more and more important until finally it dominates his life, pushing aside every other interest and concern, undermining his self-respect, his work, his family life and relationships of trust with others, leaving ruin and desolation in its path" (Custer and Milt, 1985, p. 175).

**PATHOLOGICAL GAMBLER**

For the sake of the present article, the main focus will be on the compulsive gambler (i.e., those that meet the criteria for pathological gambling disorder). The following diagnostic criteria is from the current Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association (2000, p. 674):

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. Gamblers 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.

**"Action" and "Escape" Gamblers**

The two sub-types of compulsive gamblers are the "action" gambler and the "escape" gambler. According to the American Psychiatric Association (2000, p. 671), most gamblers "are seeking 'action' (an aroused, euphoric state) or excitement even more than money." When describing an individual who gambles to achieve a state of excitement and energy, one can say he or she is an "action" gambler. Hulen and Brumfield (2004a) describe "action" gamblers as "domineering, controlling, manipulative men with large egos" who "see themselves as friendly, sociable, gregarious and generous." Even though Hulen and Brumfield (2004a) refer to "action" gamblers as men, they state that they do not mean to imply that all "action" gamblers are male or that all "escape" gamblers are female.

Within the Illinois Institute for Addiction Recovery (IAR), "action" gamblers have presented narcissistic traits. For example, they view themselves as unique and needing a different treatment program to address their special needs. The "action" gambler can be quite dominating, boisterous, and aggressive in his or her interactions with others. Berman and Siegel (1992), even though they do not talk specifically regarding "action" gamblers, they report that a gambler's narcissism is a coping skill developed to deal with uncomfortable feelings. Narcissistic qualities that gamblers may exhibit include: belief in being special and unique (even to the extreme of expecting extra attention and special arrangements), use of others for their own means, difficulty accepting criticisms, focus on success (much of the time expecting success without working for it), unempathetic, and black and white thinking (Berman and Siegel, 1992). This information has been included in the "action" gamblers section due to the IAR's experience of this being more related to the "action" gambler than the "escape" gambler. This is not to say that the "escape" gambler, described later, cannot exhibit many of these characteristics.
“Action” gamblers enjoy games of skill (e.g., poker) (Hulen and Brumfield, 2004a). Much of the excitement may come from the thrill of being smarter than the others playing. Hulen and Brumfield (2004a) cite the “action” gamblers usually have IQs over 120. Within the IIAR’s experience, the thrill of performing or playing games adds to being in “action.”

The “escape” gambler’s profile is quite different than the action gambler. Webster’s Dictionary (1996) defines Escape as “1 To break free (from). 2 To avoid capture or harm. 3 To succeed in avoiding punishment. 4 To elude the memory of. 5 To issue involuntarily (from): leak out.” Hulen and Brumfield (2004c) describe the escape gambler as “nurturing, caring responsible people for most of their lives.” Usually they have suppressed emotions regarding traumatic experiences resulting in symptoms of depression (Hulen and Brumfield, 2004c). “Escape” gamblers, in order to improve their moods, turn to gambling as a way to “escape” from their problems. They usually experience problems with gambling later in their lives (Hulen and Brumfield, 2004d).

Hulen and Brumfield (2004c) utilize the feminine pronouns in describing the “escape” gambler. They refer again to informing their readers that this does not mean all “escape” gamblers are females. However, Lesieur and Blume (1991) performed research using an all female sample and discovered that more of the women used gambling to escape stressors/problems. Lesieur and Blume (1991) state some women fall into the category of seeking action/winning, but noted this trend is usually more typical for male gamblers. In this research, the differences between “action” and “escape” gamblers were described with the terms “adventurer” and the “escapist” (Lesieur and Blume 1991, p. 186).

“Escape” gamblers are more attracted to games that involve luck (e.g., slot machines or bingo) (Hulen and Brumfield 2004c,d). Typically, they are attracted to games they can get lost in; again, remembering their main goal is to escape from life problems. “For them, ‘winning’ may have to do more with the empowerment that comes from entering a world which is free from outside controlling factors which provides a narcotic-like relief or escape from their worries” (Hulen and Brumfield 2004c).

