"Ideas for Treatment Improvement"

ADDICTION Messenger

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Problem Gambling - Part 2
Screening and Treatment

"I like to play blackjack. I'm not addicted to gambling, I'm addicted to sitting in a semi-circle."

~ Mitch Hedberg (1968 - 2005) ~

We know that between 10 and 30 percent of a substance abuse counselor's clients will have a co-occurring problem gambling disorder. So what can the counselor do to better assess and screen clients for problem gambling? This issue provides some basic strategies that can be added to the counselor's treatment tools. It is important to remember, however, that although pathological gambling often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment automatically qualifies them to treat people with a pathological gambling problem.

Screening

There are over 27 instruments for identifying disordered gambling, with more in development; however, there is considerable debate about the instruments and what each measures. Two commonly used screening tools are highlighted below, as they represent what is most likely to be used by alcohol and drug treatment agencies that screen for gambling problems among their substance abuse clients:

The Lie/Bet. For clinicians and researchers interested in a very brief problem gambling survey, the Lie/Bet questionnaire contains only 2 items: "Have you ever felt the need to bet more and more money?" and "Have you ever had to lie to people important to you about how much you gambled?" Separate investigations have indicated that the measure has good predictive validity in ruling out a gambling problem and is appropriate for use with both clinical and community populations.

The South Oaks Gambling Screen (SOGS). The SOGS, based on the DSM III, was developed in the mid-1980s for use with clinical populations; it is arguably the most commonly used screening instrument. The instrument consists of 20 items that ~~—~~assesses for characteristics of problem gambling such as: ~~,~~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 pay gambling debts, etc. A score of five or higher suggests the presents of pathological gambling and indicates a need for further assessment. There is also a version for adolescents, called the SOGS-RA. The SOGS is a public domain instrument.

What Is Known About Treating Problem Gamblers?

Pathways Model and Implications for Treatment

One model of problem gambling, referred to as the pathways model, identifies multiple determinants of problem gambling and may be a useful guide to treatment. This model identifies 3 main subgroups of problem gamblers:

- Normal: "normal" pathological gamblers who, through a combination of the availability of

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gambling opportunities and reinforcements to continue gambling, become habituated to gambling. The resulting disorders (e.g., anxiety, depression, substance abuse and dependence) are then the consequences of the problems created by the habituated (learned) gambling behavior.

- Psychologically Predisposed: individuals who begin gambling with a predisposing psychological vulnerability manifesting as a "desire to modulate affective states ... or meet specific psychological needs." This subgroup is characterized by premorbid psychopathologies such as anxiety, depression, substance dependence, and deficits in their ability to cope. Individuals with a significant trauma history commonly fall in this category.

- Biologically Predisposed: gamblers with neurological or neurochemical dysfunctions that are primarily genetically based but could be associated with damage to the brain caused by injury, illness, or substance abuse.

Best Practices?

At present there are no universally agreed upon "best practices" nor standardized models of treatment specific to gambling. A review of the best-designed treatment studies indicates the following:

- Cognitive-behavioral treatment (CBT) approaches, even when delivered via a manual and involving only minimal therapist contact, have the most empirical support, compared with no treatment. CBTs, generally brief and delivered on an outpatient basis, have been shown to strengthen motivation.

- Pharmacotherapy (that is, with Naltrexone, Welbutrin, and selective serotonin reuptake inhibitors [SSRIs]) may be an important adjunct to verbal interventions. However, the body of knowledge on problem gambling treatment has not determined which specific type of CBT or medication is most effective, for which individuals, under what circumstances, or whether other approaches have better efficacy.

- As with other treatments, the initial intervention should strive to increase the individual's commitment to treatment and resolve treatment-disrupting ambivalence as much as possible. The relatively high rates of support group dropout and treatment non-completion among problem gamblers suggests that more effort should be made to strengthen the client's commitment to change. Interventions consistent with the motivation stage of change model would be appropriate.

- Daughters reviewed the available treatment literature and suggested that gambling-treatment outcomes can be improved by addressing the factors contributing to treatment failure. Several predictors of poor treatment outcome include gambling-related cognitive distortions and beliefs about randomness, impulsivity or sensation seeking, biological vulnerabilities, and negative affect or mood symptoms.

Treating Co-occurring Disorders

Significant research identifies co-morbidity between problem gambling and substance use disorders, mood disorders, ADHD, and personality disorders (for example, Specker et al. found that 54% of pathological gamblers had an Axis I disorder (most frequently, affective, substance abuse, and anxiety disorders) and 25% of subjects displayed Axis II personality disorders (most frequently, avoidant personality disorder)). Other research has found that subjects who abused substances and had a gambling problem reported increased levels of somatization, obsessive–compulsiveness, interpersonal sensitivity, and paranoia. A more recent study found that gamblers with a history of treatment for substance abuse reported more depression, hallucinations, suicidal ideation and attempts, and difficulty controlling violent behavior over their lifetime, compared with gamblers who had not been previously treated for substance abuse.

