

## **CONTENTS**

	<u>Page</u>
<b>CHAPTER ONE</b>	
<b>INTRODUCTION</b>	1
1.1 BACKGROUND	1
1.1.1 National Responsible Gambling Programme (NRGP)	5
1.2 PERSONAL BACKGROUND	7
1.3 RESEARCH FINDINGS	8
1.3.1 Summary/description of all treatment seekers	9
1.3.2 Gender differences in treatment seekers	12
1.3.3 Summary of treatment effectiveness	14
1.4 UNDERSTANDING PROBLEM GAMBLING	15
1.5 OBJECTIVES OF THIS STUDY	19
1.6 CONCLUSION	21
 <b>CHAPTER TWO</b>	
<b>RESEARCH METHODOLOGY</b>	23
2.1 RESEARCH METHODS	23
2.1.1 Quantitative methods	23
2.1.2 Qualitative methods	28
2.2 METHODOLOGICAL UNFOLDING OF THE STUDY	32
2.2.1 The nature of ethnography	32
2.2.2 Determining a focus for inquiry	33
2.2.3 Determining where and from whom data will be collected	34
2.2.4 Data collection	38
2.2.5 Determining instrumentation	38
2.2.6 Data recording procedures	39
2.2.7 Data analysis	40

	<u>Page</u>
2.3 AUTO-ETHNOGRAPHY	42
2.4 CONCLUSION	46

### **CHAPTER THREE**

#### **PERSONAL DISPOSITION IN PROBLEM AND PATHOLOGICAL**

#### **GAMBLING**

	47
3.1 PROBLEM GAMBLING AS A MULTIFACETED BEHAVIOUR	47
3.2 TYPE I – THE BIOLOGICAL VULNERABLE GAMBLER	49
3.2.1 Biochemical vulnerability	51
3.2.2 Neuropsychological vulnerability	53
3.3 TYPE II – THE EMOTIONAL VULNERABLE GAMBLER	55
3.3.1 Personal vulnerability and experiential factors	57
3.4 TYPE III – THE CODEPENDENT VULNERABLE GAMBLER	63
3.4.1 The missing link?	65
3.4.2 The meaning of codependency in a historical context	67
3.4.3 Defining codependency	69
3.4.4 Recognizing codependency	71
3.4.5 How does codependency start?	74
3.4.5.1 The aggressive codependent	83
3.4.5.2 The passive codependent	86
3.4.6 The “interpersonal” link between codependency and problem gambling	90
3.5 TYPE IV – THE PSYCHOSOCIAL VULNERABLE GAMBLER	95
3.5.1 Psychosocial vulnerability and gambling	97
3.6 CONCLUSION	100

### **CHAPTER FOUR**

#### **SITUATIONAL AND STRUCTURAL DETERMINANTS OF GAMBLING**

	103
4.1 SITUATIONAL DETERMINANTS OF GAMBLING	103
4.2 STRUCTURAL DETERMINANTS OF GAMBLING	109

	<u>Page</u>
4.2.1 House advantage	112
4.2.2 Game preference	115
4.3 PSYCHO-STRUCTURAL INTERACTION IN GAMBLING	122
4.3.1 The impact of technology on gambling: Salient factors	124
4.3.2 Sub-types of gamblers	126
4.4 CONCLUSION	130
<b>CHAPTER FIVE</b>	
<b>THE CYCLE OF PROBLEM GAMBLING</b>	<b>133</b>
5.1 THE CYCLE OF PROBLEM GAMBLING	133
5.2 THE WINNING/INTRODUCTORY PHASE (apparent/impaired control)	135
5.2.1 Beginner’s luck: The “early win” hypothesis	137
5.2.2 Reinforcement theory	138
5.3 THE LOSING PHASE (poor control – problem gambling developing)	142
5.3.1 Poor coping skills	143
5.3.2 Denial patterns	144
5.4 THE CHASING PHASE (loss of control – gambling problem developed)	147
5.4.1 The role of cognition	151
5.4.2 Chasing – It’s not just about money	162
5.5 THE ADDICTIVE PHASE (absence of control (compulsion) – pathological gambling)	164
5.5.1 Diagnostic criteria for pathological gambling	167
5.5.2 Theory of addiction	168
5.5.3 Defense patterns	172
5.6 DISTORTED SENSE OF SELF	175
5.7 THE ESCAPE PHASE	178

	<u>Page</u>
5.8 THE DEVELOPMENT OF A DISTORTED REALITY WITH CHARACTER AND COPING DEFECTS	181
5.8.1 Character defects	184
5.9 CONCLUSION	187

## **CHAPTER SIX**

<b>TREATMENT CONSIDERATIONS</b>	189
6.1 INTRODUCTION	189
6.2 BIOPSYCHOSOCIAL ASSESSMENT IN TREATMENT	189
6.3 STAGE-CHANGE MATCHING IN THE TREATMENT OF GAMBLING ADDICTION	193
6.4 COMPONENTS OF TREATMENT IN PROBLEM AND PATHOLOGICAL GAMBLING	194
6.4.1 Pharmacotherapy	195
6.4.2 Cognitive and behavioural treatment approaches	198
6.4.3 Solution-focused therapy	205
6.4.4 Motivational interviewing approach	207
6.4.5 Gamblers Anonymous 12-step programme	208
6.4.6 Self-exclusion (banning)	211
6.4.7 Medical/disease model approach	212
6.4.8 Codependency treatment approach	215
6.5 CONCLUSION	218

## **CHAPTER SEVEN**

<b>HENRY: A BIOLOGICAL VULNERABLE GAMBLER</b>	221
7.1 INTRODUCTION	221
7.2 HENRY'S STORY	221
7.3 ASSESSING HENRY'S GAMBLING PROBLEM	228
7.4 ANALYSIS OF HENRY'S GAMBLING PROBLEM	229

	<u>Page</u>
7.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS	238
7.5.1 Initial phase of treatment	239
7.5.2 Middle phases of treatment	241
7.5.2.1 Addressing Henry's deviant sexual behaviour	245
7.5.3 Middle to end phases	247
7.6 MY RELATIONSHIP WITH HENRY AND ROLE AS HIS THERAPIST	250
7.7 CONCLUSION	252
 <b>CHAPTER EIGHT</b>	
<b>TINA: A PSYCHOLOGICALLY VULNERABLE GAMBLER</b>	255
8.1 INTRODUCTION	255
8.2 TINA'S STORY	256
8.3 ASSESSING TINA'S GAMBLING PROBLEM	262
8.4 ANALYSIS OF TINA'S GAMBLING ADDICTION	262
8.4.1 Tina's syndrome of codependency	265
8.4.2 Tina's motivation for gambling	267
8.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS	269
8.5.1 Initial phase of treatment	271
8.5.2 Middle phases of treatment	274
8.6 TINA'S OTHER COMPULSIONS	277
8.7 TINA'S GAMBLING ADDICTION AS SUBSTANTIAL AND COMPELLING CIRCUMSTANCES IN HER COURT CASE	278
8.8 MY RELATIONSHIP WITH TINA	281
8.9 CONCLUSION	282

	<u>Page</u>
<b>CHAPTER NINE</b>	
<b>SANTJIE: A PSYCHOSOCIAL VULNERABLE GAMBLER</b>	285
9.1 INTRODUCTION	285
9.2 SANTJIE'S STORY	286
9.3 ASSESSING SANTJIE'S GAMBLING PROBLEM	291
9.4 ANALYSIS OF SANTJIE'S GAMBLING ADDICTION	291
9.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS	295
9.5.1 Initial phase of treatment	296
9.5.2 Middle to end phases of treatment	299
9.6 MY RELATIONSHIP WITH SANTJIE AND ROLE AS HER THERAPIST	304
9.7 CONCLUSION	306
<b>CHAPTER TEN</b>	
<b>CONCLUSION AND IMPLICATIONS</b>	309
10.1 GENERAL DISCUSSION OF THE STUDY	309
10.2 EMERGING HYPOTHESES	310
10.3 STRENGTHS OF THE STUDY	336
10.4 LIMITATIONS OF THIS STUDY	338
10.5 CONCLUSION AND IMPLICATIONS FOR BEST PRACTICE	340
<b>REFERENCES</b>	343
<b>ANNEXURES</b>	
Annexure 1 : DSM-IV Diagnostic Criteria for Pathological Gambling	358
Annexure 2 : Gamblers Anonymous 20 Questions	359
Annexure 3 : Spann-Fischer Codependency Scale	360

	<u>Page</u>
Annexure 4 : Personal Gambling Disposition Profile	361
Annexure 5 : Personal Gambling Disposition Profile: Henry	363
Annexure 6 : Personal Gambling Disposition Profile: Tina	366
Annexure 7 : Personal Gambling Disposition Profile: Santjie	369

## **FIGURES**

Figure 3.1 : The biological gambler	50
Figure 3.2 : The emotional vulnerable gambler	56
Figure 3.3 : The codependent vulnerable gambler	64
Figure 3.4 : The psychosocial vulnerable gambler	96
Figure 3.5 : An integrated biopsychosocial vulnerability model of problem gambling	101
Figure 5.1 : A psycho-structural model of the cycle of problem gambling	136
Figure 5.2 : Schematic illustration of the gambler's fallacy	160

## **TABLES**

Table 2.1 : Demographic and gambling-related characteristics of the three participants at the time of interview	37
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# CHAPTER ONE

## INTRODUCTION

### 1.1 BACKGROUND

With the election of a new democratic government in South Africa in 1994, gambling laws were liberalized and the government granted 40 casino licenses. What is the result after ten years of regulated gambling? According to an article retrieved from the National Gambling Board's website on research advances, ([www.ngb.org.za](http://www.ngb.org.za)), Mr Chris Fismer, deputy chairperson of the South African Responsible Gambling Trust stated that the seventeen casinos that South Africa inherited from the "old South Africa" have grown to thirty-one. Illegal gaming machines are down from approximately 150 000 to less than 10 000. Legal gaming machines have increased from approximately 7 000 in 1994 to 25 000 in 2003 and there are over six hundred gambling tables. The Gauteng Gambling Board has issued seventeen Bingo licenses, of which eight are operational with 3 537 seats in 2002, as well as awarding new licenses for Limited Payout Machines (LPM's). Horseracing, which existed since the eighteenth century is being managed by two operating companies and, after an initial decline following the introduction of casinos, stabilized and even registered a slight growth. South Africa now has a tightly controlled and regulated gambling industry in which the state imposes high standards of compliance on operators with regard to social issues. Gambling today is far from being a secret vice undertaken by a deviant few – it has been transformed into a respectable and popular leisure activity.

Independent research commissioned by the National Gambling Board in 2001/2 has found that South Africans have a high propensity to gamble, and there has

been predictable displacement of spending to gambling from household and other disposable income ([www.ngb.org.za](http://www.ngb.org.za)). However, the published study also found that South Africa's new regulated gambling industry has a high level of public acceptability. Capital investments of R12-billion have been made between 1997 and 2001, representing 2.1% of the total South African capital formation during that period and more than 50 000 jobs have been created (16 000 direct and 35 000 indirect). There has been growth of about 50% in casino gambling since the days of the old illegal industry.

South Africans have a high propensity to gamble, averaging an expenditure of 1.9% of disposable household income in 2002. This is a higher percentage than in the United States (0.6%), but less than that of Australia (3.1%). However, unlike these two jurisdictions, South Africa is a developing country in which there are proportionately greater numbers of people who can less afford this level of recreational spending on gambling. This is demonstrated by the fact that internationally South Africa ranks 23<sup>rd</sup> in terms of gross gambling revenue, and yet only 91<sup>st</sup> with regard to per capita gross national income as a welfare indicator ([www.responsiblegaming.co.za](http://www.responsiblegaming.co.za)).

According to the 2004 National Responsible Gambling Programme Annual Report, retrieved from ([www.responsiblegaming.co.za](http://www.responsiblegaming.co.za)), findings and conclusions of research conducted in 2003/4, are as follows:

- Gambling overall has grown; the number of people who never gamble is now 20.1% (compared with 25.6% in 2001).
- The principal gambling activities in South Africa are the lottery, slots, scratch-cards, and the horses, in that order.
- The number of people playing the lottery regularly has increased from 67.6% to 72.3%.

- The number of people playing slot machines has grown from 28.9% to 31.1%; although there is a 5% decline in the regularity of play.
- Similarly, the number of people playing scratch-cards has increased by about 3% - from 20.8% to 23.7% overall and from 12% to 15% in terms of regularity.
- Gambling in South Africa is still a predominantly middle income activity. All income groups tend to play the lottery, including the poorest. Fairly poor people tend to play the horses, and more affluent people the slots.
- Conversely, when poor people play the slots and horses, they spend a very high proportion of their income doing so, whereas they spend only modestly on the lottery.
- The overall number of people in the South African population with gambling problems is broadly in line with international norms.
- There are probably now 550 000 people who gamble too much to the point where it is causing serious problems to themselves and those close to them, and who would benefit from education and/or counseling – 1.4% of the total population of 40 million. Further, there are probably now 70 000 people in South Africa who could be described as compulsive or addicted gamblers.
- The number of problem gamblers as a proportion of regular gamblers is about 50% higher than in more developed countries. This is to be attributed to the fact that poor people in countries with no welfare state will get into trouble more quickly if they spend too much on gambling (or anything else). Also, less well-educated people may not understand odds.

- Slot machine gambling and playing the online national lottery game are both generating new problem gamblers. This is probably due to the fact that many people in South Africa have dangerously false beliefs about gambling. Many believe that if they buy several hundred lottery tickets they will have a really good chance of winning. Others believe that the more a slot machine is played without a big win, the more likely it is to pay out next time. They do not understand that slot machines work like roulette wheels, with each spin producing a random number.
- The incidence of problem gambling is similar to the incidence of problem drinking. There are fewer regular drinkers than regular gamblers and among regular drinkers the incidence of problem drinking is about 9.4% as against about 6% for regular gamblers.
- Attitudes to the legalizing of gambling in South Africa are positive by a ratio of about 2:1

It should be borne in mind that problem gambling is a condition which develops over a fairly long period of time. This means that the incidence of problem gambling will tend to grow over the coming years as people who have started gambling in the past two or three years develop the problem behaviours which may be expected to show up in future surveys.

A publication by the National Gambling Board on the promotion of responsible gambling in South Africa, retrieved from their website ([www.ngb.org.za](http://www.ngb.org.za)), indicates that while the majority of South Africans gamble with little or no adverse consequences, the percentage of adults with gambling problems is bound to increase with time as gambling becomes more socially acceptable and accessible. Although the South African gambling industry is still in its infancy, concerns are growing about the impact of gambling on society and the potential

problem of “problem” gamblers. Section 13 (1), (b) and (c) of the National Gambling Act, 1996 (Act No. 33 of 1996) provide that:

- *“Members of the public who participate in any licensed gambling activity shall be protected and that society and the economy shall be protected against over-stimulation of the latent demand for gambling.”*

At the first meeting of the National Gambling Board, after its appointment on 29 April 1998, the Board’s chairman, Mr Chris Fisser highlighted that: *“...gambling is a sensitive industry and it can become a liability when not run properly. That responsibility is on our shoulders. Never lose sight of the ordinary citizen and the damage we could do to him”*. In his address to the Board on 6 August 1999, Minister Erwin further stressed the importance of balancing the socio-economic effects of gambling with the resulting positive effects. The Minister said: *“All the evidence in our society points to the fact that if we are not watching this, we are going to create some problems. We must be well informed of what is happening in the whole industry so we have a better picture of what effect it has on our society. The positive effects, economical effects and possible negative and socio-economic effects”* ([www.ngb.org.za](http://www.ngb.org.za)).

#### 1.1.1 National Responsible Gambling Programme (NRGP)

The National Responsible Gambling Programme (also referred to as NRGP) came into being in May 2000, after 24 of the 40 casino licenses which South African law permits had been awarded. It came about partly because Provincial Gambling Boards, who have the responsibility of determining the conditions with which casino licensees must comply, typically required successful bidders to include in their bids plans for addressing the issue of problem gambling. It also came about because the casino companies perceived that, quite apart from considerations of moral responsibility, it was in their interests to address this problem pro-actively and on a voluntary basis rather than waiting to be compelled to act by government in circumstances likely to be unpropitious. (Collins & Barr, 2001). This treatment programme for problem and addictive

(compulsive) gambling over six sessions (one hour session once a week for 6 weeks) is designed to provide the patient with a cognitive insight into the dynamics of the problem so that behaviour changes may be effected and a recovery process facilitated. It subscribes to a disease concept model of understanding, currently described as a disorder of impulse control. The programme also has a 12 Step facilitation component that aims to integrate the patient into a 12 Step recovery programme as a member of an ongoing self-help support group of proven value. The treatment programme philosophy commences from a threshold of a "disease of unknown origin" with a probable but unproven neurobiological basis, but does not attempt to delve into psychodynamic, systemic or social conditioning explanations for the problems. It also strongly avoids a moral or judgmental stance, even though many gamblers engage in criminal activities or socially unacceptable behaviour as a result of their compulsion.

According to the NRGP's National Quarterly Report for the period July to September 2003, retrieved from ([www.responsiblegaming.co.za](http://www.responsiblegaming.co.za)), there are probably now 550 000 people who gamble too much to the point where it is causing serious problems and who would benefit from education and/or counseling. The number of problem gamblers referred for treatment over this quarter has nearly doubled in comparison to the previous quarter, evidence that the NRGP's public education initiatives are meeting with success. The availability of the NRGP's new spouse or family member treatment service over the past three months has seen a significant rise in usage. Nationwide, the overall number of problem gamblers referred for treatment through the Problem Gambling Counseling Line (PGCL) (previously referred to as the problem gambling helpline) has increased by one third compared to the previous quarter. On average the counseling line refers 118 problem gamblers for treatment every month. At the time of publication of the abovementioned quarterly report, a total number of 2 860 referrals for problem gambling treatment, since the inception of the programme, had been made by the NRGP.

## 1.2 PERSONAL BACKGROUND

As a registered Social Worker in private practice as well as a registered member with the South African Board of Healthcare Funders for the past six years, I have been working in the field of addiction, with a particular focus on gambling addiction. I spent two years counseling at Tara, The H. Moross Centre (psychiatric institution) during 1996 to 1997. After obtaining my BA (Hons) degree in Psychology during 1999, I joined Aspen Oak Associates as an associate member in private practice. In 2003 I became a founder member of Oak Associates, an outpatient private practice rehabilitation facility for the treatment of addictions.

In May 2000 the National Responsible Gambling Programme (NRGP) was founded on the basis of a public/private sector partnership between the gaming industry and government regulators (it is the only programme of its sort in Africa) for the purposes of operating a 24-hour counseling helpline service, an outpatient treatment programme to individuals with gambling problems and their families, as well as other ancillary services. At the time of inception of the NRGP, I was approached by the NRGP to join a group of eleven counselors nationwide to assist with the counseling for their problem gambling outpatient programme. To date, the number of counselors has grown to over sixty.

Over the past years in private practice over five hundred patients with gambling related problems have been referred to myself for outpatient treatment which included clinical assessment, cognitive insight, relapse prevention, problem solving skills, twelve-step facilitation, education, crisis intervention and family counseling. Screening for other mental disorders such as alcohol and drug problems, mood, anxiety and stress disorder as well as suicide risk were also included. Family needs are also addressed through a series of separate individual counseling sessions where issues such as education and insight into problem gambling, codependency, dysfunctional relationships, loss of family

income, neglect, violence and abuse and problem management strategies are addressed.

I have also been attending regular Gamblers Anonymous meetings which assisted me greatly with insight and understanding of the problem gambler and their families. I often visit Gamanon (family support group of compulsive gamblers) where I assist family members with insight needed to deal with this problem and its consequences effectively. I have also participated in presenting various training seminars of the NRGP to professionals and industry on the psychology of problem gambling, and has also undergone training by internationally renowned, Amsterdam based, Jellinek Consultancy on addictive gambling.

In 2003, I obtained a Masters degree for my research thesis titled “**Treating Gambling Addiction: A psychological study in the South African context**”. This study – which was a first ever in South Africa - was supported and funded by the NRGP. It represents a major contribution in understanding the biopsychosocial characteristics of problem gamblers in treatment in South Africa, as well as the treatment effectiveness of the NRGP’s six week outpatient programme. The results of this study were released in the media.

### 1.3 RESEARCH FINDINGS

Since there are few scientific studies of gambling treatment outcomes and a notable absence of treatment related research worldwide, it is essential to present an overview of a treatment outcome study in the South African context. This study – a first ever in South Africa – was conducted by myself in 2001 and also focused on the biopsychosocial characteristics of the problem gambler (Bulwer, 2003).



### 1.3.1 Summary/description of all treatment seekers

- **Gender:** 37% of treatment seekers consisted of females and 63% consisted of males.
- **Age:** Treatment seekers are on average between 27 and 47 years old.
- **Ethnic/cultural background:** The largest proportion of individuals seeking treatment are people of White background (81%). People with Indian heritage accounted for 7% of patients. People with Coloured background accounted for 7% and people with a Black cultural background accounted for 5%.
- **Occupation:** Most treatment seekers (24%) were employed in a sales position or were self-employed (23%). Professional jobs (accounting/law/management/other) accounted for 18%. Only 7% were unemployed.
- **Level of education:** The sample presented with an average to above average level of education and 79% were high school (grade twelve) graduates. Only 21% had less than a grade twelve qualification and 38% had a college or university degree.
- **Phase of gambling:** 50% fell in the desperate phase and 49% in the critical stage of gambling.
- **Type of gambler:** 99% of treatment seekers fell in the probable pathological gambling range, with 50% indicated their motivation for gambling was “action” with 49% indicating it as “escape”.
- **Length of time gambling:** The majority of treatment seekers (56%) had been gambling between 6 to 15 years, with an average of 11.51 years.
- **Frequency of gambling:** 40% were gambling daily and 45% were gambling between three to six times per week in the last three months prior to entering the treatment programme. Others were gambling at the end of the month or when access to monies was available.
- **Type of gambling location:** 23% had gambled at private illegal casinos in the past, before the legalization of casinos in South Africa in 1996. 2% claimed to have gambled online. 43% gambled most often at the nearest casino and 72% at various casinos. 85% visited lottery outlet locations,

38% visited different tabs and totes and 26% made use of bookmakers. 11% made use of stockbrokers and 11% visited their local community hall for bingo gaming.

- **Type of gambling activity:** 81% played slot machines, 85% played the lottery, 9% played roulette, 11% played bingo and 9% played dice – games of chance. 53% played table card games and 41% indicated that they also engaged in wagering (horse punting). 4% engaged in sports betting and 11% in stock market gambling.
- **Largest amount of money spent on gambling:** The largest amount of money ever spent on gambling in one day by treatment seekers were as follows: 8% spent between R100 to R1 000, 62% spent between R1 000 to R10 000, and 30% had spent R10 000 plus.
- **Various identified problems:**
  - Primary relationships:** 90% reported conflict in primary relationship, 28% had a relationship break-up/separation and 13% reported divorce as a consequence of excessive gambling prior to entering treatment.
  - Residential:** 14% had lost their property/house, 32% reported that their bond/rent was affected or in arrears and 21% were forced to live with friends or family as a consequence of gambling prior to treatment.
  - Financial:** 78% were using household money for gambling, 55% borrowed from their spouse/partners, 68% borrowed from friends or family, 66% borrowed from banks, 37% borrowed from money lenders, 17% borrowed from loan sharks, 35% were selling their effects/cashed in securities, 26% borrowed from pawnbrokers, 13% cashed false/bad cheques, 70% had revolving credit with banks and 6% had revolving credit with casinos. 19% reported *actual gambling debt* between R1 000 and R10 000, 30% between R11 000 and R50 000, 30% between R51 000 and R200 000 and 8% between R201 000 and R500 000 plus.
  - Occupational:** 66% reported being absent from work, 86% reported loss of productivity and 28% lost past employment as a consequence of excessive gambling prior to entering treatment.

- **Psychiatric history:** 38% had previously formally been diagnosed with depression, 5% with anxiety/panic related disorders, 2% with obsessive compulsive behaviour, 3% with bipolar affective disorder and 1% with impulse control disorder. 35% reported suicidal thoughts related to gambling and 11% reported actual suicide attempts related to gambling. 10% reported previous suicide attempts not related to gambling.
- **Type of criminal activity:** 25% admitted to theft from their employer of which only 2% had been caught and charged. 20% reported theft from family and friends, including general petty theft. 10% admitted to cheque fraud and 8% to credit card fraud.
- **History of chemical or gambling problems in family of origin:** History of chemical or gambling problems in family of origin of treatment seekers presented as follows: mother with alcohol problem (8%), father with alcohol problem (27%), mother with gambling problem (17%) and father with gambling problem (19%).
- **Dependency behaviour:** 60% were dependent on cigarette smoking, 30% reported an alcohol abuse problem, 12% reported compulsive eating (obesity), 13% reported compulsive spending, 11% reported compulsive sexual behaviour, 6% reported abusing recreational drugs and 3% reported dependency on prescription drugs.
- **Dependency and other treatment history:** 16% had received previous treatment for their gambling problem, 6% for alcohol and 3% for drug dependency. 50% of treatment seekers reported having received treatment with a professional for depression/anxiety or other related mood disorders.

As can be seen from the above, the average treatment seeker who participated in this programme was in his/her early to middle adulthood with mostly a white cultural background. This individual also presented with an average to above average level of education and intelligence. Even though the majority of individuals were employed at the time of seeking treatment (more or less

middle-income group), a large percentage had lost previous employment or self-employment as a consequence of excessive gambling. It is of interest to note that a large percentage of these individuals were employed in a sales position or other professional position, or were self-employed with only a small percentage being unemployed. Almost all individuals entered the treatment programme at a very late and desperate stage of problem gambling and had on average been gambling between six to fifteen years, and in the last three months prior to entering treatment - between three to seven times per week. The majority of individuals indicated slot machines followed by table card games and wagering (horse punting) as their game of preference. Even though the lottery was played by the vast majority, it was never indicated as the game of preference with substantially much smaller (affordable) amounts spent in comparison with other types of gambling. Almost one quarter of treatment seekers had engaged in illegal gambling before the legalization of casinos in South Africa in 1996.

More than 40% of individuals (mostly females) reported a history of depression and other mood related disorders of which most had sought treatment for prior to starting gambling. Many treatment seekers also reported a history of chemical and/or gambling problems in their family or origin. The severe negative consequences of pathological gambling manifested in all areas of the gambler's life. By the time most individuals entered the treatment programme their lives were in total chaos, manifesting in severe emotional, relationship and financial problems, which resulted in relationship break-up, divorce, severe financial difficulties or sequestration, criminal activities, emotional depletion, depression, substance abuse and eventually suicide.

### 1.3.2 Gender differences in treatment seekers

37% of treatment seekers consisted of females and 63% consisted of males. On average females were significantly older than males when they entered the treatment programme. The average age for females entering the programme was 41.47 years and males were 35.06 years. Females also tended to start

gambling at an older age than males. The most prominent ethnic/cultural background was white Afrikaans- and English-speaking among treatment seekers. Females of Indian, Coloured and Black cultures did not feature prominently. Pathological gambling featured significantly among treatment seekers who were self-employed - both male (21%) and female (27%) - and very prominently among males who were employed in a sales/marketing position (35%). The majority of both male and female treatment seekers had an above average level of education. Even though there was no significant difference in the education level of males and females, 14% more males obtained a university degree. Both males and females fell equally in the probable pathological range, with female diagnostic scores somewhat lower than those of males.

Males and females differed in respect to the phase of gambling they were in. Males tended to be more in the desperate phase and had on average been gambling significantly longer than females before entering treatment. Females tended to be more in the critical phase and progressed to treatment more quickly than males. Females thus sought treatment for their problem at an earlier phase of problem gambling development than males. Females also clearly tended to be escape gamblers and males action gamblers. Even though both males and females played several different games, the game of preference among female treatment seekers was slot machines, and card playing and horse punting among males, and males had spent significantly more money on gambling while females tended more towards smaller amounts. Males on average had significantly higher actual gambling debt than females and were much more inclined to borrow from household money, banks, money lenders, loan sharks, pawnbrokers and revolving credit with casinos. Males were also more inclined than females to sell their effects or cash in securities and to cash false/bad cheques. A significant number of females (57%) reported a mood related disorder as an initial primary condition in the form of either depression or anxiety/panic attacks of which most had been professionally treated for their

condition prior to starting gambling, together with related suicidal thoughts and a significant number of actual suicide attempts *not* related to their actual gambling behaviour. More males attempted suicide related to their actual gambling behaviour than females.

### 1.3.3 Summary of treatment effectiveness

The primary measure of treatment success was if treatment seekers did not, after one year, revert back to gambling fulltime. Treatment seekers may have relapsed once or twice, or reported that their gambling was controlled (approximately once or twice per month – which had to be confirmed by a significant other), but if they did not revert back to gambling fulltime, at the end of one year, they were considered to be a successfully treated gambler. While a longer follow-up period may yield different results, the current study focused on treatment results after one year.

25% of treatment seekers reported that they reverted back to gambling fulltime which leaves the success rate of the treatment at 75%. While 80% did not relapse (gamble) during the six week treatment programme, the number of treatment seekers without any gambling relapses during each follow-up period declined, and those falling back into gambling increased as time went on. After one year 47% of treatment seekers managed not to revert back to gambling – total abstinence. As anticipated, gamblers experienced an overall reduction in gambling participation, debt and expenditure and an overall improvement in vocational functioning.

It appeared that after the six week discharge to the one year follow-up, belonging to Gamblers Anonymous assisted treatment seekers in abstaining from gambling and also in having fewer relapses. Banning/self-exclusion seemed to have little effect on abstaining and relapsing. The attendance of a family member or concerned other at the fourth session, indicative of family or other support, correlates positively with treatment success. This indicates that

respondents with family support at the fourth session were more likely to abstain and not revert back to gambling. Even though problem severity presented not statistically significant with treatment success, it was a borderline figure (0.064), very close to the pre-decided significance level (0.05). Where individuals entered treatment with one or other substance abuse problem, especially alcohol, substituting one addiction for another, is one reality which cannot be ignored. Approximately the same number of males and females reverted back to gambling after one year.

It is important to note the lasting and devastating effects of pathological gambling on marital and family relationships, even after the gambler has stopped gambling. One third of treatment seekers reported no improvement in these relationships and 20% reported a relationship break-up/separation or divorce after the gambler has stopped gambling.

#### 1.4 UNDERSTANDING PROBLEM GAMBLING

While working with problem gamblers it became clear to me that the aetiology of problem gambling is enormously complex and appeared to be multidimensional in nature, and hence the reason for my research study. I came to the conclusion that problem gamblers are a heterogeneous group who gamble for a variety of different and individual reasons. It seemed to be a very complex interplay amongst environmental factors, cognitive, behavioural and emotional determinants. Especially in long term treatment of the pathological gambler, I found different single theoretical explanations limiting in clinical management.

Pathological gambling is defined as persistent and recurrent maladaptive gambling behaviour characterised by an inability to control gambling, leading to significant deleterious psychosocial consequences: personal, familial, financial, professional and legal (APA, 1994). Although the debate continues whether pathological gambling is a disease or a social problem, the American Psychiatric Association, in its most recent Diagnostic and Statistical Manual of Mental

Disorders (DSM-IV, 1994), decided to regard gambling as a psychiatric condition but was not fully in favour of considering it a true addiction because there was no external substance involved. As a compromise, the decision was reached to include pathological gambling in the category of "Disorders of Impulse Control Not Elsewhere Classified" alongside a range of seemingly unrelated problems such as intermittent explosive personality, compulsive shoplifting (kleptomania), fire-setting (pyromania) and hair pulling (trichotillomania). Importantly, however, the diagnostic criteria for pathological gambling were deliberately and directly based on those used for the substance abuse disorders (Blaszczynski, 1998).

Aasved (2002), like so many others – myself included - asks the question why do people gamble? Why do some continue to gamble even when they consistently lose more than they win? Why do some continue to gamble even when they have lost everything they have? Many theories have been proposed by various clinicians, laboratory and field researchers, and participant observers in their attempts to discover and explain the reasons for gambling. In the past it has generally been assumed that all instances of gambling – normal and pathological – have the same underlying cause irrespective of individual preferences. Many authorities have even proposed single, monolithic explanations to account for excessive or uncontrolled behaviours of all kinds. It should be obvious that some of these theories may, indeed, offer some insights into certain instances of gambling behaviour while the utility of others may be extremely limited. Gambling, according to most definitions, means risking something of value on the unknown outcome of some future event. The ultimate goal, or more accurately, the ultimate hope of gambling is to realize a value greater than that risked. Many specialists are convinced that as opportunities for gambling continue to increase, so will the problems associated with it. A thorough understanding of this problem thus becomes imperative. While our current understanding of the nature and causes of pathological gambling is limited and insufficient, the consequences of gambling are well known. Among its most well-known consequences are the enormous financial losses, severe



personal and family debts, substance abuse, stress, depression, actual physical ailments, break-up of families, loss of employment, illegal activities and suicide.

To date, there are no papers describing an empirically validated theoretical model of pathological gambling that effectively integrates into a coherent conceptual framework the complex array of biological, psychological and ecological factors to explain the aetiology of the disorder (Blaszczynski & Nower, 2002). Advances in this area are hampered by imprecise definitions of pathological gambling, failure to distinguish between gambling problems and problem gamblers and a tendency to assume that pathological gamblers form one, homogeneous population with similar psychological principles applying equally to all members of the class. However, Blaszczynski and Nower (2002) created a “pathways model” that integrates the complex array of biological, personality, developmental, cognitive, learning theory and ecological determinants of problem and pathological gambling. He proposes that three distinct subgroups of gamblers manifesting impaired control over their behaviour can be identified. These groups include (a) behaviourally conditioned problem gamblers, (b) emotionally vulnerable problem gamblers and, (c) antisocial, impulsivist problem gamblers. The pathways model is predicated on the argument that the quest to impose one theoretical model to apply equally and validly to all pathological gamblers is a misguided venture. An alternative and more productive approach is to acknowledge the existence of specific sub-types of gamblers, each influenced by different factors yet displaying similar phenomenological features.

