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# eGambling

THE ELECTRONIC JOURNAL OF GAMBLING ISSUES



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Wayne Skinner  
Centre for Addiction and Mental Health  
Toronto, Ontario, Canada

January 28, 2002

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*Phil Lange, Editor*

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[Internet Gambling: Preliminary Results of the First U.K. Prevalence Study](#)

*[This article prints out to approximately 9 pages.]*

*[ Correction: Figure 1 was omitted from the original article. The first paragraph of the Results section has been altered accordingly. We apologize for this error. –Ed. ]*

### Brief Research Report

## Internet Gambling Among Ontario Adults



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## **Abstract**

The increased popularity of the Internet among the general population is of particular relevance to the area of Internet gambling. This paper describes the prevalence of Internet gambling among Ontario adults. Data are based on a random telephone survey of 1,294 Ontario adults. Overall, 5.3% of the Ontario adults interviewed in 2000 reported having gambled on the Internet during the past 12 months. Although women were more likely to gamble on-line than males (6.3% vs. 4.3%), the difference was not statistically significant. Only marital status was significantly related to Internet gambling. Those previously married (divorced, widowed) were significantly more likely to report on-line gambling compared to those who were married (10.9% vs. 4.9%). There were no dominant age, regional, educational or income differences.



# Introduction

The global growth of gambling and the increased popularity of the Internet have led to a greater number of people having the ability and willingness to engage in Internet gambling (Sinclair, 2000). Although Internet gambling is considered to be at an early stage, virtually all observers assume the rapid growth of Internet gambling will continue (National Gambling Impact Study Commission, 1999). According to some estimates, \$2.3 billion (US) a year is being spent on Internet gaming worldwide, and the market has more than tripled in size since 1997 (Mitka, 2001). One study, which features details on more than 1,400 gambling sites available worldwide, estimates that the number of Internet gamblers will grow from approximately 4 million people in 1999 to 15 million by the year 2004 (Sinclair, 2000).

It has been argued that new technologies are linked to "technological addictions" such as computer game playing or gambling using video lottery terminals (Griffiths, 1995, 1996, 1999). Because the Internet can be used anonymously and is open 24 hours a day, concerns have been raised regarding its potential abuse by underage gamblers, seniors and pathological gamblers (National Gambling Impact Study Commission, 1999).

In Canada, legalized gambling experienced a rapid expansion in the 1990s and recent studies show that the prevalence of gambling and gambling-related problems in the general adult population is increasing (Jacques, Ladouceur & Ferland, 2000; Korn, 2000; Shaffer, Hall & Vander Bilt, 1999). Although Internet gambling represents another emerging public health issue (Korn, 2000; Mitka, 2001), to date, there is no published research in the professional literature on prevalence of Internet gambling among adults in Canada. The purpose of this paper is to provide epidemiological estimates of Internet gambling among Ontario adults.

# Method

Our data are derived from the 2000 cycle of the Centre for Addiction and Mental Health *CAMH Monitor (CM)*, an annual cross-sectional telephone survey of Ontario adults. The *CM* cycle consists of 12 independent monthly

surveys with 200 completions expected each month. The 2000 survey used random-digit dialling (RDD) methods via Computer Assisted Telephone Interviewing (CATI).

The design employed a two-stage probability selection procedure. Each month a random sample of telephone numbers was selected with equal probability in the first stage of selection (i.e. households). Within selected households, one respondent aged 18 or older (who could complete the interview in English or French) was chosen according to which household member had the most recent birthday. To increase the precision of estimates from different areas of Ontario, the sample was equally allocated among six strata by area code. The design resulted in a total sample of 2,406 respondents, representing an effective response rate of 61%. To maximize content coverage without increasing the length of any single interview, two questionnaires were employed in CM 2000: Panel A, representing interviews conducted from January to June, 2000, and Panel B, representing interviews conducted from July to December, 2000. The gambling items discussed in this study were asked only of Panel B respondents (N=1,294). Further details about the CM 2000 are available (Adlaf, Ialomiteanu & Paglia, 2001).

Prevalence of Internet gambling refers to betting money on-line to gamble. Respondents were asked how often, in the past 12 months, they bet money using the Internet? Because our design employed complex sampling methods, we used Taylor linearization methods in order to ensure proper variance estimation for weighted complex sampling (Stata Corporation, 1999). Subgroup analyses were conducted by gender, age, marital status, region, education and income, using logit models. The significance of the group effect was determined by adjusted Wald statistics.

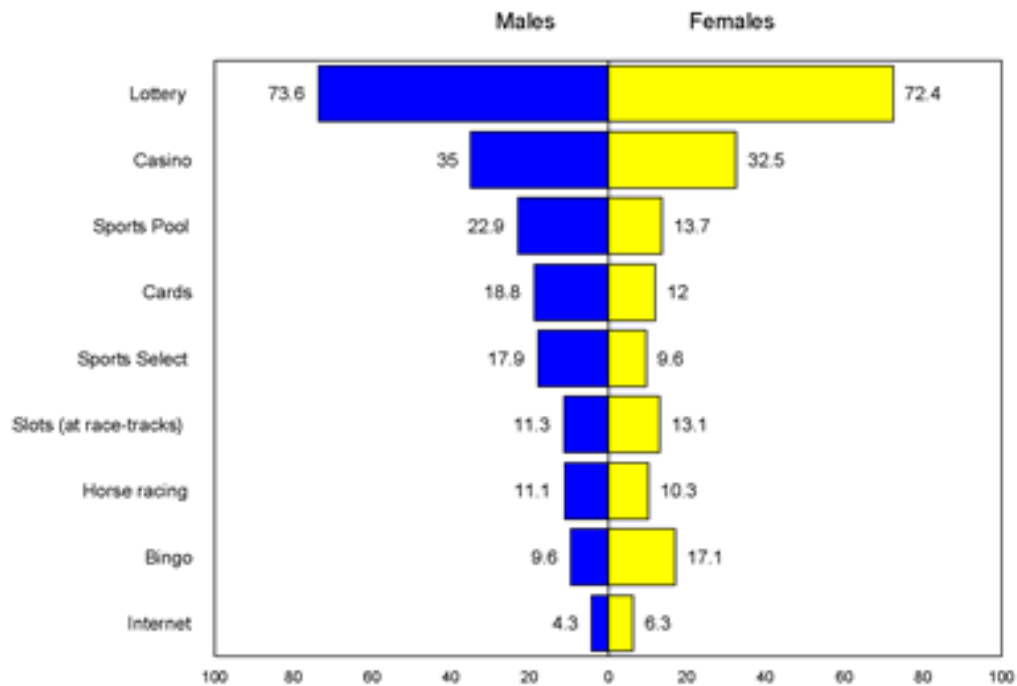
## Results

As seen in Figure 1, Internet gambling was the least commonly reported form of gambling for both men and women. Overall, 5.3% (4.1% to 6.9%, 95% CI) of Ontario adults interviewed in 2000 reported having gambled on the Internet during the past 12 months (see Table 1). Although women were more likely to gamble on-line than males (6.3% vs. 4.3%), the difference was not statistically significant. There was a significant univariate effect for age, with people aged 50 to 64 reporting the lowest rates of Internet gambling, and those aged 65 and over reporting the highest rates (1.5% vs.

8.1% respectively), but after controlling for other demographics this effect did not hold.

**Figure 1**

Types of Gambling Activities in the Past 12 Months by Gender, Ontarians Aged 18+ , 2000



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Only marital status was significantly related to Internet gambling. Previously married (widowed, divorced) people were significantly more likely to report on-line gambling compared to those who were married (10.9% vs. 4.9%). There were no dominant regional, educational or income differences.

Additional analyses revealed that 6.7 % (5.1% to 8.7%, 95% CI) of past year gamblers (N= 1,042) reported past year Internet gambling. Moreover, findings evident among the total sample also held for those who gamble among the respective demographic groups: women, people over 64, and previously married people reported the highest rates of Internet gambling. But only marital status was a significant predictor of gambling on-line after controlling for other variables (data not shown).

Table 1. Percentage reporting Internet gambling during the past 12 months, unadjusted and adjusted group differences, Ontario residents aged 18 or older, 2000

		N	%	95% CI	Unadjusted Odds Ratio	Adjusted Odds Ratio for Factors 1 to 6
Total Sample		1,294	5.3	(4.1, 6.9)		
1) Gender					NS	NS
Women	(Comparison Group)	722	6.3	(4.5, 8.6)	---	---
Men		572	4.3	(2.7, 6.8)	.67	.78
2) Age					*	NS
18-29	(Comparison Group)	294	4.4	(2.4, 8.0)	---	---
30-39		302	6.9	(4.3, 10.9)	1.59	1.09
40-49		266	5.6	(3.2, 9.6)	1.26	.86
50-64		242	1.5	(0.5, 4.2)	.32*	.19**
65+		205	8.1	(4.4, 14.5)	1.90	1.04
3) Marital Status					**	**
Married/Living with Partner	(Comparison Group)	768	4.9	(3.4, 6.9)	---	---
Never Married		272	3.5	(1.8, 6.9)	.72	.64
Previously Married		239	10.9	(6.4, 17.9)	2.38**	2.72**
4) Public Health Regions					NS	NS
Toronto	(vs. Provincial Average)	208	7.7	(4.4, 13.3)	1.63	1.79
Central South		120	5.0	(2.2, 10.9)	1.03	.95
Central West		167	3.2	(1.3, 8.1)	.66	.75
South West		224	5.2	(2.9, 8.9)	1.05	.98
Central East		155	3.2	(1.3, 7.7)	.65	.63
East		207	7.1	(4.3, 11.6)	1.49	1.64
North		213	4.3	(2.1, 8.6)	.87	.79
5) Education					NS	NS
Less than high school	(Comparison Group)	180	6.7	(3.3, 13.2)	---	---
Completed high school		370	6.0	(3.6, 10.1)	.89	.92
Some college or university		390	5.4	(3.5, 8.3)	.79	.77
University degree		343	3.6	(2.1, 6.3)	.52	.49
6) Income					NS	NS
<\$30,000	(Comparison Group)	219	6.3	(3.3, 11.6)	---	---
\$30,000-\$49,000		217	4.4	(2.2, 8.7)	.69	.94
\$50,000-\$79,000		284	6.5	(3.9, 10.6)	1.03	1.72
\$80,000+		278	5.3	(2.9, 9.5)	.83	1.79
Not stated		296	4.3	(2.4, 7.7)	.67	.97

Notes: \*p&lt;.05; \*\*p&lt;.01

Asterisks in shaded rows indicate the significance of the group effect, based on Wald test.

Odds greater than 1.0 indicate that gambling is more likely to occur in the group being compared to the comparison group.

Odds less than 1.0 indicate that gambling is less likely to occur in the group being compared to the comparison group.

(click figure for larger image)

## Discussion

Although the data provide some unique and timely information regarding Internet gambling in Ontario, they are not without limitations. Indeed, we must recognize that the estimates of Internet gambling are potentially affected both by errors in reporting Internet gambling and errors due to missing respondents. It is likely that both types of error would understate the Internet gambling estimates. Also, no information was gathered regarding the prevalence and frequency of Internet use among Ontario adults.

Several implications and observations may be drawn from the findings. First, many traditional demographic factors, such as sex, age, region and socioeconomic factors, are not particularly forceful factors in Internet gambling. This form of gambling is robust and appears to span all configurations of individual social and economic status. Second, although rates of Internet gambling are not excessive, given the simultaneous expansion and diffusion of both Internet access and gambling, continued surveillance is important. Third, given the absence of a significant association between Internet gambling and low income, some may speculate the existence of a potential regressive influence of Internet gambling (Korn, 2000). In this context, investigations must assess the association between Internet gambling and disposable income, which was not examined in this study.

Some of the findings provide a conduit for future investigation. First, we need to assess what may be generalized and what are potential factors related to the elevated rate of Internet gambling among previously married respondents. Although this group also reported elevated rates of alcohol problems and psychological distress (Adlaf & Ialomiteanu, 2001), additional analyses indicated that such factors did not nullify the significant association between marital status and Internet gambling. Another finding worthy of attention is the elevated rate of Internet gambling among people aged 65 years and older. Although the association between age and Internet gambling was not significant, this finding still merits attention in future research.

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## Treating the Person with a Gambling Problem



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## **Abstract**

This short article presents compelling reasons for the treatment of problematic gambling from a solution-focused brief therapy (SFBT) perspective. It reviews a set of techniques designed for use by practitioners and clients who face this problem and its serious emotional, social and financial consequences. Although SFBT has theoretical and philosophical foundations, the focus of this article is the "how-to" aspect of importance to both clinicians and clients. SFBT lends itself well to self-help models and group therapy settings, since clients can benefit from asking similar questions of themselves or of one another in group settings.

## **Why SFBT Is Useful to Clinicians**

Factory Worker Hits the Big One! Super Jackpot Now Worth \$142,000,000! These stories make glamorous headlines for local papers. However, reading such stories pales in comparison to the excitement when faced with all the bells and whistles and glorious possibilities upon entering a casino, or the adrenaline of anticipation when buying bands of lottery tickets. Even these experiences pale in comparison to hearing the jingle of apparent winnings, which in turn can only be a fraction of what it must feel like to win big! On a scale of 1 to 10, if the excitement of reading these success stories is a 1, then hitting it big must be 115!

Stories of personal destruction, which are at least as common as tales of big winnings, seem to get lost in the back pages. There is no vicarious excitement or adrenaline rush associated with reading about "Family Sells House to Pay Gambling Debt" or "Suicide the Cost of Man's Shame Over Gambling Debts." But if you are taking the time to read this article, you already know that gambling can be a serious problem. Perhaps the more relevant and important question, then, is "What are the solutions?"

It is reasonable to expect that a problem as persistent and serious as gambling, with its insidious effects on every aspect of a problem gambler's life, would take a long time and lots of money and energy to solve. Yet, our experiences have shown us that problematic gambling is not a uniform entity with a predictable course of treatment and outcome, but comes with complex, multi-faceted symptoms that make it difficult to foretell what might be the problem and the appropriate treatment. We are confident in asserting, however, that most clients' life goals are similar to those of the rest of the population. That is, they want to be competent in what they do, earn a living, raise a family and feel productive in their endeavors; they also want to feel respected for their abilities and accepted and loved for who they are. These are modest and realistic goals but they may be difficult to achieve for those with serious problems.

As will be described more in detail later, rather than "dis-solving" problems, building solutions focuses on a desirable future state of being rather than understanding what went wrong. Thus, it builds on strengths, rather than shoring up personal deficits. It is a time-sensitive, cost-effective approach that meets relevant criteria for efficient, effective and collaborative ways of working with clients.

## **Problem-Solving and Solution-Building Approaches**

The most widely accepted perspective in the field of mental health, addiction and other human services is based on the "scientific," or medical, model. Described as a "problem-solving" approach (DeJong & Berg, 2001), this model begins with a detailed description of the problem, based on the belief that there is a causal relationship between problems and solutions.

This is typically carried out by (1) obtaining detailed information about the origin of the problems and description of symptoms to understand the nature

of the problems. The next step (2) is to assess what category the problem falls in; for example, whether it fits the mental health description of depression or compulsive behavior, or whether the origins have a genetic basis. The third step, (3) is to find the solution that matches the problem, followed by the fourth step (4) of a prescription for the appropriate remedy. It is easy to see that this problem-solving model is reasonable and sensible in many ways since we all want to know the causal relationship between problems and solutions. It is easy to recognize that this approach is heavily dependent on the expert knowledge of the professional who diagnoses the problem, makes the connection between problem and solution, prescribes the remedy and then follows up with an evaluation of whether the remedy was carried out and whether it worked.

When the nature of the problem is physical or medical, this kind of mechanistic approach makes sense and has yielded an amazing array of new remedies once thought impossible in medicine and science. However, what clients bring to the mental health or addiction treatment field is much more complex than treating physical problems where one can see the broken bones or identify the bacterium that causes fever. People, unlike germs, attach meaning to their illness, their misery or undesirable behaviors, all based on their unique personal experiences and history. This distinctive human activity of attaching meaning to events and wanting to understand what is behind them is both normal and highly individual.

The solution-building approach, in contrast, begins with eliciting clients' views of what would be a better life. By seeking professional help, clients acknowledge that their current state of affairs is unsatisfactory or unacceptable on a personal level or to the people around them, or both. Therefore, beginning with a client's views and criteria for what is a desirable state of being, therapists set the stage for goal negotiation (which is addressed later). Once the goal is negotiated, the next step is to learn about the client's frame of reference; that is, what is this person's unique way of orienting himself or herself in this world? For example, does this person view the world as hostile or friendly? Does the person view the problem as solvable, or hopeless and beyond solution? A host of other information can guide us toward understanding what might be a useful way to work with this client.

The third step is to discover the client's ability to find solutions; that is, the client's experience of exceptions to problems. For example, times when he or she could have gambled but somehow managed to stay away from it. These exceptions become the building blocks for tailoring solutions to fit a particular client. As treatment progresses, clients are asked to assess their own progress until they feel confident to carry out daily tasks in a manner they

consider satisfactory.

The solution-building process is driven by the client's view of his or her daily life in the real world outside of the therapy room. This approach further assumes that clients not only have ideas about what is good for them but also possess the beginning to their solutions, which is significant, however small. It becomes apparent why client resistance is at a minimum, thus treatment moves along rather quickly and without the need to confront denial.

We contend that these are compelling reasons for clinicians to adopt this solution-building stance. Therapists using this approach (1) employ goal-driven activities negotiated with the client; (2) recognize that only the client can change (since we follow what the client is interested in changing); (3) are highly respectful of clients' own expertise in their own life circumstances based on personal history and life experiences; and (4) build on resources already existing in the client's life, rather than filling in or eliminating deficits. When this non-pathological approach is used, (5) the treatment becomes short-term and long-lasting because we are working with the client's resources, not her or his deficits.

More detailed descriptions of the underlying assumptions and clinical postures are described and explained by writers who have worked with a wide variety of client populations from many cultural backgrounds in many settings (de Shazer, 1985, 1988, 1994; Berg & Miller, 1992; Dolan, 1992; Berg & de Shazer, 1993; Berg & DeJong, 1996; Berg & Reuss, 1997; DeJong & Berg, 1998; Berg & Kelly, 2000; Berg & Dolan, 2001; Berg & Steiner, 2002). Now we will make a more detailed description of the useful techniques that form the foundation of SFBT.

## Goal Construction and Negotiation

The beginning point for working with problematic gambling (or any other presenting problem) is a goal—not just any goal, but the client's goal(s). This is a particularly important emphasis, especially in relation to such a personally value-laden topic as gambling. Therefore, a session might begin with the therapist asking the client, "So, what needs to come out of our meeting today that will let you know it was useful and helpful?" This beginning immediately sets the tone for the client by stressing that the therapist is interested in learning what she or he wants from the session and that something positive might come out of even this one meeting. This orients clients toward a positive outcome and an expectation that there will be an end to their

problems and suffering.

It is easy to assume that all clients know specifically what they want. Our experience, however, tells us that most people think of goals in vague terms and as the absolute absence of the problem. Most clients say, "I'm so tired of being in debt, being scolded or sneaking around that I just want this monkey off my back." While such desires are perfectly understandable, constructing a workable goal requires more precise definition of the beginning of a successful outcome, as the following dialogue indicates.

**Client (C):** I am so sick of being broke, feeling guilty all the time, sneaking around.

**Therapist (T):** I can imagine you are tired of living this way. So, what would you like to see yourself doing instead?

**C:** I don't know ... I just want to be at peace with myself and my family.

**T:** Good idea, and it sounds like you could use some of that. So, what would you do when you get this peace that you are not doing right now?

The goal of treatment should be stated as a presence of something, not the absence of the problem. That is, what will the client do with his or her time, energy, money, and so on, when no longer gambling? The goals must be concrete, measurable, behavioral and countable; an operational definition. In other words, goals must be constructed in a fashion that creates an opportunity for clients to recognize the signs that they are moving toward successful mastery over their problem. The goal must point to the beginning of a solution rather than the ending of a problem; it must be realistic and congruent with the client's lifestyle and social context.

For example, a large proportion of the initial meeting can be devoted to turning vague goals into something that is measurable so that the client can recognize the beginning of successful steps toward her or his goals. For instance, consider the following, common dialogue:

**C:** I just want to understand why I have this problem, why do I keep doing things that are personally destructive. I feel like such a hopeless case. Why am I doing this to myself?

**T:** Of course, it makes sense that you would ask that. So, suppose you somehow come to understand why you keep doing



things that are destructive to you, what will you do then that you are not doing right now?

**C:** I don't know, but at least I'll feel like a normal person, like everybody else, spend more time with my family, do what most people do. You know, like going out to eat, going to a movie, taking my kids to a park, going for a walk, stuff like that will make me feel normal like everybody else.

**T:** So, what you really want is to be normal, do normal things that other people do and feel good about doing those things.

**C:** Yeah, I haven't felt like that for such a long time, it seems.

In addition to respecting the client's desire to be "normal," which clearly needs further clarification in operational terms, feeling and doing "normal" things is much easier to conceptualize because "being normal" has a much longer list of activities and wider choices than "kicking the gambling habit." We want clients to find ways to feel successful immediately so that they begin to be hopeful about themselves, perhaps even as early as tomorrow morning. We also like to emphasize that the client's goal must be described in terms of his or her social context and significant social relationships because of the very nature of destructive influences on the people around the gambler. Therefore, further negotiation of goals might go like this:

**T:** So, suppose you are calmer, can hold your head up high, spend more time with your family and help your children with homework and these things you've been talking about. What would be different between you and your wife (children, best friends, employer, etc.)?

**C:** That'd be so good; we would get along, talk more, have dinner together now and then, spend more time around the house with each other. We avoid each other right now, and we hardly talk anymore, except for "Who is taking the kids to school?" and stuff like that.

At every step of the way, the clearly articulated client goal takes the center stage in subsequent contacts and becomes the guidepost for successful treatment. We believe it is important to know when to stop treatment even as the relationship begins.

Even when the client comes to treatment under coercion, or outside pressure from a spouse, court or employer, and is seemingly unmotivated, the following

dialogue shows how the therapist can find out what and who is important to the client. The approach is founded on basic respect for client competence and the belief that clients know what is good for them. We believe the client's ideas should take priority over our "expert" knowledge, since it is the client who must actually implement the necessary changes. This is illustrated in the following dialogue where a client comes to see a therapist under duress.

**T:** What would you like to accomplish as a result of coming to see me? How can I be most helpful to you today?

**C:** I don't know. My wife wanted me to come and see you. She thinks I have a problem.

**T:** Oh, I see, and she wants you to do something about this problem she thinks you have?

**C:** Yes.

**T:** So you must agree with her, or at least want to get along with her in order for you to follow through with her request.

**C:** Well, I don't know if I agree that it's a problem. But I do care about her enough to at least come here and talk to you about it.

**T:** I can see that you are respectful of her ideas. Would it be helpful for me to know what this problem is that your wife wants you to change?

**C:** Well, she thinks I gamble too much.

**T:** I see. How is this a problem for you, her thinking that you gamble too much?

**C:** Well, I don't want to fight with her all the time and she has even threatened to walk out on me and I really don't want that. I love her and we've been together for over 10 years and we've got two kids.

As you can see from this example, the client's goal shifts rather quickly from "my wife wants me to come and see you" to "I don't want to fight with her all the time," to "I love her," and the desire to keep the marriage. The client was not able to articulate this when he first walked into the meeting with the therapist, but by the end, things have become clearer to both the client and



the therapist. Keeping the marriage together and not fighting with his spouse, along with letting her know he loves her is what is important and meaningful to the client. These could easily become the primary motivating factors for the client.

## Negotiating Goals When There Are Multiple Problems

Rather than assuming that a consuming, overwhelming and out of control problem such as gambling must stop before other problems can be solved, we ask the client which problems need to be addressed first to feel like he or she is taking the beginning step. Clients often come up with concrete steps that give them feelings of hope to move forward, instead of leaving them overwhelmed and paralyzed. These steps may be quite contrary to what the therapist believes should be the first step. Before the next dialogue, Mr. Taylor (a pseudonym) presented a long list of problems that he was facing: possible job loss, separation from his wife and possible divorce, foreclosure of his house, the inability to afford the uniforms and travel costs for his children to join a baseball team. Of course, he was depressed and felt discouraged; his drinking problem had become so serious that he was increasingly absent from his job. When we asked Mr. Taylor which problem he needed to solve first to feel like there was some light at the end of the tunnel, without hesitation he responded that he needed to start jogging first. Surprised at this answer, the therapist asked him further about his ideas on how jogging would be helpful, "Explain to me again, what difference would it make for you?" He described how whenever he stopped jogging, his whole outlook on life changed. Further exploration of this idea produced the information that whenever he felt physically fit, he started to take care of himself better, he reduced his drinking considerably and ate healthier, he felt more productive, his depression lifted and he was more focused on his goals, and his gambling was also under better control.

Again, we contend that when we therapists engage clients in useful conversations to recognize that every problem has an ebb and flow, then we are more likely to listen for the client's solutions. Clinicians can follow through with questions that elicit information about who in the client's social environment will support and encourage such positive behaviors and how. The following questions produced useful information about Mr. Taylor's support from those significant others.

**T: So, suppose you start jogging, say, tomorrow morning, what**

would your family say that tells them this is helpful for you?

**C:** My wife would say that I am calmer, easier to be around, and the children like it because I pay them more attention.

**T:** So, when she notices that you are calmer, what does she do that is helpful to you?

**C:** I can tell it helps her also because she herself is calmer and easier to talk to.

**T:** So, what else is different around the house when you are jogging regularly?

**C:** You know, I never thought about it but I would have to say that the children are calmer, also, and they want to be around me more, instead of avoiding me and being cranky and irritable. Boy, I never realized how much influence I have on them.

**T:** So, what do you need to do first? (Or what would your family say that you need to do first?)

Since the idea of getting started on jogging was initiated by Mr. Taylor, he is much more likely to invest in carrying out his own idea. You can see the ripple effect that he can create simply by getting up and jogging; not only for himself but also his entire family, and perhaps, his marriage.

## Exceptions to Problems

As the client's goal(s) becomes well defined, another area of emphasis to focus on is exceptions to the problem. We have observed uncountable examples wherein workable goals or solutions were evident even before the client entered treatment. Contrary to the common language usage that implies that problems exist all the time (e.g., He's an alcoholic; she's lost control over her gambling problem; he's depressed all the time), we contend that all problems have exceptions. That is, times when a client could have gambled, but somehow managed to stay away from buying lottery tickets. For instance, perhaps the person deliberately went to a gas station that does not sell them.

Consistent with our respect for client competence, we are more interested in learning about the client's own expertise about the absence of the problem

than promoting our own "expertise" about eliminating or avoiding the problem. Accordingly, we spend considerable time and energy exploring exceptions to the problem in detail.

In problematic gambling, as in most other problems of impulse control, we find that these exceptions are bountiful. The following are some of the examples of questions that help us learn about exceptions:

- Tell me about the times when you have experienced reaching this goal you've been talking about, even a little bit.
- Tell me about the times when you don't feel the urge to gamble.
- What is different about those times?
- When you are not gambling, or don't want to gamble, what are you doing instead?
- What do you suppose your family (spouse, children, etc.) would say they like the best about you when you are not thinking about gambling?
- What do you suppose they see as different about you during those times?
- When you are more loving and a good parent, one your children would want to continue in a relationship with, what are you doing differently?

We are highly interested in *different* and *instead* questions. Answers to questions about *exceptions*, *differences* and *instead* provide us with the stepping stones to solutions. Accordingly, such questions of *difference* and *instead* open doors to other resources that a client may have forgotten about.

Exceptions point toward solutions; that is, exceptions indicate what the client is capable of doing, thus highlighting successes and suggesting what the client needs to do more of. Because these exceptions are self-generated and come from the client's own social and environmental contexts, these small successes are easier to repeat and amplify once they have been identified.

## Scaling Questions

Another useful tool in this approach is the use of scaling questions. It seems

that impulses to measure, count, compare before and after, compete with oneself as well as with our neighbors, and so on, are universal. Consequently, everyone who understands the numbers 1 to 10 can respond to and benefit from scaling questions.

Language and conversation are the only true tools of therapy, which is both good and bad. We can often run into difficulties because language can be vague and uncertain. At other times, language forces us into dichotomies such as black or white; trustworthy or untrustworthy; honest or dishonest, and so on, in which we must take a position. Since language is the most common tool we have to describe and create reality, this can be limiting and liberating at the same time. In an attempt to reduce some of the ambiguities of language, we substitute numbers for concepts and constructs to make them more precise. In other words, we "make numbers talk" (Berg & de Shazer, 1993). Doing this helps clients to assess their own situation and determine what steps they need to get to the next level of achievement and success.

Described as "self-anchored measurement," numbers on scales move up and down; thus, this form of conversation is more flexible than the language we commonly use. Using numbers in a scaling fashion also assists in breaking down the erroneous perceptions of false dichotomies that many clients and professions endorse: problems vs. no problem, confidence vs. no confidence, motivated or unmotivated, and so on.

Beginning practitioners can easily misunderstand scaling questions to be assessment questions, as if the scale of 1 to 10 is based on normative standards, where the answer 7 represents something objective or has some analytical meaning. "Unlike scales that are used to measure something based on normative standards (i.e. scales that measure and compare the client's functioning with that of the general population along a bell curve), the scales we use are designed to facilitate treatment. Our scales are used to 'measure' the client's own perception, to motivate and encourage and to elucidate the goals and anything else that is important to the individual client" (Berg & de Shazer, 1993, p. 10). Here are some examples:

**T:** OK, on a scale of 1 to 10, where 1 is your gambling when at it's worst and 10 stands for when the problem is gone, where would you say you are at today?

**C:** I don't know. I haven't been gambling for the past two weeks, but I'd say I'm only at 3 or 4.

**T:** A 4?! Already? This is good! How did you do that?

**C:** Well, I decided that it was getting out of hand and that it won't kill me if I just stay away from there for two weeks and really test if I can do it or not. Actually, it's not been that bad. I try to distract myself, I think about something else, like how much the apartment needs fixing, how I've neglected my exercise, haven't called my mother for almost a month, so I just picked up the phone and called her.

**T:** It sounds like you've got a great start going. What do you suppose will be different as you maintain this 4 and maybe even start moving toward a 5?

Scales can be used to measure confidence, progress toward client's goals, instill hopefulness and motivation to make life better, and a host of other intangible elements too vague to describe, thus creating incremental, small steps toward the client's goals. Further elaboration of a client's personal meanings attached to certain numbers can be made in the following ways:

- What tells you that you are at 4?
- How is your life different at 4 compared to when you were at, say, 1 or 2?
- How long have you been at 4?
- What would you say your partner (best friend, employer) likes about your being at 4?
- You have had many ups and downs with your gambling over the years. How confidently would your family say that they believe you will maintain 4 and move up to 4.5 this time?

The potential to expand on answers to these questions is limitless. We find that scaling questions not only make vague concepts more concrete but also direct the client's attention to the significant people in his or her life. The utility of scaling questions is immeasurable because clients of all intellectual abilities and cultural and ethnic backgrounds are able to make sense of this tool. We have even used it with a five-and-a-half-year-old to deal with his temper problem.

# Relapses and Setbacks

Problems and solutions often occur simultaneously. Serious, long-standing problems seem to take the path of "two steps forward, one step back" or a "good days and bad days" pattern on the way to a lifelong solution. Like most compulsive behaviors, it is difficult to predict what course of recovery an individual will take at the outset of treatment. It makes sense to view problematic gambling as similar to other problems of living. Therefore, solution-building processes must account for the inevitability of "two steps forward, one step back" in the recovery process. Therapists must prepare for these setbacks and not see them as failures. Since relapses are a fact of life, we take a pragmatic stance and suggest a five-step approach to build ways to minimize the negative fallout from such setbacks. The natural temptation is to ask why again? or why this time? —for which most people have no answer. It is best not to press the "why" question since it naturally leads to a defensive posture and language.

## A Five-Step Model of Relapse Management

### Step 1 - Positive attitude

It is understandable that clients, their families and friends may feel disappointed and frustrated or betrayed by setbacks or relapses. It is easy to fall into blaming, anger, guilt and remorse, and thus, become discouraged enough to say, "To hell with it all!" and give up. During such times, it is particularly useful for therapists to be hopeful and positive with the client and direct attention to any period of successful control over the impulse and the temptation to slide back into gambling. Therapists should emphasize how the client stayed on course for awhile toward the goal of a gambling-free life. Sometimes, this successful exception has lasted for months, even years. We should remind the client and family of the exception and find out the details of how she or he managed to stay gambling-free during that period.

### Step 2 - Control

Find out what internal or external cues the client responded to when he or she stopped gambling, or walked out of the casino, or made sure to drive right



past the gas station that sells lottery tickets. Frequently clients report that the decision to stop gambling was not their own, but that they simply ran out of money, thus denying that they have self-control over the behavior. It is useful to accept this view, but then gently lean forward with a curious expression, and ask, "I can see that you ran out of money and that was certainly a good time to stop. But tell me, how come you did not borrow money or promise the house to get more money to continue to gamble? You know that there are people who would do anything to get money, including selling their grandmother?" Implied in this curiosity is the message that it was the client who walked out or stopped the negative behavior and not just in response to the circumstances.

By finding out about the minute details of the client's self-control, whether it was thinking about the children's need for shoes or the threat of facing an angry spouse, the therapist implies that the client had control when the money ran out. This same control can be expanded to other situations related to gambling.

### **Step 3 - Options**

The next step is to find out what the client actually did after exerting the self-control to walk away from the casino, drive the long way around to avoid the lottery counter, or turn off the TV when the commercial for a big jackpot came on. Often, a client reports going outdoors and shooting some baskets with his or her children, going directly home and spending time with the children, cutting the grass, shovelling the sidewalk or helping around the house. Obviously these solutions are what the client needs to repeat often once he or she recognizes the pattern of how the temptation to gamble slowly turns into actual behavior. Ways to divert attention to other activities that make the client feel productive and competent become a habitual activity with repetition over time.

### **Step 4 - Differences**

"What was different about this relapse compared to the last one?" The typical language of relapse implies not only that it is constant but also that each relapse or setback is the same. We find that each setback is slightly different; each time what the client does is slightly different from other times. Finding out the details of each setback may reveal that the client is making slow progress toward his or her treatment goal or that the problem is becoming worse. Most of all we find that the details of differences between setbacks are something the client has control over. The client can learn to increase these instances, and thus, gain a sense of mastery over his or her own behavior.

## Step 5 - Lessons

"What have you learned about your problematic gambling from this setback?" This question and other similar ones indicate to the client that each event in life offers us a chance to learn and improve our lives; thus, taking advantage of setbacks as an opportunity to learn. Detailed discussion of how the client will incorporate this learning into daily life is useful to make the experience more concrete and practical.

## Research and Evaluation of SFBT

Because SFBT was developed inductively in a clinical setting (de Shazer, 1985; Berg, 1994; DeJong & Berg, 1998, 2001) rigorous research that shows its effectiveness is only starting to come forth. Many informal studies have been conducted worldwide in a variety of settings. However, rigorous studies with pre- and post-measurements using controlled and experimental populations are difficult to develop and are just beginning to emerge. Recently, Gingerich and Eisengart (2000) reviewed the research literature on SFBT from the last 25 years as it was being refined as a viable treatment model. An on-line review of SFBT (Macdonald, 2000) is available at <http://www.enabling.org/ia/sft/evs.htm>.

What is particularly encouraging about the emerging research is the assessment that SFBT is a time-sensitive, cost-effective and highly collaborative approach, with similar or better outcomes, including fewer sessions, than traditional approaches. Further studies are needed to assess the effectiveness of the SFBT approach with different client populations and several such research projects are currently underway in many corners of the world.

## Conclusion

We have presented a brief examination of the SBFT approach with problem gamblers and hope that this provides additional tools for clinicians and clients faced with difficult and complex situations. At a minimum, we hope this article sparks an interest in trying some of the techniques presented here. If nothing else, we suggest therapists use scaling questions as the beginning step. Then therapists may want to add exception questions and watch how clients' faces



light up. We find that clients' responses to the many suggested questions are the most convincing argument for adopting this model. These small differences are the reasons for our endeavors.

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# Characteristics of People Seeking Help from Specialized Programs for the Treatment of Problem Gambling in Ontario

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## Abstract

### Objectives:

The objectives of this study are to estimate the number of people seeking treatment on an annual basis in Ontario at specialized problem gambling treatment programs and describe important characteristics of clients.

**Method:**

Agency staff prospectively collected four broad information categories from clients: demographics, gambling activities, problem severity and services received, and submitted the data to a central database.

**Sample:**

The report includes submissions (total caseload equals 2224) from 44 designated problem gambling programs between January 1, 1998 and April 30, 2000.

**Results:**

Of the 2224 clients in treatment, 1625 (73.5%) were seeking help for their own gambling problem, and 504 (22.8%) were seeking help in dealing with a family member/significant other's gambling problem. The overall gender ratio of cases in treatment was about 1.4:1 (58.3% to 41.7%) males to females. A wide range of gambling activities was reported as problematic.

**Conclusion:**

Only a small percentage of people experiencing problems related to gambling are seeking help from specialized treatment programs. Population survey data are needed in Ontario to assess the potential over- or under- representation of particular sub-groups in treatment compared to the epidemiology of problem gambling in the community.

# Introduction

The past decade has seen a burgeoning interest in research and policy analysis with respect to problem gambling. Despite the community focus of much of this work, there is little evaluation research at present concerning the impact of problem gambling on health and social services in general or the specialized sector of services, now in many communities for treating problem gambling. Thus, there is a need to broaden the research frame for problem gambling to include health services research and policy analysis (Aday, Begley, Lairson & Slater, 1998). One of the key aspects of services research includes "performance monitoring" of publicly funded services that provide treatment to problem gamblers. Generally, this kind of monitoring and evaluation is a fundamental part of services research in the addiction field (Dennis, 1999). To date, there have been a small number of studies about the characteristics of problem gamblers in specialized treatment services (e.g., Crisp et al., 2000); however, only one study has been done in a Canadian context (Beaudoin & Cox, 1999). The results suggest that gambling to relieve dysphoria or escape from life problems characterize a large subset of problem gamblers in treatment. In addition, in contrast to other U.S. studies where older males predominate (Volberg, 1994), their treatment sample was approximately one-third female, and 43% were between the ages of 18 and 34. Other studies in some jurisdictions suggest that female problem gamblers increasingly participate in treatment (Moore, 1998; Stinchfield & Winters, 1996). Crisp et al. (2000) report on the gender differences in the types of gambling activities and related problems that were reported at initial assessment for entry into the program.

Specialized treatment services for problem gambling have rapidly expanded across Ontario in response to needs at the community level; provincial policy since 1996 directs a proportion of gambling revenue to treatment programs for problem gambling, community information services and prevention and research. Currently, 2% of slot machine gross revenue is committed to expand the problem gambling initiatives in the province. This funding totaled \$3.5 million in 1998/1999, \$10 million in 1999/2000, and \$17 million in fiscal 2000/2001. The share of funding that went to treatment was \$2.2 million (1998/1999), \$3.1 million (1999/2000) and about \$6 million in 2000/2001.

As part of this funding envelope, specialized treatment services for problem gambling have been developed largely through designated funding to existing addiction treatment services. As of this writing, 43 substance-abuse programs have received supplementary funding for a service component dedicated to problem gambling. Under the auspices of general health and social services that focused specifically on the Chinese-Canadian community, another

problem gambling program was funded by the Ontario Substance Abuse Bureau (OSAB). The Mnjikaning First Nation at Rama, Ontario, also funded a specialized gambling treatment program for the First Nations community. (Data from this treatment centre are not included in the present report.) Thus, there were 45 programs in operation, and 44 of them were funded by OSAB. OSAB's commitment to specialized problem gambling treatment programs increased from three agencies and \$1 million in funding in 1995/1996 to 44 agencies and just under \$6 million in funding in 2001. Included in this figure is funding for seven new programs targeted at special populations (ethno-cultural, older adults, women and youth).

It should be kept in mind that OSAB-funded treatment agencies are not the only sources available to Ontario citizens seeking help for gambling related problems. This report does not consider additional guidance or treatment received from existing non-OSAB funded sources, such as Gamblers Anonymous/GAMANON, Employee Assistance Programs or religious groups.

## **Drug and Alcohol Treatment Information System (DATIS)**

All substance-abuse services funded by OSAB (approximately 200 programs) participate in an ongoing client-based information system, which monitors the number and characteristics of clients seeking help, and an assessment of the services they have received. Ogborne, Braun and Rush (1998) provide an overview of DATIS, and a report is currently being prepared that summarizes annualized data from this provincial monitoring system for the fiscal year 1999 and 2000. Since early 1998, the 44 OSAB-funded, designated treatment programs for problem gambling have been participating in DATIS and reporting on a special component developed specifically for problem gambling services.

## **Objectives**

The objectives of this report are to

- estimate the number of people seeking specialized treatment on an annual basis at problem gambling programs in Ontario; and



- describe the characteristics of problem gamblers entering treatment, including demographic characteristics, type of gambling behaviour and problem severity.

## Method

### Data Elements

There are four broad categories of data submitted by the participating agencies: client demographics, gambling activities, problem severity and services received (see Table 1). The agencies also collect the required information for the larger DATIS information system, with links to the gambling data provided by a unique client identifier, which is based on birth date, initials at birth and gender (Dalrymple, Lahti, Hutchison & O'Doherty, 1994). A person becomes a "case" in the information system when he or she has been registered in the program as a client. For the majority of programs this will mean there has been face-to-face contact with clients. One treatment program has a well-established telephone counseling service and, as a general rule, callers are registered as clients if the call is about counseling and exceeds 20 minutes. It should be noted, however, that the data collection process and data definitions will underestimate the overall involvement of agency staff with problem gamblers and their families; telephone support for people who chose not to formally enter the program, and the staff's prevention work in the community are not captured in the information system.

Table 1. Data elements in the problem gambling treatment information system

<u>Demographic characteristics</u>	<u>Gambling activities</u>
<ul style="list-style-type: none"> <li>• Problem gambler or family member/significant other</li> <li>• Age</li> <li>• Gender</li> <li>• Ethnic/cultural background</li> <li>• Reason for seeking help (gambling or other treatment)</li> </ul>	<ul style="list-style-type: none"> <li>• Type and frequency of gambling activity</li> <li>• Type and frequency of gambling locations</li> </ul>

<u>Problem severity</u>	<u>Services received</u>
<ul style="list-style-type: none"> <li>• Length of time since last gambled</li> <li>• Years of negative consequences</li> <li>• South Oaks Gambling Screen (11)</li> </ul>	<ul style="list-style-type: none"> <li>• Duration of different service activities (e.g., Assessment, counseling)</li> </ul>

## Data Collection, Transmission and Analysis

At the agency site, the data elements are captured on three forms. Form A is completed at intake and records the client's demographic characteristics, frequency of different gambling activities and location of gambling. Form B collects the South Oaks Gambling Screen (SOGS) data (Lesieur & Blume, 1987). A third form, the Individual Activity Timesheet, is then completed after each face-to-face or telephone contact with the client. The roll-up of the data from this third form summarizes the type and duration of services received. The forms were designed using Teleform software, so that, upon completion, they are faxed to a central 1-800 number and the data is read directly into Microsoft Access database. A research clerk scans the Teleform data and implements a standard cleaning protocol involving the identification of unreadable and out-of-range data. Following the data-cleaning process, the Access database is read into Statistical Package for the Social Sciences software for analysis and generation of statistical tables. All admission records date-stamped between January 1, 1998 and April 30, 2000 were selected for this paper.

## Missing Cases

In this report, we summarize the information captured in the central database as reported by the participating agencies; the data used has undergone the cleaning process. While missing data ranged from 2% to 3% for the majority of items, there was an unexpected volume of missing data on a small number of items (e.g., about 20% of the SOGS were missing). There was also a considerable amount of out-of-range data (e.g., the unscored SOGS item concerning the largest amount of money ever gambled on any one day; and

items on the data collection form that captured duration and type of services provided on an ongoing basis). Some of the problems were due to a few agencies not completing the required forms or data fields. Most of the data quality problems that resulted in machine-readable errors, however, have been traced to problems using the Teleform system that resulted in machine-readable errors. Thus, extensive cleaning processes have been applied manually to the information used for this report. With training and ongoing communication between the agencies and the new DATIS field staff, these errors in data collection and transmission have been significantly reduced.

Because the problem gambling programs have not reported all of their clients to the information system, the total use of these services will be underestimated. All agencies were contacted prior to the preparation of this report. Their participation was verified, and any outstanding issues related to their involvement, case reporting and data quality were discussed. Four programs reported that they had not yet seen any clients. For those programs that did not send in each of the required forms (e.g., the SOGS), the count of their clients will still be an accurate reflection of their total caseload. Some programs reported not sending in any forms for a small number of clients, and we estimate this number to be less than 100 for the province as a whole. Thus, we believe the data system and this first report from the database reflect a reasonably accurate estimate of the provincial caseload of Ontario's problem gambling treatment programs.

## Results

### Caseload

Table 2 shows 44 OSAB-funded treatment programs in operation with a total caseload of 2224 over the study period. The table also places these provincial totals into a regional context by displaying the information separately for the seven Ministry of Health and Long-Term Care (MOHLTC) regions and adjusting the data for population size. It is important to note that the treatment caseload data are based on the geographic location of the treatment program, not the residence of the client. The agency location, however, will be a reasonably close proxy for the location of the clients' residence since the treatment programs are all non-residential programs and draw the large majority of their clients from a 50 to 100 kilometer radius. An exception to this group is the program with the telephone counseling service, which receives occasional calls from outside their district. On a per capita basis, the South West Region has the highest user rate of problem gambling

treatment programs in Ontario (2.98 per 10,000), a rate that is about 44% higher than the provincial average. Ontario's North Region has the second highest number of users at 2.82 per 10,000, followed by the South Central Region at 2.43 per 10,000. The West Central Region has the lowest user rate at 1.46 per 10,000.

Table 2. Regional context for specialized services for the treatment of problem gambling in Ontario

Region <sup>1</sup> (Largest city/ municipality)	No. of programs funded	Problem gambling two-year caseload	
		N	Rate <sup>2</sup>
Central East <sup>3</sup> (Oshawa)	4	251	1.50
Central South (Hamilton)	4	265	2.43
Central West (Kitchener- Waterloo)	4	265	1.46
East (Ottawa)	8	258	1.74
North (Sudbury)	15	240	2.82
South West (London)	7	429	2.98
Toronto	2	501	2.10
No region identified	-----	15	-----
<b>Total</b>	<b>44</b>	<b>2224</b>	<b>2.07</b>

<sup>1</sup>Planning region for Ministry of Health and Long-Term Care.

<sup>2</sup>Rate per 10,000 population.

<sup>3</sup>Excludes Mnjikaning First Nation at Rama

Figure 1 examines the total caseload reported across the study period (28 months from January 1, 1998 to April 30, 2000), as it was reported during four-month segments. There are two reasons for reporting the data in this manner. Firstly, one can clearly see the rapid increase in use of the gambling treatment programs during 1998, and the stabilization in total utilization during 1999 to the end of the study period. This reflects the growth in provincial treatment capacity through 1998, since the number of programs grew dramatically during this period. Undoubtedly, it also reflects the increasing use of the individual programs as they became established in their community. Secondly, the four-month breakdown allows one to derive a projection of the current annual caseload by taking the average of the caseload of the last four, relatively stable periods (mean= 476), and multiplying by three to yield a total annual estimate of 1428 clients.

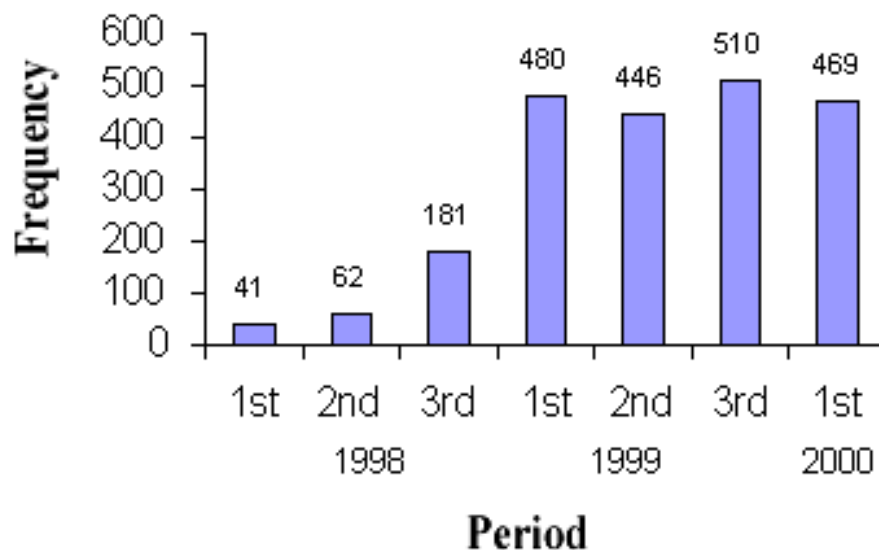


Figure 1. Frequency of use by four-month period between January 1/98 and April 30/00

These figures will still be an underestimate of total service use because four programs had not yet seen any clients during the study period. However, the estimation approach provides the necessary adjustment for the rapid increase in treatment capacity over the two-year period and the start-up phase for many of the agencies that are now fully operational.

## Demographic Characteristics

Of the 2224 clients in treatment, 1625 (73.5%) were seeking help for their own gambling problem, and 504 (22.8%) were seeking help in dealing with a family member/significant other's gambling problem. The remaining 82 (3.7%) were seeking help for both their own gambling problems and dealing with a family member's. The overall gender ratio of cases in treatment was about 1.4:1 males to females (58.3% to 41.7%). A significantly higher percentage of women compared to men sought help for their difficulty with a family member/significant other (37.3% of women compared to 12.1% of men [ $\chi^2=194.45$ ,  $df=2$ ,  $P<.001$ ]). Consequently, when only those clients who sought help for their own gambling problems (including a small proportion of clients seeking help for both their own and a family member/significant other's gambling problem) are considered, the gender ratio widens to 1.9:1 males to females (65.6% to 34.5%). (See Table 3.)

Table 3 shows the age distribution of male and female clients seeking help for their own problem gambling. The age distribution for both genders combined is bell-shaped, with the largest percentage (33.6%) falling within the age category of 35 to 44. The difference in the age distribution between males and females is statistically significant ( $\chi^2=68.85$ ,  $df=8$ ,  $p<.001$ ); male clients tend to be younger.

Table 3. Age by gender of problem gamblers in treatment<sup>1</sup>

Age category	Male		Female		Total	
	N	%	N	%	N	%

<b>&lt;16</b>		.3	0	0	3	.2
<b>16-17</b>	3	1.0	2	.4	13	.8
<b>18-24</b>	11	7.4	16	2.8	97	5.8
<b>25-34</b>	81	26.7	102	17.6	397	23.6
<b>35-44</b>	295	34.2	188	32.5	566	33.6
<b>45-54</b>	378	20.8	156	26.9	386	22.9
<b>55-64</b>	230	7.7	94	16.2	179	10.6
<b>65-69</b>	85	1.3	11	1.9	25	1.5
<b>70-100</b>	14	.6	10	1.7	17	1.0
<b>Total</b>	7					
	1104	100.0	579	100.0	1683	100.0

<sup>1</sup> Includes those in treatment for their own gambling problem and those in treatment for both their own problem and a family member/significant other's.

Table 4 shows the ethnic and cultural background of clients seeking treatment for their gambling problem. The largest proportion of clients seeking treatment are people of white background (83.3%). People of Aboriginal/ First Nation's heritage accounted for 4.9% of clients, and people with Asian backgrounds accounted for 7% and small percentages were drawn from several other ethnic groups.

Table 4. Ethnic/cultural background of problem gamblers in treatment<sup>1</sup>

Ethnic/cultural background	Total	
	N	%



<b>Aboriginal/First Nations</b>	74	4.9
<b>Asian</b>	106	7.0
<b>White</b>	1261	83.3
<b>Other</b>	72	4.8
<b>Total</b>	1513	100.0

<sup>1</sup> Includes those in treatment for their own gambling problem and those in treatment for both their own problem and a family member/significant other's.

The forms in the data-collection system record whether the client initially came for help with a gambling problem or whether the problem surfaced later in the course of providing support for substance abuse or some other issue. Almost 90% came to the agency for their gambling problem; these percentages were similar for both male and female clients.

## Problem Severity

The number of years that gambling has negatively affected a client's life is also recorded. Of the clients in treatment for their own gambling problem, 27.8% have been negatively affected by their gambling for one year or less, 15.2% for two years, 25.2% for three to five years, 14.3% for six to 10 years, and 17.4% for 11 years or more.

The South Oaks Gambling Screen is a widely used instrument for assessing the severity of problem gambling based on DSM-III criteria (Lesieur & Blume, 1987). A cut-off score of five or more is typically used as evidence of pathological gambling. Some researchers and clinicians use a score greater than 10 as the criterion. As shown in Table 5, about 90% of the client population seeking help for their own problem gambling scored above the cut-off score of five; 48.5% were above the more conservative cut-off of 10.

Table 5 examines the relationship between the SOGS score (combining scores 1 to 4 for "problem gambling," and five and over for "pathological gambling") and years that gambling has had negative consequences. There

was no statistically significant relationship between duration of negative consequences and problem severity as measured by the SOGS.

Table 5. Number of years gambling has negatively affected clients' lives<sup>1</sup> (by SOGS score)

Years	SOGS categories			
	1-4 (some gambling-related problems)		5-20 (probable pathological gambling)	
	N	%	N	%
<b>1</b>	31	29.8	213	20.2
<b>2</b>	17	16.3	174	16.5
<b>3-5</b>	22	21.2	296	28.1
<b>6-10</b>	14	13.5	166	15.7
<b>11+</b>	20	19.2	205	19.5
<b>Total</b>	104	100.0	1054	100.0

<sup>1</sup> Includes those in treatment for their own gambling problem and those in treatment for both their own problem and a family member/significant other's.

## Gambling Activities

Each client entering the gambling treatment program was asked to identify his or her major problem gambling activity and, if appropriate, up to two additional problem activities. Table 6 shows the diversity of gambling activities that were identified as problematic by these clients. The most frequently cited problem activities were slot machines (37.7%), cards (30.6%) as well as lottery and scratch tickets (34.5% and 29.5% respectively). Bingo was cited by 22.6% and sports betting by 20%.

Table 6. Type of gambling activity reported as a problem<sup>1</sup>

<b>Activity</b>	<b>Total (N=1197)</b>	
	<b>N</b>	<b>%</b>
<b>Slots</b>	451	37.7
<b>Lottery tickets</b>	413	34.5
<b>Cards</b>	366	30.6
<b>Scratch tickets</b>	353	29.5
<b>Bingo</b>	271	22.6
<b>Sports</b>	239	20.0
<b>Tear tickets</b>	230	19.2
<b>Horses, dogs</b>	169	14.1
<b>VLT <sup>2</sup></b>	101	8.4
<b>Roulette</b>	83	6.9
<b>Games of skill</b>	58	4.8
<b>Other</b>	39	3.3
<b>Dice games</b>	37	3.1
<b>Mahjong</b>	25	2.1
<b>Stock options</b>	21	1.7
<b>Keno</b>	19	1.6

<sup>1</sup> Collapsed across clients' reports of major problem activity and first and second other problem activity.

<sup>2</sup> As VLTs are illegal in Ontario, clients reporting this type of activity as a problem are either using the machines illegally or are gambling in a province in which VLTs are legal.

Table 7 shows what locations clients in treatment for problem gambling frequent the most. Consistent with the above data concerning gambling activities, the most common locations were casinos (58.2%), kiosks (38.3%) and bingo halls (22.8%).

Table 7. Gambling locations frequented the most

<b>Location</b>	<b>Total (N=1195)</b>	
	<b>N</b>	<b>%</b>
<b>Casino</b>	695	58.2
<b>Kiosk</b>	458	38.3
<b>Bingo hall</b>	272	22.8
<b>Track</b>	143	12.0
<b>Off-track</b>	95	8.0
<b>Telephone</b>	95	8.0
<b>Charity casino</b>	91	7.6
<b>Community</b>	78	6.5
<b>Family</b>	62	5.2
<b>Social club</b>	53	4.4
<b>Internet</b>	16	1.4

<b>Television</b>	16	1.4
<b>School</b>	4	0.1

<sup>1</sup> Collapsed across clients' reports of top three locations for gambling.

## Discussion

This paper presents highlights from a client-based information system that collects and collates data from the designated programs for the treatment of problem gambling in Ontario. The primary goals of the information system are to contribute basic accountability and planning information at the agency, regional and provincial levels. A series of standard statistical tables are being prepared that summarize the complete set of data elements as well as structured feedback reports to the participating agencies, so that they can compare their client population to the provincial averages. The primary aims of this paper are to estimate the annual caseload of these problem gambling programs and describe important characteristics of clients. The data also establish a baseline of key indicators to be monitored over time.

The results of the information-collection system showed that just over 2200 people have sought help at provincial problem gambling programs since early 1998. Of this total, about one-third were seeking help for difficulties related to a family member or a significant other's gambling problem. Thus, the provision of support to people affected by someone else's gambling behaviour is an important role played by the gambling treatment programs in their community. An annualized estimate of just over 1425 total cases was projected because of a relatively stable pattern of service use over the fiscal year 1999/2000. Of this total, we estimate that about 950 to 975 problem gamblers are seeking treatment each year; the remainder of cases are family members/significant others.

This number is quite small in comparison to estimates from Canadian prevalence studies of problem gambling. A review of studies conducted in eight of Canada's 10 provinces suggested that between 2.7% and 5.4% of Canadians were problem or pathological gamblers in 1996 (National Council of Welfare, 1996). Comparable data that is specific to Ontario is difficult to find because of the lack of consensus as to what constitutes a "problem gambler." In 1993, 7.7% of Ontario respondents scored between one and four on the SOGS, indicating some gambling problems, and an additional 0.9% met the criteria for probable pathological gambling (e.g., a score of five or higher) (National Council of Welfare, 1996; Ladouceur, 1996). More recently

in 2000, 2.6% of a representative sample of Ontario respondents scored two or greater on the SOGS (Adlaf & Ialomiteanu, 2001). It should be noted that the widespread use of the SOGS in community-based studies has received some recent criticism owing in part to the lack of validation work with the general population (Ferris, Wynne & Single, 1998). There is also evidence that it may considerably overestimate the prevalence of gambling-related problems in the community (Lesieur & Blume, 1993).

These limitations aside, however, the small number of people seeking treatment for gambling-related problems in Ontario compared to the estimates reported by these prevalence studies suggests a large unmet need for treatment in the community. It also reveals the need for wider promotion of the service delivery system that has been put in place for problem gambling treatment. There is also a need for further study of the help-seeking patterns of problem gamblers and the extent to which they are either reluctant to seek help, or are seeking assistance from other, more generic health and social services in the community (e.g., family physicians, community mental health programs, family counseling, credit counseling).

The second objective of this paper is to describe the clients presenting for treatment in a way that is relevant for program and policy development and evaluation. There are a number of interesting comparisons that can be made with the data. For example, how do these clients compare to clients seeking help from substance-abuse service providers? Unpublished information from DATIS and reports from previous surveys of the addiction treatment system in Ontario (Tyas & Rush, 1994) suggest that problem gamblers are older, and a larger percentage of them are women and people who seek help for someone else's problem. The fact that problem gamblers in treatment tend to be older than their counterparts in substance-abuse services is cause for some concern. While the prevalence of problem gambling is higher among adolescents, students and young adults (Shaffer, Hall & Vander Bilt, 1999; National Council of Welfare, 1996), older gamblers appear to be under-represented in the treatment population (Adlaf & Ialomiteanu, 2000). For instance, a study conducted in 1994 found that 33% of Ontario adolescents 12 to 19 had gambling-related problems, and 4% were probable pathological gamblers (Canadian Foundation on Compulsive Gambling, 1994), making them roughly four times more likely than adults to have considerable gambling-related problems. A survey conducted in 1999 found that 13.3% of a representative sample of Ontario high-school students scored two or greater on the SOGS, compared to 2.6% of the adult population at roughly the same time (Adlaf & Ialomiteanu, 2000). Both of these studies used the revised SOGS for adolescents (SOGS-RA), which is similar to the adult version but has not been validated with young people in the community (Adlaf & Ialomiteanu, 2000). This limitation notwithstanding, the data suggest a wide

discrepancy between the prevalence of problem gambling among youth and help-seeking from specialized treatment services. This, in turn, points to the need for early detection and intervention programs in addiction and other types of community services serving young people.

The SOGS data show the full spectrum of problem severity among people seeking treatment for their gambling problem. The data also show that the number of years of negative consequences related to gambling highlight the rapid onset of these problems for a substantial proportion of clients —43% in two years or less. That there is no relationship between problem severity, as measured by the SOGS, and years of negative consequences also underscores the rapid onset of serious problems. Future studies need to explore the relationship between problem onset and type of gambling activity.

The descriptive data on the types of gambling activities identified as problematic are also of interest since they point out the diversity of these activities among problem gamblers in treatment. The sheer variety of problematic gambling activities beyond casino and racetrack venues is important for the development of policy as well as public education and prevention programs. For example, a large percentage of problem gamblers in treatment report problems related to lotteries and tear tickets; these two forms of gambling have become part of the fabric of daily life for many Canadians.

The data presented here will also be valuable in monitoring changes in the size and nature of the clientele accessing these problem gambling treatment programs. Broader stakeholder consultation is required to narrow a list of "system performance indicators." However, the selection process might usefully begin by considering some of the following: total caseload per year; proportion of female clients; mean and median age; proportion of clients from different ethnic/cultural groups known to have particular needs; and the proportion of clients reporting certain problem activities (e.g., slots, bingo) and locations (e.g., casinos, racetrack, Internet). Other indicators will need to be developed for the duration and type of various treatment activities (e.g., hours of assessment and counseling; proportion of direct versus indirect care and support). This kind of data has not been reported here because it is still undergoing a cleaning and editing process. In this regard, efforts will need to continue with the participating programs to reinforce the importance of reporting high quality and complete data into the information system. Planned enhancements to the DATIS project will build the gambling component directly into the new software to be developed and disseminated to OSAB-funded agencies.

Finally, from the perspectives of both system/program accountability and



ongoing system/program quality improvement, there is a critical need to expand the gambling monitoring system to include modules related to service costs and client outcome. A cost-outcome monitoring system has been successfully piloted within Ontario's substance-abuse services (Rush, Hobden, Aiken Harris & Shaw Moxam, 2000; Rush, Wall & Shaw Moxam, 2000), and many of the lessons learned in that project will apply to this sector of problem gambling programs.

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*—The Editor*

## Slot Machine Gamblers —Why Are They So Hard to Study?



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The literature examining the psychology of slot machine gambling is limited. The lack of research seems surprising given the billions of dollars generated from slot machine gambling worldwide coupled with the fact that a small proportion of the population plays them pathologically (Griffiths, 1995). However, we have both spent over 10 years playing in and researching this area and we can offer some explanations on why it is so hard to gather reliable and valid data.

The explanations represent experiences of several research efforts to examine the psychology of slot machine gamblers in the United Kingdom, Canada and the United States. They are roughly divided into three categories:

- player-specific factors
- researcher-specific factors
- miscellaneous external factors.

## Player-specific factors

A number of player-specific factors can impede the collection of reliable and valid data. These include such factors as activity engrossment, dishonesty, social desirability, motivational distortion, fear of ignorance, guilt, embarrassment, infringement of player anonymity, unconscious motivation, lack of self-understanding, chasing and lack of incentive to participate in research.

*Activity engrossment.* Slot machine gamblers can become fixated on their playing almost to the point where they "tune out" to everything else around them. We have observed that many gamblers will often miss meals and even utilise devices (such as catheters) so that they do not have to take toilet



breaks. Given these observations, there is sometimes little chance that we as researchers can persuade them to participate in research studies —especially once they are already gambling on a machine

*Dishonesty and social desirability.* It is well known that some gamblers are dishonest about their gambling behaviour. Social and problem gamblers alike are subject to social desirability factors and may be dishonest about the extent of their gambling activities to researchers as well as to those close to them. This obviously has implications for the reliability and validity of any data collected.

*Motivational distortion.* Many slot machine gamblers experience low self-esteem and when participating in research may provide ego-boosting responses that lead to motivational distortion. For this reason, many report that they win more (or lose less) than they actually do. Again, this self-report data has implications for the reliability and validity of the data.

*Fear of ignorance.* We have observed that many slot machine gamblers claim to understand how slot machines work when in fact they know very little. This appears to be a face-saving mechanism so that they do not appear ignorant.

*Guilt and embarrassment.* Slot machine gamblers may often be guilty and/or embarrassed to be in the gambling environment in the first place. They may like to convince themselves that they are not "gamblers" but simply "social players" who visit gambling environments infrequently. We have found that gamblers will often cite their infrequency of gambling as a reason or excuse not participate in an interview or fill out a questionnaire. Related to this, some gamblers just simply do not want to face up to the fact that they gamble.

*Infringement of player anonymity.* Some slot machine gamblers play on machines as a means of escape. Many gamblers perceive the gaming establishment in which they gamble as a private arena rather than a public one. Researchers who then approach them may be viewed as infringing on their anonymity.

*Unconscious motivation and lack of self-understanding.* Unfortunately, many slot machine gamblers do not themselves understand why they gamble. Therefore, articulating this accurately to researchers can be difficult. Furthermore, many gamblers experience the "pull" of slot machines, the feeling of being compelled to play despite better judgment, but they cannot articulate why.

*Chasing.* Many frequent gamblers do not want to leave "their" slot machine in case someone "snipes" their machine while they are elsewhere. Therefore, it

is understandable that most gamblers are also more concerned with chasing losses than participating in an interview or filling out a questionnaire for a researcher.

*Lack of incentive.* Some slot machine gamblers simply refuse to take part in research because they feel that there is nothing in it for them (i.e. a lack of incentive). Moreover, few gamblers view research about their gambling habits and experiences as potentially helpful to others.

## Researcher-specific factors

In addition to player-specific factors, there are also some researcher-specific factors that can impede the collection of data from slot machine gamblers. Most of these factors concern research issues relating to such participant and non-participant observational techniques as blending in, subjective sampling and interpretation, and lack of gambling knowledge.

*Blending in.* The most important aspect of non-participant observation research while monitoring fruit machine players is the art of being inconspicuous. If the researcher fails to blend in, then slot machine gamblers soon realise they are being watched and are therefore highly likely to change their behaviour. For instance, some players may get nervous, perhaps agitated and stop playing. Others may do the opposite and try to show off by exaggerating their playing ritual. Furthermore, some gamblers will discourage spectators if they consider them to be "skimmers" (i.e. individuals who try to win by playing "other peoples machines"). Blending into the setting depends upon a number of factors, including whether the venue is crowded and easy to wander around in without looking suspicious.

The researcher's experience, age and sex can also affect the situation. In the United Kingdom, amusement arcades are generally frequented by young men and elderly women. If the arcade is not crowded and the researcher does not fit the general profile, then there is little choice but to be one of the "punters." The researcher will probably need to spend lengthy periods of time in the arcade; therefore, spending money is unavoidable unless the researcher has a job there—an approach which may have benefits (see below).

*Subjective sampling and interpretation.* It is impossible for the researcher to study everyone at all times and locations in the gambling environment. Therefore it is a matter of personal choice as to what data are recorded, collected and observed. This affects the reliability and validity of the findings.

Furthermore, many of the data collected during observation will be qualitative in nature and therefore, will not lend themselves to quantitative data analysis.

*Lack of gambling knowledge.* Lack of "street knowledge" about slot machine gamblers and their environments (e.g., knowledge of the terminology players use, machine features, gambling etiquette, etc.) can lead to misguided assumptions. For instance, non-participant observation may lead to recording irrelevant data and idiosyncratic interpretation of something that is widely known amongst gamblers. This can also lead to subjective interpretation issues.

## External factors

In addition to player- and researcher-specific factors, there are also external factors that can impede the collection of data from slot machine gamblers. Most of these factors involve the gaming industry's reactions to the presence of researchers in their establishments, but there are other factors as well.

*Gaming establishment design.* Years of research experience have demonstrated that many arcades and casinos are not ideally designed for doing covert research. Non-participant observation is often difficult in small establishments or in places where clientele numbers are low.

*Gatekeeper issues and bureaucratic obstacles.* The questions of how and where access to the research situation can be gained raise ethical questions. According to Burgess (1984), access is usually determined by an informant (often an acquaintance of the researcher) or gatekeeper (usually the manager). Obtaining permission to carry out research in a gambling establishment can be difficult and is often the hardest obstacle that a researcher has to overcome to collect the required data. Many establishments do not have the power to make devolved decisions and must seek permission from the head office. The industry may prevent access for many reasons. The main ones are described below.

*Management concerns.* From the perspective of arcade and casino managers, the last thing they want are researchers disturbing gamblers, their customers, by taking them away from their gambling. Furthermore, they do not want researchers to give their customers any chance to feel guilty about gambling. In our experience, management sees researchers in this light, which influences whether they give permission to carry out research.

*Industry perceptions.* From the many years we have spent researching (and gambling on) slot machines, it has become clear that some people in the gaming industry view researchers as anti-gambling and expect research to report negatively about their clientele, establishment or organisation. As with management concerns, this also has an impact on obtaining permission to carry out research.

## Practical advice for collecting data on slot machine gamblers

Having presented what we believe to be the main impediments to collecting data about slot machine gambling, we offer some practical advice in this section on how to get around these potential problems.

*Network with the gaming industry.* Since gaining formal access to gambling establishments is difficult, it is sensible to network with the gatekeepers in order to facilitate access. The more they know about the researchers and what their goals are, the more likely they are to make a decision based on informed choice.

*Be flexible and adaptable in fieldwork.* Researchers must constantly monitor their activities, and they have to be flexible and adaptable. For instance, if a researcher enters the field with certain hypotheses, misconceptions may result which will need rapid revisions. Redefining methodology and hypotheses on the basis of early observations may also be necessary (Burgess, 1984)

*Collect relevant data.* There are few guidelines on what are relevant data when engaged in observational work. Schatzman and Strauss (1973) suggest categorising behaviour into these categories; (a) routine events, in which activities are part of the daily round of life, (b) special events, which are fortuitous but can be anticipated and (c) untoward events, which cannot be anticipated or predicted. Alternatively, Spradley (1980) suggests three different types of observation. These are (a) descriptive observations, which describe the setting, the people and the events that took place, (b) focussed observations, which give the descriptive observations a more detailed portrait and (c) selective observations, which link the questions posed by the researcher.

*Introduce incentives to take part in research.* To get participants involved, it

may be useful to pay the participants, give them gifts or include them in prize draws, etc. There are of course ethical issues concerning giving potential problem gamblers more money with which to gamble, but such issues may be handled on an individual basis.

*Utilise data that are already there.* For observational purposes it may be possible to use observational behavioural data through such sources as surveillance footage. However, ethical issues here are paramount and may affect if such approaches can be employed at all.

*Idiographic methodology.* When it is difficult to recruit the appropriate participants, it may be necessary to study a smaller sample size to gain valuable insights through collecting content-rich data through means such as in-depth explorative interviews or observational analysis (see following section) rather than simply doing questionnaires. Researchers' evaluations can thus be triangulated with other methods of data collection in order to be more confident about the validity and reliability of their findings. For example, Griffiths (1995) researched adolescent gambling utilising a range of methodologies including questionnaires, interviews and participant and non-participant observation. If a participant appears to have given socially desirable responses in the questionnaire or initial interview, additional evaluations can be made through observational sessions or a more probing interview.

*Observational methodologies.* Fieldwork can be ideal for studying "social worlds," described by Lindesmith, Strauss and Denzin (1975) as "those groupings of individuals bound together by networks of communication or universes of discourse and who share perspectives on reality" (pp. 439-440). There are countless social worlds frequently segmented into various subworlds (Strauss, 1978), many of which go unnoticed, and so-called "invisible worlds" of socially problematic populations (Unrah, 1983).

Whenever possible, it is recommended to supplement self-report data with the use of observational methodologies. Non-participant observation usually relies on the researcher being unknown to the group under study. The one distinct advantage of non-participant observation is that the researcher can study a situation in its natural setting without altering the conditions -- but only if the researcher can blend in naturally, as previously discussed. The one obvious advantage is that non-participant observation relies only on observing behaviour. Since the researcher cannot interact in the social behavioural processes, most data collected will be qualitative, interpretative, and to some extent, limited. However, by using other methodological research tools (e.g., structured interviews), suspicions, interpretations and even hypotheses can be confirmed.



*Contact treatment agencies.* Recovering pathological gamblers may be more helpful in participating in research than gamblers found in gambling establishments. However, there are problems with utilising these populations. They will have distinctive viewpoints on gambling, and gamblers recruited from treatment agencies to participate in research do not represent a cross-section of the continuum of gamblers. These individuals may have gambled much more frequently and taken more risks than the average gambler. Furthermore, they may have experienced significantly higher levels of life disruption as a result of their gambling. Thus, they view gambling as a problem and are motivated and taking positive steps to combat related problems. For these reasons, their opinions and attitudes may well be different from those of the average gambler. Nevertheless, provided that conclusions and generalisations are not based solely on such a population, the data can often make a rich contribution to research findings.

*Get employed in a gaming establishment.* One way to collect invaluable data is to work in a gaming venue, an approach that has been taken by prominent researchers in this field. For example, Sue Fisher collected all of her observational data while employed behind the change counter of her local amusement arcade. Employment within the environment can be used to establish the researcher's identity and allow blending into the environment. Slot machine gamblers are usually unaffected by onlooking staff because there is no real risk of staff playing their machine when they have finished their gaming (see "skimming" referred to above). Hence, staff are fully permitted to observe playing behaviour and are often required to do so to be vigilant for fraudulent practices. Furthermore, while submerged in this social world, researchers can gather large amounts of relevant and fruitful information indirectly through participation in the gambling environment. We recently utilised this approach to obtain data and it proved effective.

*Become a gambler.* By becoming a gambler, the researcher can take an auto-ethnographic approach in the collection of data. Auto-ethnography literally means the study of one's own group (Rosecrance, 1986) and involves research processes as well as research methods (Burgess, 1984). It can have a number of advantages; for instance, it may allow acceptance by the group under study, familiarisation with gambling terminology, longitudinal perspective and development of tacit knowledge. According to Hayano (1979), the criteria for auto-ethnographic research are knowledge of the people, culture and language, and the ability to pass as a "native" member of the group.

Obviously, the choice of fieldwork is dictated by the identity of the researcher and it is quite possible for researchers to use this type of methodology without knowing their approach was auto-ethnographic. However, it needs to be

remembered that the "insider role" (Rosecrance, 1986) can result in a lack of objectivity resulting in a research bias in interpreting and reporting information. Hayano (1979) countered this argument by stating that subjectivism and personal involvement may not be methodological problems but rather assets that can deepen ethnographic understanding. Furthermore, first-hand experiences of gambling used in conjunction with some form of objective analysis may enhance the researcher's understanding and outlook.

It is hoped that these proposed explanations will benefit future research in this area by providing researchers with an understanding of some of the difficulties of gathering data and offering practical advice on what can be done to facilitate data collection, and thus, improve validity and reliability.

Unfortunately, identification of slot machine gamblers is often accomplished by a "search and seek" method of trawling local gambling establishments. Therefore, researchers are often limited to collecting data during playing time and not outside it. Data acquisition would be improved if gamblers were not occupied by playing their slot machine.

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# eGambling

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## first person

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## First Person Account

*[This article prints out to approximately nine pages.]*

## Internet Gambling

*By Nigel Turner, PhD*

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I'm not actually much of a gambler. Up until four years ago, I had risked less than \$2 on gambling in my lifetime. I couldn't see much point in it. But after winning at Casino Niagara and the Canadian Nation Exhibition in Toronto, I realized, "Hey, this is kind of fun." But my gambling is strictly professional. I make my living as a researcher specializing in problem gambling prevention, and the 20-odd times that I've risked money in the past year has been more about learning than a real attempt to make money. Well, that's my story anyway, and I'm sticking to it. Sure, I'd like to win, I've even found myself dreaming about winning enough to pay off my car and so on. It hasn't happened. What I found fascinating about winning was that even though the amount of money was so trivial and couldn't make a difference in my life (as much as a hundred dollars), the effect of winning was none-the-less exciting, even thrilling.

I've been curious about Internet gambling for a while. There's a lot of media interest in Internet gambling that appears to be grossly out of proportion to its status as a social problem. A recent study found that less than 1 per cent of the population in Canada has gambled on-line (see [www.ccsa.ca/Releases/cpgirelease-e.htm](http://www.ccsa.ca/Releases/cpgirelease-e.htm)), whereas in 1997, 22 per cent of adults in Ontario had been to a casino in the past year (Room, Turner & Ialomiteanu, 1999). The treatment system in Ontario records less than 2 per cent of problem gamblers who list the Internet as their primary means of gambling (Rush, Shaw Moxam & Urbanoski, 2001). Most of the people in treatment play at bricks-and-mortar casinos at games such as slots and blackjack. I'm not denying the real potential for on-line gaming as a serious social problem, but I just want to put it in perspective.

I was also curious about the appeal. Why do people go on-line to gamble? There is no socializing, no interaction, no night out. Perhaps that's part of the lure. You can feel pretty much anonymous.

Technically, on-line gaming in Canada is illegal. Here, only the government, charities and the horse industry can legally run gambling operations. However, Canadians are allowed to own gambling casinos that operate offshore. Most of the world's on-line casinos are located in the Caribbean, in the Dominican Republic for example. Several British on-line casinos were set up on the Channel Islands to avoid the U.K.'s gambling tax, and Australia recently started to license on-line casinos.

There are basically four types of gambling sites on the Web. First, there are on-line lotteries. These are ordinary lotteries where you can buy lottery tickets. Sweden has put its national lottery on-line, but limits access to Swedish citizens. Quebec plans to put its lottery on-line in the next year or so. Currently in Ontario, you can only check your numbers on-line, but you have to buy your tickets at a store.

Second, there are sports and race books where you're allowed to place bets on the outcome of sports games or races. Sports books currently make up most of on-line gaming. The advantage of sports books is that you don't have to trust a gambling site to find out if you've won; wins and losses are public information.

Third, there are on-line casinos that include slot machines, blackjack, roulette, craps and various poker games. These pretty much amount to what is available on many video lottery terminals (VLTs) in other provinces. Also available in this category are card rooms where you can play against other players rather than against the house.

The fourth type is electronic stock-trading sites, which, although not technically considered gambling, are often used as a way of gambling.

There are also a number of information sites about gambling, including on-line gambling book stores, sites that sell information about sports teams (so that the punter can determine his or her best bets) and sites that teach people how to gamble. One site, the Wizard of Odds ([www.thewizardofodds.com/index.html#gambling](http://www.thewizardofodds.com/index.html#gambling)), has an extensive library of information about gambling including rules and strategies. This site also discusses various incremental betting systems (i.e. chasing by increasing your bets), and why these strategies don't work.

After a short Web search, I found a number of gaming sites. I continued surfing to find ones with interesting games. By the summer of 2000, there were over 800 sites run by over 250 different companies. These numbers have likely doubled since then. At some sites, you have to download software. Downloading takes a few minutes, but speeds up the process of gaming and increases the potential quality of graphics and sound. Other sites run "no download" games. The no-download games run fine, but you will notice delays between actions, and occasionally, the graphics aren't updated.

Casinos usually have a tour in full-colour graphics, during which you can learn what games are available and the rules of the games. Some sites offer multiplayer games of blackjack and poker, where you can "chat" with the other players at the table. I selected PlanetLuck since they promised me multiplayer blackjack and poker. Their home site was mostly in black with flashing lights. Card symbols moved in and out around the "Open Account —Begin Winning Now" message. Across the top of the screen was a moving banner, which alternated between a picture of a car and a "Click Here to Win" message. Just below it another banner claimed, "We've already paid out \$57,284,154.32." Near the bottom of my screen the following was posted —

*INDULGE magazine says, "PlanetLuck provides clients with everything land-based casinos offer, including the sights and sounds of a real casino... [www.planetluck.com](http://www.planetluck.com) is one of the best sites on-line."*

Flags indicated that the site was available in Spanish, Japanese, German and French. The graphics were spectacular, but I found the animation annoying.

Cashing in was a two-step process. I registered an account at PlanetLuck and was transferred to EzCash —an on-line bank that does the banking for a number of on-line casinos. EzCash set up my account, checked my age by

asking what year I was born and took my credit card number, e-mail address and street address. At both the casino and bank, I had to set up a user name and password. In addition to asking me my card number and name, they also asked me for the address of the bank that supported my card. I thought that perhaps this was a credit check or a way of ensuring that I was not under-aged. However, I recently found out that it relates to a case in California where a woman refused to pay her credit card. She claimed that she didn't have to pay because Internet gambling was illegal. As a result, some credit cards refuse to honour gambling purchases. Although intended to protect the casino from fraud or non-payment, asking for an address does ensure some protection for minors because it makes it a bit more difficult to get onto the site.

I set up my account with a credit card that I rarely use so that I'd be able to keep track of the charges and payouts. I recommend using a card with a low limit to curb your losses in the event of fraud. However, in general, the sites are secure and honest. According to speakers at the Global Interactive Gaming Conference in Montreal, Canada (May 10- 12, 2000), security at on-line casinos is as good as other Internet sites, such as Amazon.com, and it has yet to report any security-related fraud. They also know that cheating their customers is bad for business, so they tend to be honest. They want your money, and they know that you'll spend more if you win a bit. They know they'll win it all back eventually, so they do pay out for wins. But since much of the on-line gaming industry is unregulated, there is no guarantee that the site you've selected is legit. Some claim to be accredited or licensed, but there is no guarantee of honesty. (For more information on security issues, go to the FAQ section at [www.clubchance.com](http://www.clubchance.com).)

There is a lot of competition in the on-line gaming industry. So, many sites offer bonuses from 5% to 20% of your initial bankroll for opening an account. This dramatically cuts into their edge. But, there's a catch. You can't claim your bonus and then just cash out. You have to play two or three times the amount of the bonus, sometimes more, before you can cash out and claim your bonus. They also say that they will not pay out the bonus if the punter engages in irregular betting patterns, such as covering the whole board in a game of roulette. In addition, many sites offer prizes such as trips or bonus rewards as incentives to keep you coming back to the site.

So, on-line I went. I cashed in for \$50 US. I was awarded a bonus of \$5 for typing in 777, a bonus number I had found in an advertisement for a different on-line casino. I started playing blackjack for \$1 a hand. I like blackjack, but I can't really afford to play at a casino where the minimum bet is often \$10 or even \$25. So the Internet definitely offers an inexpensive gambling alternative. Of course, small bets offer little hope of big wins, but larger bets



are available. Bets available include \$1, \$2, \$5, \$10, \$25 and \$50, which provide more room for incremental betting than is often available at casinos in Ontario, where allowed bets might range from \$10 to \$50. So on-line gaming might attract people who like to use incremental betting systems. The problem with incremental betting is that it works most of the time —not all the time. So you keep trying it until, by chance, you reach a long losing streak, and then you lose everything.

I wonder if the maximum bet is dependent on your bankroll. It would be easy to program a Web site to alter the allowable bet size to accommodate the amount of money that the person cashes in with. Coincidentally, the maximum bet equalled my cash-in bankroll, but I haven't gone back with a bigger bankroll to test this hypothesis. As it stands, a bet range from \$1 to \$50 per hand makes Internet gambling a relatively low-stakes game.

The game seemed to progress in a manner consistent with a random drawing of cards, while playing against a house edge of about 2.5 per cent (the expected house edge for a player that usually follows the Basic Strategy described by Thorp, 1964). The rules of play were a bit more liberal than those in our local casinos. The Web game allowed surrender (i.e. giving up half the bet when your hand is hopeless, say, a hard 16 against a dealer's ace) and hitting after splitting aces. Betting \$1 per hand, I initially just intended on playing until my \$5 bonus was gone. I won a few hands, then started losing. Since Internet gaming is unregulated, there is no way of knowing how valid the randomization procedure is, but the experience was not unlike my other bricks-and-mortar gambling experiences; that is, I win some, lose some, win a bit back, while slowly, but surely, see my bankroll shrink. After losing about \$17 US, I cashed out. As correctly noted by [www.clubchance.com](http://www.clubchance.com), if the random number generator was biased, "An expert player could discover the bias and spread the word, quickly breaking that casino's bank." Thus, "it's in the casino's best interest to be as random and unbiased as possible."

Cashing out was also a two-step process. I first cashed out from the casino and then from EzCash. Cashing in was posted to my credit card immediately; however, cashing out took another month. This delay is apparently due to the credit card company trying to discourage credits, not to the on-line casino. I also found that the customer service of the on-line casino responded quickly to my inquiries.

If I had won more than I cashed in for, I would have received a certified cheque. Cashing out at a bricks-and-mortar casino is usually more difficult than cashing in. You have to wait in line for a cashier. If you're down to your last few chips or tokens, you may feel that it's hardly worth it and just gamble the rest away. In contrast, cashing out at an on-line casino was actually less



tedious than cashing in, except for the one-month delay in getting my cash back.

I discovered something annoying —when you exit the site another site automatically starts up. This technique is also used by the porno industry (or so I've been told) to keep customers on their sites. To get out of this loop, you need to close the new site before it finishes loading up.

Over the next few weeks, I received an average of one e-mail promotion every two days encouraging me to return to that site or to try another site. Each letter gave instructions about how to be removed from the list, but out of curiosity about the promotions, I haven't asked to be removed yet. One message encouraged me to go back to the site so that I could win a trip to Tahiti. Another told me that I could win a bonus of \$1000 if I bet \$100 on a roulette number. A recent message told me I could win a BMW and \$100,000 in cash. Many messages mentioned bonuses for cashing in or for referring people to their on-line site. Another told me, "soon everyone would be a winner, you could be next." The last time I checked, the opening banner on their site read, "We've already paid out \$61,313,471.93 (in prizes), you could be next." That is, while researching and writing this paper the amount had increased by \$4 million.

The on-line industry is growing rapidly. On-line gambling revenue (not counting day trading) was a \$2 billion per year industry in 2000 and is projected to rise rapidly over the next few years. However, the industry is worried about the possibility of an Internet betting ban by the U.S. government. Several attempts have been made to pass bills banning Internet gambling, but so far, none have been passed. One bill tried to extend the (American) Federal Interstate Wire Act to on-line gaming and make it illegal to bet on-line using a credit card. Another attempted to ban all other types of banking instruments for on-line gaming and to make it illegal to own shares in a company that runs on-line casinos. One recent attempt was aimed at stopping money laundering, which would have forced credit card companies to police transactions.

The Internet's betting-ban amendment was removed before the anti-money laundering bill was passed. Speakers at the Global Interactive Gaming Conference in Montreal (May 10- 12, 2000) seemed confident that a ban on Internet gambling would be ignored and that the industry would continue to grow. But some speakers noted that the ban would hurt the industry. They pointed out that currently over half of the on-line gaming revenue around the world comes from the United States. Meanwhile, the Nevada state government has taken steps that may lead to legalizing and licensing Internet gambling in Nevada. (More information about the Internet gambling industry

can be obtained at [www.igamingnews.com](http://www.igamingnews.com).)

According to speakers at the same conference ([www.igamingnews.com](http://www.igamingnews.com)), future casino banking might be conducted by debit cards, e-cash, special Internet gaming cards or prepaid telephone cards. Security may utilize fingerprint-recognition technology, and mobile phones may become the most common way to place Internet bets.

On the plus side, on-line gambling is more affordable than casino table games. However, on-line gambling may offer a greater potential for incremental betting, which could lead to problematic play. On-line gambling offers the potential ability to monitor gamblers in order to detect problematic patterns of play, such as incremental betting and frequent re-buy-ins, which could then automatically trigger information about problem gambling. Currently, however, no on-line casino does this, although Lasseter's On-line casino in Australia offers self-selected daily betting limits. (For more about the plus side of on-line gaming, you can go to [www.clubchance.com](http://www.clubchance.com) and look for their news, editorials and letters, or go to [www.thewizardofodds.com](http://www.thewizardofodds.com) and look at their information on the basics of on-line gaming.)

Overall, I found that on-line gambling was a reasonably enjoyable experience. Cheaper, but less exciting than playing live. The greatest areas of concern from my point of view are security, availability and protecting adolescents. No fraudulent charges were made to my credit card, so my security fears have been resolved.

Availability is a more difficult issue. On-line casinos are available from anywhere in the world, 24 hours a day. The automatic loading of other sites and large amounts of promotional e-mail could be particularly difficult for problem gamblers. Autolinks could encourage a winner to try to win more, or a loser to try another site to win it back, and e-mail ads could induce a relapse. Self-exclusion policies are available at Lasseter's, and links to Gamblers Anonymous and Net Nanny are available at some sites.

There are a number of gambling related sites that provide information to prevent problems. For example, [www.professionalgambler.com](http://www.professionalgambler.com) sells information on the odds for various teams, but it also provides a list of 10 ways to throw away your money on sports bets. This list is designed to educate gamblers about bad betting strategies (e.g., using betting systems). Currently, protection for minors from these sites is inadequate. But the industry claims there is a greater potential for security problems on the Web than in other gambling venues because everyone is checked, and fake IDs are excluded ([www.clubchance.com](http://www.clubchance.com); see also [www.igamingnews.com](http://www.igamingnews.com)).

However, it remains to be seen if this will come to pass. For the time being, it is up to parents to use blocking devices such as Net Nanny and to keep credit cards out of their children's hands. Account names and passwords should also be kept hidden. Parents and educators must teach adolescents about their real chances of winning and dispel myths of "easy money" by showing how the games are stacked against them.

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*This account was not peer-reviewed.*

*Submitted: May 18, 2000*

*Updated: November, 8, 2001*

*Accepted: November 12, 2001*

*Nigel Turner received his doctorate in cognitive psychology from the University of Western Ontario in 1995. He has worked at the Addiction Research Division of the Centre for Addiction and Mental Health for the past five years where he has developed psychometric tools to measure addiction processes. He is currently focused on understanding the mental processes related to gambling addiction. He has extensive experience in various research methods including psychometrics, surveys, experimental studies, computer simulations, interviews and focus groups. He has published numerous papers in peer-reviewed journals, including several on problem gambling, and he has made numerous conference presentations.*

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### Service Profile

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## The Problem Gambling Program at COSTI Family and Mental Health Services

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### Agency Mandate and Profile

COSTI Immigrant Services is a not-for-profit agency whose mission is to provide educational, social and employment services to help all immigrants in the Greater Toronto Area attain self-sufficiency in Canadian society. To this end, COSTI's 180 staff members provide a range of services including English classes, employment counselling and settlement services in over 40

languages at 12 locations across Toronto and York region. They work in partnerships with approximately 80 mainstream and ethno-specific organizations.

## **Problem Gambling Program Description**

The Problem Gambling Program (PGP) at COSTI Family and Mental Health Services was launched in June 2000. One program component assists Italian-Canadians in identifying and resolving personal and family problems related to gambling through ethno-specific counselling services, including individual, marital, family, support and educational groups, telephone counselling and referrals to credit counselling and psychiatric services. The program's public education component includes awareness raising workshops and presentations on prevention, responsible gambling, risk factors and services available.

## **Problem Gambling Treatment**

COSTI's treatment component is an adapted harm-reduction model. The "mainstream" harm-reduction approach developed within the context of a North American culture is primarily urban, individualistic and literate. However, the roots of the Italian-Canadian culture are primarily rural, collective and oral. Given these realities, every aspect of intervention needs to be examined through this cultural lens. For example, when discussing bailouts, the counsellor must consider that in Italian-Canadian culture, family obligations to care for all its members are central. Parents see no other alternative and feel inadequate and guilty if they are not able to provide a bailout. Adult children contribute to family finances because of a sense of duty and obligation to a parent with gambling problems. Suggesting that spouses protect themselves financially by opening separate bank accounts goes against cultural values and norms, and therefore, needs careful consideration. In this predominantly oral culture, written materials and exercises are sometimes not useful for Italian-Canadian immigrants; counsellors have had to incorporate story telling and analogies to demonstrate concepts. Following through with written homework can be difficult. Counsellors have found that clients prefer to keep a mental log of behaviours. Clients keep track of what triggers their desire to gamble by describing situations that precipitate gambling activity. They also describe how they felt before gambling and how they feel or cope following

gambling.

## Community Development

In addition to providing public education and treatment services for the Italian-Canadian community, the PGP at COSTI also has a community development component that currently works with the Spanish, Polish, Portuguese, Punjabi, Tamil and Vietnamese-speaking communities. These projects include needs assessments using focus groups and questionnaires on cultural attitudes, beliefs and perceptions on gambling and problem gambling. The data that is gathered supports public education initiatives in these communities. COSTI's community development approach in this project involves partnering with community leaders and respected ethno-specific organizations. Focus group questions and questionnaires were developed with the involvement of community leaders and agencies. These same people also help organize focus groups, distribute questionnaires and develop public education initiatives, which include talk shows on ethnic radio programs, articles in ethnic newspapers and presentations. To ensure that culturally sensitive and linguistically appropriate literature is available for public education and counselling, community leaders and organizations helped translate materials and screening tools. Information sessions for settlement counsellors heightened their awareness of problem gambling issues and were conducted along with the Problem Gambling Service (CAMH).

Please contact us for further information about COSTI and the PGP or to arrange a workshop or presentation for a specific group.

*This Service Profile was not peer-reviewed.*

*Submitted: November 27, 2001*

The Electronic Journal of Gambling Issues: eGambling *invites clinicians from around the world to tell our readers about their problem gambling treatment programs. To make a submission, please contact the editor at [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net).*



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## First Person Account

*(This article prints out to approximately 12 pages.)*

## ***Excerpts from Losing Mariposa***

## **A Memoir of a Compulsive Gambler**

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*[All names are pseudonyms except for those of the author's family. —Ed.]*

The first time I went to Windsor was, ostensibly, to get a job. I had applied to be executive director of the downtown Windsor business association. In reality, I went to gamble. It was the fall of 1995. I had quit bingo in June, but after a summer of all work and no gambling, I was ready to escape. Big time! A geographic cure had its appeal. Maybe it was because I couldn't wait for the casino in Orillia to open.

I knew I was burned out, but what could I do about it? Along with all of the other stuff I did for my 80-hour-a-week job and the festivals that summer, I

also served as Orillia's representative on the official opening ceremonies committee for the new \$100-million Ontario Provincial Police General Headquarters. I was also on the steering committee of a \$150,000 regional tourism study, largely overhauling an organization that I once managed. Although there were rumours, it was a little-known secret that I resigned from that position in the mid-1980s because I had been borrowing from office cash. Then I was paying for Melanie's figure skating and chasing another kind of dreamworld.

In order to maintain my control and to hide things I was doing now, I couldn't say "no" when anyone asked me to serve on committees or take on new responsibilities. I couldn't say "no" and I couldn't unload any of my responsibilities. My job, the festivals, Winter Carnival, and even Canada Day were all wrapped up together; first in my need to prove myself and then in my need to hide what I was doing with the money.

A new job and a new town, not to mention a new casino, were attractive. The plan was to kill two birds with one stone. Do the interview and win enough money to get these accounts under control. That was my goal at Casino Windsor: \$1,200 and some hot luck. Then I'd be free to do whatever I wanted, even move to Windsor.

Casino Windsor, the Government of Ontario's first casino, opened in 1994. By all accounts I'd heard, it was a raving success. Downtown Windsor was looking to share in the benefits and wanted a new manager. I was asked to come to Windsor for an interview. It was a five-hour trip and although I was driving a van, it seemed like I flew.

One thing that puzzled me was the lack of billboards or road signs announcing Casino Windsor along Highway 401 from Toronto. Even within the city, directional signs were lacking. I guessed I was coming from the wrong direction to catch the casino's target marketing. It must have all been aimed across the river at Detroit, from which, I bet, the directions were exact. Attracting American gamblers and U.S. dollars was a key rationale for establishing this first casino in the border city of Windsor. Money in. Problems out. Orillia was being sold its casino on a similar basis: increasing tourism by attracting Toronto and other southern Ontario residents who would come to gamble, but also stay and shop. Less than five per cent of Casino Rama's revenue would come from the local market. Money in. Problems out. I just happened to be part of the local percentage that couldn't wait.

I tried doubling back from the U.S. border and found my way past the casino's twinkling front lights with ease. While my heart raced at the sight, I was stoic

in my patience. I had two hours. First, I wanted to find the location of the agency where the interview was to take place at two o'clock. This way I would know exactly where I had to go, how long it would take from the casino and exactly how long I had to gamble. Surprisingly I was able to park right next to the casino.

Where were the thousands of cars and jammed parking lots we kept hearing about in Orillia? It reminded me of the other big casino I'd been to in April, in Sault Ste. Marie, Michigan. There, we had to take the worst, most convoluted back roads into the middle of nowhere. The Sault casino was made up of a menagerie of buildings built like a mining town, in both haste and hesitation, not spending much money just in case it didn't last. Only the flashy Kewadin Vegas sign met my expectations of gambling paradise. However, you could park at the door, at least during the April weekends when I was there every night for four nights during that Festivals Ontario conference. And there were no traffic jams.

Casino Windsor was also stuffed into an unimpressive building, its temporary site in an old art gallery. However, its flashy, lighted facade was more reminiscent of the Las Vegas from movies I had seen, and the heat of my excitement climbed as I walked through the doors. Inside it was a palace, three floors of glitter and neon—all the bells and whistles to literally set my heart fluttering. There was even a non-smoking floor. Two hours, I reminded myself, as I dashed around the building like the proverbial kid in a candy store with a pocketful of money from his mother's purse.

I had been learning blackjack on the computer and working on a system for roulette, my first love in gambling. But just like my first casino visit at Kewadin, I couldn't get past the slot machines. The ding-ding-ding and clink-clink-clink of winning coins dropping, the spinning reels, the siren sounds and flashing lights of jackpot winners enthralled me as I wandered up and down the aisles looking for my machine. From my April visit in Kewadin I knew my favourites: the ones with Haywire icons and crazy action, where the reels go erratic, spinning out of control, racking up bonus winning credits. I couldn't find any as I sped around the casino looking from side to side, floor to floor. Maybe it was an American thing. I also couldn't waste any more precious gambling time.

I settled on the non-smoking floor, a nod to the sensitivity of my nose. Before I even started I was flushed, sweating and hyperactive. I could feel my blood boiling. I passed the next hour and forty-five minutes among these rows of slots.

I bought five \$20 rolls of dollar tokens and five \$10 quarter rolls from the coin change cart as soon as I hit the floor. Clang! I whacked a roll of tokens

against the side of the coin tray at the bottom of the slot machine and flipped the tokens out of the paper wrapper into the coin tray. With a crescendo of clinks and clanks, they bounced around and then settled. I deftly swooped a handful from the tray and dropped three coins in rapid succession. Click! Click! Click! If they went too fast one coin fell all the way through and I had to swoop down again, grab another token and reload. It was a precision I learned at Kewadin, and now, it seemed like second nature. The next move was to push the maximum button to play the three-coin maximum. Then I pulled the lever on the right side to crank it down and start the wheels spinning.

Whirl, whirl, whirl. Ka-chunk. One wheel stopped. Bar. Ka-chunk. Second wheel. Two bars. My heart raced, my mind blurred. Ka-chunk. Three bars. I won. I tried to keep myself cool, to keep from dancing in the aisles and making a fool out of myself. Clink, clink, clink, the coins dropped into the waiting tray, clinking on my coins that were already there.

I looked quickly to the top of the slot machine at the payout menu. Three single bars: \$20. Three double bars: \$40. Three triple bars: \$60. I couldn't figure what I'd won until the clinking stopped and the flashing LED showed \$20.

Swoop. Three more coins in. I cranked the arm and stopped breathing again as the reels spun hypnotically before my eyes. I glanced up to the menu to try to catch the various payouts without having to focus, not daring to take my concentration off the spinning wheels.

I was convinced that you have to see the reel stop in order to make it stop where you want. Ka-chunk. Right wheel. Three bars. My heart beat faster. My hand massaged the sides of the machine. "Come on," I whispered. Ka-chunk. Left wheel. Three bars. My heart was in my throat. I held my breath. "Come on baby." Ka-chunk. Three bars. "Yes!" I hollered. No. It was on the line. No clink, clink, clink. I looked over the winning menu. Close, but no cigar. Close. Next time. I could feel it. This machine was hot. It wanted to pay.

Swoop. Click. Click. Click. Whack the maximum button and crank the lever. No, you should have tried the button, just to change things. The reels spun. I needed to calm down. You can't expect to win every pull. Relax. I looked over at an elderly woman leaning from her stool in front of one machine to slap the buttons on the adjacent machine. Wow! She was playing two machines at once. She reminded me of the women at bingo who could play 24 cards on the regular games and then 36 for the jackpot game.

Ka-chunk. Ka-chunk. Ka-chunk. Nothing, except a "Wild" symbol almost in the

middle window. Breathing in deeply and blowing out like a sigh, I checked out the payout for three Wilds – \$2,400. Wow!

Swoop. Click. Click. Click. Whack. Crank. Whirl. Ka-chunk. One double bar. Ka-chunk. Two double bars. Ka-chunk. Wild. Clink, clink, clink ... The machine started spitting out dollar tokens as I searched the menu for what two double bars and a wild symbol meant. Eighty dollars. The tray was going to be full. While the coins were dropping, I gathered up three tokens and leaned over to the next machine. Clink, clink, clink. Whack and whack. I hit the maximum and spin buttons. Cranking the one-armed bandit had lost its novelty. The reels of the second slot spun. It was a "blazing sevens" icon, three sevens rising out of what looks like the fires of Mel Brooks' Blazing Saddles logo. One seven. Two more blazing sevens. Two more sevens. Nothing.

Back at Wild Bars my winnings were scattered all over the tray, although not nearly filling it as I had imagined. I remembered a button that I pushed in Sault Ste. Marie that retained your winnings as credits so you didn't have to keep feeding in the coins each play. No swoop. No click, click, click. I whacked the button and fed a handful of tokens down the coin slot.

Maximum, whack. Spin, whack. Whirl. Ka-chunk. Triple bar. Ka-chunk. Wild. My eyes darted up, two triple bars and a wild pay \$120. Eyes back. Ka-chunk. Wild on the line. "Shit," I said under my breath. Two wilds and a triple bar: \$240.

"It wants to pay," I said out loud to myself as I whacked the buttons and set the reels whirling once again. Concentrate, keep your eyes on the wheels. Ka-chunk. Wild. I felt my heat rise. Bar. Double bar on the line. Ding. Ding. Ding. Ding. Ding. Ding. The new sound confused me. Did I win? I looked up to the menu as the slot recorded six electronic credits to the four I still had left. There it was. One wild: six dollars.

Back to the buttons. Whack. Whack. Another two wilds and a third one on the line. Oh, so close. Twenty-four-hundred dollars. Instead I won 12 bucks. So the machine teased me, enticed me with the occasional win and lured me to add more coins. I went back to the change cart three times for another \$300 in tokens.

My faith in Wild Bars faltered after the second trip back to the cart and I started to roam the slot corridors, pumping three dollars in each machine as I passed, staying to play out the ones that let me win a few credits. I was over the clink-clink-clink infatuation. The lucky machines eluded me as I looked from machine to machine for the one that was calling my name. The light on the top of the Wild Cherry machine was flashing. I answered its call.



Clang! I broke my last roll of tokens into the coin tray and swooped a handful of ammunition into the coin slot with one fluid motion. Click. Click. Click. Whap. Whap. Whirl., whirl, whirl. Ka-chunk. Cherry. Ka-chunk. Bar. Ka-chunk. Bar. Fifteen credits.

The only reality able to penetrate my absorption with the one-armed bandits was the two o'clock appointment, likely because it was connected to gambling, to my being able to get back here again. I checked my watch hundreds of times while I played hundreds of games, over and over, winning and losing, winning and losing. As much as I wanted to win, I didn't mind losing as long as I could stay there. I hadn't won a big jackpot, the kind where they came and gave you the money in cash and reset your machine. I was up considerably at one point but I continued to gamble until all the credits were gone and then all of the special slot coins were gone.

One forty-five. Time to go to the interview.

I got in my van and raced along my predetermined beeline to the agency in time for my two o'clock appointment with the job recruiter and her assistant. No Windsor committee. It was just a screening interview. My ego was in full bloom, bolstered by two hours of gambling action. I could do this job standing on my head. I was the former president of Ontario Downtowns, four years as president of Festivals Ontario, vice-president of the Canadian Association ... blah, blah, blah. I didn't care about the job, I just wanted to gamble.

My blood pressure was still through the roof throughout the interview and I fidgeted in my chair like a schoolboy needing to pee, or worse. Let's get the questions over and get back to the real task at hand, winning back my \$500, along with piles more of Casino Windsor's money. Funny, I didn't even expect I'd get a callback. Too bad. Poor Windsor. It didn't know what it would be missing. I didn't care. I came to gamble.

Another beeline back to the casino. This time it would be different. I could concentrate on the game now that the stupid interview was out of the way. The nerve of them, dragging me all the way down here and not even a member of the board there.

\* \* \*

In June of 1996 I was at the apex of my gambling frenzy. I was \$20,000 in the hole to eight different bank accounts. Anxiety and panic attacks swept over me with regularity and my concentration at work and everywhere else was shot. Sweating in bed at night I worried about getting caught, going to jail and



having my life defined by the fact that I was a gambler and a thief.

I wondered if I would even make it to the opening of Casino Rama in Orillia. On those late-night drives back home from gambling in Barrie, I worried that I would get caught first, or worse. Desperation weighed me down after three nights of losing at the charity casino, giving me the notion of ramming my van into one of the grey concrete overpasses on Highway 400 during my 23-kilometre ride home at 4:30 in the morning.

All the way back I would talk to myself, cursing my stupidity, my bad luck. Why didn't I quit when I was up? If only I hadn't run out of time. If only they hadn't changed dealers. I was on a roll, then everything changed. Oh, why didn't I quit, take my chips and go home?

The charity casinos closed at 4:00 a.m. Whether I was winning or losing, they closed. The last half-hour was pure insanity, a kind of reverse, bleak "happy hour," where instead of drinking twice as much, you bet with even greater hysteria. If I was down, I needed to get even. If I was up, it was never high enough to cover off all I had previously lost, all that I owed, all that I had stolen.

"Why didn't I go home at two o'clock?" I thought to myself as Sherrie shuffled the deck for the next shoe of cards. If I had, I would have been up a thousand on the night and only \$3,000 in the hole this week. Now I was down \$5,000. How the hell was I going to pay that back by Friday? Those bank deposits had to be made within a week or else there would be no plausible excuse.

How I hated the shuffle in a charity casino. That break in the action allowed the real world to come reeling into my mind. I'm here to gamble, not think. In a bona fide casino there are lots of distractions during a shuffle; drop a couple of green quarters on number 17 in roulette, slip \$50 into a five-dollar slot machine on the way to the washroom, watch the Asian guys bet \$20,000 a hand in the VIP Baccarat Room, playing a game that amounts to little more than high stakes card-cutting. Here, all I could do was wait.

Michael, the pit boss, knew I was down. Could he see the desperation in my face or did he just do the math? In charity casinos, the action is small enough that the house knows who is winning or losing at all times. Especially VIP players like me.

VIP blackjack: I bet all seven spots on the table, me against the dealer. It was the only way I played now, ever since partnering with Arnold went sour a few months earlier. Nothing really happened, I just couldn't win with him anymore. We'd either both lose or I'd lose alone. Earlier, he saw me at the table and

came over.

"Want to play together?" he asked, gesturing at my seven spots, searching for his three. "No," I said, avoiding his eyes. "I'm down. I gotta stay on my own. I haven't been winning lately." "It's okay, it's okay. I'll play over here. Go get 'em." He walked away. I knew he felt bad. Maybe it was recreation to him; maybe he could afford to be nice, but I couldn't. Shit. He taught me the game.

Arnold owned a local golf course and was a regular at the charity casinos when I started playing at them last year. On many nights we were a team, dominating the table, playing like we could do no wrong, stacking up the chips, breaking the house! "You're on fire," one of the guys standing around said. "It's like you can read the cards." Recalling those heady days, it's hard to understand how I could be so down, how I could owe so much money.

"Are you almost ready, Sherrie?" I asked, annoyed with my own angst. "Almost, darling, and I feel a good shoe coming on." Most of the dealers, including Sherrie, liked me. For one thing, they knew me because I sponsored the Stephen Leacock charity casino nights that their company operated. Also, I tipped. On the surface, I was a good loser. I never blamed anyone else, never got mad, swore or threw things like some of the guys. I thought that was an invitation to bad luck, negative vibes and bad karma, that sort of thing. Inside I was screaming. Did they genuinely feel sorry when I lost? I thought so, but that's how they got paid.

Having been on the other side of the table as a sponsor, I knew one hot VIP gambler like me could mean a losing night for the charity casino operators. Sure, that meant the sponsor didn't make any money either, but it really meant the operator lost because he still had to pay the staff and overhead. In Toronto, and even in Barrie, at the other casino company, they hated to lose and tried all kinds of tricks to stop a player on a roll; some of them I'd have bet were "illegal." Once, at Huronia Casino, a regular player and I were having a good night controlling a table, each of us up several hundred dollars. Then the owner of the company asked if we minded if he dealt for a while. I don't know whether she cared but I sure as hell did. I didn't want to play against the damn owner, but my gambler's ego wouldn't let me say it. I finally quit when I had about \$200 left. I never went back to Huronia's events. These were the types of shenanigans that gave the government the excuse it needed to take over control of all gambling.

Finally, Sherrie was ready for me. I felt tired during the break, but now I was animated, bobbing and weaving, standing in front of the green felt table, my chips lined up along the padded sides. Watching her bury the hole card, I was wide-awake, ready for another round. Ready for redemption.

"Okay, let's do it," I said, and all the worry of the outside world, everything but Sherrie darling, and me and the cards disappeared.

I had two five-dollar chips in each of the seven circles; the maximum \$10 bet allowed in charity casinos. I was really making a \$70 bet per hand but let's not quibble on the fine points. I had 10 piles of five-dollar chips in front of me, \$500, and a pocketful of green quarters, \$25 each. Twenty. I always knew how many. It was another thing I did during the shuffle to keep my mind occupied. They were the remainder from earlier in the evening when I was up a grand.

Snap, snap, snap, snap, snap, snap and snap. Sherrie whacked my first cards beside the circles. My eyes were on her card. Snap. A seven. Good, I had a chance. I feared an ace, of course. Blackjack is an ace and ten; it didn't have to be a jack. I also feared any face card or ten. Now I could watch what she was giving me and the battle was underway.

A king on a queen. "Good," I said, as I waved her off.

"Don't want to split those tens," Sherrie joked as she gave me a three on a four on the next square. "Yuck."

"Hit me," I said, scratching on the green felt with the middle finger on my right hand, the one with the tell-tale Band-Aid covering the dried, cracked skin from too much of this very scratching.

Eight. Fifteen. "Hit me," I scratched.

Queen. Bust. "Oops, sorry," Sherrie feigned as she swooped up those cards with her right hand and slammed them in the crib, deftly sliding my \$10 from that circle into her tray.

Next came an eight on a face card. "Eighteen." I waved Sherrie off.

Snap. Another three on an eight. Eleven. "Double down," I said as I placed another \$10 at the back of that circle. Another card. Ten. "Yes! That's better, Sherrie, keep it up."

A six on a six. Shit, what do I do? I searched my brain for the computer prompt or the book instruction or Arnold's voice. Always split sixes or is it never split sixes? I couldn't remember.

Sixes against a seven: I split them. It's another all or nothing night. I moved

\$10 more to the side of the circle. Another six. "Split," I said and moved another \$10 out.

Nine. Fifteen. "Hit me." Scratch. Four. "Stay." A hand wave on the next hand.

Ten. Sixteen. "Hit." Scratch. Ten. "Too hard." Swoop cards, discard, money slides into Sherrie's tray.

Five. Eleven. "Double down." Another \$10 from my tray.

Jack. Twenty-one. "That's one you're not going to get, missy," I said as I exhaled some anxiety and twisted out a kink in my neck. I could feel the heat in my blood. My throat was dry.

"Don't get cocky," Sherrie said as she slapped a five on my eleven. I paused, knowing what was next as soon as I thought it. Shit. Sixteen, I have no choice. "Hit me."

Seven. Bust. Swoosh, slam, swoop, clink into her tray. I toyed with a cyst on the back of my neck, twisting my back against my other hand. I looked, I am sure, like a straitjacket contortionist.

The sixth spot. A two. A three. Three small cards, it'll be a face.

"Hit," I said and scratched the table. Close, a nine. "Now a face," I said with resignation, regretting the prediction as soon as it passed my lips. Positive, you idiot. Ace.

"I could have used that next, Sherrie," I chided. "Hit me," I scratched.

Ten. Bust. "They're always together, eh?" Sherrie sympathized as she swooped up the cards, and my money, from the table.

My last spot. Another ten. Three. "Ten and three, thirteen," Sherrie said. I looked at her seven, thinking about what she needed, what I wanted her to have. A ten —she has to stay on seventeen. "Lucky 17," I murmured out loud, prompting Sherrie to repeat, somewhat sarcastically, "Thirteen!"

The object here was for me not to take the card I wanted her to have. This was the players' advantage in the charity casinos; you could influence the dealer's second card by taking or not taking a card on the anchor spot. When you have several experienced people playing at a table, sometimes the person at the end in the anchor seat would "take one for the table." In the big

casinos, the play is different with the dealer getting both his cards off the mark, taking away this players' edge.

I didn't want a ten. I scratched, "Hit me."

Six. Another nineteen. Six would have been good for her, giving her thirteen, I thought, second-guessing myself. No, I've seen too many thirteens topped with eights.

"What's it going to be, Dougie?" Sherrie taunted me.

I waved my hand to pass and returned the jab, "Ten, come on, Sherrie, you can do it."

She turned a four. "Eleven," my mouth said, but my mind cringed as I took the first shot of the inevitable one-two combination. I looked back at the cards already on the table, grimacing, trying to see but not wanting to think the worst, to forecast the worst. To make it happen. What would have happened if I had given her the six? Seven, six and four. Seventeen. Damn. Now we've had four, six, three. Damn, my mind moaned. Don't say it, don't even think it. But, it was too late: tens are due.

Ten. "Dealer has 21," Sherrie said succinctly, knowing I was on the ropes.

We "pushed," or tied, on three hands of 21, meaning I got to keep three \$10 bets. I lost \$70 more.

So it went for the remainder of the shoe and I was down another \$500. My brain couldn't take the torture of watching and waiting for another shuffle so I went over to next table where there were a couple of empty spots and plopped my \$10 chips on each. I was now literally running from my thoughts. I won. I lost. I won. On and on.

Finally Sherrie was ready for me. As we took our positions, aggressor and defender, or the illusion thereof, Michael stepped over and announced "Last shoe." Closing time.

I couldn't win. I'd had near-perfect shoes before. You can only win about eight hundred dollars. I was already down \$1500 for the night and \$5,500 for the three days. Despair washed over me. My concentration was gone. Not even the action could keep my wretched feelings at bay. I played a couple of hands on autopilot, hardly knowing what I was saying.

'That's it for me, Sherrie. I'm beat," I said, as I picked up the last of my red chips to head for the cashier's booth before the four o'clock poker crowds. The last thing I needed was a whole bunch of "How much did you win, Little?" questions from those guys.

I had \$240 left. Enough to leave Roberta \$100 on the kitchen table when I went to work, pretending I won, and some money for lottery tickets and Nevada to tide me over until the next weekend's charity casino in Orillia. But what was I going to do about the missing \$6,000 from the bank deposit?

"Maybe I've already won the lottery," I told myself, bolstering my courage for the long, concrete-pillared drive home to Orillia.

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*This account was not peer-reviewed.*

*Doug Little now lives and works in Ottawa where he is the Marketing and Communications Manager of the Canadian Tulip Festival. October 22, 2001, marked five years since he last gambled. Losing Mariposa will be published in 2002 by ECW Press.*

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### Book Review —A Classic

*[This article prints out to about five pages]*

## The Gambler

*By Fyodor Dostoyevsky. (1996;1866). Trans. by Constance Garnett. New York: Dover Publications, 117 pages, paperback, \$2.00 US  
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When I first started working in the problem gambling field in the winter of 2000, the first book I wanted to read on the topic was Fyodor Dostoyevsky's classic gambling narrative *The Gambler* (1866). I felt sure that if anyone had anything to say about gambling it would be Dostoyevsky. An inveterate gambler himself, Dostoyevsky bet his entire oeuvre that he could write *The Gambler* in a month while in the midst of writing *Crime and Punishment*. I was not disappointed. Dostoyevsky creates memorable characters that bristle with energy and portrays the class-conscious casino society of his day with cutting satire.

In *The Gambler*, Dostoyevsky introduces a scheming cast of characters gathered in Roulettenberg, a fictitious German spa town with a casino and international clientele. Dostoyevsky employs the literary device of a diary to reveal the tumultuous inner life of Alexei Ivanovitch, a poor but educated young man who works as a tutor for the General. As a servant and outsider, Alexei both observes and participates in the tempest that surrounds the General and his entourage of blue bloods and social climbers. Alexei, painfully aware of his social class, both envies and mocks the aristocrats' airs and pretensions. The General, despite maintaining the trappings of wealth, is impoverished and heavily indebted to the Marquis de Grioux who bailed him out when he was accused of embezzling. He desperately loves Mlle. Blanche, a "gold-digger," while Alexei moons over Polina, the General's destitute stepdaughter. All fortunes depend on the impending death of Granny, a rich 75-year-old woman who arrives in Roulettenberg, very much alive, and proceeds to the casino.

Alexei and Granny are introduced to roulette and soon become hooked, although they start gambling for different reasons: Alexei thinks that "Money is everything!" whereas Granny wants to prove to her nephew, the greedy General, that she is still very much in control of the purse strings. They both "chase their losses" and pursue a cycle of winning, losing, desperation and exhaustion. Granny eventually burns out and returns to Moscow, but almost two years later, Alexei, still in denial, drifts from casino to casino.

Alexei, the protagonist, is a crass, immature and rather despicable character driven by greed and desire (one amazon.com reviewer refers to him as a "semi-psychotic provocateur"). At the beginning of *The Gambler*, Alexei is obsessed with Polina: he debases himself in front of her; he is her slave and loves her without hope; yet he hates and fears her. Alexei is jealous of her mysterious relationships with the Marquis de Grioux and the enigmatic Mr. Astley, the only decent character in the book. Given to emotional excess, Alexei vacillates between elation and despair. A slave to Polina, first, and then the roulette wheel, Alexei is tortured by his passions.

Dostoyevsky's Alexei is a prototypical gambler who rationalizes and defends his growing obsession with roulette. For Alexei, a big win at roulette would earn him entrance into the aristocracy and transform him from outsider to insider. Deliberately baiting the General, Alexei contends that "the Russian is not only incapable of amassing capital, but dissipates it in a reckless and unseemly way," a dig at the General whose lavish lifestyle belies his mounting debt. Yet, to "act in a reckless and unseemly way" is exactly what Alexei does after his first big win at roulette. Impulsively, he runs off with Mlle. Blanche to Paris, abandoning Polina and leaving the General to pine for Mlle. Blanche.

While the plot (which I don't want to give away) borders on farce with its fantastic twists and turns, it is also a vehicle for Dostoyevsky's savage wit and social commentary.

Granny is one of Dostoyevsky's most amusing and flamboyant characters. She arrives at this gambling saloon on the Rhine amidst various plots and schemes all predicated on her death. Incensed by the General's transparent agenda to get his hands on her fortune, Granny ridicules him for wishing her dead. She heads off to the casino, retinue in tow, and impetuously bets large sums on roulette. As luck would have it, she wins, and leaves the casino in an exalted state. Later that night, restless and unable to sleep, she summons Alexei and returns to the casino where she proceeds to lose all her winnings and more. Disgusted with herself, Granny decides she must leave Roulettenberg and return to Moscow; but despite her intentions, she stays and gambles away most of her fortune.

In Dostoyevsky's hands, Granny is an outspoken eccentric who exposes the artifice and deception of the Russian aristocracy. She calls a spade a spade, unmasks hypocrisy and has a great time at the roulette wheel until she starts losing. Granny is at her best when she is defying bourgeois social conventions by breaching gambling etiquette with her fits of pique. When Granny wins at roulette, she is elated, when she loses heavily, she throws tantrums. Dostoyevsky captures the tragedy of her descent into problem gambling, yet, *The Gambler* is also a social comedy, a dark but witty lampooning of high society.

In *The Gambler*, Dostoyevsky explores the subjects of class, obsession, chance and morality. Dostoyevsky probes the conflicts and dilemmas that create and perpetuate human suffering. These themes were important in his own life. Dostoyevsky paid heavily for his early anti-monarchist activism, and in 1849, a last minute reprieve saved him from execution by firing squad for crimes allegedly committed against Tsar Nicholas I. He spent the next five years exiled in Siberia, the subject of *The House of the Dead* (1860). During his incarceration, he endured physical and mental pain and recurring epileptic seizures. *The Gambler* is based on Dostoyevsky's love affair with Apollinaria Suslova as well as his frequent casino visits to play roulette, which he began playing in 1863, at a time when he was extremely poor. He experienced first-hand the excesses of gambling so aptly described in *The Gambler*.

In the end, the wheel of fortune was kind to Dostoyevsky. He married Anna Snitkina, the stenographer who transcribed *The Gambler*, and they had a happy union and raised children. He proceeded to write literary masterpieces—*Crime and Punishment* (1866) and *The Idiot* (1868)—despite his continued heavy gambling until 1871 when he declared himself free of this delusion

(Knapp, 2000). He went on to write *The Brothers Karamazov* (1880) published a year before his death. That Dostoyevsky eventually stopped gambling should provide hope to any reader of *The Gambler* who has problems with gambling.

*The Gambler* is a particularly good read for those interested in the psychology of problem gambling. I sometimes felt like a voyeur —imagine your private musings, rants and raves laid bare for public consumption! Although Dostoyevsky is not known for his humour, I found *The Gambler* very funny. The first half of the novel sparkles with its behind-the-scenes plotting and snide gossip, while the second half seems quickly sketched. Still, Dostoyevsky is a masterful storyteller and a scathing social commentator. Short and engrossing, I had a hard time putting *The Gambler* down.

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## Notes

- 1) Sergey Prokofiev composed the opera *The Gambler* in 1915.
- 2) For a history of roulette, see: [http://www.gamble.co.uk/roulette\\_history.htm](http://www.gamble.co.uk/roulette_history.htm)

*Submitted: November 15, 2001*

*This book review was not peer-reviewed.*

issue 5 —february 2002



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*(This letter prints out to about three pages.)*

## Response to a letter about "Chips, Chatter and Friends"

Playing poker can cause problems. Playing too long, too late, or losing more than one can afford are among the hazards. There are players in treatment for a gambling problem because of their involvement in poker.

The game of poker is, perhaps, the most popular form of gambling in North America. Prior to the proliferation of legalized gambling, millions of people played weekly, with friends and relatives. Playing in a public poker room in a casino has replaced many of these home games.

Playing in a public poker room can lead to gambling problems. I interviewed one player in treatment and in GA (Gamblers Anonymous - Ed.) who started as a low stakes recreational player in the casinos. His involvement increased, leading to playing at higher and higher stakes. He lost his business, his girlfriend, and wound up in treatment.

It is important to understand why some people do become problem gamblers. It is also important to understand why others can play safely. My article ([http://www.camh.net/egambling/issue3/first\\_person/index.html](http://www.camh.net/egambling/issue3/first_person/index.html)) was about the pleasure that many people find in playing poker. I am sorry that my descriptions caused the reader's wife pain.

*Barry Fritz  
Quinnipiac University,  
Hamden, Connecticut, USA*

*Received: December 8, 2001*

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We invite our readers to submit letters on gambling topics. Please note that we can publish only a fraction of the letters submitted. All letters must be signed. We cannot publish anonymous letters, or those of a libellous nature. Letters to the Editor are reviewed and chosen by the editor and members of the editorial board. Letters may be sent by e-mail or to the mail address given below. Once a letter is accepted, we will request an electronic version. Each published letter will include the writer's first and last names, professional title(s) if relevant, city, province or state, and country. Alternatively, for good cause, the editor may confirm a letter's authorship and publish it as [Name withheld]. We reserve the right to edit each submission for uniform format and punctuation.

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## Links

<http://www.ncpgambling.org> **NEW**

**National Council on Problem Gambling :** to increase public awareness of pathological gambling, ensure the availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and education.

[http://www.gov.ab.ca/aadac/addictions/subject\\_gambling.htm](http://www.gov.ab.ca/aadac/addictions/subject_gambling.htm)

**Alberta Alcohol and Drug Abuse Commission:** information, brochures and survey results

<http://www.responsiblegambling.org>

**Responsible Gambling Council (Ontario):** information, publications and calendar of international gambling-related events

<http://www.unr.edu/unr/colleges/coba/game>

**Institute for the Study of Gambling and Commercial Gaming:** an academically oriented program on gambling and the commercial gaming industries

<http://www.ncrg.org>

**National Centre for Responsible Gaming:** funding for scientific research on problem and underage gambling

<http://www.problemgambling.ca>

**Problem Gambling: A Canadian Perspective Website** (Gerry

Cooper): annotated international links

<http://www.youthgambling.org>

**Youth Gambling Research & Treatment Clinic** (McGill University, Montreal, QC, Canada): information, self-quiz and FAQ's



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Occasionally other messages on related topics may be issued to the list by our Editor. Postings from subscribers are not allowed on the list —only messages from the Editor. We are currently evaluating the idea of setting up a separate discussion list for *EJGI* topics.

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We welcome contributions on gambling and gambling-related issues. Please note that submitted manuscripts are limited to 5000 words in length, not including a 150 word abstract and references. (For First Person Accounts and Reviews please see below.) Prospective authors should always read the last issue of *EJGI* for the latest version of Invitation to Contributors. We encourage electronic submission and accept mail submissions, but cannot accept fax submissions. For details, please see the submission process below. All authors whose manuscripts are accepted will receive a standard legal form to complete, sign and return by mail.

## The Review Process

All submitted manuscripts (except Reviews ) are reviewed anonymously by at least two people. Each reviewer will have expertise in the study of gambling and will assess and evaluate according to the criteria listed below. The editor will mediate their assessments and make the final decisions.

Submissions are either

1. accepted as is, or with minor revisions;
2. returned with an invitation to rewrite and resubmit for review, or
3. rejected. (Decisions of the editor are final and cannot be appealed.)

Authors will receive an e-mail copy of their manuscript before publication, and must answer all queries and carefully check all editorial changes. Please note that there will be a deadline for a response to queries and no corrections can be made after that date. Authors are responsible for the specific content of their manuscripts.

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The editorial board will make specific invitations to chosen authors. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit and/or contribution to public debate in the field of gambling studies. All submissions will be mediated by the editor.

## **Research**

We invite researchers to submit manuscripts that report new findings on gambling. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit, and mediated by the editor.

## **Policy**

We invite manuscripts that examine policy issues involving gambling. All submissions will be peer-reviewed in confidence by at least two reviewers and mediated by the editor. The editor will evaluate how successful the author is in exploring how gambling affects public life and policy, historically and currently.

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practicing clinicians.

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These narratives will show how gambling affects the author and others (perhaps as family, friends, gambling staff, or clinicians). Submissions will be reviewed in confidence by at least two reviewers and mediated by the editor. The editor will evaluate how successful the author is in making gambling issues come alive to the readers. First Person Accounts do not need abstracts or references.

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Authors opting to submit hard copies should mail four copies to the address below and ensure that the guidelines are followed. If possible, an e-mail address should accompany mail submissions.

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## Examples:

### Books

Lesieur, H.R. (1984). *The Chase: The Compulsive Gambler*. (2nd ed.). Rochester, VT: Schenkman Books, Inc.

### Book chapters

Shaffer, H.J. (1989). Conceptual crises in the addictions: The role of models in the field of compulsive gambling. In H.J. Shaffer, S.A. Sein, B. Gambino & T.N. Cummings (Eds.), *Compulsive Gambling: Theory, Research, and Practice* (pp.3-33). Lexington, MA: Lexington.

### Journal articles

Gupta, R., & Derevensky, J. (1997). Adolescent gambling behavior: A prevalence study and examination of the correlates associated with problem gambling. *Journal of Gambling Studies*, 14 (4), 319-345.

### Miscellaneous articles, including government publications

Ontario Ministry of Health. *Schedule of Benefits, Ontario Health Insurance Plan*. Kingston, Ontario: Ontario Ministry of Health; April 1987.

### Papers presented at a conference, meeting or symposium presentation

Ganzer, H. (1999, June). A seven session group for couples. Paper

presented at the 1999 13th National Conference on Problem Gambling, Detroit, MI.

### **Signed newspaper article**

Brehl, R. (1995, June 22). Internet casino seen as big risk. The Toronto Star, pp. D1, D3.

If the article is unsigned or the author's name is unavailable, begin with the title:

Man gambled crime returns at casino. (1996, February 9). The Christchurch Press, pp.32.