Whether a gambling disorder is treated first, second or simultaneously is a matter of clinical judgment based on the relative intensity or emergent nature of the various disorders present. Counselors who are more conversant with substance use disorders may run the risk of underemphasizing a co-occurring gambling that is in need of immediate attention.

What's Different About Treating Problem Gamblers?

Cognitive Errors

Cognitive errors are not new to substance abuse counselors, however there are cognitive errors in problem gamblers that the average counselor may not be aware of. For example, research suggests that a core cognitive error among gamblers lies in their notions concerning randomness. Pathological gamblers hold many erroneous beliefs ("the machine is due; I need to continue"; "he is my lucky dealer; I always win when he is there"), as do even occasional players. Studies done with different games—blackjack, roulette, lotteries, and video lotteries—and replicated in different and independent laboratories have produced similar robust results regarding the frequency and extent of erroneous beliefs on the part of the pathological gambler.

Gambling as an Activity With Risk

Most counselors will help clients identify risky situations that should be avoided as they recover from a substance abuse disorder, yet gambling is often missing from the discussion. Given the prevalence of problem gambling among substance abusers, at a minimum gambling should be addressed and discussed as a risky behavior that can impact relapse or the development of a new problem.

Financial Implications

Many substance abuse clients will experience financial difficulties, but pathological gamblers almost by definition will have serious financial issues, which must be appropriately

addressed. A well-meaning counselor might not know that "appropriate" includes an immediate discussion of finances including availability to money. Those who specialize in treating problem gamblers know that their role is not to provide financial advice, but rather to include financial issues appropriately in the treatment and recovery process.

Harm Reduction

For most problem gamblers seeking treatment, the form of harm reduction most commonly used is abstinence from all forms of wagering. However, it is not uncommon for a problem gambler to successfully quit their problem form of gambling (e.g., electronic machine gambling) while gambling on activities that have never caused problems. While addiction counselors would never endorse a client's plan to solve their drinking problem by switching from vodka to beer, a problem gambling counselor may endorse an "experiment" where a client wants to continue to gamble on games that have not resulted in problems for them. For example, a problem slot machine player may not be willing to stop playing the lottery once a week or wagering with friends on the golf course. There is some controversy in the problem gambling field about harm reduction approaches but the theory behind harm reduction is gaining broader acceptance.

A Case Study

The following case study, excerpted from SAMHSA's recent Treatment Improvement Protocol on Co-Occurring Disorders (TIP #42), describes a common situation with a positive intervention on the part of a substance abuse treatment counselor and is illustrative of the need for substance abuse counselors to help their clients with gambling problems as well:

Case Study: Counseling a Substance Abuse Treatment Client With a Pathological Gambling Disorder

Louis Q. is a 56-year-old, divorced Caucasian male who presented through the emergency room, where he had gone complaining of chest pain. After cardiovascular problems were ruled out, he was asked about stressors that may have contributed to chest pain. Louis Q. reported frequent gambling and significant debt. However, he has never sought any help for gambling problems. The medical staff found that Louis Q. had a 30-year history of alcohol abuse, with a significant period of meeting criteria for alcohol dependence. He began gambling at age 13. Currently, he meets criteria for both alcohol dependence and pathological gambling. He has attended AA a few times in the past for very limited periods. He was referred to a local substance abuse treatment agency. Assessment indicated that drinking was a trigger for gambling, as well as a futile attempt at self-medication to manage depression related to gambling losses. The precipitating event for seeking help was anxiety related to embezzling money from his job and fear that his embezzlement was going to be found by an upcoming audit. During the evaluation, it became clear that treatment would have to address both his gambling as well as his alcohol dependence, since these were so intertwined. Education was provided on both disorders, using standard information at the substance abuse treatment agency as well as materials from Gamblers Anonymous (GA). Group and individual therapy repeatedly pointed out the interaction between the disorders and the triggers for each, emphasizing the development of coping skills and relapse prevention strategies for both disorders. Louis Q. also was referred to a local GA meeting and was fortunate to have another member of his addictions group to guide him there. The family was involved in treatment planning and money management, including efforts to organize, structure, and monitor debt repayment. Legal assistance was obtained to advise him on potential legal charges due to embezzlement at work. He began attending both AA and GA meetings, obtaining sponsors in both programs.

What worked in this scenario? According to the TIP, **"**The counselor takes time to establish the relationship of the two disorders. He takes the gambling problem seriously as a disorder in itself, rather than assuming it would go away when the addiction was treated. Even though his agency did not specialize in gambling addiction treatment, he was able to use available community resources (GA) as a source of educational material and a referral. He recognized the importance of regular group involvement for Louis Q. and also knew it was critical to support the family in working through existing problems and trying to avoid new ones."

Next Issue:

"Recovery and Resources"

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