Clinical wisdom has long recognized that, although symptoms of depression, substance use, impulsivity and antisocial type behaviours are observed typically in pathological gamblers, the role and implication of these variables in the aetiology and management of the disorder varies widely for each case. For example, three-quarters of problem gamblers manifest symptoms of depression (Blaszczynski & McConaghy, 1988). For some, gambling is used as a means to

induce dissociation to reduce or escape states of chronic depression (Blaszczynski & McConaghy, 1989), while for others, depression appears to represent the emotional reaction to financial crises and other problems created by excessive gambling behaviours. Each has its own significant implication in determining appropriate interventions for clinical management. According to Blaszczynski and Nower (2002), the defining feature of a problem gambler is not only the emergence of negative consequences but also the presence of a subjective sense of impaired control, construed as a disordered or diseased state that deviates from normal, healthy behaviour. Impaired behavioural control, defined by repeated, unsuccessful attempts to resist the urge in the context of a genuine desire to cease, is the central, diagnostic and foundational feature of pathological gambling.

Because gambling usually involves money, it is still believed by some that therein lies the answer to its attraction and popularity – that this motivation alone explains why people gamble. People are thought to gamble in the hope of winning money they don't already have, of winning more money than they already have, or, chasing after money already lost. Even though the attraction to, and importance of money might be the motivation behind some gamblers' behaviour, I believe this certainly does not alone explain this problem behaviour. Just as the cocaine addict needs money to buy cocaine to feed his drug addiction – and will do anything in his power to obtain money for this purpose – the problem gambler will do anything in his power to obtain money - *to gamble* – not to do anything else with, but to gamble. They gamble “*with*” money rather than “*for*” money. Money thus becomes a means to an end.

It also became very obvious to me that certain subgroups of gamblers are attracted to certain specific gambling activities and that central to understanding gambling behaviour, is the *structural characteristics* of different gambling activities. Structural features as well as the actual *gambling space* within certain classes of activities vary considerably and have implications for gamblers'

motivations and the potential “addictiveness” of gambling activities. I believe it is imperative for a treatment professional to be familiar with the different types of games/gambling that the gambler is involved with.

### 1.5 OBJECTIVES OF THIS STUDY

It is clear from the results of the pilot study conducted by me (Bulwer, 2003) that the NRGPs six week outpatient treatment programme, based on the medical model, proved a significant success rate in a short period of time. The results of the research on the effectiveness of the National Responsible Gaming Programme – which indicated a 75% treatment effectiveness over a one year period - is an above average evidence-based success rate which cannot be disputed. However, a question mark still remains as to the 25% of gamblers where this type of treatment proved less effective. When the multidimensionality and complexity of problem gambling is considered, one answer to this question might be that a single-theory based short term treatment programme might not be adequate in the treatment of these (25%) problem gamblers. Single domain models that assume pathological gamblers form a homogeneous population may no longer be adequate in the face of data that putatively demonstrates gambling to be a heterogeneous and multidimensional disorder, the end result of a complex interaction of genetic, biological, psychological and environmental factors, which might have a significant impact on clinical management (Blaszczynski & Nower, 2002). Simple consideration of gambling as an addiction or as a compulsive or impulse control disorder may be too limiting in scope. Considering the many theories to explain problem gambling, it is probable that most of these theories were developed with male problem gamblers in mind, and certainly the vast majority of past research about problem gambling has concentrated on males. Today, however, the widely held assumption that problem gambling is a male problem and that what is true for males is also true for females, needs to be challenged.

After having completed extensive research on problem gambling (Bulwer, 2003) the multidimensional nature of problem gambling became abundantly clear to me. Peoples' initial motivation/vulnerability for starting gambling, the choice of a gambling activity, the gambling space and the motivation behind gambling once a problem has developed, are important considerations in clinical management.

As can be seen from the results of the same pilot study conducted by Bulwer (2003) there are considerable psychological and behavioural differences between different subgroups of gamblers when entering treatment, especially with regard to gender differences. The above study also provides more evidence of the need for careful attention to diagnosing and investigating the interactions of co-morbid disorders.

As an addiction therapist who works full-time with problem gamblers it further became clear to me that working with different subgroups of gamblers pose some very different and distinct challenges. Investigating the interaction of co-morbid disorders with gambling behaviour and the order of onset of the disorders became imperative. For example, a patient who developed depressive symptoms after the onset of pathological gambling in response to financial, legal or marital problems should be treated differently than a patient who developed depressive symptoms, and later, found that gambling temporarily relieved the symptoms of depression. In this example, the clinical approach should be different, even if both patients reported that their depressive symptoms increased their desire to gamble or their gambling behaviour.

The objectives of this study are the following:

- To explore the different underlying biopsychosocial vulnerabilities in problem and pathological gambling.

- The integration of a detailed psychotherapeutic stage matching model to explore and identify certain biopsychosocial manifestations in the respective stages of pathological gambling in different subgroups of gamblers.
- The implementation of this model according to in-depth biopsychosocial case studies of one individual male and two female pathological gamblers (initially referred by the NRGF) in long term counseling treatment (one year and longer) with the writer.
- To explore patient treatment matching in clinical management and long term treatment strategies for the different subgroups of gamblers. This will include the exploration of the effects of co-morbid problems on participants' gambling.

Griffiths, et al. (2001) warns about the importance of contextual factors when addressing the issue of problem gambling. According to him gambling is a multifaceted rather than a unitary phenomenon, strongly influenced by contextual factors that cannot be encompassed by any single theoretical perspective. Focusing upon self-reported factors maintaining the behaviour does not provide insights into the factors that led to the behaviour developing. Thus, when one takes a biopsychosocial view, it becomes possible to perceive the individual gambling in terms of its broader social and cultural context. According to Dickerson (1993; 1995), variations in the motivations and characteristics of gamblers and in gambling activities themselves mean that findings obtained in one context are unlikely to be relevant or valid in another.

## 1.6 CONCLUSION

Gambling is a complex, multi-dimensional activity that is unlikely to be explained by any single theory. Instead, this research is best served by a biopsychosocial model that stresses the individual and idiosyncratic nature of the development of

gambling problems and emphasis on the role of contextual factors internal and external to the process of gambling itself. Exploring gambling and problem gambling as a biopsychosocial behaviour makes it evident that individual differences and broader contextual factors must be considered and not ignored.

To date, there have been a small number of studies worldwide about the characteristics of problem gamblers in long term treatment services. Part of the objective of this study is further to explore different theoretical perspectives and treatment approaches which may assist in building on any short term treatment programme and to provide valuable insight into the long term treatment of different subgroups of gamblers. The findings and insight from this study could be used as a valuable tool by other professionals and clinicians in the understanding and treatment of pathological gambling.

## **CHAPTER TWO**

### **RESEARCH METHODOLOGY**

The purpose of this chapter is to discuss, in detail, the research method followed in this study. This will include a discussion on quantitative and qualitative methods in general followed by an explanation of the methodological unfolding of this study.

#### 2.1 RESEARCH METHODS

In this study I made use of quantitative methods as well as qualitative methods and these methods will be described as follows:

##### 2.1.1 Quantitative methods

This study makes use of quantitative measurement instruments to assess certain variables. According to Ruben and Babbie (1993), quantitative research may be more appropriate when we study a phenomenon about which we already know much, when we have a relatively high degree of control of the research situation, or when we seek to verify hypotheses or describe with precision the characteristics of a population. For the purpose of this study it was to describe with precision the characteristics of a population (e.g. the problem severity of the participants) before the start of long term treatment. In the next section I will discuss the measurement instruments used:

##### Measurement instruments

For the purpose of this study it was important that a thorough assessment be done with regard to the participants' gambling severity. I used two diagnostic tools to determine the gambling severity of the three participants:

- DSM-IV diagnostic criteria for pathological gambling (Annexure 1).
- Gamblers Anonymous 20 Questions (Annexure 2).

The DSM-IV diagnostic criteria were completed by myself for each participant in treatment after having performed a thorough assessment. I further requested each participant to personally complete the Gamblers Anonymous 20 Questions screening tool. A brief discussion on these instruments which have been used to measure problem gambling will be presented as follows:

*DSM-IV diagnostic criteria for pathological gambling*

The DSM-IV diagnostic criteria for pathological gambling were published by the American Psychiatric Association (APA, 1994). The diagnosis for pathological or problem gambling is based on this set of eleven criteria. This list is typically used by mental health professionals and determine, based on what the patient is saying, how many criteria fit. It can be difficult for a person to make a “self-diagnosis” because someone can manipulate the questions in a manner that is not accurate. Unfortunately there is no real scoring key for the DSM-IV assessment tool. Based on careful research and clinical experience, the authors of this symptom list decided that five or more positive, or “yes” responses, indicate a diagnosis of pathological gambling (Shaffer, et al. 1997). However, there was a lot of discussion about the number of symptoms needed and some of the authors felt strongly that four symptoms were sufficient for the diagnosis of problem gambling. In this study subjects who endorsed 1 to 4 symptoms were evaluated as problem gamblers rather than pathological gamblers. I would like to reiterate that the issue of making a diagnosis can be very complex. I have counseled some patients who did not endorse five symptoms and yet clearly were pathological gamblers, for example, a gambler who is dishonest about their gambling, borrows money from many people or institutions, and/or has had a financial bail-out from someone. In this situation the gambler does not meet the criteria, but may be a pathological gambler, or on the way to becoming a pathological gambler.



The DSM-IV diagnostic criteria are less focused on the financial aspects of gambling problems than the Gamblers Anonymous (GA) 20 Questions, and more focused on the loss of control aspects of gambling problems. This behavioural focus is a strength of the measure, as it results in a more balanced view of gambling problems than is possible with the GA 20 Questions. The end result is a more conservative estimate of gambling problems (Shaffer, et al. 1997; Stinchfield, 2002). Stinchfield's 1997 paper is one of the few containing psychometric comparisons between instruments and he uses the DSM-IV diagnostic criteria as the gold standard for measurement. The DSM-IV diagnostic criteria were administered to the general population and hotline caller samples where a sub-sample of the treatment group was given the DSM-IV diagnostic criteria. (Stinchfield, 1997). Stinchfield felt that the DSM-IV diagnostic criteria achieved good validity in terms of obtaining high correlations with the SOGS (South Oaks Gambling Screen) and recommends that the DSM-IV diagnostic criteria be used in general population surveys.

#### *Gamblers Anonymous 20 Questions*

This series of 20 questions are completed by the gambler and is intended to identify compulsive gamblers. Those who qualify as compulsive or pathological, according to Gamblers Anonymous (GA), are those scoring a "yes" to seven or more of the twenty questions, and these are, presumably, those who would benefit from the Gamblers Anonymous 12-Step Programme (Gamblers Anonymous, 2002). The higher the score, the more severe the gambling problem. In terms of rough domains, the questions address personal correlates of gambling, (e.g. difficulty sleeping, remorse over gambling, gambling to forget worries, and decreased ambition and efficiency), social correlates of gambling (unhappy home life, gambling in response to arguments and frustrations, and damage to one's reputation), and financial correlates (gambling until one's last rand is gone, borrowing money or selling property to finance gambling and committing illegal activities to finance gambling).

According to Collins and Barr (2001) a 1998 Spanish study found that the GA 20 Questions was effective in distinguishing individuals known to be problem gamblers from those known not to be and found it compared well with SOGS. They have some reasons for preferring the GA 20 Questions, on the grounds that it relies less on borrowing behaviour, which may be culture-specific.

### *The Spann-Fischer Codependency Scale*

As I identified codependency as an additional underlying vulnerability in developing a gambling addiction, it was important to identify a proper measurement instrument to assist in the assessment of this condition. After much exploring, I decided on the Spann-Fischer Codependency Scale (Annexure 3).

When the fourth edition of the Diagnostic and Statistical Manual was published, codependency was not included among the mental disorders (APA, 1994). To the best of Harkness and Cotrell's (1997) knowledge, listing codependency as a mental disorder was never considered. According to them, paradoxically, addiction counselors may be more reliable judges of codependency than psychiatrists and psychologists are of the Axis II personality disorders that appear in the DSM-IV. The diagnostic reliability of the antisocial personality disorder, for example, was examined in one of the twelve national field trials conducted in the development of the DSM-IV (Widiger, et al. 1996). The procedures used in the field trial employed semi-structured protocols to interview cases, conducted pilot training, asked clinicians to diagnose videotaped case interviews, and measured the inter-rater reliability of their judgment. The coefficient of inter-rater agreement for the diagnosis of anti-social personality disorder was  $r = 0.56$  for inmates incarcerated in medium-security penal institutions,  $r = 0.38$  for outpatients from methadone clinics, and  $r = 1.00$  for psychiatric inpatients, using DSM-III criteria. Heumann and Morley (1990) reported that the coefficient of inter-rater reliability for the diagnosis of borderline

personality disorder was only  $r = 0.17$  that asked clinicians to evaluate standardized vignettes. A recent review of the literature suggests that inter-rater agreement on Axis II diagnoses is modest at best, when corrected for agreement by chance (Zimmerman, 1994).

Harkness, Swenson, Madsen-Hampton and Hale (2003) conducted a comprehensive research study to examine the reliability and validity of a rating scale for codependency in substance-abuse treatment – the Spann-Fischer Codependency Scale. The procedures used in this research study were similar to the national field trials conducted in the development of the DSM-IV. The investigators developed an example-anchored rating scale to operationalize codependency as addiction counselors construe it in practice. Counselors were able to distinguish adult outpatients and their spouses from members of Codependents Anonymous and normals, distinguished between students and Smoke Jumpers, and also distinguished between students and those in recovery. The findings suggest that the rating scale yield reliable and valid evaluations of codependency without appreciable gender bias and that many addiction counselors believe that codependency plays a causal role in addictive behaviour. It appeared that the “diagnosis” of codependency by addiction counselors may be reliable and valid and that this distinction appears to have clinical significance.

As I identified codependency as an additional biopsychosocial vulnerability, I decided to use the Spann-Fischer Codependency Scale as an added measurement tool. This scale is a 16-item self-report instrument. Individual items are rated on a 6-point Likert scale and then summed with two reversed items to describe codependency on a scale from a high of 96 to a low of 16. Spann-Fischer scores have been associated with membership in Codependents Anonymous, gender, self-esteem, locus of control, depression, relationship with parents and anxiety, narcissism, parental codependency, treatment outcomes and education, parenting style, powerlessness in relationships and risk-taking –

but *not* with parental chemical dependency, the number of family addictions, the severity of dysfunction in the family of origin, or alcoholism, childhood trauma or family cohesion and adaptability. The Spann-Fischer Scale has enjoyed good test-retest reliability ( $\geq .80$ ) and acceptable internal consistency ( $.62 \leq \leq .92$ ) across studies (Fischer, Spann & Crawford, 1991).

### 2.1.2 Qualitative methods

Janesick, (in Denzin & Lincoln, 1994) equates qualitative research to a dance by declaring: "All dances make a statement and begin with the question: What do I want to say in this dance? In much the same way the qualitative researcher begins with a similar question: What do I want to know in this study? This is a critical beginning point." According to Creswell (1998) these questions are open-ended, evolving and non-directional. They start with words such as 'what' or 'how' rather than 'why'.

Strauss and Corbin (1990) refer to qualitative research as a non statistical, non mathematical analytical procedure which is the outcome of data gained through interviews, observations and stories of participants. Quality refers to the nature of the phenomenon under study rather than its quantity. Qualitative researchers concern themselves with issues such as attempts to uncover the nature of peoples' experiences with a phenomenon such as problem or pathological gambling for example.

According to Ely (1991) qualitative research has certain fundamental characteristics which will be discussed and applied to this study:

- Qualitative research is characterized by the researcher's attempts to understand the phenomenon under study. This understanding of the phenomenon is of value not only to the researcher or to the readers but also to the subjects who participate in the study. When the problem

gamblers in treatment read this study it should make sense to them by being real, valid and reliable.

- In qualitative research the inside perspective of the respondent is important. In the case of this study I attempt to understand the following:
  1. What predisposes a person to developing a gambling problem – what are the underlying vulnerabilities of problem gamblers?
  2. How do these underlying vulnerabilities interact with the structural characteristics of gambling in the different stages of pathological gambling?
  3. How to match the different vulnerabilities (predispositions) to different treatment approaches in long term therapy.
- In qualitative research the researcher is the primary data collection instrument because it would be virtually impossible to devise a *priori* a non human instrument with sufficient adaptability to encompass and adjust to the variety of realities that will be encountered.

#### Data collection and analysis

In data collection there are four basic types of information to collect in qualitative research: (1) observations (ranging from non-participant to participant); (2) interviews (ranging from semi-structured to open-ended); (3) documents (ranging from keeping a journal to public documents or autobiographies); (4) and audio-visual materials (which include photographs and videotapes).

Data analysis is a formidable task for a qualitative researcher. According to Creswell (1998) there is no consensus for the analysis of qualitative data. The

following are some data analysis strategies according to Miles and Huberman (1994):

- Write margin notes in field notes;
- Write reflective passages in notes;
- Draft a summary sheet on field notes;
- Create metaphors;
- Make contrasts and comparisons;
- Write codes and memos;
- Note patterns and themes;
- Count frequency of codes;
- Note the relation among variables and build a logical chain of evidence.

During data representation, according to Creswell (1998), researchers describe in detail, develop themes or dimensions through some classification system, and provide an interpretation in the light of their own views or views of perspectives in the literature. When writing the qualitative dissertation the researcher engages the reader through a chronological approach as events unfold slowly over time.

Lincoln and Guba (1985) refer to reliability and validity as establishing trustworthiness in qualitative research and that all research must respond to the following questions. These questions will now be answered as applied to this study:

1. *What is the truthfulness of the findings of a particular study and how can we establish that?*

This study rests on the assumption that the underlying vulnerabilities of problem and pathological gamblers are a construction of reality as they themselves and their families perceive it. There is more than one way of experiencing this reality that they shared with me.

2. *What is the applicability of these findings in another context or with other respondents?*

My role as participant observer could impact on the generalization of this study. The context or the setting where the research took place is very significant. It might limit the applicability of the findings but it enriched the content and its significance and contributed towards the interpretation of the data.

3. *If the study were to be repeated in the same context with the same participants would the findings be the same?*

Dealing with a complex issue such as gambling addiction all actions are interrelated and connected to the context in which they occur and a linear model of cause and effect is negated in this study.

4. *Are the findings a product of the researcher's biases or own motivations, or are they a product of the participants of the study?*

My connection with the participants of the study is not objective. There is a profound relationship between us. I selected a topic which was of interest to me and fitted my belief of the importance of the individual. I also learned a great deal from the respondents as they too learned a lot about their constructions of their gambling addiction and how it has shaped their lives. This particular inquiry is value bound. A respect for and recognition of values adds to an understanding of context.

Lincoln and Guba (1985) refer to these questions as establishing the "truth value" of the study, its applicability, its consistency and its neutrality.

I will conclude the discussion on qualitative research with Creswell's (1998) view of qualitative studies: "Research is not done to gather data but rather to discover answers to questions such as *what are the biopsychocosomal*

*vulnerabilities of a compulsive gambler; how does this interact with the structural characteristics of gambling and how do we best match these different vulnerabilities with different treatment approaches*, by applying systematic procedures such as the naturalistic inquiry in the case of this study. In a qualitative study the research question often starts with a *how* or *what* which leads to an exploration and description of the topic. The outcome of the study is more a process than a product. The qualitative researcher is therefore interested in what happens to the subjects/gamblers from the subjects' own frame of reference. How do they make sense of their experiences and what meaning do they attach to it. The patient/gambler is treated as a primary data source from whom much can be learned.

## 2.2 METHODOLOGICAL UNFOLDING OF THE STUDY

This study is based on two conceptual frameworks: auto-ethnography and ethnography. As auto-ethnographers vacillate in their research process between culture (ethnos) and self (auto) (Ellis & Bochner, 1996a), I will explain briefly in this chapter the principles of ethnographic inquiry as this was the theoretical and conceptual framework I used to collect, record and analyse my data. The following aspects will be discussed:

- The nature of ethnography
- Determining the boundaries for the study
- Data collection
- Recording modes
- Data analysis procedures
- Trustworthiness

### 2.2.1 The nature of ethnography

Ethnographic research, according to Van Maanen (1995), has the following features:



- People's behaviour is studied in everyday contexts, rather than under conditions created by the researcher, such as experiments.
- Data is gathered from a range of sources, but observation and informal conversations such as interactive interviewing as used in this study, are usually the main ones.
- The approach to data collection is "unstructured", in the sense that it does not involve following a detailed plan set up in the beginning, nor are the categories used for interpreting what people say and do entirely pre-given or fixed. This does not mean that the research is unsystematic, simply that initially the data is collected in as raw a form and on as wide a front, as is feasible.
- The focus is usually a small number of cases, perhaps a single unit of study (case study research) or a group of people, of relatively small scale. It involves life history research which could include the researcher too. This is then termed "auto-ethnography".
- The analysis of data involves interpretation of the meanings and functions of human actions and mainly takes the form of developing a story, from which descriptions and explanations are extracted.

### 2.2.2 Determining a focus for inquiry

In an ethnographic inquiry, it is impossible to specify all the elements of the design in advance. But no inquiry, regardless of the paradigm that guides it, can be conducted without a focus (Lincoln & Guba, 1985). The focus may very well change as the research unfolds but it has to be there in the beginning. Determining the focus of an inquiry serves two purposes: Firstly it establishes the boundaries of the study; it defines the terrain wherein the investigation is to take place. Secondly focusing determines inclusion and exclusion criteria of a

study. This is important as in the beginning of an ethnographic inquiry data is collected with a “wide net” and the researcher might land up with information that is not exactly relevant, so focusing helps to discard the information that is not relevant to the inquiry (Hammersley, 1998). It is important to note though that these boundaries are not cast in stone. They can be altered and the naturalist researcher expects such changes. The researcher therefore starts with a particular focus in mind but does not hesitate to alter that focus as new information comes to mind. I use the term naturalistic researcher, as naturalism, according to ethnographic proponents (Van Maanen, 1995; Hammersley, 1998 & Creswell, 1998), and is an assumption on which ethnographic inquiry stands. The assumption is that ethnographic research aims to capture the character of naturally occurring human behaviour, and that this can only be achieved by first hand contact with it, not by inferences from what people do in artificial settings (such as experiments). This is why ethnographers carry out their research in “natural” settings: settings that exist independently of the research process, rather than in those set up specifically for the research purpose.

### 2.2.3 Determining where and from whom data will be collected

According to Brink (1991) the intent of the sampling processes in qualitative research is to identify subjects which fit the needs and qualities of a specific study. They should also be able to give a rich and comprehensive description of the problem under study. Decisions about whom to interview or what to observe should be based not only on the purposes of the research but also on the potential of the person or event to help the researcher gain insight and understanding about the phenomenon.

For an ethnographic inquiry, maximum variation sampling is most useful (Hammersley, 1998). The sample should be selected in ways that will provide the broadest range of information possible. Sampling can be expanded until redundancy with respect to information is reached at which point sampling is

terminated. This implies that the researcher does not initially know what will comprise the final sample (Creswell, 1998).

The choice of a sample in this particular study was guided by the focus of this study which was to explore the different underlying vulnerabilities in different subgroups of gamblers and to integrate a detailed psychotherapeutic stage matching model to explore certain biopsychosocial manifestations in the respective stages of pathological gambling as well as to explore patient treatment matching for the different subgroups of gamblers. This implies that I needed to gain entrance into a system (a natural setting according to ethnographic terminology) where such subjects were available and were willing to give comprehensive and rich descriptions of what it is like to live with a pathological gambling problem. I applied the following sampling criteria:

- Numerous potential subjects were originally telephonically assessed by a NRGP telephone counselor and referred to me for outpatient counseling. Several other treatment counselors service the Gauteng area and the allocation of gamblers to certain treatment professional is solely done at the discretion of the helpline counselors.
- The subjects had to be a problem or pathological gambler as screened and scored by myself on the DSM-IV classification (APA, 1994). A second screening tool, Gamblers' Anonymous 20 Questions, as completed by the participating gambler, was also be used.
- It was a pre-requisite that all considered participants completed seven sessions of the NRGP customized outpatient treatment programme – based on the medical model - before being approached. This ensured that all subjects participating in the study started with the same preceding treatment background.

- After completing the NRGP seven session treatment programme, I identified three subjects, each fitting into the respective vulnerability pathways (biological, psychological, co-dependent and psychosocial).
- I approached the three subjects separately and respectively and informed them of my study. It was important that they be willing to take part in the research. It was agreed that their real identity would be protected and that pseudonyms would be used for the purpose of this study. This is an important consideration in qualitative research as respondents who take part in a study because of some obligation and not because they are really willing to, do not give rich and comprehensive data.

With the above criteria in mind I did not have to negotiate my entry into a system (a natural setting according to ethnographic terminology) as I was already inside the system as a therapist specializing in pathological gambling since 2000. I have further been a contract gambling counselor with the NRGP for the past six and a half years. It was however important that the subjects finished their treatment contract with the NRGP as it would otherwise have been unethical to interfere or approach any subject while still in treatment with the NRGP. I did, however, verbally inform the National Responsible Gambling Programme's medical director, Dr Rodger Meyer, of my study.

Ethnographic sampling is very different to conventional sampling. It is based on informational and not statistical considerations. Its purpose is to maximize information, not facilitate generalization. Its procedures are very different too, and depend on the particular ebb and low of information as the study is carried out rather than on a priori considerations. Finally, the criterion used to stop sampling is informational redundancy and not a statistical confidence level (Cresswell, 1998). Table 2.1 gives a description of the demographic and gambling-related variables of the sample of subjects:

GAMBLER Type of gambler (vulnerability)	Henry (biological)	Tina (psychological)	Santjie (psychosocial)
<b><u>Demographic characteristics</u></b>			
Gender	Male	Female	Female
Age	38	58	49
Cultural and religious background	White, Jewish	White, Christian	Coloured, Christian
Level of education	Grade 12	Grade 11	Grade 8
Marital status	Single	Divorced	Divorced
Occupation	Motor garage administration clerk	Dismissed from job, temporary work	Unemployed
Physical/medical problems	Sexually trans- mitted diseases	Epilepsy, damaged leg, colon problems	Paraplegic, back & thyroid problems
<b><u>Gambling-related characteristics</u></b>			
<b><u>Gambling activities</u></b>			
Type of gambling activity	Tables (black jack, roulette) horses, dice, lottery	Machines (slots & video poker)	Machines (slots video poker, video lottery)
Length of time gambling	14 years	7 years	13 years
Type of gambling location	Casinos, illegal venues, race track	Casinos & illegal gambling venues	Casinos & illegal gambling venues
<b><u>Problem severity</u></b>			
DSM-IV score	10/10	10/10	9/10
GA 20 Question score	20/20	20/20	16/20
Phase of gambling	Desperation phase & suicidal ideation	Desperation phase, no suicidal ideation	Desperation phase & suicidal ideation
<b><u>Identified problems prior to treatment</u></b>			
Primary relationships	Severely affected	Severely affected	Severely affected
Residential	Rent in arrears	Sequestered	Lost accommodation
Occupational	Employed, previously fired 2x	Dismissed due to company fraud	Begging
Financial	Severe financial pressure	Severe financial pressure	Severe financial pressure
Gambling debt	± R150 000	± R900 000	No debt – no money as result of gambling
Psychiatric history	Bipolar disorder & ADD?	Depression & anxiety, obsessive	Depression, anxiety, obsessive
Criminal activities	Company fraud & theft	Company fraud & theft	Petty theft
Legal	Black listed, admin order, judgments, no charges	Criminal charges, court case pending	Blacklisted, judgments
Dependency history	Alcohol abuse, grandparents gamblers	Husband alcoholic (codependency)	Uncertain
Subsidiary addictive behaviour	Compulsive sexual behaviour	Obesity (compulsive eating)	Obesity (com- pulsive eating?)

**Table 2.1 : Demographic and gambling-related characteristics of the three participants at the time of interview.**

#### 2.2.4 Data collection

The choice of data collection method depends on the type of data that the researcher needs (Cresswell, 1998). The aim of this study was to explore the different underlying vulnerabilities as well as certain biopsychosocial manifestations in the respective stages of pathological gambling in different subgroup of gamblers and to match them with different treatment approaches. As the situation in which qualitative research, and so too for ethnographic inquiry, is done is indeterminate, i.e. it cannot be controlled like in conventional research methods and the qualitative researcher has to rely on techniques such as interviews, observations, document analysis and non verbal cues (Ellis & Bochner, 1996b). Data collection also included interviews with family members and the completion of two respective gambling screening tools and one codependency screening tool.

#### 2.2.5 Determining instrumentation

Qualitative research, under which ethnographic inquiry as research inquiry resides, demands a human instrument, one fully adaptive to the indeterminate situation that will be encountered (Ellis & Bochner, 1996a; Hammersley, 1998; Denzin, 1997). In the present study the human instrument was myself who collected and analyzed the data personally. The researcher as instrument is responsive to the context; he/she can adapt techniques to the circumstances; the total context can be considered; what is known about the situation can be experienced through sensitivity to non verbal aspects; the human instrument can process data immediately, can clarify and summarize as the study evolves and can explore anomalous responses (Merriam, 1988).

#### *The qualitative or unstructured interview*

An informal conversational interview is an unplanned and unanticipated interaction between an interviewer and a respondent that occurs naturally during the course of observation (Ruben & Babbie 1993). The qualitative or

unstructured interview implies that the interview as data gathering technique for this study had no rigid rules before hand. When I conducted the informal conversational interview I was extremely flexible so that I could pursue relevant information in whatever direction seemed appropriate. Questions should be generated naturally and spontaneously from what the researcher happens to observe at a particular point in a particular setting or from what individuals in that setting happen to share with the researcher (Ruben & Babbie, 1993). In other words, this is the type of interviewing that will occur spontaneously when you are conducting observations and want to maximize your understanding of what you are observing and what the subjects whom you are observing think about what is happening. Because I could not anticipate the situations beforehand, I conducted informal conversational interviews with no predetermined set of questions. One of the special strengths of this type of interviewing is its flexibility. It allowed me to respond to things I heard and saw that I could not otherwise anticipate.

The fact that the qualitative or unstructured interview was used to gather data, meant that there was no interview protocol and that placed more responsibility on me to listen and hear the direction of the respondent. The interview sessions were weekly, bi/weekly and monthly individual interviews running over a thirteen month (Santjie), fourteen month (Henry) and three and a half year (Tina) period. The time devoted to each session was one hour.

#### 2.2.6 Data recording procedures

Due to the in-depth, open-endedness of qualitative interviews, recording responses poses quite a challenge to the interviewer. The aims and philosophical roots of qualitative inquiry mandate that the respondent's answers should be recorded as fully as possible (Ruben & Babbie, 1993). Tape recording is viewed as an effective tool in recording interviews. However, due to the nature and symptoms of pathological gambling (i.e. suspicion), I decided not to use a tape recorder during our sessions. The notebook or journal is an

important equipment tool that a qualitative researcher should have. I took notes of my observations as I observed including non-verbal behaviour. When that was not possible, I wrote down my notes as soon as possible afterwards. My notes included both my empirical observations and my interpretation of them. I recorded what I “know” had happened and what I “thought” had happened. In broad, I developed a “Personal Gambling Disposition Profile” and data recording included the exploration of the following information for all participants:

- Demographic characteristics
- Gambling characteristics
  - Problem severity
  - Gambling activities
  - Identified problems
  - Criminal activities
  - Biopsychosocial vulnerability
  - Childhood and dependency history
  - Stage of change

### 2.2.7 Data analysis

The data obtained in this study were constructions or stories stemming from the researcher-respondent interaction. The data analysis lead to a reconstruction or re-authoring of these construction or stories (White, 1995). The process of interpretation enables a person to make sense of his/her world. However, these ideas are informed by the interpreter’s values and therefore the notion of truth or correspondence to an objective reality, are not important issues in this approach which does not adhere to the belief in an objective reality. The data analysis included the following phases:

#### Phase 1

Data collection and analysis was an ongoing process. I had a preliminary understanding of the meaning of the collected data. This understanding was



gained by making transcripts and continuously reading through everything repeatedly to immerse myself in the data. This helped me to become more aware and make sense of the subjects' worlds. The first step was to assess each subject's gambling problem severity through calculating their scores on the DSM-IV criteria for pathological gambling (completed by me) and the GA 20 Questions gambling screen, as completed personally by each subject.

### Phase 2

Data analysis in ethnographic inquiry is inductive (Cresswell, 1998), which means that inductive analysis does not begin with theories or hypotheses but with the data itself, from which theoretical categories and hypotheses may be arrived through inductive reasoning processes. It is thus a bottom-up approach. After reading through the transcripts, information was grouped under themes and headings to determine their respective personal disposition (biological, psychological, codependent and psychosocial). In recognizing codependency as an additional vulnerability, I used the Spann-Fischer Codependency Scale as a measurement instrument.

### Phase 3

I then recorded how each respective subject, with their own personal disposition (biological, psychological, codependent or psychosocial) experienced the psycho-structural interaction with gambling according to their own construction of reality. These experiences were recorded under different headings (e.g. type of gambling activity, length of time gambling, type of gambling location).

### Phase 4

The next step was the integration of a basic model of the cycle of problem gambling. Certain themes in the different subgroups of participants were identified (e.g. need for gaining control versus a need to lose control; aggressive versus passive) as well as additional biopsychosocial manifestations in the respective stages of pathological gambling. I then used this information to

further develop the basic cycle of problem gambling and renamed it the Psycho-structural Model of Pathological gambling. The aim was to explore the difference in personal disposition, the psycho-structural interaction, and the difference in the manifestation of the gambling pathology in different subgroups of gamblers.

