GAMBLING PROBLEMS: AN INTRODUCTION FOR BEHAVIORAL HEALTH SERVICES PROVIDERS

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Course Author: John H. Tinsley, PhD

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ABOUT THE INSTRUCTOR

Dr. John H. Tinsley is a former assistant professor of Medical Physiology at the Texas A&M University System College of Medicine. He received his Ph.D. from Texas A&M University, College Station, Texas; M.S. from the University of North Carolina; and his B.S. from the University of Oklahoma.

He has been teaching, training, consulting and conducting research in the fields of Medical Physiology and Behavioral Biology for over twenty-nine years. Dr. Tinsley has authored over twenty-five professional and refereed articles, including invited reviews. He has been a member of the American Society for Physiology, and work done in 2001 led to an international award from The European Society on Microcirculation. Dr. Tinsley has received research funding from the Veteran's Administration, American Heart Association, and Scott and White Hospital. In addition, he has served on numerous review committees for national grant-funding agencies and scientific journals.

Gambling Disorder: Updated Evidence on Comorbidity, Risk, and Treatment

The SAMHSA Advisory on which this course is based introduced behavioral health providers to the fundamentals of gambling disorder, its DSM-5 diagnostic criteria, its co-occurrence with substance use and other psychiatric disorders, and the cognitive-behavioral and motivational approaches available for treatment. Since that Advisory was published, the research base has expanded substantially, producing population-level data on psychiatric comorbidity, mortality risk, gender-specific treatment gaps, digital intervention delivery, and youth gambling patterns that update the clinical picture this course presents.

The comorbidity estimates this course cites, drawn primarily from the National Epidemiologic Survey on Alcohol and Related Conditions, have been updated by a 2025 systematic review and meta-analysis of population-based surveys spanning 1993 to 2024. The analysis found that 82.2% of individuals with gambling disorder met criteria for any co-occurring mental disorder. Substance use disorders were present in 34.2%, mood disorders in 30.9%, and anxiety disorders in 29.9%. Individuals with gambling disorder demonstrated 10.7 times higher likelihood of developing any mental disorder compared to the general population, with odds ratios 5 to 12 times higher for addictive disorders and 3 to 4 times higher for anxiety and mood conditions (Galeazzi et al., 2025). For behavioral health providers using this course's framework, the Galeazzi et al. data reinforces the clinical reality that gambling disorder rarely presents in isolation. The 82.2% comorbidity rate means that providers screening for gambling problems should expect that the vast majority of clients who screen positive will have at least one additional psychiatric diagnosis requiring attention. The practical implication is that gambling screening should be routine in all behavioral health settings, not just in programs specifically targeting gambling, because the overlap is far too extensive for any single-disorder treatment system to capture.

The mortality dimension of gambling disorder, which this course addresses primarily through its discussion of financial, legal, and social consequences, has been quantified with unprecedented precision. A 2026 nationwide matched cohort study using Taiwan's National Health Insurance database followed 961 individuals with gambling disorder, 3,844 matched controls, and 675 unaffected siblings for a mean of 8 years. Gambling disorder was associated with a dramatically elevated risk of unnatural mortality (adjusted hazard ratio 6.15) and especially suicide mortality (adjusted hazard ratio 10.03), meaning that individuals with gambling disorder died by suicide at approximately ten times the rate of matched controls (Chen et al., 2026). A separate 2026 meta-analysis of 14 observational studies quantified the suicide risk further, finding elevated rates of suicidal ideation (OR 1.58), suicide attempt (OR 2.91), and suicide mortality (OR 8.52) among individuals with gambling disorder, with European populations showing greater associations than Asian populations (Wang et al., 2026). For behavioral health providers, these findings transform gambling from a financial and behavioral problem into a life-threatening clinical condition. The suicide mortality risk of 8.52 to 10.03 times that of the general population places gambling disorder in the same risk category as major psychiatric conditions for which routine suicide screening is already standard practice. Providers who identify gambling problems in their clients should conduct a suicide risk assessment as a clinical imperative, not an optional follow-up.

The treatment landscape has evolved beyond the face-to-face cognitive-behavioral and motivational interviewing approaches this course describes. A 2026 proof-of-concept study examined guided internet-delivered cognitive behavioral therapy for individuals with gambling disorder and comorbid

psychiatric conditions, a population that has historically been difficult to engage in traditional outpatient treatment. Among 25 participants who completed an average of 19.9 behavioral exercises through the online platform, the intervention produced significant decreases in gambling, anxiety, and depression symptoms with large effect sizes. Seventy-two percent met responder criteria at post-treatment, though this declined to 52% at follow-up (Molander et al., 2026). For the treatment framework this course presents, the Molander et al. findings represent an important expansion. The shame and stigma this course identifies as barriers to treatment seeking may be partially addressed by digital delivery, which allows clients to engage with evidence-based CBT content without the face-to-face disclosure that many find intolerable. The attrition from 72% to 52% responder status between post-treatment and follow-up, however, echoes a consistent finding in the gambling treatment literature: initial treatment gains are difficult to sustain, and ongoing support structures, whether digital or in-person, appear necessary to maintain recovery.

The gender dimension of gambling treatment, which the SAMHSA Advisory does not address in depth, was examined in a 2026 systematic review of 18 studies evaluating prevention and treatment interventions specifically for women with gambling problems. The review found that while prevention programs enhanced knowledge and reduced gambling frequency, and CBT-based treatments lowered gambling severity, interventions "insufficiently address their unique needs." Women with comorbid mental health conditions showed higher dropout rates from gambling treatment, and gender-specific frameworks were largely absent from the evidence base (Monreal-Bartolomé et al., 2026). For behavioral health providers using this course as an introduction to gambling problems, the gender gap in treatment research has a practical consequence: the CBT and motivational approaches this course describes were developed and tested primarily with male-majority samples, and their applicability to women, who may gamble for different reasons, experience different patterns of harm, and face different barriers to treatment, cannot be assumed without adaptation.

The youth gambling landscape has also shifted since the advisory on which this course is based. A 2025 cross-sectional study of 617 young people aged 16 to 25 in Spain found that nearly 60% reported lifetime gambling experience, with 3.5% showing problem gambling symptoms. Despite reduced exposure to gambling advertising compared to pre-pandemic periods, gambling normalization persisted among youth. Factors associated with problem gambling included enhancement motives, predictive control beliefs, the cognitive distortion that one can predict outcomes, negative urgency, and peer influence (Barceló-Soler et al., 2025). For behavioral health providers, the youth findings highlight that the cognitive distortions this course describes, the belief that gambling outcomes can be predicted, that losses are "due" to reverse, are not just clinical features of established gambling disorder but developmental risk factors identifiable in young populations before gambling reaches clinical severity. Screening for these distorted beliefs during routine adolescent and young adult assessments may identify at-risk individuals before the financial, legal, and psychiatric consequences this course describes have fully developed.

How Well Does Cognitive Behavioral Therapy Work?

This course presents cognitive behavioral therapy as the primary psychological treatment for gambling disorder, and recent evidence both confirms its value and adds an honest qualification that every provider should understand. Pfund and colleagues (2023) conducted a systematic review and meta-analysis of 29 randomized controlled trials involving 3,991 participants, the most comprehensive synthesis of cognitive behavioral techniques for gambling to date. At the end of treatment, the results were strong. Compared with control conditions, cognitive behavioral therapy produced a large reduction in gambling disorder severity, with a standardized effect size of 1.14, along with meaningful reductions in how often people gambled and how much money and time they put at risk. By the standards of psychotherapy research these are substantial effects, and they confirm that the approach this course teaches genuinely helps people reduce their gambling.

The qualification is about durability. When the analysts looked at follow-up assessments conducted after treatment had ended, the significant advantages had faded. Cognitive behavioral therapy had no statistically significant effect on gambling outcomes at follow-up. The authors were also candid about the limitations of the underlying research, noting evidence of publication bias and high variability across studies, and concluding that the post-treatment effects were likely overestimated. This is the kind of finding that is tempting to leave out of a course because it complicates a clean message, but leaving it out would do providers and their clients a disservice.

For the provider, this is not a reason to abandon cognitive behavioral therapy, which remains the best-supported psychological treatment available for gambling disorder. It is a reason to think about gambling treatment the way the field increasingly thinks about substance use treatment, as the management of a chronic, relapse-prone condition rather than as a single course of care that produces a lasting cure. The practical implications follow directly. Gains made during treatment cannot be assumed to hold on their own. Building in continued contact, booster sessions, relapse-prevention planning, and links to ongoing support is not an optional extra but a direct response to what the outcome data actually show. A client who completes a successful course of cognitive behavioral therapy and is then discharged with no follow-up is a client at real risk of relapse, and planning for that risk from the first session is part of competent care.

There is also a way to use this finding with clients themselves. Many people who relapse after treatment conclude that they failed, or that treatment failed, and abandon the effort in discouragement. Knowing in advance that gambling is a condition prone to recurrence, and that a lapse is a signal to re-engage rather than proof that recovery is impossible, can keep a client in the process through exactly the moment when many drop out. Framing recovery as a long arc with expected setbacks, rather than a single decisive victory, aligns the client's expectations with what the evidence shows and protects against the all-or-nothing thinking that turns a lapse into a full relapse.

Medication Options for Gambling Disorder

The SAMHSA Advisory on which this course is based focuses on psychological and psychosocial treatment, and for good reason, because no medication is currently approved specifically for gambling disorder. That does not mean medication has no role. A recent network meta-analysis clarifies what the pharmacological evidence actually supports. Ioannidis and colleagues (2025) reviewed 22 randomized controlled trials and pooled 16 of them, covering 977 participants, to compare medications against placebo and against one another for gambling severity.

The clearest signal came from the opioid antagonists, the same class of medication used to reduce craving in alcohol and opioid use disorders. Nalmefene produced the largest reduction in gambling severity, with a standardized mean difference of 0.86 against placebo, and naltrexone produced a smaller reduction of 0.42. Both also improved quality of life. The rationale fits the addiction framing of gambling, since these medications dampen the reward signaling that drives compulsive behavior, the same signaling the neuroimaging research discussed later in this update has documented. By contrast, some medications that have been tried showed no benefit over placebo, including the antipsychotic olanzapine and the anticonvulsant topiramate, a useful reminder that plausible-sounding treatments do not always work and that the evidence has to be checked rather than assumed.

The evidence carries an important caution. Both opioid antagonists caused significantly more people to drop out because of side effects than placebo did, which limits their usefulness for some clients and means the decision to try one has to weigh benefit against tolerability. The overall picture is that medication is a legitimate but adjunctive option, most reasonable for clients with more severe gambling disorder, those who have not responded to psychological treatment alone, or those with co-occurring alcohol or opioid problems for which an opioid antagonist may help both conditions at once.