### **Electronic source**

Brown, S., & Coventry, L. (1997, August). Queen of Hearts: The Needs of Women with Gambling Problems, (Internet). Financial and Consumer Rights Council. Available:  
<http://home.vicnet.net.au/~fcrc/research/queen.htm>.

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Table 1 about here

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*Phil Lange, Editor*

*E-mail: [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net)*

## Statement of Purpose

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

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

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# The Biopsychosocial Approach to Gambling: Contextual Factors in Research and Clinical Interventions

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## Abstract

### Objective

This paper argues that adherence to a single, specialised theory of gambling is largely untenable. It highlights limitations of existing theories of gambling at three increasingly specific levels of analysis; namely, the social, psychological and biological.

## Method

An overview of each level of analysis (social, psychological and biological) is provided by critically evaluating the contemporary literature on gambling. This is followed by discussions of the limitations and interdependence of each theoretical approach and the implications for research and clinical interventions.

## Results

While several recent critiques of gambling research have provided considerable insight into the methodological limitations of many gambling studies, another problem is seldom acknowledged —the inadequacy and insular nature of many research paradigms. It is argued that gambling is a multifaceted behaviour, strongly influenced by contextual factors that cannot be encompassed by any single theoretical perspective. Such contextual factors include variations in gambling involvement and motivation across different demographic groups, the structural characteristics of activities and the developmental or temporal nature of gambling behaviour.

## Conclusion

This paper suggests that research and clinical interventions are best served by a biopsychosocial approach that incorporates the best strands of contemporary psychology, biology and sociology.

## Introduction

Gambling is one of the few activities that cuts across all barriers of race, class and culture. Although almost all surveys into gambling on a national level have concluded that there are more gamblers than non-gamblers (e.g., Blaszczynski, Walker, Sagris & Dickerson, 1997; Cornish, 1978; Kallick, Suits, Dielman & Hybels, 1979; Volberg & Steadman, 1992), most participants gamble infrequently. Estimates based upon survey data indicate that between 80% and 94% of British adults (Cornish, 1978), between 24% and 68% of American adults (Culleton, 1985; Culleton & Lang, 1985; Kallick et al., 1979) and between 81% and 92% of Australian adults (Grichting, 1986; McMillen, 1995) have gambled at some time in their life.

The introduction of national lotteries, proliferation of gaming machines and construction of casinos has greatly increased the accessibility and popularity of gambling worldwide, and as a result, the number of people seeking assistance for gambling-related problems (McMillen, 1996). Therefore, it is not surprising that there has been a large increase in research into gambling, and more specifically, into the underlying mechanisms and motivations to gamble and the differences between non-gamblers, "normal" gamblers and problem gamblers. Much of this literature has been summarised in a number of recent reviews (Dickerson, 1989; Lesieur & Rosenthal, 1991; Walker, 1992; Griffiths, 1996), all of which applaud the many useful findings yielded by recent gambling research. However, what is also evident is that considerable pessimism has been expressed regarding the extent to which researchers have adequately addressed many fundamental issues of gambling. These include the factors or characteristics which distinguish normal from problem gambling, how to classify and identify problem gamblers, and the mechanisms underlying each level of gambling involvement. Although most reviewers commonly attribute the failure to address these issues to the methodological limitations of many existing studies (e.g., sample size, lack of ecological validity, poor design) and lack of clarity in the theories, concepts and arguments advanced to explain gambling.

A more serious problem is the fragmented, insular nature of research programmes. Despite token recognition of the complexity of gambling behaviour, most research has been rigidly confined to narrow areas of specialisation. Singular theoretical perspectives (e.g., behaviourism, cognitivism, addiction theory) have been assiduously pursued with few attempts to establish links or contrast them with other research programmes. This assumes that a single explanation or theory is sufficient to explain every aspect of gambling behaviour and that rival perspectives are thereby misguided. Yet, as Brown (1986) and Griffiths (1995) recently asserted, this may not be so.

Gambling is a multifaceted rather than unitary phenomenon. Consequently, many factors may come into play in various ways and at different levels of analysis (e.g., biological, social or psychological). Theories may be complementary rather than mutually exclusive, which suggests that limitations of individual theories might be overcome through the combination of ideas from different perspectives. This has often been discussed before in terms of recommendations for an "eclectic" approach to gambling (Brown, 1986) or a distinction between proximal and distal influences upon gambling (Walker, 1992). However, for the most part, such discussions have been descriptive rather than analytical, and so far, few attempts have been made to explain why an adherence to singular perspectives is untenable. Accordingly, the aim of this paper is to highlight limitations of existing theories of gambling at three

increasingly specific levels of analysis: social, psychological and biological.

Central to this view, no single level of analysis is considered sufficient to explain either the etiology or maintenance of gambling behaviour. Moreover, this view asserts that all research is context-bound and should be analysed from a combined, or biopsychosocial, perspective. Variations in the motivations and characteristics of gamblers and in gambling activities themselves mean that findings obtained in one context are unlikely to be relevant or valid in another (Dickerson, 1993, 1995). In each of the following sections, broad details of each level of analysis are provided, followed by discussions of the limitations and interdependence of each theoretical approach and the implications for research and clinical interventions. They begin with a discussion of distal factors thought to influence gambling involvement (Walker, 1992) and continue with an analysis of the limitations of theories of ongoing behaviour.

## Explanations of gambling involvement

According to economic theory, gambling is considered merely another commodity, which provides utility to the consumer in the form of entertainment, excitement and the opportunity to win money (Eadington, 1995). Therefore, to determine how many people gamble in a given society it is necessary to consider the success of the gambling industry in distributing and promoting its products (Brown, 1986). Research has consistently shown a positive relationship between the availability of gambling and both regular and problem gambling (Custer, 1982; Dickerson, 1989, 1995; Dielman, 1979; Kallick-Kaufmann, 1979; McMillen, 1995; Marcum & Rowen, 1974; Skolnick, 1978; Weinstein & Deitch, 1974). Whenever new forms of gambling are introduced, or existing forms become more readily available, there is an increase in gambling, suggesting that the demand for gambling products is closely linked to their supply. The more gambling industry infrastructure that is established (e.g., new venues), the larger the range of gambling products (e.g., through the application of new technologies), and the greater the industry's marketing efforts, the more likely people will be to gamble in the first place. For example, these factors have been critical to the success of the UK National Lottery. Not only is the lottery heavily advertised on billboards, television and in national newspapers but also accessibility is so widespread that it is difficult to avoid in most shops (Griffiths, 1997). Similar trends have emerged in Australia where slot machines have been introduced in shopping malls, hotels and suburban clubs in nearly every state (McMillen, 1995).



But why is gambling so popular? According to sociologists, gambling is an inherent component of human society (Goffman, 1967) and human beings have a natural penchant for play, risk and competition. Gambling, they argue, fits easily with cultural values, virtues and lifestyles (Abt, Smith & McGurrin, 1985), so that when gambling becomes more accessible and socially acceptable, more people will gamble. As a form of social interaction, gambling provides a means by which people can escape the boredom of everyday life, adopt new roles and enjoy the excitement of the "action"; namely, the suspense, anticipation and social reinforcement resulting from taking risks and being rewarded for one's daring (Abt & Smith, 1984).

Almost all surveys of gambling (e.g., Griffiths, 1995; Kallick-Kaufmann, 1979) have shown that these broad motivational factors are central to gambling and that attitudes towards gambling are positively related to availability and cultural acceptability. However, this perspective fails to take into account many key findings and observations in gambling research. Surveys have also shown that not everyone gambles and some people gamble more than others (e.g., pathological gamblers). Research has also shown that people often gamble for reasons other than broad social and economic reasons (Walker, 1992). These other motivations may vary according to personal characteristics of the gambler and the type of gambling activity (e.g., Chantal & Vallerand, 1996). Finally, broad social and economic theories fail to explain why certain gambling activities are more popular or "addictive" than others.

Demographic variations in gambling participation have been observed since surveys were first administered (Walker, 1992). Typically, gambling has been more popular in lower socio-economic groups (Blaszczynski et al., 1997; Crisp et al., 2000; Dickerson, Baron & O'Connor, 1994; Dickerson et al., 1996; Dickerson, Walker & Baron, 1994; Downes, Davies, Davis & Stone, 1976; Frey, 1984; Volberg & Steadman, 1992; Walker, 1992), in Catholics rather than Protestants (Grichting, 1986; Kallick-Kaufmann, 1979), among unmarried people (Lesieur, 1984; Delfabbro & Winefield, 1996; Dielman, 1979; Downes et al., 1976; Sommers, 1988), in younger age groups (Mok & Hraba, 1991; Griffiths, 1995; Morgan Research, 1997) and in men (Abbott & Volberg, 1996; Dickerson et al., 1996; Mark & Lesieur, 1992; Volberg & Steadman, 1992). In addition, there are significant demographic variations in gambling activities. Older people and women are significantly less likely than younger men to gamble on (and develop problems with) casino games and racing activities (Hraba & Lee, 1995; Mok & Hraba, 1991), but they are just as likely to gamble on lotteries and slot machines. On the other hand, lottery participation is higher in lower socio-economic groups and in older and middle-aged people (Delfabbro & Winefield, 1996; Dickerson, Walker et al., 1994; Dickerson, 1995). These variations suggest that overall increases in gambling participation (and the incidence of gambling-related problems) are not evenly

distributed across demographic groups. Not all gambling activities are accessible or appealing to certain groups.

Consistent with trends observed in overall participation rates, Australian research (e.g., Blaszczynski et al., 1997; Crisp et al., 2000; Delfabbro & Winefield, 1996; Dickerson, Baron et al., 1994; Dickerson, Walker et al., 1994; Dickerson et al., 1996) has found that the incidence of gambling-related problems is considerably higher in lower socio-economic groups and in younger people, and it is more likely to be associated with slot machines, one of the few activities which attract similar numbers of men and women. Accordingly, understanding demographic variations in overall participation is vital if one is to estimate the likely social effects of expansion or product changes in existing gambling markets. For example, in the future, Internet gambling and new sports betting facilities are likely to attract relatively more younger men, whereas an increase in slot machines or lotteries will have a significant effect upon the number of women gambling (Griffiths, 1999a). These variations exist because not all people hold the same attitudes towards gambling nor do they have the same motivations for gambling. For example, Protestants are more likely than Catholics to regard gambling as a waste of money (Grichting, 1986), whereas people in lower socio-economic groups (regardless of religious background) are more apt to view gambling positively as a way of escaping from the drudgery of uninteresting, routine work and a way to elevate one's living standards (Furnham & Lewis, 1986). By contrast, older people gamble less than younger people; they are less concerned with elevating their position in society (Mok & Hraba, 1991) and more interested in the opportunities for socialisation and relaxation that gambling provides (Morgan Research, 1997).

Variations in gambling preferences are thought to result from both differences in accessibility and motivation. Older people tend to choose activities that minimise the need for complex decision-making or concentration (e.g., bingo, slot machines), whereas gender differences have been attributed to a number of factors, including variations in sex-role socialisation (Abt & Smith, 1984), cultural differences (Walker, 1992) and theories of motivation (Delfabbro, 2000). Specifically, the underrepresentation of women in casino games, racing and sports betting has been explained in terms of the long association between these activities and male subcultures; for example, boys' childhood and adolescent games and male gambling venues. Alternatively, as suggested by recent Australian research, it may be that women have different motivations for gambling (Loughnan, Pierce & Sagris, 1997); namely, a greater desire for relaxation and escape from worries (Crisp et al., 2000). Research by Chantal and Vallerand (1996) suggests that such motivations are more likely to be satisfied by participation in chance activities, such as lotteries, rather than more skilled activities, such as racing.

Variations in motivation are also frequently observed among people who participate in the same gambling activity (Dickerson, Walker, Legg England & Hinchy, 1990; Dumont & Ladouceur, 1990; Fabian, 1995; Griffiths, 1993). For example, slot machine and video poker players may gamble to win money, for enjoyment and excitement, to socialise and to escape negative feelings (Dumont & Ladouceur, 1990; Griffiths, 1995). Some people gamble for one reason only, whereas others gamble for a variety of reasons (e.g., Lesieur, 1984; Moran, 1970). A further complexity is that people's motivations for gambling have a strong temporal dimension; that is, they do not remain stable over time. As people progress from social to regular and finally to excessive gambling, there are often significant changes in their reasons for gambling. Whereas a person might have initially gambled to obtain enjoyment, excitement and socialisation, the progression to problem gambling is almost always accompanied by an increased preoccupation with winning money and chasing losses (Lesieur, 1984).

## **The importance of the structural characteristics of activities**

Another factor central to understanding gambling behaviour is the structure of gambling activities. As shown by Weinstein and Deitch (1974) and Griffiths (1993), gambling activities vary considerably in their structural characteristics, including the probability of winning, the amount of gambler involvement, the amount of skill that can be applied, the length of the interval between stake and outcome and the magnitude of potential winnings. Structural variations are also observed within certain classes of activities such as slot machines, where differences in reinforcement frequency, colours, sound effects and machines' features can influence the profitability and attractiveness of machines significantly (Griffiths, 1993). Each of these structural features may (and almost certainly does) have implications for gamblers' motivations and the potential "addictiveness" of gambling activities.

For example, skilful activities that offer players the opportunity to use complex systems, study the odds and apply skill and concentration appeal to many gamblers because their actions can influence the outcomes. Such characteristics attract people who enjoy a challenge when gambling. They may also contribute to excessive gambling if people overestimate the effectiveness of their gambling systems and strategies (see discussion of cognitive theories below). Chantal and Vallerand (1996) have argued that people who gamble on these activities (e.g., racing punters) tend to be more

intrinsically motivated than lottery gamblers in that they gamble for self-determination (i.e. to display their competence and to improve their performance).

People who gamble on chance activities, such as lotteries, usually do so for external reasons (i.e. to win money or escape from problems). This was confirmed by Loughman et al. (1996) in a clinical survey of problem gamblers wherein racing punters emphasised the importance of skill and control considerably more than slot machine players. Although many slot machine players also overestimate the amount of skill involved in their gambling (e.g., Walker, 1992), other motivational factors (such as the desire to escape worries or to relax) tend to predominate (Walker, 1985). Thus, excessive gambling on slot machines may be more likely to result from people becoming conditioned to the tranquilising effect brought about by playing rather than just the pursuit of money. On the other hand, racing punters tend to be more likely to gamble for excitement (Blaszczynski, McConaghy & Winter, 1986). This has important implications for the psychological study of ongoing gambling behaviour.

Another vital structural characteristic of gambling is the continuity of the activity; namely, the length of the interval between stake and outcome. In nearly all studies, it has been found that continuous activities (e.g., racing, slot machines, casino games) with a more rapid play-rate are more likely to be associated with gambling problems (Dickerson, 1989; Dickerson, 1995; Dickerson et al., 1996; Griffiths, 1995; Walker, 1992; Walker & Dickerson, 1996). The ability to make repeated stakes in short time intervals increases the amount of money which can be lost and also increases the likelihood that gamblers will be unable to control spending (O'Connor, Dickerson & Phillips, 1995). Such problems are rarely observed in non-continuous activities, such as lotteries, in which gambling is undertaken less frequently and where outcomes are often unknown for days. Consequently, it is important to recognise that the overall social and economic impact of expansion of the gambling industry will be considerably greater if the expanded activities are continuous rather than non-continuous.

## Theories of gambling behaviour

Although sociological, situational and demographic factors can explain why some people are more likely to gamble than others, these theories cannot explain why some people gamble more than others or what factors contribute to behaviour maintenance in gambling. Psychological theories become

important at this level. Research in this area is remarkably diverse. Almost every major branch of psychology (e.g., cognitivism, behaviourism, Freudian theory, addiction theory), has been utilised in an attempt to understand gambling. Despite this, it is possible to distinguish two broad, general perspectives: first, theories that attribute ongoing behaviour and excessive gambling to habitual processes which are the consequences of gambling; second, theories that state that variations in behaviour result from variations in the characteristics, or "make-up," of individual gamblers. In other words, whereas the first places a stronger emphasis upon psychological determinants of gambling, the second emphasises biological differences between individuals.

Central to psychological explanations is the idea that every person who gambles has the potential to become a problem gambler. This is because gambling activities are difficult to resist by their very nature: excitement, risk-taking and the possibility of monetary gains. The more a person gambles, the more difficult it becomes to resist the temptation to commence a gambling session or stop once gambling has commenced (Dickerson, 1989). Accordingly, it has been suggested that there is no neat distinction between problem gambling and normal gambling; rather there is a continuum from social gambling to "regular" gambling to problem gambling.

People who gamble regularly may display many of the same behaviours as people with gambling problems, although to a lesser degree. This view gives rise to conceptualisations of problem gambling that emphasise the developmental and habitual nature of problem gambling behaviour rather than individual pathology. This perspective avoids terms such as compulsive, addiction or pathology in preference for terms such as impaired control (O'Connor et al., 1995). Although researchers' views differ concerning the psychological mechanisms behind loss of control, three general classes of theory will be used to illustrate the limitations of psychological accounts. They are behaviourist theories that explain persistent gambling as a conditioned process; need-state models that see gambling as a form of psychological or physiological dependence; and cognitive theories that attribute excessive gambling to erroneous beliefs about the potential profitability of gambling.

## **Behaviourist Approaches**

Both classical and operant conditioning principles have been applied to the study of gambling. In operant explanations for problem gambling (e.g., Delfabbro & Winefield, 1999a, 1999b; Dickerson, Hinchy, Legg England, Fabre & Cunningham, 1992), persistent gambling is seen as a conditioned behaviour maintained by intermittent schedules of reinforcement, most likely a variable-ratio schedule. This involves the provision of infrequent rewards after



varying numbers of responses. On the other hand, proponents of classical conditioning models (e.g., Anderson & Brown, 1984) argue that people continue to gamble as a result of becoming conditioned to the excitement or arousal associated with gambling, so that they feel bored, unstimulated and restless when they are not gambling. Both the classical and operant perspectives have been central to the development of measures of "impaired control" over gambling (Baron, Dickerson & Blaszczynski, 1995) and clinical interventions using desensitization, aversive conditioning and satiation techniques (see Griffiths, 1995, for a review). In each of these examples, it is assumed that the more a person gambles, the more his or her behaviour is dictated by factors beyond the person's control.

Despite evidence supporting both theories (see Griffiths, 1995; Walker, 1992), neither is entirely satisfactory on its own. Classical conditioning theory seems useful to explain people's motivation to commence a gambling session, but appears less useful to explain persistent gambling behaviour. Conversely, while operant conditioning might explain ongoing behaviour, it appears less useful in explaining why people commence gambling or recommence gambling after a prolonged period of abstinence (Walker, 1992). Researchers have also raised questions about the extent to which gambling behaviour adheres to operant theory at all, since gamblers lose more than they win and because reinforcement magnitudes are not independent of player responses, e.g., stake sizes (Delfabbro & Winefield, 1999a; Griffiths, 1999b). Nevertheless, the importance of subtle variations in machine characteristics upon behaviour (Griffiths, 1993) reinforces the role of operant conditioning in the maintenance of behaviour, although perhaps in more subtle ways than was envisaged.

It is important to recognise that these theories cannot stand in isolation. As with other psychological theories, conditioning theories cannot explain why people exposed to similar stimuli respond differently; why some gamble whereas others do not or why some people gamble more than others. In addition, the effectiveness, or strength of the conditioning effect may be a function of motivational factors and type of activity. Some, but not all, people gamble for excitement or relaxation, and as discussed above, people satisfy these needs by different activities (Blaszczynski, McConaghy et al., 1986). Thus, it is unlikely that classical conditioning will affect all types of gambling or gamblers. Similar difficulties plague attempts to develop general operant theories of gambling. Some activities appear to suit this form of explanation more than others. Examples include slot machines and scratch tickets where there is a short time interval between stake and outcome, and where outcomes are entirely determined by chance. It seems more difficult to apply these principles to skilled gambling games such as blackjack, poker and sports betting, where player decisions can significantly influence outcomes.

## Need-State Models and Theories of Addiction

Much of the discussion relating to classical conditioning also applies to need-state theories of gambling, which assume that people gamble to escape unpleasant feeling states such as anxiety, depression and boredom. These perspectives have been applied to all facets of gambling, including involvement, ongoing behaviour and excessive gambling. They are incorporated into the DSM-IV classification for pathological gambling (i.e. gambled as a way of escaping from problems or intolerable feeling states). Although not all researchers agree that these motivations signify the existence of a physiological addiction (Walker, 1989), most agree that people can become psychologically addicted to gambling.

The concept of arousal has been studied most extensively (e.g., Anderson & Brown, 1984, 1987; Brown, 1986; Dickerson et al., 1992; Griffiths, 1995) but results have not been consistent. Arousal increases have been observed in some studies, but not in others (see Griffiths, 1995, for a review), and most increases have been relatively small. Variations in arousal have neither co-varied reliably with the persistence of behaviour (Dickerson et al., 1992) nor the onset of gambling sessions. Furthermore, Walker (1992) questioned the explanatory value of arousal theories arguing that the excitement of gambling is unlikely to be independent of people's desire to win money.

Similar problems have plagued attempts to associate gambling with anxiety and depression. While a considerable number of studies (e.g., Bergler, 1957; Blaszczynski & McConaghy, 1989; Blaszczynski, McConaghy & Frankova, 1990; Dickerson, Cunningham, Legg England & Hinchy, 1991; 1992; Greenson, 1947; McCormick, Russo, Ramirez & Taber, 1984; Moran, 1970) have revealed that negative mood states commonly accompany gambling or predict the duration of gambling sessions (Dickerson et al., 1991), most analyses have been confined to problem gamblers and high-frequency gamblers. For this reason, it is unclear whether these mood states are also associated with less frequent gambling. Moreover, it is not possible to determine whether mood states precede or arise as a consequence of gambling. Indeed, as Walker (1992) points out, it may be that gamblers become depressed as a result of losing more money than they can afford.

Again, the temporal dimension suggests that the role of mood states is unlikely to be independent of the gambler's characteristics. As with arousal, it is unlikely that avoidance of negative feeling states will be common to all activities or all gamblers. Blaszczynski, McConaghy et al. (1986) suggested that some activities satisfy these needs more than others; for example, slot machines appear to reduce anxiety, whereas racing provides arousal and excitement. In addition, variations in gambling motivation among participants



involved in the same activity suggest that not all people gamble to satisfy unfulfilled needs. It is also unclear why some people apparently have a greater need for arousal or relaxation than others, and whether this would be sufficient to explain differences between normal and excessive gambling? As suggested by McCormick et al. (1984), it is important to place behaviour in a social context to understand how gambling compensates for, or assuages, problems or deficits experienced in other areas of life. Alternatively, as will be suggested later in this paper, it may be useful to look for dispositional or biological differences to explain the varying motivations and behaviour of individual gamblers.

## Cognitive Theories

Despite the fact that the odds of almost all activities are weighted strongly in favour of the house, gamblers continue to believe they can win money from gambling (Walker, 1992). This observation leads to the conclusion that gambling may be maintained by irrational or erroneous beliefs. For example, people overestimate the extent to which they can predict or influence gambling outcomes and tend to misjudge how much money they have won or lost. This hypothesis has been confirmed in numerous studies (e.g., Langer, 1975; Langer & Roth, 1983) showing that people overestimate the degree of skill or control which can be exerted in chance activities, and also, studies using the so-called "thinking aloud" method (see Gaboury & Ladouceur, 1988), which reveal high levels of irrationality in verbalised statements made during gambling sessions. These findings have been confirmed not only under laboratory conditions (e.g., roulette: Gaboury & Ladouceur, 1988; Ladouceur & Gaboury, 1988; Ladouceur, Gaboury, Dumont & Rochette, 1988) but also in ecologically valid gambling settings, using "regular" gamblers (video poker: Ladouceur, Gaboury, Bujold, Lachance & Tremblay, 1991) and in various countries (e.g., slot machines in the United Kingdom: Griffiths, 1994a; slot machines in Australia: Walker, 1992).

Based upon these findings, it has been suggested that irrational thinking may be related to problematic gambling behaviour (Ladouceur & Walker, 1996; Wagenaar, 1988), with persistent behaviour thought to be the result of people's overconfidence in their ability to win money (Griffiths, 1994a; Wagenaar, 1988; Walker, 1992). Evidence suggests that problem gamblers frequently overestimate the amount of control and skill involved in gambling (Loughnan et al., 1997). Unfortunately, these observations have also been made using students with no gambling experience (e.g., Ladouceur et al., 1988, 1991) indicating that irrational beliefs are not positively related to level of gambling involvement. A further problem is that irrationality does not appear to co-vary with other observable facets of gambling; for example, the level of risk-taking (Ladouceur & Gaboury, 1988) or reinforcement frequency

(Ladouceur et al., 1988). Alternatively, where irrationality positively relates to involvement, few differences in behaviour have been observed. Consequently, Dickerson and Baron (2000) have concluded that irrational thinking is probably more a reflection of demand characteristics than a rational underlying behaviour. A lot of what people say may only result from the difficulty of trying to come up with rational, meaningful statements in chance-determined situations.

In addition to these conceptual difficulties, it is also possible that contextual factors play a role in cognitive research. For example, Griffiths (1994a) found that regular players had greater difficulty than occasional players in verbalising their thoughts while they were gambling. Regular players seemed capable of gambling without attending to what they were doing, suggesting: (a) that cognitive processes did not play a major role in the maintenance of their behaviour, or (b) that the original justifications or rationales for behaviour were less accessible. In either case, Griffiths' observations suggested that temporal factors (namely, how long a person has been gambling) appear to be important. Therefore, all other things being equal, it appears that valid comparisons cannot be drawn between gamblers with differing levels of gambling experience; for what holds for infrequent gamblers might not hold for regular players, and vice versa.

Similar problems arise when combining samples of people who may or may not have similar motivations for gambling. Cognitive approaches assume that people overestimate their chances of winning because obtaining money is an important motivation for their gambling. However, as is clear from the previous discussion, not all people gamble for this reason. Moreover, as shown by Burger and Cooper (1979) and Burger and Smith (1985), the way in which people respond to or interpret gambling tasks may vary according to their level of control motivation. People who for whatever reason, are more motivated to seek control in their lives appear more prone to overestimate the extent to which they can influence the outcomes of chance-determined activities. Accordingly, variations in control motivation in cognitive studies of gambling would be an additional, and uncontrolled source of within-sample variation, which could influence the reliability of the statistical effects observed.

Finally, it is again important to observe that cognitive theories need to take structural variations in activities into account. Many cognitive processes thought to underlie gambling behaviour (e.g., overestimations of control, biased attributions) are more likely to be observed when activities are perceived as having some skill component (Langer, 1975). With some activities, there is a genuine possibility for skilful play (e.g., racing, blackjack, table poker). The more people play or know about these activities, the greater

their awareness of the skills involved. Thus, beliefs about control and skill are neither completely irrational nor consistent across players. Instead, in these situations, researchers must examine the quality of play; for example, to what extent the person adheres to optimal strategies, rather than look for evidence of irrational thinking (e.g., Keren & Wagenaar, 1985).

Even in activities where outcomes are chance-determined, there are likely to be variations in the extent to which gamblers' perceive that the outcomes are solely chance-determined (e.g., roulette and craps are probably more likely to be perceived as skilful than Australian slot machines because of the greater complexity of the rules and the possibility for variations in playing strategy). Therefore, it may be ineffective to compare results across studies using different chance activities without controlling for variations in perceived skill.

## **Biological and Dispositional Theories**

Social and psychological explanations are insufficient to explain the full complexity of gambling behaviour. Whether ongoing behaviour is explained in terms of behaviourism, need-state models or cognitive theories, it remains unclear why one person gambles more heavily than another. In other words, while it seems likely that increased involvement with gambling is likely to contribute to loss of control over behaviour, development of irrational beliefs and greater psychological dependence, it is important to determine what makes some gamblers more susceptible to these factors than others. It is here that research into biological and personality factors becomes important. Central to this research is to ascertain whether pathological gamblers possess qualities which would predispose them to excessive gambling. Much of this literature was summarised by Walker (1992), so this discussion is confined to three research areas: whether problem gamblers are particularly disposed towards developing an addiction; whether they have a greater need for arousal; and whether gamblers are naturally more impulsive than non-gamblers.

Studies into the first question have been undertaken by examining overlaps between potentially addictive and problematic behaviours with alcohol, illicit drugs and gambling. This includes research into problem gamblers with psychoactive substance abuse problems (e.g., Ramirez, McCormick, Russo & Taber, 1984; Linden, Pope & Jonas, 1986; Ciarrocchi & Richardson, 1989) or those who also have drug or alcohol use problems, or both (e.g., Lesieur, Blume & Zoppa, 1986; Lesieur & Heineman, 1988; Griffiths, 1994b, 1994c). The incidence of cross-addictions in populations of pathological gamblers has been cited as evidence for the existence of an addictive personality type (Blaszczynski, 1996). In addition, research by Comings et al. (1996), for example, has suggested a genetic basis for gambling in some people. They

reported that a variant of the dopamine D2 receptor gene (DRD2), which has been associated with other addictions, including alcoholism, was found in 51% of pathological gamblers compared with only 26% of controls. The effect of this gene was more closely associated with pathological gambling than any other addiction. This suggested that the genetic variants of the DRD2 gene may play a significant role in pathological gambling, which supports the concept that variants in this gene are an important risk factor for addictive behaviours.

Although intriguing, such evidence does not provide convincing evidence for the existence of a biological basis for gambling addiction. For a start, many pathological gamblers do not have other addictions (Blaszczynski, 1996). Moreover, as Comings et al. (1996) show, only half of the problem gamblers possessed the so-called "gambling gene," suggesting that this gene is not a necessary factor in the etiology of gambling addiction. Finally, researchers (e.g., Blaszczynski, 1996; Walker, 1989) have questioned the notion of physiological addiction altogether, arguing that there is very little evidence to support the applicability of traditional addiction models to gambling. Gamblers rarely experience cravings, withdrawal symptoms or tolerance in the traditional addictions sense, suggesting that excessive gambling is more likely to arise as a result of other processes. If the term "addiction" is to be used at all, it is better used in a general sense to denote a condition broadly characterised as a repetitive and uncontrollable behaviour that has undesirable consequences for individuals and those around them (Griffiths, 1995).

Secondly, attempts have been made to associate gambling with an excessive desire for arousal or risk-taking. For example, Brown (1986) has hypothesised that pathological gamblers are habitually underaroused or understimulated and need gambling to reach an optimal level of arousal. However, the available evidence offers little support for this notion. While studies by Wolfgang (1988) and Anderson and Brown (1984) have shown that regular gamblers tend to score higher on measures of sensation-seeking than controls, other studies have failed to find any associations at all (Allcock & Grace, 1988; Ladouceur & Mayrand, 1986), or paradoxically, studies have found that problem gamblers tend to score lower than population norms on the sensation-seeking scale (Blaszczynski, Wilson & McConaghy, 1986; Blaszczynski et al., 1990; Dickerson, Hinchy & Fabre, 1987). This has been attributed to the fact that problem gamblers tend to engage in a very limited range of activities compared with other people, which limits the number of items endorsed (their scores) on the sensation-seeking scales. Consequently, it seems unlikely that this variable provides a reliable basis for distinguishing problem gamblers from other gamblers.

Thirdly, researchers have tried to associate excessive gambling with the inability to control impulses. This notion was central to the development of the first psychiatric definition of gambling in the DSM-III (American Psychiatric Association, 1980), which classified pathological gambling as a form of impulse disorder, not unlike compulsive stealing (kleptomania) and hair-pulling (trichotillomania). Gamblers were hypothesised to have experiences characteristic of other recognised impulse disorders, such as, physical and psychological tension prior to the commencement of gambling and to experience a strong sense of pleasure or release once the activity had commenced (McGurrin, 1992). Implicit in this explanation was the idea that gambling was unplanned, or involuntary, and highly repetitive.

Despite the inconsistency of psychometric evidence on this topic (Allcock & Grace, 1986), clinical observations suggest that a loss of control is common to problem gambling (Blaszczynski & McConaghy, 1989; Carlton & Manowitz, 1987; McCormick, 1994;). Researchers have argued that there are similarities between problem gambling and children with attention deficit disorder (ADD) (Goldstein, Manowitz, Nora, Swartzburg & Carlton, 1985), in that both are characterised by limited attention spans, impulsive behaviour, inability to delay gratification and insensitivity to punishment. Carlton et al. (1988) confirmed this by administering a modified ADD scale to a sample of 16 problem gamblers and found that they scored significantly higher on ADD items than a control group. This suggested the possibility that ADD during childhood may be an antecedent to the development of gambling problems in adulthood. Recent psychobiological evidence suggests that such traits can be directly linked to deficiencies in the production of certain neurotransmitters thought to be associated with impulse control. One of these substances is serotonin (5-hydroxytryptamine: 5-HT), which has an inhibitory effect upon the cortex and is associated with more controlled behaviour (McGurrin, 1992). It has been found that decreased 5-HT levels are associated with heavy alcohol consumption (Branchy, Shaw & Leiber, 1981), whereas higher levels increase the likely effectiveness of alcohol treatment programmes (Naranjo, Sellers & Lawrin, 1986). McGurrin (1992) and Griffiths (1995) have argued that this substance may also play a role in the development of problem gambling.

The question that remains, however, is how researchers will ascertain the direction of causality; namely, whether decreased 5-HT levels are the result, or cause, of excessive gambling. This problem extends to all attempts to draw associations between dispositions and gambling behaviour. This indicates the importance of a temporal dimension in gambling. Since gambling is likely to influence the characteristics of gamblers, it may be unwise to assume that observations of one sample can be generalised to other samples of gamblers with different levels of gambling experience.



Physiological accounts assume that such factors should override other environmental or contextual factors and allow for the development of a general theory of gambling addiction. However, this is clearly not so. Apart from the conceptual difficulties associated with determining a causal relationship between characteristics and behaviour, these theories are unable to account for the full diversity of gambling patterns and behaviour. They fail to explain demographic differences in the preference for activities and variations in motivation. Neither can they explain why some activities are more "addictive" than others and why the structural characteristics of specific activities (e.g., slot machines) can influence behaviour. Therefore, it appears that excessive gambling is likely to result from both dispositional and psychological factors and the complex interaction between them.

Psychological explanations must play a role because of the obvious importance of external factors (e.g., environmental and situational variables) in the development of gambling habits. However, it is also clear that internal factors influence how certain individuals respond to these situations. The implications of this observation for the study and treatment of problem gambling are discussed below.

## Conclusions and Implications for Research and Interventions

In summary, it seems that gamblers are first influenced by sociological factors; for example, the availability of gambling opportunities, attitudes and habits of parents, friends and peer groups as well as a lack of alternative activities. During the middle stages of development, there are many factors which heavily influence the maintenance of gambling behaviour. Three of these factors are schedules of reinforcement, the "escape" qualities of gambling and cognitive biases, all of which have been summarised in this paper. While it remains unclear exactly how some people come to gamble excessively, it is agreed that persistent gambling eventually leads to a desperate "spiral of options" (Lesieur, 1984) where gambling is largely maintained by the desire to win money, recover losses and pay back debts. Gambling is thus a complex, multidimensional activity that is unlikely to be explained by any single theory. Instead, this research is best served by a biopsychosocial model that stresses the individual and idiosyncratic nature of the development of gambling problems and emphasises the role of contextual factors internal and external to the process of gambling itself.

Recognition of this complexity has important implications for gambling research both in terms of the selection of samples and data analysis. Firstly,

the existence of structural variations in activities suggests that results obtained using one activity cannot be generalised to other activities that are not structurally equivalent. Existing research suggests that continuity and the element of skill involved are two factors that must be similar in order for valid comparisons to be made. Secondly, studies of gambling motivation are unlikely to be valid unless both individual and situational factors are taken into account. Since motivations differ across demographic groups (e.g., different genders and ages), across activities and over time, studies must ensure that these factors are controlled before drawing conclusions. Samples should contain equal numbers of men and women of a similar age with similar levels of gambling experience. Alternatively, in situations where this cannot be achieved, gender, age and experience should be used as co-variants, or as the first variables in regression analyses.

Thirdly, in recognition that personality may influence the strength of experimental effects, it is important that researchers match comparison groups in terms of these variables. For example, cognitive experiments investigating the illusion of control should include measures of "desirability for control" (Burger & Cooper, 1979), whereas arousal experiments should include measures of gambling motivation. In addition, researchers should not assume that biological differences or psychological factors will explain all gambling behaviour. Instead, it may be useful to explore the interaction between these different levels of analysis; for example, by examining whether variations in the structural characteristics of activities (e.g., reinforcement frequency) affect people with, or without, the characteristic under observation.

## Implications for Prevention, Intervention and Treatment

Since sociological factors appear to be critical in the acquisition of gambling behaviour, prevention needs to be aimed at the social and situational antecedents. This can be approached from a number of levels (e.g., societal, school, family, individual, etc.), some of which may be more practical than others. Since problem gamblers start gambling at a significantly earlier age than non-pathological gamblers, an obvious step would be for governments to legislate against young people gambling (i.e. below 18 years of age). A "blanket ban" on gambling would, in most cases, reduce acquisition until at least late adolescence. Both parents and peers may model gambling; therefore, the family's role in maintaining gambling behaviour should be addressed in therapy and prevention plans should aim to increase the gambler's contact with non-gambling peers. Also, evidence or knowledge of a



gambler's own negative thoughts or feelings about gambling behaviour, and irrational biases may provide useful cues for behaviour modification (Stumphauzer, 1980).

These findings have led to suggestions to enhance educational awareness of the dangers of gambling not only amongst children and adolescents but also parents, guardians and teachers. Although recommendations of this nature have typically tended to focus upon the need for greater awareness of the "true" odds and the unprofitability of gambling, we believe that this approach needs to be applied with caution. It is quite possible for education to have the opposite effect; namely, to increase students' knowledge of how to gamble. In addition, it is questionable whether knowing the true odds has a significant effect upon dissuading people from gambling, given that many problems gamblers are well educated and have, in some cases, some knowledge of basic mathematics. For many, the belief that they are inherently lucky or different from others helps maintain their interest in gambling. Accordingly, educational campaigns that focus upon the negative consequences of gambling and alternatives to it may have greater success. While these sorts of campaigns are unlikely to prevent gambling in all young people, they might reduce (a) the total number of adolescents who start to gamble and (b) the amount of time an adolescent spends gambling.

The fact that some gamblers are socially rewarded for gambling cannot be altered directly, but more adaptive personal and social skills can be taught as responses to stress (i.e. emotional antecedents); for example, relaxation, assertion and social skills training (Stumphauzer, 1980). Alternatively, where people seek the company of other gamblers as a way to escape from unpleasant feeling states or life stress, the development of alternative interests, hobbies and social networks should be afforded priority during intervention. This approach could also be extended to people who gamble alone. An essential aspect of treatments should be to identify and address the factors that are antecedents to gambling, those that provide the underlying motivation and social and cultural context in which the behaviour has developed. Only when these are addressed can treatments be extended to more specific psychological aspects of the behaviour itself. This is because these broader social and structural factors influence a person's exposure to gambling, their opportunities to gamble and their ability to recover. Detailed analysis of the person's daily schedule and the nature and extent of available social supports is essential during this phase of treatment.

Viewing problem gambling as a biopsychosocial process recognises the diversity of psychological factors involved in maintaining the behaviour as well as the fact that problem gamblers are not a homogeneous group; in fact, there appear to be a number of subtypes. This has major treatment implications.

For instance, Griffiths (1995) outlined two very different types of gamblers. The first type appeared to be addicted to gambling itself and played to test skill, gain social rewards and mostly, for excitement (i.e. the "buzz" or "high"). This was termed a "primary addiction" and appears to be a mixture of Moran's (1970) "subcultural" and "impulsive" types of gamblers. Identifying the environmental, situational or emotional factors that precede a gambling session would be next stage in the intervention. The use of imaginal desensitization, counterconditioning and situational exposure are methods, which have been used to teach people to resist the urge to gamble. Of course, therapists differ in their view concerning the factors underlying this urge. Whereas some emphasise the learned or conditional quality of the behaviour and emphasise the role of stimulus-control, others may emphasise irrational beliefs or the person's desire to obtain physiological stimulation from the activity.

Furthermore, as emphasized by Griffiths (1995), a second type of gambler may gamble for the reasons described earlier, such as escape. These gamblers are usually depressed and socially isolated, and could be described as having a "secondary addiction" in that the player uses gambling as an escape from a primary problem (e.g., broken home, relationship crisis, etc.). It seems that this type of "escape gambler" is not confined to the United Kingdom. This type appears to be a mixture of Moran's (1970) "neurotic" and "symptomatic" types. If the primary problem is resolved by excessive gambling, then playing should disappear. This distinction obviously has clinical usefulness and may also help explain conflicting research, some of which states that gambling is a social activity and some of which states that it is a solitary activity. As discussed above, such gamblers are likely to benefit from any intervention that tries to find alternative activities that take the place of gambling.

## Conclusions

Examining gambling and problem gambling as a biopsychosocial behaviour makes it evident that individual differences and broader contextual factors must be considered and not ignored. This paper provides evidence that a narrow focus upon one theoretical perspective in research and clinical interventions may, in many cases, not be justified. Such an approach fails to consider the interrelationships between different levels of analysis. It would be of limited value to many gamblers whose problems have a different etiology, which may be multifaceted. As Gambino and Shaffer (1979) pointed out over two decades ago, individuals are self-determining agents, and therefore, a taxonomy of situations must be developed to describe the vast majority of contexts and conditions in which people use substances or engage in habitual behaviours to alter their perceived experience.

They also make the important point that these behaviours are not completely self-developed or understood by the people themselves and should be examined more broadly. This is because, gambling becomes a habitual behaviour. Since the perceived experience of the individual can change over time, it is possible that focusing upon the self-reported factors currently maintaining the behaviour does not provide insights into the factors that led to the behaviour developing. Thus, when one takes a biopsychosocial view, it becomes possible to perceive the individual gambling in terms of its broader social and cultural context. This approach also suggests that different perspectives and approaches may be beneficial, so long as they appear to apply to the particular gambler concerned. Moreover, it indicates that a variety of treatments could be beneficial simultaneously.

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# The Effect of Skilled Gamblers on the Success of Less Skilled Gamblers

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## Abstract

This paper uses computer simulations to examine the effect of highly skilled gamblers on the success of moderately skilled gamblers. It shows that

skilled players negatively impact the outcome for less skilled players. A player's winnings are not only affected by the house rake or vigorish but also by the skill of other players. It is concluded that less skilled players are often better off playing a game of chance than a game of skill.

It is our contention that professionals in the field of gambling studies can gain a great deal of insight into problem gambling by closely examining the games gamblers play. The purpose of this article is to examine some differences between games that involve some skill and those that involve only chance in order to help treatment and prevention workers understand the dynamics of these games. For example, understanding the nature of the game and its effects on the individual gambler can help a therapist understand a client's motives and beliefs, which may facilitate a more individualized, client-centered approach to the treatment.

Gambling games can be divided into two categories: games of chance, such as lotteries, keno, craps, roulette, baccarat, bingo and slots; and games of skill, such as horse race betting, sports betting, poker and blackjack. For example, playing bingo requires perceptual and motor skills, but winning is purely a matter of chance. In contrast, winning at poker is dependent on skills relative to the other players. The number of skills involved and the long-term prospects of financial return vary for each type of game. In Hold'em poker, skilled players can make a decent living (Warren, 1996), but in poker games played against the "house," such as Caribbean Stud Poker, players cannot beat the house edge, regardless of how skilled they are (Cardoza, 1997). Players of games based on skill are more likely to be male, with the exception of horse racing, and more likely to be younger (Kelly et al., 2001).

The relationship between skill and problem gambling is particular interesting. According to data on problem gambling treatment collected in Ontario, just over 40% of gamblers in treatment list a game of skill as their major area of concern (Rush & Shaw-Moxam, in press). Several researchers have noted that problem gamblers often have an inflated sense of their own skill (Gadbourey & Ladouceur, 1989; Toneatto, Blitz-Miller, Calderwood, Dragonetti & Tsanos, 1997). Are problem gamblers who play games of skill simply unskilled players? An alternative view is that some of the "skilled" gamblers in treatment might actually be skilled but not be as skilled as other players.

Books on how to gamble successfully often portray games of skill as games in which the player has a chance of winning in the long run (e.g., Warren,

1996; Patterson, 1990). However, the mixed skills of gamblers playing these games affect the outcome for every player. Against novices the first author (Nigel), can play a successful game of poker, but against experienced players, he most often loses. The second author (Barry) fairs somewhat better against good players. The goal of this paper is to measure how skilled players affect the success of less skilled players, so that the dynamics of a game of skill can be understood.

## Method

The goal of this paper is difficult since it often takes thousands of games to accurately measure skill in gambling. Furthermore, tracking enough gamblers for a sufficient amount of time is time consuming and probably not possible (casinos don't like people researching on their property). Consequently, this paper relies upon simulations.

Two games are compared: roulette (see Wong & Spector, 1996) and Hold'em poker (see Warren, 1996). One hundred thousand simulations on both poker and roulette were conducted. Conducting these simulations at exactly the same skill level is not particularly realistic because players do improve (and sometimes get worse). However, applied to the current moment in time, these simulations allow us to get an accurate estimate of a player's level of skill and their expected financial return.

Roulette is a game in which a little ball is thrown around the edge of a spinning wheel. A player places a bet on one of the 37 (or 38) numbered slots that they think the ball will land on. There are many betting options available.

Hold'em poker is a popular casino poker game where as many as 10 players can play at the same time. Players play against each other while the dealer merely deals the cards and handles the money. Each player is given two cards face down; the remaining cards are community cards that are dealt face up in the middle of the table. Players make their hands by creating the best five-card combination of their own two cards and the community cards. There are four rounds of betting. For the poker simulation, Wilson's Software Turbo Texas Hold'em was used.

Turbo Texas Hold'em is an elaborate program that allows players to teach themselves the game. In addition to basic playing instructions, the game provides extensive statistics on how players play as well as how the other characters play. The opponents in this game are not random; they have

programmed profiles that react to the many specific poker situations that they might encounter. These profiles are designed to match the types of players one might meet around an average poker table—they have names that are amusing and relevant.

The game comes with 40 pre-designed profiles. Player profiles can vary from "tight" (folds most hands) to "loose" (stays in most hands) to "passive" (checks or calls, but rarely bets or raises) to "aggressive" (often bets or raises). Specific types of players such as "loose but aggressive," or "tight but passive" can be selected, and opponents can learn how to counter their styles. Players can also create their own characters. More to the point, players can set up a line-up of characters and then run a high-speed simulation to determine the long-term outcome of various strategic moves.

In the context of poker, an operational definition of skilled play means that players adjust their play to their position in the hands (i.e. Are they first or last to bet?); they gauge the odds of making a particular hand compared to the size of the pot (the "pot odds"); they try and figure out their opponents hands by "tells" and betting patterns, and usually tend to play tight and aggressive, but must occasionally vary their play by bluffing (loose) or checking (passive) in order to avoid giving away their strength (see Warren, 1996, for details).

Three simulation studies were conducted.

## Study 1

### Poker

First, a line-up was constructed using an average player, a player that was neither particularly good nor bad, nor tight or loose—but fairly aggressive. This profile is called Igor (by the company's software). To see the normal spread of scores when only average-skilled players were involved, Igor was copied 10 times into the line-up. That is, Igor played against nine other copies of Igor. The game played was 10-20 Hold'em, where a blind bet (a forced bet for the first two players) and the first and second rounds of betting are in \$10 increments, and the third and fourth rounds ("turn" and "river") are in \$20 increments.

The "rake" is the casinos way of making money. They take a percentage of each pot as profit or charge a per hour fee. The rake in casino card rooms varies from 3% to 5%. We selected 5%. The simulation data did not include

the rake, so we had to estimate the effect of the rake on each player's net balance, which was based on the average size of pots and the number of pots won.

In real life, the rake is taken off in fixed amounts (e.g., \$1, \$2, etc.) and is capped at a maximum (e.g., \$4). Thus, sometimes the rake is more than 5%, while other times it is less. In this simulation, the rake is an exact percentage from each hand. This inaccuracy somewhat overestimates the size of the rake, but does not otherwise affect any of the conclusions that we draw from the data.

## Roulette

Roulette was much easier to simulate than poker because there are few decisions to make. One of the difficulties was to determine how to create a roulette simulation that would produce the same range of scores as a poker game. To do this we first conducted 100,000 simulations of poker and obtained from the program the average investment per hand (\$14.80) and average winning pot size (\$86.40). It was then determined that the closest roulette bet to these numbers was a \$15 bet on a "six line" or "double street" that pays 6 for 1 (i.e. returns \$90).

The double street is a group of six numbers that are together on the betting table (e.g., 4, 5, 6, 7, 8, 9) but may be scattered around the wheel. The player wins if the ball lands on any of these six numbers. Poker bets, however, vary from zero to hundreds of dollars. To mimic this situation, the roulette bets were varied from \$0.50 to \$30, averaging at \$15. A rake of 5% on a poker game would produce a house edge in poker of about 2.7%.

To get the equivalent edge in roulette we used the parameters of the European wheel, (one zero), which is available in Europe, Quebec and a small number of casinos in Las Vegas and has a house edge of about 2.7%. These parameters were programmed into a quick basic program similar to Turner's (1998), and then the simulation was run.

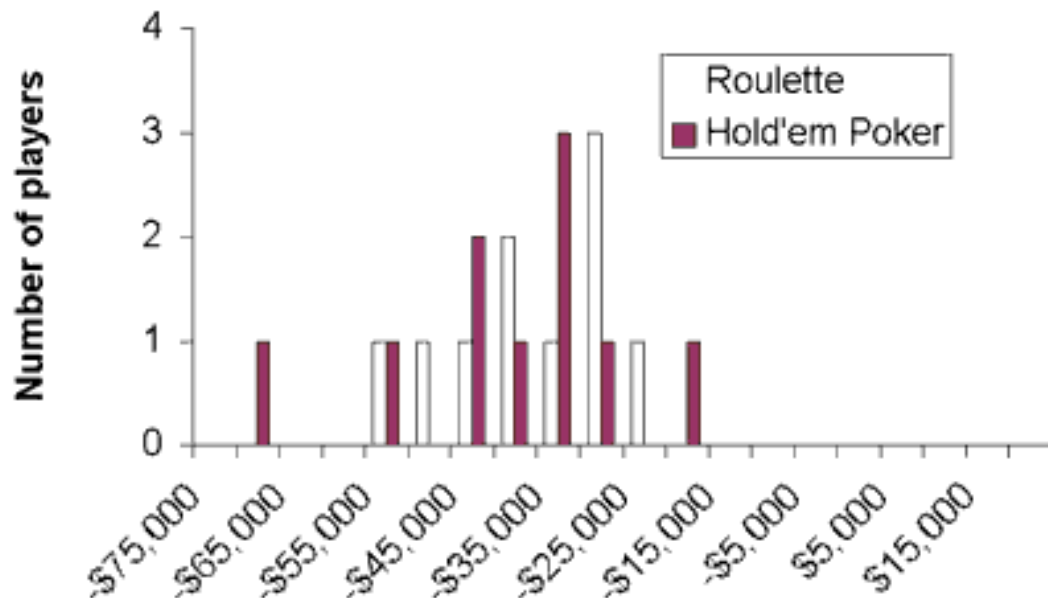
## Results

Figure 1 shows a comparison of the two games. The poker range is similar,  $t(18) = .45$ , ns, but includes both lower and higher scores due to the greater variability of the bets. Since all 10 poker players were matched in skill, all of



the variation in their outcomes is random. That is, when a group of players are up against players of equal ability, the net outcome is random, and in the long run, only the casino wins.

**Figure 1: Distribution of outcome after 100,000 spins/hands of roulette and poker.**



(click figure for larger image)

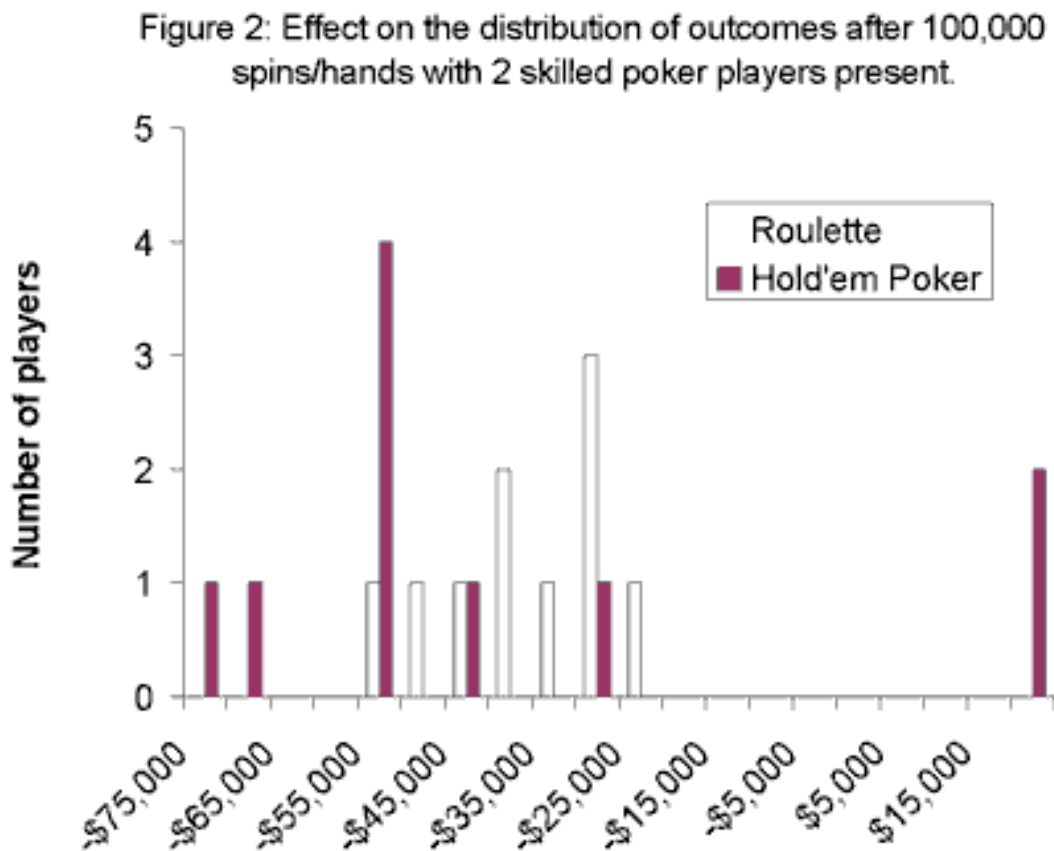
## Study 2

A second poker simulation was conducted where two more skilled poker players were introduced: (1) Tricky Dicky, a tight player who "slow" plays (i.e. checks acting as if he has a poor hand then raises, a strategy that is particularly effective against loose players), and (2) Advisor T., who plays "pump it or dump it" (i.e. if the hand isn't good enough to raise, he folds it, which is effective against tight players). Both of these players are tight, but they vary their strategy depending on circumstances. The roulette data is the same as the first simulation since skilled roulette play is not really possible.

For comparison, additional simulations for poker were conducted where the number of skilled players varied from 20% to 80%. Simulations were also run where even fewer skilled players were added to the mix.

## Results

Figure 2 shows a comparison of the two games. The poker range is now very different from the roulette range. The two skilled players have scored large wins, while the remaining eight average-skilled players ("Igor") have racked up large losses. Since the eight average players were matched in skill, all of the variation between them is random. However, the difference between the average-skilled players and the two skilled players is not random but due to the superior playing ability of the two skilled players. What this simulation shows is that when skilled players are introduced into the mix, the average player may be better off playing a game of chance (e.g., roulette) than a game of skill,  $t(16) = 3.3$ ,  $p < .01$ . As noted below, the actual outcome depends on a number of factors including the mix of players.



(click figure for larger image)

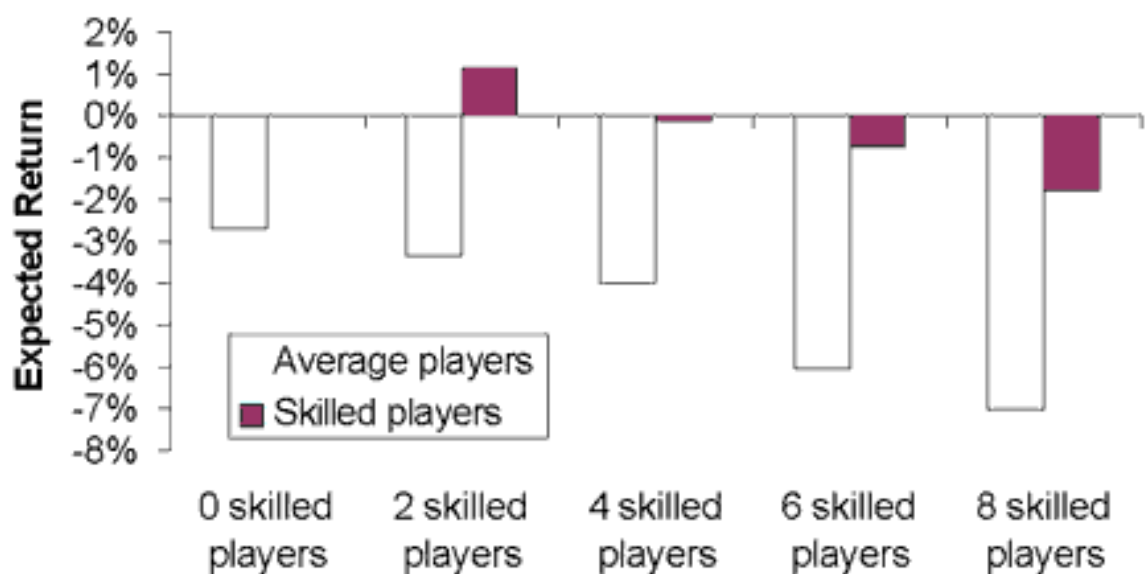
Interestingly, the skilled players did not come out ahead because they won more often. On the contrary, the skilled players won between 8,605 and 9,271 pots, while the eight average-skilled players won between 10,216

and 10,638 pots each. This illustrates an important rule in poker: skilled poker players are more selective, and therefore, enter fewer pots. They win less often, but are more likely to win the pots that they do enter. Average-skilled players tend to pursue more hands, and therefore, lose more when they do lose.

On average, these poker players played against an expected return (house edge) of -2.69%; however, when playing against skilled players the average return was -3.1% for the Igors, which is a relatively small house edge. The skilled players achieved an average return of +1.35%, approximately the same advantage card counters can achieve in blackjack.

Figure 3 shows the effect of adding additional skilled players to the game. When playing against eight skilled players, the expected return drops steadily for the average-skilled players to -7%. Interestingly, the expected return also drops for the skilled players, because they are playing against each other. In fact, according to this analysis, skilled poker players only have a positive expectation if the majority of their opponents are less skilled. If the final two Igors were replaced with skilled players, the outcome for the skilled players would be random —identical to the results of the first stimulation in which all players were of average ability.

**Figure 3: The expected return for skilled and unskilled players as the number of skilled players increases.**



(click figure for larger image)

As stated earlier, the profile/character used to represent an average player, Igor, was not a particularly bad player, just a little too loose and aggressive. Other profiles representing players that were much too loose, too tight, too aggressive or too passive were also tried. For example, when a very loose player and a very tight player were played against the Igors, the Igors had an average return of +1.6%. The very loose player, G.A. Joe, achieved an average return of -22.3%, and the very tight player, Crusty Jack, played at a return of -10.1%. Against average players, these two particularly weak players played with an expected return that was worse than most slot machines. Alternatively, if Igor played against both weaker players and more skilled players, he tended to break even, more or less (+0.05%).

The point is that the outcome of play depends on the mix of players present; against equally matched players, the game results are random and have a return that is about the same as European roulette and somewhat better than most slots machines. However, against more skilled players, the player disadvantage for weak players can be extremely great. It should be noted that even though many average-skilled players face a negative return, they often do not have a gambling problem. They often play poker just to enjoy the game.

### Study 3

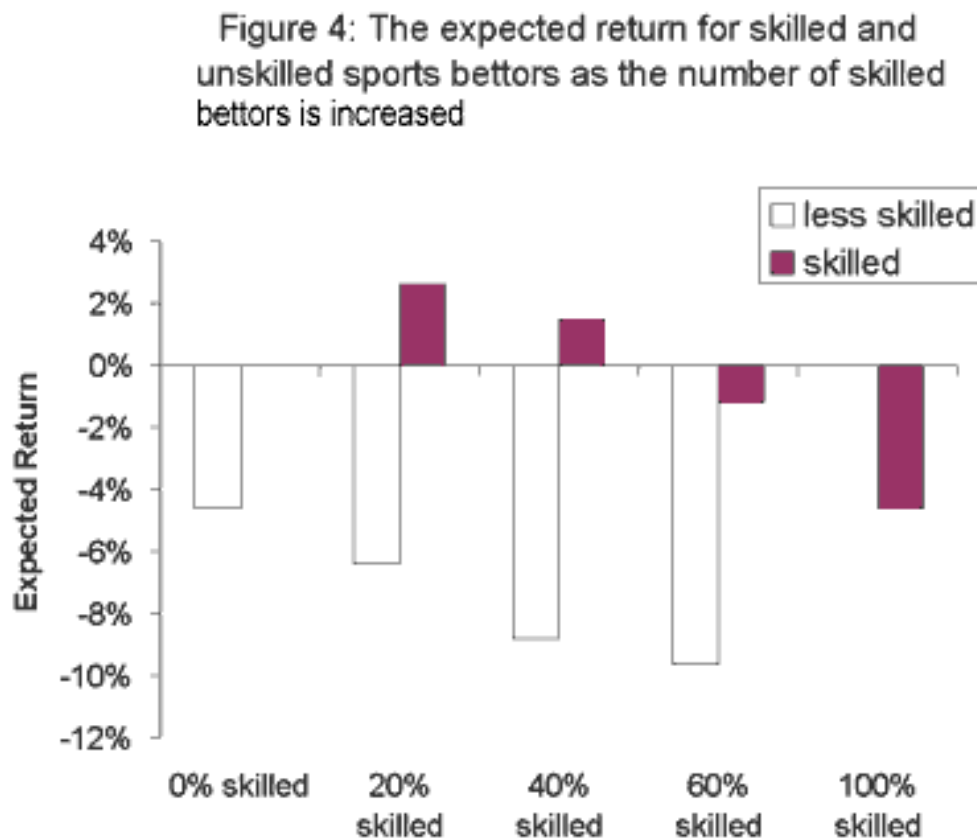
A final simulation was conducted to illustrate that these findings are not restricted to poker but also apply to sports betting and other skills-based games. In sports betting the house edge averages at around 4.55%, and this is accomplished by a 9.09% vigorish or commission charged on all wins (see [www.professionalgambler.com/vigorish.html](http://www.professionalgambler.com/vigorish.html) for more information). For example, if an \$11 bet is made, it pays \$21 for a win (a bet of \$11 plus a \$10 win). The extra \$1 is the commission.

The bookie sets a "line" for the teams that turn the sport game into a situation where the player has a 50% chance of winning. For example, if the line says that the Yankees will win by one and a half runs, then a player only wins the bet if the Yankees score two runs (more than another team). If the bookie places the line with 100% accuracy, the game is random; but since bookies are only human, there is usually some opportunity to win. In addition, a bookie sometimes has to shift the line to encourage bets on an underdog that isn't getting enough action. A skilled player has to out-think both the bookies and the other players and look for opportunities.

A relatively simply program was constructed to examine this situation. In this simulation, a situation was set up where all players had an equal chance of winning. The next simulation was conducted in which 20%, 40% or 60% of the players were 5% more likely to guess the winning team than the less skilled players; but the line was adjusted to maintain the 4.55% overall house edge. This program does not really take into account the skill of the bookie. But the skills of the bookie would simply add more random variation to the data and would not otherwise affect the results.

## Results

Figure 4 illustrates what happens to the expected return of the less skilled bettors as the number of skilled bettors is increased. The results are nearly identical to the results obtained in the poker simulation.



(click figure for larger image)

## Discussion

The results of this study illustrate two important aspects of playing a game of skill. Firstly, if all players are equally matched in skill, the outcome is random. Secondly, if highly skilled players are introduced into a game, the less skilled players are more likely to lose. These rules also apply to horse racing, sports betting and stock market investing. In each case, players can only make money if they have better information and strategies than other players do. If the information is shared and the strategies are the same, the outcome is random. Andrew Beyer (1983) describes how "speed handicapping" is no longer a sure-fire moneymaker. He states, "If [speed figures] have become somewhat less profitable than they used to be, it is only because so many bettors have discovered what a wonderful device they are (pg. 88)."

In sports and horse betting, players do not play directly against each other; a player's level of skill affects other players because pay-out odds in horse racing or the "line" in sports are adjusted based on the bets of other gamblers. A player's skill level is also affected by the skill of his or her bookie; a particularly good bookie will leave fewer opportunities for the astute player. Only those players who take the time to rationally evaluate all the information available, watch the races or games for subtle clues, look for games where the bookies and other bettors have underestimated horses' or teams' abilities can get an edge. "Trip handicapping" (Beyer, 1983) can help, but knowing that a second place horse from two weeks ago lost because it was "parked" in the fifth path around the last turn, and that its speed figures are underestimated, requires prodigious study and observation.

If all of the players are using the same information, no one can achieve any real long-term edge, and like roulette, in the long term, only the house (e.g., bookie, broker, casino) wins. However, some highly skilled players often have more information, and as a result, the average-skilled player in each of these games can be at a tremendous disadvantage.

Blackjack is perhaps the only game where skilled players do not immediately hurt the short-term success of less skilled players. However, the successes of card counters forced the casinos to change the rules and made it harder to win at blackjack (see Patterson, 1990; Thorpe, 1962).



In interviews with poker players, Horbay and Fritz (1998) found that poker players in treatment for gambling problems over-emphasized the luck element and under-emphasized the skill element. Successful skilled players (those that do not have a gambling problem), on the other hand, emphasized the skill factor—they see luck as having a minimal role.

Books by skilled gamblers (e.g., Warren, 1996) stress the importance of understanding the short-term influence of luck in contrast to the long-term influence of skill. This idea is key to both retaining emotional control during bad beats (e.g., losing what should have been a sure win) and keeping weaker players in the game. However, even players with problems do possess some skill. According to Browne (1989), many players have periods of problem ("tilt") and non-problematic play.

Are problem gamblers simply players who have a poor level of skill? Do they all suffer from false beliefs about their abilities? According to the data presented here, a person could be reasonably good, and yet, in the long term, still lose money. A problem gambling counsellor might conclude that a problem gambler has a distorted belief about his or her own skill, but the reality may be subtler. Moderately skilled gamblers may be caught in a rather odd net—they might know that they are above average players, and yet, may still lose money in spite of winning more often than not.

The counsellor may find that a slightly different approach is needed for such clients. Telling them, for example, that they cannot win because winning is random, would not sit well with clients who know they have the skills. Their self-appraisal may be, in fact, reasonably accurate. But they may not realize just how skilled they would have to be to beat the house edge and the edge of other players (especially in horse racing). However, if they focus instead on how the house rake and better players take their cuts, this may lead to an understanding. The point is that a counsellor should consider the game that a player frequents, and in the case of skilled games, help players understand how even skilled play does not guarantee winning in the long run.

There are a number of limitations to this study. In this simulation, skill was defined in terms of card playing skills (probabilities, pot odds and the ability to apply strategies). In real life, emotional upsets, fatigue and other psychological states also affect the outcome of a game of skill. The ability to read the non-verbal cues of other players while masking their own is also an important factor for skilled players. This simulation does not take into account these specific kinds of skills; however, for the purpose of the simulation, the specific type of skill doesn't really matter. What matters is



the difference in skill between one group of players and another. Another limitation is that this simulation treats the two groups —skilled and less skilled —as if they were distinct. In reality, skills vary continuously between individuals. It is unlikely that a table exists where all players are matched in terms of skill.

In addition, the behaviour of the individuals in this simulation are fixed, whereas the behaviour of real players vary considerably. Real players with mediocre skills may become more skilled, drop out of play, play well on one occasion, or get too emotionally involved in a game on another occasion and play badly.

The goal of this simulation is not to show how an unskilled player would fair over the course of his or her life. Instead, the goal is to make a realistic estimate of their expected return (probable long-term outcomes over three years), given their current level of skill, and the mix of skilled and less skilled players at the table. The actual results would only apply to individuals who continued to play against skilled players without improving their own skills. These results, however, are consistent with observations of a player in treatment for poker related gambling problems (Horbay & Fritz, 1998), who lost \$40,000 over a three-year period.

Part of the allure of poker and other games of skill is that players feel they can win in the long term. The results of this study show that this belief is often illusory, especially if the other players are more skilled. In a game of skill, the less skilled players can be at a greater disadvantage since they are playing against both the house edge (the rake) and the skilled players' edge. It should be noted that many social players who play for fun rather than money are unlikely to develop gambling problems, even if the odds are stacked against them.

However, consider the plight of the average horse race bettor. The house edge at the track is at least 17% (see Beyer, 1983) and actually higher for some of the more exotic bets (e.g., exactas). Apparently, there are horse bettors who win and have a positive expected return (see Beyer, 1983). This means that the remaining horse bettors are not only up against a 17% house take but also contribute to the 1% or 2% positive return that the expert horse bettors take home. If 10% of the horse bettors are bringing home a positive return of 1%, then the average loss of the remaining players has to drop to around -19% to accommodate this 1% profit. Up against 17%, it would take a fair amount of skill to achieve a return of -10%. This explains why even very skilled horse bettors may end up losing money. Today, perhaps only 1% or 2% of horse bettors make money.

Consequently, when a player from a game of skill reports losing consistently, it does not necessarily indicate a lack of ability, but rather that the player has played against the house edge and the edge of more highly skilled players.

This study also has implications for prevention. The types of simulations used in this paper may have a practical application. Showing gamblers how dismal their long-term prospects are may facilitate a re-evaluation of gambling as an activity. Simulations could be used to teach various games as a form of harm reduction. Finally, simulations could also be used to correct such erroneous expectations as the belief that one is due to win.

In summary, this paper shows that an unskilled player is sometimes financially better off in a game of chance than in a game of skill. However, it should be noted that many people play poker not because they expect to make a fortune but because they enjoy playing the game. As long as there are no serious financial consequences, they will continue to play even though they may lose less money at games of chance.

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*The Opinion section has many purposes including being a forum for authors to offer provocative hypotheses, as in this article, that are not supported by science.*

*—The Editor*

## Why Don't Adolescent Problem Gamblers Seek Treatment?



*By Mark Griffiths, PhD  
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**Acknowledgement:**

I would like to thank Robert Ladouceur for posing the original question contained in this article and for his continued debates with me on this problem.

## Abstract

Surveys have consistently shown that the prevalence rates for problematic gambling are higher in adolescents than for adults. Given this finding, why is it that so few adolescents, compared to adults, enrol in treatment programs? This paper outlines ten speculative reasons why this situation exists.

The possible reasons why adolescent problem gamblers don't seek treatment include the following:

1. More adolescents deny they have a gambling problem compared to adults, and therefore, fewer of them seek treatment.
2. Adolescents may acknowledge they have a gambling problem but do not want to seek treatment.
3. There are few or no treatment programs available for adolescents.
4. Available treatment programs are not appropriate and/or suitable for adolescents.
5. Adolescent problem gamblers may undergo spontaneous remission and/or mature out of gambling problems, and therefore, may not seek treatment.
6. Adolescent problem gamblers are constantly "bailed out" of trouble by their parents, and therefore, do not get treatment.
7. The negative consequences of adolescent problem gambling are not necessarily unique to gambling and may be attributed either consciously or unconsciously to other behaviours.
8. Adolescent gamblers may lie or distort the truth when they fill out survey questionnaires.
9. Screening instruments for assessing problematic gambling may not be valid for adolescents.
10. Researchers may consciously or unconsciously exaggerate the



adolescent gambling problem to serve their own careers.

All over the world, prevalence surveys of adolescent gambling have shown that a small but significant number of adolescents display signs of problematic gambling. Further to this, surveys consistently show that the prevalence rates for problematic gambling are higher in adolescents than in adults. Given this consistent finding, it raises the interesting paradox of why so few adolescents enrol for treatment programs compared with adults. This short paper speculates and gives 10 reasons why this situation might exist. Each reason is examined briefly in turn before conclusions are reached.

### **(1) More adolescents deny they have a gambling problem compared to adults, and therefore, fewer of them seek treatment**

This proposition seems plausible, but there is no direct empirical evidence to support such a claim. It is well known that many adult gamblers continually deny they have any kind of gambling problem, an observation that has also been noted in adolescents (Griffiths, 1995). However, there is no evidence to indicate or even suggest that adolescents experience denial at a higher rate than adults do.

### **(2) Adolescents may acknowledge they have a gambling problem but do not want to seek treatment**

Again, this is plausible, but there is little empirical evidence to support the claim. However, it has been noted that families of adolescent problem gamblers are often protective—if not overprotective—and try to keep the problem within the family (Griffiths, 1995). Therefore, it may be speculated that seeking formal help may be a last resort option for most adolescent gamblers.

### **(3) There are few or no treatment programs available for adolescents**

It is true that specialized treatment programs for problem gamblers have only really started to emerge in noticeable numbers over the last 10 years, and that they have been confined to a few countries (e.g., USA, Australia, Canada, Spain, The Netherlands). Services specifically for adolescent problem

gamblers appear to be few and far between. It could be argued that this is a "Catch 22" situation: If only a few adolescents turn up for treatment, treatment programs won't be able to provide specialized service, and adolescent problem gamblers cannot turn up for treatment if it does not exist!

#### **(4) Available treatment programs are not appropriate and/or suitable for adolescents**

To some extent, this explanation is interlinked with number 3, but is, in fact, different. This explanation points out that there are gambling treatment programs available, but most of the programs are group-oriented (e.g., Gamblers Anonymous, hospital treatment programs, etc.). Adolescents may not want to be integrated into what they perceive to be an adult environment. For instance, there is some evidence from the U.K. that shows that adolescents who turn to Gamblers Anonymous feel they don't fit in and may be alienated by the dominating presence of older males (Griffiths, 1995). Also in the U.K., the majority of adolescent gambling problems concern slot machine playing; however, adult problem gambling is more likely to consist of horseracing and/or casino gambling. Adult problem gamblers, therefore, find it hard to accept gambling problems outside of their own experience and cannot understand why adolescents find slot machines to be problematic (Griffiths, 1995).

#### **(5) Adolescent problem gamblers may undergo spontaneous remission and/or mature out of gambling problems, and therefore, may not seek treatment**

There are many accounts in the literature of spontaneous remission of problematic behaviour (e.g., alcohol abuse, heroin abuse, cigarette smoking), and problematic gambling is no exception. Because levels of problem gambling are much higher in adolescents than in adults, and fewer adolescents receive treatment for their gambling problem, it is reasonable to assume that spontaneous remission occurs in most adolescents at some point, or that there is some kind of "maturing out" process. There is a lot of case-study evidence (Griffiths, 1995) highlighting the fact that spontaneous remission occurs in problem adolescent gamblers, and that gambling often ceases because of some kind of new major responsibility (job, marriage, birth of a child, etc.).

## **(6) Adolescent problem gamblers are constantly "bailed out" of trouble by their parents, and therefore, do not get treatment**

Unlike adult problem gamblers who quite often take responsibility for themselves and their families, adolescents have no "real" responsibilities and are usually housed, fed, clothed and generally looked after. If adolescents get into trouble because of their gambling, their families will mostly likely act as a safety net and bail them out. It could be speculated that very few adolescents reach treatment programs because they are constantly "bailed out" by their parents or guardians. In addition, adolescents are typically at a rebellious phase in their lives, and to some extent, society tolerates these undesirable behaviours because in most cases the behaviour subsides over time. The same kinds of behaviours in adults aren't usually tolerated, and so they are treated differently by both family and society in general.

## **(7) The negative consequences of adolescent problem gambling are not necessarily unique to gambling and may be attributed either consciously or unconsciously to other behaviours**

Some adolescents may attribute their undesirable and/or criminal behaviours (e.g., stealing) to other behaviours, such as alcohol abuse or illicit drugs. For instance, in the U.K., some writings (Yeoman & Griffiths, 1996; Griffiths & Sparrow, 1996) have noted that criminal behaviour attributed to a drug problem is probably more likely to result in a lighter sentence than if problematic gambling were the cause. It appears that problematic gambling as a mitigating circumstance is of less importance to judges and juries than, say, drug abuse.

## **(8) Adolescent gamblers may lie or distort the truth when they fill out survey questionnaires**

This is a reasonable enough assumption to make and can be made against anyone who participates in self-report research — not just adolescents. All researchers who utilize self-report methods put as much faith as they can into their data but are

only too aware that other factors may come into play (e.g., social desirability, motivational distortion, etc.) that can either underscore or overplay the situation. In these particular circumstances, it may be that adolescents are more likely to lie than adults, therefore increasing the prevalence rate of problematic gambling. However, it seems unlikely that the large difference in prevalence rates would be due to this factor alone.

## **(9) Screening instruments for assessing problematic gambling may not be valid for adolescents**

Although there are many debates about the effectiveness of screening instruments (e.g., SOGS, DSM-III-R, DSM-IV, GA Twenty Questions) for assessing problematic gambling, it could be the case that many of these question-based screening instruments are not applicable, appropriate and/or valid for assessing adolescent problem gambling. Although there is now a validated junior version of the DSM-IV (DSM-IV-J) (Fisher, 1993), most research assessing problematic gambling in adolescents has used adult screening instruments. It may be that there is little difference between adult and adolescent screening instruments. If there is a difference, the results are most likely to be under-reported as items asking about illegal behaviours, such as fraud or embezzlement, are highly unlikely to be reported by adolescents.

## **(10) Researchers consciously or unconsciously exaggerate the adolescent gambling problem to serve their own careers**

This explanation is somewhat controversial but cannot be ruled out without at least examining the possibility. If this explanation is examined on a logical and practical level, it can be argued that those of us who have careers in the field of problem gambling could potentially have a lot to lose if there were no problems. Therefore, it could be argued that it is in the researcher's interest for problems to be exaggerated. However, there is no empirical evidence that this is the case, and all researchers are aware that their findings will be rigorously scrutinized. It's not in their best long-term interest to make unsubstantiated claims.

## **Concluding Comments**

Although the list may not be exhaustive, it does give the main speculative reasons why adolescent problem gamblers may be under-reported in turning up for treatment. It is likely that no single reason provides more of an explanation than another does. However, there does not seem to be any empirical evidence for at least three of the assertions made (i.e. adolescents denying having a gambling problem, adolescents not wanting to seek treatment, and researchers exaggerating the adolescent gambling problem to serve their own careers). However, just because there is no empirical evidence does not mean that it is not possible.

Of the reasons remaining, some include those that are not unique to adolescents (e.g., invalid screening instruments for measuring problem gambling, lying or distorting by participants on self-report measures, denying having a gambling problem, and not wanting to seek treatment). These may therefore be more unlikely reasons why adolescents do not turn up for treatment compared to the reasons that seem to particularly refer to adolescents only (i.e. spontaneous remission and/or maturing out of adolescent gambling problems, adolescents being constantly "bailed out" by parents, lack of adolescent treatment programs, and inappropriateness of treatment programmes).

What is quite clear is that there is no single assertion in this article that provides a definitive answer to the adolescent gambling treatment paradox. It is most likely the case that many of the plausible explanations interlink to produce the obvious disparities between prevalence rates and enrolling in treatment programs.

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### Brief Research Report

## Internet Gambling: Preliminary Results of the First U.K. Prevalence Study



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## Abstract

Technology has always played a role in the development of gambling practices, and new technologies such as Internet gambling may provide many people with their first exposure to the world of gambling. Further to this, Internet gambling could be argued to be more psychologically enticing than previous non-technological incarnations of gambling because of anonymity, accessibility and interactivity. This paper reports on the results of the first U.K. study of Internet gambling; 2098 people were interviewed for their behaviour and attitudes. Results indicated that only 1% of Internet users (n=495) had ever gambled on the Internet and that there was no evidence of problematic gambling behaviour associated with the Internet.

## Introduction

What seems clear is that the field of gambling is not immune to the technological revolution taking place in other fields. Griffiths (1996a, 1999) has argued that these new technologies (e.g., Internet gambling, telephone wagering, interactive television, etc.) may provide many people with their first exposure to the world of gambling and be more psychologically enticing than previous non-technological incarnations. Further to this, it has been alleged that social pathologies are beginning to surface in cyberspace, i.e. "technological addictions" (e.g., Griffiths, 1995a, 1996b, 1996c). Technological addictions can be viewed as a subset of behavioural addictions (see Marks, 1990) and feature all the core components of addiction (e.g., salience, mood modification, tolerance, withdrawal, conflict and relapse, see Griffiths, 1995a, 1995b, 1996b, 1998). Given these assertions, Internet gambling is an issue of potential social and psychological concern.

# Internet gambling

No-one is really sure how the Internet will develop over the next five to 10 years, but Internet gambling as a commercial activity has the potential for large financial rewards for its operators. The success of Internet gambling depends on many factors including diversity, accessibility and advertising. Internet gambling is provided by a network of networks that span geographical borders and are not discrete. Internet gambling is therefore global, accessible and available 24 hours a day.

The growth of the Internet raises interesting questions. Perhaps one way to think of this growth is to see the Internet as providing a medium for other addictions (e.g., gambling, computer game playing, etc.). It has been argued (Griffiths, 1996a, 1998) that the Internet could easily be a medium for obsessive and/or compulsive behaviours such as gambling. Some observers (e.g., O'Neill, 1998) have argued that Internet gambling provides "a natural fit for compulsive gamblers." Griffiths (1999) also raises the following issues:

- *Underage gambling.* How can you be sure that adolescents are not accessing Internet gambling by using a parent's credit card?
- *Problem gambling.* How can you stop problem gamblers from gambling?
- *Gambling while intoxicated.* How can you be sure that a person under the influence of alcohol or other drugs does not have access to Internet gambling?
- *Internet gambling in the workplace.* How can you be sure that a person is not wasting time at work gambling on the Internet?
- *Electronic cash.* How can a person with a credit card be prevented from spending more than they intended? It is very likely that the psychological value of electronic cash will be less than "real" cash (and similar to the use of chips or tokens in other gambling situations). This may lead to some kind of "suspension of judgment."
- *Hours of operation.* How can you prevent a person from playing all day? The Internet never closes, so it is theoretically possible to gamble all day, every day.

Internet gambling is a new phenomenon and to date no research on prevalence has been published. This study, therefore, provides the results of the first U.K. survey of Internet gambling, examining both behaviour and attitudes.

## Method

A total of 2098 people (918 male and 1180 female) were interviewed across 167 different sampling points by MORI, a market research company. (MORI was founded in 1969 and is the largest independent research service agency in the United Kingdom.) People were interviewed face-to-face in their homes, and the interviewers used computer-assisted techniques. The data were weighted in order to represent the entire U.K. population. Of the 2098 participants, 495 (24%) were Internet users.

## Results

### Attitudes toward gambling:

Participants were asked a number of questions about their attitudes toward gambling in general. Gambling was defined as "risking money for a future reward on a particular activity," such as horse race betting, slot machine gambling, etc. Fifty-one per cent thought gambling was generally addictive, 20% described it as an unhealthy activity, 22% said it was a dangerous activity and 56% thought it was a waste of money.

### Attitudes toward Internet gambling

Participants were also asked a number of questions about their attitudes toward Internet gambling compared to non-Internet gambling. Eight per cent thought Internet gambling was more addictive, 5% said it was more unhealthy, 9% claimed it was more dangerous, 13% said it was less regulated and 21% claimed it was more likely to attract children.

## **Gambling on the Internet:**

Participants who were also Internet users (n=495) were asked about their actual Internet gambling behaviour. The results showed that no-one gambled regularly (i.e. once a week or more) on the Internet and that only 1% were occasional Internet gamblers (i.e. less than once a week). Results also showed that a further 4% had never gambled but would like to do so, whereas the remaining 95% had never gambled on the Internet and said they were unlikely to do so.

## **Teenage Internet gambling:**

Participants who were between 15 and 19 years old (n=119) were also asked if they had ever gambled on the Internet, and if they had, whether they had used a parent's credit card. No-one in the sample had done either, although 4% said they would like to gamble on the 'Net.

## **Female Internet gambling:**

Female participants (n=1180) were also asked about their attitudes toward gambling online as compared to gambling in a betting shop. Of those surveyed, 73% said they would never gamble on the Internet. However, 2% reported that they would rather gamble on the Internet because it's safer, 9% said it's less intimidating, 9% claimed it's more anonymous, 2% said it's more fun and 13% claimed it was more tempting.

## **Conclusions**

The results of this first U.K. survey of Internet gambling behaviour and attitudes are interesting but not that surprising given the relatively low use of the Internet in the U.K. (Traditionally, in the U.K. most people have to pay by the minute for Internet access, which most likely inhibits use.) Interestingly, general attitudes toward gambling were quite negative (i.e.

people thought it was addictive, unhealthy, etc.), whereas attitudes toward Internet gambling appeared quite positive. However, this may be due to inexperience and/or ignorance of the issues involved. For instance, only 13% of the sample thought Internet gambling was less regulated than other forms of gambling. This is clearly not the case as there is little legislation in the U.K. concerning Internet gambling.

Although there has been speculation that Internet gambling is addictive, there is no evidence from this study. Although a problem gambling screen was not administered, the fact that no-one in the study was a regular gambler suggests that there were few problems (if any) among this particular population. However, as the number of online users in the U.K. increases, the potential for problem gambling will increase. This study should therefore be viewed in the context that it was carried out at a time when Internet use was limited in the U.K. The U.K. has a higher prevalence of Internet use than France or Germany, but its rate is much lower than the U.S. and many Scandinavian countries (Snoddy, 2001).

This survey also highlights a small minority of women who think that Internet gambling may be a more positive experience than visiting the male-dominated environment of the bookmaker. These women claimed the Internet was not intimidating, but was safer and more fun. Internet gambling may therefore (in the future) provide a safe forum for women wanting to gamble—at least from a perceived point of view.

Since many teenagers now have access to the Internet either at home or at school, there has been a pressing concern that children and adolescents will take up gambling on the Internet. This perception was partly shared by participants; one in five of those surveyed felt that Internet gambling would be more attractive to teenagers. Having said that, no teenagers in this study gambled on the Internet. However, one in 20 teenagers interviewed found the prospect of using their parent's credit card to gamble tempting.

Internet gambling is at the cutting edge of future entertainment and is an issue that must be grasped by many people (legislators, social policy analysts, psychologists, sociologists, etc.), as the number of sites and users will rise dramatically over the next decade. Gambling online, which is currently a minor activity, may be tempting because of the anonymity and accessibility of the Internet. It therefore has the potential to become a social problem in the near future, unless guidelines and legislation are introduced. It has also been speculated (Griffiths, 1993, 1995c) that structural characteristics of future software programs might promote addictive tendencies. Structural characteristics (i.e. features which manufacturers

design into their products) promote interactivity and to some extent define alternative realities to the user, allowing them feelings of anonymity. These features may be very psychologically rewarding to individuals with these tendencies. There is little doubt that Internet use among the general population will increase over the next few years, and if social pathologies exist, then there is a need for further research.

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## Programme Description

GamCare provides a "stepped-care" approach for the support and counselling of problem gamblers and their families in the United Kingdom. The first stage of this programme is the GamCare Helpline.

The GamCare Helpline provides confidential counselling services and offers advice and information for anyone in the U.K. affected by a gambling dependency. The Helpline is caller-centred and combines telephone counselling, crisis intervention, information delivery and referrals. The Helpline is specifically targeted to reach three main groups: problem gamblers; partners, parents or family members of problem gamblers; and professionals

working in the field of gambling dependency or with gambling related issues.

The GamCare Counselling Service is the second stage of the "stepped-care" programme. It provides individual and couple counselling and abides by the British Association for Counselling Code of Ethics and Practice. All counsellors receive regular supervision of their client work.

## Philosophy of Service

There are still limited resources for the treatment and support of problem gamblers and their families in the United Kingdom. By offering telephone counselling along with advice and information, the Helpline helps the caller engage in the counselling process, possibly for the first time. The caller makes a significant start by addressing a gambling problem on the Helpline and developing insights for future counselling work.

If the caller wants to have individual or couple face-to-face counselling, the caller can phone the GamCare Counselling Service and arrange for an assessment session(s). In 2000, 77 per cent of all counselling referrals came through initial contact with the Helpline.

The main aims of counselling are to:

- help reduce the frequency of problem gambling
- develop ways of coping with problem gambling behaviour
- understand some of the underlying reasons why gambling has become a problem, and
- address associated issues and behaviours.

The counselling is integrative and uses a range of therapeutic interventions relevant to the needs of each person. The most effective approach is found to be a combination of cognitive behavioural therapy, which helps reduce or stop problem gambling, and developing coping skills and psychodynamic therapy, which helps clients gain insight into the reasons for their behaviour.

## Profiles of our Services

## Staff

The Helpline is staffed by GamCare trained and supervised Helpline counsellors. They are employed largely on a volunteer basis. Some have counselling or counselling skills training, others have personal problem gambling experience and some have both. The counselling service staff are qualified counsellors or psychotherapists and have extensive client experience. They are paid on a sessional basis.

## Description of our clients

Typically, both callers to the Helpline and clients attending face-to-face counselling have long-standing gambling problems. These problems have often resulted in substantial financial loss, the breakdown or near breakdown of relationships, and impaired physical and psychological health. In 2000, only a small percentage of callers and clients were female problem gamblers. Clients under 35 tended to access the Helpline while the counselling service attracted a slightly older group. Twenty-seven per cent of clients who met with counsellors face-to-face were from ethnic minority communities.

Slot machines and on and off course betting were the most common modes of problem gambling, representing 92 per cent of calls to the Helpline and 89 per cent of counselling work. Other problem areas were casino table games, scratch cards, private card games and spread sports, and financial betting.

## Programme Evaluations and Research Involvement

At assessment, clients have a semi-structured interview covering the DSM-IV criteria for pathological gambling and the South Oaks Gambling Screen. They are also evaluated across different areas of client functioning. At closure, and again at follow-up, the extent of the client's resolution or improvement across all domains is measured.

At present, there is no research involvement.

## Outcomes

During 2000, 77 per cent of clients at closure had either stopped or reduced their problem gambling behaviour. There were also considerable improvements across areas of client functioning. During follow-up, many clients who had regressed in their gambling reported prior deterioration in their problem area(s) of day-to-day functioning as well.

*Adrian Scarfe  
Counselling Manager, GamCare*

*This Service Profile was not peer-reviewed.*

*Submitted: April 10, 2001*

*The Electronic Journal of Gambling Issues: eGambling invites clinicians from around the world to tell our readers about their problem gambling treatment programs. To make a submission, please contact the editor at [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net).*

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### First Person Account

*[This article prints out to about 5 pages.]*

## October 24 Was the Day I Took the Drastic Step

*The author's name has been withheld on request, and all names have been changed.*

*—The Editor*

Friday, April 7, 2000 was my first meeting with Gen, my gambling counsellor. I could have saved a lot of grief had I seen her sooner, or ended up in a worse predicament, had I waited any longer.

A lot of things were both good and bad for my husband Paul and I that year, and so it was the same with my new pastime: gambling. Prior to the beginning of this year, I was not sure that gambling was, in my case, bad. There were, of course, many factors and excuses leading to my problems. My life had changed—and so did my survival skills. I had retired and remarried, determined to love all of the above.

It is true I chose my new husband, but without realizing it, I married the whole Macho Group in a more real way than I was aware of at the time. Suddenly, I was no longer captain of my own ship. My new family consisted of his seven children, their mates, and my son and his lady. Grandchildren and dogs are

never an issue with me, but there are five and two, respectively. Not relations, but influential on the impact of my new life were Wilhelm, Ursula and Bohdan, the list goes on. My, no, *our* little home had so many huge egos in it that I, the Lion and King of the Castle, became a mouse. This was slow to register with me, but stress signals surfaced; stomach pains, an ulcer, insomnia, loss of joy.

Relief originally came from Paul, although I can't give him all the credit (or blame). He took me to a casino, a totally new experience for me. It did not impress me too much at first, but I learned the rudiments of what happens there. It was "take it or leave it" for some time, but it became a godsend when I needed a diversion to get away from an overbearing situation at home and to regain my car driving skills and my confidence.

The drive from west Toronto via the QEW highway to Casino Niagara became a time to listen to the radio and tapes; the short bus rides from parking lot to casino, a time to talk or listen in on conversations. I would time my trips to counteract what I considered Paul's unfair treatment of me. I now had a way out: the slots.

Paul went up north for the weekend, with Bohdan, his son for the day, then topped it off with golfing. (I would liked to have been included.) No matter, I could gamble by myself; it was safe, inconspicuous, comfortable and time passed.

Paul was often too busy to take me out. He worked on the computer, or watched endless sports on TV. I would have liked more couple stuff. (I used to keep trim and slim by dancing and I miss it so.)

Visits with kids are outings for Paul, but I am new to drinking wine and conversations that often bypassed me and reverted to a language I did not understand. I could go to the casino anytime so I would select times with less traffic, a time of day when my car wouldn't overheat, and I could watch the sunset over the Burlington Skyway. The casino is open 24 hours a day.

It is important to say here that this was quite acceptable to Paul, he was off the hook so to speak. The person hooked was me. At first I went to the casino because it was something to do, then I got to like it, and finally, I had to go. It did not happen over night, or did it? For my birthday, Paul gave me a card with some money to spend at the casino. I went for the evening and stayed past midnight, until morning. This party for one became expensive as did many others.

Paul went through his own traumatic time, his wife was out of control in more ways than could be tolerated. He had many moods. He was often just quiet when he saw how miserable I looked and felt, and would say there was nothing he could say or do. He was relieved when I got home safely. Other times he would do other stuff, be out when I got home or not answer the car phone. We did not discuss our relationship. Paul is not one to verbalize; his anger comes to the surface whenever I suggest a talk.

He did notice however that I did not realize how serious this problem had become—and I didn't. I believed I could control it; I was a strong, principled person. I tried, but I could not go home once I was in the casino. I never felt tired; money did not seem real, just tokens. It was only when I had to take some money from my RRSPs that I realized I needed help.

Typical of the way we were at that time, Paul said he would get me info on gambling on his computer, but he put off doing it. In the meantime I emptied my bank account. I asked Paul to lend me some money. I should not have asked, and he should not have said no. This was probably the first time in my life I had asked for help; usually, if I couldn't get what I needed from my own earnings, I just did without. I felt many things; I was worried, lonely, but mostly, I was unhappy.

Divorce had come up when Paul was angry, even before my gambling. I told him we could go through with it, but my way was not giving up on something as serious as marriage vows. I was still firm in that belief. My resilience was law and this time I told him that his strong personality was too much for me. Divorce may have to happen if all else failed. I did not want anything of his, and he could not have anything of mine. It would have to be final and happen very quickly, not be just a word to use in disagreements. This was a day of emotional upheaval for both of us.

Help came with a phone call to the Problem Gambling Service. I spoke to Gen who explained how I could go and speak to her in confidence as often and as long as it took me to get better. Paul came with me and waited until she met us both in the waiting room. Gen then took me to her office for the first of many hour-long consultations. Gen proved to be just the person for me. We worked together each week making plans about how to get me to slow down and control the obsession—but to no avail. I did not stop gambling until October 2000 when I went to Mohawk Race Track security and registered for self-exclusion. I am certain that I would still visit the slots if I hadn't taken this drastic step.

Paul and I moved to the country, and we developed a new understanding of each other. Divorce came up once, but we both know that our life together is

good, and with mutual respect for each other we can only get happier. I no longer look to Paul to do things with me that he does not enjoy. I have regained my life. I don't allow others to impose on my territory. My personal likes, wishes and feelings are just that —personal —and I share them with discrimination. I have cultivated bonds and respect with most of the family and our friends. I had to distance myself from a couple of people and that too feels good too, because it was necessary.

I am impressed with the achievements of my therapist who helped turn my life around —just as I am incredulous that so much harm penetrated my mature and strong personality. I fantasize about visiting the casino, just as I fantasize about losing weight or winning a lottery, but I hope these things stay as possibilities and that life goes on.

Gen suggested that I have a list of things I can do when I get the old urge to flee, and now I fantasize about these things as well. Come spring (it is now mid-February), I will look for work with animals (my first love). Paul and I will drive to the ocean (my second love). If we don't go together, then I will find a way to do it myself. Other things that I like to do include going to my room, which is totally mine (no one else goes there but me) to read, write and listen to music; going for a walk or car ride. If I'm feeling really frustrated, I can check into a friendly hotel to repair whatever ails me. Closer to home, I now have my space and lots of countryside to gaze at.

*This First Person Account was not peer-reviewed.*

*Submitted: February 20, 2001*

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### Book Review

## Double Down: Reflections on Gambling and Loss

*By Frederick and Steven Barthelme (1999).  
New York, NY: Houghton Mifflin, 198 pages. Cloth cover.  
Price: US\$24.00. ISBN: 039-595-429-0.*

*Reviewed by Nigel E. Turner, Centre for Addiction and Mental Health, Toronto, Ontario, Canada  
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*Barry Fritz, Quinnipiac University, Hamden, Connecticut, USA*

**Double Down** by Frederick and Steven Barthelme is an autobiographical account of two brothers' descent into gambling addiction. The twist is that it is not the gambling losses, but a bizarre legal hassle that form the conflict and (partial) resolution of the plot.

In the book, the Barthelme brothers describe how they started gambling casually, often going to the casino with friends for a good night out. After their mother's death, their gambling escalated and it increased to problematic levels following their father's death.

Double Down introduces gambling counsellors and researchers to the world of gamblers in action; gamblers that don't really want to quit. The book nicely illustrates to the reader that social class, education and intelligence do not necessarily immunize people against becoming problem gamblers. These brothers are not stereotypes of degenerate gamblers but rather more akin to the professor-gambler portrayed by James Caan in the film *The Gambler*.

The brothers do not gamble because they hate themselves or as a way to punish themselves. Difficulty coping with the deaths of their parents may play a role in their problem, but their main motivation appears to be the thrill of the experience rather than escape. The brothers want to win but can tolerate losing. In fact, they claim that losing is nearly as good as winning. About halfway through the book, they challenge the reader to experience a big loss in order to understand it. But perhaps the brothers' losses were little different from their wins because the losses have no real consequences for them. Through their jobs as English professors and their inheritances, the brothers have no shortage of money to gamble with. Even by the end of the story, after losing in excess of \$250,000, they still appear to have enough money left to pay for a good lawyer.

The book also shows how gambling as a social activity does not necessarily protect people from developing gambling problems. Not only do the brothers encourage one another to go to the casino, but they also prevent each other from leaving. There are instances in the book where one of them is ready to leave the casino, but the other wants to stay to win back his losses, so the first one stays, and thus, continues to gamble. Sometimes, the brothers played all night since they were never ready to leave at the same time.

Another insight is the apparent awareness of the addiction and the nearly complete lack of motivation to do anything about it. The brothers appear to be "happily" addicted to gambling.

The weakest parts of the story are the stories of their childhood and their relationships with their parents. The family history is pretty ordinary —lacking any history of abuse, poverty, drug use, gambling problems or trauma that would make their family a plausible source of the problem. Perhaps their emotionally complex family history is a factor, but nothing leads the reader to say "There's the problem; there's the cause." This suggests that they were not



trying to escape from anything in particular, but instead, acting like spoiled middle-class kids that just want to have fun.

The one strong family connection is the deaths of three family members in rapid succession: their eldest brother, Don, followed by their mother, and then, their father. These deaths contributed to an acceleration of their gambling problems, but their problems appear to have started before the deaths. The main effect of the deaths and the substantial inheritance they received was to lessen the threat of any real financial consequences of gambling.

While too much space is taken up regarding their rather ordinary relationship with their parents, hardly any space is given to discussing the role of their wives and girlfriends. For instance, exactly how did Stephen's wife feel while he was throwing away his inheritance? The only hint we get from the book is a brief mention of a credit card ritual. Before heading off to a casino, Stephen would take out his credit cards and leave them on the table, which was an empty gesture since the brothers would obtain casino credit.

Also unexplained is the death of their brother Don and its effect on them. When did it occur relative to the beginning of their gambling problems? The authors hardly mention Don's death, except to say that it caused them both to quit smoking.

The main conflict that drives the plot of the story is that the brothers are accused and arrested for colluding with a dealer to try and cheat the casino. The casino had no real evidence other than a few sloppy plays by the dealer. It's a cautionary tale that suggests that you should not expect a casino to appreciate you after you gamble away your money. It is also a warning about the political power of the gambling industry in the United States.

At the end of the book, the reader is left dangling without any real resolution of the story or the gambling problems; although the flap on the book cover informs you that the case was dismissed. It is particularly interesting how the casino seemed to have so much difficulty understanding these brothers, and assumed that after gambling away so much money, the brothers must want to cheat.

We recommend this book for its insights into the motivations for problem gambling. The reasons offered for their gambling passion are varied. They include grieving, early wins and an emotionally complicated family of origin. But the brothers are most convincing when they discuss the thrill of risk and the excitement of entering a social world separated from their ordinary lives. The price the authors pay for this spice in their life, however, is excessive:

\$250,000.

Why do people gamble? There is no single reason. Part of this book's value for counsellors and researchers is that it paints a picture of interconnecting dots, which journals in the field have difficulty capturing. It also left these reviewers with a desire to visit this changing part of the Mississippi landscape. We'd like to taste that Gulf seafood and see the bright lights on the beaches

*This book review was not peer-reviewed.*

*Submitted: May 3, 2001*

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**Barry Fritz** is professor of Psychology at Quinnipiac University, Hamden, Connecticut. He is a member of the board of the Connecticut Council on Problem Gambling. He graduated with a BA from the University of Vermont, an MA from Connecticut College, and a PhD from Yeshiva University.

"My current research interests are focused on understanding the motivation to gamble and those factors which differentiate between problem gamblers and recreational gamblers. I enjoy the game of poker and hope that my research will keep

me on the recreational side of the table."

---

## Video Review

# Winning Strategies: Slots with Video Poker (1997)

*Running time: 30 minutes*

*Producer: Winning Strategies*

*Available at Amazon.com for US \$17.99*

*Reviewed by Nigel E. Turner, PhD*

*Centre for Addiction and Mental Health, Toronto, Ontario,  
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Late one Saturday night, I saw an advertisement on TV for a video about how to win at slots. My first reaction was "How can they legally sell such crap?" The advertisement promised legal "casino-busting strategies ... designed to make you a better, smarter slots player." "Not possible," I said to myself, but being curious, I ordered a copy.

The big surprise was that it was actually quite good. The video is part of Frank Scoblete's Winning Strategies series and is narrated by Frank Scoblete. James Coburn briefly introduces the video and narrates a few bridging sequences. Far from being filled with misinformation, the video contains a lot of good information about slots. It includes a brief history of slots, a discussion of how slots actually work, a comparison of payouts in various cities around North America, money management strategies and popular myths about slots and why they aren't true. There is a brief section near the end on video poker, but it's mostly just a plug for yet another video devoted entirely to video poker.

My aim in writing this review is to describe the extent to which the information in the video is accurate or misleading and to evaluate the video for potential educational or counselling uses.

Overall, the video gives a number of good tips. It provides information about the nature of slot play and the different types of games available. It recommends using the spin button rather than the lever since less work is

involved. It recommends playing in your "comfort zone," only betting with money you feel comfortable about losing. It also suggests avoiding "progressive machines." A progressive machine is one in which the top prize increases each time a person plays the machine until the jackpot is won. These machines tend to have a lower payout to compensate for the large jackpot prize. The video also advises avoiding the oversized machines called "Big Berthas" that have a lower payout percentage than other slots because they take up more room.

But this video won't escape criticism completely —a few of the points were not adequately explained. In addition, the video encourages betting with "maximum coins" (i.e. the maximum bet allowed —often three or five quarters on a quarter machine) because the best payout comes with larger denominations. This is true. Typically, a slot may pay out 88 per cent for one quarter, but 92 per cent with three quarters. So, max coin does produce a higher payout, but most often the minimum bet will still ultimately lead to lower losses in spite of the lower payback. The video does state that losing 10 per cent of \$10 is still less than losing two per cent of \$100, but I don't feel that the point is made strongly enough. I also didn't like the way the video implies that money management strategies can help you win. They can't. They can only help you avoid losing too much money. The video may influence viewers and give them undue confidence in the strategies recommended in the video. As a result, they may gamble thinking that money management can help them win.

Many problem gamblers might benefit from watching parts of this video. However, be very selective about which parts of the video to show them because some sections promote the idea that slots are fun and exciting. The sections on how slots work and gambling myths are particularly good and would be appropriate for clients. The section about money management strategies may not be helpful because it sounds like keeping to the system will help you win. However, keeping to the system will only limit how much you lose. For a non-problem population (i.e. primary prevention and education), the entire video may be appropriate if followed by a brief discussion of the limits of money management.

This video is actually quite good and sections of it might be useful in a clinical setting, but only under supervision and with appropriate debriefing. Although it comes with criticism, it does provide better information than many other "how to gamble" books and videos. I have only two objections. First, the promised video poker section was little more than a plug for another video. (Advertising gambling in books and videos is very common.) Second, the advertisement of this video promises strategies that will help you win. Such a promise would be impossible since slot wins are purely a matter of chance; however, people will

buy the product expecting to learn how to win.

They've marketed it quite cleverly —it doesn't say you will win, but only that you "might" win since careful playing strategies —specifically money management —can stretch your playing time without stretching your risk. I suspect that the people who will buy this video after watching the advertisement will be annoyed when they realize that it doesn't tell them how to win. However, it would be interesting to survey people who purchased the video to see if the video influenced how they play.

*This video review was not peer-reviewed.*

*Submitted: August 1, 2000*

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## I have read the article by Barry Fritz ...

I have read the article by [Barry Fritz \("Chips, Chatter and Friends"\)](#) in [Issue 3](#). As the partner of someone with a gambling problem, I would like to comment.

The article makes it sound like there can be nothing better in life than gambling. And that the "special people" one can meet while gambling are somehow more special than people met elsewhere. He seemed proud to say that the "elderly lady" defined her own character by her poker playing!

I could substitute my wife with the narrator of this article, and picture her, in the depths of her problem, validating and rationalizing her "hobby" and her newly found "friendships."



She read the article and immediately fell into the trap of "Why can't that be me?" She became irritated and provoked and was inspired to gamble!!

Other articles in EJGI address the roots of gambling and attempt to clinically analyze problem gambling. The Fritz article covers the joy of gambling!

Am I so focused on the problems that I missed something here? It has certainly promoted discussion.

Thanks for your hard work.

*[Name withheld by request]*

*Received: February 22, 2001*

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## **"..the pain symptoms disappeared when I play poker"**

I have arthritis. I noticed that the pain symptoms disappeared when I play poker.

I attributed that effect to a) distraction , b) endorphin production as a result of playing, or c) some other physiological process as a result of the excitement of gambling.

It would be interesting to have a look at people who gamble recreationally, the elderly playing bingo, for example, to see if they get pain relief from the activity. It would also be of interest to develop a laboratory analog of gambling, where we have the subjects experience a mild aversive stimulus (unpleasant noise) and see if the gaming experience blocks the unpleasantness of the noise.

Are there studies that measure endorphin production while people are gambling? This information might also be useful to have.

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Received: May 17, 2001

*This letter is in reference to a discussion on gambling as analgesic (or pain reliever) in Issue 4 – the Editor <[http://www.camh.net/egambling/issue4/case\\_conference/index.html](http://www.camh.net/egambling/issue4/case_conference/index.html)>*

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## Don't Repeat the Mistakes

I have worked in the treatment of substance use problems for over 20 years. In that time, I've seen numerous errors committed repeatedly by most of the many addictions workers I've known. At the time of this writing, serious thought is being given in the United States to allotting major federal funding to "faith-based" programs to provide drug and alcohol addictions treatment. As one critic put it, the public sees secular treatment programs as failures. Regardless of what one thinks about the faith-based idea, the accusation has merit. It does because of several clinical (read: crucial content) mistakes that have been made in alcohol and drug addictions treatment.

The issue of gambling is relatively new in the addictions field, and represents the chance to start afresh. Professionals working with gambling problems can learn from the errors encountered in drug and alcohol addictions treatment.

This is an outline of the more common mistakes in drug and alcohol addictions work. They are, of course, highly interrelated.

### 1. Lack of critical thinking

Drug and alcohol addictions treatment workers often stay with just one set of ideas throughout their professional lives, especially ideas originating with what worked in their own recoveries or what they learned in school. Many workers become defensive when asked to consider new concepts, especially those that contradict their original set of beliefs.

Addictions clinicians need to logically and objectively consider new information, regardless of their fondness for other ideas. Doing so is the only way to grow and to bring optimal benefits to our clients. New ideas may or may not be accepted finally, but

fresh information always deserves serious examination.

## **2. Disregard for research**

Disturbingly, very little attention has been given to research findings in drug and alcohol addictions treatment. Part of this is the responsibility of the workers themselves who are too comfortable in their assumptions. Another part is on researchers who too often make little effort to speak easily understood English. However, addictions bureaucracies have also contributed to this avoidance. "Clinical supervision" usually becomes just an administrative backup job, rather than real guidance of staff in best practices.

Administrators and staff of treatment programs need to put as much emphasis on research currency as on administration. Researchers need to make increased efforts to reach out to workers to communicate empirical findings.

## **3. Fondness for simple answers**

A "Keep it simple" approach may be helpful for some addicts in early recovery, but it's no way to think about addictions treatment. However, simplistic ideas have been remarkably popular with drug and alcohol addictions workers. Prime examples concern what works in treatment, what causes addiction and how the families of addicts behave. As recent high-profile chaos theory explains, though, we must be willing to sort through complexity to discover real patterns and cause and effect.

Addictions workers need to examine all possible factors that may contribute to the phenomena they see in their work to determine the best ways to approach the problems encountered by addicts and their friends and families. The reality of what is happening with our clients can be clarified, but only with intellectual effort.

## **4. Blaming the client**

"She's in denial. He's not ready." These are popular responses by addictions workers to failures of treatment. Infrequently do staff realize that they are the ones in denial (about the need to

advance their clinical skills) or lacking readiness (to make changes in their work). Blaming the clients puts staff in the comfortable position of not having to question their own abilities — and of telling the public that addictions treatment failures are not due to staff practices, but to the nature of the addicts.

The drug and alcohol addictions treatment field has developed stereotypes about family members and others close to addicts, stigmatizing them as pathological people who have deliberately contributed to the continuation of the addiction. There is no well-executed research that substantiates any such profile, but the blame continues.

Mothers have also been solely blamed for alcohol- and drug-related birth defects, even though evidence exists that fathers' substance use affects their reproductive success.

In the tradition of critical thinking, addictions workers need to always question whether their treatment practices are adequate in light of the inherent resistance in addicted clients. Putting the blame on the clients is not helpful, and indeed, clinically, leaves us at a dead end. And when clients are stigmatized by professionals, objectivity and inquiry are typically absent.

Those who work with problem gamblers as well as any other type of addictive behavior or substance addiction may enjoy reading the articles listed below, which expand on the points in this letter.

## **Suggested readings:**

### **Babcock, M. (1995).**

Critiques of codependency: History and background issues. In M. Babcock & C. McKay (Eds.), *Challenging Codependency: Feminist Critiques* (pp.3–34). Toronto: University of Toronto Press.

### **Brown, J.D. (1991).**

The professional ex: An alternative for exiting the deviant career. *The Sociological Quarterly*, 32, 219–30.

### **Chiauzzi, E.J. & Liljegren, S. (1993).**

Taboo topics in addiction treatment: An empirical review of clinical folklore. *Journal of Substance Abuse Treatment*, 10, 303–16.

**Cicero, T.J. (1994).**

Effects of paternal exposure to alcohol on offspring development. *Alcohol Health and Research World*, 18, 37–41.

**Hare-Mustin, R.T. (1994).**

Discourses in a mirrored room: A post-modern analysis of therapy. *Family Process*, 33, 19–35.

**Kanda, Z. & Oleson, K.C. (1995).**

Maintaining stereotypes in the face of disconfirmation: Constructing grounds for subtyping deviants. *Journal of Personality and Social Psychology*, 68, 565–79.

**Orford, J. (1992).**

Control, confront or collude: How family and society respond to excessive drinking. *British Journal of Addiction*, 87, 1513–25.

**Taleff, M.J. & Babcock, M. (1998).**

Hidden themes: Dominant discourses in the alcohol and other drug field. *The International Journal of Drug Policy*, 9, 33–41.

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## **TriCounty Addiction Services Concerned About Insufficiency of Public Education Campaign Intended to Address Gambling Issues**

On May 2, 2001, the Board of Directors of the TriCounty Addiction Services

(TriCAS) of Lanark, Leeds and Grenville, Ontario, circulated a letter to the editor to newspapers, radio and TV stations, and public groups expressing our concerns:

Ontario provincial government policies about gaming are pro-gambling without thorough examination of the social, economic and personal impacts of gaming and without proper disclosure to the public of the nature and scope of policies bearing on expansion of gambling. We noted particularly the planned introduction of interactive slot machines —essentially video slot machines—to charity casinos and racetrack gaming floors, without requirement for a public approval process or announcement, and before the completion of impact studies at all charity casinos.

Designated addiction service agencies and other stakeholders dealing with gambling research and treatment were professing a "gambling neutral" position that inappropriately became "gambling policy neutral" and failed to ensure the public would be sufficiently informed to choose wisely about the processes by which the gaming industry is expanding into our communities and about personal involvement in gambling activities.

A pro-gambling shift in most media coverage accompanied that very audible silence of the addiction service agencies and other stakeholders dealing with gambling research and treatment, and there seemed to be collusion between them and the provincial government to delay release of a strong, well-researched, province-wide problem gambling awareness campaign, which addressed risks, costs to society and how to seek help.

We were concerned that we had become inadvertent partners in that silence. Such a campaign had been produced at a cost of approximately \$200,000 and was ready to distribute. Advertisements in all media and glossy, coloured posters and brochures were to be distributed to designated treatment agencies in September and October 2000. Our local interest was to have that material circulated prior to municipal referendums in November 2000 to decide voter interest in building a charity casino in the 1000 Islands area east of Kingston. But that did not occur, as the campaign did not go public until mid-May 2001, after the referendums had passed and construction of the 1000 Islands Charity Casino was underway.

Organized and managed by the [then] Canadian Foundation on Compulsive Gambling (Ontario)[currently the Responsible Gambling Council (Ontario) - ed.], the Ontario Partners for Responsible Gambling campaign was diminished to some pale posters and pamphlets and black-and-white local newspaper ads that ran for 22 weeks. This is a far cry from the promised campaign that was to make "Ontarians . . . aware of the problem of and

warnings signs for problem and compulsive gambling, and the treatments available." It was also to "communicate with the target audience when they are most susceptible to receiving the message . . . ." Like before a referendum? Or before a new charity casino opens locally?

Since our original letter, little has changed, and we now have additional concerns:

- Delay of the first component of the campaign, aimed at adult treatment, makes the next components, aimed at prevention for adult, youth and older adults, untimely because research tells us that youth and seniors are the highest at-risk groups.
- Approximately \$200,000 was spent to develop the educational products that we have, but is a mere drop in the bucket when approximately \$39 million was spent last year by the Ontario Lottery and Gaming Corporation to promote gambling.
- Our agency has not yet received monies promised by the Ontario Substance Abuse Bureau to purchase software and projection equipment needed by our problem gambling addictions counsellor to enable use of the Community Awareness Resource Package at speaking engagements and presentations.
- Our failure to be in the minds of the public may have had repercussions in local town councils, which refused a baseline study of gambling before the 1000 Islands Charity Casino opens.

Some of the questions we are left asking ourselves are

- How do we as volunteers, who commit our time and energy out of concern for our communities, justify our work to them, and our spending of public dollars, if we do not insist on a strong public awareness and problem gambling campaign?
- Without such a campaign and the resources to disseminate it, our capacity to address problems after the fact is hardly accountable. We are aware that any public messages about problem gambling —no matter the media in which they appear —must be repeated over and over for a long time before they become part of public consciousness.
- Do we want our communities to recognize the importance of having input into policy developments that govern both the expansion and management of gaming? If so, communities must first have the information to make informed choices and decisions.



- Providing information to assist the public in making informed choices and having opportunities to give input regarding strategic planning and policy-making is an appropriate way to be accountable to the taxpayers who fund us. Where are our professional and academic colleagues in taking responsibility to promote this accountability?

Addiction service agencies work to address the development of municipal alcohol policies and workplace safety policies. We notice that such work has occurred historically after the fact of awareness about consequences of problem drinking in public places. If we are to learn from our belated response to addiction risks, we need to develop public consciousness now about problem gambling. Communities need preliminary studies prior to establishing new gambling venues, to better assess and address social and financial impacts and accomplish better strategic planning. Again, a solid problem gambling public awareness campaign is necessary.

We do not see our arguments as gambling neutral or anti-gambling, but "pro-learning" ahead of time about the benefits of gambling and the risks of problem gambling. We invite your readers to speak out on these issues and to raise these concerns in their communities.

*Sincerely,  
John Gill  
Chairperson  
Board of Directors, TriCounty Addiction Services (TriCAS) of  
Lanark, Leeds and Grenville*

*Received: October 5, 2001*

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We invite our readers to submit letters on gambling topics. Please note that we can publish only a fraction of the letters submitted. All letters must be signed. We cannot publish anonymous letters, or those of a libellous nature. Letters to the Editor are reviewed and chosen by the editor and members of the editorial board. Letters may be sent by e-mail or to the mail address given below. Once a letter is accepted, we will request an electronic version. Each published letter will include the writer's first and last names, professional title(s) if relevant, city, province or state, and country. Alternatively, for good cause, the editor may confirm a letter's authorship and publish it as [Name withheld]. We reserve the right to edit each submission for uniform format and punctuation.

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## intro

### Issue 4, May 2001

## From the Editor

Anniversaries can be exciting, and we are elated that this fourth issue marks our first year anniversary of electronic publishing. One of our goals is to offer international coverage of gambling issues. We are glad to have articles about developments in gambling treatment and policy in Switzerland, northern Cyprus and Australia as well as from the USA and Canada.

A new section for [Case Conferences](#) begins in this issue (it's listed in the sidebar at left as **Case Study**). Alex Blaszczyński describes a case from his practice, a client whose severe back pain was relieved by gambling intensely and chasing his losses. Three other clinicians comment on the case and its ramifications for treatment in general, and Dr. Blaszczyński concludes with an overview of the discussion.

This issue presents some new ideas on how gambling can fit into our communities in a healthy manner. One article offers developments in the concept of a public health approach to both help assess the benefits of gambling and prevent and treat its negative effects (Feature; David Korn). Another describes how Swiss gaming policy requires that potential casino operators compete to offer better prevention, treatment and research facilities in order to win the right to run casinos (Policy; Daniela Dombrowski and colleagues). Another article takes the case of poor gaming policy and questions the ability of jurisdictions to manage gaming policy effectively by

examining these issues in a centre-periphery context, that of northern Cyprus (Research; Julie Scott).

I invite readers who enjoy these articles to tell their friends about the *Electronic Journal of Gambling Issues: eGambling*, and I ask those who would like to write to contact me. Please tell us what you think of our journal.

Phil Lange, Editor

E-mail: [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net)

## Statement of Purpose

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

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

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*[This article prints out to approximately 18 pages.]*

## Examining Gambling Issues From a Public Health Perspective



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### Abstract

Public health has a tradition of addressing emerging and complex health matters that affect the whole population as well as specific groups. AIDS, environmental tobacco smoke and violence are examples of contemporary health concerns that have benefited from public health analysis and involvement. This article encourages the adoption of a public health perspective on gambling issues.

Gambling has been studied from a number of perspectives, including economic, moral, addiction and mental health. The value of a public health

viewpoint is that it examines the broad impact of gambling rather than focusing solely on problem and pathological gambling behavior in individuals. It takes into consideration the wider health, social and economic costs and benefits; it gives priority to the needs of vulnerable and disadvantaged people; and it emphasizes prevention and harm reduction.

This paper looks at the public health foundations of epidemiology, disease control and healthy public policy, and applies them to gambling. Major public health issues are analyzed within a North American context, including problem gambling trends amongst the general adult population and youth, and their impact on other specific populations. There is significant opportunity for public health to contribute its skills, methodologies and experience to the range of gambling issues. By understanding gambling and its potential impacts on the public's health, policy makers, health practitioners and community leaders can minimize gambling's negative impacts and optimize its benefits.

**Key Words:** Gambling, public policy, prevention, public health issues, community health

**Competing Interests:** none

## Introduction

Public health initiatives achieved remarkable successes in the last century, reducing morbidity and mortality from childhood infectious diseases such as diphtheria and measles; identifying modifiable risks associated with heart disease and cancer; and promoting healthy lifestyles and environments. At the beginning of this new millennium, public health has the opportunity to contribute understanding and solutions to a range of complex health and social issues that affect the quality of life of individuals, families and communities. The unprecedented expansion of legalized gambling is one such challenge that can benefit from a public health perspective.

In North America during the early part of the 20th century, most types of gambling were considered criminal, and legal gambling was highly restricted. Recently, an unprecedented expansion of legalized gambling has occurred within a new, expanded public policy framework. The primary driving force behind the explosion of gambling in North America is the economic necessity

of states, provinces and local governments. Organizations in the United States promote the leisure and recreational aspects of gambling, whereas in Canada, the social benefits to charities, non-profit and community service agencies are emphasized (Campbell & Smith, 1998).

Historically, gambling has been understood from moral, mathematical, economic, social, psychological, cultural, and more recently, biological perspectives. Within the health care field, interest has come primarily from mental health and addiction professionals. Until recently gambling was not viewed as a public health matter. (Wynne, 1996; Productivity Commission, 1999; Korn, 2000). The value of a public health perspective is that it applies different lenses for understanding gambling behaviour, analysing its benefits and costs as well as identifying multilevel strategies for action and points of intervention. **note 1** Policy makers, researchers and practitioners in the gambling field can incorporate a public health framework to minimise harmful consequences, enhance quality of life and protect vulnerable people.

## Why Use a Public Health Perspective?

A public health approach incorporates various elements that make it an attractive frame for addressing gambling issues. It offers a broad viewpoint on gambling in society — not focusing solely on individual problem and pathological gambling. It conceptualizes a range of gambling behaviours and problems at points along a health-related continuum, which is similar to the approach taken in alcohol studies.

Public health goes beyond biomedical and narrow clinical models to address all levels of **prevention note 2** as well as treatment and recovery issues. It offers an integrated approach that emphasizes multiple strategies for action and points of intervention within the health system and community. A public health approach emphasizes **harm reduction note 3** strategies to address gambling-related problems and decrease the adverse consequences of gambling behaviour. It addresses not only the risk of problems for the gambler but also the **quality of life note 4** of families and communities affected by gambling.

Public health action reflects values of social justice and equity, and attention to vulnerable and disadvantaged people. Public health professionals often play an advocacy role or act as a bridge between local citizens and policy

makers on particular issues such as environmental tobacco smoke. One example where they play a similar role is the issue of government gambling policy acting like a regressive tax on lower income socio-economic groups.

Public health agencies exist at municipal, regional, provincial or state and federal levels. They are well suited to developing surveillance systems to track trends in problem and pathological gambling as well as the indicators to monitor social and economic impacts of gambling on communities and population groups. A public health position recognizes both costs and benefits associated with gambling. By appreciating the health, social and economic dimensions of gambling, public health professionals can foster strategies that minimize the negative effects of gambling while recognizing its potential benefits.

## Public Health Foundations for Gambling

### 1. Gambling and Health

Public Health embraces the World Health Organization (WHO) characterization of health as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change and cope with their environment (World Health Organization, 1984). Health is viewed as a dynamic process and as a resource for living rather than an end in itself. It is a positive concept emphasizing social and personal resources as well as physical capacities. Building on this broad definition, gambling can be conceptualized as either *healthy* or *unhealthy*.

Healthy gambling entails informed choice, including an awareness of the probability of winning, a low-risk pleasurable experience (i.e. legal, safe, regulated) and wagering sensible amounts. Healthy gambling sustains or enhances a gambler's state of well-being. Conversely, unhealthy gambling refers to various levels of gambling problems. This terminology complements the notions of healthy people, families and communities.

## 2. Gambling and Public Policy

During roughly the same period that gambling was beginning to be seen as health issue in the 1980s and 1990s, there was a growing interest in *healthy public policy*. This expression was embedded in the WHO Ottawa Charter for Health Promotion in 1986, followed by the Adelaide Statement on Healthy Public Policy in 1988 (World Health Organization, 1986; World Health Organization, 1988). Healthy public policy refers to the WHO's thrust that policy initiatives *in every sector* should promote health-sustaining conditions.

In Canada, gambling is regulated under federal law, the Criminal Code of Canada, adopted in 1892. Only governments can "manage and conduct" gaming ventures or authorize charitable gaming under license. Private sector ownership is prohibited. Over the years, periodic amendments to the sections on gambling have permitted its growth, but only since the 1970s have lotteries and casinos been operating legally. In 1985, computer, video and slot devices were legalized and the provinces were given exclusive control of gambling. Stakeholder and social policy groups have raised concerns about the role of government policy in encouraging gambling, while at the same time, protecting the public interest.

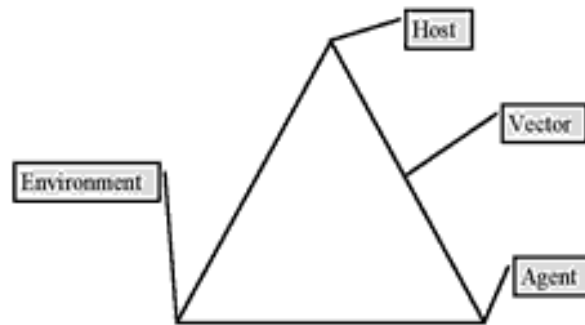
## 3. Gambling and Public Health Research

Public health is the study of the distribution and determinants of health, disease and mortality in a defined population and the of related public policy measures to prevent, eliminate or control its occurrence and spread.. Epidemiology is its central empirical research tool. Prevalence estimates of gambling-related problems in the general adult population have been carried out in numerous North America jurisdictions. Fewer epidemiological reports have described the impact of gambling on vulnerable and specific populations such as youth, women, older adults and Aboriginal people. To date, no Canadian national prevalence study of problem and pathological gambling has been commissioned. There remains a need for research on the incidence of pathological gambling and longitudinal studies on its natural history in gamblers.

A review of existing prevalence studies by the Harvard Medical School Division on Addictions revealed that 152 gambling prevalence studies have been conducted in North America as of 1997, including 35 in Canada (Shaffer, Hall et al., 1999). The estimated lifetime prevalence in the general adult population for problem and pathological gambling combined (levels 2 and 3 in Harvard study nomenclature) was reported at 5.5%. There were no significant differences in prevalence rates between the United States and Canada. Male sex, youth and concurrent substance abuse or mental illness placed people at greater risk of a gambling-related problem. Studies carried out by the United States National Research Council and the National Opinion Research Center at the University of Chicago as part of the National Gambling Impact Study Commission generally support these prevalence estimates (National Gambling Impact Study Commission, 1999; National Research Council, 1999).

#### **4. Gambling, Public Health Theory and Practice**

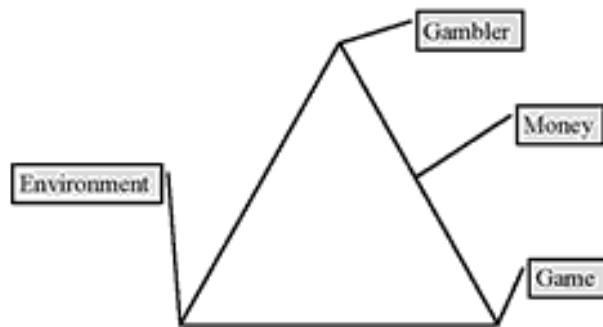
The communicable disease control paradigm of public health is instructive to the gambling phenomenon. It describes the causal factors and interactions of host, agent and environment that contribute to a particular infectious disease, such as AIDS, and the strategies necessary to control its spread ([see Figure 1](#)). This model resembles the addictions paradigm of drug, set and setting that illustrates the interactions amongst these components which lead to a particular drug use experience and a range of possible outcomes (Zinberg, 1984).



**Figure 1: A Public Health Model of Communicable Disease**

As applied to gambling ([see Figure 2](#)), the model can describe the multiple determinants of gambling problems and their complex interrelationships (Korn & Shaffer, 1999). The host is the individual who chooses to gamble, and who may be at risk for developing problems depending on their neurobiology, genetics, mental health and behaviour patterns. The agent represents the specific gambling activities in which players engage (e.g., lotteries, slot machines, casino table games, bingo, horse race betting). The vector can be thought of as money, credit or something else of value. The environment is not only the gambling venue but also the family, socio-economic, cultural and political context within which gambling occurs (e.g., whether it is legal, its availability and whether it is socially sanctioned or promoted). This public health paradigm invites a broad range of prevention and treatment interventions directed at various elements in the model.