#### Phase 5

After exploring and identifying certain themes and biopsychosocial manifestations in the different subgroups of subjects, I developed the Gambling Disposition Profile (Annexure 4) which was completed for each participant during their long term treatment.

#### Phase 6

Certain treatment approaches were then investigated and carefully matched with the different biopsychosocial manifestations in the different subgroups of participants.

#### Phase 7

The recording of each participant's story and how they responded to the different treatment matching approaches was done.

### 2.3 AUTO-ETHNOGRAPHY

According to Ellis and Bochner (1996b) auto-ethnographic work is about interaction between the researcher and the participants. Investigators are a part of the world they investigate and the ways in which they make it and change it, thus breaking away from the epistemology of depiction that privileges modes for inscribing a pre-existing and stable social world. Thus the interactive researcher cannot unilaterally determine the direction of the research, it is a co-evolved process. Auto-ethnographic inquiry is embedded in relationships and the research is dependent on the setting up of an interpersonal context where trust and respect are essential ingredients. The process demands intimacy from the

participants, an honesty and openness in the issues that one is grappling with. One should always be sensitive to what the participants are grappling with and be prepared to explore their concerns and not hold on to what one wants to do (Ellis, 1998). Developing deep insight and knowledge of the person and his/her gambling behaviour enabled me to discover real truths that would otherwise not have been able to be obtained by an external party.

As mentioned earlier, I had no problem in gaining entry into a system as I was already “inside” and part of the system. Once the subjects had completed the NRGP seven sessions, I approached the identified subjects. I informed them individually that I was doing a qualitative research study and wanted to study the multiple meanings of their individual experiences with gambling in order to ultimately find effective treatment approaches. It was agreed that I would treat their cases as pro bono work while they were in treatment and that I would not reveal their real identities.

Auto-ethnography according to Ellis (1997) is an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural. Back and forth auto-ethnographers gaze, first through an ethnographic wide angle lens, focusing outwardly on social and cultural aspects of the personal experience; then they look inwardly, exposing a vulnerable self that is moved by and may move through, refract and resist cultural interpretations. As they zoom backward and forward, inward and outward, distinctions between the personal and cultural become blurred, sometimes beyond recognitions.

Usually written in the first person voice, as is this thesis, auto-ethnographic texts can appear in the form of stories or personal essays or journal writing, be it fragmented or whole. The personal narrative of the researcher is important in auto-ethnographic inquiry. In this type of research the participants are encouraged to participate in the research or therapeutic process and take an

active role in what happens. I was personally exploring the feelings and emotions in myself and in the participants of this study in each session.

Understanding is one of the central assumptions in auto-ethnographic inquiry (Ellis, 1997). Central here is the argument that human action does not consist simply of fixed responses or even of learned responses to stimuli but involves interpretation and construction of responses. If we are to explain human actions effectively we must gain an understanding of the cultural perspectives on which they are based.

For this study I decided to use interactive interviewing to include both research and psychotherapy. The research consisted of a narrative mode of interviewing in which the participants shared their gambling related experiences. The telling of the experience (i.e. each gambler's story) was considered to be an appropriate method of gathering data for this study for the following reasons (Reissman, 1993):

- Stories determine which aspects of our experiences get expressed as well as the shape of that experience.
- People live by the stories they have about their lives and for the purposes of this study it is these stories or constructions that gamblers have about their own personal experience with their gambling addiction.
- Stories provide the frames that make it possible for us to interpret our experiences and I shared my interpretations of their gambling-related experiences with them. These acts of interpretation were achievements that I and the participants took an active part in and this contributed to the trustworthiness of this study.

- Stories bring a researcher or therapist closer to an understanding of the people they work with, be it in therapy or research. Attempting to understand people you work with and wanting them to know that you are moving towards an understanding of their dilemma, are a way of gaining confidence between the two parties, which leads to the gathering of information as well as new possibilities. This is an important assumption on which auto-ethnography is based.

I was the data-gathering instrument. Although the information itself was recorded in a journal, it was filtered, sorted, edited and interpreted by me. The interaction between myself and the participants was the most vital connection in the collection of information. My ability to conduct an interview, gain the respondent's trust and interest, influenced the amount and type of data gathered. Auto-ethnographic inquiry is not value-free (Ellis, 1997) therefore the researcher's previous experiences, assumptions and his/her realities will also influence data gathering and interpretation. Every researcher is unique and every inquiry is unique, therefore the study cannot be replicated by another researcher. In my contact with the participants I also respected the fact that each participant viewed their experience from their own reality.

The explication of tacit knowledge is an important characteristic in auto-ethnography (Denzin, 1997; Reissman, 1993). This tacit knowledge shapes the participants' view of their gambling addiction and in order to understand how the participants experience the addiction the tacit knowledge needs to be extracted from the stories and shared with the participants. This would help the participants in understanding and in finding meaning in their struggle. Therefore, I needed to use my senses, intuition, creativity and past experiences as well as present awareness to get the most information from the inquiry. The assumption in this thesis is that the individual constructs the gambling addiction in his/her head therefore qualitative methods, in particular, the unstructured

interview and story telling were used because they enable the construction to emerge from the creator.

## 2.4 CONCLUSION

In this chapter attention is paid to the methodological unfolding of the study, which includes procedures such as sampling, data collection, data analysis and the recording of treatment matching approaches in different subgroups of pathological gamblers. In addition, my role as auto-ethnographer was discussed.

The next chapter will focus on the personal disposition in problem and pathological gambling.

## **CHAPTER THREE**

### **PERSONAL DISPOSITION IN PROBLEM AND PATHOLOGICAL GAMBLING**

The purpose of this chapter is to focus on the complex array of biological, psychological and social vulnerabilities in developing problem and pathological gambling in order to explain the aetiology of this disorder. A series of distinct vulnerabilities in different subgroups as potential predisposing risk factors leading to the development of problem and pathological gambling will be described.

#### **3.1 PROBLEM GAMBLING AS A MULTIFACETED BEHAVIOUR**

Gambling is a multifaceted behaviour, strongly influenced by contextual factors that cannot be encompassed by any single theoretical perspective (Griffiths & Delfabbro, 2001). Blaszczynski and Nower (2002) developed a pathways model that integrates the complex array of biological, personality, developmental, cognitive, learning theory and ecological determinants of problem and pathological gambling – with an emphasis on biochemistry and genetics linked to pathological gambling. He proposed that three distinct subgroups of gamblers manifesting impaired control over their behaviour can be identified. These groups include (a) the psychological vulnerable gambler, (b) the biological vulnerable gambler (including anti-social and impulsivist), and (c) the behaviourally conditioned problem gambler.

It has been known for some time that some people are genetically more vulnerable than others to certain addictions. People with one addiction are also more likely to develop another, and this likelihood needs to be addressed in treatment. However, although I do not dispute some kind of biochemical

impairment, the question remains as to whether the biochemistry or brain changes precede the gambling, or occur as a result of gambling. It could be that either or both may occur, depending on the individual. There is also no evidence that all three of Blaszczynski's pathways have the same genetics or brain chemistry. The behaviourally conditioned problem gambler often presents without any prior experience of addiction. I recall a sixty-year old lady with a perfectly normal, successful life until she encountered electronic gaming machines. One year later, severely depressed and suicidal, she had lost almost everything – part time job, family and life savings. I am almost certain her brain functioning was not the same as it had been the year before. Does this mean that she has gone through the previous sixty years with a genetic vulnerability that never emerged? Somehow I doubt that. Just because some people are more vulnerable than others does not mean that everyone else is risk-free. There are many more contributory factors than just genetics. I believe that there is a shifting, multidimensional range of risks over a person's lifetime and across individuals which could leave everyone at some level of risk.

In treating problem and pathological gamblers I became aware that motivations vary according to personal characteristics of the gambler and it is therefore important to determine what makes some gamblers more susceptible than others to losing control over gambling, and whether pathological gamblers possess qualities which would predispose them to excessive gambling. While I agree, in principle, with Blaszczynski and Nower's (2002) three subgroups of gamblers, I do however want to add another pathway dimension – **codependency** – as an additional predictor of problem gambling which could possibly assist in explaining a person's vulnerability in developing a gambling problem. Determining the existence of a codependency syndrome in problem gamblers has major implications for treatment matching and long term intervention.



Thus, it is important to acknowledge the existence of specific at risk sub-types of gamblers, each influenced by different factors yet displaying similar phenomenological features. If, and when these specific at risk subtypes come into contact with the structural characteristics of gambling, it is possible that a gambling problem can develop. These specific at risk subtypes will be discussed under the following headings:

- Type I - The biological vulnerable gambler
- Type II - The emotional vulnerable gambler
- Type III - The codependent vulnerable gambler
  - Type A: Aggressive type
  - Type B: Passive type
- Type IV - The psychosocial vulnerable gambler

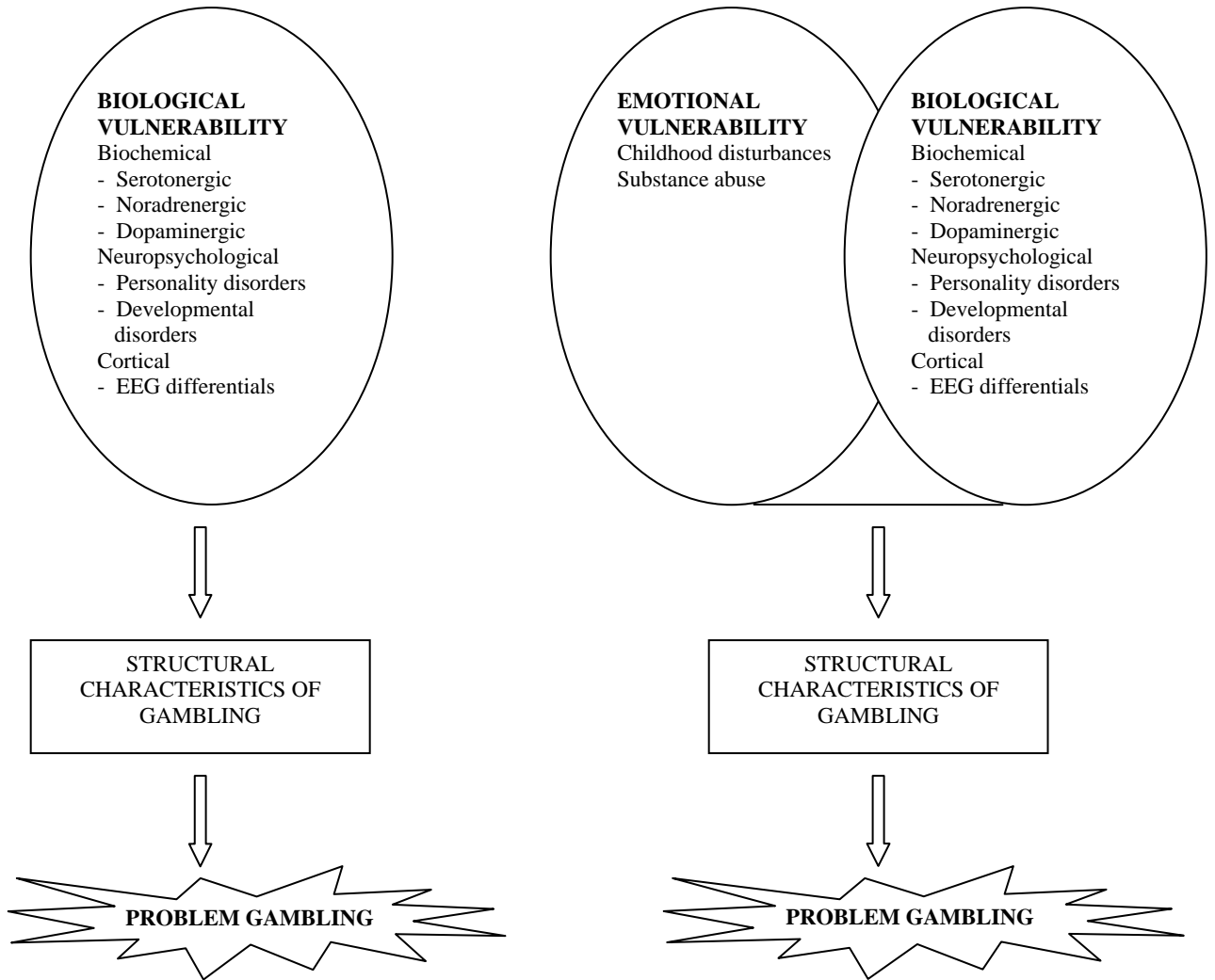
The above typology can also be used as a basis to present an integrated biopsychosocial vulnerability model of problem gambling as can be seen in Figure 3.5.

### 3.2 TYPE I – THE BIOLOGICAL VULNERABLE GAMBLER

#### **Type I – Biological vulnerability**

(Figure 3.1) - adapted from Blaszczynski and Nower (2002).

- Biochemical impairment (dopamine, serotonin and noradrenaline deficiency) can predispose a person to problem gambling.
- Neuropsychological impairment (e.g. ADHD, impulsivity and antisocial personality disorders) can predispose a person to problem gambling.
- A genetic predisposition is also suggested by family histories of addiction.
- However, biological vulnerability is very often linked to some kind of emotional vulnerability (childhood disturbances or substance abuse – in this type without a codependent vulnerability), which necessitates exploration of both the biological and emotional vulnerabilities.



**Figure 3.1 : The biological vulnerable gambler**

Much research has been done on the biological vulnerability of the problem gambler as presented in Figure 3.1. Although it is extremely hard to determine whether the biochemistry or brain changes precede the gambling, or occur as a result of the gambling, it still remains important to assess the gambler's biological vulnerability, as pharmacological treatment becomes necessary in treating any underlying biological vulnerability or condition. The following is a summary of certain biological research findings as cited in Blaszczynski and Nower (2002).

### 3.2.1 Biochemical vulnerability

#### Serotonergic, Noradrenergic and Dopaminergic

According to Rosenthal (2004), as cited in Blaszczynski, (2002), there are a number of studies that point toward the importance of biological and genetic factors tentatively linking receptor genes and neurotransmitter deregulation to reward deficiency, arousal, impulsivity and pathological gambling. Studies of biological markers have suggested deficits in the *serotonergic* (mood regulation) (serotonin receptor hyposensitivity and hypersensitivity) (Moreno, Saiz-Ruiz & Lopez-Ibor, 1991; Carrasco, Saiz-Ruiz, Hollander, Cesar & Lopez-Ibor, 1994; Blanco, Orensanz-Munoz, Blanco-Jerez & Saiz-Ruiz, 1996; DeCaria, Begaz & Hollander, 1998a), *dopaminergic* (reward regulation) (increased release of dopamine) (Berg, Eklund, Sodersten & Nordin, 1997) and *noradrenergic* (mediating arousal) (increased noradrenergic activity) (DeCaria, et al. 1998a) systems, playing a role in impulsivity, mood disorders and impaired control.

A *genetic* predisposition is also suggested by family histories of problem gambling (Gambino, Fitzgerald, Shaffer, Renner & Courtnege, 1993; Winters, Stinchfield & Fulkerson, 1993; Winters, Bengston, Dorr & Stinchfield, 1998), through twin studies (Eisen, et al. 1998; Slutske, et al. 2000), and genetic research (Comings, et al. 1996, Ibanez, Perez de Castro, Fernandez-Piqueras & Saiz-Ruiz, 2000; Comings, et al. 2001). EEG (Goldstein, Manowitz, Nora, Swartzburg & Carlton, 1985) and neuro-imaging studies utilizing PET scans and MRI's (Goyer, Semple, Rugle & McCormick, 1999; Potenza, 2001) show significant differences between pathological gamblers and normal controls. It is also emphasized that pathological gambling is not a single gene disorder, and that mutant genes are not disease-specific but rather associated with a spectrum of interrelated disorders.

In genetic studies of pathological gambling, Comings, et al. (1996) demonstrated that, compared with controls, gamblers were significantly more likely to have the

A1 allele for the dopamine D2 receptor gene, which proved a significant risk factor in pathological gambling. The more severe the gambling pathology, the more likely they were to possess the abnormality. This genetic variant has also been found more often in individuals with impulse control disorders and has been associated with reduced D2 receptor density and deficits in dopaminergic reward pathways. Of note, 76.2% of pathological gamblers who were co-morbid alcohol abusers carried the gene compared to 49.1% of males without co-morbid alcohol abuse or dependency. It is hypothesized that a lack of D2 receptors cause individuals to seek pleasure-generating activities, placing them at high risk for multiple addictive, impulsive and compulsive behaviours, including substance abuse, binge eating, sex addiction and pathological gambling. The discovery of a link between the D2A1 allele and impulsive-addictive-compulsive behaviours such as pathological gambling may also have implications for pharmacological treatment. Blum, Sheridan, Wood, Braverman, Chen, Cull and Comings (1996) speculate that pharmacological sensitivity to dopaminergic agonists may be determined in part by DRD2 genotypes and that carriers of the A1 gene would be more responsive to D2 antagonists.

Since serotonin has been implicated in the regulation of impulsivity and compulsivity, noradrenaline in the mediation of arousal and novelty seeking, and dopamine in reward and reward dependency, the above findings, albeit preliminary, are of significance. Rosenthal (2004) believes that all three neurotransmitters are involved in pathological gambling, but at different stages of the gambling cycle. Thus, anticipatory arousal may be linked to the noradrenergic system, the “high” of the actual gambling episode associated with the serotonergic system, and difficulties extinguishing the behaviour under the aegis of the dopaminergic system.

It is important to take note that these deficits could be a consequence of gambling or it could point to a prior dopamine deficiency that would make people vulnerable to a gambling addiction. While prolonged use or exposure to an

addictive substance or an activity like gambling may cause depletion of dopamine or other neurotransmitters, it is also possible that the deficiency occurred first and created the vulnerability for addiction. The primary deficiency could be related to genetic factors, early trauma or other environmental conditions, or another disorder such as depression (Rosenthal, 2004).

### 3.2.2 Neuropsychological vulnerability

According to Blaszczynski (2002), this subgroup of pathological gamblers describes highly disturbed individuals with substantial psychosocial interference from gambling and is characterized by signs suggestive of neurological or neurochemical dysfunction. This subgroup also possesses both psychosocial and biologically based vulnerabilities. However, this group is distinguished by disorders of *impulsivity* and *antisocial personality* (Steel & Blaszczynski, 1996; Blaszczynski, et al. 1997) and *attention deficit* (Rugle & Melamed, 1993), manifesting in severe multiple maladaptive behaviours and impulsivity affecting many aspects of the gambler's general level of psychosocial functioning.

### Attention Deficit Hyperactivity Disorder

The hyperactive subtype of Attention Deficit Hyperactivity Disorder (ADHD) is a developmental disorder characterized by impulsivity that commences in childhood and is often found in conduct disorder and anti-social personality behaviours. Researchers have argued that there are similarities between problem gambling and children with Attention Deficit Disorder (ADD) (Goldstein, Manowitz, Nora, Swartzburg & Carlton, 1985) in that both are characterized by limited attentions spans, impulsive behaviour, inability to delay gratification and insensitivity to punishment. Petry (2001) also found a significant association between impulsivity, *substance abuse* and pathological gambling. Rugle and Melamed (1993) concluded that childhood differences in behaviours related to over-activity, destructibility and difficulty inhibiting conflicting behaviours are of primary importance in differentiating gamblers from controls. They suggested that at least attention deficit-related symptoms reflecting traits of impulsivity are

present at childhood and predate the onset of pathological gambling behaviour. This biological vulnerability weakens behavioural control not only in the domain of gambling but also in other areas of life. This gives rise to the hypothesis that impulsivity proceeds and is independent of gambling and functions as a good predictive factor for severity of involvement in at least a subgroup of gamblers. Recent psychobiological evidence suggests that such traits can be directly linked to deficiencies in the production of certain neurotransmitters thought to be associated with impulse control. One of these substances is serotonin (5-hydroxytryptamine: 5-HT), which has an inhibitory effect upon the cortex and is associated with more controlled behaviour (McGurrin, 1992).

### Impulsivity

It is possible that biologically based traits of impulsivity may create a subset of gamblers who manifest differential responses to reward and punishment, characterized by a marked propensity to seek out rewarding activities, an inability to delay gratification, a dampened response to punishment and failure to modify behaviours because of adverse consequences (Blaszczynski, 2002). Kruegelbach and Rugle (1994) found gamblers to be more impulsive than cocaine addicts or alcoholics, and also found that, at least for a subgroup of pathological gamblers, high impulsivity preceded the history of gambling problems. Potenza (2001) found that the gambling urges of the problem gambler activate the same regions of the brain (e.g. the anterior cingulate) as the cocaine cravings of people with chemical dependence.

### Anti-social personality disorder

According to Blaszczynski and Nower (2002), gamblers with a background history of impulsivity engage in a wider array of behavioural problems independent of their gambling, including substance abuse, suicidality, irritability, low tolerance for boredom and criminal behaviours. In an interactive process, the effect of impulsivity is aggravated under pressure and in the presence of negative emotions. These people view the world as a competitive place, they

are self-confident and do not depend on others. They dislike authority and being controlled. They are impulsive and mistrustful, tend to avoid emotional engagement, lack empathy and use people for their own purpose. Poor interpersonal relationships, excessive alcohol and drug experimentation, non-gambling-related criminality and a family history of antisocial and alcohol problems are characteristics of this group. Gambling commences at an early age, rapidly escalates in intensity and severity, may occur in binge episodes and is associated with early entry into gambling-related criminal behaviour. These gamblers are less motivated to seek treatment in the first instance, have poor compliance rates and respond poorly to any form of intervention. Blaszczynski and Nower (2002) have labeled these gamblers the “antisocial impulsivist subtype”.

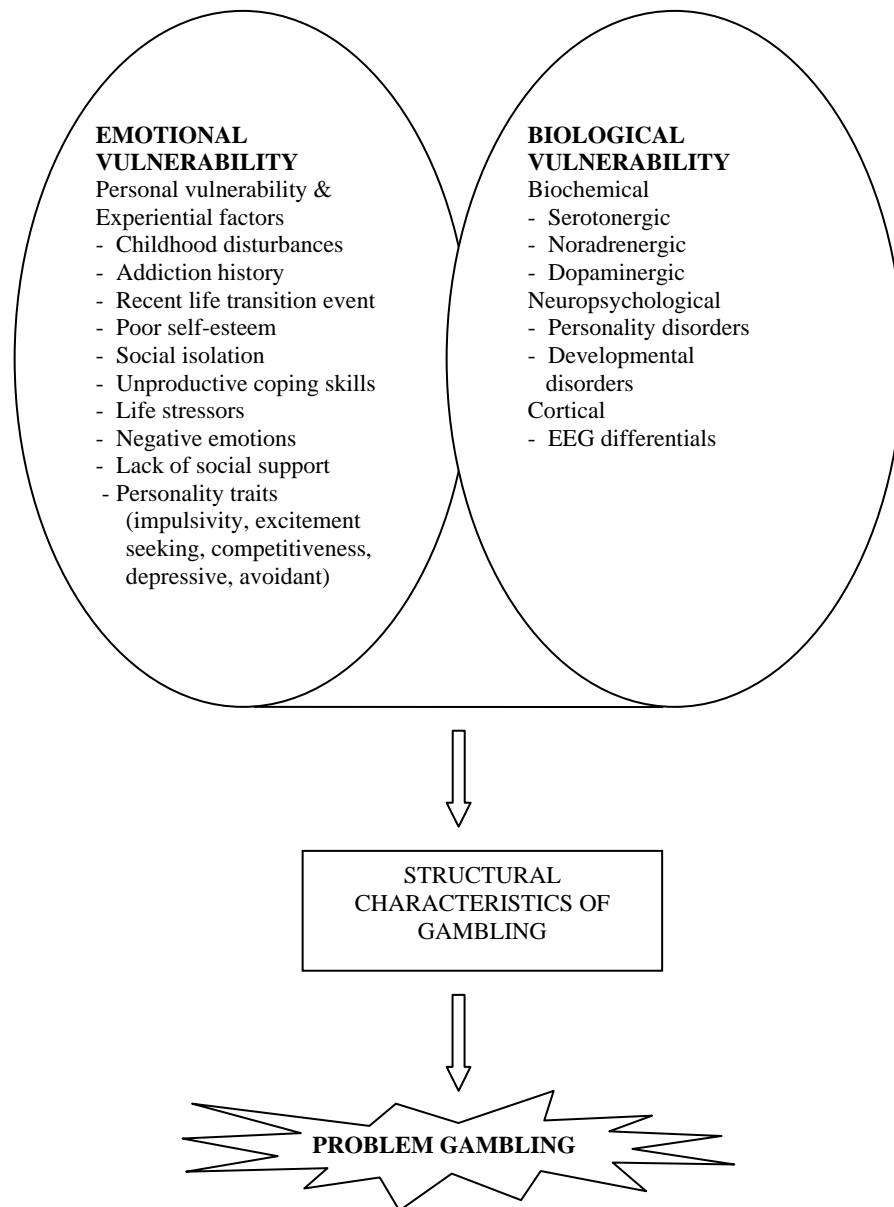
Thus, there are a number of studies that point toward the importance of biological factors in gambling addiction. Determining the biological vulnerability has implications for pharmacological treatment as medication can help to achieve abstinence and can help provide the much-needed structure and support necessary to maintain some patients in treatment.

### 3.3 TYPE II – THE EMOTIONAL VULNERABLE GAMBLER

#### **Type II – Emotional vulnerability** (Figure 3.2)

- Emotional vulnerability (e.g. recent life transition event, poor self-esteem, social isolation, unproductive coping skills, life stressors, negative emotions, lack of social support) can precipitate a gambling problem. Gambling becomes a reactive method of unproductive coping with the negative emotions by producing stress relief and emotional escape through the effect of dissociation on mood alteration and narrowed attention.
- Certain personality *traits* (and not disorders) (e.g. impulsivity, excitement seeking, competitiveness, depressive, avoidant) can predispose a person to problem gambling.

- Emotional vulnerability (e.g. childhood disturbances, addiction) might lead to more chronic psychological disorders (e.g. depression, anti-social, impulsivity, ADHD) which can result in neurobiological impairment (without a codependent vulnerability).



**Figure 3.2 : The emotional vulnerable gambler**



According to Blaszczynski and Nower (2002, p.493), the emotional vulnerable gambler as presented in Figure 3.2 presents with pre-morbid anxiety and/or depression, poor coping and problem-solving skills and negative family background experiences, developmental variables and life events. These factors each contribute in a cumulative fashion to produce an “emotionally vulnerable gambler”, whose participation in gambling is motivated by a desire to modulate affective states and/or meet specific psychological needs.

From what I have experienced in practice with this sub-group is that gambling becomes a reactive method of distraction from everyday problems, a way of avoiding dysphoric states such as loneliness, boredom, anxiety, depression and stress. As more problems arise from gambling, dysphoric moods increase, leading to a cycle of “escaping” through gambling, with resulting financial loss and family problems and dysphoric mood. Psychological dysfunction in this subgroup of gamblers necessitates treatment that addresses the underlying vulnerabilities as well as the gambling behaviour. I would however like to add that the psychological vulnerable gambler can present with or without a codependent style. Initially these two groups might present with a similar history and symptoms which makes it hard to differentiate between these two subgroups. It might then necessitate some kind of formal measurement to establish the existence of codependency traits. It is important to differentiate between these two subgroups as it has implications for long term treatment and relapse prevention. The following is a description of the emotional vulnerable gambler without a codependent style.

### 3.3.1 Personal vulnerability and experiential factors

Jacobs (1988), in his general theory of addiction, postulated that certain personality characteristics and life events, interacting with physiological states of arousal, are instrumental in influencing the development of gambling problems. He states that excessive gambling is produced by the interaction of two sets of

predisposing factors: abnormal physiological resting states of hyper- or hypo-arousal states, and a history of negative childhood experiences.

Personal vulnerability is linked to childhood experiences of inadequacy, inferiority and low self-esteem (McCormick, Taber & Kruedelbach, 1989). Research reveals disturbances during childhood related to problem gambling, such as loss of a close family member due to divorce, separation or death (Whitman-Raymond, 1988). Experiences of abandonment, rejection, emotional neglect and physical abuse have also been reported in qualitative studies (Rich, 1998; Whitman-Raymond, 1988). These findings are consistent with psychodynamic theories of gambling (Rosenthal & Rugle, 1994) and the Walters lifestyle model of gambling (Walters, 1994). Specifically, early parental deprivation and neglect while growing up and an ambivalent relationship with one's father are frequently noted in the psychoanalytic literature as significant aspects of problem gamblers' childhoods (Rosenthal & Rugle, 1994).

In addition to the genetic link, a child growing up in an environment where both, or one of the parents suffer from a gambling problem, there are other emotional aspects – besides codependency - which need to be taken into consideration. For example, a child's attitude towards money begins early in life. Children of problem gamblers experience the rush of the big win when the parents come home laden with presents and good cheer. Life is good! The message is twofold: *Money is to be spent and money is love*. There is also little internal value placed on how money is attained. Money is, in and of itself, the goal. Money enhances our self-esteem. Money gives us satisfaction. Money is success. We know that early life experiences have a profound effect on the way that the brain constructs itself, and furthermore, that the associations between emotional states and certain experiences are deeply ingrained in the brain pathways. This leads the child to associate, often unconsciously, the experience of gambling with emotional happiness.

As is found in the lives of people with mood disorders life stress plays a contributing factor. According to Jacobs (1888) problem gambling develops out of the need to obtain relief from a stressed state, be it noxious feelings of inferiority, guilt, rejection, and/or inadequacy, recurring dysphoria/depression and chronic under stimulation, or a combination thereof. Depressed pathological gamblers experienced a significantly greater number of negative life events before the onset of their gambling compared to control subjects (Blaszczynski and Nower, 2002). Individuals who suffer from such negative affective states may turn to gambling in a reactive attempt to *regulate their experiences*. The intense focus and concentration on gambling may serve to push unpleasant aspects of life out of awareness so the activity allows gamblers to “self-medicate” or “dissociate” from the condition of stress. Gambling becomes a conscious reactive attempt to avoid distressing feelings. In addition, everyday life stress is an issue that both men and women have to deal with - we live extremely stressful lives. Especially here, it is important to take into consideration the changing role of women in our society. The demand to be “Superwomen”, juggling family and career, has created a whole new set of problems for women who feel that they should, but do not, measure up – resulting in exhaustion, frustration and depression. Stress is increasing for women at a rate that places stress levels above those of men (Grant, 2002) and the greater burden on women to provide care, affects the health of women rather than men. If female problem gamblers, in particular, are deliberately choosing to gamble to escape dysphoric emotions their gambling could fundamentally be seen as a form of coping, albeit a maladaptive form. The Folkman and Lazarus (1988) model of stress proposes that individuals appraise potential stressors and search for a coping strategy to reduce the threat. These strategies can range from active attempts to “solve the problem”, through to emotional responses, help-seeking or attempts to escape from the situation, either physically or mentally. Therefore, coping resources are theorized to mediate the impact of stressors (Billings & Moos, 1984), although it is clear that some strategies will be more effective than others. Avoidance or escapist

coping refers to activities or cognitions used by people to divert attention away from a source of distress (Folkman & Lazarus, 1988). This method of coping is very common and can range from culturally acceptable activities such as jogging to destructive behaviours such as taking drugs or alcohol (Folkman & Lazarus, 1988). It is possible that gambling could be used in a similar way to divert attention away from a distressing issue. In this context, gambling is viewed as a reactive means of producing stress relief and emotional escape through the effect of dissociation on mood alteration and narrowed attention (Anderson & Brown, 1984).

General dissatisfaction is one of the primary ingredients of both depressive states and boredom, two important risk factors for the development of problem gambling. Therefore, it could be that those who feel that their daily life is unrewarding, troublesome, or lacking in complex and novel stimuli – that is, individuals who feel dissatisfied with their lives – are at higher risk for excessive gambling. According to a study conducted by Dickerson, Haw and Shepard (2003), with regard to psychological predictors, increased levels of harmful gambling are shown to be related to increased levels of negative emotions, such as depression, anxiety and stress. Research suggests that mood and gambling problems appear to be inextricably linked. These findings were similar to a study conducted by Bulwer (2003). Short term negative emotions correlated significantly with impaired control over gambling. Quantitative research into problem gambling interestingly revealed evidence of elevated dysphoric states, such as depression, anxiety, stress, isolation, worries, boredom and loneliness in both male and female gamblers (Blaszczynski & McConaghy, 1988; Trevorrow & Moore, 1998). There is also strong empirical evidence to suggest that social support plays an important role in alleviating personal problems and problem gambling (Dickerson, et al. 2003; Bulwer, 2003). The conclusion made is that the effect of emotional stressors on problem gambling may be moderated by certain coping tendencies.

Dickerson (2003) found that those who maintain control over their gambling use significantly less of the type of coping strategies traditionally thought of in the literature as maladaptive, than those players who do not maintain control over their gambling. People who have high levels of control over their gambling activities prefer coping strategies that deal with the problem they are facing, for example, developing a plan of action, rather than non-productive coping strategies such as self blame, abuse, escape, confrontation or avoidance. In other words, the way people deal with life events and stressors is related to the way they deal with their gambling. People who maintain control over their gambling are able to set realistic time and monetary budgets and stick to them, and also staying away from gambling venues when it is felt that time/money spent is escalating. At the other end of the control scale, those people who are unsuccessful in their attempts to stick to time limits and monetary budgets experience feelings of anger and self blame. Also, the manner in which people cope with a recent distressing or disruptive life event such as relationship problems, divorce, retirement, death or career setback, do relate to harmful gambling. Gambling may legitimize the time spent in the company of others and provide a sense of belonging, social support and group solidarity through engagement in a parallel activity with other players. Unlike committed interpersonal relations, however, this camaraderie makes no claims for intimacy, which might cause discomfort in gamblers with underdeveloped coping skills in seeking social and emotional support.