**PHASES IN A GAMBLER’S LIFE**

Custer and Milt (1985) identified three phases for a compulsive gambler. These are the winning phase, the losing phase, and the desperation phase. The progression occurs after the preparatory period. Certain characteristics may make some individuals more vulnerable to gambling (e.g., difficulty with rejection or lack of approval, impulsivity, depression and anxiety, feeling omnipotent, etc.) (Custer and Milt, 1985). There may also be conditions that contribute to the development of a gambling disorder (e.g., abuse, trauma, value placed on money and power, rejection from parents, etc.) (Custer and Milt, 1985).

The winning phase occurs after the preparatory period. According to Custer and Milt (1985), the gambler first starts gambling here and there with a small amount of money. As the gambler progresses in the winning phase, he or she may increase the amount of betting; this may involve asking others for money or sneaking money from others. He or she may resort to lying to obtain extra funds. The gambler is still meeting the demands of work and family, but is starting to gamble more frequently. Money starts taking on a new role for the gambler. The gambler starts to feel important with money (Custer and Milt, 1985). To gamblers, money starts to fix their problems.

Next the gambler wins a very large amount of money in his or her perspective (Custer and Milt, 1985). This starts a process for the gambler. “The big win is the booster on the rocket that tears him loose from the gravitational forces of reason and reality and sends him flying into a weightless flight of illusion and fantasy where there are no limits to what he can do and become” (Custer and Milt, 1985, p. 103). The gambler views this win as representing he has skill in gambling and he can win more. He starts viewing gambling as the main way to obtain money and starts paying less attention during family and friend activities. During this time period, the gambler is primarily winning.

However, the next phase is the losing phase (Custer and Milt, 1985). As the title notes, the gambler starts to lose and loses for some time. Compulsive gamblers start to bet more in order to make up for their losses. “Before all this happened—before the losing streak began—he was gambling to win. Now he is gambling to recoup. He is doing what gamblers call ‘chasing’—the frenetic pursuit of lost money” (Custer and Milt, 1985, p. 106). The gambler who has built his or her self-esteem on his or her gambling ability starts to feel depressed and irritable (Custer and Milt, 1985). Fear of whether he or she was such a great gambler sets in. Winning and the effects of winning are no longer the main impetus for gambling; instead, trying to be rescued from the feelings, whether it is depression, embarrassment, etc., becomes the main reason for gambling.

Compulsive gamblers during this phase lie, steal, and manipulate (Custer and Milt, 1985). Their main attention is on gambling. They find
alternative ways to obtain money in order to gamble (e.g., stealing, loans to cover loans, and selling items). The ability to find alternative ways of getting money demonstrates to the gambler he or she still has "it." With more money, the emotional symptoms improve for the time being. However, as soon as he or she loses again, the uncomfortable feelings surface and the behaviors return (irritable with family, hiding the gambling, lack of participation in family activities, lying about absences from work, etc.).

Desperation sets in when the gambler, even after their “lucky” has changed through the arrival of a bailout, still loses (Custer and Milt, 1985). In the desperation phase, the gambler turns to even worse means of obtaining money (Custer and Milt, 1985). No longer stopped by ethics and morals due to despair he or she is feeling, illegal activities may occur. During this phase, the gambler has not only lost money from gambling, but other losses can include work, family, friends, etc., due to these behaviors. "He alternates between periods of explosive anger and periods of zombie-like behavior" (Custer and Milt, 1985, p. 120).

He or she cannot gamble due to having very little or no money (Custer and Milt, 1985). In this phase, the gambler may experience agitation, depression, restlessness, poor sleep, poor appetite, and poor hygiene. At this point, the gambler wants relief from the aforementioned symptoms.

According to Hulen and Brumfield (2004b), recently a fourth phase, the hopeless phase, has been referenced by those in the field. In this phase, gamblers have given up hope. They may experience thoughts of not caring what happens to them or thoughts of suicide. They may end up in jail. They meet criteria for depression. "The hopeless phase is the time when the pathological gambler either gets help or ends with suicide or prison" (Hulen and Brumfield, 2004b).

