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Staying in action: The pathological gambler's equivalent of the dry drunk



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Abstract

Alcoholics Anonymous refers to the alcoholic who has stopped drinking, but who still demonstrates alcoholic attitudes and behaviors, as a "dry drunk." Such individuals are said to have abstinence but not sobriety. They are considered at risk for relapse. Although the concept of the dry drunk has been adopted by other self-help programs, "staying in action" is an equivalent and arguably more meaningful expression to use for the understanding and treatment of many pathological gamblers. The author discusses covert gambling, mind bets, switching and fusing of addictions, procrastination, risk-taking, and power games; a repertoire of ways in which the individual can remain in a gambling mind-set while technically abstinent. This is a clinical paper, based on the author's experience, especially in treating the more traditional, action-seeking gamblers. Vignettes are utilized to illustrate various behaviors and states of mind. The emphasis is on their identification and on the need for the therapist to confront these behaviors and attitudes before they lead to relapse. **Key words:** pathological gambler, treatment of pathological gambling, action, staying in action, covert gambling, mind bets, risk-taking, behavioral equivalents.

Introduction

Alcoholics Anonymous refers to the alcoholic who has stopped

drinking, but who still demonstrates the same alcoholic attitudes and behaviors, as a "dry drunk." They say that such an individual has abstinence but not sobriety. This concept has been adopted by most twelve-step programs. It appears on almost all of the Web sites devoted to the different addictions, although characteristics of the dry drunk syndrome differ widely from site to site. Most often mentioned are: (1) depression; (2) anxiety; (3) irritability, anger; (4) grandiosity, pomposity, an inflated ego; (5) an inability to delay gratification, impatience and impulsivity; (6) self-pity; (7) being a workaholic, other compulsive behaviors, tunnel vision, a lack of balance; (8) intolerance, rigidity, being overly judgmental; (9) nostalgia toward or romanticizing of one's drinking or drug use; and (10) emotional constriction, lack of spontaneity, failure to enjoy life.

Despite differences of opinion as to its symptoms, traits or components, and the paucity of attention paid to it by clinical researchers (for the exceptions see Flaherty, McGuire, & Gatski, 1955; Gogek, 1994), the lay term "dry drunk" remains extremely useful. It describes those individuals who have abstained from the substance or behavior to which they were addicted, but who have not changed attitudes and behaviors that accompanied that addiction. They have not dealt with problems which had been masked or temporarily avoided due to it, and as a consequence are not progressing in their recovery. The dry drunk is at risk for relapse.

Although the term has been used to varying degree by all of the twelve-step programs including Gamblers Anonymous (GA), certain crucial differences are pertinent. For the gambler, not only is there the absence of an ingested substance as the crucial distinguisher between "dryness" and "wetness," but what the individual is addicted to is not so clearly avoided. In this respect, pathological gambling is more like an eating disorder than like alcohol or cocaine dependence. Pathological gamblers must continue to use money, and while they stop gambling with it, uncertainty and risk continue to be part of their lives. They must learn to manage these things rather than to abstain from them. Risk and uncertainty can be overtly or covertly played with and manipulated. The pathological gambler, while not technically gambling (in other words, dry), has a number of ways of "staying in action."

This notion of staying in action is, for the pathological gambler, equivalent to the alcoholic's dry drunk. It poses a threat to recovery and is something gambling counselors and clinicians need to address. While gamblers mean different things when they talk of "action" (Rosenthal & Rugle, 1994), the word generally refers to excitement, risk, the thrill of getting away with something, the possibility of significant loss or the opportunity for spectacular

success. Action! The term has connotations of movement, of making things happen and of doing something, fixing things, finding solutions. In other words, action means the opposite of passivity, stagnation, paralysis or helplessness.

What could be wrong with this kind of approach? Men, in particular, have a fix-it-now attitude toward problems. Unfortunately, what may occur are external manipulations in the service of avoiding reality. The state of mind in which these actions are carried out is then an omnipotent one. Omnipotence has been defined as an illusion of power and control that defends against helplessness and other intolerable feelings (Rosenthal, 1986). There is a false sense of conviction about what one is doing. Omnipotence is borne out of desperation. I need to win, therefore I will. Wishing will make it so.

"Omnipotent action" (Rosenthal, 1986) is a defense mechanism in which one must do something, anything, in order to create for oneself this illusion of being powerful and in control. Such attempted solutions may be totally ineffectual, and merely serve as a gesture to show one can do something. More often the action is destructive, and produces the opposite effect from the one needed. As Rosenthal (1986) has suggested, when pathological gamblers speak of their need for action, they may be referring to just such omnipotent solutions.

Some of the attitudes and behaviors described in this article are obviously more associated with the action-seeking gambler (Lesieur, 1988; Lesieur & Blume, 1991) than with the escape seeker. Although Lesieur's categorization remains the most clinically useful method of subtyping, on some level most pathological gamblers are seeking both. Action provides physiological arousal, fantasy gratification, and escape from feelings and situations that are believed to be intolerable.