**Figure 2: A Public Health Model of Gambling**

## Major Public Health Issues

A public health issue goes beyond consideration of the individual and their personal health to matters that affect groups of people who share common characteristics, geography or interests. The recent, dramatic growth of legalized gambling and its widespread acceptance raises concerns about its impact on the public's health and well-being. There are a range of public health issues related to populations at risk for gambling problems, suffering from gambling disorders or affected by the gambling practices of others. In addition, public policy decisions on gambling have implications for communities.

### 1. Gambling Expansion and Problem Gambling Trends in the Adult Population

In the last decade before the millennium, an unprecedented expansion of government-sanctioned gambling occurred throughout North America. The dominant concern is the emergence of gambling addiction, which may be stimulated by increased availability and promotion of casinos, lotteries and

VLTs. Currently, the estimated lifetime prevalence rates for problem and pathological gambling combined in the general adult population in both the United States and Canada is low; however, the Harvard meta-analysis of available studies shows that over the past 25 years there has been a rising trend.

The relationship between access to gambling and gambling problems is widely debated. A significant number of replication studies associated with the introduction of new gambling opportunities in states such as New York, Iowa, Minnesota and Texas demonstrate an increase in problem and pathological gambling (Volberg, 1995; Miller & Westermeyer, 1996; Volberg, 1996; Wallisch, 1996). Research done in the United States shows a higher prevalence rate in states with higher per-capita lottery sales and in areas within 50 miles (80 km) of casinos (Volberg, 1994; Gerstein, Murphy et al., 1999). These findings support the general conclusion that gambling expansion is associated with related to increases in problem and pathological gambling.

## **2. Youth and Underage Gambling**

Youth is a development stage associated with experimentation, novelty and sensation seeking. However, the current youth generation is the first to grow up within a society where gambling is widely available and government sanctioned. The implication of this societal change for youth gambling behaviour and risk of developing gambling problems as adults is unclear.

Surveys in Massachusetts, Minnesota, Nova Scotia and elsewhere point to a high prevalence of problem and pathological gambling among youth, estimated to be two to three times higher than in the general adult population (Winters, Stinchfield et al., 1993; Shaffer, LaBrie et al., 1994; Poulin, 2000). A meta-analysis showed that the estimated lifetime prevalence for both problem and pathological gambling in the adolescent study population was 13.3% (14.0% for the college population), a proportion that has been relatively steady over the past 25 years (Shaffer, Hall et al., 1997). This high prevalence of gambling and gambling-related problems among youth, including sports betting at colleges and universities, is cause for concern and invites innovative approaches to prevention.

### 3. The Impacts of Gambling on Special Populations

A number of special populations have been identified for focused attention because of their financial vulnerability, health status or distinct needs. This review of special populations examines people from lower income socio-economic groups, women, Aboriginal people and older adults, but it is not inclusive. Other groups that deserve consideration include ethnocultural minorities, incarcerated populations, substance abuse and mental health treatment groups and gambling industry employees. In general, gambling research within special populations is in an early phase, and these groups deserve further systematic study before conclusive statements can be made.

#### a. **Socio-Economic Status**

There has been considerable interest in the relation between gambling and socio-economic status. Recent Statistics Canada reports indicate that although gambling participation rates and actual expenditures tend to increase with household income, lower income households spend proportionately more than do higher income households (Marshall, 1998; Marshall, 2000). For example, in households in which at least one person was involved in gambling, those with incomes of less than \$20,000 spent an annual average of \$296 on gambling pursuits. This sum represented 2.2% of total household income, whereas those with an income of \$80,000 or more spent \$536, only 0.5% of total income. Given the share of gambling revenue in Canada and elsewhere that goes to government, these data suggest that gambling expenditures may be regarded as a voluntary but regressive tax that has a proportionately greater impact on lower income groups.

#### 2. **Women**

Women appear to have distinct gambling behaviours; and they are gambling more now than in previous years. In the United States, the percentage of women who have ever gambled rose between 1975 and

1998 from 22% to 82%. In the same period, the percentage for males increased from 13% to 86% (Gerstein, Murphy et al., 1999). Female gamblers prefer slot machines, VLTs and bingo to action table games and horse racing. Compared to males, females gamble more to escape, reduce boredom or relieve loneliness than for excitement, pleasure or financial gain (Coman, Burrows et al., 1997).

### 3. **Aboriginal People**

Aboriginal Peoples deserve attention because of the evolution of gaming policy and its potentially positive economic impact on Aboriginal communities through revenue generation and employment. At the same time, Aboriginal Peoples may be particularly vulnerable to the negative impacts of gambling for a variety of complex health and social reasons.

### 4. **Older Adults**

There has been considerable interest but little empirical research into the gambling behaviour of seniors who are a sizable and growing proportion of the adult population (North American Training Institute, 1997; Gerstein, Murphy et al., 1999; McNeilly & Burke, 2000). Seniors appear to be disproportionately represented at bingo halls, charitable gaming activities and day excursions to casinos. Although seniors are generally considered low risk-takers, there are concerns about their vulnerability to gambling problems springing from fixed incomes, social isolation and declining health. However, seniors may also receive health benefits from gambling activity and its impact on social connectedness. Research that examines the impact of gambling on depression, physical mobility and quality of life would enhance our understanding of the risks and benefits of gambling for seniors.

## **4. Effects of Gambling on Family Life**

Gambling-related family problems deserve to be positioned centrally as important public health issues. A healthy family is integral to developing and sustaining individual self-worth, meaningful interpersonal relationships, mutual respect and personal resiliency. Robert Glossop of The Vanier Institute of the Family recently noted, "Families are perhaps the central determinant of health, the central influence in the lives of individuals that determine their health status and their chances of survival" (Avard, 1999). When family

members are problem or pathological gamblers, they can adversely affect their relatives and significant others. To date, researchers in the gambling field have described a range of negative health and social consequences for family members associated with adult disordered gamblers. These effects have been identified in spouses (Lorenz & Yaffee, 1988), siblings (Lorenz, 1987), children (Jacobs, Marston et al., 1989) and parents (Heineman, 1989; Moody, 1989). Family issues include dysfunctional relationships, loss of family income, neglect, violence and abuse. Both the general public and health professionals need to be better informed of these potential consequences and elaborate a full range of family support interventions.

## **5. Gambling Sites and Community Quality of Life**

When jurisdictions face the opportunity to establish a gambling facility or expand gambling activities, there is often extensive, heated community debate regarding the social costs and economic benefits. Ideally, a community gambling assessment is shaped by consideration of local community needs, community values, strategic plans and research findings on community impact. Active participation of its citizens, involvement of key stakeholder groups and transparent decision-making are characteristics of a successful community process.

The outcome of this process should preserve or enhance the quality of community life; sustain or improve the overall health status of its members; and demonstrate local economic vitality as a result of either the presence or absence of gambling. Ongoing monitoring and impact analysis is necessary to evaluate the decision over time and to make appropriate adjustments.

## **6. Emerging Gambling Trends with Public Health Implications**

The Internet provides a new and virtual environment for gambling. It has experienced explosive growth in the numbers of gambling Web sites, players and revenues (Adiga, 2000). It is unregulated in North America; operating offshore, it offers sports betting and casino-style gambling opportunities to individuals possessing a computer modem and a credit card. It attracts gamblers because it provides access to gambling activities at anytime in the privacy of their home or office. Underage gambling is difficult to monitor.

Technology has become a significant dimension of gambling in general. Concerns have been expressed about the wide availability and addictive potential of VLTs. On the positive side, computer- and Web-based technologies can incorporate personal risk assessment tools for gambling problems, and innovative prevention programs and monitoring instruments. One type of gambling that has received little attention to date is gambling that occurs in the financial world. Economic well-being is a significant determinant of population health. Thus, high risk or impulsive financial speculation, such as day trading, can have profound impacts on health status and social institutions.

## Creating a Public Health Framework for Action

What is done to resolve a particular societal matter depends on how it is framed. Approaching gambling from a public health perspective offers a strategic vantage point to address its broad health challenges and inform related public policy.

Three primary principles guide and inform decision-making. The first is to ensure that preventing gambling-related problems is a community priority, along with the appropriate allocation of resources to primary, secondary and tertiary prevention initiatives. The second is to incorporate a mental health promotion approach to gambling; one that builds community capacity, incorporates a holistic view of mental health (including its emotional and spiritual dimensions) and addresses the needs and aspirations of gamblers, individuals at risk of gambling problems and those affected by them. The third principle is to foster personal and social responsibility for gambling policies and practices.

These principles in turn inform a set of public health goals:

- to *prevent* gambling-related problems in individuals and groups at risk of gambling addiction
- to *promote* informed and balanced attitudes, behaviours and policies

towards gambling and gamblers both by individuals and by communities

- to *protect* vulnerable groups from gambling-related harm.

An action agenda based on these public health goals and principles has been proposed. [note 5](#)

In conclusion, this public health perspective on gambling issues offers policy makers, researchers, health practitioners and community leaders a focus for public accountability and the opportunity to minimize gambling's negative impacts while balancing its potential benefits.

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### Brief Policy Report

# Casino Gambling in Switzerland – The Legal Situation, Politics and Prospects for Prevention and Harm Reduction

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## Abstract

In April 2000, a new law came into effect in Switzerland that permits casino gambling with unlimited stakes for the first time since 1921. Casinos can now be run only with a concession granted by a newly established federal agency. In addition to economic and administrative information, each casino applying for a concession has to submit a fully developed "social concept" that includes detailed prevention measures for dealing with people with gambling problems, staff training and evaluation research, which an independent advisory board will control. In the fall of 2001, the first casino concessions will be granted based on the quality of each applicant's overall proposal.

The new legislation is creating a unique situation in Switzerland. To reduce the potential harm for gamblers that is associated with new forms of gambling, the legislation should be standardized and continuously optimized. These new measures require evaluation and government control.

## The Legal Situation

On April 1, 2000, the new *Federal Law on Games of Chance and Casinos* (*Bundesgesetz über Glücksspiele und Spielbanken*, 1998) came into effect in Switzerland. The law is specified by the *Federal Casino Decree* (*Bundesrätliche Spielbankenverordnung*) and was ratified by the federal government on February 23, 2000 (see <<http://www.admin.ch/>> for information on Swiss legislation). [note 1](#) This law permits gambling with unlimited stakes in Switzerland. In the corresponding decree, detailed guidelines specify the conditions under which gambling in Switzerland may take place. According to the Swiss legislative process, this law was made possible by a referendum in 1993; three-quarters of the electorate voted in favor of re-establishing casinos with high stakes (a 1920 referendum disallowed gambling in casinos where it had been allowed before 1921). In 1920, 55% of the population had supported the closing of casinos. This change in voting behavior between the 1920s and the 1990s reflects a general trend in market economies to emphasize individual liberties and decision making, which has also affected attitudes toward other public health policies (e.g., alcohol policy) .



Until the Federal Law on Games of Chance and Casinos came into effect, the maximum stake in gambling had been limited to CHF five per game. Slot machine gambling had different cantonal [note 2](#) (state) laws that controlled the management of the amusement arcades (facilities with only machines) and small casinos. This led to a total banishment of gambling in some cantons (e.g., Zurich) while a relatively high number of machines were distributed to small casinos, amusement arcades and public places such as bars and restaurants in other cantons (e.g., Ticino). Additionally, many grand casinos [note 3](#) in France, Italy, Austria and Germany are situated alongside the Swiss border.

This new federal law distinguishes between two kinds of gambling:

- games of skill (e.g., card games like poker, as well as machine games where the outcome depends to some degree on the skill of the player)
- games of chance that cannot be influenced by the skills of the gambler (e.g., slot machines or one-armed bandits; in the following text they are referred to as "chance amusement machines").

Games of chance will be strictly limited by law to special resorts like casinos and amusement arcades. Every person or legal entity wanting to run a gambling enterprise must apply for a concession from the federal government. The newly formed Federal Swiss Casino Commission [note 4](#) will review the applications and make recommendations to the federal government.

The deadline for applications was September 30, 2000. The commission has promised to take about a year to review and make a decision on the applications. Two different types of concessions will be granted: Type A concessions for grand casinos (these will be taxed less), and Type B concessions for smaller casinos (these will be taxed more). Type A casinos will be allowed to offer 14 different table games with unlimited stakes, jackpots and maximum winnings at all machines. Type B casinos will only be allowed to offer three kinds of table games with limited stakes, jackpots and maximum winnings at all machines.

Taxation will be regulated as follows: Casinos of Type A pay 40% of their revenues up to CHF 20 million, and for each additional million the taxation rises by 0.5%. Casinos of Type B pay 40% of their revenues up to CHF 10 million, and for each additional million the taxation rises by 1%. The plan is to evenly distribute the concessions across Switzerland. Type A casinos will only be permitted within a catchment area of a million people or more. Overall, the intended result is to have about two to six Type A casinos and 15 to 20 Type B casinos all over Switzerland.

Gambling via telecommunications, especially the Internet, is forbidden. In Switzerland however, there are no models for prosecution in case of violation, nor does the law or the decree provide any. Cantonal law will control machines offering games of skill (in contrast to machines that solely depend on chance).

A five-year transitional law came into effect on April 1, 2000 for amusement machines depending solely on chance in both public places (restaurants, bars, waiting lounges, etc.) and amusement arcades, as well as for casinos that already exist. On April 1, 2005, operation of all games of chance amusement machines run by persons or legal entities that have not been granted a concession will be stopped.

## **The Social Concept – A Nationwide Approach**

### **The legal basis for a social concept**

In order to obtain a concession on the recommendation of the Swiss Federal Gambling Commission, each applicant is required to meet certain standards concerning

- measures for prevention and harm reduction of pathological and problem gambling,
- proper training of the casino staff, and
- provision of data for research.

Each applicant must describe in detail in a *social concept* how these criteria will be fulfilled.

These very strict requirements laid down by federal law create a peculiar situation; systematic, preventive and harm reduction measures have to be introduced nationally and at the beginning of grand casino gambling in Switzerland. To our knowledge, these are unique prerequisites in a nation

legalizing gambling.

## Experiences in other countries

Most countries that allow large-scale gambling lack systematic, nationwide regulation for preventive measures. Though internationally there has been an increase in gambling policy development in both public and private sectors, the level of interest and the funds available for education, prevention and treatment have not kept pace with increases in legal gambling revenues or in the availability of gambling .

In some Canadian provinces, in Germany, Sweden and the U.S., as well as in some states in Australia, the government grants money for prevention, treatment and research. For instance, two U.S. federal health agencies: the National Institute of Health, and the Substance Abuse and Mental Health Services Administration have allocated funds for research and services. However, "the level of funding is often minuscule compared to similar programs for mental health, substance abuse, and other human services."

In other countries, governments do not engage in funding prevention and harm reduction measures at all. There may be some private funding either in addition to or instead of public funding. In the U.S. and the Netherlands, the private enterprises running casinos have started several initiatives. In the U.S., the gaming industry became active in the field of underage and problem gambling during the 1990s. The American Gaming Association (AGA) founded and financially supports the National Center of Responsible Gaming (NCRG), which grants funds to research projects carried out by academic institutions in North America, and to organizations providing counseling for underage and problem gambling.

In the Netherlands, gambling was legalized in 1975 and the government granted Holland Casino's exclusive rights to run casinos in the Netherlands. Part of the corresponding regulations asked for a prevention concept. Holland Casino's and VAN (the Dutch amusement machine industry) are co-operating with Jellinek Consultancy (a counseling and prevention service linked to the Amsterdam Institute for Addiction Research – Jellinekhuis) to provide prevention and harm reduction measures.

Together, they worked out a prevention plan that includes

- the display of brochures with guidelines for responsible gambling

- information about the odds of winning and losing in the casinos
- the possibility of suspending people who have gambling problems, and
- a training program for casino and amusement arcade employees, social workers and relatives on how to deal with those who have gambling problems.

In addition to the legal casinos, there are an estimated 40 to 50 illegal casinos ; most of the gambling in Dutch casinos remains uncontrolled. Furthermore, innumerable slot machines are located in eating establishments and amusement arcades throughout the Netherlands. In an attempt to reduce uncontrolled gambling opportunities, the number of amusement machines in public places was reduced, but interestingly, the number of lotteries rose at the same time. Preventive measures for amusement machines, lotteries and illegal casinos are carried out in a non-standardized way, if they are carried out at all: meaning, they do not co-operate with the Jellinek Consultancy.

The Dutch example seems to indicate that government funding for prevention and harm reduction may not be necessary and could be replaced by funding provided by the sector itself. Such efforts have to be regulated; however, it is not only government regulations that are important, but also their enforcement. If most of the casinos are not participating in a standardized, national approach, the result will not be effective.

## **The implementation of social concepts in Switzerland**

There will probably not be a standardized concept for all casinos in Switzerland as the applicants for a concession had to submit a fully developed social concept of their own. Until the concessions are granted in fall of 2001, the applicants are effectively in competition with each other, which makes exchanging concepts and ideas highly unlikely. However, each submission is bound to contain what's required by law since the granting of the concessions will be based on quality, along with other factors such as location, local traffic and size of the catchment area. Because competition is tough, it is expected (and hoped by some) that a well-planned social concept could mean winning the bid.

For each casino or for each company representing several casinos, a social

advisory board will supervise the translation of its concept into action. Depending on the concept, its members will often be independent experts from the therapy, social services and research fields, but will also sometimes include casino executives. The advisory boards will report directly to the Swiss Federal Casino Commission.

Last but not least, the law in Switzerland creates a unique chance to collect research; providing data for research is part of the social concept. Implementing grand casinos in a country where gambling had been strictly limited has been rarely evaluated until now (see Room, Turner & Iolamiteanu, 1999 for an exception) and could be especially interesting for other countries that also wish to legalize gambling. Furthermore, comparing development in cantons where gambling had been totally abolished, and development in cantons where gambling had already taken place might prove to be interesting. However, most evaluations will require baseline data (e.g., the current level of problem gambling) in order to be able to interpret results and make valid conclusions. Unfortunately, such data has been lacking so far.

## **An Example of a Social Concept in Switzerland: The Social Concept of Grand Casino SA**

The Addiction Research Institute in Zurich has developed a social concept that the Grand Casino SA and its partners (ACE Admiral Casino & Entertainment AG, Escor AG, German Casino Management Group) will use to apply for concessions for 10 different casinos (two of Type A, eight of Type B) all over Switzerland. To obtain a concession, the casinos have agreed to subscribe to this social concept outlined below.

After the legal requirements, the social concept has the following components:

- preventive measures
- plans for dealing with problem gambling
- training program for staff

- research
- social advisory board.

The preventive measures are divided into primary and secondary prevention. Key elements for primary prevention include information and sensitization campaigns for casino customers and the public, a Web site with relevant information, media prevention campaigns, information on odds and pathological gambling, and contact information for professional help. Information brochures and advice on responsible gambling will be openly available in the casinos. Advertising for gambling will be strictly limited. In addition, structural changes to the casino will be made: an ID control at the entrance will prevent the admission of adolescents under 18 or suspended problem gamblers. Although credit cards will be accepted, no cash dispensers will be placed in the casino and no loans will be granted to customers. To prevent staff from relying on tipping, a relatively high fixed wage will be administered, increasing their monthly allowance and allowing them to be freer and less biased when intervening with those who have problems.

As part of secondary prevention, checklists for self-diagnosis will be displayed and combined with the offer of counseling by specially trained staff in each casino. A toll-free, 24-hour telephone hotline will provide the caller with information (e.g., where to obtain professional help). Customers who feel in danger of losing control will be able to have themselves suspended from either their favorite casino or every casino across the country.

To help deal with those who have gambling problems, staff will be trained to speak with customers who are obviously having trouble. A first counseling session may be held in the casino and contact information for professional help will be provided. Problem gamblers can be suspended nationwide, even if they do not agree to that intervention. A fund supplied by the casinos' revenues and managed by the social advisory board will be established for people with gambling problems with financial problems, who wish to immediately enroll in therapy.

All casino staff will be trained in a three-day workshop before starting their job. Training will include information about pathological gambling, risk and protective factors, different types and stages of gambling problems, preventive measures and therapy for problem gamblers. Potential problematic



behaviors because of any addiction will be thoroughly examined, and social competencies in dealing with problem gamblers will be practised in role-playing. Staff will be retrained annually. Additionally, at least one supervisor will receive extra training in how to interact with problem customers. He or she will also receive regular professional supervision.

Research will focus on data collection and interpretation of gambling frequencies, the socio-demographic characteristics of casino customers, the frequencies and circumstances of suspensions, and customer turnover in the casinos. Ideally, there would be national or even international monitoring, which however, depends on the co-operation of the other casinos and government regulations. Furthermore, the effectiveness of the preventive measures and social consequences in regions around the casinos will be evaluated by studying hotline usage, co-operating therapy and counseling centers, social services and crime rates.

The social advisory board will consist of seven independent experts from the prevention, therapy, social services and research fields. Up to two casino executives will be allowed to participate in the meetings (without the right to intervene or vote). The board's main function will be to supervise the implementation and realization of the social concept and to report regularly to the Swiss Federal Casino Commission. It will examine, authorize, order and control the preventive measures, training, research and public relations. It will decide upon suspensions and have authorization to grant funds for therapeutic aids for pathological and problem gambling.

Until now, the phenomenon of problem gambling has hardly been studied in Switzerland on a large scale. With the financial support of Loterie Romande and Romande des Jeux SA (i.e. representatives of the gaming industry in the French-speaking part of Switzerland), one major study was carried out in 1998 that estimated the existing prevalence of pathological and problem gambling in Switzerland. The authors screened a representative sample of the adult population for each Swiss region with the SOGS for current problem gambling and found that 0.8% of the Swiss population were probable pathological gamblers and another 2.2% were potential pathological gamblers. These prevalence figures are slightly higher than the corresponding Swedish figures. This comparison is justified as Sweden is also about to open casinos, with the first expected to be opened in spring 2001.

In addition, the Swiss study also found a relationship between gambling and alcohol problems; the latter screened by the CAGE. The study showed a positive relationship between the availability of gambling and the prevalence of problem gambling: the higher the relative density of amusement machines per 1000 inhabitants, the higher the prevalence of probable and potential



pathological gamblers.

When comparing those with gambling problems to the total population these statistics emerged; for all sets of figures, the first percentage is that of problem gamblers and the second percentage is for the total population: 73% of the group with gambling problems were male, while only 49% of the total population was male. Those under the age of 29 were 43% of those with gambling problems, but only 20% of the total population; 76% of problem gamblers were employees compared to 55% of the total population; full time workers composed 79% of the problem gamblers compared to 52% of the total population. Among people with gambling problems 18% were of non-Swiss nationality, compared to being 8% of the total population; and 48% of the problem gamblers were unmarried, compared to 30% unmarried among the total population. A smaller group of gamblers with problems was in the low-tax category (13% vs 29%), Protestant (28% vs 46%) or spoke French as their mother tongue (7% vs 18%) compared to the total population.

The number of probable pathological gamblers in Switzerland is estimated to be between 33,000 and 78,000; the number of potential pathological gamblers is between 107,000 and 180,000. These numbers are at the lower end of the international problem gambling statistics (Evans & Hausamann, 1998), (Henriksson in press), (Petry & Armentano, 1999), (Shaffer, Hall & Vander Bilt, 1999), (Ladouceur, 1996), (Volberg, 1996), (Osiek, Bondolfi, et al., 1998), although grand casino gambling has not yet started in Switzerland. Thus, problem gambling already exists in Switzerland despite the strict restrictions that have been in force until now.

Although there are exceptions, international and Swiss results show higher rates of problem gambling in regions with more gambling opportunities. This leads to the expectation that there will be rising numbers of problem gamblers following the implementation of grand casino gambling in Switzerland. We believe that a well-founded harm reduction policy should be in place to deal with this expected increase.

## Conclusion

The new legislation has created a unique situation in Switzerland regarding grand casino gambling. While gambling with unlimited stakes will become daily business in Switzerland in the near future, the casinos themselves will be legally required to implement effective prevention methods and to establish a network of consultation and therapy for problem gambling. The Swiss law

limits gambling activities strictly to casinos and forces each of the casinos to implement and carry out a social concept with detailed *a priori* stated prevention measures, measures for dealing with problem gamblers, training of staff, and associated evaluation research. An independent social advisory board will control the actual implementation and realization of the measures.

In spite of these precautions, an increase in the prevalence of pathological gamblers is expected in Switzerland. So far, this prevalence rate is at the lower end of the international statistics, but national and international research has shown that the number of people with pathological levels of gambling problems tends to rise with more gambling opportunities.

This calls for a thorough harm reduction approach. To optimize its effectiveness, standardization of the measures and strict evaluation will be very important. It also requires commitment from the government to continue the regulation and control of all the steps. As we learned from the Dutch example, not only will control and regulation be necessary, but also enforcement of the regulations.

There are currently different social concepts in Switzerland that may differ in their effectiveness. It would be in the interest of the Swiss government to put the onus on the casinos to provide evidence for the effectiveness of their concepts. This seems to be particularly possible in a situation when a new law is being implemented.

Traditional medicine and public health have often encountered the problem that evidence of effectiveness is often established *post hoc*, taking into account many historical aberrations. These problems could be avoided if evidence of the effectiveness of countermeasures is presented at the beginning of the implementation. By routine monitoring and conducting standardized comparative evaluations of the effectiveness of different social concepts, such concepts could be shaped, and ineffective concepts could be abandoned or improved. Therefore, social and public health problems related to gambling in Switzerland might be less dramatic than would otherwise be expected.

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# "Everything's Bubbling, But We Don't Know What the Ingredients Are" —Casino Politics and Policy in the Periphery

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## Abstract

With the global spread of commercial gambling, the casino industry is fast establishing itself in many of the world's peripheries —economically and politically marginal locations, simultaneously remote from, but dependent on metropolitan centres of finance and decision-making. Using the case of northern Cyprus, this paper examines the political and economic context of decisions by such peripheries to embark on casino tourism as a

development strategy and explores some of the problems faced in attempting to regulate and control the sector. The paper suggests that it is the condition of dependency, rather than simple resource constraints, which is the major obstacle to establishing an adequate policy and regulatory framework.

**Keywords:** casino tourism, dependency, periphery, policy, politics, northern Cyprus

## Introduction

The title of this paper is taken from a comment made to me by the Turkish Cypriot manager of a casino in northern Cyprus during fieldwork in 1999. What was bubbling was northern Cyprus's casino sector, 20 casinos having recently opened, with another 20 applications pending in a territory with an area of 3,355 sq. kilometres (1,295 sq. miles) with a permanent population of about 250,000. His comment reflected double perplexity: firstly, that of a casino manager operating in a climate of enormous uncertainty; secondly, the concern of a Turkish Cypriot concerned at the effects he observed of the casino industry on his home. From both a professional and a personal point of view, he confessed to grave doubts about the sustainability of the sector.

In this paper I want to try to describe this bubbling mixture and identify its ingredients. I shall argue that the problems and dilemmas faced by northern Cyprus, as it seeks to come to grips with its new industry, are representative of the problems faced by peripheral regions in general when they engage in casino tourism development. And for a number of reasons, it is precisely in such peripheral regions that much of the casino development of the past decade has been concentrated. On the one hand, locating casinos in physically peripheral regions effectively isolates gambling activity, rationing the gambling opportunities for the residents of metropolitan centres and shifting many of the associated problems and costs elsewhere (Stansfield, 1996; Felsenstein & Freeman, 1998).

On the other hand, the economic marginality of many peripheral areas may make them eager to cash in on the growing demand for casino gambling. In doing so, they can turn their location into a comparative advantage, whether they are an urban economy in need of regeneration in the aftermath of industrial and economic restructuring (Goodman, 1995;



Deitrick, et al., 1999); an emerging former Soviet-bloc state seeking the means to kick-start post-communist economic activity (McMillen, 1996a; Thompson, 1998); or a small, offshore island with limited development options. Northern Cyprus, in the eastern Mediterranean, is one such island.

## Northern Cyprus

The Turkish Republic of Northern Cyprus (TRNC) could be considered perhaps the quintessential peripheral location. Recognised politically and diplomatically only by Turkey, this northern third of the island of Cyprus has been literally cut off from the rest of the world since its partition in 1974, following an attempted coup engineered by the military junta in Athens and subsequent military intervention by Turkey. Boycotts put in place by the United Nations ensure that all post and telecommunications to northern Cyprus must be routed through Turkey, and there are no direct international flights to the north.

These problems of accessibility and negative image render the north artificially remote from the mass tourism markets of northern Europe, the mainstay of the Greek Cypriot tourism industry in the south. They make them triply dependent on mainland Turkey, which is their gateway to the rest of the world, the main source of aid and investment in the north, and also, the main tourist market (Scott, 2000a). The primary attractions of northern Cyprus for Turkish tourists are sun, sea, sand, shopping, and the opportunity for casino gambling.

## The Development of the Casino Sector in Northern Cyprus and Turkey

Research in northern Cyprus's casino sector was undertaken as part of a wider project looking at diversity and sustainability in tourism development. The author, an anthropologist at the Business School of the University of North London, worked in collaboration with Turkish Cypriot colleagues at Eastern Mediterranean University, Famagusta, Cyprus. Using a combination of survey, interview and participant observation methods, our research explored the relationship between northern Cyprus's conventional tourism product and the casino tourism sector (Scott and Asikoglu,

forthcoming), and the impact of casinos on traditional gambling (Scott, 2000b).

At the commencement of fieldwork in spring 1999, 20 casinos were operating in northern Cyprus. All were attached to, or located within, hotels, holiday villages or other tourist accommodation, and eight were in town centre locations, the majority of these in the main tourist resort town of Kyrenia (Girne). By far the largest is the Emperyal Casino, with 22 gaming tables and 377 slot machines. This compares with an average of 10 tables and 70 slot machines per casino, although the smallest has only seven tables and 18 machines (Ministry of Tourism, 1998). The main games played are American and French roulette, Las Vegas craps, Black Jack, poker, chemin-de-fer, punto banco, baccarat and keno. However, a number of other games are also permitted on casino premises, including chug-a-lug, wheel of fortune, rummy, backgammon, and betting on horse and dog races and football matches. Casino opening hours are subject to government regulation, and operation is currently permitted from early afternoon to early morning, with seasonal adjustment from winter to summer. Alcoholic drinks are available free of charge, and may be consumed at the gaming tables. At the time of writing, citizens of northern Cyprus and students, regardless of nationality, are not permitted to gamble on casino premises (nor, technically, in any other location).

The scale of the current level of casino activity has caused enormous local controversy, yet casinos themselves are nothing new in northern Cyprus. A law permitting the licensing of premises for betting and gambling was first passed in 1975, to encourage tourism investment and diversify the north's fledgling tourism product in the aftermath of the island's partition. Casino operators were required to meet tourist bed/night targets as a condition of their licence, but this requirement was soon dropped when it became clear that none of the casinos had been able to meet their targets, and that all would face heavy penalties (Yesilada, 1994). In the face of the low level of demand, would-be operators who had received permission to open casinos bided their time. By 1991, only four small premises were in operation, although permission had been granted for 10 casinos to open.

Throughout the 1990s, however, the licensing and opening of casinos gathered pace. The development of the Israeli "casino junket" market began to ensure a steady stream of weekend gamblers, but posed enormous logistical problems in the absence of direct flights to and from Israel. Turkey presented a much more accessible and potentially much larger market.

Although casino gambling was legalised in Turkey in 1983 —again with the aim of stimulating investment in tourism and attracting overseas tourists — Turkish citizens were initially barred from the live game areas of casinos. High rollers were obliged either to play the slot machines —where some individuals would lose as much as US \$2,000 to 3,000 on a daily basis (Kent-Lemon, 1988:409) —or to visit casinos outside Turkey, with northern Cyprus a convenient location only one hour by air from Istanbul or Ankara.

By 1995, a further eight casinos had been licensed in northern Cyprus, but with the liberalisation of gaming laws in Turkey, allowing Turkish nationals access to the gaming tables, the Cypriot casinos again found themselves struggling to survive. However, by 1997 the tide of public opinion in Turkey was turning against the casinos, fuelled by an apparent increase in widespread problem gambling (Duvarci, et al., 1998) as well as stories linking casinos with organised crime and corrupt politicians. The electoral success of the Islamic Welfare Party, who opposed gambling on religious and moral grounds, hastened their demise, so that by autumn 1997, Turkey's 78 casinos had been closed down.

For the biggest casino operators, however, the closure represented only a temporary hiatus. As early as March 1997 *Sabah* newspaper reported on plans to shift casino operations to locations outside Turkey —to Poland, the Czech Republic, Russia, Slovenia, Azerbaijan and France. Furthermore, six operators announced their intention to move to northern Cyprus (*Sabah*, 1997). By 1998, the Turkish Cypriot Ministry of Tourism had granted a further six casino licences, bringing the total to 24, but many more were waiting in the wings, eager to capitalise on the Turkish market for casino gambling where it had become an essential leisure activity. By the spring of 1999, a further 20 entrepreneurs were lobbying hard for casino licences. If all were successful, the total number of casinos in northern Cyprus would reach well over 40, a situation that raised a number of dilemmas for the new minister of tourism.

## Policy Dilemmas

While on the one hand, giving the go-ahead to all of the casino applications might have provided a pragmatic short-term solution to many of the problems besetting northern Cyprus's tourism industry, the wholesale licensing of casinos holds threats and uncertainties for the long term.

Partisans of gambling tourism and casino expansion argued that the casinos had raised the demand for hotel accommodation and would potentially increase the demand for other tourism services, such as travel agencies, restaurants, car hire, entertainment, etc. Even some of the smaller hotels that did not have a casino claimed they had improved their chronically low occupancy rates by accommodating the overspill from the larger casino hotels. Furthermore, the casinos themselves would provide a source of local employment. Indeed, to promote this objective, legislation passed in the mid-1990s required that the proportion of foreign nationals employed in any casino should not exceed 30 per cent. Taxes and licence fees levied on casinos, it was argued, could provide a lucrative source of income for the government. Finally, from 1994 onwards, casino licences were granted only to hotel premises with a minimum four-star rating and 200 to 250 beds. After 1996, this was raised to five-star premises with a minimum of 500 beds, with the intention that casino investors should improve the level and quality of hotel stock in the north.

In addition to fears that the casinos would lead to increased crime and rates of problem gambling (the anecdotal evidence for which is so far unverified by definitive research; c.f. Scott, 2000b), critics of the casinos identified a number of negative impacts on existing tourism and its future prospects. These criticisms had two major themes: firstly, that the benefits of casino tourism were exaggerated and unevenly distributed; and secondly, that casino tourism was distorting the north's tourism product and introducing a dangerous element of dependency on the casinos.

## Who benefits?

There is no doubt that large flows of money have accompanied the establishment of casinos in northern Cyprus. The casino investors and operators own association estimates their annual contribution to the local economy to be in the region of US \$65,000,000 (*Kibris*, 20/6/99). But it is far from clear who is benefiting from these flows, and it seems likely that the gains to the public purse are extremely modest. Certainly, the issuing of casino licences is proving less lucrative for the government (which grants two-year licences for an annual fee of between \$80,000 and \$100,000 US) than it is for the licence-holders who then illegally sell their (supposedly non-transferrable) licence to third parties for much larger amounts; according to one casino manager, amounts up to \$2,000,000 US.

Hotel owners renting out casino premises are also reported to be charging an average rent of \$100,000 US a year, although during fieldwork, amounts of up to \$35,000 US *per month* were also mentioned. In the eyes of many,

this speculation in casino licences and rents functions as a secret subsidy to hoteliers, which has ensured their economic survival and enabled them to refurbish and maintain their properties in the absence of either established tourism or adequate financial assistance from the cash-strapped government. Yet it has also reinforced the casino sector's status as a largely hidden and secretive industry, and weakened central government's grip on development and their capacity to exercise effective controls.

The lack of effective government control is reflected in their inability, so far, to enforce local employment quotas. Despite the legal requirement that a minimum of 70% of the casino personnel should be local, research carried out by the Ministry of Tourism in 1998 indicated that this requirement was honoured more in the breach than in the letter. Thirteen out of 18 casinos surveyed employed fewer than 50% local staff, and four employed fewer than 20%. Only two either met or exceeded the 70% target (Ministry of Tourism, 1998). The majority of the staff are from either Turkey or Eastern Europe.

Far from boosting business for local shops, bars and restaurants, many of them claim to be suffering as a result of the casinos. Restaurateurs complain that the casino tourists seldom venture out to sample the local restaurants. What is worse, they also claim that their local business (i.e. their Cypriot clientele) is influenced by the free food, drink and entertainment offered in the casinos. This particularly hits alcohol sales, where local restaurants derive most of their profits. Although no official statistics have been gathered, anecdotal evidence from the restaurateurs' association suggests that restaurant closures have increased with the upswing in casino activity.

## **Relationship to tourism**

Despite the fact that rents and illegal income from selling off licences provide a 'hidden subsidy' to hotels in northern Cyprus, this income benefits only a small proportion of the hotels trying to make a living from tourism. Only four- and five-star hotels are allowed to have casinos, yet 85% of the membership of the hoteliers' association is made up of one- and two-star hotel owners. Small-scale hoteliers complain that their traditional market is being squeezed out by the priority given to casino tourism. The president of the hoteliers' association claims that tour operators have stopped actively promoting northern Cyprus as a "family market," thereby changing its tourist profile. Travel agents point out that casino tourism is exacerbating the transportation bottlenecks to which the north is subject by monopolising



scarce aircraft seats at the expense of other tourists. There is also evidence that the local tourist supply chain is being distorted by the trend for casinos to deal directly with tour operators in Turkey and elsewhere, thereby cutting out local travel agents. This practice is technically illegal, but appears to be increasingly rarely policed.

## A Policy Stand-Off?

The casino sector in northern Cyprus is characterised by uncertainty and lack of clarity, at least a partial consequence of the stop-and-go, contingent nature of casino tourism in northern Cyprus and its extreme dependency on developments in Turkey. The government has been criticised for being too reactive and ad hoc in relation to the casino sector. But some casino operators go further and accuse politicians of deliberately prolonging the state of uncertainty surrounding the casinos and exploiting the polarisation of public opinion for political capital. In a public statement in June 1999, the head of the Association of Casino Investors and Operators claimed: "The government does not accept us as a sector, they have classified us in the same category as gambling houses, whore houses and seedy coffee shops. Their goal is to shut us down" (*Cyprus Today*, 19/6/99, p. 2). According to this view, the government's failure so far to establish a gaming control board is symptomatic of its unwillingness to seriously engage the casino sector.

The pressures on the government to grant new licences have become so great, however, that it is finally being forced to take a position, which is proving to be no easy matter. Personal interests flourished in the previous laissez-faire climate and casino operators are now unwilling to bow to stricter regulation by government. The publication in June 1999 of a draft bill amending the Gambling Establishments, Casinos and Gambling Prevention Law provoked a strong reaction from casino operators. The bill proposed tightened restrictions on entry into casinos and an entry fee of \$10 US. The bill also provided for more vigorous action against "illegal gambling" (i.e. by citizens of northern Cyprus and students), with increased fines and up to two years' imprisonment for individuals, and even stiffer penalties (fines, three years' imprisonment and possible closure) for casino management who permit illegal gambling on their premises. The Association of Casino Investors and Operators, which had been moribund up to this point, responded with a full-page public announcement in *Kibris* newspaper (20/6/99) denouncing the proposals, and threatened to close

down all of the casinos over the summer season "so it is understood how much this sector affects tourism and the economy" (*Cyprus Today*, 19/6/99: p. 2). The amendments were watered down, and the threatened closures did not occur.

## Conclusion

Eadington (1995) has pointed out that places eager for the economic benefits of casino tourism development often overlook the associated costs of establishing and maintaining an adequate policy and regulatory framework. Resource constraints alone, however, do not fully explain the experience of northern Cyprus. As McMillen (1996b) points out, to approach casino tourism development solely from the angle of costs, benefits and technical management solutions ignores the radical transformations in social, cultural and economic relations into which casino tourism destinations are thrust, and in which the state, out of necessity, plays a central part as the source of legitimation, legislation and public policy. The history of northern Cyprus's involvement with casino tourism provides a telling illustration of McMillen's further observation, that governments are "constrained and complex forums for competing ideas, rather than the autonomous and single-minded organisations assumed from a paradigm of economics and public choice" (1996b: 31).

What is most striking in the northern Cyprus case are not the financial barriers to achieving regulatory efficiency, but the state's inability to reconcile conflicting internal and external political and ideological pressures (exacerbated by its symbiotic relationship with Turkey and dependence on developments there); its failure to send out clear signals to the competing interest groups and the general public and its unwillingness to engage the casino sector seriously, from a position of strength. The example of northern Cyprus suggests that the obstacles to economic development which characterise peripheral regions, and which are rooted in conditions of dependency, vulnerability and uncertainty, are likely to be intensified rather than alleviated by the relationship with the footloose, global casino industry.

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## Problem Gambling Service

**Centre for Addiction and Mental Health (CAMH)**  
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### Programme description:

The Problem Gambling Service (PGS), a Centre for Addiction and Mental Health (CAMH) program, is the only mainstream problem gambling treatment program in the Greater Toronto Area (GTA). All services are offered on an outpatient basis. It provides counselling to gamblers and family members who are concerned about the effects of gambling on their lives.

We offer one-to-one counselling, marital and family counselling, telephone counselling (18% of our clients choose phone counselling; of these, 72% are female) and weekly groups. Family members may be seen with or without the gambler, and separate groups are available to them. The Corrections Program operates on-site at three correctional facilities, offering group and individual counselling.

Five populations (youth, older adults, women, corrections and ethno-cultural groups) receive special attention from the PGS for problem gambling awareness, education, research and clinical programming.

## **Philosophy of Service:**

Our service is client-centred and extremely easy to access: clients need no referral and generally speak to their counsellor during their first phone contact. We use a harm reduction approach.

Treatment modalities include motivational, cognitive-behavioural and solution-focused counselling, as well as relapse prevention techniques. Weekly education and support groups have utilized a LifeSkills format, as well as a process-oriented approach.

## **Profiles of Our Services**

### **Staff:**

The staff come from Social Work, Addictions and Psychology backgrounds, with six full-time equivalent addiction therapists. The PGS works closely with CAMH educators, scientists, and writers to produce and disseminate information about problem gambling.

## **Description of Our Clients:**

Last year, the PGS provided service to 25% of all Ontarians who presented for treatment. For the entire province, these were: 315 men (70%), 133 women (30%). Fifty eight percent self-reported a primary ethnic identification other than Canadian.

Games that our clients identified as problematic were: casino table games, track betting, private card games, slot machines, sports betting, lotteries, bingo, scratch cards and Nevada tickets.

## **Outcomes:**

Based on 1999 outcome measures, 72% of clients contacted one year after treatment either maintained their goals, further reduced their gambling behaviour or experienced only minor relapses.

## **Research Involvement:**

Four PGS staff are the principal investigators on seven funded research projects:

- youth prevention study: an interactive presentation and performance presented to approximately 450 students in the GTA
- gender study: 400 gamblers are being surveyed to determine gender-related differences in gambling populations
- research on provincial treatment needs and barriers for women gamblers
- Project Weathervane: with the Canadian Foundation on Compulsive Gambling (Ontario), this study surveys Ontarians' attitudes, beliefs, knowledge and gambling behaviours
- research on the experience of winning among non-problem and problem gamblers
- validation of the Inventory of Gambling Situations, an instrument that helps identify risk situations for relapse
- research on the efficacy of a selective serotonin reuptake inhibitor in the treatment of gambling disorders.

*This Service Profile was not peer-reviewed.*

*Submitted: October 13, 2000*

*The Electronic Journal of Gambling Issues: eGambling invites clinicians from around the world to tell our readers about their problem gambling treatment programmes. To make a submission, please contact the editor at [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net)*

**issue 3 – february 2001**



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### First Person Account

## Chips, Chatter and Friends

*By Barry Fritz*

*Professor of Psychology*

*Quinnipiac University*

*Hamden, Connecticut*

*E-mail: [Barry.Fritz@quinnipiac.edu](mailto:Barry.Fritz@quinnipiac.edu)*

You meet people at casinos. While you are playing for money, you can also socialize. Last week I began chatting with a woman who turns out to be a corrections officer. She and I discussed gambling problems among prison inmates (there are plenty). Another fellow player identified himself as a recovering alcoholic. He began comparing AA meetings with GA meetings. GA meetings are much longer.

A woman with a British accent tells me that her name is Barbara. I tell her that my name, Barry, was given to me to honor my grandmother whose name was also Barbara. She tells me that she was named after a racehorse. Her father had owned a betting shop in England.

Once I was explaining, in my academic style, how I had played a hand. I was talking to a professional player who began looking at me with a pained expression. "What are you —a teacher"? I nodded affirmatively. He introduced me to another teacher in the room, also a professor, now retired. It turns out that we went to college together, and played in the same poker game, week

after week. He met his present wife while playing poker in Las Vegas. It is now forty years later and we sit down to play poker, together again.

I first met Sal while he was playing cards at the low stakes poker table. Later I ran into him at my supermarket, where he was picking up groceries. We exchanged pleasantries. He told me he was getting groceries for his Friday night house game. I asked if I could join and he invited me along. I've been playing in this game for five years. Some have been playing together for 35 years. I've never laughed as hard as I did at some of those Friday night games. I'm the baby of the group, the average age being death. Some can't hear so well and some can't see, but we play on nonetheless. I imagine the day when we'll each have a nurse's aid behind us helping us bet, call and raise.

I have a special fondness for home games. Both my mother and father had weekly games, almost their whole lives. My mother played mah jong, and I remember falling asleep as a child to the sounds "one bam, two crack" and the mah jong tiles clicking across the table. There was always prime candy in the house on those nights. Years later, I was standing at a local auction and a guy held up a box and said: "I don't know what these are. Chinese dice?" I knew and bought a box of 100 mah jong tiles for \$10. I later sold the box of tiles, keeping one as a keepsake. I sold them to a craftsman who makes bracelets out of them.

Once, at a tournament, I began chatting with a fellow player. Turns out he is a professional player from Canada, as is his wife. I meet him again in Las Vegas, and we become friends, and he, his wife, and I have dinner when they come to Foxwoods. Through them, I meet Roy, a retired geologist, who also travels to Foxwoods. Poker is his hobby as is collecting gambling materials (antique cards, faro equipment, etc.). We exchange phone calls and visits, and he invites me to the next International Card Collectors Convention in New Haven, Connecticut.

At the Orleans casino in Las Vegas, I was playing in a low-stakes poker game when I overheard two of the players discussing how a third person wouldn't let one of them take a nap in his hotel room. "Take a nap in my room," I interjected. "I'm too old to molest and I've got nothing to steal." Ray took me up on the offer. He is a Las Vegas dentist who plays poker regularly and his friend is a retired insurance agent. They both appreciated my offer, and began showing up every day at the casino to have coffee with me and discuss the day's gambling. Now I call Ray every time I'm in Vegas, and recently he turned up at Foxwoods to visit and play poker.

My favorite way to play poker is in tournaments. Tournaments are fixed entry-fee poker contests. You buy in for a fixed amount, are given tournament chips, and you play to win the chips sold to other players. The prize is a percentage of the total pools (all of the entries sold). People are usually in better spirits in a tournament since the risk of losing is limited to the buy-in. Some people will only play in tournaments. One told me he had been an out of control gambler and drinker. He straightened out his life, and gave up all forms of gambling, with the exception of tournaments. Tournaments can offer all of the thrills of high-stakes games without the attendant risks.

Every Sunday at the Mohegan Sun casino, you can play in a seven-card stud tournament for \$20. With your entry fee the casino gives you a buffet ticket for breakfast. Over a 100 people show up each Sunday.

Most of my playing time is spent in poker tournaments. I meet the same people, week after week, playing in these tournaments. We schmooze, laugh, get irritated and try to win. At the last one, Flo leaned over and told me a delightfully raunchy joke, which you can ask me for if we ever meet.

The first tournament I played in was at Foxwoods as part of a major tournament series. They gave me a room at their hotel for \$30 if I entered a \$25 tournament. I lasted about five minutes in the tournament, was among the first ones knocked out, but I loved the thrill of the contest.

I travel from time to time to play in tournaments in other parts of the country. These are larger tournaments and are sponsored by the casinos; they attract thousands of people from all over the world. Often people in these tournaments get discounts on their hotel rooms and food. While I have won at smaller local tournaments, I have never won anything at these larger ones. Nevertheless, I get a big kick out of them. It is like a professional convention or a meeting of hobbyists. You will meet people from all over the world and in every walk of life. You'll meet famous players, who have the status of stars and have won million dollar prizes. And you can also meet less famous players (i.e. me). You can play against the "Tiger Woods" of the Poker World for the price of the entry. You will see them again, in Las Vegas, California and Connecticut. If you want (I never have) you can play in these events in Costa Rica, Russia, France, Austria, Finland, and at the Canadian National Exhibition.

In a recent article in the New York Times (April 30, 2000), Walter Goodman speaks out in favor of gambling. He feels that gambling transcends gaming. The other ingredient is the bonding of like-minded players who hope to outwit fate's pessimistic outcome.

As Goodman points out, all players, poker players, slot machine buffs and roulette fanatics see themselves as part of the gaming club. The rules of entry are very simple:

*"Whatever game you favor, the casino makes it easy to join up. Women and men, blacks and whites, the disabled and the able-bodied – all are welcome...As the poker regulars like to say, all you need is a chair and a chip.*

*That is the special lure of the casino, be it upstate or downstate or on the reservation. For your time at the table or at the machine, loneliness is abolished; you are among a cadre of the like minded. Win or lose, the world seems a friendlier place. All right, if you win, it is a little friendlier."*

I played daily for awhile with an elderly woman who came to the table with a walker. She played very well and now has some of my money. She was heard saying, "What would I be without poker? Just an old lady with a walker." Poker added pleasure to her life, as it does to mine, and to others.

Sex is good, but poker lasts longer. There are lots of players for whom sex is a memory, but they can still cut the cards.

*Submitted: July 20, 2000*

*This account was not peer-reviewed.*

*Barry Fritz is Professor of Psychology at Quinnipiac University, Hamden, Connecticut. He is a member of the board of the Connecticut Council on Problem Gambling. He graduated with a BA from the University of Vermont, an MA from Connecticut College, and a PhD from Yeshiva University.*

*"My current research interests are focused on understanding the motivation to gamble and those factors which differentiate between problem gamblers and recreational gamblers. I enjoy the game of poker and hope that my research will keep me on the recreational side of the table."*

*The W. Goodman quote above is copyright © 2000 by The New York Times Co.*

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## review

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### Book Review

## Betting the House: Winners, Losers and the Politics of Canada's Gambling Obsession

*By Brian Hutchinson. (1999).*

*Toronto, ON: Viking Penguin, 264 pages. Hardcover price \$32  
Cdn. ISBN: 067-088-586X.*

*Reviewed by Lisa Schmidt*

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The first and only time I was in a casino, I was 12 years old. I was on holiday with my parents travelling from Vancouver to California with a stopover in Reno. There isn't much to Reno —certainly there wasn't then—but I can say that the flashing lights, and the men with shiny, studded white shirts with matching Stetson hats and heavily mascara'd wives made a huge impression

on me. So did the pair of elderly women clutching plastic margarine tubs half filled with quarters. They lunged in unison at my mother screaming "don't touch *that*, it's *ours*!" when she tentatively approached a vacant slot machine with \$2 worth of coins in her hand.

That memory came back to me as I read *Betting the House*, a recent Canadian book that explores the psychology of gambling, the business interests that propel it and the not-quite-innocent relationship between all levels of government and casino developers. Written by journalist and self-acknowledged naive gambler Brian Hutchinson, the book offers a brief history of the gaming industry, a cross-country round-up of gambling's rabid grip on governments and gamblers alike, and finally, some proposals to end what Hutchinson calls "a feverish experiment that's gone wildly, madly, out of control." It also takes a peek at the ephemeral highs of winning and the more common desperation of those, like the two who accosted my mother, who in their quest to score, lose not only a respect for others, but possibly their life savings.

If Hutchinson's research has value, the citizens of Canada, along with the vast majority of its governments are slowly going mad with wager fever. As evidence, he offers anecdotes about people like Mary, a happily married, gum-chewing government worker who has lost close to \$20,000 in the past two years playing the slots. When asked why she still keeps at it, Mary exclaims: "Because it's fun. It's exciting. When I walk out of here with nothing, I feel alive, like I've done something really, really naughty. My heart pounds every time. Maybe it's like a drug. After a while you kind of crave it."

No less distressing are Hutchinson's findings that governments at almost every level, strapped for cash as costs rise and revenues fall, take advantage of Mary and others like her, seeing the introduction of massive 24-hour casinos as a genie's proffered wish come true. No matter that crime rates rise when a casino is introduced to a community, or that problem gambling behaviours balloon in people who are ill-equipped to pay rent once their bets are placed and typically lost. In the mad dash to pad their coffers, Hutchinson's compelling evidence that politicians of every political hue look with greedy reverence to the gaming industry to pull them out of cash-flow wreckages of their own making is cause for alarm.

I'd be bluffing if I said the book was a great read. The truth is, it's rather depressing and mildly tedious. On the one hand, Hutchinson is adept at sorting fact from fiction, much in the way a croupier neatly sorts and divvies up poker chips. But —to this reader at least —the thoroughness of his research comes at the expense of an engaging narrative. In some chapters



there are so many statistics stacked one upon the other that it's hard to stay with the story. And my hope to learn more about why so many Canadians gamble was dashed by simplistic explanations that only led me to more unanswered questions.

However, when Hutchinson shares a more personal glimpse into the world of lotteries and blackjack, either by divulging his own forays into games of chance or moves from the purely informational into tale-telling about the lengths people will go in search of a jackpot, the book takes on the slight edgy feel of a page-turning thriller. To enjoy the author's gift for rousing my interest in some chapters only lose it in others was a disappointment.

Overall, I did like much of what the book offered simply because Hutchinson writes well. With a practised ease, he can shift from quoting Freud, who claimed gambling was a "secular religion for the obsessional neurotic," to recounting how he became "a croupier's dream" by virtue of his substantial losses at the gaming tables. I enjoyed his recounting of events in the life of Don Idiens, for instance, which began in the sleepy town of BC's Campbell River and ended in Vegas, when the small-time Canadian gambler was discovered dead, with part of his naked, battered corpse wrapped in plastic. In this sequence, Hutchinson demonstrates his talent at braiding together skeins of drama and detail into a tidy tale.

Given the depth of Hutchinson's study and his carefully articulated evidence that government is brashly promoting gambling yet is silent on the rising tide of despair left in gambling's wake, one would expect a militant call to action. Instead, readers are left with a handful of ideas, spelled out in less than two pages at the book's close. A moratorium on further casino development, elimination of gambling advertisements, funding of problem gaming programs and outlawing video lottery terminals are his recommended efforts to slow down expansion of Canada's gaming industry.

In the end, families, futures and finances will continue to fall victim to gambling's greedy appetite for winning at all costs, regardless of what measures are taken. It matters not, to my mind, if another casino never sees the light of day or if all the one-armed bandits are rounded up and buried in a big, deep hole. Because on the horizon is a growing swell of Internet gambling that will likely prove difficult to suppress. And this likely means, if Hutchinson's warnings are to be believed, that governments who have walked down gambling's plush red carpets and found them dusted with gold, will find it easier to figure out how to get a piece of that action than to U-turn back to smarter, less hazardous routes for paying their bills.

*This book review was not peer-reviewed.*

Received: September 7, 2000

## Book Review

# Diary of a Powerful Addiction

*By Alexandra King. (1999).*

*Winnipeg, MB: Crown Publishing, 256 pages.*

*Approximately \$22.95 Cdn and \$15.95 US. ISBN: 0-9685470-0-1*

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Alexandra King grew up in a farming community in Manitoba, where poverty, hard work and a belief that women do not need an education were the norm. She left school at 17, worked as a waitress, then took a secretarial course and found employment at Atomic Energy of Canada Ltd. During these early years, King married. Her husband was a gambler and over time his gambling worsened. King worked, raised two children with little help, and put herself through university on a part-time basis. Ultimately she found the courage to leave her husband of 14 years, convinced that gambling was "evil" and vowed never again to marry a gambler. King married again six years later. She had completed her BA and been promoted to a position in Human Resources. Life was good and full of promise.

King's world began to crumble when she was laid off after 22 years on the job. Forty-eight years old, angry, discouraged, disappointed in job search efforts and frightened about her future, King found her self-esteem and optimism plummeting. It was then that she discovered video lottery terminals (VLTs) at a local bar. She played and won. Despite everything she had been through while living with her husband, she began to gamble. She writes, "It was like a powerful drug that altered my mood instantly..the VLTs became my escape from my present reality."

*Diary of a Powerful Addiction* is King's account of the next six years as an obsession with gambling creates chaos in her life. She details the financial drains, the escalating tensions and deterioration of her relationship, her aborted attempts to regain control through Gamblers Anonymous and a brief stint with the Addiction Service of Manitoba. King walks us through her lapses,

painting a landscape of emotional turmoil – depression, self-hatred, fear, anger and thoughts of suicide. Her feelings are compounded as her husband, in the face of his ineffective efforts to make her stop gambling, also begins to gamble.

King eventually stops gambling. The last section of the book contains her reflections on the gambling experience and healing process, offering advice and support to others who may encounter problems with gambling. Liberally dispersed throughout the writing is King's critical commentary on the role of the government in creating and profiting from gambling addiction.

*Diary of a Powerful Addiction* is well worth reading. As a candid autobiographical account of a female slot player, it is a unique and welcome addition to the gambling literature. The socio-economic pressures bearing down on King, the emotional vulnerability she experiences, the social pressure to gamble, and the rapid progression into problems are but a few of the ways in which she represents many female "escape" gamblers.

King offers some simple and poignant descriptions of intrapsychic duality, describing the conflict between the "monster" within and the logical part of herself. She notes the emotional hijacking of her reason. She describes her developing immunity to losses and her strategies to support her denial and keep her gambling a secret. She exposes the violation of her own value system to enable her gambling. She cites psychology literature to elucidate the addictive process created by intermittent reinforcement. She offers an insider report on the process that traps the gambler into the repetitive cycle of gambling, remorse and temptations. King also describes with graphic accuracy, the mental mechanics that perpetuate the problem.

While worth reading, *Diary of a Powerful Addiction* is not easy to read. The retrospective diary format of much of the book is artificial, unconvincing and lacking in passion. The most emotionally powerful piece in the book is the poem written by her daughter Nadine. The entries do not elicit empathy for King's emotional turmoil, but create a sense of disbelief at her boringly repetitive and mindless visits to the machines despite the consequences. Perhaps this underscores the horror of the addiction as we witness how unconscious and automatic gambling becomes, but the writing fails to convey a sense of struggle. Nor does King provide a clear account of the dynamics of what seems to be her almost instantaneous cessation of gambling. She mentions two critical factors – the unconditional, non-judgmental support of a feminist counsellor and the therapeutic benefits of refocusing her energy, in her case, on writing this book. While these are key and critical elements of change for many women, it would have been helpful to have more detail about the process.

The reader needs to work too hard to know what was helpful and to get around the sense that King did it on her own. Perhaps this would not be problematic if King did not assume a role of mentor, critic and adviser to others having gambling problems. She shifts from sharing personal stories in the diary to what comes across as finger-wagging – authoritatively using "you" in the last section of the book. This serves to alienate rather than invite self-awareness and change. She does not take responsibility for her gambling behaviours, but presents as critical and blaming of the government and current treatment programs for her addiction. Finally, she presents as her own models of addiction and recovery what one suspects have been seeded and influenced by her exposure to treatment and newspaper articles (her primary form of research). If she is attempting to be academic, it behooves her to acknowledge the work of others rather than present them as her thoughts.

Professionals and students who would like to walk through the experience of a woman's addiction to slots will find *Diary of a Powerful Addiction* enlightening. It is an account of a resourceful, determined woman who fought to overcome obstacles and improve her life, only to be blindsided by an addiction to gambling. The book dramatically illustrates many of the stressors that distinguish women's experience of gambling problems from men's; issues around autonomy, guilt and shame connected to children, relationship problems, the empty nest, aging and powerlessness. It speaks to the male bias inherent in current treatment programs and the special treatment needs of many women. It would serve well in a study curriculum. Whether it would effectively inspire and guide other female problem gamblers out of the woods is questionable.

*This book review was not peer-reviewed.*

*Received: August 31, 2000*

## Movie review

# The Flintstones in Viva Rock Vegas (2000)

*By Nigel Turner, PhD, Scientist  
Centre for Addiction and Mental Health,  
Toronto, Ontario, Canada*

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*Length: 91 minutes*

*Subject: An action version of the TV cartoon series. Comedy.*

*Ratings: Canada: in Ontario F for Family, and in Quebec G for General*

*US: PG for language and innuendo*

*Studio: Universal Pictures*

*URLs:*

*-production information: <http://movieweb.com/movie/flintstones/flintsto.htm>*

*-promotional material: <http://www.vivarockvegas.com>*

When I first saw ads for the movie *The Flintstones in Viva Rock Vegas*, I was rather puzzled. Las Vegas is an adult playground for sex and gambling; not a child oriented city. Is this movie a *Joe Camel*, trying to get pre-teens hooked on gambling, or could it be an attempt to prevent gambling? I was intrigued.

For my review I took along my three older children; Naomi is 11 3/4 years, Justin, 7 1/2, and Ian is nearly 4. My children do have a somewhat heightened awareness of gambling, but otherwise appear to be fairly typical for their age and gender.

The movie, released by Universal and directed by Brian Levant, is set before Fred (Mark Addy) and Wilma (Kristen Johnston) are married. As the movie begins Gazoo (Alan Cumming), a short, flying alien, is sent to earth to investigate mating rituals. Fred and Barney (Stephen Baldwin) are discussing their new jobs at the rock quarry and their future plans when Gazoo crash lands nearby and starts to follow them around. Meanwhile Wilma is dissatisfied with her life at home and runs off to Bedrock where she meets Betty (Jane Krakowski) and finds a job at the Bronto King restaurant. Fred and Barney meet Betty and Wilma and they go to a carnival where Wilma and Fred fall in love. Fred is surprised to find out that Wilma's family is rich. However, Chip Rockefeller (Thomas Gibson), Wilma's former boyfriend, wants Wilma back. Wilma's mother (Joan Collins) prefers Chip. Chip invites Fred, Wilma, Barney and Betty down to his Rock Vegas casino.

Once at the casino, Fred has a remarkable winning streak at craps. Barney tries to get him to cash out, but he continues to play, dreaming about impressing Wilma. Meanwhile, we learn that Chip needs to marry Wilma for her money to payoff the mob. Chip invites Fred to the high rollers table and offers him a casino line of credit. In the middle of Fred's winning streak Chip switches a lever and Fred starts to lose. After all his clams are gone, Fred asks Chip for more credit. Chip tells Fred that he will erase his one million



clam debt if Fred leaves without Wilma. Fred refuses so Chip has Fred framed for stealing Wilma's pearl necklace. Gazoo shows up and reveals Chip's plot to Fred and Barney who then escape and save the day. Although the plot is never actually resolved, in the end they live happily ever after.

The movie utilises the stereotype of the mob involvement in gambling. Obviously, Rock Vegas is modelled after the old Vegas of Bugsy Siegel, not the new corporate Vegas.

The movie glamorises Las Vegas and gambling. But it also suggests that casinos cheat players. The movie shows Fred lose it all, not because of random chance and a house edge, but because of cheating. Will kids come away believing it is possible to win if you can figure out the casino's scheme and quit before the 'Lose' switch is pulled?

During the movie Naomi watched attentively. Her expressions ranged from smiling to laughing. Justin, however, sat still looking somewhat bored, and Ian had trouble sitting still. At one point Ian said, "I hate this movie."

Naomi liked the movie. She liked the fact that it showed what really happens when you gamble. First you win, then you lose. She apparently believes that the portrayal of how casinos cheat was accurate. She liked the bright lights and thought that Rock Vegas looked cool. She liked the fact that everything turned out good in the end. She liked Dino and liked seeing dinosaurs being used as tools such as vacuum cleaners. She thought it was funny in parts, but there was too much mushy gushy stuff. Naomi rated it as a 6.5 out of 10. She isn't interested in going again, but would go if given a ticket. She would like to gamble in Rock Vegas.

Justin, liked the very beginning, but otherwise found it pretty boring. His favourite character was Dino. He felt there were too many gambling and love scenes. He liked the animated animal characters such as an octopus that gives backrubs, a roller coaster made up of long-neck-dinosaurs, and a pterodactyl aeroplane. Wouldn't want to see it again. On a scale of 1 to 10 he gave it a '1.7.' (Do seven year olds understand decimals?) The movie did not make him want to gamble.

Finally, Ian didn't have much to say, but when I asked if he'd like to see it again, he said 'yes.'

I'm still puzzled over exactly who the movie was aimed at. It is rated as F for family. It has little violence and no sex, so parents might find it acceptable for young children. However, it has too little action or kid-relevant humour to hold their interest. The emphasis on the love story of Fred and Wilma would

perhaps suggest a pre-teen and teenage girls' audience, but such youths would consider this "Flintstones" too juvenile.

The movie was at times funny, and the animation and puppets were integrated well into the movie. Personally, I found the movie a bit boring, but by no means the worst kids film I've had to endure. I'd give it a 6 on a scale from 1 to 10.

In general, the movie does not appear to be a Joe Camel, but it's hardly an anti-gambling message either. The gambling serves mainly as plot vehicle that allows Chip to gain control over Fred. Perhaps it is simply a sign of the times that the producers would think nothing of adding gambling as a key plot element in a children's movie. On the plus side, it portrays how wins, financial need, and the desire for respect can lead to problem gambling. It shows how gambling can lead to losing. On the other hand, the wins and the losses portrayed in the movie were the result of non-random cheating that were specific to one person and one situation; this will not help a young audience to understand gambling.

*This movie review was not peer-reviewed.*

*Received: June 1, 2000*

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## Understanding the Laws of Probabilities

We live in a world of chance or as the mathematicians call it, probability. We hear the weatherman say that the chance of rain tomorrow is 30 per cent, meaning that there is one chance in three that rain will fall. A doctor may say that a certain treatment has a 50-50 chance of success. That means in two cases, one should be successful. The chances of being killed in a commercial plane crash are one in 22 million flights.

Chance enters into gambling and some games are called games of chance. The lotteries are a form of gambling where the odds of winning the big jackpot are very poor. It is not uncommon for the odds of winning the largest prize to be one in five million or more. I will use the odds of *one in five million* chances to explain how I understand lotteries.

The chances of winning are so remote that one wonders what people are thinking when they spend their hard-earned money purchasing lottery tickets. Perhaps it takes two forms. Some may not understand chance, while others may not understand large figures – like what a million of something really is. Some may not understand either concept.

I have devised a method that may help us understand both large numbers and chance. It's a scenario where I purchase five million tongue depressors. I then take them to our local civic center and start off by pushing them into the ground an inch (2.54 centimetres) apart. I continue this over hill and dale, putting one tongue depressor in the ground every second, eight hours a day. I

continue this for many miles. Every day of the week, I push those depressors into the soil. Finally, after 173 days (or 24.6 weeks) I place the last one. The distance covered by the five million depressors is 79 miles (127 kilometers).

But I haven't told you a secret. One of the five million depressors that was inserted into the earth has red paint daubed on the end of it.

Next, I find an avid lottery player and I show him the trail of depressors. I tell him that one of the sticks has red paint on the buried end. If he gives me a dollar and then pulls up the red-daubed one, I will give him a million dollars. Can you see him looking away farther than the eye can discern? Can you see him decide and then say, "What are you trying to tell me? I am to pick out the one with red paint from those over the whole 79 miles? You must think I'm crazy."

"No, mister, I don't think you are crazy. This just shows the chance you take when you invest in the lottery. Better by far to take the dollar, roll it up and stuff it in a rat hole. It might choke the rat."

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## On Random Musings

In Issue 2 of the *Electronic Journal of Gambling Issues: eGambling*: <http://www.camh.net/egambling/issue2/research/index.html> Nigel Turner provides an interesting and informative overview of the nature of randomness and the origins of misunderstandings surrounding aspects of randomness. There is no doubt that cognitive schemas characterised by erroneous perceptions, irrational beliefs and distorted cognitions play a primary role in the maintenance of gambling and problem gambling behaviours in particular. This view is well articulated in the publications of key researchers and clinicians such as Robert Ladouceur, Michael Walker and Tony Toneatto and presented conceptually in the cognitive model offered by Sharpe and Tarrier. There is no contentious issue for debate within this context; beliefs are important ingredients fuelling the gambling urge.

However, on reading Nigel Turner's article, I mused over the concept of

regression to the mean that was used to explain why the probability of a toss of coin gradually converged to a ratio of 50% heads and 50% tails. Turner argues that a difference of 10 heads in a series of 18 tosses is noticeable but that this difference becomes increasingly negligible with repeated tosses. After a million tosses, a difference of 10 is so small as to be meaningless. But is this explanation accurate and valid? Referring to Hayes' (1969) textbook, the concept of regression has strong roots in the work of Francis Galton. Galton noted that in the prediction of natural characteristics there was an apparent movement to the value of the group average. For example, tall parents were predicted to have children of smaller height while short parents were expected to have taller children. Consistent with the linear prediction rule, it is best-bet practice to predict that an individual will show a tendency to converge to the group average (regression to the mean) on any variable chosen. If this were not the case, we would find a gradual separation of humanity into two classes over generations as the trend continued for the tall to become taller and the short, very short. Regression to the mean is not an invariable phenomenon because exceptions to the rule are possible, tall parents can have taller children. But stated simply in statistical terms, for a value of any standard score  $Z_x$ , the best linear prediction of the standard score  $Z_y$  is one relatively nearer the mean of zero than is  $Z_x$  (Hayes, 1969, p.500).

In my musings, I wondered whether the concept of regression to the mean could be validly applied to categorical random events such as coin tossing, as well as continuous data. Perhaps the phenomenon of equal probabilities for a heads/tails coin toss, I thought in this instance, was best explained by recourse to other statistical laws. By chance, I had recently re-read Wykes (1964) interesting description of the history of gambling. Contained within its pages was an attempt to set the reader on the right path to understand why the ratio of heads to tails in coin tossing approximates 50%. Alan Wykes explains that the popular view held is that in a series of tosses heads must eventually come up because of the *law of averages*. However, he goes on to state that the phrase 'law of averages' is incorrectly used and in this context is meaningless. What is really meant is the *law of large numbers* which states that all cases will happen an equal number of times as the number of tosses approaches *infinity*. In a single toss, the probability of a head is 50%. In the next toss, the probability remains 50%. The preceding outcome has no influence given that these tosses are mutually independent events. In a short series of tosses, it is common for a disproportionate run of outcomes, say heads, to occur. This is interpreted as the lucky streak by the gambler. But, as the number of tosses approach infinity, the outcome reveals a 50% probability.

While the end result is similar, the statistical principles underlying the

phenomena of the law of large numbers and the concept of regression to the mean differ.

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## Response to 'On Random Musings'

Regression to the mean is actually a product of the law of large numbers, so there is no real contradiction. Regression to the mean in no case requires that the regression will happen. In fact, if you follow numbers along, then sometimes the percentage of heads and tails deviate further from 50%, but over the long term will gradually regress towards 50%. I suppose that to be precise, the law of large numbers is the principle that explains best what is happening in this situation of the number of coins, and regressing towards the mean describes what the percentage is doing—that is getting closer to 50%. Call it what you will, I argue that it is the experience of this phenomenon, that after such extreme deviations from chance as losing streaks, that subsequent experience will be more like the norm and give the person the illusion that the numbers are correcting themselves to conform to the expected average. Many gamblers call this the law of averages. I call it regression because it is a regression of the average in one instance or gambling session to another that produces this illusion. Yes, it is in fact the law of large numbers operating, with a subsequent sample that is more like the norm, but it is most likely still a

small sample of gambling experiences.

The use of regression in Galton's example of the height of different people is also an instance of this phenomenon. Height is partly determined by chance and it is the presence of the random component that produces regression over time. If an individual's score is close to an extreme, the potential range of random deviation is constrained by the maximum possible range so that the score will most likely move towards the middle. People in the middle of the distribution can have children that are either taller or shorter and thus the population's height remains stable; the number of tall people that have shorter children is matched by the number of shorter people that have taller children. Note in fact that Galton's example only really works if there is some degree of random breeding. Since height is largely determined by genes and nutrition, you can remove the random component almost completely by proper nutrition and selective breeding. Great Danes, for example, usually have offspring that are very similar to their parents, and do not regress towards the height of the average dog. However, if variation still exists amongst Great Danes they will regress towards the Great Dane mean. A Great Dane is a tall dog because its ancestors were selected for their height, not because of random chance. If random dog breeding were allowed, the Great Dane offspring would on average be smaller because most other breeds are smaller.

The following table outlines the parallel between the height example and gambling sessions to illustrate why I use the term regression to the mean to describe the experience of what happens to people.

Generation 1 Tall Man (e.g., 6' 8")	Random Mating →	Generation 2 Shorter Son but still tall (e.g., 6' 3")
Gambling Session one Long Losing Streak	Random Drift →	Gambling Session two Normal number of wins and losses

In the case of height, it is the random breeding that produces an offspring that is more average. In the case of gambling sessions after an unusual session of wins or losses, it is the random wins and losses that produce a session that is more like the expected average. Of course, by chance the offspring could be as tall or taller than the parents, and by chance you could have two winning or two losing sessions in a row. But if chance is operating, the most likely outcome is that extreme events will be followed by less extreme events. And I argue that it is the experience of having a great losing streak (or winning streak) followed by a more average session that produces the illusion of correction.

As for controversy, I think there is more controversy than you think. I've talked

to numerous people who believe that solving problem gambling is about helping people deal with underlying issues, rather than their experiences and beliefs. While underlying issues are extremely important, I think we need to understand the beliefs and where they come from in order to solve and prevent problems.

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## Issue 3, February 2001

### From the Editor

This issue of the *Electronic Journal of Gambling Issues: eGambling (EJGI)* offers several challenges to conventional thinking about problem gambling.

Do you accept that problem gambling is an addiction or do you question that definition? Stanton Peele's Feature article queries whether the concept of "addiction" is even appropriate for problem gambling. Another current debate concerns the accuracy of classifying problem gambling as an impulse control disorder as found in the latest 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Both the Feature article and the first Research article by Mark W. Langewisch and G. Ron Frisch also question this disease classification. These articles raise important issues and we hope readers will offer debate and comments.

If you've ever wondered about the beginnings of Las Vegas and how it got to be the way it is, you will find new insights on how this gaming centre grew out of the Mojave desert in our second Research article by David Schwartz. And to understand some non-western views that challenge mainstream assumptions about gambling and its place in society, we've reprinted an article from Australia by Diane Gabb in our Opinion section about gambling among people who may be your neighbours. Whether you love the game of poker or hate it, you may enjoy comparing your feelings to those of author Barry Fritz in First Person Accounts.

The *EJGI* also offers a new section, Service Profile, which we hope will encourage clinicians from around the world to tell our readers about their problem gambling services.

A handful of book reviews, a movie review and a debate in Letters to the Editor round out this issue. Please tell us what you think.

– *Phil Lange*

**Disclaimer:** The opinions expressed in this journal do not necessarily reflect those of the Centre for Addiction and Mental Health.

## Statement of Purpose

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

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

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## Is Gambling an Addiction Like Drug and Alcohol Addiction?

### Developing Realistic and Useful Conceptions of Compulsive Gambling



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## Abstract

As compulsive gambling and problem gamblers attract continued and increasing attention —due to state reliance on gambling for revenues and government and private marketing of the gambling experience —conceptions of compulsive, or addictive, gambling have evolved. The disease model of alcoholism and drug addiction, which predominates in the U.S. and North America, has generally been widely adopted for purposes of understanding and addressing gambling problems. However, this model fails to explain the most fundamental aspects of compulsive

drinking and drug taking, so it can hardly do better with gambling. For example, people regularly outgrow addictions —often without ever labelling themselves as addicts. Indeed, gambling provides a vivid and comprehensible example of an experiential model of addiction. Elements of an addiction model that gambling helps to elucidate are the cycle of excitement and escape followed by loss and depression, reliance on magical thinking, failure to value or practice functional problem solving and manipulative orientation towards others.

## News Item

*On May 9, 2000 the seven-state "Big Game" lottery provided a prize of \$366 million. The odds of winning were 76 million to 1. In the days before, the lottery sales outlets were overrun with people buying hundreds of dollars worth of tickets. The weekend before the lottery was held, 35 million tickets were sold. Annually, Americans spend \$36 billion on lotteries.*

## Introduction —The Purpose and Development of Addiction Theory

In 1975, I proposed a general theory of addiction in *Love and Addiction* (Peele & Brodsky, 1975/1991): that any powerful experience in which people can lose themselves can become the object of an addiction. The result of this immersion is deterioration of the person's engagement with the rest of his or her life, which increases the person's dependence on the addictive object or involvement. Certain people are far more prone to form such addictive involvements —those with tenuous connections to other activities and relationships, and whose values do not rule out antisocial activities.

Initially, both scientists and people who misused alcohol and drugs thought that the expansion of the addiction concept to incorporate such non-substance based activities cheapened and minimized the idea of addiction. At the same time, the popularity of the idea of non-drug addictions grew through the 1980s and beyond. This trend was fueled by the growing claims by many people who gambled destructively: they were equally unable to control their habit and suffered just as much pain and loss in their lives as those destructively devoted to drugs and alcohol (and quite a few of these individuals shared gambling and substance addictions).

Since 1980, successive editions of the *Diagnostic and Statistical Manual* of the American Psychiatric Association have recognized compulsive (called "pathological") gambling, although the definitions have continued to evolve. Nonetheless, for many, the idea that gambling comprises an addiction is hard

to accept; along with notions that gamblers undergo withdrawal like heroin users and that people who gamble excessively at one point in their lives are necessarily afflicted with a lifetime malady. In fact, gambling sheds light on the fundamental dynamics of all addictions: (1) addiction is not limited to drug and alcohol use, (2) spontaneous remission of addiction is commonplace, (3) even active "non-recovered" addicts show considerable variability in their behavior, (4) fundamental addictive experiences and motivations for addiction are readily apparent in compulsive gambling, and (5) gambling even helps to clarify the motivations of drug and alcohol abusers.

In an effort to make sense of addiction, gambling researchers and theorists often fall prey to the reductionist fallacy that typifies theorizing about drugs and alcohol. Blaszczynski and McConaghy (1989), for example, referred to data showing that there is not a specific kind of pathological gambler, but rather that gambling problems occur along a continuum. This is an indication that a disease model of gambling addiction is inadequate. They then cited some preliminary findings of physiological differences that might characterize pathological gamblers as potentially strong support for the disease model. Blaszczynski (2000), in this journal, posited a typology of pathological gambling including one type that is genetically caused and incurable.

The logic that dictates that an activity must be shown to be biological or genetic in its nature to be genuinely addictive is exactly backwards—for drugs, alcohol, and gambling. If a model does not begin to explain the behavior in question, then any number of associations with biological mechanisms and measurements will fail to provide an explanation (and, by extension, a solution) to the problem. Science is built on accurate and predictive models, not laboratory exercises to demonstrate, for example, how drugs impact neurochemical systems. No work of this kind will ever explain the most basic elements of addiction; particularly that people addicted at a certain time and place cease to be addicted at a different time and place (Klingemann et al., in press/2001; Peele, 1985/1998; 1990).

## **Gambling is addictive; it is not a disease**

### **Defining addiction**

Saying gambling is addictive but not a medical disease begs for definitions of "addiction" and "disease." The essential element of addiction to gambling is that people become completely absorbed in an activity and then pursue it in a compulsive manner, leading to extremely negative life outcomes. These individuals often describe a sense of loss of control in which they believe they are incapable of avoiding or stopping gambling.

The disease model looks to an inescapable biological source for addictions; some neurochemical adaptation that accounts for compulsive behaviors. In addition, a disease model posits that these neurochemical adjustments lead to measurable tolerance and withdrawal. Because the biological systems underlying the addiction are thought to be irreversible, the disease model includes the idea of a progressive worsening of the habit which requires treatment in order to arrest the addiction. According to the 12-step model of addiction and therapy presented by Alcoholics Anonymous, recovery from addiction requires lifetime abstinence, acknowledgment of powerlessness over the activity in question, and submission to a higher power.

Social psychological (or social cognitive) models of addiction (Orford, 1985/1995; Peele, 1985/1998) instead emphasize social causality, psychological dynamics and the behavioral definition of addiction—which is seen as a continuum of behavior. All of the elements said to define addiction—like compulsive pursuit and preoccupation with a substance or activity, and personal disorganization and desperation after cessation—are known through behavioral, experiential, and phenomenological observation and criteria. That is, no physiological measure defines the expression of continued need for a substance. Many post-operative patients, for instance, readily abandon large narcotic regimens without notable discomfort or the desire for more of a drug. My experiential model in particular (Peele, 1985/1998) focuses on the addict's sense of him or herself, the modification of the person's experience by the substance or activity, and the way this modified experience fits in with the rest of the individual's life.

My experiential model, while rejecting a disease formulation, creates an alternative model of addictive gambling, one which recognizes the undeniable realities that people do sacrifice their lives to gambling and that they assert or believe they cannot resist the urge to do so. At Gamblers Anonymous meetings compulsive gamblers attest to sacrificing everything for their addiction and claim they have no control over their habit, providing evidence of this subjective and lived reality. On the other hand, disease-model explanations for these phenomena may be questioned, and indeed, in many cases explicitly disproved. Yet, addiction theorists and gambling researchers err by discounting gambling's genuine addictive qualities even though gambling falls short of attaining medical disease status. While discounting gambling's genuine addictive qualities, they often assume that alcohol and drug addictions fulfil criteria for an addictive disease that gambling fails to meet.

## **Diagnostic studies of gamblers in comparison with substance abusers**

Wedgeworth (1998) found that "patients coming into treatment do not fit the

addictive disease conception of gambling behavior" (p. 5). He interviewed (both directly and through examination of autobiographies created for treatment) 12 patients admitted to a private inpatient treatment center who were diagnosed as pathological gamblers. Wedgeworth found the patients did not meet criteria of "compulsive" gambling. Rather, he found that individuals were diagnosed for practical purposes, in order to fulfill insurer criteria while allowing them to repair their personal relationships. Nonetheless, in a case extensively described, the patient "had burned all his bridges" —separated from his wife, lost his job, and faced embezzlement charges (p. 10).

Patients who receive hospital treatment for addiction frequently do not meet all the criteria for addiction, but this does not distinguish gambling from alcohol and drug patients. For decades, research has found that intakes in heroin treatment centers often reveal negligible (or sometimes no) signs of opiate consumption, and that private drug and alcohol centers commonly admit anyone who shows up for intake in order to fill their treatment rolls. In 1999, the founder of the American Society of Addiction Medicine, G. Douglas Talbott, was found liable for fraud, malpractice and false imprisonment for coercing a physician into treatment who was not alcohol dependent (Peele, Bufe & Brodsky, 2000).

Orford, Morison, and Somers (1996) compared problem drinkers with problem gamblers. Orford et al. employed an attachment scale, which found that problem drinkers and gamblers were equally devoted to their habits. However, drinkers scored significantly higher on a severity-of-dependence scale including both psychological and physical components of withdrawal. For Orford, these findings call for a refocusing on subjective states rather than on withdrawal symptoms as indicators of addiction. Orford's view that addiction is best understood from an experiential and behavioral perspective is close to the position I take. However, I believe that symptoms of addiction, including withdrawal and tolerance, are simply behavioral manifestations of the same attachment that Orford et al. measured (Peele, 1985/1998).

There are reasons not to accept that withdrawal and tolerance are absent in gambling addiction, or at least any more so than they are in alcohol and drug addictions. Wray and Dickerson (1981) claimed that gamblers frequently manifest withdrawal, although their definition of withdrawal as restlessness and irritability might be questioned. However, classic studies of withdrawal have found that even heavy narcotic users manifest extremely variable symptoms, which are highly subject to suggestion and environmental manipulation (Light & Torrance, 1929). Moreover, the recent WHO/NIH Cross-Cultural Applicability Research Project found that withdrawal and other alcohol-dependence symptoms varied tremendously from cultural site to site (Schmidt, Room & collaborators, 1999, p. 454).

Thus Orford et al.'s view that dependence symptoms exist objectively and that factors such as treatment experiences and social learning do not determine



their prevalence is not well founded (Peele, in press). Indeed, Orford and Keddle (1986) showed that a subjective scale of dependence, prior treatment and AA experiences yielded better predictive models of alcoholism treatment outcomes (particularly with regard to the achievement of controlled drinking) than did the same severity-of-dependence measure Orford et al. used for the purpose of differentiating gambling from drinking problems. In the DSM-IV (American Psychiatric Association, 1994), the manifestation of tolerance and withdrawal is not essential for a diagnosis of dependence.

Thus, while I remain highly sympathetic to Orford and his colleagues' view that an essential element of addiction is the experience of attachment; I find the distinction they draw between an attachment-based definition of addiction and manifestations of withdrawal and tolerance unjustified and unnecessary.

## **Distribution, continuity, and self-identification of addictive problems**

If there is a disease of alcoholism, or of compulsive gambling, some people should manifest a distinct addiction syndrome. Yet population studies (as opposed to clinical studies of individuals in treatment) of alcoholism, drug addiction, and compulsive gambling regularly reveal that different people display different types of problems, and that the number and severity of these problems occur across a continuum rather than forming distinct addict and non-addict profiles. Moreover, interview studies of general populations of drinkers (or of large populations of clinical alcoholics, like the Rand studies and Project MATCH) find tremendous movement and variability in severity of problems such that over time (sometimes quite brief periods), the severity of their problems shift—including substantial numbers who are no longer found to have a diagnosable problem (cf. Dawson, 1996 and Peele, 1998, in the case of alcohol; Shaffer, Hall & Vander Bilt, 1998, reviewed in Hodgins, Wynn & Makarchuk, 1999, provide similar data for gamblers).

Obviously, some people's gambling problems are worse than others. A person can have an unhealthy gambling habit that can be termed pathological without being a fully addicted (i.e. compulsive) gambler. Blaszczynski (2000) dealt with such differences by defining a three-part typology of gamblers. He based these types on an outcome study (McConaghy, Blaszczynski & Frankova, 1991) in which the three groups are characterized by non-abstinent recovery, abstinence from gambling, and continued pathological gambling. Blaszczynski posited that the first group of problem gamblers are "normal": people who successfully reduce their gambling habits and who otherwise have normal personalities. The second group—"emotionally disturbed gamblers"—have pre-existing personality disorders to which pathological gambling is a response. The third and irremediable group of gamblers—whom Blaszczynski does not label—are highly impulsive and are

hypothesized to have a strong biological component and a specific allele at the D2 receptor gene site (Comings, Rosenthal, Lesieur & Rugle, 1996).

But the Blaszczynski model shows the same weaknesses as other such models in regards to epidemiological, typological, and etiological data and theory. In the first place, it seems quixotic and visionary to imagine that outcomes of gambling treatment will be related on a one-to-one basis to gambling types. Certainly, severity of pathological gambling could well be related to the likelihood of resumption of non-pathological gambling and of successful resolution of a gambling addiction. But that there are distinct demarcation points of severity that indicate distinct syndromes—and moreover that these are related to entirely distinct causal factors, genetic or otherwise—belies the kind of integrated bio-psycho-social model Blaszczynski (2000) endorses. And, indeed, McConaghy, Blaszczynski and Frankova (1991) did not find distinct personality differences to characterize treatment outcomes in their study. Rather, all such pathologic gamblers can be understood to use gambling as a response to some combination of personal, situational, and biological characteristics according to a social cognitive model.

Blaszczynski and his colleagues have focused on the personality trait of antisocial impulsiveness as being central to a key type of (one might say "genuine") gambling addiction. This syndrome includes other emotional disorders (Blaszczynski, Steel & McConaghy, 1997; Steel & Blaszczynski, 1998). In this research, the gamblers studied are unable to curb their urges, disregard the consequences of their actions on others, use gambling as a response to dysphoria and emotional problems, and are predisposed to substance abuse and criminality. These individuals are manipulative and readily sacrifice personal relationships to their urges—stealing or diverting money from family and friends and carrying on campaigns of duplicity.

For Blaszczynski (2000), this type of gambling addiction is genetically determined by a gene claimed to cause alcoholism and other addictions. For many genetic researchers, this connection is not only unlikely but has already been disproved (Holden, 1994). Yet, many of the traits identified by Blaszczynski et al. (1997) resemble those found in alcohol and drug abusers—particularly antisocial impulsivity (Peele, 1989/1995). Likewise, drug abusers and alcoholics frequently demonstrate manipulative and alienated relationships. Such similarities in the lives of those addicted to disparate involvements indicate common addictive patterns and motivations with different triggering events, social milieus, and personal predilections leading individuals to one or another type of addictive object. At the same time, a given individual often alternates or substitutes from among a variety of addictions, including problem drinking and gambling. For such individuals, it is the experiential similarities in these involvements that link the activities.

The movement of individuals from one group or outcome to another refutes



Blaszczynski's distinct gambling types —especially the incurable genetically based variety. Just because a person failed to benefit from treatment at one point does not mean he or she is doomed to gamble compulsively forever. Nor is the severity of a gambling problem a guarantee of its permanence. In the 12-step approach to alcohol, gambling and other addictions, the individual is required to admit that he or she is genuinely addicted. In my view such self-labeling is rarely helpful. For example, when surveys objectively measure compulsive behavior in remission (subjects who in a lifetime prevalence measure score as addicted, but do not currently score as such), many such individuals say they have never had a gambling or other addictive problem.

The failure to identify or at least to treat alcohol dependence, accompanied by remission, is more common than not for those who have been alcohol dependent (Dawson, 1996). Likewise, Hodgins et al. (1999) surveyed over 1800 Canadians and identified 42 respondents who revealed a lifetime gambling problem but who had had no problem in the last year. "Only 6 of the 42 in the target sample acknowledged ever having experienced a problem with gambling ..." (p. 93). This could be regarded as demonstrating the clinical symptom of denial. However, it may be a functional attitude when it permits people to leave a gambling or other addictive problem behind; perhaps more readily than if they identified themselves as addicts.

## **The addiction cycle and the proclivity to addiction**

Some people have extremely destructive gambling experiences and some develop chronic gambling habits and problems. The individual loses more than she or he intended, feels bad about the losses, tries to recoup them by continuing to gamble —only to lose more, and good money follows bad. Even though the risk of gambling or the prospect of winning can be exhilarating, the aftermath of gambling losses are emotionally deflating and create increasing legal, job and family problems. At the same time, future gambling relieves the anxiety, depression, boredom and guilt that set in following gambling experiences and losses. At this point, the individual can come to feel that he or she only lives when involved in the gambling experience.

The addictive cycle is central to my experiential model of addiction (Peele, 1985/1998), and is described repeatedly in the gambling literature (cf. Lesieur, 1984). One critical element of the pathological gambling experience is money. For Orford et al. (1996, p. 47), the problem cycle begins with "negative feelings associated with gambling losses" in combination with the "person's positive experience of the gambling activity itself, shortage of money and the need to keep the extent of gambling a secret" (p. 52). The individual who is lost in this cycle relies on magical solutions —as do drug and alcohol abusers —to produce desired outcomes without following functional plans to achieve his or her goals (Marlatt, 1999; Peele, 1982).

Although Blaszczynski (2000) emphasized the diversity of pathological gambling, he identified "elements relevant to all gamblers irrespective of their subgroup." These elements include the association of gambling with "subjective excitement, dissociation, and increased heart rate" often "described as equivalent to a 'drug-induced 'high.' " Another common element is the "downward spiral of gambling ....When gamblers lose, they attempt to recoup losses through further chasing ...Despite acknowledging the reality that gambling led them into financial problems, they irrationally believe that gambling will solve their problems." The subjective allure of the addiction and the self-feeding nature of the addictive process describe the addictive cycle and the predisposition to magical solutions central to the addiction experience.

## Conclusions: Gambling and Society

Unlike illicit drug use, which the state prohibits, and alcohol, which is manufactured privately, the state has a central role in gambling —both administering lotteries and other gambling venues, and licensing casinos, race tracks, gambling machines, etc. This direct relationship between the state and addictive gambling versus the state's indirect role in drug and most alcohol addiction has critical implications. For one thing, gambling venues continue to expand rapidly. Yet, the third element that Blaszczynski (2000) identified as central to all pathological gambling is that prevalence "is inextricably tied to the number of available gambling outlets." There is also a special temptation to think that addiction in this area is genetically determined, since this would minimize the responsibility of governments for the incidence of the problem. Modern thinking about drug addiction and alcoholism encourages this reductive view of gambling addiction. However, it is unfounded, not useful for understanding and ameliorating addiction, and leads (as it does in the case of gambling) to dysfunctional social policy.

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## Beliefs and Value Systems: Understanding All Australians

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### **Most explanations of problem gambling depend on British or American models, yet there are other ways of viewing the world**

Governments at state and federal level are beginning to take seriously the growing evidence of problem gambling in many communities throughout Australia. This concern often takes the form of funding for strategies such as specialised counselling and the development of self-help manuals on how to handle problem gambling, that are addressed to the general public in lay terms.

These are undoubtedly very worthy measures designed in different ways to tackle the problem, the magnitude of which threatens the lives, livelihoods and



family relationships of increasing numbers of people.

Problem gambling is now being seen not only as a social and economic problem but as a serious mental health issue that has implications for mental health services and practitioner expertise in a multicultural community. A quarter of the population has origins in more than 100 countries, and the rest represent a rich heterogeneous heritage of indigenous and non-indigenous Australian born.

Counselling services for problem gambling are proliferating. Although most counsellors have mainstream backgrounds and North American theoretical perspectives, an increasing number are being recruited from ethnic minority groups and indigenous communities. Counselling agencies are starting to understand that mainstream counselling is itself a cultural artifact that is based on psychological theories developed in Europe and the United States for largely WASP populations with middle-class status and college education. Therefore we are beginning to see some efforts to modify established counselling methods to take in different cultural value systems, client expectations and help-seeking behavior.

The newest self-help books are readable, affordable and readily accessible that is, for Australians who read English and live within, or at least understand, the cultural boundaries of the mainstream Anglo-Australian culture in which there are certain shared and recognisable underlying values.

However, if you are outside the mainstream culture, if you are indigenous or from an ethnic background culturally distant from the mainstream, such books may be of little or no help. This is because the cultural values that underpin your life's path and your community may have little to do with prominent Anglo-Australian notions of individualism and the cult of self as reflected in the ever-shrinking nuclear family. In problem-gambling terms, there may be very different traditions and belief systems influencing your behavior and your thinking about games of chance and the unseen forces that control life's outcomes.

## The meaning of gambling

It seems that most societies engage in some form of gambling, which is an extension of play. However, gambling takes on a new meaning because stakes are introduced, leading to risk-taking. In some cultures there are sanctions against gambling because of a prevailing view that gaining something purely through luck or chance is morally unsound.

Islam and early Protestantism adopted this view, and discouraged participation in games of chance, as it somehow represented interfering in divine law. Indeed, Islamic teaching suggests that by indulging in games of chance, human beings are attempting to meddle with "blind" fate and therefore inadvertently mock the divine plan in which nothing is left to chance.

A Persian verse suggests that gambling is a metaphor for life. Death is the croupier:

This world is the dicing den of the devil. In it,

We are the players. Fate supervises the numbers thrown.

(Quoted by Hyde, in Rosenthal, 1975, p.161)

Another poet compared life's vagaries to the roll of the dice:

Fate is the player. We the counters are.

Heaven the dice, our earth the gaming board.

(From Ibn Sina, quoted in Rosenthal, 1975, p.161)

Indeed institutionalised centres of gambling, like casinos, reflect the society surrounding them: elegant upper-class meeting places in parts of Europe; the great leveling experience of Las Vegas; or the stage for the machismo performance of masculinity, pride, loss and chance found in Latin America (Thompson, 1991). Indeed important values of the prevailing society are embedded in each gaming setting, allowing patrons to play a role attached to notions of leisure, daring and risk-taking all underpinned with the heady excitement of access to money.

One point seems certain: "People of the Book", whose traditions have come to them through the Judaic-Christian-Islamic heritage of monotheism, have religious and moral sanctions in place against gambling. In many instances throughout history this has been translated into formal government policy, leaving those who gamble to incur the consequences of flouting the rules and laws of church and state. Despite this, people continue to gamble, for many reasons.

One reason might be interpreted as an assertion of individuality against authority. The drive to individualism in Western cultural norms might explain why people who feel anxious or ambivalent about their gambling

transgressions tend to explain them away in terms of making a personal choice, about the need to feel a sense of excitement, the desire to take risks despite traditions that hold gambling as an undesirable activity.

A different philosophy exists in many neo-Confucian cultures, those ancient cultures in which a combination of Buddhist teachings and the writings of Confucius have given people another blueprint for understanding the world. Here we see a mixture of fatalism and activism. Strong beliefs are held simultaneously about the inevitable effect of external forces that are beyond human control, like the Buddhist precepts of fate or a former life. At the same time people must strive to achieve honorable earthly goals that are within their reach for the glory of family and ancestors (Yu, 1996).

An ancient proverb puts it this way: One's life is determined first by destiny, second by luck, third by feng shui, fourth by moral conduct, and fifth by education. So one very important goal is the achievement of personal success, both monetary and educational, which will reflect favorably on one's ancestors and family. A common New Year's greeting is: "I wish you increased wealth." In fact, the accumulation of wealth through educational success may be the main path to family honor. The concept of yuan explains a person's success or failure, as it represents the external invisible force that is beyond control. A person with du yuan exhibits an affinity with gambling, a special quality that will make winning very likely, as it harnesses those invisible outside forces. Yuan also works against feelings of guilt or hostility as it takes away the need for blame and promotes a passive acceptance of life's vicissitudes. But yuan is not fixed forever; Confucian teaching encourages people to take action to change and manipulate fate, and to work hard for a better future (Yu, 1996).

In the same vein is feng shui, the ancient science of geomancy that encourages humankind to plan buildings and surroundings to enhance opportunities for gaining luck and prosperity. This has the effect of driving out the malevolent and bringing in all that is good and life-enhancing. Part of this time-honored system is the ancient application of numerology to life's decisions and events.

Indeed people who come from neo-Confucian cultures may approach gambling and concepts of luck and chance from a different mindset which holds that those who play for money are not transgressing a moral law. Instead they are testing karma or fate. This is not to suggest that there are no sanctions against the personal and societal risks involved. We know that gambling activities often form part of New Year celebrations associated with attracting luck at an auspicious time. These are controlled within the collectivist norms of the community, thus working against the rise of the

isolated problem gambler (Nguyen, P., 1998).

Gambling in the neo-Confucian context may be contrasted to gambling in the Judaic-Christian-Islamic tradition which through received religious teachings maintains sanctions against indulging in games of chance for personal gain. In this context, people have to go outside those precepts to engage in gambling.

What is interesting is that the personal motivation for traveling the potential path to good fortune through a game of chance requires very different explanations from different cultural-value perspectives.

## Beyond recreation

There are other ways of understanding gambling from a social and economic perspective. For the Tiwi people of North Australia, playing cards for money has become part of an adaptation to an imposed socio-economic system that implies a distinct division between work and leisure that did not exist in earlier times.

Tiwi women are the main "small time" gamblers, as winning small amounts of money is seen as equivalent to providing food for family members either by gathering from natural sources or by buying items at the local store. For Tiwi men it is less frequent, and the stakes are higher: once again it is seen as the equivalent of providing food, but in the same order as the occasional and successful hunt, the windfall being used for purchasing symbols of success in the white world like cars or travel to the mainland.

The inevitable consequence of the gambling paradigm is the opportunity for the family or community to share in the losses and the gains, which is a central cultural tradition of the Tiwi (Goodale, 1986). This pattern may be prevalent among other Aboriginal communities of similar size and geographical isolation.

## How we explain gambling

Central to mainstream explanations of why people gamble is the notion of individualism and personal self-interest. Self-help manuals describe problem gambling as any gambling behavior that is beyond the control of the individual and causes personal, economic and social hardship for the person, the family and friends (Coman & Burrows, 1998).

As a statement of fact, this may apply in all cultures in describing a personal and social problem at a relatively superficial level. However, it says nothing about underlying value systems unfamiliar to mainstream thinking, and therefore poses several significant questions. What messages do minority cultures receive through the media about gambling as a state-sanctioned pastime? When people come from a culture that respects benevolent authority to a new country where prominent politicians openly support casino activities, what conclusions do they draw?

In addition to these, what is the result of a convincing advertising campaign aimed at particular ethnic communities showing fellow countrymen enjoying casino wins and receiving casino vouchers in lucky red New Year envelopes? The answer can be seen in the demographics: a community that represents 1% of Victorians is over-represented at Melbourne's casino making up 60% of the clientele.

## **Gambling and mental health**

There is ample evidence of the depression-addiction cycle surrounding problem gambling in all cultures in Australia. Mental-health professionals are increasingly turning their attention to this issue among ethnic and indigenous communities, however they may be unaware of their own ethnocentric views on what constitutes rational and irrational thinking in terms of belief systems other than their own. In addition to the barrier of language in the therapeutic encounter, techniques that challenge beliefs relating to luck and chance may be used without effect when the underlying value systems of the parties are culturally distant.

Comfortable middle-class professionals may also be largely unaware of the effects that result from the migration or refugee experience. It is possible that post-traumatic stress disorder following a history of torture and trauma is a real factor in the origins of problem gambling in some communities.

## **Life events and stress**

It is now apparent that the lowered status of unemployed Vietnamese men and the rise in independence and earning power of their employed wives has changed family roles irrevocably. This has led to severe depression, increased marriage breakdown and domestic violence. The vision of a win at the casino to redeem a man's place of honor and power in the family in an alien land may be a powerful trigger in the gambling cycle.

Latin American communities relate similar scenes of despair. Problem gambling may be associated with the frustration of machismo and its attendant values of masculinity, risk-taking, challenging fate, honor, hesitancy to delay gratification, and demonstration of bravery. These have their cultural origins in the destruction of mestizo communities over centuries of colonial oppression, but they find few outlets in the migration-settlement-unemployment cycle in contemporary Australia.

## Conclusion

It is apparent from the current literature that the understanding of problem gambling and strategies for countering it are embedded in mainstream Anglo-Australian concepts of individualism, autonomy and personal responsibility. This includes approaches to counselling models, self-help manuals, advertising of opportunities for seeking help and the promotion of good mental health. There is little or no mention of understanding collectivist value systems in which the family or community is the core unit, not the individual.

This would mean a change in approach to expectations of client help-seeking, client understanding of what counselling is, and the model of counselling itself. It may require counsellors to extend their repertoire to include unfamiliar elements like subtlety and indirectness in communications, avoidance of confrontation and direct interpretation of motives and actions, and respecting different meanings in family relationships.

We also need to encourage and support members of ethnic communities to join the helping professions in much larger numbers than at present. They will provide the key to parallel beliefs and value systems, which are vital in helping us understand the gambling habits and attitudes of Australians from non-Anglo traditions. This will enable us to offer more culturally appropriate strategies to combat the same potentially destructive effects that may be visited upon all cultures. In this way there will be greater opportunity for equity in helping all Australian problem gamblers, whatever their birthright traditions.

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# Classification of Pathological Gambling as an Impulse Control Disorder

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## Abstract

The purpose of this paper is to examine the appropriateness of the current classification of pathological gambling as an Impulse Control Disorder. Controversy over the current categorization is as heated as it has ever been with more research suggesting that gambling is in fact not strictly an impulse-driven behaviour. Research also shows that pathological gambling is similar in presentation and treatment outcome to other addictive behaviours such as alcohol and substance abuse. Given such findings, it is arguable that pathological gambling needs to be re-examined in terms of where it fits into a psychiatric classification system.

# Introduction

The Diagnostic and Statistical Manual of Mental Disorders (3rd ed., 1980) was the first to treat compulsive or pathological gambling as a separate condition labelling it a "mental disorder" (Levy & Feinberg, 1991). The DSM-III-R (1987) categorized pathological gambling as one of several Impulse Control Disorders, vaguely defined as mental disorders characterized by an irresistible impulse to perform harmful acts (McElroy, Hudson, Pope, Keck & Aizley, 1992). People with impulse control disorders have three central characteristics:

1. they fail to resist impulses to perform some act that is harmful to them or others;
2. they experience an increasing sense of tension before committing the act; and
3. they feel pleasure or release at the time the act is committed (Murray, 1993).

Pathological gambling specifically involves repeated failure to resist the urge to gamble, resulting in disruptive patterns that impair the ability to function in personal, family and occupational roles.

## Personality Profiles of Pathological Gamblers

Descriptions of gamblers' personalities have been derived primarily from personality inventories. It is unclear whether the personality traits identified in the inventories preceded and contributed to pathological gambling or followed after and resulted from the gambling activities (Lesieur, 1979). In other words, if gamblers score high on scales of impulsivity, then presumably, they have difficulty controlling their impulses (hence an Impulse Control Disorder); it cannot be determined if this impulsivity trait was a cause of the gambling behaviour or caused by the gambling behaviour.

Langewisch and Frisch (1998) conducted a study in which they compared non-pathological gamblers [individuals with scores of less than five on the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987)] with pathological gamblers [individuals who scored five or greater on the SOGS] on measures of impulsivity. They found that the relationship between gambling and impulsivity scores were not significantly different for non-

pathological gamblers compared to pathological gamblers. Increased gambling severity (as measured by the SOGS) was not significantly related to increased impulsivity scores for pathological gamblers. They also found a strong relationship between gambling and other addictive behaviours.

Dickerson (1979) observed people betting on horses and dogs in a betting office in Scotland. He found that frequent bettors appeared to delay placing their bets until just before the start of the race. Additionally, people who follow horse racing carefully spend considerable amounts of time and energy attempting to increase their odds of winning. Studying horses, jockeys and tracks all figure into their calculations (Ladouceur, Giroux & Jacques, 1998). In the same manner, people who gamble on sporting events will often invest hours examining players, injuries, previous games and match-ups in hopes of increasing their knowledge and subsequently their odds. A reviewer for this journal pointed out that "even chasing is often a carefully calculated attempt to tap into the law of averages." Admittedly, not all gamblers (social or pathological) behave in this purposeful manner. These are just a few examples of how gambling can be a very deliberate and calculated act, rather than a rash, impulsive behaviour. These patterns of behaviour would seem to be more indicative of someone who has control over their actions rather than someone who is acting on impulse alone. In fact, when examined, this behaviour would be better labelled as compulsive rather than impulsive.

Little research has been conducted on self-control in gambling. Evidence for loss of control as an identifying or distinctive feature of gamblers (as expected in the DSM-III-R and DSM-IV, 1994) is not yet clear (Murray, 1993). Are there distinctive personality characteristics in pathological gamblers? While much has been learned about the personality traits of gamblers, both pathological and social, a personality profile distinguishing them has not yet been identified (Murray, 1993). As a result, it seems premature, even unfounded, to categorize individuals as pathological gamblers according to a behavioural pattern rooted in a personality trait. Whether or not gamblers can be split into two distinct groups, pathological or social, or those who lack control and those who do not, are issues that require further research and clarification (Dickerson, 1987; Greenberg, 1980; Murray, 1993).

The DSM category of Impulse Control Disorders is a diagnostic group that is not well understood. An "impulse" is not defined, and by placing "impulse, drive, or temptation" (DSM-IV) together any debate about what is meant by an impulse and what is meant by a drive is completely avoided. Several authors have questioned the DSM category's diagnostic validity, especially

with respect to gambling; many believe that pathological gamblers do not really experience irresistible impulses and that they retain control over their behaviour (Murray, 1993).

## **Pathological Gambling as an Addiction**

There is no universal agreement about what exactly constitutes an addiction. The primary area of controversy surrounding the definition of an addiction is substance use versus behavioural activity (Griffiths & Duff, 1993). Most professionals in the field have little difficulty accepting the idea that the consumption of a substance (for example, alcohol and illicit drugs) is potentially addictive. In contrast, when referring to behaviours such as gambling, the definition of addiction becomes the primary focus of debate. Traditional views hold that in order for addiction to occur, a chemical substance and subsequent physiological effect must be present. However, more modern models of addiction attempt to identify components of excessive behaviour and the effects (i.e. social, occupational and personal problems) thereof. In doing so, the definition of addictions is expanding to include behaviours as well as substances.

The DSM-III-R's criteria for pathological gambling were modelled after the criteria for psychoactive substance abuse (from the DSM-III) and included notions such as "tolerance" and "withdrawal" (Lesieur & Rosenthal, 1991). Pathological gambling can also be viewed as an addiction whereby a pathological gambler appears to be completely enthralled in the gambling activity and will tend to increase bets in the same way that drug addicts increase their dosage and/or use (Jacobs, 1988; Lesieur, 1988). Similarly, pathological gambling is often treated in programs based on or modelled after other addictions, i.e. Alcoholics Anonymous and Gamblers Anonymous. Pathological gambling, clinically speaking, is generally considered analogous to alcoholism and substance abuse as they are often present in the same people, as well as in the same families (Blume, 1987; Lesieur & Rosenthal, 1991). Pathological gamblers have actually been successfully treated in treatment programs with alcoholics and substance abuse addicts (Murray, 1993). Admittedly, pathological gambling differs from substance abuse addictions because physical drugs are not consumed. However, what gamblers often describe as the sensation they experience while gambling is similar to the sensation substance abusers describe when using drugs or alcohol. Gambling, similar to drug and alcohol abuse, are all characterized by increases in tolerance, cravings and a consistent need to continue to take the drug or indulge in the behaviour.

# Conclusion

Future Diagnostic and Statistical Manuals of Mental Disorder need to carefully evaluate where pathological gambling fits into a classification system. While there are arguments for and against both the current classification and the idea of gambling as an addiction, the latter seems to be gaining more and more support, from both researchers and clinicians. The implications of achieving the most applicable and "correct" classification spread into the realms of prevention, treatment and social policy.

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# **Ambient Frontiers**

# **The El Rancho Vegas and Hotel**

# Last Frontier: Strip Pioneers



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## Abstract

The first two casino resorts built on the roadway that became the Las Vegas Strip broke new ground in several ways. The El Rancho Vegas inaugurated the winning combination of gambling, dining, entertainment and vacation amenities that has become the basis of the casino gaming industry. The Hotel Last Frontier was the first truly "themed" casino that encouraged patrons to lose themselves in a fantasy world of Old West nostalgia while vacationing and gambling within the casino. These two casinos originated two concepts that would define American casino gaming into the next century: self-contained vacation pleasure within a suburban resort and the heady use of lavish theming to encourage patronage. Understanding their stories deepens appreciation of the history and current reality of casino gaming.

The casino gaming industry, particularly on the Las Vegas Strip, has historically intertwined two seemingly paradoxical ideas: the breaking of exciting new ground and an emphasis on comfort and convenience. Casinos transport patrons to a personal frontier not of hardship but of

wealth (or its lure); they vie with each other for the title of largest and most modern, but they also promise familiar vacation comforts and friendly customer service. Casinos thus offer a special kind of frontier where ambience and opportunity are subtly shuffled in a reality-blurring thematic prestidigitation. The first two casino resorts of the Las Vegas Strip pioneered in the pairing of these two conflicting concepts; though their important role in the successful selling of casino gaming as a legitimate form of public entertainment has been obscured over time.

Since the late 1940s pushing the frontiers of "the newest with the mostest" in casino design has encouraged operators on the Strip to build regenerative expansions, additions, and renovations, often sacrificing their existing physical plants. Progressive waves of "frontier-breaking" gaming operators, each of which sought to recreate the Strip in his own image, have thus inadvertently obliterated most physical signs of the Strip's history. Consequently, much of the Strip's history has been muddled. For example, the most notorious of the early casinos, the Flamingo, is often mistakenly identified as the first "real" casino on the Strip. This oversight is particularly unfortunate because the two casinos that preceded the Flamingo in breaking the frontier of the casino landscape of the Strip contributed important concepts to the evolution of the unified casino resort complex that has come to dominate American gaming.

The first, the El Rancho Vegas, represented the earliest genuine synthesis of a gaming casino, lodging and entertainment within a single, self-contained complex —the casino resort. The second, the Hotel Last Frontier, pioneered the use of Old West nostalgia in the selling of casino gaming, and its application of a themed environment as a marketing tool was a distant harbinger of the lavish theming that would be revived with the opening of Caesars Palace in 1966 and codified into the Las Vegas experience with the spate of themed casinos of the early 1990s. Together, the El Rancho and Last Frontier both foreshadowed and inspired trends that would dominate the gaming industry into the next century.

In the early 1940s, Las Vegas seemed to be a minor resort town in need of further commercial development. Though not completely insulated from the Depression, the city enjoyed the boon of a significant federal presence, first through the Hoover Dam and later through military bases. Consequently, the city did not suffer as badly as other regions of the state, particularly Reno, during the lean years of the 1930s. The town's proximity to Los Angeles more than anything else spurred its potential; as Southern California increased in population and wealth, Las Vegas's tourist base grew. The city's possibilities as a hospitality center seemed promising.

However, the primary development of resorts in Las Vegas spiraled in a suburban, rather than urban, direction. The casino resorts that would pace the region's economy were not centered on the town's downtown, but on its major southern artery, Highway 91. This roadway segued into Fifth Street to the north and meandered south about 300 miles (480 km) across the Mojave Desert to Southern California; thus its alternate designation as the Los Angeles Highway. There had been minimal development on Highway 91 before the early 1940s. The best-known club there, the Pair-o-Dice, predated the 1931 decriminalization of gambling. Before that year, patrons had to knock on the front door and identify themselves before gaining admittance. After gaming decriminalization, the Pair-o-Dice ran "wide-open." Its operators, Italian immigrants Frank and Angelina Detra, were reputedly connected to Al Capone. Los Angeles's Guy McAfee bought the Pair-o-Dice in 1939 and aptly renamed it the 91 Club. Though the Pair-O-Dice/91 Club was, by all accounts, a pleasant gambling operation, it was not affiliated with a motel or hotel. The club's structure eventually became subsumed into the original Last Frontier (Wright, F., personal communication, December 28, 1999).

Las Vegas and American gaming entered a new era on April 3, 1941 when Thomas Hull opened the El Rancho Vegas just south of city limits (San Francisco Avenue, later re-christened Sahara Avenue) on Highway 91. Thomas Everett Hull had operated hotels in most of the major urban centers of California, including San Francisco, Fresno, Sacramento and Los Angeles before setting his sights on Las Vegas. As the owner of the El Rancho motel chain, Hull decided to open a franchise in Las Vegas after consulting a number of local business leaders (Castleman, 1997). It is inconceivable to believe that Hull had anything but the Los Angeles trade on his mind when he planned his casino on the highway to Los Angeles.

Later Strip boosters parlayed Tommy Hull's decision to build on the Los Angeles Highway into an almost Biblical parable of a stranded traveler suddenly receiving a lucid vision of profit. As a Las Vegas travel guide of the mid-1950s relates:

Other years saw other near ventures, but never did Las Vegas see a completed resort hotel until 1940 when hotel man Tom Hull and a friend were



*Fig. 1. El Rancho Vegas in the 1940s. The unprepossessing main building doesn't seem to point towards the giantism and flash of today's Las Vegas Strip – but today's casino resorts are strikingly similar in philosophy to the El Rancho. [© University of Las Nevada-Las Vegas 2000]*

*(Detail - click the picture to view a larger image)*

driving from Las Vegas down the now-paved Highway 91 towards Los Angeles. On the edge of city limits, Mr. Hull had a flat tire, and while his friend hitchhiked back into town for help, Mr. Hull stood on the highway and counted the cars. An hour of this and he became convinced that the mesquite and sage-stippled fright of a desert behind him was a mighty wholesome spot for a luxury hotel (Best & Hillyer, 1955).

This anecdote plays on one of the key points of the Las Vegas mystique: stumbling into riches, but belies Hull's deliberation; he had not ended up in Las Vegas by pure luck. Finally, had Hull not decided to get a jump on the Southern California trade by leapfrogging Fremont Street and building his casino on Highway 91, another enterprising casino impresario certainly would have.

Hull built his casino complex in a frontier/Spanish mission style, and its conception and execution owed a debt to the "Hollywood back-lot" school of design; the casino's structures were built primarily for impressive show rather than efficient function. The casino, in which patrons could gamble at craps, blackjack, roulette or slot machines and could enjoy an Old West ambience replete with archaic firearms and cowboy hats. The physical structure of the El Rancho set a pattern for Strip casinos until the high rise era, with a central structure housing the casino, restaurants





and theater, surrounded by motel wings. The motel had 65 bungalow-style rooms in a number of independent structures. The El Rancho was built along the lines of a suburban subdivision rather than a typical urban gaming hall. Each "cottage" was directly accessible by car via paved and lighted streets. Although the complex had public restaurants and recreation facilities, the presence of private lawns, porches and kitchens in the El Rancho's vacation cottages suggests the private space of the suburbs.



*Fig. 3. A bird's eye view of the El Rancho Vegas in its first decade. The insular nature of the first trip casino resort is clear from this photograph, and the motel bungalows surrounding the main building recall a suburban subdivision. The then low-rise city of Las Vegas is scattered to the north. [© University of Las Nevada-Las Vegas 2000]*

*(Detail - click the picture to view a larger image)*

According to Guy Landis, an El Rancho employee, the casino pioneered the idea that "all of a guest's needs could be found on the premises" (Stamos, 1979, April 1). Among the services that the El Rancho featured were a travel agency, retail shops and nightclub-

*Fig. 2. El Rancho builder Thomas Hull (right) and three cowboy entertainers. This photo was taken in the 1950s at the El Rancho's first rival, the Last Frontier. [© University of Las Nevada-Las Vegas 2000]*

*(Detail - click the picture to view a larger image)*

The casino's casual western decor seems more a product of an undertaxed imagination than a deliberate marketing approach. Because Nevada gaming halls had catered to the "boots and jeans" crowd since the 19th century, Hull's El Rancho Vegas did as well. In retrospect, it is clear that Hull, the first real builder on the Strip, was crossing into a new frontier of casino design armed with increasingly dated ideas of what a casino should be. Still, Hull sensed that traditional western gaming halls had to be at least tweaked to pull in Southern Californians. Not content with giving his patrons recycled cowboy relics, Hull also imported showgirls from San Francisco and Hollywood to liven up the casinos (Stamos, 1979, April 1).

Hull's casino also featured a prescient focus on creating a uniformly tranquil vacation experience for his guests. The El Rancho's managers touted customer service as a premium attraction.

style entertainment, as well as a steakhouse, swimming pool and spacious lawns (Castleman, 1997). Employees were instructed to make guests "feel both welcome and excited about visiting the El Rancho." This, rather than keeping an eagle eye on the bottom line, was their "most important task" (Stamos, 1979, April 1). The El Rancho was successful at keeping its patrons happy. Former El Rancho cocktail waitress Goldie Spicer described in an oral history taken over thirty years later the large numbers of patrons drawn from the nearby Basic Magnesium Plant, and wartime federal projects in the area, such as the airfield north of Las Vegas, kept the motel reasonably filled (Spicer, 1977).

Although Hull had a winning idea, he was not successful in his proprietorship of the casino; and the El Rancho persisted through several ownership changes in the 1940s. By 1947, it had passed into the hands of Beldon Katleman, a UCLA mathematics major and something of a wunderkind. He was 29 when he assumed control of the El Rancho, holding a bachelor's degree, which was a point of pride for civic boosters in an era when most casino operators had not finished high school. Paul Ralli, Las Vegas attorney and booster of the early 1950s, synthesized his praise of Katleman with his adulation for the atomic bomb: "[Katlman] typifies the Atomic Age: relentless urge, overflowing imagination, bubbling ideas" (Ralli, 1953). Having inherited a share in the El Rancho Vegas from an uncle, Katleman bought out the other owners and became the casino's sole proprietor of record.

Katlman oversaw a comprehensive renovation and expansion of the facility. He imported architect Tom Douglas from Los Angeles and expanded the complex from the 22-building/144-room complex he had inherited to 69 structures with 220 rooms (Stamos 1979, April 1). Katleman did more than add rooms; he substantively changed the flavor of the complex, starting the Strip tradition of constant, phoenix-like regeneration. The stylistic revision of the El Rancho transformed its look from cowboy kitsch to French provincial pastiche. The gourmet room, for example, had its name changed from the Round-up Room to the Opera House (Ralli, 1953).

If its theming and conception borrowed from the existing vocabulary of Nevada gaming, the El Rancho's self-contained, insular nature positioned it as the first suburban casino resort in the state. The casino was never promoted as having the best service in Las Vegas; it was merely assumed that guests would never even think about going to the city with their needs already met. The El Rancho marks the dawn of the suburban casino resort both because it was physically aloof from its surrounding cityscape and



because it catered to middle-class suburbanites on vacation rather than workaday city dwellers. In a quadrant of the nation where the automobile was the pre-eminent factor in residential and commercial development, and in an age when urban gambling would come under increasing fire, this was a logical and natural adaptation. Significantly, the renovations of the late 1940s hardened the boundary between the El Rancho and its surroundings by replacing the corral fence that had originally circumscribed the property with a solid wall. This, perhaps, was an unconscious reflection of the El Rancho's shift in identity from desert frontier outpost to suburban neighbor.

The integrated casino-resort complex that Hull pioneered was smart business. Ronald Coase in his seminal essay "The Nature of the Firm," hypothesized that the real reason behind the emergence of firms as business entities was their suppression of the price mechanism. A business that integrated many functions under a single directing hand and avoided paying the market price for them would gain a competitive advantage over those that did not (Coase, 1993). By combining several functions within his self-contained suburban resort, Hull lowered the costs for patrons, thus making the El Rancho and later Strip resorts a smarter buy for the tourist dollar.

Casino resorts, as they developed on the Strip, could afford to run their hotel, entertainment, and food and beverage departments at a loss. In a perfect world, everyone would be happy: casino operators would have a captive group of patrons, and casino patrons would get cheap meals, entertainment and accommodations, thus stretching their travel budget. Indeed, this is how the Strip has been promoted, officially and unofficially, throughout its history; although, the success of retail and other tourist adjuncts on the Strip has, since the early 1990s, challenged and ultimately weakened this former iron law of casino economics.

The Hotel Last Frontier, which opened on October 30, 1942, was like the El Rancho, a self-contained roadside gambling hall and motel. However, it refined and extended the use of Nevada's frontier past as a marketing tool. Its builder, R. E. Griffith, the proprietor of a chain of movie theaters in Texas and Oklahoma, was best described as a "good-natured and likeable Texan" (Scott, 1957). His nephew, architect Bill Moore, actually designed the complex and supervised its construction. After Griffith's death in 1943, Moore became the casino's chief operator, though he transferred ownership in 1951 to a group including Guy McAfee, Beldon Katleman and Jake Kozloff (Ralli, 1953; "Last Frontier," 1951).

The story of Griffith and Moore's initial involvement in Las Vegas is similar



*Fig. 4. Friendly neighbors from the Old West styling on the ground of the Last Frontier in the early 1950s. [© University of Las Nevada-Las Vegas 2000]*

*(Detail - click the picture to view a larger image)*

to Hull's in its reliance on happenstance. The two were planning a hotel/theater building in Deming, New Mexico. Having heard promising news about Las Vegas, they stopped off in the desert town and decided "the opportunities were fabulous." They immediately canceled the Deming project and began planning the Hotel Last Frontier to the south of the El Rancho on the opposite side of Highway 91 (Moore, 1981).

With no previous gaming experience, the hoteliers found themselves in dire need of seasoned casino employees and managers. Griffith and Moore hired away many of the El Rancho's employees, beginning a bidding war that increased the bargaining power of casino workers. A cocktail waitress who

worked at both the El Rancho and Last Frontier described her employers and working conditions as unconditionally "wonderful" and asserted that competition between the two gaming halls drove up wages and created opportunities for employees at both casinos (Spicer, 1977).

The frontier of the hotel's name and essence was, of course, the Old West. The complex was "conceived to be as near western as we [Griffith and Moore] could make it," Moore related in his oral history:

The lobby had extremely high ceilings with the fireplace running right up through the middle of it—actually two fireplaces in the lobby, in the form of an octagon. The ceilings were of hewn timbers—logs—rough-sawed boards antiqued in such a way as to look many years old. And the whole structure was laid out on that basis (Moore, 1981).

The casino's western decor also featured buffalo heads, saddles and other "genuine" pioneer fixtures throughout the complex. The sandstone patios and fireplaces were hewn by Ute Indians imported from New Mexico for both their skill and the "authentic" western flavor their work would have (Best & Hillyer, 1955). In an apparent nod to the Southwest's mission tradition, the main showroom was christened the Ramona Room. Other noted attractions included the Horn Room, whose walls showcased a



*Fig. 5. Last Frontier architect and operator William J. Moore. Moore, together with his uncle Robert Griffith, founded the Hotel Last Frontier and brought the Last Frontier Village to Las Vegas. [© University of Las Nevada-Las Vegas 2000]*

number of animal horns, and the Gay Nineties Bar, a fin-de-siècle saloon (Stamos, 1979, April 8).

The Gay Nineties Bar was in fact much of the Arizona Club of Block 16, Las Vegas's pre-war red-light district. Moore simply bought up the bar and its leaded-glass front entrance and put it into the hotel as the Gay Nineties Bar. Though largely faithful to the original design, Moore added a "western" flourish:

...we did add some saddle bar stools made out of leather in the form of a western saddle.

Naturally, we had to make it comfortable. We didn't use the

complete saddle design, but looking at the rear of the bar stool was like looking at the rear of a saddle. So in some cases there were stools big enough for two people because you would actually be—what looked like—seated on the side of the saddle (Moore, 1981).

No comment could reveal more about the theming of the Last Frontier. As "the Old West in Modern Splendor," it gave patrons the trappings of the frontier west but the comfort expected of a resort hotel. Where the real western town of Las Vegas was not "west" enough, Moore embellished without sacrificing his guests' comfort. This elevation of ambience over reality was to become a touchstone of casino resorts along the Strip.

The most outstanding feature of the casino, however, was the Last Frontier Village. Brought to life by 1950, it presaged both Disneyland and later elaborately themed casino resorts in its unabashed exploitation of a themed environment. This complete re-creation of a "genuine" western village boasted a variety of "Old West" and Chinese artifacts. Nevada gambler and casino owner Robert F. Cauldhill, better known by his colorful nickname Doby Doc, originated the village with his collection of memorabilia. In the early part of the 20th century, Cauldhill began his career cooking on a chuck wagon in Nevada cattle territory. After purchasing a joss house from the "Chinese Syndicate" of Elko, Nevada, Cauldhill discovered his passion: assembling a massive collection of relics from Nevada's frontier past (Ralli, 1953).



*Fig. 6. The entrance to the Last Frontier Village. This village predated Disneyland as a consumer-based themed fantasy town. [© University of Las Nevada-Las Vegas 2000]*

In 1947, Griffith and Moore convinced Cauldhill to open his heretofore private collection to public view and designed the Last Frontier Village around it. The village was designed to display artifacts so that "the public would be allowed to see it and use it and actually were not charged for viewing it." But Moore did not only want to preserve the past; he admitted that he wanted to use it as "an advertising method in order to induce people to come to the hotel and stay there—patronize the hotel, patronize the village" (Moore, 1981).

The Last Frontier Village included a mix of museum pieces with working "authentic" western attractions and retail establishments. Included within in were three "complete railroad outfits with engine, tracks and the usual accessories." The village featured a drug store, general store, post office, schoolhouse and jail, as well as the "original printing plant of the venerable Reese River Reveille, Nevada's oldest newspaper" (Ralli, 1953).

Moore and his compatriots in the Last Frontier transcended dry historic preservation. The Golden Slipper Saloon and Gambling Hall, which opened in 1951 within the Village, allowed guests to wager at various games including an antique Wheel of Fortune, reportedly used in 19th century mining camps. It was considered a "genuine" reconstruction of an Old West watering hole. A group of dancers called the Flora-Dora girls, outfitted in period costumes, performed nightly in the Old Bar ("Old West," 1951). The Last Frontier Village was to provide guests with a total entertainment experience centered upon, of course, gambling. In addition, patrons could relive the Old West through purchases at retail establishments like a rock shop and an art gallery that featured paintings of western subjects: landscapes, mining towns, horses and cowboys.

A Texaco gas station on the grounds of the Village crystallized Moore's use of history to market the gaming experience. The obvious anachronism of a gas station in the Old West was assuaged by the use of "period replica" design. In other words, the gas station was a reproduction of what an Old West gas station would have looked like had the internal combustion engine been in use a generation earlier—an interesting commentary on the bottom-line oriented historicism of the Last Frontier Village. Within this gas



station, faux western design was neatly merged with customer service and astute marketing. William Moore describes the gas station's genesis:

It was designed by [Walter] Zick and [Harris] Sharp, Las Vegas architects. Originally, because Texaco [had] been using a fire chief—old, you might say, western-type advertising on their stations and promotion—we felt that it was a good tie-in with the old fire engine and tied in with Texaco's advertising... Part of the idea was to put showers, restrooms, and so forth that would be inducive [sic] to the people cleaning up after a drive across the desert. The restrooms were rather elaborate—quite a number of stools and lavatories—various types of equipment that we could use in promotion, where the people would have the service that could be advertised on the road (Moore, 1981).

By Moore's admission, the gas station was a tourist trap, as was the village that surrounded it.