**SPECIAL POPULATIONS**

A treatment program should have a solid understanding of gambling and its effects on certain populations. As with any good treatment program, one must consider the age of the patient when providing services and how the disorder/problems may affect him or her. According to the Illinois Department on Aging (2005), seniors can be more vulnerable to develop pathological gambling due to a desire to numb feelings associated with life changes (e.g., death of a spouse, health or financial problems, loneliness, boredom, or depression). Besides the above life issues as well as not understanding the risks involved with gambling, seniors may be at a higher risk of becoming “escape” gamblers due to gambling being more acceptable and more accessible (e.g., bus trips and group outings) (Illinois Department on Aging, 2005). Seniors may not have a wide variety of choices for social, entertaining, or exciting activities. Some seniors may gamble with the thought of making it rich so not to worry anymore over finances, where others may have enough money they do not see it problematic to spend some money here and there gambling (Illinois Department on Aging, 2005). According to the Illinois Department on Aging (2005), other reasons for gambling could be that others are doing it and it appears to be a safe environment for seniors.

On the other spectrum of age is pathological gambling with adolescents. Scuffham (2005) reports that an adolescent gambler may not appear to have a problem and may exhibit positive attributes, such as a good academic record or popularity within his or her peer group. However, teens are at risk for developing gambling problems. According to Derevensky and Gupta (2004), "there remains little doubt that adolescents constitute a particularly high-risk group for acquiring a gambling problem given their high rates of risk-taking, their perceived invulnerability, their lack of recognition that gambling can lead to serious problems, and the social acceptability and glamorization of gambling throughout the world." With adolescents, the clinician is looking for similar symptoms as described with the adult compulsive gambler, except in relation to the adolescent’s lifestyle. For example, Scuffham (2005) cites a decline in grades, less involvement in activities at school, new use of gambling terminology, and a new social group as signs of possible problems (to name just a few).

Another area for awareness is the compulsive female gambler. According to the American Psychiatric Association (2000), female compulsive gamblers are more likely to experience depression and more likely to gamble as a way to escape. Lesieur and Blume (1991) note that female gamblers may experience guilt over not fulfilling certain societal roles. And if not trying to escape through gambling, perhaps it is a desire to compete in a male driven environment (i.e., gambling) (Lesieur and Blume, 1991).

The Arizona Council on Compulsive Gambling, Inc. (2006) reports that 95 percent of the female callers to their helpline are “escape” gamblers. Hulen and Brumfield (2004d) report that “escape” gamblers need empowerment versus learning to be humble. Therefore, a program may want to focus on empowering their female clients and having them identify their strengths. However, Hulen and Brumfield (2004d) make note that the subtypes (“escape” and “action”) are not an issue of gender. It is
of importance to remember there can be “escape” male gamblers and “action” female gamblers. For example, female “action” gamblers may have a difficult time trying to understand why they do not relate to the other females (i.e., “escape” gamblers) in their treatment program or group (Arizona Council on Compulsive Gambling, Inc., 2006).

Additionally, a treatment program should be aware of other problems their patients experience. In a study on females and compulsive gambling, it was found that some of the sample reported additional problems, e.g., depression, substance abuse/dependence, shopping/spending addictions, problems with overeating, paranoia, and possible sexual addiction (Lesieur and Blume, 1991).

In keeping with this information, it is crucial that a treatment program be aware patients may present with more than one diagnosis, whether it be multiple addictions or mental illnesses. The IIAR realizes the possibility of cross addiction as well as multiple addictions. As the discussion on phases of the life of a gambler referenced, depression and suicide are possibilities that must be examined. According to the American Psychiatric Association (2000, p. 672), gamblers “have relatively high rates of suicidal ideation and suicide attempts.” Also found are higher rates of other psychiatric diagnoses. “Increased rates of Mood Disorders, Attention-Deficit/Hyperactivity Disorder, Substance Abuse or Dependence, other Impulse-Control Disorders, and Antisocial, Narcissistic, and Borderline Personality Disorders have been reported in individuals with Pathological Gambling” (American Psychiatric Association, 2000, p. 672). Further research examining these special populations is warranted to obtain knowledge of dual diagnoses and other important aspects in the pathological gambler as well as to adjust treatment strategies to meet the needs of these patients.

**SCREENING AND ASSESSMENT TOOLS**

Please note for the remaining sections of this paper, we are focusing on the IIAR’s experience in treating the pathological gambling population. Therefore, IIAR’s recommendations and strategies for treatment will only be discussed. Other treatment approaches are outside the realm of this paper. This current section will identify screening and assessment tools as well as other issues the pathological gambler will address while in treatment at the IIAR. The first week of treatment is spent gathering information through psychological screenings, a biopsychosocial interview, medical history, a Concerned Person Questionnaire, financial survey, and a Patient Gambling Questionnaire amongst other information gathering techniques.