Symptom substitution/Behavioral equivalents

There are many ways for the gambler to take risks, or remain in a gambling mind-set, without making a bet. For example, a patient with five month's abstinence reviewed some of his current behavior and concluded: "I'm still a gambler, and I play poker with people all the time. We just don't use cards."

Switching addictions

It is well known that addicts will substitute one addiction for another. For example, the alcoholic who stops drinking but then starts gambling is at risk for developing a gambling addiction. He or she is then more likely to start drinking again. Secondary

addictions may appear either sequentially or simultaneously. In the latter situation, some therapists believe in treating them one at a time. If at all possible, I would not recommend delaying treatment. As an example, let us consider the rationale for addressing nicotine dependence early in recovery.

There are studies demonstrating that patients in alcohol and drug treatment programs who quit smoking have a much better prognosis than those who do not (Miller, Hedrick, & Taylor, 1983; Bobo, Gilchrist, Schilling, Noach, & Schinke, 1987; Bobo, 1989; Burling, Marshall, & Seidner, 1991). Sees and Clark (1993) found that patients presenting for substance abuse treatment reported high interest in stopping smoking, and for the inclusion of smoking cessation in their initial treatment. Although I do not insist that gamblers stop smoking, I discuss three reasons with them for quitting. First of all, when someone is in treatment and learning to deal with feelings, it does not make sense for them to be doing something that numbs their emotions. Patients begin to recognize that every time they start getting close to something meaningful in therapy, their impulse is to reach for a cigarette. Second, as long as they are smoking, they are still in an addictive state of mind, and third, as many obstacles as they can place between themselves and their gambling, the better off they are. The impulse to smoke can serve such a function, so that when they encounter some uncomfortable situation they will have an urge for a cigarette before they will have an urge to gamble. It will serve as a red flag alerting them to pay attention to the feeling or situation, and maybe to talk to someone about it or go to a meeting.

Following patients over time, the therapist has the opportunity to see addictions change and evolve. Sometimes, what appears to be a new problem is merely new wine in an old bottle:

Example: After a period of individual therapy and regular attendance at Gamblers Anonymous, Mr. A appeared to have turned his life around. He abstained from gambling, which no longer seemed attractive, and his old debts were being paid off. He had remarried (his first wife divorced him because of his gambling), and claimed he and his wife were happy. His career had gone in a new direction and he was doing even better than before. He worked hard, but got satisfaction from his work. His employer and clients praised his accomplishments, and he was rewarded with frequent bonuses. By all accounts he would be considered successful.

What was wrong? With a great deal of embarrassment, he confided that he had begun frequenting prostitutes. He attempted to rationalize his behavior by telling the therapist that his sex drive was stronger than his wife's, and that she had been less available for him recently because of their different work schedules, and

because of her involvement with her ailing mother. His turning to prostitutes, he said, was "quick and easy."

As he continued talking, the self-deception became obvious. If all he wanted was sexual gratification, he knew a number of women willing to accommodate him. He was a good looking, rather charming and outwardly confident young man, and women were sometimes quite forward in indicating interest. They did not even seem to mind that he was married. However, he rejected any and all such opportunities, preferring instead to seek out prostitutes on the street.

Such assignments were anything but "quick and easy." He experienced enormous anxiety that the prostitute would give him AIDS or some other disease which he would then pass on to his wife, or that the prostitute would turn out to be a policewoman and he would be arrested. In addition, he was certain that if his behavior became known, his wife would leave him and his career would be ruined. It dawned on him that he was gambling, and that the more he engaged in this behavior, the more certain he was to lose.

Why, he then asked, when he found a prostitute who appeared "safe," would he not go back to her, but would insist on trying someone different each time? Obviously he either wanted to lose, or was excited by the risk of jeopardizing everything and escaping unharmed. Mr. A then recognized that the feelings he had while looking for prostitutes were identical to the feelings previously experienced gambling. He not only had the same "rush," but the compulsive aspects were the same. He would find himself preoccupied by it while at work, inventing excuses for driving home through neighborhoods where there were streetwalkers. The anticipation, and the guilt afterwards, and the need to lie about where he spent his time and money, all reminded him of his previous gambling.

For Mr. A, his gambling and the sexual compulsion were fused. This is not an uncommon occurrence. Fused addictions need to be recognized and may be difficult to treat. It is important to ascertain that this is, in fact, what the therapist has uncovered. While risk-taking is an associated or incidental feature of most drug abuse (for example, the alcoholic who drives while intoxicated, or the young woman who passes out at a fraternity party), it is neither deliberate nor essential. However, for Mr. A, and in the following example, gambling is central.

Example: Mr. B had stopped gambling and was a respectable member of his community. No one, especially not his wife, knew about his anonymous phone calls. He would go through the phone book until he found a woman's name, and if the name interested

him he would call her up. He would then try to keep her on the line and convince her to agree to meet him. His objective was to talk her into having sex with him. That was his "big win." On occasion he was successful, although one woman met him at a coffee shop accompanied by policemen waiting to arrest him. While on probation he continued making his phone calls.