In addition, players with higher levels of a personality described in terms of impulsivity and/or excitement seeking also reported higher levels of harmful gambling (Dickerson, et al. 2003). Indeed, it has been assumed for some time that certain psychiatric syndromes may be influenced by pre-morbid personality *characteristics/traits* (and not *disorders* as explained in the biological vulnerable gambler) and that these personality characteristics may interact with treatment approaches. Competitiveness and deferment of gratification are also personality characteristics associated with problem gambling. When evaluating the

“person-situation interaction” proposals (Kendrick & Funder, 1988), support is given to the investigation of competitiveness as a predictor of pathological gambling. This is based on two of the person-situation interaction assumptions. Firstly, Rausch (1977) in Parke, et al. (2000) highlights that a person’s personality trait can actually influence the environment and situation. Applying this to the gambling environment, competition in the shape of predatory slot machine gambling creates a competitive, potentially hostile slot machine arcade. Secondly, individuals choose to engage in environments that match their personality traits. From this, it is reasonable to speculate that gamblers with a high level of competitiveness will be attracted, comfortable and motivated to continue gambling in an environment that they perceive as competitive. In addition to the person-situation interaction, the idea of the competitiveness of the activity being a primary motivator to gamble is also supported. Shaffer (1998) postulated that men are more likely to develop problematic gambling behaviour because of their conventionally high levels of aggression, impulsivity and competitiveness. Based on such evidence, it is hypothesized that a gambler who is highly competitive will experience more arousal and stimulation, and be drawn to gambling as an outlet to release competitive instincts and drives. Competitiveness may be particularly relevant to pathological gambling when trying to understand why in the face of negative and damaging consequences, pathological gamblers persist in their self-destructive habit. Highly competitive individuals (gamblers) are more sensitive to social comparison with peers regarding their task performance (Parke, et al. 2000).

Parke, et al’s. (2000) study showed that a low level of deferment of gratification is also a risk factor for pathological gambling. Gamblers will often perceive their stake as having disproportionately less utility than potential money won. Furthermore, those with low levels of deferment of gratification are more inclined to aim to increase financial status through instantaneous means rather than aiming to improve their financial situation through employing a long-term strategy such as saving. One can also understand how a person with low levels

of deferment of gratification can be prone to developing pathological gambling by considering “chasing” behaviour once again. As a gambler incurs losses their financial situation deteriorates. A person with a low level of deferment of gratification is less inclined to try and recoup their losses through behaviour such as saving or foregoing luxuries. They are more likely to aim to alleviate any losses incurred by gambling further, and once again a vicious cycle ensues where as the situation deteriorates the need to recoup losses increases, leading to more gambling.

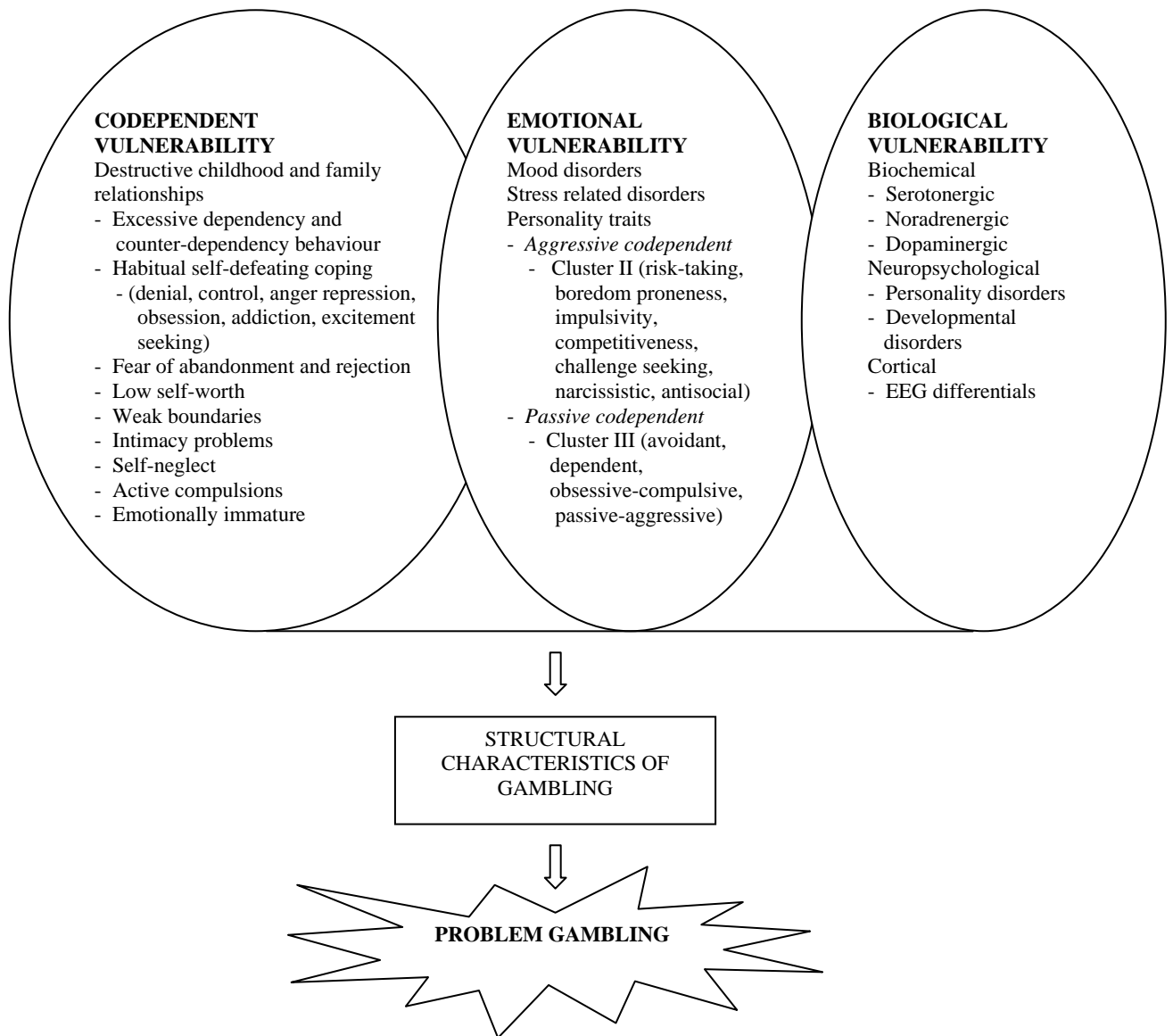
According to Dickerson, et al. (2003), the erosion of self-control arises from the player’s current number of *hours* spent gaming per week, the strength of the *emotion* they experience during play, made worse by any *mild* depressed or negative mood they “bring” with them to the venue and by a more impulsive personality. Excessive gambling can also cause serious problems by itself. Nevertheless, the gambling behaviour may also be seen, at least in some cases, as a symptom of experiential dysfunction that must be addressed along with the problematic behaviour. Furthermore, the clinician should not assume that the same experiential factors underlie problem gambling in all people. The importance of addressing particular experiential problems such as life dissatisfaction, loneliness of various kinds (e.g. social loneliness or emotional loneliness), sensation seeking, and other negative affective states will most likely vary between men and women, and between the codependent and non-codependent gambler.

### 3.4 TYPE III – THE CODEPENDENT VULNERABLE GAMBLER

#### **Type III – Codependent vulnerability** (Figure 3.3)

- The syndrome of codependency can predispose a person to develop certain personality traits, coping styles and/or mood/anxiety/stress disorders, which in turn can develop into a neurobiological impairment. The manifestation of these certain personality traits, coping styles and/or affective disorders can predispose a person to developing a gambling

problem. This can be described as an emotional predictor of problem gambling as a result of a person trying to cope with the difficulty of codependency. When this certain personality/coping style or mood disorder, possibly initiated by the syndrome of codependency, comes into contact with the structural characteristics of gambling, a potentially vulnerable gambler is created.



**Figure 3.3 : The codependent vulnerable gambler**



Codependency remains an extremely complicated syndrome and research work on codependency and the related subject of addiction remains controversial and is by no means accepted by all psychiatrists, psychologists and doctors. Until recently, codependency was very difficult to treat as few professional therapists had received relevant training, and there were no treatment centers or self-help groups. This has however changed. Codependency is now increasingly being recognized as a progressive syndrome, intimately related to addictions of all kinds. There are still few centers where people can be treated for codependency, and many health professionals do not acknowledge the term. However, many people whose gambling problems have remained a mystery for years, can now possibly be more successfully treated, once they understand the impact of codependency, and can relate it to certain events and behaviours in their own home. The syndrome of codependency might be the empirically “invalid” missing link in the search for causes and vulnerabilities of problem gambling related to effective treatment approaches.

#### 3.4.1 The missing link?

Research clearly demonstrates that there are high levels of co-morbidity amongst problem gamblers that blur the boundaries between discrete diagnostic categories (Crockford & el-Guebaly, 1998). The most common disorders found are part of an affective disorder spectrum including depression and anxiety. Efforts to determine cause or effect have yielded mixed results. Although the sample sizes in many studies are small, these findings indicate that many pathological gamblers display additional psychiatric disorders, which may contribute to problem gambling and which are often amenable to psychopharmacological treatment. Little attention has been paid to the presence of pathological gambling amongst patients with codependency syndrome. This may be a function of a low awareness of the potential link between the two disorders. Studies on psychiatric comorbidity conducted by Crockford and el-Guebaly (1998) and Bulwer (2003) concluded that pathological

gambling was associated with psychiatric comorbidity of mixed types including substance abuse, mood, anxiety, attention deficit, hyperactivity, eating and dissociative disorders. According to Bulwer's (2003) study 31% of treatment seekers reported an existing alcohol problem, 12% an eating disorder, 13% compulsive spending, 11% compulsive sexual behaviour, 6% recreational drugs and 3% prescription drug abuse. The reviewers concluded that based on the research to date, a significant comorbidity with depression is probable, although they note serious methodological shortcomings in the research prevent firm conclusions from being made. There is some support for the hypothesis that pathological gambling may be part of an "affective spectrum disorder". Could this possibly have its origin in the syndrome of codependency?

The experiential world of individuals who are struggling with gambling problems remains sparsely mapped. As discussed above, Blaszczynski (2002) developed a pathways model that proposed three distinct subgroups of gamblers manifesting impaired control over their behaviour. I do however agree with Blaszczynski to some extent on these different pathways, but from my experience with problem gamblers I believe that there is a blind spot related to the biopsychosocial vulnerabilities of problem gamblers that prevents us from treating this addiction effectively.

Throughout the years of counseling problem and pathological gamblers, I became more and more aware of the negative internal states as well as *interpersonal difficulties* of these gamblers. *The manner, in which problem gamblers experience their lives and themselves in relation to others, may play a crucial role in the development and/or maintenance of their gambling.* Negative interpersonal experiences in developing and/or maintaining problem gambling is a reality which cannot be ignored. Interpersonal (relationship) difficulties in problem gamblers became abundantly clear to me. I soon realized that these difficulties manifested in many gamblers' personal histories and necessitates long term treatment that addresses the underlying vulnerabilities, as well as the

gambling behaviour. As I started addressing this with many problem gamblers, clear symptoms of the syndrome of codependency crystallized. In addressing the symptoms of codependency, the long term treatment outcome was positively surprising and I experienced patients to be more committed to counseling treatment.

### 3.4.2 The meaning of codependency in a historical context

The conceptualization of codependency as a putative mental disorder amenable to diagnosis and treatment emerged as an issue in the last quarter of the 20<sup>th</sup> century. Originally, codependency reflected a view of human behaviour that the foot soldiers in the war against drugs brought with them. That view was formed in the Twelve-Step culture of Alcoholics Anonymous and Al-anon (Staub & Kent, 1973). It referred to a recognizable pattern of behaviour and attitudes characteristically found in family members of an alcoholic (Cermak, 1986). At the heart of the pattern was *enabling*, which connotes aiding and abetting an addicted person's behaviour through over-zealous helping (Frank & Golden, 1992). But as recruits from the Twelve-Step tradition became health-care providers, the meaning of codependency changed.

The growing health-care presence of the Twelve-Step tradition sparked the interest of popular culture. Talented speakers and writers found a surprisingly large market for codependency workshops and literature, and established a profitable cottage industry to address the demand. Rich narratives on the subject were published (Black, 1981; Friel, Subby & Friel, 1984; Potter-Efron & Potter-Efron, 1989). The scope and prevalence of codependency mushroomed in concert.

Academic interest may have made matters worse. The academic community developed a heuristic interest in codependency as the construct flourished in the popular media. Social scientists sought to fit the construct they found in the popular literature to academic theories of human behaviour (Collins 1993;

Gemin, 1997; Rice, 1992), feminist scholars sought to deconstruct codependency as a page in the text of oppression authored by men to subordinate women (Asher, 1992; Collins, 1993), and methodologists designed self-report measures to operationalize codependency for empirical research (Clark & Stoffel, 1992; Crothers & Warren, 1996; Fischer & Crawford, 1992).

According to Benshoff and Janikowski (2000), there is a growing, practical concern about developing a scientifically valid definition for codependency and its prevention, diagnosis and treatment. Increasingly, both private and public funders of dependence treatment are demanding greater selectivity in treatment admission, diagnosis and levels of care. Treatment must be based on an accurate diagnosis of client problems and planned in such a way as to deliver an effective outcome in the most efficacious manner. Many insurers are limiting the number of available treatment days or episodes, and they are requiring that all treatment be based on diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the American Society of Addiction Medicine (ASAM) diagnostic and levels of care standards, or the guidelines of the International Classification of Diseases (ICD-10). However, codependency is not a recognized disorder under any of these classification systems. Some treatment centers have offered codependency treatment services to families by wrapping the costs of these services into the overall costs of individual care. Other centers have diagnosed family members, often inappropriately, with psychiatric diagnoses to bill for family codependency services. Adjustment disorders of adulthood or childhood and depressive disorder diagnoses have also been used in this way. Paradoxically, addiction counselors may be more reliable judges of codependency than psychiatrists and psychologists are of the Axis II personality disorders that appear in the DSM-IV. Research conducted by Harkness, Swenson, Madsen-Hampton and Hale (2003) indicated that the "diagnosis" of codependency by addiction counselors may be reliable and valid and that this distinction appears to have clinical significance.

With the emergence and explosion of problem and addictive gambling worldwide where we are left with so many unanswered questions and possible hypotheses and theories, could it be that one of the vulnerabilities and pathways to problem and addictive gambling lie in the “unacknowledged” and excluded syndrome of codependency, and that we are ignoring the clinical significance of this syndrome? As the world around us changes with vast and huge technological advances and development that facilitate new addictions, should we not adapt to these changes and be looking at the possible adoption of a new diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, instead of trying to fit new psychological phenomena into existing black boxes? Codependency connotes a relational problem between two or more people, and the DSM provides diagnoses only for mental disorders in individual persons, not for relational problems (Francis, First, Widiger, Miele, Tilly, Davis & Pincus, 1991). Research has proved that addiction counselors know codependency when they see it (Harkness, et al. 1997). In conducting this study, I would like to be cautiously optimistic that it will stimulate challenging replications by other addiction specialists and encourage new lines of research related to the significance of codependency in problem and addictive gambling.

#### 3.4.3 Defining codependency

Reviewing the professional literature for a core definition, Morgan (1991) found six conceptualizations of codependency:

1. An emotional, psychological and behavioural condition.
2. Interpersonal reactivity and obsession with interpersonal control.
3. Learned self-defeating behaviours.
4. Suffering associated with attending to others.
5. An addictive disease.
6. A preoccupation with others characterized by extreme dependency.

To these definitions, Cermak (1986) added one more, conceptualizing codependency as a possible personality disorder that should be diagnosed on the basis of five signs and symptoms:

1. Deriving one's own self-esteem from the feelings and behaviour of others.
2. Subordinating one's own welfare to the welfare of others.
3. Impaired judgment and stress in close or distant interpersonal relationships.
4. Interpersonal relationships with individuals that most persons seek to avoid.
5. Companion disorders of mood, anxiety, substance-abuse and health status.

Fischer, Spann and Crawford (1991) describes codependency as a psychosocial condition manifested through a dysfunctional pattern of relating to others characterized by an extreme focus outside of the self, lack of open expression of feelings and attempts to derive a sense of purpose through relationships. According to Stafford and Hodgkinson (2000), codependency is an emotional, psychological and behavioural condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules, rules which prevent the open expression of feelings, as well as the direct discussion of personal and impersonal problems. It develops in a person whose dependency needs were not met during early developmental stages, who is continually seeking validation of self worth and who attempts to recreate the parent/child relationship in other significant relationships. Codependency is a dependence on people and things outside the self, along with neglect of the person to the point of having little self identity. It involves a habitual system of self-destructive thinking, feeling and behaving toward themselves and others that can cause pain. Many codependents were raised in families where addictions existed, some were not. Many were later influenced by an addicted or codependent person. According to a pilot study conducted by Bulwer (2003),

8% of problem and pathological gambling treatment seekers' reported a mother with an alcohol problem and 27% reported a father with an alcohol problem; 17% reported a mother with a gambling problem and 19% reported a father with a gambling problem. Although it often manifests itself around some form of chemical dependency, codependency could also surface when there is not substance abuse of any kind. In either case, the reality in codependents' lives is that codependency is a deeply rooted compulsive behaviour and that it is borne out of sometimes moderately and sometimes extremely dysfunctional family systems.

What is common to all the above approaches is the conviction that codependency exists - independent of a drug dependent family - and that many of its manifestations become more overt in the context of a committed relationship. While the diagnosis of codependence has been of pragmatic value in the alcoholism field, it has not been integrated into the standard nomenclature set forth in the Diagnostic and Statistical Manual of Mental Disorders. Also common to all these definitions is that little attention has been paid to them by professionals outside the substance dependence field.

#### 3.4.4 Recognizing codependency

At first, people now known as "codependents" were called "enablers". They would always welcome back an alcoholic from a drunken bout, feed and clothe a heroin addict, make sure a gambler had a hot meal, a home and money. "Enabling" battered wives would frequently allow a husband addicted to violence back into the home, believing – or at least wanting to believe – his promises that abuse would never be inflicted upon them again. Not that there is anything wrong with being supportive or loyal, but such behaviour becomes codependent when it is misplaced, when balanced judgment is lost and the support or loyalty continues when it is not deserved or appropriate.

Codependents are relationship addicts and it affects both sexes and has no relation to standard of education, intelligence or social backgrounds. A codependent needs people in the same way an alcoholic needs a drink. Codependency is an addiction to a person and that person's problems. They use people in much the same way a dependent person will use alcohol or gambling and, like other addicts, they need to achieve a high. They get their buzz of high from feeling useful, needed and wanted and an almighty low letdown when they sense they are not being appreciated enough. They put themselves out endlessly for others and then wonder why people are so often ungrateful, so dismissive and so nasty.

At the very heart of the codependent's problems is the deep-seated feeling that other people are aspects of themselves. In essence, a codependent cannot ever see what might be best for others, because he/she has become incapable of detaching and understanding clearly what the needs of others might be. They actually project their own needs onto other people. It is a pattern of learned behaviours, learned feelings and learned beliefs that make life painful. It is a dependency on people and things outside of the self to the point of self-neglect. For most people, recognizing codependency is acutely painful because the condition flourishes on denial, as do all addictions. Codependents feel compelled to put other people first at the expense of themselves and deny their own reality and identity – they have no essence, no self. Codependents are doing their utmost to meet the needs of others instead of living their own lives. Although they may seem exceptionally caring, loving and unselfish, there is a different side to their behaviour – a side that perhaps they themselves find hard to acknowledge. Although they appear to be pushed around and manipulated by those close to them, they are actually trying to exert some kind of control over the actions of their loved ones. They are being compelled by a strong inner voice which says: "If you are needed by others, they will never leave you". They tend to equate need with love so that they can feel loved only if they are deeply needed. Codependents feel powerless to run their own lives. Having



only a very hazy notion of who they are, it becomes easier to define themselves in terms of their roles or relationships to other people.

Codependency is unhealthy and brings about much chronic illness because it is a stressful state. Stress related disorders can lead to cancer, heart disease, lowered immunity, resistance to infections, high blood pressure, ulcers, sleep disorders, nervousness and an inability to express intimacy or sexuality are common. Codependents always feel nervous inside. They have little self-confidence and almost no sense of identity. They are frantic worriers, take excessive responsibility for others and can never relax. Helping others gives them a false sense of security and self-worth. Emotional problems such as depression, anxiety, insomnia and hyperactivity are evident in many codependents. According to Bulwer (2003), 38% of treatment seekers had previously (before entering treatment) formally been diagnosed with depression, which was also much more common among females; 57% of females were diagnosed with depression compared to 27% of males. The most common consequence of codependency is depression and anxiety, very often severe. Another frequent consequence is active addiction, whether to alcohol, shopping, food, gambling or prescribed or street drugs. Some of the codependency or dependency disorders are: perfectionism, work holism, procrastination, compulsive overeating, compulsive gambling, compulsive lying, compulsive talking, dependent relationships or over possessiveness in relationships. According to Bulwer's (2003) study of treatment seekers, 60% were dependent on cigarette smoking, 31% on alcohol, 12% reported a compulsive eating problem, 13% compulsive spending, 11% to compulsive and promiscuous sexual behaviour, 6% to recreational drugs and 3% to prescription drugs. Other dependency disorders can be dependency on status, prestige, material possessions, power or control, to the extent that one's behaviour causes problems in social interactions with family members, co-workers, friends and authority figures. Like all compulsions, codependency is a progressive condition and will get steadily worse unless it is addressed. It will not clear up of its own

accord. And, because it is so debilitating with so many negative reverberations, it needs to be replaced with healthy ways of relating.

#### 3.4.5 How does codependency start?

According to Stafford and Hodgkinson (2000) codependency is passed down from parents to their children in everyday interaction. Nobody is actually born codependent. It is a learned behaviour which has its origin in destructive and dysfunctional family relationships. These are the families where there is a lot of covering up and pretence – where nothing is what it seems. Many such families harbour what they regard as a shameful secret. Dad drinks a lot or gambles, or Mum is on tranquillizers. There may be rows, escalating into violence. Perhaps, more devastatingly, there is sexual abuse. Maybe there is a drug addict in the family. The concept of shame is central to understanding codependency. Enormous efforts are usually made to pretend that everything is normal and that it is an exceptionally happy and close-knit family. So there is always an ongoing cover-up which prevents family members having a strong sense of personal identity. How can you learn to be yourself when you have had to play a false part from your earliest years?

The experience of growing up in a home where problem gambling is present is different from that of a child that is raised in a functional home environment. This experience disturbs and interferes with a child's normal development. Very often a lack of a stable environment disturbs the development of trust in the child's environment and can lead to a lack of personal identity, which is vital for successful maturity. Problem gambling affects every member of a family on a psychological, behavioural and social level. One individual in the family might be the gambler but the whole family suffers the consequences. The impact of problem gambling on the welfare of the gambler's partner, children and family can be extensive. The consequent financial difficulties in particular cause strain and friction within the family. The more severe the gambling problem the more the suffering of the family. The partner often experiences a sense of betrayal,

anger or despair and may suffer stress-related disorders. Children in such living circumstances suffer considerably when exposed to a climate of tension, arguments and hostility, leading them to display signs of disturbed conduct and behaviour. The child responds with confusion, depression and a sense of low self-worth. The gambler is often absent (from home and work) but when present, is irritable, edgy and withdrawn. Constant arguments between partners create an environment of tension and fear. Tragically, some studies have shown that possibly a fifth of problem gamblers perpetrate acts of child physical abuse or domestic violence against their wives (Blaszczynski, 1998). Continuous conflict in the home can lead to the child withdrawing and starting to avoid and ignore certain things. These children experience also very little real communication and expression of their emotions.

A family history of problem gambling may be one risk factor; however, it cannot be construed as a sufficient cause alone. Also, when a child is raised in an environment that is recognized by divorce, death, anxiety, abuse, depression or materialism, this child has very often never had the opportunity to develop proper functional emotional coping mechanisms to help him/her through difficult circumstances. When this child is faced with a crisis, it manifests very often in something like gambling, or some other addiction. Problem gamblers tend to deal with emotional distress by using defense mechanisms of distraction and rationalization. In other words, like other types of addicts, they have a lot of problems coping with their emotions.

Jacobs (1988), Lesieur and Rothschild (1989) and Gambino, Fitzgerald, Shaffer, Renner and Courtage (1993) each reported strong evidence that a family history of pathological gambling is an important predisposing risk factor for children. In Gambino, et al's. (1993) study, subjects with parents identified as problem gamblers were three times more likely to be problem gamblers; that figure increased to 12 times the risk when both parents and grandparents were problem gamblers. Bulwer (2003) reported that 17% of treatment seekers

reported a mother with a gambling problem and 19% reported a father with a gambling problem.

Most families have “skeletons” in the cupboard, but in homes which breed codependency the skeletons are not allowed to come out, help is not sought. Because children from such a background feel they have to pretend that everything is fine, they are always on their guard and never learn to relax and be themselves. So, they grow up never having learned how to be themselves or even what their true identity is. What causes the problem of codependency is denial that there is anything wrong – denial that the children have anything but a loving and nurturing home, denial that the parents are anything but perfect. As children, this denial becomes a form of survival, as it helps them cope. Children of dysfunctional homes enter adulthood coping with life in the same ways that proved valuable to them as children. They take their childhood roles, survival strategies and rules with them into adulthood. Because codependents do not know how to get their basic needs met, they use other things, either chemicals, behaviour, places or people to try and remedy the situation. But, unless they can address the basic dilemma, their sense of self-esteem and self-worth will remain low.

According to Stafford and Hodgkinson (2000), there will always be at least two significant factors in homes which breed codependency:

1. The parents will, in important ways, either emotionally or physically, not be properly there for the children.
2. The children though, will be there for the sake of the adults.

This is why in adulthood there is an over-identification with other people. Codependents basically focus on other people’s problems to avoid having to look at their own. They try to change others but never attempt to change themselves. Because codependents are so terrified of rejection and

abandonment – associated with their needs not being met as small children – they tend to take jobs and form relationships where rejection will not be an issue. Codependents' feelings of self-worth are so low that they are certain they will be rejected before long, so they also tend not to stay in jobs, or take jobs at less than their true abilities. All the feelings of low self-worth and low self-esteem, the perception that one is not worth anything unless helping somebody even more needy, is at the heart of codependency. Having received very little emotional nurturing, the codependent tries to fill this unmet need vicariously by becoming a care-giver, especially to any person who appears in some way needy. Helping others give codependents a false sense of security and self-worth. They often develop unhealthy relationships that eventually become unbearable. The paradox here is that codependents really fear relationships, because of their bad track record at home. But, they continually search for them. In the relationship, they fear abandonment and rejection, or they are chronically angry. But outside of a relationship they feel empty and incomplete. This is because their self-esteem is critically low and deep inside there is some sort of belief that they do not deserve the love they seek – they do not deserve to be happy. They may be predisposed emotionally and often biochemically to becoming addicted to drugs, alcohol and/or certain foods. They have a tendency toward episodes of depression, which they try to forestall through the excitement provided by unstable relationships.

In a healthy family, members can talk, can feel and they can tell the truth. Living in an environment where one feels as if they are constantly “walking on egg shells” and “waiting for the other shoe to drop” causes a great deal of stress and anxiety. This stress/anxiety is heightened when there are rigid, inflexible rules and belief systems imposed on people trapped in one of these families. As a result, the codependent develops habitual self-defeating coping mechanisms in an attempt to survive: such as - “my fear of rejection determines what I say or do” or, “I like to avoid your anger”. Further to this, these mechanisms cause the codependent to be out of touch with who they are because they have been in a

mind altering experience. Often, codependents have experienced in their own ways the painful trauma of the emptiness of their childhood and relationships throughout their lives. They attempt to use others, their spouses, friends and even their children as their sole source of identity, value and well being and as a way of trying to restore within themselves the emotional losses from their childhood. Their histories may include other powerful addictions which they have used to cope with their codependencies. The bottom line here is that those other addictions may possibly be symptoms of a codependency syndrome.

Codependency is multi-generational and can be present even when there is no active drinking or drug use – or – many were later influenced by an addicted or codependent person. Codependency is a disease which has, as its basis, a dysfunctional family of origin. Non-alcoholic ways in which parents may not be “there” for the children can include:

- gambling addiction
- violence and sexual abuse
- work holism
- tranquilizer addiction
- womanizing
- chronic invalidism
- frequent journeys abroad
- death
- suicide
- being unemployed or unemployable
- frequent hospitalization
- mental or physical handicap
- excessive religiosity
- rigid rules and regulations
- homes where children are never allowed to be themselves, but must always be pleasing the adults

This is not to say that everybody who has had these experiences will become codependent. Codependent ways, like other forms of dysfunction, exist on a continuum with some that are strongly tied to these strategies and others that are a “little codependent”. All homes have problems; healthy ones admit them, codependent homes keep them under wraps. The reason for this is clear – the hope is that if the problems are never brought to the surface, they will simply go away. In fact, the opposite happens – they fester and get progressively worse. When problems are denied the fears and shame become submerged and repressed. They remain below conscious level and are liable to surface in inappropriate ways. You can have a chemically dependent home where the children escape codependency. But nobody can escape where there is denial of some form of human misery – even in teetotal, fundamentalist Christian homes where all self-indulgences such as alcohol, gambling and smoking are absent. Codependent children usually lack an emotionally safe environment where they can express their own emotions, needs, thoughts, and desires. They have learned that it is dangerous and painful to be honest about their thoughts and feelings. Rather than lead to any resolution, being open just seems to make matters worse.

The three stages of codependency are:

1. Early: In the early stage, the codependent learns how to cope and here the acceptance or rationalization of their addict's, parent's or spouse's behaviour takes place. They constantly try to help out and please this person.
2. Middle: The codependent develops habitual self defeating coping mechanisms. When the coping mechanisms do not work, the codependent does more and takes on more responsibility. They adapt

their behaviour to accommodate the other person. Their focus is on the other person.

3. Control: The codependent, in frustration, tries to control more and more aspects of the other person's life. This often leads to family collapse and a crisis in personal values. Codependency, at this point, is reduced to continual self-defeating behaviour.

The whole process is circular and rotates within the family from person to person. What needs to be done in treatment is help breaking the cycle.

Characteristics of codependent people are the following:

1. Caretaking (an overdeveloped or underdeveloped sense of responsibility)  
(Passive response to codependency – crying, hurt, helplessness)  
(Aggressive response to codependency – violence, anger, dominance)
2. Low self-worth and lack of identity (self-neglect)
3. Repression
4. Obsession
5. Controlling
6. Denial
7. Dependency
8. Poor communication
9. Weak boundaries
10. Lack of trust
11. Anger
12. Sexual problems
13. Depression/Anxiety
14. Emotional, mental or physical illness
15. Addiction
16. Isolation



17. Approval seeking/compliance patterns
18. Excitement seeking
19. Fear of abandonment
20. Relationship dysfunction

As we can see from the above, nearly everyone has at least a couple of these symptoms. Many people struggle occasionally with their identity or with wanting to control others or with setting boundaries or trying to please. However, codependents do not just struggle with a couple of these occasionally. They consistently rely on a codependent style as their basic way of relating to themselves and others. Codependency is not about a relationship with an addict, but it is the absence of a relationship with the self. Codependency can be an over-involvement in relationships with others or it can be the avoidance of relationships. The avoidance may come from the fear of over-involvement, the fear of intimacy, the fear of abandonment or the fear of losing too much of oneself in a relationship. Independence is the opposite side of the coin of codependence. A person with codependency may adopt a posture of independence. A person who isolates from relationships is in as much pain as a person who becomes lost in relationships.

Thus, codependents generally have an excessive dependency on external cues and feel disconnected from many of their inner thoughts, feelings and needs. Since they are so concerned with what others expect and so out of touch with their own needs, it is not surprising that codependents are confused about their internal and external boundaries. While they take excessive responsibility for keeping the peace or pleasing others, they also may expend incredible energy trying to change the other person. Since they blame the other person for their unhappiness, they assume they have a right to try to change that person, and an excessive need for control develops.

Codependency research is in its infancy though it has been found to be related to self-defeating personality characteristics (Stafford & Hodgkinson, 2000). Five major characteristics of codependency have been outlined:

1. Continual investment of self-esteem in the ability to influence or control feelings and behaviour in the self.
2. The assumption of responsibility for meeting the needs of others to the exclusion of his or her own needs.
3. The suffering of anxiety in periods of intimacy or separation.
4. Emotional involvement in relationships with personality disordered, drug dependent and other compulsive people.
5. Constriction of emotions, depression, hyper-vigilance, compulsions and anxiety.

One important factor is that not everybody reacts in the same manner to the syndrome of codependency – there is no “one-size-fits-all” codependency that fits everyone. People cope with codependency problems in their own unique individual ways which can predispose them for developing certain personality traits or coping styles. In practice I have not yet come across one single personality disorder being the cause of problem gambling. **I believe that it is rather the manifestation of a combination of different personality traits, coping styles and negative mood states – possibly originated by the codependency syndrome - leading to a vulnerability in developing and maintaining problem gambling.** I have used these traits, as I have seen them manifesting in different types of gamblers, to form a profile of different types of gamblers – related to codependency. These personality traits will be grouped under the aggressive codependent and the passive codependent, and will be explained as follows:

#### 3.4.5.1 The aggressive codependent

In reaction to codependence many people become counter-dependent, defying or rebelling against authority, against intimacy, against law, against their own dependency needs. They reject dependency in themselves and others. Counter-dependence is a more aggressive posture than independence and involves a battle with the self in a system that creates more chaos and isolation. Sometimes counter-dependence is necessary to break out of the repression of being over-controlled. Adolescents, for example, become counter-dependent because their curiosity, creativity or being has been repressed or abusively controlled. It is a reactive codependent posture because it does not create true identity and facilitate integration and boundary development. Counter-dependence can be a posture of power, but it is not self-empowering and tends to destroy the power of others. Much acting out is counter-dependence. It seems that many of these codependency traits tend more towards the Cluster II personality traits which include histrionic, narcissistic, anti-social and borderline. According to Carson and Butcher (2000) individuals with these personality traits have in common a tendency to be dramatic, emotional and erratic. Their impulsive behaviour, often involving anti-social activities, is more colorful, more forceful, and more likely to get them into contact with mental health or legal authorities. Some of the traits of the aggressive codependent type that I frequently experience are, impulsivity, instant gratification, boredom proneness, competitiveness, sensation/challenge seeking, narcissistic, antisocial, risk taking, grandiose, control and obsessiveness. For this subtype, gambling usually commences at an early age and rapidly escalates in intensity and severity. These gamblers are less motivated to seek treatment in the first instance, have poor compliance rates and respond poorly to any form of intervention.