In treating a pathological gambler, it is imperative to screen for other addictions, such as alcohol, drug, sex, Internet, food, and compulsive shopping/spending as well as other mental health disorders. According to the National Gambling Impact Study (NORC, 1999), 70% of individuals diagnosed with pathological gambling are also diagnosed with depression; 57% are also diagnosed with alcohol dependency. In 1993, the IIAR integrated a comprehensive treatment program for pathological gamblers after seeing the power of screening for other addictions because more than half of their clientele who identified a drug or alcohol dependency were also pathological gamblers.

As the disease of addiction progresses for the pathological gambler, the risk of suicide attempts increase. This is a result of the pathological gambler feeling desperate and hopeless due to his or her financial consequences. The prevalence rate of suicide attempts for this population is 20% (NCPG, 2006). Within the first 72 hours of treatment, pathological gamblers have a higher risk for attempting suicide due to the “crash” and reality setting in of the devastating losses they have incurred. The “crash” from pathological gambling is comparable to the “crash” of cocaine, with the individual experiencing extreme depression, paranoia, helplessness and hopelessness. A psychiatric evaluation is appropriate and essential to determine if a client is at risk of harm to self or others especially during this time. This evaluation may also determine any comorbidity as well as need for medication. It would also be encouraged to complete a Suicide Risk Assessment to determine precautions necessary and have the client sign a No Harm Contract.

Along with the psychiatric evaluation and the psychological screenings, it is helpful to complete a mental status examination to determine the client’s orientation to person, place and time as well as screen for any organic disorders. These screening tools will assist in the development of the client’s treatment plans. It is the philosophy of the IIAR to treat the whole person; if we do not treat the whole person, we are doing an injustice to the client and his or her risk of relapse will increase.

Within the first 24 hours of treatment, the nurse completes a nursing assessment and the attending physician completes a history and physical. Some considerations in working with a pathological gambler and his or her medical well-being include the following:
A diabetic pathological gambler who does not leave the slot machine to eat or check blood sugars and, as a result of this, needs medical attention to regulate his or her blood sugars.

A pathological gambler neglecting to take his or her blood pressure medications and, therefore, experiencing high blood pressure; when he or she comes into treatment, he or she needs evaluated for the appropriateness of medication and continued monitoring.

The biopsychosocial assessment allows for the therapist to gather more information from the client to determine his or her course of treatment. This assessment covers history on the following issues: family, legal, educational, sexual, abuse (as well as any domestic violence issues), chemical and other addictive behavior, emotional, spiritual, environmental (i.e., where do you live? Who has financial control in your household? Any financial concerns while in treatment?), and occupational. Recreation/leisure activities prior to coming into treatment are also assessed as well as goals for after treatment and the client’s strengths and weaknesses.

Other tools that can facilitate gathering more information to determine the course of treatment is having the significant other and/or other family members complete a Concerned Person’s Questionnaire (CPQ), a South Oaks Gambling Screen (SOGS) and/or the 20 questions of Gamanon. The Concerned Person’s Questionnaire is similar to the detail of the biopsychosocial for the patient, but the CPQ can be completed by the individual and not necessarily in an interview format. Although the South Oaks Gambling Screen is primarily used to determine a need for further assessment of someone who may be a pathological gambler, it is also a helpful tool to receive collateral information from the significant other. It allows the therapist to determine if there are any discrepancies within the pathological gambler’s “story.” Finally, the Gamanon 20 questions offers the therapist insight into how this disease is affecting the family member or other concerned persons.

The financial survey is another tool to gather further information from the pathological gambler and the concerned person. This section will only highlight the financial survey while the following section will discuss it in more detail. This survey is to be completed by both the gambler and the concerned person. The survey determines the family cash flow and the debt incurred by gambling. Once the financial survey is completed, the gambler and concerned person will begin working with other members in Gambler’s Anonymous through pressure relief and/or working with a financial counselor to develop a budget and a repayment plan.

Finally, the gambler completes the patient gambling questionnaire. This questionnaire allows the gambler to see the progression of his or her disease and the financial consequences of it. It also allows the person to evaluate how his or her disease has impacted the family, work, social activities, and emotional well-being.