Mind bets

Compulsive gamblers may stop wagering for money, but may continue making "mind bets." This is something they may not reveal unless specifically asked. It is common among sports bettors, who will check out the odds, then watch the game on television, making a mental wager with themselves. "If I had bet a hundred dollars on the Dallas Cowboys," they will say, "and taken the points, then..." They are not betting money, but they are keeping track of what they would have won or lost through the week. Some newly abstinent gamblers say that what they are keeping track of is what abstinence has saved or cost them. Mind bets are a not uncommon way to remain in action. However, the gambler may start to get "juiced" and be unable to shake off the excitement.

Obsessive-compulsive rituals

Some gamblers, particularly those with more obsessive-compulsive features to their personality, will make a different kind of wager with themselves. They will be preoccupied with various counting rituals, for example, odd versus even license plate numbers, or how many times a telephone will ring. If they guess right, they win, meaning a certain wished-for event will occur, or that they will or will not be committed to a certain course of action. Such rituals are used to contain performance anxieties or guilt about forbidden activities.

These wagers or tests are arbitrary, and so is the response. If not satisfied with the outcome, they can do "two out of three," and, in true obsessive-compulsive fashion, keep repeating it. As with the gambling, luck and skill may be accorded a role, or the ritual be viewed as a form of divination.

Covert gambling

Some pathological gamblers engage in a kind of behavior that has been described as "covert gambling" (Rosenthal, 1987). In this respect they resemble patients with narcissistic personality disorders who are not gamblers. The behavior involves a need to take risks and test limits, in effect to continuously test themselves, not at a racetrack or casino, but with the everyday events of their

lives. Such individuals typically gamble with time and with the meeting of obligations and responsibilities. Nothing is too small or too big to bet on. They will drive without gas in the car, be late for appointments, or not pay their phone bill. Betting they can get away with it, their self-esteem depends on the outcome. Graded pass-fail, such tests are often a way to remove themselves from their over-involvement with the reactions of others, specifically their excessive need for approval.

Similarities between these pathological gamblers and patients with narcissistic personality disorder are found in their win-lose orientation, all-or-nothing thinking, and fragile sense of identity. There is often more at stake than self-esteem. By seeing how close they can come to some imaginary line, and what would happen should they cross it, these narcissistic individuals are challenging their environment, and luck itself, in order to find out where they stand, or even whether they have the right to stand. They are not seeking punishment, out of some sense of guilt, although that may be present also, so much as they are involved in a kind of omnipotent provocation (Rosenthal, 1981), a deliberate flirting with danger in order to test their powers and prove they are in control.

Procrastination

After the gambling itself, procrastination is perhaps the most common and incapacitating symptom. There are several reasons for this. We have just discussed how a deadline may be used as a test, with the gambler trying to see how close he or she can come to it. Many gamblers feel that nothing they do is good enough, or that they can never do enough. Hence there is a sense of futility about completing a project or assignment where they anticipate failure. They may fear or resent the unrealistic expectations of others. Instead, they cling to their grandiosity, while postponing the cold shower of reality.

Example: Between his compulsive gambling and his procrastination at work, Mr. C was in the process of ruining a promising legal career. He waited until the last minute to start assignments, and while he frequently got away with it, he could never feel good about the outcome. He would frequently then go gambling. He was aware of never having done his best at anything, and that he was afraid to try. While discussing this, he remembered a recurrent nightmare which had occurred regularly between the ages of six and eight, and sporadically as he got older.

In his nightmare, he was always standing on huge alphabet blocks and trying to jump from one to another. He wouldn't make it, and would fall into a whirlpool. He would then wake up screaming. In

discussing the dream he could remember standing on the letter A and off in the distance was Z. There were other letters, but he was always jumping from A to Z. As striking as this was, both at the time of the dream and in his retelling of it to his therapist, it was something he had never thought about or questioned. It had never dawned on him to go from A to B to C.

The therapist said that he did not think Mr. C wanted to go from A to Z, but had believed it was expected of him since he thought he had to be adult all at once. In response, the patient started crying and brought forth a flood of memories. He had grown up precociously, he said, and had never felt like a child. "As far back as I can remember, people always expected great things of me. Every year, no matter what I did, it was never enough. When your parents tell you at age six that, when you were one and a half, they knew you were going to be a surgeon because of the way you could use a knife and fork, well, it makes T-ball unimportant."

In subsequent sessions, the focus was on how he had been raised to make up for his parents' own prior frustrations and failures. In recounting this, he experienced a feeling of being cheated. He could see how his passive-aggressive behavior, the procrastination and brinksmanship, as well as his gambling, had been an expression of that resentment. Gambling had also been an attempt to please his parents, to get rich quick, in order to satisfy the expectations that they, and now he, himself, had for him. Work was too slow. He didn't have the time to go from A to B to C.