For the behavioral health provider, the practical takeaway is threefold. First, medication should not be presented to clients as a cure or a substitute for the psychological work this course describes, but it is worth knowing about and, where appropriate, worth a referral to a prescriber. Second, because the best-supported medications are opioid antagonists already familiar from substance use treatment, providers who work with co-occurring addiction are often already positioned to recognize when a medication consultation might help, and to coordinate care with the prescriber. Third, the client should be told honestly what medication can and cannot do, that it may take the edge off the urge to gamble and support the psychological work, but that it is not a switch that turns the disorder off, so that a client who tries it and still feels the pull does not conclude that treatment is hopeless.

A Three-Question Screen for Everyday Practice

This course emphasizes screening, and one of the most useful developments for busy behavioral health settings is the availability of very short, validated screening tools that can be folded into a routine intake without adding meaningful burden. The best studied of these is the Brief Biosocial Gambling Screen. Gebauer, LaBrie, and Shaffer (2010) developed and validated it using data from a large national survey, and its performance is remarkable for a three-item instrument. It correctly identified 96 percent of people with a gambling disorder, a sensitivity of 0.96, while correctly clearing 99 percent of those without one, a specificity of 0.99. Screening tools rarely achieve both high sensitivity and high

specificity, and a three-question instrument that does is unusually valuable.

The screen works because its three questions each tap a different core dimension of addiction. One asks about the restlessness or irritability that comes with trying to cut down, a form of withdrawal. One asks about lying to family members or others to conceal the extent of gambling. One asks about relying on others for money to relieve a desperate financial situation caused by gambling. A single yes on any of the three is enough to warrant a fuller assessment. In practice this means a provider can add gambling screening to an intake with three plain questions that take under a minute to ask, and that map onto experiences clients can readily recognize in themselves.

Two honest notes accompany this recommendation. The screen was validated against the diagnostic criteria in use before the current DSM-5, though the criteria overlap heavily and the instrument remains widely used and endorsed. And like any screen, it identifies people who need further assessment rather than diagnosing anyone by itself, so a positive result is the beginning of a conversation, not a conclusion.

The larger point is why screening matters so much for this particular disorder. Gambling problems are, in a phrase often used in the field, an invisible addiction. There is no substance on the breath, no track marks, no failed drug test, and often no outward sign at all until a financial or legal crisis erupts. Clients carry intense shame and rarely raise the subject on their own, and providers who do not ask will usually not find out. Because gambling disorder so often travels with the substance use, mood, and anxiety disorders that behavioral health providers already treat, a brief routine screen is frequently the only way the problem comes to light while there is still time to intervene. Making a three-question screen a standard part of intake for every client, not just those who somehow raise gambling themselves, is one of the highest-yield and lowest-cost changes a program can make.

The Digital Transformation of Gambling

The SAMHSA Advisory on which this course is based was published in 2014, and the single largest change in the gambling landscape since then is the migration of gambling onto phones and computers, together with the rapid spread of legalized sports betting across the United States. This is not a minor update. It changes who gambles, how they gamble, and how much harm results, and it is essential context for any provider working from a pre-2018 framework.

The strongest recent evidence comes from Tran and colleagues (2024), who conducted a systematic review and meta-analysis for a major public health journal, drawing on 380 representative samples across 68 countries and territories. Their central finding on harm is striking. While the overall rate of problematic gambling among adults was about 1.4 percent, the rate among people who gambled on online casino or slot formats was 15.8 percent, more than ten times higher. Online formats concentrate harm in a way that traditional, occasional, in-person gambling does not.

The reasons are not mysterious. A casino requires a trip, but a phone is always in a pocket. Online and mobile platforms allow continuous, rapid, solitary play, often around the clock and often in complete privacy, which removes the natural brakes that time, travel, cost, and social visibility once placed on gambling. Sports betting applications in particular have woven gambling into the ordinary experience of watching a game, with constant in-play wagering on individual plays and heavy,

normalized advertising that presents betting as a routine part of being a fan. The privacy that makes online gambling appealing is also what makes the resulting problem so easy to hide, from family and from clinicians alike, and the speed and constant availability shorten the path from casual play to compulsive play.

For the behavioral health provider, this shift has direct clinical consequences. A client's gambling may be entirely invisible, conducted silently on a phone with no cash changing hands, no tickets, and no trips to a casino to signal it. A spouse may have no idea until the money is gone. Screening questions framed around older images of gambling, the casino floor, the racetrack, the lottery counter, may miss a young client whose entire gambling life takes place inside an app. Providers should ask about online and sports betting specifically, using current language that clients will recognize, and should recognize that a phone can now deliver the most harmful forms of gambling to anyone at any hour. They should be especially alert to gambling problems in demographic groups, particularly young men, who may never set foot in a traditional gambling venue but who are heavily targeted by sports betting marketing. The assessment and treatment tools this course teaches remain valid, but the provider has to apply them to a form of gambling the original advisory could not have fully anticipated, and to clients whose problem may be advancing quickly and silently on a device they carry everywhere.

Why Gambling Counts as an Addiction

When the DSM-5 was published, it made a significant change that this course reflects, moving gambling disorder out of the impulse-control disorders and into the category of substance-related and addictive disorders. This was the first time a behavioral condition, one involving no ingested substance, was formally classified as an addiction. The reclassification was not a matter of convenience or analogy. It rested on accumulating evidence that gambling disorder engages the same brain systems as drug addiction, and the neuroimaging research has continued to strengthen that case.

Clark, Boileau, and Zack (2019) reviewed the brain-imaging evidence, drawing together studies that measured both reward-related brain activity and neurotransmitter function in people with gambling disorder. The picture that emerges is one of shared machinery. People with gambling disorder show dysregulated activity in the same reward circuitry implicated in substance use disorders, centered on the ventral striatum and the medial prefrontal cortex, regions that process reward, motivation, and decision-making. The studies also point to amplified dopamine release in response to the uncertainty and near-misses that characterize gambling, which helps explain why the unpredictability of a slot machine or a bet can be so powerfully reinforcing. The very feature that defines gambling, not knowing whether you will win, is the feature that drives the reward system hardest, and it is no accident that the most harmful modern formats are the fast, continuous ones that deliver that uncertainty over and over.

The review is careful in a way worth passing along to clients and colleagues, because it also notes where gambling disorder differs from drug addiction. The structural changes in the brain seen in gambling disorder appear more modest than the pronounced structural deterioration associated with chronic substance use, which makes sense given that gambling introduces no neurotoxic substance. Gambling disorder, in other words, shares the reward-circuit dysregulation of addiction while sparing much of the physical damage that drugs inflict, a distinct profile rather than a simple copy.

For the provider, this evidence does more than justify a diagnostic label. It reframes how gambling

problems should be understood and explained. A client who gambles compulsively is not simply weak-willed or morally deficient, a judgment that both clients and their families often carry and that fuels the shame this course identifies as a central barrier to treatment. The behavior is driven in part by a reward system that has been captured much as it is in drug addiction. Being able to explain this to a client, that their brain has learned to respond to gambling in ways that parallel a substance addiction, can reduce shame, support the case for structured treatment, and help a client understand why willpower alone has not been enough. The same explanation helps families move from anger at a perceived moral failing toward support for treating a genuine disorder, which improves the client's odds of staying in care.

Brief Interventions and the Question of Stepped Care

Not every person with a gambling problem needs, wants, or will accept a full course of cognitive behavioral therapy, and this course's attention to engaging reluctant, shame-laden clients raises the practical question of what to offer people who fall short of severe disorder or who resist formal treatment. The evidence supports a modest but real role for brief, low-intensity interventions. Quilty and colleagues (2019) conducted a meta-analysis of the small set of randomized trials available, five in the primary comparison, and found that brief interventions produced a small but statistically significant short-term reduction in gambling behavior compared with assessment-only control, with an effect size of 0.19.

The effect is genuinely small, and honesty requires saying so. A brief intervention, whether a single session of personalized feedback and motivational conversation or a short self-help workbook, is not equivalent to a full course of treatment for someone with severe gambling disorder. But a small effect delivered cheaply and acceptably to a large number of people has real public health value, and brief interventions fit naturally into the stepped-care logic that behavioral health increasingly uses. For a client who screens positive but is not ready for intensive treatment, a brief motivational intervention is a reasonable and evidence-supported first step, one that may reduce harm now and open the door to more intensive care later. It also respects the client's autonomy and readiness in exactly the way this course's guidance on rapport and shame would recommend, meeting the person where they are rather than insisting on a level of treatment they are not prepared to accept.

A word is warranted about Gamblers Anonymous, which many clients will encounter and some providers will consider recommending. Gamblers Anonymous offers real community, structure, and the support of others who understand the problem from the inside, and for many people that fellowship is genuinely valuable. It is important, however, to be accurate about its evidentiary status. The research base for Gamblers Anonymous as a stand-alone treatment is thin and inconsistent, without the controlled-trial support that cognitive behavioral therapy has. The reasonable stance is to present it honestly, as a potentially helpful source of ongoing peer support and accountability, particularly alongside professional treatment rather than in place of it. Framing it this way respects both the client's autonomy and the limits of what the evidence can promise, and it avoids setting a client up to feel that they have failed if peer support alone does not resolve a serious disorder.

A Practical Assessment Workflow

The individual findings in this update, on comorbidity, mortality, screening, and the shift to online gambling, are most useful when combined into a single practical routine that a provider can actually follow at intake. What follows is one way to translate the evidence into a concrete sequence.

Begin by screening everyone, not only those who mention gambling. Because gambling disorder is invisible and shame keeps clients silent, the only reliable way to detect it is to ask every client as a matter of routine, the same way a program screens every client for alcohol or drug use. The three-question Brief Biosocial Gambling Screen makes this feasible in under a minute, and its high sensitivity means that few true cases will slip through. Normalizing the questions helps, for example by introducing them as something asked of everyone, which lowers the client's sense of being singled out or judged and makes an honest answer easier.

When a client screens positive, expect company. The comorbidity data described earlier in this course, with more than four in five people with gambling disorder meeting criteria for another mental disorder, mean that a positive gambling screen is rarely the whole story. The provider should treat it as a prompt to assess, or reassess, for the substance use, mood, and anxiety disorders that so often accompany it, and to consider how these conditions interact. A client whose gambling escalates when depressed, or who gambles and drinks together, needs a plan that addresses the combination rather than any single piece in isolation.

