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Problem Gambling and Attention-Deficit Hyperactivity Disorder

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Abstract

There is evidence to suggest that a considerable subset of problem gamblers have attention-deficit hyperactivity disorder (ADHD), with characteristic features of impulsivity and difficulty sustaining attention. The two disorders, problem gambling and ADHD, interact on various levels; for instance, gambling impulses are poorly controlled and ADHD symptoms such as chronic boredom, depression and low self-esteem are relieved by the stimulus and reward of gambling. This article outlines some of the clinical issues encountered in this population and uses case studies to illustrate common ways in which these clients present. Suggestions are made with regard to identification and assessment and it touches on interventions, including medication, therapy and the use of strategies to improve functioning and reduce impulsivity.

Introduction

The article "Pathways to Pathological Gambling: Identifying Typologies" (Blaszczynski, 2000) in the first issue of the *Electronic Journal of Gambling Issues* suggests that there are three main subgroups of problem gamblers: (1) "normal," (2) emotionally vulnerable and (3) biologically-based impulsive gamblers. This last group consists of individuals who, due to the presence of neurological or neurochemical dysfunction, are impulsive and/or have difficulty sustaining attention. Blaszczynski outlines evidence suggesting that neurological differences are precursors to problem gambling. Attention-deficit hyperactivity disorder (ADHD) is one particular condition, which is often present in the third subgroup of problem gamblers.

There is no question that a percentage of clients who seek treatment for problem gambling have symptoms of ADHD. Specker, Carlson, Christenson and Marcotte (1995) found that 20% of pathological gamblers studied met the criteria for ADHD. Clinical experience suggests that at least this number are triggered to gamble by impulses and issues related to this disorder. This article will explore the interface between ADHD and problem gambling through case studies, with a focus on identification and treatment.

What Is ADHD?

ADHD, according to the Diagnostic and Statistical Manual – fourth edition of the DSM-IV (American Psychiatric Association, 1994), is the most common psychiatric disorder in childhood, with three main impairing symptoms: impulsivity, inattention and motor hyperactivity. Motor activity tends to subside by adulthood, although an individual may present as restless and fidgety. Some outcome studies (Barkley, 1990; Weiss & Hechtman, 1989) suggest that ADHD is robust into adulthood with a prevalence rate around 3% to 5% of all adults.

Common symptoms and characteristics in adults with ADHD include low self-esteem, underachievement, poor concentration, lack of organization, impulsive behaviour, emotional lability, chronic boredom, and interpersonal relationship problems. Impulsivity is a central feature of the disorder and seems to result from disruptions in the brain’s inhibitory control processes.

Individuals with ADHD have difficulty maintaining adequate levels of stimulation in some brain centres. They apparently compensate for this by having a heightened sensory arousal system that draws in more information than usual from the environment and tends to process it indiscriminately. This results in distractibility, racing thoughts and a scattered presentation. Individuals act impulsively on sensory information before they consider consequences. They also seek out novel or changing stimulation from the environment and without such stimulation they are easily bored. When they engage in this type of activity, and gambling is a good example, they tend to become excessively involved to the point of hyperfocus and the exclusion of other stimuli. Novelty seeking and high exploratory behavior, as in gambling and ADHD, can be akin to self-medication for a low mood state.

Case examples

Case examples may illustrate some of the ways in which ADHD interacts with problem gambling. These individuals all present somewhat differently, but they typify the issues found in clients with ADHD: (Note: Client names and identities have been changed.)

James, a 32-year-old man, related a story of lifelong underachievement, inability to sustain attention, frequent job changes and susceptibility to boredom. The difference between his abilities and his actual accomplishments was frustrating, depressing and continuous. He was about to embark on another attempt at a new career, but he reflected pessimistically on his inability to follow through and attend classes. He noted that his mind raced from one thing to another, making it difficult for him to focus on tasks. Throughout his school history he had struggled with boredom, had trouble focusing on reading and had a tendency to bother other children. James saw gambling as his only area of achievement since high school. Generally, he managed to make money at it, usually by hustling at poker.

Ryan, a single man aged 27, reported only a six-month history of problem gambling with a rapid financial decline. He was a bright, high-energy individual, with a great deal of drive and creativity, particularly around initiating new projects. However, he was so disorganized and bored with detail that he was poor at following his projects through to completion. He developed a business that was initially very successful until he won $25,000 at a casino, lost it within two weeks and began to gamble $1000 a week. Ryan described himself as having ADHD and wanted to address the

resulting disorganization and impulsivity.

Eve, a 37-year-old divorced woman, had a long history of problem gambling, depression, mood swings and difficulties in concentrating and making use of her considerable talents. Her extremes of mood and her feelings of vulnerability caused serious relationship difficulties and often left her living from one emotional crisis to another. Although well able to be intensively introspective on personal philosophy and psychological issues, at times she had great difficulty accomplishing day-to-day tasks. She went to bingo or casinos on impulse when depressed or upset and had failed to be consistent in her long-term plan to avoid all gambling.