Substitutes for stimulation

This includes activities involving speed and danger. One patient, for example, stopped gambling and in his first year of abstinence took flying lessons, tried sky diving, bought a motorcycle, and went skiing every possible weekend. He seemed driven by a need for intense physical activity, strong sensations, and competition. The therapist initially did not know how to respond, but was able to ascertain that the activities were being done in a responsible manner and were not life-threatening. It then had to be decided whether, for this particular patient, such risk-taking sublimated his gambling urges, or would serve to trigger more conventional forms of gambling.

Another kind of stimulation is provided by the ingestion of legal stimulants: coffee, cola drinks, and cigarettes. The therapist needs to be aware of the gambler's attempt to find substitute stimulation through multiple cups of coffee, drinking caffeinated soft drinks, and smoking. Cravings for chocolate and for sweets would also fit in this category.

Playing catch-up

In one respect, pathological gamblers have a more difficult time of it than other addicts. Their gambling typically has left them in debt; once they stop they find themselves "playing catch-up." They may be working multiple jobs, juggling bills, struggling to meet expenses and stay ahead of creditors. Their state of mind often duplicates that of their gambling days. Money is experienced as the solution to problems. It seems nothing has changed in that respect. When they are in debt and have to come up with a big payment, it is like being in action for them. And when they make a sale or put a deal together and get paid, they feel they have won. This is a difficult issue for patient and therapist.

One patient referred to his situation as "dancing." He was in a business where he would buy goods at the beginning of the month on credit, and to stay in business he would have to sell them and get more goods. His credit was always at risk, and he felt he was dancing all the time. He would say "At least when I was gambling there was the chance that I could have a big win and get ahead, but I'm just doing this month after month, with no end in sight."

Lying, cheating, and stealing

Various authors and teachers of psychotherapy have stressed the importance of the therapist being nonjudgmental. This is partly an outgrowth of the psychoanalytic concept of neutrality, and partly a product of the moral relativism that in recent years has dominated our educational system. I would suggest that effective therapy is also "moral therapy," and that therapists who think they can remain morally neutral may be deceiving themselves and shortchanging their patients. At any rate, they will have difficulty treating pathological gamblers, since moral conflicts and dilemmas are being raised constantly.

The gambler is frequently testing how their therapist will respond, and trying to corrupt them or get them to collude with the patient's dishonesty. This is an attempt to devalue the therapist, so as to sabotage treatment and confirm their cynical view of the world. "See, everyone is greedy; people steal if they think they can get away with it." This is a common way to deny their own culpability.

Example: Mr. D took a magazine from the waiting room and brought it into the session with him, and then, afterwards, while driving home, realized he still had it with him. Actually he had wanted to finish reading an article, so his forgetting, although not conscious, nevertheless served a purpose. He had not thought of asking if he could borrow it, because the therapist might say no, and besides it would have made him aware of his dependency on

another person, something he went to great lengths to avoid. He did have a momentary thought that he should go back and return the magazine, but "put it out of (his) mind."

The following week he forgot to bring the magazine with him for his appointment. He intended to mention it but started talking about something else, and it was again forgotten. He was shocked when the therapist brought it up halfway through the session, and referred to it as a kind of stealing. Mr. D became very defensive, and argued that everybody did things like that, but then realized that he had been feeling particularly uncomfortable about coming for the session, and had not known why.

Nevertheless, he persisted in trying to trivialize the incident, and could not accept the therapist's contention that it was something for them to examine in the session. It was only later that he could admit to other "omissions"—obligations that were forgotten, bills he ignored, promises he failed to keep—a pattern of lying and cheating that he had not consciously recognized. By stealing the magazine, the patient was gambling that he could get away with it. He was also protecting, and trying to keep out of the therapy, a part of his personality that believed these kinds of activities were all right. This included his secrecy and sense of entitlement. Only when this was acknowledged and dealt with was there any chance of recovery.

The example illustrates not only how one little lie or omission can lead to another, but the kind of "primitive avoidance" so common among pathological gamblers. Uncomfortable realities can be just put out of mind, or "shoved under the rug." Primitive avoidance and denial, and the pathology of lying, will be discussed in a future paper. "Lying, cheating and stealing" is a phrase used frequently by Gamblers Anonymous members, not only to describe actions taken to support their gambling, but behaviors which continue after abstinence is achieved. "Lying, cheating and stealing" is a common "character defect," requiring the attention of those who take recovery seriously.

The pathological gambler must develop, or reestablish, an internalized value system based on honesty and integrity. When a gambler/patient reports feeling guilty about current dishonesty, they do not need the therapist to decrease their discomfort. Rather the therapist needs to help the gambler feel the reality of their guilt and to recognize that when they do something wrong, a consequence is to feel emotional pain. In other words, if you lie, cheat, or steal it is appropriate and understandable that you will feel bad.

One of the major reasons for intractable or unrelenting guilt is the continuation of some harmful behavior, however covert, subtle, or

rationalized.¹ The first step toward self-forgiveness is an acknowledgment of change. In other words, being able to say "I used to do such-and-such. I don't do that any more."