Treat a positive screen as a reason to assess suicide risk directly. This is the step most likely to be skipped and the one with the highest stakes. The mortality evidence covered earlier, showing suicide risk many times that of the general population, places gambling disorder in the same category as the serious psychiatric conditions for which routine suicide screening is already standard. A provider who identifies a gambling problem and does not ask about suicidal thoughts has missed the most dangerous dimension of the disorder. The financial ruin that gambling can produce, sudden, total, and deeply shaming, is precisely the kind of acute crisis that can precipitate a suicidal act, which makes this assessment urgent rather than optional.

Ask specifically about how the person gambles, including online and mobile formats. Given that online casino, slot, and sports betting formats concentrate the greatest harm, and that they can be hidden completely, the assessment should ask in current, concrete terms. Questions about apps on the phone, about sports betting, and about online casinos will surface patterns that questions about casinos and lottery tickets alone would miss, particularly with younger clients and with men who follow sports. Understanding the format also informs the plan, since a client whose gambling lives on a phone that is always present faces a different daily challenge than one who has to travel to a venue, and practical steps such as self-exclusion tools, app blockers, and handing financial control to a trusted person may be relevant.

Attend to finances and to the people around the client. Gambling disorder is unusual among addictions in the speed and scale of the financial destruction it can cause, and the resulting debt, legal problems, and family conflict are often what finally bring a person to treatment. A thorough assessment asks about financial harm and about the impact on family members, both because these are among the most pressing problems the client faces and because family members are frequently harmed themselves and may need support or referral. Involving a supportive family member, with the client's consent, can

strengthen the plan and counter the isolation that shame produces.

Finally, match the intensity of the response to the client's severity and readiness. A client with mild problems who is not ready for intensive treatment may be well served by a brief intervention and follow-up, while a client with severe disorder, heavy comorbidity, and suicide risk needs a comprehensive plan that may include cognitive behavioral therapy, a medication consultation, relapse-prevention planning, and coordinated care for co-occurring conditions. The evidence in this update does not prescribe a single path. It equips the provider to build a response that fits the person, which is exactly what this course's emphasis on individualized, rapport-based care intends.

Engaging the Client Who Will Not Raise It

Everything in this update depends on a client being willing to talk about gambling, and that willingness cannot be assumed. Gambling disorder is uniquely wrapped in shame. Because it leaves no physical trace and is widely regarded as a failure of character or self-control rather than a recognized illness, a person struggling with it often carries a private conviction that they are simply weak, and that conviction is precisely what keeps them silent. A few practical stances help a provider get past that silence to the conversation that treatment requires.

The first is to normalize the question rather than singling the client out. Asking every client, as a routine part of intake, whether gambling has ever caused them difficulty communicates that the question is standard and the topic unremarkable, which lowers the client's sense of being judged or accused. A question framed as something asked of everyone is far easier to answer honestly than one that feels prompted by suspicion. The neuroscience covered earlier in this update gives the provider a genuinely useful tool here, because being able to explain that gambling engages the brain's reward system much as drugs do reframes the problem from a moral failing into a treatable medical condition. For many clients, hearing that their struggle has a recognized biological dimension is the moment shame loosens enough for an honest disclosure.

The second stance is to meet ambivalence with the motivational approach rather than confrontation. A client who minimizes the problem, insists they can stop whenever they want, or bristles at the suggestion of treatment is not being difficult so much as protecting a painful and threatened part of their life, and pushing hard against that defense usually strengthens it. Open questions that invite the client to describe the costs and benefits in their own words, reflective listening that shows the person they have been understood, and affirmation of any steps they have already considered do more to move a reluctant client than warnings or lectures. The goal at the first contact is not to extract a commitment to intensive treatment but to keep the person in the conversation and to help them articulate their own reasons for concern, which are the only reasons durable enough to sustain change.

The third stance is to treat financial harm as both a clinical priority and an engagement opportunity. The financial destruction that gambling produces is often what finally brings a person to seek help, and it is also among the most acute dangers they face, because sudden, total, and shaming financial ruin is exactly the kind of crisis that can precipitate a suicidal act. Asking directly and without judgment about debt, borrowing, and the financial impact on the family accomplishes two things at once: it surfaces a pressing problem the client needs help with, and it signals that the provider is prepared to deal with the practical wreckage of the disorder rather than only its psychology. Concrete steps, such as helping the

client consider handing temporary control of finances to a trusted person, installing app blockers or self-exclusion tools, and connecting them to credit counseling, give a client tangible reasons to stay engaged and some immediate relief from the pressure that fuels both the gambling and the despair.

The fourth stance is to include the family with the client's consent, because gambling disorder harms the people around the client and because those people are often the client's best support for recovery. Family members frequently arrive exhausted, angry, and financially depleted, and the same reframing that helps the client, that this is a treatable disorder engaging the brain's reward circuitry rather than a simple moral failure, can help a family move from blame toward the support that improves the client's odds of staying in care. Family members may also need help and referral in their own right, both because they have been harmed and because their wellbeing shapes whether they can sustain a supportive role. Handled with attention to shame, financial harm, and the family, the engagement that all of this evidence presupposes becomes possible, and the client who would never have raised gambling on their own is given a way into the care that can help.

From Evidence to Practice

Taken together, the research assembled here updates the introductory picture this course provides in several concrete ways, and the updates point toward a coherent set of clinical commitments.

The first commitment is to screen, routinely and briefly. Gambling disorder is common in behavioral health populations, it travels with the substance use, mood, and anxiety disorders providers already treat, and clients rarely disclose it unprompted because of shame and because the addiction leaves no outward trace. A validated three-question screen makes detection nearly free, and the comorbidity data already cited in this course make clear that the payoff is large. The second commitment is to treat gambling disorder as the serious, potentially lethal condition it is. The mortality and suicide data described earlier in this course, combined with everything known about comorbidity, mean that a positive gambling screen should trigger a suicide risk assessment as a matter of routine, not as an afterthought.

The third commitment is to deliver the best available treatment while planning honestly for its limits. Cognitive behavioral therapy works, and it is the right first-line psychological treatment, but its benefits fade without continued support, so relapse prevention and ongoing contact belong in the plan from the start. Medication, principally the opioid antagonists nalmefene and naltrexone, is a legitimate adjunct for more severe or treatment-resistant cases and for clients with co-occurring alcohol or opioid problems, though no medication is approved specifically for gambling and side effects limit its use. Brief interventions have a modest place for those not ready for more, and peer support can help so long as it is not oversold as a proven treatment.

The fourth commitment is to meet gambling as it actually exists today. The migration of gambling onto phones and into sports betting has concentrated harm in online formats and made problem gambling easier than ever to hide, which means providers must ask about online and mobile gambling directly and stay alert to it in populations that never enter a traditional venue. Underlying all of this is the reframing that the neuroscience supports. Gambling disorder is a genuine addiction, engaging the brain's reward systems much as drugs do, and understanding it that way helps replace the shame that keeps clients silent with the recognition that this is a treatable medical condition rather than a moral failing.

The introduction this course provides remains a sound foundation. The evidence gathered here sharpens it into a more complete, more current, and more clinically demanding picture of what good care for gambling problems requires. A provider who screens everyone, takes a positive result seriously enough to assess for suicide, offers evidence-based treatment with honest expectations about its durability, knows when to consider medication or a brief intervention, asks about the online and mobile gambling that now drives much of the harm, and can explain to a client why gambling behaves like an addiction, is practicing at the level this updated evidence base calls for.

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Gambling Problems: An Introduction for Behavioral Health Services Providers

Gambling problems can co-occur with other behavioral health conditions, such as substance use disorders (SUDs). Behavioral health treatment providers need to be aware that some of their clients may have gambling problems in addition to the problems for which they are seeking treatment. This *Advisory* provides a brief introduction to pathological gambling, gambling disorder, and problem gambling. The Resources section lists sources for additional information.

Gambling is defined as risking something of value, usually money, on the outcome of an event decided at least partially by chance.[1] Lottery tickets, bingo games, blackjack at a casino, the Friday night poker game, the office sports pool, gambling Web sites, horse and dog racing, animal fights, and slot machines—there are now more opportunities to gamble than ever before. More than 75 percent of Americans ages 18 and older have gambled at least once,[2] and many people view gambling as a harmless form of entertainment.

Only about 10 percent of people with a gambling problem seek treatment for the problem.[3,4] When people do seek help, financial pressures that result from their gambling problem are often the main reason they seek treatment, not a desire to abstain from gambling.[5,6] In addition, people with a gambling problem are more likely to have sought help for other behavioral health conditions than for their gambling problem.[2,3]

Behavioral health services providers need to be aware of financial and legal consequences that may indicate excessive gambling (see the section later in this *Advisory*, How Can Behavioral Health Services Providers Help Clients With Gambling Problems?). If the client assessment reveals a problem with gambling, then that disorder (and its consequences) is a major issue in the client's treatment for any behavioral health condition. Furthermore, a variety of other problems can be related to gambling, including victimization and criminalization; social problems; and health issues, including higher risk for contracting sexually transmitted diseases and HIV/AIDS.[7]

Gambling problems are associated with poor health,[8] several medical disorders, and increased medical utilization—perhaps adding to the country's healthcare costs.[9] People with pathological gambling tend to have lower self-appraisal of physical and mental health functioning than those who gamble little or not at all; people with gambling problems are significantly more likely than low-risk individuals to rate their health as poor. People with gambling problems are also more likely to have received expensive medical services during the prior year, such as treatment in an emergency department.[9]

What Are Pathological Gambling, Gambling Disorder, and Problem Gambling?

Pathological gambling was a diagnosis formerly included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association. When the manual was revised in 2013 (DSM-5),[10] "Pathological Gambling" was renamed "Gambling Disorder." Exhibit 1 lists the diagnostic criteria for gambling disorder. Exhibit 2 summarizes the changes in diagnostic criteria, from pathological gambling to gambling disorder. Of note: Whereas pathological gambling was classified as an Impulse-Control Disorder Not Elsewhere Classified, gambling disorder is categorized under Substance-Related and Addictive Disorders. Reclassification may improve treatment coverage, diagnostic accuracy, and screening efforts.

Exhibit 1. DSM-5 Diagnostic Criteria for Gambling Disorder

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better accounted for by a manic episode.

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Exhibit 2. From Pathological Gambling to Gambling Disorder: A Summary of Diagnostic Changes

- The number of diagnostic criteria that must be met as a basis for diagnosis was lowered from five to four.
- The diagnostic criteria must have occurred within a 12-month period. (Previous versions of the DSM had no established timeframe.)
- Committing illegal acts to finance gambling was removed from the list of diagnostic criteria.