Although these screening tools may appear to gather similar information and thus perhaps be redundant, it assists the therapist in getting a clear picture of his or her client. A pathological gambler typically is an “expert” at manipulation and deceit. These tools allow the therapist to determine discrepancies within the gambler’s “stories,” which will allow the therapist to confront the gambler and bring him or her to the reality of his or her disease.

PATHOLOGICAL GAMBLER IN TREATMENT

Along with the screening tools and gathering information, it is important to keep the pathological gambler busy with assignments within the first week of treatment. This is essential because he or she may still be in action. When a compulsive gambler (either “escape” or “action”) is “in action,” he or she experiences intense euphoria through reliving his or her past gambling experiences or planning his or her next gambling episode. Being “in action” for the compulsive gambler is similar to someone craving crack/cocaine.

If the compulsive gambler is not kept busy within the first week of treatment, he or she will typically leave treatment within the first 72 hours, will find everything wrong with the treatment center, and/or will speak only of his or her winnings. One of the assignments the IIAR gives to the pathological gambler within the first 72 hours of treatment is defining abstinence. The gambler needs to begin to take a look at what abstinence means to them (i.e., “what is gambling?” because there are many gray areas). Other assignments given include reading the Combo book of Gambler’s Anonymous (GA) as well as beginning step one of GA. The gambler also needs to become involved in GA meetings right away and complete the 20 Questions. He or she also needs to be involved in other group therapy related to his or her addiction, as well as be involved within the overall milieu of the unit (including, but not limited to, education on various types of addiction, not just gambling).
THERAPY CONSIDERATIONS
WITH PATHOLOGICAL GAMBLERS

Throughout the treatment process, there are many special considerations a therapist must be aware of when working with compulsive gamblers. Although many similarities exist between chemical addicts and compulsive gamblers, some of the various personality characteristics of gamblers pose unique obstacles to the therapy process. In this section, we will discuss the group therapy process as it relates to the specific types of compulsive gamblers. We will address various issues surrounding the treatment of the “escape” gambler as well as the “action” gambler. Throughout the section, we will discuss the role of the family and support system. We will also discuss the therapist’s role in addressing financial issues with the compulsive gambler and his or her family. As with most treatment programs, a significant emphasis is placed on relapse prevention and the development of a stable discharge and follow-up plan. Here we will address the use of relapse prevention techniques and tools along with the role of ongoing Gamblers Anonymous (GA) and other Twelve Step meetings and outpatient follow up.

As stated earlier, the remaining discussion reflects the knowledge obtained and practices developed by the HIA in working with this population.

As with most addiction and mental health treatment programs, group therapy is the preferred modality. The process of group therapy provides the structure needed to develop the therapeutic alliance that is crucial when working with compulsive gamblers. Although issues of shame and guilt tend to be universal for people with addictions, these issues ring even louder for the compulsive gambler. As discussed earlier, the significance of depression and increased suicide risk presents specific problems during the initial phase of the therapy process. Due to this increased sense of guilt and shame, many compulsive gamblers are initially resistant to discussing the wreckage their addiction has created. Often the person will attempt to discuss the problem in therapy as simply a financial problem that could easily be solved if there was more access to money. During this initial phase of therapy, it is the therapist's primary task to address this cognitive distortion in order to approach the deeper issues of shame and guilt.

During the therapy process, compulsive gamblers may use various distortions and manipulations to avoid accountability for their addiction. The “escape” gambler may play upon the sensitivity of the peer group to elicit sympathy for the difficulties he or she is experiencing. The primary distortion of this type of gambler is the notion he or she is a “victim” (i.e., that his or her life and those in it have been unfair). The primary task of the therapist and peer group during this “victim stance” role is to provide a consistent message of accountability and encouragement to discuss their thoughts and feelings. As with many addicted individuals, the “escape” gambler thrives on the ability to manipulate and avoid accountability. When the therapy group is in a state of flux with little structure or accountability among members, the “escape” gambler will fade into the backround. This ability to go unnoticed in the therapy group is exactly the tactic they relied on with family and friends to avoid being discovered. As the term “escape” denotes, these types of individuals use the process of gambling to avoid coping with life issues as well as providing comfort from emotional pain.