Flooding

Gamblers who rely on avoidance as a defense mechanism are frequently flooded with feelings and memories when they become abstinent. This can occur in several ways. Most commonly the gambler becomes overwhelmed with guilt as he or she remembers things that were done, people that were hurt, episodes of lying and cheating. A common refrain is "I can't believe I did that." Flooding may also refer to the uncontrollable crying. Gamblers may be flooded with tears as they get in touch with painful feelings that had been suppressed.

A similar experience is the sudden realization of time wasted. During the years they had been gambling, their lives had gone on and they are now older. There is an acute sense of lost opportunities, and of lost youth and innocence. Disappointment becomes self-pity and there is an impulse to give up or to punish oneself by a return to gambling or some other self-destructive behavior. It may be helpful to remind the patient that they could be sitting in a therapist's office ten or twenty years from now having the same conversation, or, alternatively, might never have learned anything. The fact that they are having this realization now gives them the opportunity to do something constructive with however much time they have ahead of them.

A third kind of flooding involves the sudden remembrance of painful and traumatic memories of childhood—physical or sexual abuse, extreme neglect, disturbed parents. This may occur when the patient stops gambling or quits other addictive behaviors. The therapist does not have the luxury of waiting until the individual is stronger before dealing with it. Providing sufficient structure, however, is necessary. Addressing the helplessness, confusion, shame, and guilt, as well as the rage and feelings of being cheated, is a very important experience for the gambler.

Boredom

According to the description in DSM-IV, as well as the writings of most clinicians (for example, Custer & Milt, 1985, p. 52), the typical pathological gambler is "restless, and easily bored." This proneness to boredom has been the focus of two studies (Blaszczynski, McConaghy, & Frankova, 1990; Elia, 1995) that compared pathological gamblers to normal controls; boredom scores were significantly higher for the pathological gamblers.

In their discussion, Blaszczynski and his colleagues noted that the two instruments for measuring boredom assessed different aspects of the experience and, in fact, did not correlate with each other. The Boredom Proneness Scale (Farmer & Sundberg, 1986) evaluates "one's connectedness with one's environment... as well as the ability to access adaptive resources and realize competencies." Most significantly, it correlates with depression, as measured by the Beck Depression Inventory. Farmer and Sundberg describe the boredom-prone individual as exhibiting a lack of interest, and varying degrees of depression, hopelessness, loneliness, dissatisfaction, and distractibility.

The other instrument is the Boredom Susceptibility subscale of Zuckerman's (1979, 1983) Sensation Seeking Scale. Boredom susceptibility is characterized by an inability to tolerate repetitive experiences and monotony. These are individuals who are understimulated and therefore seek out external distraction. These would be the true sensation seekers.

Blaszczynski then reminds us that McCormick (1988) previously had described two subtypes of pathological gamblers characterized by chronic states of hypoarousal but differentiated according to the relative presence of depression or boredom. Subtype A had a premorbid depression, and turned to gambling for its affect-enhancing excitement. These are the gamblers who might be expected to score high on the Boredom Proneness Scale. McCormick's Subtype B, on the other hand, was chronically understimulated, and experienced, not dysphoria, but "excessive levels of boredom, low frustration tolerance, and a need for varied stimulation and constant rearousal." These are the individuals who would have high scores on Zuckerman's Boredom Susceptibility subscale.

This kind of subtyping holds promise. Farmer and Sundberg's (1986) boredom-prone individuals, who lack connectedness with their environment and the ability to access adaptive resources, might have problems in self-soothing. Those who score high on Zuckerman's Boredom Susceptibility subscale, the understimulated group, may represent the sensation seekers and "adrenalin junkies." The first group may respond preferentially to serotonergic agents, while the second group may be more responsive to dopaminergic drugs. While such a distinction holds promise, it remains speculative until we have clinical trials that look at what the medications are actually treating. For the individual clinician, meanwhile, it is important to carefully question what the patient means by "boredom." Particularly for someone who has just stopped gambling and is struggling to change, boredom can mean a number of things.

For early onset male gamblers, particularly if there have been

decades of gambling activity, the gambling was typically how they defined themselves. Without their identity as a gambler, they do not know who they are. Giving up gambling leaves a large vacuum or hole in their lives. They have no other interests, and there are few activities that can compete with the excitement of gambling.

As already noted, boredom can mean understimulated. For the pathological gambler with ADHD, when they stop gambling and "get off the roller coaster" of strong sensations and self-created crises, they may find the underlying restlessness unbearable. Patients who are manic or cyclothymic also need time to adjust to being normal. What others regard as normal feels like being in slow motion to them, or as if something is missing. They describe it as strange and uncomfortable.

Boredom can mean that individuals cannot be alone because of problems in self-soothing. One might inquire about how they fall asleep at night and how they take care of themselves when they are ill. Boredom can mean that they are left alone with intolerable feelings, such as depression, helplessness, shame, or guilt. There is a need to escape, to get away from themselves. For some, being alone means an intolerable state of emptiness or deadness. Those individuals who did not bond in infancy may carry within themselves an image of parental rejection or disgust, or affects engendered by an overwhelmed mother. Being alone and quiet means experiencing these intolerable affects, which they instead try to externalize through addictive substances and behavior.