#### Anti-social and narcissistic behaviour

People displaying antisocial traits view the world as a competitive place, they are self-confident and do not depend on others. They dislike authority and being

controlled. They are impulsive and mistrustful, tend to avoid emotional engagement, lack empathy and use people for their own purpose. Poor interpersonal relationships, excessive alcohol and drug experimentation, non-gambling-related criminality and a family history of antisocial and alcohol problems are characteristic of this group.

According to Carson and Butcher (1992), individuals with narcissistic traits have feelings of superiority, strong beliefs in themselves, a dislike for being externally controlled, sociable, outgoing and have a propensity for showing anger or disappointment and a lack of empathy. The common components of narcissistic traits included a search for recognition, disregard for society's values and rules, and crimes committed because of rage or to avoid defeat. Individuals with narcissistic personality traits have a chronically fragile, low self-esteem and a strategy for asserting their own self-worth so that they and others do not recognize their own basic frailties. Their sense of entitlement is frequently a source of astonishment to others, although they themselves regard their lavish expectations as merely their just dues. By and large, they do not permit others to be genuinely close to or to become dependent on them. They behave in stereotypical ways (for example, with constant self-references and bragging) to gain the acclaim and recognition that feeds their grandiose expectations. These tactics, to those around them, appear to be excessive efforts to make themselves look good. Six areas of functioning are considered to be central to narcissistic traits: A narcissistic individual: -

1. has a basic sense of inferiority, which underlies a preoccupation with fantasies of outstanding achievement;
2. is unable to trust and rely on others and thus develops numerous, shallow relationships to extract tributes from others;
3. shows a superficial commitment to excellence – instead he or she has an aimless orientation toward superficial interests. Such a person is often

- socially charming and successful, however, and is preoccupied with appearances;
4. has a shifting morality – always ready to shift values to gain favour. He or she may, however show to the outside world a calculated sense of modesty;
  5. is unable to remain in love, showing an impaired capacity for a committed relationship. Consequently, marital instability and promiscuity are prominent;
  6. although he or she may impress others with knowledge and decisiveness, a narcissistic person's information base is often limited to trivia. Such a person characteristically shows "headline intelligence" knowing only sketchy details, yet is able to use language to enhance his or her self-esteem and impress others.

Narcissistic personalities share another central element – they are unable to take the perspective of others, to see things other than "through their own eyes". In more general terms, they lack the capacity for empathy, which is an essential ingredient for mature relationships. In this sense all children begin life as narcissists and only gradually acquire a perspective-taking ability. Some children do not show normal progress in this area, and indeed, in extreme cases, show little or none. The latter grow up to become adult narcissistic personalities.

*Profile of the aggressive codependent gambler (Type A)*

Personality traits (Cluster II)

- risk taking, boredom proneness, impulsivity, deferment of gratification, competitiveness, challenge seeking, narcissistic, anti-social

Counter-dependent

Underdeveloped sense of responsibility

"Child" in relationships

Ego and profit driven

Facade of self-confidence/low self-esteem (posture of power)  
 Action/sensation seeking, risk taking (sociable, out going - hypermanic behaviour)  
 Needs to appear in control and powerful (wants to gain control through gambling/money)  
 Strong denial patterns  
 Lack of trust  
 Approval seeking and strong need for recognition (undernourished ego)  
 Obsessive compulsive traits (no balance - extremists) (other addictions)  
 Competitive and image conscious (sensitive to social comparisons)  
 Sense of entitlement and unrealistic expectations of others  
 Emotionally immature (self-defeating behaviour)  
 Intelligent (amazing ability to intellectualize)  
 Procrastinates  
 Rebelling against authority figures and being controlled  
 Underlying depression and anxiety ridden  
 Grandiose expectations (fantasies of outstanding achievement)  
 Streetwise and manipulating ("conmen" – takes advantage of others inadequacies)  
 Poor frustration tolerance  
 Hostile, angry and aggressive  
 Background of behavioural problems and abuse  
 Poor interpersonal relationships (relationship instability and sexual promiscuity)  
 Shifting morality (due to fear of rejection)  
 Self-defeating behaviour  
 Prefers games of skill/action

#### 3.4.5.2 The passive codependent

It seems that this subgroup tends more towards the Cluster III personality type and includes personality *traits* such as avoidant, dependent, obsessive-compulsive, and passive-aggressive. Anxiety and fearfulness are very often

part of these personality styles, making it difficult in some cases to distinguish them from anxiety-based disorders (Carson & Butcher, 2000). Because of their anxiety and often depressive states, individuals with these styles are more likely to seek help. Gambling usually commences at a later age when the caretaking role is being threatened

### Avoidant

According to Carson and Butcher (2000) individuals with avoidant traits are hypersensitive to rejection and apprehensive of any sign of social derogation. Such individuals readily see ridicule or disparagement where none was intended. Avoidant people would like to relate to others but avoid social interactions because of the anxiety they cause. This character style is described as mistrustful, suspicious, feelings of worthlessness and desiring isolation, as well as low self-esteem, suppression of feelings and sexual inhibitions. Avoidant people are associated with being hypersensitive, shy and insecure. A gambling environment (casino) might prove to be a comfortable place for the person with an avoidant style. A person can visit a casino on his/her own, feel totally safe and secure, without having the concern of interacting with others. Gambling is an isolated activity where an illusion of social interaction can be created without feeling the pressure of having to interact with other people. This type of environment seems to fit the needs of an avoidant coping style.

### Avoidance coping and dysphoric mood

On the basis of case material (Lesieur & Blume, 1991; Loughnan, Pierce & Sagris, 1996; Pierce, Wentzel & Loughnan, 1997; Bulwer, 2003) it is implied that women's gambling may be differently motivated from men's gambling. They concluded that women use gambling to escape depressed emotions and personal and family problems, whereas men are more likely to gamble for excitement and financial gain. These studies suggest that gambling motivations may not be homogeneous across gender and that women may be gambling to temporarily escape negative moods and situations, rather than for excitement or

to win money. According to Bulwer's (2003) study, 38% of treatment seekers had previously (before entering the treatment programme) formally been diagnosed with depression, which was also much more common among females. 57% of females were formerly diagnosed with depression compared to 27% of males. Females were also more likely to obtain treatment (medication or counseling) for their mood disorder than males before entering the treatment programme ( $p = 0.001$ ), and 45% of the sample had suicidal ideation related to gambling. Interestingly, 19% of females had claimed to attempt suicide *not* related to gambling in the past compared to 5% of males while 13% of males had suicide attempts related to their gambling compared to 8% of females.

#### *Obsessive-compulsive and passive-aggressive behaviour*

According to Carson and Butcher (2000) individuals with obsessive-compulsive personality characteristics show excessive concern for rules, order, efficiency and work, coupled with an insistence that everyone do things their way. Such individuals tend to be over-inhibited, over-conscientious, over-dutiful and rigid, and have difficulty in doing anything just for fun. Individuals with passive-aggressive behaviour typically express hostility in indirect and non-violent ways, such as procrastinating, pouting, "forgetting" or intentionally inefficient. Passive aggressive individuals resent and manage not to comply with demands others make on them; the behaviour is most apparent in their work situations but also occurs in their social relationships. Resentment of authority figures, coupled with a lack of assertiveness, is typical – never confronting a problem situation directly.

People with self-defeating behaviour presents with a persistent involvement in disappointing relationships. They choose relationships or situations that lead to disappointment, failure, or mistreatment even though better options are available. These individuals appear to be almost magnetically drawn to punishing relationships and seemingly discourage or reject the attempts of others to help them extricate themselves from these painful experiences. They



fail to accomplish tasks or goals that are crucial to their personal objectives in spite of the fact that they have the ability to perform them. If they do achieve personal recognition or accomplishments, these individuals might react by feeling depressed or guilty or by engaging in some inappropriate behaviour rather than feeling self-enhanced as most people would. They are drawn to relationships in which they will suffer. Self defeating personality traits have a clear overlap with other disorders, such as avoidant, dependent and borderline personalities.

*Profile of the passive co-dependent gambler (Type B)*

Personality traits (Cluster III)

- avoidant, dependent, obsessive-compulsive, passive-aggressive
- Over-developed sense of responsibility (over-involved with everybody)
- Caretaking role ("parent" in relationships - addressing everybody else's needs)
- Lack of personal identity
- Controlling patterns (and has a need to lose control through gambling)
- Self-defeating behaviours (emotionally immature)
- Low self-esteem and weak boundaries
- Very trusting
- Victim mentality and feels neglected (experience emotional deprivation)
- Strong denial patterns
- Destructive interpersonal relationships
- Often the "enabler"
- Intimacy problems (lack of sexual desire)
- Poor self-image
- History of emotional or physical abuse
- Poor social/interpersonal skills (few friends/hobbies, lack of fun, lonely)
- Fear of abandonment/rejection
- History of depression, stress and anxiety
- Feelings of inadequacies and insecurity
- Unproductive/self-defeating coping style (avoidant, ruminative, escape)

Poor assertiveness skills

Resentful and confused

Feelings of powerlessness

Compulsive spending and eating/weight problem

Suicidal ideation and previous attempts

Prefers games of chance

More males tend to fall into the category of the aggressive codependent type and tend to be action gamblers – preferring games of skill. More females tend to fall into the passive codependent type and tend to be escape gamblers – preferring games of chance.

#### 3.4.6 The “interpersonal” link between codependency and problem gambling

*The Chase* (Lesieur, 1984) is one of the seminal works in the field of problem gambling. Its description of the gambler’s need to pursue money to cover losses in an ever narrowing spiral and repeatedly returning to gamble with increasing desperation to try and win back losses, depicts one of the key dynamics of pathological gambling. The financial aspects of chasing are certainly what many, if not most, pathological gamblers are focused on when they enter treatment. Some of the most common irrational beliefs among the gamblers I have treated are that “money will solve all my problems” and “if I win the big one, I will stop gambling and everything will be all right”. This, however, never happens. No matter how much money they win, it will never be enough, even though they cling tenaciously to the distorted belief that their gambling is about money.

What I find quite astonishing in practice is the gambling addict’s amazing ability for self-deceit - a very powerful denial system - a delusional belief system with (sometimes severe) cognitive distortions and disassociations. Such a person presents with a codependent syndrome/traits and has been using a highly sophisticated denial system and mind altering experience as a coping technique and a form of survival almost all of his/her life. This permitted the codependent

person to conduct his/her daily life in a quasi-normal way with the least anxiety, depression, shame or anger overwhelming them and in the long run, it is counterproductive. With an already sophisticatedly developed denial system in existence, the codependent person becomes vulnerable and capable of developing a more superior complex delusional belief system in the form of cognitive distortions and illusions if and when this comes into contact with the structural characteristics of gambling. This type of “magical thinking” is, most often than not, part of a pathological gambling problem – it becomes part of the “chase”.

For the codependent, gambling becomes a symbolic psychological way of replaying their childhood drama. As children they try and try to get the response they need from their parents, at least until they give up completely. But they remain always drawn to the same sort of familiar person – an emotionally unavailable person whom they can try to get love from – whom they can try to change. The need to replay the childhood drama and try, try, try to achieve a different ending is so intense, that it determines even the type of person or *activity* the codependent is drawn to. For the codependent problem gambler, gambling is about trying and trying to get the *emotional* ending they want – to get the approval that they have been fighting for their entire lives – to feel that they have eventually succeeded in changing and controlling the outcome of a life long struggle. Every spin of the reel, every roll of the dice, every hand they play becomes a replay of their whole lives – hoping and believing that this time the outcome will be different. “Winning money” gives them an enormous (false) sense of “being in control” - of “independence” - and that they have eventually managed to reach their life long goal – of being accepted and respected. Codependent problem gamblers are not gambling with money, they are gambling with their lives – to try and get a different emotional ending. They are looking at external cues (money) to increase their low self-worth – they are chasing recognition and empowerment. “Money gives status, independence, power and respect, and if I have money, others will accept and respect me.”

A person who is kind, stable, reliable and interesting would not be attractive, typically to the codependent person – they would appear “boring”. Gambling as an activity is not stable or boring. It is unpredictable, challenging and exciting and the codependent person deals with gambling in the exact same manner as he would as if it was a relationship with another needy person. They give and give and give, and become very resentful and determined if they do not receive the same, or even more in return – they then become the “victim”. They develop a sense of entitlement that persists in even the most defeating circumstances.

Codependents become addicted to emotional pain. They are drawn to relationships and people that are not available to them, or who reject them or abuse them. Gambling becomes a symbolic way of recreating this relationship. Gambling is an activity where rejection (losing) is at the order of the day – the constant chasing of an unavailable win result in constant feelings of failure – almost a way of self-punishment and self-destruction. The emotional pain has to be there because this is what the codependent gambler is addicted to. Persons suffering from codependency often experience themselves being caught up in a kind of treadmill existence so that whether or not goals are achieved, there is a driven compulsion for more; an anxious feeling of incompleteness or emptiness remains no matter what is accomplished.

Accustomed to lack of love in a relationship, codependents are willing to wait, hope, and try harder to please – winning in gambling becomes symbolic for succeeding to please and control. At the same time, they have a desperate need to control the relationship (the machine or game). This is because the need to exact the missing love and security is the foremost motivation in any relationship for a codependent. Codependents constantly feel empty and incomplete due to a critically low self-esteem - and deep inside - there is some sort of belief that they do not deserve the love (win) they seek, they do not deserve to be happy. Because relationships hurt so much, codependents are

more in touch with the dream of how the relationship “could” be, rather than the reality of the situation. Gambling gives them an opportunity for hope - to dream and live in a fantasy world filled with illusions of a wealthy Monte Carlo existence. Before they have actually won anything, the money is already spent. The codependent gambler is often immobilized by romantic obsessions. They search for the “magical quail” in others (and in gambling) to make them feel complete.

Codependents are drawn to people and situations (gambling) that are chaotic, uncertain and emotionally painful to avoid focusing on their responsibility to themselves. While constantly seeking intimacy with another person, the “desperate” quality of their needs makes true intimacy (the win) impossible. In trying to conceal the demandingness from themselves and others, they grow more isolated and alienated from themselves and from the very people they long to be close to. They have a tendency toward episodes of depression, which they try to forestall through the excitement provided by unstable relationships (and gambling).

Codependents do not only rationalize and justify their behaviour, but also have a great tendency to spiritualize their codependent style. Christians who are codependents are often afraid to learn healthy self-care because they believe that would be selfish or unspiritual. For the codependent, gambling becomes a way in which God, Lady Luck or fate will financially reward them for all their unselfish efforts. And, the irony, once they receive their “reward”, it will immediately be spent on the needs of others – “to buy my wife that washing machine that she so badly wants” or “to pay for my husband’s inpatient treatment for his alcohol problem”. Very often, pathological gamblers experience themselves as people with “special powers” – they can “see”, “read” and “feel” things – they tend to be highly superstitious. The codependent problem gambler lacks a healthy sense of self and the good boundaries that allow spiritually and emotionally mature people to find a balance between their

own welfare and the welfare of others. They tend not to know the difference between selfishness and self-preservation.

Belonging to a sub-culture of “gamblers” give the codependent person some sense of identity. Codependents feel powerless to run their own lives. Having only a very hazy notion of who they are, it becomes easier to define themselves in terms of their roles or relationships to other people – or to gambling. Insecure attachment, in turn, increases the risk of developing gambling-based relationships as an alternative to meaningful, committed ones. Winning at gambling provides them with a false sense of power and confidence over their own personal lives.

The most common consequence of codependency is depression and anxiety, very often severe, and also active addiction, which in turn, predisposes a person to seek relief through the hypnotic qualities of gambling. Gambling as an activity provides distraction. Certain games require focus and the narrowing of attention (e.g. games of skill) and other games (games of chance) becomes a mindless activity with many escape qualities. Gambling can relax a person and make the blood boil at the same time. By distracting a person’s attention from stressful life circumstances (which is chronic in the codependent) it serves as a secondary re-enforcer of gambling by reducing anxiety and tension and alleviating depressed affect. Continued financial losses as a consequence of continued gambling worsen depressed effect and anxiety resulting in the need to continue gambling.

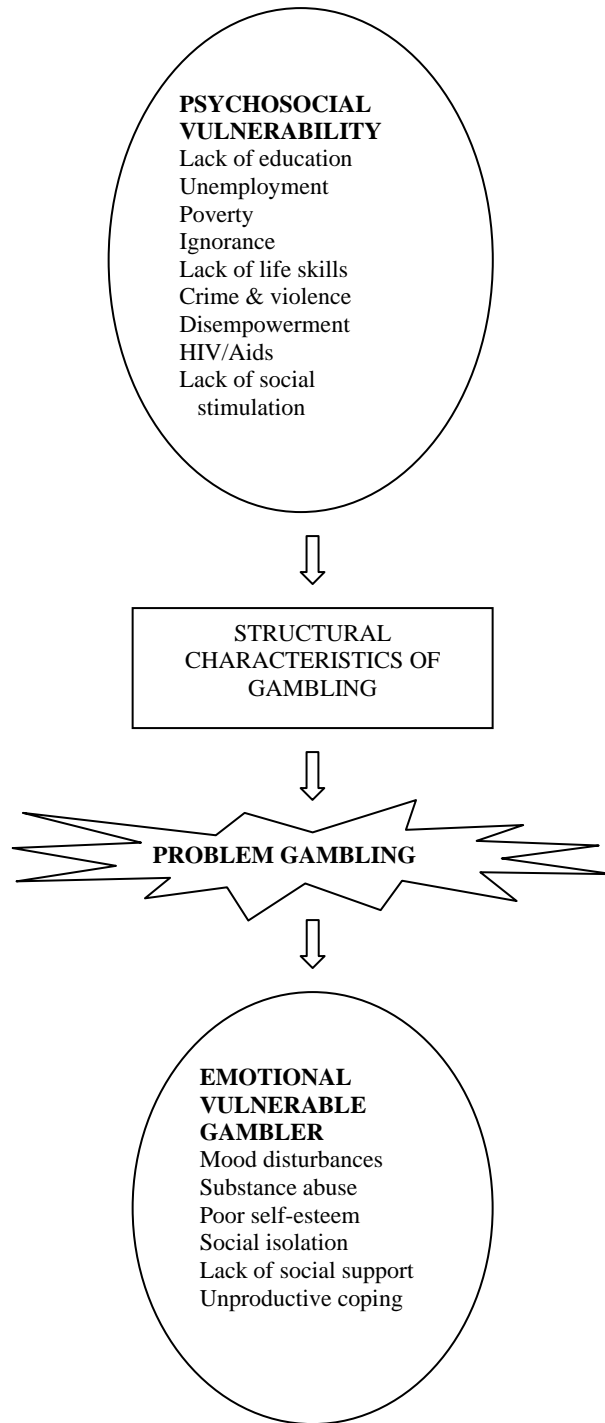
Codependents frequently experience an inability to express intimacy or sexuality. According to Bulwer’s (2003) study, 11% of treatment seekers reported compulsive sexual behaviour. The codependent’s relationship with gambling becomes so intense and so intimate that some gamblers have expressed the feeling of winning as experientially superior to a sexual orgasm. No other relationship can offer what “Lady Luck” offers – in every sense.

An important factor is that codependency is a syndrome that is very much culture-specific. Especially in South Africa with its diverse cultures there is a word –“ubuntu” – which has the meaning that “no man is an island” – no one can care for himself and people need each other and need to take care of others. Codependency as a syndrome tends not to be accepted among the African population of our country, as “ubuntu” is how they live their lives – caring and sharing and being in harmony with all of creation, with a shared identity and inter connectedness. However, codependency goes beyond a lack of identity, or overdeveloped sense of responsibility, or lost intimacy. Codependence threatens the survival of all of us. It is the basis of the victim-offender relationship, the need for control and power to destroy and hurt. Codependency is the inability to stand up for what we believe and feel. In the face of crazy, destructive courses, it is the feeling of helplessness to effect change and bring about peace.

### 3.5 TYPE IV – THE PSYCHOSOCIAL VULNERABLE GAMBLER

#### **Type IV – Psychosocial vulnerability** (Fig.3.4)

- Psychosocial vulnerability (e.g. lack of education, poverty, ignorance, lack of social stimulation), as presented in Figure 3.4, *only* can predispose a person in developing a gambling problem when these vulnerabilities come into contact with the structural characteristics of gambling. This group lacks psychiatric pathology but falls prey to a highly addictive schedule of behavioural reinforcement. However, the consequences of excessive gambling can in turn predispose a person for emotional (and in extreme cases biological) vulnerability (depressed and anxious mood), which in turn can act as a motivational factor (escape) in continuing gambling.



**Figure 3.4 : The psychosocial vulnerable gambler**



### 3.5.1 Psychosocial vulnerability and gambling

According to an article in the Cape Times (Megan Power, June 2003), more than 70% of South Africans, rich and poor, take their chances on the national lottery, spending a staggering R80-million a week. Ticket sales in the last 12 months topped R4.2 billion, almost half South Africa's total education budget for last year. According to institute director John Simpson (Unilever Institute of Strategic Marketing – University of Cape Town), “.....playing the lottery forms the biggest component of gambling in South Africa, seven times greater than the lottery proportion in other countries. Less than 25% of South Africans gamble at casinos or bet on horses. Slowly but surely lottery spend is increasing, with the lower-income levels in society making big sacrifices to play.

Approximately 43% of players earn less than R2 000 a month and a quarter are unemployed. Most players say they would have spent the money on household necessities if they had not spent it on gambling. All those who buy tickets say they play the lotto. It is a game, a fantasy. And the poorer you are, the more you believe your only chance of getting rich is through the lotto. Of the 70% who play either occasionally or regularly, 60% play on both Wednesdays and Saturdays. Approximately 45% of all adults are regular players. Average spend per draw in the last twelve months was between R7.50 and R84.99 per month. One in ten gamblers spent more than R150.00 per month. However, the amount spent each week increases dramatically during rollover periods. It appears that those who usually spend R20.00 will spend up to R200.00 on a big rollover. South African Breweries actually noticed a decline in beer sales during such times”.

According to a Cosatu Parliamentary Report (2003) the majorities of people in South Africa are socio-economically challenged and are faced with grinding poverty rooted in soaring unemployment and low wages. It leads individuals to think they can only change their lives through luck, rather than helping collectively solve the challenges the country are facing – and in the process,

gambling can destroy people and their families. According to this report, people are sinking their hard-earned money into gambling operations and gambling machines in the hope that they will win. Approximately 50% of adults in the urban areas buy lottery tickets. About 40% earn between R800.00 and R4 000.00 per month, and 11% under R800.00 per month. Some of them admit that they cut spending on necessities like food and clothing in order to play the Lotto.

Working class communities have become enmeshed in gambling schemes as a way of trying to survive the hard realities of a capitalist economic system. In the context of the high unemployment rate, many people have become discouraged from looking for work and are tempted to believe that gambling is their salvation. Even people with higher incomes and substantial disposable income are seriously being challenged by the negative consequences of their bad financial management, credit control and other habits, including gambling. Of the 49 countries surveyed for the World Competitiveness Report, South Africa was lowest in economic literacy and second lowest in financial education. Whilst people have the right to spend their money in any legal way they see fit, it is largely the social cost and implications thereof that makes gambling such a controversial activity.

The prospect of turning a meager amount of money into a fortune at the casinos exerts a powerful attraction and a quick-fix to a lifetime of poverty. In South Africa unemployment is severe and the elderly, barely surviving on monthly pensions of around R700.00, are among those drawn to gambling by its promises of fortune. Pension plans, health care and other developments for the elderly are meager and inadequate. Nursing homes and retirement communities that were once fairly funded have experienced economic crunches and “less essential” services, such as professionally run recreation programmes, have suffered. Some groups of elderly persons have found gaming to be great fun and they have also developed new friends with whom they share

conversation and family pictures – with the result that they have gambled away the money that was available to support them during retirement. Perhaps an even sadder phenomenon is that some elderly patrons come to believe that a “big win” will restore them to a central place in the family. Fueled by that belief, the gambling increases and can become quite reckless. It may not be pathological gambling, since there is a certain rationality to the belief, but it qualifies as problem gambling without a doubt.

As for criticism of the gaming industry for its potentially harmful social effects, gaming executives make the argument that it is a regulated industry, which contributes to job creation in the economy and gained respectability through its close association with the funding of welfare projects. Gambling is also promoted as an important leisure activity for many South Africans. There is a substantial community and industry infrastructure in place to support gambling in all its levels and aspects. It has also moved beyond simple gambling to a point where the overall experienced casino resorts eclipse shopping malls, cinemas, restaurants and theatres in the competition for consumers' entertainment.

South African citizens, black or white, are facing enormously challenging psychosocial stressors on a daily basis. The behaviour (powerlessness and hopelessness) of a person who is fighting with death, violence, poverty, lack of education and disempowerment on a daily basis tends to be different from someone who does not have to endure this daily stress. Gambling and a casino space can fuel the fantasies of these vulnerable people and also provide an escape from the daily stress and pain of reality. Although other motivations might affect peoples' reluctance to cease gambling, one clear barrier is the “eternal spring of hope”. Many South Africans hope for a big win to resolve their problems and improve their life situation and harbour the false believe that they can empower themselves through gambling. Intermittent experiences of winning, exposure to other people's wins and promotions by the gaming industry may reinforce this hope and strengthen resistance to abstinence.

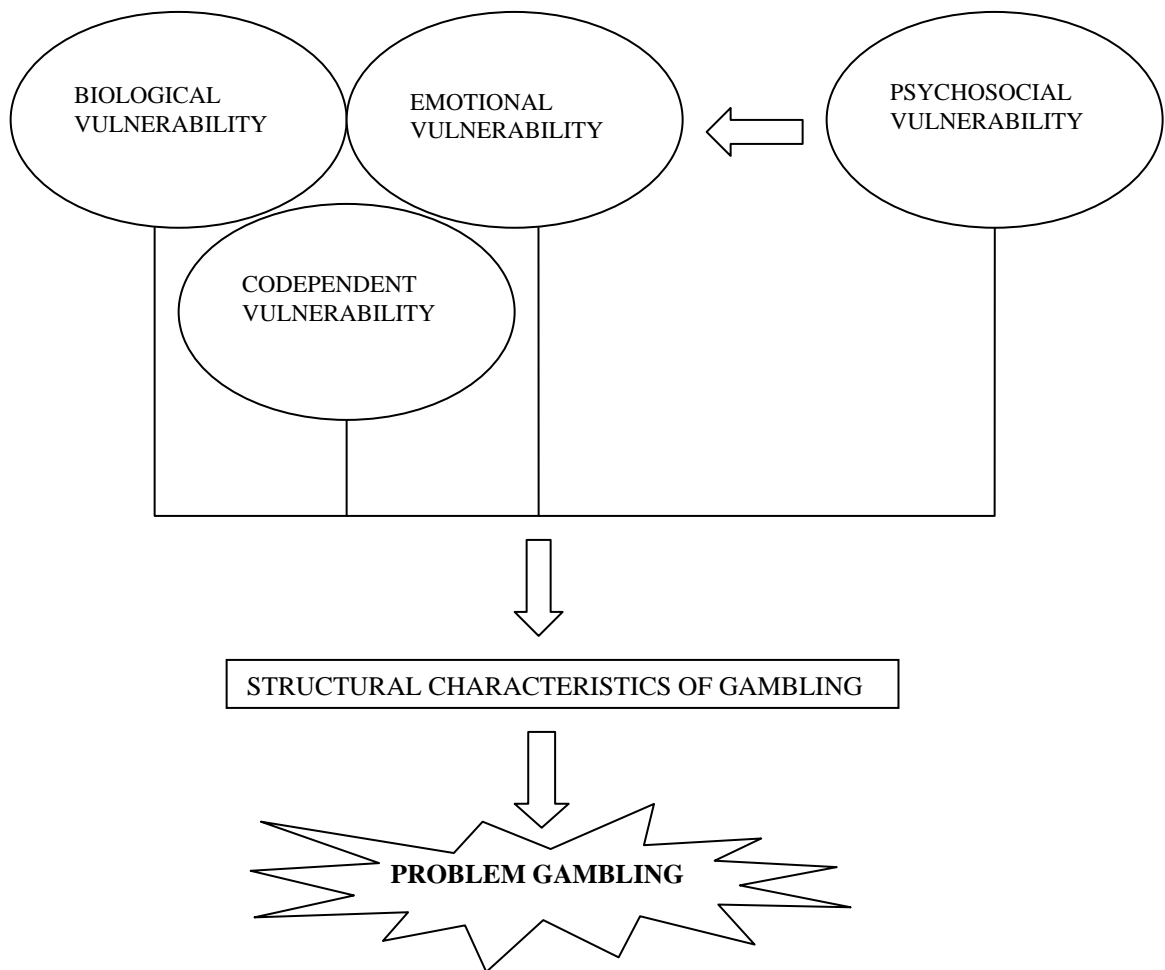
In addition, much problem gambling is a product of various kinds of ignorance, including false beliefs about how gambling works, superstition, and lack of money management and other life skills. Broadly, for full-blown gambling addicts, the central problem is an impulse control disorder, a recognized medical condition (APA,1994). For the much larger number of excessive or problem gamblers, the central problem is various kinds of ignorance related to gambling, especially among the poor and uneducated – and this needs to be addressed in treatment.

### 3.6 CONCLUSION

As can be seen from Figure 3.5, I explored four specific vulnerability factors – *when it comes into contact with the structural characteristics of gambling* - in developing a gambling problem. A person with a neurobiological impairment might become vulnerable to developing a gambling problem, if and when this comes into contact with the structural characteristics of gambling. However, biological vulnerability is very often linked to some kind of emotional vulnerability (childhood disturbances). Both the biological and emotional vulnerability might have its origin in codependency, or even lead to codependent behaviour. Psychosocial vulnerability, in turn, might lead to an emotional vulnerability (depression), which, if this persists over time, might turn into a biological vulnerability (dopamine, serotonin and noradrenaline deficiency). In addition, experience of wins and knowledge are related to the psychosocial pathway in which people develop problems as a result of certain beliefs and wins. Each of these underlying vulnerabilities will direct the *long term treatment* approach.

The question for each treatment professional to ask himself/herself is: “What exactly am I dealing with”. A treatment professional will not be able to assist the problem gambler effectively if he/she does not know what it is that they are dealing with. Problem and pathological gambling is a complex and complicated addiction that cannot be pushed into a little black box – it requires the careful

exploration of the different interconnected vulnerabilities to enable effective long term treatment.



**Figure 3.5 : An integrated biopsychosocial vulnerability model of problem gambling.**



## **CHAPTER FOUR**

### **SITUATIONAL AND STRUCTURAL DETERMINANTS OF GAMBLING**

In this chapter I will focus on the situational and structural determinants of gambling. In addition, I will present a description of the psycho-structural interaction of gambling.

#### **4.1 SITUATIONAL DETERMINANTS OF GAMBLING**

The gambling industry uses every marketing method it has at its disposal to entice people to gamble and to keep on gambling (Griffiths, 2003). These methods mainly fall into two types – situational and structural – and are the starting blocks to developing a gambling problem. Situational determinants of gambling activities tend to impact most on the acquisition, whilst structural determinants impact most on the development and maintenance of gambling.

The situational determinants of gambling are those features that entice people to start gambling. These are primarily features of the environment and include such things as the location of the gambling outlet, accessibility of different types of gambling, the number of gambling outlets in a specified area, and the use of advertising to stimulate people to gamble. These variables may be very important in the initial decision to gamble and also explain why some forms of gambling are more attractive to particular socio-economic classes. There is little doubt that these determinants have been critical in the success of the gambling industry to date. Not only are they heavily advertised on billboards, television and in newspapers, but the accessibility is so widespread that it is difficult to avoid. According to Blaszczynski and Nower (2002) ecological determinants of

gambling are those influences that relate to public policy and regulatory legislation that create and foster an environment in which gambling is socially acceptable, encouraged and promoted. This has been achieved through the legalization of licensed off-track betting offices and other gambling opportunities such as pull tabs, lottery ticket sales, fruit machines, video lottery games and other electronic gambling games in public places. These variables may be very important in the initial decision to gamble.

In South Africa there are currently 32 casinos operating countrywide. The majority of these casinos falls in the Gauteng region and is as follows: (National Gambling Board of South Africa, 2002) ([www.ngb.org.za](http://www.ngb.org.za)).

Fourways	:	Monte Casino
Gold Reef City	:	Gold Reef City Casino
Vanderbijlpark	:	Emerald Safari Resort Casino
Kempton Park	:	Emperors Palace
Brakpan	:	Carnival City Casino

Other casinos currently operating, per region, are as follows:

Eastern Cape	:	3 casinos
Free State	:	3 casinos
Kwazulu-Natal	:	5 casinos
Mpumulanga	:	3 casinos
Limpopo	:	2 casinos
Nothern Cape	:	2 casinos
North West	:	5 casinos
Western Cape	:	4 casinos

Access to gambling venues is thus commonplace, widespread, close to home or the workplace, and has 24-hour availability. Theoretically, people can gamble all day every day of the year. Given that prevalence of behaviours is strongly correlated with increased access to the activity, it is not surprising that the



development of regular casino gambling has increased significantly across the population, especially among the female population. For the female population, visiting the casino on their own is a very acceptable way of entertainment. Increased accessibility may also lead to increased problems. What has been clearly demonstrated from research evidence in other countries is that where accessibility of gambling is increased there is an increase not only in the number of regular gamblers but also an increase in the number of problem gamblers. This obviously means that not everyone is susceptible to developing gambling problems, but it does mean that, at a societal (rather than individual) level, the more gambling opportunities, the higher the incidence of gambling problems (Griffiths 2003). Visiting the casino on a recreational level can be an affordable way of family entertainment if no entrance fee is charged and a fast-food meal is available at a cheap rate. Denominations as low as five cents are also available on some of the electronic gaming machines which also make it relatively easy for financially challenged individuals to maximize the enjoyment derived from the actual gambling experience. In addition, it appears that most gambling operators actively stimulate gambling through mass television advertising and advertisements in the press.