The pithy phrase "The Old West in Modern Splendor" neatly sums up the marketing strategies of the earliest western-themed casino resorts. They wanted their patrons to see the Old West, but not necessarily smell it, so to speak. The operators of these casinos envisioned visitors "roughing it" in the ambience of the Old West while enjoying all of the "modern" amenities of the Atomic Age. There is deep historical irony in casinos like the Last Frontier simultaneously evoking the Old West frontier and offering their patrons a complete travel experience in air-conditioned comfort. A travel guide of the period captures the irony implicit in the dualistic promotion of Strip casinos:

Tourists enjoy the Chuck Wagon suppers, served from ten in the evening till seven the next morning – price, \$1.50 – and breakfast is served twenty-four hours a day. Nowhere in the world is there anything quite like it – this informal magnificence at multi-million dollar hotels at little more than motel rates; and you can take your choice of nearly a dozen of the nation's top-flight shows for the price of a drink. Of course, the casinos carry the load (Scott, 1957).

This is a unique construction of the Wild West: promiscuously free-flowing food, lodging, and quality entertainment, with nary a frontier hardship in sight. It captures, though, the freewheeling but comfortable ambience that casino operators successfully engineered on the Strip.

The constant re-creation of the Strip has left few traces of the first two casinos. The El Rancho's central structure burned to the ground in a suspicious conflagration in 1960; after languishing as a non-casino motel and eventually a storage facility—it was razed entirely and is currently a vacant lot across the Strip from the Sahara. In 1955, the Last Frontier was replaced by the space-age New Frontier, which in turn was demolished and replaced by the adjective-less Frontier in 1967.

This Frontier, too, may soon pass; its current ownership has floated the possibility of shuttering and imploding the Frontier and replacing it with a San Francisco themed resort. Given the current trend towards redevelopment of Strip casino hotels into hyper-themed megaresorts (and Steve Wynn's plans for the extravagant rebuilding of another fellow north-Strip landmark the Desert Inn), the closing of the "new" Frontier's is likely to happen sooner rather than later.

Even though these first casinos' physical presence proved ephemeral, they cast long shadows in the areas of casino design and promotion. Almost all casino gaming in North America takes place in self-contained casino resorts, and many of these resorts, particularly in crowded, competitive markets like Las Vegas and Atlantic City, use theming to attract customers and stimulate play. Although the El Rancho and Hotel Last Frontier have faded into obscurity, the basic paradigms they advanced have never been questioned. Patrons continue to negotiate the ambient frontiers of the casino as they choose from a buffet of themed, self-contained gaming destinations. The notion of casino operators as frontiersmen (and women) breaking revolutionary ground has been retold in each generation of the Strip. But, the contributions of the earliest frontier breakers cannot be underestimated. The El Rancho began the evolution of the casino as a self-contained suburban resort, while the Last Frontier's use of theming to promote gaming tourism would eventually become a Strip staple. Even as new resorts on the Strip outdo each other in opulence and casinos proliferate across the United States, the lessons to be learned from the "first frontiers" of the early Strip, like the idea of the "new frontier" itself, can be applied anew.

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## intro

### From the Editor

The second issue of the *Electronic Journal of Gambling Issues (EJGI)* offers new insights into a range of gambling topics. The Feature article describes why gambling becomes a problem for some youth, the Research article uncovers the mysteries of randomness and how we often misunderstand it, and the Clinic article explains how attention-deficit hyperactive disorder can be involved in problem gambling. The First Person Accounts section presents a lively rant on e-trading as gambling and the Review section features an informative video on problem gambling. Please check the Letter to the Editor and the Calendar. If you missed the first issue you can access it through the Archive. We hope you find this issue interesting and that you tell your friends and colleagues about *EJGI*.

If you would like to receive a live-link to each future issue of the *EJGI*, please go to the bottom of any article and click on "Subscribe to our automated announcement list." You'll receive an email message with a live link to every new issue.

At this early stage in the life of the *EJGI*, it seems like the right time to thank everyone who helped begin this e-journal. Geoff Noonan, now with the Canadian Foundation for Compulsive Gambling (Ontario), was a strong presence in the beginning and so were Andrew Johnson, Nina Littman-Sharp, Robert Murray, Wayne Skinner, Tony Toneatto and Nigel Turner. We thank Mara Korkola and Alan Tang for their expertise in creating an attractive and smooth functioning Web site.

We're excited about these first few issues – and we're still growing. We'd appreciate your feedback on what you would like to read. We're also pleased to

include our first official link to a related Web site - the Youth Gambling Research & Treatment Clinic (McGill University, Montreal, Canada) at <http://www.education.mcgill.ca/gambling>: Here you'll find useful information, a self-quiz, treatment and research updates and FAQs. Our plan is to create an entire section for useful and relevant links in the very near future.

- *Phil Lange*

## Statement of Purpose

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

The *EJGI* is published by the [Centre for Addiction and Mental Health](#) and is fully funded by the Ontario Substance Abuse Bureau of the Ministry of Health and Long-Term Care. We welcome manuscripts from researchers and clinicians, people involved in gambling as players, and family and friends of gamblers.

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## feature

# Youth Gambling: A Clinical and Research Perspective

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## Abstract

This paper provides an overview of the current state of knowledge of youth gambling problems. The goals and contributions of the McGill University Youth Gambling Research & Treatment Clinic are highlighted. The authors integrate their clinical and research program findings within the context of the necessity of identifying risk factors associated with problem gambling amongst adolescents. Specific recommendations are made as well as a call for collaborative effort between the public, industry, legislators, clinicians and researchers to help resolve this growing problem.

With the proliferation of gambling venues worldwide, there has been a renewed interest in the social, economic and psychological costs associated with problem gamblers. While problem gambling has been primarily thought of as an adult problem, there is a growing body of empirical evidence to support examining problem gambling during adolescence (Derevensky, Gupta & Della Cioppa, 1996; Gupta & Derevensky, 1998a, 1998b; Jacobs, in press; Ladouceur & Dubé, 1994; Ladouceur, Dubé & Bujold, 1994; National Gambling Impact Study Commission, 1999; National Opinion Research Center, 1999; National Research Council, 1999; Stinchfield, in press; Volberg, 1998; Wiebe, 1999; Wynne, Smith & Jacobs, 1996).

There is little doubt that gambling and wagering remains a popular activity amongst both children and adolescents. Research conducted over the past decade suggests that gambling activities remain particularly attractive to today's youth. Moreover, its popularity is on the rise amongst both children and adolescents. Large-scale prevalence studies and reviews all confirm the high prevalence rates of youth gambling. In particular, it is estimated that between 4% and 8% of adolescents presently exhibit a serious gambling problem with another 10% to 14% of adolescents at risk for developing or returning to a serious gambling problem (Shaffer & Hall, 1996).

An alarmingly high percentage of children and adolescents have reported engaging in gambling activities. In one of our recent studies, we found 80.2% of adolescents between the ages of 12 and 17 reported having gambled (defined as wagering money) during the past 12 months, with 35.1% admitting gambling at least once per week. The data further revealed that while 55% of adolescents were casual or recreational gamblers, 13% reported having some gambling related problems and 4% to 6% had a serious problem (Gupta & Derevensky, 1998a).

It is important to note that differences in findings are often related to the sampling procedure employed (e.g., telephone interview versus school survey), the types of instruments used (e.g., SOGS-RA, DSM-IV-J, GA20), cut-off criteria established and access to both legal and illegal gambling opportunities (see Derevensky & Gupta, in press, for a more comprehensive discussion of these issues). While some discrepancies may be attributable to differences between assessment instruments, similar rates of problem/pathological gambling for older adolescents (age 17 - 19) were found comparing different instruments on the same sample (Derevensky & Gupta, in press). Independent of differences, Shaffer and Hall's (1996) Harvard meta-analysis concluded that "...compared to adults, youth have had more exposure to gambling during an age when vulnerability is high and risk-taking is a norm; consequently, these young people have higher rates of disordered gambling than their mature and less vulnerable counterparts."

The growing concern with adolescent gambling was the focus of the North

American Think Tank on Youth Gambling held at Harvard University in April 1995. It was part of the NORC gambling impact and behaviour study (NORC, 1999), and was of particular concern to the members of the Committee on the Social and Economic Impact of Pathological Gambling, U.S. National Research Council (NRC, 1999). This renewed interest in youth gambling has resulted in a significant increase in the number of funding opportunities and empirical research studies concerning youth gambling. More recently, the field has begun to go beyond merely conducting prevalence studies in an attempt to broaden our understanding of youth gambling behaviours and to identify specific characteristics and high-risk indices associated with problem/pathological gambling (Gupta & Derevensky, 1998a; Griffiths & Wood, in press).

Of significant importance is that for most adults, teens, educators and many psychologists, gambling continues to be viewed as an innocuous behaviour with few harmful or negative consequences. Our clinical experience shows that even when adolescents with serious gambling and gambling-related problems enter our treatment program they don't perceive themselves as compulsive or pathological gamblers (Gupta & Derevensky, 1999; Hardoon, Herman, Gupta & Derevensky, 1999). As one adolescent remarked, "everyone seems to think I have a gambling problem, but I don't think I have one." Their perception of a pathological gambler is a classic stereotypical picture, one that bears no resemblance whatsoever to a teenager. As a result, most adolescents often fail to present themselves for treatment.

Characteristically, most individuals perceive the typical problem gambler to be an adult, usually male, who has lost his job and family, who has committed a crime in order to support this behaviour, who has deserted his children, etc. While these gambling related problems are synonymous with adult pathological gambling, the adolescent gambler with serious problems looks somewhat different. Many are still students, who have never been married, who reside with their parents, and who have never held a full-time job or deserted their families. As a result, treatment paradigms must be modified to accommodate their developmental needs, interests, concerns, behaviours and the difficulties they experience (Gupta & Derevensky, 1999; in press).

Problematic gambling among adolescents has shown results in increased delinquency and crime, the disruption of relationships, and impaired academic performance and work activities (Ladouceur, Dubé & Bujold, 1994). While these youth present themselves differently when they compare themselves to adults, they nevertheless have similar characteristics. They repeatedly lie to family and friends, borrow and steal money to support their gambling behaviour, preoccupy themselves with gambling, sacrifice school, parents and friends in order to continue their gambling, and engage in 'chasing' behaviour (Derevensky & Gupta, in press; Fisher, in press; Gupta & Derevensky 1998a; 1998b; Wiebe, Cox & Mehmehl, in

press).

Contrary to public opinion, our research and clinical work (Derevensky & Gupta, 1996; 1998; Gupta & Derevensky 1998a; 1998b; 1999) suggests that money is not the predominant reason why children and adolescents gamble. For adolescents with gambling problems, money is used as the vehicle that enables them to continue playing. Most adolescents report that the primary reasons for gambling are for the excitement and enjoyment derived from these activities. Through their gambling activities (video lottery terminals, sports betting, cards, lotteries, bingo or other forms of gambling) adolescents with gambling problems exhibit a number of dissociative behaviours, such as escaping into another world, often with altered egos (Gupta & Derevensky, 1998b). When gambling, adolescents with serious gambling problems report that nothing else matters and that all their problems disappear. They view gambling as a coping mechanism, albeit an ineffective one, for dealing with their daily stresses and feelings of depression (Gupta & Derevensky, 1998b; 1999). For an adolescent with a gambling problem, a good day is walking into a gaming room with \$20, playing all day, and losing all their money. A bad day is when the \$20 only lasts 10 minutes.

While parents and educators remain concerned about student smoking and use of alcohol and drugs, little attention has been focused upon youth gambling behaviour. Both elementary and secondary school students regularly engage in gambling and do so more frequently than any other potentially addictive behaviour (Gupta & Derevensky, 1998a).

Our research program has been designed to identify risk factors associated with youth gambling problems, to examine the antecedents of the problem, and to delineate effective strategies for prevention and the treatment of youth with serious gambling problems. Despite some conflicting findings, there appears to be an overall consensus that:

- a. gambling is more popular amongst males than females (Fisher, 1990; Govoni, Rupcich & Frisch, 1996; Griffiths, 1989; Gupta & Derevensky, 1998a; Ladouceur, Dubé & Bujold, 1994; Stinchfield, Cassuto, Winters & Latimer, 1997; Wynne et al., 1996)
- b. probable pathological gamblers are greater risk-takers (Arnett, 1994; Breen & Zuckerman, 1996; Derevensky & Gupta, 1996; Powell, Hardoon, Derevensky & Gupta 1999; Zuckerman, 1979; 1994; Zuckerman, Eysenck & Eysenck, 1978)
- c. adolescent prevalence rates of pathological gamblers are two to four times that of adults (Gupta & Derevensky, 1998a; Shaffer & Hall, 1996)

- d. adolescent problem/pathological gamblers have lower self-esteem (Gupta & Derevensky, 1998b)
- e. problem gamblers have higher rates of depression (Gupta & Derevensky, 1998a; 1998b; Marget, Gupta & Derevensky, 1999)
- f. youth problem gamblers dissociate more frequently when gambling compared with peers who have few gambling problems (Gupta & Derevensky, 1998b)
- g. adolescents with gambling problems are at heightened risk for suicide ideation and suicide attempts (Gupta & Derevensky, 1998a)
- h. while adolescents with gambling problems report having a support group, old friends are often replaced by gambling associates (Derevensky, 1999)
- i. adolescents remain at increased risk for the development of an addiction or polyaddictions (Gupta & Derevensky, 1998a; 1998b; Kusyszyn, 1972; Lesieur & Klein, 1987; Winters & Anderson, in press).

Personality correlates reveal specific at-risk traits with adolescent pathological gamblers; they are more likely to be excitable, extroverted, anxious, and have lower self-discipline and are less able to conform (Gupta & Derevensky, 1997a; Vitaro, Ferland, Jacques & Ladouceur, 1998). These personality traits have been found to be positively correlated with risk-taking behaviours (Arnett, 1994; Gupta & Derevensky, 1997b; Zuckerman, 1979). Our research and clinical data seem to suggest that these adolescents have poor coping and adaptive skills. They remain unable to successfully cope with the many adversities they experience on a daily basis, which are particularly heightened during adolescence. As such, they use gambling as a form of escape from the realities of daily life (Marget et al., 1999).

Age of onset also appears to be a risk factor. Pathological gamblers reported starting serious gambling at early ages (approximately age 10) (Gupta & Derevensky, 1997b; 1998a; Wynne et al., 1996). Of particular concern is the finding that the time between the onset of their initial gambling and problem/disordered gambling appears to be significantly decreasing. Still further, results indicate that children start gambling with family members, especially parents and grandparents. Moreover, contrary to children's involvement with alcohol, drug and cigarette use, most of them do not feel the need to hide their gambling behaviour from their families (Gupta & Derevensky, 1997b; Ladouceur, Jacques, Ferland & Giroux, 1998). The early "big win" has also been reported to be a factor underlying problem gambling behaviour (Custer, 1982; Griffiths, 1995).



Problematic gambling during adolescence remains a growing social problem and public health concern with serious psychological, sociological, health and economic implications (Korn & Shaffer, in press). Results have shown that pathological gambling among adolescents increases delinquency and crime, antisocial behaviour, disruption of relationships, and negatively affects overall school performance and work activities. Given that there are frequently few observable signs of gambling dependence among children and adolescents, such problems have gone relatively undetected compared to other forms of addiction (e.g., smoking, substance and alcohol abuse). The psychosocial costs to the individual, his or her family and society as a result of problem and pathological gambling are numerous (Lesieur, 1998).

While occasional gambling should not necessarily be considered problematic, the probability of children and adolescents becoming problem or pathological gamblers remains worrisome. That many perceive gambling to be an innocuous behaviour with few negative consequences has been supported by findings that children and adolescents frequently gamble for money with their parents and other family members. Young children form partnerships with their parents in the purchase of lottery tickets and play cards and bingo for money with relatives (Gupta & Derevensky, 1997b).

Even in jurisdictions that prohibit sales of lottery and scratch tickets to youth, there is ample evidence that the enforcement of these laws is minimal. For example, New York State has legislation prohibiting the sale of lottery tickets to any person under the age of 18. Under state law, individuals selling even one lottery ticket to a minor can be charged with a misdemeanor. As part of its commitment to protect minors, the New York State Lottery launched Project 18+ to ensure the vigilant safeguarding of sales to minors. While improvement has occurred, a random spot check in 1998 of 65 retailers indicated a failure rate of 26%. In addition to the heightened vigilance prohibiting retailers from selling lottery tickets to minors and the threat of license revocation (after three offenses), every lottery advertisement (television, radio, print, etc.) explicitly contains a notice "You must be 18 or older to play lottery games." Public service announcements, billboards and stickers clearly visible to consumers also indicate only individuals over 18 can purchase them. In some jurisdictions no laws exist and unenforceable policies are in place. Many of the children in our research report both purchasing and receiving scratch lottery tickets as Christmas stocking stuffers. In yet another research study, we found that by the time children leave elementary school (age 12), less than 10% of children fear getting caught gambling (Gupta & Derevensky, 1999). Similar results would not be found for cigarette smoking, alcohol consumption or drug use.

Today, children and adolescents are educated about the dangers inherent in smoking, alcohol, and drug consumption. Few, however, are informed to

understand the potentially addictive qualities inherent in gambling activities. Many schools and religious groups inadvertently endorse gambling by sponsoring bingo or casino nights for both adults and youth as social events and for fund-raising. Frequently, adolescents only recognize the potential addictive quality of gambling after either they or their friends develop problematic gambling behaviours. The widely held belief that gambling is an innocuous behaviour with few negative consequences has contributed to the lack of public awareness that gambling amongst children and adolescents can lead to serious problems.

Educators have long advocated that the way to succeed in life is through hard work, study and academic achievement. Yet governments throughout the world, via state-supported lotteries, argue that for \$1 you can become an instant millionaire. The fantasy of winning that Harley-Davidson motorcycle, a luxurious automobile, or an exotic vacation may be extremely tempting for many youth. While marketing arms of lottery corporations report not to gear their advertisements toward youth, they nevertheless use sophisticated and alluring advertisements particularly attractive to today's youth. Our data suggests that sports pools, sports lotteries and sports betting are extraordinarily appealing to youth, especially boys, as they believe their knowledge ensures their accurate prediction of the outcome of sports events (Gupta & Derevensky, 1998a). For children and teens, allowance and lunch money are often used to purchase these tickets. Sports wagering (both legal and illegal) continues to be a growing problem on college campuses in the United States and Canada.

State and provincial lottery associations need to adopt responsible advertising programs. Advertisements that dissuade youth from engaging in these activities should form part of their public service announcements, print, and television campaigns. Lottery associations, and state and provincial legislatures should provide severe penalties for retailers that permit underage gambling. A systematic procedure for the enforcement of laws prohibiting youth gambling must be initiated.

We need to change the focus from the "treatment of the dysfunctional" or "disease model" to a prevention model aimed at youth. While little has been done in the field of gambling prevention (there are several in development at the present time), there are ample successful models from the substance abuse literature to emulate (Baer, 1993; Baer, MacLean & Marlatt, 1998; Botvin, 1986; Shuckit, 2000; Winick & Larson, 1996).

Prevention models must incorporate:

1. the need for awareness of the problem
2. activities that increase knowledge about youth gambling problems

3. programs to help modify and change the attitude that gambling is a harmless behaviour
4. the teaching of successful coping and adaptive skills that would prevent the development of problematic gambling
5. the changing of inappropriate cognitions concerning the role of skill and luck, the illusion of control, and the misperception of the independence of events in gambling activities, and
6. the identification, assessment, and referral of students whose gambling behaviour is indicative of being at risk. These programs should be school-based and incorporated at both elementary and secondary school levels.

Gambling venues and outlets continue to grow with government agencies throughout the world sanctioning and encouraging participation despite rising social costs. The reality remains that most individuals gamble responsibly, that gambling has become a mainstream socially accepted form of entertainment, and that governments throughout the world have become dependent upon and addicted to the enormous revenues so generated. While gambling is illegal for minors in many jurisdictions, there is clear evidence that underage youth continue to gamble and many report doing so with family members.

Our research efforts have been focused upon basic issues such as assessing gambling severity; identifying physiological, psychological and socio-emotional mechanisms that underlie excessive gambling behaviour among youth; the efficacy of our treatment model; and the development of effective, empirically validated prevention programs. Why some individuals continue to gamble in spite of repeated losses is a complex problem. How to best educate, prevent and treat these problems has become the focus of our research program.

Little doubt remains that gambling amongst youth is an important area in need of further basic and applied research. It also needs a substantial infusion of funding to support empirically based studies, and the development and implementation of responsible social policy. Clinicians and researchers must advocate for stronger legislation and enforcement of laws prohibiting gambling by underage youth. Only a collaborative effort between the public, industry, legislators, clinicians and researchers will ultimately help resolve this problem.

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We invite submissions that offer insights into how gambling policies – whether at the sub-national, national or international level – affect public life. These studies may take a current perspective, analyse historical events – or they may include both approaches.

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*Phil Lange, Editor*

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## research

*[Our Research section will occasionally have articles that combine new insights into gambling research with a popularized approach to help non-scientists understand what lies behind some principles of gambling.*

*—The Editor]*

## Randomness, Does It Matter?

*By Nigel Turner, PhD, Scientist*

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### Abstract

Many gamblers hold erroneous beliefs about the nature of random events, but is understanding randomness relevant to prevention? This paper examines the nature of randomness and the origins of misunderstandings about randomness. In addition, it examines the issue of whether or not knowledge of randomness is important in terms of the prevention of problem gambling. The goal is to provide readers with better tools to address these issues with clients or in preparing prevention materials.

### Introduction

Last year on the TV sitcom *Friends*, Ross, the know-it-all science guy, pointed out a woman standing around a casino and told his friends that she was a lurker, someone who keeps track of which machines have not paid out. Then, when a player leaves, she swoops in to steal the jackpot. While many of us might scoff at the idea, some undoubtedly think, "Hmm, I should try that."

In actual fact, the core idea makes sense. Surely if a machine pays off 1 out of every 10 spins, and it hasn't paid out in over 20 spins, it must be due to pay out any minute. According to our research, 70% of the population of Ontario believes that if a slot machine has just paid out three times in a row, the chance of winning on



the next pull are lower than would otherwise be the case (Turner, & Liu, 1999). The corollary that it is beneficial to look for the machines that haven't paid out recently is logical but not true.

So, Ross is wrong. Why? Slot payouts are random events. Slot machines use a computer that creates an erratic sequence of numbers generated continuously. When the player presses the spin button, these numbers determine the positions of the reels. A microsecond difference in pressing the button would result in a different outcome. Whether a machine has or hasn't paid out is irrelevant.

Considerable research suggests that gambling behaviour is associated with a wide variety of erroneous beliefs or cognitive distortions about gambling. These include mistaken myths about ways to beat the odds, superstitions and the personification of gambling machines. Since many of these errors are related to misunderstandings about the nature of randomness, or probability, it is important to consider the extent to which understanding probability contributes to the development of a gambling problem – and to treatment, recovery and prevention.

It is often said that gambling isn't about the money, it's about excitement or escape. This argument suggests that problem gamblers' erroneous beliefs are irrelevant because they aren't trying to win. However, if you took away the possibility of winning, or asked a gambler to play games without betting, there wouldn't be any escape or excitement. Gambling is only exciting because of the possibility of winning real money. And that possibility seems plausible because of erroneous beliefs. Thus, beliefs, excitement and winning aren't really separate issues and there is no clear line separating the cognitive thoughts and emotional experiences of gambling.

Does this mean that gamblers rationally weigh the pros and cons of a bet? No. In fact, when I talk about the logic of gambling, in most cases I'm talking about unconscious beliefs about the way things work – schemas or mental models. Most of our "rational" thinking, such as understanding the words in a sentence, takes place automatically. Most often our unconscious mental processes produce schemas that are accurate, but when it comes to randomness, our minds often come up with the wrong schema.

## Randomness explained

Why do our minds mess up so badly when it comes to randomness? My thesis is that the nature of randomness itself messes up our minds. I'll begin by considering where randomness comes from. Every movement is caused by some force. For example, when you throw a ball it doesn't always go where you want it to go. There are always tiny little changes in how you throw it: error variance or uncertainty. Even the greatest pitcher doesn't always throw the ball accurately. In addition, randomness is the result of complexity – too many things happening to keep track of. The squareness of a dice causes it to bounce erratically. If it lands on its side it bounces one way; if it lands on an edge it bounces in a different way. In contrast, the weight and smoothness of a bowling ball make its movement fairly uncomplicated. The complexity

of the dice amplifies the tiny variations in how the dice is thrown so that rolling a dice produces a much more erratic movement than rolling a ball. Statisticians would say that a ball is more reliable than a dice.

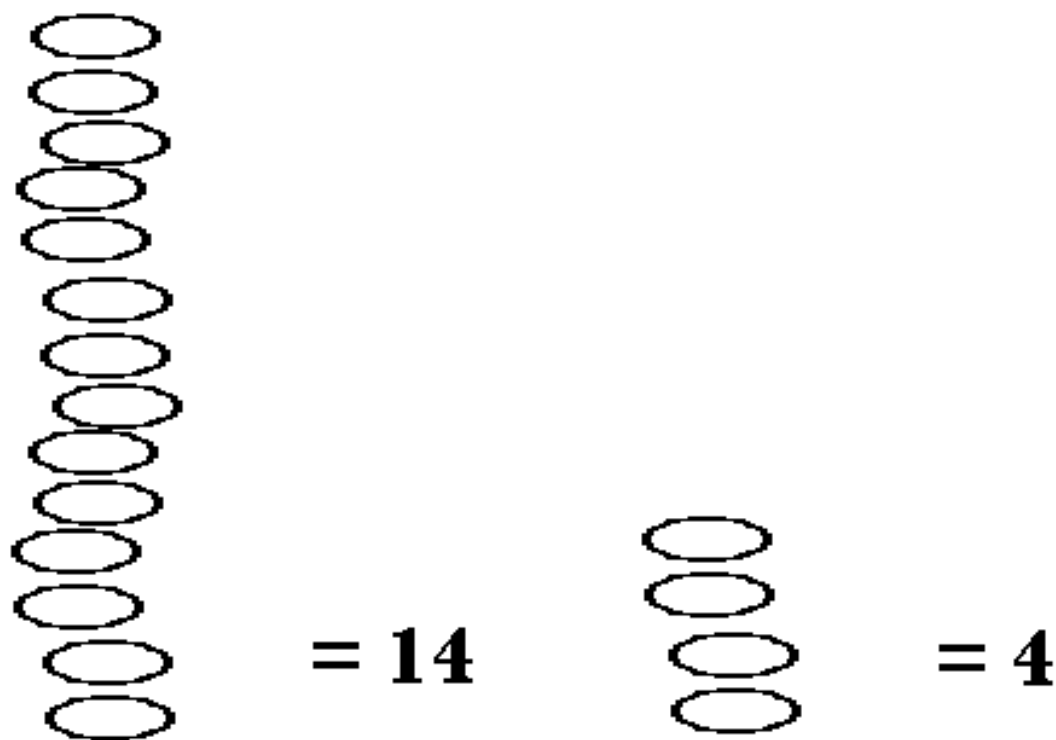
Many people, including scientists, underestimate the impact of a little error. But mathematicians have found that under some conditions, a tiny change can have a huge and unpredictable effect on the final result. In the movie *Jurassic Park*, Jeff Goldblum's character, a self-declared chaos theorist, gives the following description of this effect, "...A butterfly flaps its wings in Central Park and then it rains in China."

Chaos is in fact a very disturbing idea to many traditional physicists (Gleick, 1987) because it suggests that prediction is not possible in some situations. However, complete randomness probably does not exist. Everything is the result of some force and if you knew exactly what those forces were and you could precisely measure all aspects of the complexity of the system, you could predict outcomes. In the early 1980s a group of California engineers spent several years building a computer to predict the outcome of roulette (Bass, 1985). In theory it is possible, however, in practice, exact measurement or control is not possible and therefore many gambling devices are very good at producing randomness.

## Regression to the mean

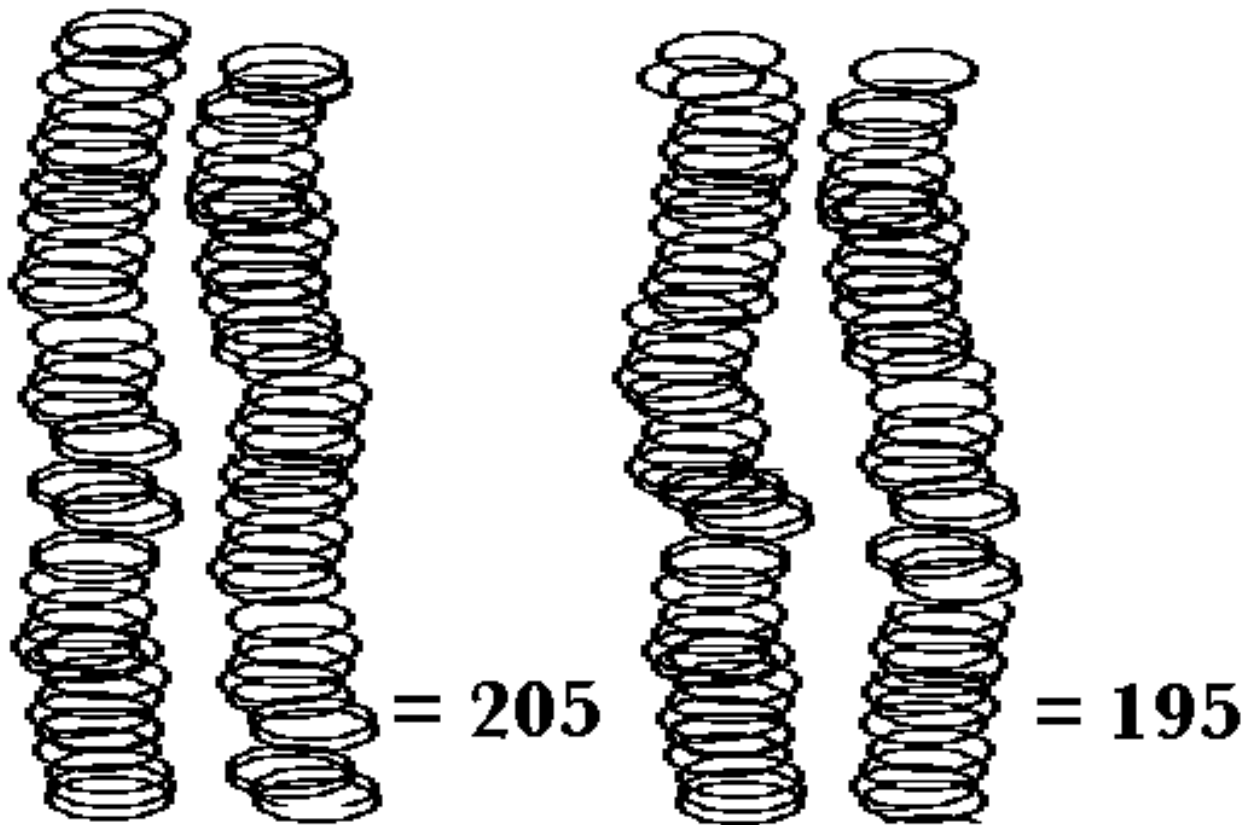
Random numbers are erratic and unpredictable. You cannot predict which number will occur based on previous numbers because each number is independent of each other. On average a coin comes up heads 50% of the time. But coins have no memory! Even if heads come up 1000 times in a row, the next flip could be a head or a tail. If a coin flip is truly random, then it must be possible (although very unlikely) for it to come up heads 1 million times in a row. Furthermore, the number of heads and tails does not have to even out. A head is just as likely to occur after five heads as after five tails. The more flips you make the closer the average gets to 50%, but nothing can force it to even out.

Yet sometimes it seems to even out. What fools many people into believing that it is self-correcting is that the more times you flip a coin, the closer the average of heads or tails gets to 50%. After 18 flips, 10 more heads than tails is a very noticeable difference (See Figure 1).



*Figure 1: After flipping a coin 18 times, a difference of 10 heads is noticeable.*

Even after 400 flips there could still be 10 more heads than tails, but the difference becomes less noticeable (See Figure 2). The per cent gets closer to 50 but the actual number of heads and tails doesn't have to even out. After 1 million flips a difference of 8000 would still round off to 50%. This process of gradually converging on 50% is called regression to the mean.



*Figure 2: After flipping a coin 400 times, a difference of 10 heads is barely noticeable.*

I believe that the belief that randomness is self-correcting stems from our experiences of witnessing regression to the mean. A number is never due to come up but the odds are it will sooner or later. There is a subtle but important distinction between "due" to come up and "likely" to come up in that observing the past flips of a coin will not tell you when tails will come up. So, information about past numbers, flips or spins tells you nothing, and yet it often seems to. You cannot beat the odds by lurking, looking for the machine that is "due" to come up.

## Experience leads to errors

Some of my recent research indicates that problem gamblers have a poorer understanding of randomness compared to non-problem gamblers (Turner & Liu, 1999). For example, problem gamblers were more likely to believe that betting on a number that looks random gives you a better chance of winning. Random numbers don't necessarily look random. A ticket with the numbers **1 - 2 - 3 - 4 - 5 - 6** has exactly the same chance of winning as a ticket with the numbers **3 - 17 - 21 - 28 - 32 - 47** but many people have trouble believing this. Most of the time random numbers look random. In a lotto 6-49 there are only 43 possible consecutive sequenced number tickets out of approximately 14 million possible tickets. Consequently, sequenced numbers rarely seem to come up in a lottery although all ticket numbers have the same chance of winning. As a contrast, consider lotto 2/2; a lottery where the only possible

ticket numbers are **1-2, 2-1, 1-1** and **2-2**. In this case, all tickets appear to have a pattern or sequence so that whatever number is drawn, the winning ticket does not appear to be a random number.

## Chasing

Another important aspect of understanding randomness is "chasing." Chasing often involves betting larger and larger sums to win back what you've lost. The problem with chasing is not that it doesn't work but that it often does. If you double your bet every time you lose, your chance of winning back what you have lost is as high as 99% depending on your bankroll and the betting limit (Turner, 1998). In contrast, betting the same amount each time gives a person at best a 45% chance of winning back what he has lost. The downside is that when chasing doesn't work the result is catastrophic.

Last year, at Casino Rama in Orillia, Ontario, I calculated that I could work out a Martingale system (doubling after each loss) starting at \$5 a hand and doubling with each bet until I won, to a maximum bet of \$2000. This would require changing tables occasionally since each table had a maximum bet about 10 times its minimum (e.g., min = \$5, max = \$50; min = \$50, max = \$500). I could work it so that I would have a 99% chance of winning \$5 and less than a 1% chance of losing \$2555. Since it works so often people may come to believe that it always works. When that one 1% event occurs, the result is as much a shock as it is a nightmare.

## The role of mind

The human mind is not very good at dealing with randomness. Our minds are designed to find order, not to appreciate chaos. Ever notice how easy it is to find faces in clouds? We are wired to look for patterns and find connections, and when we find patterns we interpret them as real. Consequently, many people will see patterns in random numbers. When people see patterns in randomness (e.g., repeated numbers, apparent sequences or winning streaks) they may believe that the numbers aren't truly random, and therefore, can be predicted.

Many gamblers have experienced a wave-like roller coaster effect of wins and losses and may believe that you just have to ride out the down slope of the wave to follow the wave back up. Much of this learning process takes place unconsciously. The problem is that betting based on these patterns sometimes appears to work in the short term, reinforcing the belief. But it will not work in the long term; these patterns are flukes. Suppose you start playing roulette and you have a lucky winning streak by alternating your bets between red and black, it will actually take quite a while before you realise that the betting strategy is not working. Your initial wins may keep you on the plus side for quite a while because randomness doesn't correct for winning streaks either.

The same is true for superstitious beliefs. Because we don't understand randomness we interpret coincidences as meaningful, and consciously or unconsciously we learn associations that are merely due to chance. Implicit learning is the driving force behind both betting systems and superstitious playing strategies. Furthermore, our memory of an event is not just about what happened but about the emotional experience of what happened. An important area for future research is the interplay between emotion, experience and belief.

## Randomness, prevention and treatment

My point is that these beliefs and expectations are not irrational; they are often logically induced from a person's experience with random events. In a sense we are programmed by experience, the implicit learning of expectations. Theoretically, if a person experiences enough random events, he should have a pretty good sense of its nature. However, our minds tend to focus on early experiences, and we often pay more attention to experiences that support our beliefs than to those that don't, so what we expect tends to be distorted. An early win, for example, will result in distorted expectations. Our data suggest that as many as 50% of problem gamblers have experienced a large early win (Turner & Liu, 1999). Another key factor is need. If the win fills an emotional, spiritual or practical need, the distorting effect of the win will be greater.

Our research has shown that problem gamblers tend to have a poorer understanding of random events compared to non-problem social gamblers, and that untreated recovery from gambling problems is associated with higher levels of understanding about randomness (Turner & Liu, 1999). These findings suggest that teaching people about randomness may be an important part of both treatment and prevention.

In conclusion, often problem gamblers don't have distorted thoughts, but unrepresentative experiences which have resulted in distorted beliefs. I believe that altering or preventing these erroneous beliefs is at least one important ingredient in effective prevention and treatment programs.

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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. Blaszczyński (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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## first person

*We hope that the narratives in First Person Accounts will evoke an understanding of how people experience gambling. These experiences may come from gamblers, from family or friends of gamblers, and may be positive or negative. We invite others to share their experiences as First Person Accounts or to a dialogue in our [Letters to the Editor](#).*

First Person Account – An Opinion

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## Dot-com looniness, phantoms of avarice and appetite.

by Rex Murphy

*Excerpted from the 'Magazine' portion of CBC News THE NATIONAL television broadcast for April 17, 2000.*

"What lives must die; what rises must set; and what goes up must – must come down. These are axioms; self-evident truths that have been available to the generations of man since there have been generations. The birth of high-tech and the arrival of the boomers, the Yuppie incarnation, were of course to have changed all that. Rules that have obliged every other moment of history obviously cannot be held to apply to this one. The most self-regarding generation of all history is going to live forever; jog till it's 90; chemically extend its furious sexual capacity; replace and enhance all body parts and get continuously rich forever. It is this happy exceptionalism that has made the practice of building hopes and dreams on the

stock market, and in particular that portion of it known as the NASDAQ, such a delightful habit for so many North Americans.

Of course the stock market, even the new economy NASDAQ is nothing more than old-fashioned gambling. And the NASDAQ, properly understood, is nothing more than bingo for yuppies. The difference is that for this generation, bingo is a game in which everyone is entitled to win all the time. So when last week rolled in with stock declines and when Friday hit with gale force and the loss of \$2 trillion, well, the response of some was desperate unbelief; shivering incredulity. A delusion had been laid waste. What had been going up was now going down. How could anyone really be surprised? The itch to dot-com the world cannot be infinitely scratched. A web site is not a gold mine. Companies going public for billions that produce nothing, make no profits, hardly exist outside the ether in which they are promoted.

The last great stock market shill was Bre-X. But at least Bre-X pretended to be something on the earth – or in the earth. These IPOs and on-line trading stores – anything in fact with the word 'Net in it that isn't made of string – are phantoms of avarice and appetite.

Dot-com looniness is the vapour of hot breathing greed, and the oldest idea in the world; that of getting something for nothing or a very great deal of something for hardly anything at all. North America has become a society of speculators; people who would rather guess their future than earn it. One large 24-hour casino – a Las Vegas of dividends and mutual funds and people who wander around muttering about their portfolios – in other words, their betting slips.

Any society that becomes intimate with the language of the stock market; where the broker is called more often than the teacher, and dips in the stock market carry more anxiety than a shortage at the grocery store, has wandered away from common sense and is waiting for a fall. There is no new economy. There never was. Riches without effort, are without effort withdrawn.

What the mouse click hath given, the mouse click will take away. Last week wasn't a glitch. It was the oldest force in the universe. It was gravity. What goes up comes down, and sometimes vice versa. For the Magazine, I'm Rex Murphy."

We gratefully acknowledge the kind permission of Rex Murphy and the CBC to republish this account. It is available at <http://cbc.ca/news/national/rex/rex20000417.html> and other CBC News features are at <http://cbc.ca/news>.

# Biographical Notes

*Rex Murphy was born and raised in St. John's, Newfoundland, graduating from Memorial University. A Rhodes Scholar, in 1968 he went to Oxford University. Once back in Newfoundland he was soon established as a quick-witted and accomplished writer, broadcaster and teacher.*

*He is noted throughout Newfoundland for his biting comments on the political scene through his nightly television supper hour show "Here and Now."*

*Rex has worked extensively with CBC and from Newfoundland he has contributed many items on current affairs issues, including a weekly essay for THE NATIONAL, winning several national and provincial broadcasting awards.*

*He divides his week between Toronto and Montreal with frequent forays to St. John's.*

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## Romancing the Odds (1997)

*By Gary Bell, Audiovisual Review Committee Co-ordinator at the Centre for Addiction and Mental Health Library, Senior Library Assistant, Centre for Addiction and Mental Health, Toronto, Ontario, Canada*

*E-mail: [Gary\\_Bell@camh.net](mailto:Gary_Bell@camh.net)*

*Length: 40 minutes*

*Subject: Problem gamblers*

*Distributor: Nova Scotia Government Bookstore*

*(902) 424-7580, in Nova Scotia call toll-free 1-800-526-6575*

*URL: <http://www.gov.ns.ca/bacs/books/gambling.htm>*

*Fax: (902) 424-5599, E-mail: [lynchcd@gov.ns.ca](mailto:lynchcd@gov.ns.ca)*

*Cost: \$125.00*

Comedian Bette MacDonald hams it up, sings and acts her harried way through this dramatization of the lives of several problem gamblers. These gamblers deal with the economic, social and family consequences of devoting too much time and money chasing their losses. One gambler is locked into a desperate cycle and constantly rationalizes his behaviour, convincing himself he must "win big" so he can pay his debts. Yet he postpones bill payments and other important commitments. He pockets his employer's money hoping the bookkeeper won't notice before he "pays it back" and attempts to borrow from anyone against his future hopes to win. The video illustrates the struggle with relapse for gamblers in recovery and recognizes triggers in relapsing. The video conveys the difficulty some gamblers may face with ever-present advertising for lotteries and other gambling venues. Occasional brief interludes offer information on the antiquity of gambling.

Much of the gambling action takes place in a bar with video lottery terminals (VLTs). Brian, the friendly bartender, offers advice to the audience, comments about gamblers, makes change for the VLTs, polishes glassware, reads aloud from Dostoyevsky's *The Gambler* and doesn't seem to sell much alcohol. He laments that the usual social conviviality of the beverage room seems to have been reduced by the presence of the gambling machines. Interestingly, the video gives the impression that there is a sexualised component to gambling as the bettors use suggestive talk with the electronic host on the VLT screen, seemingly trying to "romance the odds." This concept is not pursued very far, and it would be interesting to know if this is a common component in problem gamblers' experiences, or just cleverness on the part of the video producer.

The video presents some basic aspects of recovery from gambling problems. A receptionist on the Problem Gambling Helpline outlines how this service works. A counsellor with the Drug Dependency Services briefly comments on his attitude to gambling therapy. He sees problem gambling as a kind of "self therapy" that not only interferes with the process of dealing with life problems, but may mask other issues. He offers four basic steps for someone seeking help: stop yourself from accessing money, begin an exercise program as a start to a lifestyle change, participate in Gamblers' Anonymous support groups and attend counselling sessions. The Helpline number is shown during the introduction and at the conclusion of the program.

One of the more compelling segments of the video involves a secondary school class doing a project on gambling. They explore questions of gambling, the role of chance and the odds of winning a lottery, for example, compared to other kinds of random events. One of the students in the class plays the part of the son of a problem gambler. He approaches the teacher at the end of the class and presents his dilemma about "a person he knows" with a gambling problem.

I believe this video would be a useful adjunct to an information session about problem gambling. The program is not without faults and some segments last rather long—"Why I gamble"—for example. Though intended to puncture the bubble of excuse making, it comes perilously close to condescending mockery. Looking at demographic characteristics, the gamblers portrayed appear to be remarkably consistent; they are all white, 30 to 40 years old and low to middle income workers. Is this the group most often experiencing gambling problems? The video covers a lot of issues though, has an offbeat sense of humour and would be appropriate for an adult audience. As an added bonus, viewers can try their hand at the recipe for "turnover chips."

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## letters

*{This letter resulted from a retirement tea discussion about gambling and addiction to electronic devices. – The Editor}*

### How I Became Famous Once

Once upon a time (in a galaxy far away) ARF's [*Addiction Research Foundation –ed.*] training department was known as the School for Addiction Studies Division ("ARF U."), and was housed in a renovated mansion in Rosedale, in downtown Toronto. I spent 13 years there as an Education Consultant.

In the early '80s video games burst upon the scene. Parents worried that their kids would fritter away time on video games to the detriment of school and family life, and their fears were justified in some cases, as usual. Eventually there was talk of kids who were "hooked" on video games, kids who were "addicted" and pursued the games to the exclusion of everything else. They even stole money from mom's purse, and ran off to play games at the video game arcade. Kids were reported to have gone to play video games at lunch and not returned for afternoon classes.

The mayor of North York, a spotlight magnet named Mel Lastman, supported a proposed bylaw that would prohibit the establishment of a video game parlour within N meters (250? 500? I forget) of a school.

A reporter for one of Toronto's newspapers got the idea that he would look into reports of video game addiction. A logical step in his research was to call up the Addiction Research Foundation, the Provincial Government agency with the responsibility in that area. The SAS receptionist knew me as a person who was willing to shoot off his mouth on any topic in the addiction field, so she put the reporter's call through to me.

"Can a person be addicted to video games?" he asked. I said that the word

'addiction' was being used loosely, because gaming obviously doesn't involve the ingestion of chemicals; a characteristic of mainstream addiction. However, there may well be changes in the brain as a consequence of repeated patterns of behaviour, and in that sense might parallel addiction. Off the top of my head I also thought that there might be other parallels.

Video games result in very rapid reinforcement compared to, say, school work. Depending on what we think the reinforcement is, it might be seen to come rapidly and frequently. For example, if your friends tell you that shooting down an alien rocket is super cool, you might be able to have that sense of accomplishment many times per minute, and with only a split-second delay after your action. Sense of accomplishment, or mastery, or achievement, can get a real workout with a video game. Rapid, high-rate reinforcement is a well-known way to instill a behaviour.

The reinforcer is available at very low economic cost, thereby reducing one of the most obvious barriers to addiction. Availability is also enhanced by the absence of age barriers and the (then) widespread appearance of game parlours.

Another barrier to addiction is missing, in that the route of administration is not aversive, as smoking is initially, and as needles are in the common mind. Becoming skilled at the game brings more challenging levels of play, with less frequent reinforcement, but most importantly, the reinforcement occurs on an unpredictable schedule. Once a behaviour has been instilled by a reliable, high-rate schedule of reinforcement, it can be amazingly resistant to extinction by shifting to an unpredictable schedule of reinforcement.

Having played out these parallels between video game addiction and historical "typical" addiction, the reporter was full of enthusiasm for the topic, and quoted me extensively in a newspaper article.

The next thing I knew there was a radio station from Hamilton, Ontario on the phone. Then a TV station called up for a session in their studio, then Homemaker's magazine, a radio station from Halifax, another from Kingston, then one from out west.

For a few weeks the topic was hot, and so was I. The Powers That Be decided that there was nothing dangerous in my philosophical ramblings, and it made ARF look good; being helpful in the midst of public controversy. Pretty soon it all died down, and the crisis of video game addiction faded away.

Unless there is a bylaw on the books of the former City of North York, I doubt that there is much left from that brief time, apart from my memories of "How I became Canada's foremost expert on video game addiction."

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We invite our readers to submit **Letters to the Editor** on gambling topics. Please note that we can publish only a fraction of the letters submitted. All letters must be signed. We cannot publish anonymous letters, or those of a libellous nature. Letters to the Editor are reviewed and chosen by the editor and members of the editorial board. Letters may be sent to either the e-mail or the regular mail address given below. Once a letter has been accepted, we will request an electronic version. Each published letter will include the writer's first and last names, professional title(s) if relevant, city, province or state, and country. We reserve the right to edit each submission for uniform format and punctuation.

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## National Council on Problem Gambling

### 14th Conference on Problem Gambling Philadelphia, Pennsylvania, US

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**Contact:**

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**[ncpg@ncpgambling.org](mailto:ncpg@ncpgambling.org) for registration and additional info.**

---

# **Call for Research Project Applications for Ontario, Canada**

These notices offer details on a recent request for research applications by the Ontario Problem Gambling Research Centre. There are two documents; the first describes the call for applications, and the second details the requirements for the initial Letter of Intent including its August 18, 2000 deadline. Please note that only Canadian residents can apply, and they must conduct the research in Ontario and focus on Ontario residents.

## **Ontario Problem Gambling Research Centre Research Awards Solicitation**

The mission of the newly created Ontario Problem Gambling Research Centre (the Centre) is to enhance understanding of problem gambling, and strengthen treatment and prevention practices through research. The main goal of the Centre is to support the development of high quality research projects that examine various facets of problem gambling.

To achieve this goal, the Centre is requesting applications from researchers interested in conducting problem gambling research in Ontario. These submissions will be adjudicated, and successful applicants will be invited to submit full research plans in stage two.

### **Description of Research Projects**

In general, the Centre will fund applied research projects that advance knowledge relative to the treatment and prevention of problem gambling. These projects may include:

- Research that advances the basic understanding of gambling behaviour in



general, and problem gambling behaviour in particular.

- The development and testing of specific prevention and/or treatment programs, and piloting such programs for special population groups.
- Treatment programs that focus on new models and methods of improving existing approaches, with comparisons of such methods to existing treatment approaches.
- Explorations of the gambling recovery process with and without formal treatment.
- Development and testing of models of service, gambling behaviours, or new ways of conceptualizing gambling and problem gambling behaviours.

Projects that will not be funded include the social/economic impact of gambling, attitude surveys, needs assessments, and literature reviews. Research projects that involve community collaboration and partnerships will be given priority.

## **Awards Amount**

One-year research awards will be available to a maximum of \$175,000 per project.

## **Eligibility**

To be eligible for support, the applicant must be legally residing in Canada. Researchers throughout Canada are eligible to apply, but work must be conducted within Ontario communities and focus on Ontario residents. Collaboration with Ontario organizations/ researchers is preferred.

## **Application Deadline**

The deadline for receiving Letters of Intent is August 18, 2000. Invitations to submit a complete research plan will be made on or about August 31, 2000.

**Application guides may be requested from:  
The Ontario Problem Gambling Research Centre  
304 Stone Road West, Suite 403  
Guelph ON, N1G 4W4**

**Telephone: (519) 763-8049**

**Toll Free: (877) 882-2204**

**Fax: (519) 827-9196**

**E-mail: [opgrc@home.com](mailto:opgrc@home.com)**

NOTE: The Centre reserves the right to modify or discontinue the awards process at its sole discretion.

# **Ontario Problem Gambling Research Centre**

## **Guidelines for Letters of Intent**

### **Background**

On July 12, 2000 the Ontario Problem Gambling Research Centre (the Centre) issued a research awards solicitation for projects to be initiated in the 2000-01 operating year. Researchers who wish to apply for funding are asked to submit a Letter of Intent that complies with the following guidelines.

### **Cover Page**

The cover page should include:

- The title of the research project
- The name of the Principal Investigator, and (if different) the project Contact Person. Include each person's institutional affiliation, title, address, telephone and fax numbers, and e-mail address
- The names, addresses, affiliations, and titles of collaborators or other members of the project team
- Indication of the status (e.g. not for profit, hospital, university) of the institutional affiliation
- Signature of the Principal Investigator and (if different) the project Contact Person.

### **Second and Subsequent Pages**

- Describe the specific aims of the project and what you hope to accomplish
- Briefly explain how this project will extend existing knowledge and make a significant contribution to the field
- Describe the proposed methods and key activities for the project
- Provide a general timetable for the project
- Discuss the qualifications of the principal personnel and affiliated institution(s) to implement the project
- Provide an estimate of the budget for the project, broken into general categories (salaries, operating, other expenses, etc.)

## Specifications

- Awards amount: one-year research awards will be available to a maximum of \$175,000 for direct project costs. In addition, up to 20% of direct costs will be available to cover associated indirect costs (e.g. ethics review, legal costs, computer services, library services, etc.)
- Due Date: the deadline for receiving Letters of Intent is Friday, August 18, 2000 at 5:00 p.m. Eastern Daylight Time
- Copies: include the original Letter of Intent and three copies
- Layout: use standard letter size paper with a 12 point font, single spaced
- Length: do not exceed five pages, including the cover page
- Ethics: an ethics review will be required before research awards are finalized
- Assistance: contact the Centre by telephone, fax, mail or e-mail if you have questions or would like assistance with the completion of your Letter of Intent
- Selection Process: Letters received by the Centre will be reviewed by its Research Review Committee, and those meeting its standards for scientific merit and relevance will be invited to prepare a detailed research plan for the final round of consideration for funding.

An invitation to prepare a detailed plan is not a guarantee that funding will be granted. Rather, it is an indication that the proposal merits further consideration in a more fully described form

## **Key Dates**

**August 18, 2000 deadline for receipt of Letters of Intent**

**August 31, 2000 notification of review results**

**October 13, 2000 deadline for receipt of detailed research plans**

**November 28, 2000 notification of awards**

## **Contact Information**

**The Ontario Problem Gambling Research Centre  
304 Stone Road West, Suite 403  
Guelph ON  
N1G 4W4**

**Telephone: (519) 763-8049**

**Toll Free: (877) 882-2204**

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**E-mail: [opgrc@home.com](mailto:opgrc@home.com)**

Note: the Centre reserves the right to modify or discontinue the awards process at its sole discretion.

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For the **Calendar of Events** we invite our readers to submit notices of upcoming gambling-related conferences, presentations, symposiums and other educational events, civic events, and media events that are open to the public. We will gladly publish news of events that may occur years in the future.

We ask that these notices be submitted by electronic mail. With each submission we require the e-mail address of someone with whom the editor can verify details about the event. (We understand that this e-mail address may perhaps not be part of the published calendar listing.) We reserve the right to edit each submission for

uniform format, punctuation and grammar.

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## intro

### Welcoming Remarks

I am pleased to extend a welcome to all whose interest in gambling-related inquiry has led them to this first edition of *The Electronic Journal of Gambling Issues* (EJGI), a forum for researchers, clinicians, the gambling industry, gamblers and the interested public. EJGI is intended to be a vehicle for ongoing dialogue about issues ranging from gambling as a social phenomenon to what constitutes responsible gambling and the most effective treatment interventions for problem gamblers. For example, the Features section contains research statements from significant thinkers in the area of gambling studies. If you work with clients with gambling-related problems, the Clinic section offers up-to-date treatment information. And our First Person Accounts section provides a unique opportunity to learn from the narratives of individuals whose lives have been affected by gambling.

The Centre for Addiction and Mental Health is itself actively involved in treating individuals who experience problems with gambling, and takes a leading role in training people who plan to work with problem gamblers or are in a position to encourage responsible gambling. In addition, the Centre is committed to gambling-related research and policy initiatives. This journal reflects the breadth of that commitment to the treatment of problem gamblers and the emerging field of gambling studies.

This initiative is especially important as gambling assumes a greater presence in more and more communities through lotteries, casinos, bingo halls and sports betting. Fully understanding the impact of this phenomenon is essential for people who choose to gamble, community leaders, the gambling industry and those involved in the treatment of problem gamblers and their families. The Centre is

particularly excited about providing leadership in understanding, prevention and treatment of problem gambling provincially, nationally, and indeed, internationally. The fact that this journal is available through the Internet to whomever has access to a computer underlines our commitment to disseminating knowledge to as wide a public as possible.

*Dr. Paul Garfinkel, President and CEO of the Centre for Addiction and Mental Health*

## Statement of Purpose

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

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

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## feature

# Pathways to Pathological Gambling: Identifying Typologies

*By Alex Blaszczynski PhD, MAPSs; Director, Impulse Control Research Clinic, School of Psychiatry, University of New South Wales, Sydney, NSW*

## Abstract

The majority of explanatory models of pathological gambling fail to differentiate specific typologies of gamblers despite recognition of the multi-factorial causal pathways to its development. All models inherently assume that gamblers are a homogenous population; therefore theoretically derived treatments can be effectively applied to all pathological gamblers. This article describes a comprehensive and alternative conceptual-pathway model that identifies three main subgroups: "normal," emotionally vulnerable and biologically based impulsive pathological gamblers. All three groups are exposed to common influences related to ecological factors, cognitive processes and contingencies of reinforcement. However, predisposing emotional stresses and affective disturbances for one group, and biological impulsivity for another, are additional risk factors of aetiological significance in identifying separate subtypes. The implications for treatment are discussed with particular reference to the need to match client subtype with specific treatment interventions.

# Introduction

Historically, societal attitudes toward gambling were influenced by the effects of gambling on public order, the erosion of prevailing moral values and social mores, and the cheating and exploitation of the masses (Peterson, 1950; Ploscowe, 1950; Blakely, 1977). The move to medicalize pathological gambling originated from the case studies of early psychoanalytic writers (Von Hattinger, 1914; Bergler, 1957), and by the inclusion of pathological gambling in DSM-III (American Psychiatric Association, 1980), as a psychiatric disorder of impulse control. The formalization of pathological gambling as a psychiatric disorder led to recent attempts to develop theoretical models, which explain the aetiology of problem gambling (Ferris, Wynne & Single, 1998).

Contemporary psychological models include gambling as:

- an addictive disorder (Jacobs, 1986; Blume, 1987)
- an unresolved intrapsychic conflict (Bergler, 1957; Rosenthal, 1992; Wildman, 1997)
- having its causation through a biological/psychophysiological dysregulation (Blaszczynski, Winter & McConaghy, 1986; Carlton & Goldstein, 1987; Lesieur & Rosenthal, 1991; Rugle, 1993; Comings, Rosenthal, Lesieur & Rugle, 1996)
- a learned behaviour (McConaghy, Armstrong, Blaszczynski & Allcock, 1983; Anderson & Brown, 1984)
- a result of distorted/irrational cognitions (Sharpe & Tarrier, 1993; Ladouceur & Walker, 1996).

This diversity of models has led to the search for qualitative similarities and differences between social and pathological gamblers in personality traits (Blaszczynski, Buhrich & McConaghy, 1985; McCormick, Taber, Kruegelbach & Russo, 1987; Castellani & Rugle, 1995), co-morbidity (Kruegelbach & Rugle, 1994) and biological correlates (Rugle, Semple, Goyer & Castellani, 1995; Comings et al., 1996).

The fundamental assumption contained within each model is that pathological gamblers constitute a homogenous population, and that theoretically derived treatments can be effectively applied to all pathological gamblers. There is minimal evidence to support this implicit assumption. On closer inspection, learning theories (Dickerson, 1979) refer to fixed and variable schedules of reinforcement. But these learning theories fail to explain why not all gamblers suffer impaired control. Cognitive theories (Sharpe & Tarrier, 1993; Ladouceur & Walker, 1996) emphasize irrational cognitive schemas but have not demonstrated that these are of

causal significance. Heated debate continues on the validity of the addiction model of gambling, particularly by those adhering to the socio-cognitive approach.

Divergent frameworks, however, can be reconciled if gamblers are accepted as a heterogeneous group (Blaszczynski, 1996) with multi-factorial causes. It cannot be denied that the majority of gamblers seek monetary gain. But some continue to participate and persist because they are inexorably motivated to find relief from boredom, to dissociate and to escape from negative life circumstances, or to modulate negative mood states. The task confronting clinicians is to refine the categorization of problem gamblers into increasingly homogenous subgroups or typologies of gamblers.

In a series of long-term controlled outcome studies (Blaszczynski, 1988; McConaghy, Blaszczynski & Frankova, 1991), three types of responses to treatment were observed: controlled gambling, abstinence and uncontrolled gambling. Controlled gamblers were characterized by an absence of psychopathology, abstinent gamblers continued to exhibit moderate levels of affective disturbances and elevated neuroticism; while uncontrolled gamblers persisted in showing high levels of psychopathology across a number of domains. These findings matched my clinical experience. I found that some gamblers displayed integrated personalities; others showed evidence of depressive affect and situational stresses which precipitated increased gambling. Others manifested traits of impulsivity and severe disruptive behaviours in gambling and in other parts of their lives.

These findings made me question if the response to treatment was predicated on personality or demographic differences, which were present between groups prior to treatment. However, no such differences emerged when statistical comparisons were applied to group variables. An alternative possibility was therefore considered: that is, that the end results of gambling had affected their psychological profile so that it masked group differences. I argued that with gambling the common manifestation of affective disturbances (anxiety, substance use and criminality) were a complex mixture and/or interaction of both primary and secondary processes involved in gambling. In some cases, depression was instrumental in causing impaired control over gambling; while in others, gambling produced depression resulting from financial and marital difficulties. During a psychometric assessment, both groups obtained similar scores on depression. But this depression had significantly different implications in respect to etiological significance and relevance to treatment strategies. This led to the postulate that specific subgroups of gamblers existed and shared features in common, yet differed significantly in many respects.

I have proposed a prototypical model that attempts to integrate biological,

personality, developmental, cognitive, learning theory and environmental factors into one model. This model is based on clinical experience and attempts to integrate relevant research findings. It suggests the existence of three major types of gamblers: the gambler who is not pathologically disturbed, the gambler who is emotionally vulnerable, and the gambler whose impulsivity is biologically based.

There are three elements relevant to all gamblers irrespective of subgroup membership. The first relates to ecological determinants. These determinants revolve around public policy issues that promote availability and access to gambling facilities. Substantive data clearly demonstrates that the incidence of pathological gambling is inextricably tied to the number of available gambling outlets (Abbott & Volberg, 1996; Volberg, 1996; Productivity Commission, 1999).

The second element resides in the role of classical and operant conditioning. Studies have demonstrated that gambling produces a state of subjective excitement (Dickerson, Hinchy & Fabre, 1987), dissociation (Jacobs, 1986) and increased heart rate (Anderson & Brown, 1984; Leary & Dickerson, 1985; Brown, 1988; Griffiths, 1995). Wins, delivered at variable ratios that are resistant to the effects of extinctions, produce states of excitement described as equivalent to a "drug-induced high." Repeated pairings classically condition this arousal to stimuli associated with the gambling environment (Dickerson, 1979; Sharpe & Tarrier, 1993). Through second order conditioning, gambling cues elicit an urge to gamble, which results in a habitual pattern of gambling. As Rosenthal and Lesieur (1992) observe, excitement can be experienced in anticipation, during, or in response to exposure to gambling situations or cues. This process of conditioning can be used to explain gambling as an addiction produced by the effects of positive and negative conditioning, tolerance and withdrawal.

An alternative non-addiction explanation has also been offered, and is based on a neo-Pavlovian "neuronal model" of habitual behaviour, which relies on the concept of cortical excitation (McConaghy, 1980).

Superimposed on the conditioning framework and irrespective of whether or not an addiction type model is adopted, is the development of cognitive schemas. Early and repeated wins result in irrational belief structures that promote gambling as an effective source of income. These schemas shape illusions of control, biased evaluations, erroneous perceptions, superstitious thinking and faulty understandings of probability (Langer, 1975; Gilovich, 1983; Ladouceur & Walker, 1996; Walker, 1992; Griffiths, 1995).

The reinforcing properties of gambling and the irrational cognitive schemas combine to consolidate and strengthen habitual gambling practices. At this point, the downward spiral of gambling, perceptively described by Lesieur (1984), takes

its toll. When gamblers lose they attempt to recoup losses through further chasing, which results in accumulating financial debts. Despite acknowledging the reality that gambling led them into financial problems, they irrationally believe that gambling will solve their problems.

It is emphasized that the above processes are applicable to all gamblers. At this point additional factors can be invoked to differentiate between three broad subgroups of gamblers.

## **Subgroup one: "Normal" problem gamblers**

The first subgroup can be labelled, perhaps somewhat oxymoronically, as the "normal" pathological gambling subgroup. Members of this subgroup may meet formal criteria for pathological gambling at the height of their gambling disorder. What distinguishes this subgroup is the absence of any specific premorbid psychopathology. Conceptually, these gamblers can be seen as occupying the diffuse domain between regular-heavy and excessive gambling. Excessive gambling behaviour occurs as a result of bad judgments or poor decision-making strategies, which are independent of any intrapsychic disturbance. Features of a preoccupation with gambling, chasing losses, substance dependence and depression and anxiety are all seen as the end response to the presence of financial pressures caused by continual losses. These symptoms are the consequence not the cause of excessive gambling.

Clinically, the severity of difficulties in the "normal" gambling subgroup is the lowest of all pathological gamblers. They do not manifest gross signs of major premorbid psychopathology, substance abuse or impulsivity behaviours. Placed at the low end of the problem-gambling scale, these gamblers move between heavy and problem gambling. They are more motivated to seek treatment, to comply with instructions and post treatment are able to achieve controlled levels of gambling. Counselling and minimal intervention programs are of benefit.

## **Subgroup two: Emotionally disturbed gamblers**

The next subgroup is characterized by the presence of predisposing psychological vulnerability factors where participation in gambling is motivated by a desire to modulate affective states and/or meet specific psychological needs. This subgroup manifests a history of problem gambling in the family, negative developmental



experiences, neurotic personality traits and adverse life events. These problems may contribute in a cumulative fashion to produce an emotionally vulnerable gambler.'

Evidence in support of this contention comes from a number of sources. Jacobs (1988), Lesieur and Rothschild (1989), Gambino, Fitzgerald, Shaffer, Renner, and Courtage (1993) observed that a family history of pathological gambling was an important predisposing risk factor for children. Jacobs (1986), in his *General Theory of Addiction*, postulated that certain personality characteristics and life events, which interacted with physiological states of arousal, influenced the development of gambling problems. He stated that excessive gambling was produced by the interaction between abnormal physiological resting states of hyper or hypo-arousal, and a history of negative childhood experiences. Personal vulnerability was linked to negative childhood experiences of inadequacy, inferiority, low self-esteem and rejection (McCormick, et al., 1987; McCormick, Taber & Kruegelbach, 1989).

This subgroup of gamblers displays higher levels of premorbid psychopathology. In particular, they display depression, anxiety, substance dependence, and deficits in their ability to cope with and manage external stress. Gamblers within this subgroup cannot express their emotions directly and effectively, and they show a tendency to engage in avoidance or passive aggressive behaviours. Emotionally vulnerable gamblers see gambling as a means of achieving a state of emotional escape through the effect of dissociation on mood alteration and narrowed attention (Anderson & Brown, 1984; Jacobs, 1986).

The abstinent gamblers in Blaszczynski's (1988) and Blaszczynski, McConaghy and Frankova's, (1991) two-to-five year treatment outcome study appear to fall within this subgroup. In respect to psychopathology, the abstinent gamblers were placed on an intermediate position between the more adjusted controlled and severely disturbed uncontrolled gamblers. Because of their negative developmental history and poor coping skills, these gamblers were regarded as too fragile to maintain sufficient control over behaviour to permit controlled gambling.

## **Subgroup three: Biological correlates of gambling**

The third subgroup of pathological gamblers is defined by the presence of neurological or neurochemical dysfunction reflecting impulsivity (Steel & Blaszczynski, 1996) and attention-deficit features (Rugle & Melamed, 1993). Briefly, evidence supporting neurological deficits in gamblers is found in



electrophysiological, neuropsychological and biochemical studies.

Goldstein and his colleagues (Goldstein, Manowitz, Nora, Swartzburg & Carlton, 1985; Carlton, Manowitz, McBride, Nora, Swartzburg & Goldstein, 1987) reported differential patterns of EEG activity and self-reported symptoms among gamblers found in childhood attention deficit disorder. Supporting this finding, Rugle and Melamed (1993) on the basis of neuropsychological measures of executive functions concluded that childhood differences in behaviours related to overactivity, destructibility and difficulty inhibiting conflicting behaviours were of primary importance in differentiating gamblers from controls. These authors noted that attention- deficit related symptoms reflecting traits of impulsivity were present in childhood. These traits predated the onset of pathological gambling behaviour and gave rise to the hypothesis that impulsivity precedes gambling; and that impulsivity is independent of it and is a good predictor factor for severity of involvement in at least a subgroup of gamblers.

From preliminary evidence in the field of genetics and from neurotransmitter activity comes the tentative hypothesis which links receptor genes and neurotransmitter dysregulation in reward deficiency, arousal, impulsivity and pathological gambling (Roy, De Jong & Linnoila, 1989; Lopez-Ibor, 1988; Moreno, Saiz-Ruiz & Lopez-Ibor, 1991; Carrasco, Saiz-Ruiz, Hollander, Cesar & Lopez-Ibor, 1994; Comings et al, 1996; Bergh, Eklund, Sodersten & Nordin, 1997; DeCaria, Hollander, Grossman, Wong, Mosovich & Cherkasky, 1996).

Genetic studies have recently reported that pathological gamblers, similar to substance abusers, are much more likely to have the D2A1 allele for the dopamine D2 receptor gene than controls leading Comings et al., (1996) to suggest that the D2A1 allele may be a major risk factor in pathological gambling. When gamblers were evaluated on severity, 63.8 per cent of them in the upper range carried the D2A1 allele compared to 40.9 per cent in the lower range. Of note: 76.2 per cent of pathological gamblers who were co-morbid alcohol abusers carried the gene compared to 49.1 per cent of males without co-morbid alcohol abuse or dependency.

It is argued that gamblers manifest differential responses to reward and punishment because of their biologically based impulsivity. These gamblers manifest a marked propensity for seeking out rewarding activities. They are unable to delay gratification, and have a diminished response to punishment. When the consequences of their actions are painful, they fail to modify their behaviour.

Clinically, impulsive gamblers display a broad spectrum of behavioural problems which are independent of gambling. These problems include substance abuse, suicidality, irritability, low tolerance for boredom, sensation seeking and criminal

behaviours. Poor interpersonal relationships, excessive alcohol and poly-drug experimentation, non-gambling related criminality, and a family history of antisocial behaviour and alcoholism are characteristic of this group. Gambling commences at an early age, rapidly escalates in intensity and severity, occurs in binge episodes and is associated with early gambling-related criminality. These gamblers are less motivated to seek treatment in the first instance, have poor compliance rates, and respond poorly to any form of intervention.

## Discussion

The starting premise of the proposed pathway typology model is that problem gamblers form a heterogeneous population; the end result of a complex interaction of genetic, biological, psychological and environmental factors. From this population, subgroups of gamblers sharing commonalties can be extracted. The strength of this approach is that it integrates disparate findings reported in the literature. It takes into account the notion that there are groups of non-disturbed gamblers. These gamblers lose transient control over their behaviour because of irrational cognitions, which lead to a series of poor judgments and they become temporarily over-involved in gambling. Fluctuations between heavy and excessive gambling are observed; their disordered gambling may remit spontaneously or with minimal interventions. At the same time, the pathway typology recognizes subgroups of gamblers who participate for emotional reasons: to dissociate as a means of escaping painful life stresses, to reduce boredom, or to deal with unresolved intrapsychic conflicts or childhood traumas. The model also acknowledges that there are some gamblers who exhibit biological correlates of disturbed behaviours. These traits qualify them as sufferers of a medical and/or psychiatric condition characterized by impulsivity and features of attention deficit disorder.

All three subgroups are affected by environmental variables, conditioning and cognitive processes. From a clinical perspective, each pathway contains different implications for managing emment strategies and treatment interventions. "Normal" pathological gamblers require minimal interventions, counselling and support strategies and may resume controlled gambling post intervention. Self-help groups such as Gamblers Anonymous are effective, as are self-control self-help educational materials.

The needs of emotionally vulnerable gamblers who seek solace through dissociation produced by gambling (Anderson & Brown, 1984) to deal with emotional distress, life circumstances or trauma and loss (Taber, McCormick &

Ramirez, 1987) require more extensive psychotherapeutic interventions. Relevant here are stress management and problem-solving skills, as are therapeutic endeavours directed toward resolving intrapsychic conflicts and procedures designed to enhance self-esteem and self-image.

For those gamblers with biological correlates, clinicians must attend to problems related to attention and organizational deficits, emotional liability, stress intolerance, and poor problem solving and coping skills. These gamblers may require intensive cognitive behavioural interventions aimed at impulse control, which is administered over longer terms. Medication aimed at reducing impulsivity through its calming effects may be considered (for example, Prozac); although more random-controlled outcome trials are needed before the benefits of the medication can be established with confidence.

The proposed pathway model is a conceptual framework that attempts to integrate research data and clinical observation to assist clinicians in the identification of distinct subgroups of gamblers requiring different treatment strategies. It is hoped that the model will provide a practical clinical guide that will improve the effectiveness of treatment by refining diagnostic processes and matching gamblers to intervention techniques. The model is open to empirical testing.

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## policy

# Gambling on the Edge in Alberta

*By Harold J. Wynne, PhD, Wynne Resources, Edmonton, Alberta*

## Abstract

Alberta is Canada's gambling hotbed. In this article, the author explores the preoccupation of Albertans with this form of entertainment and discusses recent events related to gambling in this province. These include the divisive community video lottery terminal (VLT) debate, hotel operators lobbying for gambling expansion, the government's role in Internet gambling and the increasing reliance of charities on gambling revenues.

The author concludes by forecasting four "gambling megatrends" based on experiences from this bellwether province:

1. gambling in Canada will continue to expand in the foreseeable future;
2. a high-tech gambling future will include Internet gambling in the home;
3. special "gaming rooms" and "mini-casinos" will appear in hotels and convention centres; and
4. charitable organizations will increasingly depend on gambling revenues for their good works.

# Alberta's Gambling Boom

Alberta is Canada's gambling hotbed. Nine out of ten adult Albertans gamble on some form of legally-sanctioned "game" and this province has the distinction of having the widest array of gaming entertainment options available to its citizenry of any jurisdiction in North America. Even the kids are getting into the act as seven out of ten adolescents age 12 to 17 have gambled for money, either on a legal game or informally with family or friends (Wynne, Smith, & Jacobs, 1996).

Further evidence of Albertans' preoccupation with gambling is apparent when one examines the staggering amount that is wagered in this province each year. In the research report *Gambling and the Public Interest* (Smith & Azmier, 1997), the Canada West Foundation reported that the gross amount wagered on all forms of gambling in Alberta rose from \$1.6 billion in 1993 to \$2.7 billion in 1996-a shocking increase of \$1.1 billion, or 70%, in only three years! This translates into every Albertan over 18 spending \$1,344 each year on gambling in 1996. This was the highest per capita wagering total in the country (Saskatchewan was second highest at \$1,183 and British Columbia was the lowest at \$589). No other industry in Alberta or in the rest of the country - not even the banking fraternity, long chided for its revenue generating propensity - has experienced this phenomenal financial growth in the past few years.

This gambling boom has translated into a windfall of revenue flowing to provincial government coffers. In crafting the 1999-2000 budget, the Alberta government projects that lottery revenue will total \$770 million. This lottery revenue comes from video lottery terminals (VLTs), slot machines, and ticket lotteries only and it does not include other gambling revenues, such as licensing fees or income to non-profit organizations derived from horse racing, bingos, raffles, or charitable casino gambling. To place this in perspective, the estimated \$770 million in lottery revenue compares with \$1.1 billion collected annually from school property taxes, \$690 million from health care insurance premiums, \$570 million from fuel taxes, \$452 million from liquor taxes, \$350 million from tobacco taxes, and \$346 million from crude oil royalties. Fully 4.5% of Alberta's estimated budget of \$17 billion is expected to come from lottery revenues and this compares with 37% from combined personal and corporate income taxes and 14% from all natural resource revenues.

Clearly, as well as providing entertainment for the citizenry, gambling has become a major component in Alberta's fiscal policy. In fact in the 1999 spring cabinet shuffle, the Alberta government created the new Ministry of Gaming ([www.gaming.gov.ab.ca](http://www.gaming.gov.ab.ca)) to oversee gambling operations throughout the province. "Gaming" now has a permanent, high profile place at the cabinet table alongside

Learning, Health and Wellness, Environment, Community Development, Children's Services and other significant portfolios.

## Recent Gambling Happenings in Alberta

It is much easier to describe what is happening on the Alberta gambling scene than why gambling has been so enthusiastically embraced in this province. The latter necessitates an examination of the settlement history, socio-political climate, and economic forces at play in a diverse and bountiful environment - all considerations far beyond the scope of this article. It is, however, instructive to track recent gambling happenings in a province that is so preoccupied with this form of entertainment for two main reasons: first, as a precursor to understanding why gambling is paramount in Alberta and second, as a harbinger of gambling trends that may spread to other Canadian provinces.

## The Great VLT War

There are about 6,000 VLTs in over 1,200 sites across Alberta. On October 19, 1998, Albertans in 36 communities voted on whether to keep VLTs in their villages, towns and cities or to ask the province to remove these gambling machines from bars and lounges. In the end, most communities, including the major cities of Edmonton and Calgary, voted to retain VLTs, although in Edmonton the vote margin was very narrow.

This is a watershed event in Alberta and Canada's gambling history as it represents the first time the people have exercised a direct vote on any form of gambling expansion. The proponents of the "yes" (VLT removal) side engaged in a media war with the "no" (VLT retention) advocates and the rhetoric raged for months. Those who are interested in the details of the Great VLT War can find details in the Canada West Foundation ([www.cwf.ca](http://www.cwf.ca)) report entitled *Rolling the Dice: Alberta's Experience With Direct Democracy and Video Lottery Terminals* (Azmier, 1998).

In the final analysis, the people of Alberta have spoken. Petitions signed in Edmonton and Calgary that forced the VLT plebiscites garnered nearly a quarter of a million signatures, which is an extremely strong indication that many Albertans insist on having a say in gambling decisions that affect their communities. Based on this highly visible and successful experience with direct democracy, it is very

likely that the people will continue to lobby the Alberta government to be more involved in the gambling policy decision-making process.

## **Alberta Hotel Operators Lobby for More Gambling - Again**

Several weeks ago, the Alberta Hotel Association approached the Alberta government with an idea for a "pilot study" that involves swapping VLTs for coin slot machines in 40 bars and lounges. The hoteliers are proposing giving up the VLTs in 40 establishments in return for 50 coin slots to be placed in new "gaming rooms" to be developed in these selected hotels. Interestingly, although the government has capped VLTs at 6,000 province-wide, there is no similar limit on the number of coin slots permitted (these presently number about 3,000). The hotel association proposes creating a foundation to funnel 15 per cent of the slot machine revenues into medical research with hotel operators getting another 15 per cent and the province getting the final 70 percent.

The specter of hotel operators lobbying government for more gambling business is nothing new in Alberta. In the early 1990s, the hotel lobby was a major factor in the government's decision to conduct the VLT "pilot projects" in Edmonton and Calgary that ultimately resulted in the wide distribution of VLTs in bars and lounges throughout the province.

Once again, the hotel lobby is attempting to influence the Alberta government to expand gambling to the industry's benefit. If approved, the coin slot "pilot project" suggested by the hotel industry will see some 2,000 coin slots rolled out in 40 new gaming rooms, replacing about 300 VLTs in the process. So far, government MLAs who have been quoted in the media do not favour the hotel association proposal. Ironically, both the pro- and anti-VLT spokesmen in Calgary are also quoted as being opposed. Nevertheless, history shows that the hotel lobby in Alberta is powerful, so I wouldn't bet the farm against lobbyists ultimately succeeding in getting their gaming rooms- starting with coin slots at first and, perhaps, expanding to table games in the future.

## **Is Internet Gambling Coming to Alberta?**

Internet gambling is already available in Alberta, as it is in other provinces. On-line gambling is presently illegal and is typically operated from offshore locations, such as the Caribbean islands, which are outside the jurisdiction of Canadian governments. In our recent study *Gambling and Crime in Western Canada* (Smith & Wynne 1999) Garry Smith and I conclude that, because the present laws against Internet gambling are inadequate and unenforceable, consumers are vulnerable to crimes such as fraud, credit card theft, and cheating. Moreover, there is no way for provinces to stop under-age gamblers from playing. Consequently, we speculate that legalization of Internet gambling seems likely because prohibition is futile in the face of advanced technology and there is tremendous potential for governments to raise large revenues.

Coincidentally, the day after our study was released, provincial newspapers ran a story "Internet Gambling Could Be in the Cards" referring to the Alberta government's plans. In the Edmonton Sun, Gaming Minister Murray Smith was quoted as saying, "You never rule anything out categorically. But we're not considering it at this point. We don't see it as viable at this point" (Beazley, 1999). The story was sparked when it was learned that the Alberta Gaming and Liquor Commission (AGLC) executive was to get a briefing on Internet gambling operations in Canada and abroad. The purpose of the briefing was ostensibly to bring AGLC up to speed on which Internet gambling operators offer their product in Alberta.

This is not the first time that the prospect of Internet gambling in Alberta has surfaced. The Sun also reported that, in 1995, a Caribbean-based Internet gaming company, Internet Casinos Inc., offered to make a personal pitch to Premier Ralph Klein to set up an Internet gambling service in Alberta. The outcome of this overture was not reported. The Liberal opposition has made a Freedom of Information request for any studies and documents relating to Internet gambling and the government has promised these will be delivered in early October.

Clearly, The prospect of Internet gambling in Alberta promises to be a political hot potato in the near future. The government is in the unenviable position of having to either enforce and attempt to eradicate illegal Internet operations or sanction and regulate this form of on-line gambling. Of course, doing nothing is also a government option as is legalizing, promoting and regulating a made-in-Alberta Internet gambling operation. It will be very interesting to watch how the Alberta government deals with this difficult issue in the months ahead.

## Charities Are Hooked on Gambling



# Revenues

A recent Canada West Foundation study of 400 non-profit charities across Canada (Berdahl, 1999), concluded that "gambling revenues are an increasingly important source of funding for the non-profit sector, despite the facts that such revenues are often unstable and present ethical conflicts for a number of organizations." Of the 400 non-profits participating in the study, 28% rated gambling grants as their top funding source and 50% said gaming grants were in the top three sources of their funding. Furthermore, about 20% said they received over half of their annual revenues from gaming grants.

Alberta charitable organizations are especially dependent on gambling revenues. Twenty per cent of Alberta non-profits receive more than half of their revenues from charitable gambling as opposed to 10 per cent in Ontario and 5 per cent in Saskatchewan. More than 8,000 charitable organizations in Alberta currently either have a gaming licence or have conducted a gaming activity in the past two years. The list includes agricultural societies, service clubs, community associations, community leagues, and various types of groups (e.g., youth, music, multicultural, sports, religious, seniors, social action). In the current fiscal year, it is estimated that these non-profit organizations will share in \$146 million in net revenue realized from four charitable gambling sources - bingo, \$58 million; casinos, \$60 million; pull tickets, \$9 million; and raffles, \$19 million (Berdahl, 1999).

Depending on gambling revenues for charitable "good works" causes an ethical dilemma for some board members and volunteers. The Canada West study found, however, that the prevailing sentiment among non-profits was that the "commitment to their cause overrides their ethical concerns about gambling" (Berdahl, 1999). In other words, most take the money and hold their nose. The study concludes by offering 10 recommendations, with the main focus being on reducing charitable organizations' reliance on gambling revenues by replacing these with government grants to organizations to meet community needs.

## Gambling Megatrends

In his pop-futurist best seller *Megatrends* (1982), John Naisbitt identified "ten new directions transforming our lives." Ironically, Naisbitt ignited a trend of his own as his seminal work spawned a parade of similar futurist publications - Faith Popcorn's *The Popcorn Report* (1992) and *Clicking* (1996), Naisbitt and Aburdene's *Megatrends 2000* (1990), David Foot's *Boom, Bust and Echo* (1996)



and Angus Reid's *Shakedown* (1996) to name a few. Each of these authors uses different methods to read the tea leaves in an attempt to enlighten us as to where Western society is heading. In the original *Megatrends*, Naisbitt describes "bellwether states" as those wherein "social invention" in response to social issues and local conditions, seems to occur time and time again. He identified five bellwether states as the leaders and trendsetters in the United States - California, Florida, Washington, Colorado and Connecticut - and through monitoring local media accounts of social invention in these states, he extrapolated the first 10 "megatrends."

While other futurists use different approaches - Foot examines demographic shifts, Popcorn depends on interviews, and Reid relies on polling data and research - there is merit in Naisbitt's observation that there are bellwether states wherein socioeconomic trends are most likely to be conceived, incubated or, at least, quickly adopted.

I believe that Alberta is such a bellwether state when it comes to gambling expansion, regulation and experiencing the inevitable socioeconomic fallout. Therefore, I suggest that it is instructive to monitor the gambling happenings in Alberta for clues about emerging "gambling trends" that may ultimately be experienced in other provinces. At the risk of being labeled a gambling futurist, I offer for consideration four gambling trends inferred from these Alberta happenings:

1. Gambling in Canada will continue to expand in the foreseeable future and machine-based gambling - including VLTs, coin slots, electronic Keno and bingo, and video poker - will grow significantly and become the most pervasive gaming format.
2. This high-tech gambling future will include legalized Internet gambling where citizens will wager on the outcome of table games, horse races, sporting events, elections, and a myriad of yet-to-be determined gambling opportunities, all on their personal computer and in the privacy of their home.
3. The Canadian hospitality and tourism industry will be successful in lobbying governments to allow special "gaming rooms" or "mini-casinos" in larger hotels, convention centres, and tourist destination facilities as part of providing a better entertainment package to attract guests.
4. Canadian charitable organizations will rely heavily on gambling initiatives - lotteries, raffles, casino nights, bingos, and grants from government-sponsored gambling - to fund their programs and administration.

The Alberta people have also clearly voiced that they want a say in the government's future gambling expansion plans and other provincial governments would be prudent to involve the public in gambling decision-making lest they, too, suffer the wrath of the citizenry.

In Alberta, gambling is on the edge. But the edge of what? Proponents would argue that the province is on the leading, trendsetting edge of crafting responsible gambling expansion plans while mitigating the harmful effects of gambling - in other words, creating a healthy balance. In contrast, detractors argue that Alberta is on the edge of a precipice. They see unfettered gambling expansion as a black hole that impoverishes the vulnerable, enriches governments and a few fat-cat operators, and generally seduces people into valuing "luck" above sacrifice and hard work. Which is the true Alberta gambling edge - precipice or trend-setting? It will be interesting to watch the gambling happenings in this bellwether province as the answer to this question emerges.

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## research

# Relationship between gender and substance use among treatment-seeking gamblers

*By Tony Toneatto, Senior Scientist, Centre for Addiction and Mental Health, Toronto, Ontario and Wayne Skinner, Clinical Director, Concurrent Disorders Program, Centre for Addiction and Mental Health, Toronto, Ontario*

## Abstract

Very little is known about gender differences in psychoactive substance use among gamblers. In this study, 200 individuals seeking treatment for problem gambling were assessed with respect to lifetime and current use and abuse of licit and illicit substances. As a group, they were found to have experience with psychoactive substances exceeding that reported for the general population. There were no gender differences in patterns of illicit drugs; however, the women gamblers reported greater experience with psychiatric medications over the lifetime and during the treatment and follow-up periods.

## Introduction

A considerable body of research, recently reviewed by Spunt, Dupont, Lesieur, Liberty and Hunt (1998), has shown a strong relationship between substance abuse and dependence, and pathological gambling. In general, the research reports higher rates (ranging from two to three times) of alcoholism and other substance use

among gamblers than among the general population (e.g., Abbott & Volberg, 1991; Ladouceur, Dube, & Bujold, 1994; Rupcich, Frisch, & Govoni, 1997). Similarly, rates of pathological gambling seem to be higher among substance-abusing populations than the general population (e.g., Feigelman, Wallisch, & Lesieur, 1998; Roehrich, Sorensen, & Good, 1994; Steinberg, Kosten, & Rounsaville, 1992).

However, Spunt et al. (1998) note the lack of data regarding the effect of gender on substance use among pathological gamblers. Mark and Lesieur's 1992 survey of the gambling research literature found that very few studies included female gamblers; those that did rarely analyzed results according to gender. They observed that the failure to include female gamblers seriously limited the generalizability of the findings.

The purpose of the current study was to describe the relationship between gender and patterns of legal, illicit and prescribed psychoactive substance use in a sample of treatment-seeking pathological gamblers.

## Method

Individuals seeking treatment for problem gambling were recruited from addiction and mental health agencies, community mental health professionals, assessment and referral agencies, credit counselling agencies, employee assistance programs as well as directly soliciting participants through advertisements in major and local daily newspapers in Toronto, Canada. Individuals who were referred to the study or responded to newspaper advertisements were invited to participate in the baseline assessment procedure.

The severity of the individual's gambling problem was measured using the Diagnostic and Statistical Manual (DSM-IV) criteria for pathological gambling (American Psychiatric Association, 1994) and the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987), a widely used screen for gambling problems. The Gambling Behavior Questionnaire (Toneatto, unpublished) was used to assess the types and duration of gambling problems, previous gambling treatment, family history of gambling, positive and negative perceptions of gambling and negative consequences of pathological gambling.

Lifetime use, problematic use and treatment history for up to 11 psychoactive substances were also measured. Recent use (during the month pre-treatment) and use during the year following treatment were assessed. Substances were classified into two broad categories: drugs (cannabis, cocaine, hallucinogens, inhalants, opiates, stimulants) and psychiatric medications (anti-depressants, anxiolytics,

sedatives, anti-psychotics). Prescription opiates and alcohol were considered separately.

Gambling treatment consisted of one of four modalities: cognitive-behavioural therapy, brief motivational intervention, 12-step therapy and solution-focused therapy. As the treatments were administered in separate geographic locations, random assignment was not possible. All treatments were administered on an outpatient basis and averaged six sessions except for the motivational intervention, which was one session.

Frequency of gambling, money wagered and relapse (i.e. any gambling if the treatment goal was abstinence; excessive gambling if participants did not choose abstinence as the treatment goal) were assessed for the periods: a) 30 days prior to the baseline, b) six months post-treatment and c) 12 months post-treatment. Relapse was assessed as any gambling if the treatment goal was abstinence and as excessive gambling if participants did not choose abstinence as the treatment goal. At the 12-month follow-up assessment, use of psychoactive substances during the preceding year was assessed again. Additional details describing the treatments and the study can be found in Toneatto, Dragonetti and Brennan (unpublished).

## Results

### *Sample characteristics*

Table 1 describes the overall demographic and gambling-related characteristics for the sample as a whole. The sample was primarily male, middle-aged, earning a middle income, largely non-partnered, with some college education and generally employed. Almost everyone met clinical criteria for pathological gambling according to DSM-IV or SOGS. All subjects were included in the analysis, however, as these measures were not employed as inclusion criteria, but rather as indicators of the severity of the gambling problem.

At the time of seeking treatment, the individual's gambling problem was typically of several years duration, associated with multiple negative consequences (including substantial total estimated financial losses). Almost half of the sample had sought treatment for gambling previously at Gamblers Anonymous (GA). Participation in other addiction programs was not assessed.

**Table 1****Description of sample**

<b>Variable</b>	<b>Total (n=200)</b>
<b>Demographic</b>	
Mean (SD) age in years	41.3 (11.1)
% male	74.9
% married/common-law	48.2
% some college education	30.3
% full-/part-time employment	61.9
Mean (SD) income in thousands	33.0 (23.0)
<b>Gambling-Related</b>	
Mean (SD) SOGS score	12.1 (4.0)
% pathological gamblers, SOGS score > 4	96.0
Mean (SD) DSM-IV symptoms	6.9 (2.2)
% pathological gamblers, DSM-IV 5 symptoms	84.9
Mean (SD) years pathological gambling	7.2 (7.6)
Mean (SD) lifetime financial loss in thousands	90.0 (140.0)
% ever attended GA	47.5
Mean (SD) number of consequences <sup>1</sup>	6.2 (2.2)
Mean (SD) problem gambling behaviors <sup>2</sup>	2.4 (1.6)

<sup>1</sup> maximum 10    <sup>2</sup> maximum 12



## Gender and substance use patterns

Lifetime use of psychoactive substances was extensive in this sample (see Tables 2 and 3). The highest use rates were reported for certain psychiatric medications (i.e., anti-depressants and anxiolytics), cannabis, cocaine and prescription opiates (see Table 2). Several gender differences in psychoactive substance use were observed. Females were more likely to report lifetime use of psychotropic medications, primarily anti-depressants (62% vs. 22% for males;  $\chi^2 [1] = 27.3, p < .0001$ ), anxiolytics (50% vs. 22% for males;  $\chi^2 [1] = 14.9, p < .0001$ ) and sedatives (28% vs. 13% for males;  $\chi^2 [1] = 5.7, p < .02$ ).

The women were also more likely to report drug use during the 12-month post-gambling treatment follow-up period as well; anxiolytics (19% vs. 2% for males;  $\chi^2 [1] = 7.0, p < .01$ ) and anti-depressants (37% vs. 14% for males;  $\chi^2 [1] = 5.4, p < .05$ ). There were no gender differences in the proportion of individuals reporting lifetime use of any specific drugs, history of drug problems or drug treatment, or drug use either pre-treatment or during the 12-month follow-up.

## Gender and alcohol use patterns

Males were more likely than females to drink alcohol in the month prior to seeking treatment for gambling (64.3% vs. 26.0%, respectively;  $\chi^2 [1] = 22.7, p < .0001$ ) as well as during the 12-month follow-up period (59.7% vs. 24.2%, respectively;  $\chi^2 [1] = 8.3, p < .005$ ) (See Table 2.) Males also consumed significantly more alcohol drinks ( $M [SD] = 4.4 [6.0]$ ) on any one day in the month prior to treatment than did females ( $M [SD] = 1.5 [4.3]$ ;  $F [1: 197] = 9.6, p < .005$ ). This margin of difference decreased in the month prior to the 12-month follow-up assessment ( $M [SD] = 3.6 [6.3]$  vs.  $M [SD] = 1.3 [3.1]$ , for males and females, respectively;  $F [1: 91] = 4.0, p < .05$ ). There were no significant differences in the proportion of males (12.9%) and females (9.1%) who reported a current alcohol problem.

Females also reported more days of abstinence in the month pre-treatment ( $M = 28.4, SD = 4.3$ ) than did males ( $M = 23.9, SD = 8.1$ ;  $t [197] = -3.72, p < .0001$ ). The same was true in the month prior to the 12-month follow-up assessment ( $M = 28.4, SD = 4.8$  vs.  $M = 23.7, SD = 8.7$  for females;  $t [91] = -2.82, p < .01$ ). There were no gender differences, however, in the lifetime rates of alcohol problems or treatment-seeking for problem gambling.

In addition, there was no significant gender effect of either alcohol use on gambling behaviour (21.0% of males vs. 10.0% of females reported increased gambling when drinking alcohol) or gambling on alcohol consumption (14.4% of males and 12.0% of females reported increased alcohol use when gambling).

## Table 2

Patterns of use for individual psychoactive substances, by gender

Substance		Ever used		Ever a problem		Ever treated		Used in 30 days pre-treatment		Used during follow-up period <sup>1</sup>	
		M <sup>2</sup>	F <sup>3</sup>	M	F	M	F	M	F	M	F
Alcohol	%	na <sup>4</sup>	na	26	24	12	22	664.3	26	59.7	24.2
	n	na	na	22	8	10	7	97	13	37	8
Cannabis	%	67	54	15.3	12	6	6	8.7	8	1.3	4
	n	100	27	23	6	9	3	13	4	2	1
Cocaine	%	30	22	8	10	4	18	0.7	4	0.7	0
	n	45	11	12	5	6	2	1	2	1	0
Opiates	%	7	10	2.7	4	1.3	2	1.3	0	2	0
	n	11	5	4	2	2	1	2	0	1	0
Hallucinogens	%	31	24	6.7	6	3.3	4	0	0	0	0
	n	46	12	10	3	5	2	0	0	0	0
Inhalants	%	5	6	0.7	0	0	0	0	0	0	0
	n	7	3	1	0	0	0	0	0	0	0
Stimulants	%	21	22	6	10	1.3	8	1.3	2	0	0
	n	31	11	9	5	2	4	2	1	0	0

Anti-depressants	%	22	62	1.3	6	0	0	14.7	34	14	37
	n	33	31	2	3	0	0	22	17	7	10
Anxiolytics	%	22	50	4	14	1.3	10	4.7	22	2	19
	n	32	25	6	7	2	5	7	11	1	5
Antipsychotics	%	4	12	0	0	0	2	2.7	8	8	15
	n	6	6	0	0	0	1	4	4	4	4
Sedatives	%	13	28	3.3	16	0.7	8	4	10	6	15
	n	20	14	5	8	1	4	6	5	3	4
Prescribed opiates	%	33	46	4	16	1.3	8	9.3	10	6	15
	n	49	23	6	8	2	4	14	5	3	4

<sup>1</sup>*n* = 93   <sup>2</sup> Males, *n* = 149-150   <sup>3</sup> Females, *n* = 50

<sup>4</sup> Lifetime use of alcohol not assessed.

## Gender and aggregated psychoactive substance use patterns

Table 3 describes the relationship of gender and aggregated substance use patterns. More females reported lifetime use of psychiatric medications ( $\chi^2 [1] = 16.7, p < .0001$ ), abuse of medications ( $\chi^2 [1] = 10.2, p < .005$ ), treatment for abuse of medications ( $\chi^2 [1] = 17.0, p < .0001$ ), medication use at the time of seeking treatment for the gambling problem ( $\chi^2 [1] = 17.8, p < .0001$ ) and medication use during the 12-month follow-up period post-treatment ( $\chi^2 [1] = 10.9, p < .001$ ). Frequencies for the use of psychiatric medications also showed similar, significant gender differences. There were no gender differences in the patterns or frequency of drug use.

### Table 3

## Lifetime, current and follow-up drug and medication use, by gender

Variable	Males	Females
Mean (SD) number of:	% <i>n</i>	% <i>n</i>
Drugs <sup>1</sup> ever used	70.5 (106)	60.0 (30)
Drugs ever a problem	24.0 (36)	22.0 (11)
Drugs ever treated for	9.3 (14)	10.0 (5)
Drugs used in 30 days pre-treatment	10.0 (15)	10.0 (5)
Drugs used during follow-up period <sup>2</sup>	6.5 (4)	3.0 (1)
Medications ever used <sup>3</sup>	38.7 (58)	72.0 (36)
Medications ever a problem <sup>3</sup>	7.3 (11)	24.0 (12)
Medications ever treated for <sup>3</sup>	1.3 (2)	16.0 (8)
Medications used in 30 days pre-treatment <sup>3</sup>	18.0 (27)	48.0 (24)
Medications used during follow-up period <sup>2,3</sup>	14.5 (9)	46.0 (15)

<sup>1</sup>excluding alcohol    <sup>2</sup>*n* = 93

<sup>3</sup>chi-square significant at  $p < .0001$     <sup>4</sup>chi-square significant at  $p < .005$

## Discussion

No study has systematically assessed gender differences in substance use patterns, problematic substance use and substance treatment history among pathological gamblers. The results of the present study suggest that female problem gamblers

reported significantly greater lifetime use of psychiatric medications, in particular anti-depressants, anxiolytics, and sedatives, than male problem gamblers.

This pattern parallels the relationship observed between gender and psychiatric medications in the general Canadian population. In a survey of drug use among Canadians (McKenzie, 1997), more women used tranquilizers (5.3%), sedatives (5.4%) and anti-depressants (4.2%) in the past year than did men (3.4%, 3.7%, 1.7%, respectively).

While the lifetime prevalence of illicit drug use in the Ontario population (e.g., cannabis, 26.8%, cocaine, 4.9%, heroin, 1.1%) is considerably lower than that for legal substances (e.g., nicotine, alcohol) and prescribed medications, the rates are generally twice as high for males as for females (Van Truong, Williams, Timoshenko, 1998; Adlaf, Ivis, Ialomiteanu, Walsh, Bondy, 1997). The present study found the same relationship wherein illicit drug use was higher in males, although not significantly so. While the relationship between gender and substance use appears to be consistent with what is found in the general population, the rates are considerably higher among problem gamblers seeking gambling treatment.

There were no gender differences in the reported rates for problems with, or treatment for, drug, medication or alcohol use. Furthermore, very little drug use was reported at the time that participants were seeking gambling treatment. None of the participants reported that their current substance use was problematic. Nor was there any evidence that gambling behaviour was substituted by increased use of psychoactive substances as a result of treatment, since there was no change in the use of psychoactive substance during the post-treatment period compared to substance use prior to entering gambling treatment.

The relatively high rates of medication usage among treatment-seeking female gamblers suggest higher levels of psychological dysfunction, sufficient to warrant psychopharmacological intervention. It is well-documented that women tend to suffer from mood and anxiety disorders at rates higher (approximately two to three times) than men in the general population and they are also more likely to seek treatment for anxiety and depression (Kessler, et al. 1994; Ross, 1995). Medications would frequently be a component of such treatment.

Problem gamblers have been shown to suffer considerably from concurrent psychiatric symptomatology. Reviews of the literature show that affective disorders and anxiety disorders are particularly common (Lesieur & Blume, 1991; McCormick, Russo, Ramirez & Taber, 1984; Linden, Pope and Jonas, 1986). Specker, Carlson, Edmonson, Johnson and Marcotte (1996) found that almost all of a sample of 40 problem gamblers had had a lifetime mood disorder and most female (but not male) problem gamblers had been diagnosed with an anxiety

disorder during their lifetime. In general, this literature has not examined psychopathology by gender.

The results of this study suggest that substance use among treatment-seeking problem gamblers, while highly prevalent over the course of the lifetime for both genders, does not seem to be a relevant clinical issue. However, the elevated rates of psychotropic drug use, especially among female problem gamblers, suggest that there may be considerable psychiatric comorbidity in this population, which is consistent with other research in this area.

It is not clear from the study whether such psychopathology is functionally associated with the gambling behaviour. The finding that neither gender changed greatly in their use of antidepressants and anti-anxiety medications in the year following treatment for gambling may indicate an independent psychiatric syndrome. Additional research is needed to evaluate the impact of concurrent medication use and/or psychopathology on the outcome and long-term effect of treatments for problem gambling.

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## clinic

We invite submissions from clinicians - for example, from therapists, counsellors, social workers, and case managers - who work with problem gamblers and their families. We would like to hear what you have learned in your practice that can help other clinicians to better serve their clientele. If you are thinking about beginning an article for us, please see the '[Invitation to Contributors](#).' All submissions will be peer-reviewed in confidence by at least two clinicians and mediated by the editor for their soundness and value to practicing clinicians.

If you have questions, please contact the editor:

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## first person

*We hope that the narratives in First Person Accounts will evoke an understanding of how people experience gambling. These experiences may come from gamblers, from family or friends of gamblers, and may be positive or negative. We invite others to share their experiences as First Person Accounts or to a dialogue in our [Letters to the Editor](#).*

## At Greenwood Racetrack

*By Geri Lockwood*

*(written in 1996)*

During the summer of '93, I occasionally talked my mother into going with me to Greenwood Racetrack in Toronto. It wasn't her favourite place, nor was it the favourite place of most of the people I knew. My daughter refused to go there "amongst the scumbags," as she so aptly put it, but it was my weekend recreation. To escape from dwelling on things of the past, which left me empty and broken, I would rush off on Friday or Saturday or both nights to spend money I didn't have, but which my bank overdraft could accommodate. A quick trip to the Green Machine and I was literally off to the races.

When my daughter moved out the first time, the support from my former husband was cut in half and my finances began to worsen. As I tried to make sense of my state of affairs, I looked back to my first gambling experience and totalled up the years: ten years of chasing a myth and living one. I had a secret life that I exposed to few people, certainly not to the people I worked with. And of course, I gave up my friends - they would not learn of my unhappy penchant for losing money.

A psychic thing I had occasionally experienced resurfaced one summer night in Guelph, where I lived in 1980. A lower downtown street in Guelph had been closed

off and a carnival set up. My husband, my daughter and I went - an affluent family secure with themselves.

As the evening progressed, the fair seemed to come into focus, unreal, and yet somehow, heightened. It was a strange experience, almost like being in a car accident when every detail is slowed down and in horror and helplessness you know you are mortal.

I shrugged off that experience, but it foretold a fascination with what was to come. Sometime after this experience, the three of us moved to Montreal. Within two months of this move, my marriage was over and my daughter and I wound up in Toronto, more aware of each other than we had ever been. In one evening, I celebrated my wedding anniversary and ended my marriage, all while eating dinner at Ruby Foo's.

It was March of '82 when we left Montreal at my husband's invitation. The train route to Toronto ended at Union Station and from there we rode the subway to Kennedy station. With our two suitcases in tow, we walked to my mother's apartment, which she shared with my dear stepfather.

I had originally intended to return to Guelph. But Mom and my stepfather talked me into staying at their Toronto apartment with my daughter, where I slept on the pullout bed in their spare room.

It was tough trying to secure an apartment, and I played the waiting game for a home of our own. I worked temporarily while I waited. I had \$10,000 in the bank and was somewhat financially secure. I held off getting a permanent job until I was settled in my own place and had my furniture and possessions with me in Toronto.

I found an apartment, and my stepfather, who never let me down, saw that my furniture was delivered. I then applied for a job with a bank and after weeks of their deliberating, I was offered a permanent position. My life seemed to be settling down.

My daughter and I went to the Canadian National Exhibition on Labour Day weekend, and I was to start work the following Monday. We walked through the CNE and I don't really remember all the details, but I began to play the games of chance. It was fun. In fact, as closing time came my daughter and I were all smiles, thrilled to have enjoyed ourselves for the first time since we left Montreal.

After that I lived for the CNE, and began buying \$2 instant scratch-and-win tickets. I was consumed. One of the early scratch-and-win tickets also had a number for a future draw with a prize of \$100,000. I eagerly kept all these tickets in anticipation

of the future draw. One day I counted them up, I had over \$200 in useless tickets. I began to realize that something was wrong. I searched for the number of Gamblers Anonymous and hesitatingly called. That night, unlike the other nights I called, someone answered.

I told him that I thought I might have a gambling problem, and that I had been buying lottery tickets. The reformed gambler on the other end of the phone scoffed at me and said buying a few lottery tickets was not gambling. He had gone to the track for years and *that* was real gambling. I told him I had bought more than a few tickets, but he was not impressed. Not being at all forceful, I hung up. I decided that I would try the racetrack and that weekend - fearful, but drawn to it, I made my way to Greenwood Racetrack.

It was overwhelming to a novice: noise, crowds and strange odds, which I would later become a master at, showing displayed on television screens beside the horses' numbers.

Thoroughbred horses were running that day, and asking help from a ticket seller, I made my first bet. The horse won and I lined up to cash my \$5 winning ticket.

I asked a man in line ahead of me, obviously also a winner, how much I had won. He said the horse had been at 4 to 5 odds and I would get back \$9. I was disappointed. The man showed me his winning ticket: a \$100 bet. I wasn't so much impressed as in wonder at someone risking so much money when the payoff was so small. Obviously, he was adept at playing "sure things": the bane of all gamblers.

I made some other bets, but finally I made two or three at once; one of which was a show bet on a horse going off at 20 to 1 odds. I was learning about odds quickly. I went to put my tickets in my wallet and I couldn't find it. Frantically, I dug around in my purse. Of course I couldn't have lost my wallet, I told myself, but my search was fruitless. I was in a panic.

I retraced my steps, but my wallet with \$17 in it and my means of getting home were gone. The track was a long way from where I lived. No one knew that I had actually come to a place like this alone. How would I get home and explain my shame, not only at having gone, but also at being the victim of a pickpocket.

A prickle of fear was all over my body, but I calmed myself and hoped that maybe one of my horses would win. Having nothing better to do, I nervously watched the race. My 20 to 1 long shot came home. I cashed the winning ticket and got back \$6, enough to get home and back to real life.

I left the track sobered by my experience. But I would return to that haven of shame and compulsion many times in the years that followed and walk a tightrope of living a dual identity.

In a way, I would remain true to my nature and not be dishonest or cheat anyone involving a money transaction for the sake of gambling. But to myself, I heaped lies onto lies and my self honesty was diminished. Thus what I *was* changed forever. Changed too, was how I would look at the people who passed through my life. I regarded the addicted as fellow travellers for whom, at times, I would share an unspoken empathy that did not always produce sympathy. The unaddicted became God's chosen; just normal folks, but sometimes within me I wondered if they too harboured a secret self. I regarded anyone with a forced smile or show of gaiety with suspicion.

The compulsion to gamble took a firmer grip on me. I left reason and reality behind on the nights when I discovered that I had inadvertently brought my banking card. One night when I discovered the card, I made a frantic trip to the automatic teller to withdraw money and then raced to the betting window just in time to make a huge bet. It never mattered if I won or lost; though I usually lost. Winning just kept me in the grip and atmosphere of the racetrack, but I always left with nothing in my pocket. I would trudge out and wait by the bus stop at the Harvey's.

Sometimes, but only sometimes, I had the \$1.60 to purchase one of Harvey's wonderful chocolate milkshakes and I enjoyed the reality and treat of it as I entered the real world and shook off the horror and hopelessness of the madness. The many trips I made to the banking machine drained my account, even with my overdraft, and I would steel myself to survive until my next paycheck.

As the bus moved through the darkness, I would look out the window and dwell on how secure the homeowners were, but I knew that such a luxury as a house of my own could never be mine.

Once, when the bus stopped for a light at Greenwood and Danforth, I looked up to the top window of the bank. Perched on the window ledge was a lone pigeon, which huddled on the ledge with its feathers ruffled outward, the small head turned around and buried into its back feathers as it sought shelter from the bitter night cold, and I wondered in whose grip we both were held.

Then a series of events came out of reading horoscopes, an amusing pastime for some. My sister, who was also born under the sign of Libra as I was, played a game with me during our evening telephone calls.

We speculated for what we read made us believe that soon the heavens would be



with us. We found a new horoscope that forecast hope and promises for us both. I took special meaning from a forecast that urged me to look into a relationship from far back in my past and deal with it, for there I would find the key. I remembered a love I had encountered when I was 17 and the great dysfunctioning that had begun for me with that love. I began to explore my early past and how I was still living with it.

I continued to go to the racetrack, but I carried a memory of someone I had loved, now dead. My betting frenzy increased and my feet dragged with the sheer hopelessness of it all. Then one night my gambling frenzy peaked as I sat in the smoking room, hanging my hopes on the outcome of the televised races. I bargained with God that he should let me win one time and secure enough money to walk away forever from that place and go no more. I kept making trips to the banking machine, buying more and more vouchers, only to lose.

I was in more of a fever that night than ever before. As I frantically purchased my last voucher, I believed I heard the ticket sellers talking about me, but I made a bet and sat at a table to watch the outcome of the race. The force of my need to win was so great that I called upon Heaven to let me win as a sign that I could walk away. Heaven answered with silence and I lost the race. But I got up and walked away feeling that something had left me.

In the weeks that followed I went no more to Greenwood. I told those who loved me and who grieved over my compulsion that it was gone. What took hold of me was a thirst for the beauty and caring of life - the small joys. I began to have money in my pocket and was now able to purchase the little things I had learned from gambling to do without. I looked to a future when I would have enough money to buy more expensive items.

This metamorphosis had not begun just with the horoscope. With my sister's help, encouragement and sympathy, we talked and I exposed the true horror of the gambling and my helplessness. Many factors all came together. In the end, I was someone who cared about smiling at people and listening to them. However, because of my nature I still cared too much about everything else, but not myself.

I took myself back to age 17, when my odyssey had begun and then arrived at 50, still the same person. I lived the filling of those years trying to deal with the disapproval the world had heaped on me when I was 17. I sought safety in marriage and created a child. My reality for many years was to put my heart and soul into being a dutiful wife, but all that I offered my husband was rejected and I began gambling. I heaped scorn and abuse on myself by gambling, but within I knew I had been true to myself. I never stole or cheated to gamble, and if I borrowed money, I always paid it back.

I was 50 and my future was to learn to find small joys and the perks of life. I bolstered myself with daydreams of a man I once loved and a sometime belief that we could be together. Perhaps true heaven, even on earth, is the ability to dream dreams.

Our mood of the moment is how we look to our end. The gamble of life and the chances we deal with are our reality. In despair we want oblivion, but if we have ever achieved the brass ring, we cling to the pleasures of life and want more.

At 50 years of age, I cared again. I never made a mark on the world, save for those who loved me and those with whom I dealt fairly. I wondered sometimes if I even wanted to go 'round on the go 'round of life yet another time, if I had the chance. I was not certain if I wanted to go.

I took better care of myself and I laughed more; I gained my daughter's respect and I functioned and went to work everyday. I had money in my pocket and most days I lived in the reality of the world. I had come to terms with life.

But someday, if you feel a hollowness or if you're in a place and it sparks an echo within - you know - they call it deja whatchamacallit, then remember this tale and think of me. If you listen closely, you may hear me laughing as I go around again with a certain someone, reaching for the brass ring.

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## review

### Hooked: A Gambler's Nightmare (1996)

*Running time: 15 minutes*

*Producer: Loose Change Film Associates and Alberta Alcohol and Drug Abuse*

*Commission (AADAC)*

*Distributor: Kinetic Canada 511 Bloor Street West, Toronto, Ont., M5S 1Y4*

*Phone: (416) 538-6613, 1-800-263-6910*

*:<http://www.kineticvideo.com>*

*Cost: \$99.00*

Winning, Losing, Desperation and Exhaustion: these are the four parts of *Hooked: A Gambler's Nightmare*, a video profiling the progress of the problem gambler. This well-paced video combines professional commentary with the perspectives of both casual and problem gamblers to highlight the major elements that lead to problem gambling.

*Hooked* is comprehensive in the types of gambling considered - from bingo to casinos to VLTs. It shows that contributing factors to the increased risk of problem gambling are similar to those for alcohol and other drug use problems: early exposure, social difficulties, emotional or mental health problems, and for young people, problems at school.

Starting off with a montage of Las Vegas-style images of the gambling world, *Hooked* conveys some of the excitement of having the chance to win big. The high reward value of winning is another important factor, especially for beginners. The video suggests that this early phase is important; it contributes to an increasing commitment - like upping the ante in an attempt to relive the excitement of the first win. As the gambler's commitment progresses, he or she devotes more resources to

betting, and may continue or escalate betting to pay off debts. In more extreme examples, again like the problem alcohol user, the gambler becomes isolated from friends and family, may lie to hide the extent of the problem or steals money or sells valuables to finance continued gambling.

*Hooked* outlines two case histories and examines the destructive impact of problem gambling on family life. One family speaks of both damaged relationships and serious financial losses. The painful emotions and loss of trust are evident when the family appears together onscreen and in highly emotional moments clearly shows their great pain suffered from loss of trust. In another story, a single man relates how his inability to control his gambling, even though he knew he was in trouble, resulted in the loss of his family through divorce.

Strategies for getting help are mentioned briefly, from attending Gamblers Anonymous meetings to seeking professional counselling. More time could have been devoted to the kinds of treatment available and this area may have to be enlarged upon by a resource person. Though this is a weak point in the video, *Hooked* is never the less well-produced. Generally it moves at a fast pace, the slower segments where gamblers talk about their lives are emotional and have high impact.

Another issue some presenters may want to deal with is the close parallel made between problem gambling and alcohol or other drug use problems. The implication is that the pharmacological effects of substance use (e.g., tolerance and dependence) have some behavioural equivalent in the process of becoming a problem gambler.

This is a good video for presenting the major issues in problem gambling. Given its rather short running time, *Hooked* covers a great deal of material and would serve as a discussion-starter for general adult audiences, workplace presentations and senior students.

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## letters

### Letters to the Editor

We invite our readers to submit **Letters to the Editor** on gambling topics. Please note that we can publish only a fraction of the letters submitted. All letters must be signed. We cannot publish anonymous letters, or those of a libellous nature. Letters to the Editor are reviewed and chosen by the editor and members of the editorial board. Letters may be sent to either the e-mail or the regular mail address given below. Once a letter has been accepted, we will request an electronic version. Each published letter will include the writer's first and last names, professional title(s) if relevant, city, province or state, and country. We reserve the right to edit each submission for uniform format and punctuation.

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For the **Calendar of Events** we invite our readers to submit notices of upcoming gambling-related conferences, presentations, symposiums and other educational events, civic events, and media events that are open to the public. We will gladly publish news of events that may occur years in the future.

We ask that these notices be submitted by electronic mail. With each submission we require the email address of someone with whom the editor can verify details about the event. (We understand that this e-mail address may perhaps not be part of the published calendar listing.) We reserve the right to edit each submission for uniform format, punctuation and grammar.

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## Gambling Information and Counseling Services

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### Program Description

**Gambling Information and Counseling Services (GICS)** is a Division of Human Technologies Corp., in Utica, NY. GICS, a not-for-profit service, provides counseling services for gamblers, their families and others affected by gambling. GICS also provides educational and informational presentations. It currently provides group services for inmates in one New York State correctional facility. The counselors, through Volunteer Services at the prison, hold a ten-week module with inmates who have been evaluated as having problems with gambling behaviors. We are the only service of this kind in the New York State prison system. Our program is one of eight funded by a grant through the New York State legislature and overseen by the Office of Mental Health. GICS services several counties in central New York.

## **Philosophy of Service**

We work closely with the New York Council on Problem Gambling. Our objective is to provide help to those who are adversely affected by gambling. The New York legislature acknowledges that legalized gambling can be a problem for some and offers a grant for these services. We provide services regardless of one's inability to pay for services. We mainly offer weekly and hourly counseling sessions that address gambling behavior and imbalances in one's life that make it difficult to abstain from gambling (gambling is often a symptom of other problems). We also run group sessions as needed.

## **Profiles of Our Services**

Our program staff consists of two CSW (New York State Certified Social Worker) providers. One worker is solely involved in counseling and the other is the co-ordinator, who does some educational programming and administration as well as counseling. Both staff members have worked in family, individual and couple counseling before this position. We have a co-operative working relationship with Gamblers' Anonymous and provide a facility for GA meetings.

## **Description of Our Clients**

Clients are self-referred, family-referred and referred from other sources such as the judicial system, human services and the medical community. Clients of all ages are served and couples and families receive counseling as needed.

## **Program Evaluations and Research Involvement**

Statistical information is compiled by the New York Council for Problem Gambling and the Office of Mental Health and used for evaluation and research studies. New York Corrections is also using information from our prison group for their own evaluation studies.

*This Service Profile was not peer-reviewed.*

*Submitted: March 18, 2001*

*We invite clinicians from around the world to tell our readers about their problem gambling treatment programs. To make a [submission](#), please contact the editor at [Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net).*

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## case study

*[This article and its two response documents print to approximately 27 pages.  
– The editor]*

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### Case Conference Report

## Gambling-Induced Analgesia: A Single Case Report

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### Abstract

This paper describes a single case study of analgesia induced by gambling. The subject is a 48-year-old male diagnosed with pathological gambling

problems, suffering chronic back pain resulting from a road trauma. The reported intensity of arousal associated with slot machines and roulette produced a state of dissociation or distraction that temporarily reduced levels of pain. Consistent with an operant conditioning model, this reduction in pain was a negative reinforcer that acted to elicit further gambling whenever the pain reached a certain level of discomfort. In the absence of any effective analgesic medication, he used gambling as his predominant strategy to manage pain. He began to enjoy gambling, and within a relatively short period, lost more than he intended and commenced chasing losses. Pain levels decreased following chiropractic interventions, but his gambling continued. The additional, positive reinforcing effects of the excitement generated by the slot machines and roulette gaming became sufficient to maintain persistence in gambling independent of pain experienced. This case highlights the possibility that psychological factors involved in establishing a gambling habit may differ from those involved in maintaining persistence.

## Introduction

Several authors have suggested that the need to escape negative emotional states partially explains the motivation for persistent gambling in a proportion of participants (Blaszczynski & McConaghy, 1989; Jacobs, 1989; Wynne, 1994). The central concept underlying this view is that gambling is capable of producing sufficient arousal to induce a state of narrowed attention, or an altered state of consciousness characterised by amnesic episodes, trance and dissociation. It is argued that this state of consciousness permits a person who is gambling to temporarily 'switch off' from stressful thoughts, reduce boredom (Blaszczynski, McConaghy & Frankova, 1990), escape emotionally from their current situation or cope with feelings of inadequacy or rejection. Although imprecisely defined, the phenomenon of dissociation, the cornerstone of Jacobs' *General Theory of Addictions* (1989), is claimed to mediate this process.

Studies demonstrate that gambling is associated with subjective and physiological indices of arousal (Anderson & Brown, 1984; Leary & Dickerson, 1985; Dickerson & Adcock, 1987; Roby & Lumley, 1995) and high scores on measures of dissociation (Kuley & Jacobs, 1988; Brown, 1997; Gupta & Derevensky, 1998). Empirical data offered by Diskin and Hodgins (1999) demonstrate the ability of gambling to engross participants during play. The authors demonstrated that reaction time in response to visual stimuli during a laboratory session of gambling was slower and scores on a dissociative scale

higher among 12 people with pathological gambling problems who played video lottery compared to 11 occasional players.

We present an interesting case of a male for whom arousal associated with gambling invoked a dissociative-like state (or level of distraction) that induced analgesia for chronic back pain. His gambling rapidly escalated as it was an effective strategy that distracted him from his chronic back pain. According to principles of operant conditioning, removal of pain negatively reinforced gambling and led to the development of a gambling habit. However, consistent with the behaviour completion mechanism model (McConaghy, 1980; McConaghy, Armstrong, Blaszczynski & Allcock, 1983), once his gambling became a habit, he acknowledged that he played independently of pain. He enjoyed gambling for the excitement it generated, and in response to urges triggered by stresses of any nature or source.

## Case history

Mr. S.M. was a 48-year-old married, self-employed businessman. He referred himself for treatment because, for one year, he played slot machines and roulette excessively. He reported a mean net expenditure of AUD \$500 to \$800 per session (on infrequent occasions, more than AUD \$1,000), frequently playing twice a week for two hours. He endorsed seven of 10 DSM-IV criteria and obtained a South Oaks Gambling Screen (Lesieur & Blume, 1987) score of 11. Mr. S.M. produced bank statements verifying recurrent withdrawals of AUD \$200 from gambling venues.

Mr. S.M. consented to publication of this case study.

## Personal details

Mr. S.M., second youngest of four boys, was born in Germany in 1950, went to school, and then migrated to Australia with his family at age 20. His father, a cabinetmaker, died 20 years ago from a heart condition and his mother lives near his residence. His developmental milestones were normal and his childhood unremarkable. The family was close and he maintains irregular contact with his brothers.

In Australia, he commenced but did not complete a diploma in chemistry. He was employed as a technical assistant in a painting and printing research and



development laboratory. He subsequently embarked on a relatively successful career as a self-employed businessman, importing goods and earning approximately AUD \$240,000 per annum. He is a gregarious and talkative person.

At age 21, he married a nurse and they had three children. He described the relationship as "good." In 1984, because they both worked long hours, they experienced marital difficulties, which resulted in a two-month separation.

Mr. S.M. denied the presence of a family or premorbid history of psychiatric illness, alcohol dependency or illicit drug use. He consumed alcohol socially; less than two standard drinks per day on average; although, because of a car accident, he drank more when he experienced severe pain. There was no evidence suggesting a personality disorder, thought disorder, antisocial or conduct-behavioural problem, nor was there evidence of any significant medical illness prior to the injuries sustained in the accident.

## **History of physical injuries**

In June 1997, Mr. S.M. was involved in a motor vehicle accident and sustained severe bruising, soft tissue whiplash injuries and a fractured spine and sternum but did not lose consciousness. He continued to suffer significant back pain and psychological changes characterised by increased irritability, anger and depression. His back pain was located in the lumbar regions L1 and L2 and upper neck and shoulder area. He described it as severe fluctuating episodes lasting a day or two with continual moderate pain. Using the McGill Pain Questionnaire (Melzack, 1975), his pain was rated at a score of three; which is distressing because of its intensity. Using the rank value method, the following pain scale scores were obtained: sensory, 6; affective, 16; evaluative, 10; and miscellaneous, 13; giving an overall total Pain Rating Index of 45. He stated that he was unable to stand or sit for any length of time and said this had hampered his ability to function at work.

Taking analgesic medication such as Panadeine Forte and Efexor (300 mL) daily temporarily alleviated pain but did not eliminate it completely. When the pain was severe, he would consume several glasses of alcohol over a few hours.

Mr. S.M. became depressed due to the pain, which interfered with his capacity to work and restricted his quality of life. He consulted a psychiatrist for counselling and a hypnotist for pain management and he initiated

compensation because of his injuries.

## Gambling history

Mr. S.M. commenced gambling at 17, infrequently betting AUD \$5 on horse races at off-track betting venues. He also began playing slot machines socially, and infrequently attended a casino with friends and or his wife. There was no reported loss of control over the 15-year period prior to 1998.

In March 1998, Mr. S.M. attended a casino with his wife and won AUD \$4,500. Significantly, he noted that gambling (and winning) produced a state of excitement —powerful enough to act as an effective analgesic for his pain. The excitement altered his mood and self-confidence: "Nothing but happy thoughts, I'm on cloud nine."

As a result, Mr. S.M.'s gambling escalated rapidly over the following three months after learning that gambling was effective in reducing his chronic back pain. Whenever the pain increased, he gambled to reduce its intensity. All other concerns and physical sensations were excluded from conscious awareness:

"..the concentration on the gambling is so intense that I don't feel anything. I talk with people at the roulette table and become very happy and relaxed. The concentration is on the gambling. Very important, when gambling just small amounts it becomes boring and the pain becomes noticeable. To chase gives full concentration. The pain disappears. This does not work without real [meaning substantial amounts] money."

On the Jacobs (1989) four-item dissociative scale, he failed to endorse depersonalization ("..ever felt like you were outside yourself watching..") and reported only occasional memory lapses. The remaining two items were rated as frequently: "I'm really into it [gambling], everybody is a shadow when I am playing" and "I feel totally happy, invincible."

The negative reinforcing effects of gambling led to a cycle where gambling represented a costly approach to pain management. He lost substantial amounts and, given his restricted capacity to earn money, was forced to sell investment properties to cover expenses. He began to chase losses and developed erroneous beliefs about his skills and probability of winning. Over three months, he lost approximately AUD \$20,000 and made repeated,

unsuccessful efforts to cease gambling.

Between March and September, Mr. S.M. was offered imaginal desensitisation (McConaghy et al., 1983) and cognitive therapy designed to correct erroneous perceptions. He reported an estimated improvement of 60 to 90 per cent (as assessed by frequency and amount used to gamble).

Chiropractic manipulation partly contributed to this positive outcome of pain reduction, and his back pain stabilised to tolerable limits. In September 1998, he reported that he gambled less frequently, reduced the amount substantially, and that current gambling sessions were not motivated by the need to induce analgesia. His gambling patterns changed significantly and he often gambled within controlled limits motivated by social enjoyment. He made the conscious decision to play for excitement in weekly one-hour sessions with a net expenditure of \$100. However, there were additional binge episodes that were triggered by a range of stresses or depressed moods related to worries over his compensation proceedings and inability to work. At these times, he spent more than intended, losing up to AUD \$250 to \$350 per session.

At his October 1999 follow-up, he reported continued improvement of approximately 80 per cent from pre-treatment levels of amount and frequency of gambling. However, he still had intermittent lapses during the intervening 12 months in which he lost up to \$400 (amounts significantly less than those lost in earlier binge episodes). On one occasion, he was under considerable pressure and decided to gamble despite the efforts of his friends to contain him. He acknowledged awareness of his actions but felt the need to release pent-up stresses and the overwhelming drive to gamble. In another episode, conflict with barristers and anxiety associated with the preparation of compensation reports provoked a serious episode where he gambled AUD \$1,000 but aborted the session despite having access to money.

When last seen, in December 1999, he reported no subsequent episodes of excessive gambling. On several occasions he entered gambling premises with his wife, but either did not gamble or limited his gambling to a small amount with no difficulty, deciding to cease despite having AUD \$2,000 or more in cash. He acknowledged a persistent underlying urge to gamble but claimed it was controllable. Given his fluctuating pattern of improvement, his prognosis was regarded as positive, but uncertain in the longer term. Cognitive therapy and counselling continued to be offered.

## Discussion

It makes intuitive sense to argue that gambling represents an exciting activity capable of generating sufficient levels of arousal. Gambling offers an opportunity for emotional escapism by narrowing a player's attention, and altering his or her state of consciousness and sense of disconnection from self and environment. From a behavioural learning perspective, the reduction in aversive mood states is a negative reinforcer. Once immersed in gambling, all extraneous aspects of a person's life can be excluded from conscious thought, while attention and concentration are directed at the single task of winning, anticipating the next outcome and the powerful, ego-boosting fantasy associated with winning.

A number of authors have underscored the desire to escape stressful situations, memories and aversive mood states as a primary motivation for continued participation in gambling. Anderson and Brown (1984) first hypothesised that the physiological arousal and subjective excitement associated with gambling could sufficiently narrow attention to allow participants to escape from their current state of emotional distress.

Jacobs (1989; 1998) incorporated this concept as a central feature of his *General Theory of Addictions*, arguing that such arousal was comparable to dissociative-like phenomena. He has produced convincing empirical data to show that people who gamble experience blurred reality, shift in persona, depersonalisation and amnesia for events occurring during gambling (Jacobs, 1998). According to Jacobs, addiction is defined as "a dependent state acquired over time by a predisposed person in an attempt to relieve a chronic stress condition" (Jacobs, 1989, p. 35). Addiction to gambling specifically arises from an interaction of two predisposing variables: an abnormal state of physiological hyper- or hypo-arousal and negative childhood experiences invoking rejection, inadequacy and low self-esteem.

