

# **Gambling: The Secret Invisible Addiction**

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Gambling is listed in DSM-IV under impulse disorders rather than chemical-dependency disorders. However, it is interwoven with all mood-altering substance disorders and their treatment.

Therapists working with individuals abusing alcohol, tobacco and other drugs should be aware of the comorbidity of gambling in this population.

The increase in legalized gambling in many parts of the United States has increased the prevalence of individuals who develop an addiction to gambling.

In this introduction to the world of the pathological gambler and its relationship to mood-altering substance disorders, we will describe the characteristics of compulsive gambling, the similarities between compulsive gambling and chemical dependency, some of the differences between the two, and assessment and treatment considerations for compulsive gambling.

## **The nature of compulsive gambling**

Gambling is usually described as risking money or valuables on the outcome of a predictable chance, event or contest. Gaming (e.g., at casinos or in state lotteries) is wagering on an odd with a percentage of the wager being kept by the organization where the wager is placed (Berman and Siegel, 1992; Heineman, 1992; Lesieur, 1984). Gambling and gaming have become synonymous with one another.

The 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) lists pathological gambling under impulse-control disorders not elsewhere classified. The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior that

disrupts personal, family or vocational pursuits. The gambling pattern may be regular or episodic, and the course of the disorder is chronic. DSM-IV describes the presence of a familial pattern, recognizing that children of pathological gamblers have a higher incidence of substance and gambling problems than the general population.

Regarding gender differences, female gamblers tend to use slot machines as a way of disassociating from pain and depression, and their gambling often starts later in life (Custer and Milt, 1985; Svendsen and Griffin, 1993). This appears to happen because females in our culture are introduced to these activities later than males.

### **Similarity of addictions**

Persistent, recurrent maladaptive behavior, as well as the familial pattern are the essential features of chemical dependency and parallel those of pathological gambling.

As with all addictions, the mood-altering effect tends to increase during times of stress or with changes in the client's perception of stressors/triggers. These triggers or events lead substance abusers to increase chemical use as a way of dealing with the stress, and the same holds true for gamblers.

The symptoms of both illnesses tend to parallel each other in their progression. There are three phases in the progression of pathological gambling (Custer & Milt, 1985; Moore, 1981):

#### **\* Early/Beginning Phase**

Gamblers in this stage evince the same defense mechanisms as persons in the early stage of chemical dependency, including minimization, rationalization, justification and denial. Like chemically dependent persons, gamblers perceive that they have found the secret to providing a sense of purpose and competence in their lives.

#### **\* Losing Phase**

In chemical dependency, this is called the *Critical Stage*. During this stage, the addict is consumed with the addiction and everything else is secondary. For both diagnostic categories, the symptoms include the loss of family and friends, the development of money and work problems, the loss of other outside interests and the emergence of unreasonable resentments.

#### \* Desperation Phase

This final stage corresponds to the *Chronic Stage* for the chemically dependent individual.

At this stage, both pathological gamblers and chemically dependent individuals become powerless over their compulsions. This stage is characterized by a moral/physical/emotional/spiritual deterioration, impaired thinking and the development of indefinable fears and a tendency to isolate in their addictions. The gambling problem is no longer invisible or secret at this stage.

Both addictions have caused an exhaustion of all avenues of escaping the inevitable carnage of the addicts' past. Reality sets in, denial is broken and the consequences of death/suicide or incarceration/insanity are the only options remaining without recovery.

Other poignant similarities of the two addictions include poor self-esteem and diminished self-worth. Both addictions involve preoccupation, denial, loss of control, increased tolerance and continued use despite negative consequences. Personality characteristics such as poor communication/intimacy skills as well as a low tolerance for frustration and poor coping skills mushroom in both disorders (see table opposite).

#### **Some differences**

With substance use, standards are available to measure the level of usage. This is not the case with gambling. There is no physical evidence or visible dependency in the compulsive gambler — and no way to detect the presence of addiction through a blood or urine test. This allows the gambler to continue to gamble for many years, despite negative consequences, without detection by friends, family members or coworkers

(Berman and Siegel, 1992). Families are seldom aware of any problem until it has become very serious.

Compulsive gambling also tends to progress faster and to bring more severe financial problems than chemical dependency.