Jack, a 48-year-old married man, presented as restless, talkative, and impatient when others were speaking. He changed subjects frequently. Jack described himself as "scattered" and somewhat depressed. He had poor self-esteem. He had had an alcohol problem off and on and had started gambling in his teens – it supplied "action" when he was bored. (His initial experiences with gambling was so exciting that he described it as "what he had been waiting for all his life.") His marriage was in trouble due to these and other problems, and his wife had asked him to get help. His occupational history was unstable. Jack quit gambling when he entered treatment but his resultant boredom increased the depression he was already experiencing. His fights with his wife intensified. Although relieved that he was not gambling, she complained of Jack's mood swings and his intense, negative persistence when angry.

ADHD and Problem Gambling: Clinical Issues

The depression overlap

Poor self-esteem and depression are extremely common in people with ADHD. Their poor performance and their impulsive behaviour often baffle them and those around them and may be attributed to lack of will or laziness. Constant disapproval and negativism from others creates a sense of failure. Symptoms of chronic boredom or an "I don't care" attitude are consistent with the learned helplessness model of depression. A lack of stimulation can lead to depression in individuals with ADHD.

Gambling is an antidote to depression. The variable stimulation it provides is exciting and challenging, which can lead to intense over involvement in the activity. An appearance of success, at least in the short term, counters feelings of failure and depression. Exaggerated levels of confidence (i.e. feelings of omnipotence or an "I can't lose" mentality) are common in this population of gamblers and are highly rewarding. Such feelings provide escape from a life in which lack of control and failure are common experiences. Arguably, gambling by a person with ADHD could be seen as an attempt to self-medicate.

Personality issues

ADHD of the hyperactive-impulsive or combined subtypes seems to have a connection with the dramatic cluster of personalities (Jain, 1999). There is a strong tendency to antisocial, narcissistic, histrionic and borderline personalities. Inherently, these personalities have a common feature of being self-centred, superficially omnipotent, though with fragile coping strategies. Interpersonal issues around trust, abandonment, rejection and attachment are constant factors. There are issues around emotional isolation and lack of empathy for others. When these personality issues exist, the act of gambling may be a self-serving and destructive behaviour with grave consequences for an individual's loved ones and associates.

However, it is important to note that not all individuals with ADHD behave destructively or experience chronic failure, as symptoms vary in severity. Gambling counsellors are familiar with the extroverted, optimistic, somewhat egocentric, somewhat impulsive client who is highly focused on the present and does not worry much about past gambling losses or future plans. These clients often have a great deal of success in their lives, including a loving, if exasperated, family. They may be more vulnerable than average to developing addictions or other problems but they have compensating resources and skills. Such clients appear to have milder forms of ADHD. Blaszczynski (2000) describes impulsive gamblers as having many antisocial features; however, a client who physiologically tends toward impulsivity is not necessarily antisocial.

Identification and intervention

Checklists available in self-help manuals can be helpful in identifying clients with ADHD. There are also longer screens available (e.g., Brown, 1996). It helps to take a developmental history with collateral information. At the Centre for Addiction and Mental Health, 62% of all referrals to the adult ADHD clinic were parents of children who had been recently diagnosed with ADHD. Therefore, it is worth asking gambling clients about their children's behaviour, or indeed, about any

family history of learning or impulsivity problems.

Education

When working with clients that have gambling problems with concurrent ADHD, the first strategy is always education. Of the four clients described above, only one had been diagnosed with ADHD as a child and yet all four had suffered years of frustration and failure. It was extremely helpful to discuss the possibility of a neurochemical basis for some of their experiences and to give them information about ADHD. The central issue for these individuals was the sense that some of their impulses, thoughts and feelings were simply out of their control in ways that outward circumstances, history, and so forth were insufficient to explain. It was a tremendous relief for them to have an explanation that validated their perceptions and one that offered more effective solutions than they had found to date.

Case studies continued

James was referred to a specialist, and was diagnosed as having the disorder. He was prescribed both stimulants and fluoxetine (Prozac). The results were dramatic. James found he was able to concentrate and learn steadily for the first time in his life. He was able to continue with his course, organize himself and plan ahead. His interest in gambling faded and he noted that he was much less impulsive in other ways as well. His self-esteem improved markedly.

Jack finally agreed to an assessment for ADHD at his wife's insistence. He was diagnosed and placed on stimulant medication. He experienced greatly improved levels of concentration. His relationship with his wife improved, as he was able, at least sometimes, to listen, to react more calmly to stress and to think before he acted. They began to work more successfully on managing their finances together. His impulses to gamble lessened, particularly as he experienced more success in other areas of his life.