In this model, the potential to induce a dissociative-like state that diverts attention from chronic aversive arousal states, deflects thoughts of self-perceived inadequacies from consciousness and fosters the emergence of wish-fulfilling fantasies that give gambling its "addictive" qualities. Gambling represents a problem-solving method that permits psychological escape through mechanisms of dissociation.

"[It is a] normal..defence we all use against distractions in everyday life. We also use dissociation as a defense when high levels of psychological distress, physical pain, or sense of helplessness caused by a traumatic incident or a continuing

aversive condition overwhelms a person's resources for coping with the stress it engenders" (Jacobs, 1998, p. 4).

That people who gamble obtain elevated scores on measures of dissociation has been found repeatedly; (Gupta & Derevensky, 1998; Kuley & Jacobs, 1988) although with some contrary results. For example, Diskin and Hodgins (1999) found that a small sample of people diagnosed with pathological gambling problems had higher dissociative scores than people who gambled occasionally, but neither differed from normative scores.

However, dissociation is a complex concept that lacks a single framework. It is variously conceptualised as a non-integrated mental module or system, an alteration in consciousness resulting in a disconnection from self or environment, or a psychological defence mechanism (Cardena, 1994). In Jacobs' model, dissociation is used with various meanings with no attempt made to distinguish it from altered states that emerge as correlates of ordinary "distraction." As Cardena (1994) cautions, labelling any simple disconnection between self and perceptions, or emotions and thought as dissociative weakens the utility of the construct. The term should be retained for circumstances where there is a qualitative disconnection from ordinary modes of experience. We are suggesting that there are many normal activities that engross the participant wherein they become so focused they lose perceptions of external and internal stimuli. These activities are enjoyable and participation is sought recurrently. Examples are sporting contests, computer play, reading and board games. Gambling can be conceptualised in the same vein without recourse to more complicated concepts of dissociation.

In the present case study, Mr. S.M. was so engrossed in gambling that he was distracted from pain, which led directly to increased participation. It should be noted that distraction is used effectively in pain management strategies without recourse to dissociation as an explanatory process. Once the habit was established, other factors superseded the analgesic effects as the primary reasons for participation, notably, excitement and erroneous perceptions surrounding the likelihood of winning.

Blaszczynski and McConaghy (1989) adopted a similar position. They argued that gamblers experiencing anxiety selected low-skill games, while dysphoric gamblers chose high-skill games to modulate mood states and achieve optimal levels of physiological arousal (Zuckerman, 1979). However, adopting a neo-Pavlovian, behaviour completion mechanism model, McConaghy and his colleagues (McConaghy, 1980; McConaghy et al., 1983) did not consider dissociation or negative childhood experiences a necessary component of the aetiological process. Rather, a wide range of current external or internal stresses was considered sufficient to trigger the drive to gamble once a

gambling habit was established. This behaviour completion mechanism would drive the person to engage in and complete the sequence of behaviours underlying the urge. The person would experience this as a persistent preoccupation and urge to engage in the behaviour and to carry it through until satisfactorily completed. Attempts to impede this process would lead to an aversive state of increased tension and continued drive to complete the behavioural sequence.

In addition to the operant reinforcing qualities of the excitement of winning, the reduction in aversive arousal associated with the urge to carry out a habitual behaviour to completion and aversive emotional state were seen to represent important negative reinforcers. In the case of Mr. S.M., when the physical pain overwhelmed his coping resources, he gambled as a means of temporarily reducing pain through distraction. Once this became a habitual pattern, this strategy was applied to escape negative emotional states.

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## **Case Conference Responses**

### **Response to a Case of Gambling-Induced Analgesia**



*By Durand F. Jacobs, PhD, ABPP  
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Sciences)  
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### ["In our work with young gamblers..."](#)

*By Rina Gupta  
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### Case Conference Responses

## Response to a Case of Gambling-Induced Analgesia

*By Durand F. Jacobs, PhD, ABPP*

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I will attempt to cast the case of Mr. S.M. within the context of the *General Theory of Addictions* (Jacobs, 1982; 1986), key elements of which are summarized in the Discussion section of Dr. Blaszczynski's paper. From this perspective, I view the most devastating immediate and continuing result of the patient's accident as the loss of the psychological, social and financial rewards that stemmed from the business that he had created, and in which he had become so involved that at one time it even threatened his marriage.

In effect, the accident robbed this man of the essential substance and quality of his life, and left him virtually adrift from his previously established moorings.

His chronic and episodically severe pain further restricted his former, physically active work and social life. This combination of physiological and psychological stressors set the stage for his later, enthusiastic "discovery" that high

excitement while gambling actually provided an escape from all his stressors: from his preoccupation with feelings of low self-worth; from his worry about his failing business and attending money problems; as well as from his severe pain and its attending physical limitations. Moreover, he stated that he frequently experienced an altered, clearly dissociated, state of consciousness and identity while gambling. In this altered state, his mood and self-confidence were dramatically improved and he felt superior to others —invincible.

That his analgesic release from pain, while gambling, was only one component of the above dissociated experience is evidenced by the fact that his gambling "binges" continued long after the pain had become manageable. As Dr. Blaszczynski relates, the later gambling binges continued to be triggered by a range of situational stressors much like those I have described above.

The patient acknowledged that Dr. Blaszczynski's treatment of his erroneous perceptions and expectations regarding gambling had greatly reduced the frequency and amount spent per period of gambling. Yet, the patient also admitted that, despite his own and others' attempts to control his gambling, he still continued to rely on bouts of gambling to escape the build-up of intolerably frustrating stressors in his life that periodically peaked during the treatment period and continued one year after his treatment.

Fifteen months post-treatment, when last seen by Dr. Blaszczynski, the patient reported no binges during the previous three months but admitted that he had a "persistent, underlying urge to gamble," which he claimed he was controlling.

From the perspective of the *General Theory of Addictions* (and my own clinical experience), I don't believe one can talk or reason anyone with pathological gambling problems (or any person with an addiction) out of his or her chosen pattern of addictive behavior, while it is serving that person's needs. After all, in the case of Mr. S.M., pathological gambling was not the patient's "problem." For him, it was his best available solution to his long-standing underlying problems (Gupta & Derevensky, 1998) that were exposed by the physical and the functional disabilities caused by his accident. Until these underlying physiological (hypotensive) and psychological (self-worth) issues are ameliorated by whatever means, and until the patient acquires more effective coping skills for dealing with his daily stressors, I expect that his episodic gambling binges will continue.

I would like to offer a word about the differences between my view of dissociation and those expressed by Drs. Blaszczynski and Cardena. My

clinical experience and research findings consistently support the position that the phenomenon of (self-induced) dissociation constitutes an unbroken continuum of behaviors. This extends from simple, everyday forms of reverie or concentration or distraction to a middle ground, wherein a commonly held and extensively verified set of dissociative reactions are reported by people with addictions, while they are indulging (Jacobs et al., 1985; Jacobs, 1988). Towards the far end of this continuum are ever more extreme dissociative reactions, such as those reported by patients showing post-traumatic stress disorders, functional fugue states and dissociative identity disorders (Jacobs, 1982).

Consequently, I cannot agree with Cardena's argument (1994) that the concept of dissociation should be restricted to the more clinically abnormal circumstances "where there is a qualitative disconnection from ordinary modes of experience." He would thus relegate involvements with ordinary modes of experiences such as board games, computer play and reading to the (non-dissociative) realm of normal engrossments.

I believe it is far more parsimonious to view dissociation as the unbroken continuum described above. Within this conceptual framework, increases in the frequency and types of dissociative reactions reported would indicate the extent to which the person chooses to progressively separate himself or herself (via self-induced changes in thought, emotion, identity, time and/or memory) from ordinary, mildly challenging to highly aversive reality situations. For example, tables 1 and 2 reveal the progressively increasing use of five different dissociative reactions as direct correlates to the increasing extent of self-reported problems with gambling (Jacobs, 2000).

**Table 1: Potential Effects of Gambling on Personality among Ontario Adolescents (N = 400)**

Personality Effects (SOGS Scores)	No Problems (0)	Some Problems (1–2) (3–4)		Probable Pathological
Lost track of time while gambling	12%	36%	55%	65%

Felt like you were a different person	3%	10%	26%	53%
Felt like you were outside of yourself watching yourself gamble	2%	8%	9%	29%
Felt like you were in a trance	0%	8%	7%	24%
Experienced a memory blackout for things that happened while you were gambling	0%	3%	2%	12%

*Compiled by D.F. Jacobs, PhD*

*Reprinted with permission of Insight Research Canada (1994).*

**Table 2: Potential Effects of Gambling on Personality among Alberta Adolescents**

Dissociative State	% Non-Problem Gamblers (N = 430)	% At-Risk Gamblers (N = 148)	% Problem Gamblers* (N = 77)
Lost track of time while gambling	24%	56%	75%

Felt like you were a different person	7%	23%	29%
Felt like you were outside yourself, watching yourself gamble	2%	7%	26%
Felt like you were in a trance	1%	2%	27%
Experienced a memory blackout for things that happened while you were gambling	1%	6%	20%

*\* Classification of gambler categories based on SOGS scores.*

*Reprinted with permission of Wynne Resources, Ltd. (1996).*

As one knowledgeable about pain management strategies, I find it unacceptable to propose "distractions" as a freestanding entity arbitrarily and without supportive evidence. Distraction, via reading or meditation, is firmly included within the range of simple to more complex dissociation techniques (e.g., self-hypnosis) regularly taught to hospitalized patients reporting chronic, intractable pain (Jacobs, 1980; 1987).

This is a final comment about the respective motives for gambling, which Dr. Blaszczynski attributes to social and pathological gamblers. Overwhelmingly, both groups enjoy the excitement and opportunity to win money. What

separates them is that social gamblers typically set and hold to time and loss limits for a given playing session. When they win larger amounts, social gamblers tend to pocket their winnings and leave. Gamblers with pathological-level problems, like Mr. S.M., find it very difficult when stressed to set or maintain time or loss limits. They rarely pocket the money and leave even when they win very significant amounts. Their overriding motivation is to use winnings and other sources of money to keep playing. Their primary objective is to maintain and enjoy the dissociated, altered state of consciousness that results from gambling. In the words of one person with pathological gambling problems: "The next best thing to winning is losing – just so I stay in action!"

Submitted: November 6, 2000

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## Case Conference Response

# "In our work with young gamblers..."

*By Rina Gupta*

*Youth Gambling Research and Treatment Clinic*

*McGill University, Montreal, Quebec, Canada*

It was a real pleasure reading the article "Gambling-Induced Analgesia: A Single Case Report," as it echoes what we see and experience in our treatment of adolescent gamblers.

The single case report describes a man in his late forties who turned to gambling as a way of escaping the pain of a back injury incurred from a serious car accident. Gambling, for him, resulted in analgesic properties allowing him to escape physical pain for brief periods of time. The article also reported that he experienced depression as a result of his pain, and that he would also engage in binge drinking as a means of escape. One must wonder if he was also intentionally escaping feelings of depression with his gambling and use of alcohol.

What is particularly interesting about this individual is that he continued his gambling despite an improvement in his physical condition, and he was aware



of gambling for reasons other than its analgesic effects; that is, primarily for the excitement. He continued to gamble beyond the limits he set for himself and recognized that the reasons causing him to begin gambling in a problematic fashion were not the same as those maintaining his gambling involvement.

In our work with young gamblers, we often encounter adolescents whose motivations underlying their gambling change over time. However, we are more likely to see youth who start gambling primarily for reasons of socialization and excitement, and then realize over time, the "escape" that gambling provides. Those who feel they benefit from the escape are more likely to continue gambling for this property and less for the excitement and socialization advantages that attracted them in the first place.

Our research efforts have consistently indicated a strong linear relationship between degree of gambling and reported degrees of dissociation experiences by youth while gambling. They report that gambling is a "whole different world" where "problems do not exist," where they "feel good." It is not uncommon for us to work with youth who are either mildly or seriously depressed, and they explain that only when gambling do they feel "not depressed" and "alive."

More likely than not, youth who experience gambling problems lack adequate problem-solving, coping and social skills. They often find themselves having friendships that lack depth and closeness, feeling as though they "don't belong" and as though they are incapable of successfully facing the challenges of adolescence. Most of our adolescents in treatment can reflect back on previous years and honestly admit to feeling dysfunctional in many ways—in terms of interpersonal relationships with friends and family, and often, with respect to their academic performance. More often than not, these youth are struggling with identity issues and issues of belonging.

Many of these youth are anxious or fidgety, and may only feel comfortable when engaged in highly stimulating activities. It is no wonder they quickly come to recognize gambling as a solution to their unhappy states of being; to recognize gambling as their new "best friend." This best friend keeps them busy, does not judge or criticize them, satisfies their need for high arousal and stimulation and allows them to forget that they are not functioning well in the outside world.

These words from an 18-year-old girl sum up what we have come to understand about the motivations underlying gambling very well:

" ..It was a whole fantasy life and I felt happier than I ever did before. I didn't

feel sad or bored, or as if I did not belong. I realized that I did not have any real friends, my whole life. I never really had a friend that I could confide in or cry with, or even really laugh with. Now, I felt satisfied and happy and I thought gambling was the best thing for me. ..Now I can't stop. I need it to make me forget my problems at school and with my family, and the fact that I have no real friends."

We have not yet treated any youth who were gambling for analgesic reasons, but we have frequently worked with youth who gambled to numb emotional pain resulting from the death or loss of a parent as well as other traumas. While gambling they can feel good and let go of the pain, resulting in a very powerful situation where gambling serves as a negative reinforcer. Most youth, due to a lack of previous gambling involvement, are unaware that gambling will help them escape pain and unhappiness, but they latch onto gambling for these reasons through repeated exposure and their primary motivations for gambling seem to fall into the background.

In sum, we must acknowledge the strong analgesic and escape properties inherent in gambling participation, as well as the fact that reasons for gambling participation can change over time. This awareness will serve to develop better prevention messages and allow for more successful treatment outcomes.

*Submitted: October 24, 2000*

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## **Case Conference Response**

# **Further Specifying Our Models of Problem Gambling**

*By David Hodgins*

*Coordinator, Program Development and Research*

*Foothills Medical Centre, Calgary, Alberta, Canada*

This 48-year-old German man living in Australia could easily be living in Calgary, Alberta, playing our infamous video lottery terminals, or he could be anywhere else in Canada or North America. I am struck by how the clinical presentation of gambling problems is so similar from country to country and continent to continent, despite the fact that our gambling venues, habits and

traditions vary considerably. In many ways, people with gambling problems in different countries seem more similar than different. Frequently, the person with gambling problems describes the functional role of gambling as escape from dysphoria. Grief, depression, relationship difficulties, and pain are commonly cited causes of the dysphoria. Also very common is the report of a "big win" early in the course of the development of the problem.

Various models and theories attempt to account for these aspects of problem gambling phenomena. The author draws upon concepts such as arousal, dissociation, excitement, narrowing of attention and operant conditioning among others. Specific reference is made to Jacobs' general theory and the behavior completion mechanism model. The concept of dissociation in the general theory is accurately identified as particularly fuzzy. It is interesting, however, that all these concepts can be invoked in the conceptualization of this case. None, however, seems necessary or sufficient. Our models are ripe for further development and integration, particularly with clearly specified, parsimonious and testable tenets.

Self-reports and observations of people with gambling problems have been helpful in developing our models. These retrospective reports can, however, be misleading. The challenge to theorists and researchers is to specify these models in a way that allows testable hypotheses that do not depend upon the retrospective reports from problem gamblers. Years ago, we believed that the etiology of Down's syndrome, now recognized as a chromosomal disorder, was related to stressful life events during pregnancy. We based these beliefs on research using retrospective reports of mothers who were struggling to understand a very stressful situation compared with mothers of babies without Down's syndrome (Brown & Harris, 1978). It is not surprising that they were more likely to recall stressful events during their pregnancies. Similarly, various self-medication models of substance abuse, albeit intuitively attractive, have failed to yield strong empirical support when prospective designs are used. Likewise, in the gambling area, we need to move away from sole reliance on retrospective reports as the major dependent variables, and instead, use prospective designs and/or non-self-report variables in studying our models.

I have a number of clinical observations about Mr. S.M.'s treatment. Cognitive therapy designed to correct erroneous perceptions appears to have played a central role in this man's treatment. This approach is curious given that the conceptualization of the case does not focus on erroneous perceptions. Mr. S.M.'s gambling was conceptualized as offering "emotional escapism" through distraction, dissociation or some type of narrowed attention. A logical treatment thus would involve training in alternative distraction techniques generally, and cognitive pain management techniques specifically.

Would Mr. S.M.'s progress have been faster with a treatment more consistent with the conceptualization? Or was the conceptualization limited by the lack of integration of cognitive features? The author alludes to fantasies associated with winning and anticipations of the next outcome but does not appear to view them as central in either the development or maintenance of the problem. I am also curious about why this man developed a gambling problem versus an alcohol problem, or even a narcotic problem. He clearly used alcohol and antidepressant medications to cope with pain with at least some positive effect. Presumably these coping options were more accessible than gambling, but gambling became the "analgesic" that became generalized to coping with other aversive states. Why so? We have much to learn about this fascinating disorder.

*Submitted: October 16, 2000*

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# Author's Response to Reviewers' Comments and References

*By Alex Blaszczynski*

In this article, we have presented an interesting case describing the development of pathological gambling and attempted to argue that factors instrumental in precipitating impaired control over gambling may no longer be relevant in its maintenance. David Hodgins correctly highlights the fact that there is currently no conceptual model that integrates the myriad factors underlying the development and maintenance of impaired control in pathological gambling.

One can only fully support Hodgins' view that most models make reference to concepts that are neither sufficient nor necessary to explain the onset and continuation of problem gambling behaviours, and that there is an imperative need to advance testable hypotheses and models that rely more on prospective designs, and less on retrospective or subjective reports. Sadly, most efforts to date are founded on the premise that those with pathological gambling problems constitute a homogenous group of individuals influenced by the same complex set of interacting variables. As a consequence, in an effort to explain the aetiological process underlying gambling, there is a tendency to force all gamblers into the one cast. Durand Jacobs' *General Theory of Addictions* models fit into this mould, whereas McConaghy's behaviour completion perhaps less so.

A consistently reported clinical observation is that stresses precipitate bouts of

gambling and that gambling represents a gambler's attempt to escape from emotional turmoil. Gambling produces heightened arousal, narrowed attention and an "altered state of consciousness" variably referring to the gambler as being in a state of dissociation or "in action." The fundamental drive underlying gambling is to maintain this state of arousal with winning as the means by which this state can be prolonged. I endorse Rina Gupta's and Durand Jacobs' views that many gamblers utilise gambling to cope with psychological distress and stresses, but argue that such an explanation applies only to a proportion of those with gambling problems.

Jacobs calls upon a set of predisposing stressors in interaction with hyper or hypo states of baseline arousal. Accordingly, two conditions need to be met in all pathological gamblers: pre-morbid stresses leading a sense of rejection, low self-worth and poor self-image, and a physiological resting state that requires either augmentation or reduction. The psychological motivation underlying gambling is the creation of a state of dissociation that provides temporary relief from psychic pain. Rina Gupta's experiences echo this perspective.

McConaghy's model, on the other hand, invokes the concepts of cortical neuronal substrates and behavioural completion mechanisms to account for recurrent patterns of gambling behaviour. The prerequisite requirements are the development of a habitual pattern of behaviour with no reference to the presence of premorbid psychopathology or negative life experiences. Once a habitual pattern of behaviour is established, a wide range of stressful internal and external events are capable of precipitating the drive to carry out the behaviour. The excitement of gambling distracts the gambler's focus of attention from aversive stresses and thus becomes negatively reinforcing.

I have long argued that it is limiting to conceptualise those with pathological gambling problems as a homogenous population subject to the same pathogenic processes. We must divide this population into at least three subtypes: "normal" pathological; emotionally vulnerable; and biologically disposed impulsive gamblers. Jacobs' model can be legitimately applied to the emotionally vulnerable gambler but falls short of accounting for the normal gambler. McConaghy's model can account for all three groups, and therefore, it is more comprehensive and parsimonious.

Durand Jacobs' clinical assessment that the back injury and resultant chronic pain exerted a profound impact on the client's quality of life, self-image and psychological functioning is not in dispute. But his interpretation that the "enthusiastic discovery that high excitement...provided an escape" through the mechanism of dissociation, while attractive on some levels, is limited in its ability to explain the phenomenon witnessed in this unique and unusual case.



Jacobs correctly observes that gambling is an inherently exciting activity for both social and problem gamblers. He advances the position that the pathological gambler's drive to induce a dissociated, altered state of consciousness is the end consequence of his or her attempt to deal with stresses, and that the primary objective is to maintain this state for as long as possible. This distinguishes the pathological from the social gambler.

However, it is noted that Mr. S.M. described a 15-year history of social gambling yet during this period he did not use the dissociation of gambling as a coping strategy in the context of other life stresses. Why so? If dissociation is to be invoked as the fundamental motivating component underlying impaired control over gambling, it is necessary to provide an explanation of the processes that lead from social to impaired gambling behaviour in individuals with a premorbid history of social gambling and stresses. At the same time, it is important to explain why, in the absence of stress or poor self-image or poor self-worth, a proportion of "normal" gamblers lose control over their behaviour only to regain mastery and resume participation in patterns of controlled gambling.

Part of my argument hinges on the pivotal role purportedly played by dissociation, the key construct forming the foundation of Jacobs' model. Notwithstanding Jacobs' disagreement with Cardena's argument, I must agree with David Hodgins' comments that dissociation is a particularly fuzzy concept.

But have we lost touch with considering the simpler possibility that gambling is an intrinsically exciting and enjoyable pastime pursued for its own sake, much the same as people seek out any other enjoyable activity such as chess, sports or watching movies? Jacobs alludes to this when he refers to the underlying motivation of a gambler as the need to "stay in action." Csikszentmihalyi (2000) defines such recreational activities as "autotelic experiences," ones in which there is no implicit external reward or goal beyond the pursuit of the activity and maximising enjoyment for its own intrinsic sake. Is this not so with gambling? The central feature of this experience is the funnelling of attention toward a limited stimulus field (narrowing of attention), loss of ego or self-consciousness and merging of awareness and activity. In other words, the person pursues the activity for its own sake because it is enjoyable, and in so doing, loses his or her perspective of time, self and environment. The gambler is in action.

The arousal associated with this enjoyment is of a sufficient level, in the case of Mr. S.M., to cause a distraction from pain, perhaps much in the same way that a sportsperson is oblivious to an injury sustained in the height of play, a level of arousal capable of greater distraction than reading or meditation. To call this dissociation imposes an unnecessary complexity on the

epiphenomenona.

Gambling is simply an exciting and enjoyable activity that engrosses one's attention. As such it falls along a dimensional plane as Jacobs suggests. However, in support of Cardena, I would argue that some states of dissociation do not represent an extreme position on a continuum, but a qualitatively different state of consciousness. Therefore, if the term dissociation is to be used in gambling, it is necessary to clarify the term used and to define its operational boundaries. Otherwise, let us just use the simpler term of *distraction* to describe the excitement or enjoyment experienced while gambling.

Hodgins raises a valid point when he questions why cognitive therapy was used rather than training in alternative distraction and pain management techniques. Although not described in the case study, the psychiatrist and hypnotherapist had applied a variety of pain management techniques that together with medication and alcohol use did not prove effective. I would hazard the guess that had such interventions been effective, Mr. S.M. might not have lost control over his gambling. By the same token, alcohol and medication, while ameliorating the severity of pain to some extent, did not match the same profound effect produced by gambling, hence causing gambling to become the effective "drug" of choice.

The inherent arousal produced by the enjoyment of gambling caused a significant reduction in pain, a comparatively greater reduction than was achieved by alcohol, medication or other interventions. Mr. S.M.'s gambling experiences shaped cognitive belief structures leading him to believe that he could eventually win and recoup losses. The cognitive intervention that was formulated and applied was justified on the grounds that, independently of the negative reinforcement produced by the analgesia, his experiences at gambling modified cognitive belief structures that acted to perpetuate further gambling.

Pathological gambling is a major public health problem that exerts a destructive influence on individuals, their families and society in general. To understand the behaviour we need to advance clearly articulated and testable conceptual models. In so doing, we need to be cognisant of several elements: people with pathological gambling problems are not a homogenous population; pathological processes leading to the development of the condition differ between cases; and variables relevant in the development of pathological gambling may not contribute to its persistence.

*Submitted: February 1, 2001*

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### First Person Account

*[This First Person Account tells how a high school student used the challenge and opportunity of a class assignment to explore gambling among her peers. Note: OAC classes referred to in this article are university preparation courses for students in Ontario secondary schools.]*

*This article prints out to about six pages.]*

## The Evolution of Discovery: Finding Out the Truth for Myself

*By Jennifer Zechmeister  
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Gambling has become, over the years, an increasingly popular and socially acceptable way for us to spend our leisure time; at the same time, it has become a significant problem for many people. We, as a society, generally tend to focus more on the entertainment value of gambling and fail to fully recognize the negative side, which shows that 10%\* of us Ontarians struggle with severe gambling addiction and losses every day. With gambling problems there are no physical remnants to be found by loved ones, as there are with



alcohol or drug addictions. With problem gambling, there is nothing to hide except guilt, shame and, especially, secrets to keep. It is a painful addiction, which can be cleverly covered up by those who want to hide it, and one that destroys the lives of many. It is the hidden addiction.

After personally experiencing how problem gambling can affect others, I have come to a point where I can look at gambling no longer with fear, but with courage. I have chosen to join the battle of awareness and discovery surrounding a problem more severe than the average person imagines. In the past, I was naive enough to believe gambling was merely for fun, and like many, I believed gambling was just another silly gimmick to try to get rich quick. But I've seen the power and control such an addiction possesses. I was left with many questions about gambling that I had never considered before I saw its effects, and many of the questions began with "why?"

In January 2000, I was given the opportunity to search for the answers to my questions. The OAC (Ontario Academic Credit) class called Families in Canadian Society (fancy terminology for sociology) was how I was given this chance. It was simple. Do a research project on an issue or topic that focuses on "the family." Naturally, I jumped at the chance to research the one thing that had torn apart people close to me and the one thing I failed to understand. I read all about gambling: the characteristics and symptoms of a compulsive gambler, his/her family and their own related problems, what help is available—all the while picking out more and more parallels to my own situation. I realized how serious gambling addictions really are. For example, how many people know that compulsive gambling is recognized by the American Psychiatric Association as a mental illness? Compulsive gamblers commonly experience difficulties with drug and alcohol addictions and are more likely to suffer from depression, hyperactivity, agoraphobia and compulsive disorders. They are also more likely than the general population to commit suicide and to smoke; they often suffer more from stomach ailments, insomnia, ulcers, colitis, high blood pressure, heart disease, migraines and skin problems.

After reading information like this, I began to realize how dangerous problem gambling can be and, I began to worry about the gambling practices of children and teenagers (the people who society needs to be most responsible for). In my library visits, I found a multitude of books on teen gambling and statistics that explained why there were so many teens with gambling problems. I found out some startling pieces of information. For example, teens who are involved in gambling are four times more likely to develop addictions than their adult counterparts. As with alcohol or substance addictions, the children of compulsive gamblers are more likely to develop problems with gambling in later years. I realized that via such means as the Internet, children and teens have access to gambling pretty much whenever they want it.

Here's where the problem lies. There are plenty of statistics and studies out there proving over and over how vulnerable teens are to gambling, yet the authorities who are responsible for informing them of this weakness, fail to do so. Furthermore, these authorities promote gambling by advertisements and positive slogans that lead teens to believe that there can't be a negative side to gambling. Teens know that if they drink alcohol or do drugs they do so at their own risk. Because of advertisements and programs at school, many are aware that they may develop addictions due to such behaviours. Are they also aware that the very same adverse effects can come from gambling? Or are they too naive, like I was, thinking that gambling is just a game, for fun, or just something to do?

In my sociology class, I had an opportunity to ask these questions myself. Our assignment was to experience the process of primary research by polling the students in our school with a questionnaire. The goal of the assignment was to learn to appreciate the time and hard work put into the studies we were using everyday as secondary research. I aimed to discover my peers' views about gambling and what their gambling practices were.

For a number of reasons, I went into the assignment with my own opinions and assumptions about my peers' attitudes towards gambling. The secondary school I attended at that time was in a predominantly white, middle-class location, a fair distance away (about an hour) from a large-scale gaming institution. I believed that because of their age most of the students would be unaware of the negative effects of gambling. Most cannot legally gamble.

Age was actually a large factor in my questionnaire. I decided that from the range of students I could access, I would interview OAC (Grade 13) students (N = 37) who were at least 18 and could legally gamble, and Grade 9 students (N = 42) who were 14 or 15 and were the youngest students in our school and too young to legally gamble. I naturally hypothesized that the OAC students, due to their age, would gamble more often and would be more aware of the

negative aspects of gambling.

I administered most of the questionnaires in classrooms and with their teachers' written permission. Others were given randomly to students in the halls or cafeteria. I was always present to explain that all information was strictly confidential and to answer any questions or address any concerns.

My first question was basic. I asked whether gambling is best defined as a good source of entertainment, a good way to get rich quick or a possibly harmful addiction. Surprisingly, over half of the students surveyed (55% of Grade 9 students and 51% of OAC students) believe gambling is best described as "a possibly harmful addiction." I was impressed that students think of gambling in this way. Due to advertisements and our social acceptance of gambling, I believed the majority of students would perceive gambling as "a good source of entertainment"; 38% of the Grade 9 students and 41% of the OAC students did, in fact, choose that answer.

My second question worked with the first in addressing the effect gambling has on our society. Although about half of the students believe gambling is best described as a harmful addiction, 64% of the Grade 9 students and 46% of the OAC students say that gambling has a neutral effect on our society, while 31% of the Grade 9 students and 30% of the OAC students believe gambling has a negative effect on our society. If gambling is best described as an addiction, isn't it natural that it would have a negative effect on us? Perhaps, the students don't see gambling addictions as serious, or perhaps the entertainment value of gambling is too strong to ignore. Only 5% of the Grade 9 students and 22% of the OAC students believe gambling has a positive effect on our society. I expected the answers of the Grade 9 students compared to the OAC students to be drastically different because of the age difference. Yet, looking at the statistics, they are similar, showing an impressive level of awareness by the younger students.

Another question brought similar responses from the two age groups. However, this time the results weren't as positive. First, I gave them a commonly used definition of gambling:

"Gambling means placing a bet, whether for money or not, where the outcome of an event is uncertain or depends on chance, and in which the player may or may not be able to improve the chances of winning because of his or her skill."

Then I asked them to keep this definition in mind while answering if they gamble or have ever gambled. Eighty-three per cent of the Grade 9 students and 92% of the OAC students (only 9% more) answered this question in the

affirmative.

About 40% of the Grade 9 students who gamble report that they do so approximately once a year; half of these 14 to 15 year old teenagers gamble at least once a month; 6% gamble at least once a week and 6% gamble more than once a week. Should we worry about the 12% who are gambling on such a regular basis?

Yet again, their responses show little difference between the two age groups. Of the OAC students who gamble, 56% report themselves as yearly gamblers; only 35% are monthly gamblers; 6% gamble once a week and 3% gamble more than once a week. These older students can gamble legally and only 9% do so on a regular basis. Comparing the statistics, Grade 9 students, who are illegal gamblers, are more regular gamblers than the OAC students, who are legal gamblers.

Since the Grade 9 students are not permitted to enter casinos or any other large-scale gaming institution, or to purchase lottery tickets, the statistics show that their gambling tends not to be institutionalized. When asked what forms of gambling they participate in, over half (57%) report they play cards for money and 51% contribute to sports pools or other types of pools. Forty per cent of these students report having played lottery tickets and 40% played bingo. Do their parents buy them lottery tickets? Do they go to family bingo? Are the people they trust the most treating these actions as harmless?

The students were also asked what they win when they gamble. The results were age-appropriate: the Grade 9 students report winning such things as tickets to movies, candy, bicycles; whereas the OAC students only report winning money. This reinforces the fact that the younger students are participating in small-scale, non-institutionalized gambling. But does this necessarily mean that they are participating in harmless gambling? Are these innocent gambling practices of their youth creating potentially dangerous attitudes for adult behaviour?

Over all, from both age groups, the students reported that 71% of their parents gamble, and that 23% gamble yearly, 34% monthly, 34% gamble weekly and 9% gamble more than once a week. These numbers suggest most parents are social or casual gamblers as opposed to problem gamblers. However, in this day and age, are casual gamblers giving children and teenagers the impression that gambling is acceptable to the point where teens see no wrong in gambling more than once or twice a week? Is this setting the teens up for future problems? How will they differentiate between safe and problem gambling practices?

Thirty eight per cent of all students surveyed know or have known somebody with a gambling problem. Twenty-seven per cent of the students report the gambler to be under 20 years of age. This suggests to me that they are friends of the students; 7% of the students report the gambler to be between 21 and 30; 13% between 31 and 40; while 43% report the problem gambler to be between 41 and 50 (the probable ages of their parents); and 10% report the gambler to be over 51. Seventy per cent of the students report that the people they know or have known who have gambling problems have not yet recovered and still struggle with the illness. This suggests that some students are regularly exposed to gambling problems through their friends, parents, and relatives. Isn't it time they learned how to help their loved ones?

After doing my own research and analyzing all of this for myself, I am still left with many questions. However, I have started to answer many of them, and hopefully have made others start thinking as well. It is important to understand that what we do as children, more often than not, influences our actions as adults. Things that may seem innocent and harmless, like playing cards for money, may do more long-term damage than we even care to imagine. Ten per cent of us currently have problems with gambling. I would be willing to bet money that 10% of us believe scratching lottery tickets as young children cannot possibly have adverse effects later in life. I'm not a social scientist with multiple degrees attached to my name, so take my opinions and statistics for what they are worth to you. Do your own research, question what the advertisements say and join the battle of awareness and discovery. It's time to expose the hidden addiction. Thank you.

*\*The statistic of "10% of [adult] Ontarians" with gambling problems can be seen as an inflated figure. The source for this figure (Van Rijn, 1995) chose to include those who endorsed having even one gambling problem on the South Oaks Gambling Screen (SOGS). However, to be identified as having a clinically significant gambling problem, a person would have to endorse at least five items on the SOGS. Recent research on the prevalence of gambling problems offers a different view. A widely accepted meta-analysis by Shaffer, Hall and Vander Bilt (1999) describes lifetime prevalence rates of probable pathological gambling of 1.7% for adults and 4.3% for adolescents in the United States and Canada.*

—The editor

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Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health* 89(9), 1369-1376.

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One million in Ontario said hooked on gambling. *The Toronto Star*, p. A2.

*Submitted: September 17, 2000*

*This account was not peer-reviewed.*

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### Book Review

## Gambling and Governments in Canada, 1969–1998: How Much? Who Plays? What Pay-off?

*By François Vaillancourt and Alexandre Roy. (2000).*

*Toronto, ON: Canadian Tax Foundation, Special Studies in Taxation and Public Finance, No. 2, xi, 72 pages. Price: \$30.00 Cdn.*

*ISBN: 0-88808-156-1.*

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With the ongoing growth of state-sponsored gambling throughout Canada and much of the western world, this study by Vaillancourt and Roy is of more than a passing interest. Following a brief history of gambling, the authors present a comprehensive overview of the level, composition and importance of government gambling revenues in Canada. The compendium of statistical tables drawn from a variety of domestic and international sources is a useful general reference for researchers in the field.

Three themes emerge from the statistical presentation that invite comment. First, the authors focus on government revenue from gambling and do not include non-government gambling activities in their analysis. While this was no doubt in the interest of simplicity, it may understate the true importance of gambling as a funding mechanism for traditional government responsibilities. For example, hospital lotteries have become a staple in many Canadian cities, while community service agencies have often come to depend on the proceeds of raffles and bingos to fund "off-loaded" activities.

Second, on a more technical note, the authors' breakdown of gambling revenue by source includes a specific designation for video lottery terminals (VLTs). As some readers may know, controversy surfaced over VLTs in several Alberta communities because of concerns about the "addictive" properties of these devices. The question of whether any meaningful distinction can be drawn between VLTs and slot machines represents a continuing challenge for the research community.

Third, using 1995 estimates, the authors show that Canadian government gambling revenues now constitute about two per cent of total government revenues. What I find interesting about this statistic is that it invites study on the relationship between the revenue and the expense side of government ledgers. A high proportion of Canadian provincial budgets is spent on health care. An aging population, technological advances and a competitive international market for health care practitioners will heighten cost pressures further. If governments expand gambling in ways that are later found to cause even tiny increases in health care expenditures, the revenue "growth" becomes illusory, particularly with the advent of intensified competition from offshore locations and the Internet.

The expense summary of provincial lottery corporations is nicely done. An interesting minor addition would be a detailing of marketing and promotion costs. Agencies such as the British Columbia Lottery Corporation rank among the largest advertising accounts in their provinces. It is important to maintain awareness of these expenditures into the future given the well-understood example of tobacco and alcohol marketing.

The authors then review family expenditure surveys using an impressive number of domestic and international sources. They present a multivariate analysis in order to identify the key determinants of purchasing decisions. Their evaluation of the incidence of gambling taxes reveals that they are second only to tobacco in terms of regressivity.

The final part of the study has attracted some interest in the popular press. It

finds that the benefits of gambling in Canada greatly outweigh the costs. The authors begin by reviewing the methodological issues. Appropriately, they point out the need for an "incremental" approach. In the case of problem and pathological gambling, for example, it is important to try to separate out the costs created by other illnesses such as alcoholism in order to get useful results. Unfortunately, the underlying causal linkages remain uncertain, and so, remain "problematic" for cost estimation projections. The difficulty is exacerbated by our limited knowledge of incidence, due to the inherent limitations of self-report data and poor (or unreported) response rates, evident in the two British Columbia incidence studies with which I am most familiar.

The authors' cost estimations include only "real" resource costs. What economists call "transfers" are not included. "Real resource costs ...do not include any form of transfers, including the proceeds of crime (theft), government transfers (welfare), inter-family transfers and bad debts (transfers from creditors to debtors), since transfers do not use additional resources" (p. 41). This is good economic practice but it is also a good reason why so many students of the overall effects of gambling dismiss economic studies that take this line as irrelevant. Such studies do tell us something, but they manifestly do not tell us *everything* about the social impacts of gambling.

To put the economist's definition of economic gain and loss into perspective, consider a tax of \$100 on the 100,000 poorest people in the country, the proceeds of which are used to pay a lump sum to the richest person. This would be neither good nor bad (economically) as it merely transfers wealth from one set of people to another. Closer to the problem at hand, if gamblers are driven to embezzle money from others, and they seek out poorer and less well-informed people as the easiest victims, but the government does not respond with additional police and other resources that are costs to the justice system, there is no "loss" to be set against the gains of gambling.

Similarly, if an unemployed or retired person commits suicide because of insufferable gambling losses, there is no economic cost (in fact, there may be an economic gain in the sense that the person will not consume more medical and hospital resources). A cost is recorded only if the person who committed suicide is an employed person, and then, only if he is not replaced by someone who is employed (p. 41). Of course, it is interesting to uncover the narrowly defined economic costs of gambling (and I am not ridiculing the attempt), but as these examples show, the costs are much less than the social losses, many of which show up in economists' calculations as "mere" transfers. Thus, the authors' conclusion that gains from gambling exceed losses must be interpreted with extreme caution.

The "population health paradigm" —defined as a conceptual framework for

thinking about why some people (and hence, some societies) are healthier than others —will help shed more light on gambling as a desirable fiscal tool for governments. Vaillancourt and Roy's treatment of income distribution and socio-economic status is useful in this regard because both have been found to be important determinants of population health.

The authors' assertion that more research is needed to help understand provincial and regional issues associated with gambling expansion is well taken. Their conclusion suggests that the risks of expanded state-sponsored gambling in Canada can be justified by societal and government benefits. On that point, I must respectfully disagree (Henriksson, in press; Henriksson & Lipsey, 1999). That said, I found this study to be a useful contribution to the literature.

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Should provinces expand gambling? *Canadian Public Policy*, XXV(2), 259–275.

*The author thanks Professor Richard Lipsey for his insightful comments and suggestions.*

*This book review was not peer-reviewed.*

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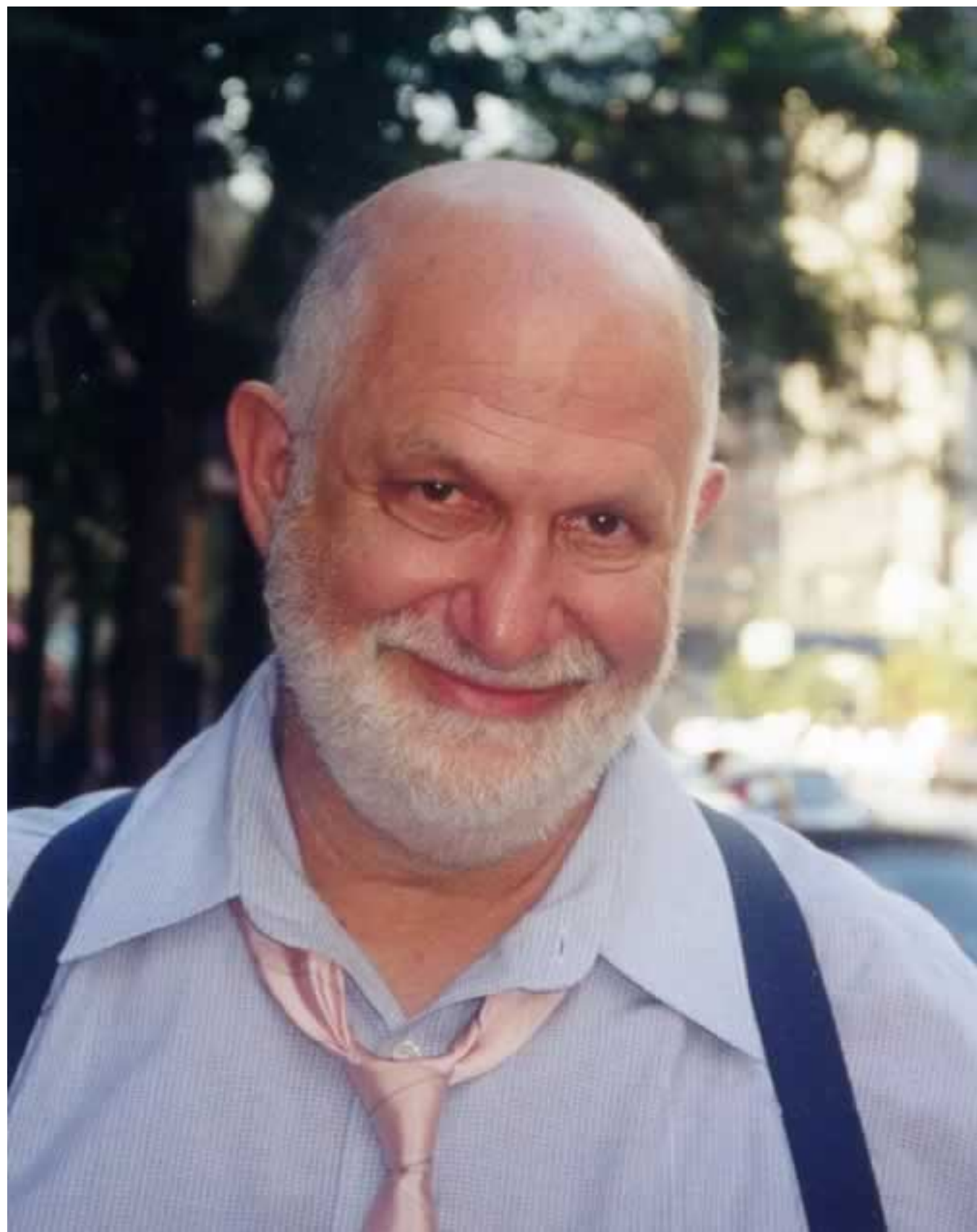
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# eGambling

THE ELECTRONIC JOURNAL OF GAMBLING ISSUES

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## intro

### Issue 7, December 2002

#### From the editor

#### Readership Survey Results

A year ago we posted a readership survey and wrote

"We want to publish an e-journal that examines the gambling issues that are of interest to you, our readers. So we would like to ask what you like, what you dislike and what changes you would like to see in the *Electronic Journal of Gambling Issues: eGambling (EJGI)*."

We had two goals for our survey: the first was to learn what you like about the *EJGI* and what you don't like and would like changed. The second goal was to find out who are our readers and what is their involvement in gambling. Are they counsellors? Interested citizens? Someone with a gambling problem or a family member who has gambling problems? Researchers? Gaming industry staff?

#### Who returned the survey?

Forty-seven people responded, or 22% of our subscribers in early 2002. (Our current subscribers' list is approximately three times what it was then.) Of these, some filled in only their year of birth and gender and nothing else, but 35 people (or about 16% of subscribers at that time) offered their ideas. We

are grateful that they made the effort to tell us their thoughts and feelings about the *EJGI*.

We caution that we cannot extrapolate from these results to suggest characteristics of the entire readership, but it is valuable to understand the views of those who took the time and effort to answer. (All percentages have been rounded to whole numbers and are based on these 35 who responded with comments.)

More women than men answered: 57% and 43%, respectively. The typical respondent was a 44-year-old woman who provides treatment both for people with gambling problems and for their families; about half of the respondents provide such treatment. Another one-third identified themselves as gambling researchers. About one-eighth work in government gambling policy and an equal number are part of the gaming industry. A couple of readers (6%) identified themselves as either having a gambling problem or having a family member, colleague or friend with gambling problems. Some indicated overlapping involvements; about one-fifth work in both research and treatment, and one-tenth reported working as both treatment providers and in developing gambling policy with either the gaming industry and/or a government agency.

In assessing their responses, please remember that many gave several answers to each question. And we've reported when even one person responded; after all, there is a completely unproven folk wisdom that if one person comments about an issue, then perhaps 50 think the same but didn't take the time to speak up.

## **What do readers like about the *EJGI*?**

Fourteen (40%) wrote that they like the ease of electronic access and nine (26%) like the up-to-date and current nature of the contents. Nine people (26%) appreciate the range of articles by both experts and by "everyday people." Five (14%) answered that they like the quality of the articles and yet another five also like that the authors are expert, well-known and credible international authors. Three people (9%) appreciate that articles are well written and easy to read. Two (6%) value it as a forum for discussion. Each of these likes was listed by only one person (3%): that the *EJGI* has theoretical articles, is provocative, has book reviews, covers relevant topics, has an attractive format, is free of cost and is Canadian-based. And last, two people (6%) listed among their likes simply that the *Electronic Journal of Gambling Issues: eGambling* exists.

## What do readers dislike about the *EJGI*?

Fewer people told us what they disliked; nine (26%) left this query blank and seven (20%) wrote that they had "no answer." Four people (11%) complained that we don't publish often enough. (The editor apologizes and comments that the low number of articles submitted, and their attrition in peer-review, accounts for our slow publishing rate.) Complaints about the content included that there are not enough research articles (three respondents, or 9%) and that there are too few articles (one respondent, or 3%).

Other comments included that several articles in one issue are by the same author (one respondent) and that articles are parochial (one respondent). One person disliked seeing reprinted articles from other journals in the Opinion section. Two people complained that the Web site is cumbersome to navigate (6%), one, that it is hard-to-read; and another, that it is "ugly." Some complaints suggest that readers may have problems with their Web browsers (i.e., no Archives or back issues, no author e-mail addresses).

Each of the following comments was offered by just one person (3%): the dislike that there are no pop-up titles with abstracts in the table of contents and no regular youth column. One person complained that there was no synopsis of letters-to-the-editor to assess what opinions are being offered. (The editor notes that, to date, all letters submitted have been published.) One person complained about access being only from the e-mail Inbox. (The editor notes that this can be solved by going to the current issue of the *EJGI* and then saving the site under Favorites or Bookmarks, depending on the browser, at the top of the screen). One person wrote: "I like everything."

## What changes do readers want in the *EJGI*?

Predictably, most of the dislikes also reappeared as requests for changes and these will not be repeated here, although we are looking into each of them.

Seven people (20%) left this section blank and four (11%) responded with "none" or "nothing." However, the rest of the respondents offered us valuable guidance. Three (9%) asked for more hyperlinks within articles; we also want to implement this option for your convenience. Some readers asked for theme issues or articles in areas where we also want to have more input. These are:



public policy discussions on gambling, gaming industry perspectives and cross-discipline issues (problem gambling and childhood trauma or sexual abuse, mental health problems, co-occurring substance abuse, suicide, family violence and gambling issues among Aboriginal peoples).

The following suggestions were made by one respondent (3%) each, although please note that one person may have made several requests. Examining the actual contents of articles, there was one plea that we be less clinical because readers may not understand the terminology used in the field. (The editor notes this would be difficult to implement; professionals within the fields of gambling research and treatment are the overwhelming majority of our readers and we have to offer them original, worthwhile and technical articles to hold their interest.) On Web site design issues, readers requested pagination and more print options (i.e., to print each article, each section, or an entire issue) and these are now available through the PDF option for each and every article that we've ever published. One reader asked for a phenomenology section and we recommend the First person accounts in each issue.

## **What other comments did readers have about the *EJGI*?**

Seventeen people (49%) left this blank and 10 (29%) left notes saying "thank you" or offering appreciation. Two people (6%) wrote "nothing." Two separate readers each wrote how much they enjoy the combination of articles by professionals with those by gamblers and their significant others, and the variety of contributors.

One reader looks forward to each issue, but never knows what to expect: should we have standard columns? (The editor: We already try to fill certain standard sections —Feature, Policy, Research, Clinic, First person accounts, Reviews —but sometimes we do not have an article for each topic section. And we do want to surprise you with each issue!)

Guidance by you, our readers, in what you want and don't want to read in the EJGI will help us to make many publishing decisions. Thank you to all who took the time to respond to our readership survey.

If you have further thoughts on improving the *EJGI*, please contact the editor at [phil\\_lange@camh.net](mailto:phil_lange@camh.net). We plan another survey in two years to assess if we have fulfilled your expectations.

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# Statement of Purpose

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

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

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*[This article prints out to about 15 pages.]*

An [explanation of Cramer's V](#) is available at the end of the article.

## Gambling by college athletes: An association between problem gambling and athletes



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## Abstract

This investigation compares the prevalence rates of pathological and problem gambling between college athletes and non-athletes. Participants in the study included 954 students enrolled in health and safety classes from nine universities belonging to the Southeastern Conference (SEC). Of these students, 129 (14%) were classified as athletes. The South Oaks Gambling Screen (SOGS), designed to measure pathological gambling, was used as the testing instrument. Participants were asked additional questions to determine athletic participation and to gather demographic information. Cross tabulations, Pearson chi-square tests and Cramer's V tests were used to determine if there were significant associations between groups. On the whole, significant associations were not found between athletes and non-athletes and pathological and problem gambling; however, a statistically significant association was found between problem gambling and female athletes. The prevalence rates of pathological and problem gambling among athletes were 6.2% and 6.2%, while the prevalence rates among non-athletes were 3.4% and 3.3%.

**Key words:** college students, athletes, gambling

## Introduction

Pathological gambling is a condition that affects many Americans and is a concern of psychology professionals. According to the American Psychiatric Association (1994, p. 615), pathological gambling is a persistent and recurrent maladaptive gambling behavior that disrupts personal, family and vocational pursuits. Problem gambling is more encompassing than pathological gambling because it includes all patterns of gambling behavior that may compromise, disrupt or damage family, personal or vocational pursuits (Lesieur & Rosenthal, 1991). Research (Culleton, 1985; Shaffer, Hall & Vander Bilt, 1999, Sommers, 1988; Volberg & Steadman, 1988, 1989) has suggested that the prevalence rates of "probable pathological gamblers" in the United States are between 1.4% and 3.4%.

While pathological gambling can infiltrate all segments of society, research suggests that college students are particularly susceptible to the risks and effects of pathological gambling. The rate of pathological gambling among college students is four to eight times higher than the rate of adults not currently enrolled in college (Lesieur, et al., 1991). Similarly, Frank (1990) reported prevalence rates of pathological gambling among college students attending a college in New Jersey to be 6%. Ladouceur, Dubé and Bujold (1994) found the prevalence rates of pathological gambling among college students in Quebec City to be 2.8%



A subsegment of the college student population is college athletes. Despite strict rules created by the National Collegiate Athletic Association (NCAA) prohibiting college athletes from gambling, popular media suggest that college athletes still gamble. Although the media draw attention to the cases of college athlete gambling, few studies have been conducted to research the gambling participation rates of athletes. Weiss (1995) discovered that athletes are more likely than non-athletes to exhibit maladaptive behaviors, including gambling. In another study conducted at the University of Cincinnati, Cullen and Latessa (1996) reported that 25% of the 648 football and basketball players surveyed in Division I gambled on sporting events. One recent study (Cross, 1999) found that nearly 72% of all athletes gambled in some manner during their four years of college eligibility.

The primary purpose of this study is to compare the prevalence rates of pathological and problem gambling between college athletes and the general student body (non-athletes), using the South Oaks Gambling Screen (SOGS). While previous research has not examined this issue, researchers posited that the rates for athletes would be higher than the rates for non-athletes.

## Participants

The data for this investigation were obtained from non-athletes and athletes who attended universities that are members of the Southeastern Conference (SEC) of the NCAA. A sample of convenience was drawn from first aid or health and safety classes during the Spring 1998 semester. These particular classes were chosen because many universities offer them, a diversity of students participate in them and they typically have large enrollments.

Nine hundred and fifty four non-athletes and athletes representing nine of the 12 universities belonging to the SEC volunteered to participate in the study. Based upon estimates of college enrollments and athletic participation rates, provided by the SEC office (Pigg, L., personal communication, March 15, 1999), 8.7% (n= 24,000) of college students attending all 12 SEC institutions are classified as athletes. For this study, an "athlete" was defined as any participant who at the time of the study was a member of a varsity intercollegiate athletic team. Approximately 13.5% (n= 129) of the respondents were athletes. Since the survey was administered during class time, the participation rate was very high (95%).

The sample consisted of 129 athletes. Almost 57% (n= 69) of the athletes were males and 74% (n= 89) of the athletes were between 19 and 21. Seventy-three percent (n= 88) of the athletes were white, 20% (n= 24) African-American, 3.3% (n= 4) other, 2.5% (n= 3) Hispanic, 0.8% (n= 1) Asian and 0% Native American.

Of the 825 participants who were classified as non-athletes, 32% (n= 256) were males and 67% (n= 545) were between 19 and 21. Eighty-two percent (n= 662) of the non-athletes were white, 11.3% (n= 91) African-American, 2.7% (n= 22) Hispanic, 2.9% (n= 23) Asian, 0.5% (n= 4) other and 0.2% (n= 2) Native American.

## Instrumentation

The South Oaks Gambling Screen, the most widely used instrument to measure pathological gambling, was administered to each participant. This diagnostic tool is based on the seven criteria for pathological gambling as proposed by the DSM-III-R and has been found to be both reliable and valid (Lesieur & Blume, 1987). A score of five or higher on the 20-item index represents pathological gambling. Previous research (Abbott & Volberg, 1996) suggests that a score of three or four indicates that the individual has problem gambling tendencies; therefore, any student scoring three or four was classified as a problem gambler.

## Procedure

Researchers mailed the surveys to a contact person at each participating university. The contact person administered the testing instruments during class time in hopes of securing a high return rate of usable surveys. In addition, to help ensure truthful responses, subject anonymity was assured by requiring that subject names did not appear on the surveys and surveys were coded to indicate only university affiliation. After all classes participated in the study, the contact person mailed the surveys back to the researchers. When the surveys were received, they were hand-scored and then analyzed.

## Data analysis

Frequency rates and cross tabulations were calculated to allow the researchers to establish prevalence rates of gambling for the different subcategories of participants. Pearson chi-square tests were performed to determine if relationships existed between the variables. For any Pearson chi-square tests that were found to be significant ( $p < 0.05$ ), Cramer's V tests were calculated to measure the strength of these relationships. By using Cramer's V tests, the researchers were able to measure the degree of association between variables.

## Results

Eighty-one percent ( $n = 104$ ) of the athletes and 81.3% ( $n = 670$ ) of the non-athletes surveyed reported that they gambled. In total, 4% ( $n = 36$ ) of the 954 participants were found to exhibit signs of pathological gambling (Table 1). Approximately 6% ( $n = 8$ ) of the 129 athletes surveyed scored five or higher on the SOGS, while 3.4% ( $n = 28$ ) of the 824 non-athletes scored five or higher. Overall, 3.7% ( $n = 35$ ) of the 954 participants were found to exhibit signs of problem gambling. Approximately 6.2% ( $n = 8$ ) of the 129 athletes surveyed scored three or four on the SOGS, while 3.3% ( $n = 27$ ) of the 824 non-athletes scored three or four. In addition, male athletes were found to have a higher

prevalence rate of pathological gambling, 11.6% (n= 8) compared to male non-athletes at 6.6% (n= 17). On the other hand, male non-athletes had a higher prevalence rate of problem gambling than male athletes, 8.2% (n= 21) and 5.8% (n= 4), respectively. While more female non-athletes exhibited signs of pathological gambling (1.5% and 0.0%), the prevalence rates of problem gambling were higher in female athletes, 1.1% (n= 6) and 5.7% (n= 3), respectively.

**Table 1**

**Summary of Athlete and Non-Athlete Rates  
of Pathological and Problem Gambling (%)\***

<b>Athletic Status</b>	<b>n=</b>	<b>Pathological %</b>	<b>n=</b>	<b>Problem %</b>	<b>n=</b>
All participants	954	3.8	36	3.7	35
Athlete	129	6.2	8	6.2	8
Non-athletes	824	3.4	28	3.3	27
Males	325	7.7	25	7.7	25
Male non-athletes	256	6.6	17	8.2	21
Male athletes	69	11.6	8	5.8	4
Females	603	1.3	8	1.5	9
Female non-athletes	550	1.5	8	1.1	6
Female athletes	53	0.0	0	5.7	3

\*The discrepancies in the population numbers are due to incomplete participant responses. One person failed to answer the athletic participation question. Twenty-six people failed to answer the gender question.

Significant associations were not found between pathological and problem gambling and athletic participation ( $\chi^2= 2.41$ ,  $df= 1$ ,  $p= 0.12$  and  $\chi^2= 2.96$ ,  $df= 1$ ,  $p= 0.09$ ). While the scores on the SOGS ranged from 0 to 14, the mean score for non-athletes on the SOGS was 0.60 (95% CI: 0.50-0.70), while the mean score for athletes was 1.01 (95% CI: 0.63-1.39). In addition, the mean score for those individuals who were classified as pathological gamblers was 7.11.

When the data were adjusted for gender differences, the researchers found only one statistically significant association between athletic participation, gender and gambling: female athletes and problem gambling ( $\chi^2= 6.71$ ,  $df= 1$ ,  $p= 0.01$  and Cramer's  $V= 0.11$ ,  $n= 595$ ,  $p< 0.05$ ). Significant associations were not found between female athletes and pathological gambling ( $\chi^2= 0.04$ ,  $df= 1$ ,  $p= 0.38$ ). Additionally, significant associations were not found between male athletes and non-athletes and pathological ( $\chi^2= 1.88$ ,  $df= 1$ ,  $p= 0.17$ ) and problem gambling ( $\chi^2= 0.32$ ,  $df= 1$ ,  $p= 0.57$ ).

Slot machines, poker machines and lotteries were the most common forms of gambling used by participants in the survey. Forty-nine percent ( $n= 465$ ) of the total sample responded that they participated in these types of activities (Table 2). Athletes most commonly participated in games of skill, such as golf, bowling or billiards, and 51.9% ( $n= 67$ ) of them responded that they participated in the same kind of gambling. Forty-nine percent ( $n= 403$ ) of the non-athletes participated in lotteries, which was the most common gambling activity for this group. Statistically significant associations were found between athletes who played cards ( $\chi^2= 6.24$ ,  $df= 2$ ,  $p= 0.04$  and Cramer's  $V= 0.08$ ,  $n=953$ ,  $p= 0.04$ ), dice ( $\chi^2= 22.54$ ,  $df= 2$ ,  $p= 0.00$  and Cramer's  $V= 0.15$ ,  $n= 953$ ,  $p= 0.00$ ), slot machines and poker machines ( $\chi^2= 10.14$ ,  $df= 2$ ,  $p= 0.01$  and Cramer's  $V= 0.10$ ,  $n= 953$ ,  $p= 0.01$ ), games of skill ( $\chi^2= 19.21$ ,  $df= 2$ ,  $p= 0.00$  and Cramer's  $V= 0.14$ ,  $n= 953$ ,  $p= 0.00$ ) and pull tabs and paper games ( $\chi^2= 19.21$ ,  $df= 2$ ,  $p= 0.00$  and Cramer's  $V= 0.14$ ,  $n= 953$ ,  $p= 0.00$ ).

Table 2

## Summary of the Gambling Preferences of Participants (%)\*

Type of Gambling	Non-Athletes $n= 824$	Athlete $n= 129$	MalAt $n= 69$	FemAt $n= 53$	MalNA $n= 255$	FemNA $n= 550$	Overall $n= 953$
Numbers/lotteries	48.9	48.1	50.7	43.1	49.4	48.6	48.8
Slot/poker machines	48.7	49.6	49.3	52.8	53.5	46.0	48.8
Cards	39.2	49.6	66.7	28.3	62.5	27.9	40.6
Casino	37.0	39.5	40.5	37.7	45.1	32.5	37.4
Games of skill**	33.1	51.9	66.7	32.1	67.3	16.9	35.7
Bingo	23.7	23.3	22.3	26.4	18.9	25.3	23.6
Sports	23.3	22.4	30.4	11.3	50.1	10.7	23.2
Dice games	17.9	31.8	41.2	11.3	32.5	11.5	19.8
Bet animals	17.5	15.5	14.5	15.1	24.9	14.2	17.2
Tabs/paper	16.4	20.2	20.9	20.8	13.9	17.4	16.9
Stocks	16.5	17.8	19.4	17.3	23.8	13.0	16.7
Other forms	3.4	5.4	12.7	0.0	6.5	2.9	3.7

\*The discrepancies in the population numbers are due to incomplete participant responses. One participant failed to answer the athletic participation question. Twenty-six participants failed to answer the gender question. One participant failed to answer the gambling preference question. An incomplete response on this question does not impact SOGS scores since it is not used to measure pathological gambling when using the

## SOGS.

**\*\***Some age appropriate examples of games of skill are betting on billiards and bowling.

To further analyze the differences between athletes and non-athletes, gender and athletic status was compared to the types of gambling in which the subjects preferred to participate in. Statistically significant associations were found between male non-athletes and betting on sports ( $\chi^2= 8.53$ ,  $df= 2$ ,  $p= 0.01$  and Cramer's  $V= 0.16$ ,  $n= 322$ ,  $p= 0.00$ ) and playing slot machines ( $\chi^2= 6.20$ ,  $df= 2$ ,  $p= 0.05$  and Cramer's  $V= 0.14$ ,  $n= 322$ ,  $p= 0.05$ ). The results also suggest that male athletes have a statistically significant association with playing dice games ( $\chi^2= 9.85$ ,  $df= 2$ ,  $p= 0.01$  and Cramer's  $V= 0.18$ ,  $n= 323$ ,  $p= 0.01$ ). Statistically significant associations were found between female athletes and betting on horses and dogs ( $\chi^2= 10.42$ ,  $df= 2$ ,  $p= 0.05$  and Cramer's  $V= 0.13$ ,  $n= 603$ ,  $p= 0.05$ ) and betting on games of skill ( $\chi^2= 16.90$ ,  $df= 2$ ,  $p= 0.00$  and Cramer's  $V= 0.17$ ,  $n= 603$ ,  $p= 0.00$ ).

The majority of the participants gambled relatively small amounts of money. Slightly over 71% ( $n= 757$ ) of the participants indicated they gambled less than \$100 in one visit, and only 9.1% ( $n= 87$ ) gambled over \$100 (Table 3). Thirty-three percent ( $n= 324$ ) of non-athletes responded that they gambled between \$10 and \$100. Athletes gambled similar amounts of money compared to non-athletes with 36.9% ( $n= 50$ ) gambling between \$10 and \$100. Although the majority of athletes and non-athletes gambled between \$10 and \$100, a statistically significant association was found between athletes and the amount of money gambled ( $\chi^2= 17.74$ ,  $df= 6$ ,  $p= 0.01$  and Cramer's  $V= 0.14$ ,  $n= 952$ ,  $p= 0.01$ ). There were no significant associations between male athletes and non-athletes and the amount of money gambled ( $\chi^2= 4.03$ ,  $df= 6$ ,  $p= 0.67$ ). Similar results were found for female athletes and non-athletes and money spent gambling ( $\chi^2= 6.00$ ,  $df= 5$ ,  $p= 0.31$ ).

**Table 3**

**Amount of Money Spent on Gambling (%)\***

<b>Largest Amount Gambled in One Day</b>	<b>Non Athletes n=823</b>	<b>Athlete n=129</b>	<b>MalAt n=69</b>	<b>FemAt n=53</b>	<b>MalNA n=255</b>	<b>FemNA n=550</b>	<b>Overall n=952</b>
Never gamble	20.0	17.8	8.7	32.1	8.2	25.8	19.7
\$1 or less	9.2	3.3	1.4	5.7	1.2	13.1	8.4
\$1 less than \$10	29.3	25.6	20.3	34.0	23.5	31.2	28.8
\$11 less than \$100	33.2	38.8	49.3	20.8	49.0	25.6	33.9
\$101 less than \$1000	7.4	13.2	17.4	7.5	16.5	3.2	8.2

\$1001 less than \$10,000	0.9	0.8	1.4	0.0	1.6	0.4	0.8
Over \$10,000	0.0	0.8	1.4	0.0	0.0	0.0	0.1

\*The discrepancies in the population numbers are due to incomplete participant responses. One participant failed to answer the athletic participation question. Twenty-six participants failed to answer the gender question. One participant failed to answer the amount of money spent gambling question. An incomplete response on this question does not impact SOGS scores since it is not used to measure pathological gambling when using the SOGS.

## Discussion

The results of this study suggest that there was no significant association between pathological gambling and college athletes. Although the researchers hypothesized from previous findings (Weiss, 1995; Cullen & Latessa, 1996; Cross, 1999) and found that athletes as a whole had a much higher rate of pathological gambling compared to non-athletes, the current study found no significant associations. In fact, among female participants the results demonstrate that female non-athletes had a higher prevalence rate of pathological gambling than female athletes.

While statistically significant associations were not found for pathological gambling and athletes, male athletes were found to have a very high prevalence rate of pathological gambling. Out of the four groups, the prevalence rate for male athletes was almost two times higher than the next highest group, male non-athletes. Despite the fact that none of the female athletes suffered from pathological gambling, these prevalence rates for men were high enough to cause the rates of pathological gambling among athletes to be higher than the rates for non-athletes.

Additionally, the results of the current study suggest that athletes have a higher rate of problem gambling than non-athletes do. These findings support Weiss' (1995) findings that college athletes have a higher rate of problem gambling. According to Curry and Jiobu (1995), the socialization of athletes includes a continuous emphasis on competition. This competitive nature "spills over" from the playing fields to the athletes' lives. Gambling in its many forms gives the athletes additional outlets in which to compete.

Conversely, when the data were adjusted for gender, male athletes actually had a lower rate of problem gambling than male non-athletes. This finding does not support Curry and Jiobu's (1995) conclusions. According to the current results, competition may not serve as a stronger motivation for gambling among athletes than non-athletes. Male non-athletes may also turn to gambling as a means to compete with others.

The results also suggest that gender impacts the rates of problem and pathological gambling. Although athletes as a whole group were found to have a higher prevalence rate of problem gambling, male athletes actually had a lower prevalence rate than male



non-athletes. Further analysis of the prevalence rates of pathological gambling suggest that male athletes had a higher rate than non-athletes. On the other hand, female non-athletes had a higher rate of pathological gambling than female athletes. To further cloud the issue, the current study found that the only statistically significant association between athletes and problem gambling was among female athletes. It should be noted however that according to the Cramer's V test the association between female athletes and problem gambling was weak.

Despite the relatively high prevalence rates among athletes and non-athletes, the results from both groups suggest a relatively low mean score on SOGS. In fact, neither group's mean scores were in the problem or pathological range. Although these results suggest that gambling may not have reached the problem stage for either group, it does suggest that many college students are social gamblers. Since college athletes are strictly prohibited from gambling by the NCAA and risk losing their eligibility to compete, it does suggest a problem for college athletes and the NCAA. In addition, even gambling among non-athletes suggests a problem for college administrators because of the high participation rates—not to mention that most forms of gambling in the United States are illegal until the age of 21. The results suggest that college administrators have to worry about another illicit behavior occurring on their college campuses.

The results also suggest that only a relatively small portion of the participants suffered from pathological and problem gambling. These findings support the previous findings of Frank (1990) and Ladouceur, et al. (1994). Additionally, they seem to contradict the findings that the prevalence rates of pathological gambling among college students are four to eight times higher than what the rates are for the adult population (Lesieur, et al., 1991).

Although only a relatively small portion of the participants showed signs of pathological and problem gambling, males in both groups had a higher rate of pathological and problem gambling. These findings support previous studies which suggest that males are more likely to gamble than females (Lesieur & Klein, 1987; Lesieur, et al., 1991; Browne & Brown, 1994; Ladouceur, et al., 1994; Curry & Jobu, 1995; Weiss, 1995;) as well as suffer from pathological and problem gambling (Lesieur, et al., 1985; Sommers, 1988; Volberg & Steadman, 1988, 1989; Ladouceur, et al., 1994).

In addition, the results of this study suggest that athletes prefer to gamble on games of skill such as bowling and billiards; researchers found that this was the largest difference between athletes and non-athletes. We can speculate that because athletes choose to participate in games of skill, they prefer gambling activities that are competitive. By placing bets on these activities, athletes increase the risk, which adds to the level of competition. Athletes, like people who are addicted to alcohol or drugs, build up a tolerance to the "adrenaline rush" associated with competition. They need to be actively competitive even when the activities are friendly or for fun (for example, playing nine holes of golf with friends). To be more competitive they wager money on the outcome of the game. A good example of this phenomenon is Michael Jordan, who got in trouble by wagering on golf in such a manner. These findings are also supported by the fact that athletes can make money from the skills they have perfected during their competitive sports careers. Since opportunities to work are limited by the NCAA and school and practice restraints, being proficient at a sport offers athletes an alternative way to earn money.



Again, these findings were affected when adjusted according to gender. Although they were similar (67.3% and 66.7%), male non-athletes had a higher rate of participation in gambling on games of skill than male athletes. Female athletes had a much higher rate of participation in games of skill compared to female non-athletes. One possible reason for this finding is that it may still be more socially acceptable for men and female athletes to participate in these activities than it is for female non-athletes. Unfortunately, women still face some barriers to participation in these games of skill.

As outlined in the NCAA eligibility rules, participation in gambling is prohibited. The NCAA is particularly intolerant about sports gambling because it threatens the integrity of college athletics. One would expect these rules to minimize this type of behavior. Although the survey instrument did not measure gambling on college athletics, the survey did measure gambling on sport. There was no statistically significant association found between athletes and non-athletes and gambling on sports, which is of particular concern to the NCAA. These findings suggest that many college athletes still gamble on sports, particularly male athletes (30.4%). These results further support Cullen and Latessa's (1996) findings that 25% of their surveyed athletes gambled on sports.

Gambling large amounts of money is one of the indicators of pathological gambling, according to the DSM-IV (American Psychiatric Association, 1994). The results of this study indicate that the majority of both athletes and non-athletes gamble relatively small amounts of money, between \$10 and \$100 per episode. These findings correspond with the findings of previous studies. Rockey, Beason, Lee, Stewart and Gilbert (1997) found that the average amount spent by college students during a visit to a casino was \$41.55. Similarly, Frank (1990) found that 78% of the students surveyed gambled with less than \$50. Other studies (Lesieur, et al., 1991; Ladouceur, et al., 1994; Devlin & Peppard, 1996) reported similar results.

Despite the fact that the majority of the sample gambled a relatively small amount of money, a significant association was found between athletes and the amount of money gambled. The results suggest that athletes gamble more during one episode of gambling than non-athletes. It should be noted though that the Cramer's V test suggests that this association is weak and that factors other than athletic status are involved. This is further supported by the lack of association when adjusted for gender.

Although this study has investigated the prevalence rates of pathological and problem gambling among athletes, its conclusions are limited. The most significant limitation of this study is the number of athletes in the sample. For a prevalence study to be effective, the sample should be larger. Instead of measuring pathological and problem gambling during the participant's college years, SOGS measures throughout the student's life time, which is another limiting factor of this study.

Despite its limitations, this study is an important first step in determining whether college athletes have a significant problem with gambling. No previous studies have addressed the issues of athletes and pathological gambling. Only one significant association in the prevalence rates of pathological and problem gambling was found between non-athletes and athletes; however, the NCAA benefits from knowing that 80% of their athletes gamble and that 22.1% of them gamble on sports. This information may be used to establish programs and treatment modalities that assist athletes in need before their problems become addictive, and they establish ruinous behavior, which could jeopardize

their academic or athletic success as well as the integrity of intercollegiate athletics.

Obviously more research is needed in this area. One recommendation for future research is to measure the differences in competitive behaviour among groups. It would also be beneficial to measure gambling participation in college athletics as well as NCAA-sponsored games in which the athletes are participating. Another area that requires further study is whether or not athletes, after their eligibility expires, gamble more because their need to compete is no longer satisfied through athletic participation.

Comparing in-season and off-season gambling habits to measure the effects of discretionary time on the athletes' gambling habits is also recommended. Finally, a comparison of college athletes participating in the NCAA Divisions I, II, III and the National Association of Intercollegiate Athletics is an additional direction that would allow comprehensive comparisons to be made between athletes that receive scholarships and athletes who do not.

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Cramers's V is a measure of association derived from chi-square and it is particularly useful with categorical data. Values can range from 0.0 to 1.0. Here's an aid to help remember its parameters:

-A value less than .33 indicates a weak relationship.

-A value between .34 and .67 indicates a modest relationship.

-A value greater than .67 indicates a strong relationship. [back to top](#)

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*[This article prints out to about 14 pages, and the appendices that follow the article print out to about 43 pages. –Ed.]*

### Research methods

## Understanding the school culture: Guidelines for conducting gambling research in secondary schools

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### Abstract

This article provides an overview of the importance of youth gambling research, the methodological issues faced when conducting research in secondary schools, and recommendations for conducting effective youth gambling research that benefits academia, the community, staff, students and parents within the school systems. Based on our recent experience, we



advocate a research approach that integrates the findings of youth gambling research into school curriculum, community youth agencies and the development, evaluation and enhancement of program and policy interventions. By doing so, we find that we are able to foster strong, respectful relationships with the community and encourage collaboration, co-operation and multidisciplinary alliances. If researchers follow these guidelines, they can ensure that youth gambling research goes beyond scholarly publishing and is transferred and applied within the community to reduce youth gambling problems.

**Key words:** adolescent gambling, research methodology, school-based research, youth research

## Introduction

This generation of youth is the first cohort to grow up in an era when gambling is easily accessible, socially acceptable and extensively promoted. Prevalence studies continue to indicate that between 52% to 89% of youth gamble (National Research Council, 1999), 4% to 8% of adolescents have gambling problems (Gupta & Derevensky, 1996; Fisher, 1992; Jacobs, 2000; Shaffer & Hall, 1996, 2001; Wynne, Smith & Jacobs, 1996), while another 10% to 15% of adolescents are at risk of developing a gambling problem (Gupta & Derevensky, 1998; Shaffer & Hall, 1996, 2001; Wynne et al., 1996). Moreover, youth problem gambling is two to four times higher than adult problem gambling (Shaffer, Hall & Vander Bilt, 1999). Although recently these prevalence rates have been challenged as being inflated (Derevensky & Gupta, 2000; Shaffer & Hall, 2001), it is clear that gambling behaviours of adolescents should be of interest to parents, educators, researchers, social workers and others concerned about young people.

## Need for further youth gambling research

While research on youth gambling has focused on prevalence rates, correlates, risk factors, theoretical frameworks and coping processes, these areas of research cover only a small part of a comprehensive understanding of youth gambling. To date, no research has examined protective factors that may act as buffers for youth problem gambling nor



the interaction between protective factors and risk factors. Few longitudinal studies have been conducted and the development, evaluation and proven effectiveness of youth education, prevention and treatment interventions are still in the early stages. Once compiled, this information indicates that youth gambling research is still in its infancy, and further studies need to be conducted in order to better understand this area of inquiry. A more comprehensive understanding of youth gambling and youth problem gambling will allow for the development and refinement of effective education, prevention and treatment interventions that reduce the harm of youth problem gambling. It is therefore very important that appropriate procedures be in place when research in schools is conducted to ensure that access to students is maintained.

## Methodological issues

Although there is an urgent need for further youth gambling research, it is often difficult to access a representative population of adolescents. Currently, the majority of youth gambling studies consist of small samples of adolescents. While some studies recruit youth via telephone interviews, the majority recruit youth from the school system. Two approaches are generally used in order to obtain parental consent for a child's participation in school-based research. The first procedure involves active parental consent: parents are asked if their children can participate. The second type involves passive parental consent: parents are informed that their non-response implies permission for their children to participate in the study. At this time, many schools are moving toward the former consent procedure.

Unfortunately, the implementation of active consent procedures, employed to protect students, often result in low parental response rates, low participation rates and a distinct subpopulation of youth that threaten the external validity of the study (Anderman et al., 1995; Dent et al., 1993; Noll, Zeller, Vannatta, Bukowski & Davies, 1997; Ross, Sundberg & Flint, 1999; Severson & Ary, 1983). Research has found that youth who do not receive parental permission are quite unique compared to those who do receive permission. For example, youth without parental consent are rated by peers and teachers as being less popular (Frame & Strauss, 1987; Noll et al., 1997), less academically competent (Frame & Strauss, 1987; Noll et al., 1997), more socially withdrawn (Frame & Strauss, 1987; Noll et al., 1997), more aggressive (Frame & Strauss, 1987; Noll et al., 1997), higher in risk-taking (Dent et al., 1993), less assertive (Dent et al., 1993), have lower self-esteem (Dent et al., 1993) and tend to engage in substance use and other problem behaviours (Dent et al., 1993; Kearney, Hopkins, Mauss & Weisheit, 1983; Severson & Ary, 1983).

Overall, the literature suggests that youth who typically would not receive parental consent are generally at a higher risk for a number of health and social problems. Given that research on youth gambling often looks at many of these comorbid risk factors, our research team believes that it is imperative for high-risk youth to be included in our research samples — especially when assessing the effectiveness of youth gambling prevention programs. If they are not included, youth gambling prevention programs, interventions and policies will not meet the needs of this population of youth, who in fact are the target of the intervention in the first place (Dent et al., 1993; Noll et al., 1997; Ross, et al., 1999; Severson & Ary, 1983). We believe that school board officials need to be educated about these issues, and researchers need to advocate for the adoption of an informed but passive parental consent procedure, which will provide a more representative sample of youth.

However, given the likelihood of having to continue with active consent procedures, we would like to suggest to youth gambling researchers several strategies that we have found to be effective in boosting response rates. Based on our past experience, we will recommend a set of guidelines for conducting school-based research that have been accepted favourably by school officials, teachers and parents in our region. As a result of these positive experiences, the school environment/community remains open to continuous research.

### **School-based research**

Before our research team developed any protocols for our youth gambling research, we hired an educational consultant who was both a former teacher and principal in many of the secondary schools in our region. The consultant's role was to educate our research team about the secondary school system and to liaise with school officials in order to recruit secondary schools for participation in our study. During the process of contacting school administrators, our educational consultant found that the majority advocated youth research and understood its importance; however, several well-merited criticisms about past school-based research were also brought to our attention. Many school administrators reported problems with past research efforts:

- youth surveys were too long;
- survey questions were not age-appropriate (or contained unsuitable

content);

- surveys were not administered in an organized fashion;
- surveys placed too many demands on school and staff time;
- the research process often disrupted the school schedule, and;
- survey results often were not disseminated to schools (and the community) in a comprehensive manner.

Based on these criticisms, it was evident to us that past researchers often did not meet the needs of the schools. Procedures for school-based research appeared to be both unreasonable and impractical, taking up far too much of the teachers' and students' time, and significantly disrupting the school schedule. Conversations with school administrators in our region demonstrated that such procedures gave school staff a poor impression of school-based research. To our knowledge, these issues led school board officials in our region to move away from passive consent procedures and to adopt informed and active parental consent procedures, to develop their own research review committees, and generally, to overhaul their procedures and protocols for school-based research. Despite these difficult circumstances, our research team felt that it was our duty to address the concerns and criticisms that were voiced by many school officials. To do so, we developed a new set of guidelines and protocols for conducting school-based research. The guidelines that our research team developed were effective for data collection and received favourably by school officials, teachers and staff as indicated in their project evaluation forms. Our research team would like to share the protocols and guidelines that we used with other youth researchers, and hope that by doing so, we can advance procedural standards for youth research and lay a foundation for improved practices in school-based research.

### **Forming a multidisciplinary committee to guide the research project**

As researchers, we have an obligation to understand school culture and to plan well so that disruption to the school schedule and demands upon school staff are minimized. As mentioned previously, our research team hired a former principal to fulfill a role as our educational consultant. Our consultant's background and knowledge about the school system ensured that our research team was conscientious about school culture and did not repeat past mistakes. In addition, our research team recruited several other persons who became part of our advisory committee, which guided the youth gambling project. Members of our committee included

researchers, parents, youth and clinicians from a community alcohol, drug and gambling treatment agency. Our multidisciplinary team was crucial in developing survey materials and procedures that met the needs of school administrators, teachers, students, parents and the community. Committee members provided helpful suggestions and ensured that our research project overcame the many difficulties often faced when conducting research in schools. The committee made certain that our survey contained suitable and comprehensive questions for youth. Parent committee members ensured that the consent procedures and materials were comprehensive and reasonable, given the busy schedules of most parents. Our educational consultant ensured that the research procedures were both reasonable and feasible within the school system. In addition, we pilot tested our survey two grades below our target audience to ensure that the survey was set at an appropriate reading level and was comprehensible to teens with a wide range of reading skills.

### **Ensuring minimal disruption to the school, staff and students**

Our research team decided that the most effective way to gather data in the shortest period would be to survey an entire school. The challenge for us was to find a time within a school's busy schedule when students could complete a survey. We were mindful that surveying students would ultimately result in a loss of instructional time for the schools. For example, if 1,000 students were to complete a 30-minute survey, the school would have to give up 500 hours of instruction time. As researchers, we were conscious of this and developed a 20-minute survey. Our concern was that a survey which ran over the time limit would have a serious effect on the atmosphere, efficiency and order in the school.

The school's timetable should dictate the length of data gathering sessions, and researchers must work within these parameters. Our research team was fortunate because the participating schools had timetables that included a block of time for a Teacher Advisory Group's (TAG) class. In Ontario, TAG is a class that is not part of the mandatory school curriculum. Instead, this class promotes development of yearly educational plans, goal-setting and decision-making skills and helps students come to understand themselves as individuals. One teacher is assigned to approximately 20 students, and these students attend the same TAG class regularly until they graduate from high school. Our research team was fortunate because the research conducted during TAG classes raised awareness about the issue, provided an opportunity for

class discussion and did not infringe upon school curriculum.

Not all schools will have such an ideal setting for administering a survey; however, most schools will have blocked-off time for football games, assemblies or other special events, which are more amenable to accommodating research than regular classes. It's not difficult to set up a special timetable for an event such as a research survey provided the research team presents a specific request and then ensures they abide by the terms. Having an educational consultant as a member of your research team can be very useful as she or he will already understand the schools' timetables and be able to work more easily with school officials. to find an appropriate time to administer the survey. Our educational consultant brought knowledge, sensitivity and understanding to this process; often other research team members do not possess a broad understanding of the secondary school system.

To further accommodate the schools' busy schedules, our research team also ensured that demands on teachers and other staff were minimal. For example, our team was responsible for mailing consent forms directly to parents, tracking responses, forwarding reminder slips, conducting telephone follow-ups and administering the survey. In addition, we recruited and trained senior students who administered the surveys in every classroom and ensured consistency in the way the survey was conducted and reduced the demands on the teacher. Preparation, including maps of the school and class lists indicating which students have parental consent, was critical to minimizing the burden on school staff and disruption to the students' timetables. School Survey Procedures and Protocols in [Appendix A](#) contains the procedures for administering the survey, which all research assistants followed.

### **Educating school administrators and staff**

In addition to accommodating the schools, it is also important to educate all staff by providing them with a brief overview of the study and the research procedures. This step is beneficial because it reduces resistance, increases awareness and establishes support and co-operation. To meet these objectives, our research team sent an information package to all principals for review. In addition, this package remained in each school's office for parents, staff and other interested parties to view at their convenience. The information package contained the following: cover letter, overview of our research, research objectives, survey, copy of the



alternative task (see description of alternative task below), parent and youth consent forms, debriefing form, thank-you letter and a set of detailed procedural instructions. [Appendix A](#) contains all of these documents.

The cover letter indicated that the project manager would be in touch to schedule a meeting with the principal to discuss the information package and to set up a time and date to administer the survey if permission was granted. Our educational consultant and project manager then met with each principal and explained the purpose of our research, its importance to youth, schools and the community, and the procedures that would take place from the beginning to the end of the research project. If the principal gave permission for the survey to be administered, then the educational consultant and project manager set up a date to present the same information to all school staff. This 15 minute presentation allowed the teachers and research team to develop a rapport as teachers were fully informed of the procedures and given the opportunity to express any concerns or ask questions. This presentation increased teachers' awareness of youth problem gambling and motivated them to join us in this endeavour. The importance of the issue, the minimal work required by the staff, and the promise to feedback comprehensive results and recommendations to school staff seemed to motivate parents, students and school staff to assist us with our research project. Principals announced when the survey would be administered, information was printed in school newsletters, and teachers reminded students to have their parents sign and return consent forms.

## **Obtaining parental consent**

In the past, a process of passive consent was the norm, whereby parents only indicated that they did not want their child to be involved. But now it's more likely that school board policy will require active and informed consent. This procedure not only requires more administrative time but also demands careful presentation. Our research team employed several strategies to increase response rates since active and informed consent was required. Firstly, our team used several communication channels such as school newsletters, parent council meetings, student council meetings, morning announcements, local newspapers (an article about the project that coincides with the consent process) and radio stations to inform schools, teachers, parents, students and our community about our research project. It was also useful to educate teachers at staff meetings about our research and to prepare homeroom announcements to assist in

promoting the survey. As well, we developed a package for parents that included the consent form; a brief description of the study, written in appropriate language, and contact names and phone numbers for addressing concerns. Parents could check off a section on the consent form indicating that they wanted a copy of results.

We were only permitted to obtain parental consent in writing; however, other researchers may find it useful to establish multiple channels for providing consent (mail, phone, e-mail). Lastly, parents who did not forward a consent form by the specified date were forwarded a reminder notice and then sent an additional package if a response was still not sent. Telephone follow-up is also another strategy to increase response rates if the school board and university's ethics committee allow for this protocol. We found that by providing parents with the project manager's phone number and e-mail address, we increased response rates and opened channels of communication. In fact, many parents contacted our project manager to ask for additional consent forms, to discuss the issue of problem gambling and to indicate their support for the project. Of note, one parent, whose son had already completed the survey, offered to assist with the administration of the survey in the remaining schools.

For those students who do not receive parental permission, it is important to provide an alternative activity. We developed a brief activity: a reading on youth gambling, followed by open-ended questions related to this reading. The purpose of this alternative activity was to ensure that all students were kept busy, to decrease the likelihood that students without permission would be identified, and to ensure that all students were involved in an educational experience. The majority of students and teachers who recently participated in our survey and the alternative activity showed a genuine interest in youth gambling and expressed a new awareness afterwards. Many teachers requested additional copies of the alternative activity to use and discuss in follow-up TAG classes.

## **Disseminating the results**

One of the most important elements in the contract between our research team and the schools was to provide comprehensive and clear results from the survey, and recommendations based on these findings. Without this effort to disseminate information, the schools, students and parents might have felt that their time and energy was wasted. The results were presented in both written and verbal formats. We developed a



comprehensive executive summary of our results (written in simple language), which we mailed to parents who expressed an interest in the study's findings. [Appendix B](#) contains the executive summary for parents.

Similarly, we developed a comprehensive report for school administrators and youth agencies in the community, which included the results of our study, illustrative graphs and applicable recommendations. [Appendix C](#) contains the comprehensive report.

Interesting and interactive presentations were made to principals, students, teachers, parents and youth agencies to increase awareness about youth gambling, provide a snapshot of our results, suggest recommendations based on these results and provide an opportunity for discussion. Where applicable, we provided specific recommendations based on the surveys' results along with links to youth gambling prevention materials, curriculum and treatment resources. These presentations provided a nice transition from research to application while further increasing awareness. All of these steps helped to ensure that our research team left a positive impression, which in turn led the schools to welcome our research team back for further research.

## Ethical issues

One of the ethical questions that our committee faced was over how specific the feedback to individual schools should be. On one hand, some schools hoped that the information gathered in the survey could be used to inform administrators about the extent of problems or activities in their schools, and thus, help them decide whether or not they need prevention/education and/or treatment interventions. But on the other hand, there was the potential complication that the media would compare the results of different schools, which could have ramifications for the school boards. In the end, we did not provide any separate feedback to individual schools. In hindsight, this ethical issue should have been discussed with all school administrators before the surveys were administered. If a particular principal is interested in his or her school's results, we recommend that these results be provided verbally and that a comparison is made only to the overall results—not to each school individually.

## Conclusion

With youth gambling on the rise and youth gambling research still in its infancy, it is imperative that researchers continue to have access to the school system and its target population. An acceptance and understanding of the school environment is needed to carefully plan and organize school-based research that is both effective and unobtrusive. Most importantly, findings from youth gambling research need to be disseminated in a comprehensive manner that benefits teachers, principals, parents, students and the community. Transferring and gearing research findings to different audiences (besides just academia) can increase awareness and in itself act as a prevention tool. If findings are disseminated appropriately and comprehensively, other community members will have the opportunity to take advantage of the practical applications of this research. In turn, youth gambling research can be used to guide the development of new policies, education, prevention and treatment interventions all aimed at reducing the harm of youth problem gambling. It is hoped that this article, our experiences and the proposed guidelines will lay a foundation for best practices in youth gambling school-based research.

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## **Appendices**

### **Appendix A Sample information package for principals**

Letter to principal  
Information sheet on youth gambling  
School survey procedures and protocols  
School newsletter and announcement  
Letter to parent/guardian  
Parent/guardian consent form  
Student consent form  
Youth gambling survey  
Alternative activity – Level I  
Alternative activity – Level II  
Debriefing form for students

### **Appendix B Cover letter to principals**

Evaluation form  
Comprehensive report for principals

## **Appendix C Letter to Parent/guardian**

Executive summary of results for parents

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### Clinical report

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## Online help for problem gambling: Why it is and is not being considered



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**Key words:** Computer-Mediated-Communication, Internet, Online Assistance, Peer Support, Problem Gambling, Self-Help, Stigma

### Abstract



Despite an increasing prevalence of gambling problems, evidence suggests that most people do not receive help for their problems. The issue of stigma has been cited as a contributing factor.

Technological advances have now made it possible for individuals who are concerned about stigma to seek help for their problems without making any personal disclosures. In this way, the inherent advantages of the Internet (privacy, convenience, safety and portability) help to ensure that assistance for problem gamblers is always available and that concerns about stigma are neutralized.

Unfortunately, many who might benefit from Internet-based help are unaware of these possibilities, and treatment specialists and other health-care professionals may not direct problem gamblers to these services.

This paper considers:

1. What is available to problem gamblers through the Internet?
2. What is known about the efficacy of such services?, and
3. Possible reasons why problem gamblers have not been referred to the Internet by point-of-entry personnel. Implications for future action will be discussed.

## Introduction

Despite the increasing prevalence of gambling problems in today's society, evidence suggests that most people are not receiving help. ([National Gambling Impact Study, 1999](#)). Some studies have shown that the issue of stigma is a contributing factor in this regard (for example, see [Cooper, 2001a](#); [Hodgins & el-Guebaly, 2000](#); [Marotta, 2000](#)).

New technological advances have now made it feasible for individuals who are concerned about stigma to seek help for their problems without making any personal disclosure ([Cooper, 2001a](#)). This makes it possible for people who are initially reluctant to seek help to be more willing to follow through in the future. The inherent advantages of the Internet (privacy, convenience, safety, portability and so on) ensure that help is always available to those with access to the Internet. Seeking help through the Internet does not have to involve others, in this way, stigma can be neutralized.

Unfortunately, many who might benefit from Internet-based assistance appear to be unaware of the possibilities. Unless individuals are lucky enough to find an online support group on their own, they are likely unaware that these Web sites exist. As clinicians and other point-of entry service personnel are quick to suggest the benefits of more traditional approaches such as treatment programs and peer-support groups (e.g., [GA](#)), we have observed that online interventions are not nearly as popular as their face-to-face counterparts.

This paper speculates about why treatment specialists prefer in-person resources versus online ones. In addition, we will discuss what might be done to better educate the problem gambling community about the Internet and its resources. We will examine what is available online and what is known about clinical outcomes associated with using Internet resources.

## What Internet resources are available to assist problem gamblers?

### note 1

There are a growing number of Web sites devoted exclusively to providing information and support to problem gamblers (and those interested in the subject). Most of these sites offer information (for example, signs and symptoms of a problem gambler) and where to go for face-to-face treatment and/or peer support. Most search engines if prompted with key terms such as "problem + gambling" will yield a wide selection of Web sites such as the following (the list is not comprehensive).

- Responsible Gambling Council (Ontario): <http://www.responsiblegambling.org/>
- The Directory of Organizations and Activities Addressing Problem Gambling in Canada, The Canadian Centre on Substance Abuse (CCSA): <http://www.ccsa.ca/gambdir/gambhome.htm>
- *The Electronic Journal of Gambling Issues: eGambling*, The Centre for Addiction and Mental Health (CAMH): <http://www.camh.net/egambling/>
- GamCare from the United Kingdom: <http://www.gamcare.org.uk/>
- *The Wager*, Harvard Medical School: <http://www.thewager.org/>
- Gamblers Anonymous: <http://www.gamblersanonymous.org/>

- Problem Gambling: A Canadian Perspective Web site, Gerry Cooper:  
<http://www.problemgambling.ca>
- Problem Gambling News Page, CCSA:  
<http://www.ccsa.ca/gambngen.htm>
- The National Council of Problem Gambling from the United States:  
<http://www.ncpgambling.org/>

It is not always readily apparent if the content of a Web site is primarily educational or therapeutic; indeed, some would argue that both can be quite similar in appearance and effect. With online (or computer-mediated) forms of communication, views about how people interact, learn and change differ. For this reason, distinctions about such therapeutic variables as clinical approach, modality and setting are not as easy to characterize. For example, what might have been a relatively static and directive self-help guidebook ("bibliotherapy") in the pre-Internet years could now be transformed into a fluid interactive tool available 24 hours every day (regardless of weather, or geography and so forth) via the Internet. **note 2** Those using an online guidebook could conceivably have instantaneous access to more current feedback from clinicians or coaches, support from others pursuing recovery, links to other supportive materials including audio and/or video-based information (not just print-based). The general hallmark of online help is the Internet's interactivity (immediate or delayed). We qualify using the term "general" because there will always be exceptions to the rule: what some people will find to be therapeutic, others will find educational. Thus beauty—or in this case, therapy—is in the eye of the beholder.

In 2002, Web sites that offer direct help to problem gamblers beyond simple information are not common, but can be found. In other words, Web sites that provide visitors with an opportunity to interact with others (either through temporal sequenced "asynchronous" communication as in the case of bulletin boards, or instantaneous "synchronous" formats like chat rooms) are less common than Web sites that primarily provide information (even if they are instructive). Here are some examples of Web sites that go beyond mere information dissemination:

- Compulsive Gamblers Hub (a peer-support Web site):  
<http://cghub.homestead.com/pst.html>
- Self-help materials written by psychologist Geoffrey P. Jones:  
<http://www.gamblingtoomuch.com/>

- New Zealand's Gambling Problem Helpline (providing among other things e-mail counselling): <http://www.gamblingproblem.co.nz/>
- The South African Resource for Compulsive & Problem Gamblers: <http://www.cghub.co.za/>

## What is known about the effectiveness of online help for problem gamblers

Unfortunately, little is known about the effectiveness of online resources for problem gamblers. Online assistance is a recent phenomenon, generally speaking. For a variety of other health or social problems, some sources have reported favourable outcomes when the results of online help are compared to the results of face-to-face help ([Ferguson, 1996b](#); [Zimmerman, 1987](#)).

Research has yet to empirically address many of the relevant questions. (For example, how well do problem gamblers respond to online help? Do some individuals have better outcomes than others, and if so, why?) A recent exploratory study by [Cooper \(2001a\)](#), one of the few studies in this area, showed that about 70 per cent of the individuals who expressed an opinion felt that GAweb (a peer-support group, which was available from 1986 to 2001 [note 3](#)) had made a difference to their gambling behaviour. There are key methodological challenges, however, with a study such as this: its participants were self-selected and all recruited from one Web site. Therefore, it is difficult to generalize about other problem gamblers who seek help online.

On the other hand, it is clear that increasingly people are using the Internet. For example, it has been estimated that as of August 2001, there were about 513 million people worldwide who were connected to the Internet, including roughly 181 million North Americans ([NUA Internet Surveys, 2001](#)). As many as 53 per cent of Canadians were connected to the Internet in 2000 compared to just 18 per cent in 1994 ([Brethour, 2001](#)).

For those who do utilize online resources, they often report their fondness for the

- readily accessible services ("24/7")
- availability, regardless of geography, weather conditions, lack of public transportation, and the amount of time they have at their disposal

- safety in knowing they are truly anonymous, and therefore, they have the ability to be more honest with others without fear of reprisals
- opportunity to "test drive" the service without declaring their presence (known as "lurking")
- equal distribution of power in online environments —consumers are truly in the "driver's seat," with the ability to carefully select information at leisure rather than having it pushed at them
- "democratic ideals" of the Internet where information or advice is considered for its value without being unduly influenced by the author's characteristics (qualifications, gender, race and so forth), and
- ability to overcome what might ordinarily be obstacles (physical and/or emotional) to their participation, and hence, they feel connected with like-minded people from around the world ([Ferguson & Madara, 1998](#)).

There is some evidence to suggest that those who benefit the most are those who experience the negative effects of social stigma. For example, [Davison, Pennebaker & Dickerson \(2000\)](#) found that the highest online participation levels in support groups were correlated with the most stigmatizing health and social conditions —conditions that were not well served by the more traditional helping community.

In smaller communities where peer-support groups like Gamblers Anonymous are not always available or if low membership necessitates infrequent meetings, the opportunity to connect with a supportive network through the Internet is important. Moreover, there is less pressure on the individual to attend every meeting, unlike small group participation where a missed meeting may result in feelings of guilt.

Lastly, because geography is neutralized in cyberspace, individuals have a much greater choice of support groups with different ideologies to choose from. Arguably, this might even create a closer relationship between professional therapists and the peer-support community. For example, clients can use online help as an adjunct to their professional treatment, and therapists can have a better understanding of the kind of support available online. There, therapists too can observe firsthand the kind of help and advice their clients are exposed to at the support group.

Clearly, there are many advantages associated with online forms of help.

Equally clear, however, is the fact that the Internet will not be helpful for everybody. For example, even though many more people now have access to computers and the Internet, many do not, particularly senior citizens and those from lower socio-economic circumstances. While it is true that access to the Internet is increasingly available from public locations, such as libraries, it isn't quite the same as connecting from home. More importantly though are issues of literacy; for the most part, taking advantage of online content requires both a certain degree of comfort with computers and an ability to read. Perhaps these barriers will soon be overcome as computer and software manufacturers make their products easier to use; however, it is important to acknowledge the current limitations to this form of assistance.

## **Why problem gamblers have not been referred to the Internet by point-of-entry personnel**

To begin with, it is important to note that we are not reporting new data nor have we found any research to substantiate our claim that individuals seeking help for gambling problems from traditional point-of-entry personnel (i.e. toll-free help lines, local assessment and treatment agencies, family physicians and other caregivers) are not being informed of what is available to them online. At this stage, it is important to be clear that our premise is based on anecdotal observation and wide-ranging discussions we have had with numerous colleagues in the field. Fortunately, we have heard that clients are increasingly being advised of Internet resources at some locations, but this is only a recent development and not necessarily typical of the field at this stage.

That said, we postulate four principal reasons why individuals are not being referred to Internet resources for assistance. These include the following:

- i. There are too few online clinical resources specific to problem gambling and they are difficult to locate.**
- ii. Until recently, problem gambling training programs for clinicians didn't pay much attention to the benefits of online assistance.**
- iii. Many clinicians are concerned about consumers' safety and well-being when consumers are pursuing online help.**
- iv. Many clinicians may be concerned, when referring clients to**



**online resources, for themselves either because of legal liability or because they fear being accused of promoting what some might consider to be competition.**

This is a valid point since most of what is available to problem gamblers seeking help from the Internet (in early 2002) might best be described as information dissemination (as opposed to being more clinically relevant or oriented; Griffiths & Cooper, in press). That is, much of what is available on the Web either speaks to the etiology of problem gambling, the recognition of signs and symptoms and/or the prevalence of such problems in communities. It seems that not much Web site content is directed towards action a problem gambler might take to address problem(s) (for example, how to adjust cognitions, how to inventory high-risk cues, how to establish alternative coping strategies and so forth). In addition, there are relatively few online peer-support resources where one can obtain quick advice from others who happen to be connected to the same Web site. In short, the majority of our collective online efforts seem to be going towards influencing pre-contemplators and contemplators versus helping those already in the action stage of the [Prochaska & DiClemente Model \(1982\)](#). To be sure, if point-of-entry personnel are to be more prolific with their recommendations about online resources, more sites will need to be established that focus primarily on the action-oriented stages of clinical issues

Web sites specializing in clinical issues will also need to promote their presence to others more vigilantly in the future. To illustrate this point, we were unable to locate one of the busiest online peer-support groups for problem gamblers through repeated and differential use of a variety of the most popular search engines. In addition, we found few Web sites that had content specific to problem gambling that linked to [CG Hub](#). This suggests that many problem gamblers and their significant others who might be looking for this kind of help will fail to find it online.

In part, this speaks to the lack of resources available for the development and maintenance of Web sites specializing in clinical issues for problem gamblers. As it now stands, proprietors of sites like CG Hub may be unable to devote much time to promotion because so much time is taken up with maintenance. Indeed, if they had the resources to further promote their site, they could easily receive more traffic (to an already busy site), which, of course, means more maintenance work for an overextended Webmaster.

#### **v. Until recently, problem gambling training programs for clinicians**



## **paid little attention to the benefits of online assistance**

Again, it has been our experience that training programs, training guides and professional conferences oriented towards problem gambling have paid little attention to how the Internet might help problem gamblers. This is likely related to the above point, but many who do know about online sources have been slow to incorporate them into their standard packages of references to others in the field. If professional training resources are not educating clinicians about the existence of online assistance for problem gamblers, then many might not know of them, and without that knowledge, clinicians and point-of-entry personnel are unable to notify their clients.

Fortunately, this is beginning to change as the word spreads about the potential benefits of Internet-facilitated recovery. One might expect that as new training resources and conferences include discussions on how the Internet might help problem gamblers that it will stimulate and encourage others to take up the discussion as well. Respectively, the Centre for Addiction and Mental Health's Helping the Problem Gambler resource guide ([Murray, 2001](#)), which includes a related chapter ([Cooper, 2001b](#)), and sessions at events such as the Canadian Foundation on Compulsive Gambling's Innovation 2001 conference and the National Council on Problem Gambling's 2001 Building Partnerships for the Future conference exemplify the growing emphasis on this subject.

### **vi. Many clinicians have concerns about consumers' safety and well-being**

Clinicians might argue that they have been slow to embrace online forms of assistance because there is a paucity of scholarly discussion, research and debate about the topic. This is understandable, but one wonders if there is a double standard at play. Many clinicians, for instance, have been known to refer to other more traditional face-to-face interventions in the absence of supportive empirical outcome data.

Still, the absence of consistent rules of conduct and ethical fair play on the Internet make this point worth considering. Once again, to illustrate this point, when we used a variety of popular search engines to locate online help for problem gamblers (for example the meta-search engine [Dogpile](#)), several sites were listed that could clearly pose difficulties for unsuspecting problem gamblers. In other words, several online casino/gambling sites apparently have managed to convince some search engines that they provide a helpful service to problem gamblers.

In some cases, these casinos may have a link buried within their content to qualify them to use the term "problem + gambling" (see for instance, the "[Ask Pinocchio!](#)" Web site [when we began writing this paper in early 2001, the Pinocchio site was easily linked from the "FindWhat.com" search engine; this has since changed]). In other instances, advertisers unabashedly take the user directly to betting action without any intention of providing a link to problem gambling help despite their claim to provide "links to sites for problem gamblers" (e.g., [Gamblenet](#) which had been linked from the [Looksmart](#) search engine). For example, to the question "Want to try "[problem gambling](#)" at the world's #1 site?" one is taken to an online sports casino). Sometimes, the user must move through several screens bearing the casino's logo before getting to the intended destination ([www.casinogambling.about.com/](#)). and/or endure a series of pop-up screens calling attention to various online gambling opportunities. For some, this might even suggest an affiliation with credible problem gambling sites like [Institute for Problem Gambling](#), essentially making that Web site appear to reside within the casino's boundaries for those not familiar with how hypertext links work.

Arguably, many if not most online casinos are well resourced. They appear to easily persuade search engines to include multiple links, even if these links appear through inappropriate key terms. This also contributes to making it more difficult for people to find bona fide resources; that is, if a helpful Web site for problem gamblers is overshadowed by what some might term "fraudulent links" to casinos, the person who is seeking help may be easily dissuaded, or worse, harmed by unexpectedly finding themselves at an online casino instead of his or her intended abstinence-oriented support group. Of special note in this regard is the fact that many North American casinos tend to favour responsible gaming practices. These practices are not necessarily shared by several online casinos (now numbering in the hundreds); casinos which are typically difficult to hold accountable.

- vii. **Many clinicians may be concerned, when referring clients to online resources, for themselves either because of legal liability or because they fear being accused of promoting, what some might consider, competition.**

Some clinicians might be concerned that if they refer a client to an online support group for adjunctive assistance and he or she becomes involved with online gambling, the client has not been well served, or worse, that the clinician might be held accountable for such a referral. Again, this may speak to a double standard since clients are often referred to face-to-face interventions without the same kind of

considerations. In fact, several researchers have found that the health-related information and advice found in asynchronous bulletin boards is quite accurate, and moreover, that false information is typically corrected in a timely fashion. Some have even suggested that online help compares to help from experienced clinicians.

Consider, for example, the following account reported by Internet researcher and physician, Dr. Tom Ferguson. He describes a very moving letter from "Jack in Utah" who had posted a message in a "death and dying" support group. Jack discussed his son's accidental death by strangulation while attempting to make a haunted house for Halloween in the family's garage. The father's anguish was overwhelming as he asked for help from those associated with the online group. Within the next two days, Jack received dozens of responses of support, empathy and advice. Sometime afterwards, Ferguson presented Jack's story at a conference where he illustrated the powerful possibilities of online self-help. Following his address, Ferguson was approached by "two very distinguished therapists" who concluded that had Jack come to them for help "that although they [were] both well-trained, highly respected therapists, that they probably would not have been able to help him in nearly such an immediate, compassionate, practical and powerful way ([Ferguson, 1996a](#), paragraph 34)." Powerful stories like this are common within computer-mediated literature.

Clinicians may be less apt to refer to other traditional or non-traditional resources because of the nature of their professional training and way they've done business historically. This might be especially true if agency caseloads are low and there is pressure to see more clients to stop the risk of funding reductions.

While there is no direct evidence to suggest that clinicians are fearful of losing their jobs because of these online resources, there is a possibility that this is true for some. Many labour disputes in other sectors have centered on job security because of advances in technology such as automation. Perhaps this is an issue, which needs further attention to better understand the thoughts and concerns of point-of-entry personnel and clinicians regarding their professional relationship with the Internet.

## Implications and summary

Now that help for problem gamblers is available through the Internet, the opportunity exists to engage and impact on many lives successfully. In the past, many of these people might have avoided seeking any help from traditional face-to-face counselling, and their problems may have worsened as a result. Work now must be undertaken to ensure that those in need of Internet-based assistance can readily find it. This is a task that will require action on many fronts.

Agencies will need to examine how their human resources are used in the development, maintenance and promotion of online forms of assistance to problem gamblers. Research organizations will need to study online services to better understand critical issues of client-to-intervention matching (who does best and under what circumstances). Training specialists including those who help to prepare our future clinicians and social service personnel will need to find ways to call attention to the existence of online resources as part of their efforts at informing users of what is available in the "counsellor's therapeutic tool kit." These individuals may benefit from a test of their receptivity towards and biases about online help. Those concerned about the potentially misleading advertising claims of some online casinos will need to find a mechanism to collaborate and lobby search engines in an effort to prevent possible harm to problem gamblers. There is much work needed ahead and across many domains.

Assuming that we aspire to ensure that problem gamblers have easy access to safe and affordable help for their problems, we cannot afford to miss this important opportunity. As we have attempted to illustrate in this brief paper, there are several reasons which may be limiting the availability of an important new resource to problem gamblers. These should not be seen as insurmountable, but neither should they be seen as unimportant. Our collective care, support and nurturing is required to further the advances of online forms of assistance.

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## Footnotes

1. The authors guarantee that the following hypertext links were active as of February, 2002, but caution that Internet Web sites can and often do change.

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2. Even though the Internet per se is just over 30 years old, we refer here to about pre-1994 for this is when the Internet started to become popular.

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3. In 2001, some frequent visitors to GAweb experienced problems with that Web site because it was not updated often enough. They have since established a new peer-support location at CG Hub (i.e., Compulsive Gamblers Hub): [<http://cghub.homestead.com/pst.html>](http://cghub.homestead.com/pst.html). GAweb discontinued its Internet presence as of September 2001. A link now exists which transports visitors who are looking for GAweb to the CG Hub web site.

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### First person account

*[This article prints out to about seven pages. —ed.]*

## Arnie Wexler's story:

**I am a recovering compulsive gambler who placed my last bet April 10, 1968.**

*By Arnie Wexler*

*Bradley Beach, New Jersey, USA*

*E-mail: [aswexler@aol.com](mailto:aswexler@aol.com)*

I started gambling as a kid in Brooklyn, N.Y., at about age seven or eight. It started with flipping baseball cards, pitching pennies, shooting marbles and playing pinball machines. That kind of gambling continued until about age 14 when I started to bet on sporting events with a bookmaker, and then I got into the stock market.

As a young kid growing up, I always felt that everyone was better than me. The only time I felt okay about myself was after I had a win, whether it was marbles or baseball cards or pennies. Then, at 14, I went to the racetrack for the first time; it was Memorial Day 1951, Roosevelt Raceway. At the time, I made 50 cents an hour after school, working 15 to 20 hours a week. That night at Roosevelt Raceway I had my first big win and walked out of the track with \$54. Looking back today, I think it was that night that changed my life. Even though I had only won \$54, it was about five weeks' salary to me. After that night, I believed I could be a winner from gambling, and eventually, become a millionaire. I can still recall that high feeling walking out of the racetrack that night.

By 17, I was already stealing to support my gambling. It started with stealing

comic books from the local candy store to play cards.. Before long it was stealing money from my family to gamble. By then, I was taking the bus to the racetrack a few nights a week on a regular basis. In New York in those days they closed the track in the winter months, so on weekends, I took the bus or the train to Maryland to gamble. I was betting sporting events and horses with a bookmaker on a daily basis. Back then, each sport had its own season. I remember calling the bookmaker one day and the only thing that was available to gamble on was hockey. I had never seen a hockey game, but I bet on it anyway. Only months later, when I saw my first hockey game, I realized it was played on ice.

Sometime between ages 17 and 20 I went to the racetrack one night and won \$6,000. Wow! Another big win, the equivalent of two years' salary. This reinforced my belief that I could be a winner at gambling.

By my early 20s I was betting big amounts on lots of games that I didn't really know much about and probably couldn't name more than a handful of players who played them. In some of the college games I bet on, I couldn't name one player or even tell you where the college was located, but I needed to be in action. By then I was a regular at the old Madison Square Garden, every week. I watched and bet on college and professional basketball on a regular basis. I was working full-time in a shipping department in the garment center and every Tuesday when we got paid there was a regular crap game out in the hallway. Almost every week I lost my pay in that game. I began stealing supplies and merchandise on a daily basis to pay for my gambling. I already had a bank loan and a finance company loan, and I borrowed from coworkers.

At 21, I met my future wife. Our first date was to the movies, and most of the rest of our dating was at the racetrack. We had a joint checking account to save for our wedding: she put money in —and I didn't. I needed my money for gambling. I was still looking for another big win. I thought the perfect place for our honeymoon would be Las Vegas or Puerto Rico since I knew both places had casinos. My wife-to-be didn't think that was a good idea; I guess she understood enough about my gambling already. When I was 23, we got married. I wanted to stop gambling at that point and I thought I could. But within a short time I was back at it. Even though I wanted to stop, I realize now that I couldn't.; I needed to gamble like any drug addict needs to stick that needle in their arm or an alcoholic needs to have that drink.

Four weeks after we got married I went away to the Army Reserves at Fort Dix, New Jersey, for six months. The whole time, I gambled every day, fast and furious, from placing bets by phone with the bookmaker to shooting craps and playing cards —every waking minute. When I came home in December of 1961, I owed \$4,000 and didn't even have a job.

I eventually got work in the garment center. In the showroom I worked in there were a few compulsive gamblers who I quickly got friendly with. They became my buddies. We played cards during the day and went to the racetrack at night, and on weekends, we did both. My wife thought I was at business meetings some nights. All of us lied for each other.

In 1963, my first daughter was born. While my wife was in labor for 37 hours, I went twice to the racetrack. When the doctor finally came out and told me that we had a baby, the only question I really cared about was "How much did she weigh?" You would think that my concern should have been "How is my wife?" or "How is the baby?" He answered 7 lbs., 1 oz., so my first call was to the bookmaker to bet 71 in the daily double. The next day, I saw in the newspaper that I had won, which convinced me that God had sent me a message: now I was going to be a winner.

One year later, my boss gave me an option to buy 500 shares of stock in the company for \$7,500. Within a year that stock was worth \$38,000. In those days, you could buy a car for \$2,000 and a house for about \$10,000. Within three years, all of that money was gone due to my gambling. I was now a plant supervisor for a Fortune 500 company. My gambling was already so out of control that I was stealing everything I could just to stay in action. I set up a room in the factory for playing cards, all day long. I was starting to do illegal acts, manipulating stocks in the stock market; still, at that point, I had borrowed money only from legitimate sources.

Our home life was deteriorating. Gambling was more important than anything else that went on at home. I lied about almost everything and I would come home and pick a fight so I could go out and gamble. Nothing else in my life was more important than gambling—not my family, not my job—gambling came first.

My gambling got progressively worse. As a plant manager in New Jersey, I was supervising 300 to 400 people and my boss was in New York. Most of the time he didn't know what I was doing. Besides stealing and borrowing money from coworkers, I now had loans with three banks, three finance companies, and I owed a loan shark an amount of money equal to one year's salary. I was involved with three bookmakers, both working for them and betting with them. I directed a lot of people in my company who gambled to my bookmaker and so I got a piece of the action. I even got involved in a numbers operation. Between these activities and stealing, I supported my gambling.

There were times I bet on 40 or 50 games in a weekend and believed I could win them all. One weekend, just before I hit my bottom, I called a bookmaker

and took a shot by betting a round robin equal to about two years' salary. If I had lost that bet there was no way I could have paid it at that time. Things were getting so bad, I remember calling a bookmaker one day and he said that if I didn't bring him the money I owed him, he would not take my bet for that night, so I went home and sold our car to a neighbor.

I wasn't going home to pick fights with my wife anymore; I was doing it over the phone so I wouldn't waste the trip. Most of the time I was out gambling, but when I was home we fought constantly. We rarely had sex. When I won I was so high I didn't need it and if I lost I didn't want it. There were times when we did have sex, though, and my wife would say, "Do you hear a radio?" Of course, I told her she was crazy, but I had a radio on under the pillow so I could listen to a game.

We tried to have another child, but couldn't. My wife came to me with the idea of adoption. I didn't like it, especially because it would cost money, money I needed for gambling. After three months of her bothering me, I finally went along with her, thinking that she would be so busy with the two kids she would leave me alone. I borrowed the money we needed from my boss and relatives. The day we brought our new son home on a plane was the seventh game of the 1967 World Series. My wife was busy looking at this beautiful new baby but I had no interest in him. I had a large bet on the game, and although the pilot announced the score every 15 minutes or so, I was so upset that we were on this plane. I wished and prayed the plane would land so I wouldn't miss another minute of that game.

In the next few months, the bottom fell out of my world even though I still had my job and I still looked like things were okay; that is, there were no track marks on my arm and I didn't smell. No one could really tell what was going on. I would come home from gambling and see my wife crying all the time, depressed and sick. Our daughter was four years old and I don't remember her walking or talking. Either I wasn't home, or when I was, my head was consumed with gambling. I owed 32 people the equivalent of three years' salary; I had a life insurance policy and constantly thought about killing myself and leaving my wife and two kids that money.

I would do anything to keep gambling. I still thought the big win was just around the corner as long as I could get money to stay in action. I tried to find out where I could get drugs to sell, I scouted gas stations to rob, I asked people about making counterfeit money—I was running out of options. My boss came to me one day and told me a detective who was following me had a report on my gambling. He knew I bet more than I earned and was sure that I stole from the company. If he found out, he said, he would have me arrested. Only three hours later I was stealing from the company again: I needed to go

to the racetrack that night.

On February 2, 1968, my wife had a miscarriage. I took her to the hospital, wishing and praying all the way that she would die. I thought it would solve all my problems not to have to tell her how bad things were. That morning, I called my mother to watch my kids and called my boss to say I couldn't come to work because my wife was in the hospital. That afternoon I went to the racetrack. After the track, I went to see my wife. When I got to the hospital the doctor told me that my wife was in shock, she had almost died. I was so deep into my addiction that I didn't care —about her, the two kids or myself. The only important thing was making a bet.

I thought I was the only one living that way and doing what I did. But I found out that I wasn't alone and that I could stop gambling with the help of the other people. I had hope for the first time.

It has been almost 34 years since I last gambled. Today, I have everything I dreamed I would get from gambling and then some. I have a wonderful family that is still intact and I have even been blessed with four grandchildren who I love very much. In the last 20 years, I have been able to devote my working life to helping others who have this problem and educating people on the disease of compulsive gambling. This has been a dream come true.

*Submitted: February 18, 2002*

*This First person account was not peer-reviewed.*

*Arnie Wexler is a certified compulsive gambling counselor (CCGC) and was the executive director of the Council on Compulsive Gambling of New Jersey for eight years. He currently works with his wife, Sheila, as a consultant and presenter on the subject of compulsive gambling addiction.*

*Arnie is an expert on the subject of compulsive gambling and has been involved in helping compulsive gamblers for over 34 years. He has appeared on many of America's top television shows, including Oprah, Nightline and 48 Hours. He has been quoted and profiled in hundreds of magazines and newspapers.*

*Arnie has presented workshops and training seminars nationally and internationally. He has spoken to gaming industry executives, Fortune 500 corporations and legislative bodies, and on college campuses. He has carried out training for the National Football League.*



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**Book review —**

*[This article prints out to about three pages]*

## The Habit Change Workbook: How to Break Bad Habits and Form Good Ones.

*By James Claiborn and Cherry Pedrick (2001).  
Oakland, CA: New Harbinger Publications, Inc., 243 pages.  
Price: \$19.95 (US).  
ISBN: 1-572242-63-9*

*Review by Mark Griffiths, PhD  
Psychology Division  
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This book was jointly written by a cognitive-behavioural psychologist and a nurse turned writer. Consequently, it is an easy-to-read work that claims to include "proven techniques for eliminating a wide range of unwanted habits" of which gambling is one of many. In one of the early chapters, the authors state that this book is not a substitute for medical, psychiatric or psychological treatment. They also state that the treatment of addictions is beyond the scope of the book. Furthermore, addictions are viewed as primarily physiological, involving the ingestion of a psychoactive substance like nicotine, alcohol or other drugs. This suggests the implicit assumption that gambling is not a bona fide addiction and is akin to other "bad habits" covered in the book, such as sleeping problems, relationship issues and health and fitness concerns.

The book is divided into four parts, each of which is broken down further. The sections are Habits —We All Have Them (four chapters), The Habit Change Program (eight chapters), Detailed Guidance on Specific Habits (seven chapters) and a single concluding chapter, Further Help. The first four chapters in the book cover basic but important ideas: an overview of good and bad habits, a look at how habits develop, the reasons for changing or not changing habit patterns and a brief overview of some common habits. Most of these can be readily applied to gambling, and many gambling practitioners and gamblers themselves will find the material easy to digest and follow.

The second part of the book contains seven chapters that are the core of the book —the habit change program itself. This is necessarily generic but is supplemented by seven specific guidelines (in the third part of the book) covering nervous habits, sleeping problems, health and fitness problems, relationship problems, shopping and spending problems, excessive leisure problems (including problematic Internet and video game use) and problem gambling. As the authors point out, each reader "will take the same first steps, take a different direction, then meet together to complete the journey."

The habit change program contains many self-assessment exercises that can either be used for self-help or adapted by practitioners to help their clients. Much of this section is a step-by-step guide and provides detailed instructions for eliminating specific habits. The theoretical basis for effective habit change is based on the well-known stages of change model developed by James Prochaska and his colleagues (precontemplation, contemplation, preparation, action and maintenance). Many other areas of psychological theory underpin the program (habit formation, the role of reinforcement in behaviour, the basics of behavioural therapy, relapse prevention, cognitive therapy and cognitive-behavioural therapy, etc.) in addition to addressing behaviours that go beyond habits (addiction, obsessive-compulsive disorders). The latter, these behavioural excesses, are only examined briefly; but again, there is an implicit assumption that gambling does not fall under these.

The authors' habit change program includes self-help assessments on many important (but predictable) aspects, including why changing behaviour is difficult (fear, disgust, excuses, denial) and self-help behaviours that can be used in conjunction with the program (breathing, muscle relaxation and meditation exercises, etc.). Some of the program case studies, such as Changing the Way You Think (Chapter 9) use gambling scenarios as examples. Gambling practitioners will obviously find these the most helpful.

The third section outlining specific habits to break is a mixed bag in terms of

underlying theory and the chapter layouts. There is no common structure to the chapters (13 to 19), although this may reflect that they cover such a diverse set of bad habits. Some of the chapters included background research in the area (e.g., Nervous Habits, Sleep Disorders) whereas most chapters featured little research. The chapter on gambling was primarily concerned with cognitive distortions. While important, there are many other aspects that could also have been covered. The final section includes just one chapter that centres upon family and group habit change with a small section that is a selective list of follow-up resources.

The book is generally well written, which is not surprising given that one of the authors is a freelance writer! It is readable, logically and systematically organized, and has plenty to engage those who follow the program. Academics may be irritated that few references are provided but the book is not aimed at them. It has been written in a way that both the general public and busy therapists will find valuable. It's my guess that many practitioners with a cognitive-behavioural bias working with people who have gambling problems will be very aware of the strategies in this book (theoretically, at least). However, the case study approach that is laid out is still useful to those individuals. My only real gripe is the implicit assumption the authors make that problem gambling is not really an addiction like (say) alcoholism.

*This book review was not peer-reviewed.*

*Submitted: May 7, 2002*

*Mark Griffiths, PhD, is a professor of gambling studies at Nottingham Trent University, and is internationally known for his research on gambling and gaming addictions. In 1994, he was the first recipient of the John Rosecrance Research Prize for "outstanding scholarly contributions to the field of gambling research." He has published over 100 refereed research papers, numerous book chapters and over 250 other articles. His current interests are technological addictions, especially computer games and the Internet.*

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### Video reviews

*[This article prints out to about four pages]*

## The Effects of Compulsive Gambling on the Marriage

*Running time: 43 minutes*

*Price: \$295 (US)*

*Format: VHS format*

*and*

## Can this Marriage Recover (from the Effects of Compulsive Gambling)?

*Running time: 23 minutes*

*Price: \$295 (US)*

*Format: VHS format*

*Set of both videos: \$495 (US)*

*Distributor: Arnie and Sheila Wexler Associates*

*213 Third Avenue, Bradley Beach, New Jersey 07720 USA*

*Phone: (732)-774-0019*

*E-mail: [aswexler@aol.com](mailto:aswexler@aol.com)*

*Web site: <http://www.aswexler.com/html/videos.html>*



*Reviewed by David C. Hodgins, Erin Cassidy, Alice Holub, Maria Lizak, Chrystal L. Mansley, Adriana Sorbo, Steve Skitch, Kylie Thygesen*  
*University of Calgary, Calgary, Alberta, Canada*  
*E-mail: [dhodgins@ucalgary.ca](mailto:dhodgins@ucalgary.ca)*

*The Effects of Compulsive Gambling on the Marriage and Can this Marriage Recover (from the Effects of Compulsive Gambling)?* provide parts One and Two of a videorecorded conference presentation by Arnie and Sheila Wexler, a married couple who survived the effects of a gambling addiction. The presentation was part of the New Jersey Council on Problem Gambling Conference in 1993. It chronicles the destructive effects of Arnie's gambling problem on him and on his wife as well as their journey through recovery.

*The Effects of Compulsive Gambling on the Marriage* traces the development of Arnie's gambling problem and its effect on his relationship with Sheila. In 1993, Arnie and Sheila Wexler had been married for 32 years, and of those, 25 years had been spent in the process of recovery from Arnie's gambling problem. They are both 12-step program members.

Arnie's interest in gambling, mostly horseracing, began at age 14. His first big win was \$54 at the racetrack; a lot of money to Arnie, who was then earning only \$ .50 per hour. Gambling always played a central role in his relationship with Sheila. In fact, their second date involved sneaking the underage Sheila into the races to gamble. Arnie and Sheila take turns describing their experiences in a direct and frank fashion. We hear vivid, personal details about their decisions and actions, regardless of how painful they were.

The structure of the talk follows Custer's (1984) well-known diagram of the progression of gambling problems from the winning, losing and desperation phases (Part One) to the critical phase and re-building and growth phases. (To see the diagram, go to <http://www.state.in.us/fssa/servicemental/gambling/problems.html> and search with Ctrl+F for Perception of Gambling as an Addiction). A similar phase diagram is used to outline the effects of gambling on the spouse. The parallel phases are referred to as denial, stress, exhaustion, critical, re-building and growth.

## **Review process**

A group got together one hot summer afternoon to view the tapes; the eight people were graduate and undergraduate students, psychologists, gambling clinicians and gambling researchers. We viewed each tape (Part Two first, unfortunately, because of poor labelling) and discussed each briefly. The following review presents our consensus views.

## Critique

Arnie and Sheila are both articulate and effective speakers. The recording quality is good, although the videos follow a low-tech approach. The talks are presented as given to the audience, with the phases of compulsive gambling and recovery marked with simple camera shots of the diagrams. There are few graphics, little bridging narration and no supporting materials other than the Custer diagram. We considered this simplicity both a strength and a weakness of the videos, a strength in that the rawness of the stories is underscored. At the end of Part One, which ends with the desperation phase, we all felt subdued and saddened by the Wexlers' experiences. Part Two provided a greater sense of hope as they described the recovery phases. Throughout both videotapes, no detail is spared in illustrating the process.

The difficulty with the low-tech approach is that the structure of the videotapes was not immediately apparent. It would have helped to have some narration indicating the structure of the two-part video presentation and a graphic presenting the complete diagram. Certainly an information guide could easily be prepared. The graphics that distinguish each phase are camera shots of the classic Custer diagram of addiction and recovery. The information was difficult to read, and again, narration could guide the viewer through each phase with a brief explanation.

Our group had an extensive discussion of the intended audience for the videos. They provide a useful introduction to the Gamblers Anonymous philosophy and associated terminology. The videos emphasize the long-term nature of recovery and the importance of the spouse working on him- or herself, both of which may be useful to stimulate discussion in a treatment program with a therapist's guidance.

From a stages of change perspective (for an introduction to this concept, select [http://www.med.usf.edu/~kmbrown/Stages\\_of\\_Change\\_Overview.htm](http://www.med.usf.edu/~kmbrown/Stages_of_Change_Overview.htm)) we wondered if the extremeness of the Wexlers' experiences as presented on the videos might discourage contemplators, whose own stories might be less dramatic and lives less disrupted, from seeking recovery. A therapist could

guide the discussion appropriately to avoid this effect and, instead, instill hope for recovery and emphasize the importance of current action to prevent the development of such devastating consequences. The videos may also be useful in a teaching context. Although a guest speaker from Gamblers Anonymous or Gam-Anon would be most effective, these videos offer a good alternative.