Much of the research published to date used the criteria for pathological gambling from the DSM-IV[12] and DSM-IV-TR[13] as a research parameter. In addition, researchers have often used the term *problem gambling*. This term has been used to refer to gambling that causes harm; *pathological gambling* has been reserved for cases in which there is harm and lack of control over, or dependence on, gambling.[1]

Although gambling disorder has replaced pathological gambling in DSM-5,[10] this *Advisory* uses *pathological gambling* and *problem gambling* when the cited research uses those terms.

How Common Are Gambling Problems?

Estimates from large national surveys show that about 0.5 percent of Americans have had pathological gambling at some time in their lives.[2,14] Extrapolating from the survey estimates suggests that roughly 1.5 million Americans have experienced pathological gambling. The milder condition, problem gambling, is more common than pathological gambling and may affect two to four times as many Americans as pathological gambling.[2]

Who Typically Has a Gambling Problem?

Anyone can develop a gambling problem; such problems occur in all parts of society. However, men are more likely than women to have gambling problems.[2,14,15] Gambling problems show some association with adolescence and young adulthood, ethnic minority status, low income and low socioeconomic status, high school education or less, and unmarried status.[2,15,16]

Some people gamble because the activity is stimulating. These people tend to be "action gamblers" who favor forms of gambling that involve some skill or knowledge, such as playing poker or betting on sports. Most of these types of gamblers are men.

Gambling can also serve as a relief (an "escape") from stress or negative emotions. In this type of gambling (e.g., bingo, lottery, slot machines), the outcome is determined by pure chance. Most of these "escape" gamblers are women.[17]

What Are the Links Between Gambling Problems and Other Behavioral Health Conditions?

Gambling disorder frequently co-occurs with SUDs and other behavioral health problems. According to the National Epidemiologic Survey on Alcohol and Related Conditions, of people diagnosed with pathological gambling, 73.2 percent had an alcohol use disorder, 38.1 percent had a drug use disorder, 60.4 percent had nicotine dependence, 49.6 percent had a mood disorder, 41.3 percent had an anxiety disorder, and 60.8 percent had a personality disorder.[14] Other studies suggest that between 10 percent and 15 percent of people with an SUD may also have a gambling problem.[18,19,20] People who have both an SUD and pathological gambling have high rates of attention deficit disorder and antisocial personality disorder.[14]

Gambling disorder and SUDs are similar in many ways. Both are characterized by loss of control, cravings, withdrawal, and tolerance. In gambling, tolerance means having to gamble using increasing amounts of money to achieve the same subjective feeling.[21] The results of brain imaging studies suggest that pathological gambling and SUDs may originate in the same area of the brain.[22,23] Impulsivity in childhood has been related to the onset later in life of pathological gambling and SUDs.[24] Data also suggest that as gambling problem severity increases, so does the number of gambling precipitants, or high-risk factors for relapse to gambling. The frequency with which gambling occurs in given situations—such as when the person who gambles feels tense, nervous, or anxious; wants to celebrate; feels relaxed and confident; starts thinking about gambling debts or seeing reminders of gambling; or is out with others who are gambling—may also increase.[25]

Suicidality

Pathological gambling is associated with suicide, suicidal ideation, and suicide attempts.[26] Among the many risk factors are financial difficulties and depression. People who have pathological gambling and also have an SUD may be at greater risk of attempting suicide; some research has found substance abuse to be the only factor that distinguishes people who gamble pathologically and attempt suicide from people who gamble pathologically but only think about suicide.[27] Some people who gamble pathologically may think about making the suicide look accidental so that their families can collect life insurance to pay off gambling debts.[17] As with all clients, these individuals should be screened for suicide risk and referred appropriately.

Are There Tools for Screening, Assessing, or Diagnosing Gambling Problems?

More than 20 different tools are available for screening for gambling problems.[28] The Lie/Bet Screening Instrument consists of two questions:[29]

1. Have you ever felt the need to bet more and more money?
2. Have you ever had to lie to people important to you about how much you gambled?

A "yes" response to one of these questions warrants further investigation using a longer tool, such as the South Oaks Gambling Screen (SOGS). The SOGS consists of 16 items and differentiates between no gambling problems, some problems, and probable pathological gambling.[30] It is widely available on the Internet. Another tool is the National Opinion Research Center's Diagnostic Screen for Gambling Problems. This is a questionnaire based on DSM-IV[12] criteria; it is available at http://govinfo.library.unt.edu/ngisc/reports/attachb.pdf. In addition, several screening tools are available at http://www.problemgambling.az.gov/screeningtools.htm.

Screening for gambling problems is important because few people seek treatment for these problems and instead seek help for other complaints (e.g., insomnia, stress-related problems, depression, anxiety, interpersonal issues).[30] In addition, there are no obvious signs (e.g., needle marks) that can be detected by physical observation or examination.

How Can Behavioral Health Services Providers Help Clients With Gambling Problems?

People who gamble pathologically are often overwhelmed by feelings of shame and anger. Conveying empathy, unconditional positive regard, and a sense of hope can help build rapport with clients. Behavioral health services providers can offer nonjudgmental feedback to the client about gambling behaviors and assess the client's motivation and readiness to address his or her gambling behaviors.[17]

Clients with gambling problems often have other problems, and they may need information on resources about the following topics:[17]

- **Financial difficulties.** Money issues are the most common reason people seek treatment; addressing financial problems should be an integral part of treatment. In the face of overwhelming debts, clients may be dealing with loss of employment or their home, depletion of college or retirement savings, or incurrence of major debts. Some may not have enough money to buy food or pay utility bills. A behavioral health services provider can assess financial problems and include financial issues in treatment. A case manager can help clients prioritize needs and help them obtain housing, shelter, and food assistance, if necessary. Debtors Anonymous can help people learn how to budget their money and rein in their spending.[17] A referral to a provider with training in how to treat people with gambling disorder can help clients address the unique financial aspects of the condition.
- **Marital and family issues.** Gambling disorder has many negative consequences on marriages, partnerships, and families. It contributes to chaos and dysfunction within the family, can contribute to separation and divorce, and is associated with child and spousal abuse. Family members may have depressive or anxiety disorders and abuse substances.[31] People often hide gambling problems from their families; disclosing the gambling secret can be devastating to relationships, leading to resentment and loss of trust. The financial difficulties created by pathological gambling can profoundly affect family members.[32] The spouse or partner needs to be included in treatment to address family issues; a referral to a family or marital therapist can help families in these situations. The provider can refer the client to Gamblers Anonymous, and family members and loved ones to Gam-Anon.
- **Legal problems.** One study found that about a quarter of people who gambled pathologically had committed at least one illegal gambling-related act, such as the writing of bad checks, stealing, and unauthorized use of credit cards.[33] Counselors can instruct clients on how to obtain legal counsel or access public defenders or other assistance.

What Are Some Treatment Strategies for These Clients?

Although a variety of approaches have been researched and found to be useful in treating gambling problems,[34] none has been clearly shown to be more effective than another.[35] Most research studies have assessed a mixture of approaches (e.g., cognitive therapy [CT], motivational interviewing [MI], relapse prevention),[36] making it difficult to determine the relative effectiveness of the different approaches.

Behavioral therapy

Behavioral therapy focuses on altering behaviors by reinforcing desired behaviors, modifying attitudes and behaviors related to gambling, and increasing clients' skills to cope with environmental cues that may trigger cravings to gamble. This approach helps clients identify their personal cues and triggers to gamble and then helps clients develop alternative activities to gambling that compete with reinforcers specific to pathological gambling.[30,37] For example, during imaginal desensitization, relaxation and other techniques are used to help the client cope with gambling stimuli and blunt the urge they create to gamble.[37]

Cognitive therapy

CT is directed at changing distorted or maladaptive thoughts[17]—in this case, about gambling and the odds of winning. CT educates clients about the randomness of gambling, increases clients' awareness of their distorted thinking, helps clients doubt their irrational cognitions, and helps them restructure their thoughts.[38,39] For example, a

treatment provider might work on altering a client's belief that two events are related when they are not. Examples of distorted beliefs are that a lucky item improves the chances of winning or that a slot machine must be due to hit the winning sequence because it has not hit the sequence in a long time.[40,41]

Cognitive–behavioral therapy

The two approaches discussed above are frequently combined in cognitive–behavioral therapy (CBT). CBT tries to modify negative or self-defeating thoughts and behaviors.[17] A meta-analysis by Gooding and Tarrier[38] found that various CBTs were effective in reducing pathological gambling. Topf et al.[34] reviewed CBT studies, several of which included relapse prevention interventions, and also found that CBT was beneficial in the treatment of pathological gambling.

CBT to treat gambling disorder usually involves identifying and changing cognitive distortions about gambling, reinforcing nongambling behaviors, and recognizing positive and negative consequences.[42] CBT helps people recognize that the short-term experiences and sensations are not worth the long-term negative consequences of debt, legal problems, and harm to one's family.[43]

CBT usually incorporates some relapse prevention techniques. Relapse prevention consists of learning to identify and avoid risky situations that can trigger or cue feelings or thoughts that can lead to relapse to gambling. The gambling risk situations clients learn to identify include places (e.g., casinos, lottery outlets), feelings (e.g., anger, depression, boredom, stress), and other difficulties (e.g., finances, problems with work or family).

In addition to techniques learned in CBT, developing a support system, attending Gamblers Anonymous meetings, and participating in continuing care may help prevent relapse.[17]

Motivational interviewing

MI, also known as motivational enhancement, seeks to help clients address their ambivalence toward behavior change.[44] It has not been as well studied as CBT as a treatment for pathological gambling, but some studies have shown promise for MI.[45,46] MI is frequently combined with CBT.

Gamblers Anonymous

Gamblers Anonymous, the structure of which is modeled on Alcoholics Anonymous, is a mutual-help group for people with gambling problems. Although mutual-help groups are not treatment or counseling, they can be an important support to people in recovery. The free meetings are available in many communities.

Researchers have reported that even very brief motivational interventions can help people with gambling problems.[47,48] Treatment that combined MI and CBT has been delivered effectively over the Internet and with brief phone calls from trained therapists.[49]

Medications

Several medications have been investigated to treat pathological gambling. However, the U.S. Food and Drug Administration has not approved any medications for treating the condition.[30]

Prevention

Once a person is diagnosed with gambling disorder, prevention of further harm to the person and his or her family is important. One such approach is having the person participate in a self-exclusion program, if available in his or her state. These voluntary programs allow a person to be banned from gambling venues for a defined period, even a lifetime. Depending on state policy, if the person violates the ban, he or she is asked to leave the venue, is required to forfeit winnings, and is potentially subject to criminal trespassing charges. The few outcome studies conducted on self-exclusion show a decrease in gambling.[50,51]

A variety of prevention approaches and models have been used to try to prevent the development of gambling problems, but these have not been well studied.[52] Because gambling issues in youth may lead to the development of gambling disorder in adulthood, many prevention programs focus on young people.[53] Although youth are barred from many gambling venues, some venues in which betting is available (such as race tracks) may restrict youth only from placing bets; it is not unusual for children to attend horse races with family members who bet.