Regardless of etiology, external stimulation, action and excitement are viewed as the antidotes to boredom. The role of the therapist is to help identify what the patient means by boredom, help them tolerate the uncomfortable affects, find more constructive solutions and coping strategies, and if necessary aid self-regulation with medication. Boredom is not a natural feeling or condition, and will remain a signal, both for patient and therapist, that there is something needing to be addressed.

Problems with intimacy and commitment

By the time the gambler is in treatment and has stopped gambling, spouse and family members are aware of the debts and depleted finances, the pattern of lying, and other problems. The response is usually one of anger, helplessness, and betrayal. Not infrequently, it is only after the gambling has stopped that the brunt of the spouse's anger is expressed. This is often difficult for the gambler to understand. The anger is often proportional to the fear of being hurt and betrayed again. Holding on to the anger is a way for family members to protect themselves.

Mistrust of the gambler continues longer than it does with other addictive disorders because a relapse can be so devastating in terms of a family's financial situation, and also because it is so much more difficult to recognize. As frequently stated, gambling is not something that a wife can smell on her husband's breath nor observe by his gait or coordination. Nor are there blood or urine tests so that one can detect it with certainty. What we need to emphasize with both patient and family is that reestablishing trust will take time, and that if treatment is successful there will be observable changes in personality as well as behavior.

There are usually problems with intimacy that precede the gambling, in which case they will be there after the individual has stopped. Pathological gamblers often have difficulty being open and vulnerable and depending upon others in a meaningful way. They have learned to suppress their feelings and to detach from potentially painful situations. Much of the work in therapy has to do with identifying emotions and learning how to express them. Conjoint and family therapy may be particularly important (Boyd & Bolen, 1970; Heineman, 1987; Steinberg, 1993).

Family members have their own issues which if not dealt with may sabotage the gambler's recovery (Heineman, 1987; Lorenz, 1989). For example, some of the wives of recovering gamblers will admit that they miss the gifts they received when their husband came home after winning. They confess to a wish that he could have just one more big win, which would allow them to pay off their debts. They may realize they had been living vicariously through him, particularly if he was an "action" or "high stakes" gambler. His optimism and grandiosity were contagious. Initially they may have been attracted to him because he was a man with big dreams, a risk-taker, and big spender. According to Heineman (1987) and others, many wives of compulsive gamblers are adult children of alcoholics or of compulsive gamblers. Living from crisis to crisis may be familiar and exciting for them. In some cases there is a need for the gambler to remain "sick" so that they can take care of him.

Many pathological gamblers were brought up in a home in which intimacy was lacking.² They tolerate financial indebtedness far better than they do emotional indebtedness. Many experience claustrophobia in their personal relationships (Rosenthal, 1986), in fact in any meaningful situation. Commitment is experienced as a trap. They have difficulty saying *no*, or setting limits. This is related to an excessive need for other people's approval and validation. When they say they feel trapped by another person, what they mean is that they feel trapped by their own feelings about the other person. They may have projected various expectations or demands on to the other, so that they are overly

concerned about disappointing them, or about not being adequate to the task.

Excessive reliance on these projective mechanisms leaves them uncertain as to their boundaries, between inner and outer, self and other. A question they frequently ask themselves: what am I entitled to? Am I being too greedy or demanding, or merely asking for what is mine, while it is the other who is being unreasonable? Not knowing, they fear being exploited.

Male gamblers, in particular, are preoccupied with power games (Rosenthal, 1986). Power, as opposed to strength,³ is defined in relation to others, and is invariably gained at someone's expense. Relationships take on a seesaw quality, with the gambler battling for power and control.

Due to unresolved guilt about his gambling, a patient felt "one-down" in relation to his wife. He felt unworthy of her and not entitled to be treated decently. He did not verbalize this, but instead provoked fights at home. Similarly, his self-esteem was based on material success. When they had to scale down their lifestyle, he felt diminished. Again feeling like a failure, he blamed others and took it out on those closest to him. Compulsive gamblers are often good at "turning the tables," so that it is the spouse who feels helpless and inadequate or is apologizing to the gambler and seeking forgiveness. For male gamblers, particularly action seekers, relationships are typically adversarial.

In light of the above, it is not surprising that there are frequent sexual problems (Daghestani, 1987; Steinberg, 1990, 1993). Adkins, Rugle, and Taber (1985) found a 14 percent incidence of sexual addiction within a sample of 100 inpatient male compulsive gamblers. When "womanizing" patterns are investigated, the incidence is closer to 50 percent (Steinberg, 1990, also personal communication). The excitement associated with the pursuit and conquest of women resembles the excitement and "big win" mentality of gambling. Both Mr. A and Mr. B illustrated this.

The various authors cited agree that in treating early onset male gamblers, in particular, one typically encounters two patterns of aberrant sexual behavior: (1) celibacy or a kind of phobic avoidance of sexual relationships, and (2) compulsive sexual behavior consisting of promiscuous womanizing, or compulsive masturbation related to various forms of pornography. The two patterns may be mixed.