Due to the nature of compulsive gambling, there are often few physical signs of gambling compared to chemical use. As a result, the individual may be well into the pathological phase of gambling before others become aware of the problem. For the “escape” gamblers, secrecy and isolation are their greatest allies during their addiction. One of the primary tasks during therapy is to address the component: “escape” and what function it serves for the individual. In doing so, one of the therapist's primary techniques is to link the compulsive gambler with other members of the therapy group. This is key due to the isolative nature of “escape” gamblers. As the individuals are able to draw similarities between themselves and their group members, this sense of isolation and shame will begin to lessen.

One of the universal issues with compulsive gamblers is the financial devastation the individual and family experience. Due to the inherent private nature of finances and financial status, most compulsive gamblers will have an aversion to discussing how the financial stress has impacted their lives. With “escape” gamblers, this issue is more pronounced than with chemical addicts and even other gambler types. Statistically speaking, women tend to dominate this gambler type; with that comes multiple gender stereotypes the individuals themselves often adhere to and reinforce, specifically the idea that women, especially mothers and grandmothers, are the nurturers and caregivers of the family system. For so many women, the sense of shame they associate with the betrayal of this role becomes a key issue in therapy. In treatment, you may be dealing with cases where an individual suffering from compulsive gambling has exhausted family savings, college funds, or retirement plans. Due to this, therapists need to be vigilant to address issues regarding the family and the real and perceived impact of the gambling
behavior. It is not uncommon to get responses in group of “it’s none of your business how much I lost,” “we had all our bills paid” or “I don’t remember” as means to avoid accountability. The best way to handle these issues and shame-based thinking is for the therapy group to foster commonality and instill a sense of safety to break down some of the defensiveness.

The make up of the therapy group is also of particular concern. In many treatment settings, the groups are mixed between various addictions including chemical addicts, sex addicts and compulsive gamblers to identify a few. The make up of the group will also steer the therapist in selecting various interventions and will also impact the group process (Yalom, 1995). In settings where the groups are mixed, “escape” gamblers may use this to play upon sympathies of group members who may not understand gambling addiction. In some cases, compulsive gamblers will manipulate their peers into defending their actions or participation in the group to the therapist. As stated earlier, many “escape” gamblers use “behind the scene” manipulation to keep people off balance as to avoid discovery. The same process can transpire in treatment. It usually takes the form of eliciting pity and care-taking behaviors from peers. One of the key techniques used to address this phenomenon is through cross addiction education (i.e., addressing with the entire treatment milieu the realities of various addictive behaviors). This will expand the realm of understanding for group members and provide fewer loopholes for the compulsive gambler to exploit in therapy.

The other primary type of compulsive gambler is the “action” gambler. The various characteristics of this type of gambler were discussed earlier and we will not go into detail regarding the games and gambling patterns of these gamblers. However, we will discuss various personality characteristics, behaviors, and defenses used by the “action” gambler to thwart treatment and therapy efforts. The role of the family and support system takes on a different flavor for the “action” gambler. We will discuss when and how to address family/support issues in treatment. We will also identify how “action” gamblers, specifically in a “mixed” addictions treatment program, can affect the group process.

As with any individual life change, resistance, defensiveness and apprehension are a normal part of the process (Yalom, 1995). At the onset of the treatment process, many “action” gamblers will struggle with these various issues, as would any other individual with an addiction. However, some unique characteristics present with these individuals. One of the more problematic issues is the “action” gambler who may either be diagnosed with or have features of narcissistic personality disorder. Due to the nature of this type of gambling, a pervasive and often persistent sense of grandiosity is expressed and experienced by these clients (Yalom 1995). Within the treatment milieu, “action” gamblers can have profound impact on clients and staff. During the therapy process, these individuals attempt to present themselves as unique—having special needs and issues that others cannot or will not understand. This type of behavior can derail the group session as it presents an unsafe emotional atmosphere to address emotions and problems. The “action” gamblers may consciously or unconsciously sabotage his or her and others’ treatment through selfishness and lack of empathy for others.