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Other approaches can be considered, such as public awareness campaigns that seek to make the general public aware of the risks and potential consequences of problem gambling, the way gambling products work and the real probability of winning, and warning signs for problem gambling and the availability of help.[52,53]

Policy initiatives include restricting who can gamble and restricting the number of electronic gaming machines in a locality. The gaming industry has cooperated in some places by posting signage that reminds people to gamble responsibly (e.g., stay within their time and funding limits) and restricting money transfers into a casino and access to automated teller machines. Some electronic gaming machines remind players of the amount of time and money spent; others can be programmed to a slow speed or require that the player check out after prolonged periods of play.[52,53]

Who Can Treat People With Gambling Disorder?

Gambling disorder is a behavioral health condition. Treating gambling disorder is within the scope of practice of mental health counselors, licensed clinical social services providers, clinical psychologists, psychiatrists, and other professionals with licenses to treat mental disorders.

Resources

Resources for providers

Association of Problem Gambling Service Administrators
http://www.apgsa.org

National Council on Problem Gambling
http://www.ncpgambling.org

Problem Gambling Toolkit, Substance Abuse and Mental Health Services Administration. The toolkit provides background and financial information to help clients with gambling issues.
http://store.samhsa.gov/product/PGKIT-07

UCLA Gambling Studies Program
http://www.uclagamblingprogram.org

Resources for clients and families

Debtors Anonymous
http://www.debtorsanonymous.org

Gam-Anon
http://www.gam-anon.org

Gamblers Anonymous
http://www.gamblersanonymous.org

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SAMHSA Advisory

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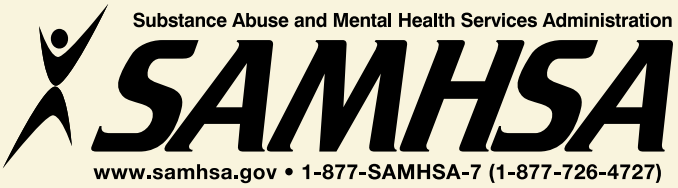

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Substance Abuse Treatment For Persons With Co-Occurring Disorders
(Problem Gambling)

Excerpts from A Treatment Improvement Protocol
TIP 42

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Substance Abuse Treatment For Persons With Co-Occurring Disorders
(Problem Gambling)

Stanley Sacks, Ph.D.
Consensus Panel Chair

Richard K. Ries, M.D.
Consensus Panel Co-Chair

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

FROM TIP 42, pp. 246–248

Pathological Gambling

What Counselors Should Know About Substance Abuse and Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits. Counselors should be aware that

- Prevalence data for gambling regularly makes distinctions among "pathological" gamblers (the most severe category) and levels of "problem" gambling (less severe to moderate levels of difficulty). Recent general estimates (Gerstein et al. 1999; Shaffer et al. 1997) indicate about 1 percent of the U.S. general population could be classified as having pathological gambling, according to the diagnostic criteria below. Cogent considerations regarding prevalence are given in the DSM-IV-TR regarding variations due to the availability of gambling and seemingly greater rates in certain locations (e.g., Puerto Rico, Australia), which have been reported to be as high as 7 percent. Higher prevalence rates also have been reported in adolescents and college students, ranging from 2.8 to 8 percent (APA 2000). The general past-year estimate for pathological and problem gambling combined is roughly 3 percent. This can be compared to past year estimates of alcohol abuse/dependence of 9.7 percent and drug abuse/dependence of 3.6 percent.
- The rate of co-occurrence of pathological gambling among people with substance use disorders has been reported as ranging from 9 to 30 percent and the rate of substance abuse among individuals with pathological gambling has been estimated at 25 to 63 percent.
- Among pathological gamblers, alcohol has been found to be the most common substance of abuse. At minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population.
- It is important to recognize that even though pathological gambling often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them automatically to treat people with a pathological gambling problem.
- With clients with substance use disorders who are pathological gamblers, it often is essential to identify specific triggers for each addiction. It is also helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers.

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling. The following bullets provide several examples:

- Cocaine use and gambling may coexist as part of a broader antisocial lifestyle.
- Someone who is addicted to cocaine may see gambling as a way of getting money to support drug use.
- A pathological gambler may use cocaine to maintain energy levels and focus during gambling and sell drugs to obtain gambling money.

- Cocaine may artificially inflate a gambler's sense of certainty of winning and gambling skill, contributing to taking greater gambling risks.
- The gambler may use drugs or alcohol as a way of celebrating a win or relieving depression.
- One of the more common patterns that has been seen clinically is that of a sequential addiction. A frequent pattern is that someone who has had a history of alcohol dependence—often with many years of recovery and AA attendance—develops a gambling problem.

Diagnostic Features of Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior (Criterion A) that disrupts personal, family, or vocational pursuits. The diagnosis is not made if the gambling behavior is better accounted for by a manic episode (Criterion B).

Diagnostic criteria

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

(1) Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
(2) Needs to gamble with increasing amounts of money in order to achieve the desired excitement
(3) Has repeated unsuccessful efforts to control, cut back, or stop gambling
(4) Is restless or irritable when attempting to cut down or stop gambling
(5) Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
(6) After losing money gambling, often returns another day to get even ("chasing" one's losses)
(7) Lies to family members, therapist, or others to conceal the extent of involvement with gambling
(8) Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
(9) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
(10) Relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 671, 674).

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.

Advice to the Counselor: **Counseling a Client With Pathological Gambling Disorder**
• Carefully assess use and frequency of sports events, scratch tickets, games of chance, and bets. • Ask if the client is at any physical risk regarding owing money to people who collect on such debts. • Treat the disorders as separate but interacting problems. • Become fluent in the languages of substance abuse and of gambling. • Understand the similarities and differences of substance use disorders and pathological gambling. • Utilize all available 12-Step and other mutual support groups. • Recognize that a client's motivation level may be at different points for dealing with each disorder. • Use treatments that combine 12-Step, psychoeducation, group therapy and cognitive-behavioral approaches. • Use separate support groups for gambling and for alcohol and/or drug dependence. While the groups can supplement each other, they cannot substitute for each other.

Discussion: 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.

Conclusion

The information contained in this chapter can serve as a quick reference for the substance abuse counselor when working with clients who have the mental disorders described or who may be suicidal. As noted above, appendix D provides more extensive information. The limited aims of the panel in providing this material are to increase substance abuse treatment counselors' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. The panel encourages counselors to continue to increase their understanding of mental disorders by using the resource material referenced in each section, attending courses and conferences in these areas, and engaging in dialog with mental health professionals who are involved in treatment. At the same time, the panel urges continued work to develop improved treatment approaches that address substance use in combination with specific mental disorders, as well as better translation of that work to make it more accessible to the substance abuse field.

FROM TIP 42, pp. 425–436

Pathological Gambling

Description
Pathological gambling (PG) has been best described as "a progressive disorder characterized by a continuous or periodic loss of control over gambling; a preoccupation with gambling or obtaining money with which to gamble; irrational thinking, and a continuation of the behavior despite adverse consequences" (Rosenthal 1992). The American Psychiatric Association's criteria for the diagnosis of PG (DSM-IV-TR) (APA 2000) are in many ways similar to those for alcohol and other drug dependence (see Figure D-18).

Figure D-18. Diagnostic Criteria for Pathological Gambling Compared to Substance Dependence Criteria

Diagnostic Criteria for Pathological Gambling	Comparable Substance Dependence Criteria
Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:	*Maladaptive pattern of substance use, leading to clinically significant impairment of distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:*
• Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)	• A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
• Needs to gamble with increasing amounts of money to achieve the desired excitement	• Tolerance
• Has repeated unsuccessful efforts to control, cut back, or stop gambling	• There is a persistent desire or unsuccessful efforts to cut down or control substance use
• Is restless or irritable when attempting to cut down or stop gambling	• Withdrawal
• Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)	• N/A
• After losing money gambling, often returns another day to get even ("chasing" one's losses)	• The substance is often taken in larger amounts or over a longer period than was intended

• Lies to family members, therapist, or others to conceal the extent of involvement with gambling	• The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
• Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling	
• Relies on others to provide money to relieve a desperate financial situation caused by gambling	
• Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling	• Important social, occupational, or recreational activities are given up or reduced because of substance use
Source: APA 2000.	

Many clients with PG display what amounts to tolerance, needing to gamble with increasing amounts of money (or make increasingly risky bets with what money is available to them) to achieve the desired effect. For some gamblers, often referred to as "action" gamblers, this effect may be excitement (Cocco et al. 1995; Lesieur and Rosenthal 1991). For other gamblers, thought of as "escape" gamblers, the sought-for effect is relief from painful emotions or stress. Consequently, gambling may act as a stimulant such as amphetamine or cocaine for some clients with PG, while acting as a sedative or tranquilizer for others. (See Figure D-19 for a list of differences between action and escape gamblers.)

Figure D-19
Comparison of Action and Escape Pathological Gambler

Action	**Escape**
• Gambles for excitement, competition • More likely to engage in "skilled" forms of gambling such as poker, horse racing, sports • More likely to have early onset of gambling • Longer progression from regular gambling to addictive/out of control gambling • More likely to be male • More likely to present narcissistic or antisocial traits	• Gambles for relief, escape from stress or negative affect • More likely to engage in "luck" forms of gambling such as lottery, slots, video poker, bingo • Later onset of gambling • Shorter progression from regular gambling to addictive/out of control gambling • More likely to be female • More likely to be dysthymic

Pathological gamblers often report withdrawal-like symptoms when attempting to stop gambling. These may include symptoms such as irritability, problems focusing or concentrating, difficulty sleeping, and even physical symptoms such as nausea, vomiting,

headaches, and muscular pain (Rosenthal and Lesieur 1992; Wray and Dickerson 1981). Currently, there are no DSM criteria for gambling disorders that compare directly to criteria for substance use disorders. However, in practice, the term "problem gambling" is most commonly considered to apply to those individuals who meet one to four of the DSM-IV criteria for pathological gambling (National Research Council [NRC] 1999). Problem gamblers are individuals who do not meet full criteria to be diagnosed as pathological gamblers, but who meet some of the criteria and indicate that gambling is contributing to some level of disruption in their lives.