Ryan was not unhappy with his high-energy, creative approach to life. He was interested, however, in acquiring some help in staying organized. He began looking for a business partner who could provide the solid backup and attention to detail that would complement his own vibrant salesmanship. He was not concerned that he would gamble again because he was experiencing no urges. Typical of the overly optimistic segment of this population, he tended to focus on his immediate experiences rather than on any examination of the past or anticipating problems in the future. Thus, he had no interest in relapse prevention efforts.

A lengthy counselling process was necessary with **Eve** who was preoccupied with her internal processes and had difficulty focusing on behavioural change. She finally attended an assessment with an ADHD clinic and was given a trial of Ritalin (methylphenidate). She noted that she could tolerate more stress without becoming reactive. She had to go off Ritalin for medical reasons, and began to look at antidepressant medications instead to address both her depression and her ADHD. Cognitive-behavioural strategies were somewhat successful in reducing her gambling binges. Interestingly, focus on her emotional issues tended to make her feel worse as she would become overly focused on her current misery. Like Jack, Eva tended to perseverate on negative feelings, elaborating and catastrophizing until she was exhausted. Changing the focus, although difficult, often helped her to gain some distance from her problems, and thus, deal with them more effectively through behavioural strategies.

Eve and Ryan typify two common, contrasting temperamental characteristics: one was highly ruminative and steeped in negativity, and the other was positive in outlook, no matter what the circumstances, and uninterested in the past or the consequences of his actions. Both had a characteristic affective response at either end of the continuum. Although life history may play a part in such characteristics, neurodevelopmental precursors are also likely. Helping individuals to see the other side of the seesaw is usually achievable.

Medical intervention

It is vital that a doctor who specializes in this area investigate concerns about ADHD. Self-diagnosis and self-medication are to be discouraged. Connecting to ADHD clinics may not be easy but they are available by referral from family doctors. A minimal assessment should involve a psychiatric interview to exclude other disorders, self-report questionnaires that establish a threshold for including ADHD as a diagnosis, a collateral history to establish childhood symptoms and some assessment of functioning to establish impairment in various domains.

Individuals with ADHD often seek medical treatment. Stimulants such as Ritalin are often the treatment of choice to address impulsivity. For depression, the addition of a serotonin-based medication is likely. Of course, careful monitoring and an evaluation of the efficacy of this intervention are indicated.

Other intervention approaches

The many emotional issues resulting from a history of ADHD cannot be resolved simply by identifying a neuropsychological disorder, even if treatment is

successful. Therapy in either individual or group settings can help resolve some of these issues and help the person move forward. Groups are particularly valuable as they give a person the opportunity to share experiences and cognitions that previously may have seemed unique to the individual. Due to their interpersonal relationship problems and a lack of internalized structure, a therapeutic relationship based strongly in cognitive-behavioural strategies is helpful. More importantly, the therapeutic alliance may be critical in helping clients with ADHD achieve a sense of security and trust that was missing in their childhood.

There are many ways to manage the symptoms of ADHD, apart from or in addition to medication, which address the specific nature of the problem. Self-help manuals and Web sites offer many techniques that can help someone with ADHD function more effectively. Suggestions include strategies such as reducing distractions, keeping lists and notes, and finding ways to make tasks stimulating. Some people find mentors to help them organize each day.

Gamblers need to acknowledge their requirements for stimulation and challenge and find new avenues to achieve them. Specific day-by-day planning can reduce their vulnerability to impulsive behaviour. They can benefit from practice controlling their impulses, starting with life areas easier to handle than gambling urges. For instance, one client characteristically rolled through stop signs. He took up the suggestion to come to a full stop each time and practiced this new way of driving. He found that the learning generalized; he was more able to pause and think before acting.

As mentioned above, impulsive individuals may never have developed the circuitry to effectively say "no" to impulses. Even average individuals (such as Blaszczynski’s "normal" subgroup) can experience deterioration in the inhibitory circuitry if they do not use it. It is not unusual to see gamblers with a good previous history of self-control having difficulty dealing with their impulses after a long period of self-indulgence. Gamblers with ADHD have obeyed innumerable impulses; this habit would be hard to break even if their inhibitory processes had originally been strong. These clients can benefit from changing any habit; the learning will likely carry over to other areas, and it can be used in the counselling process to promote self-efficacy.

Additional resources

There are organizations offering education and support such as the national chapter of Children and Adults with Attention Deficit Disorder (CHADD) and the local support group Attention Deficit Disorder Organization (ADDO). The ADDO has monthly meetings for adults as well as for parents of children with the disorder.

There are over 44,000 Web sites on the topic of ADHD, which can be overwhelming, however, it is a useful forum to deal with some issues. Popular texts on the subject include *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood* (Hallowell & Ratey, 1996) and *You Mean I'm Not Lazy, Crazy or Stupid?!: A Self-Help Book for Adults with Attention Deficit Disorder* (Kelly & Ramundo, 1995). Centres that offer resources on learning disabilities can be helpful with referrals and materials.

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