Example: Mr. E sought therapy for compulsive gambling and because he felt inadequate in relation to women. He rarely dated, but had an active fantasy life and was a compulsive masturbator.

A brief marriage ended six years ago, and since then his only "serious" relationship was with a 19-year-old prostitute with whom he lived for a while. He is a 35-year-old, successful engineer who has gone back to school to change careers. He wants to become a psychologist, but has been procrastinating about completing his degree.

The session occurred after one of his now infrequent gambling episodes. He had gone to Las Vegas—and thought it was fun. He said that he liked meeting people there, playing the big shot and being treated as special. He especially liked the sense of connectedness. "It's easier and safer," he said. "You're alone, but you feel plugged in and connected." He emphasized the lack of responsibility.

He then described a date he had gone on recently. It became clear that this is what had triggered his return to gambling. He found the woman very attractive and sexy, but he was suspicious that she was a "jet setter" who was only interested in dating wealthy men. The therapist then said that gambling was fun for him because it was a way of cheating. It provided the illusion of intimacy without his having to risk anything. This was important because he was afraid of what women might want from him. He agreed, and said that he had been aware of exaggerating her materialism. He had been looking for flaws to discredit her.

In fact, she was the first woman he went out with who came from the same social-cultural background as himself. However, he does not pursue women who are appropriate for him and toward whom he is attracted. When he does go out, it is mostly with women who pursue him. He recognizes a similar pattern in his career. He became an engineer "by accident," and his choice of schools was also passive. His career has been marked by procrastination and a lack of ambition. He relates this to unrealistic expectations—that he should always succeed—and his fear of failure. Failure, he says, is humiliation. The therapist points out a kind of magical thinking in his belief that if he does not try, then his failures will not count. This reminds the patient of an incident from his childhood, where he had struck out in a baseball game but had thought to himself afterwards that it was not so bad because he hadn't swung.

Success

A closely related problem has to do with difficulties handling success. It may be blown out of proportion. For example, in some parts of the country a GA birthday is a cross between a bar mitzvah and a Friar's Club roast. Gamblers compete with each other in seeing how many people will attend and who will receive

the most glowing testimonials. It is a critical time, in that the achievement of a year's abstinence, or some other landmark, poses an immediate risk for relapse.

There frequently are unrealistic expectations of what success will mean, so that its achievement leads to disappointment and depression. Sometimes the gambler abstained in order to prove something to someone, in effect to win a mind bet. Sometimes they were doing it for their family or for the therapist, so that after a period of abstinence they feel justified in saying "Okay, I was good for a year. Now I feel something is owed me so I'm going out to have some fun." Fun, in this case, of course, means gambling.

Sometimes their successes are attributed to omnipotent parts of the personality (Rosenthal, 1986). Success can trigger mania. They get high on their success and grandiosity takes over. Some gamblers are fearful of success, and there is a subset of gamblers with masochistic character disorders. Some of them feel more alive when they are in debt and having to work hard to pay creditors. A critical time is when they are just beginning to get in the black, when they can start to have something for themselves.

Example: Mr. F's problem was quantitatively illustrated by his eating disorder. He was 70 pounds overweight and attending Overeaters Anonymous. He had what he and his therapist came to call his "fat boy" fantasy. In the fantasy he was overweight and he dieted and exercised and was extremely successful at it. He imagined himself speaking at OA meetings, people coming to him for advice and all the recognition he would get for losing the weight. Significantly, however, in his fantasy he was 150 pounds overweight.

He would live with this fantasy for days, in which he started out 150 pounds overweight, and in which he worked at his diet and at exercising and was able to lose weight. He got a great deal of satisfaction from the fantasy, but it always ended at the point at which he was 70 pounds overweight. In reality he could neither lose weight nor allow himself to accomplish anything.

Reality

A favorite *New Yorker* cartoon shows two intellectual types in deep conversation at a cocktail party. One man is saying to the other: "My feeling is that while we should have the deepest respect for reality, we should not let it control our lives." Bergler (1958) posited, as the starting point for his theory, the gambler's rebellion against the reality principle, and against those authority figures, originally the parents, who instituted it by imposing rules and restrictions on the young child's pursuit of pleasure. Necessity

was to be avoided, limitations denied.

Like the young man who refuses to wear a watch because he does not want to be limited by the confines of time, but then finds himself always having to ask others what time it is, the gambler's relationship with reality may be adversarial, persecutory, or humiliating. The gambler may want to see himself as an exception—exceptional among people, and an exception to the rules. Not wanting to be pinned down, he is looking for "an edge," or for loopholes. This search for "freedom" is often what gets him into trouble.

Once initial problems have been dealt with and abstinence established, gamblers are often at greatest risk when life starts becoming predictable. Meeting responsibilities and living a "normal" life leads to a feeling of being trapped for those gamblers who have not yet internalized a value system based on facing responsibility. Rather than viewing their new life as a self-determined one, gamblers are more likely to see such behavior as externally imposed. Feeling controlled by their own schedule, they experience a need to rebel.