While there are similarities between PG and substance use disorders, there are some significant differences between these disorders. Research comparing individuals diagnosed with PG to individuals with substance use disorders is still in early stages, but there have been clinical reports on such differences. To begin with, it may be more difficult to define what constitutes gambling than to define a drug or an alcoholic drink. Gambling can encompass a variety of behaviors: buying lottery tickets, playing cards for money (even in friendly family games), investing in the stock market, participating in a charity raffle, betting on a golf game, betting on horse races, or playing scratch-off games to win money at a fast food restaurant.

One of the main differences between PG and substance use disorders is that there is no biological test to screen for PG. The absence of a clear physical sign of the disorder enables a person to hide gambling behavior for longer periods of time. This also may contribute to the severe and entrenched lying and deception that are included in the diagnostic criteria for PG.

Because no substance is being ingested, often it is very difficult for individuals diagnosed with PG and their families/significant others to accept PG as a medical disorder. Research is beginning to establish a biological/genetic predisposition to PG that is similar to that found in severe alcohol and drug addictions, and that gambling may affect the central nervous system in ways similar to substance use (Breiter et al. 2001; Comings et al. 1996; Potenza 2001; Slutske et al. 2000). However, it is still difficult for individuals with PG, as well as the general public, to accept a medical model for this disorder. It is easier to accept that people with substance use disorders may behave badly (become aggressive or violent) while intoxicated than for gamblers to accept that their harmful behavior can be attributed to their gambling. This possibility could exacerbate the gambler's sense of shame and guilt and contribute to the development of rigid defense mechanisms to ward off these feelings and to allow gambling to persist. These hypothesized differences need to be investigated empirically.

Prevalence

Legalized gambling is available in 47 States and the District of Columbia. The great majority of adults (81 percent) have gambled sometime during their life. This compares to recent studies of alcohol use in the United States that estimate 91 percent of adults have drunk alcohol. Between 1974 and 1995, the amount of money spent on legal gambling increased 3,100 percent in the United States, from $17.4 billion to $550 billion. A national study estimated the lifetime prevalence of pathological gambling among

adults in the United States to be 1.1 percent, while the past-year estimate for problem or pathological gambling combined was 2.9 percent. This can be compared to past-year estimates of alcohol abuse/dependence of 9.7 percent and drug abuse/dependence of 3.6 percent (NRC 1999).

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling.

Information on the prevalence of pathological gambling among adolescents has been controversial, with reported rates higher than for adults (Shaffer et al. 1997). However, adolescent rates of problem or pathological gambling, which range from 9 to 23 percent in various studies, are comparable to rates of adolescent alcohol use (8 to 23 percent). Also, past-year adolescent pathological gambling rates of 1 to 6 percent are comparable to past-month rates of marijuana use of 3 to 9 percent (NRC 1999).

Gambling prevalence studies also illuminate demographic variables and risk for gambling problems. As suggested above, younger age seems to be a risk factor. Adults under the age of 30 report higher proportions of gambling problems. Men, ethnic minorities, and paradoxically, those with household incomes below $25,000 also tend to be overrepresented among problem/pathological gamblers. Employment status did not seem to have any relationship to risk for gambling problems. However, educational level had a moderate relationship with problem gambling, with those with a high school education or less being at higher risk for gambling problems (NRC 1999).

The rate of co-occurrence of PG among people with substance use disorders has been reported as ranging from 9 to 16 percent (Crockford and el-Guebaly 1998; Lesieur et al. 1986; McCormick 1993). Among pathological gamblers, alcopethol has been found to be the most common substance of abuse. At a minimum, the rate of problem gambling among people with substance use disorders is 4 to 5 times that found in the general population.

People with substance use disorders and co-occurring PG have been compared to people with substance use disorders without PG. While some findings appear contradictory, there is some evidence that people with co-occurring substance use and PG may have higher levels of negative affect, overall psychiatric distress, impulsivity, higher rates of antisocial personality disorder, AD/HD, and risky sexual behaviors (APA 2000; Crockford and el-Guebaly 1998; Langenbucher et al. 2001; McCormick 1993; Petry 2000*b*, *c*). The high rates of co-occurrence of substance use disorders and gambling problems clearly emphasize the need for screening and assessment of gambling problems in substance-abusing populations.

Key Issues and Concerns

Despite the high prevalence, treatment services for PG are limited or lacking in many areas. According to a survey conducted by the National Council on Problem Gambling, only 21 States provide some level of funding for addressing problem and pathological gambling. According to the Association of Problem Gambling Service Administrators

(www.apgsa.org), only 16 States provide some public funding specifically for gambling treatment. Additionally, only about 1,000 Gamblers Anonymous meetings are held in the United States, fewer than the number of AA meetings found in some major metropolitan areas.

It is important to recognize that even though PG often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them to treat persons with a PG problem. Training and supervision should be obtained to work with pathological gamblers, or referral should be made to specific gambling treatment programs.

A second consideration is that clients with PG problems seeking treatment have high rates of legal problems. Research has shown that in most settings, two thirds of people with PG problems report engaging in illegal activities to obtain money for gambling or to repay gambling debts. Pathological gamblers often fail to report such activities as embezzling from their job as an illegal activity. In their own minds they label what they are doing as borrowing rather than stealing, as they are certain that they will make a winning bet and be able to pay the money back. Persons with substance use disorders also have many of these same problems.

Transference and countertransference issues in the treatment of pathological gambling can have a significant impact. Competitive, action-oriented gamblers may attempt to make treatment a competitive sport, and clinicians may become distracted by debating and arguing. Relapsing may become a way for the pathological gambler to "beat" the therapist. The lack of physical signs or biological tests for gambling can contribute to countertransference reactions, such as the therapist becoming overly zealous in trying to "catch" gamblers in their lies or overly accepting of self-reports. Either extreme can impede the therapeutic relationship.

Strategies, Tools, and Techniques

Engagement

In an initial contact with a pathological gambler, it is important to begin developing rapport quickly. Counselors should remember that when a pathological gambler makes an initial phone call to access treatment or comes in for an initial evaluation, he or she is likely to be feeling a great deal of shame, guilt, anxiety, or anger. To acknowledge gambling problems is to admit to being a "loser," an extremely difficult admission for most gamblers. The gambler whose family and friends have failed to acknowledge that he or she has a legitimate disorder also is likely to be sensitive about being judged, criticized, and condemned. Consequently, the clinician must demonstrate knowledge of the signs, symptoms, and course of pathological gambling; present a nonjudgmental attitude and empathy regarding the emotional, financial, social, and legal consequences of gambling; and convey hope regarding the potential for recovery.

It is also important for the clinician to understand how and when to probe for greater detail regarding the severity of the gambling disorder and its consequences, since as with

substance abuse, the gambling client is likely to minimize the negative impact of gambling. Clients with COD are likely to minimize or deny the disorder for which help is not being sought.

Screening and assessment

There are several valid and reliable instruments that have been developed for the screening and assessment of pathological gambling.

Screening

The South Oaks Gambling Screen (SOGS) (Lesieur and Blume 1987) is one of the most widely researched instruments. This is a 20-item questionnaire designed to screen for gambling problems and has been found to be effective in substance abuse populations. It can be conducted as a structured interview or a self-report questionnaire in both lifetime and past 6-month versions. The drawbacks are its length and the fact that the items are not specifically based on DSM-IV criteria, which precludes its use as a diagnostic instrument. Someone who scores above the cut-off on the SOGS would then require a more detailed diagnostic assessment.

A brief screening tool, the Lie/Bet Questionnaire, has been found to be effective in identifying probable pathological gamblers (Johnson et al. 1997). The questionnaire consists of two questions:

1. Have you ever felt the need to bet more and more money?
2. Have you ever had to lie to people who are important to you about how much you gamble?

A "yes" response to either question suggests potential problem gambling. Again, this instrument is likely to over-identify individuals with gambling problems and a positive screen needs to be followed by a more detailed clinical/diagnostic interview.
A computerized problem gambling screening tool that may be particularly useful in criminal justice populations is the Gambler Assessment Index (GAI) which incorporates a problem gambling scale as one of seven scales (truthfulness, attitude, gambler, alcohol, drugs, suicide, and stress). It takes about 20 minutes to complete and includes a descriptive computerized printout of risk levels for all scales (Behavior Data Systems 2000).

Assessment
A more comprehensive problem gambling assessment needs to be part of a broader biopsychosocial and spiritual evaluation. Only two instruments have been studied and used to evaluate issues of problem gambling severity. An addendum to the ASI, the Gambling Severity Index has been developed and validated (Lesieur and Blume 1991). Another instrument that has been found to be valid and reliable is the Gambling Treatment Outcome Monitoring System, or GAMTOMS (Stinchfield et al. 2001). This is a battery of four questionnaires designed to be used in assessment of problem gambling and in treatment outcome evaluation.

The Gambling Treatment Admission Questionnaire (GTAQ) is particularly useful. A 162-item self-report questionnaire that incorporates the SOGS and DSM-IV criteria, the GTAQ evaluates the range of gambling behaviors and frequency of gambling, gambling debt, treatment history, substance use, and gambling-related financial, legal, occupational, and psychosocial problems.

Structured interviews for the diagnosis of pathological gambling based on DSM-IV criteria currently are being researched and developed, but are not yet publicly available (Cunningham-Williams 2001; Potenza 2001). Most clinicians conduct a clinical interview based on DSM-IV criteria to establish the diagnosis of pathological gambling.

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling. Among those who abuse cocaine, for example, there seem to be several common patterns of interaction between gambling and drug use. Cocaine use and gambling may coexist as part of a broader antisocial lifestyle. Someone who is addicted to cocaine may see gambling as a way of getting money to support drug use. A pathological gambler may use cocaine to maintain energy levels and focus during gambling and sell drugs to obtain gambling money. Cocaine may artificially inflate a gambler's sense of certainty of winning and gambling skill, contributing to taking greater gambling risks. Cocaine may be viewed by the gambler as a way of celebrating a win or may be used to relieve depression following losses.

Cocaine and pathological gambling may be concurrent or sequential addictions. With cocaine in particular, it often is difficult to have enough money for both disorders at the same time. There is no clear evidence that one addiction is likely to precede another, although one recent study reported that in a population of people with substance use disorders who are in treatment, the onset of gambling behavior was likely to precede the use of addictive substances (Hall et al. 2000).

Several patterns of interaction may emerge for individuals who are alcohol dependent and are pathological gamblers. One of the more common clinically observed patterns is sequential addiction; for example, someone who has had a history of alcohol dependence—often with many years of recovery and AA attendance—who develops a gambling problem. Such individuals often report that they did not realize their gambling was becoming another addiction, or that gambling could be as addictive as alcohol and drugs. It is not uncommon for such individuals to seek treatment only after a relapse to alcohol (or recognizing they are close to a relapse), secondary to the gambling-related stresses. Other individuals have developed alcohol problems only after their gambling has begun to create serious adverse consequences; they begin using drinking as a response to such problems. Since alcohol is readily available (and often free) in most gambling settings, drinking and gambling may simply "go together" for some individuals.