A limitation of the stories is that Arnie is an "old style" gambler, having a problem primarily with horseracing. No mention is made of the electronic gambling machines or older-age onset of gambling that currently are issues for the majority of people seeking treatment. Families will often report that the relationship with the gambler was good prior to the development of the gambling problem. The Wexlers, in contrast, describe their relationship as starting out on a poor foundation that needed to be completely rebuilt in recovery.

The videos do not provide much information of the process of recovery for the couple. For instance, we wanted to know more on how Arnie quit gambling, reconnected with his wife and worked through the hurt they had caused one other. It seemed that they worked in isolation versus coming together and working jointly. We were also interested in the recovery process for their children and how they fared, and we assume there were many ups and downs for all of them that are not described. Generally, the recovery is presented as a linear process once initiated (as in the Custer diagram).

The Wexlers subscribe to the disease and codependency models of pathological gambling. However, although they use this language (Sheila speaks of her codependency "illness"), their rich descriptions also illustrate characteristics of other models of gambling problems. Arnie describes the behavioural changes that were important in his recovery —taking on new activities, limiting access to money, and so forth. He also speaks of the cognitive distortions that guided his wagering —superstitions, discounting losses, symbolism and luck. Sheila describes her hope that "love will conquer all" and her lack of assertiveness in confronting Arnie's behaviour. She also describes symptoms of depression, agoraphobia and panic attacks.

In summary, the two videos provide a powerfully presented recovery story that describes the experiences of the gambler and the affected family member. Their potential usefulness is in specific contexts when employed by experienced clinicians.

## Reference

**Custer, R.L. (1984).**

Profile of the pathological gambler. *Journal of Clinical Psychiatry*, 45 (12,2), 35–38.

*This review was not peer-reviewed.*

*Submitted: July 11, 2002*

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### Book review

## Best Possible Odds: Contemporary Treatment Strategies for Gambling Disorders

*By William G. McCown and Linda L. Chamberlain (2000). New York: John Wiley & Sons, Inc., 260 pages, hardcover. Price: \$55.00 (US). ISBN: 0-47118-969-3*

*Reviewed by Jeffrey I. Kassinove  
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Pathological gambling is a serious non-chemical addiction that, until recently, was a secondary concern for practitioners who treat individuals with chemical addictions. McCown and Chamberlain's *Best Possible Odds* makes an important mark by synthesizing research knowledge and clinical experience about the destructive path of excessive gambling and provides an overview of the treatment approaches that they have used effectively in their clinical practice. The text presents information about the history, characteristics, etiology, maintenance and treatment of pathological gambling. Although it has shortcomings, some of which are editorial (e.g., the index section in the review copy was upside down), it is a useful text for those with little or no experience working with pathological gamblers.

The authors take clear positions on the nature of gambling and the treatment of excessive gambling as a non-pharmacological addiction, which they relate

to other persistent, repetitive behavioral problems, such as workaholism. They state that one of the book's goals "is to encourage flexible and eclectic treatment approaches, with the eventual hope of determining what works best and for whom" (p. 104). Thus, if using a psychoanalytic technique in combination with a behavioral approach works, then it is valuable to use them in tandem. McCown and Chamberlain clearly state that the focus of treatment is best placed on behavior change, and I fully agree. Although emotions and cognitions play a role in pathological gambling, focusing on behavior as the dependent variable makes sense given that its negative consequences emerge from the motor acts of gambling. Significantly, they propose abstinence as a goal, believing that other non-harmful behaviors can be substituted to produce the elation associated with gambling. Finally, they state that much of their writing about treatment is based solely on clinical experience.

In Chapter 2, McCown and Chamberlain cover the major paradigms that describe problem and pathological gambling. They emphasize Custer's classic model illustrating the stages that lead to pathological gambling. This model is useful, particularly for the novice clinician, in understanding the typical maladaptive patterns of behavior emitted at different times in the life of gamblers. Within the chapter, lucid evaluations of Gamblers Anonymous and the disease model are also presented. The authors deserve praise for their thoughtful commentary about the cyclical, explanatory nature of the medical model.

Chapter 3 contains information about the phenomenology of gambling. At the outset, the authors compare alcohol abuse and gambling disorders in the DSM-IV, which I found informative. The term "addictive gambler" is used to describe a person with a more serious problem than a "problem gambler." In addition, the authors use the term "compulsive gambling," as opposed to "pathological gambling." Moreover, much of this chapter focuses on Custer's subtypes of gamblers. Although interesting, these are not the standard terms currently used in the field and the inconsistent terminology may confuse novice practitioners. The standard subtypes of gamblers used today are non-gambler, social gambler, problem gambler and pathological gambler.

When discussing the etiology and maintenance of gambling (Chapter 4), McCown and Chamberlain suggest that the Zeigarnik effect may underlie persistent gambling. Specifically, they hypothesize that when a gambler plays to win but ends up losing, it constitutes unfinished business. Therefore, the gambler is highly motivated to return and complete the task. This intriguing concept has not often been attached to excessive gambling and may be valuable in explaining the possible causes of behavioral persistence.



The second half of the book focuses on treatment modalities. The authors lean strongly toward a clinical experience approach as opposed to a research-based one. McCown and Chamberlain state that their focus is based on the assumption that few published studies have supported any modality by showing clear treatment efficacy. This statement is a bit too harsh, as some treatment studies have shown efficacy in reducing gambling (Sylvain, Ladouceur & Boisvert, 1997). It would also have been valuable to include some of the step-by-step treatment approaches published by clinical researchers. In addition, advice about addressing touchy subjects with gamblers, such as family and personal finances, would have been an added bonus for the novice practitioner. Nevertheless, these are minor points and the book gives some good insights into methods for treating pathological gamblers.

On a positive note, the authors provide a valuable clinical, experiential perspective on the treatment of gamblers. They also discuss measuring techniques to evaluate the behavior of gamblers. Chapter 5 covers the Gamblers Anonymous model, an inpatient model and an Internet self-help approach, which are important services. However, they fail to tell readers specifically how to gain access to them (i.e., Web addresses, telephone numbers, etc.). Chapter 6 presents a multiphasic model of outpatient treatment that describes the therapy process with gamblers. This chapter would certainly be helpful for new clinicians interested in disordered gambling.

Strategies to enhance treatment effectiveness are given in Chapter 7, but the authors note that these techniques are "adjuncts" to abstinence-based treatments (p. 136). They briefly cover social skills training, relapse prevention and covert sensitization. Although presented as adjuncts, it would have been valuable to present more detailed descriptions of these powerful behavior therapy techniques.

The authors offer a thorough description of the assessment tools used in the gambling treatment literature and practice. McCown and Chamberlain discuss the South Oaks Gambling Screen as well as other measurement tools for different age groups and for families of gamblers. The authors nicely go beyond the standard assessment tools and discuss the benefits of more general tools (e.g., Minnesota Multiphasic Personality Inventory, Thematic Apperception Test). In addition, they present a clear psychological case report completed for a problem gambler.

The authors boldly move the field forward when they discuss Chaos Theory as it might apply to pathological gambling. To my knowledge, Chaos Theory has not been examined within the realm of gambling and they are to be commended for this presentation.



The authors' disposition toward family therapy as a treatment modality is clear and there is a separate chapter on this approach. Most clinicians with experience working with gamblers would agree that integrating the family into treatment is essential. Although two family-based approaches are presented, I would have liked to see more about the specifics of treating the family.

McCown and Chamberlain present some of the classic theories regarding the development and maintenance of problem gambling, and use their clinical wisdom to provide insight into the treatment of excessive gambling. Their discussions of topics such as the Zeigarnik effect and Chaos Theory are worthy of note for the advanced practitioner. For the novice, many real and interesting case examples are presented, which drive home many of the points being made. Although it has some limitations, *Best Possible Odds: Contemporary Treatment Strategies for Gambling Disorders* is a solid resource that lays down a foundation for clinicians new to the treatment of pathological gambling.

## Reference

**Sylvain, C., Ladouceur, R. & Boisvert, J. (1997).**

Cognitive and behavioral treatment of pathological gambling: A controlled study. *Journal of Consulting & Clinical Psychology*, 65 (5), 727-732

*This book review was not peer-reviewed.*

*Submitted: July 27, 2002*

*Jeffrey Kassinove, PhD, has studied gambling and other addictive habits (e.g., alcohol use and day trading) in the United States and abroad since 1996. At Monmouth University's Gambling and Addictions Research Laboratory, he has focused on understanding the factors that lead to gambling persistence. Specifically, he has studied both the cognitive and behavioral elements that increase slot machine play. He has developed cognitive scales for understanding attitudes toward gambling as well as tools to assess such mediating factors as illusions of control. He has lectured in Russia, India and Poland on the problems associated with gambling and is a consultant with St.*

*Petersburg University in Russia. Dr. Kassinove also has a small practice where he treats people who have problems with gambling or drug and alcohol use.*

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## review

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**Web site review —**

*[This article prints out to about six pages]*

## Winning Web sites: Researching gambling on the Internet

*By Rhys Stevens  
Alberta Gaming Research Institute  
University of Lethbridge  
Lethbridge, Alberta, Canada  
Email: [rhys.stevens@uleth.ca](mailto:rhys.stevens@uleth.ca)*

On-line reports and papers are an increasingly popular way to distribute research findings. This trend seems to be especially true for the field of gambling and gaming research. New reports can be disseminated from Web sites to the rest of the Internet-connected world almost instantaneously. Oftentimes, these on-line reports contain more complete and detailed information than subsequent journal articles that report the same findings. As a librarian for the Alberta Gaming Research Institute, I've had the opportunity to identify hundreds of Web sites that include such reports. This review summarizes a number of these sites that provide access to original research reports and studies in electronic formats —generally HTML or PDF files (which are viewable in most current Web browsers).

## **Australian Centre for Gambling Research (ACGR) —*Australia***

[www.aigr.uws.edu.au](http://www.aigr.uws.edu.au)

Jan McMillen is the executive director of the ACGR and has been researching gambling issues extensively since the 1980s. The Centre is located at the University of Western Sydney and performs a wide range of research on gambling-related topics of international interest. All reports, journal articles and working papers produced by the Centre are documented on the site — and are available electronically in some cases. Abstracts of journal articles published in International Gambling Studies can also be read on the Web site.

## **Gambling Research Panel & Victorian Casino and Gaming Authority (VCGA) —*Australia***

[www.grp.vic.gov.au](http://www.grp.vic.gov.au) & [www.gambling.vcga.vic.gov.au](http://www.gambling.vcga.vic.gov.au)

The Gambling Research Panel is a state government-funded organization that independently commissions and publishes research into the social and economic impacts of gambling and the causes and prevention of problem gambling. The Victorian Casino and Gaming Authority's Research Committee was replaced by the Gambling Research Panel in November 2000. Over 30 extensive publications have been produced to date, and most are available from the VCGA Web site. I especially recommend this site to those performing research on the socioeconomic impacts of gambling.

## **Alberta Alcohol and Drug Abuse Commission (AADAC) —*Canada***

<http://corp.aadac.com/gambling/index.asp>

The AADAC Web site provides a wealth of information on alcohol, drugs and gambling. As an agency funded by the Province of Alberta, its mandate is to help citizens achieve lives free from substance use and gambling problems. The gambling section provides a good selection of recent reports, fact sheets and brochures. The Commission's resource catalogue (see Catalogue near the top of the page <http://corp.aadac.com/gambling/index.asp>) offers a complete listing of all resources available for purchase from the organization. Many of the items on this substantial list include resources designed to

educate special populations of gamblers.

### **Alberta Gaming Research Institute (AGRI) —*Canada***

[www.abgaminginstitute.ualberta.ca](http://www.abgaminginstitute.ualberta.ca)

The AGRI site can be considered a research portal for individuals interested in gambling issues. The Library Resources section of the site provides an extensive listing of on-line and print materials (e.g., reference sources, gambling journals, newspaper articles, bibliographies, etc.). Other areas of interest on the site include current and completed initiatives funded by the Institute in the Research section and the growing Grey Literature Database of gaming reports not controlled by commercial publishers, which is found at <http://gaming.uleth.ca>. The Institute is a consortium arrangement of the universities of Alberta, Calgary and Lethbridge, and its function is to support and promote research into gaming and gambling in Alberta.

### **Canada West Foundation —*Canada***

[www.cwf.ca](http://www.cwf.ca)

Unlike the United States and Australia, the Canadian federal government has never funded a national gambling study. The Canada West Foundation, an independent, non-partisan, non-profit public policy research institute, undertook a comprehensive Gambling in Canada project that ended in November 2001. The 18 reports in the series were produced over four years and are freely accessible from the foundation's Web site in the Publications section. As an added bonus, speaking notes from recent presentations on gambling issues are included in the Presentations section. It is necessary register (at no charge) on your initial visit to the Web site in order to download reports and presentations.

### **Ontario Problem Gambling Research Centre —*Canada***

[www.gamblingresearch.org](http://www.gamblingresearch.org)

This Ontario Problem Gambling Research Centre gets my vote for

technological excellence among the Web sites reviewed here. The Webcasts (i.e., video clips) and eWildman bibliography are both terrific resources. Also available are reports commissioned by the Centre in order to enhance the understanding of problem gambling and strengthen treatment and prevention practices through research. Shortcomings are the registration and sign-in requirements for access to resources.

### **Responsible Gambling Council (Ontario) —*Canada***

**[www.responsiblegambling.org](http://www.responsiblegambling.org)**

The Responsible Gambling Council (Ontario) helps individuals and communities address gambling in a healthy and responsible way, with a strong emphasis on preventing gambling-related problems. The most impressive resource is the e-Library —a collection of nearly 4000 gambling-related items (e.g., newspaper articles, on-line reports). Researchers can search this database by keyword, subject category and geographic location. Also available on the Web site are the complete archives for the Council's informative Newscan and Newslink publications. Visit this site regularly to stay abreast of new developments in gambling.

### **The Centre for Gambling Studies, University of Auckland —*New Zealand***

**[www.gamblingstudies.co.nz](http://www.gamblingstudies.co.nz)**

The recently redesigned and updated Centre for Gambling Studies (formerly known as the Gambling Studies Institute) Web site provides details of the Centre's research reports. Some exciting gambling research projects are presently underway (e.g., gambling in Samoan communities, adolescent gambling behaviour, prison problem gambling and counselling). The Centre for Gambling Studies is part of the University of Auckland's faculty of medicine and health sciences and seeks to minimize harm from gambling and promote community well-being.

### **GamCare —*United Kingdom***

**[www.gamcare.org.uk](http://www.gamcare.org.uk)**

GamCare is the United Kingdom's national centre for information, advice and practical help with regard to the social impact of gambling. A range of research-oriented books (e.g., *Adolescent Gambling* by Mark Griffiths) and counselling resources are available for purchase from the Web site. GamCare's policy is to be gambling neutral and its main objectives are to improve the understanding of the social impact of gambling, promote a responsible approach to gambling and address the needs of those adversely affected by a gambling dependency.

### **Gaming Studies Research Center, University of Nevada, Las Vegas — *United States***

<http://gaming.unlv.edu>

Dave Schwartz, co-ordinator of Gaming Studies Research Center, has done a superior job assembling a virtual potpourri of gambling-related resources on this Web site. Highlights of the site include an extensive listing of graduate dissertations, a reading room of articles on topical issues and an unrivalled collection of links to gambling sites and conferences. It is immediately evident that this resource takes a number of visits to explore fully, but it is well worth the effort. The Gaming Studies Research Center at the University of Nevada, Las Vegas, is a clearinghouse of data on the business of gaming, its economic and social impacts and its historical and cultural manifestations.

### **Gemini Research, Ltd. —*United States***

[www.geminiresearch.com](http://www.geminiresearch.com)

Rachel Volberg, president of Gemini Research, Inc., has directed or consulted on dozens of studies on gambling and problem gambling. The Gemini Research Web site provides an authoritative bibliography of journal articles, books and book chapters, and research reports that she has authored since 1986. A section of particular interest to researchers is the Reports & Links area that lists links to the reports, which are fully available on-line.

### **Institute for the Study of Gambling and Commercial Gaming —*United***



## **States**

[www.unr.edu/game/index.asp](http://www.unr.edu/game/index.asp)

The Institute, based at the University of Nevada, Reno, serves to broaden the understanding of gambling and the commercial gaming industries. A real strength of this site is its listing of current and forthcoming print publications available for order. Several article summaries and book chapters from recent publications by Institute scholars are available as well as an updated selection of gaming events and news.

## **National Indian Gaming Association (NIGA) Library & Resource Center — *United States***

<http://indiangaming.org/library>

NIGA operates as a clearinghouse and educational, legislative and public policy resource for tribes, policymakers and the general public on Native American gaming issues and tribal community development. The highlight of the Web site is certainly the Resources section, which features a searchable, browsable listing of studies, books and testimonies. The majority of these items can be downloaded from the site or read on-line in their entirety. This site is a vital resource when reviewing on-line sources for information on aboriginal gambling issues.

## **The Wager: Weekly Addiction Gambling Education Report —*United States***

[www.thewager.org](http://www.thewager.org)

No review of gambling Web sites would be complete without mention of *The Wager*. The editors at the addictions division of Harvard Medical School have been producing weekly research bulletins in order to share the latest developments in pathological gambling. The Back Issues section contains an archive of every published newsletter since 1996. Fortunately, there is also an excellent search mechanism to allow site users to quickly locate articles by keyword. Be sure to sign-up for the Mailing List if you would like to be notified when new topics are available.

*This review article was not peer-reviewed.  
Submitted: August 6, 2002*

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*Rhys Stevens is currently the librarian for the Alberta Gaming Research Institute, and he is based at the University of Lethbridge in Lethbridge, Alberta. He obtained his masters degree in Library & Information Science at the University of Western Ontario. His primary focus is to work with Institute-funded researchers and the general public who are interested in researching issues related to gaming and gambling.*

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Phil Lange, Editor

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Authors will receive an e-mail copy of their manuscript before publication, and must answer all queries and carefully check all editorial changes. Please note that there will be a deadline for a response to queries and no corrections can be made after that date. Authors are responsible for the specific content of their manuscripts.

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The editorial board will make specific invitations to chosen authors. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit and/or contribution to public debate in the field of gambling studies. All submissions will be mediated by the editor.

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We invite researchers to submit manuscripts that report new findings on gambling. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit, and mediated by the editor.

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If in doubt, please consult the Publication Manual of the American Psychological Association - 5th Edition. (2001). Washington, D.C.: American Psychological Association. Some APA style information is available at <http://www.apastyle.org>.

## Examples:

### Books

Lesieur, H.R. (1984). *The Chase: The Career of the Compulsive Gambler*. (2nd ed.). Rochester, VT: Schenkman Books, Inc.

### Book chapters

Shaffer, H.J. (1989). Conceptual crises in the addictions: The role of models in the field of compulsive gambling. In H.J. Shaffer, S.A. Sein, B. Gambino & T.N. Cummings (Eds.), *Compulsive Gambling: Theory, Research, and Practice* (pp.3-33). Lexington, MA: Lexington.

### Journal articles

Gupta, R., & Derevensky, J. (1997). Adolescent gambling behavior: A prevalence study and examination of the correlates associated with problem gambling. *Journal of Gambling Studies*, 14 (4), 319-345.

### Miscellaneous articles, including government publications

Ontario Ministry of Health. *Schedule of Benefits, Ontario Health Insurance Plan*. Kingston, Ontario: Ontario Ministry of Health; April 1987.

## **Papers presented at a conference, meeting or symposium presentation**

Ganzer, H. (1999, June). A seven session group for couples. Paper presented at the 1999 13th National Conference on Problem Gambling, Detroit, MI.

## **Signed newspaper article**

Brehl, R. (1995, June 22). Internet casino seen as big risk. The Toronto Star, pp. D1, D3.

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Man gambled crime returns at casino. (1996, February 9). The Christchurch Press, pp.32.

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Brown, S., & Coventry, L. (1997, August). Queen of Hearts: The Needs of Women with Gambling Problems, (Internet). Financial and Consumer Rights Council. Retrieved from:  
<http://home.vicnet.net.au/~fcrc/research/queen.htm>

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<http://www.cmhask.com/programs/gambling/index.html> **NEW**

Public education and community development components of the province of Saskatchewan's Problem Gambling Program

<http://www.gamb-ling.com> **NEW**

A multilingual gambling information Web site in 11 languages (Arabic, Chinese, English, Farsi, Hindi, Italian, Portuguese, Russian, Somali, Spanish and Urdu). Information in audio formats and through these click-on topics: "What's problem gambling?," "Do I have a problem?," "Get help," "Ethno-cultural resources," "Library" and a help-line number.

<http://www.youthbet.net> **NEW**

The TeenNet Youth Gambling Web site (University of Toronto) has an interactive neighbourhood (community centre, library, corner store, casino, schoolyard, and back alley) with access to youth gambling information and help resources, diagnostics, and activities related to risk assessment, time management, money management and balanced decision making.

<http://www.ncpgambling.org>

**National Council on Problem Gambling** : to increase public awareness of pathological gambling, ensure the availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and education.

[http://www.gov.ab.ca/aadac/addictions/subject\\_gambling.htm](http://www.gov.ab.ca/aadac/addictions/subject_gambling.htm)

**Alberta Alcohol and Drug Abuse Commission:** information, brochures and survey results



<http://www.responsiblegambling.org>

**Responsible Gambling Council (Ontario):** information, publications and calendar of international gambling-related events

<http://www.unr.edu/unr/colleges/coba/game>

**Institute for the Study of Gambling and Commercial Gaming:** an academically oriented program on gambling and the commercial gaming industries

<http://www.ncrg.org>

**National Centre for Responsible Gaming:** funding for scientific research on problem and underage gambling

<http://www.problemgambling.ca>

**Problem Gambling: A Canadian Perspective Website** (Gerry Cooper): annotated international links

<http://www.youthgambling.org>

**Youth Gambling Research & Treatment Clinic** (McGill University, Montreal, QC, Canada): information, self-quiz and FAQ's



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### Service profile

## A multilingual gambling information Web site

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*Myra Quinonez-Alfonso, Program Coordinator, Addiction Services*

*Niagara Multilingual Prevention/Education Problem Gambling Program*

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*E-mail: [myqui@on.aibn.com](mailto:myqui@on.aibn.com)*

*Website: <http://www.gamb-ling.com>*

### Programme description

Our Prevention/Education for Problem Gambling Program was designed to provide culturally and linguistically appropriate problem gambling services to members of ethno-cultural communities in the Niagara region through a mix of approaches.

Our multilingual Web site at [www.gamb-ling.com](http://www.gamb-ling.com) offers problem gambling information in 11 languages: Arabic, Chinese, English, Farsi, Hindi, Italian, Portuguese, Russian, Somali, Spanish and Urdu. It was launched on February 28, 2002, with a celebration to thank the cultural interpreter/translators, technical and program staff who designed and built the site.

The Web site's main page allows users to access information in any of the 11 languages. Subdued graphics allow for ease of communication in each language. For example, if you move the curser over "Portuguese" an icon in the shape of a ship's lifesaver displays the Info-Line telephone number and says "Ligue agora!" (Call now!). If you move the curser over, say, China – the word "Chinese" pops up on the map and the lifesaver icon offers the same "Call now!" message in Chinese.

The "Audio" option allows users to hear a four-minute explanation with basic information about problem gambling in any of the 10 languages. The main page, where the language-choice menu is, allows users to go to a second page that offers more choices such as "What's problem gambling?," "Do I have a problem?," "Get help," "Ethno-cultural resources," "Library" and "What's the big problem with gambling?"

Following these links leads to further choices, for example, "Do I have a problem?" yields "Symptoms and signs," "Ready for a thrill?" (lists the kinds of feelings that accompany gambling problems) and "Assessment tools." The last choice offers the user the self-scored Centre for Addiction and Mental Health (CAMH) Gambling Screen, which automatically replies with a recommendation, and the South Oaks Gambling Screen covering the DSM-IV criteria (not-automatically scored) and Gamblers Anonymous 20 questions. Many more information options also exist on other pages.

Our 24-hour gambling Info-Line 1-866-GAMB-SOS (1-866-4264-767) offers information and services in 10 languages (i.e., all of the above except English), both to gamblers and to their family and friends.

We offer public education and awareness training and/or presentations for settlement workers, services providers, the financial sector and ethno-cultural communities.

## **Philosophy of service**

Our philosophy is to offer linguistic and culturally appropriate, multilingual services in prevention, education and other problem gambling services. In designing our Web site, we ruled out simple translations from English in favour of ensuring that culturally specific concepts and sensibilities were respected. For example, a piggy bank icon was originally proposed and then dropped because pigs are devalued or even taboo for many users who will

access the site.

## Linkages

We have strong links with four multicultural centres, ethno-cultural and ethno-racial community groups and service providers in the Niagara region. We also work with such services as the Niagara Alcohol and Drug Assessment Service to provide care for our clients who have other problems (e.g., concurrent disorders, alcoholism and drug addiction). We receive support from the Problem Gambling Multilingual Advisory Committee, composed of community members from diverse cultural backgrounds.

## Impact

Three months after our Web site launch, we received about 44 users each day.

*This Service Profile was not peer-reviewed.*

*Submitted: April 02, 2002*

The Electronic Journal of Gambling Issues: eGambling *invites clinicians from around the world to tell our readers about their problem gambling treatment programs. To make a submission, please contact the editor at [phil\\_lange@camh.net](mailto:phil_lange@camh.net).*

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—The editor

### [Are lottery scratchcards a 'hard' form of gambling?](#)

By Mark Griffiths, PhD

### [Lotteries and the Problem Gambling Community: Myths and Countermyths](#)

By Don Feeney

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[Also in this section: Lotteries and the Problem Gambling Community: Myths and Countermyths](#) By Don Feeney

*[This article prints out to about ten pages.]*

*The Opinion section has many purposes including being a forum for authors to offer provocative hypotheses.*

—The editor

## Are lottery scratchcards a "hard" form of gambling?



By Mark Griffiths, PhD  
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### Abstract

This article argues that scratchcards are not an extension of the online U.K. National Lottery but an entirely different form of gambling, with its own



implications for future gambling policy. It also argues that scratchcards are potentially addictive and should be considered a "hard" form of gambling. The author suggests that scratchcard gambling could become a repetitive habit for some people because of their integrated mix of conditioning effects, rapid event frequency, short payout intervals and psychological rewards coupled with the fact that scratchcards require no skill and are highly accessible, deceptively inexpensive and available in "respectable" outlets.

On March 21, 1995, Camelot —the consortium that runs the U.K. National Lottery online —introduced scratchcards. Like the online game, 28% of ticket sales contribute towards "good causes" distributed by the National Lotteries Charities Board. Although scratchcards are not new to the United Kingdom, many people view them as intricately linked with the National Lottery. Camelot's scratchcards were the first to benefit from both heavy advertising (television, national newspapers, billboards, etc.) and large jackpots (e.g., £50,000), which meant they became successful very quickly.

## **Scratchcards: Some frequently asked questions and answers**

Before going into more detail, here is a brief overview of scratchcards in a "frequently asked questions" model used by Aasved and Schaefer (1995) in their account of pull-tab gambling.

### *What are scratchcards?*

Scratchcards are laminated cardboard tickets where the object is to win money by matching three symbols or amounts of money by rubbing a box covering the symbols or amounts. The face of every scratchcard contains the name of the game (e.g., Mystic Money), the operator's name and the objective (e.g., "Match 3 symbols to win amounts shown."). The reverse side of the scratchcard usually contains the simple play instructions (i.e., "Rub off the box. Find 3 like amounts, win that amount"), overall odds of winning (which differ in most games but are usually about one in five), the prize range (e.g., £1 to £50,000), the operator's address to claim big prizes (usually over £75) and a notice that "Players must be 16 years or older."

### *Where are they found?*

Scratchcards are sold in a wide variety of outlets, including supermarkets, news agents, petrol stations, post offices, small retailers,

etc.

### *How is the game set up?*

There are numerous different scratchcards with a wide assortment of payout structures, prizes and profit margins. Typical games have top prizes ranging from £10,000 to £1 million (but commonly £50,000).

### *How is the game played?*

All the ticket buyer must do is rub off the box's coating in an attempt to find matches of three symbols or amounts (see figures 1 to 4). Most scratchcards cost £1 to play. Games have many small winning tickets (minimum prizes of £1 or £2) but very few big winning tickets.



Figure 1 (click images to enlarge)



Figure 2

Figure 3



Figure 4



### *Where does the money go?*

Although there are a number of independent scratchcard operators,

Camelot's scratchcards have over 90% of the available U.K. market (Creigh-Tyte, 1997). Therefore in the case of most scratchcards, 28% goes to "good causes," 12% in taxes to the U.K. Treasury, 50% is returned in prizes, 5% goes to operating costs and profit and 5% represents the retailer's commission.

The rest of this paper examines the psychological aspects of "lottery" scratchcards. At this point, it is worth noting a trend for associating the word "lottery" with other forms of gambling to make these activities seem innocuous (e.g., video lottery terminals). However, this paper argues that scratchcards are not an extension of the U.K. National Lottery online game but an entirely different form of gambling, with its own implications for future gambling policy. Moreover, scratchcards are potentially addictive and should be considered a "hard" form of gambling.

## Scratchcards —A potentially addictive game?

A previous report by the Royal Commission (1978) noted that casino-type gambling activities came closest to incorporating the largest number of gambling-inducing characteristics. The characteristics outlined include a high payout ratio (i.e., small bets and large jackpots) and rapid betting or "event frequency." In addition, heavy losses were viewed as a likely occurrence because this type of gambling contains characteristics that allow continuous gambling. These three features are also present in scratchcards, and have been described by Griffiths (1995b; 1995c) as "paper fruit machines." Some operators even use the fruit machine (and other forms of gambling) in their product's basic design (see Figure 5).



Figure 5. (click to enlarge)

Further to this, a number of papers written from a psychological perspective describe how and why scratchcards may be potentially addictive (e.g., Griffiths, 1995b; 1997). Like fruit machines, scratchcards have a short payout interval (i.e., only a few second's interval separates the initial gamble and the winning payment) and rapid event frequency (i.e., the time gap between each individual gamble is very short if people engage in continuous play). This

means that the loss period is brief with little time given over to financial considerations, and more importantly, winnings can be used to gamble again almost immediately.

A number of other factors are linked with these characteristics. The first of these concerns the frequency of opportunities to gamble. Logistically, some gambling activities (e.g., the U.K. National Lottery, football pools) have small event frequencies (i.e., there are only one or two draws a week) making them 'soft' forms of gambling. However, in the case of scratchcards there are few constraints on repeated gambling as limits are set only by how fast a person can scratch off the covering of the winning or losing symbols.

The frequency of playing when linked with two other factors —the result of the gamble (win or loss) and the actual time until winnings are received —exploit certain psychological principles of learning. This operant conditioning process conditions habits by rewarding people for specific behaviour. Reinforcement occurs through presentation of rewards such as money. To produce high rates of response, schedules that present rewards intermittently are most effective (Skinner, 1953; Moran, 1987). Since scratchcards operate on such schedules, it is not surprising that high rates of response (i.e., excessive gambling) can occur. Promoters appear to acknowledge the need to pay out winnings as quickly as possible, which indicates the gambling industry views that receiving winnings acts as an extrinsic reward for winners to continue gambling.

Another related aspect to operant conditioning is the "psychology of the near miss" which can act as an intermediate reinforcer. Near misses are failures that came close to being successful. A number of psychologists (Reid, 1986; Griffiths, 1991; 1999) have noted that near misses appear to encourage future play —inducing continued gambling —and that some commercial gambling activities, particularly fruit machines and scratchcards, are formulated to ensure a higher than chance frequency of near misses. The potential danger of the near miss element of scratchcards was first documented in the 1970s: scratchcards were termed "heartstoppers" because they gave the illusion of coming close to a big prize (Moran, 1979).

Heartstoppers have never been adequately defined, and in Moran's original formulation appear to include simple near miss designs (two winning symbols when three are needed) like the scratchcards in [Figures 1](#) and [2](#) (above). This author would define heartstoppers as those instances where there are two winning symbols and a third one that looks similar to the other symbols. For instance, in Figure 3, the "£1000" and "£10000" amounts look very similar and for a split second a person may think they have genuinely won something. Another ploy that scratchcard designers use is having three near misses on

one scratchcard (e.g., [Figure 1](#)) so that it does not matter in what order the person scratches off the box, there will always be a chance that the very last panel they scratch off could be the winning one.

## Adolescent scratchcard gambling

One of the main objectives of gaming regulation, which is common to all effective systems of gaming regulation in democratic jurisdictions, is protection for children and vulnerable persons (Littler, 1996). However, with scratchcards, a concern is the ease with which adolescents can buy them. Some supermarkets, petrol stations, conveniences stores and news agents have broken the law by selling scratchcards to children as young as 11 and 12 (Garner, 1995; MacDonald, 1995; Moran, 1995). In addition to this, advertising for both the U.K. National Lottery and scratchcards is fast persuading viewers that gambling is normal. Children are thus being further saturated with the principles of gambling and are perhaps growing up to believe gambling is socially acceptable.

Many studies (see Griffiths, 1995a, for an overview) have shown that fruit machine gambling amongst adolescents is a popular activity in the United Kingdom. Although most adolescents control their gambling activity, a minority of adolescents who gamble have gambling behaviour that is pathological. Accepting that fruit machine gambling is a major problem for a minority of adolescents, some adolescents may find scratchcards equally addictive, which seems to be the case according to recent evidence. For example, two studies in the United Kingdom (Griffiths, 2000; Wood & Griffiths, 1998), reported that approximately 5% of adolescents aged 11 to 16 were "addicted" to scratchcards based on DSM-IV criteria.

## Some conclusions

At the very least, the characteristics of scratchcards have the potential to induce excessive gambling regardless of the gambler's personality, environment or genetic make-up. These characteristics include the capability to produce psychologically rewarding experiences in financially losing situations—particularly the psychology of the near miss. Therefore, it can be argued that scratchcards are a "hard" form of gambling. At present, the Home Office has a crude distinction between "hard" and "soft" forms of gambling. Their most recent definition is outlined here:



"Hard gambling is a colloquialism for those forms of gambling which are considered to carry greater potential risks than others, usually because of the high or rapid staking associated with them" [author's emphasis] (Home Office, 1996; p. 3).

From this definition and the preceding discussion, conclusion is that "soft" gambling refers to activities, such as the U.K. National Lottery and football pools, and "hard" gambling includes roulette, blackjack, fruit machines, horse and greyhound race betting and instant scratchcards.

It is not hard to see how scratchcard gambling could become a repetitive habit between its integrated mix of conditioning effects, rapid event frequency, short payout intervals and psychological rewards and the fact that scratchcards require no skill and are deceptively inexpensive, highly accessible and sold in "respectable" outlets. Although the perceived element of skill in gambling has been argued to be an important component in the development of some gambling addictions (e.g., Griffiths, 1994; 1995b) it is not necessarily critical. There is plenty of evidence (e.g., Langer, 1975; Wagenaar, 1988) to suggest that a gambler's ignorance about probability or situational cues may encourage gamblers to think they have some influence over mainly chance-determined activities. However, it is difficult to use such information directly in regulation of these activities.

Another complicating factor is the risk that educating the public about gambling may have the reverse of the desired effect and actually increase awareness, and thus, participation. It may be that regulation is best achieved not through changing the structural characteristics but through practices such as prohibition of advertising, decreasing the number of outlets available for gambling and geographically locating gambling establishments away from sites where more vulnerable members of the population are found, such as schools.

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By Mark Griffiths, PhD

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## Lotteries and the Problem Gambling Community: Myths and Countermyths

*By Don Feeney  
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Cats and dogs. Democrats and Republicans. Lotteries and advocates for problem gamblers: All natural enemies in the eyes of the public.

Yet cats and dogs can be the best of friends. Democrats and Republicans do come to bipartisan agreements. And lotteries and problem gambling advocates can work together for the benefit of all.

There are many good reasons for lotteries and the problem gambling community to work cooperatively. From a lottery's perspective, it is far better to be viewed as part of the solution than as part of the problem. And most importantly, it's the right thing to do. From the problem gambling advocate's perspective, an informed and aware lottery is less likely to inadvertently engage in practices that might exacerbate the problem. Plus, a lottery can provide resources and expertise difficult to find anywhere else.

Ten years ago, contacts between the two groups were few and far between. Sessions on problem gambling were rarely, if ever, found at lottery conferences, and lottery industry representatives were equally unlikely to be invited to participate in problem gambling conferences. Neither group understood the other's concerns or the environment in which each had to work.

Certainly the situation has improved dramatically since then. We're not strangers at each other's conferences. Many in the lottery industry have at least some understanding of the science behind addictions treatment and prevention. The number of states and provinces that contribute to programs for problem gamblers has increased substantially.

But there is still a degree of mistrust and suspicion of each other's motives on both sides. To some extent this is understandable. The interests of each group will never completely coincide. And we (the lottery industry) must recognize that they (the problem gambling community) have a responsibility to examine our practices and call them into question when appropriate, just as we have a responsibility to point out when they overstate or misstate their case. To a greater extent, though, mistrust stems from the persistence of myths and misconceptions that each side has of the other.

In trying to identify and understand these myths, I have arrived at what I will modestly call "Feeney's law": For every myth, there is an equal and opposing countermyth. Let me now identify some of the more egregious myths that get in the way of an effective working relationship. However, you must always keep in mind "Feeney's caveat": Most myths contain some element of truth.

**Myth: Problem gambling advocates are anti-gambling.**

Some certainly are, and some anti-gambling zealots have seized on problem gambling as a way to advance their moral objections, but these individuals are the exception rather than the rule. Many even gamble at least occasionally, and even most recovering compulsive gamblers don't begrudge others their entertainment. The National Council on Problem Gambling and its state affiliates maintain a neutral stance on gambling. They will, however, question industry practices they believe will adversely affect problem gamblers or exacerbate the problem. This is appropriate and often useful, though it can be uncomfortable. With a good relationship a lottery will hear these criticisms from these organizations directly rather than through the media or at a legislative hearing.

**Countermyth: Lotteries need the revenue from problem gamblers in order to maximize profits.**

This myth stems from a fundamental misunderstanding of how lotteries function as public agencies. Government agencies are not subject to the same pressures to maximize revenue as are private businesses. While most elected officials find higher revenues better than lower revenues, rarely does this preference override the greater public sector requirement of social responsibility. Few, if any, lottery officials have their compensation directly linked to increased sales; profit-sharing plans are not standard practice in the public sector. And irresponsible practices have a funny way of becoming the subject of legislative hearings and investigative news reports, something any lottery director dearly wishes to avoid. It is a well-known, though rarely spoken, fact of public sector life that the penalties for screwing up generally outweigh the rewards for doing well. This creates a strong incentive for lotteries, and those who govern them, to be risk-averse, and irresponsible sales and marketing practices are risky.

Yet there are examples of lotteries acting in irresponsible ways. I believe without exception these happen through ignorance rather than malicious intent. Ignorance is best overcome through collaboration and constructive engagement. Public accusations and counterclaims based on mutual misunderstanding of motive serve no one well.

**Myth: By working with the problem gambling community, lotteries will be criticized for "causing" the problem and for having ulterior motives.**

Another truism of public sector life is that no good deed goes unpunished. Consider this statement by "Minnesotans Against Gambling:" "The Minnesota State Lottery itself gives money for compulsive gambling treatment. Is this an admission it is producing gambling addicts?" (And is a donation to the American Cancer Society an admission that the donor causes cancer?)

But consider also this statement from an article in the Minneapolis Star-Tribune: "Kathleen Porter, director of the Compulsive Gambling Treatment Program, a division of the Minnesota Department of Human Services, said it's possible that the lottery—which funds the program with more than \$2 million annually—actually does more to fight problem gambling than promote it." Most people, including some lottery opponents, will recognize and respect a lottery for doing the right thing.

**Countermyth: By working with lotteries, advocates for problem gamblers will be accused of "selling out."**

There are certainly those who will reject any money or assistance from lotteries or other gambling entities as impure, and some will be quite vocal in

their criticism of those who accept such money. They are, however, few and far between. Most of the leading gambling researchers and service providers are quite happy to accept a lottery's assistance as long as (and this is a major caveat) it comes with no strings attached. A lottery cannot expect to review and approve research results, or a hotline's outreach plan. Technical assistance is appropriate, and one of the most important skills a lottery can offer, but the end product's complete independence is a necessity.

**Myth: Lotteries don't contribute to the problem.**

The number of problem gamblers who cite the lottery as their game of choice is small. Repeated analysis of calls to hotlines and admissions to treatment programs confirms this fact. For example, the Iowa Department of Human Services has reported that 6 percent of the calls to the state's problem gambling hotline relate to lottery play.

Nevertheless, that number is not zero. There are some people who are addicted to lottery products, and there are also those who, while not addicted, may suffer harm from spending too much money on a high lotto jackpot. The lottery industry cannot pretend that problem gambling has nothing to do with them. It does.

**Countermyth: Lotteries don't contribute to the solution.**

Some do not, but most do in some way, shape, or form. The North American Association of State and Provincial Lotteries Web site ([www.naspl.org](http://www.naspl.org)) has an extensive list of what each state is doing in support of programs for problem gamblers. Would that the rest of the gambling industry had such a record!

Still, many problem gambling advocates do not understand that lotteries are not free to dispense lottery revenues as they choose. Most of us are closely regulated by state or provincial legislatures who justifiably believe that it is their right to decide where lottery profits will be spent. There have been several instances of lottery directors urging elected officials to use lottery proceeds to fund problem gambling programs only to be turned down. But lotteries can, and do, contribute to the solution in ways other than funding by providing technical expertise, in-kind contributions, and educating employees, retailers, and the general public.

**Myth: They only want us for our money.**

Well, money is nice, and they certainly need it. But there are several examples of lotteries and problem gambling organizations that have worked



together productively even though elected officials refuse to release funding.

### **Countermyth: Lotteries only want us for public relations.**

Again, good public relations is nice, and lotteries certainly need it. But it shouldn't be the main reason to establish a relationship, and in my experience, it generally isn't. Face it: most lottery managers are not in this business just for the money. They derive some of their satisfaction from helping to raise money for good causes and from a belief in the concept of public service. They want to do the right thing. And helping to alleviate the suffering caused by problem gambling (whether caused by lotteries or not) is the right thing to do.

Beyond money and public relations, what do we have to offer each other? Most nonprofit organizations would dearly love to have a lottery's abilities and expertise in areas like marketing, advertising, graphics, purchasing, technology, and all the other things they do so well. And lotteries have ready access to some audiences, such as players, retailers, and perhaps elected officials that problem gambling groups do not. They, in turn, offer lotteries expertise and a sounding board to go to before they inadvertently do the wrong thing.

## **What can we both do to explode the myths?**

1. **We can both learn.** We can learn that lottery directors are not the spawn of the devil and that problem gambling advocates are not prudish, joyless schoolmarms. Lotteries can continue to learn the facts about problem gambling, and avoid the twin perils of hysteria and denial. Problem gambling advocates can learn the reality of lottery operations as opposed to their imaginations. Lotteries can better learn how to act in a way that minimizes harm, while problem gambling advocates can be reminded that, as one treatment provider once told me, "When you work with compulsive gamblers all the time, it's easy to forget that most people who gamble don't have a problem. "
2. **We can both educate.** Lotteries can educate their staff, their retailers, their suppliers, the government officials who oversee their operations, and their players. Treatment providers and researchers can help us with these tasks and educate the general public. And of course we can educate each other.
3. **We can both get involved.** Five years ago, having two lotteries

present at a problem gambling conference was cause for celebration. At the 2001 National Council on Problem Gambling conference in Seattle, ten lotteries were represented, two panels were devoted to lottery issues, and the Washington State Lottery was intimately involved in conference planning and operations. Lottery staff were welcomed with open arms. Likewise treatment professionals and researchers are increasingly seen at NASPL conferences both as presenters and participants. Lotteries can become active members of the various state, provincial, or national organizations that assist those with gambling problems, and members of those organizations can ask to speak at lottery staff meetings or retailer conferences. And every lottery should have a staff person whose responsibility includes learning as much as they can about problem gambling and serving as a liaison with the appropriate organizations.

4. **We can assume that both groups mean well.** Lotteries can recognize that organizations that assist problem gamblers are not trying to put them out of business, and those organizations can recognize that lotteries are not deliberately trying to create more addicts.
5. **We can both be constructive.** Problem gambling advocates can accomplish more by calling the lottery director if they are concerned about a lottery practice than by calling a press conference. Lotteries can resist the impulse to automatically act defensively when a practice is called into question, and can seek ways to work together. We can both recognize that the media is looking for confrontation that serves neither party well. Don't give them the satisfaction.
6. **We each can take the first step.** Lotteries: If you don't already have a working relationship with your local problem gambling council or organization, pick up the phone and call them. Problem gambling organizations: Do likewise. If you've already taken the first step, take the second.

Lotteries and problem gambling organizations both employ some of the finest people it's been my privilege to know, and they've taken great strides in working together. The last few years have seen a general movement from confrontation to cooperation between the two groups, and this has only been to the benefit of both. By recognizing the myths and countermyths for what they are, we can break down the stereotypes that prevent us from accomplishing even more.

**Myth: This is the director of a problem gambling council.**



**Countermyth: This is a lottery director.**



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*Information on this association can be found at:*

*<http://www.naspl.org/> and their publications are available at:*

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# Appendix A

## Sample information package for principals

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[Information sheet on youth gambling](#)

[School survey procedures and protocols](#)

[School newsletter and announcement](#)

[Letter to parent/guardian](#)

[Parent/guardian consent form](#)

[Student consent form](#)

Youth gambling survey [Not available]

[Alternative activity – Level I](#)

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[Debriefing form for students](#)

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### Letter to principal

Dear <insert principal's name>:

We have enclosed some materials for your consideration as we complete the details of conducting the youth gambling survey at your school. We will be in touch shortly to set up some dates for the survey, and a meeting to discuss your requests regarding the survey and whether or not you would like us to speak to your staff about this questionnaire.

The survey should take about 20 minutes and require no more than 30 minutes including instructions and handing out and collecting materials. For those students who are not taking the survey, we have prepared an alternative activity that has various levels of difficulty. These activities can be used for follow up discussions between students who have done the survey and those who have only read information on youth gambling.

<insert the name of the superintendent of the school board> has been kept informed of the progress and the processes of this research project. The consent process will be handled by the research project office. In this package, we have included a sample announcement, which can be used to obtain signatures from parents or guardians who can then return them in the pre-addressed, pre-stamped envelopes to our office.

We have also included an information sheet on youth gambling for school counsellors and teachers, which includes statistics on the high prevalence rates of youth gambling in Canada.

We are currently in touch with someone who is developing curriculum for secondary schools that addresses gambling issues. We hope to provide you with this curriculum for pilot testing in the <insert time of year>. The units are 30 minutes long and might fit into your TAG schedule and program.

We will be in touch with you, but please do not hesitate to contact us at the telephone numbers provided below. Thank you very much for assisting us with this important research.

Sincerely,

<insert contact telephone numbers>

---

## **Information sheet on youth gambling**

### **Questions & answers**

#### **Why are you researching youth gambling?**

- Results from six research studies already completed in Canada have indicated that 7% to 28% of teens have serious gambling-related problems. Given that average-sized classrooms in Canadian high schools seat 28 students, as many as four teens in every class may be experiencing serious gambling-related problems.
- Between 1984 and 1999 youth gambling increased from 45% to 66%, and by the year 2005, this rate is expected to rise to 80%.
- Adolescent prevalence rates for problem gambling are two to four times higher than adults.

The above points clearly illustrate that the community should be concerned with this issue and need to work toward preventing youth problem gambling.

#### **What is the purpose of this survey?**

Previous research in Canada has shown that 7% to 28% of teens in Canada have serious gambling-related problems. Since we already know that youth gambling is a problem, we want to move beyond this and find out how to prevent youth gambling, help youth at risk and assist youth problem gamblers so they can reduce or quit their gambling. Our survey specifically looks at types of teen gambling behaviours and how teens go from experimental gambling to problematic gambling. The results from this survey will be used to help us develop prevention, treatment and harm reduction interventions that will meet the needs and preferences of youth in the Niagara region.

#### **What is the definition of gambling?**

Gambling is "the act of risking money or something else of value on an activity with an uncertain outcome." Playing cards or video games for money, buying raffle tickets, betting on who is going to win the next game of pool or wagering your favourite CD on the outcome of a sports event—it's all gambling.

#### **What is the legal age to gamble?**

- In Ontario, persons under the age of 19 are not permitted to enter a casino.
- Persons under the age of 19 are not permitted to purchase or redeem tickets at a racetrack.
- Persons under the age of 18 are not permitted to purchase or sell break-open, scratch, lottery or Pro-Line tickets.
- Persons under the age of 18 are not permitted to enter a bingo hall.
- The above age restrictions vary from province to province.

#### **Why do youth gamble?**

- Most youth report that they gamble because it's exciting and enjoyable.
- Money is not the predominant reason why youth gamble – money is used as a vehicle that enables them to continue playing.
- Youth gamble for many reasons:
  - to cope with daily stresses and feelings of depression
  - to win money
  - for instant gratification
  - to escape
  - to feel less lonely
  - to feel powerful
  - to feel like they can take control of a social situation
  - to feel less shy
  - to make friends

### **What age do youth start gambling at?**

Problem gamblers report starting gambling at a serious level at approximately age 10.

### **What types of gambling do youth engage in?**

- Male teens prefer games of skill (e.g., betting on card games, pool, sports teams) while female teens prefer games of chance (e.g., bingo, scratch tickets).
- Canadian youth gamblers are most interested in bingo, lottery tickets, instant gratification games (e.g., scratch tickets, pull-tab cards), dice, board games and betting money on games of skill such as pool, cards, golf and sports teams (sports betting).

### **Why is youth gambling increasing?**

- While parents, educators and the media emphasize the dangers of smoking, alcohol use and drug use, children and teens are not educated about the potentially addictive qualities of gambling.
- Society views gambling as a fairly harmless behaviour with few negative consequences — this is supported by findings that children and teens often gamble for money with their parents and other well-intentioned family members.
- Laws regarding the sale of lottery and scratch tickets to youth are often not enforced.
- Access to illegal and legal gambling activities has increased (e.g., more casinos).

### **How do you know if you have a gambling problem?**

- Do you think about gambling at odd times of the day?
- Do you keep spending more and more money on gambling?
- Do you become restless, fed up or bad tempered when you try to reduce your gambling?
- Do you gamble to escape from problems?
- Do you gamble to win back your losses?
- Do you lie to people to hide how much you gamble?
- Do you steal money to gamble?
- Are relationships with friends or family strained because of your gambling?
- Have you have missed school or work a lot to gamble?

If you say, "yes" to 4 or more of these items you may have a gambling problem.

### **How do you know if a teenager has a gambling problem?**

- They repeatedly lie to family and friends.
- They borrow money to support their gambling behaviour.
- They sacrifice school, parents and friends in order to continue their gambling.
- They engage in "chasing" behaviours (try to win back their losses).
- It is difficult to determine if a teen has a gambling problem because some of these behaviours (e.g., lying, skipping school, arguing with parents) are part of the teenage years.

### **What is low-risk or responsible gambling?**

- gambling legally (e.g., at or above the legal gambling age)
- gambling socially — not alone
- setting a limit to the amount of time and money that you spends gambling
- not borrowing money to gamble
- not letting gambling interfere with school, work or family
- not gambling to cope or escape from problems

### **If someone has a gambling problem where can he or she go for help?**

N.A.D.A.S. Gambling Treatment	905-684-1183
Problem Gambling Help Line (24-hour telephone counselling)	905-684-1859
Problem Gambling Help Line (toll free)	1-888-230-3505

Other youth help centres that address a wide range of youth issues:



Distress Centre Niagara	905-688-3711
Kids Help Phone	1-800-668-6868
Niagara Centre for Youth Care	1-800-263-4944
Niagara Alcohol and Drug Assessment Service (N.A.D.A.S.)	905-684-1183
Family and Children's Services	905-937-7731

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### School survey procedures and protocols

To indicate students' eligibility, the researchers (not the school) will track which students obtain parental consent by using class lists.

Each research assistant will assemble a package containing a class list, which indicates eligible students; general information; consent forms and questionnaires for each of the eligible students; alternative tasks for the remaining students, and instructions to the teacher.

Research assistants will be given a script to read to the classes, which will explain the nature of the study to the students.

The research assistants will also provide students with the following information prior to the commencement of the survey:

- Name of the study
- Who is conducting and supporting the study
- Purpose of the study (The purpose of this study is to better understand youth gambling behaviours.)
- The reason why these particular students were chosen to participate in the study (Students attending secondary schools throughout the <insert region> were voluntarily selected. Students were not chosen due to personal characteristics or behaviours.)
- Voluntary involvement (Students can drop out of the study at any time. They can skip any questions that they do not feel comfortable answering. To participate in this study, students must fill out the consent forms that are distributed and return them when asked to do so.)
- Confidentiality and anonymity (All information they provide is private. They will not be required to write their names on the questionnaire.)
- Questionnaire information (Students will be asked to answer questions about gambling, substance use, school achievement, extra-curricular activities and risk-taking behaviours. They will be given 20 minutes to complete the questionnaire.)
- Instructions on how to properly fill out the questionnaire (E.g., Please use a pencil, no pens; bubbles must be completely filled in; if answers are changed, completely erase old answers)
- Instructions on completion of questionnaire (E.g., Fold survey in half and put it in the large envelope marked "surveys" at the front of the class.)
- Debriefing form (The students will be thanked for their participation. The teacher and/or research assistant will read the debriefing form and answer any questions.)
- Students will be informed of community resources and reminded of school counsellors and nurses if they need to discuss any issues.

---

### School newsletter and announcement

(For newsletter)

Attention Parents/Guardians:

<insert name of university> and <insert name of alcohol and drug assessment service> are trying to find out more about youth who gamble in the <insert region>. With parental permission, high school students in the <insert region> will have the opportunity to complete a survey on youth gambling.

Please expect to receive a letter in the mail in <insert month and year>. The letter will explain this project in more detail. There will also be a permission form that parents/guardians need to sign. We request that you return the permission form in the pre-addressed, pre-stamped envelope which is enclosed. Please indicate if you want your child(ren) to participate in this survey. If you have any questions about this project please contact <insert name of contact person>.

(

For school announcement)

All students at <insert name of high school> have been invited to take part in a <insert name of university research project> on teen gambling. Information and a permission form have been mailed to your home. Please remind your parents/guardians to sign the permission form and mail it back to <insert name of university>. <insert name of university> thanks you for your participation in this important research.

---

#### Letter to parent/guardian

Dear Parent/Guardian:

All students at <insert name of high school> are invited to take part in a very brief study about youth gambling. The goals of the study are to (1) find out more about teenagers' gambling behaviours, and (2) find out why some adolescents progress from experimental gambling to problem gambling. The study will consist of an anonymous and short paper-and-pencil survey.

If you wish to view the survey, click  
<insert Web address> or contact us to  
have a survey mailed to you.

The survey will ask your children about their gambling behaviours, school work, after-school activities, substance use and risk-taking behaviours. There are no questions about religion, sexuality or violence. The survey will be carried out during school time, in the classroom, and will take about 20 minutes to complete. The survey is totally anonymous; there are no identifying marks or codes, and there is no place for children

to put their names.

When the results of the study are reported, all answers will be grouped together, so no one can trace a specific answer back to one student. Your child's involvement in this study is completely voluntary, meaning that she or he can skip questions or stop doing the survey at any time. If your child doesn't complete the survey, this will not affect your child's school grades in any way.

Next <insert time of year> the results of this study will be presented to teachers and students, posted at the main office of the school and on our Web site. Results will also be presented in professional and scholarly forums. If you so request, a summary of the study results can be mailed directly to you.

To indicate whether your child can or cannot take part in the study, please complete the enclosed permission slip and return it to us in the pre-addressed, pre-stamped envelope. Or if you would like to talk to someone about the study, please contact <insert contact name> or the <insert name of university office of research services>. This study has been approved by the <insert name of regional board of education>, the school's principal and <insert name of university ethics review committee>.

Thank you for considering our study.

---

#### Parent/guardian consent form

**Please indicate whether your child(ren) CAN or CANNOT participate in the survey, then sign and return this form in the pre-addressed, pre-stamped envelope.**

(Please print.)

Child's name \_\_\_\_\_ Child's birthdate \_\_\_\_\_  
month / day / year

Child's name \_\_\_\_\_ Child's birthdate \_\_\_\_\_  
month / day / year

I understand the nature of the study, and  
I DO give permission for my child(ren)  
to take part in the study.

\_\_\_\_\_  
Parent/Guardian signature

Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand the nature of the study, and  
I DO NOT give permission for my child(ren)  
to take part in the study.

\_\_\_\_\_  
Parent/Guardian signature

Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I give permission for my child(ren) attending <insert name of high school> to participate in this study, I understand that I will be allowing my child(ren) to partake in a study which asks questions about gambling, behaviours related to gambling, school work and after-school activities. Results of this study will help health professionals and educators develop better prevention and treatment interventions for <insert name of region> youth. My child(ren)'s participation in this study will be completely voluntary. Therefore, my child(ren) can skip any questions on the survey or withdraw from the study at any time for any reason. All information provided by my child(ren) is anonymous and will be kept confidential. Results of this study will never identify my child(ren).

If you wish to see a copy of the survey go to <insert Web address>. If you have questions about your child(ren)'s participation in the study, contact <insert contact name> or the office of research services at <insert name of university>. Results of this study will be published and presented through professional and scholarly forums. Results will also be posted on our Web site. However, if you would like to receive a written summary of the results, please check here \_\_\_\_\_. (The results will be available in the <insert time of year> ). This study has been approved by the <insert name of school board> and <insert name of university ethics review committee and file number>.

#### Student consent form

Your parents/guardians gave you permission to take part in a study about gambling. The goals of this study are to find out (1) more about teenage gambling, and (2) why some teenagers gamble a little and others gamble a lot.

You should know that the survey is totally anonymous. This means no one —not your parents, your teachers, not even your friends —will know what you wrote on the survey. And when the results of the study are reported, everyone's answers will be grouped together so no one can trace your answers back to you. You should also know that your involvement in this study is completely voluntary, which means you can skip questions or stop doing the survey at any time.

If you agree to be in this study, you will be given a paper-and-pencil survey. The survey will ask questions about your gambling behaviours, school work, after-school activities, substance use and risk-taking behaviours. It will take you about 20 minutes to complete.

**If you want to do the survey, read this, then sign your name.**

Any questions I had about the study have been answered, and I understand that

- I am agreeing to be in this study, which asks questions about gambling, school and other behaviours (like drinking and smoking).
- My answers on the survey are anonymous, so *no one*, except me, knows what I wrote.
- **My answers on the survey will be kept strictly confidential (this means private).**
- My participation in this study is completely voluntary. Therefore, I can skip any questions, or even stop doing the study at any time for any reason.
- My answers will be grouped with other students' answers, then used to develop prevention and treatment programs for teenagers in the *<insert name of region>*.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you have any questions or concerns about the study, you may contact <insert contact name> .

Thank you for your help!

This study has been approved by your school and by the <insert name of university ethics review committee and file number>.

Youth gambling survey

[Not available online.]

(A copy of the survey was enclosed in the package for principals to review.)

Alternative activity: Level I

Please read the following article and answer the questions below:

Most people think that only adults have gambling problems. This is not true. Youth in Canada and the United States have been surveyed, and these surveys show that between 4% to 8% of teenagers (mostly males) have serious gambling problems, and another 10% to 14% of teenagers are at risk of developing a serious gambling problem. These numbers are alarming.

Teenagers who have gambling problems usually start gambling at age 10 or 11. Teens participate in many types of gambling, such as playing cards or bingo for money, games of skill, scratch and pull-tab cards, sports betting and sometimes going to the casino. Lottery tickets are teenagers' favourite way to gamble. Did you know that it is illegal to purchase lottery tickets and scratch tickets if you are not 18?

Most parents and teens think that gambling is not dangerous. Again, not true Ñ gambling can be dangerous. Teens that have gambling problems constantly think about gambling, spend more money than they want to, gamble to escape their troubles, miss school, steal to pay back their debts, lose friends and argue with parents or family members because of their gambling.

Most teens do not have gambling problems, and most teens report that they gamble just for fun, but it is important to remember that there are also negative consequences to gambling. Gambling can become an addiction just like cigarettes, alcohol and drugs. While teens are usually warned by parents, teachers and the media that alcohol and drugs are addictive, they are not warned about the negative effects of gambling. As well, the media and the government make gambling appealing to teens by naming tickets after children's games (e.g., bingo, Monopoly, Battleship) and using slogans such as "Everyone's a Winner." It has been reported that the increase in teen gambling is due to the aggressive marketing of these lottery tickets and the increase in the availability of gambling opportunities in Canada and the United States.

We hope more information will be made available to teens, parents, schools and our communities to let everyone know that gambling can lead to problems similar to alcohol and drugs. If people are more educated about the consequences of gambling then maybe they will be more careful, and there will be fewer gambling problems.

- Questions
- What is the most surprising fact in this article?
  - Why is there an increase in youth gambling?

How do you feel about the government aggressively marketing lottery tickets to kids?

What do you think should be done to ensure that young people do not develop gambling problems?

Why do you think it's mostly males who become problem gamblers?

What problems do you think adolescent problem gamblers are likely to experience?

---


### Alternative activity: Level II

#### Teen gambling

- 4% to 8% of teens (more guys than girls) have serious gambling problems.
- Another 10% to 14% of teens are at risk of serious gambling problems.



Types of gambling that teens participate in:

-  card playing for money
- bingo for money
- games of skill (such as pool and darts) for money



- scratch and pull-tab cards
- sports betting
- casino gambling.

Did you know that it is illegal to buy lottery tickets and scratch tickets if you are not 18?

#### Teens that have gambling problems



- think about gambling all the time
- spend most of their money on gambling
- gamble to get away from their problems
- miss school to gamble
- steal to pay back money
- lose friends
- argue with parents and family because of their gambling.

Gambling can become an addiction just like cigarettes, alcohol and drugs.

If more teens know that gambling can lead to problems then maybe they will be more careful and there will be fewer gambling problems.

Please answer the following questions:

What type of gambling do you think kids your age do?

Write down three bad things that can happen if you gamble a lot.

What can we do so that teens don't have gambling problems?

In the space below, draw a poster that will show how to prevent teens from gambling.

---

#### Debriefing form for students

Thank you!

We appreciate your time and co-operation in completing our survey. The answers you have provided will be grouped with the answers from all other participants. Once compiled, this information will help us understand how and why teenagers gamble. In fact, health professionals, counsellors, teachers and others will use this information to develop better prevention and treatment interventions for young people in the <insert name of region>.

Sometimes, after you do a survey like this, you may want to talk to someone about your answers. If you want to talk about anything that we covered in this study, please see your guidance counsellor or school nurse. If you don't want to do that, you can call one of the following places instead.

Kids Help Phone	1-800-668-6868
N.A.D.A.S. Gambling Treatment	905-684-1183
Problem Gambling Help Line (toll free)	1-888-230-3505

The final results of this study will be posted in several areas at your school, or you can find them on our Web site at <insert Web address>. You can also get information about the results —or any other part of this study —by contacting the researchers at <insert phone number> .

**Did you know?**

- In Canada, 4% to 8% of teenagers have a serious gambling problem, and 10% to 14% of teenagers are at risk of developing a serious gambling problem.
- Many teenagers do not think that hockey pools, Pro-line/Sports Select, break-open tickets or lottery tickets are gambling activities — ***they are!***
- Youth gambling problems are increasing.



Appendix B

[Cover letter to principals](#)

[Evaluation form](#)

[Comprehensive report for principals](#)

Cover letter to principals

Dear <insert principal's name>:

The first phase of <insert name of university, e.g., Brock University's > youth gambling research is nearing completion, and we have prepared a special report for schools, complete with an executive summary for principals.

Although we are pleased with the project thus far, there were several limitations to a survey such as this. We had a total of 2,252 students, but in some of the categories, only a handful of students were represented. As well, in a survey of this nature, we have to consider the tendency for a small percentage of youth to over or under report about their behaviours. These actions do not diminish the significance of the report but are a cautionary note on interpreting the data. This survey is one step in an attempt to understand the complexities of adolescents and problem/addictive behaviours.

As discussed previously, our research team would like to provide you and your staff with an interesting and interactive presentation that will explain the key findings of our research and suggest recommendations for secondary schools based on these results. Links to youth gambling prevention materials, curriculum and treatment resources will also be provided during this presentation. We will be in touch shortly to set up a date.

In order for our research team to evaluate how the entire research process was for all participating schools, we are asking principals to complete the enclosed evaluation form. Please do not put your name on the form <sup>N</sup> all information is confidential. Please forward the form to <insert contact name and school board>. <insert contact name> will ensure that confidentiality is maintained by placing all evaluations together in an envelope and forwarding it to <insert name of university>.

Thanks very much for being a part of this important work. Let's hope that we can continue to work together in providing education, counselling and other forms of assistance to young people who face so many challenges as they grow up.

Sincerely,

Feedback to the youth gambling research team Evaluation form

Our research team is interested in knowing how the entire research process was for you and your school. Please complete the following form and forward it to <insert name of contact> at the <insert name of school board>. Your comments and feedback are greatly appreciated.

Was communication effective in planning the administration of the youth gambling survey?

Did the research team administer the survey with minimal disruption to your school?

Did staff and students' awareness of youth gambling increase as a result of participating in this research project?

Would you or your school participate in further activities with this project?

Was the research report understandable and informative?

Additional Comments:

Comprehensive Report for Principals

Report on Adolescents and Gambling:  
Attitudes and Behaviours of Youth in the Niagara Region  
(Sample report) March 2002  
The Youth Gambling Research Initiative  
Brock University  
St. Catharines, ON  
L2S 3A1  
Phone: (905) 688-5550 Ext. 4566  
[www.youthgambling-research-initiative.ca](http://www.youthgambling-research-initiative.ca)

Authors: Dr. Kelli-an Lawrance, PhD  
Dr. John Yardley, PhD  
Lisa Root, MSc  
Bob Canham, BEd  
Jennifer McPhee, MSc

**Acknowledgements:** The authors of this report gratefully acknowledge the Ontario Problem Gambling Research Centre (O.P.G.R.C.) for funding this important study. More than 2,000 students from nine secondary schools in the Niagara Region completed our survey, which addressed adolescents' attitudes and behaviours related to gambling. We extend our sincere thanks to these students as well as the principals, teachers, staff members and school board officials who so generously assisted us with this study. Thanks is also extended to the members of our aAdvisory Committee for their contributions to this project. Members include the following: Dr. Kelli-an Lawrance (chair), Dr. John Yardley, Lisa Root, Bob Canham, Jennifer McPhee, Angela Lippert, Heather Travis, and Kristie Willson. Finally, we would like to thank our excellent team of research assistants for their devotion to the project and their assistance in administering the surveys. Many thanks to: Aimee Beaubien, Nicole Barroni, Katie Burrows, Christena Butts, Michael Clark, Ben Custers, Bonnie Davis, Wayne Deruiter, Tara Doyle, Lyndsay Elliott, Jason Failes, Anita Federici, Chrissy Fera, Eva Gazzo, Anthony Goodman, Ruma Goswami, Rob Kappes, David Lawrence, Kellie Murphy, Fern Pham, Casey Phillips, Andrea Ross, Caroline Richardson, Caroline Sottile, Nancy Santamaria, Caroline Sottile, Tanya Scott, Marcelle Sloerjes, Karilyn Reid, Wendy Shanahan, Jamie Sheepwash, and Chris Van Nest.

Executive summary

Over the past year, the Youth Gambling Research Initiative has focused on (1) exploring youth gambling perceptions and behaviours, and (2) examining patterns of gambling behaviour in teens along a continuum from experimental to problem gambling. Our goal is to better understand how some youth progress from experimental gambling to problem gambling and why some don't. We believe that if we gain a better understanding of this process, we can use this information to guide the development of prevention/education and harm reduction interventions.

A questionnaire was completed by 2,252 secondary school students in the Niagara Region. This self-report survey included questions that asked teens how often they gambled, what types of gambling they did, what tempted them to gamble and how they perceived their own gambling behaviours. In a survey of this nature we have to consider the tendency for a small percentage of youth to over and under report about their behaviours; however, these actions do not diminish the significance of the information in this report. Preliminary findings are outlined in this descriptive report. The report is designed to function as an information guide for school boards, related agencies, students who participated in the survey and the parents of these students. Most importantly, the information contained in this report will be used to guide the development of interventions aimed at preventing or reducing youth gambling problems.

Survey responses

**Prevalence rate of teen gambling in the Niagara region:**

- 28% of high school students reported that they have never gambled
- 72% reported that they do gamble

**Frequency of gambling among teens in the past year:**

- 25.2% reported that they have not gambled at all in the past year
- 31.4% reported gambling a few times in the past year
- 22.5% reported gambling at least once a month
- 9.2% reported gambling at least once a week
- 1.7% reported gambling everyday

**Preferred gambling activities:**

- The majority of teens reported they played lottery tickets and instant-win tickets.
- Teens most frequently engage in gambling activities such as cards, darts or pool for money as well as sports pools and Pro-Line.

**Teens' self-perceptions of their gambling behaviours:**

- 26.3% of teens labelled themselves as a non-gamblers
- 46.9% of teens labelled themselves as non-gamblers who gamble sometimes
- 18.5% of teens labelled themselves as occasional gamblers; 6.6% as regular gamblers; 1.7% as problem gamblers

**Beliefs about the positive outcomes and negative consequences of gambling:**

- Gamblers were more likely to believe that gambling has positive outcomes.
- Occasional gamblers were more likely than non-gamblers to believe that gambling has positive outcomes.
- Non-gamblers saw more negative consequences associated with gambling than occasional gamblers and regular gamblers.

**Temptation to gamble:**

- Gamblers felt a greater temptation to gamble under both positive outcomes and negative circumstances compared to occasional and non-gamblers.

**Skill versus luck:**

- Gamblers more frequently believed that skill was needed to be a good gambler than non-gamblers and occasional gamblers did.
- All groups believed that a little bit of luck was needed to be a good gambler.

**Alcohol use, drug use and smoking among teens that gamble:**

- Gamblers reported more alcohol use, drug use and cigarette smoking in comparison to non-gamblers and occasional gamblers.

**Clinical measures of teen gambling.**

According to an adolescent screening tool used to assess teens' level of gambling severity:

- 6% of the students surveyed were identified as gambling at problematic levels
- 20% of these students were female and 80% were male
- Very few of these teens labelled themselves as problem gamblers

**Comparing teens who accurately labelled themselves as problem gamblers to teens who did not:**

- Teens who accurately labelled themselves as problem gamblers showed higher scores on the clinical screen and reported higher involvement in gambling activities. They also placed higher bets, gambled at a very young age, used more alcohol and drugs and didn't participate in any after-school activities.

**Do teens who gamble problematically want to quit or reduce their gambling?**

- 12% of teens who accurately identified themselves as problem gamblers indicated that they wanted to quit in the following six months.
- 15% of teens who did not accurately identify themselves as problem gamblers indicated that they wanted to quit.
- None of the teens who accurately labelled themselves as problem gamblers wanted to reduce their gambling in the following six months.
- 21% of teen problem gamblers who did not label themselves as problem gamblers reported wanting to reduce their gambling in the following six months.

**Based on the findings outlined in this report, it appears that:**

- A significant number of teens are involved in gambling.
- A significant number of teens are gambling illegally.
- Teens who view themselves as gamblers see more positive outcomes than negative consequences of gambling, are more tempted to gamble and use more alcohol and drugs.
- A clinical gambling screen indicated that 6% of these students gamble at problematic levels.
- Some of them recognized the severity of their gambling but many underestimated the severity.
- Several differences have been found between teens who recognize the severity of their gambling and those who do not.
- The majority of students who do, do not want to seek counselling for their problematic gambling.

**Summary**

This information should be invaluable to help youth, families, educators, health and social services personnel, and policy makers better understand the factors leading to youth gambling and the issues it encompasses. This information speaks to the need for prevention/education and harm reduction interventions, and for adolescents it can possibly serve as protection against potential gambling problems. We plan to use this information to develop such materials, which will be made available to others who will support this endeavour.

## Appendix C

Letter to parent/guardian

Executive summary of results for parents

### Letter to parent/guardian

Dear Parent/Guardian:

The <insert name of university> would like to thank you for allowing your child(ren) to participate in our youth gambling survey. Our research team has received a lot of positive feedback from the schools and students who participated in it. Teachers, students and parents have indicated that the survey and information provided served as a useful tool by creating awareness and educating students about youth gambling issues.

The results of this survey from <insert number of schools> schools indicated that the prevalence rate of youth gambling is the same as shown in studies across North America. Some students responded that they are non-gamblers who gamble occasionally. This may indicate that some confusion exists about what activities constitute gambling. Students whose answers indicate they are at risk (15%) or are experiencing problems around gambling (6%) are about the same as shown in other studies.

Those who gamble and those who don't have different perceptions of the dangers. Not surprisingly, non-gamblers see gambling more negatively, and gamblers focus on the positive outcomes. Both groups believe that some luck is involved in gambling.

Risky behaviours seem to go together; gamblers are more likely to use alcohol, smoke cigarettes or be involved in drug use. Of those who are experiencing problems around gambling, 80% are male and 20% female. Again, this is consistent with other studies.

One of the challenges in dealing with youth problem gambling is convincing adolescents to seek help. An interesting finding in our study showed that all teenagers who admitted to having a gambling problem were told by someone else they had a gambling problem. This suggests that good communication within the family unit is important, that counsellors have a role to play, and even the observations of peers can help an individual recognize a gambling problem.

As promised, our research team would like to share with you some of the key findings from our survey.

### Survey responses

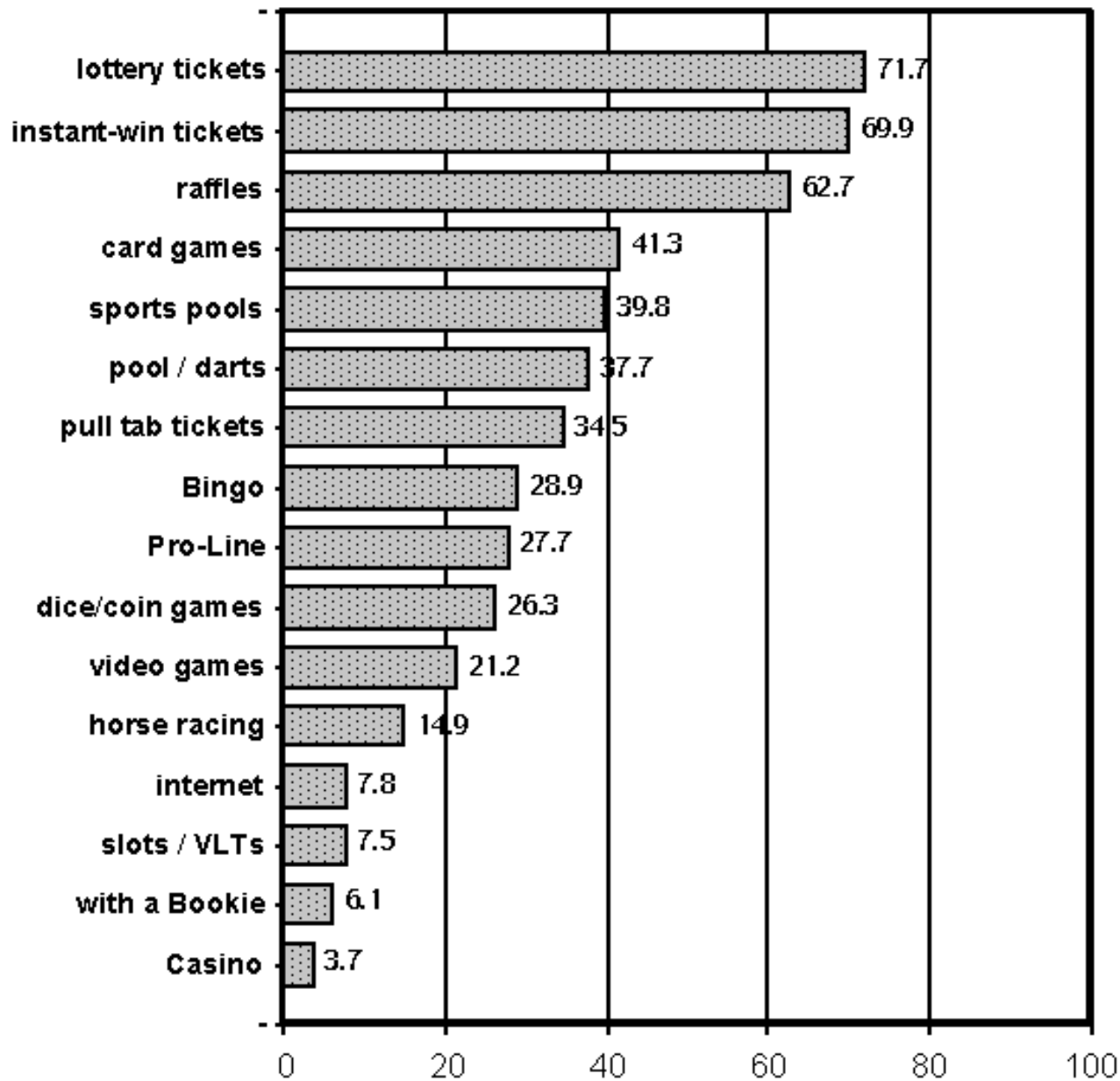
*Prevalence rate of teen gambling in the Niagara region:*

- 28% of high school students reported that they have never gambled
- 72% reported that they do gamble

*Frequency of gambling among teens in the past year:*

- 25.2% reported that they have not gambled at all in the past year
- 31.4% reported gambling a few times in the past year
- 22.5% reported gambling at least once a month
- 9.2% reported gambling at least once a week
- 1.7% reported gambling every day
- 9.7% did not answer this question

## Preferred gambling activities:



*Preferred gambling activities:*

- The majority of teens reported they played lottery tickets and instant-win tickets.
- Teens most frequently engage in gambling activities such as cards, darts or pool for money as well as sports pools and Pro-Line.

*Self-perception of gambling behaviours:*

- 26.3% of teens labelled themselves as a non-gamblers
- 46.9% of teens labelled themselves as non-gamblers who gamble sometimes
- 18.5% of teens labelled themselves as occasional gamblers; 6.6% as regular gamblers; 1.7% as problem gamblers

*Beliefs about the positive outcomes and negative consequences of gambling:*

- Gamblers were more likely to believe that gambling has positive outcomes.

Occasional gamblers were more likely than non-gamblers to believe that gambling has positive consequences.

- Non-gamblers saw more negative consequences associated with gambling than occasional gamblers and regular gamblers.

*Temptation to gamble:*

- Gamblers felt a greater temptation to gamble under both positive outcomes and negative circumstances compared to occasional and non-gamblers.

*Skill versus luck:*

- Gamblers more frequently believed that skill was needed to be a good gambler than non- gamblers and occasional gamblers did.
- All groups believed that a little bit of luck was needed to be a good gambler.

*Alcohol use, drug use and smoking among teens that gamble:*

- Gamblers reported more alcohol use, drug use and cigarette smoking in comparison to non-gamblers and occasional gamblers.

*Clinical measures of teen gambling, according to an adolescent screening tool used to assess level of gambling severity:*

- 6% of the students surveyed were identified as gambling at problematic levels
- 20% of these students were female and 80% were male
- Very few of these teens labelled themselves as problem gamblers.

# Summary

This information indicates that there is a need for effective prevention/education and harm reduction interventions that can possibly serve to protect youth against gambling problems. We plan to use this information to guide the development of such programs and to ensure that these programs meet the needs of youth in <insert name of region>.

The results of the <insert name of survey> suggest that education about responsible gambling is important, that family plays a role in developing appropriate attitudes, and that our youth need some protection. They also need the opportunity to develop their own defences against the possibility of developing gambling problems.

If you have any questions about the results of this study please contact <insert name of contact person>. A 20-page descriptive report of this research is available for your review at the office of your child(ren)'s school or you can download this report from our Web site at <insert Web address>.

Thank you again for your allowing your child(ren) to participate in this research project.

Sincerely,

---

## Executive summary

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## 1.0 Initial Findings

### 1.1 Who was surveyed?

A total of 2,252 students (1,067 or 47.8% were girls and 1,163 or 52.2% were boys) from nine high schools in the Niagara Region completed surveys for this study. The remaining 22 students did not indicate their gender. Students came from all grades, and their average age was 15.4 years.

Most of these students engaged in after-school activities, only 10% reported doing nothing after school. Sports, clubs or



work were the most common after-school activities. The majority of students indicated that their school grades were good, and three-quarters of all students said their overall average exceeded 70%.

## 1.2 What is gambling?

The cover page of the survey offered students this definition of gambling: "Gambling is betting money, or anything of value on activities such as Sports Select/Pro-Line, lottery tickets, scratch tickets, slot machines, poker machines, card games, dice games, sports pools, games of skill (like pool or darts), arcade and video games and Internet betting games."

## 1.3 Who has gambled?

Think of the grade you were in when you first gambled. How old were you?  
 \_\_\_\_\_ *years old*  
☐ I have never gambled.

Students were asked when, if ever, they had first gambled. In response to this question, about one-quarter (28%) said they had never gambled. Among the 72% who had gambled, most started gambling between the ages of 8 and 12, the average age was 10. Similarly, when asked how often they had gambled in the past year, about one-quarter (25.2%) said they had not gambled at all. Nearly one-third (31.4%) said they had gambled a few times in total. Almost one-quarter (22.5%)

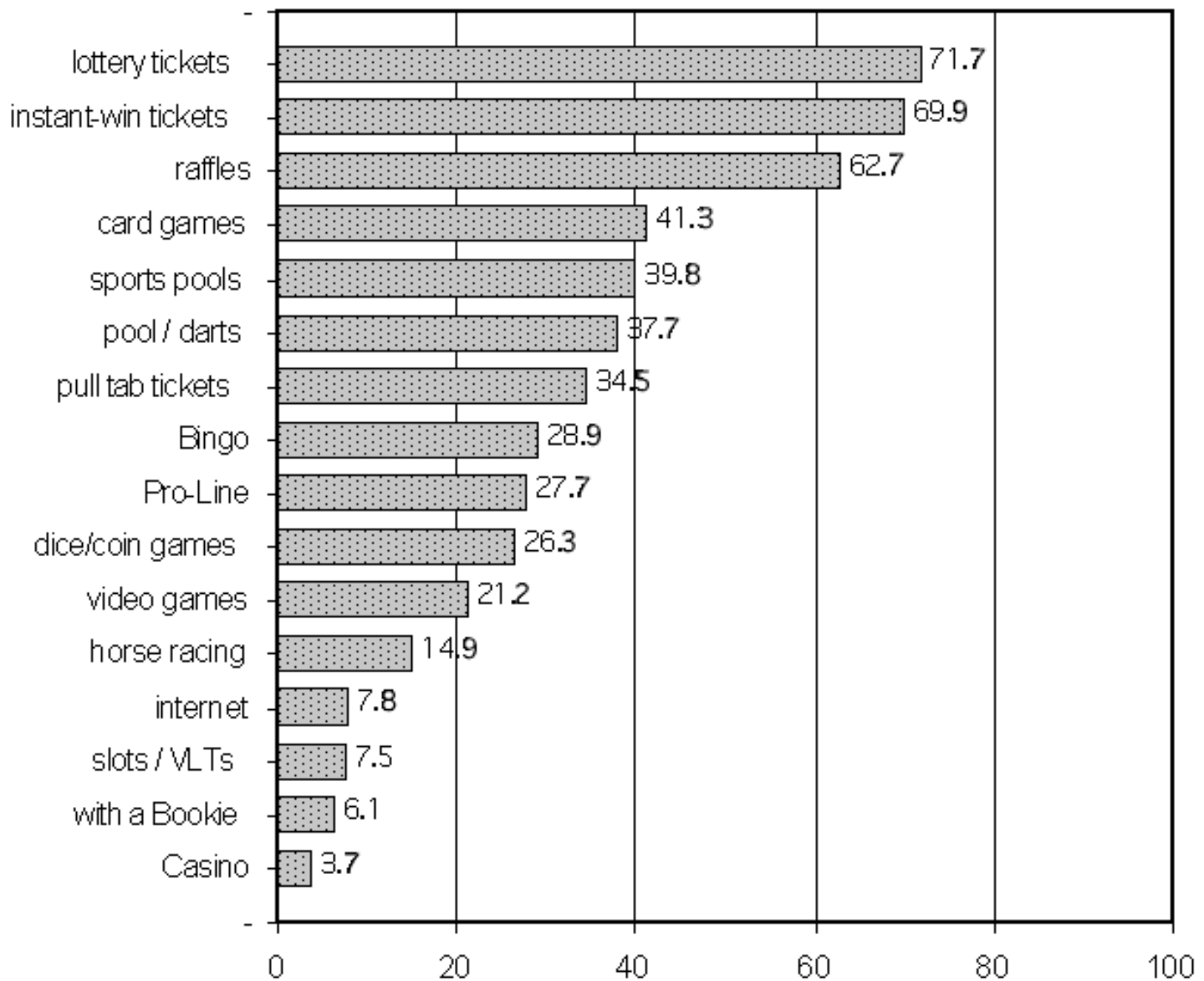
gambled at least once a month, 9.2% gambled at least once a week and 1.7% gambled every day.

## 1.4 How do teens gamble?

The students were given a list of 16 gambling or betting activities and asked to check all the activities they had done in the past year. Figure 1 (below) shows the different types of gambling activities that students engaged in.

## 1.5 Figure 1: Percent of students engaging in various gambling/betting activities

[\[KL1\]](#)



## 1.6 Self-perceptions of gambling

To determine how teens perceived their own gambling behaviours, we asked them to describe their gambling according to one of five categories, as shown in Table 1 (below).

1.7 Table 1: How teens see their own gambling status

Self-Perceived Gambling Status	Number	% of Sample
Non-gambler who never gambles	573	26.3
Non-gambler who gambles sometimes	1,023	46.9
Occasional gambler	403	18.5
Regular gambler	143	6.6
Problem gambler	37	1.7
Total	2,252	100

---

As Table 1 shows, about one-quarter of teens label themselves as non-gamblers who never gamble. This is consistent with earlier responses also showing that one-quarter of teens had not gambled in the past year, if ever. On the other hand, nearly half of all students describe themselves as "non-gamblers who gamble sometimes." These students may be purchasing lottery tickets, playing cards for money, participating in sports pools or engaging in other types of betting activities without realizing that they're gambling. Some of these teens will progress to more serious, potentially problematic levels of gambling.

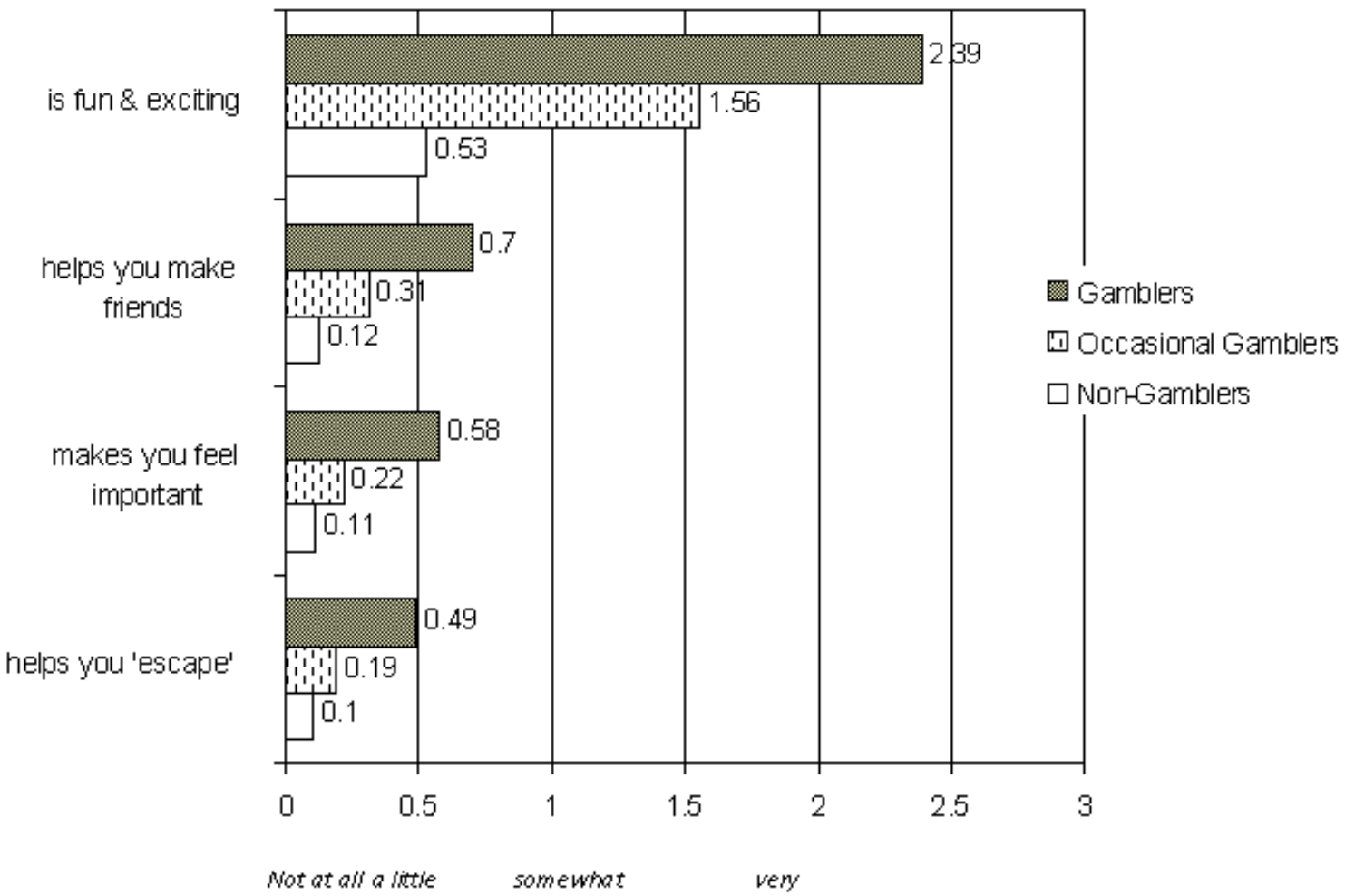
## 2.0 Comparing non-gamblers, occasional gamblers and gamblers

Students were grouped based on their gambling frequency and perceived gambling status. Non-gamblers were students who indicated they had not gambled in the past year, and who saw themselves as non-gamblers who never gamble. Occasional gamblers included students who gambled, but not regularly. Gamblers were students who reported gambling at least once a month, and who saw themselves as occasional, regular or problem gamblers.

The three groups of gamblers were compared in terms of their attitudes toward gambling, temptations to gamble and beliefs about the involvement of skill and luck in gambling. These comparisons are presented in Figures 2 and 3 (below).

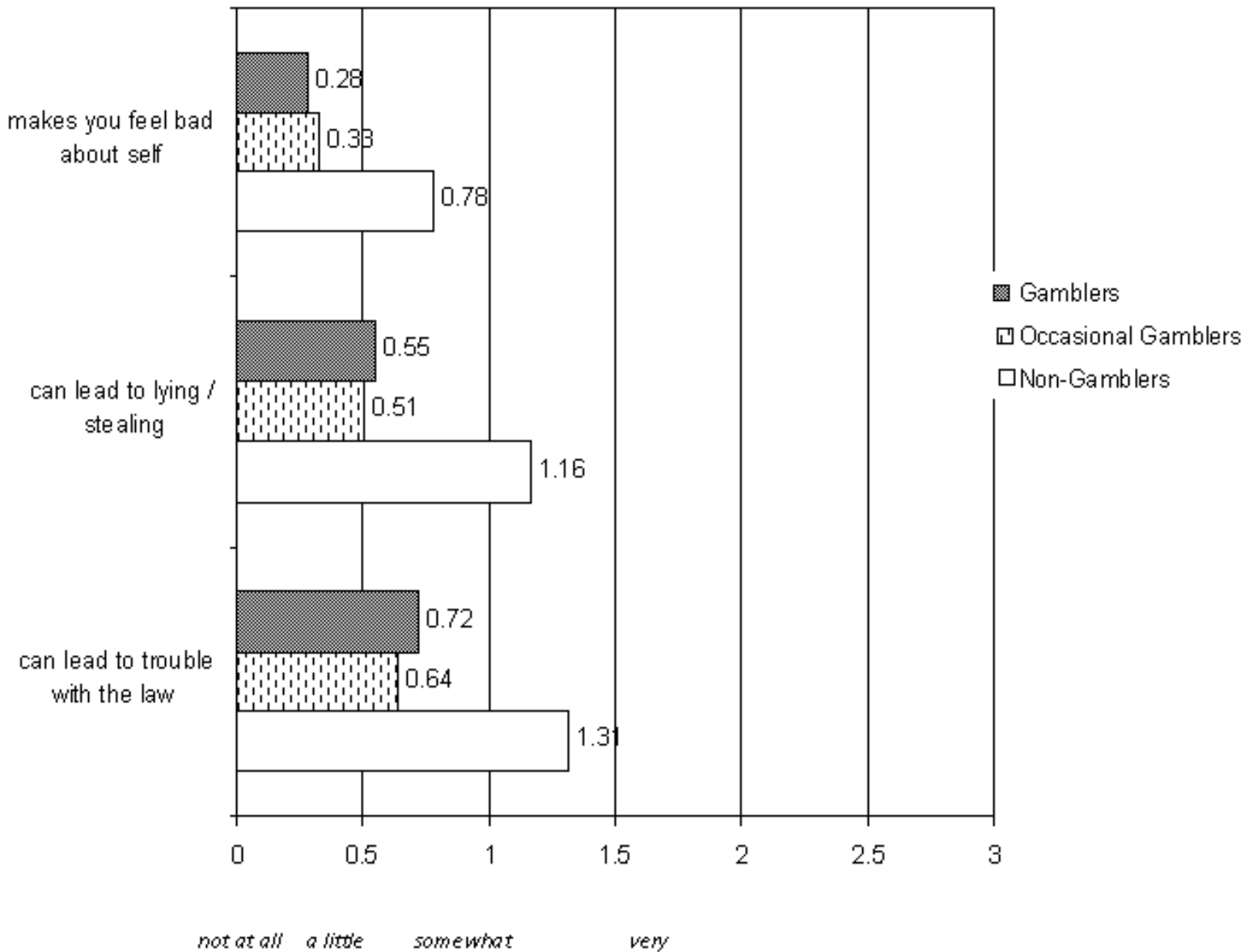
### 2.1 Figure 2: Teens' beliefs about the positive outcomes of gambling

## Degree to which teens believe gambling...



2.2 Figure 3: Teens' beliefs about the negative consequences of gambling

## Degree to which teens believe gambling...



Gamblers were more likely than occasional gamblers to believe that gambling has positive outcomes, and occasional gamblers were more likely than non-gamblers to believe that gambling has positive outcomes. Non-gamblers saw more negative consequences than either gamblers or occasional gamblers.

Compared to the other two groups, gamblers felt more tempted to gamble under both positive circumstances (e.g., when feeling good or socializing) and negative circumstances (e.g., when feeling stressed, after already losing money). On a four-point scale with 1 representing "not at all tempted" and 4 representing "very tempted," gamblers' scores for positive circumstances ranged from 2.4 to 2.8, while occasional and non-gamblers' scores ranged from 1.2 to 1.7. The single exception was that occasional gamblers scored 2.1 for wanting to gamble when feeling lucky. For negative circumstances, gamblers' scores ranged from 1.5 to 2.1, while the other two groups had scores of 1.2 to 1.7.

How much skill is needed to be a good gambler?

1 - 2 - 3 - 4 - 5 - 6 - 7

Students were asked to rate how much skill is needed to be a good gambler. Gamblers felt that some skill was needed; on average they chose a 4.0 score. Non-gamblers and occasional gamblers, on the other hand, believed less skill was needed; on average they chose 3.1 and 3.2, respectively. Surprisingly, all three groups agreed that a little bit of luck is needed to be a good gambler. On average, for this attribute, they all chose close to 4.6.

### 2.3 Risky behaviours among non-gamblers, occasional gamblers and gamblers

In adolescence, teens often engage in risk-taking behaviours. Furthermore, risky behaviours tend to encourage other high-risk behaviours. As shown in the following table, drinking, drug use and smoking are often associated with gambling.

2.4 Table 2: How often non-gamblers, occasional gamblers and gamblers engage in risky behaviours

Frequency of Behaviour	Never	Sometimes (1 to 8 times per month)	Often (3 to 7 times per week)
<b>Alcohol consumption</b>			
Non-gamblers	57.2	40.9	1.9
Occasional gamblers	37.8	56.2	6.0
Gamblers	20.3	64.4	19.4
<b>Drug use</b>			
Non-gamblers	80.7	15.3	4.0
Occasional gamblers	73.7	18.2	8.1
Gamblers	53.1	24.4	22.4
<b>Cigarette use</b>			
Non-gamblers	81.7	9.7	8.6
Occasional gamblers	75.9	12.4	11.8
Gamblers	67.7	12.1	20.2

### 3.0 Youth problem gambling

In addition to using self-reporting 'to identify students' level of gambling, this study also used a classification measuring system called the South Oaks Gambling Scale-Revised for Adolescents (SOGS-RA). This measure classifies adolescents into three categories: (1) gamblers with no problems; (2) gamblers at risk of having problems; and (3) problem gamblers.

The SOGS-RA is commonly used by clinicians to determine an adolescent's level of gambling severity. Teens who

answer yes to at least five of the 11 SOGS-RA statements are classified as gambling at a problematic level (meaning that their gambling has caused social, emotional or financial problems for them). Figure 4 (below) illustrates the percentage of teens who answered yes to each of the 11 SOGS-RA questions.

These findings illustrate that boys scored considerably higher than girls on every SOGS-RA question, and 6% of students are already gambling at problematic levels. Of these teens, who were identified as gambling at problematic levels, 20% were girls and 80% were boys.

### 3.1 Most teens classified by the SOGS-RA as gambling problematically underestimate the severity of their gambling

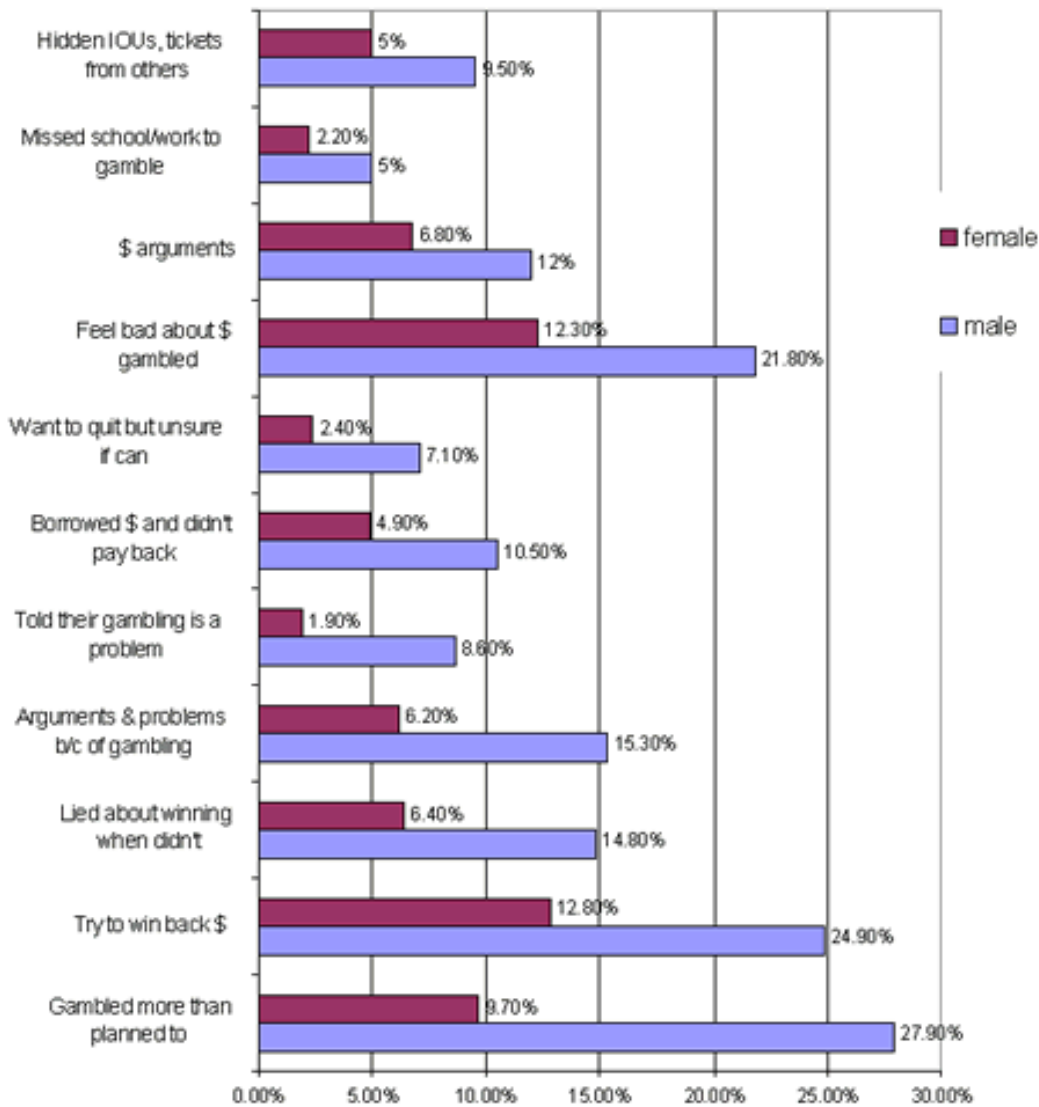
This study examined whether teens classified as problem gamblers by the SOGS-RA perceived themselves as problem gamblers. Among teens classified as problem gamblers, only 14% recognized that they were gambling at problematic levels, 5% saw themselves as non-gamblers who never gamble, 13% saw themselves as non-gamblers who gamble sometimes, 28% saw themselves as occasional gamblers and 33% saw themselves as gamblers. Thus, teens that are considered to be gambling at problematic levels are more likely to perceive themselves as gamblers rather than problem gamblers.

### 3.2 Differences between teens who recognize the severity of their gambling and those who do not

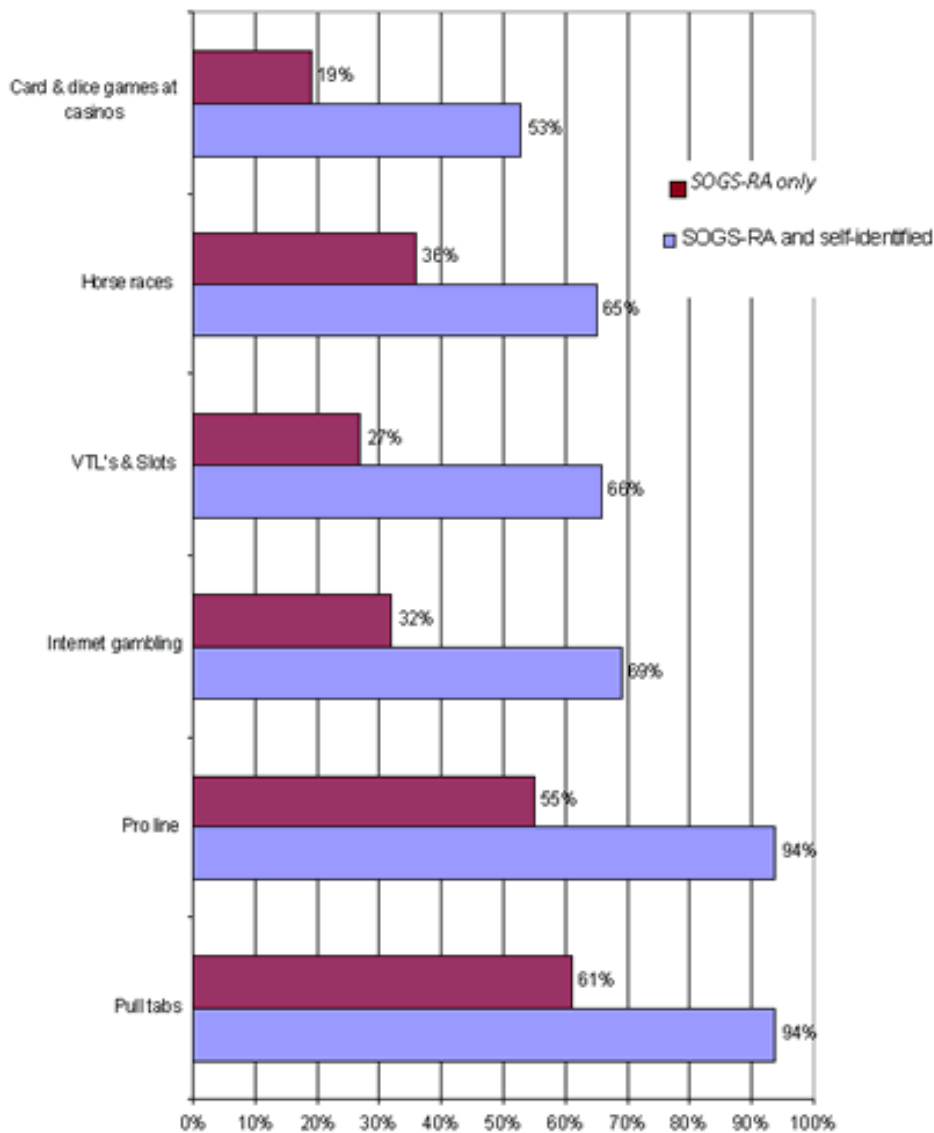
Characteristics of teens who did and did not accurately identify their problematic gambling were examined. Teens who accurately perceived their problematic gambling reported significantly higher rates of involvement in many gambling activities (see Figure 5). Many teens failed to recognize their problems. The average age for problematic gambling, which was identified by the SOGS-RA, was 15.

### 3.3 Figure 4: Percentage of affirmative responses to the SOGS-RA questions as a function of gender





3.4 Figure 5: Comparison of the kinds of gambling preferred by problematic gamblers identified only by the SOGS-RA vs. SOGS-RA and self-identified problematic gamblers



In addition, teens who accurately identified themselves reported more alcohol and drug use and less involvement in after-school activities (e.g., work, sports, clubs, etc.) in comparison to their counterparts. These teens also reported gambling at an earlier age and placing larger bets when gambling. Table 3 (below) outlines these differences in more detail.

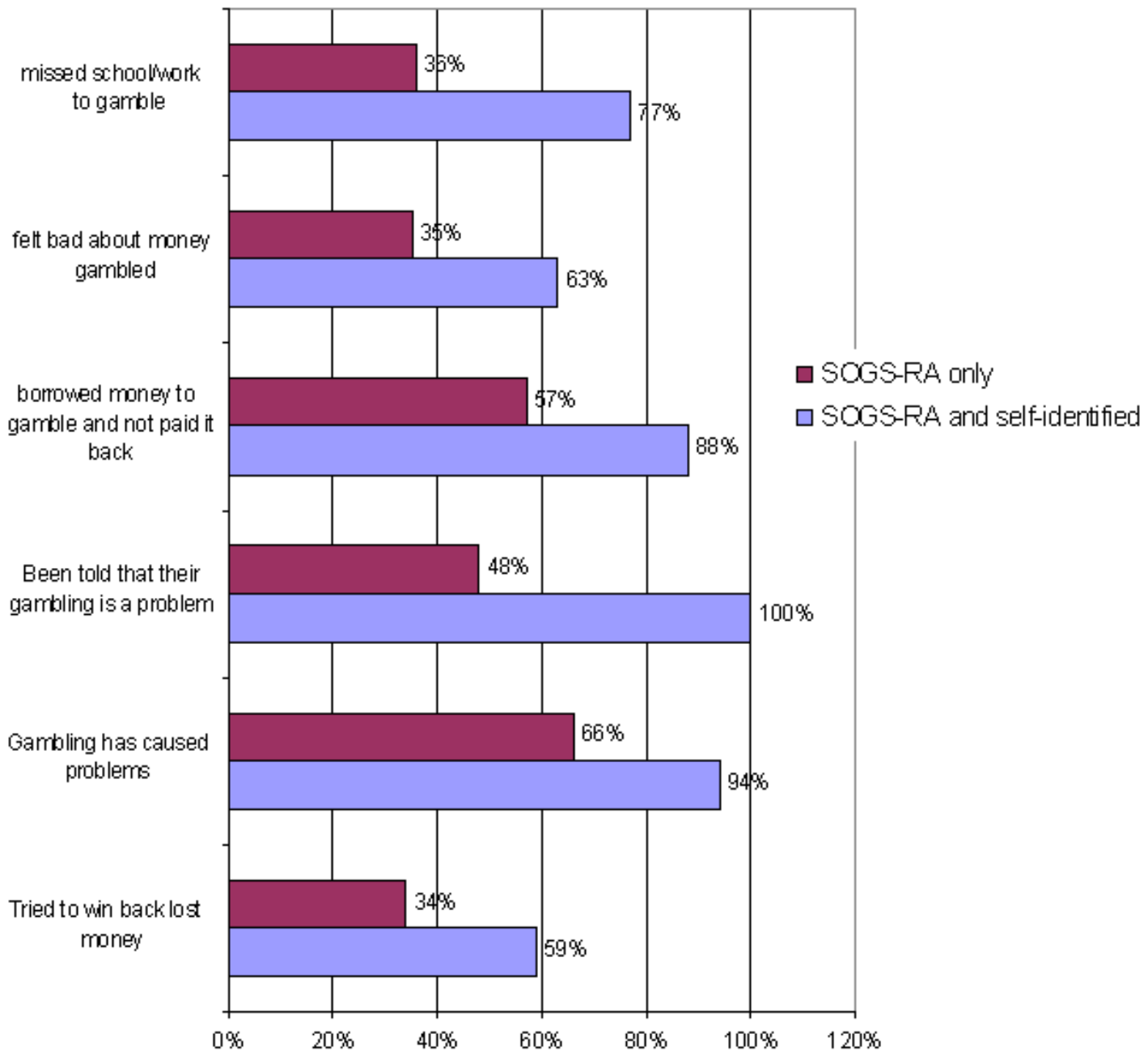
3.5 Table 3: Comparison of problematic gamblers identified by the SOGS-RA vs. SOGS-RA and self-identified problematic gamblers on various factors

	SOGS-RA and self-identified	SOGS-RA only
Alcohol use (3 to 7 times a week)	75%	35%

Drug use (3 to 7 times a week)	71%	35%
No involvement in after-school activities	41%	13%
Age began gambling	8 years old	10 years old
Average amount spent in past month	\$1,081	\$100

It was thought that the teens who accurately identified themselves might have higher scores on the SOGS-RA in comparison to the teens that did not accurately self-identify, assuming that the former group may have an increased awareness of their gambling severity. Indeed, those teens who accurately self-identified scored (on average) 8/11 on the SOGS-RA while those teens who did not scored (on average) 6/11. A score of five or more (answering yes to five or more questions) out of 11 indicates problematic gambling. Figure 6 illustrates these differences by identifying specific questions from the SOGS-RA which these two groups differed significantly.

3.6 Figure 6: Comparison of problematic gamblers identified by the SOGS-RA vs. the SOGS-RA and self-identified problematic gamblers on questions from the SOGS-RA



While all of these differences remain limited by the small number of teens who gamble at problem levels (120 students), the significant differences that have been reported by accurate self-identifiers (e.g., placing large bets, engaging in a multitude of gambling activities, gambling at an early age, feeling bad about their gambling) may be contributing factors in their greater level of awareness, compared to teens that did not accurately self-identify.

### 3.7 Do teens who gamble problematically want to quit or reduce their gambling?

While it may appear that the students who accurately self-identify have a greater awareness of their problem in comparison to those who did not accurately self-identify, no differences were found in their responses to the question "Do you plan to stop gambling in the next six months?" Twelve per cent of teens who accurately identified themselves as problem gamblers indicated that they wanted to quit in the next six months, while 15% of teens that did not accurately identify themselves as problem gamblers indicated that they wanted to quit. When asked "Do you want to reduce your gambling in the next six months?" none of the teens who accurately identified themselves wanted to reduce their gambling, while some (21%) teens who did not accurately self-identify indicated that they wanted to reduce their

gambling in the next six months.

#### 4.0 Conclusions

This study provides preliminary data on patterns of gambling behaviour in teens along a continuum from experimental to problem gambling. The current research examines the types of gambling activities teens participate in, the pros and cons teens associate with gambling, how tempted teens are to gamble, risky behaviours associated with gambling and how teens perceive their own gambling behaviours. In addition, individual differences were examined among teens who classified themselves as problem gamblers. It is our intent that findings from this study will be used to guide the development of youth gambling prevention, education and treatment interventions.

In terms of teens' gambling behaviours, this survey revealed that a large percentage of teens (72%) in the Niagara Region do gamble. The range of gambling activities was broad-based and showed high participation rates in lottery tickets, instant-win tickets, raffles and games of skill, such as card games, sports betting and betting money on games of pool or darts. Most research thus far has also found high rates of youth participation in these gambling activities (Gupta & Derevensky, 1998; Jacobs, 2000). In this study, the top four gambling activities that boys participated in were scratch tickets, betting on sports teams, raffles and playing games of skill for money. The top four gambling activities that girls participated in were scratch tickets, raffles, break-open tickets and bingo. Past research that has examined gambling preferences among youth has consistently found that boys prefer games of skill and girls prefer games of luck (Gupta & Derevensky, 1998; Jacobs, 2000).

A majority (72%) of the teens in this study indicated that they gambled in the past year; however, most of them labelled themselves as non-gamblers who gamble sometimes. Very few teens perceived themselves as occasional gamblers, regular gamblers or problem gamblers. This is not surprising given the fact that people often identify themselves with labels that differ from the way they behave (Tagliacozzo, 1979). For example, how many cigarettes would it take to call yourself a smoker? It is possible that teens may perceive themselves as non-gamblers who gamble sometimes because they participate in only a few gambling activities or because they do not consider what they do as gambling. In fact, results from this study show that teens who perceived themselves as non-gamblers who gamble sometimes participated in fewer gambling activities than teens who perceived themselves as occasional, regular or problem gamblers. Past research has suggested that activities such as instant-win tickets may not be viewed as gambling because they are easily accessible, often based on childhood games (such as Monopoly or Battleship), easy for underage youth to purchase illegally and often given to teens by well-intentioned family members (Korn & Shaffer, 1999). It is important to keep in mind that the activity of gambling in itself does not necessarily lead to a gambling problem. However, these findings further exemplify the need to develop prevention and education materials that will create more public awareness and allow youth and their families to make healthy decisions about their gambling behaviours.

Another dimension of this study examined teens' beliefs about the positive and negative consequences of gambling as well as their temptation to gamble. These factors were examined along a continuum of non-gambling, occasional gambling and gambling. Teens were grouped into these categories based on their reported gambling frequency and perceived gambling status. Findings showed that gamblers were more tempted to gamble and more likely to associate positive consequences with gambling in comparison to teens in the remaining categories.

Future research is needed to determine whether these beliefs lead teens to gamble more or if gambling frequently leads to adopting these beliefs. Some researchers have suggested that a teen's first big win can lead to several cognitive distortions regarding the odds of winning and the positive outcomes of gambling (Stinchfield & Winters, 1998). Moreover, it is reasonable to expect that some teens may attribute more positive consequences than negative consequences to gambling since the costs of gambling for teens are very different than those for adults. Unlike their adult counterparts, teens do not often have a job or spouse to lose nor do they incur such large debts. Together, these findings emphasize the value in educating teens about the odds of winning and the negative consequences associated with

problem gambling. Prevention programs that are aimed at teaching teens the definition of gambling, the odds of winning at gambling and the problems that arise from problematic gambling may help teens to make healthier, more informed choices, and in turn, reduce the harm associated with youth gambling.

The examination of risky behaviours and gambling was emphasized in this study. Overall, findings indicate that risky behaviours tend to cluster; teens who were categorized as gamblers (based on frequency of gambling and self-perceived gambling status) reported more alcohol use, drug use and cigarette use in comparison to their counterparts. When examining the percentage of teens who reported using alcohol and drugs three to seven times a week, differences between groups (non-gamblers, occasional gamblers and gamblers) were greatly magnified in comparison to group differences where substance use was less frequent. These results indicate that substance abuse and gambling problems are closely related.

Many other studies have also found that rates of alcohol, drug and cigarette use tend to be highest among teens with moderate and severe gambling problems compared to non-gamblers or at-risk gamblers (Griffiths & Sutherland, 1998; Ladouceur, Dube & Bujold, 1994; Vitaro, Ferland, Jacques & Ladouceur, 1998). Previous studies have shown that gambling and substance use are linked in a network of other youthful problem behaviours (e.g., delinquency) (Proimos, Durant, Pierce & Goodman, 1998). It is evident that further research is needed to better understand the relationship between gambling and substance use among adolescents. More research can help determine whether gambling increases substance use, substance use increases gambling or other factors influence both of these patterns. Although more comprehensive research is needed, these preliminary findings have potentially important implications for the design of interventions aimed at preventing or treating problem gambling in teens. For example, these results highlight the need to screen adolescents seeking treatment for alcohol and drug problems for gambling problems and to screen adolescents seeking gambling treatment for alcohol and drug problems.

This study also examines the prevalence of problem gambling in this sample of teens. Students completed a survey measure, called the SOGS-RA, which is used by clinicians to determine an adolescent's level of gambling severity. Using the SOGS-RA, six per cent of teens from this study were identified as gambling at problematic levels. Comparisons were made to determine if teens who were classified as problem gamblers according to the SOGS-RA also identified themselves as problem gamblers. Results showed that the majority of teens who were identified as gambling at problematic levels (by the SOGS-RA) perceived themselves as regular gamblers, and only 14% of them perceived themselves as problem gamblers. Individual differences between teens who did perceive themselves as problem gamblers and teens who did not perceive themselves as problem gamblers were examined. Many interesting results were found. For example, teens who did perceive themselves as problem gamblers reported higher rates of involvement in many gambling activities, gambled at an earlier age, placed larger bets, indicated higher rates of substance use and were less involved in school activities than their counterparts. Of interest, all 14% of teens who perceived themselves as problem gamblers reported that others told them they had a gambling problem. Given these findings, it is possible that the combination of the above factors (e.g., being told they have a problem, placing large bets, etc.) may be responsible for the increased awareness that these teens have about their gambling behaviours. Thus, developing interventions that allow teens the opportunity to examine these different factors (or life areas) may raise awareness and assist teens in evaluating their gambling behaviours.

Surprisingly, teens that did not self-identify accurately as problem gamblers expressed more of an interest in reducing or quitting their gambling in comparison to their counterparts. A larger sample of problem gamblers is needed to further explore these results. These findings may explain the low percentage of teens who seek treatment for their gambling problems. Perhaps those teens who recognize they are gambling problematically do not want to change. Further research is needed in this area. It is important to note that this study also asked teens "If you think you have a gambling problem why don't you seek help to reduce your gambling?" Few teens answered this question; therefore the results are not representative. Future studies that attempt to examine if problem gamblers want to quit or reduce their gambling and whether or not teens want to seek treatment is important as it will help guide the development of effective interventions.

The present study attempts to better understand adolescents' patterns of gambling behaviour from experimental to problem gambling. Findings from this research can be used as baseline data that can guide further research aimed at developing effective education/prevention and treatment interventions that meet the needs of youth. The authors acknowledge that more comprehensive research needs to be carried out to further explore adolescent gambling and effective strategies that can be used to develop youth gambling interventions. While data from this study is preliminary, further analyses will be conducted and published in the form of a monograph at a later date. It is predicted that the findings from this study in combination with findings from future studies will be helpful in guiding the development of interventions aimed at preventing or reducing youth gambling problems.

If you have any questions concerning the findings that are outlined in this report, or if you are interested in further results, please contact Ms. Jennifer McPhee, Project Manager of the Youth Gambling Research Initiative, by phone at (905) 688-5550, ext. 4566 or by e-mail at [jmcphee@arnie.pec.brocku.ca](mailto:jmcphee@arnie.pec.brocku.ca).

If you are interested in learning more about the issues around youth gambling, please refer to any of the following Web sites or the references cited at the end of this report.

Youth Gambling Web sites:

[www.gamblingresearch.org](http://www.gamblingresearch.org)

[www.camh.net/egambling](http://www.camh.net/egambling)

[www.responsiblegambling.org](http://www.responsiblegambling.org)

[www.education.mcgill.ca/gambling](http://www.education.mcgill.ca/gambling)

[www.aadac.com](http://www.aadac.com)

[www.ccsa.ca](http://www.ccsa.ca)

[www.thewager.org](http://www.thewager.org)

Free, confidential counselling services are available for persons with gambling problems at the N.A.D.A.S. Problem Gambling Program located in St. Catharines, Ontario. Please call (905) 684-1183 to arrange for an appointment. Free telephone counselling is also available at the Problem Gambling Hotline (24-hour service) at (905) 684-1859.

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## intro

### Issue 8, May 2003 Guest editorial



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The same criticisms made 20 years ago about the literature on alcoholism are now being made about the problem gambling literature. Gender comparisons are rare, and most of the existing research is based on studies of men. As Mark and Lesieur (1992) pointed out 10 years ago, too few women are included in many samples to determine whether there are differences between men and women. In many cases as well, researchers assume that what holds true for males will also hold true for females. Given recent changes in women's gambling and rapid growth in the number of women seeking help, an entire issue (*EJGI*, Issue 8) devoted to the topic of women and gambling is timely and, we hope, will help create a "critical mass" of knowledge in this area.

As [Bunkle](#) points out in this issue, if women are going to drink, smoke and



gamble as much and as often as men, we should expect to see the same "negative externalities" associated with these behaviors —alcohol abuse and dependence, tobacco-related morbidity and mortality, and gambling disorders —achieve parity between the genders. The research presented in this issue strongly suggests that, in fact, gender may be only one of several important dimensions that must be considered when seeking to understand differences and changes in gambling involvement over time. [Borsoi and Toneatto](#) suggest that gender may have less to do with gambling problems than deficits in self-confidence and problem-solving skills. While [Thomas and Moore](#) identify significant differences between male and female gamblers, their data point to an excessive reliance on particular coping styles by both male and female problem gamblers.

Much of the work presented here has implications for the treatment of women with gambling problems. [Boughton, Martin](#) and the [anonymous author](#) of the first person account clearly show that women in problem gambling treatment bring with them gender-specific issues that must be addressed, including experiences of abuse and caregiving demands. Women entering treatment are also more likely than male problem gamblers to have emotional issues with autonomy and rebellion that will color the therapeutic relationship. However, it also seems clear that fostering self-confidence, teaching problem-solving skills and enhancing positive coping strategies are important elements of a problem gambling treatment program, regardless of the gender of the problem gambler seeking help.

It may be, as [Griffiths](#) speculates, that different factors lead men and women to gamble. Based on research presented in this issue, it appears that similar factors lead men and women to continue to gamble despite adverse consequences. Recent research clearly shows, however, that women seeking help for gambling problems start gambling later in life and that the progression of the disorder appears to be more rapid among women than among men (Ladd & Petry, 2002; Potenza, et al., 2001; Tavares, Zilberman, Beites & Gentil, 2001).

What stands out as this issue goes to bed is that women remain less involved in gambling than men. Women are still far less likely than men to begin gambling at a young age. And yet, the number of women accessing gambling helplines has grown substantially as has the number of women seeking help for a gambling problem of their own.

What are the factors that keep women away from gambling up to a certain point but then facilitate quicker, deeper involvement? How have the types of gambling as well as social attitudes toward gambling changed to normalize such behavior? What has happened to the stigma that was once attached to

women gambling? Are deficits in problem-solving skills and coping strategies a symptom or a precursor to gambling problems? What are the factors that explain why women (and men) begin gambling, and how are these different from factors that explain why women and men continue to gamble in spite of adverse consequences?

These are questions that we do not have answers to yet. As with so many of our questions, they require more and better research to answer. But at least we have identified some of the key questions—and that is an important step forward.

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# Statement of purpose

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

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## feature

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### Has there been a "feminization" of gambling and problem gambling in the United States?



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#### Abstract

This paper examines the question of whether there has been a "feminization" of gambling and problem gambling in the United States. Feminization refers to the idea that more women are gambling, developing problems and seeking help for problems related to gambling than in the past. Data from a theoretically derived sample of four states are examined to identify patterns in the distribution of gambling participation and the prevalence of problem

gambling in the general population. Despite widespread acceptance of the notion of the feminization of gambling and problem gambling, men remain significantly more likely than women to participate regularly in most types of gambling. Most gambling activities remain highly gendered; however, in the United States, the widespread introduction of gaming machines is associated with increases in gambling and problem gambling among women. The present analysis highlights the importance of taking socio-demographic characteristics besides gender into account when considering the distribution of gambling and problem gambling in the general population.

## Introduction

The final quarter of the 20th century saw a rapid expansion in the availability of legal, commercial gambling throughout the world, and particularly, in the affluent Western societies of Australia, Europe and North America. In the United States, the availability of legal gambling grew tenfold between 1975 and 1999. In the same period, annual revenues from legal gambling in the United States grew eighteen-fold from \$3 billion to \$58 billion (National Gambling Impact Study Commission, 1999). Casinos and lotteries joined more mature forms of gambling, such as horserace wagering and bingo, which have been joined in their turn by even newer forms of gambling, including widely distributed non-casino gaming machines and Internet gambling (Gerstein et al., 1999).

The recent rapid growth in the availability of legal gambling has raised concerns about the potential impact of such legalization on the overall rate of gambling problems in the general population and, more significantly, on specific at-risk groups in the population, including youth (Gupta & Derevensky, 2000), older adults (Korn & Shaffer, 1999; Petry, 2002), minorities (Wardman, el-Guebaly & Hodgins, 2001) and women (Ladd & Petry, 2002; Lesieur & Blume, 1991).

Gambling participation and gambling problems are not distributed evenly throughout the general population (Abbott & Volberg, 2000; Gerstein et al., 1999; Volberg & Abbott, 1997; Volberg, Abbott, Rönnerberg & Munck, 2001). With regard to gender and gambling, a particular concern has been with what Australia's Productivity Commission (1999) called the "feminization" of problem gambling. "Feminization" refers to the notion that more women are gambling, developing gambling problems and seeking help for such problems than in the past. Like their counterparts in Australia, problem gambling service providers in Canada and the United States have also observed that growing numbers of women are seeking help for gambling problems (Potenza et al., 2001; Toneatto & Skinner, 2000).

The feminization of gambling and problem gambling appears to be linked particularly to increased availability of gaming machines. Several researchers have noted the distinct preference that women problem gamblers have for gaming machines (Hing & Breen, 2001b; Lesieur & Blume, 1991; Tavares, Zilberman, Beites & Gentil, 2001). While epidemiological studies have found that, commonly, about one-third of problem gamblers in the general population are female (Shaffer, Hall & Vander Bilt, 1999), prevalence rates for men and women are nearly identical in jurisdictions where gaming machines operate in venues frequented by women, such as restaurants, convenience stores, social clubs and hotels (Polzin et al., 1998; Productivity Commission, 1999; Volberg & Moore, 1999a). In Australia, the Productivity Commission (1999) noted that the proportion of women problem gamblers in the general population grew from 14% to 41% between 1991 and 1999, a period during which the number of gaming machines per capita increased rapidly in that country.

This paper examines the question of whether there has been a feminization of gambling and problem gambling in the United States. The importance of this question lies in the growing availability of non-casino gaming machines in many American communities as well as the increasing dominance of gaming machines within the American casino environment (Connor, Kelly & Parets, 1996; National Gambling Impact Study Commission, 1999). The paper begins by reviewing the literature on gender, gambling and problem gambling. Data from a theoretically derived sample of states that vary along the dimensions of gaming machine availability and problem gambling prevalence are then examined. Finally, the results of this analysis are considered in relation to the question of whether there has been a feminization of gambling and problem gambling in America.

## **Literature review**

### **Gender and gambling**

Historically, many forms of gambling have been class based. Reith (1999) and Rosecrance (1988) have both observed that gambling among the upper classes, whether on horses, cards, casino games, real estate or stocks, has long been condoned in Western societies. While broadly tolerated, similar activities among the working and lower classes have been widely condemned, and until the middle of the 20th century, gambling among the middle classes was thoroughly discouraged.

Historically, many forms of gambling have also been highly gendered. In general, men are more likely than women to gamble on the stock market, on sports, at the racetrack and at off-track betting facilities; men are much more

likely than women to engage in certain other types of gambling, including cockfights and dogfights (Evans, Gauthier & Forsyth, 1998; Geertz, 1973). Hing and Breen (2001a) recently noted that the broad range of gambling activities deemed suitable for men coexists with widely accepted views of men as risk-takers, innovators and speculators. In contrast, women in Western cultures are generally viewed as caretakers and nurturers, social roles that are not easily reconciled with many types of gambling. In a separate article, these same researchers suggested that gambling preferences are culturally based and influenced by the availability and social acceptance of different types of gambling for both males and females (Hing & Breen, 2001b).