Example: Mrs. G had been abstinent from gambling for eight months. She was a sales representative and had been doing well in her work. She was very organized, kept accurate records, set up and kept sales appointments. Additionally, her marital and family relationships were also significantly improved. Her husband and grown children felt much less worried as Mrs. G would report all income and bills and was readily talking about her day's activities. Only one problem still bothered her husband. She frequently would come home an hour or two later than she said she would. After checking with others and confirming that Mrs. G was in fact where she said, her husband was no longer concerned about whether she was gambling during this time. While discussing this issue, Mrs. G smiled sheepishly at the therapist and her husband, and looked like a little girl who was getting away with something.

Mrs. G was a bright woman who was aware that she could have called if she was going to be late, or simply told her husband she would be home at a more realistic time. The family had begun adding a few hours onto her statements of when she said she would be home. Clearly, this behavior pattern was not simply lack of consideration or an inability to accurately estimate her schedule. In talking about it, Mrs. G was able to acknowledge the feeling that she was "getting away with something," which in some ways felt like the excitement of gambling. This was her way of holding on to a sense of independence, during a time when most of her life was becoming increasingly responsible and predictable.

Mrs. G also acknowledged that on those occasions when she was coming home late, she would have brief thoughts about gambling. While she had dismissed these thoughts, she was now able to recognize that her pushing the limits to prove her independence was creating a potential situation for relapse. Not only was she holding on to old ways of thinking and behaving to deal with her feelings, but she was setting up her family to "trust" her lateness so that she could use that time for gambling.

Reality imposes limitations for the therapist as well as for the patient. As therapists we cannot ignore the realities of the patient's life, and perhaps especially those realities that will sabotage treatment. When setting up the structure or frame for therapy, the patient may agree to conditions that are not practical or even possible. They may do this out of desperation (thinking omnipotently), or because they do not want to disappoint the therapist. They agree to a fee that they cannot realistically afford, or they do not mention the distance they must travel to get to the therapist's office, or the time off from work it will require. Only much later does the therapist learn about the problems treatment has created.

The patient may not reveal the extent of their financial and legal problems, or may fail to mention that there is a warrant for their arrest, or that they are driving without a license or without insurance. Sometimes they do not mention these things because they are ashamed of them, but sometimes it is a form of action for them, and they "get off" on the risk involved. One patient parked regularly in a tow-away zone outside his therapist's office; another did not put money in the parking meter and explained that he was "playing the odds."

Once aware of these covert forms of gambling, therapists can be on the lookout for them. Pathological gamblers also typically neglect their health. Many have not seen a medical doctor in years. Since problem gambling is associated with a number of stress-related physical disorders (Lorenz & Yaffee, 1986; Russo, N.D.; Westphal, Rush, & Stevens, 1998), including obesity, hypertension, and heart disease, this is an area in which patients may be gambling with their lives.

Conclusion

Staying in action is, for the pathological gambler, equivalent to the alcoholic's dry drunk. It is a way to maintain attitudes and behaviors associated with gambling while superficially complying with treatment and Gamblers Anonymous. After the patient has initially achieved abstinence, it is important to look for more covert forms of gambling and other ways in which the patient may still be

in action. Even in the case of the patient who seems to easily stop gambling, it is important to remember that this is why they initially sought help, and to regularly relate the material of the session back to their gambling.

As therapy progresses, the gambling will take on different meanings and reappear in the material in different guises. Slips do not occur spontaneously, and patient and therapist need to work together to recognize the progression of internal and external events that may lead to an episode of gambling. Connections will be sought between gambling and the other aspects of the patient's life.

Lasting abstinence requires personality change. At a minimum, there is a need to identify and confront whatever it is from which the gambler is escaping. This would include the intolerable situation and feelings as well as the mechanism of their avoidance. Honesty means more than not lying to others about one's gambling; it means being honest with oneself about one's feelings. One learns to take honest emotional risks, rather than those based on the need to manipulate or control external events.

As is true for all addicts, gamblers at the beginning of treatment cannot trust themselves. Self-trust requires self-knowledge, which in turn requires curiosity about oneself. Stated differently, "The key to building self-trust" (Kramer & Alstad, 1993, p. 252) "is the ability to utilize one's own experience, including (one's) mistakes, to change."

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End notes

1 Other possible obstacles to self-forgiveness include: (1) shame-based issues, (2) the use of guilt as a defense against helplessness, (3) repressed guilt about some behavior which preceded the gambling, or (4) a perverse or sadistic conscience.

2 Affection was often expressed through the giving of gifts and money. The gambler may identify with this behavior, or express resentment about it by stealing or wasting ("pissing away") money.

3 The difference is significant. One *is* strong, but one *has* power. There are degrees and gradations of strength, while power is thought of in all-or-nothing terms. Strength is related to one's inner qualities, and the development of one's abilities through work. It is not something one can lose readily.

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