“Action” gamblers have a tendency to view himself or herself as special and thus should be given specific attention and respect by others. This distortion often is fueled by their tendency to use fantasies to reinforce their sense of uniqueness. These individuals’ greatest hurdles in the beginning phases of treatment are to address their distorted views of the world and themselves. As with most narcissistic individuals, “action” gamblers will overly emphasize other people’s problems and shortcomings. During the group session, therapists need to be keenly aware of this issue. “Action” gamblers can be so skilled at this they will have other group members arguing and fighting amongst themselves. The “action” gambler will then use this to point out the ineptness of the therapist and treatment program to address even “basic” issues. Left unchecked, these individuals will attempt to discredit the therapist as a means of gaining a distorted sense of importance. In some cases, it is not uncommon to hear statements such as, “These counselors don’t know what they are doing. Tell me your problem and I can help you better than they can.” All of these distortions are an attempt to keep the group off balance and avoid coming under the scope of the therapist and peer group. When addressing these clients during the therapy session, they have a tendency to report dramatic improvement and minimize the deeper extent of their addiction. For these individuals, the addiction is so closely linked to their sense of self that any perceived attack will quickly be discounted and minimized as not relevant to them. This distorted perception of being “cured” is of particular concern to avoid premature termination of the therapy process.

When discussing the role of the family/support system, there are some key issues to keep in mind. First of all, “action” gamblers more often than not want to minimize the involvement of others. This is similar to the “escape” gambler, but the reason tends to be different. Whereas the “escape” gambler wants to avoid the shame and guilt associated with family and work, the “action” gambler wants to keep things under
his or her control so as not to have information leaked to the therapist by
the family. This attempt to control the treatment process is a central
theme for "action" gamblers. For them, secrecy will allow for loopholes
for which they can return to gambling once they have "control" again. If
the family is involved, their manipulations and distortions will be chal-
lenged and this is viewed as a threat to their control, not only on an emo-
tional level, but financial as well. Just as the "escape" gambler fears the
discussion about finances, the "action" gambler has an even more pro-
found and distorted fear about financial consequences. Due to their dis-
torted, grandiose view of themselves, the ability to possess, use, and
control money is part of their fantasy world. During the group therapy
process, specific attention should be paid to addressing such cognitive
distortions. Consistency on the part of the treatment team and support
system is key to help the individual confront and avoid continued
thought distortions.

FINANCIAL ISSUES

The involvement of the family system is essential when addressing
compulsive gamblers of both types. The family or support system iden-
tified by the patient becomes a key component for accountability re-
respect to family/support system

At the beginning of the treatment process, each client needs an indi-
individual financial assessment to identify particular concerns that will be
the focus of the financial counselor meetings. The financial counselor
plays a vital role in the assessment, identification and restructuring of
financial matters with the client. It is during this process the development
of trust and rapport with the treatment program will be put to the test. If
the counseling rapport has not been established, you are likely to see the
client sabotage the financial process either through out right resistance
or simply neglect to fully disclose creditors, financial accounts, or other
outstanding bills. The financial counselor will need the full cooperation
of the individual and his or her support system to provide the best possi-
ble financial plan. During the treatment process, the financial counselor
may meet with the client numerous times to address resistance and de-
velop financial plans. During the process of addressing financial con-
cerns, the primary therapist will work in conjunction with the financial
counselor to provide support and address resistance issues. Both the fi-
ancial and clinical counselors will discuss and identify areas where
"bailouts" may present themselves. The compulsive gambler will fre-
cently be looking for "bailouts" from his or her support system and
peers in treatment. Bailouts consist of various forms of rescue and
relief from not only financial debts, but also personal accountability for
past, present and future actions. The concept of "bailouts" is a difficult
one for both clients and support systems to understand. For the average
person, the idea of getting some financial help/relief from family or
friends when you are down is generally acceptable. For compulsive
gamblers, this is often internalized as one more instance they have
"won" and keeps them in a continued state of action as the direct pain of
re-payment or accountability is once again escaped. For safety reasons,
not only for the compulsive gambler but also for themselves, the sup-
port system needs to understand to never loan money to the compulsive
gambler (even if it is as simple as loaning money for a can of soda).
These are key concepts to address during family and group therapy.