One possible key to understanding changes in gambling participation by women is the attractiveness, including the perceived safety, of gambling venues. For example, a study of bingo players in England in the 1980s identified several factors that influenced working-class women to participate, including flexible hours, local availability, the low price of playing and the safety of the venues (Dixey, 1996). Similarly, researchers today argue that the growing proportion of women at modern gambling venues stems from the provision of clean, attractive locations where patrons are treated with respect and experience a feeling of physical safety (Hing & Breen, 2001b; Trevorrow & Moore, 1999). The availability of childcare likely contributes to women's willingness and ability to gamble at many casinos in the United States (Connor, 1996) while the availability of lottery products and gaming machines in growing numbers of grocery stores, convenience stores and restaurants as well as the low price of participation makes it easier for women to engage in these activities as well.

## **Gender and problem gambling**

Much of what is known about problem gambling comes from studies of male pathological gamblers to the exclusion of women. Criticisms similar to those of the literature on alcoholism have been made of the literature on pathological gambling—too few females are included in samples to determine whether there are differences between males and females and researchers often make the assumption that what holds true for males will also hold true for females (Mark & Lesieur, 1992).

In the earliest studies of women problem gamblers, researchers found that women in Gamblers Anonymous were less likely to be married than their male counterparts. These women were more likely than male problem gamblers to have gambled alone and to have hidden the extent of their gambling from friends and family (Lesieur & Blume, 1991; Strachan & Custer, 1993).

More recent studies of problem gamblers who call helplines or enter treatment

have found that women with gambling problems started gambling later in life than the men. However, there are few differences in the age at which men and women seek help for gambling problems, suggesting that the progression of the disorder may be more rapid among women than men (Tavares et al., 2001). Across the board, women seeking help for gambling problems are much more likely to have experienced difficulties with gaming machines than with any other type of gambling (Ladd & Petry, 2002; Lesieur & Blume, 1991; Potenza et al., 2001; Productivity Commission, 1999; Strachan & Custer, 1993; Tavares et al., 2001).

In a study of gender of problem gamblers in the community, Hraba and Lee (1996) examined differences between male and female problem gamblers using a telephone survey of Iowa adults. They found that education level, religion, childhood exposure to gambling, number of marriages, frequent changes of residence and alcohol consumption were all significant predictors of problem gambling for women. The only significant predictor of problem gambling for men was their level of education.

A more recent survey examined participation in gambling, gaming machine play and problem gambling among both female and male members of social clubs in Sydney, Australia (Hing & Breen, 2001a, 2001b). The women were more likely than their male counterparts to engage in patterns of gaming machine play that maximized playing time. They experienced gambling problems at levels comparable to men who gambled at the same intensity.

## **A methodological note**

Observers have commented on the dearth of coherent theories and models in the field of gambling studies (Abbott & Volberg, 1999; National Research Council, 1999; Shaffer, Hall & Vander Bilt, 1997; Wildman, 1998). Given the lack of theoretical integration in the field, an exploratory approach seems likely to yield valuable insights for future investigation.

My approach in this paper rests, to a significant degree, on the "grounded theory" method developed by Glaser and Strauss (1967). Grounded theory refers to the systematic discovery of theory from data, rather than the other way around. Grounded theory stands in contrast to more conventional scientific approaches of theory testing and verification. As with other qualitative approaches, the evidentiary rules of grounded theory are rather different from those associated with quantitative data, such as accuracy and validity. As Glaser and Strauss caution, "when theory is the purpose...the representativeness of the sample is not an issue" (1967, p.189).

One important element of the grounded theory approach is theoretical



sampling (Glaser & Strauss, 1967). In contrast to random sampling, which is designed to equalize the chance of every permutation turning up, theoretical sampling aims to identify cases that are likely to upset our thinking. Theoretical sampling rests on the notion that general ideas are a reflection of the selection of a small number of cases from a larger universe of cases. The "trick" in theoretical sampling is to select cases that maximize the chances of something unusual turning up that will challenge our taken-for-granted views or open new directions in our thinking (Becker, 1998).

While the data considered in this paper were obtained using traditional population research methods, the selection of jurisdictions for inclusion in the analysis was driven by theoretical sampling concerns. The strength of this approach lies in the unexpected patterns and new insights that emerge when a sample is developed according to a theoretical framework rather than based on availability or convenience. The limits of this approach lie in its unconventionality—researchers trained in quantitative methods are unlikely to appreciate the results of such an exercise.

The feminization of gambling and problem gambling has been linked to the availability of gaming machines. As a consequence, the sampling framework was driven by the desire to select jurisdictions where the availability of gaming machines and the prevalence of problem gambling varied from low to high. In selecting "cases" for this exercise, I was further constrained by the need to select from studies where I had access to the original data. This is because I wanted to analyze them in ways that were not part of the original reports on these studies. The jurisdictions selected for this exercise include the following states: Washington (machines: low; prevalence: low), New York (machines: low; prevalence: high), Oregon (machines: high; prevalence: low) and Montana (machines: high; prevalence: high). (Note: In this paper, Washington and New York refer to the states, unless otherwise specified.)

### **Characteristics of the theoretical sample**

In this section, I review features of the four jurisdictions selected to represent extremes on the two dimensions of gaming machine availability and problem gambling prevalence. First, I consider the differences in population demographics in each of these jurisdictions and the availability of legal, commercial gambling, and then address features of the surveys conducted in each state.

### **Table 1: Characteristics of the jurisdictions and surveys**

	<b>Washington</b>	<b>New York</b>	<b>Oregon</b>	<b>Montana</b>
<b>Machines/1,000 adults</b>	>1	(not legal)	3	26
<b>Problem gambling prevalence</b>	2.3%	3.6%	2.3%	3.6%
<b>Geographic region</b>	West Pacific	Northeast Mid-Atlantic	West Pacific	West Mountain
<b>Population 18 years+*</b>	4,380,278	14,286,350	2,574,873	672,133
<b>Urban population**</b>	76.4%	84.3%	70.5%	52.5%
<b>White</b>	83.9%	64.4%	86.6%	92.3%
<b>Year completed Baseline</b>	1992	1986	1997	1992
<b>Replication</b>	1998	1996	2000	1998
<b>Sample size</b>				
<b>Baseline</b>	1,502	1,000	1,502	1,020
<b>Replication</b>	1,501	1,829	1,500	1,227
<b>Response rate</b>				
<b>Baseline</b>	60%	65%	51%	63%
<b>Replication</b>	59%	45%	48%	83%

\*Population figures from Census 2000.

\*\*Urban and rural population percentages for 1990 are available at [www.census.gov/population/censusdata/urpop0090.txt](http://www.census.gov/population/censusdata/urpop0090.txt)

The four jurisdictions in question are characterized by notable differences in their resident populations. New York, the only northeastern state, has the



largest and most urban population, while Montana has the smallest and most rural population. The four states also differ in terms of ethnic and racial diversity. The population of New York is the most diverse with 14% of the population described as "Black," another 14% described as "Hispanic," and 6% described as "Asian." In contrast, the population of Montana is the least diverse, with Native Americans (6% of the adult population) as the only significant minority group. Both Oregon and Washington represent middle points on this spectrum with significant minority populations of Hispanic people (6% in both states), Asian people (3% and 5%, respectively), African American people (1% and 3%, respectively) and Native Americans (just over 1% in both states) (U.S. Census Bureau, 2000).

### **Availability of gambling**

Washington was selected because of its low availability of gaming machines and low prevalence of problem gambling. Although legal, few electronic gaming machines are in operation. However, substantial opportunities exist to gamble legally in Washington. The Washington State Lottery offers a full range of games, including several large jackpot games, daily games and instant scratch tickets; charitable gambling is legal and on-track and off-track wagering is permitted on horse and dog races. In the wake of the Indian Gaming Regulatory Act of 1988, 17 Native American tribes in Washington State established compacts to operate casino gambling, and at least 28 tribal gaming facilities are currently operating. In response to the expansion of the tribal gaming industry, the Washington State Legislature permitted commercial cardrooms to expand their operations, and by 1998, many had grown large enough to be labeled "mini-casinos" (Volberg & Moore, 1999b).

New York was selected because of its low availability of gaming machines and high prevalence of problem gambling. In 1986, when the first survey of gambling and problem gambling was carried out in New York, legal gambling included charitable bingo, on- and off-track wagering on horseraces and a well-established state lottery. New York residents also had relatively easy access to casino gambling in New Jersey (Volberg & Steadman, 1988). By 1996, legal gambling in New York had grown to include simulcasts of horseraces as well as off-track betting (OTB) theaters where patrons could watch and wager on races while dining in a restaurant-like setting. New York residents also had easy access to casino gambling in the central region of the state as well as in Montreal, southeastern Connecticut and Atlantic City. Although the lottery had expanded to include instant scratch tickets, there were no legal gaming machines operating in New York in 1996 (Volberg, 1996).

Oregon was selected because it has high availability of gaming machines and a low problem gambling rate. Legal gambling opportunities in Oregon include

a state lottery that offers a full range of lottery products and the nation's only sports lottery. In 1992, the Oregon Lottery received approval to operate video poker at establishments where alcohol is served. There are now nearly 9,000 video poker machines operating in Oregon, or approximately 3 per 1,000 adults in the state. On- and off-track wagering on horseraces, commercial cardrooms and charitable gambling, including bingo, are all legal and operational in Oregon as well as eight tribal-run casinos, which are permitted to operate video lottery games, blackjack, keno, off-track wagering and card and dice games (Volberg, 2001a).

Finally, Montana was selected because it has high availability of gaming machines and a high prevalence rate of problem gambling. Gambling in Montana has evolved from a long tradition rooted in the freewheeling atmosphere of the mining and logging camps of the 19th century. In 1985, Montana became the first state to permit video gaming machines in bars. Establishments that are licensed to serve alcohol are also permitted to operate live bingo or keno games and non-banked card games. Montana gaming establishments differ from full-service casinos—they do not offer traditional slot machines or table games such as blackjack, roulette or craps (Polzin et al., 1998). Montana has one of the highest concentrations of gaming machines in the United States with 26 machines per 1,000 adults—a ratio as high as that of Australia, widely regarded as the most saturated gaming machine market in the world (Productivity Commission, 1999). In addition to video gaming machines, gambling in Montana includes a state-operated lottery and pari-mutuel wagering on horse and dog races.

### **Surveying the population**

The data were collected in surveys of gambling and problem gambling carried out in the general population. Two surveys were carried out in each state, although the interval between baseline and replication varies from 10 years in New York to three years in Oregon (Polzin et al., 1998; Volberg, 1992, 1993, 1996, 1997, 2001a; Volberg & Moore, 1999b; Volberg & Steadman, 1988). To provide a basis for comparison, it is important to examine how these data were collected in some detail. While the author directed all of the surveys, the responsibility for data collection was contracted to a different survey research organization in each state.

The questionnaires for all of these surveys included sections on gambling involvement, problem gambling and demographics. Different gambling activities were assessed in each state; however, in each case it was possible to isolate casino gambling, lottery play, private wagering, and wagering on gaming machines. Similar demographic questions were included in each survey. Finally, the revised South Oaks Gambling Screen (SOGS-R), used in

most of the problem gambling surveys conducted internationally, was included in all of the questionnaires, with the exception of the baseline survey in New York. The baseline survey in New York was further limited in terms of the data collected about respondent's gambling participation.

The original SOGS is composed of 20 weighted items that include questions about hiding evidence of gambling, spending more time or money gambling than intended, arguing with family members over gambling and borrowing money from a variety of sources to gamble or to pay gambling debts (Lesieur & Blume, 1987). The SOGS-R is composed of 20 lifetime and 20 past-year questions and is designed to provide both lifetime and current measures of problem and pathological gambling (Abbott & Volberg, 1996). Individuals who score 3 or 4 on the lifetime or current items are classified as "problem" gamblers, while those who score 5 or more are classified as "probable pathological" gamblers.

In all of the surveys, the respondents were contacted, recruited and interviewed by telephone. Respondents were randomly recruited within households that were selected from banks of randomly generated telephone numbers. One respondent per household was interviewed and a minimum of five and maximum of 10 callbacks were made to complete an interview with an eligible respondent. All of the achieved samples were representative in terms of gender, age and ethnicity, with one exception. The data from the New York replication survey were weighted to adjust for the low number of respondents recruited from the New York City region.

Table 1 presents information on the sample sizes and response rates for all of the surveys. It shows that, with the exception of New York, the sample sizes for the surveys changed very little between baseline and replication. The largest sample was achieved in the New York replication survey, while the smallest samples were achieved in the New York and Montana baseline surveys. Table 1 also shows that response rates for the surveys changed very little in Oregon and Washington, where the same organization collected data at baseline and replication. In New York, the response rate was substantially lower at replication than at baseline, while in Montana, the opposite was true. Given falling response rates for telephone surveys in general, the response rate from the Montana replication survey is somewhat surprising but may have been due to the much larger budget for the replication survey than for the baseline survey in that state.

Even the best telephone surveys are limited because some groups are excluded from the sampling frame. Excluded groups included people who reside in non-residential dwellings, such as hospitals, nursing homes and prisons, residents in households without telephones and some demographic

groups whose members are more likely to gamble regularly, such as older African-American men and unemployed people (Abbott & Volberg, 1999; Gerstein et al., 1999).

There is great uncertainty about the characteristics of individuals who choose not to participate in gambling surveys. It has generally been assumed that people who are not contacted or who decline to be interviewed in gambling surveys include disproportionate numbers of problem gamblers (Lesieur, 1994). Another possibility is that both problem gamblers and people who do not gamble may be underrepresented in surveys with low to medium response rates. If this is the case, the effects of their omission may partially or totally cancel each other out (Abbott, Volberg & Rönberg, 2001).

Comparison of the results of recent national surveys in Australia and New Zealand suggests that low response rates may be less of a concern in gambling surveys than previously hypothesized. Abbott (2001) compared the results of the most recent New Zealand survey with the results of a recent Australian national survey that also used the current SOGS (Productivity Commission, 1999). In contrast to the high response rate achieved in the New Zealand survey, the Australian study achieved a relatively low response rate, comparable to response rates attained in recent U.S. gambling surveys. The analysis showed that the New Zealand prevalence estimate was very similar to prevalence estimates obtained for the two Australian states that had per capita gambling expenditures and numbers of gaming machines closest to those in New Zealand and was markedly lower than estimates for the Australian states with higher per capita gambling expenditures and numbers of machines.

In the present context, however, the question of whether the original survey data is accurate is not a salient one. Indeed, though some basic statistical tests of significance have been included here, the strongest associations are actually less interesting than several of the weaker associations that appear more theoretically relevant (Glaser & Strauss, 1967).

## **Results**

### **Recent changes in gambling participation**

Two national studies of gambling carried out in the United States provide top-line information about changes in gambling participation. The first survey was completed in 1975; the second survey in 1998 (Kallick, Suits, Dielman & Hybels, 1976; Gerstein et al., 1999). Although the 1975 and 1998 surveys used somewhat different methodologies, they were sufficiently similar to enable some comparisons to be made.

In 1975, the first national survey of gambling in the United States showed that 68% of adults had ever gambled; the second national survey in 1998 found that 86% of adults had ever gambled. In contrast, rates of past-year gambling participation changed little between since 1975 and 1998. The proportion of respondents indicating that they had gambled in the past year barely changed, rising from 61% to 63%. The small increase in past-year gambling participation in 1998 is at least partly explained by the fact that Americans are now much more likely to participate in casino and lottery gambling and less likely to participate in older types of gambling, such as bingo and horserace wagering. In 1998, the percentage of people who reported playing the lottery in the past year was two times higher than in 1975, while the percentage increase in respondents who reported gambling in a casino in the past year was even greater. In contrast, past-year participation in bingo and horserace wagering both decreased by two-thirds between 1975 and 1998 (Gerstein et al., 1999).

All of the "cases" in our theoretical sample provide information about changes in gambling participation over time. In contrast to the other three states, the baseline survey in New York was carried out in 1986, before the recent expansion of casino gambling in the United States. As in the United States in general, lifetime participation in gambling rose significantly in New York between 1986 and 1996. The greatest increases were for lottery play and wagering at casinos; pari-mutuel wagering remained steady and wagering on bingo declined.

In the three states where both surveys were conducted in the 1990s — Washington, Oregon and Montana —substantial declines were identified in the proportion of the population that gambled weekly (Polzin et al., 1998; Volberg, 2001a; Volberg & Moore, 1999b). In these three states, there were statistically significant declines in weekly gambling on lotteries and stability in weekly bingo and private wagering. In Montana, where gaming machines have been legal for more than a decade, there was a significant decline in weekly gambling of this type. A significant decline in weekly gambling on machines was also detected in Oregon. In contrast, in Washington there were significant increases in weekly participation in several recently introduced types of gambling, such as cardrooms and casinos. In Oregon, a significant increase in gambling on the Internet was identified between 1997 and 2000.

An important question in the present context is whether more women are gambling in spite of recent overall declines in gambling participation. Two national surveys showed that the proportion of women who reported ever having gambled rose substantially from 61% in 1975 to 83% in 1998. While the proportion of men who had ever gambled also rose, the increase from



75% to 88% was much smaller. Changes in past-year gambling were much smaller, with the proportion of women who had gambled in the past year rising from 55% to 60% and the proportion of men remaining unchanged (Gerstein et al., 1999).

In contrast to the national data, evidence from the replication surveys in our theoretical sample suggests that, over the 1990s, women were less likely to gamble and particularly less likely to gamble on a regular basis. In Montana, Oregon and Washington, past-year gambling among women declined substantially, with the steepest declines reported among women from minority groups in all three states (Polzin et al., 1998; Volberg, 2001a; Volberg & Moore, 1999b). At the end of the 1990s, only Native American men in Montana showed an increased likelihood of having gambled in the past year. In the 1990s, weekly gambling also declined overall among women, with two exceptions: weekly gambling rose from 17% to 23% among women from minorities in Washington (between 1992 and 1998), and from 16% to 26% among women from minorities in Oregon (between 1997 and 2000).

### Differences in gambling participation

We now consider the differences in gambling participation across the four states at the most recent point in time. Table 2 presents information about the size of the groups of males and females who are white and those from other minority groups in each state. This allows readers to assess for themselves the magnitude of differences in gambling participation presented in the tables that follow.

**Table 2: Cell sizes across four jurisdictions**

	Washington	New York	Oregon	Montana
White				
Male	605	640	665	543
Female	673	695	692	563
Other				
Male	119	202	78	60
Female	83	249	65	60

Table 3 presents information from the replication surveys on the rates of lifetime, past-year and weekly gambling among white and non-white men and women in the four states. New York stands out with the highest rates of gambling participation and Oregon clearly has the lowest rates of gambling participation.

**Table 3: Gambling participation by gender and ethnicity in four jurisdictions**

	Washington	New York	Oregon	Montana
	%	%	%	%
<b>Lifetime gambling</b>	<b>88.9</b>	<b>90.4</b>	<b>79.5</b>	<b>89.7</b>
White			***	**
Male	90.2	95.6	84.2	92.1
Female	88.7	94.0	75.6	87.9
Other		*		
Male	88.2	82.7	80.8	91.7
Female	85.5	75.9	72.3	83.3
<b>Past-year gambling</b>	<b>74.4</b>	<b>80.5</b>	<b>60.6</b>	<b>77.5</b>
White			***	***
Male	76.7	85.8	64.8	80.5
Female	73.1	85.2	55.8	73.7
Other				
Male	73.9	71.3	69.2	86.7
Female	71.1	64.5	58.5	76.7



<b>Weekly gambling</b>	<b>20.1</b>	<b>35.2</b>	<b>13.5</b>	<b>18.9</b>
White	***	*	***	*
Male	24.0	39.8	15.9	20.8
Female	14.9	34.9	9.7	16.5
Other		*		**
Male	27.7	34.7	15.4	31.7
Female	22.9	26.9	26.2	11.7

Pearson Chi-Square: \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$   
Level of significance indicated above each group.

In addition to differences in overall gambling participation, there were differences in the rates of gambling participation by men and women in the four states. Across all four jurisdictions, weekly gambling participation was much lower among women than among men. In contrast to the consistency of the differences between men's and women's gambling overall, the differences in gambling rates between white people and people from "other" population groups vary substantially.

In all four states, lifetime gambling rates were higher among white people than among people of other groups. In New York, past-year and weekly gambling rates were all higher among white people than people of other groups. Past-year gambling rates were also highest among white people in Washington. In contrast, past-year gambling rates in Montana and Oregon were higher among people from minorities than among white people in those states, and in Washington and Montana, weekly gambling rates were highest among people from minorities.

The weekly gambling rates in Oregon and Montana show variations between rates for both white and minority groups and for gender within those groups. In Montana, men from minority groups were more likely than white men to gamble weekly, but in Oregon, the data for men in both groups was similar, with white men reporting a slightly higher rate of weekly gambling. For women, the reverse appeared to be true: in Montana, women from minorities reported a lower rate of weekly gambling participation than white women, but in Oregon, women from minorities reported a much higher rate of weekly

gambling (26.2%) to that of white women (9.7%) in the state.

Table 3 shows that, in all four states, white men were significantly more likely to gamble regularly than white women. While the small size of the minority groups sample, particularly in Oregon and Montana, suggests caution in interpreting these results (see Table 2 for actual cell sizes), it is interesting that men from minorities in Montana, Washington and New York were more likely to gamble than women from minorities in these states, whereas the opposite appeared to be true in Oregon.

### Specific gambling activities

Next, we examine differences in participation rates for specific gambling activities. As noted above, there are substantial legal gambling opportunities available to residents of all four states. All of these states operate lotteries and permit bingo as well as pari-mutuel wagering on horseraces. Access to gaming machines is relatively high in Oregon and extremely high in Montana, in contrast to New York and Washington (see Table 1). Access to casino gambling also varies across these four jurisdictions: high in Washington and Oregon, much lower in New York and Montana.

Table 4 shows rates of past-year lottery play among male and female white and minority respondents in the four states. Past-year lottery play was highest in New York and lowest in Oregon. New York also stands out as the only jurisdiction where past-year lottery play was higher among white people than among minority respondents. In Washington and Oregon, past-year lottery play was higher among both men and women from minorities than among white people, but in Montana women from minorities reported the lowest rates for past-year lottery play.

**Table 4: Past-year participation in specific gambling activities in four jurisdictions**

	Washington	New York	Oregon	Montana
	%	%	%	%
<b>Lottery (total)</b>	<b>57.1</b>	<b>66.1</b>	<b>40.7</b>	<b>46.5</b>
White	*		**	*

Male	58.8	69.4	43.6	49.3
Female	53.9	70.5	36.0	43.7
Other				
Male	65.5	56.4	50.0	54.1
Female	59.0	56.2	49.2	40.0
<b>Private (total)</b>	<b>23.1</b>	<b>31.0</b>	<b>19.7</b>	<b>33.6</b>
White	***	***	***	***
Male	31.1	44.2	27.5	43.1
Female	14.9	27.1	11.4	24.0
Other	**	***		*
Male	34.5	27.2	24.4	45.9
Female	15.7	13.3	23.1	26.7
<b>Machines (total)</b>	<b>10.4</b>	<b>18.0</b>	<b>21.7</b>	<b>38.6</b>
White		*	***	**
Male	10.1	22.2	27.1	42.9
Female	10.1	17.4	14.9	34.8
Other				*
Male	14.3	15.8	30.8	47.5
Female	10.8	12.1	29.2	26.7

Pearson Chi-Square: \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$

Level of significance indicated above each group.

Table 4 also presents information about past-year private wagering across the

four states. Private wagering includes wagering on sports, games of skill and card games with family, friends or acquaintances. Table 4 shows that, across the board, and regardless of ethnicity, men were much nearly two times more likely than women to have wagered privately in the past year. The one exception is in Oregon, where women from minority groups (23.1%) were just as likely as men from minority groups (24.4%) to have wagered privately in the past year.

Finally, Table 4 presents information about past-year gaming machine play in the four states. Given our theoretical sampling procedure, it is hardly surprising that past-year gaming machine play was lowest in Washington and highest in Montana. In spite of widespread notions about the relationship between the "feminization" of gambling and the availability of gaming machines, Table 4 shows that men were substantially more likely than women to have played gaming machines in the past year. The only exceptions are in Washington, where there was little variation in past-year gaming machine play by either gender or ethnicity, and in Oregon, where minority men and women were equally likely to have played gaming machines in the past year.

Given differences in availability and access, it is difficult to compare past-year casino gambling rates across the four states. In New York in 1996, just under one-quarter (23%) of the respondents acknowledged gambling at a casino in the past year, with white men most likely to have done so (25%) and minority women least likely to have done so (21%). In Oregon in 2000, 28% of all respondents had gambled at a casino in the past year, with white men the most likely (31%) and white women the least likely to have done so (25%). The picture is quite different in Washington, where card games are widely available at both tribal-run casinos and commercial cardrooms. In Washington in 1998, 13% of the respondents had wagered on card games at a casino or commercial cardroom in the past year. Past-year participation in this form of gambling was highest among men from minorities (27%) and lowest among women (9%), whether white or minority (both 9%).

Turning to bingo and horserace wagering, we find substantial gender differences in spite of very low past-year participation rates for these mature gambling activities. Overall, women were more likely to have played bingo in the past year, with minority women more likely than white women to have played in the past year in Montana, Oregon and Washington but not in New York. Past-year wagering on horseraces was even lower than past-year participation in bingo. Overall, men were more likely to have wagered on horseraces in the past year than women, regardless of ethnicity. The one exception was, again, New York, where white men and women were more likely than minority men and women to have wagered on horseraces in the past year.

One reason to look at past-year gambling participation rates is that weekly gamblers represent only a small proportion of the entire sample in each state. There are a few noteworthy differences between men and women who gamble once a week or more often.] In Washington, female weekly gamblers were more likely than male weekly gamblers to play bingo regularly. In contrast, male weekly gamblers in Washington were more likely to wager privately on a regular basis. In New York, male weekly gamblers were more likely than female weekly gamblers to play the lottery, wager privately and gamble on horseraces regularly. As in Washington, women weekly gamblers in New York were more likely than male weekly gamblers to play bingo regularly. In both Oregon and Montana, the major difference in weekly gambling was that men were more likely than women to wager privately.

When it comes to gaming machines, the patterns of weekly gambling participation across the four states suggest that the question of availability suddenly becomes much more salient. In Washington, only 1% of women who gambled weekly and 2% of men who gambled weekly played gaming machines regularly. In New York, 10% of women who gambled weekly and 8% of men who gambled weekly played gaming machines regularly. In Oregon, 19% of women who gambled weekly and 17% of men who gambled weekly played gaming machines once a week or more often. Finally, in Montana, 45% of women who gambled weekly and 48% of men who gambled weekly played gaming machines regularly.

### **Are more women gambling?**

In considering changes in gambling over time, a more complicated picture emerges. Past-year gambling on gaming machines declined across the board in Montana, with the steepest decline among women in minority groups. In Oregon, past-year gambling on gaming machines declined among white women but went up among women in minority groups. In Washington, where gaming machines were introduced in the period between the two surveys, past-year participation rose from a baseline of zero to about 10% across all gender and ethnic groups.

Private wagering, the most "masculine" gambling activity, again presents a varied picture. Past-year private wagering increased among men, whether white or minority, in Montana but decreased among women. In contrast, past-year private wagering declined across all groups in Oregon, with the exception of minority women. Past-year private wagering in Washington declined across the board, but with the largest decline among men in minority groups. Looking at bingo, we find declines across the board in past-year participation; the one exception being minority women in Montana, Oregon and Washington who were more likely to have played bingo in the past year.

## Problem gambling prevalence rates

Next, we turn to examine the prevalence of problem gambling in these four states. We noted above that Oregon and Washington were selected because of their low rates of problem gambling while Montana and New York were selected because of their high rates. Table 5 presents problem gambling prevalence rates for the four states. Problem gambling is defined here as the proportion of the entire sample from each state that scored 3 or more points on the current (past year) items of the SOGS-R .

**Table 5: Problem gambling prevalence rates**

	Washington	New York	Oregon	Montana
	%	%	%	%
<b>Total</b>	<b>2.3</b>	<b>3.6</b>	<b>2.3</b>	<b>3.6</b>
White	*			
Male	2.3	3.4	1.8	3.1
Female	0.9	2.6	1.9	3.2
Other	**			
Male	11.8	5.0	5.1	6.6
Female	1.2	6.0	7.7	8.3

Pearson Chi-Square: \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$

Level of significance indicated above each group.

The first observation is that, overall, the current prevalence of problem gambling is quite low in the general population. The next observation is that, with the exception of Washington, there are no significant differences in current prevalence rates of problem gambling among men and women. This is interesting in view of the far lower gambling participation rates that we observed among women (see Table 3). In contrast to the lack of gender differences, there are substantial and significant differences in prevalence rates of problem gambling between the two groups identified: white people and "other," minority groups in all four states. The differences in prevalence

rates between these groups are greatest in Washington and smallest in New York.

To elucidate the relationship between gender, problem gambling and gaming machines more clearly, it is helpful to examine problem gambling prevalence rates among participants in specific types of gambling. To do so, it was necessary to combine data from the four surveys to achieve samples of past-year players that were large enough to provide useful information. Table 6 presents current prevalence rates of problem gambling in the combined samples of people who reported past-year gambling on lottery games, gaming machines, private wagers, bingo and horseracing.

**Table 6: Problem gambling prevalence among past-year players**

	<b>Lottery</b>	<b>Machines</b>	<b>Private</b>	<b>Bingo</b>	<b>Pari-mutuel</b>
	%	%	%	%	%
<b>Total</b>	<b>4.9</b>	<b>7.8</b>	<b>7.0</b>	<b>10.1</b>	<b>8.1</b>
White	(n=2810)	(n=1175)	(n=1468)	(n=432)	(n=344)
Male	4.1	6.2	6.0	9.7	7.7
Female	3.7	7.0	5.2	6.2	6.3
Other	(n=561)	(n=204)	(n=253)	(n=114)	(n=41)
Male	10.6	15.7	16.1	34.2	16.0
Female	9.8	16.2	13.0	12.5	20.0

Table 6 shows, first, that prevalence rates for problem gambling among past-year players are substantially higher for specific games than in the general population, with the highest rates among past-year bingo players and the lowest among past-year lottery players. Table 6 also shows that, across the board, problem gambling prevalence rates are higher among past-year participants from minority groups in specific gambling activities than among participants who are white. The differences in problem gambling rates between white people and people from minority groups are far greater than the differences between male and female gamblers.



## Changes in prevalence over time

Data from the replication surveys are, again, helpful in understanding that the characteristics of problem gamblers may change over time and in relation to changes in the availability of specific types of gambling. Let us consider Washington, where the availability of card games at cardrooms and casinos expanded dramatically between 1992 and 1998. This is the only jurisdiction in our theoretical sample where the overall prevalence of problem gambling is significantly higher among men than among women. Between 1992 and 1998 in Washington, the proportion of problem gamblers who were male increased from 63% to 75% (Volberg & Moore, 1999b).

Washington forms an interesting contrast to Montana and Oregon, where the availability of gaming machines has been high throughout the 1990s. In Montana, the proportion of problem gamblers who were female remained stable at about 50% between 1992 and 1998. In Oregon, the proportion of problem gamblers who were female increased from 36% to 45% between 1997 and 2000 (Volberg, 2001a). It is interesting that the proportion of problem gamblers in Oregon who were Native American increased in the same period from 3% to 7% —a possible response to an increase in the number of tribal-run casinos in that state.

## Discussion

### Gender and gambling

What do the data presented here suggest about the relationship between gender, gambling and problem gambling? It is worth beginning by considering the differences between New York and the other three states selected for this exercise. As Table 1 demonstrates, New York is the only state in the theoretical sample located in the northeastern United States. Furthermore, New York's population is more than three times larger and far more ethnically diverse than any of the other three states. Another difference is that a larger proportion of the New York population lives in urban areas. Finally, the problem gambling surveys in New York were completed somewhat earlier than the surveys carried out in the other states. The nature of the exercise attempted here means that the differences between New York and the other states are less a threat to validity than an opportunity to explore whether differences in geography, ethnicity and population size and density affect the relationships between gender, gambling and problem gambling.

Over the final quarter of the 20th century, national surveys of gambling in the United States found substantial increases in lottery and casino gambling at the expense of more mature forms of gambling, such as bingo and horserace

wagering (Gerstein et al., 1999). The data from New York, where gambling participation rose substantially between 1986 and 1996, with increases most evident for lottery play and casino gambling, echo these larger, national trends and suggest that these trends continued at least through the mid-1990s.

However, it has been suggested that the market for legal gambling in the United States matured rapidly in the 1990s, and that, with few exceptions, the U.S. gambling market is now fully supplied (Christiansen & Sinclair, 2001). The more recent data from Montana, Oregon and Washington support this contention and suggest that gambling participation rates began to decline in the late 1990s —perhaps as people who had experimented with new gambling activities stabilized their involvement to balance it with other, important parts of their lives (Volberg, 2001b).

### **Gender and specific gambling activities**

The role that gender plays in gambling participation is clarified when we turn from gambling in general to look at specific gambling activities. In general, we have seen that women are less likely to gamble than men and, in particular, less apt to gamble regularly. The data presented here support the notion of a strong relationship between gender and some types of gambling. Conventional casino gambling showed relatively little variation with between 20% and 30% of the adult population having gambled at a casino in the past year, regardless of gender or ethnicity. When it comes to other gambling activities, there are clear and substantial gender differences. Across the board, women were more likely to play bingo than men. In contrast, men were far more likely than women to wager privately and on horseraces.

There is greater variability in the regular gambling of men and women when we take ethnicity into consideration. Weekly gambling rates were higher among white people than among people from minorities in New York. In Montana and Oregon, people from minorities were more likely to gamble regularly than white people. Within the minority population, men were more likely to gamble than women in Montana and New York; the opposite was true in Oregon. This finding suggests the importance of examining differences in gender roles within ethnic groups that may affect gambling participation.

Again, New York stands out in relation to the other states in our theoretical sample. New York had higher rates of lottery play among white people than among people from minorities. New York also had higher rates of bingo participation among white women than women from minorities. Finally, horserace wagering in New York was higher among white people than people from minorities, regardless of gender. It is possible that these differences in

gambling patterns are due to geography, population density or ethnic diversity. Another possibility is that these differences are a historical artefact — the result of the fact that the surveys in New York were completed somewhat earlier than the surveys carried out in the other states. A third possibility is that these differences are due to the existence of a substantial white working-class population in New York with gambling "habits" similar to those in other working-class communities (Dixey, 1996). However, all of these are hypotheses that remain to be tested.

Another interesting difference emerges with regard to women from minority groups in Oregon. They present an exception to the more general finding that private wagering is much more common among men; their past-year rate for participation in private wagering was quite similar to that for men from minority groups in Oregon. Women from minorities in Oregon were also more likely than their counterparts in New York and Washington, but not Montana, to have played gaming machines in the past year. This difference may be due to the small sample of respondents from minorities interviewed in Oregon. Another possibility is that a real difference exists in the gambling involvement of minority women in Oregon compared with other states. A third possibility is that the availability of gaming machines affects the gambling of women from minority groups more significantly than the gambling of white women. Again, these questions can only be answered with further research.

A third interesting question relates to casino gambling in Washington. The tribal-run casinos in Washington are unique in offering primarily table games and very few slot machines. Washington is also unique in the number of large commercial cardrooms (or "mini-casinos") that operate throughout the state. Private wagering in Washington State declined across the board between 1992 and 1998, with the largest decline among men from minorities. It is possible that this change reflects a shift among this group of men from private wagering to gambling at tribal-run casinos and commercial cardrooms. As noted above (see subsection Specific gambling activities under Results), Washington was the only jurisdiction where casino participation rates were substantially lower among women compared with men —perhaps another consequence of the unique characteristics of "casinos" in that state.

Finally, consideration of the data from people who gamble regularly suggests that gender roles may become even more pronounced at the far end of a continuum of participation in some types of gambling but not others. Male weekly gamblers were far more likely than female weekly gamblers to wager privately on a regular basis while female weekly gamblers were much more likely than their male counterparts to play bingo on a regular basis. In contrast, regular gaming machine play appears to be more closely related to the number of machines in a jurisdiction than to gender roles. Unlike most

other types of gambling, nearly equal proportions of regular gaming machine players were male and female.

### **Are women more likely to have gambling problems?**

In general, the data considered here show that women are far less likely to gamble regularly than men. In spite of substantially lower rates of regular gambling among women, rates of current problem gambling were quite similar for men and women. The one exception is Washington, where both white and minority women were far less likely than men to score as current problem gamblers.

The picture becomes clearer when we consider weekly gambling among different groups of respondents separately. Among white men, the prevalence of current problem gambling varies as expected, with the lowest prevalence rate in Oregon where white men are least likely to gamble regularly, and the highest prevalence rate in New York, where white men are most likely to gamble regularly. The relationship between weekly gambling and problem gambling rates is not as strong among white women but still varies in the expected direction.

The relationship between weekly gambling and problem gambling is far less predictable among men and women from minorities. Among minority men, the prevalence of current problem gambling was substantially higher in Washington in spite of the fact that men from minorities in other states were just as likely to gamble weekly. Among minority women, the prevalence of current problem gambling was substantially lower in Washington in spite of the fact that women from minorities in Washington were just as likely to gamble weekly as minority women in other states. The question is whether this difference is due to unique characteristics of the minority population group surveyed in Washington, something unique about the available types of gambling or to another factor altogether.

The picture is further clarified when we consider gaming machine participation separately. Predictably, Table 4 shows that past-year gaming machine play increases with the number of machines in a jurisdiction. Table 5 shows that, while prevalence rates for problem gambling among white men vary independently of the availability of gaming machines, prevalence rates among white women vary almost entirely as expected. Among men from minorities, problem gambling prevalence rates appear to drop in relation to the availability of gaming machines, while the opposite is true of women from minority groups. Indeed, prevalence rates for problem gambling were actually higher among women from minorities in Oregon and Montana than among white people (male or female) or men from the minority population. These

data suggest that the relationship between gaming machines and problem gambling among women is stronger than this relationship among men and, further, that this relationship is particularly strong among minority women.

Hing and Breen (2001b) argue that social norms influence women's gambling preferences and frequency more than the characteristics of specific types of gambling. They argue further that problem gambling prevalence rates will be similar among male and female players who gamble at equal intensity. The data presented here support the argument that men and women who gamble at equal frequency experience gambling problems at about the same rate. In contrast to the lack of differences between men and women, there appear to be substantial differences in the prevalence of problem gambling among majority and minority ethnic groups. As Table 6 shows, the prevalence of problem gambling is two or more times higher among minority men and women than among white men and women, regardless of whether we are looking at past-year lottery play, gaming machine play, private wagering, bingo or pari-mutuel wagering. A question for future research is how variability between different ethnic groups in attitudes towards women and gambling may influence gambling behavior.

It is interesting, in this regard, to consider another curious intersection of gambling, gender and ethnicity. Among past-year bingo players, the prevalence of problem gambling was lowest among white women and highest among men from minorities. Although this difference may result from the small size of the group of past year bingo players surveyed, there is a possibility that male players of a traditionally "female" gambling pastime are particularly troubled individuals (Wood, 2002).

## **What lies ahead?**

In the wake of rapid growth in the availability of legal gambling opportunities, and particularly, casino and non-casino gaming machines, service providers have observed growing numbers of women seeking help for gambling problems in the United States and internationally. The majority of these women attribute their gambling problems to recent involvement with gaming machines as opposed to other types of gambling. The question is whether these growing numbers of women seeking help reflect a broader "feminization" of gambling and problem gambling in the general population.

The exercise undertaken here suggests that, in fact, little has changed when it comes to gender and gambling. Men are still the social actors predominantly engaged in "strategic," skill-based and competitive forms of gambling while women remain predominantly engaged in "non-strategic," luck-based forms of gambling (Potenza et al., 2001; Volberg & Banks, 2002). The major historical



change has been the growing involvement of women in non-strategic gambling activities at venues outside the home that provide a sense of physical and emotional safety. Gaming machines are increasingly available at venues frequented by women —restaurants, hotels and bars, but also grocery stores, convenience stores, gas stations and even laundromats. As gambling becomes more available at venues frequented by women, the data we have examined suggest that women from minority groups are especially likely to begin gambling and may be particularly vulnerable to developing difficulties related to their gambling.

One of the most interesting findings to emerge from the analysis presented here is the relationship between the availability of specific types of gambling and the socio-demographic characteristics of problem gamblers. It appears likely that the characteristics of problem gamblers in a given jurisdiction are a reflection of differences in the availability and acceptability of different types of gambling among different groups in the population. Gender and ethnicity and, perhaps, also age and social class may play a role in what type of gambling people choose and, for those who gamble regularly, who gets into difficulties with their gambling.

Another intriguing question that emerges from this exercise is the issue of why women are just as likely as men to score as problem gamblers when their overall gambling participation remains lower? Are women in fact more vulnerable to developing gambling problems? Or are women simply more likely than men to seek help for a gambling problem, just as they are more likely to seek help for other physical and psychological ailments? Another possibility is that methods for identifying problem gambling may not work equally well in different subgroups in the population. There may be something about the problem gambling screens we use that elicits more positive responses from women and people from minorities.

Finally, we must consider the emergence of new forms of gambling and ask what will be the impacts of the implosion of this means of consumption into the home (Ritzer, 1999). As Cividino (2002) notes, women represent a rapidly expanding segment of the on-line gambling population and there is a growing number of specialized Web sites for women gamblers. On-line gambling offers excitement and escape but also local availability, flexible hours, a low price of participation and physical and emotional safety —features especially appealing to women. It would be wise to give careful consideration to measures to prevent gambling problems in this new and very private gaming venue.

Qualitative research is viewed with skepticism by most gambling researchers, and there is little appreciation of its value in generating testable hypotheses.

The exercise undertaken here has raised numerous issues that deserve further exploration. While not yet a single, coherent "theory" of gambling or problem gambling, testing the hypotheses generated here is likely to move us significantly forward in our efforts to understand the role of gambling in postmodern society.

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## research

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### **The interactive effects of avoidance coping and dysphoric mood on problem gambling for female and male gamblers**



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## **Abstract**

A study involving 83 female and 72 male gamblers tested the direct and interactional effects of avoidance coping and five dysphoric moods on problem gambling via regression analysis. Important differences were found between female and male gamblers. For female gamblers, loneliness, boredom, anxiety, depression and avoidance coping were all positively related to problem gambling. Additionally, interactions between these mood states and avoidance coping significantly predicted problem gambling; female gamblers with high dysphoria and high avoidance coping showed substantially more symptoms of problem gambling than those scoring high on only one variable. In contrast, loneliness and stress were the only significant predictors of problem gambling for males —neither avoidance coping nor any of the interactional relationships between mood and coping predicted problem gambling. These results support previous qualitative studies and suggest that female problem gamblers gamble as an escape from dysphoric moods. Even though male problem gamblers expressed more negative affect than male non-problem gamblers, there was no evidence to suggest that negative mood was a precursor rather than an outcome of gambling behaviour.

**Key words:** women, gambling, avoidance, coping, depression, anxiety, loneliness, boredom

Gambling today is far from being a secret vice undertaken by a deviant few. In Australia, and indeed in most Western countries, gambling has been transformed into a respectable and popular leisure activity (Trevorrow & Moore, 1998). A recent inquiry into Australia's gambling industries found that 82% of Australian adults had participated in at least one gambling activity in the 12 months preceding April 1999. It also found that women were just as likely to gamble as men (Productivity Commission, 1999). In addition, the Productivity Commission (1999) report estimated that one per cent of the Australian adult population were experiencing severe gambling problems, and another one per cent had moderate but significant problems. Problem gambling amongst women appears to be increasing, and female and male problem gamblers are now evenly represented at counselling services in Australia. Similarly, other Western studies estimate that females represent one-third to one-half of the problem gamblers in the general population (Getty, Watson & Frisch, 2000; Hraba & Lee, 1996; Mark & Lesieur, 1992; Productivity Commission, 1999). However, few studies have investigated this change in what has historically been seen as a male issue.

There have been many theories to explain problem gambling —ranging from a focus on individual pathology to a focus on social factors. However, it is probable that most of these theories were developed with male problem gamblers in mind, and certainly the vast majority of past research about problem gambling has concentrated on males, with samples of gamblers consisting of all or almost all male participants. Other studies that included female and male problem gamblers failed to systematically assess gender differences (e.g., Blaszczyński, McConaghy & Frankova, 1990; Delfabbro, 2000; Mark & Lesieur, 1992; McCormick, 1994). This is somewhat understandable because historically the majority of problem gamblers receiving counselling were male (Blaszczyński et al., 1990; Mark & Lesieur, 1992). Today, however, the widely held assumptions that problem gambling is a male problem and that what is true for males is also true for females needs to be challenged.

On the basis of case material, Lesieur and Blume (1991) implied that women's gambling may be differently motivated from men's gambling. They concluded that women use gambling to escape personal and family problems, whereas men are more likely to gamble for excitement and financial gain. Similarly, two other studies which investigated the motivations of male and female problem gamblers found that female problem gamblers were significantly more likely to say they were gambling to escape isolation, depression, anxiety and worry compared to male problem gamblers. On the other hand, male problem gamblers were more likely to say they were gambling to win or to improve their self-worth (Loughnan, Pierce & Sagris, 1996; Pierce, Wentzel & Loughnan, 1997). These studies suggest that

gambling motivations may not be homogeneous across gender and that women may be gambling to temporarily escape negative moods and situations, rather than for excitement or to win money.

Qualitative research by Brown and Coventry (1997) also sheds light on the motivational processes involved for a sample of women who defined themselves as problem gamblers. Through telephone interviews, most of these women reported that they gambled initially for social reasons rather than as a means of increasing stimulation. However, as time went on gambling became a method of distraction from everyday problems, a way of avoiding dysphoric states, such as loneliness, boredom, anxiety, depression and stress. As more problems arose from gambling, dysphoric moods increased, leading to a cycle of "escaping" through gambling, with resulting financial loss and family problems, dysphoric mood, etc.

A review of quantitative research into problem gambling interestingly revealed evidence of elevated dysphoric states, such as loneliness, depression, boredom and anxiety in both male and female problem gamblers (e.g., Blaszczynski & McConaghy, 1988; Blaszczynski et al., 1990; Coman, Burrows & Evans, 1997; McCormick, Russo, Ramirez & Taber, 1984; Trevorrow & Moore, 1998). Indeed, the few studies that compared male and female problem gamblers dysphoric emotions showed mixed results. Some found that female problem gamblers had significantly higher levels of dysphoria compared to male problem gamblers (Specker, Carlson, Edmonson, Johnson & Marcotte, 1996; Steel & Blaszczynski, 1996). In contrast, others have found no differences (Becoña, Lorenzo & Fuentes, 1996; Ohtsuka, Bruton, DeLuca & Borg, 1997). Therefore, these quantitative studies suggest that it is possible for both male and female problem gamblers to have elevated levels of dysphoria. However, the studies mentioned earlier suggest that female problem gamblers are more likely to gamble to escape these feelings (Brown & Coventry, 1997; Lesieur & Blume, 1991; Loughnan et al., 1996; Pierce et al., 1997).

If female problem gamblers, in particular, are deliberately choosing to gamble to escape dysphoric emotions their gambling could fundamentally be seen as a form of coping, albeit a maladaptive form. The Folkman and Lazarus (1988) model of stress proposes that individuals appraise potential stressors and search for a coping strategy to reduce the threat. These strategies can range from active attempts to "solve the problem," through to emotional responses, help-seeking or attempts to escape from the situation, either physically or mentally. Therefore, coping resources are theorised to mediate the impact of stressors (Billings & Moos, 1984), although it is clear that some strategies will be more effective than others. Avoidance or escapist coping refers to activities or cognitions used by people to divert attention away from a source of distress



(Folkman & Lazarus, 1988). This method of coping is very common and can range from culturally acceptable activities such as jogging to destructive behaviours such as taking drugs or alcohol (Folkman & Lazarus, 1988). It is possible that gambling could be used in a similar same way to divert attention away from a distressing issue.

In fact, there is some evidence of excessive reliance on avoidance coping in both male and female problem gamblers. For example, a study by Scannell, Quirk, Smith, Maddern and Dickerson (2000) found that female gamblers with low control over their gambling behaviours used avoidance coping significantly more than females with high control over their gambling. Similarly, McCormick (1994) found that male substance abusers with gambling problems used avoidance coping strategies significantly more than those without gambling problems. In addition, one study that directly compared male and female problem gamblers found that they were very similar in their use of avoidance coping (Getty, Watson & Frisch, 2000).

In sum, prior research suggests that both coping style and dysphoric emotions may be important factors in explaining problem gambling; however, it is less certain that they are equally important for males and females. Recent qualitative data can be interpreted to suggest that it may not be negative mood that leads to problem gambling per se—but the use of gambling as an escape from dysphoric mood (Brown & Coventry, 1997). In other words, the effect of emotional stressors on problem gambling may be moderated by coping tendencies. This complex relationship requires an assessment of the combined effects of high dysphoric mood and high avoidance coping (as opposed to assessing only the simple or direct effects of high scores on either of these variables). To the authors' knowledge, no prior research has directly tested the extent to which the interaction between dysphoric mood and coping style predicts problem gambling.

Therefore, an initial aim of this study was to partially replicate prior research by investigating the differences between males and females and between problem gamblers and non-problem gamblers on dysphoric mood and avoidance coping. In line with prior research (e.g., Blaszczynski, et al, 1990; McCormick, 1994; Scannell, Quirk, Smith, Maddern & Dickerson, 2000; Trevorrow & Moore, 1998), it was expected that problem gamblers would score higher on avoidance coping and all measures of dysphoric mood than non-problem gamblers. Due to the mixed results of prior studies (Becoña et al., 1996; Getty et al., 2000; Steel & Blaszczynski, 1996), an exploration was undertaken to determine whether there would be significant differences between male and female gamblers or male and female problem gamblers on avoidance coping or dysphoric mood.

The main aim of this study was to test the interactional model discussed above by assessing the emotion-moderating effects of coping for both male and female gamblers, using more sophisticated analyses than those used in prior research. Three steps were taken in testing this model. Firstly, it was hypothesised that female and male gamblers with higher levels of dysphoric emotion (depression, anxiety, loneliness, stress or anxiety) would show more symptoms of problem gambling than those with lower levels of dysphoric emotion. Secondly, it was hypothesised that both male and female gamblers who had a high tendency to use avoidance coping would exhibit more problems with their gambling. Finally, it was hypothesised that these avoidant styles of coping would become very maladaptive when paired with dysphoric emotions. When placed together these factors were expected to interact to predict problem gambling more effectively than either dysphoric mood or avoidant coping alone. Whether or not these effects would differ for male and female gamblers was explored because past research did not allow for a clear hypothesis of either difference or similarity in process.

## **Methods**

### **Participants**

Current gamblers (who had gambled for money at least once in the past 12 months) 18 and older were recruited for this study. The sample comprised 155 participants: 83 females (M=28.4 years, SD=13.5 years) and 72 males (M=30.1 years, SD=12.9 years). Ninety-five participants were first-year psychology students at a university in Melbourne, Australia, 13 were recruited via a gambling counselling organisation in a suburb of Melbourne and 47 were accessed via broader community contacts. Unfortunately, the anonymous method of data collection did not allow for demographics to be collated on specific sub-samples.

### **Materials**

Participants completed a questionnaire that included questions about gambling behaviour and demographics as well as measures of coping, problem gambling and several measures of dysphoric mood (loneliness, anxiety, depression, stress and boredom). All of these mood states were included because they had been implicated in prior gambling research, but not all had been tested on both male and female gamblers or in conjunction with coping strategies.

#### **Loneliness measurement**

The UCLA Loneliness Scale (Russell, Peplau & Cutrona, 1980) rates feelings

of loneliness the participant may have experienced in relation to other people. Twenty items are rated on a four-point scale, where 1 = *never* and 4 = *often*. The measure has 10 positively scored items (e.g., *I feel isolated from others*) and 10 negatively scored items (e.g., *I do not feel alone*); overall loneliness scores are calculated by summing all items. Higher scores indicate higher levels of loneliness. The measure has shown excellent internal consistency ( $\alpha = .94$ ). That it showed positive correlations with several other loneliness scales and a lack of relationship with conceptually distinct emotions indicate that the measure has construct validity (Russell, 1982).

### **Depression, anxiety and stress measurement**

The Depression, Anxiety, Stress Scale (DASS21) (Lovibond & Lovibond, 1995) is a shortened version of the full DASS, consisting of 21 items querying the participant's feelings over the past week. All items are rated on a four-point scale, where 0 = *did not apply to me* and 3 = *applied to me very much, or most of the time*. The measure has three sub-scales that have questions (seven in each) relating to depression (e.g., *I felt down-hearted and blue*), anxiety (e.g., *I felt I was close to panic*) and stress (e.g., *I found it hard to wind down*). Scores are summed and multiplied by two so that they can be directly compared to Australian normative samples based on the full-scale DASS. Higher scores relate to higher levels of depression, anxiety and stress. The measure has shown high internal consistency (depression  $\alpha = .81$ ; anxiety  $\alpha = .73$ ; stress  $\alpha = .81$ ) and good evidence of test-retest reliability and construct validity (Lovibond & Lovibond, 1995).

### **Boredom measurement**

The Boredom Proneness Scale (Farmer & Sundberg, 1986) is a 28-item true-false scale designed to capture the participant's tendency to become bored. The measure particularly relates to feelings of emptiness and loneliness associated with boredom. It also measures the ability of individuals to access adaptive resources and their level of connectedness to environments or situations. The measure has 18 positively scored items (e.g., *Time always seems to be passing slowly*) and 10 negatively scored items (e.g., *I am good at waiting patiently*). Items are summed and high scores indicate higher boredom proneness. The measure has good reliability ( $\alpha = .73-.79$ ; test-retest reliability at one week = .83) and has shown validity via moderate to strong positive relationships with other boredom scales and self-reports of boredom (Farmer & Sundberg, 1986).

### **Coping measurement**

Billings and Moos' (1984) coping scale was used to assess avoidance coping.

This measure involves asking respondents to think of a stressful event that occurred in the last three months. It then asks them to indicate the frequency of use of 28 different coping strategies to resolve the event. The use of each strategy is rated on a four-point scale, where 1 = *never used* and 4 = *often used*. The measure has three subscales, two of which contain two individual factors. Scores for each factor are obtained by calculating the mean response of all items contained in the factor. However, as the focus of this study was on avoidance/escapist coping, only the avoidance factor (labelled emotional discharge) has been fully described here. Emotional discharge (avoidance coping) has six items and relates to attempts made by the individual to reduce tension by refocusing on potentially distracting behaviours, such as smoking or eating (e.g., *Tried to reduce tension by drinking more*). The fairly low alpha for this factor ( $\alpha = .41$ ) was argued by Billings and Moos (1984) to be due to the likelihood that only one or two distracting strategies would be utilised by an individual, thereby reducing the use of alternative responses and setting an upper limit on the reliability coefficients. For the purposes of this study, this level of internal consistency was considered sufficient.

### **Problem gambling measurement**

The South Oaks Gambling Screen (SOGS) is a 23-item instrument with 20 scored items designed to indicate the severity of problem gambling (Lesieur & Blume, 1987). The screen is based on the Diagnostic and Statistical Manual of Mental Disorders' (DSM-III) (American Psychiatric Association, 1980) problem gambling criteria and is consistent with later versions of the DSM. Questions cover problem gambling indicators such as chasing losses, gambling more than intended, feeling guilty about gambling, borrowing money to gamble and reactions of others to the individual's gambling. Scores range from 0 to 20. A score of 5 or more indicates problem gambling, and a score of 10 or more indicates severe problem gambling. The SOGS is a widely used measure of problem gambling and has shown high internal consistency and test-retest reliability as well as correlating highly with the DSM-III-R criteria for problem gambling (Lesieur & Blume, 1987).

### **Procedure**

The authors employed several methods to recruit participants for this study. From a Melbourne university, 95 first-year psychology students were recruited as part of their class requirement. From the wider community, 47 participants were recruited as a convenience sample and 13 problem gamblers were recruited through a Melbourne problem gambling counselling centre. Questionnaires were distributed either in classes, through a sample of gamblers available to the researchers or through counsellors at the gambling counselling centre. All questionnaires were completed voluntarily and

anonymously on the participants' own time and returned in a postage-paid return envelope to the researchers.

## Results

### Descriptive statistics

All participants were current gamblers. Scores on the SOGS ranged from 0 to 18 and had a mean score of 2.97 (SD=3.88). Thirty-two participants were designated as problem gamblers (a SOGS score of five or more): 21 were male and 11 female. The average SOGS score was significantly higher for male gamblers (Mean males = 3.65; Mean females = 2.39,  $F(1,153)=4.20$ ,  $p<.05$ ).

Alpha reliabilities of scales used in this study were as follows: Loneliness (.93), Boredom (.82), Depression (.91), Anxiety (.88), Stress (.87), Avoidance Coping (.49), Problem Gambling (.86). All reliabilities were considered adequate for research purposes while acknowledging that the low reliability for avoidance coping was related to the nature of this activity as previously discussed.

### Gambling behaviours

In order to gain an overall picture of their favoured forms of gambling, participants were asked to list the types of gambling they participated in most often. Percentages were calculated and are shown in Table 1.

**Table 1**  
**Percentage of female and male gamblers by their most frequent form of gambling**

	Females	Males
Gambling type	%	%
Poker machines	41	33
Lotto/scratch-it	31	21
Bet on horses/dogs	4	17

Play cards	11	10
Bet on sports	1	4
Table games at casino	4	7
Bingo	5	1
Other	4	6

Note: Percentages will not sum to exactly 100% due to rounding.

As the table illustrates, poker-machine gambling was by far the most popular form of gambling for both males and females, and lotto and scratch-it tickets were also popular for both genders. However, betting on horse or dog races appeared to be popular only with male gamblers. Table 2 highlights the favoured forms of gambling for problem gamblers.

**Table 2**  
**Number of female and male problem gamblers by their most frequent form of gambling**

Gambling type	Females	Males	n <sup>a</sup>
Poker machines	6	8	56
Lotto/scratch-it	4	2	40
Bet on horses/dogs	0	8	15
Play cards	1	0	16
Bet on sports	0	0	4
Table games at casino	0	1	8



Bingo	0	1	5
Other	0	1	7

Note: Problem gambler= SOGS score of 5+

n<sup>a</sup> = Total number of participants who designated this as their favourite form of gambling.

This pattern of popularity is similar to other gamblers, albeit with more sharply defined gender preferences. As illustrated, a substantial proportion of men and women who prefer to play poker machines displayed problematic gambling behaviours. Male problem gamblers also showed a strong preference for horse or dog races, while female problem gamblers showed a preference for lotto or scratch-it tickets.

### Initial analysis of measures

In order to partially replicate prior research, a series of initial analyses were conducted. A two-way multivariate analysis of variance (MANOVA) was performed on participants' levels of dysphoric mood. The independent variables were gender (male, female) and gambler type (problem gambler, non-problem gambler). A two-way analysis of variance with the same independent variables was performed on avoidance coping scores. Table 3 shows the means of the dependant variables.

**Table 3**

**Mean scores for male and female problem and non-problem gamblers on dysphoric mood and avoidance coping**

	Non-problem gamblers (n ranges from 119-123)			Problem gamblers (n ranges from 31-32)		
	Females	Males	Total	Females	Males	Total
Variables	M	M	M	M	M	M
Anxiety	6.39	8.12	7.11	13.45	12.29	12.69
Depression	8.13	9.76	8.80	17.45	14.86	15.75
Stress	14.42	12.75	13.72	20.55	17.24	18.38
Boredom	8.92	11.27	9.89	12.91	14.33	13.84
Loneliness	34.24	37.10	35.43	46.50	45.10	45.55



Avoidance	2.04	2.02	2.04	2.45	2.23	2.31
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Note. SOGS scores 0–4 = non-problem gamblers, SOGS scores 5+ = problem gamblers

Results indicated that problem gamblers differed significantly from non-problem gamblers on dysphoric mood (Pillai's Trace = .130,  $F(5,145)=4.35$ ,  $p<.01$ ,  $R^2=.13$ ). Univariate analyses revealed that problem gamblers were significantly more anxious ( $F(1,149)=10.38$ ,  $p<.01$ ,  $R^2=.07$ ), depressed ( $F(1,149)=16.14$ ,  $p<.001$ ,  $R^2=.10$ ), stressed ( $F(1,149)=8.71$ ,  $p<.01$ ,  $R^2=.06$ ), bored ( $F(1,149)=12.42$ ,  $p<.01$ ,  $R^2=.08$ ) and lonely ( $F(1,149)=20.23$ ,  $p<.001$ ,  $R^2=.12$ ) than non-problem gamblers. Problem gamblers also used significantly more avoidance coping ( $F(1,147)=8.80$ ,  $p<.01$ ,  $R^2=.06$ ) than non-problem gamblers.

There were no significant differences between the genders on dysphoric mood or avoidance coping, nor any significant interactions between gender and gambler type on these variables. A power analysis indicated that the study had sufficient power to detect a moderate interaction effect.

### Regression analyses

A series of hierarchical multiple regressions were used to test the hypothesised model that the relationship between dysphoric mood and problem gambling would be moderated by avoidance coping. It was expected that participants who scored high on a measure of dysphoric mood and high on the use of avoidance coping would exhibit substantially more problems than those who scored high on only one of the predictors. These regressions also assessed predicted relationships between problem gambling and (a) dysphoric mood and (b) avoidance coping. Separate regressions were performed for each mood state and all independent variables were centred to prevent problems with multicollinearity (Tabachnick & Fidell, 2001). For each regression, mood state and avoidance coping were entered at stage one and the interaction between mood state and avoidance coping were entered at stage two (Cooper, Russell, Skinner, Frone & Mudar, 1992). All analyses were performed separately for males and females in order to examine the relationships between mood, coping and problem gambling for each gender.

To facilitate interpretation, one of the significant interactions has been presented graphically, using the regression equation to generate a predicted score on problem gambling for each group, which represents all possible combinations of low and high (Cohen & Cohen, 1983). Low and high scores were operationalised using one standard deviation below and one standard

deviation above the mean, respectively, giving two regression lines.

### Hierarchical regression analyses for females

**Table 4**

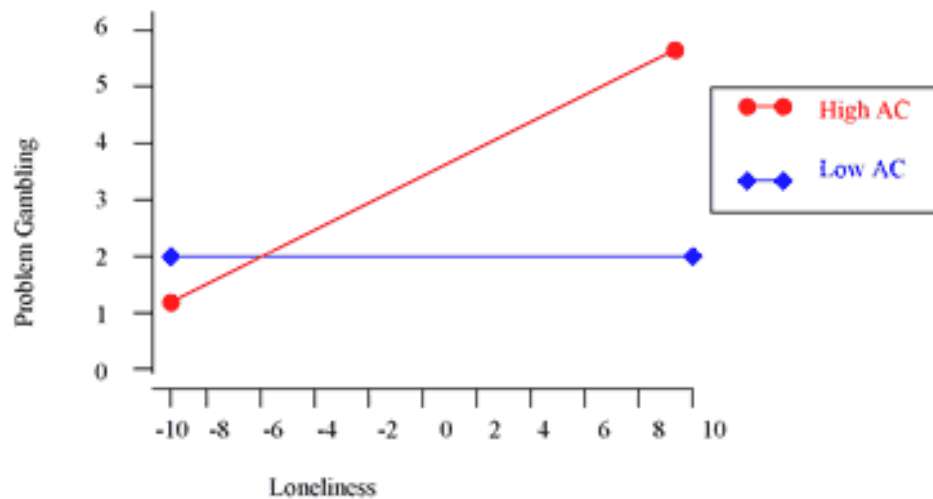
**Summary of hierarchical regression analyses showing main and interactive effects of dysphoric mood and avoidance coping on problem gambling for females**

Predictor variables	Loneliness	Anxiety	Depression	Boredom	Stress
	R <sup>2</sup> Δ    β	R <sup>2</sup> Δ    β	R <sup>2</sup> Δ    β	R <sup>2</sup> Δ    β	R <sup>2</sup> Δ    β
<b>Stage 1</b>	.31***	.23***	.25***	.19***	.17**
<b>Mood</b>	.41***	.34**	.37**	.30*	.21+
<b>AC</b>	.28*	.27*	.22*	.21+	.30**
<b>Stage 2</b>	.10**	.10**	.04*	.06*	.03+
<b>Mood</b>	.31**	.34**	.32**	.22+	.20+
<b>AC</b>	.28**	.18+	.18+	.20+	.26*
<b>Mood x AC</b>	.33**	.32**	.21*	.26*	.18+
<b>Total R2</b>	.41**	.33***	.28***	.25***	.20**

Note. N=83, R<sup>2</sup>Δ=R<sup>2</sup> change, β=Beta, AC=Avoidance Coping, p<.10+, p<.05\*, p<.01\*\*, p<.001\*\*\*

A summary of the regression results for female gamblers is shown in Table 4. In the first regression, loneliness and avoidance coping at stage one accounted for 31% of the variation in problem gambling, and as expected, both factors significantly predicted problem gambling. Lonely women and women who had a tendency to use avoidance coping tended to experience more gambling problems. At stage two, the interaction between loneliness and avoidance coping was entered. It accounted for an additional 10% of the variation in problem gambling, over and above what was explained by loneliness and avoidance coping directly. Together the model was able to explain 41% of the variance in problem gambling. The interaction (shown in Figure 1) is now the strongest predictor of problem gambling. As illustrated, female gamblers who scored high on both avoidance coping and loneliness showed substantially more symptoms of problem gambling than female gamblers showing high scores for either variable.

**Figure 1**  
Interaction between avoidance coping (AC) and loneliness for female gamblers



Click diagram for larger image.

An examination of the other regressions showed a similar pattern of results. Avoidance coping and all mood states, except stress, significantly predicted problem gambling. In all cases, women who scored high in negative mood or who had a tendency to cope by avoiding were more likely to show more symptoms of problem gambling than those who scored low in those variables. The introduction of the mood by avoidance coping interaction enabled an additional 3% to 10% of the variation in problem gambling to be accounted for, over and above what was accounted for by the mood or avoidance coping directly (see Table 4). All interactions between mood and avoidance coping were significant with the exception of the interaction involving stress. An examination of the significant interactions revealed that, as was the case with loneliness, women who scored high in negative mood and who showed a strong tendency to cope by avoiding showed substantially more symptoms of problem gambling than women who scored high in just one variable.

It should be noted that the addition of the interaction term did not substantially increase the predictive ability of the model for the regressions involving depression and boredom. However, the pattern of relationships was consistent for all regressions, and in each case, the total model accounted for a substantial percentage of the variance.

#### **Hierarchical regression analyses for males**

#### **Table 5** **Summary of hierarchical regression analyses showing main and**

## interactive effects of dysphoric mood and avoidance coping on problem gambling for males

Predictor variables	Loneliness R <sup>2</sup> Δ    β	Anxiety R <sup>2</sup> Δ    β	Depression R <sup>2</sup> Δ    β	Boredom R <sup>2</sup> Δ    β	Stress R <sup>2</sup> Δ    β
<b>Stage 1</b>	.10*	.04	.06	.07+	.07+
<b>Mood</b>	.31*	.18	.24+	.25*	.26+
<b>AC</b>	.02	.03	.03	.02	.02
<b>Stage 2</b>	.02	.02	.01	.03+	.01
<b>Mood</b>	.34*	.27+	.26+	.23+	.27*
<b>AC</b>	.00	.03	.02	.00	.02
<b>Mood x AC</b>	-.16	-.17	-.08	-.17	-.08
<b>Total R<sup>2</sup></b>	.12*	.06	.07	.10+	.08

Note. N=72, R<sup>2</sup>Δ=R<sup>2</sup> change, β=Beta, AC=Avoidance Coping, p<.10+, p<.05\*

A summary of regression results for male gamblers is shown in Table 5. The picture is quite different for males compared to females. None of the mood by avoidance coping interactions were predictive of problem gambling. Also, contrary to expectations, avoidance coping failed to predict problem gambling in any of the regressions. A power analysis indicated that the study had a 73% chance of detecting even weak correlations in the population.

Loneliness and stress were the only mood states able to significantly predict problem gambling, although the relationship between problem gambling and the predictors of depression, boredom and anxiety approached significance. Men who scored high on these negative emotions tended to show more symptoms of problem gambling than those who scored low.

## Discussion

This study provides important insights about the gambling processes of males and females; however, this data needs to be viewed in the light of several limitations. The sample was drawn from disparate sources, so it may not accurately represent the general population. Of particular concern is the over-representation of university students who may differ from the general population in terms of age, gender or education. It is possible that the inclusion of so many university students has biased the results of the study.

The rationale for the broad recruiting strategy was (a) to over-represent the number of problem or potential problem gamblers in the sample (those scoring five or more on the SOGS) through targeting a source of known problem gamblers; and (b) to target a wide range of adults who gamble, using both student and community recruitment. A second limitation was the cross-sectional nature of the study. Cause-effect relationships cannot be assumed between the key variables of coping, mood and problem gambling. Findings of the current study should be seen as supporting other work that suggests cause and effect. A third limitation of the study concerned the measure of avoidance coping. This measure was less than optimal as it questioned coping on a single occasion, targeted only a few of the many possible avoidant coping behaviours and was not a highly reliable measure. Replication of this study with a range of more developed scales would be of value. Finally, given the practical difficulties of sampling, this study did not focus on any particular gambling type, and factors predicting problem gambling may vary across gambling types. Nevertheless, it was clear that poker-machine gambling was the most favoured form of gambling in the sample and by problem gamblers. It is within the context of these limitations that the following discussion and conclusions must be viewed.

The results of this study revealed that problem gamblers, both male and female, were significantly more likely to be depressed, anxious, stressed, bored or lonely than non-problem gamblers and were more likely to use an avoidance coping style to deal with stressful events or feelings. This initial analysis supported prior research findings (e.g., Becoña et al., 1996; Getty et al., 2000; Ohtsuka et al., 1997), suggesting that avoidance coping and dysphoria are important variables associated with problem gambling for both males and females. Such a conclusion, however, does not tell the whole story, and should not be used to justify the application of a "male model" of problem gambling to female gamblers. Further investigation with more sensitive methods of analysis revealed substantial differences in the way avoidance coping and dysphoria predicted problem gambling for males compared to females. It is to a discussion of these analyses that we now turn.

### **An interactional model of dysphoric mood and avoidance coping**

An interactional model of problem gambling predicts that the effects of dysphoric mood on problem gambling will be moderated by avoidance coping. From such a model it would be expected that gamblers who scored high on both dysphoric mood and avoidance coping would show substantially more symptoms of problem gambling than gamblers who scored high on only one of these variables. These predictions were strongly supported for female but not for male gamblers.

As expected, female gamblers with high levels of dysphoria tended to experience more symptoms of problem gambling than those with low dysphoria. This prediction was supported for all mood states, except stress, giving strong support to prior research that found that women with gambling problems experience higher levels of negative mood (Brown & Coventry, 1997; Trevorrow & Moore, 1998). Secondly, as expected, female gamblers who scored high on avoidance coping tended to exhibit more problems with their gambling. Again, these results were consistent with prior research (Getty et al., 2000; Scannell et al., 2000).

Thirdly, the hypothesis that there would be a significant interaction between avoidant coping and dysphoria, such that female gamblers with high dysphoria and high avoidance coping would tend to show more symptoms of problem gambling than those high in just one variable, was supported. The introduction of a variable representing the mood by avoidance coping interaction significantly improved prediction of problem gambling for women. Again, this was true for all mood states except stress. Overall, these results gave strong support to the interactional model of avoidance coping and dysphoric mood for female gamblers. They suggest that while avoidance coping and dysphoric mood are both important factors in problem gambling, female gamblers who score high on both variables may be particularly vulnerable to problem gambling. These results are in tune with prior qualitative research that found that female problem gamblers reported gambling specifically as a means of escaping emotional problems (Brown & Coventry, 1997; Loughnan et al., 1996; Pierce et al., 1997).

The results of regressions involving male gamblers were markedly different to those involving female gamblers. Male gamblers who experienced loneliness or stress tended to have more symptoms of problem gambling. However, none of the other mood states were significantly correlated with problem gambling. Therefore, these results show very little support for prior research that found evidence of elevated loneliness, boredom, depression and anxiety in male problem gamblers (McCormick et al., 1984; Ohtsuka et al., 1997). These inconsistent findings cast some doubt on the applicability of negative mood in explaining male problem gambling.

Secondly, contrary to expectations, there was no relationship between avoidance coping and problem gambling for the male gamblers. These results appear to be contrary to prior research that found that male problem gamblers use significantly more avoidance coping than male non-problem gamblers (Getty et al., 2000; McCormick, 1994). One explanation for these apparently contradictory findings may be the use of more sophisticated methods of analysis in the current study. The regression analyses used in this study scrutinised the relationships between avoidance coping and problem



gambling separately for male and female gamblers rather than simply comparing the average level of avoidance coping. Possibly, avoidance coping is high (on average) in male problem gamblers but is not predictive of problem gambling.

Thirdly, the hypothesis that there would be a significant interaction between avoidance coping and dysphoria, such that male gamblers with high dysphoria and high avoidance coping would tend to show more symptoms of problem gambling than those high in just one variable, was not supported. None of the regressions were able to significantly predict the dependent variable via an interaction between mood and avoidance coping. These results cast considerable doubt on the applicability of this interactional model for male gamblers.

### **Gendered avoidance strategies?**

The tendency for female gamblers to see gambling as a form of distraction rather than a source of excitement or money may, in part, be due to social restrictions on gambling access for females. There is some evidence that female gamblers tend to gamble on a narrower range of activities compared to male gamblers; many showing a strong preference for poker machines over other forms of gambling (Hraba & Lee, 1996; Productivity Commission, 1999; Slowo, 1997). The tendency for female gamblers, particularly regular gamblers, to play poker machines rather than other forms of gambling may be because these venues are seen as more socially acceptable for females. Local hotels and clubs have made considerable efforts to ensure that their poker-machine venues are attractive and comfortable for women, even for women who are alone (Błaszczynski, Walker, Sagris & Dickerson, 1999). In contrast, it doesn't appear that other betting venues such as horse racing outlets have made the same sort of efforts to encourage female gamblers.

Different forms of gambling may satisfy different psychological needs. People who play poker machines often cite "escape" as their reason for gambling while racing and casino gamblers report gambling for "excitement" (Hraba & Lee, 1996; Slowo, 1997). If women are regularly exposed to a form of gambling that lends itself to escapism rather than excitement, it is possible that women who are searching for a socially acceptable means of escape find it in gambling—or in other words, poker-machine gambling. Indeed, a study investigating gambling in Australia (Productivity Commission, 1999) found that the vast majority of female problem gamblers seeking help had problems with poker machines. The Commission even went so far as to say that the "feminisation" of problem gambling appears strongly associated with the spread of gaming machines in Australia.



In contrast, male gamblers who relied heavily on avoidance coping did not show any particular tendency to display more problems with their gambling than those who showed less reliance on avoidance coping. Prior research has found that male gamblers tend to see their gambling as a source of excitement or money rather than as a means of escape (Pierce et al., 1997; Slowo, 1997), although this information is controversial (Blaszczynski, Wilson & McConaghy, 1986). Perhaps males who rely on avoidance strategies have a tendency to turn to other forms of avoidance.

It is widely accepted that many people drink alcohol to regulate negative emotions and that those who do so tend to drink more often and may be at greater risk of developing drinking problems than purely social drinkers. However, although this stressor-drinking model is quite popular, Cooper et al. (1992) found that the effect of negative life events on drinking behaviour was moderated by coping in a manner similar to what is discussed in this study. They found that negative life events only predicted alcohol use and drinking problems in men who relied heavily on avoidance coping. In contrast, men who scored low in avoidance coping did not display additional drinking problems when faced with more stressors.

It is possible, therefore, that socialisation encourages men and women to choose different methods of avoidance coping. Drinking and particularly drinking to excess are generally more socially acceptable for men than women (Broom, 1994; Cooper et al., 1992). Similarly, gambling and gambling on poker machines have become acceptable forms of entertainment for women (Blaszczynski et al., 1999). Societal values that play a big part in determining which behaviours are acceptable for men and women may also be indirectly influencing which behaviours are more likely to become maladaptive forms of coping for each gender.

## Counselling implications

The results of this study have implications for the counselling methods used with women. In terms of female problem gamblers, ongoing battles with gambling and other maladaptive behaviours may be an indication that some therapies focus too narrowly on overt gambling behaviours or cognitions and too little on underlying factors, such as poor coping strategies or dysphoria. If, for instance, a woman is gambling to escape loneliness, then counselling strategies that focus entirely on her gambling behaviour are unlikely to be successful in the long term. Even if problem gambling is successfully halted, it is possible that she may simply turn to another form of avoidance, such as excessive drinking or eating to cope with her ongoing loneliness.

The results of this study have also shown that effective counselling for female

problem gamblers should include an active search for underlying factors such as dysphoric mood or maladaptive coping strategies. Female problem gamblers who display a lack of sophistication in their use of coping strategies may find that counselling that integrates an element of coping enhancement provides long-term assistance. This may involve expanding a limited coping repertoire or simply increasing understanding around the appropriate use of various coping strategies. Counselling of female problem gamblers may also need to include an active search for underlying emotional problems. If women are gambling because of dysphoric emotions then the overt behaviours should be seen as symptoms rather than the cause of problems.

McCorrison (1999) argues that if counsellors can identify the "needs" that are satisfied by gambling, they can then work with clients to find alternate methods of satisfying these needs. In this way, they can help clients make problematic gambling behavior redundant.

## Conclusion

The results and conclusions of this research are starkly different from previous research that investigated the relationship between avoidance coping and problem gambling for male gamblers (Getty et al., 2000; McCormick, 1994). It is possible that these contrasting results are an aberration of the current sample. However, the sample size was quite large and the results of the initial analysis supported those of prior research, which suggested that male and female problem gamblers had elevated levels in avoidance coping. This implies that the current sample was not substantially different to past samples. It seems that the deviation of the results and conclusions of this research stemmed directly from the differing methods of analysis used. It is therefore important for future studies to replicate the research methodology with other samples of male and female gamblers.

Future research replicating the current study's interactional model may also find that controlling gambling type (perhaps restricting participation to current poker machine gamblers) would ensure that gender differences observed are not confounded by gambling preference (Delfabbro, 2000). Additionally, where possible, coping tendencies should be assessed on several occasions rather than the single episode measured in the present study, ensuring a more accurate assessment of stable coping tendencies (Folkman, Lazarus, Gruen & DeLongis, 1986). Of course, there are likely to be many different causal paths to problem gambling; this study has attempted to isolate one potentially causal relationship between mood, coping skills and problem gambling.

In summary, this study indicates that the motivations of female problem

gamblers may differ from those of male problem gamblers. Female gamblers who were high in both avoidance coping and dysphoric mood showed substantially more symptoms of problem gambling than those high in just avoidance or dysphoria. These results supported prior qualitative research and suggest that some female gamblers may be gambling to escape dysphoric mood, and that these females may be particularly susceptible to problem gambling (Brown & Coventry, 1997). In contrast, there was no evidence that this combination of high avoidance coping and high dysphoric mood substantially increased the risk of problem gambling for males suggesting this model may not be applicable to male gamblers.

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### Problem-solving skills in male and female problem gamblers

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#### Abstract

The current study was designed to compare the self-reported problem-solving skills of male and female gamblers. In total, 148 females and 112 males (mean age = 43.6 years, SD = 12.0), responding to an advertisement for people concerned about their gambling, completed the Problem Solving Inventory (Heppner, 1988). The PSI consists of three factors related to self-perception of problem-solving: confidence, personal control and approach-avoidance style. Gamblers were categorized into three subgroups according to their DSM-IV scores: Asymptomatic, Problem, and Pathological. Results from a series of analyses of co-variance (co-varying for the confounding

effects of current emotional distress) revealed that gender had no significant effect, but problem severity on appraisal of problem-solving confidence and sense of personal control had a significant effect. Pathological gamblers were less confident and felt less in control than the other subgroups while engaging in problem-solving activities. Problem gamblers tended to have more negative appraisals of control than Asymptomatic gamblers. Problem-solving skills were also a significant predictor of DSM-IV scores for pathological gambling (i.e., negative appraisals were associated with higher DSM-IV scores). The results suggest that problem-solving skills are deficient in pathological gamblers and problem gamblers, but are not related to gender.

## Introduction

In a meta-analytic study of gambling disorders in Canada and the United States, Shaffer, Hall and Vander Bilt (1997) estimated that the lifetime prevalence rate of pathological gambling for women in the general population is approximately 1%. Another 3% of women experience a variety of adverse consequences from their gambling activities, despite not meeting diagnostic criteria for pathological gambling. Their analyses, which included studies spanning 20 years of empirical research, suggested that up to a third of pathological and problem gamblers in the general population were women.

The vast majority of empirical studies on gambling have either included only male gamblers or an insufficient number of women to permit meaningful comparisons. Mark and Lesieur (1992), in reviewing this literature, found very few studies that addressed pathological gambling in women. Furthermore, where sizeable numbers of female gamblers have been studied, differences in sampling, methodology, representativeness (e.g., GA membership) and assessment have made comparisons with other studies including women difficult. The available data suggest that women when compared to men generally experience a later onset of gambling (Lesieur & Rosenthal, 1991), report a shorter duration between non-problem and problem gambling (Rosenthal, 1992; Lesieur, 1988), tend to gamble within a social context, focus on games that are not considered to require skill (e.g., bingo, slot machines) or intended to enhance social functioning or self-esteem (Lorenz, 1990; Rosenthal, 1992), tend to wager smaller amounts and adopt gambling as a means to cope with dysphoric emotions (Rosenthal, 1992). This suggests that there may be important gender differences in problem-solving behaviours that may produce different patterns and characteristics of gambling behaviour. The purpose of the current study is to compare the problem-solving skills of male and female gamblers.

Cognitive behaviour therapy (CBT) is among the most validated treatment

approaches to addictive behaviours (e.g., Walters, 2000). CBT interventions tend to be goal-oriented, practical and problem-focused. Commonly, distortions in thinking and perception and/or behavioural deficiencies or excesses are targeted. Motivational interventions intended to reduce ambivalence are also routinely used. Cognitive-behavioural treatment of alcohol problems often target deficits in problem-solving skills (Heather, 1995). While the evidence to date is not yet strong, a recent review of randomized control studies found CBT to be the most effective therapeutic modality for problem gambling (Toneatto & Ladouceur, in press). Since CBT can be viewed as a form of problem-solving therapy, a greater understanding of the problem-solving characteristics of problem gamblers might be important in informing CBT approaches for problem gambling and may guide the development of gambling-specific CBT interventions. Unfortunately, little is known about the problem-solving behaviours of problem gamblers. After a CBT intervention that included a specific problem-solving training component, Ladouceur and Sylvain (1999) found that treatment outcomes improved in pathological gamblers compared to a wait-list control group. Clearly, more research is needed to directly examine problem-solving skills in gamblers.

## **Method**

### **Participants**

In total, 148 female and 112 male gamblers, age 18 or older, volunteered to participate in a confidential survey about gambling. Participants were recruited primarily from advertisements placed in major urban newspapers seeking people concerned about their gambling.

### **Procedure**

Individuals interested in the study contacted the research coordinator by telephone. The coordinator described the study, answered any questions and screened individuals to see if they met the primary study criteria: Are they concerned about their gambling behaviour? Those consenting to participate were mailed a self-administered questionnaire booklet. Participants who returned completed booklets received \$40 in gift certificates.

### **Measures**

#### **Gambling severity**

The Diagnostic and Statistical Manual (American Psychiatric Association, 1994) criteria for pathological gambling was used to assess gambling severity. Participants answered 10 questions related to symptoms experienced within

the past 12 months. Scores ranged from zero to 10, and individuals scoring five or higher met criteria for pathological gambling. For the current study, gamblers were categorized into one of three levels of gambling-problem severity based on their DSM-IV gambling scores: asymptomatic (score of 0), problem (1 to 4) and pathological (5 or higher).

### **Problem-solving skills**

The Problem Solving Inventory (PSI) (Heppner, 1988) was administered as the key measuring device of problem-solving skill. The PSI is a 35-item instrument measuring how individuals believe they react to personal problems encountered in their daily lives. The instrument consists of three sub-scales: Problem-Solving Confidence (scores range from 11 to 66), Approach-Avoidance Style related to problem-solving activities (scores range from 16 to 96) and degree of Personal Control of emotions and behaviours while engaging in problem-solving activities (scores range from 5 to 30). Low scores are associated with a positive view of problem-solving skills. This instrument possesses good internal consistency (alphas range from .72 to .85 on the sub-scales and .90 on the entire test) and there is good test-retest reliability. The validity of the PSI has been evaluated in various populations including adolescents, psychiatric populations and university students. For example, validity studies have shown that the PSI is linked to psychological well-being (e.g., Heppner & Anderson, 1985); symptoms of generalized anxiety disorder (Ladouceur, Blais, Freeston, & Dugas, 1998); hopelessness, depression severity and dysfunctional attitudes in depressed outpatients (Cannon et al., 1999; Otto et al., 1997); depression, hopelessness, and psychosocial impairment in patients with chronic low back pain (Witty, Heppner, Bernard, & Thoreson, 2001).

### **Current psychiatric distress**

The Brief Symptom Inventory (BSI) (Derogatis, 1993; Derogatis & Melisaratos, 1983) consists of 53 symptoms designed to measure nine dimensions of psychopathology experienced by individuals within the past week. The Global Severity Index (GSI), based on the mean rating for all 53 items, is scored on a five-point scale, ranging from zero, meaning "not at all," to four, meaning "extremely," and provides an overall index of current emotional distress. Internal consistency coefficients for the nine sub-scales cluster around .80 with test-retest correlations ranging from .68 to .91 over a two-week period (Derogatis & Melisaratos, 1983). The GSI has a stability coefficient of .90 over a two-week period.

### **Data analysis**



A series of 2x3 analyses of covariance (ANCOVAs) were conducted to explore the effects of gender and gambling severity on each of the measures of problem-solving skills while controlling for current psychiatric distress (measured by the GSI on the BSI) that may confound coping activities (Stanton, Danoff-Burg, Cameron, & Ellis, 1994). The alpha level was set at .05 for main effects and interaction effects. Observations that were two or more standard deviations away from the mean were considered outliers, and were excluded from the analyses of covariance. A regression analysis using the STEPWISE method (SPSS 10.0) was also conducted to determine whether self-perception of problem-solving skills predicted DSM-IV scores when other demographic variables, psychiatric variables and gambling frequency were included in the regression equation.

## Results

Demographic characteristics of the sample are found in Table 1. There were significantly more unmarried men (68.8%) than women (54.1%) in the sample ( $\chi^2$ ,  $p = .016$ ).

**Table 1. Demographic characteristics by gender**

	<b>N</b>	<b>Males</b>	<b>Females</b>	<b>Total sample</b>
<b>Age (M years [SD])</b>	260	42.9 (11.4)	44.2 (12.4)	43.6 (12.0)
<b>Marital status:<sup>1</sup> n (%)</b>	260			
<b>Married/partnered</b>		35 (31.3%)	68 (45.9%)	103 (39.6%)
<b>Not married/partnered</b>		77 (68.8%)	80 (54.1%)	157 (60.4%)
<b>Education level: <sup>2</sup> n (%)</b>	260			
<b>Secondary or less</b>		50 (44.6%)	79 (53.4%)	129 (49.6%)
<b>Post-secondary</b>		62 (55.4%)	69 (46.6%)	131 (50.4%)
<b>Employment status: <sup>3</sup> n (%)</b>	258			



<b>Employed</b>		59 (53.6%)	76 (51.4%)	135 (52.3%)
<b>Not employed</b>		51 (46.4%)	72 (48.6%)	123 (47.7%)
<b>Gross annual income (\$); n (%)</b>	258			
<b>&lt; 20 000</b>		44 (39.6%)	78 (53.1%)	122 (47.3%)
<b>20 000 —39 000</b>		32 (28.8%)	44 (29.9%)	76 (29.5%)
<b>40 000 —59000</b>		23 (20.7%)	19 (12.9%)	42 (16.3%)
<b>60 000 +</b>		12 (10.8%)	6 (4.1%)	18 (7.0%)
<b>Gambling categories n (%)</b>	260			
<b>Asymptomatic</b>		16 (14.3%)	18 (12.2%)	34 (13.1%)
<b>Problem</b>		44 (39.3%)	57 (38.5%)	101 (38.8%)
<b>Pathological</b>		52 (46.4%)	73 (49.3%)	125 (48.1%)

$\chi^2$ ,  $p = .016$

$\chi^2$ ,  $p = .163$

$\chi^2$ ,  $p = .716$

Otherwise, there were no other gender differences. About half of the sample was employed, reported some post-secondary education and earned more than \$20,000 per year. The proportion of men and women whose gambling severity was asymptomatic, problem and pathological is also reported in Table 1. Within each severity category, there were comparable proportions of men and women. Almost half of the sample consisted of gamblers whose problem severity was pathological while approximately 13% were asymptomatic.

Table 2 shows the frequency of gambling behaviours for the male and female participants. Lottery, scratch tickets, casino slot machines and bingo were popular gambling activities.

**Table 2. Description of gambling behaviour by gender**

Gambling activity	Number of times per year Mean (SD)			
	N	Males	N	Females
Lottery	97	97.6 (69.4)	129	126.3 (131.4)
Scratch tickets	64	104.2 (108.8)	101	130.6 (147.3)
Pull tabs	25	106.5 (129.2)	50	76.6 (116.0)
Card games (private)	34	54.9 (62.7)	28	45.0 (72.7)
Casino card games	37	56.9 (87.3)	22	31.1 (48.6)
Casino table games	19	58.2 (74.5)	8	40.3 (69.1)
Casino slot machines	42	54.6 (77.6)	79	61.7 (89.4)
Casino video gambling	11	55.3 (112.0)	16	37.2 (53.1)
Stock market	10	45.3 (33.8)	11	23.5 (53.1)
Race track	39	50.7 (84.8)	29	59.8 (123.0)
Real estate	2	3.0 (1.4)	2	53.0 (72.1)
Sports lotteries	53	148.4 (125.0)	16	91.4 (123.0)
Sports betting	25	92.6 (116.3)	5	56.1 (61.3)
VLTs	9	129.7 (145.1)	12	44.0 (50.2)
Bingo	25	41.2 (64.3)	98	96.3 (85.2) <sup>1</sup>
Charity	15	76.4 (99.5)	15	47.7 (99.5)
Internet gambling	1	4 (--)	3	160.3 (183.1)

<sup>1</sup> excludes one extreme outlier

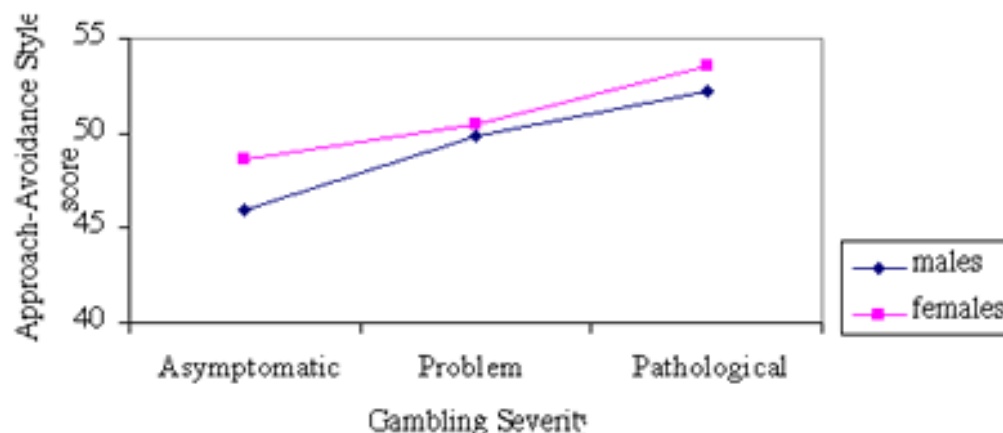
Male and female participants playing lottery, scratch tickets or pull tabs were playing on average between 1.5 and 2.5 times per week. Participants also reported playing a variety of casino games between 30 and 60 times per year. About twice as many women reported playing bingo than men. Few participants engaged in real estate or Internet gambling. The gambling

activities that were identified as causing the biggest concern for men were casino card games (23.2%), lotteries/scratch tickets (13.7%), sports lotteries (13.7%) and race track betting (12.6%). For women, the gambling activities that caused the most concern were bingo (34.1%), casino card games (27.8%) and lotteries/scratch tickets (15.0%).

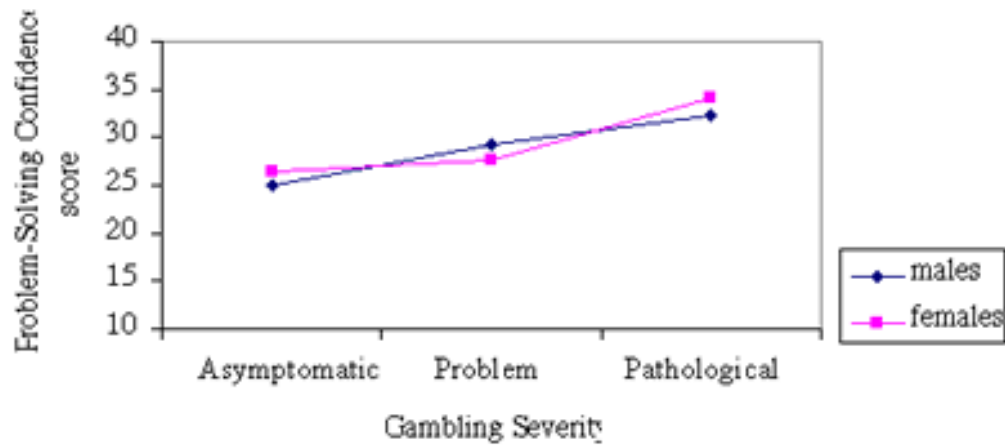
Treatment by a psychiatrist was reported by 40.2% of the sample while 45.6% reported receiving treatment by a psychologist or other mental health professional. Almost one-third had been prescribed anti-anxiety medication, 42.9% prescribed anti-depressants and 7.7% prescribed anti-psychotic medication or mood regulators. Almost one-fifth (18%) of the sample reported having been hospitalized for a mental health problem. No gender differences were found on any of these variables.

Figure 1 displays the mean scores for problem-solving confidence, personal control and approach-avoidance sub-scales of the PSI by gender and gambling severity. Results of the ANCOVA on the Problem-Solving Confidence sub-scale revealed that there was a significant main effect of gambling severity ( $F_{2,250} = 5.02$ ,  $p = .007$ ) and no significant gender or interaction effects. Simple contrasts of the severity subgroups revealed that the pathological gamblers rated themselves as significantly less confident in their problem-solving skills than both the asymptomatic subgroup (mean difference = 4.41; 95%CI = 1.52 to 7.30;  $p = .003$ ) and the problem gambler subgroup (mean difference = 2.20, 95%CI = 0.16 to 4.23;  $p = .035$ ). The difference in confidence scores between the asymptomatic and problem groups was not significant ( $p > .10$ ).

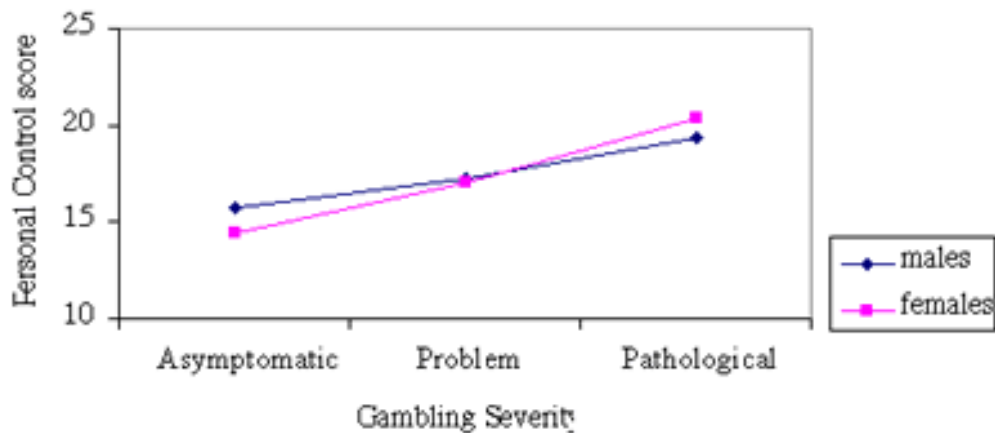
**Figure 1. PSI problem-solving confidence, personal control and approach-avoidance style sub-scale scores by gender and gambling severity.**



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On the Personal Control sub-scale, there was also a significant effect of gambling severity ( $F_{2,247} = 13.09$ ,  $p < .001$ ), but no significant gender or interaction effects. Simple contrasts revealed that pathological gamblers felt significantly less personal control during problem-solving than the problem gamblers (mean difference = 1.66; 95%CI = 0.67 to 2.65;  $p = .001$ ), and the problem subgroup, in turn, reported less control than the asymptomatic subgroup (mean difference = 1.83, 95%CI = 0.49 to 3.18;  $p = .008$ ).

Figure 1 shows that the pathological gambling subgroup had a higher mean score on the Approach-Avoidance Style sub-scale (higher scores signify a more avoidant style to problem-solving activities) than the other gambling subgroups; however, the ANCOVA revealed no significant effects of gambling severity ( $p = .13$ ), gender, and gender by severity interaction effects.

To examine whether problem-solving skills predicted DSM-IV scores for pathological gambling, the following variables were entered into a stepwise

regression: age, gender, employment status, GSI from the BSI, history of treatment by psychiatrist (yes/no), gambling frequency (frequency of the gambling activity with the highest level of participation within the past year) and total score on the PSI. The PSI total score measures perception of general problem-solving abilities and was included instead of the individual PSI sub-scale scores to avoid problems of multicollinearity. (Pearson correlation coefficients ranged from .51 to .69 among the various sub-scales in this sample.) The Global Severity Index, gambling frequency and total PSI score were the only variables retained in the final regression model (Table 3). Higher psychiatric distress, higher gambling frequency and more negative views of

**Table 3. Predictors of DSM-IV pathological gambling scores**

		Stepwise multiple regression <sup>2</sup>				
Predictors <sup>1</sup>	Step	b	D R <sup>2</sup>	df	Total R <sup>2</sup>	Adjusted R <sup>2</sup>
<b>BSI —Global Severity Index</b>	1	.370	-	1,251	.227	.224
<b>Gambling frequency measure</b>	2	.223	.062	1,250	.288	.283
<b>PSI total score</b>	3	.183	.026	1,249	.315	.306

<sup>1</sup> Variables entered into the stepwise regression but excluded from the final regression equation include: age, gender, employment status, psychiatric treatment.

<sup>2</sup>  $\beta$  denotes standardized beta coefficients of the final regression equation.

problem-solving ability predicted higher DSM-IV scores. The final regression model explained 31.5% (adjusted  $R^2 = 30.6\%$ ) of the variance in DSM-IV gambling scores, with PSI scores contributing to a small ( $\Delta R^2 = 2.6\%$ ) but significant increase in explained variance. If instead the three sub-scales scores (in place of the PSI total score) are allowed to compete for entry into the regression, the Personal Control sub-scale enters as the third step in the model following the BSI global index severity and gambling frequency, and predicts 4.4% of the total (33.2%) explained variance.

## Discussion

This study revealed that there were differences in perceived problem-solving skills among gamblers with different levels of problem severity. However, there were no significant gender differences. Both male and female pathological gamblers reported being less self-assured while trying to solve problems they encountered in their lives and felt less in control over their emotions and behaviours during problem-solving activities than either the asymptomatic or problem gamblers. The problem gamblers perceived themselves to have less control over their emotions and behaviours during problem-solving compared to the asymptomatic gamblers.

A comparison of PSI scores observed in the pathological gamblers, and to some extent the problem gamblers, were quite similar to those reported in other clinical populations (e.g., inpatient males with alcohol problems, Larson & Heppner, 1989; generalized anxiety disorders, Ladouceur, et al., 1998). These clinical populations tended to have more negative appraisals of problem-solving skills than undergraduate student populations or adult populations. This suggests that pathological gamblers and patients with substance use disorders or psychiatric disorders might benefit from interventions addressing these deficits. Both male and female gamblers in this study appear to require some problem-solving skills training.

The absence of significant gender differences in various aspects of problem-solving skills also suggests that CBT gambling-treatment interventions for men and women do not need to be drastically different with respect to problem-solving skills training. CBT interventions for problem gamblers and especially pathological gamblers may also benefit from targeting problem-solving skills that need attention (e.g., enhancing emotional and behavioural control when handling high-risk gambling situations). The relatively high avoidance scores observed in the pathological gamblers also seem to indicate that CBT interventions may be a good treatment approach in teaching gamblers a more effective style of dealing with problems.

A limitation of the study is that the PSI measures perceived and not actual problem-solving skills; however, there is some evidence that they are related (Heppner, Hibbel, Neal, Weinstein & Rabinowitz, 1982). Furthermore, there does seem to be a pattern among clinical populations to report negative appraisals of problem-solving skills, suggesting that these problem-solving skills warrant attention. While Dixon, Heppner, Burnett, Anderson and Wood (1993) found that PSI scores were both an antecedent and predictor of a depressed mood, it not possible in this study to determine whether deficits in problem-solving appraisal was a symptom of or precursor to gambling

problems. Deficits in problem-solving skills may contribute to vulnerability in the development of gambling problems, or conversely, having a gambling problem may, over time, negatively influence problem-solving skills. The current study was correlational in nature, and additional controlled research is needed to further explore problem-solving abilities in problem gamblers.

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### Gender differences in psychiatric comorbidity and treatment-seeking among gamblers in treatment

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#### Abstract

**Objectives:** To assess the effects of gender on comorbid problems and treatment-seeking among gamblers in treatment and the effects of comorbid problems on participants' gambling

**Method:** Participants completed a survey on comorbid problems and the

effects of comorbid problems on their gambling

**Sample:** Seventy-eight adults (40 males, 38 females) enrolled in state-supported outpatient programs or Gamblers Anonymous

**Results:** The majority of participants (53%) had multiple comorbid problems and 38.5% said they had a comorbid problem related to their gambling. Eleven different types of comorbid problems were reported. Females had significantly more comorbid problems than males; females reported problem drinking and both genders reported that depression increased the severity of their gambling problems.

**Conclusion:** Patterns of comorbid problems and treatment-seeking are consistent with well-known gender differences in health behaviors. Clinicians involved in gambling treatment may wish to assess for depressive syndromes and problem drinking and investigate their interaction with their patient's gambling.

**Keywords:** comorbidity, alcohol, gamblers, gender, treatment, career length, depression

## Introduction

Gender has been a determinant of many health-related behaviors, such as treatment utilization, substance use, and psychiatric symptoms and diagnoses (Robins & Regier, 1991; Verbrugge, 1985). Males tend to have earlier and higher mortality rates (Verbrugge, 1985) and use substances (alcohol, tobacco and street drugs) more than females (Robins & Regier, 1991). Females tend to use physical and mental health services more (Verbrugge, 1985) and use more proscribed drugs than males (Verbrugge, 1985). Gender is also important in psychiatric disorders, where males tend to have higher rates of disordered substance use, with the exception of prescription drug use (Robins & Regier, 1991) and females tend to have more psychiatric disorders, especially in the anxiety and mood disorder cluster (Robins & Regier, 1991).

Historically, in studies of the prevalence of gambling disorders, males have significantly outnumbered females. Volberg (1994), in a paper summarizing prevalence studies from five states in the United States, estimated males to be 76% of pathological gamblers in the community. The most current diagnostic manual states that females comprise only 33% of pathological gamblers (American Psychiatric Association, 2000). However, the expansion of legalized gambling in the United States has changed this ratio. The most

recent U.S. national survey of gambling behavior, completed in 1999, shows gambling disorders more equally distributed by gender. Although the National Opinion Research Center (1999) found higher prevalence rates of problem and pathological gambling among men than women —male lifetime rates: problem 1.6%, pathological 0.9%; female lifetime rates: problem 1.0%, pathological 0.7% —in their initial (RDD) survey, the differences were not statistically significant.

Studying the patterns of comorbid disorders can lead to better treatment and understanding of the causal factors in the disorder. Additional disorders of all types have implications for treatment. The presence of comorbid diagnoses makes it more likely that the patient will seek treatment (Andrews, Slade & Issakidis, 2002; Noyes, 2001). The presence of comorbid diagnoses also increases the likelihood of treatment failure in many psychiatric disorders: depression (Bagby, Ryder & Cristi, 2002), bipolar disorder (Frangou, 2002), obsessive-compulsive disorder (Ruppert, Zaudig, Hauke, Thora & Reinecker, 2001), generalized anxiety disorder (Noyes, 2001), post-traumatic stress disorder (Breslau, 1999) and panic disorder (Mennin & Heimberg, 2000). The presence of comorbid diagnoses affects cognitive-behavioral therapies (Mennin & Heimberg, 2000), inpatient treatment (Haettenschwiler, Rueesch & Modestin, 2001) and pharmacotherapy (Bagby et al., 2002).

The National Comorbidity Survey (Kessler et al., 1994) was the first survey to administer a structured psychiatric interview to a national probability sample of non-institutionalized people in the United States. The study found that psychiatric morbidity was highly concentrated in one-sixth, or approximately 16% of the adult population with a lifetime history of three or more comorbid disorders.

The most well-studied comorbid relationships among psychiatric disorders are the (misnamed) dual disorders, or the association between substance use disorders and psychotic, anxiety and mood disorders. The interactions can be very complex. To generalize: 1) the two disorders may occur by chance, 2) substance use may cause or exacerbate the psychiatric disorder, 3) the psychiatric disorder may cause or increase the severity of the substance use, 4) both disorders may be caused by a third condition, and 5) substance use or withdrawal may mimic the psychiatric disorder.

Studies of dual disorders often attempt to determine the temporal relationship of the onset of the different disorders to clarify causation. However, the comorbidity pattern can differ by the substance used and the specific other psychiatric disorder or disorders as well as by the population studied. For example, the National Comorbidity Study found that alcohol use problems and dependence consistently occurred after the onset of the psychiatric disorder



(Kessler et al., 1997). However, nationwide studies of psychiatric comorbidity and both alcohol and drug use disorders in six countries found that only anxiety disorders consistently preceded substance use disorders; mood disorders and substance use disorders had no consistent temporal pattern (Merikangas et al., 1998). Despite the theoretical complexity, the temporal relationship among comorbid disorders can be useful clinically, in deciding which of several disorders is primary, which have implications for treatment priorities and plans.

The study of other psychiatric diagnoses occurring with gambling disorders is early in its development. The Harvard Division of Addictions gambling disorder prevalence meta-analysis (Shaffer, Hall & VanderBilt, 1997) established psychiatric comorbidity as a risk factor for gambling disorders. Their analysis established significantly higher prevalence rates for gambling disorders among samples of adults with psychiatric or substance dependence disorders and those in prison than among community samples of adults. The relative risk varies from four to seven, depending on the population studied (Shaffer et al., 1997).

Comorbidity patterns change based on the population studied and site of assessment (Berkson, 1946). Clinical studies of patients in treatment with gambling disorders have found that other psychiatric disorders occur consistently. Ibañez et al. (2001) found comorbidity in 43% of gamblers seeking treatment. There have been more studies of treatment populations than community populations in the study of comorbid disorders in gambling. However, the number of subjects studied is usually small, especially in studies of anxiety and personality disorders. Clinically useful information, such as the nature and relevance of the specific comorbidity associations, is limited. See Table 1 for a summary of the relevant studies.

**Table 1**

**Summary table of research on comorbid diagnoses in community and treatment samples**

Disorder	Total number of studies	Community studies		Treatment studies	
		Number	Total subjects	Number	Total subjects

<b>Mood disorders</b>	20	3	9,100	17	3,200
<b>Anxiety disorders</b>	5	1	7,200	4	250
<b>Antisocial personality disorder</b>	2	1	7,200	1	109
<b>Substance use disorders</b>	12	2	9,200	10	3,200

Substance dependency has been relatively well established as a significant comorbidity with pathological gambling (Crockford & el-Guebaly, 1998; Ibañez et al., 2001; National Research Council, 1999; Shaffer et al., 1997). Approximately 50% of pathological gamblers will have a substance use or dependency diagnosis. Affective symptoms have also been found to be associated with pathological gambling (Crockford & el-Guebaly, 1998; Maccallum & Blaszczyński, 2002; National Research Council, 1999; Shaffer et al., 1997); however, the results have been inconsistent. One analysis proposed that affective disorders were a significant comorbidity in only a subgroup of problem gamblers (Crockford & el-Guebaly, 1998). Personality disorder comorbidity has also been studied, with antisocial personality disorder being the strongest association (Crockford & el-Guebaly, 1998; Ibañez et al., 2001). However, the strong association between substance use disorders and antisocial personality disorder confounds the association between gambling disorders and antisocial personality disorder (National Research Council, 1999).

There are many unanswered questions about the influence of comorbid psychiatric disorders in problem gamblers. Because of the historical predominance of males in populations with gambling disorders, the effect of gender on comorbidity patterns in gambling disorders is unstudied. In addition, since treatment populations for any psychiatric disorder are more likely to have other psychiatric disorders (Berkson, 1946), the clinical relevance of comorbid disorders in problem gambling has been minimally studied. Only one study has determined that comorbid disorders increase the severity of the gambling disorder (Ibañez et al., 2001). But do the comorbid disorders only add to disease burden and make it more likely for the patient to seek treatment or do they directly affect the gambling behavior and need to be

considered in the formulation of treatment plans for problem gamblers?

The objectives of this study were to assess (1) the effect of gender on comorbid problems and (2) treatment-seeking behavior of gamblers in treatment and (3) the interactive effects of the comorbid problems on the participants' gambling.

## **Method**

### **Participants**

An anonymous, voluntary questionnaire was distributed to all state gambling disorder treatment sites and Gamblers Anonymous meeting sites in the state of Louisiana in January of 1999 as part of a study on the social cost of gambling (Ryan et al., 1999). Seventy-eight questionnaires were returned in time for statistical analysis.

### **Materials**

Participants completed a survey that included a screen for gambling disorders, demographic questions, and questions about types and frequency of gaming activities, quantifiable consequences of gambling disorders, comorbid conditions, illicit substance use, gambling career and treatment-seeking history. Questions covered gambling behavior and work and legal and other consequences of disordered gambling based on Lesieur's model (Lesieur, 1998). Gender differences in these behaviors are under study. The questionnaire inquired about the types of other mental health and substance use problems that the participants had experienced. The questionnaire specifically asked, "Did any of these problems ever make your gambling problems worse?" Each participant's history of gambling, substance use disorder and psychiatric treatment was also reported.

### **Design and procedure**

Chi-square analyses were performed on the types of comorbid problems, total number of comorbid problems, types of mental health or substance use treatment sought and the response to whether or not gambling had been worsened by comorbid problems. A one-way ANOVA was performed on total number of comorbid problems by gender. The chi-square on each comorbid condition was analyzed separately by gender and by the dichotomous variable that reflected their worsening of the gambling problem.

## **Results**

## Previous treatment

Males reported larger treatment costs for gambling treatment and more substance abuse treatments. Females reported significantly more outpatient mental health treatment ( $\chi^2 (1, N = 78) = 5.198, p < .05$ ).

## Comorbid problems

Sixty-one of the 78 respondents (78%) reported other substance use or mental health problems. A total of 168 comorbid problems in 11 categories were reported by the sample. Twice as many males (30.7% of the total sample) as females (16.7%) had one or no other comorbid problems. See Table 2 for the distribution of the number of comorbid problems by gender. More females (32%) than males (20.6%) had two or more comorbid problems. A one-way ANOVA on total number of comorbid problems by gender showed that females (mean 2.42) had more comorbid problems than did males (mean 1.6) ( $F (1,76) = 3.948, p < .05$ ).

**Table 2**

**Total number of comorbid problems by gender with percentages of total sample**

Number of comorbid problems  Count/per cent of total	Males		Females	
0	14	17.9%	7	9.0%
1	10	12.8%	6	7.7%
2	7	9.0%	10	12.8%
3	2	2.6%	3	3.8%
4	3	3.8%	6	7.7%
5	2	2.6%	3	3.8%
6	2	2.6%	3	3.8%

Table 3 presents the percentages of males and females reporting specific

problems. Males reported significantly more alcohol problems ( $\chi^2 (1, N = 78) = 5.641, p < .05$ ) and problem use of other drugs ( $\chi^2 (1, N = 24) = 4.8, p < .05$ ) than females and showed tendencies to greater marijuana use ( $\chi^2 (1, N = 78) = 3.486, p = .062$ ). Females reported significantly higher problems with overeating ( $\chi^2 (1, N = 78) = 7.453, p < .01$ ), eating disorders ( $\chi^2 (1, N = 78) = 4.438, p < .05$ ), compulsive shopping ( $\chi^2 (1, N = 77) = 16.896, p < .001$ ) and tranquilizer use ( $\chi^2 (1, N = 24) = 10.667, p < .001$ ).

**Table 3**

**Per cent of sample reporting comorbid problems by gender**

	Per cent of total sample	
Disorder	Males	Females
Alcohol use	20.5**	7.7
Overeating	12.8	26.9**
Eating disorder	0	5.1*
Compulsive shopping	1.3	19.5***
Depression	28.2	30.8
Any drug use	14.1	14.1
	Per cent of drug users	
Substance	Males	Females
Marijuana	39.1	17.4
Tranquilizers	8.3	41.7***
Stimulants, "uppers"	8.3	8.3
LSD	4.2	0
Narcotics	8.3*	4.2
Other drugs	16.7	0

Note: \*  $p < .05$ ; \*\*  $p < .01$ ; \*\*\*  $p < .001$

## Effect of comorbid problem on gambling

Forty-nine per cent of those reporting comorbid problems (38.5% of the total sample) indicated that a comorbid problem had increased the severity of their gambling behavior. Eleven different types of comorbid problems were reported. Only two, depression and problem drinking, were identified as exacerbating gambling behavior. Females were significantly more likely than males to report that problem drinking ( $\chi^2 (1, N = 34) = 5.13, p < .05$ ) had increased the severity of their gambling. About the same percentage of males and females reported depression had increased the severity of their gambling. Chi-square analyses on depression by gender and by the variable that measured a worsening of gambling problems found that depression exacerbated gambling problems independent of gender. Both males ( $\chi^2 (1, N = 38) = 5.546, p < .01$ ) and females ( $\chi^2 (1, N = 34) = 5.903, p < .01$ ) reported that depression significantly worsened their gambling problems.

## Discussion

Many of the comorbid and treatment-seeking behaviors reported by this sample are consistent with well-known and studied gender differences in health behaviors. Males reported more alcohol and drug use problems and females reported more psychiatric problems, tranquilizer use and outpatient psychiatric treatment, which is consistent with previous reports (Kessler et al., 1994; Robins & Regier, 1991; Verbrugge, 1985).

The majority of the gamblers in this treatment sample from Louisiana had other psychiatric or substance use problems in addition to their gambling disorder. Comorbid problems were the rule rather than the exception in this population of gamblers in treatment. However, only a minority of patients with comorbid disorders answered positively to the question that the comorbid disorder had ever increased the severity of their gambling. This study partially supports the findings of Ibañez et al. (2001) that comorbid disorders increase the severity of gambling problems.

One finding of this study is that, from the participants' viewpoint, only two of the multiple comorbid problems reported had ever affected the severity of their gambling. Unfortunately, the effects were inconsistent: only about half of the patients with comorbid problems identified that depression or problem drinking had increased their gambling behavior. Most of the males with comorbid problem drinking and some of the participants with depression did not identify these problems as ever negatively affecting their gambling.

Although preliminary, this study provides more evidence of the need for



careful attention to diagnosing and investigating the interactions of comorbid alcohol (Maccallum & Blaszczyński, 2002) and affective disorders. Clinicians should further investigate the interaction of the comorbid disorder with gambling behavior and the order of onset of the disorders. For example, a patient who developed depressive symptoms after the onset of pathological gambling in response to financial, legal or marital problems should be treated differently than a patient who developed depressive symptoms, and later, found that gambling temporarily relieved the symptoms of depression. In this example, the clinical approach should be different, even if both patients reported that their depressive symptoms increased their desire to gamble or their gambling behavior.

In addition, this study provides some perspective on the inconsistent results of pharmacological treatments for gambling disorders. Inconsistent and possibly gender-related effects of comorbid disorders may be confounding the results of these trials. Several agents that affect mood and alcohol use behavior have shown inconsistent, mixed results in treatment trials. It may be necessary to sub-type gambling populations in treatment trials by both the presence and type of comorbid disorders as well as the effect of the comorbid disorder on the gambling behavior.

This study needs to be replicated with larger numbers and independent confirmation of comorbid diagnoses, rather than self-report alone. Family or other collateral information on the interaction of the comorbid disorders and the gambling would also be useful to supplement the patient's perceptions of the interactions. In addition, information on the onset of the comorbid disorders in relation to the gambling disorder would be crucial to determine causality. Further, more targeted studies are needed to clarify the clinical relevance of comorbid disorders for gamblers in treatment programs and to determine the role of these disorders in the development of gambling disorders.

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## Fruit machine addiction in an adolescent female: A case study



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Gambling is perceived as an "adult" activity primarily because of the legal restrictions placed on it. However, fruit machine gambling (a kind of slot machine playing) is one activity that is legally available to adolescents in the United Kingdom. Adolescent fruit machine playing is a widespread phenomenon, yet we still know so little about it in comparison with other potentially addictive behaviours. In the most recent U.K. study by Fisher and Balding (1998), 75% per cent of close to 10,000 adolescent participants stated that fruit machines were their favourite form of gambling.

A more thorough examination of the literature (Griffiths, 1995; Fisher, 1992;



Fisher & Balding, 1998) indicates that in the U.K.:

- At least two-thirds of adolescents play fruit machines at some point during adolescence.
- One-third of adolescents have played fruit machines in the last month.
- 10% —20% of adolescents are regular fruit machine players (playing at least once a week).
- Up to 6% of adolescents are probable pathological gamblers and/or have severe gambling-related difficulties.

Published studies report that males play fruit machines more often than females and that as fruit machine playing becomes more regular it is more likely to be a predominantly male activity. Researchers have identified few female adolescent fruit machine addicts.

Why do adolescents play fruit machines? There is no easy answer. However, research suggests that irregular ("social") gamblers play for different reasons than excessive ("pathological") gamblers (Griffiths, 1995). Social gamblers usually play for fun and entertainment, their friends or parents do (i.e., it is a social activity), for the chance of winning money, because it's challenging and easy to access or for the excitement (the "buzz") and because there is little else to do. It appears that pathological gamblers play to change the way they feel, for mood modification and to escape reality. As noted, young males seem to be particularly susceptible to fruit machine addiction. Using an adapted version of the American Psychiatric Association criteria (Fisher, 1993; Griffiths, 1995), with up to 6% of adolescents in the U.K. experiencing problems with their fruit machine playing at any given time. Not everyone who plays fruit machines will develop an addiction, just as not everyone who drinks alcohol will become an alcoholic. What it does mean is that given a cluster of factors (genetic and/or biological predisposition, social upbringing, psychological constitution, situational and structural characteristics) a small proportion of people will unfortunately experience severe problems.

Like other potentially addictive behaviours, an addiction to playing fruit machines causes negative behaviours such as truancy (Griffiths, 1990a, 1990b, 1995; Fisher & Balding, 1998), stealing money to play (Griffiths, 1990a, 1993; Yeoman & Griffiths, 1996; Fisher & Balding, 1998), having trouble with teachers and/or parents because of machine playing (Griffiths, 1990a, 1993, 1995), borrowing or using lunch money to play (Griffiths, 1990a, 1995; Fisher & Balding, 1998), doing poorly at school (Griffiths, 1990a, 1995), and in some cases, aggressive behaviours (Griffiths, 1990a, 1995). These behaviours are similar to other types of adolescent problem gambling.

Furthermore, adolescents addicted to fruit machine playing also display bona fide signs of addiction including withdrawal effects, tolerance, salience, mood modification, conflict and relapse.

As already noted, researchers have identified few adolescent females addicted to playing fruit machines. Fisher (1993) and Griffiths (1991), through their observational studies, have published the only findings relating to females who play fruit machines. Fisher reports that some female teenagers have no playing skills and little interest in acquiring them. They also gamble on fruit machines primarily to gain access to the arcade venue where they can socialize with friends (Fisher calls them "rent-a-spacers"); they prefer the role of spectators. Griffiths (1991) observed that arcades are social meeting places dominated by male activities and that female adolescents often play a "cheerleading" role in these activities. With so little known about excessive fruit-machine playing by female adolescents, this study reports the rare case of a female teenager who has a fruit-machine addiction.

## Method

The participant—an adolescent problem fruit-machine gambler—contacted the author after hearing a lecture he had given on problem gambling at the college where she studied. During a nine-month period, the author interviewed the participant three times formally and stayed in regular contact with her on an informal basis. The DSM-IV criteria for pathological gambling (American Psychiatric Association, 1994) were utilised, confirming that the participant was a former pathological gambler. At the time of the study, the participant was 22 years old.

This account tells the participant's story of how she acquired, developed and maintained her fruit-machine gambling problem. The account is presented chronologically; however, the original interviews were unstructured and allowed the participant to talk freely about whatever came to mind. A critical interpretation of the account follows in the discussion, although some initial observations are made where appropriate. Since the account is highly personal, the participant has been given the pseudonym "Jo."

## Results: The case study

### Background

Jo was brought up as an only child in a seaside town in the South West of England. She described her parents as "comfortable, middle class and loving"

but added that they made her follow reasonably strict rules. Her father was an insurance salesman and her mother a schoolteacher. She went to a mixed school, boys and girls, and up until the age of 13, received good report cards, performing in the top 10% of her class. She was also very good in sports, an active member of the school's athletic club, and described herself as "physically stronger" than most of her peers. Jo claims she couldn't really relate to the other girls in her school and often got into playground fights with them. During her early adolescence, she made a few good friends, mostly with boys her own age or a little older. She described herself as a "tomboy." When she was nearly 15, she had her "first serious boyfriend" whom she described as the "leader of the gang."

She left school when she was 16 and got an office job working as an administrative assistant. After recovering from her gambling problem, she is now back at school completing a vocational paramedical course.

### **Acquisition of fruit-machine gambling**

Jo started playing fruit machines at a young age because they were easy to access in her town, like "being part of the wallpaper." To some extent, her parents encouraged her to gamble. Like a lot of "seaside parents," they often took Jo to the amusement arcades as a child for a weekend treat. Jo's parents, like many, didn't see anything wrong with this type of gambling —"it was harmless fun and didn't cost much." However, these early experiences coupled with fruit-machine playing in her peer group were instrumental factors in Jo's acquisition of fruit-machine playing. The seaside town where Jo lived was a popular tourist attraction. It had four to five arcades, providing a popular meeting place for her friends and easy access to the machines. She was part of a gang that hung around the arcades for one of the few activities they could engage in. At 13, she regularly just watched her male friends play fruit machines and video games. However, within a year, she was playing fruit machines just as much as they were. "I'd go down to the arcade almost every day after school and be there most of the day during weekends. It was somewhere for us all to meet and have fun."

Jo felt "safe and protected" at the arcade. She liked it that everyone who worked there knew who she was —she was a "somebody" rather than a "nobody." In essence, being at the arcade boosted Jo's self-esteem.

### **Motivations to gamble**

Jo gave a number of insightful reasons why she played fruit machines. Skill did not appear to be a motivating factor for continued play. She played to win money, so she could continue to play rather than fuel fantasies of winning a

lot of money. Jo thought that playing fruit machines didn't require much skill; however, most of Jo's male friends claimed that fruit-machine playing required a lot of skill to be good at it. However, Jo always believed that to "win big" at fruit machines, unlike video games, you needed a lot of luck. Knowing how to use fruit machines didn't make her feel particularly skilful except when novices played next to her. Women older than her playing fruit machines wanted to socialize with her but not with boys her age —this made Jo feel wanted and needed.

When Jo was between 15 and 17, her fruit-machine playing became all-encompassing:

*There was a period in my life between the ages of 15 and 17 where the machines became the most important thing in my life. I didn't worry about money. I just believed I would win it back or that money would come from somewhere, because it always had. I was forever chasing my losses.*

*I would always tell myself that after a bad loss, the arcade was only "borrowing" my money and that they would have to "pay it back" next time I was in there. Of course, that rarely happened, but once I was playing again, money worries and losses went out of the window. Gambling became my primary means of escape. On the positive side, at least it helped me to give up smoking and drinking. I simply couldn't afford to buy nicotine or alcohol — or anything else for that matter. I never believed that gambling would make me rich —I just thought it would help me clear my debts.*

*I used to love the anticipation of going to play on the machines. The feeling after just being paid was almost intoxicating. Knowing I could afford to gamble because I had the cash in my purse was a wonderful feeling. Losing it all wasn't though. I remember blowing all my wages in a few hours one Friday night. I got really upset and depressed. It's like drugs, you tell yourself "never again" but deep down you know that as soon as the next pay cheque comes in, you'll be down at the arcade.*

### **Development of problem gambling**

Jo didn't acknowledge that she had a problem —even when she was going to the arcade alone and using all of her disposable income to play the fruit machines. However, in retrospect, she realized a problem was developing.

*Over time I saw less and less of my parents. Straight after school, I would go to one of two arcades and play on the [fruit] machines for half an hour or so. Originally, I would go to the arcade to meet up with my friends. As time went on, I didn't care if they were there or not. I used to spend hours in there and*

*only leave if I lost all my money, or it was time for the arcade to close. I simply wanted to play the machines. I became totally obsessed with them to the point where I couldn't get to sleep because I would be going over moves in my head. Looking back, I cannot believe I spent so much mental energy thinking about gambling.*

*...I used to spend every penny I had on the machines. It was a good job I wasn't into clothes like the other girls at school. I couldn't have afforded to buy anything, as I lost everything I had in the long run. I used to wear the same pair of jeans for months. I don't even think I washed them.*

*...My parents are lovely people but at the height of my playing, I didn't care about anyone—not even my boyfriend. We had loads of arguments about my gambling. He said it was OK for him to play on them but not for me. He called me an "embarrassment to be with." He was quite well off, which is one of the reasons I went out with him. I would always be borrowing money off him. I would tell him I needed to get cigarettes or something, but all of it went into the machines. He eventually realized my gambling was a problem. Initially he tried to help but just got pissed off and left me. At the time, I didn't give a shit as the machines were more important than anyone living.*

### **Hiding the problem**

When Jo was 15 years old, her mother received a phone call from the headmaster at Jo's school explaining that Jo had missed a lot of school in the last three months, had stopped attending athletics practice and might be having some problems in her life. When Jo was confronted, she admitted that she wasn't attending school. But the reason she gave was that all the girls in her class hated her. To some extent this was true (she didn't get on with any of the girls at her school) but it wasn't the reason she was truanting. Instead of going to school, she was spending her time in the local arcades. For a few weeks she tried to stop gambling—now that her parents knew she had a problem, she thought it would be the ideal time to give it up. However, after 17 days without gambling, her boyfriend split up with her and she relapsed and started gambling again. She played for almost two years after that.

Jo's parents were understanding and looked for ways to help their daughter. They considered switching Jo's classes so she would be with new classmates and changing schools. Jo simply said she would try to integrate more. Even after Jo received a less than favourable year-end report card, her parents viewed her situation sympathetically surmising that her decline in academic performance was caused by circumstances beyond her control. Jo's parents never suspected that her erratic behaviour was linked to anything other than problems with adolescent socializing. Jo successfully managed to keep her



secret for another two years before everything came out into the open.

As an only child it was difficult for her parents to know whether their experience was typical. They hardly saw Jo. At 16, Jo left school and then moved out of home. Her parents were upset but there was little they could do about it. When Jo left home, she assumed that all her problems would disappear; however, she got into more trouble. She was unable to make ends meet and ended up living hand to mouth. She began to steal from friends, people at work and from anyone she met. Twice she met men, went back to their houses and then stole their money and/or valuables.

*At the time it seemed the only answer. I was in debt, running up my overdraft. Having just started a job with a reasonable salary for someone of my age, I opened up a few bank accounts and abused them all. I couldn't believe how easy it was for me to get credit.*

During this period of nearly two years, Jo became more and more withdrawn, lost her friends and resorted to stealing from her place of work. Eventually she was sacked for taking the petty cash. Her employers were unaware of her gambling problem; they assumed she wanted more money to supplement her modest wages. Although she lost her job, the company did not press charges.

### **Confronting the problems and recovery**

The first major turning point for Jo was being fired from her first job for theft. She had nowhere else to go but back home. Although Jo's parents were surprised that fruit-machine playing was at the heart of their daughter's problems, they were tremendously supportive. Jo claimed her mother didn't believe her at first. Her parents wondered how someone could become addicted to a machine. Jo thought it would have been easier for her mother to accept that she had a drug or alcohol problem, rather than a gambling problem.