Griffiths and Parke (2003) examined the situational characteristics of gambling environments which included sensory factors (e.g. sound/noise effects, light/colour effects), money access (e.g. lack of change facilities, cash dispensers), physical comfort determinants (e.g. heating, seating, eating), and proximity to other activities/intrinsic association.

### Sensory factors

Constant noise and sound in a gambling environment gives the impression of a noisy, fun and exciting environment, and that winning is more common than losing (as you cannot hear the sound of losing). In addition, light and colour are two variables (often inter-related) which affect behavioural patterns in a variety of contexts. Lighting levels can affect performance and arousal levels. As light

levels increase so does visual acuity, although this is only up to a critical point. It has also been suggested that colour evokes affective states and influences behaviour and that some colours are associated with certain moods, i.e. red is exciting and stimulating, blue is comfortable, secure and soothing, orange is disturbing and green is leisurely. In addition, variations in colour can affect human physiological reactions such as blood pressure and breathing rate.

A study by Stark, Saunders and Wookey (1982) has examined the differential effects of red and blue coloured lighting on gambling behaviour. In this experiment, Stark and his colleagues hypothesized that if red was arousing, subjects exposed to red light were likely to gamble more frequently, stake more money and take more risks than subjects exposed to blue light. Their hypothesis was confirmed with red lighting having less of an inhibitory effect on gambling behaviour than blue lighting. A second more subtle effect may arise from the finding that dim lighting increases verbal latency and reduces eye contact. If dim lighting reduces social interaction, there will subsequently be more gambling if such individuals stay in the gambling environment. It has also been pointed out that "rows of dazzling neon lit machines bathes in soft lighting create an atmosphere which is probably conducive to gambling" (Caldwell, 1974, p.24).

#### *Olfaction in gambling environments*

Olfaction (smell) has also been investigated experimentally in a gambling environment. Hirsh (1995) investigated the effect of ambient aromas on gambling behaviour in a Las Vegas casino at two slot machine areas odourized with pleasant but distinct aromas and at an unodourized control slot-machine area. The amounts of money gambled in the three areas were compared for the weekend of the odourization and for the weekends before and after. The amount of money gambled in the slot machines surrounding the first odourant during the experimental weekend was significantly greater than the amount gambled in the same during the weekends before and after the experiment,

possibly due to olfactory evoked recall. The increase appeared greater on Saturday, when the concentration of odourant was higher. The amounts of money gambled in the slot machines surrounding the second odourant and in the control area did not change significantly compared to the weekends before or after the odourization. Again, although research in the area of olfaction and gambling is limited, it does suggest that smell may influence gambling behaviour.

### Familiarity

The psychology of gambling advertising and naming is also important in attracting customers (Costa, 1988). Gambling advertising is usually aimed at the social (rather than the pathological) gambler. Gambling imagery is designed to make a person spend money, and in almost all advertisement here is a lack of reference to the word “gambling”. Instead, guilt reducing statements referring to leisure are used, e.g. “Try your luck”, “Test your skill”, or “Get into the holiday spirit”. However, when tied in with more recent research on the psychology of familiarity, it is now quite often the case that many gambling establishments are named after a person, place, or event. Not only is this something that is familiar to the gambler but may also be something that the potential gamblers might like or affiliate themselves with. Essentially, the name of a casino or an arcade will create an image in the gambler’s mind. Such names may include Gold Reef City, Champions Casino, Carnival City, Emperors Palace, Graceland and Sun Coast casino.

### Money access

Another factor, according to Griffiths and Parkes (2003) is the proximity to cash dispensing telling machines. Proximity to a cash dispenser may also affect how much a player may lose. If the gambler only brings a limited amount of money into the gambling environment and there is no cash dispenser nearby, they will usually give up and cut their losses. Therefore, the proximity of the cash dispenser is likely to have an effect. For instance, the distance of the ATM to

(say) a slot machine might be inversely proportional to how much the gambler might eventually lose.

### Physical comfort

If a gambler is physically comfortable, there is more chance they will stay in the gambling environment (Griffiths & Parke, 2003). Comfort can be utilized by the management to encourage and prolong gambling. Prolonged gambling can be surprisingly tiring particularly under stressful financial situations such as chasing. Fatigue often ends the gambling session before a gambler's judgment. Often gamblers will continue to chase their losses for very long periods (i.e. the whole day) or until their money runs out. However, if players get physically and emotionally tired or lose concentration, their gambling session might become prematurely terminated. Therefore, comfortable seating, comfortable temperature and the availability of refreshments and amenities (e.g. toilets) are more customer care tactics to prolong playing.

### Floor layout

The variables that are crucial to slot machines success are floor location, coin denomination and pay-off schedules of the machines. In some casinos, restaurants are often positioned in the centre so that customers have to pass the gaming area before *and* after they have eaten (Greenlees, 1988). Another strategy is to use deliberate circuitous paths to keep customers in the casino longer; the psychology being that if the patrons are in the casino longer they will spend more money.

It is clear that situational characteristics of gambling environments have the potential to initiate gambling behaviour. Excessive gambling can occur regardless of the gambler's biological and/or psychological constitution. However, there is little evidence to suggest that the gaming industry has used the psychological literature to exploit gamblers. The success of the gambling establishment's situational characteristics (where success is defined as an

increase in gambling due to the situational characteristic) depends, I believe, upon the psycho-situational-structural interaction.

Thus, gambling behaviour is more than simply the interaction between the structural characteristics of the gambling activity and the psychology of the gambler. In addition, the gambling environment includes several variables that will inevitably have an influence. Furthermore, these situational characteristics do not simply have an effect on the acquisition stage of gambling behaviour but may play an even more important role in the maintenance of gambling. Obviously, knowing that situational variables exist, gives researchers and treatment professionals a slightly better view of the potentially unclear picture formed by gambling behaviour. For example, if treatment professionals know which aspects of the environment are likely to perpetuate gambling behaviour they might be able to train their clients to interpret these and deal with them appropriately (Griffiths & Parke, 2003).

#### 4.2 STRUCTURAL DETERMINANTS OF GAMBLING

Professionals in the field of gambling studies can gain a great deal of insight into problem gambling by closely examining the games gamblers play. The different forms of gambling and game designs seem to provide different forms of the mental state that we call "action". It should be emphasized that not all forms of gambling lead to problems. Different levels of risks are associated with different types of gambling. I believe it is imperative that treatment and prevention workers understand the dynamics of these games. For example, understanding the nature of the game and its effects on the individual gambler can help a therapist understand a patient's motives and beliefs, which may facilitate a more individualized, client-centered approach to the treatment.

Gambling games can be divided into two categories: games of chance, such as lotteries, keno, craps, roulette, baccarat, bingo and slots; and games of skill, such as horse race betting, sports betting, poker and blackjack (Turner & Fritz,

2001). For example, playing bingo requires perceptual and motor skills, but winning is purely a matter of chance. In contrast, winning at poker is dependent on skills relative to the other players. According to data on problem gambling treatment seekers in South Africa, 51% played table card games such as blackjack and poker, 41% engaged in wagering (horse race punting), 11% gambled on the stock market and 4% on sport. 85% played lotteries, 81% played slot machines and 11% played bingo (Bulwer, 2003).

Skill-based gambling activities that offer players the opportunity to use complex systems to study the odds and to apply skill and concentration appeal to many gamblers because their actions may influence the outcome. Such determinants attract people who enjoy a challenge when gambling and may also contribute to excessive gambling if people overestimate the effectiveness of their gambling systems and strategies. Skill-based gambling may be more attractive to a subgroup of gamblers who are chronically under-stimulated. In certain or specific contexts it provides the opportunity for the gambler to take on an exciting role, that of the “high roller” who is accorded a great deal of respect by others within the gambling environment. The games where skill can really make a difference require a great deal of research, self-control and calculation. Some researchers have argued that people who gamble on these skill activities tend to be more intrinsically motivated than lottery gamblers in that they gamble for self-determination (i.e. to display their competence and to improve their performance) and that they emphasize the importance of skill and control considerably more than slot machine players (Aasved, 2002). In skill-based gambling skilled players also negatively impact the outcome for less skilled players. A player’s winnings are not only affected by the house rake but also by the skill of other players. Less skilled players are often better off playing a game of chance than a game of skill. Chance may play a part but the player actually has the ability to alter his or her odds. The number of skills involved and the long-term prospects of financial return vary for each type of game and it is

important for a treatment professional to understand the dynamics of a game of skill.

The relationship between skill and problem gambling is particularly interesting. Several researchers have noted that problem gamblers often have an inflated sense of their own skill (Gadbourey & Ladouceur, 1989; Toneatto, Blitz-Miller, Calderwood, Dragonetti & Tsanos, 1997). Are problem gamblers who play games of skill simply unskilled players? An alternative view is that some of the “skilled” gamblers in treatment might actually be skilled, but not be as skilled as other players. Books on how to gamble successfully often portray games of skill as games in which the player has a chance of winning in the long run (Warren, 1996; Patterson, 1990). However, the mixed skills of gamblers playing these games affect the outcome for every player. For example, poker is a game where those with the best analytical memory, strategy skills, betting skills, bluffing skills, and the ability to tactically evaluate the betting and playing tendencies and strategies of other players, will give them an edge in the game. In addition, pathological gamblers tend to be impulsive which makes skill games problematic. The problem with, for example poker, is that it can be very predatory and if players are impulsive or a quick tempered, other players will try to exploit that liability and cause them to play badly because they are angry or emotionally upset. Emotional control is at least as important a skill as card knowledge. Problematic poker players may be very skilled in terms of cards, but by definition they may not have emotional control.

Probability-based gaming entertainment is the category of games that do not allow the player to have any control whatsoever over the odds of winning. Actually, if there is any indication that the player can influence the outcome, the game is shut down. The rules indicate that every lottery ticket and every play on a slot machine has to have an equal chance of winning and the odds have to be the same for every player on every turn. Casino games are random and unpredictable, making it impossible to figure out a system for predicting what will

happen next. People who gamble on chance activities such as lotteries, usually do so for external reasons (i.e. to win money or escape from problems). Although many slot machine players also overestimate the amount of skill involved in their gambling, other motivational factors (such as the desire to escape worries or to relax) tend to predominate. The ability to escape the outside world and to focus on a limited repetitive gambling activity would most likely appeal to the chronically over-stimulated gambler. Thus, excessive gambling on slot machines may be more likely to result from people becoming conditioned to the tranquilizing effect brought about by playing rather than just the pursuit of money.

The relative role of skill and luck depends primarily on the time frame. Game per game, random chance plays a big role in winning, but good players bide their time waiting for opportunities to utilize their skills. In a short period of play, say an hour, winning is mostly luck – say 80% chance versus 20% skill. A novice has a reasonable chance of coming out ahead in the short term. Over a longer period of play, say 10 hours, winning is mostly skill – say 20% chance versus 80% skill. Wins over the course of a lifetime of regular play are about 99% skill. That is, if a player plays regularly for a lifetime and is still making money, it is almost guaranteed that it is skill and not chance or luck.

#### 4.2.1 House advantage

One very important factor, irrespective of whether it is a game of chance or skill, is for the treatment professional to have a good understanding of the “house advantage” or “house edge”. In most forms of casino gambling, the results of the game are truly random, and the casino cannot control the results. For example, in roulette, the ball can land on any of the numbers, and the casino cannot control which number the ball stops on (without cheating). The odds of the ball landing on any of the numbers are the same. With craps, again the casino cannot control the roll of the dice. In blackjack, the house cannot control which cards are being dealt, and all cards have the same odds of being dealt.



Since the casino cannot control the outcome of the event, they set the house advantage by generally paying back to the players less than the true odds of the event. The house “skims” the rest off, thereby making its money. Payback and house edge are basically just two ways of describing the same thing (payback + house edge = 100%). The average payback percentage and casino advantage vary from game to game and vary within games as follows (approximate percentages):

- *slot machines*: between 85% and 98% player return with an average of 9% house advantage;
- *video poker machines*: skilled players may lose at a rate of 1% per bet and less-skilled players of approximately 10% per bet;
- *lottery*: (odds of one in fourteen million);
- *roulette*: 2.7% house advantage on a single zero roulette table and 5.26% on a double zero roulette table;
- *craps/dice*: between 2% and 17% house advantage depending on rules and numbers rolled;
- *baccarat*: banker (banco) 1.17% house advantage; player (punto) 1.36%; tie (stand-off) 8:1 pay-out;
- *poker*: between 3% and 5% house advantage; when playing against skilled players the average return to player decreases to -3.1%; skilled players can achieve an average return of +1.35%;
- *blackjack*: 0.5% house advantage with basic strategy; 7% house advantage without basic strategy;
- *sports betting*: 4.55% house advantage which is accomplished by a 9.09% commission charged on all wins;
- *horse racing*: between 17% and 19% house advantage

With skill games the payback also varies depending on skill. The casino can change the payouts for the games or can establish rules about the game (which change the odds, but do not control them). House advantage is the

mathematical advantage the house or gambling operator has on most wagers made by the players and is built into the games so the casino/gambling operators will make money in the long run. House advantage comes in various forms, including paying the “casino odds” on winning bets rather than “true odds” for most games, charging a commission on winning bets (e.g. baccarat) or ensuring that the rules of the games are in its favour (e.g. players can bust before the dealer takes any cards in blackjack). The other forms of house advantage, such as commission on winning bets or the rules of the games, have the same effect as paying less than true odds for the players. Some games have greater house advantage than others, but virtually all gambling/casino games have house advantage built into the games.

In practice, for example, some poker players may join a game believing they are playing against each other with the house dealing for the game. But, the house usually takes a “rake” or a percentage of each pot. This service fee averages about 5% of the pot. Some players do not fully understand these facts and feel they are being cheated after losing money over time. In fact, casinos do not need to cheat or rig games – they already have the house advantage system built into their games to make sure they will make money in the long run. What these players experience only reflects the reality of gambling games. So, if there is a fee or a rake, the question arises whether it is really about skill or chance – and yes – some players are skilled but in reality do they have any practical chance of winning?

Another fact about some casino games is that each event in a game occurs either totally, or partially, independently from all other events in that game – what has already happened has little or no effect on what will happen next. It is important, however, that it is only in dice, roulette, lottery games and slot machines where true independence (random with replacement) is achieved. Sports betting, horse races and card games have various degrees or types of dependency (e.g. blackjack is random without replacement), sports events just

are not random. Independence of events and randomness are important concepts. If misunderstood, distorted and faulty beliefs about gambling games (e.g. “winning or losing streaks” or “near miss beliefs”) can arise. Problem gamblers tend to have a poorer understanding of these concepts, making them more likely than non-problem gamblers to have faulty beliefs.

#### 4.2.2 Game preference

The structural determinants of different gambling activities have important implications for the psychological study of ongoing gambling behaviour. It can be speculated that different gambling activities (games) might have different consequences for players, for instance, in terms of potential problematic play. Some gambling activities have a strong association with problem gambling. These are usually high intensity activities and/or those that offer repeated opportunities to gamble and chase losses (e.g. slot machines and casino-type games). Each of these factors may (and almost certainly does) have implications for gamblers’ motivations and, as a consequence, the social impact of gambling. These factors are the structural determinants that are responsible for reinforcement, may satisfy gamblers’ needs, and may actually facilitate excessive gambling. By identifying particular structural determinants it may be possible to see how needs are satisfied, to see how information about gambling is presented (or perhaps misrepresented), and to see how thoughts about gambling are influenced and distorted. Showing the existence of such relationships has great practical importance. Not only could potentially “dangerous” forms of gambling be identified, but effective and selective legislation could be formulated. It is important to examine these determinants and dimensions among all types of gambling activity so that they can be described, compared and contrasted using the same parameters. In addition, this may assist in pinpointing where technology has a role (either directly or indirectly) in gambling acquisition, development and maintenance. Some of the structural determinants found in many gambling activities include the following (Griffiths, 2003):

### *“Near miss” phenomenon*

Fruit machines possess built-in structural or physical determinants that serve to encourage persistence. This is represented by the built-in mechanical features of slot machines which are constructed so that the left reel is the first to stop spinning, the center reel the second, and the right reel the last. The left reel also has the largest number of winning symbols, the center reel has fewer, and the right has the fewest. This construction design is specifically intended to keep gamblers playing longer by exploiting the “near win” or “false hope” phenomenon since one or two winning symbols are likely to appear before the end of the sequence. The symbol ratio proportions of these machines produce many “near misses” that serve to extend the gambler’s playing time.

### *Multiplier potential*

This refers to the manipulation of odds on the outcome of one or a series of events. This is achieved by playing high-stakes fruit machines and by playing daily doubles and trifectas at the racetrack. Progressive slot machines allow players to risk from one to five coins per play. The variety of risks that is available in most forms of gambling appeal to a broader range of potential gamblers since they enable participants to control the rates at which their activities proceed. Initial risks of relatively small amounts of money allow novices the opportunity to develop a sense of familiarity and skill with gambling activities that are new to them. Once they feel secure in their knowledge of the most appropriate times for increasing their stakes and making longer-odds bets they will be inclined to gamble for longer periods.

### *Event frequencies*

The event frequency of any gambling activity (i.e. the number of opportunities to gamble in a given time period) is a structural determinant designed and implemented by the gaming operator. Betting frequencies are maximized in continuous forms of gambling such as roulette, blackjack and slot machines

which involve a rapid succession of many plays per session as opposed to discontinuous forms such as lottery drawings which require longer periods between the time a stake is made and its outcome is known. The length of time between each gambling event may indeed be critical as to whether some people might develop problems with a particular type of gambling. Obviously gambling activities that offer outcomes every few seconds or minutes (e.g. slot machines) will probably cause greater problems than activities with outcomes less often (e.g. weekly lotteries). The frequency of playing when linked with the two other factors – the result of the gamble (win or loss) and the actual time until winnings are received – exploit certain psychological principles of learning (Moran, 1987). This process conditions (operant conditioning) habits by rewarding behaviour. That is, through presentation of a reward (e.g. money), reinforcement occurs. Rapid event frequency also means that the loss period is brief with little time given over to financial considerations and, more importantly, winnings can be re-gambled almost immediately. The general rule is that the faster the event frequency, the more likely it is that the activity will cause gambling problems. (Griffiths, 1997) and (Griffiths & Wood, 2001).

There is little doubt that technological advancement could have a large impact on “rapid replay”. Given the time, money and resources, a vast majority of gambling activities are “continuous” in that people have the potential to gamble again and again. Some gambling activities (e.g. weekly lotteries, football pools) have small event frequencies (i.e. there is only one or two draws per week) making them “soft” forms of gambling. However, in the case of instant scratch cards and machines there are few constraints on repeated gambling as limits are set only by how fast a person can scratch off the covering of the winning or losing symbols or how fast they can insert the next coin into the machine. The typical slot machine player initiates a new game every six seconds. That works out to 10 games per minute, 600 per hour. If the average player bet R2.00 a spin, that player is wagering roughly R1 200.00 every hour. The faster the event frequency, the more likely it is that the activity will cause gambling problems.

Addictions are essentially about rewards and the speed of rewards. The significance of this feature lies in the fact that the faster the “action”, the less time players have to think about their cumulative losses. Therefore, the more potential rewards there are, the more problematic (“addictive”) an activity is likely to be.

#### Payout intervals

The length of time between placing a bet and receiving one’s winnings can also contribute to persistence. This is particularly evident at gaming tables and slot machines where instant winnings can be instantly replayed. By eliminating the street bookie, legalized betting shops have also reduced both the time needed to learn of an outcome and the time required to collect on a winning bet. Moreover, prompt payouts not only reinforce the persistence of the winners, but they also serve as vicarious reinforcements that encourage potential players to begin betting and induce bettors who have not yet won to chase their previous losses. Since this feature promotes the recirculation of winnings into new bets and attracts new money it is especially important for generating and maintaining a steady flow of cash into the game.

#### Bettor involvement/interactivity

This is the degree to which gamblers perceive themselves as being active participants in a gambling game. It has been shown that the increased personal involvement in a gambling activity can increase the illusion of control, which in turn may facilitate increased gambling. This is encouraged by the “nudge”, “hold” and “gamble” buttons, as does being allowed to choose one’s own lottery numbers. One’s physical presence at a gambling venue coupled with active involvement in its activities and choosing among a number of betting alternatives is also believed to reinforce repeated and riskier betting. The interactivity component of some of the games may also be psychologically rewarding and different from other more passive forms of entertainment (e.g. television). For example, although craps is a game of chance it is exceptionally popular because

it has the highest degree of player involvement of all casino games: the players not only select and place their bets from a wide variety of options but they also throw the dice. Racetrack betting combines a high degree of player involvement with the need for experience and skill.

#### *Illusion of skill and control*

This is the degree to which gamblers believe a game requires skill whether any is actually required or not. Again, the fruit machine's play buttons offer various player options which foster this perception and prolong playing sessions. Whether one plays at the track or in an off-track betting office, racing forms provide information that is deemed essential to all serious handicappers. The ability to read and carefully weigh all the published facts before betting provides horse players with a strong feeling of involvement and enhances the perception of control over their betting choices. Visiting the track in person as opposed to betting through a bookie or betting office affords closer access to the horses, their owners and trainers, and other track personnel through which they can increase their store of "inside information" about the possible outcome of a race. The great feelings of foresight, control and confidence in one's selections that this knowledge inspires can cause optimistic bettors to overestimate their chances for success and adjust their bets accordingly. Even in such games as roulette, which requires no skill and minimal player involvement, the illusion of skill and control have also been found to exert a strong influence over one's betting behaviour.

#### *Win probability*

This refers to the true odds of winning. The objective mathematically calculable chances for winning and the potential payout ratios always favour the house in commercial gambling situations. Although these facts are known to commercial gambling interests, the true odds of winning often are not known to their customers since gambling promoters generally are very careful to avoid publicizing this information. Any lack of specific information about the house

advantage and takeout ratios of various gambling games would clearly prevent a gambler from making optimal (from his point of view) betting decisions. Slot machines generally have fixed rates of return ranging from 85% to 98%. However, the probability of winning money does not appear to be very important to fruit machines players. Like video game players, their primary goal is to play for as long as possible by spending the least amount of money.

### Payout ratio

This refers to the size of the prize compared to the size of the stake. The highest possible fruit machine jackpots and lottery prizes are many times much larger than the price of a play (e.g. with one R2.50 lottery ticket the player may win R1 million).

### Light and sound effects

Such sensory stimuli as the machines' flashing lights, music and other sound effects create an ambience that is conducive to gambling by generating feelings of fun, activity and excitement. Not only are certain colours associated with particular moods and emotions, but changing patterns can influence such physiological responses as heart and breathing rates that are associated with heightened arousal. Many machines emit a loud buzz or musical refrain after each win. These sounds, augmented by the clatter of coins falling into metal trays, suggest that wins are more common than losses. They also create the impression that the amounts won are much larger than they actually are. Some casinos are now experimenting with the release of certain odors in their slot machine areas which will add to these effects.

### Machine naming

The names of various machines are chosen to elicit certain emotional responses. For example, the name of the first slot machine, "The Liberty Bell", was intended to evoke sentiments of independence and patriotism. Many fruit



machine names refer to money (“Cashline”), banks (“Piggy Bank”), skill (“Fruitskill”) and the reels (“Reel Money”).

### Suspension of judgment

This refers to tactics which impede a gambler’s normal economic value system such as the use of small denomination coins which lead the gambler to believe that little can be lots. In some instances the machine credits or tokens that are won cannot be exchanged for currency thereby forcing the player to put any winnings back into the machine. The use of chips, tokens, small stakes, or small denomination coins in place of currency or larger monetary units also minimizes the perception of many gamblers that any “real” money is being risked. For most gamblers, it is very likely that the psychological value of “chips” and “tokens” in gambling situations will be less than “real” cash. Gambling with chips or tokens may lead to what psychologists call a “suspension of judgment”. The suspension of judgment refers to a structural characteristic that temporarily disrupts the gambler’s financial value system and potentially stimulates further gambling. This is well known by both those in commerce (people typically spend more on credit and debit cards because it is easier to spend money using plastic) and the gaming industry. This is the reason why chips are used in casinos and why tokens are used on some slot machines. In essence, chips and tokens “disguise” the money’s true value (i.e. decrease the psychological value of the money to be gambled). Tokens and chips are often re-gambled without hesitation as the psychological value is much less than the real value. Evidence would seem to suggest that people gamble more using chips and tokens than they would real cash (Griffiths, 2003).

### Intrinsic structural competition

In most forms of gambling there is intrinsic structural competition. According to Parke, Griffiths and Irwing (2000), gambling is essentially viewed as an instrumental outlet to express an individual’s competitive urges and also as a mechanism to try to improve one’s financial situation rapidly. Kohn (cited in

Parke, Griffiths & Irwing, 2000) states that structural competition is a situation in which two or more individuals vie for tangible or intangible rewards that are too scarce to be equally enjoyed by all. In terms of gambling, tangible rewards are obviously the money or prize won and intangible rewards refer to the social aspects of gambling, where the gambler is acknowledged through peer comparison to possess skill (admirable gambling ability). Essentially, the gambling is a zero-sum game where one party profits and one party loses as a result of the other's gain. The structural competition of an environment leads to individuals being motivated to be competitive and creating and sustaining a "competitive psychological climate" where efforts are focused on obtaining goals. This theory can be applied to gambling institutions. Gamblers are in competition with opposing gamblers for scarce resources (for money), and to a similar extent with the proprietors of such gambling environments for money. There is temptation to speculate that it may be the structural competition of the games and the environment which motivates and induces gamblers to be competitive. Therefore, evaluation of the predictive validity for the personality trait of competitiveness for identifying pathological gamblers may be questionable because it may be the gambling which creates the competitiveness, rather than the competitiveness causing the excessive gambling.

#### 4.3 PSYCHO-STRUCTURAL INTERACTION IN GAMBLING

There is no precise frequency level of a gambling game at which people become addicted since addiction will be an integrated mix of factors in which frequency is just one factor in the overall equation. Such factors and dimensions (external to the person themselves) include the following (Griffiths, 2003):

- Stake size (including issues around affordability, perceived value for money).
- Event frequency (i.e. time gap between each gamble).
- Amount of money lost in a given time period (important in chasing).

- Prize structures (i.e. number and value of prizes).
- Probability of winning (e.g. 1 in 14 million on the lottery).
- Size of the jackpot (e.g. over R1 million on the lottery).
- Skill and pseudo-skill elements (actual or perceived).
- “Near miss” opportunities (i.e. number of near winning situations).
- Light and colour effects (e.g. use of red lights on slot machines).
- Sound effects (e.g. use of buzzers or musical tunes to indicate winning).
- Social or asocial nature of the game (individual and/or group activity).
- Accessibility (e.g. number of outlets).
- Location of gambling establishment (e.g. out of town, next to workplace).
- Type of gambling establishment (e.g. betting shop, amusement arcade).
- Advertising (e.g. television commercials).
- The rules of the game (i.e. ease of understanding).

Each of these structural differences may (and certainly does) have implications for the gambler’s motivations and, as a consequence, for the social impact of gambling. It is also the case that technological advances could influence almost every one of these characteristics. For instance, on the issue of gambling alone or with others, technology could have a negative impact. It has also been speculated that structural determinants of the technical software itself might promote addictive tendencies (Griffiths, 1995). Structural determinants promote interactivity and to some extent define alternative realities to the user and allow them feelings of anonymity – features that may be very psychologically rewarding to such individuals. Further examination of the structural determinants in the list above demonstrates that, for many of the categorizations (e.g. the near miss, light and colour effects, skill levels), it is difficult to separate the gambler’s individual psychology from the situation. For instance, the success of a slot machine’s structural determinants (where success is defined as an increase in gambling due to the structural determinants) depends upon the psycho-situational-structural interaction. The importance of a psycho-situational-structural deterministic approach to gambling is the possibility to

pinpoint more accurately where an individual's psychological constitution is influencing his/her gambling behaviour. Such an approach also allows for psychologically context-specific explanations of gambling behaviour rather than global explanations such as "addictive personality". Although many of the gambling-inducing situational and structural determinants are dependent on individual psychological factors (e.g. reinforcement), they are a direct result of the structural determinants and, in many cases, could not have influenced gambling behaviour independently. It is for this reason, above all others, that a psycho-situational-structural approach could be potentially useful.

#### 4.3.1 The impact of technology on gambling: Salient factors

In general, structural determinants of gambling appear to be enhanced through technological innovation. One of the major concerns relating to the increase in gambling opportunities is the potential rise in the number of problem gamblers (i.e. "gambling addicts"). Addictions always result from an interaction and interplay between many factors, including the person's biological and/or genetic predisposition, their psychological constitution, their social environment and the nature of the activity itself. However, in the case of gambling, it could be argued that technology and technological advance can itself be an important contributory factor. To what extent does technology facilitate excessiveness? Computerization of electronic gambling machines has dramatically increased their potency because it has enabled the following (Griffiths, 2003):

- Increased spin speeds
- Complex graphics with high visual appeal
- Increased lines in play
- Increase in the numbers of free games offered
- Range of complexity
- Ability to display suggestive and complimentary messages on the screen

In addition, there are a number of psychological reinforcers that make gambling activities potentially more seductive and addictive which include the following:

### Escape

For some, the primary reinforcement to engage in casino gambling is the gratification they experience while gambling behind an electronic gaming machine. However, the experience of gambling itself, may be reinforced through a subjectively and/or objectively experienced “high”. The pursuit of mood-modification experiences is characteristic of addictions. The mood-modification experience has the potential to provide an emotional or mental escape and further serves to reinforce the behaviour. Excessive involvement in this escapist activity may lead to addiction. Especially machine gambling behaviour can provide a potent escape from the stresses and strains of real life.

### Dissociation/immersion

Gambling can provide feelings of dissociation and immersion and may also facilitate feelings of escape. Dissociation and immersion can involve lots of different types of feelings. This can include losing track of time, feeling that you are someone else, blacking out, not recalling how you got somewhere or what you did, and being in a trance-like state. In extreme forms it may include multi-personality disorders. All of these feelings when gambling may lead to longer play either because “time flies when you are having fun” or because the psychological feelings of being in an immersive or dissociative state are reinforcing and moving closer to the threshold of a potentially addictive pattern of behaviour

### Asociability

One of the consequences of technology has been to reduce the fundamentally social nature of gambling to an activity that is essentially asocial. Both Fisher (1993) and Griffiths (1991) have carried out observational analyses of slot machine players and have reached similar conclusions. Those who experience

problems are more likely to be those playing on their own (e.g. those playing to escape) (Griffiths, 1990). Retrospectively, most problem gamblers report that at the height of their problem gambling, it is a solitary activity. Gambling in a social setting could potentially provide some kind of “safety net” for over-spenders - that is - a form of gambling where the primary orientation of gambling is for social reasons with the possibility of some fun and a chance to win some money (e.g. bingo). However, it could be speculated that those individuals whose prime motivation was to constantly play just to win money would possibly experience more problems. One of the major influences of technology appears to be the shift from social to asocial forms of gambling. This implies that as gambling becomes more technological, gambling problems will increase due to its asocial nature.

### Sociability

On the other hand, different gambling games may structure social interaction via the socially standardized “rules” gambling provides. Certain codes of conduct and expectations of members surrounding gambling interactions – once learnt – provide a meeting/discussion point for strangers who would otherwise not speak to each other. Gambling games may structure social interaction in the following ways:

- promotes a sense of group and moral support that enable members to identify with one another;
- the gaming situation itself provides all the materials necessary for a successful gathering;
- the excitement of gambling games encourages people to become spontaneously involved in the task.

#### 4.3.2 Sub-types of gamblers

Blaszczynski, Winter and McConaghy (1986) and Blaszczynski (1988) have argued that there exist at least two subtypes of gamblers who differentially seek

to reduce or augment arousal states. Reducers suffer anxiety and select low skill activities to narrow their focus of attention and produce states of dissociation, while augmenters may choose high skill games to overcome states of dysphoria, a view consistent with Jacobs' general theory of addictions model (Jacobs, 1989). Jacobs' theory does however incorporate a physiological precondition. He suggests two underlying and interacting conditions which cause discomfort for an individual, leading to an attempt to self-medicate by engaging in addictive behaviour. The first factor Jacobs mentions is a unipolar physiological resting state (in which an individual is chronically over, or under stimulated). The second factor is a psychological problem such as rejection or insecurity that creates considerable psychological pain. In order to escape the discomfort caused by these factors, the individual uses the addictive behaviour to retreat into a dissociative state, which allows the individual to escape from the pain or discomfort. This model fits within both the biological and psychological disciplines and is intended to explain all addictions.

### Escape gamblers

Studies have reported a high prevalence of mood disorders, particularly anxiety and/or depression among problem and pathological gamblers (Bulwer, 2003, Black & Moyer 1998; Beaudoin & Cox 1999). Affective states may differ by gender. Marks and Lesieur (1992) reviewed the literature and concluded that female gamblers differed systematically from male gamblers in relation to manifesting psychological distress. According to Blaszczynski (2002), depression is a common condition found among pathological gamblers and important subtypes have been reported. Graham and Lowenfeld (1986) identified a depressive reaction personality type while both McCormick (1994) and Castellani and Rugle (1995) found a chronic dysthymic subgroup with a depressogenic cognitive style, which is prognostic for predicting a relapse. Pathological gamblers within the depressive category, particularly females, were reportedly more likely to choose modes of gambling that were socially isolating, repetitive or monotonous to modulate this mood state (Bulwer, 2003; Rosenthal,

& Lesieur, 1992; McCormick 1994). Escape gamblers reported they were gambling to achieve numbness and a sense of oblivion.