It often is helpful, if not critical, to obtain collateral information from family and significant others. One scale that is helpful in this process, the Victorian Problem

Gambling Family Impact Scale, is undergoing validation (Research Evaluates Gambling's Impact 1998).

Obtaining collateral information often can be challenging, as the gambler may want to control both what the clinician knows and what the family knows. The gambler may not want the clinician to know how angry and devastated the family is feeling, or the gambler may not want the family to know the extent of his or her gambling and gambling debt. Also, the gambler may give specific instructions to family members about what to tell or not to tell the clinician. This may be related to gambling or finances, but it also may relate to substance use.

Therefore, while it is advisable to involve family members as early as possible in the assessment and treatment process, it may take time to develop a trusting clinical relationship with the gambler before he or she gives consent to family involvement. The clinician needs to consider carefully the best way to involve family members or significant others in the assessment and treatment process. Initial sessions with both the gambler and family present may help to alleviate the gambler's anxiety. Such sessions can be followed up with meetings without the gambler present. It is essential that the therapist not be viewed as taking sides in this process.

Case Study: Pathological Gambling Assessment

A 36-year-old, married male, Andy J. entered treatment for pathological gambling. An initial assessment involving questionnaires and structured diagnostic interviews found indications of excessive alcohol use and use of cocaine. On a family assessment interview, Andy J.'s wife denied knowledge of any excessive alcohol use or any cocaine use on her husband's part.

As treatment proceeded, it became apparent that Andy J.'s substance use was more extensive and problematic than first presented. Staff members were particularly concerned about his apparent hiding of his substance use from his spouse. Andy J. became angry and agitated, threatening to discontinue treatment when staff indicated that the issue of his substance abuse needed to be addressed at the next family session. Andy J. was given the choice of communicating the extent of his substance use to his wife prior to the session or waiting until the session.

Andy J. initially withdrew consent to communicate with his wife. However, after intensive group and individual work focusing on relapse potential, dishonesty as a relapse risk factor, and assessment of further negative consequences, he decided to tell his wife. In the next joint session, his wife expressed relief and reported that she had been aware of and concerned about his substance use. She had lied at the initial assessment at her husband's request, as he had convinced her that it would be best for his treatment not to get the therapist distracted by his substance use so that he could fully focus on his gambling problem. Andy J., once the initial anger and anxiety had subsided, acknowledged that he was holding onto his substance use for fear of living life without an

addiction to fall back on. He realized that continued substance dependence would continue to maintain all the problems he was attributing only to his gambling.

Crisis stabilization

Pathological gamblers frequently come into treatment in a state of panic and crisis. The attempted suicide rate among gamblers in treatment is high (20 percent) (NRC 1999), which makes a careful evaluation of suicide potential essential. A common suicide plan for PG clients is to have an automobile accident so that family can collect life insurance to pay off gambling debts. Concurrent substance use adds to the risk potential for self-harm, so it is important that the gambler who is at risk for suicide contracts not to use any mind-altering substances in addition to not endangering him/herself or others. (However, as noted in the discussion of suicide, counselors should not rely solely on such contracts.) Placement in a structured environment, inpatient, or residential setting may be necessary in some cases.

Addressing financial and legal issues

Financial crises may involve eviction and homelessness; inability to pay for food or utilities; or families discovering that savings accounts, college funds, and so on are totally depleted. It is important in handling financial crises to make sure the basics of food and shelter are met for the gambler and his family. This may mean referring the family to homeless shelters or finding temporary living quarters with extended family. Resolving the entire extent of financial problems takes more time; however, in the crisis situation it is essential to convey to the gambler and family that coping with financial stress is a part of treatment, and to outline the process for addressing the problems. It is important to help the gambler and family prioritize immediate needs (i.e., food, shelter) separately from those that can be managed later to relieve the feelings of being overwhelmed. The counselor can help the client make specific lists of what can be done now and what can wait until later. For example, if the family is being evicted, the clinician could provide a list of shelters to call or have the client call shelters from the clinician's office.

Case Example: Counseling a Pathological Gambler

Michael B. was a gambler who relished the competitiveness of card playing and had developed a reputation as a tough player and as a winner early in his gambling career. His gambling gradually became out of control and it was clear that he was unable to stop gambling until he had lost all his money. However, when he attempted to abstain from gambling he would feel depressed. In treatment he confessed to feeling increasing anxiety when he was winning, and to feel relief only when he had lost everything.

Michael B.'s father had been a successful business executive who had been very demanding and critical of Michael B. throughout his life. Michael B. had been determined to "beat his father at his own game" and become even more successful. While Michael B. had developed many businesses, they always seemed to collapse after an initial success, a pattern that mimicked his gambling. In therapy, it became clear that Michael B. felt guilty at thoughts of "beating" his father, which contributed to the

destructive pattern of his gambling and of his unsuccessful businesses.

Treatment helped Michael B. let go of his guilt-producing fantasy of spectacular success and focus on how he could enjoy his life without feeling a need to compete with his father. He was able to set more realistic goals to achieve a sense of accomplishment and was able to abstain from gambling without feeling depressed and inadequate.

Legal issues can create an additional crisis for the pathological gambler and the family. Embezzling from an employer or writing bad checks are two common illegal practices of pathological gamblers. When facing potential legal charges for such activities, the gambler often is in a state of panic, looking for money to borrow from family or friends to pay off the checks or pay the employer back to avoid legal consequences. It often is difficult for the family or friends of the gambler to refuse such requests when they fear the result will be sending the gambler to jail. In such cases, the clinician needs to direct the gambler to obtain legal counsel prior to making impulsive decisions. The clinician needs to work with both the gambler and potential "bail out" sources to explore other options.

Financial and legal issues also can trigger domestic violence. The pathological gambler may face physical violence from a spouse or significant other when he or she confesses to the extent of gambling debt. Alternatively, a spouse or significant other may face violence if he or she attempts to withhold money from the pathological gambler. The clinician needs to assess the history of domestic violence or potential for violence very carefully before suggesting any plan for dealing with money management or financial disclosure.

Self-banning
To assist a client with a PG problem to abstain from gambling, some gambling venues (mainly casinos and some race tracks) offer "self-banning." This is a process of completing a written document indicating a desire to be prohibited from entering a casino or race track. Some States have made this a legal process with criminal consequences if a gambler who has self-banned is found gambling at the banned location. Information on this process can be obtained from the gambling venue's responsible gaming office, from State Councils on Problem Gambling, or from State-funded problem gambling treatment programs.

Short-term care and treatment
This section will first discuss specific treatments that have been used in the treatment of pathological gambling, then explore how this knowledge can be applied to the pathological gambler with a substance use disorder. Although a broad range of treatment modalities have been applied to the treatment of pathological gamblers, to date there has been little research to support one type of treatment over another.

Psychodynamic therapies
Some of the earliest clinical writing on the successful treatment of pathological gambling was based on psychodynamic approaches. Such approaches emphasize identifying the

underlying conflicts and psychological defenses that contribute to addictive gambling. Therapy involves helping the gambler gain insight into the psychological meaning of his or her gambling (Rosenthal and Rugle 1994), decreasing defenses that support denial and irrational thinking, and developing more adaptive coping skills to resolve internal conflicts. Such dynamic therapies generally are incorporated into a comprehensive treatment approach with the therapist taking a more active and directive role than in traditional dynamic approaches.

Cognitive-behavioral treatment

While early reports of behavioral treatment of pathological gambling focused exclusively on gambling behaviors using aversive conditioning and systematic desensitization, more recent approaches involve a range of cognitive as well as behavioral interventions. Similar to approaches to substance use disorders, these include relapse prevention strategies, social skills training, problem solving, and cognitive restructuring (Sharpe 1998).

A component that is specific to pathological gambling in this strategy involves modifying irrational beliefs about gambling and the odds of winning. Research repeatedly has shown that gamblers hold beliefs in "the illusion of control," biased evaluation, and the gambler's fallacy (Ladouceur and Walker 1998).

- The illusion of control is the belief that one can control or influence random or unpredictable events, such as picking winning lottery numbers or controlling the fall of the dice by how they are thrown.
- Biased evaluation involves attributing wins to one's special skill or luck, while losses are blamed on external circumstances.
- The gambler's fallacy is the misunderstanding of independent probabilities. For example, if a coin is tossed 10 times resulting in 10 heads, one would think it more likely to get a tail on the next toss, rather than realizing the odds of a head or tail is the same for any one toss.

Cognitive-behavioral interventions are targeted at identifying and correcting such irrational thinking and erroneous beliefs.

As with substance abuse, relapse prevention includes identifying gambling-related internal and external triggers. Money is a common trigger and interventions generally involve removing money from the gambler's control. This can include removing the gambler's name from joint checking and savings accounts, limiting the amount of cash the gambler carries, discontinuing credit cards, and choosing a trusted family member or friend to become the gambler's money manager. As might be anticipated, this can be a difficult and conflictual process; successful use requires creativity and sensitivity to issues of power and control. The goal is not only to remove the trigger of money from the gambler, but also to protect the gambler's and the family's finances. It can be helpful if this is explained as a process of assisting the gambler in regaining financial control of his or her life. Negotiating a workable and tolerable system of financial accountability and safety is a key therapeutic task in the treatment of pathological gamblers, regardless of therapeutic approach.

Case Study: Counseling A Pathological Gambler

Jan T. is a 32-year-old divorced, single parent with a history of cocaine and marijuana dependence, alcohol abuse, and two prior treatments for her substance use disorders. She entered treatment following a bout of heavy drinking resulting in a citation for Driving Under the Influence (DUI). During assessment, she screened positive on the SOGS for probable pathological gambling. She had been going to casinos several evenings per week, losing on average $200 to $500 per week playing video poker. Her rent and utilities were past due, and she feared losing her job due to tardiness and inefficiency because often she would go to work after staying up all night gambling. She had begun drinking while gambling after a 2-year abstinence from substances, and her drinking had increased as her gambling problems progressed.

Jan T.'s DUI occurred while driving home from an all-night gambling episode. Her gambling had begun to increase following her first substance abuse treatment and she acknowledged that her alcohol relapse after her first treatment was related to her gambling, as was her current relapse. She reported having increased her gambling due to feelings of stress and loneliness. As her gambling increased, she discontinued going to continuing care and AA and Cocaine Anonymous meetings. However, in her second substance abuse treatment, no one had asked her about her gambling and she did not recognize it as a problem at the time.