The cessation of her gambling began when Jo, with her parents' help, got another job in a remote village in Cornwall (South West England). There was no arcade, no fruit machines in the local pub and no fruit machines within a four-mile radius. She did not drive a car, and it was too far to walk to the nearest town. Essentially, the lack of access to fruit machines forced her to stop playing. She still had cravings but she couldn't do anything about them. She also reported a number of serious withdrawal symptoms. At work she was short-tempered, irritable with colleagues and constantly moody. She had trouble sleeping, occasionally experienced stomach cramps and felt nauseous.

When Jo lived on her own, there was little overt family distress (although she claims her parents worried about her living on her own). Even when her parents discovered she was skipping school, they were supportive rather than punitive. It wasn't until she was sacked from her job and came home penniless and deep in debt did they realize how many problems Jo had. Even then, they stuck by her. They realized she wanted to live independently, so they got her an apartment about half an hour away. As Jo says, it was "near enough for (her parents) to come over in an emergency but far enough away that they didn't pop over all the time."

Jo eventually joined a local Gamblers Anonymous (GA) group, which her parents drove her to every week. She attended a few sessions but stopped because she was the only female, the only fruit-machine player and also the youngest. Despite the opportunity to share her experiences with eleven or twelve people in a similar situation, she felt psychologically isolated. Being able to talk about her problems with people she trusted (i.e., her parents) was a great help. Because she wanted to stop gambling and had no access to fruit machines, Jo managed to curtail her gambling. She claims she "wasted four years of her adolescence" because of fruit-machine playing—and she doesn't want to waste any more of her life. However, there is no certainty that Jo is "cured"—she feels a number of incidents could trigger her fruit-machine playing again, like being rejected by someone close to her. Talking to people has been what Jo calls her "salvation." She always thought that fruit-machine playing couldn't be a problem; therefore, she found it hard to believe that people accepted it as an "addiction." Because people accepted her addiction as something akin to alcoholism or drug addiction she was able to recover.

## Discussion

As in most case studies, it is hard to make generalizations about people affected by similar phenomena. However, this study highlights a number of findings that have yet to be reported in the general literature about adolescent gambling. Similar to previous survey research, this case study confirmed that gambling acquisition was the result of sociological factors, rather than psychological or biological factors (Griffiths, 1995). More specifically, these factors included widespread legal accessibility of fruit machines and parental encouragement and acceptance of fruit-machine gambling. Fruit machine-playing is also a major peer-group activity. Another acquisitional factor is what Griffiths (1995) described as "choice limitation" (i.e., there is not much else for this particular age group to do). All these factors appear to play a part in behaviour acquisition. It's highly unusual for a young female to be addicted to fruit-machine playing, and as far as the author knows, there no accounts of female fruit machine addiction in the gambling literature. The participant in this study described herself as a "tomboy"—her male friends may have felt more



comfortable with her because of this.

As with previous male case studies of fruit-machine addiction (Griffiths, 1995), the participant's gambling pathology only seemed to affect a few people. Her boyfriend and, to some extent, her parents were directly affected by her problematic gambling behaviour. The number of people affected is significantly less than the commonly quoted figure of 10 to 15 people cited by Lesieur and Custer (1984).

The development and maintenance of the participant's gambling habits appear to be because of psychological and physiological factors. Feelings of self-worth and a way of escape appear to be the primary motivations for continuing to gamble. Winning money allowed the participant to keep gambling, rather than providing financial stability—playing with money rather than for it. One interesting point to note was that at the beginning of her gambling career, the participant conformed to the female arcade stereotype as "cheerleader" (Griffiths, 1991) and "rent-a-spacer" (Fisher, 1993). However, within a short period, the participant's behaviour was similar to males who gambled excessively. This implies that further observational research needs to take account of how people can change over time rather than being in the fixed and static category of player.

In previous studies, gamblers report skill as being one of the possible critical factors in fruit-machine gambling (Griffiths, 1994). However, this case study is markedly different. The participant believed that to play fruit machines, you didn't need to be particularly skilful. She also had a balanced view of chance and winning. Because males are generally more competitive, they may define "skill" differently than females. This is one area where further research could prove useful. The participant's motivation to gamble appeared to come from a number of desires. In the arcade, she felt that she was a "somebody" rather than a "nobody" because everyone knew her. Women older than her playing fruit machines also sought her views. Her popularity at the arcade seemed to raise her self-esteem. The arcade and machines also provided a means of escape in her life. This is a common feature of most addictions and appears to be no different in this case.

From this author's research experience, the account presented here is fairly typical of people addicted to fruit-machine playing. This individual began playing fruit machines socially. Steadily, she gambled more and more over time, spent every last penny, borrowed money and then finally stole money to fund her gambling habit. Criminal proceedings may have proceeded against her but fortunately for her, she was only punished by losing her job. The one major difference between this account and other accounts is that this participant is female. By examining the participant's gambling behaviour in

detail, there is little doubt that she was addicted to playing fruit machines. In addition to fulfilling the DSM-IV classification as a pathological gambler, the participant displayed the classical features of addiction:

- **Salience:** The participant became totally preoccupied with gambling and thought about it all the time. She also claimed she had become "obsessed" with fruit machines and that they were the most important and all encompassing thing in her life.
- **Tolerance:** Over time the participant went from watching others gamble to gambling for short periods to gambling all the time.
- **Mood modification:** The participant used gambling as a means of escape and to forget about everything. She also found some of the anticipatory feelings "intoxicating."
- **Withdrawal:** The participant experienced both psychological and physiological effects when prevented from gambling. These included moodiness, irritability, nausea, stomach cramps and insomnia.
- **Conflict:** The participant experienced a lot of conflict in her life because of gambling. It happened at an interpersonal level with her boyfriend. Her behaviours were adversely affected —she didn't go to school or have many friends. Gambling caused intra-psychic conflict.
- **Relapse:** After a period of non-gambling a key personal relationship disintegrated and the participant returned to full-time gambling.

In addition, she constantly chased her losses and exhibited other classic signs of adolescent problematic gambling behaviours, such as having cravings, borrowing and stealing money, truanting from school, etc.

The participant eventually curtailed her gambling behaviours without formal treatment, although she did attend GA for a handful of sessions. However, she perceived GA as a negative experience particularly because of the psychological isolation she felt. Not only was she the only fruit-machine player in the self-help group, but she was the only female and the youngest. All these factors led to her eventual dropout, and raise important issues for treatment. Other vulnerable individuals may require help but drop out of programs such as GA because they cannot identify with people in the particular self-help group. The good thing in this case was that despite the lack of treatment, the participant managed to overcome her problems. As with previous case studies (Griffiths, 1995), one of the most salient themes in preventing bad gambling behaviours is family communication and support.

The major limitation of a study such as this is that it relies totally on retrospective self-report. Not only does the author have to take the participant's account as true, but the report is also subject to the fallibility of human memory. Because this study is based on one person's account, generalizations about the findings are limited. However, further research made with larger samples may help confirm these observations and speculations.

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## A feminist slant on counselling the female gambler: Key issues and tasks

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This article explores key issues and tasks involved in counselling women who are gambling at a problematic level. It draws upon feminist literature, gendered studies and research specific to the female problem gambler — including findings of a recent study, *Voices of Women Who Gamble in Ontario: A Survey of Women's Gambling, Barriers to Treatment* (Boughton & Brewster, 2002). The study, referred to here as *Voices*, involved 365 female gamblers from across the province of Ontario.

## A social context for understanding women's gambling and related problems

"No one has the luxury of a gender-free view of the world, and there is plenty of evidence that the genders see the world differently" (Chambliss, cited by Grant, 2002, p.7). A gendered analysis is not simply about sex (physical, biochemical or genetic differences between men and women) but about



"different roles, responsibilities and activities prescribed for women and men, based on cultural conventions and expectation. These differences relate primarily to power —the relative possession or absence of it" (Grant, 2002, p.4).

Gambling also reflects gender differences. "Women experience gambling and gambling problems differently than men" (Brown & Coventry, 1997, p.25). These differences emerge in "underlying motivations to gamble and in problems generated by excessive gambling" (Potenza et al., 2001; see also Crisp et al., 2000; Delfabbro, 2000; Martins, Lobo, Tavares & Gentil, 2002). To appreciate this, consider male and female orientations to the world. Tannen (1990, p.25) writes that men engage the world as "individuals in a hierarchical social order" in which one is either one up or one down. It is a "world of status where independence is key." Women approach the world as "individuals in a network of connections. Life is community, a struggle to preserve intimacy and avoid isolation. Though there are hierarchies in this world too, they are hierarchies more of friendship than of power and accomplishment."

Although Tannen notes that these differences are a matter of relative focus and degree, it is a helpful paradigm for understanding the typical gambling choices of men and women. Men tend to prefer fast action and competitive games based on some degree of strategic skill. Male tendencies to promote themselves in a hierarchy by beating other players or showing a superiority of skill are facilitated in card games, sports betting and handicapping. Thus, Fischer (cited by Walker, 1992, p.80) discovered that for male adolescent fruit-machine players the "acquisition of self-esteem and recognition among peers for the prowess shown was more important than monetary gains. Fruit machines become an arena of contests through which social hierarchies are worked out." Males score significantly higher on competitiveness and mastery than do females, "placing more value on outperforming others and winning in competitive situations" (Martin & Kirkcaldy, 1998, p.4).

Female priorities of connection and intimacy are better met in games where winning is not at the direct expense of others. Women generally prefer games that are less directly combative: for instance, games of chance such as bingo, slot machines and scratch tickets (Wiebe, Single & Falkowski-Ham, 2001). They often gamble in a social context in which relationships are nurtured. Dixey (1987, p.207) notes that bingo winnings are usually shared: "Sharing is a way of sustaining special networks." Women are more concerned about being liked than jockeying for status: "Having information, expertise or skill at manipulating objects is not the primary measure of power for most women. Rather they feel their power enhanced if they can be of help" (Tannen, 1990, p.68). Indeed, Brownlow, Whitener and Rupert (1998, p.283) hypothesize that women "may also misrepresent their levels of capability in order to be more



likeable...Women are perceived as unlikeable, unfeminine and unfriendly when they show competence and dominance."

In keeping with this women are prone to minimize differences and be modest and self-effacing rather than boastful (Tannen, 1990). This may partially explain why King (1990) found that bingo players tend to make excuses and deny responsibility for winning, interpreting wins as luck. She hypothesizes that the women struggle with a moral conflict about playing for self-interest (greed) rather than for charity. They may also be concerned with symmetry in relationships, sensitivity to the feelings of others and a socialization process that encourages modesty and eschews competition. But not all women avoid competition; some female gamblers, particularly middle-class career women "become empowered through competition in a male-dominated world" (Lesieur & Blume, 1991, p.191).

## Problem gambling and women

Whether or not they seek treatment, most women with gambling-related problems experience difficulties related to playing scratch tickets, bingo and casino slots (Potenza et al., 2001; Rush & Shaw Moxam, 2001; Wiebe, Single & Falkowski-Ham, 2001). The most common gambling activities of the women in the *Voices* study were lottery tickets (87%), instant win or scratch tickets (83%), casino slots (71%) and bingo (64%). On average, the women played 4.2 different games each month, the majority selecting casino slots or bingo as their first choice or favourite game.

Many (74%) of the women in the *Voices* study scored as probable pathological gamblers on the South Oaks Gambling Screen (>4) and 20% scored as having some gambling problems (1–4). The women described an escalation in play and an increase in risk tolerance related to their gambling. They increased the time spent gambling (47%), the number of games played (51%) and the amount of money per hand or game (58%). While 56% tend to increase play when they win, playing until the money is gone, only 36% report cutting back on gambling after losing. The women gamble during the day (78%), the evening (85%), and sometimes, through the night (43%).

Access to money is a factor: 60% of the women gamble *whenever I have or can get the money to do so* and 41% *play more at certain times of the month because of the availability of money*. Many (55%) have become immune to the losses. Another 43% find that *the game loses interest if I try to cut back on the amount of money played*.

The women surveyed identified multiple drawbacks to gambling. Financial concerns —*losing money I can't afford*—was the most frequent response

(59%), followed by *stress over money loss* (53%) and *financial worries about the future* (54%). Another concern was *secrecy over time or money spent gambling* (57%). While only 33% named gambling-related debts as a drawback, some women focused on financial concerns directly related to the gambling; for instance, *diverting money from other things* (41%), *spending savings or inheritance* (28%), *interest charges on credit cards* (25%), *confrontations about spending* (24%), *borrowing* (19%) and *spending the whole paycheck on gambling* (19%).

The significant differences between the women gambling at a pathological level who have never attended treatment or Gamblers Anonymous (GA) and those who have are interesting. Although the demographic and gambling profiles are the same, the latter group reported risking much larger amounts of money at one time and having much higher gambling-related debts (\$18,366 compared to \$4,000). It would seem that increasing financial distress is a factor in propelling women to seek treatment.

A second cluster of drawbacks describes psychological or emotional distress. A large percentage of the women identified guilt (46%), anger (45%), depression related to gambling (43%), worry (37%), fear and anxiety related to gambling (31%) and loss of self-esteem (28%). Ten percent indicated both suicidal thoughts and/or attempts related to the gambling and increased use of medications for anxiety and/or depression.

A third group of drawbacks concerns the negative impact on relationships: *losing the trust and respect of others* (43%), *breaking promises to oneself or others* (34%), *increased tensions and arguments* (24%) and *lying and manipulations* (19%).

Despite the considerable drawbacks to gambling identified by these women in *Voices* many were resistant to treatment. Almost 90% had thought about making changes in the 12 months prior to the study, 25% said they think about it all the time. Most (80%) had tried to stop or cut down on gambling; however, the majority had never sought gambling-specific counselling (89%) or attended GA (91%). Although a number of barriers exist, including lack of awareness of services, a significant number of women identified fears that treatment would *require me to give up all gambling when I don't want to* (57%). Consistent with this they supported a harm reduction approach to change that included moderation (51%) over total abstinence (29%).

Although other motivations affect women's reluctance to cease gambling, one clear barrier is the "eternal spring of hope." Many women hope for a big win to *resolve problems* (59%) and *improve their life situation* (41%).

Intermittent experiences of winning, exposure to other people's wins and promotions by the gaming industry may reinforce this hope and strengthen resistance to abstinence. This element of hope distinguishes women problem gamblers from women with substance use disorders: although both groups may seek escape and relief from stress, the gambler actively believes that the outcome of the behaviour will be positive, improving her life in the long run. This belief influences women's preference to set controlled gambling as the goal of treatment. While it is a legitimate treatment goal, it can complicate treatment. Significant wins may lead to a shift in motivation and the return to problematic gambling.

Summing up, female problem gamblers are involved predominantly in the continuous-play forms of gambling. They report increasing involvement and preoccupation as gambling progresses. The multiple negative consequences often involve financial pressures and intra-psychic issues of guilt and shame, compounded by emotional distress and relationship problems. Despite the consequences of gambling and thoughts about making changes, many women are unwilling to cease gambling entirely.

## Relationship concerns

Feminist therapists direct us to the centrality of relationship and connection in the lives of women (Claremont de Castillejo, 1973; Gilligan, 1993; Greenspan, 1983; Miller, 1986; Tannen, 1990). Relationship issues are also important in the treatment of both women with gambling problems (Mark & Lesieur, 1992) and those struggling with drug and alcohol dependence (Currie, 2001; Wilke, 1994).

Married female problem gamblers often have poor relationships. Their marriages are often chaotic, marked by spousal addiction to drugs or alcohol, mental illness, infidelity or absences, anger and abuse (Boughton & Brewster, 2002; Lesieur & Blume, 1991). Many women in the *Voices* sample reported having spouses with gambling (22%) or drug (32%) problems. This resembles the relationships of women struggling with chemical addictions, of whom Gordon (2002) reports that an estimated one-third to one-half are living with a person who also has a drug or alcohol addiction. Often women have difficulties with anger, assertiveness and setting relational boundaries; thus, it is no surprise that 45% to 50% of respondents identified assertiveness, setting healthy boundaries, dealing with anger and conflict and meeting personal needs in relationships as very or extremely helpful topics to address in treatment. There were no significant differences between the married, single, divorced or widowed women in this; however, women who indicated abuse in their current relationships (n=84) selected these interpersonal issues as helpful more

frequently and showed less interest in the topic of sexuality (28%).

Curiously, although important to almost half of the women in the *Voices* study, topics related to relationships were selected less frequently than topics related to personal enrichment, finances and leisure. This challenges the emphasis on relationships in the feminist literature. Perhaps the average age (45) of the women in *Voices* helps explain this in that many of the women may have resolved relationship tensions, accepted or resigned themselves to the status quo or separated from unhappy partnerships. It may also be relevant to consider other social pressures and stresses in women's lives.

Women are society's caregivers, constituting 80% of people providing care, whether or not that care is paid for or provided in institutions or at home (Grant, 2002). Even when employed outside the home, women are still "largely responsible for looking after their homes and families" (Statistics Canada, 2000). The "demand to be Superwomen, juggling family and career, has created a whole new set of problems for women who feel that they should, but do not, measure up" (Greenspan, 1983, p.287). Stress is increasing for women at a rate that places stress levels above those of men (Grant, 2002) and the "greater burden on women to provide care...affects the health of women rather than men" (Morris, 2002, p.2).

It is not surprising then that dealing with stress was the issue most often identified as problematic (72%). Gambling counsellors also identified stress most frequently (98%) as an issue for female gamblers (Brewster & Boughton, 2002); it pre-empted relationship concerns. This might reflect some exhaustion and frustration with caretaking demands and the "sex-class" expectation to perform the "labour of relatedness" (Greenspan, 1983, p.228). Dow Schull (2002, p.2) argues this, proposing that for many women gambling is a highly addictive mechanism of "escape from what they experience as an excess of demands and responsibilities to care for others."

The *Voices* women confirm the role of gambling in escaping stress and overwhelming responsibilities. Between 40% and 60% cited items related to stress relief as very or extremely important gambling motivations: *relief from stress* (53%), *a break from reality* (49%), *escape from problems or worries* (48%), *a break from responsibilities or work* (46%). Reasons of autonomy were also common: to be *free to do what I want* (56%), to *treat myself* (48%) and to *have time for myself* (46%).

Women demonstrate a greater sense of responsibility for the well-being of others and experience more life-stress than men as a result. Lerner (1985,

p.20) notes women are socialized to be over-responsible in relationships, "prone to de-self, putting the needs of others first, allowing too much of herself to be negotiable under pressure from the relationship." Women may also be poor at self-care, feeling guilty and selfish about taking time for themselves (Lesieur & Blume, 1991). Many lack a healthy balance between caring of their own needs and caring for others. Perhaps the women in *Voices* illustrate a shift in relational interests, a shift, sometimes defiant, away from caretaking and into self-care. Their responses emphasized the critical importance in treatment of addressing issues of personal enrichment: *dealing with stress* (72%), *self-esteem* (63%), *empowerment* (57%), *spiritual well-being* (53%) and *dealing with burn-out* (41%). Dow Schull (2002, p.11) notes that, paradoxically, gambling involves more loss of self: "Although the women who spoke with me frequently remarked on the way in which their caretaking behaviour disappears when they gamble, surprisingly they did not talk about gambling as a means of asserting a coherent, independent self. Instead, they described both caretaking and gambling as activities that can bring about a loss of self."

Dealing with relationship issues is valuable in the treatment of female gamblers; however, in counselling women, we must be careful not to collude with societal and internalized expectations and pressure women to engage in yet more caretaking to fix problematic relationships. While skill training in areas such as assertiveness may benefit the client, it may be more essential to attend to and explore more effective means of self-care. Counsellors need to validate a woman's right and need to "escape" but encourage her to find healthier ways than gambling to nurture and reward herself.

## Support issues in recovery

Many female gamblers are separated, divorced or single; about half of female problem gamblers are married (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Rush & Shaw Moxam, 2001). As noted, some have partners with drug, alcohol or gambling problems. Gordon (2002, p.14) observes that partners may resist treatment for themselves or their mates and "because women are heavily influenced by their partners' attitudes towards treatment, these women often fail to seek treatment."

A lack of spousal support may be a treatment issue. Many women fear their spouse's anger or rejection if they disclose the extent of the gambling. The literature suggests that husbands of women with gambling or alcohol use problems are more likely than the wives of men with gambling or alcohol use problems to leave the marriage (Custer & Milt, 1985; Gordon, 2002; Lesieur & Blume, 1991). This is compounded by the strong shame and guilt



many women feel, which leads them to cloak the gambling in secrecy, not only from partners but also from friends and family members who might be willing to help.

Some of the women in *Voices* indicated that they don't have anyone to support and encourage them in making changes (18%) and many identified *fear of being recognized* (17%), *fear of having others learn of the gambling* (22%), *fear of being criticized or judged* (34%) and *embarrassment or shame* (33%) as barriers to seeking treatment. Furthermore, many of the women (73%) believe *I should be able to make changes on my own*, which also prevented them from reaching out for support. Such self-reliance is commonly identified as a barrier for women to seek support and help (Gordon, 2002; Hodgins, 2000).

In short, support systems for women wanting to change their gambling behaviour are often non-existent or limited, increasing their isolation. Developing these supports can be key to recovery. Women's groups can be vital. Mark and Lesieur (1992, p.556) suggested 10 years ago that "treatment is currently meeting the needs of only the male segment of the population" arguing that women-only groups are advisable in early recovery. Mixed gender groups can be less effective for some women because of what they refer to as a "masculine tilt." Other researchers also note that different gambling styles, preferences and issues between men and women make it difficult for women to seek help in co-ed groups. The dropout rate from Gamblers Anonymous is high for women; they have difficulty gaining credibility and empathic acceptance as a gambler (McGurrin, 1992). Hulen and Burns (1998, p.12) note that women often feel uncomfortable: "Most men whom I know cannot relate to female gamblers, nor can most women relate to male action gamblers. Many male, egotistical, controlling action gamblers, like myself, looked down on female gamblers... Women were hit on in male-dominated meetings. Swearing was commonplace. Women were made to feel unwanted." One woman, notes Wildman (1997), had difficulty getting admittance to GA because she had trouble convincing them that she was a gambler.

Second, co-ed treatment can impede successful outcomes because of women's common histories of harmful or painful relationships with men (Underhill, 1986; Wilke, 1994), and focusing on gender dynamics may be counterproductive in early recovery, when women are vulnerable and need a safe, supportive environment.

Third, socially conditioned gender roles and power dynamics are active in mixed groups. Males tend to dominate, speaking more often and interrupting others. They "use manipulative techniques to silence women or

direct the discussion" (Wilke, 1994, p.32). Women use more language that connotes uncertainty when men are present than when in a group of women. In short, the tendencies of women to nurture others, to "de-self" and underfunction in relationships with men is recreated in the group context. It becomes problematic in meeting women's recovery needs. As Deborah Smith, executive director of the California Women's Commission on Alcoholism quips: "In mixed groups, men talk about their problems. The women support the men. The men get better, the women don't" (cited by Underhill, 1986, p.47).

These factors combine to make women-only groups preferable to meet the recovery needs of many women. *The Hidden Majority* (Addiction Research Foundation, 1996), a guidebook for counsellors who work with women, notes that such groups offer freedom and increased comfort to talk about issues such as sexuality or intimacy, body image, the impact of factors such as PMS, pregnancy and menopause, and their experience of violence. Women learn to value themselves and other women. They understand and share similar experiences. This process of normalizing, sharing and supporting is a critical therapeutic factor in change. It brings hope and energy to recovery (Yalom, 1985). Evidence shows that a women-only treatment group "produces positive results for women in terms of increased self-esteem and sense of personal power" (Wilke, 1994, p.32). Moreover, women may benefit socially; group members often form bonds of friendship, offering both extended support and recreational networks. This helps to address issues of isolation, boredom and loneliness.

The women in the *Voices* study frequently endorsed the option of a women's group as a very helpful or extremely helpful treatment service and showed a significant difference, almost two to one, between the perceived value of a *women's group* (59%) and a *co-ed group* (33%).

## **Social and leisure issues for female gamblers**

Women's needs for relationship, connection, social comfort and safety help mould their choices of gambling venues, in particular, their attraction to bingo halls and casinos. Brown and Coventry (1997, p.14) write that "fear of sexual harassment and violence still make many public spaces out of bounds for women. Gaming venues are one of the few places where women feel safe enough to attend alone." Dixey (1987, p.206) also notes "the absence of male domination in these venues allows women to relax and to be in control of any sexual innuendo."

Brown and Coventry (1997, p.14) also suggest that women prefer "local venues where they feel safe and a sense of belonging. Gambling provides



a cheap means of entertainment, a social outlet by which the women can escape their home and be with other women." While this is true, gambling often ceases to be a social activity for women who develop problems. More than half (55%) of the women in *Voices* gamble mostly alone or always alone, and the social activity aspect of gambling, *to spend time with friends*, was the least frequently identified incentive (16%). While many women indicated that gambling helps them *feel less lonely* (34%) and *less isolated* (30%), fewer women saw gambling as a *way to spend time with friends* (28%) or their *partner* (9%) or *look for romance* (4%). They were more likely to indicate that gambling allows them to *be around people without the pressure to talk* (41%) and *to be alone* (33%).

These findings are consistent with the observation by Specker, Carlson, Edmonson, Johnson and Marcotte (1996) that many female problem gamblers tend toward isolative gambling behaviour. Though social reasons may help account for their initial involvement in gambling, it becomes asocial as problems develop. As Griffiths (1999) notes, most problem gamblers report that gambling becomes a solitary activity. Ultimately, many female problem gamblers suffer the same fate as many of their alcoholic counterparts. What may begin as a way to reduce isolation and meet social needs ends up creating more isolation as a result of the increasing preoccupation with gambling and the internal shame it generates.

Reconnecting socially and replacing gambling with satisfying, meaningful social and leisure alternatives are critical for many women, but finding these alternatives is often a challenge. This was underscored in the *Voices* study. Over two-thirds of the women identified *meaningful use of my free time* (70%) and *having fun* (69%) as very or extremely helpful topics to be addressed in treatment. Sixty-five per cent recommended accessible, affordable and safe alternative leisure activities as key prevention measures. Furthermore, over half (54%) considered *dealing with isolation and loneliness* an extremely helpful treatment topic. Unmarried women, women with a psychiatric history and bingo players were significantly more likely to identify this as helpful. Concurrent issues can complicate the already difficult and challenging task of filling the leisure vacuum created by abstinence.

## Concurrent issues of female problem gamblers

Many women struggling with gambling are also dealing with mental health issues, depression and anxiety being the most common. Although Greenspan (1983) notes that depression is endemic to women as a group, the rates among women who gamble are higher than for women in the general population (Specker et al., 1996; Westphal & Johnson, 2000a). In

Ontario, the prevalence of depression in the general population of women is 10% and anxiety, 28% (Zoutris, 1999). But even higher percentages of the *Voices* respondents reported having seen a professional for *depression* (63%) or *anxiety* (53%).

Specker et al. (1996, p.78) found that female problem gamblers have significantly higher rates of anxiety disorders than male gamblers (73% vs. 16%); and the most frequently diagnosed personality disorder was avoidant, diagnosed in 13% of the females but none of the males. They refer to women with isolative gambling behaviour described earlier as "avoidant gamblers."

Concomitant problematic behaviours are common. Westphal and Johnson (2000a) found two to three comorbid disorders in addition to gambling. Women were dealing with anorexia or bulimia (11%), overeating (55%) and compulsive shopping (39%) significantly more often than men (also Black & Moyer, 1998; Lesieur & Blume, 1991). Likewise the *Voices* women reported considerable levels of current or past problematic behaviours. The most common current problems were *smoking* (48%), *binge eating* (27%) and *compulsive shopping* (24%). The rates of problematic behaviours were higher than the rates reported in studies of the general population (Adlaf & Ialomiteanu, 2001; Christenson et al., 1994; Woodside et al., 2001).

Studies of problem gamblers report varying rates of substance use problems (Black & Moyer, 1998; Lesieur & Blume, 1991; Specker et al., 1996; Westphal & Johnson, 2000b). Generally, women are less likely than men to have alcohol problems or use illicit drugs (Potenza et al., 2001; Toneatto & Skinner, 2000; Westphal & Johnson, 2000b). However, more female than male gamblers report lifetime use of psychiatric medications, inappropriate use of medications and medication use at the time of seeking treatment (Toneatto & Skinner, 2000).

## Issues of abuse and trauma

Women who are vulnerable to developing gambling-related problems often have a family or personal history of trauma and abuse. Their childhoods were often traumatic, impacted by parental alcohol abuse, gambling problems or mental illness (Custer & Milt, 1985; Jacobs, 1986, 1993; Lesieur & Blume, 1991). Similarly, the *Voices* women report high rates of family problems: including fathers (38%), siblings (28%) and relatives (28%) with alcohol-related problems, and mothers (20%) and siblings (24%) treated for psychiatric issues. Gambling problems within the family were ascribed to mothers and fathers at the same rate (16%).

In the general population, a history of physical and/or sexual abuse is significantly more common in females than males (MacMillan et al., 1997; Specker et al., 1996). Specker et al. (1996, p.79) suggest "physical/sexual abuse is a precipitating factor in pathological gambling"; female gamblers in this study had high rates of physical or sexual abuse, "considerably higher than child abuse rates of 1% to 2% found in a national sample." The *Voices* women also report high incidents of childhood physical abuse (41%) and sexual abuse (38%). These childhood rates are higher than in the general population of women in Ontario (21%; 13%) (MacMillan et al., 1997).

Almost half (46%) of the *Voices* women also report experiencing physical abuse as adults and 28% report experiencing sexual abuse as adults. Although alarming, these rates are on a par with a Statistics Canada (1993) finding that half of Canadian women (51%) have been victims of at least one act of physical or sexual violence since the age of 16. Turning to domestic relationships, Lesieur and Blume (1991) report that 29% of the married female problem gamblers had physically abusive husbands. Thirty per cent of the *Voices* respondents report physical abuse in current relationships; which is a much higher rate than partner violence towards women (8%) reported by Statistics Canada (1999). More than half (51%) of the *Voices* sample also report physical abuse in past relationships.

Given the endemic nature of violence towards women, and the concurrent issues and life stress many women face, not surprisingly, women are often described as "escape gamblers" (Blaszczynski, 2000; Blaszczynski, Walker, Sagris & Dickerson, 1999; Brown & Coventry, 1997; Custer & Milt, 1985; Hulen & Burns, 1998; Jacobs, 1986, 1993; Lesieur, 1989; Lesieur & Blume, 1991). Gambling, like substance use, serves as a means of changing mood states. For some women, the psycho-physiological mechanism of escape is mediated through the action of the game: "Action is an aroused euphoric state comparable to the high derived from cocaine or other drugs. Action means excitement, thrill and tension... Being in action pushes out other concerns for women" (Lesieur & Blume, 1991, p.186). For others, the mechanism may induce dissociative experiences (Jacobs, 1986, 1989, 1993). Many female gamblers (like many women in treatment for chemical dependence, many of whom are addicted to tranquilizers) are seeking a way to numb emotions, shut out the world and orchestrate a time-out. "Gambling is a psychic anesthetizer with tension-relieving and anti-depressant (analgesic) effects. It provides relief from psychic distress, including anxiety, depression, anger, loneliness, emptiness, boredom, worry, hopelessness. Relief and escape gamblers differ in seeking the analgesic rather than the euphoriant effects of gambling" (Custer & Milt, 1985, p.29).

The motif of escape was apparent among the reasons for gambling. Among *Voices* respondents, between 40% and 60% indicate their gambling is related to mood management: used to *cheer myself up* (61%), *deal with boredom* (52%), *feel less depressed* (44%), *feel hope* (51%), *feel charged and energized* (43%), *soothe myself* (40%) or *get a break from reality* (49%).

Summing up, counsellors working with female problem gamblers must be conscious of the layers of the addictive gambling behaviours and possible co-mingling with mental health issues, which are often accompanied by a history of abuse and trauma. Working with women means attending to the whole person and often involves addressing more than a specific focus on the gambling behaviours. Many fall into the emotionally vulnerable subgroup described by Blaszczynski (2000). To the extent that gambling is a coping or survival strategy to deal with psychological, physical and emotional pain, changes to behaviour will not occur without attention to underlying issues, either in treatment sessions or through appropriate referrals.

## Financial issues of female gamblers

When gambling reaches problematic levels, gamblers are often in or bordering on financial crisis. On average, the *Voices* women spent the equivalent of 80% of their personal net income on gambling. The average gambling-related debt was almost \$7000. Consistent with this financial stress, they frequently identified topics related to finances as very or extremely helpful to address in treatment: *ways to increase income* (69%), *money management* (66%), *money values* (60%) and *resolving debts* (60%).

Financial counsellors tell us that money conflicts are a chief factor in marital discord (Barbanel, 1996; Blumstein & Schwartz, 1983; Collins & Brown, 1997; Dowling, 1998; Mellan, 1994). Thus, it is not surprising that almost half (49%) of the women in partnered relationships selected *couples and money* as an extremely helpful issue to address in treatment. Finances are a potential source of conflict by the time gambling has reached problematic proportions. Forty percent of the *Voices* sample indicated that money arguments have centred on their gambling. Money conflicts, however, may also precede and even contribute to the development of problem gambling. Money tensions are like depression, which can serve as both a cause and consequence of gambling. Many *Voices* women indicated that *how money is spent* (55%) and *lack of money* (43%) were also sources of conflict in their relationships.

Money is often central to the power dynamics of relationships (Barbanel, 1996; Blumstein & Schwartz, 1983; Collins & Brown, 1997; Dowling, 1998; Mellan, 1994; Zuo, 1997). In addition to representing security, autonomy and love, it can serve as a weapon of power and revenge. Collins and Brown (1997, p.58) suggest there may be "paybacks" when financial power is hoarded: "A payback is a sting—an overt or camouflaged retaliation for a partner's behaviour. It conveys everything from frustration to fury, without the need to exchange one word." Revenge spending and skimming are two common payback strategies. Gambling may also serve as a defiant protest of anger or autonomy. It is striking that 28% of the *Voices* women in relationships reported financial abuse in their relationships and 24% admitted *setting aside money my partner doesn't know about*. Half (50%) indicated being able *to do what I want with my money* as a reason for gambling.

In sum, financial concerns are important to address in helping women rebuild and recover from gambling problems. Credit counselling services can help with consolidation, budgeting and debt repayment. Employment or retraining programs will work with clients to plan more hopeful financial futures. Equally important is the therapeutic task of exploring the meaning, history, values and relational power dynamics attached to money for the female problem gambler.

## Summary

We've considered women's gambling and problem gambling issues from a woman-centred perspective to highlight the social context in which women's gambling can be better understood. Important issues of gender stratification, patriarchy, disempowerment, bias and oppression shape the lives of women (Dixey, 1987; Greenspan, 1983; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Wilke, 1994). No therapy is complete, suggests Greenspan (1983), unless it includes helping the woman understand herself in relation to her society.

Women's gambling behaviours and vulnerability to develop gambling problems are shaped by a number of factors. Women's orientation to the world, with an emphasis on connection rather than hierarchy, often influences her choice of gaming venues. Socio-economic forces, such as lower income and limited access to financing, shape gambling behaviour and contribute to the more rapid development of problems. Social constraints may affect many women who have limited alternative leisure options.

Many women who develop gambling-related problems struggle with issues



of psychiatric comorbidity, of which depression and anxiety are the most common. Some women with gambling problems reveal a painful history of family problems, childhood and adult experiences of abuse, violence and trauma. Many struggle with other problematic behaviours, most commonly smoking, compulsive eating and compulsive shopping. The lives of women are often stressful, managing demands of caretaking and employment pressures. Many female problem gamblers are isolated and may be in relationships disturbed by spousal problems, including addiction. Gambling provides an escape for many female problem gamblers.

Counselling female gamblers requires a feminist sensitivity to the reality of women's lives. While not all women who develop gambling problems will present with the issues described above, many will have some of the concerns we've explored. Others will fall into the pathway of the "normal" problem gambler described by Blaszczynski (2000), in which problematic gambling is not related to a pre-morbid psychopathology but "occurs as a result of poor judgment or poor decision-making strategies." Supporting women through a process of making changes to their gambling can involve a variety of tasks in addition to relapse prevention: developing support systems, addressing relationship and leisure needs, working with financial issues, dealing with psychiatric concerns or the aftermath of violence and trauma.

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**Case study conference —Introduction**

## Counselling Mary about her gambling problems: A self-reliant person

### Introduction

This is a case review with a slight difference. Mary M. is not a real person. She represents a composite of the "average" woman with gambling problems based on research conducted by Roberta Boughton, Problem Gambling Services, Centre for Addiction and Mental Health, (Toronto, Canada).

Like many people with a gambling problem, Mary brings a complex interplay of family genetics, personal history, precipitating life events and environmental influences to therapy. This challenges the clinician to carefully consider which element of the individual's narrative to respond to and when.

Through anecdotal data and epidemiological studies we know that problem gamblers are reluctant to seek help. A recent Ontario study found that of the estimated 318,000 people in the province with gambling problems, only 1,425 had sought help from the formal treatment system. Of those, only 975 were

problem gamblers—the rest were family members (Rush, Shaw Moxam & Urbanoski, 2002). We also know that problem gamblers often approach treatment after all other avenues have been exhausted, yet we do not really understand why. It may be the stigma associated with getting help for a mental health problem, lack of knowledge that help is available, denial of the extent of the problem, or uncertainty about what happens during the therapeutic process.

Many differing treatment models exist to explain problem gambling and guide clinicians in their delivery of care. Some models borrow from our understanding of the treatment of other addictive disorders; others are unique conceptualizations, which build on newly emerging understanding of the diverse needs of problem gamblers. Communicating the value of treatment and the hope for recovery is essential to enhance greater use of the treatment system.

This case study provides an opportunity to compare and contrast how the understanding and treatment of clients varies depending on the theoretical filter applied by the therapist. Most clients who seek professional care do not know the differences between cognitive therapy, psychotherapy, narrative therapy and the role of psychopharmacology in getting well. They only know things feel out of control. Successful treatment requires a "good fit" with the therapist and a shared belief in the efficacy of treatment, the treatment process and how it will help.

We invite clinicians to participate in this case study, to make transparent the therapeutic model that you would select based on your conceptualization of Mary's situation. Clinicians are also challenged to include a brief explanation of the therapeutic process in language that Mary and her family could understand to engage them in a therapeutic contract. Please consider your priorities of care, the therapist's role in family therapy and any additional information or assessments that would be advantageous to understand Mary's situation. Also consider what additional community supports and resources could or should be brought into play to aid her recovery and why.

Recent research is beginning to document the correlation between the availability of gambling opportunities, the various modalities of play and the rise in problem gambling prevalence rates. With the active involvement of government in both the proliferation and management of gambling activities, this presents some interesting ethical issues that challenge the traditional client-centered focus of clinical care. Mary's gambling decisions may also provoke your consideration of what role, if any, therapists have in personal and systemic advocacy with the gaming industry and government. Mary

clearly blames herself for her gambling problems, but are there issues to consider beyond personal responsibility? If so, how should these issues be handled within the therapeutic alliance and within the community?

## Case study

The Ontario Problem Gambling Help-Line referred Mary to therapy. She made the initial appointment from the parking lot of the casino following what she reports as "another brutal beating at the slots." Her presenting complaint was:

"I can't control my gambling anymore, it's invading my life. I hate what has happened to me and what gambling is doing to my family and my life. Everything is a lie. I want control of my life back!"

## Presentation

Mary is 46-year-old female of Anglo-Irish decent. She presented as an attractive middle-aged woman. She arrived on time and was neatly dressed and well groomed. Her thoughts were normal in form and flow. She displayed a wide range of affect throughout the assessment interview appropriate to content of conversation.

Mary reported episodes of forgetfulness and distraction. She complained of decreased appetite, of weight loss and nighttime waking, with an inability to return to sleep. She complained of increasing feelings of irritability and dread, and a loss of interest in normal activities. Although she has no active plan, she reports increasing preoccupation with thoughts of suicide: "I would never do anything but I wish that my life would just end."

Mary reported long-standing difficulty with anxiety dating back to her teens, which is currently treated by her family physician with medication. He is unaware of the presence of a gambling problem and has provided increasing doses of an anti-anxiety medication to help her "cope with my fathers' death." Mary reports a growing dependency on the medication and admits to taking more than the prescribed amount. She expressed feeling ashamed of her deception.

Mary feels that gambling has "stolen my self-esteem." Mary described the development of a gambling problem as a "complete shock...I am an intelligent, responsible person...I can't believe that I've lost control...it is a nightmare...I have to accept that I have become a compulsive gambler." Mary has always prided herself on her ability to competently manage the household finances, over which she has control. She expressed pride in her ability to

save significant amounts of money in RRSPs (registered retirement savings plans) through careful money management. Fortunately, these were placed in her husband's name to take advantage of tax savings. In retrospect, she sees this as a "saving grace," for she is certain that she would have used the money to try to win back her losses.

## **Gambling history**

The family has a combined annual income of approximately \$32,000. Mary reported being over \$6,500 in debt, accumulated by credit card use, bank overdrafts and borrowing from family and friends. At this point, she reports having trouble meeting even the minimum charges on her debt and is behind in paying household bills. Creditors call frequently and are increasingly aggressive in their demands.

Mary reluctantly admits that if she had money she would probably be at the casino "trying to make things right." She is angry with herself that she can't control her gambling. Mary's husband is unaware of the extent of her problem with gambling or the amount of debt incurred. She is fearful of him finding out; this makes her "a nervous wreck." Mary reports feeling tired of maintaining the deception that everything is fine when she feels totally overwhelmed and out of control. Although her husband, Steve, is conscious that things are not quite right, he ascribes Mary's sadness and anxiety to her father's death.

In an effort to stop gambling, Mary registered herself with the self-exclusion program at the local casino. It did not take long for Mary to "test the system" and return to play. Although she is frustrated that the staff have never asked her to leave, she feels her losses are her own fault and a sign of her weakness of character.

Mary reported that gambling has always been a part of her life. She recalls going to the community bingo hall with her mom and a time when the family bought a weekly lottery ticket. Fantasizing about winning a million dollars in the lottery was a frequent game with her family. Mary's problem with gambling began with the introduction of the casino into her community three years ago. Mary and her friends and neighbours all saw it as an exciting opportunity to create needed jobs and bring tourist dollars into their community. Mary occasionally visited the casino with her girlfriends as part of a "girls' night out." The bright lights and excitement dazzled her. Initially she set a spending limit and had no difficulty keeping to it, but things rapidly changed following the death of her father. At the same time, her husband began a job as a long-distance trucker and was away from home more often.

Mary reports that she plays approximately \$25 each week in break-open

lottery tickets and experiences an average loss of \$250 per visit to the casino to play the slots. At first, Mary went once a month with friends, but lately she has gone two or three times a week on her own. She says that while playing on the machines her mind completely empties and she feels vaguely soothed by the rhythmic quality of play. "When I sit down at a video lottery terminal, I don't see anything else around me. I feel nothing...nothing matters but playing the game." But Mary notes that when play stops and she appreciates the reality of her losses "...life crashes down upon me...I go to bed and pull up the covers, hoping that when I wake up, it will all just be a bad dream. But it's not, and even though I don't want to, I go back to the casino and try again."

Mary reported playing 18 hours straight at the same slot machine without interruption. Her son Terry was concerned when she failed to return home that night. The next day, Mary broke down in tears, told him about her gambling and swore him to secrecy about her problem. Mary recognizes that this is causing increased tension within the family and weighs heavily on her son. Mary has noticed that Terry is becoming more withdrawn and sullen and she fears this is related to her gambling problem. She reports this fear as a major motivator for her seeking help. Mary's friends are unaware of the degree of her gambling problem and this secret leaves her feeling isolated from both family and friends.

Mary described with great enthusiasm a "big win early on in her play. Playing her "lucky machine" she won over \$10,000, which she spent on a family holiday and shared amongst her family and friends. Mary enjoyed the attention she received and loved being able to treat her family to a "luxurious vacation with all the trimmings."

Approximately two years ago, Mary's father developed lung cancer. She cut down her hours working as a cashier to help her mom care for him at home. Although he was drinking less by then, he was still a difficult man to care for. When he died, Mary described an overwhelming sense of relief.

### **Personal history**

Mary reports being happily married to Steve for the past 26 years. They live together in their own three-bedroom home in the same small town where they were born. Mary and Steve started dating in high school and married two years after graduation. They have three grown children, ages 25, 23 and 18. Their youngest son lives with them while he completes school. Her two daughters moved away before their grandfather became ill. Both appear to be happy and well adjusted.

Mary is the eldest and only daughter of four children. She described her father



as a "hard drinking, hardworking man" who was prone to aggressive flare-ups when drunk. Although violent with her brothers, Mary reports her dad never hit her or her mom. Her mother was a stay-at-home mom, with whom Mary reports having a close, loving relationship. Although her mother was never treated for depression, Mary suspects that there were periods of illness throughout her life. At times her mother became irritable and withdrawn and would take to her bed for what seemed to Mary like months on end. Her periods of depression were never discussed inside or outside the home. When her mom was well they would go out together to the local bingo hall. At these times, her mom was friendly and outgoing, and appeared to be well liked in the community.

Mary expressed pride in her ability to support the family when her mother "was not herself." As a teenager, she cooked meals and cared for her younger brothers. She wanted to make things seem as "normal as possible" and keep her brothers out of "the line of fire." During this time, she took a job as a cashier at the local grocery store. Again, Mary expressed pride at her ability to responsibly hold a job, care for her family and save money.

During high school, Mary described periods where she felt highly anxious "but nobody would ever know." Mary was a good student, worked hard and achieved good grades. She participated in school activities and had a number of friends but never felt she could trust anyone enough to let them know what was going on at home. It was at this time she started to date Steve who was her one and only boyfriend. Mary was attracted to Steve because he was "steady, hardworking, and had a friendly, kind nature."

Mary reports that two of her brothers have adjusted well; they are working and married, with families of their own. They do not live in the same town and Mary sees them only on special occasions. She reports that one brother is a heavy drinker, unable to hold a steady job and has had two "failed" marriages.

Mary describes herself as a sociable and outgoing person with a number of female friends. But Mary reports that she currently has no interest in seeing her friends because of her "shameful problem." Being with others feels like a chore. Mary does not participate in any of her previous interests.

For the first time in her marriage, Mary feels cut off from her husband. Probing revealed a deep-seated fear that her husband would leave her if he knew the extent of her problem. He has always spoken contemptuously of people, like her brother, who were "too weak to stop drinking" and believes they should "just pull up their socks" to overcome their problems. From his perspective, discipline, hard work and family are all that a person needs to live a good life. Without Steve, Mary feels there would be no purpose in living. Her shame at



being "weak" and her fear of Steve leaving her have contributed to both the secrecy of her addiction and (unsuccessful) attempts to "win back" her losses.

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## case study

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**Case study conference —Responses by clinicians**

### **Counselling Mary about her gambling problems: A self-reliant person**

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**Addressing medical aspects, targeting the gambling behaviour, managing urges, preventing relapses and developing new coping skills**

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### **Addressing medical aspects**

Comorbidity with mood disorders is more common in females than males seeking treatment for pathological gambling. In the present case, Mary clearly is undergoing a major depressive episode. Her symptoms include loss of interest in usual activities, irritability, decreased appetite with consequent weight loss, terminal insomnia, reduced concentration and memory, and suicidal thoughts.

It is not clear if the depression antedated the onset of problem gambling three years ago, as no information is provided regarding the progression of depressive symptoms. Even acknowledging that the gambling problem and its consequences (debts and fear of disclosure, among others) might have had an impact on triggering this depressive episode, at this point, it has probably acquired an autonomous course and requires specific treatment. It could also be that depressive symptomatology (linked to her father's death) would render her more vulnerable to the development of a gambling addiction. Either way, adequate management of depression is crucial to the outcome of the gambling treatment, as Mary's depressive symptoms may directly (loss of interest, for instance) or indirectly (cognitive difficulties, such as reduced concentration and memory) make it difficult for her to participate in and benefit integrally from gambling treatment.

Antidepressants, such as a selective serotonin reuptake inhibitor (SSRI) would be appropriate pharmacological treatment. An assessment of her history of anxiety symptoms since adolescence is warranted, and communication with her family doctor is essential to obtain details regarding the medication Mary takes for anxiety. That Mary takes more medication than prescribed indicates she may already have developed a dependency problem with the medication. Individuals with an addiction problem should not be prescribed potentially addictive medications, such as benzodiazepines (BZD).

Also, no indication supports the long-term prescription of BZD in any condition. Unfortunately, female clients are more at risk than male clients of being prescribed benzodiazepines. In addition to having increased the risk of developing another addiction problem, long-term use of BZD may have worsened Mary's depressive symptomatology (particularly cognitive features).

Also, if the anxiety symptoms are intense enough to warrant specific treatment, given the duration of the symptoms, a non-habit forming medication such as an SSRI is more appropriate. Among SSRIs, no clear evidence suggests specific medications that would be more effective. In addition to the effect on the depression, preliminary evidence shows that some SSRIs may be useful in the treatment of pathological gambling, particularly in the short-term (e.g., fluvoxamine and citalopram).

Mary's mood assessment should also include her menstrual history, noting mood fluctuations within the menstrual cycle and hormone levels (e.g., estrogen and progesterone) as well as checking thyroid functioning. These steps are best accomplished by working closely with physicians with addiction expertise in the community. Clinicians and physicians should communicate regularly regarding shared cases in treatment to ensure continuity of care.

### **Targeting the gambling behaviour**

The gambling behaviour needs to be addressed, and at the same time, the first medical steps must be taken as described above. The approach has to take into account that Mary does not begin treatment at the full capacity of all her psychological resources. Hence, a supportive feature will prevail in the initial phase of the therapeutic intervention. This is precisely where problems arise. To have further support, Mary has to disclose her gambling behaviour.

The secrecy over gambling may have a double meaning. It may be the result of negative consequences brought about by gambling, but it may also reveal an ambivalent motivation towards gambling abstinence. Moreover, the secret enables the gambling. Motivational sessions are needed until the client agrees to share her problems with her husband or another close relative. Pros and cons of keeping the secret must be addressed in a non-judgmental fashion.

Treatment must challenge misperceptions about breaking even as well as hopeless strategies to predict outcomes on games that are random by nature. Building a log of the last gambling episodes could help Mary realize that the sum of her gambling winnings did not cover the sum of her losses. This is called a negative rate of return. The therapist should stress that gambling machines are programmed to operate this way; therefore, losing money is not the result of a lack of skill. The logical conclusion most likely to come out of this process is the knowledge that her gambling activity will be uncovered sooner or later by the mounting debts, but the sooner it stops, the lesser the harm. At this point, the patient should be willing to accept the following suggestions:

- a conjoint session with her husband or a close relative of her choice

- the temporary avoidance of gambling cues, such as handling chequebooks, credit cards and other means of access to money.

### **Managing urges, preventing relapses and developing new coping skills**

No matter how hard disclosing the secret may be, patients usually experience a strong feeling of relief after it is done. Yet, the abstinence prompted by these initial steps has to be regarded only as a window of opportunity, not as the magical cure some patients and families fantasize about. Internal and external triggers for gambling urges have to be investigated and addressed; a debt management strategy has to be put in place; and high-risk situations need to be identified and preventative strategies established. Therapist and client may want to rehearse some of these strategies. Clients must explore alternatives for leisure. Getting acquainted with relaxation techniques and developing stress coping skills are warranted, particularly among female gamblers since they report a greater proneness to anxiety and depression. The family has to be further educated on the nature of pathological gambling and how to support recovery.

A treatment program for gambling should be able to provide these interventions; nonetheless, if Mary's community lacks such a program, she should seek out alternatives. Self-help groups such as Gamblers Anonymous (GA) and Gam-Anon cover most of the needs described above. Female clients have reported difficulties fitting in at GA; however, the profile of gamblers is rapidly changing, with more women gambling nowadays. Consequently, a greater proportion of women now attend GA meetings. Clients should try different meetings before rejecting self-help groups. If difficulties persist, Mary still has the option of women-only groups such as Women for Sobriety. Searching for complementary support from community resources is a must-do, as recovery usually takes years, and treatment programs, even where available, are unlikely to last that long.

*Submitted: April 25, 2002*

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## **..Mary appears to be typical of the women I have seen**

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I am interested to learn from others in the field who work with female gamblers. I apologize that, unfortunately, my response is to be short and to the point. Presently I am busy writing my final project to complete master's degree requirements; this area has been my focus for the last several months, and continues to be so.

I have worked with over 300 female pathological gamblers to date and Mary appears to be "typical" of the women I have seen. My first priority with Mary would be to encourage her to "fess up" to her family physician. Many women are embarrassed and ashamed to admit to their family doctor that they have been gambling excessively. If Mary refused, I would encourage her to be assessed by one of the psychiatrists at the clinic where I work to rule out depression. I would be concerned as Mary is displaying many of the symptoms of a clinical depression. I would also be very concerned about the medications she is prescribed.

My second priority would be for Mary to have her spouse, Steve, accompany her to an appointment with me. I find that most women resist their husband's knowing, and yet, once the gambling problem has been revealed, their stress level decreases. I would want to explain to her husband in plain language,



without jargon, how, initially, gambling may be fun and exciting but can become stressful and lead to financial loss and escapism. Most spouses I have worked with were unaware of their wife's dilemma and are understanding when they find out. I would also stress the importance of communication and refer them for marital counselling as well as family counselling, since their son has been triangulated into the "problem" by having to pick sides and keep secrets. I would also encourage their son to come for counselling at the next session and encourage the family to talk with each other.

I would also address the importance of limiting access to money and accountability for the money Mary does access as well as for her time. Most women are hesitant when it comes to this topic and are resistant to have their spouses "control their lives." I would encourage Mary to attend my all-female gamblers group or Gamblers Anonymous (GA).

The non-GA group that I conduct has several members in long-term recovery. It appears that most women who enter the group will take direction from a peer rather than from myself (an authority figure). The group that I facilitate is not a 12-step program but an opportunity for the women to discuss issues that are of importance to them in a group setting. We work on self-esteem, confidence building, ways to deal with urges to gamble, conflict resolution and healthy coping methods. The issues discussed are important to the women themselves and they have a choice in what we discuss.

I would also discuss self-banning from the casino for Mary. Unfortunately, she has experienced the lack of enforcement that so many others have also encountered with self-exclusion programs. I would also encourage Mary to take responsibility and to avoid driving or walking by the venues where she likes to gamble. I would encourage Mary to replace the gambling activity with other activities. Like many others, Mary has learned to use gambling as a quick fix to her problems and must now learn to incorporate healthy activities and stress-reducing tactics.

From my experience, eliminating gambling from one's life takes time and patience. The more support Mary has from family and friends the easier this daunting task will be. Initially, I would see Mary on a regular basis and then reduce individual appointments to a less frequent basis as long as she attended groups. Mary has many issues she needs to discuss and work through, which will take time.

In short (very short), this is how I would initially work with Mary. I would appreciate feedback or suggestions from others. Thanks for the opportunity to participate.



*Submitted: May 13, 2002*

*Evelyn McCaslin is a problem gambling counsellor with the Regina Qu'Appelle Health Region in Saskatchewan. She has counseled pathological gamblers since 1997, working with individuals and family members. Evelyn facilitates an all-female gambling support group and co-facilitates a dual diagnosis group. She is a registered social worker and recently completed a masters degree in educational psychology.*

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## **Using Wilber's developmental approach in working with Mary**

*By Gary Nixon, PhD  
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### **Wilber's Spectrum of Development Model**

Wilber's (1977, 1986, 1990, 1995, 1997, 2000) spectrum of consciousness model mapped out nine stages, or levels, in a developmental, structural, holarchical, systems-oriented format. Wilber synthesized the initial six stages from the cognitive, ego, moral and object relations lines of development of conventional psychology, represented by such theorists as Piaget (1977), Loevinger (1976), and Kohlberg (1981), and the final three stages from Eastern and Western sources of contemplative development. Wilber's model is unique in that not only is it a developmental spectrum of pre-personal, personal and transpersonal consciousness but also a spectrum of possible pathologies, as there are developmental issues at each stage. It is a model that allows us to integrate many of the Western psychologies and interventions. Originally used for mental health issues (Wilber, 1986), it has now been applied to substance use issues (Nixon, 2001), and this case study looks at the application of this model to gambling issues. Here is an outline of

the first six stages of the developmental model as they apply to working with Mary on her gambling issues.

### **Pre-personal stages**

The first three stages of development, all pre-personal stages, are sensoriphysical, phantasmic-emotional and rep-mind (Wilber, 1986). The first stage, sensoriphysical, consists of matter, sensation and perception. Pathologies at this level need to be treated with equally basic physiological interventions, as the whole point is to stabilize the person. In addictions treatment, this typically means detox programs; for gamblers, some form of physical exclusion from the casinos.

The second stage, phantasmic-emotional, is represented by the development of emotional boundaries to self (Wilber, 1986). Problems at this stage show up as a lack of cohesive self. The self treats the world as an extension of the self (narcissistic) or is constantly invaded by the world (borderline). Typical interventions focus on ego- and structure-building techniques, such as object relations and psychoanalytic therapy. In addictions treatment, 12-step programs can provide a structured format and focus on the selfishness of the person's lifestyle. Chronic cocaine users can regress to this core narcissistic level; an interesting issue is whether pathological gamblers regress to this level as well.

The third developmental stage is rep-mind (Wilber, 1986). This stage represents the birth of the representational self. This is typified by the development of the id, ego and superego and intrapsychic structures. Problems at this level are experienced through psyche splits, such as issues of inhibition, anxiety, obsession, guilt and depression. Interventions focus on intrapsychic resolution through awareness of cognitive distortions, stress management, assertiveness training and feeling awareness.

### **Personal stages**

The pre-personal stages are followed by rule/role, formal-reflexive and vision-logic stages of development and represent the mature ego developmental phase. The rule/role phase, Wilber's fourth stage of development and first personal stage, is highlighted by individual development of rules and roles to belong. A person's stance is becoming less narcissistic and more sociocentric (Wilber, 1986). Because problems at this level are experienced as a fear of losing face, losing one's role or breaking the rules, typical interventions center on script pathology, such as transactional analysis, family therapy, cognitive therapy and narrative therapy. At this level, a person with gambling issues may have developed a whole set of unique roles and rules to support an

addictive lifestyle.

The next personal stage and fifth overall, formal-reflexive, represents the development of the mature ego (Wilber, 1986). A person at this level has a highly differentiated, reflexive self-structure. At this stage, identity issues need to be explored and the processes of philosophical contemplation and introspection need to take place. At this stage, the underlying identity of a person with an addiction can be challenged. The next stage of development, the final personal stage and sixth overall, is the vision-logic or existential stage. Here, the integrated body-mind confronts the reality of existence (Wilber, 1986). Thus, we see a concern for the overall meaning of life, a grappling with personal mortality and an effort to find the courage to be. At this level, a person may be forced to deal with the emptiness of their addictive lifestyle.

The first six stages culminating in the vision-logic or existential stage represent conventional Western psychology. To this conventional scheme of development, Wilber (1986, 2000) also added psychic, subtle and causal contemplative levels that represent psycho-spiritual levels of development.

### **Counselling Mary using a developmental model**

Wilber (1986) makes the point that counselors using the developmental model must start with the basic levels first to avoid an elevationalist stance. It is evident that Mary is out of control with her gambling. So, at a basic sensoriphysical level, it is important for Mary to have strategies to avoid gambling in the casino. Self-exclusion appears not to have worked for Mary. A referral to Gamblers Anonymous may be helpful in giving Mary a place to turn to other than the casinos. A financial management program in co-operation with her husband may be the best option, but Mary may need a few counselling sessions before she feels she can disclose her gambling problems to him.

The big win can be a moment in time that any gambler constantly tries to recreate. At the time of winning her \$10,000, Mary felt she had the answer. In our counselling session, we would recreate the glory of that moment so Mary could recognize her thoughts and feelings about that "big win," which she has been trying to recreate ever since. Mary could be challenged to view this as a counterfeit way to being a success, just as Grof (1993) observed that substance abuse can be a counterfeit quest for wholeness.

The real clinical work with Mary, however, would begin with the intrapsychic work of the representational mind (level three). At this level, Mary could begin to examine the thought processes that keep her preoccupied with gambling. A

cognitive therapy approach could be used to teach Mary about the cognitive distortions she embraces when she is gambling, such as chasing losses and other distortions she uses to convince herself her luck is about to change. Mary could be asked to log her distortions.

In addition, Mary is having thoughts of suicide. A split in the psyche can represent conflict at this level; Mary's super-ego is overfunctioning with strong critical messages. An empty chair technique from Gestalt therapy could be used with Mary in which her normal self and her critical self are split off into two chairs. Therefore, Mary could see how huge and negative her critical voice is. This awareness of her critical self could be expanded to deal with the theme of anxiety that has haunted Mary her whole life. Mary could learn just how much her critical voice has shut her down in life and begin to reframe her anxiety as energy when she begins to become more aware of her split off judging part. We could also work on recognizing that gambling has served as a sanctuary to escape all of this psychic tension, including, perhaps, the recent grief of her father dying and her anxiety.

As the counselling work progressed, the process could now look at the rules and roles Mary has embraced in life (Wilber's fourth level). As Feinstein and Krippner (1988) asked, what has Mary's mythic journey been like? Mary could be asked to talk about the family myths she grew up with. She might describe learning to be a harmonizer to deal with her dad's drinking. She might have learned to take care of everybody and adopt the martyr role in her family. Taking care of others and putting others needs ahead of hers is a myth she might have carried into her adulthood. We can process what it means to be the mother and how she has always been there for other people. At this point, it might be important to consider the feminist perspective in that she has served as a nurturer and a mother her whole life, yet at a societal level, this role can be devalued. Mary could be asked if she has ever had any time for herself; she could be encouraged to start exploring personal passions and interests.

At this point in time, it may be important to involve Mary's husband in the counselling process. Hopefully, she would now have the strength to disclose her gambling history and be able to process any shock and anger her husband might feel about the lost money as well as the strength to get him on board in both her recovery plan and money management issues.

While the family therapy work could take up a number of sessions, it would be important for Mary to continue her individual counselling work. She would need to continue to monitor her work so far, including the cognitive therapy work around her distortions and watching her critical voice. Mary might be ready to do the introspective work of level five: asking who she really is. She

has been a wife and mother, a good money saver all her life, and recently, she has fallen into the gambling track. Who does she really want to be? The pull of gambling can be about so many unmet needs in Mary's life. Can she have the courage to look at those unmet needs of her own journey? Mary could be encouraged to look at herself beyond the mother and nurturer archetype.

This would naturally lead to the existential level (level six) in which Mary could look at what gives meaning in her life. It is clear that she loves her husband, and her family gives her tremendous meaning in life. But using a Frankl logotherapy approach (Frankl, 1985), maybe Mary could look at what steps she can take to increase the meaning in her life beyond these roles. She may have passions, hobbies or career interests that she has put on hold for a long time. She may have psycho-spiritual needs that she wants to investigate. Obviously, this would be a time to look at terminating the counselling process, as Mary would now be into her life journey herself and doing much exploring beyond the counselling process.

### **A concluding note**

This clinical case study response is designed to show how using a developmental approach allows for an integration of multiple perspectives, in that one technique or approach does not work for all issues of the client. In this response, cognitive, gestalt, family, Jungian and logotherapy perspectives are combined to deal with a person with a multitude of gambling-related issues.

*Submitted: May 15, 2002*

*Gary Nixon followed a brief legal career by pursuing master's and doctoral degrees in counselling psychology. Initially attracted to the humanistic traditions of Rogers and Maslow, in the late 1980s he became excited about Wilber's transpersonal developmental approach as a tool for integrating schools of psychotherapy. Since completing his doctorate in 1993, Gary has worked in addictions and mental health settings and joined the faculty of the Addictions Counselling Program at the University of Lethbridge in 1998. He currently researches quantum change in recovery and gambling mythic structures and*



*archetypes and explores clinical applications of Wilber's developmental approach. Gary also maintains a private practice.*

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## **Mary is at a crisis point...**

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Mary appears to be a high-functioning woman who, up until three years ago, had strong relationships with family and friends and has always had steady employment. She was responsible and took good care of herself, her family and her finances. However, her family of origin was not so positive; it included alcoholism and depression in her two parents, which left her in a position as eldest of having to care for her family at an early age without getting the support she needed herself. Mary developed an anxiety disorder around this time. Positive times with her mother were associated with gambling.

Mary's increased gambling appears to have been precipitated by the introduction of a gambling venue near her home, her father's illness and death, and perhaps fewer demands for her at home: her children were growing up and moving out and her husband was around less due to changed hours. An early big win probably helped tip her into problem levels of gambling.

Mary is at a crisis point with regard to her gambling for several reasons: her son is showing the effects of holding this secret for her; her debts are becoming too pressing to conceal; she is afraid her husband will reject her if he finds out about her problem; her self-esteem is suffering severely; and she feels out of control of her life. However, she has not yet reached the point of deciding to change her gambling behaviour.

If I were seeing Mary, I would be addressing this decision point. This is a time for motivational interviewing. I would encourage her to explain her concerns about her gambling and the effects it was having on her life and those around her. I would ask her about the consequences of either continuing to gamble or quitting. We might do a decision matrix. Although I would gather information

on the anxiety disorder and family history, I would not spend a lot of time on them initially. As a gambling counsellor my role would be to explore the immediate gambling problem first, and try to move toward getting it under control before tackling other issues. With someone as articulate and high functioning as this, the other problems are unlikely to be so disabling as to block practical strategies for change.

Assuming that Mary did move from contemplation into preparation, we would contract for some period of abstinence at the beginning, and then, plan together the best means of avoiding gambling. Barriers would be discussed. It might be helpful to find some way to reinforce self-exclusion so that the casino could be counted on to recognize and bar Mary in the future. During this time, I would encourage her to spend time with at least one friend, despite her discomfort. I would also engage Mary in looking at non-harmful ways to escape her troubles for a brief time.

I would suggest bringing in her family, and would try to help her through the decision-making process around "if" and "when" to tell her husband. This might take some time, but concern for her son would be a good lever. If her father and/or her children came in, my role would probably include education around problem gambling and help in processing their anger, hurt, disappointment, grief and loss of trust. Since the relationships have been positive, I would support the family in returning to previous good levels of communication.

The issue of Mary's medication would need to be addressed; I would refer her back to her doctor, or to a specialist in anxiety. I would address other issues arising out of her family of origin as they emerged; I suspect that over-responsibility would be an important issue. Mary might have difficulties accepting any weakness in herself and might be reluctant to allow others to support her because of parentification early on.

*Submitted: June 19, 2002*

*Nina Littman-Sharp, MSW, CGC is the manager of the Problem Gambling Service of the Centre for Addiction and Mental Health. She has worked in addictions for 16 years and with gamblers for eight. Nina is involved in a wide variety of clinical, research, training, outreach and public education efforts. She has made presentations and written on many gambling topics, including strategies for change and relapse prevention, gambling and attention deficit*



*disorder. She is a co-developer of the Inventory of Gambling Situations, an instrument that assesses areas of risk for relapse. Nina moderates a 330-member international listserv for problem gambling professionals.*

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**Case study conference —Summary and Reference**

## **Response to clinicians' comments on Introduction: Counselling Mary about her gambling problems**

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What makes Mary unique? Certainly not the profile of problems she presents in treatment; Mary reflects the "average" female gambler. Mary is unique because she has actually sought out treatment, something the "average" female problem gambler is not doing in droves!

Like many before her, Mary is at an important crossroads of intersecting problems. Her unique biology, family history of abuse, altered life roles and changed environment have all contributed to developing problems that have

tipped the balance in her capacity to cope. The therapist's challenge is to consider which avenue to pursue and when.

Mary does not know how to gain control of her gambling or how to make sense of her unravelling life. She is surprised to find herself in difficulty. Successful therapy is a dynamic partnership that hinges on a shared understanding and agreement between the therapist and client in defining the problem and how to move forward. Through this case study I hope to gather some current insights and ideas from treatment experts on how therapy can help Mary.

However, the current low rate of access to treatment provokes my interest in extending our thinking beyond the walls of existing treatment programs to consider how therapists can reach people with gambling problems through the development of self-directed resources, involvement within the community to promote public awareness and at a systemic level, to reduce the potential for harm.

I would like to thank Nina Littman-Sharp, Evelyn McCaslin, Gary Nixon, Hermano Tavares and Monica Zilberman for sharing their wisdom in treating Mary. While there are many similarities in the approaches recommended, there are also marked differences in the contributors' recommendations.

## **An overview**

Nina Littman-Sharp notes in her response that Mary's gambling is at a crisis point; her son is showing negative effects from withholding her secret, her debts are becoming too pressing to conceal, she is afraid her husband will reject her, her self-esteem is suffering severely and she feels that her life is out of control.

Littman-Sharp also recognizes that Mary brings many strengths and capacities to therapy, which can be supported, reinforced and built upon through treatment. To quote her: "Mary appears to be a high functioning women who, up until three years ago, had strong relationships with family and friends and has always had steady employment. She was responsible and took good care of herself, her family and her finances."

Beginning therapy by sharing with Mary a vision of her wholeness as a competent person who is struggling with difficult problems, but within a context of great strength, will help to lay a balanced, empathic approach to moving forward as partners in therapy. It will instill a sense of hopefulness in Mary that her active participation in treatment will restore her sense of well-

being. Understanding that therapy is not something that is done to her, or over which she has no influence, will also help instill a sense of personal ownership of and responsibility for managing her gambling problem, but with support and resources available to help with this task. "You alone can do it, but you can't do it alone," is an important message for people with gambling problems who seek magical solutions for life's problems while, simultaneously, they fear the dependency of a therapeutic alliance.

## Biological aspects

Let us start by considering Mary at a biological level. Given her family history she may well be burdened by a major depressive disorder that both renders her vulnerable to and can keep her stuck in problem gambling behaviour. The changes she reports in thinking (forgetfulness, distractibility), feeling (anxiety, irritability, dread, hopelessness, shame, suicidal urges) and physical changes (sleep disturbances, weight loss, decreased interest in previously enjoyed activities) all point to a major depressive episode. Her family history of depression, substance abuse and her personal history of emotional trauma place Mary at high risk for depression. Unfortunately, it can be easy to overlook the presence of a major depressive disorder as readily explainable events could account for Mary's presenting depressed and anxious moods. When left untreated, depression compromises the efficacy and responsiveness to treatment, and in combination with substance abuse and dependence, seriously increases the risk for suicide. Depression worsens problem gambling, problem gambling worsens depression, and prolonged problem substance use worsens both.

Research suggests a positive correlation between problem gambling and the presence of mental illness in the client's family. In U.S. studies, problem gamblers were found to have two times the rate of major depression compared to recreational gamblers, and other studies revealed pathological gamblers in inpatient settings have rates of depression as high as 50% to 75% (Linden, Pope & Jonas, 1986; McCormick, Russo, Ramirez & Taber, 1984). In comparison, depression in the general population is estimated at 10% to 25% (Parikh & Lam, 2001). Family histories of mood disorders are frequent, with one-third of pathological gamblers reporting a biological parent or sibling with a major mood disorder (Roy et al., 1988; Linden et al., 1986).

Monica Zilberman and Hermano Tavares in their response note that "it is not clear if the depression antedated the onset of problem gambling three years ago... Even acknowledging that the gambling problem and its consequences (debts and fear of disclosure, among others) might have had an impact on triggering this depressive episode, at this point, it has probably acquired an autonomous course and requires specific treatment."

They comment further: "It could also be that depressive symptomatology (linked to her father's death) would render her more vulnerable to the development of a gambling addiction. ... Either way, adequate management of depression is crucial to the outcome of her gambling treatment, as Mary's depressive symptoms may directly (loss of interest, for example) or indirectly (cognitive difficulties, such as reduced concentration and memory) make it difficult for her to participate in ... treatment. Antidepressants such as selective serotonin reuptake inhibitors (SSRI) would be appropriate."

Zilberman and Tavares also note that "individuals with an addiction problem should not be prescribed potentially addictive medications, such as benzodiazepines (BZD) " and that "no indication supports the long-term prescription of BZD in any condition. Unfortunately, female clients are more at risk than male clients of being prescribed BZD."

Zilberman and Tavares recommend the use of SSRIs because they may have the additional advantages of alleviating Mary's depression and addressing her longstanding anxiety, they are non-addictive and preliminary evidence suggests they may also prove useful in treating pathological gambling, particularly in the short-term (e.g., fluvoxamine and citalopram).

However, they also recognize that other physiological processes can alter mood, including hormonal changes associated with menopause and thyroid function, which should be assessed by her physician.

## **A shared care approach**

The family physician remains the single most important point of contact for people with mental health and addictions problems. Problem gambling therapists are well advised to work within a "shared care" model and build upon this primary element of support, which Mary has relied on over many years.

In her response, Evelyn McCaslin notes that Mary is typical of the women she sees in therapy. McCaslin's first priority would be to "encourage her to 'fess up' to her family physician." Like Mary, McCaslin says "many women are embarrassed and ashamed to admit to their family doctor that they have been gambling excessively." McCaslin would want Mary to be assessed to rule out depression and expressed that she "would also be very concerned about the medications she is prescribed." A psychiatric assessment performed by a mood and anxiety disorders specialist would be highly desirable.

If Mary's gambling activity temporarily alleviates her depression and contains

her anxiety, then she may be less willing to stop gambling or give up the use of BZD and risk suffering the psychic pain of untreated illness. Helping Mary understand the link between mood and gambling and her familial vulnerability to depression as well as providing her with reassurance that relief will be forthcoming may also make her more receptive to changing her gambling behaviour. That said, addressing the medical issues does not preclude targeting the problematic gambling. Instead, it provides Mary with empathic support and helps bring her full psychological resources into play to address her gambling behaviour.

## **Theoretical approaches provide a road map**

Mary's case is complex. Various theoretical models were proposed by participants, which provide a useful road map in deciding suitable approaches.

Gary Nixon in his case response proposes using Wilber's developmental approach in working with Mary. Originally used for mental health issues it is now applied to managing disordered substance abuse. He sees its potential value in treating gambling issues. Nixon's sophisticated model is distilled here into the core elements that apply to Mary's care.

According to Nixon, Mary's problems are addressed within the Wilber model in a sequential fashion that mirrors developmental phases of cognitive, ego, moral and object relations lines of development as well as higher order contemplative development. In this way, Nixon believes that many Western psychologies can be successfully integrated into care in a rational and coherent fashion.

Nixon advises that Mary's care starts with physiological interventions to introduce stability; they include physical exclusion from gambling facilities, moves towards ego- and structure-building techniques, which could involve the use of 12-step programs to give Mary a place to turn other than the casino. Additional structure is introduced through a financial management program in cooperation with her husband.

At the third stage within Wilber's framework, after addressing Mary's physiological needs, a therapist can help her develop healthy intrapsychic structures (i.e., ego, and super ego), addressing her anxiety, depression, obsessions and guilt related to gambling through building self-awareness, challenging cognitive distortions, assertiveness training, and teaching stress management and feeling awareness. "In our counselling sessions, we would recreate the glory of that moment so Mary could recognize her thoughts and feelings about that 'big win,' which she has been trying to recreate ever



since."

Building on this strong foundation shifts Mary's focus outward in the next phase of therapy by addressing individual rules and roles for belonging. At this point, the therapist can draw upon transactional analysis, family therapy, cognitive therapy and narrative therapies. The goals are to restore lost roles and develop a new, healthy lifestyle to replace the emptiness of the lifestyle being left behind. Nixon proposes addressing Mary's suicidal thinking by exploring her strongly critical, over functioning super-ego. This will help her to see how huge and negative her critical voice is so she can then begin to monitor and tame it.

The final existential level is to help Mary explore issues of self identity, uncovering unexplored passions and undeveloped roles beyond her love of family, which will help Mary identify and become the person she wishes to be. Beginning the dialogue of finding meaning in life and responding to psycho-spiritual needs launches Mary into her own life journey beyond the bounds of the counselling process.

The pathways model of problem gambling described by Alex Blaszczynski (1998) provides a useful approach. It uses a developmental approach to allow for the integration of multiple perspectives and suggests that all people do not develop gambling problems by the same route. Some gamblers have distorted concepts and ideas about gambling, predict erroneous outcomes and place themselves at risk (Pathway 1). Others have personal and emotional vulnerabilities that play a contributing role (Pathway 2). Yet others have impulse and personality disorders that increase their risk for addiction (Pathway 3).

Within this framework, I believe Mary would be considered a Pathway 2 gambler, whose pre-existing psychological factors, inadequate role models, past trauma and depression or anxiety leave her vulnerable to developing gambling problems. Gambling has helped her relieve anxiety, find an escape from interpersonal and intrapsychic problems and instill a sense of hope in coping with difficult events (i.e., her father's death, an absent husband). Cognitive therapy would be used to manage her gambling and psychotherapy to deal with past trauma and loss, in either an individual or group setting.

The stages of change model (Prochaska, DiClemente & Norcross, 1992) proposes that clients move through predictable stages in resolving their addictive behaviour. The client will move back and forth through the pre-contemplative stage, where they are unaware, under-aware or unwilling to do anything about their problem, to the contemplative stage, where change is considered and planned for, towards the preparation, and finally, the action



stage, where they work to maintain new healthy behaviours. The client does not always come to therapy ready to change their behaviour. The task for the therapist is to accurately gauge where a client is and to match interventions appropriately.

As Littman-Sharp notes, "Assuming that Mary did move from contemplation [of reducing her gambling] into preparation, we would contract for some period of abstinence at the beginning, and then, plan together the best means of avoiding gambling. Barriers would be discussed. ...During this time, I would encourage her to spend time with at least one friend, despite her discomfort. I would also engage Mary in looking at non-harmful ways to escape her troubles for a brief time."

## **Motivational interviewing**

Ambivalence is a characteristic of the problem gambler. The drive to win and the thrill and relief felt during play can overwhelm the desire to avoid the negative consequences of gambling. The motivational interview helps clients recognize the problem behaviours and strategize ways to manage them.

While Mary actively sought out treatment, her willingness to give up gambling remains unclear. Littman-Sharp recommends using this current crisis as a time for motivational interviewing as defined by Miller and Rollnick (1991). "I would encourage her to explain her concerns about her gambling and the effects it was having on her life and those around her. I would ask her about the consequences of either continuing to gamble or quitting." She suggests the possibility of using a decision matrix (Soden & Murray, 1993).

Secrecy "enables the gambling," note Zilberman and Tavares, and it can often indicate an ambivalence to quit. Mary is keeping secrets from her doctor, her husband and her friends; a willingness to give up the "secret" becomes an important indicator of motivation to change.

Helping Mary to consider the risks and rewards of giving up her secret must be done within a non-judgmental and supportive environment. Mary is clearly concerned about the negative impacts that her gambling and associated secrets are having on her son, which could provide a valuable lever for change. But she is also concerned at the risk of disclosure to her marriage. This fear is best addressed by exploring the risks and rewards of moving forward.

## **Gambling is a family problem**

Bringing the family into therapy can accomplish a number of ends, as pointed out by all respondents, including education around problem gambling and support in processing the anger, which can accompany disclosure of the financial consequences, as well as feelings of hurt, grief and loss of trust. Building on Mary's previously close relationship with her husband and restoring open communication between family members will help to recruit the support Mary will need in managing her finances and gambling addiction.

As McCaslin notes, "I find that most women resist their husband's knowing, and yet, once the gambling problem has been revealed, their stress level decreases. I would explain in plain language ...how, initially, gambling may be fun and exciting but can become stressful and lead to financial loss and escapism. ...Their son has been triangulated into the 'problem' by having to pick sides and keep secrets."

Sharing the gambling secret can bring immediate relief and open up a window of opportunity for change, but rarely does it bring the "magical cure some patients and families fantasize about," say Zilberman and Tavares. Learning to manage urges and developing strategies to prevent relapse and new coping mechanisms become important next steps in therapy.

## **"You are not alone"**

Sharing the gambling secret does not come easily and many people benefit from practicing disclosure within self-help groups such as Gamblers Anonymous or Women for Sobriety. In a safe, supportive environment, gamblers share their experience without fear of judgment, gain comfort in knowing they are not alone, learn coping strategies, build confidence, give and provide support to others who are struggling and they are challenged by their peers when denial or minimization of their problem places them at risk. This positive experience can empower people to share their experiences and concerns more openly with others. The Internet is also opening up opportunities for sharing and peer support and affords people a level of autonomy and privacy that is highly valued.

In addition, groups also provide a wider base of long-term support to draw on. As Zilberman and Tavares point out, "Searching for complementary support from community resources is a must-do, as recovery usually takes years, and treatment programs, even when available, are unlikely to last that long."

## **Teach a man to fish...**

Most gamblers have misperceptions about the nature of gambling and the

likelihood of their success in winning. Many harbour fantasies that their system of play will ultimately pay off. Gamblers stay, bound to play, long after their losses have mounted, falsely assuming they are "due to win," or chasing their losses through continued play. These cognitive distortions and fallacies about winning help to keep gambling levels high. For women gamblers, for whom hope may be scarce and problems many, the "big win" can remain a beacon of light to solve life's problems. This hope contributes to their unwillingness to give up gambling, even as they head for the rocky shores of financial, emotional and social ruin. Learning more about negative rate of return, understanding odds and probabilities and house advantage and gaining a realistic understanding of gambling risk can help clients manage impulses more effectively, particularly Pathway 1 gamblers.

## Reducing harm

If Boughton and Brewster's (2002) research on women problem gamblers is broadly reflective of that group, treatment that takes a harm reduction approach over total abstinence may be more attractive to them. In fact, 51% of the survey's respondents reported they were reluctant to seek professional gambling counselling for fear that they would be pushed into quitting. Some problem gamblers, either through therapy or independently, learn to adjust their gambling behaviours to minimize risk and continue with the more enjoyable elements of play. Others find the allure of gambling too hard to resist and abstinence is their only solution.

Avoiding such gambling cues as handling chequebooks, credit cards and other means of accessing money and having a spouse or family member take short-term control of finances can help to buffer clients in the early stages of change. However, learning over time to manage personal finances is an important goal to restore previous areas of competence. Staying away from gambling venues is also important. It is unfortunate that the casino's self-exclusion program was not effective in keeping Mary out because it can serve as a deterrent some people. One option is for Mary to contact the casino to discuss how to improve recognition so she will be barred from entry in the future should she relapse. However, given the plethora of gambling opportunities available within the community, the responsibility to avoid gambling triggers will ultimately rest with Mary.

Mary can also work with the therapist to identify triggers such as loneliness and boredom and plan appropriate alternatives. Mary will also need to consider new routines to replace the functions gambling previously served. Her high levels of anxiety can be addressed through supporting her to learn new stress-reducing techniques, such as yoga, meditation and relaxation therapies. This has the added advantage of providing important activities to

replace gambling and will help restore her social network. McCaslin notes, "Like many others, Mary has learned to use gambling as a quick fix to her problems and must now learn to incorporate healthy activities and stress-reducing activities."

## Mary's changing roles

Mary is struggling with changes in her life roles, as her children grow up and leave home and her husband is away more frequently. People with gambling problems like Mary frequently lose touch with friends and previously enjoyed leisure pursuits. But we also know from Mary's history that she was placed prematurely in a caregiving role and missed out on important opportunities to explore her own interests and needs.

All respondents recognized the importance of helping Mary understand that the roles she assumed within her primary family (harmonizer, martyr, caregiver) have been carried into her adult life with negative effect. Littman-Sharp writes, "I suspect that over-responsibility would be an important issue. Mary might have difficulties accepting any weakness in herself and might be reluctant to allow others to support her because of parentification early on."

Nixon notes, "She has been a wife and mother, a good money saver all her life... Who does she really want to be?" In many ways the pull of gambling can be about so many unmet needs in a person's life. Can Mary find the courage to look at the unmet needs of her own journey?

Replacing the focus of "care of others" with "care of self" will be a challenging and potentially invigorating process. In therapy, Mary can be encouraged to place herself and her own needs in the center of her life and take time to explore her own passions and interests to create new ways of defining herself. What are the roads Mary has not taken in her life? Should they be explored further?

The drive for self-realization is universal. Mary's willingness to explore her own needs will serve as a powerful benchmark of progress. Learning that it is only through caring for oneself we are able to care for others is part of the journey of self-actualization. As Mary learns to master her urges, monitor her feelings, assert her rights and discover her true identity, she will define a life of purpose and meaning where gambling holds no power.

This journey of self-discovery will not be easy for Mary. In Boughton and Brewster's (2002) research with female problem gamblers disturbing trends emerged. These women have experienced significantly higher rates of emotional (60%) and physical abuse (40%) as children and adults than the

general population as well as higher rates of childhood sexual abuse (38% vs. 13%). They have higher rates of personal struggles with other problematic behaviours, including smoking, eating disorders, shopping addictions and substance use problems with alcohol, prescription and non-prescription drugs. These factors will have a profound effect on their levels of trust, self-identity, sense of personal entitlement and self-esteem. Creating a connection between these hurts and violations and the escape into gambling is essential to move forward avoiding further need sublimation with a different addiction.

Yet Boughton and Brewster (2002) also found that this was a group of women who were highly motivated to make positive changes: 89% were thinking of making changes and 80% had tried to stop or cut down, but the majority had the goal of moderation rather than abstinence in mind. These women were highly self-reliant and strongly believed that they should and could control their gambling without help. However, they reported wanting written materials to understand their gambling problem and self-directed strategies for change. They would like others to talk to who understand what they are going through. The fear of being judged and criticized leads to embarrassment and shame and a reluctance to seek out professional help.

## **A broader context**

We also need to consider Mary within the context of her community. The opening of the casino brought with it much needed jobs and economic revitalization which have benefited many people. There is no question that the opening of a casino in Mary's community also made gambling more attractive and accessible; however, it is obvious that Mary's problems with gambling have far more complex origins than accessibility alone can explain. Gambling represents just one of many opportunities for addictive behaviour available to Mary.

Canadians have entered a period of unprecedented growth in the proliferation of gambling opportunities. Games of chance are promoted as a solution for funding hospitals, charities, stimulating regional economic growth and development and a way to sell all kinds of products. But social, economic and public health costs of this growth are yet to be fully understood. A recent Canada West Foundation study (Azmier, 2001) noted that the public's level of current acceptance for and tolerance of gambling is tied to their belief that government, which in Canada both manages and regulates gambling, will ensure a balance in public and individual interests.

In Ontario, the use of problem gambling treatment remains disappointingly low, with only .004 per cent of the estimated 318,000 problem gamblers in 2000 seeking help (Rush, Shaw Moxam & Urbanoski, 2002). A recent public



awareness survey, Project Weathervane (Kelly, Skinner, Wiebe, Turner & Noonan, 2001), documented that the level of awareness of problem gambling and what constitutes responsible gaming and the availability of treatment resources amongst the public is spotty at best. Clearly there is a lot of work to be done to raise awareness and educate the public of the potential risks associated with gambling activities.

Research and treatment providers are learning important information about risk factors through working with problem gamblers: who is particularly vulnerable, how to minimize harm and what helps people recognize and overcome their addiction. This information can also help to inform larger public policy.

Mary's road to treatment started with the toll-free helpline number posted on casino machines. Because the gambling environment remains an important point of contact with problem gamblers, it is strategic for treatment providers to work with the gambling industry to develop "point of sale" customer information. This will include teaching gaming industry staff to understand risk and help customers assess harm, appreciate when gambling is a problem and determine where to go for assistance. To help mitigate harm, it is necessary to evaluate and strengthen the effectiveness of self-exclusion programs and train gaming staff and lottery retailers to identify potential concerns and direct customers to assistance. Policies and programs that enhance informed consent and promote duty of care by gaming staff will be best informed by the knowledge acquired through clinical practice and research.

Awareness, prevention and treatment effectiveness are most likely to be achieved through a shared commitment by government, the gaming industry, treatment providers and problem gambling advocates. Each has a unique but complementary role to play. The larger questions regarding what is an acceptable level of gambling availability, responsible gambling promotion and when the potential for harm exceeds the public good require the active participation of all stakeholders, including treatment providers as well as an informed public.

Hopefully, through sharing the stories of problem gamblers like Mary and identifying successful intervention strategies, we can encourage others to come forward for help and put a personal face on a growing public health issue, and thereby, mobilize a community of shared concern.

**Acknowledgement:** *I have drawn heavily upon the Centre of Addiction and Mental Health's publication Helping the Problem Gambler (2001) edited by Robert Murray, as a*

*comprehensive reference guide.*

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### **Amethyst Women's Addiction Centre**

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*Contacts:*

*Community Relations/Media Coordinator:  
Natalie Champagne*

*Anglophone Problem Gambling Counsellor:  
Rosemary Barrett*

*Francophone Problem Gambling Counsellor:  
Marguerite Tennier*

### **Program description**

Amethyst works with women, individually and in groups, who are concerned about their substance use and/or problem gambling. We provide structured community based day treatment and educational services which promote healthy lifestyles. Treatment programs are structured and include individual and group therapy. Through education and social action, we help prevent women and children at high risk from developing an addiction. At a community level, we provide training and consultation to improve understanding of women's addiction issues.

The Problem Gambling Program works with women to develop their goals of reducing or stopping gambling. Services are free and are available in both French and English.

Here is an outline of the Problem Gambling Program:

**Intake:** To see a counselor for an assessment, clients must call Amethyst and complete a brief intake interview over the phone. An appointment for the client will usually be made for one week later.

**Assessment:** During the first meeting, the counselor will assess the client's gambling problem and decide if Amethyst is the right place for the client to seek treatment.

**Individual counseling:** Provision of counseling using a variety of therapeutic approaches including: cognitive behavioral, feminist, empowerment, humanistic counseling.

**Group support:** Therapeutic groups are facilitated by a problem gambling counselor.

**Twelve-week treatment program** (available in English only): The program consists of 12 psycho-educational groups and is held two hours per week for 12 weeks. The following topics are covered in the group discussions:

- Problem gambling
- Women and gambling
- Finances and the emotional meaning of money
- Assertiveness
- Stress
- Body image and self-esteem
- Relationships
- Relapse prevention
- Women and violence

- Anger
- Women and depression
- Priorities and goals

**Two-year follow-up support:** Individual counselling and support groups are available for up to two years after cessation of treatment.

**Other services available to Amethyst clients** (available in English only):

- Sexual Abuse Program: A 12-week support group for Amethyst clients confronting painful memories of childhood sexual abuse.
- Childcare: Available two half days per week for women attending appointments.
- Children's programming: Children who have parents in either the gambling program or the substance abuse program can participate. There are two programs available for children at Amethyst: a play-therapy group for four- to seven-year-olds and a drug abuse prevention program group for eight- to 12-year-olds.
- Parenting course for women in recovery
- Other services: Amethyst often offers courses on a variety of topics, such as dealing with anger, stress or building self-esteem. Other courses include Art Therapy and Structured Relapse Prevention.

## **Philosophy of service**

Amethyst is grounded in the feminist belief that women's experience with problem gambling, alcohol or other drugs cannot be separated from our experiences and status as women. We address the direct links between gambling and/or substance use with the unequal position of women in society and the many forms of violence against women. A central task for Amethyst is to help women take charge of their lives by changing or ending their gambling habits and by making changes that enhance their strengths, their freedom and their choices. We help link women to other services that are available in the community for issues such as abuse, mental health and housing.

## **Staff background**

Amethyst staff come from a variety of different educational backgrounds, including social work, psychology and counselling.



## Description of our clients

Amethyst is mandated to work with women 18 and over. Couple counselling is available as requested and services for children are available. Our primary clients are adult women. The majority of the women we work with have experienced physical and/or sexual abuse.

## Program evaluation and research involvement

Amethyst has been involved in several research initiatives since the inception of our Problem Gambling Program in 2000. We were a part of the advisory board for a research project on women and gambling with the University of Toronto. Students working toward their master of social work degree at Carleton University conducted research that evaluated problem gambling treatment services for women; this evaluation tool has been administered to Amethyst service users. We look forward to contributing to and benefiting from further research on gender specific issues with problem gambling.

*This service profile was not peer-reviewed.*

*Submitted: July 19, 2002*

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## first person

**First person account**

*[This article prints out to about five pages.]*

### Reflections on problem gambling therapy with female clients

*Name withheld by request*

I am an addiction therapist who works full-time with problem gamblers. In the course of my brief career, I have seen hundreds of clients, with a little more than one-third being female. When the e-journal editor asked me to write about my therapeutic experiences with women clients, I necessarily had to reflect on the many challenges this work holds for me. Some of these musings concerned what impacts me emotionally; what female clients bring to therapy that is unique; how their therapy unravels; how female clients mark success in treatment; and what they demand of me as their therapist.

It is abundantly clear to me that working with women poses some very distinct challenges compared to working with men. In describing overall experiences working with women and problem gambling in general, there is always the risk of stereotyping. So, I shall qualify my biases right up front. First, let me say that I really enjoy gambling. In my personal life, I am often up for a good outing at the casino. What I cannot abide is exploitation of people with gambling problems. I should also say that I am a feminist, female and I think women are fabulous. Still, when I work with them, the issues of transference and counter-transference can be overwhelming. The work can leave me infuriated and deflated, or revved up and rejuvenated. I find that women

possess multilayered abilities to endure and survive all kinds of adversity. Their strength inspires me, while their wounds inflict pain.

Some of the unique emotional issues I see women bring to problem gambling therapy concern rebellion and autonomy. Almost every female client I have seen states that gambling is in some manner a way of her "letting go of her obligations"; "rebellious"; "doing what I want, finally, after taking care of everyone else all my life." Many of my clients have experienced abusive relationships and lasting loneliness. Several are grandmothers, many are divorced, and a few are young and with partners. The crux of this rebellion seems to be the end result of feeling emotionally and physically responsible to others first and themselves last. When the pressure cap finally blows, and the woman says, "Screw you, world, watch me do what I want!" she finds herself "asserting" her autonomy in a casino or bingo game, etc.

My typical therapeutic challenge is to ask the woman to make sense of this for me: how is losing her money and her time liberating? I tell her I am confused as to how this anger is solved by an activity so filled with loss and regret. All the while, as I explore this thread, I know that as women, in our society, their real and imagined alternatives for expressing rebellion are very limited. This is a real issue that cannot be minimized or ignored in therapy.

It is always strange and disheartening for me to hear women say that gambling is the only activity they have that allows them to "enjoy a social outing alone" without being judged, scrutinized, approached sexually or harassed. One can only wonder what is occurring in a culture where casinos, bingo halls or racetrack or slot venues are the only places some women experience as safe and acceptable to go by themselves. How did it happen that games of chance, with their built in losses, became synonymous with "a nice outing for grandma"? I wonder about our cultural values. When my clients are urged to uncover alternative activities that meet the same criteria — safety, anonymity and social approval — they are hard-pressed to come up with any.

In sessions with clients, I have a difficult time not sharing my disappointment in our culture's values when I encounter this issue. I find myself having some "wicked" counter-transference, wanting to say: "But this is not right. Every social environment should offer you these possibilities, without costing your life savings." Men can go almost anywhere for social activity and it is accepted. Except for maybe attending figure skating or something like that, but you catch my drift. It is still a man's world, and when women seek some autonomy, it seems strange that it comes at such a cost and in such a form. I have asked every female problem gambler if she feels she received the value

of what she purchased by gambling. Each one has given an unqualified *No*: she paid for much more than she received in terms of a dollar value assigned for entertainment, escape or rebellion.

It is easy to see why women clients say that they need a socially acceptable outlet where they feel safe and anonymous in their activities. I have heard more stories of women feeling neglected, alone, abused, rejected and enslaved than I could possibly count. Usually, when I hear these tales, I find myself wondering how this person "escaped" these experiences with "only" a gambling problem. Of course, on exploration, it is obvious that many have more issues to deal with than gambling. When I hear these stories, I always marvel at women's resilience. Usually, women recount the same terrible tales that men tell of loss, loss, loss: financial devastation; shattered values and self-respect; lost jobs and homes. Women also speak clearly about losing their ability to connect with others emotionally and about losing their sense of connectedness, period.

And when women tell these stories, they further relate their mental health diagnoses and struggles with violence from the past. They speak to me about how these issues are connected. A female client told me how, with scratch tickets, "I felt like I was scratching the abuse away, and all thoughts of the abuse. If only I could keep scratching...." When I explore what the material concerns are in their daily lives, I often discover that they are working, taking care of practically every household detail, dealing with children and in-laws and, additionally, dealing with ghosts of the past. Invariably, male clients do not deal with all of these issues; they just gamble and work. It seems so easy for the men that I wonder how all of them can't suddenly experience full recovery in a hurry. And many do, as a matter of fact. But the women: they have so damn much to do in a day that even the all-consuming nature of problem gambling does not allow them to avoid.

This is why I may be called biased. I think women deal better with both the daily and emotional tasks of life. The men get off easily compared to the women. The men usually have the goal of getting their finances in order first, their relationships second, which, alone, they often consider treatment success. On the other hand, many women clients not only have gambling-related and financially related goals but also real, current and explicit concerns about dealing with underlying issues. The men rarely want to deal with those: with abuse, feelings invoked by encounters with their fathers, and the like. Women often tell me they need to deal with these issues, as their unresolved emotions are triggers to gamble. Women see the connections between all of their difficulties, while men more easily compartmentalize their problems—this is gambling over here, that is my relationship over there. The lines of demarcation are rarely so black and white for the women.

Women, on the other hand, come to therapy with much less concrete goals and are much harder on themselves in evaluating success than men. This makes working with women much more challenging for me. The treatment goals are more elusive and the client's measure of success harder to pin down. Her goal will rarely be "to stop gambling" in and of itself, and she will usually be much harder on herself than her male counterpart if she has a setback. For female clients, measures of success are typically so large that, clinically, it is one of my greatest challenges to help the client make treatment goals that are measurable and humanly achievable.

Emotionally, I have many experiences that are exclusive to working with female clients. Counter-transference for me looks like this: I expect a lot from women, more than I expect from men. Referring to the fact that women seem to contend with all that men contend with on a daily basis plus a hearty dose more, I have the distinct feeling women need to be tougher to survive in the world, period. When I see a female client become so trapped in a cycle of victimization that she has no hope or willpower left, sometimes I feel angry at the woman herself. This troubles me. I was taught early that girls had a lot to deal with and they had to be twice as good as boys to be given close to the same respect. So, when I have this feeling of "Come on, lady, toughen up or the world will eat you alive," I am actually confronting my own past. My own childhood awareness of discrimination and victimization suddenly stares me right in the face.

Men do not evoke this response but I cannot avoid encountering it when I work with women. I observe this feeling in myself in most sessions with women who are really struggling. It takes great vigilance, and presence with the client, to ensure I do not recreate for her an experience of "failure," wherein she does not measure up to some "superwoman" standard for me, her therapist.

Female clients also seem to have pretty high expectations of me. I have yet to feel any woman wanted me to "mother" her, as I often find with male clients. I do feel, though, that female clients expect me to join them in a way that men do not. This can be painful and it is certainly rigorous. It involves me being open to their experiences and reflecting them with absolute presence. With men, you can often get the job done quite nicely by offering cerebral interpretations of events and some good, pragmatic behavioural assignments. Not so with women; at least, not usually.

I feel I am called upon to help women clients sort through so many competing issues, real and current, that all of my great CBT\* techniques are not enough. The women want good strategies from me, but this is not what I feel they demand most. They seem to want to know that I am there with them, to

acknowledge that I see their pain and I am not afraid of them; that I can bear their stories and carry them, and that I will attend to them when they feel unworthy. I feel I am asked to testify to their survival; to help them see what I see: a person, deeply injured, and with great, unbelievable resilience.

\*cognitive behavioural therapy

*This First person account was not peer-reviewed.*

*Submitted: September 23, 2002*

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## review

*[This article prints out to about five pages.]*

### **Net-working the steps: Web-based support for women in recovery from problem gambling**



*Reviewed by Virginia M. McGowan,  
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Computer-mediated communication, echoing other quantum leaps in technology, is transforming social lives on a global scale as networks formed in cyberspace reach across group boundaries, space, and time itself. In some instances, people's on- and off-line lives intersect as they develop multi-dimensional, intentional communities (Rheingold, 2000; Wellman, 2001). Increasingly, professional counsellors and psychotherapists are creatively exploring use of the Internet to augment standard interventions or to reach individuals who are reluctant or unable to use existing in-person or real-time services (Cunningham, Humphreys & Koski-Jannes, 2000; Galanter & Brook,

2001; Hsuing, 2000). Paralleling the boom in the reliance on self-help resources and mutual aid to complement or replace the help of a treatment professional, electronic support groups are forming to help people struggling with illness, disability, loss, addiction and other problems.

Women Helping Women (WHW), [www.femalegamblers.org](http://www.femalegamblers.org), is a popular Gamblers Anonymous (GA)-based Web site designed to support women's recovery from problem gambling. Marilyn L. and Betty C., two GA members residing in Phoenix, Arizona, began to edit and publish *WHW* as a way to respond to requests for their newsletter, which has been published on-line monthly since July 1999. *WHW* serves both advocacy and information functions, providing a virtual space where women dealing with problem gambling can cultivate an on-line dimension to the self-help resources and mutual help they receive through real-time GA step groups. Moreover, *WHW* responds to the need for gender-specific support expressed by many women in recovery who struggle with the male-dominated dynamics of many GA groups (Arizona Council on Compulsive Gambling Inc., 2002).

The Web site is self-described accurately as "informal but informative." At the centre of the homepage is a menu that changes monthly to highlight the core article appearing in the current issue, or the most recent article in a multi-part series. Consistent with the GA approach to recovery, the central message to homepage readers is that mutual support is critical for recovery. Similar messages provide succinct points for action, and reinforce the existential experience of being a problem gambler (Makela et al., 1996, p.124). As one might expect to see on the walls where a GA or other 12-step group meeting is taking place, slogans, mottos and proverbs such as "You can't do it for me, but I can't do it without you" and "We may not have it all together, but together we have it all" have been hung on most of the *WHW* homepages published on-line since 1999.

The *WHW* homepage is accessed easily through a variety of search engines such as Google using search terms such as "women and gambling" or "female and gambling" on AltaVista. Alternatively, hypertext links are available from a variety of other websites such as the Arizona Council on Compulsive Gambling ([www.azccg.org](http://www.azccg.org)). All past issues of the monthly newsletter can be accessed from the *WHW* homepage, which, in turn, provides hypertext links to a selection of other resources as well. A clear purpose statement appears on the *WHW* homepage: To support and educate women in recovery for a gambling addiction. There is no explicit mention of the orientation of *WHW* as GA-based, but this perspective is readily apparent from the content of the newsletters. The source of the newsletter is obvious, with the editor and publisher providing no less than three places on the somewhat busy *WHW*

homepage where the reader can click to contact them by e-mail.

A private sector Internet service provider, Infinet, is clearly identified as the corporate sponsor, and donates Web server and hosting functions in return for a hypertext link from the *WHW* website. Nine other active links provide quick access to a variety of reliable sources of information, such as an essay on women and gambling from a site hosted by the Substance Abuse Network of Ontario, the text of a lecture on women and problem gambling delivered in 1998 by an Australian gambling expert, and the Web sites published by Women for Sobriety, the Responsible Gambling Council of Ontario, and the Arizona Council on Compulsive Gambling Inc., which provide further links to a wide range of information and other resources.

Raising concerns about the distinction between promoting products or services and providing objective, unbiased information or perspectives (Alexander & Tate, 1996, pp. 26–27), the two remaining links blend advertising and information. Hazelden Books is a well-known publisher of 12-step- and co-dependency-based recovery literature and Viva Consulting is a private Quebec-based company offering a range of counselling, education and other services.

The newsletter is the core of *WHW* Web-based support, replicating the oral tradition of GA on-line in print form. The newsletter is generally brief, comprising narratives provided by readers with occasional submissions from professional therapists. Brief contributions are solicited from the readers, but the newsletter does not function as an electronic bulletin board. Postings to the newsletter must be sent to either the publisher or editor, who choose the contributions to post in the next issue. The newsletter has a limited "snail-mail" distribution also, which included 100 women around the U.S.A. in February, 2001.

In accordance with the philosophy of support groups modelled on Alcoholics Anonymous, the editor, publisher and other contributors to the *WHW* newsletters take their authority on problem gambling and recovery largely from their individual life experiences and existential identity of being in recovery (Makela et al., 1996). Both the editor and publisher are active GA members, a fact that can be confirmed by reading their personal stories in past issues of the newsletter, such as Marilyn L.'s contribution to mark her 10-year GA anniversary.

As with many Web-based sources of information, the reader must take it as a matter of faith that the person contributing to the newsletter is neither misrepresenting her identity nor attempting to deceive the readers in other ways about her personal story. Fortunately, the personal accounts ring true.

Personal stories presented as testimonials and moral tales are a central motif in GA-based recovery; they provide compelling narratives of downward spiralling chaos, culminating in restitution and recovery. Many stories focus on the role of GA in an individual woman's recovery; others provide pointers for "doing GA"; that is, how the GA-based recovery process unfolds and how to "do the steps." Occasionally, a brief article discusses a particular Unity or Recovery step in detail. Other stories provide a motivational or inspirational message, reinforcing the "yes, you can" message, and poetry or prayers appear occasionally. From time to time, particularly in recent issues, articles written by professional therapists are included on the role of counselling and other topics. Clinical Corner was a section that appeared in earlier newsletters published in 2000, but was dropped in favour of an ad hoc approach to contributions by professionals, such as a four-part series on empowered recovery in 2001.

Lest the contributors commit the sin of pride in extolling their successes in recovery, humorous anecdotes and jokes bring the reader down to earth by poking fun at common perceptions, habits, cognitive distortions and other characteristics of active problem gamblers.

*WHW* is an important resource for women who seek to resolve problem gambling through GA-based recovery processes. In the virtual community created by *WHW*, women will find the more expressive and responsive interactions that many women say is lacking in male-dominated GA groups. Women will read personal narratives that resonate with their own experiences and needs and address life problems that reflect women's socialization and gendered roles. In addition to advice and support for working the GA steps, women will also find other features, such as discussions of professional help and issues that are not often addressed in face-to-face GA groups, such as unhealthy messages about female identity and opportunities that many women absorb growing up.

Simply put, *WHW* places value on women's experiences with problem gambling, recovery and life. For those women who are seeking support in their recovery, but are unable to find a local gender-specific support group or have access to support in the right way, time or place, *WHW* will become a regular stop on the information highway.

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## opinion

*[This article prints out to about 10 pages. Colloquial words and acronyms are in italics at their first use and are explained in a glossary at the end of the article.]*

### The changing participation of women in gambling in New Zealand

*From an address given by Phillida Bunkle to the Centre for Gambling Studies, University of Auckland, and the Problem Gambling Foundation of New Zealand, April 2002. At the time, Phillida Bunkle was a member of Parliament, Wellington, New Zealand.*

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In order to understand the rapid change in women's participation in gambling, it is helpful to develop a sense of the cultural politics within which this change has occurred.

Some time ago I was in Foxton, a rundown, low-income community —probably the poorest part of the area where I live. That day I saw a sight which gave me a great deal of hope; I thought there must be some cultural or community revival going on. There was a long line of women outside the local pub at 9:30 in the morning. I thought they must be coming together for something exciting. They began to jostle a bit and at 10 o'clock, when the pub opened, I went over to see what they were doing —what they were doing was fighting to get near

the pokie machines.

This event summed up for me a major change in this society, which needs investigation. When I arrived in New Zealand 30 years ago, I found an extremely gender-segregated society. A woman's place was quite clearly in the home. The liquor licensing and gambling laws were a legacy of the suffrage movement, which, having failed to achieve prohibition, had sought to segregate women from participation in any aspect of the culture of drinking and gambling. Drinking and gambling were successfully corralled into the male-only preserves of the pub and the TAB (Bunkle, 1980).

By the 1970s, this meant that on Friday nights the boys all went drinking after work and it was quite clear that women weren't welcome. This activity was somewhat hidden, the law demanded that the bar could not be seen by passersby, so that you couldn't see what was going on unless you went inside. They were unpleasant and thoroughly unwelcoming, at least to women. The TAB was associated with this activity and it too was also extremely discrete —women didn't really get to see it—it was clearly a male preserve. The only forms of gambling that women had any involvement with were the occasional on-course flutter and housie, or its Maori equivalent called batons-up.

Well, of course, I was enthusiastic about changing the world, so with a group of other women, I went to war against the wowsers of society and sex segregation. We began with the university club —we got some women together and formed the Academic Women's Association and set forth to normalise the presence of women in the university tearoom. This took quite a lot of effort. We decided we would always go to the club at the same time so no one was ever exposed to being the only woman there. We were sitting together on one of these occasions and a senior professor came up and said, "What are you witches brewing up?" And I replied, "We're learning from you, professor. We're doing what you've been doing for years." Which made him turn pale.

In return for all of this, Geoffrey Palmer had me removed from the tearooms for a whole term. The occasion of my removal wasn't for my insistence on "drinking with the boys," it was actually that I laughed at sex segregation in the judiciary. The law faculty was there one evening, so I asked, "Well, why are all the judges men?" And Sir Geoffrey (he was just Geoffrey then) answered that it was because the profession selected the best available people. I laughed and said that just showed how prejudiced the law profession really was. He gravely explained that only a distorted mind could call this process prejudiced; the guarantee that judges were disinterested was that their appointment processes were in-house: the profession consulted all the best people and they made confidential recommendations

to the minister. I absolutely howled with mirth and said it sounded like an old boys club to me. So he gave me the boot and I had a whole term to learn why one should take the old boys club seriously and shouldn't laugh at Sir Geoffrey. I am still learning —I obviously didn't get the message clearly enough or I wouldn't be where I am today.

So it was rather surprising that I found myself some 20 years later designated as the new *wowser* and leading the parliamentary charge for the sort of wowser-ism that seemed to be such an evil in the '70s.

I think several dramatic changes occurred in the '90s, as more of a market approach and ideas of individual choice as sovereign took hold, embedding the changes initiated in the '80s. Those women going into the bar at 10 in the morning embody three of these changes that have impinged quite drastically on the health of women.

Firstly, we have a dramatic increase in the consumption of alcohol by women; and we haven't yet come to grips with the health implications of that. I am one of the people who have been supportive of trying to get health warnings about fetal alcohol effects on alcohol labels. I believe we are building in disadvantage to the bodies and brains of a whole generation of children because we refuse to actively recognise the impact of alcohol during pregnancy.

If you had said that to me 30 years ago, I would have been outraged at the very idea that women should be judged as ambulant uteri. And, indeed, at that time I opposed the idea that the Ministry of Health should even have a separate concern about women because it was called "maternal health" and reinforced the idea that gender segregation was based on biological destiny. I called New Zealand "the land of the free positive-pregnancy test" because if you went along to the doctor and had a pregnancy test and it was positive, it was part of your "maternity services" and was free, but if it was negative, you paid. That demonstrated the official policy towards women's role in society. New Zealand had a thoroughly pro-natal health policy. Enlightened women used to try to obtain permission to leave the maternity hospital earlier than the two weeks designated in statute. (In fact, one corner of my hospital card said "independent mother" and they whisked me out as quickly as they could. But my secretary was allowed to finish knitting her baby jacket before she was allowed to leave the maternity hospital.)

At the time, if you had said to me that women shouldn't drink during pregnancy, I would have said you were thoroughly paternalistic; that women were perfectly capable of making up their own mature minds. But a

rapacious liquor industry has somehow managed to muddle liberation and liberalism, and there are some serious consequences of young women's increased alcohol consumption, which we haven't sorted out.

The second change is —and I am sure Sir Geoffrey would approve of my attitude here —the dramatic increase in women smoking. Now, I don't smoke, but if you look at who is taking up this activity, it is young women, and it is young Maori women. Now, at least we acknowledge that this has had a dramatic impact on our public health and some effort is going into trying to reduce this consumption.

The third change is, of course, the dramatic change in women's behaviour around gambling. At this stage it is difficult to give you actual figures —and we desperately need them —but women certainly appear to be the fastest-growing segment of the population taking up gambling. Abbott and Volberg's prevalence studies in 1991 and 1999 do not comment on changes in women's level of gambling (Abbott & Volberg, 1991, 2000). But a re-analysis of their data shows that between 1991 and 1999 the number of regular women gamblers rose by 5.1% per year. At the same time, that of men fell by 2.2% per annum. In 1991, 1.86 men for every woman gambled regularly, but in 1999, it was 1.05 man for every woman. In other words, the gender figures have converged to the point that women's gambling activity was almost the same as men's.

Now that women gamble more, they lose more money. In 1999, treatment providers found that in the four weeks prior to seeking treatment, men lost on average \$2,849, and women, \$1,542. But only one year later, the gap between men and women was almost non-existent: men were losing \$2,703 but women were losing \$2,619 (Clifford, 2002). Given women's much lower average income, such losses could have terrible implications for the women and their families.

Since women are gambling more they are also experiencing more problems. In 1997, when I first became patron of the Compulsive Gambling Society, just over 12% of all new referrals to problem gambling services were women. Two years ago, it was over 30% and now more than 50% of the people receiving counselling are women. And if we select particular segments of the population of women —young women, Maori women and women from Pacific Islands women —we find a particularly rapid growth. Of women presenting for treatment now, up to 70% are Maori and Pacific Islands women (Paton-Simpson, Gruys & Hannifin, 2001).

Since the chance of winning has nothing to do with skill, machine gambling is equally available to all players; the machines do not discriminate between

people. A woman can choose to be a player without qualifying as "attractive." Since no skill is required participation does not depend on physical, mental or linguistic capabilities or gender. Nor are there class barriers to access. It may be that the appeal of the machines in communities like Foxton is that they are "equal opportunity" facilities, which include people who are otherwise socially excluded.

When women are asked why they like playing the machines, they respond that they feel safe. Their presence in the pub is not interpreted as trying to attract male attention. While playing the machines they are observers rather than the observed; they are not objects of sexual evaluation; they are players and subjects not objects; they are consumers not the consumed. They can claim a space in the pub without challenging men's space or exposing themselves to the sexual marketplace. They also enjoy the fact that they can be part of a crowd without having to risk rejection (Kaita, 2002).

Today gender segregation feels like a social anachronism. Sir Geoffrey now works alongside women in their capacities as chief justice, attorney general, senior partners in his law firm, not to mention prime minister and governor general. But while the change has no doubt been good for the privileged women who were well positioned to take advantage of this change, the new behaviours have had serious health consequences for the rest.

I want to look briefly at the shift in cultural attitudes that underlie women's changed participation in gambling, because I think we've got to understand that as well as researching the statistics.

Firstly, I think that this behavioural change has everything to do with the normalisation of gambling. The fact that gambling has become so accessible gives a false message about safety. And the more we open up access to a variety of forms of gambling, the more we normalise it.

Gambling on Lotto, *scratchies* and daily Keno has spread to the suburbs and is integrated with your grocery outlet, your post office, your dairy, your bowling alley and even your local mall. This reinforces the message that it is safe. So we have seen an integration of this activity into daily suburban life and a complete change from the segregation of this hidden activity 30 years ago that I described earlier. The message that goes with it is that there is no danger; it is just part of shopping.

The massive advertising around Lotto, for example, is all about the activity being innocuous fun, all about happy families. Lotto is the second biggest product advertised on television, and an integral, normal part of most



families' Saturday night in front of the tele. We know that the poorer you are the more likely you are to see gambling as an investment, so much so that buying your Lotto ticket is so important that you actually feel deprived if you can't play. Budgeting agencies try to leave enough in the pockets of the poor to buy their ticket. It is their ticket to hope; their one "real" chance for something that might change their lives.

Along with advertising and normalisation, we have what I call a "driver" that clearly links gambling with poverty —I call it "addicted to hope." I think it is vital to start the research to unravel this connection. If we have a third of our children living in poverty and if female-headed households are the poorest group in this society, then you don't have to look very hard to find out why the budget advice services want to give people enough left over to buy their "lucky dip." And in a society that has closed off virtually every other possibility of hope, this is not an unrealistic view.

It is really worrying that now pokies are following down the same path as lotto shops, with "convenience" gambling located in suburban high streets and shopping malls. Communities like Taradale and Gisborne sensed the danger but found themselves powerless to stop them from creeping out of the segregated confines prescribed by our suffragette foremothers and penetrating everyday domestic life.

Recently, I have been on the Select Committee considering new gambling legislation. One pokie operator proudly came before the committee to show us a video of his mini-casino premises. He emphasized that it was in a mall; not at all like traditional pub outlets, but alongside shops. It had a bar license but was more like a coffee bar serving café food. It was marketed to couples going to the movies or women having lunch or just a coffee break. You could play the pokies or pop into the dress shop next door. He was proud of the fact that his outlet had moved away from the segregated world of the pub into "respectable company."

We have to give communities and individuals the tools to make choices. But the legislation as proposed only pays lip service to empowering local government or individuals. What we need to do is to make sure that we change the context of these "tickets to hope" in such a way that we control the supply side, while giving the demand side realistic guides to behaviour and real information about the risks, and to direct this message to the people who are drawn to these risks.

I think people who become addicted to gambling are more difficult to help than those addicted to cigarettes or alcohol. If you're stuck on cigarettes, you have a physical addiction problem and there are some services to help

you (although perhaps not as many as you might like). If you've got an alcohol problem and you get off it and you get on the wagon and dry out, you're off it. But with gambling, you've always got the debt issue driving you back into the behaviour. Once you're into debt it's the only way out, so you drive right back into that behaviour of hope. So once you've helped the person stop the behaviour, you've then got to deal with the debt issue—and then break the association with hope and with normality, and I think those are powerful issues.

In terms of government response, it is important that we begin to get wider government input into the legislation that is coming up and the implementation of it. I believe that it is important that Maori Affairs and Women's Affairs start to give policy advice in this area and it is disappointing to me that so far they haven't. We do have to get a much stronger sense of social responsibility into the flow of policy advice; but the truth is, it is not going to be effective until we have some real research to back it up, research that looks at the outputs of the market economy in a way which is not merely anecdotal. What I am asking you to consider is the cultural change backing up the behavioural change that underlies what has emerged as a serious public health issue.

## Glossary

### **batons-up**

A community-oriented, relatively informal, indigenous version of housie, previously popular in Maori communities and usually played for donated items rather than money. An important fundraising form for communities, as the players make a small donation for each baton. The first person to put all their "batons up" wins the prize.

### **housie**

A version of bingo; the first person to match all the numbers on their card with those called wins a prize. Housie can be relatively informal or a regular "house" can be established in a neighbourhood and licensed by police. Proceeds are usually for community, charity or political fundraising.

### **pokies**

Electronic gambling machines with a game on screen and an attached mechanism allowing the player to bet on the outcome. The game requires no skill to play as the result is pre-programmed and ensures that the machine is always the net winner. Profits are



supposed to benefit community or club activities.

### **scratchies**

Tickets covered with a metallic surface layer which can be scratched off to show if the purchaser has a winning combination of numbers or other icons.

### **TAB**

Totalisator Agency Board, the government-owned agency with a monopoly on all betting on horse and dog racing and sports betting, with the exception of limited on-course betting at local race days. The agency pays substantial taxes but profits support the thoroughbred industry or the various sports organisations.

### **wowser**

A supporter of prohibition of smoking, drinking alcohol and gambling. Wowzers were closely associated with Protestant fundamentalist churches and women's suffrage and were politically well organised and important from the 1890s to 1930s. Their activities resulted in strict regulations limiting these activities, especially in Maori-dominated areas that were supposedly "dry." For the purported Australian origins of this word:

[www.cyberbondi.com.au/reception/bondi/history/people/wowser.html](http://www.cyberbondi.com.au/reception/bondi/history/people/wowser.html)

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*Phillida Bunkle studied in Britain and the United States. In the 1970s, she helped introduce women's studies into New Zealand universities and was the first patron of the Compulsive Gambling Society of New Zealand. From 1996 to 2002, she was a member of the New Zealand Parliament. Her bill to give a local option on casinos prompted the government to introduce its own*

*(unpassed) responsible gambling bill. From 1999 to 2002, she developed the policy that gambling should be regulated as a public health issue along with alcohol and tobacco smoking. As Minister of Consumer Affairs 1999-2001, she initiated consumer protection measures supporting an informed choice to "purchase" gambling.*

*Bunkle did not stand in the 2002 election, which saw her former party wiped out in the Parliament. She is now visiting professor at the Centre of Gender Studies, Foreign Languages College, Dalian University, China.*

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# eGambling

THE ELECTRONIC JOURNAL OF GAMBLING ISSUES

## invitation

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## Invitation to contributors

We welcome contributions on gambling and gambling-related issues. Prospective authors should always read the last issue of the *EJGI* for the latest version of Invitation to Contributors. We encourage electronic submission and accept mail submissions, but cannot accept fax submissions. For details, please see the submission process below. All authors whose manuscripts are accepted will receive a standard legal form to complete, sign and return by mail.

## The review process

All submitted manuscripts (except Reviews ) are reviewed anonymously by at least two people. Each reviewer will have expertise in the study of gambling and will assess and evaluate according to the criteria listed below. The editor will mediate their assessments and make the final decisions.

Submissions are either

1. accepted as is, or with minor revisions;
2. returned with an invitation to rewrite and resubmit for review, or
3. rejected.
4. Decisions of the editor are final and cannot be appealed.



Authors will receive an e-mail copy of their manuscript before publication, and must answer all queries and carefully check all editorial changes. Please note that there will be a deadline for a response to queries and no corrections can be made after that date. Authors are responsible for the specific content of their manuscripts.

## **Feature articles**

The editorial board will make specific invitations to chosen authors. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit and/or contribution to public debate in the field of gambling studies. All submissions will be mediated by the editor.

## **Research**

We invite researchers to submit manuscripts that report new findings on gambling. All submissions will be peer-reviewed in confidence by at least two reviewers for their scientific merit, and mediated by the editor.

## **Policy**

We invite manuscripts that examine policy issues involving gambling. All submissions will be peer-reviewed in confidence by at least two reviewers and mediated by the editor. The editor will evaluate how successful the author is in exploring how gambling affects public life and policy, historically and currently.

## **Clinic**

All submissions will be peer-reviewed in confidence by at least two clinicians and mediated by the editor for their soundness and value to

practicing clinicians.

## **First person accounts**

These narratives will show how gambling affects the author and others (perhaps as family, friends, gambling staff, or clinicians). Submissions will be reviewed in confidence by at least two reviewers and mediated by the editor. The editor will evaluate how successful the author is in making gambling issues come alive to the readers. First person accounts do not need abstracts or references.

## **Reviews**

Reviewed by the editor, these brief summaries and discussions will evaluate gambling-related books, videos, Web sites and other media. Reviews should have references if cited, but do not need abstracts.

## **Letters to the editor**

We invite our readers to submit letters on gambling topics. Please note that we can publish only a fraction of the letters submitted. All letters must be signed. We cannot publish anonymous letters, or those of a libellous nature, or portions that use personal attacks. Letters to the editor are reviewed and chosen by the editor and members of the editorial board. Letters may be sent by e-mail or to the mail address given below. Once a letter is accepted, we will request an electronic version. Each published letter will include the writer's first and last names, professional title(s) if relevant, city, province or state, and country. Alternatively, for good cause, the editor may confirm a letter's authorship and publish it as 'Name withheld on request.' We reserve the right to edit each submission for readability, uniform format, grammar and punctuation.

# Submission process

We accept submissions in Microsoft Word, WordPerfect (PC) or ASCII formats. We regret that we cannot accept Macintosh-formatted media. Communications can be sent electronically to ([Phil\\_Lange@camh.net](mailto:Phil_Lange@camh.net)) to the editor for review. We will take all possible care with submissions. Neither the editor nor the Web site managers accept the responsibility for the views and statements expressed by authors in their communications.

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## Manuscripts and Abstracts

Manuscripts should be word processed in Times New Roman 12-point typeface, and should be formatted with 1.25 inch margins on all four sides. Do not use a font size smaller than 10 anywhere in the manuscript. The first page should be a title page and contain the title of the manuscript, the names and affiliations of the authors, their addresses and e-mail addresses. The second page should only have the manuscript title and the abstract; this is for the purpose of anonymity. This abstract (of 150 words or less) should describe what was done, what was found and what was concluded. List up to eight key words at the bottom of the abstract page. Minimally, an abstract should be structured and titled with objective, methods or design, sample, results and conclusion. The structured abstract format is acceptable, but not required.

# References

These should be placed at the end of each manuscript (not as footnotes on each page) and should be cited consecutively in the author/date system (e.g., author(s), year). Ultimate responsibility for accuracy of citations rests with the authors(s). Do not use italics, underlining or tabs in the references; *EJGI* will add these in the editing process. Please see the latest issue of *EJGI* for our referencing format.

If in doubt, please consult the Publication Manual of the American Psychological Association - 5th Edition. (2001). Washington, D.C.: American Psychological Association. Some APA style information is available at <http://www.apastyle.org>.

## Examples:

### Books

Lesieur, H.R. (1984). *The Chase: The Career of the Compulsive Gambler*. (2nd ed.). Rochester, VT: Schenkman Books, Inc.

### Book chapters

Shaffer, H.J. (1989). Conceptual crises in the addictions: The role of models in the field of compulsive gambling. In H.J. Shaffer, S.A. Sein, B. Gambino & T.N. Cummings (Eds.), *Compulsive Gambling: Theory, Research, and Practice* (pp.3-33). Lexington, MA: Lexington.

### Journal articles

Gupta, R., & Derevensky, J. (1997). Adolescent gambling behavior: A prevalence study and examination of the correlates associated with problem gambling. *Journal of Gambling Studies*, 14 (4), 319-345.

### Miscellaneous articles, including government publications

Ontario Ministry of Health. *Schedule of Benefits, Ontario Health Insurance Plan*. Kingston, Ontario: Ontario Ministry of Health; April 1987.

## **Papers presented at a conference, meeting or symposium presentation**

Ganzer, H. (1999, June). A seven session group for couples. Paper presented at the 1999 13th National Conference on Problem Gambling, Detroit, MI.

## **Signed newspaper article**

Brehl, R. (1995, June 22). Internet casino seen as big risk. The Toronto Star, pp. D1, D3.

If the article is unsigned or the author's name is unavailable, begin with the title:

Man gambled crime returns at casino. (1996, February 9). The Christchurch Press, pp.32.

## **Electronic source**

A basic form is given below. For other forms see <http://www.apastyle.org/elecsource.html>

Brown, S., & Coventry, L. (1997, August). Queen of Hearts: The Needs of Women with Gambling Problems, (Internet). Financial and Consumer Rights Council. Retrieved from:  
<http://home.vicnet.net.au/~fcrc/research/queen.htm>

# **Tables**

When submitting tables within the text, indicate the approximate position of each table with two hard returns and dotted lines above and below each location, as illustrated here.

---

Table 1 about here

---

Please submit your manuscript with the tables after the references.

## Graphs and illustrations

Authors whose manuscripts include graphs or illustrations should communicate with the editor regarding submission formats and standards.

## Abbreviations

Well-known abbreviations (e.g., DNA, EKG) may be used without definition; all others must be defined when first used. Except in First person accounts, measurements should be stated first in metric units and, if desired, then using Imperial, American or other local equivalents in parentheses. For example, "The two casinos are 10 km (6 miles) apart." However for First Person Accounts authors may use whatever measurements they prefer. Other units of measurement should be used in accordance with current custom and acceptability. Generic names of drugs are preferred; a proprietary name may be used if its generic equivalent is identified.



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## Links

<http://www.cmhask.com/programs/gambling/index.html>

Public education and community development components of the province of Saskatchewan's Problem Gambling Program

<http://www.gamb-ling.com>

A multilingual gambling information Web site in 11 languages (Arabic, Chinese, English, Farsi, Hindi, Italian, Portuguese, Russian, Somali, Spanish and Urdu). Information in audio formats and through these click-on topics: "What's problem gambling?," "Do I have a problem?," "Get help," "Ethno-cultural resources," "Library" and a help-line number.

<http://www.youthbet.net>

The TeenNet Youth Gambling Web site (University of Toronto) has an interactive neighbourhood (community centre, library, corner store, casino, schoolyard, and back alley) with access to youth gambling information and help resources, diagnostics, and activities related to risk assessment, time management, money management and balanced decision making.

<http://www.ncpgambling.org>

**National Council on Problem Gambling** : to increase public awareness of pathological gambling, ensure the availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and education.

[http://www.gov.ab.ca/aadac/addictions/subject\\_gambling.htm](http://www.gov.ab.ca/aadac/addictions/subject_gambling.htm)

**Alberta Alcohol and Drug Abuse Commission:** information,

brochures and survey results

<http://www.responsiblegambling.org>

**Responsible Gambling Council (Ontario):** information, publications and calendar of international gambling-related events

<http://www.unr.edu/unr/colleges/coba/game>

**Institute for the Study of Gambling and Commercial Gaming:** an academically oriented program on gambling and the commercial gaming industries

<http://www.ncrg.org>

**National Centre for Responsible Gaming:** funding for scientific research on problem and underage gambling

<http://www.problemgambling.ca>

**Problem Gambling: A Canadian Perspective Website** (Gerry Cooper): annotated international links

<http://www.youthgambling.org>

**Youth Gambling Research & Treatment Clinic** (McGill University, Montreal, QC, Canada): information, self-quiz and FAQ's



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Occasionally other messages on related topics may be issued to the list by our Editor. Postings from subscribers are not allowed on the list —only messages from the Editor. We are currently evaluating the idea of setting up a separate discussion list for *EJGI* topics.

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## Figure 1

Interaction between avoidance coping (AC) and loneliness for female gamblers

