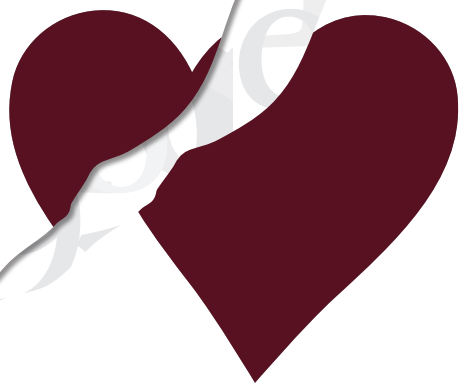
PROBLEM GAMBLING TOOLKIT

For substance abuse counselors, health therapists, primary care physicians, and social service workers



A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Association of Problem Gambling Service Administrators

National Council *on* Problem Gambling

PROBLEM GAMBLING TOOLKIT

Substance abuse counselors, mental health therapists, primary care physicians, and social service workers are increasingly confronted with consumers who are in need of services that address problem gambling issues. This toolkit was developed by the National Council on Problem Gambling (NCPG) and the Association of Problem Gambling Service Administrators (APGSA) to respond to requests for basic problem gambling screening, assessment, referral, and treatment information.

The rate of co-occurrence of problem or pathological gambling among people with substance abuse disorders has been reported as ranging from 9 percent to 16 percent. At a minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population. **Therefore, it is recommended that all consumers presenting with substance abuse and mental health issues should be screened for gambling problems.**

The following materials have been assembled to respond to requests for information about problem gambling:

- Excerpts on problem gambling from TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*. Excerpts from TIP 42 identify key elements of programming in substance abuse treatment agencies that address co-occurring disorders. The elements described have relevance for mental health agencies and other service systems that seek to coordinate mental health and substance abuse services for their clients who need both.
- *Problem Gamblers and Their Finances: A Guide for Treatment Professionals.* This guide is designed to provide treatment professionals with a basic understanding of the financial issues that confront the problem gambler and potential financial strategies.
- *Personal Financial Strategies for the Loved Ones of Problem Gamblers.* This handbook is designed to help loved ones of the problem gambler. It will suggest ways to deal with personal financial issues due to gambling before they become a major financial problem. It also can help the loved one of a problem gambler recover financially if he or she already has serious money problems.

It is important to note that this material does not mitigate the need for specific training when treating a problem gambler.

NCPG is the national advocate for programs and services to assist problem gamblers and their families. The NCPG Web site (**www.ncpgambling.org**) contains additional information and materials. APGSA (**www.apgsa.org**) is a strong, unified voice to support the development of state of the art, publicly funded problem gambling services.

For nationwide, 24-hour access to confidential information and referral services, call The National Problem Gambling Helpline Network toll-free at 1 (800) 522-4700.

This toolkit was developed by the National Council on Problem Gambling and the Association of Problem Gambling Service Administrators with support from SAMHSA's Center for Substance Abuse Treatment.

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
www.samhsa.gov

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

Excerpts from A Treatment Improvement Protocol
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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

Acknowledgments
TIP 42 was produced by The CDM Group, Inc. under the Knowledge Application Program (KAP) contract, number 270-99-7072 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Karl D. White, Ed.D., and Andrea Kopstein, Ph.D., M.P.H., served as the Center for Substance Abuse Treatment (CSAT) Government Project Officers. Christina Currier served as the CSAT TIPs Task Leader. Rose M. Urban, M.S.W., J.D., LCSW, CCAC, CSAC, served as the CDM KAP Executive Deputy Project Director. Elizabeth Marsh served as the CDM KAP Deputy Project Director. Shel Weinberg, Ph.D., served as the CDM KAP Senior Research/Applied Psychologist. Other KAP personnel included Raquel Witkin, M.S., Deputy Project Manager; Susan Kimner, Managing Editor; Deborah Steinbach, Senior Editor/Writer; and Erica Flick, Editorial Assistant. In addition, Sandra Clunies, M.S., I.C.A.D.C., served as Content Advisor. Special thanks go to Susan Hills, Ph.D., for serving as Co-Editor on this TIP, and Doug Ziedonis, M.D., for his contribution to chapter 8. Jonathan Max Gilbert, M.A., Margaret K. Hamer, M.P.A., Randi Henderson, B.A., Susan Hills, Ph.D., and David Shapiro, M.S., M.Ed., were writers. Appendix K was prepared by Margaret Brooks, J.D., and SAMHSA staff in consultation with the Office of the General Counsel, the U.S. Department of Health and Human Services, Washington, D.C.

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Recommended Citation
Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders (Problem Gambling)*. DHHS Publication No. (SMA) **07-XXXX**. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

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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