Current treatment emphasized her gambling problems as well as substance abuse. She attended gambling-specific education and therapy groups as well as AA, Cocaine Anonymous, and GA meetings. Due to serious, continuing financial problems and debt, Jan T. moved in with an older sister who had a 12-year history of abstinence from alcohol and attended AA meetings regularly. This sister also agreed to be her money manager.

With clients with co-occurring PG and substance use disorders, it often is essential to identify specific triggers for each disorder. It also is helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers. Increasing evidence supports the effectiveness of treatment approaches with the goal of reduced or limited gambling, particularly for problem gamblers who do not meet all criteria for a diagnosis of pathological gambling or who are low-severity pathological gamblers. This approach generally involves money management along with cognitive-behavioral interventions to set and achieve goals for controlled or limited gambling. Manuals are available to guide this type of treatment, and a self-help manual also has been published (Blaszczynski 1998).

Psychopharmacological treatment

Two main types of medication have been reported to reduce gambling cravings and gambling behavior: SSRIs, such as fluvoxamine (Luvox), and opiate antagonists, such as naltrexone, which has also been found to be effective in treating people with substance use disorders (Hollander et al. 2000; Kim et al. 2001).

As people with co-occurring substance use and PG disorders may be more likely to experience a broad range of additional mental disorders, psychiatric medication to address affective disorders, anxiety disorders, and attention deficit hyperactivity disorder may sometimes be needed.

Integrated multimodal treatment
Treatments combining 12-Step, psychoeducation, group therapy, and cognitive-behavioral approaches have been found to be effective in the treatment of pathological gamblers with co-occurring substance use and mental disorders (Lesieur and Blume 1991; Taber et al. 1987).

Gamblers Anonymous
It is advisable for persons with substance use and PG disorders to attend separate support groups for gambling *and* for alcohol and/or drug dependence. While the groups can supplement each other, they cannot substitute for each other.

It may be difficult for some individuals to adjust to both types of groups, as Gamblers Anonymous (GA) meetings can be different from AA. It is not uncommon for people with substance use disorders who have had extensive experience with AA, Narcotics Anonymous, or Cocaine Anonymous to find fault with GA groups. While GA often places less emphasis on step work, sponsorship, and structure than other 12-Step programs, it still provides a unique fellowship to address gambling issues. GA also can be useful in helping gamblers and their families cope with money management, debt, and restitution issues through a process called "Pressure Relief." Clinicians new to the treatment of pathological gambling are advised to attend open GA and Gam-anon meetings in their area to gain a better understanding of this support system.

The experience of some clinicians is that initially, limited gambling may be an approach for those with substance use disorders and gambling problems who are willing to work on abstinence goals for their substance use, but who are less motivated to abstain from gambling. Rather than distracting from the substance abuse treatment, the clinician can suggest either a limited gambling approach or a time-limited period of abstinence from gambling. These may be presented as experiments. Cravings for both gambling and substances can be monitored in either approach to help clients understand the potential interactions of both disorders and to make better informed decisions about whether they can gamble at all. The same can be done with the client who is motivated to abstain from gambling but more ambivalent about the need to reduce his or her substance use or abuse. This approach may help minimize a client's defensiveness toward treatment in general and reduce the risk of dropping out of treatment or denying a problem altogether.

Longer term treatment
PG, like substance use disorders, may be conceptualized as a chronic, recurring disorder. Potential for lapses and relapses must be recognized for both disorders—and perhaps particularly for people with both disorders. It is important to educate clients about this possibility, if not likelihood, and to develop a plan for re-engaging in treatment if a lapse or a relapse occurs. Professionally facilitated continuing-care groups that focus on

recovery maintenance skills can be effective, particularly in combination with mutual self-help groups.

Continuing-care groups often can be facilitated by peer counselors or treatment program alumni with several years of abstinence. Such continuing-care groups particularly may be useful for clients with COD to maintain contact with therapy resources, to help "catch" a relapse in the making, and to supplement limited availability of GA in many communities. Development of a treatment alumni network also can be a useful strategy to maintain contact with clients over longer periods of time and to increase the likelihood of using supportive resources in times of stress, vulnerability, or crisis.

Since Gam-anon groups are even less prevalent than GA groups, continuing-care groups for family members or for family members and PG clients jointly particularly can be useful to provide support for coping with financial issues that may persist for many years despite gambling abstinence.

Resolving financial problems and accomplishing debt repayment also can be a relapse trigger for pathological gamblers, so often it is important to schedule a "check up" visit around the anticipated time when gambling debts may be paid off. In general, it may be advisable to attempt to maintain therapeutic contact beyond the gambler's 1-year anniversary of abstinence, since often this seems to be a time of vulnerability, overconfidence, and complacency regarding recovery.

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Appendix A: Gambling Problems: An Introduction for Behavioral Health Services Providers

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions.

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater you will have access to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at ceumatrix@ceumatrix.com and ask for help.

Answer the following questions by selecting the most appropriate response.

Quiz

1. What is the new classification for gambling disorder in the DSM-5 compared to pathological gambling?
   A. Impulse-Control Disorder Not Elsewhere Classified
   B. Substance-Related and Addictive Disorders
   C. Mood Disorder
   D. Anxiety Disorder

2. Which of the following is a common reason people seek treatment for gambling problems?
   A. Desire to abstain from gambling
   B. Financial difficulties
   C. Family support
   D. Legal issues

3. What percentage of Americans are estimated to have experienced pathological gambling at some point in their lives?
   A. 0.5 percent
   B. 1.5 percent
   C. 2.0 percent
   D. 3.0 percent

4. Which cognitive therapy technique is used to help clients cope with gambling stimuli?
   A. Imaginal desensitization
   B. Behavioral activation
   C. Motivational interviewing
   D. Cognitive restructuring

5. What is a significant risk factor for developing gambling problems according to the document?
   A. High income
   B. Married status
   C. Low socioeconomic status
   D. College education

6. What is the primary goal of cognitive-behavioral therapy (CBT) in treating gambling disorder?
   A. To provide medication for gambling addiction
   B. To promote gambling as a recreational activity
   C. To increase the frequency of gambling
   D. To modify negative or self-defeating thoughts and behaviors

7. What is a potential consequence for violating a self-exclusion program in gambling?
A. Increased gambling opportunities
B. Forfeiture of winnings and possible criminal charges
C. Access to exclusive gambling events
D. Mandatory counseling sessions

8. Which of the following is NOT a characteristic of Gamblers Anonymous?
A. It provides professional counseling
B. It is modeled after Alcoholics Anonymous
C. It is a mutual-help group
D. It offers free meetings in many communities

9. What type of gambling problems do prevention programs primarily focus on?
A. Adult gambling disorders
B. Online gambling addiction
C. Youth gambling issues
D. High-stakes gambling

10. What is the status of medications for treating pathological gambling according to the document?
A. Several medications are FDA approved
B. No medications have been approved by the FDA
C. Medications are the first line of treatment
D. Medications are only used in combination with CBT

11. What is the minimum rate of problem gambling among people with substance use disorders compared to the general population?
A. Two to three times
B. Four to five times
C. One to two times
D. Six to seven times

12. Which of the following is NOT one of the diagnostic criteria for pathological gambling?
A. Preoccupation with gambling
B. Chasing losses
C. Lying to conceal gambling involvement
D. Experiencing withdrawal symptoms

13. What is a common behavior of a pathological gambler after losing money?
A. They stop gambling altogether
B. They seek help immediately
C. They often return another day to get even
D. They ignore their losses

14. What is emphasized as critical for clients with both substance use disorders and pathological gambling?
A. Identifying triggers for each addiction
B. Avoiding any form of gambling
C. Focusing solely on substance abuse treatment
D. Minimizing family involvement

15. What is the essential feature of pathological gambling?
A. Temporary gambling behavior
B. Persistent and recurrent maladaptive gambling behavior
C. Occasional gambling without consequences
D. Gambling only during manic episodes

16. What is the estimated lifetime prevalence of pathological gambling among adults in the United States according to national studies?
A. 1 percent
B. 5 percent
C. 10 percent
D. Unknown

17. Which of the following is a brief screening tool effective in identifying probable pathological gamblers?
A. Gambler Assessment Index
B. Lie/Bet Questionnaire
C. Substance Abuse Screening Tool
D. Gamblers Anonymous Questionnaire

18. What percentage of adults under the age of 30 report higher proportions of gambling problems?
A. 20 percent
B. 30 percent
C. 40 percent
D. 50 percent

19. What is a common misconception about the nature of gambling as a disorder?
A. It is always associated with substance abuse
B. It can be diagnosed with a biological test
C. It is not considered a medical disorder
D. It only affects men

20. What is one of the main differences between action gamblers and escape gamblers?
A. Action gamblers seek excitement, while escape gamblers seek relief
B. Action gamblers are more likely to be female
C. Escape gamblers have a longer progression to addiction
D. Action gamblers are less likely to engage in skilled forms of gambling

21. What is a common pattern observed in individuals who are both alcohol dependent and pathological gamblers?
A. Sequential addiction
B. Simultaneous addiction
C. Causal addiction
D. Temporary addiction

22. What is the purpose of the Gambling Treatment Admission Questionnaire (GTAQ)?
A. To assess family involvement
B. To diagnose alcohol dependence
C. To evaluate gambling behaviors and related problems
D. To measure anxiety levels

23. What is a critical consideration for clinicians when involving family members in the treatment process?
A. To take sides in the treatment
B. To ensure family members are present at all sessions
C. To avoid being viewed as taking sides
D. To focus solely on the gambler's issues

24. What can trigger domestic violence in the context of pathological gambling?
A. Therapeutic interventions
B. Substance use
C. Family involvement
D. Financial and legal issues

25. What is a common emotional response of gamblers when they attempt to abstain from gambling?
A. Increased anxiety
B. Euphoria
C. Indifference
D. Relief

26. What was Jan T.'s relationship with her older sister during her treatment process?
A. She was her financial advisor
B. She moved in with her for support
C. She was her therapist
D. She was estranged from her

27. What specific type of therapy did Jan T. attend in her current treatment?
A. Cognitive-behavioral therapy
B. Family therapy
C. Gambling-specific education and therapy groups

D. Individual counseling

28. What is a significant factor that can trigger relapse in pathological gamblers according to the document?
A. Financial problems
B. Social isolation
C. Lack of support groups
D. Increased gambling frequency

29. What is the role of continuing-care groups in the treatment of pathological gambling?
A. To provide financial advice
B. To offer recreational activities
C. To replace individual therapy
D. To maintain contact with therapy resources

30. Which cognitive distortion is commonly held by gamblers as mentioned in the document?
A. Illusion of control
B. Overconfidence
C. Fear of failure
D. Desire for social acceptance