Most escape gamblers may have been nurturing, caring responsible people for most of their lives. Most may not be egotistical, have no indications of narcissism and may not be out-going. They appear to be “normal” and have almost the exact opposite character profile than that of the action gambler. Gambling becomes a problem later in their lives, frequently after 30 or as late as 70. In many cases during their lives, various psychological traumas have occurred and they may often be victims of abuse. These individuals frequently suppress those negative feelings and do not deal with them. As time goes by and the traumas increase, a single traumatic event may take place which causes situational or clinical depression. The desire may be to escape from painful emotional states (e.g. resentment, anger, stress, anxiety, depression, loneliness and self-pity) or any other uncomfortable feeling. The desire is to escape into a change of mood (though short-lived) in a world of their own where they can withdraw into themselves - to numb-out, to fantasize and to escape. These gamblers have chosen to use gambling as a coping strategy – as a way of dealing with unpleasant emotional states and may feel free from physical and/or emotional pain while gambling. After the predisposing issues have come to the surface, depression is prevalent and the individual will often do what most do, attempt to self-medicate or escape from the trauma (to make themselves feel better). These individuals are prone to use drugs, food, spending, sex, alcohol or gambling as a way to self-medicate. They tend not to like confrontation and are in desperate need of empowerment. When they choose gambling the individual may realize that the act of gambling does help them forget and escape their problems where they may become numb and almost in a hypnotic-like state while gambling. The individual may become addicted to gambling very quickly and the progression of the disorder may be rapid. Many escape gamblers often relate their gambling to relationship problems and the need to anesthetize painful effects. Dissociation while gambling may aid in their



escape seeking. They are attracted to repetitive, even monotonous games, which they play alone. They tend not to take a strategic approach to gambling, do not play directly competitive games, and typically do not boast when they win. Escape seekers are more apt to be female and start gambling at a later age than their male counterparts. Their games of choice are slot and video poker machines, bingo and lotteries.

### Action gamblers

Boredom may also be related to aspects of depression and it has been demonstrated that pathological gamblers have poor tolerance for boredom (Blaszczynski, McConaghy & Frankova, 1990). McCormick (1994) described a hyperactive subtype, characterized as chronically under-stimulated and constantly searching for relief from boredom. Lesieur and Blume (1991) referred to these gamblers as “action-seekers”. Not only were these individuals chronically bored, but even the action provided by gambling became boring unless it was novel, varied and capable of producing increasing levels of arousal. These action-seekers sought big payoffs, played competitive, skill-oriented forms of gambling and possessed a need to impress. Action-seeking gamblers have also been characterized by high energy levels, a need for stimulating situations, hyperactive, impulsive, unable to endure emotional tensions, unable to relax and hypo-manic (Custer, 1984; Peck 1986; McCormick & Taber 1987). Those falling within this profile tend toward activities considered highly stimulating such as horse racing and stand in contrast to the depressed profile gamblers who typically prefer slot machines (Blaszczynski, et al. 1986). Action gamblers, who are more likely to be male, look for big pay-offs, play competitive, skill-oriented forms of gambling, and speak of the “action” or excitement of gambling. They have a need to impress others and Gamblers Anonymous refers to their “big shot” mentality. Gambling for them often begins with an early winning phase - a memorable, early “big win”. Action seekers typically favor the traditional forms of gambling; cards and casino table games, sports betting and horse race wagering and have a desire for quick money – “a

quick fix". Both legal and illegal gambling is dominated by these gamblers. They gamble to beat other individuals or the "house" and often believe they can develop a system to achieve this goal which will then aid in improving their own self-worth. They are more likely to "handicap", "count cards" or be "percentage players". They tend to be energetic, assertive, persuasive and confident. In spite of this, they usually have a low self-esteem. Action seekers may begin gambling at an earlier age, often in pre-adolescence, and they have an earlier onset of problems than the escape seekers. Action seekers also have gambling careers of longer duration (usually over a ten to thirty year time span) than those of escape seekers, whose careers tend to be telescoped.

It is important to note that the differences between the action gambler and the escape gambler are not a gender issue. The accessibility of casino type gambling affects males who had no previous history of gambling in the same manner it affects females. For the escape gambler gambling is about "how long I can play for". For the action gambler it is about "how much I can win".

#### 4.4 CONCLUSION

Each form of gambling has its own particular blend of determinants that encourage extended play. Because casino owners, racetrack managers and slot machine manufacturers are also well aware of all these determinants, their table games, racing events and gambling machines are finely tuned to maximize player persistence and, hence, their own profit margins. All of the above structural influences can act in concert both to induce the initiation of a gambling session and to prolong a session once it has begun. In addition, the machines and other structural and environmental determinants do have the potential to influence gambling behaviour irrespective of an individual's psychology or physiological condition. However, a thorough understanding of all such determinants would permit psychologically context-specific explanations of gambling behaviour rather than any global explanation. It may be difficult and counter-productive to separate the gambler's individual psychology from the

situation. This knowledge, if acted upon, might also aid in reducing the potential for addiction.



## CHAPTER FIVE

### THE CYCLE OF PROBLEM GAMBLING

This chapter will focus on the cycle of problem gambling. Furthermore, the integration of a detailed psycho-structural stage matching model will be described in order to identify certain biopsychosocial manifestations in the respective phases in the development of pathological gambling.

#### 5.1 THE CYCLE OF PROBLEM GAMBLING

There is a recognizable cycle or pattern found in problem gambling. People with a gambling problem may thus have the experiences or go through the phases that are outlined in Figure 5.1.

The starting block common to the four pathways are the **situational determinants** of gambling – the acceptability, availability and accessibility to gambling. Situational determinants are those that relate to public policy and regulatory legislation that create and foster an environment in which gambling is socially accepted, encouraged and promoted. When a person with a **personal disposition** (any of the four vulnerabilities), whether biological, psychological, codependent or psychosocial, comes into contact with the **structural determinants** of a gambling space or gambling activity and the **psycho-structural interaction** is a pleasant and a positively rewarding experience (emotionally or financially) the person may return and continue gambling.

The next phase commonly applicable to all gamblers in this cycle is the influence of classical and operant conditioning with increasing participation and the development of habitual patterns of gambling, leading to impaired control

over their gambling behaviour. Due to the house advantage it is impossible to win at gambling over an extended period of time and the gambler will **lose** more often than win (if he does not quit while he is ahead), which may be rationalized as only being on a losing streak (denial). When losing, feelings of panic and despair can drive a person to chase what has been lost through further gambling, as debts rapidly escalate.

As the frequency of gambling progresses, stronger denial patterns leading to distorted cognitive schemas appear. These schemas shape beliefs surrounding attribution, personal skill and control over outcome, biased evaluations, erroneous perceptions, superstitious thinking and probability theory. The potency and pervasiveness of the gambler's distorted and irrational cognitive belief structures strengthen with increasing levels of involvement in gambling. When **chasing**, the gambler desperately tries to extricate him/herself from a deteriorating financial predicament. By this stage, diagnostic indicators for pathological gambling become readily identifiable.

The next phase – **compulsion** - is indicative of neuroadaptation with signs of tolerance and psychological withdrawal symptoms and uncontrolled gambling behaviour despite negative consequences. Repeated gambling alters the brain in profound ways that both stimulate more gambling and render choice more difficult. By this stage, severe negative consequences in the form of financial, emotional and relationship difficulties can lead to psychological disorders including mood disorders (depression and anxiety) and possible co-addiction (e.g. alcohol dependence) as damage to the gambler's self-worth may create a need for an additional coping strategy. He is now physically, emotionally and financially depleted and desperate and may be engaging in illegal activities and suicidal ideation or attempts.

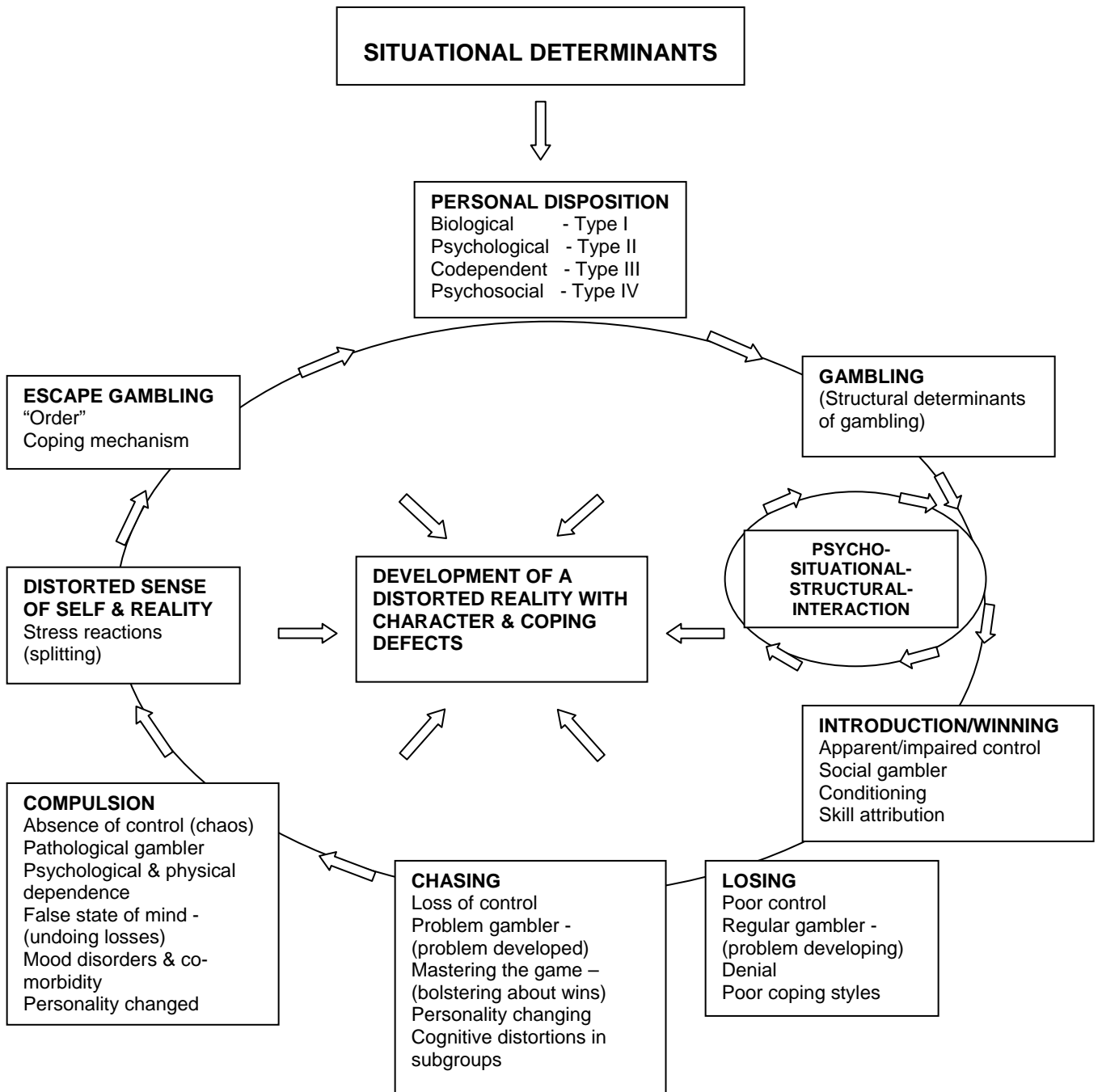
As a result of the severe acute and chronic stress as a consequence of the gambling behaviour, the gambler now finds her/himself in a constant altered

state of mind with a **distorted sense of self and reality**. Discontinuity/splitting refer to the ability of many gamblers to compartmentalize their lives and act as two entirely different people. On the one hand they may act as respectable and honorable pillars of the community; on the other hand they may resort to criminal activities to support their gambling addiction. Inconsistent or uncharacteristic behaviour is a key indicator of discontinuity. They again return or **escape** into gambling as it becomes the only place that provides some kind of “order” in their chaotic lives and where they feel in control and free of guilt and shame with a glimpse of hope – even though it is only an illusion.

## 5.2 THE WINNING/INTRODUCTORY PHASE (apparent/impaired control)

In its initial stages, gambling is experienced as fun and a social activity that provides pleasure and amusement. In these early stages the person may sometimes win large amounts of money. A large profit may be seen, just like winning in general, as the result of one’s playing skill or playing system. Owing to this, a feeling of self-esteem increases. Other first-time players, who have little knowledge of the game rules, may not like or enjoy gambling or the gambling environment and decide not to return to gambling. Others, who find gambling a pleasant experience (emotionally and/or financially) will return and continue to gamble. Gambling produces a sense of physical and emotional excitement. The early or winning phase is similar to the learning phase of a substance addict where the “high” is fun and the consequences minimal or non-existent. It may provide the player with the following:

- comfortable passing of time and a recreational activity
- excitement and entertainment
- big win or initial period of winning
- increased self-esteem
- unreasonable optimism – feelings of omnipotence
- may last months to years



**Figure 5.1 : A psycho-structural model of the cycle of problem gambling**



Large wins may be used to pay debts so as to free up credit for future gambling. Even though players do go through some losing episodes, they seem to have apparent control over their gambling. However, impaired control may manifest at times. During this phase they generally win more often than losing and start to replay their winnings (playing with the “casino’s money”). The more times players gamble, the less they value the wins or the money. Money starts losing its personal value. At this stage gambling is one of many possible diversions that offer entertainment and excitement. Most players either stop gambling, learn to gamble in a moderate and controlled manner, or advance to the next phase of involvement. Problem gamblers risk their wins by further gambling.

#### 5.2.1 Beginner’s luck: The “early win” hypothesis

There are individual differences that make some people more vulnerable to problem gambling than others but these risk factors may not explain all problem gamblers (Turner, Sharp, Zengeneh & Spence, 2003). We need to be aware that when we explain x-percentage of the variance according to some set of risk factors, we often leave a larger percentage (100-x) unexplained. Some of the unexplained variance may simply be due to winning early in ones gambling career; other parts of that unexplained variance are still simply unexplained. It may be that an early win sets up false expectations that will bias subsequent experiences.

Winning is frequently linked to problem gambling (Turner, Sharp, Zengeneh & Spence (2003). Problem gambling is also significantly related to the size of an individual’s first win. That is, people that reported larger first wins are more likely to report gambling-related problems. The data also suggested that wins lead people to believe that they can beat the odds. Problem gamblers are more likely to report that wins make them happy and excited and increased their self-esteem. Winning, especially for the psychosocial vulnerable gambler who has a poor understanding of randomness and probability, can be a great risk factor in developing a gambling problem. In chance situations, where people are, by

chance, successful at early trials, it is likely that an attribution to personal causation will be made. On the other hand, in chance situations where the outcome is a loss early on, people may attribute the outcome to bad luck or some other external attribution. Thus, even when losing, the player's established attributional style or locus of control orientation is held responsible for persistence during a current gambling session as well as for the initiation of new gambling sessions. An early fairly consistent pattern of successes may lead to a skill attribution, which in turn lead players to expect future success. The more wins there are, the greater the comfort that is felt in the possibility of a next win. The wins also desensitize the player to the risk. Sometimes wins, by themselves, are sufficient to cause problem gambling but most often people have a number of risk factors and thus it is the combination of factors that is the key to understanding problem gambling. Winning by itself can lead to problem gambling but winners are more likely to develop problems when they are ignorant, have erroneous beliefs, are living under much stress, depressed, are impulsive or easily bored, or use escape to cope. The more factors, the more likely they are to develop a gambling problem (Turner, et al. 2003).

### 5.2.2 Reinforcement theory

Learning theorists see excessive gambling as a consciously learned habitual response to immediate external stimuli that can appear at any stage of life (Aasved, 2002). The two basic types of learning that are responsible for repetitive behaviour patterns are Skinnerian or operant conditioning and Pavlovian or classical conditioning. Both classical and operant conditioning principles have been applied to the study of gambling. Repetitive behaviours are reinforced by the rewards that are experienced as a result of these behaviours. In the case of gambling these rewards can be financial or emotional, or both. Classical conditioning theory seems useful to explain people's motivation to commence a gambling session, while operant conditioning might explain ongoing behaviour. Both the classical and operant perspectives have been central to the development of measures of impaired

control over gambling. Reinforcement intervals, including all the other structural characteristics of gambling, (e.g. multiplier potentials, event frequencies, payout intervals and sizes, bettor involvement, perception of skill, win probability, light and sound effects, machine naming, suspension of judgment, intrinsic association) are influential in the acquisition, maintenance and escalation of gambling behaviour. Each form of gambling has its own particular blend of characteristics that encourage extended play.

Proponents of classical conditioning models argue that people continue to gamble as a result of becoming conditioned to the excitement or arousal associated with gambling, so that they feel bored, unstimulated and restless when they are not gambling. The basic premise of the classical conditioning model is that an involuntary reflexive response to a specific stimulus can be elicited by an environmental cue that is regularly presented in association with that stimulus. In other words, one stimulus can produce the expectation of a second stimulus as well as the behavioural response that the latter elicits. New gambling sessions can be initiated by external environmental cues that the gambler has learned to associate with the rewards of gambling. Thus, gambling advertising through the media, the croupier's call, the sight or sound of chips or coins, the spinning of a gaming wheel or the shuffling of cards can induce states of arousal, excitement, tension or anxiety that can reinforce the gambling response and perhaps even contribute to the onset of the problem.

In operant explanations, the strongest and most compelling reward sequence for shaping and maintaining gambling behaviour is the variable-ratio schedule and may even be the basis for all gambling systems (Aasved, 2002). Although the average monetary payout ratio may be fixed, reinforcement in such patterns always occurs in a random and unpredictable manner. The gambler can thus never be sure when the next reward will occur or how great it will be. Most gambling ventures therefore involve not only variable-ratio but also variable-magnitude schedules of reinforcement. Under these circumstances, whether a

gambler's last bet or play was won or lost, the next could always be a winner, and possibly a big winner. This fact is well-known by those in the gaming industry, as well as professional gamblers. By creating a sense of false hope and anticipation, slot machine owners gain an even greater advantage from the "near miss" or "near win" phenomenon which may be as instrumental in conditioning persistence as actually winning. By paying off very generously – the jackpot – for "three bars", the device eventually makes two bars plus any other figure strongly reinforcing. "Almost hitting the jackpot" increases the probability that the individual will continue to play the machine although this reinforcer costs the owner of the device nothing. Heavy persistent gambling might be attributed directly to the uncertainty factor which is built into variable-ratio and variable-magnitude schedules of reinforcement since it is characteristic of intermittent reinforcement that behaviour may be sustained over long periods with very little return (Aasved, 2002). In addition, professional gamblers have the advantage of being able to alter a reinforcement schedule during a game by allowing their opponents to win more frequently at the beginning of a game but continually less frequently as the game progresses. The professional gambler "leads his victim on" by building a favourable history of reinforcement. He begins with a low mean ratio under which reinforcement occurs so frequently that the victim wins. The mean ratio is then increased, either slowly or rapidly depending upon how long the gambler plans to work with a particular victim. This is precisely the way in which the behaviour of a pigeon or rat is brought under the control of a variable-ratio schedule.

What makes gambling such a potentially powerful dependency, compared to other behavioural and substance dependencies, is the "pay-off" (reward) – the emotional *and* financial reinforcement. There is reinforcement through increased arousal as a result of gambling and there is partial reinforcement through material, monetary rewards. Compared to other dependencies there are usually only emotional reinforcements. Gambling provides the player with the potential of emotional happiness and money. Everybody wants to be happy

*and* have lots of money. There is probably no other more powerful reinforcement for any human behaviour than emotional happiness and money. Thus, gamblers learn that wins will be intermittent but that they will occur and so they learn to continue gambling despite repeated losses.

### Action gamblers

During the winning phase (frequently three to seven years), action gamblers – who prefer games of skill - win more often than they lose and this is attributed to their own playing skill or playing system. They probably may have had a “big win” and this justified to these gamblers their opinion of being smarter than others and, of course, superior gamblers. Winning money is their primary motive. This provides a major boost to their feelings of self-worth, confidence, importance, recognition, respect and omnipotence. Action gamblers hope and believe in winning – in obtaining quick money (a “quick fix”) – and that money/winning will solve all their problems. These gamblers frequently believe that they are capable of becoming “professional” gamblers and may even perceive themselves to be just that. As these gamblers progress through the winning phase, they begin to gamble more often and for larger amounts of money. Eventually they begin to lose.

### Escape gamblers

Most escape gamblers begin by visiting the casino with friends or family once or twice as a social event. This is experienced as an opportunity to take a break from their problems and have some fun. In other words, they gamble for recreation. Some escape gamblers may rapidly fly through the winning phase. However, for some, often no winning phase exists. It is more an introductory phase. On occasion there may be winning episodes, but not phases. They may or may not have a big monetary win. Although money is usually secondary for escape gamblers, they may see gambling as a way to solve financial difficulties, become financially independent or make extra money after these winning episodes. For them, “winning” may have to do more with the empowerment that

comes from entering a world which is free from outside controlling factors which provides a narcotic-like relief or escape from their worries and problems. A self-esteem boost is experienced that comes from a false sense of empowerment as they experience an “it’s my turn” feeling without family members or others present to make demands on their time and energy. Emotional escape from life’s problems experienced while in the act of gambling is the sole “win”. Independence is yet another intoxicating win, especially if they are in a relationship where the spouse or significant other is domineering or controlling or if physical ailments or disabilities keep them from leading a normal life. Social interaction at the casino may also fill the void by many who suffer from loneliness. The progress into the next phases - losing, chasing and compulsion - happens usually within two to three years.

### 5.3 THE LOSING PHASE (poor control – problem gambling developing)

Unfortunately, luck does not hold out and this phase often begins with an unpredictable losing streak. Players start to develop an increased tolerance for gambling with more time, higher stakes and bigger losses. Poor control is evident and the problem starts to develop. During this phase players believe that they are simply on a losing streak and start to double up on bets. Losses are explained away and attributed to external causes. Continuous losses are rationalized as bad luck or a wrongly adjusted slot machine, with the “big win” just around the corner. Players start to lose more often than they win. The longer gambling continues, the greater is the likelihood of losing and they start borrowing money in order to gamble. Behavioural outcomes are the following:

- excuses for being late at work or home or for losing money
- gamble with borrowed money
- covering-up, lying
- other activities are neglected
- lowered self-esteem
- gambling during the week

- staying longer than intended
- first level of denial
- manifestation of poor coping skills
- may go back to social phase without help

After gamblers' own reserves are depleted, money is lent from the bank or at work and they proceed to play with borrowed money. Loans are hidden as much as possible from their partners, parents or other family members. Problems arise when this immediate circle finds out. The gambler invents excuses and tries to keep this circle at a distance. Gambling gives them an opportunity to relax for a while. To try to undo the losses and to be able to repay the loans, gamblers spend more and more time gambling. Owing to this, work and other activities become a burden and mistakes are made. They start to borrow more, now also from family, friends and fellow gamblers. All the time gamblers remain convinced they will be able to pay it all back.

### 5.3.1 Poor coping skills

Whether or not the gambler gambles once the urge develops or to the point where it is problematic also seems to be related to the gamblers' coping skills. In this context "coping skills" mean the ability to:

- control heightened arousal
- challenge irrational thoughts and cognitions
- delay gratification and decision making
- delay reinforcement and the ability to apply problem-solving skills

The consequences of continued losses which include low-self-esteem, alcohol use, financial difficulties, stress and social pressure, may undermine a person's coping skills. Individuals with poor coping skills are more likely, therefore, to have their gambling behaviour become problematic, as they are unable to resist gambling once a trigger for the behaviour is encountered. It has been noted that

gamblers in treatment, for instance, used significantly more avoidant and impulsive coping styles. The fact that there are a high proportion of problem gamblers who also report drug or alcohol abuse supports the idea that they tend to have problems with coping skills (Bulwer, 2003). This also means that it is difficult for gamblers to manage many aspects of their lives, including interpersonal relationships, intimacy, behavioural consistency and negative affect. In addition, to the casual observer, many problem gamblers give the appearance of being enormously egotistical. A closer look at coping styles may reveal that an undernourished ego belies this idea.

### 5.3.2 Denial patterns

We all subconsciously use defense mechanisms at times to protect ourselves from being hurt. Gamblers, because of their gambling behaviour, are more vulnerable and open to attack. They therefore use defense mechanisms with increasing frequency. Defenses become part of their daily pattern of coping, of protecting themselves from the pain and guilt they would otherwise feel. Defenses work because it relieves their immediate anxiety, yet are unsuccessful because they block the gamblers' ability to see and experience reality. This distortion of perception caused by the excessive use of defense mechanisms accounts for the discrepancy in the interpretation of events and behaviours given by gamblers, as compared with that given by other observers.

During the losing phase gamblers start to develop a denial system to conceal the poor control patterns of their gambling from themselves. In doing so, they try to make it seem like an acceptable behaviour. In the process, the need to do something about the problem is lost and the gambling gets worse. The denial is not a deliberate attempt on the part of gamblers to deceive themselves. Rather, it is a subconscious process that serves to protect gamblers from the often frightening reality that they are unable to control their gambling effectively and therefore need to stop. Denial is not a single psychological defense mechanism disavowing the significance of events, but more broadly a range of subtle, and



often subconscious, psychological maneuvers designed to reduce awareness of the fact that gambling is the cause of the individual's problems rather than the solution to those problems

There are different levels of severity of denial manifesting during the development of pathological gambling and the denial and defense mechanisms become more intense, repressed and delusional as the problem becomes worse. During the losing phase gamblers' first level of defenses start to crystallize and the following forms are common (Meyer, 2001):

- Simple denial
- Minimizing
- Comparison
- Rationalization
- Blaming
- Intellectualizing
- Avoidance
- Manipulation

### Action gamblers

In the losing phase, which may last more than five years, the action gambler begins betting larger amounts and gambling even more. He starts to believe that he is simply on a losing streak and starts to double up on bets and stay in hands when he knows he should fold. He bets on long shots which he knows do not have much of a chance but will pay big. He starts losing more often than he wins but loves the thrill and excitement of the gambling environment. These frequent losses cause him to gamble even more in order to try and win back his losses. He continues to boast about his skills at gambling, talks often about his wins and rarely about his losses. At some point he has his first major set-back. Experiencing financial problems, he may convince his family or employer of some phony major catastrophic disaster which requires a loan. He borrows

money with which to gamble. He must lie in order to cover his tracks and to convince people that he is still the “happy-go-lucky” gambler and all around “good guy”. He has been able to obtain this first “bail-out” and probably asked for more than he needed to settle up his gambling losses, therefore, providing extra gambling money. He considers the “bail-out” as another win. He is back in action and gambling even more feverishly than before.

### Escape gamblers

Not every escape gambler will experience all of the symptoms or progress through the symptoms of a phase in the same order or at the same rate. Some may return to a previous stage for a short period of time. This is often seen after a bailout has occurred. Bailouts by friends or family may pay off loans or bills in an attempt to help the escape gambler get back on track. Some may start losing almost immediately but the “emotional wins” out-weigh their financial losses. Occasional winning only mean that they can play longer. Often these gamblers play low denominations (e.g. five cent or twenty cent machines) which may extend their playing time. For the escape gamblers losses are also at times rationalized as bad luck with the “big win” right around the corner. The cycle of winning, losing and breaking even continues. During this phase escape gamblers often gamble alone and hide their gambling from others and in many cases their gambling is often a “closet-activity”. More time is spent gambling or thinking about gambling or obtaining money to gamble with. They start lying to cover the money spent, are behind in bills and start neglecting themselves, their household responsibilities and families. They become irritable when not gambling and have unsuccessful attempts to limit or stop gambling. They gamble for longer than intended and literally until their last cent is gone. Some gamble during their lunch hour, after work or while the husband is at work and the children are school. Gambling may start affecting their focus, concentration, productivity and short term memory. They may start selling their personal belongings, (e.g. jewelry) to finance their gambling. Gambling quickly replaces all other coping skills and becomes a way to escape life’s problems. Much guilt,

remorse and self-loathing are experienced by these gamblers which fill them with anxious and depressed emotions, which in turn, create a greater need to return to gambling. However, they quickly step over the line into problem gambling in order to escape from painful emotional states and find gambling a useful coping strategy. The desire is to escape to a change of mood (though short-lived) to a world of their own where they can withdraw into themselves and “numb-out”.

#### 5.4 THE CHASING PHASE (loss of control – gambling problem developed)

Eventually gamblers start losing more than they intended or can afford and attempt to recover by “chasing” their losses. That is, pouring more and more money into gambling with the hope of winning amounts already lost. Soon gamblers are plunged into the critical and chasing phase, caught up in a cycle of chasing losses, winning occasionally, then suffering more losses and so on in a tightening downward spiral. Much of the gamblers’ time during this phase is spent mastering the intricacies of their games with a complete commitment and a nearly total preoccupation with gambling. Their gambling is now out of control but they are still boasting about their wins. The gamblers’ thoughts and cognitions become distorted and they focus only on the positive and immediately gratifying aspects of gambling such as the “high” to the exclusion of any that are negative or rational such as the monetary losses.

In time, however, gamblers become habituated to the level of arousal they once felt and must increase their betting levels to continue to experience the level of thrill and excitement needed to maintain their optimal hedonic state. As their involvement escalates they may come into closer contact with the core group of heavy gamblers who might begin to exert social pressures for even heavier betting. Both influences – tolerance to the emotionally arousing effects of betting and social learning or peer pressure – eventually lead to progressive larger losses and chasing. When continuously losing, feelings of panic and despair can drive gamblers to chase what has been lost. It often begins with

gambling away funds from a bailout that were supposed to pay debts. Gamblers in the chasing phase are unable to accept their losses and believe that if they continue, they will get their money back. It is the desire to get back what they risked to lose in the first place. They are not able to stop gambling without resenting it and feel that it is unfair for some reason. They believe that after losing so much money, surely a win is close at hand. Feeling entitled to a win can lead to plea-bargaining with “fate”/“lady luck” or others for extended credit. Even more time is spent gambling or thinking about gambling and belief and hope for a big profit is maintained. The chance that they will stop gambling diminishes all the time as they experience a lowering in self-respect. In the meantime, loans are rewritten and refinancing of existing credits is frequent. There is no realistic financial overview anymore. At home there are frequent arguments and conflict. Time and time again they promise to stop but are unable to stop gambling on their own. They need professional help. Significant symptoms are:

- financial, emotional and relationship crisis
- conceptualization of their gambling problem as really being a money problem
- may promise self or others to quit gambling but is unable to
- engages in “creative financing” by obtaining loans and credit, refinances mortgages or loans, cashes in life insurance
- feels shame guilt and remorse after gambling
- becomes manipulative and controlling
- making excuses about whereabouts and poorly explained absences from home and work – attempts to justify, rationalize, hide and/or minimize their behaviour to others
- loses interest in regular activities and hobbies
- gambles when there is a crisis and also to celebrate good fortune
- withdraws from family and friends

- changes in personality, (e.g. angry, irritable, critical, sarcastic, depressed, argumentative)
- gambles on holidays and special holidays
- uses gambling to cope when life seems overwhelming
- much lying
- secret gambling
- uses phone excessively
- loses the sense of the value of money as currency
- feels excited and great when gambling or about to gamble
- tries to win money needed for basic living expenses
- gambling establishments may feel like “coming home” when they enter after an absence
- other gambling patrons are thought of as “friends”
- the solution to financial problems and stress created by gambling is to gamble more in order to finally hit a big win or at least to recover their losses. Thus, the problem is also seen as the solution, a characteristic of addiction

In addition, gambling has a major impact on social and family life, affecting not only the gambler, but most importantly the spouse/partner, children and other relatives, including parents. The preoccupation with gambling, fear that others may discover the true extent of their behaviour and financial predicament all motivate the gambler to shun social contact. Social occasions that conflict with gambling opportunities are avoided or excuses are being made. The preoccupation with gambling virtually eliminates any enjoyment or motivation to participate in non-gambling related leisure pursuits. Repeated refusals of invitations to go out with friends lead to such invitations becoming fewer and less frequent. Marital arguments over financial matters and gambling make it unpleasant for the couple to be together in public and to avoid embarrassment it is much easier to remain at home. Because of the social embarrassment of not having enough money to buy clothes and goods, the partner of a gambler may

not wish to talk to friends and may instead avoid any situation where such subjects are raised and where it might be necessary to lie in order to cover up the true situation. These circumstances lead to:

- social withdrawal and isolation
- loss of friends
- reduced motivation for activities other than gambling
- irritability, tension and mood swings when pressured to attend social functions that interfere with gambling
- abusive behaviour by the gambler
- periods of marital separation
- divorce

Thus, the overall picture of the gambler and his/her family is an extremely unhappy one and in the vast majority of cases, the spouse/partner is unaware of the level of financial debt. To avoid detection the gambler is deceitful and dishonest with frequent lying and excuses to explain why bills are not paid or purchases/holidays cannot be afforded. The following are some of the many stratagems used by gamblers to conceal problems from their families:

- inventing excuses as to why they cannot afford purchases
- redirecting bills to post office boxes so that the spouse/partner remains unaware of unpaid or overdue bills
- intercepting the mail before the spouse/partner has a chance to see what is coming in to the household
- picking up bank statements directly from the bank
- forging partner's signature on loan applications or other documents
- pawning items of value and then claiming these to be lost or stolen

These stratagems may be successfully applied for several years with partners, family members and relatives remaining oblivious to the deteriorating financial

circumstances. At times a partner may be perplexed and concerned over the gambler's behaviour. Often, a lack of interest in him- or herself or in the family, a preoccupied manner, lack of money and time spent away from home may lead a partner to assume that the gambler is having an extramarital affair or has a problem with alcoholism. Discovery of the true situation often comes alarmingly sudden and from unexpected sources which include the following:

- bank statements revealing large loans or overdue bills
- deposit account statements revealing the loss of savings and assets
- credit card statements showing frequent and large cash advances
- forged signatures on documents
- police visiting to interview the gambler or level charges for offences committed
- receipt of legal notices threatening repossession or similar action

#### 5.4.1 The role of cognition

The human mind is not very good at dealing with randomness (Turner, 2002). The mind is designed to find order, not to appreciate chaos. Ever noticed how easy it is to find faces in clouds? Humans are wired to look for patterns and find connections, and when they find patterns they interpret them as real. Consequently, many people will see patterns in random numbers. When people see patterns in randomness (e.g. repeated numbers, apparent sequences or winning streaks) they may believe that the numbers are not truly random, and therefore, can be predicted. Many gamblers have experienced a wave-like roller coaster effect of wins and losses and may believe that they just have to ride out the down slope of the wave to follow the wave back up. Much of this learning process takes place unconsciously. The problem is that betting based on these patterns sometimes appears to work in the short term, reinforcing the belief. But it will not work in the long term; these patterns are flukes. Suppose a player starts playing roulette and he has a lucky winning streak by alternating his bets between red and black, it will actually take quite a while before he realizes that

the betting strategy is not working. His initial wins may keep him on the plus side for quite a while because randomness does not correct for winning streaks either. The same is true for superstitious beliefs. Because some people do not understand randomness, they interpret coincidences as meaningful and consciously or unconsciously learn associations that are merely due to chance. Implicit learning is the driving force behind both betting systems and superstitious playing strategies. Furthermore, our memory of an event is not just about what happened but about the *emotional experience* of what happened. In addition, these beliefs and expectations may not be irrational; they may often have been logically induced from a person's experience with random events. In essence, humans are programmed by experience, the implicit learning of expectations. Theoretically, if a person experiences enough random events he should have a pretty good sense of its nature. However, our minds tend to focus on early experiences and we often pay more attention to experiences that support our beliefs than to those that don't, so what we expect tends to be distorted. Another key factor is need. If a win fills an emotional, spiritual or practical need, the distorting effect of the win will be greater.