Depending on state-to-state laws, most citizens have the right to "opt
out" from credit card solicitors. This is especially important for the
compulsive gambler to avoid the constant barrage of credit card compa-
nies that present frequent opportunities to access new cards and poten-
tial triggers for gambling. Depending on what financial counseling
program you use, most financial counselors will help the individual
submit the "opt out" forms. Another issue of key importance when
addressing not only financial issues but also relapse prevention, is the
river boat/casino self-exclusion programs that exist throughout the coun-
try. Depending on what state you are in will dictate the laws and programs available for self-exclusion. All compulsive gamblers should, if able, self-exclude regardless if they have ever gambled in a casino or on a riverboat. The focus is again on accountability and risk reduction for relapse. For example, the Illinois Gaming Board (IGB) handles the self-exclusion process of residents of Illinois. Throughout the state, there are set facilities in which an individual may present to have themselves excluded from the Illinois Riverboat casinos. Once the exclusion application is completed, the forms are sent to the IGB, processed by them and the information is then distributed to all Illinois riverboat casinos. The self-exclusion process should be combined into the treatment plan for the compulsive gambler to complete prior to successful completion of the treatment program.

RELAPSE PREVENTION

Relapse prevention planning, as with all addictions, begins from day one when the individual enters treatment. The relapse prevention process is a well-defined series of steps the individual can take to reduce the risk he or she will return to active addiction. The relapse prevention process can take on different roles and variations depending on the individual’s level of care. While clients are in an inpatient modality, relapse prevention is a preparatory process to aid the client once they enter into an outpatient setting. During the inpatient phase, plans are made to develop support networks, identify Twelve-Step meetings, and list possible relapse triggers and potential warning signs they may be headed toward a relapse. Once the client enters into the outpatient setting, the focus changes into practical application of relapse prevention tools and techniques. Here the compulsive gambler will begin to utilize the information provided during the more intense phases of treatment. For clients who do not enter into an inpatient program, the educational and planning process is similar to the inpatient setting. Clients in the outpatient setting will need heavy involvement with Twelve-Step meetings such as GA and regular, intense relapse prevention groups. One of the treatment planning goals for the therapist to consider is the implementation of GA meeting attendance and obtaining a GA sponsor early in the treatment process. As discussed earlier in the paper, GA is a vital part of each client’s social support and relapse prevention network.

During the treatment process, clients and their support systems need to be aware that continued financial stress and new potential financial problems may occur even after the involvement of the financial counselor and development of a re-payment plan. Due to this possibility, the financial counselor needs to be an ongoing part of the relapse prevention plan and follow-up care both in and out of formal treatment. It is highly recommended the client and his/her support system be part of the financial follow-up appointments.

As with all addictive behaviors, the importance of continued follow-up is crucial to long-term success. Once primary treatment has been completed, ongoing continuing care groups are strongly encouraged to provide a longer-term support mechanism for the client and his or her support network. This continued care may consist of many different components including, but not limited to: psychiatric, medical, pastoral, financial, psychotherapy, GA, and GamAnon. The exact combination of modalities should be developed prior to starting the continuing care program. As with all forms of therapy, regular reviews of the treatment plan are useful to determine if current needs are being met or if new issues have arisen.

CONCLUSION

The role of gambling in modern society has been a developing and persistent phenomenon. As with all addictive behaviors, the roots of gambling can be traced back to century-old practices all the way to the flashy high profile casinos of today. Just as society has seen the development and impact of chemical addiction, so too are we just beginning to understand the problems and damage caused by compulsive gambling. As our knowledge and understanding of compulsive gambling increases, so will our ability to provide effective treatment for those who develop compulsive gambling addictions. Clearly, we as professionals are in our infancy when it comes to addressing and treating compulsive gambling as we were decades ago with chemical addiction. The possibilities for improved treatment options are rapidly increasing with new discoveries in neurobiology, pharmacology, and psychotherapy. For these reasons, future research on pathological gambling and effective treatment modalities is crucial for the behavioral health field.

The ability for individuals to seek help and access treatment providers has continued to progress with more states adopting programs to identify and treat compulsive gamblers. The development of self-exclusion and “opt out” programs provide people with the means to intervene on the behavior. The individual’s ability to get linked with treatment
providers through websites and state funded 800 numbers and treatment initiatives are also advancing. We, as a society, are bombarded on a daily basis with images of the rich and famous enjoying lavish vacations and material goods. For many people, this distorted sense of reality becomes an obsession and the idea of “get rich quick” seems almost a reality. For that percentage of the population that suffers from compulsive gambling, this feeling is all too real. As professionals, we are facing an uphill battle in educating the individual, government, and society to the dangers of compulsive gambling. However, we have begun and will continue to climb the hill until all those seeking assistance for this problem have found the help they need.

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