The suicide rate for gamblers is 10 times the national average, and 75 percent of pathological gamblers admit to having thoughts of suicide (Custer and Milt, 1985).

In contrast, chemically dependent individuals report feelings of hopelessness and helplessness rather than suicidal ideation tendencies.

Chemical dependency is more widely accepted by the public as a treatable disease, if only because it has received publicity over a longer period.

Gambling continues to be viewed as a moral weakness, reflecting greed, poor judgment or irresponsibility. Public awareness of gambling disorders, and the costs and inevitable consequences of compulsive gambling, is limited, but presumably will rise as the rapid expansion of legalized forms of gambling leads to a higher incidence of compulsive gambling.

In addition, public policy reflects a more informed view of intervention with individuals who are abusing substances, as reflected by courts, employers and insurance providers.

Other significant differences between the two addictions include the fact that the gambler tends to remain functional until he/she "hits bottom" and that the financial crises that have developed, such as paying off bookies or sports betting brokers, demand immediate intervention.

Treatment for chemical dependency is currently available at three levels: residential, outpatient and intensive outpatient. Treatment programs for gambling are virtually nonexistent. (Some gambling treatment is available on an outpatient basis.) Few clinicians are trained to assess and treat compulsive gambling.

Finally, education/prevention programs, especially for young gamblers, are rare compared with those for chemical dependency.

## **Assessment and treatment**

At present, there are three recognized assessment tools for clinicians to use in evaluating the problem gambler:

\* **The South Oaks Gambling Screen (SOGS)** developed by Henry Lesieur, PhD, and Sheila Blume, MD, for the Brecksville, Ohio, Veterans Administration hospital, the first facility nationwide to provide a unit for the treatment of the compulsive gambler. It is available on several Web sites, including that of the Illinois Institute of Addiction Recovery .

\* **The 20 Questions** developed by Gamblers Anonymous (see Table 2 opposite page).

\* **The 3 Quick Questions** developed by Patricia D. Sweeting as a tool for quick client assessment. A "yes" answer to any question requires clinicians to use one of the other assessment tools listed above. The 3 Quick Questions are:

- (1) Have you ever gambled more than you intended to?
- (2) When you lose money, do you return to gain it back?
- (3) Has anyone ever commented about your gambling?

## **Additional assessment tools**

Other assessment instruments were developed for special populations such as teenagers, financial investors and seniors.

Once a comorbidity factor is determined, the treatment planning for gambling is similar to that for chemical dependency. Components include:

\* Stress management techniques. Deep breathing exercises, impulse control, progressive relaxation and problem-solving techniques need to be addressed.

\* Improved communication skills. The practice of avoiding confrontation

and people pleasing at the expense of one's own feelings and needs has usually been a personal life script for compulsive gambling clients.

- \* Self-awareness and assertiveness training skills. Without these skills, the abuser will continue his/her isolating behaviors.

- \* Writing an autobiographical paper helps the client begin to connect destructive consequences with behavior. This is necessary for the client to begin to move beyond the blame and rationalization stages of early recovery.

- \* Developing "fair fighting" skills helps in communicating effectively.

Treatment of the addicted gambler requires that the financial carnage of the disease be addressed immediately (Custer and Milt, 1985). Family members/clients tend to develop a "quick fix" mentality once awareness has begun. "Bailouts" such as bank loans, home refinancing, salary advances and borrowing from family members are an instant "fix" (Berman and Siegel, 1992). By taking a loan, gamblers can further remove themselves from the consequences of their actions, similar to the enabling of chemically dependent addicts.

In response to this, Gamblers Anonymous offers a Pressure Relief Committee involving the entire family that is immediately available when the gambler begins to attend meetings. This committee works under the premise that the longer the gambler is actively involved in debt repayment, the greater and longer lasting are the consequences of the addiction.

## **Conclusion**

Therapists working with individuals presenting with substance abuse problems must also assess for gambling. Clients presenting with gambling problems should also be assessed for substance-abuse problems. In this manner, we address the whole person in his/her addiction. The potential to relapse is increased by the propensity of the user to substitute one addiction for the other. When both addictions are assessed and addressed simultaneously, the potential for relapse is greatly reduced.

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