### *Irrational thinking*

Regular gamblers persist in trying to win money at gambling because they hold a set of false beliefs about the nature of gambling, randomness, the likelihood of winning and their own expertise. As a consequence of these false beliefs, information about gambling decisions is processed in a consistently biased manner which leads the gambler to make less than optimal choices. Gambling may only be exciting because of the possibility of winning real money and that possibility seems plausible because of erroneous beliefs. Cognitive psychological models explain gambling persistence as a consequence of the erroneous beliefs gamblers have about gambling and the false hopes they have about their ability to win (Aasved, 2002). Problem gamblers may frequently know a lot about their games and about the odds. Some of the information is accurate, but many problem gamblers may hold a number of erroneous beliefs



about how these games work and how to beat the odds. In particular they may hold numerous beliefs that the games run in cycles, or that the machine is due to pay out, or that they can figure out a winning strategy by studying the games. Many gamblers are convinced that persistence is the only logical strategy when they are losing; their only chance of getting ahead or merely breaking even is to continue since they would have *no* chance of doing so if they quit. Of course, any past experience of a big win after plunging – whether their own or someone else's – helps to reinforce this idea, even if it has happened only once. Since the actual probability is that they will continue to lose, persistence leads to even greater losses and more chasing in an attempt to get even.

During the chasing phase, there is a shift from external environmental influences to a focus on internal psychological factors. Like religious, political and other convictions that are often accepted and internalized without being questioned, beliefs related to gambling can be either culturally instilled or they can be learned and assimilated from exceptional or venerable individuals who are respected, admired and emulated. The beliefs and expectations of winning that many gamblers entertain often serve to maintain or reinforce their gambling even when they are losing. For example, a gambler may firmly believe that a special system of playing or handicapping must eventually prove to be successful or that he/she “knows” when a machine is about to pay out or when a horse will win. It is well known that a “hunch player” of this sort is the bookie's best friend. Chasing is essentially a cluster of beliefs and behaviours that lead a person to continue to gamble despite heavy losses “because a run of bad luck must end; because a machine owes them money; because it is the only way to get their money back”. Casino owners also know that the longer a gambler occupies a seat at a gaming table or machine, the more money he/she is likely to lose. Thus, chasing and the illusion of control - fostered by unrealistic and irrational thinking - are two cognitive phenomena that play a central role in persistent gambling. While payout rates and cognitive factors both appear to reinforce persistence once play has begun, the initiation of new gambling

sessions appears to be largely a matter of the gambler's pre-existing beliefs about his/her chances for winning. It has therefore been suggested that it is the machine reinforcement schedule that *drives* the behaviour and that the cognitive processes are by-products that provide the player with a verbal *explanation* of the behaviour.

*Cognitive distortions – distorted thinking in problem gamblers*

Cognitions are mental activities such as thoughts, beliefs, attitudes, images and memories, which together form a person's schema or mental representation of the self, others and the world around them in general. A schema contains an organized set of core beliefs about specific things and regular gamblers persist in trying to win money at gambling because they hold a set of false beliefs about the nature of gambling and their own expertise. As a consequence of these false beliefs, information about gambling decisions is processed in a consistently biased manner which leads the gambler to make less than optimal choices (Walker, 1992). It would also seem that many problem gamblers KNOW THE ODDS, but they believe they can BEAT THE ODDS. For example with a slot game, enough people win often enough to give them the illusion that it is beatable. Many gamblers profess a solid knowledge of the mathematics of chance but their behaviour does not reflect it. In addition, gamblers have biased evaluations of the odds involved in gambling and overestimate their chances of winning. More often than not the discriminative stimuli or expectations that influence much of people's gambling behaviour are founded on faulty logic, the emotional experience while playing, erroneous beliefs in the laws of probability, or on other irrational and often purely superstitious beliefs. On the other hand, electronic gaming machines may also create a "perceptual paradox" wherein rational and normal players know that they cannot beat the odds but their experience (emotions and cognitions) while playing is the very opposite. This may lead to most players eventually losing the ability to make rational decisions while playing. During the chasing phase gamblers may hold an irrational

optimism related to winning and some of their cognitive distortions are as follows (Walker, 1992).

*Biased estimates of probability*

Players' false perceptions influence their beliefs and behaviours related to probability and risk.

*Illusion of control*

Gamblers believe they can predict or influence the outcome of purely chance events and believe that games of chance have elements of skill. On the basis of a "two process model" of control that had recently appeared, Ladouceur (1997) suggested that *primary illusory control* refers to the belief that through their personal actions gamblers can directly influence the outcome of events; *secondary illusory control* refers to the belief that they have the ability to predict these outcomes.

*Wishful thinking*

Wishful thinking is a foresight bias that causes the betting choices of gamblers to be influenced by their hopes for particular outcomes. Any overconfidence in predicting outcomes is believed to play a major role in maintaining gambling behaviour. Even lottery players who have an obviously poor understanding of chance and probability entertain unrealistic levels of optimism regarding their chances of winning.

*Magnification of gambling skills*

Some gamblers, perhaps more than is imagined, hold a strong belief that they somehow have a great level of inbuilt special skills, knowledge or other natural talents that give them a winning "edge" over other gamblers. It is interesting to note that belief in one's own skill and ability to win persists despite the obvious evidence of continued losses.

### Illusory correlations

Such as the belief that “I can win more often at night; the machines pay out more at three-o’-clock in the morning after they have been fed full by everybody else”, including some superstitious beliefs.

### Selective memory/filtering out of losses

During this phase it seems that gamblers tend to remember and recall their wins to a greater extent than their losses and will further attribute wins to their own skill and ability. The more involved players become in their gambling activity, the more likely it is that they feel that they can influence the outcome

### Entrapment

Entrapment occurs when gamblers have lost so much that they cannot afford to quit since they have passed the point at which they could safely cut their losses. In essence, gamblers become entrapped when they begin to believe that they are “in too far to quit now”. However, it is believed that since the seeds for entrapment are often planted by an early winning phase, gamblers become hypnotized into thinking that their “system” (whatever it may be, and none of them work for long) actually is valid. All they need now is faith in their “system”, they believe, for with faith they can go on to greater triumphs that will impress the world. Gambling becomes a religion, but a blind one.

### The gambler’s fallacy

Many gamblers believe that a particular outcome is likely to occur simply because it has not occurred for some time. They therefore bet as though each previous loss increases their probability of winning on the next play no matter what form of gambling they pursue. According to Aasved (2002) the “gambler’s fallacy” has also been explained as:

1. the belief that a sequence of events in a random process – say the tossing of a coin – will represent the essential characteristics of the process even when the sequence is short;
2. the idea that probability or chance is a self-correcting process in which a deviation in one direction induces a deviation in the opposite direction to restore the balance; and
3. the treatment of independent events as dependent.

The gambler's fallacy is exemplified by gamblers who look for patterns or streaks and then bet accordingly. For example, many roulette players believe in a phenomenon known as the "periodicity of luck" or certain time periods during which red or black numbers will be more likely to win and reason that if red or black has not win recently, then it is also overdue and therefore more likely to win on the next play. However, this belief appears to operate in one direction; while gamblers who have experienced a series of losses often expect to win on the next play, those who have experienced a series of wins rarely expect to lose. In reality, of course, every spin of the wheel, every roll of the dice, and every toss of the coin is an independent event which remains totally unaffected by any previous outcome or series of outcomes and which has no predictive relevance for any future outcome. Thus, the chances for red or black, odd or even and heads or tails to appear on *any* play remain the same for *every* play. More recently, according to Aasved (2002), a "Type II" gambler's fallacy has been proposed as a complement to the standard or "Type I" fallacy. A Type I fallacy refers to the conviction that if things have been running a certain way they are bound to change, as in the belief that a black outcome in roulette is more likely after a series of red outcomes has occurred. Conversely, a Type II fallacy refers to the belief that if things are running a certain way they will tend to stay that way. This is also referred to as "temporal telescoping" – expectations of an imminent win. Racetrack bettors, lottery players and other kinds of gamblers are also susceptible to these fallacies. Many track bettors will continue to bet on a particular horse, increasing the size of the bet after each loss, in the erroneous

belief that irrespective of its condition the animal is overdue for a win and “owes” them the money that they lost in previous races. Others repeatedly play the favourites and escalate their bets race after race in the belief that each favourite’s loss further increases their chances of winning. Some will continue to bet on a “hot jockey” in the belief that he will continue to win while others bet against him in the belief that he is overdue for a loss irrespective of which horse he happens to be riding. Many lottery players make their selections on the basis of their belief in “hot” or “cold” numbers. Some will select numbers that have not been drawn recently since they believe them to be overdue or believe that winning numbers are more likely to be drawn again in the near future. Similarly, sports betters have also been shown to base their betting strategies on the belief that teams that are on “hot streaks” have better chances of winning than are warranted while those that are on “cold streaks” will probably continue to lose.

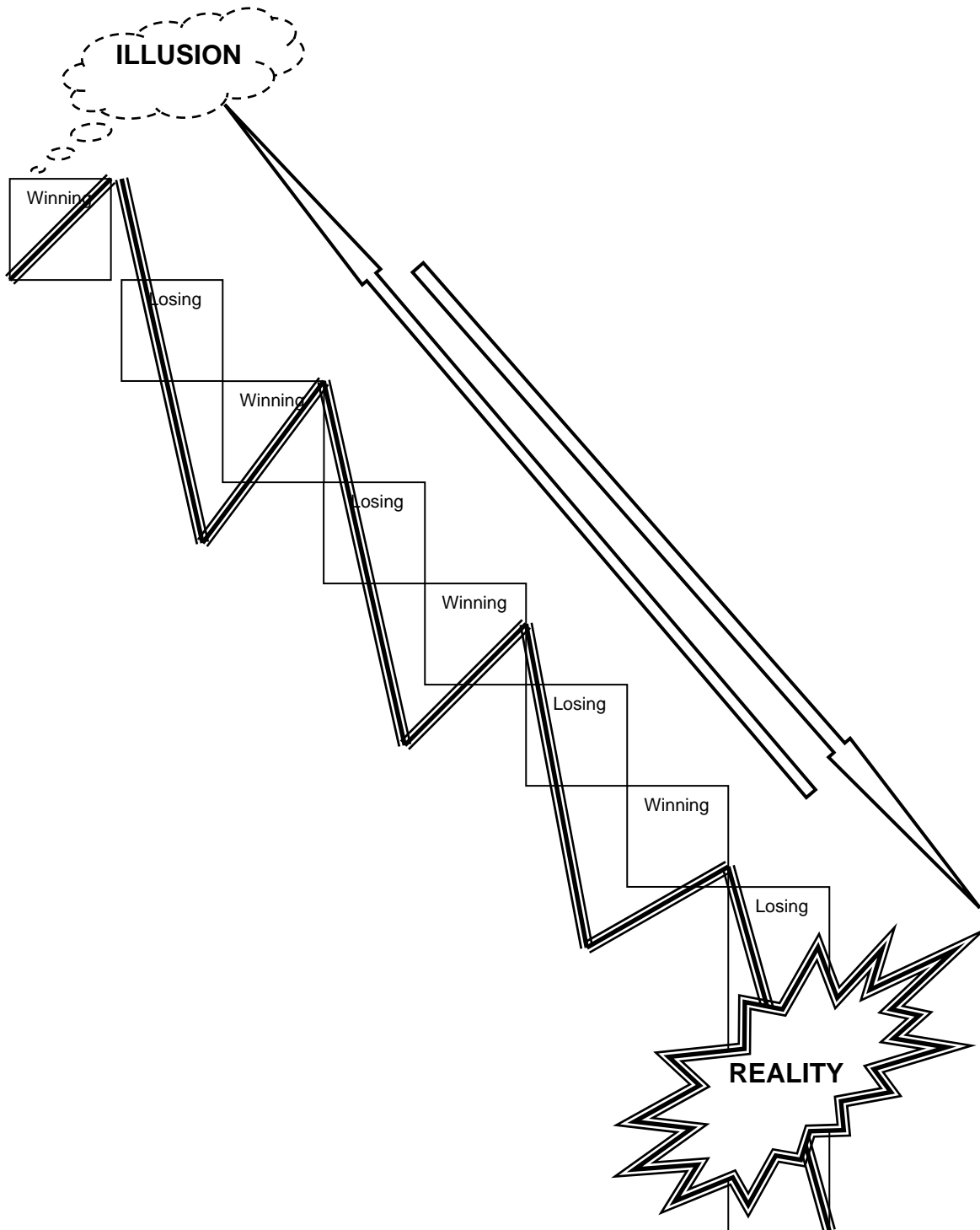
Gambling is not just about winning *or* losing – it is about winning *and* losing. Thus, what the gambler believes, and what he becomes so focused on, is the *illusion* that he will eventually win - (because it has happened so many times before) – that he will eventually outsmart the system or Lady Luck. He thus creates his own distorted cognitive belief system which directs and controls his behaviour, despite reality which is staring him in the face. (This cognitive distortion may be similar to the distorted belief system of a person that is suffering from an eating disorder – the reality of a skeleton is staring them in the face but they believe that they are overweight – and this belief controls their behaviour). (See Figure 5.2 for a schematic illustration of the gambler’s fallacy).

Why do gamblers persist, chase and succumb to the “gamblers fallacy” and other forms of irrational thinking. The answer seems to be that people generally attribute their successes to internal causes or to things that are within their control but ascribe their failure to external causes or to things that are beyond their control (Aasved, 2002). This appears to be the case for many gamblers

who interpret their wins as verification of their superior knowledge or sound handicapping skills – proof that their “system” is working – but explain away their losses as “bad luck” rather than any personal shortcomings.

### Action gamblers

The chasing phase can last for a short period of time or for many years and these gamblers often talk about their gambling as a high-risk-high-return “investment”. During this phase the majority of these gamblers’ time is spent planning or thinking about gambling or being in action. They no longer have control over their gambling and the borrowing and bailing-out continue. Their lying and manipulation are now constant and they become controlling of others, yet feel shame, guilt and remorse after gambling. Changes in their personalities become clear and they are angry, irritable, critical, sarcastic, depressed and argumentative. They have lost interest in regular activities and hobbies and gamble when there is a crisis and also to celebrate good fortune. When others do not believe their lies, they become angry with them, blaming them for his problems. They must obtain money with which to gamble and pay off their debts. Gambling establishments may provide them with a sense of belonging. They have withdrawn from family and friends and their families are in shambles and suffering in many ways; the rent or house payment is behind, they have lost interest in their jobs, accounts and bank statements are being hidden or destroyed, utilities may have even been turned off, they disappear for long periods of time with their cell phone switched off, and few of the relatives even speak to them anymore. Credit cards are “maxed” and the spouse does not know what is wrong. She knows he is gambling. She knows he continually lies and is very temperamental with constant mood shifts related to him winning or losing. She has heard him say a thousand times that he would stop and that everything will be okay. She is suffering from depression, but because she has a false sense of pride, she does not want anyone to know how critical the situation is and pleads with him to stop. Yet he continues to gamble.



**Figure 5.2 : Schematic illustration of the gambler's fallacy**



### Escape gamblers

Most escape gamblers may reach this phase one to three years from the onset of problem gambling. It is also important to remember that escape gamblers may not chase at all and just continue to play even while they are constantly losing. Gambling has now replaced all other coping skills and becomes a way to escape life's problems. A patient once told me that she played R19 000.00 on one machine when she much later realized that the jackpot was only R5 000.00. She felt so hypnotized by the machine that she became totally oblivious to everything and everyone around her.

Access to money is a crucial factor and escape gamblers gamble whenever they have or can get the money to do so. They may even play more at certain times of the month because of the availability of money and have become immune to losses. If they are in recovery from another dependency, there is a real possibility of a relapse. They are now obsessed with gambling and their physical well being and appearance are being neglected. They may experience major stress over the money loss, the secrecy that accompanies their gambling behaviour as well as the fear of having others learn of their gambling. Many escape gamblers in this phase may hope for a big win to resolve their problems and improve their life situations. Intermittent experiences of winning, exposure to other people's wins and promotions by the gaming industry may reinforce this hope and strengthen resistance to abstinence. They may now even be more depressed than before with panic and anxiety symptoms for which they may need medication. Their reputation has been affected with loss of friends and family and a lack of concern for others with drastic mood swings and illegal acts (embezzlement, bad cheques, insurance or credit card fraud). Intra-psychic issues of shame and guilt, compounded by emotional distress and relationship problems may become unbearable and they may have suicidal thoughts – yet they continue to gamble.

#### 5.4.2 Chasing – It's not just about the money

Rugle (2004) suggests that the concept of “chasing” can be extended to explore how gamblers chase in their attempt to meet emotional and spiritual needs. The financial aspects of chasing are certainly what many, if not most pathological gamblers are focused on when they enter treatment even if their behaviour contradicts this belief. It does not matter how much money is won at times, it is never enough. Chasing involves more than the material need for money. It is about emotional and spiritual needs as well. Many gamblers are chasing ego losses. Rosenthal (1995) wrote persuasively about the phenomena of the “bad beat” - the fluky loss that robs the gambler of a “sure win”. Losses like this may enrage the gambler who feels that fate has been unfair. This kind of thinking contributes to a sense of victimization and vulnerability. The gambler must therefore chase to overcome these feelings so he/she can regain a sense of power and control. The gambler focuses on having power over something external; power over the other players at the table or the fall of the dice. Gamblers may think that power and control can also mean having special knowledge, skill abilities or luck that allows them to feel protected and invulnerable. The more the gambler loses the more out of control and small and vulnerable he/she feels and the more desperate the chasing becomes.

Gamblers seeking relief and escape often care little about winning. Rather, research has suggested that their goal is to keep gambling as long as possible (Hing & Breen, 2001). What these gamblers are chasing is oblivion; repeatedly returning to gambling, even though they often do not expect to win. They use gambling as an escape from life's problems rather than as a way to cope with their problems in a more effective manner; yet their problems mount and they feel increasingly overwhelmed. They continually return to gambling to chase an illusory feeling of peace and freedom. Gambling also adds to their existing problems, so the chasing intensifies. One patient described a horrendous childhood of chaos and abuse. When her abusive, alcoholic father would come

home, he started yelling at whomever he saw first. When this happened, she would curl up in a corner and pretend she was invisible. She described the time that she spent playing video poker as giving her the same relief. She could be at her machine and be invisible and oblivious to any pain and stress in her life. No one could hurt her while she was gambling.

The pathological gambler is thus chasing a desire, and at the same time, running away from pain, fear and vulnerability. According to Rugle (2004) in the Buddhist tradition, desire or craving is the first in a list of hindrances or afflictions that lead to suffering. From this perspective, craving or desire represents an attempt to hold onto what is impermanent. Craving is based on the belief that we do not have within ourselves what we need to be happy. Therefore, we must have something beyond ourselves and beyond what we have right now. When gamblers chase, they maintain the illusion that they are catching what will bring them happiness, satisfaction and peace. However, ironically, the faster the gambler chases what always seems to be just out of reach, the greater the desire becomes. The pathological gambler becomes attached to his/her desire: "I must be a winner in order to be happy". "I must gamble to get relief". In this way, the gambler defines him/herself as someone who must have something more, better and different than what they are right now. Gamblers who chase are never satisfied with who they are or what they have at the present moment.

Chasing is therefore always about the past and the future. It is about evening the score for the emotional losses, inequities and mistakes of the past. It is about running away from the past and the present as much as it is about chasing a fantasy future that will bring an end to their suffering. The next bet will solve the problems, alleviate the pain or right all the wrongs.

In the intensity of the chase, it is nearly impossible for gamblers to accept that they are straining to reach the unattainable. The carrot seems to be so tantalizingly within reach. In the 12-step tradition, the first step of recovery is

accepting that one is powerless, in this case, powerless over gambling. For the gambler, this means truly accepting that the chase is over. While the chase has created mental, emotional as well as financial suffering, when it stops, the gamblers come face to face with the reality of the present moment. For most gamblers, the pain of facing reality far exceeds the familiar suffering of the chase. At least with the chase, they have the illusion of hope. When gamblers give up the chase, they often feel as if their lives are completely bereft of hope. Chasing gives gamblers the false hope that winning enough would make up for lost relationships, lost time, lost jobs and lost opportunities. Every time they stopped chasing, depression, self-anger and despair would set in as they struggle to accept what they had lost.

Chasing is a mindless activity. Clearly, the gambler who chases oblivion seeks the perfect mindless state – not thinking and not feeling. However, even for someone who gambles to chase power and control and who seems to put much thought into gambling systems, handicapping or strategizing, the chase becomes a mindless repetition. All the mental energy that goes into the scheming, conniving, lying and planning of the chase; the next bet is the “trance” of chasing, as psychologist and meditation teacher Tara Brach (2003) would label it.

#### 5.5 THE ADDICTIVE PHASE (absence of control (compulsion) – pathological gambling)

During this phase irrational gambling is evident and represents the point at which the strength of the gambling lifestyle begins to diminish. With the concomitant accumulation of negative experiences, all impulse-disorder lifestyles – including drug abuse, criminality and gambling – eventually begin to alter in conformance with the behavioural norms of greater society. This occurs because the behaviour no longer provides the thrill it once did and, as a result, the individual begins to mature psychologically and to regard his preoccupation with gambling and past gambling activities with disgust and remorse. However,

the frequency and size of bets increase and bigger debts are accumulated until rock bottom is reached. Everything else is neglected – work, family, relationships and social life. At this point the gambler is completely out of control. Nothing matters except finding more money to gamble, even to the point where many will steal or embezzle funds to support their habit. Gambling becomes a full-time occupation with loss of employment and social supports and includes the following:

- uncontrollable urge (compulsion) to gamble
- obsessed with gambling
- physical well-being neglected
- constant bail-outs
- reputation severely affected
- loss of friends and/or family (divorce)
- lack of concern for others and drastic mood swings
- long periods of disappearing
- lying becomes a way of life
- increases types of gambling
- gambles alone
- illegal acts (embezzlement, fraud, bad cheques, theft)
- suicidal thoughts or attempts
- co-morbid substance abuse
- emotional/psychological breakdown (depression)
- arrests

The addictive phase takes anything from three to seven years to develop. During this hopeless phase the gambler may be all alone, divorced, lost his job, friends, family and living in a back room of a “good Samaritan” - and gambling full-time. He has feelings of disappointment and dejection – dashed hopes, or “as if let down” with a great sense of remorse and feelings of helplessness and hopelessness. He has no material possessions as he sold everything to be able

to gamble and may have been sequestered. He has an appalling credit record, has been blacklisted with several judgments against him and hiding to avoid loan sharks, money lenders and creditors. To obtain money a number of gamblers will commit crimes like theft, fraud and embezzlement. The earlier optimism of the gambler that winning will return (to solve financial problems), begins to disappear. At the low end of the spiral gamblers talk about going to gamble knowing that they shouldn't, knowing that they will stay until they lose everything, knowing it makes no sense and knowing that they will get caught and it will drive a nail in their most cherished relationships and dreams. They also know they will definitely feel terrible both while gambling and afterwards. They are not chasing anything and do not expect to win anything. It is difficult to pull a "reward" out of these cognitions and feelings other than satisfying the compulsion and ending the obsession. They don't gamble because they want to, they gamble because they need to feed their addiction. Once this point is reached and in particular when illegal risks have been taken, they are moody, restless, irritated, highly-strung and sleep disturbances occur. Eating habits become disrupted and there is little pleasure in life. There are wins sometimes, but that leads to heavier gambling with heavier losses as a consequence. They have become alienated and isolated from everybody. Increasingly, they begin to play alone. At this stage, gamblers are physically, emotionally and mentally exhausted. They feel desperate, impotent and serious depression or other disorders or dependencies may occur. Even when they are completely out of money, just being in the casino or gambling environment is enough. They have lost all self-respect and at times beg or borrow money from other gamblers. Gamblers have a tendency not to be mean with their winnings and help out fellow gamblers, because who knows, "one day I might need you to help me out". Pathological gamblers in the final phase often have four options: suicide, prison, running away or seeking help.

### 5.5.1 Diagnostic criteria for pathological gambling

Pathological gamblers have a psychiatric disorder diagnosable by strict criteria. It describes a gambler who loses control over his/her gambling behaviour and is regarded as a disorder of impulse control, with a very poor prognosis. Such gamblers have an inability to control their gambling, with consequent significant damage to themselves and others, and are difficult to treat. According to the DSM-IV (APA, 1994), persistent and recurrent maladaptive gambling behaviour should occur which causes disruption or damage to several areas of a person's functioning, including personal, family or vocational pursuits. The gambling cannot be explained by a psychiatric condition of mania or a manic episode. In addition, at least five or more of the following features need to be present:

1. An excessive pre-occupation 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 or stop gambling.
4. Is restless or irritable when attempting to cut down or stop gambling.
5. Gambles as a way to escape from problems or relieve a dysphoric mood (i.e. feeling of helplessness, guilt, anxiety and depression).
6. After losing money, often return on another day to get even ("chasing" one's losses).
7. Lies to family members 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 educational or career opportunity because of gambling.
10. Relies on others to provide money to relieve a desperate financial situation caused by gambling ("bail-out").

As mentioned above, the criteria have been deliberately based on those for the substance abuse disorders. Certain criteria suggest the concept of craving, the notion of tolerance and that of withdrawal symptoms.

### 5.5.2 Theory of addiction

Addiction is the *compulsive* use of a substance *or* an activity (behaviour) resulting in physical, psychological, or social harm to the user and the user continues in this pattern of behaviour despite the harm that results. It characterizes a form of relationship – a pathological relationship with a mood-altering experience or thing – that causes damage to the individual or other. Addiction is not simply a property of drugs, though drugs are highly correlated with addiction. Addiction results from the relationship between a person and the object of their addiction. One simple model for understanding addiction is to apply the three **C's** (Shaffer, 2002):

1. Behaviour that is motivated by emotions ranging along the **c**raving to **c**ompulsion spectrum.
2. **C**ontinued use in spite of adverse consequences.
3. Loss of **c**ontrol.

There are at least 3 key elements involved in why people become addicted:

1. The nature of the addiction.
2. The powerful motivation behind some people's need to alter their internal emotional experience or to change their mood artificially.
3. The individual's physical/psychological vulnerability to addictive substances or behaviours.

The beginning of all addictions is a combination of these three elements. According to Shaffer (2002) not everyone who is predisposed genetically to



alcoholism develops the disorder. Some people who are not prone biogenetically to alcoholism or other addictions will acquire the condition. Therefore *social* and *psychological* forces will remain very important in determining who does and who does not develop addictive behaviours. Addicts in general begin by using some substances or behaviours in an inappropriate way to produce pleasure or avoid pain, thus affecting their emotional state. The kinds of experience sought after are many and varied, but they all have one thing in common – a desire to repeat the experience. There are four kinds of such experiences:

1. Creating a feeling of elation or excitement.
2. Creating a feeling of power or confidence.
3. Creating a feeling of connection or unity.
4. Relieving anxiety or some other emotional distress.

One very important observation about addiction is that every addict has a particular preference for certain behaviours/substances. The substance or behaviour of choice is determined by the kind of experience sought.

Addiction consists of two inter-related components:

- *Psychological dependence* where a person comes to rely more and more on the effects of a substance/behaviour to meet his/her psychological needs and help him/her cope with unpleasant aspects of him/herself or his/her life.
- *Physical dependence* which consists of:
  - *Tolerance* which necessitates the person to engage more and more in the behaviour/substance to obtain the effect he/she requires.

- *Withdrawal* (negative physical and psychological symptoms) occurs when the person is deprived of his/her usual mood-altering experience.

All addictions involve changing the chemistry of the brain. Like all drugs of abuse, pathological gambling is thought to stimulate the release of dopamine – a neurotransmitter involved in the regulation of emotions, movement and survival drive states – in an area in the brain called the reward pathway. Gambling, like addictive drugs, fools the brain by causing brain reward for self-destructive behaviour. The brain tells the user that gambling is good – just as it tells others that food is good when they are hungry. These brain changes are manifested behaviourally as mental preoccupation with gambling accompanied by a narrowing of interests and compulsive gambling in spite of adverse consequences, and failed attempts to quit or cut down. Gambling for money provokes physical symptoms including increased heart rate, high blood pressure, shaking and the release of certain hormones that contribute to an overall state of arousal, and eventually addiction. Physiological responses to gambling enhance the mood and winning has the ability to produce a “euphoric” state. The release of hormones mimics a stress event such as parachute jumping – and such an elevation in mood and excitement is often maintained for a number of hours after the gambling has ceased.

Psycho-active substances certainly have the capacity to produce physical dependence and an abstinence syndrome, for example, neuroadaptation. New evidence suggests that neuroadaptation (e.g. tolerance and withdrawal) also results from addictive behaviours that do not require ingesting psychoactive substances, for example, gambling (Shaffer, 2002). Neuroadaptation and physical dependence can emerge even in the absence of psychoactive drug use. For example, upon stopping, pathological gamblers who do not use alcohol or other psychoactive drugs often reveal physical symptoms that appear to be very similar to either narcotics, stimulants or poly-substance withdrawal (Wray &

Dickerson, 1981). Perhaps repetitive and excessive patterns of emotionally stirring experiences are more important in determining whether addiction emerges than does the object of these acts. Just as the use of exogenous substances precipitate imposter molecules vying for receptor sites within the brain, human activities stimulate naturally occurring neurotransmitters. The activity of these naturally occurring psychoactive substances likely will be determined as important mediators of many process addictions. According to Shaffer (2002) we may be able to advance the field by considering the objects of addiction to be those things that reliably and robustly shift subjective experience. The most reliable, fast-acting and robust “shifters” hold the greatest potential to stimulate the development of addictive disorders. In addition, the strength and consistency of these activities to shift subjective states vary across individuals.

Currently we cannot predict with precision who will become addicted. Nevertheless, psychoactive drugs and certain activities like gambling, exercising and meditating will correlate highly with shifting subjective states because these activities reliably influence experience – and therefore - neurochemistry. Addiction is not simply a qualitative shift in experience. It is a quantitative change in behaviour patterns; things that once had priority become less important and less frequent behaviours become dominant. Addiction represents an intemperate relationship with an activity that has adverse biological, social, or psychological consequences for the person engaging in these behaviours. To emphasize the relationship between the addicted person and object of their excessive behaviours serves to remind us that it is the confluence of psychological, social and biological forces that determine addictions. No single set of factors adequately represents the multi-factorial causes of addiction (Shaffer, 2000).

Pathological gambling is not just a bad habit. Just as some people can become addicted to alcohol or drugs, pathological gamblers become obsessed with an uncontrollable urge to gamble. ACTION (playing) is what pathological is all

about. Being in ACTION is like taking a tranquilizer or stimulant to put the gambler in a desired mood. The effect, however, wears off when the gambler must face the reality of lost money and lost time. As the stress increases, the compulsive gambler finds he/she must seek relief through even more gambling. The result is progressive financial and emotional deterioration which can destroy both the gambler and his/her family.

### 5.5.3 Defense patterns

During this phase, the first level of denial has disappeared and the gambler enters a higher level of defense, manifesting in cognitive distortions. His ability for self-deceit becomes highly advanced and sophisticated. Compared to the chasing phase where the gambler learnt and mastered the intricacies of his game where he still believed that he was going to win, this phase is recognized by the gambler acknowledging that he can not beat the system, but due to his uncontrollable compulsion to gamble, he must develop an ability to “rationally cope” with the unexpected results. The gambler is fully aware that his gambling is completely out of control and may admit to this. He may even see himself as beyond help. He does not only now gamble at different games, but gambles on anything and everything around him – even with the lives of the people that he loves. Gamblers gain enjoyment and satisfaction from the ability to control their environment and their satisfaction is greatest when they are made to believe that they can control the uncontrollable. The pathology in gambling during this phase is evident when the illusion of control itself becomes the sought-after reward of gambling. Pathological gambling is basically an addiction to a false state of mind and includes the following (Aasved, 2002):

#### Manipulation of luck

Many gamblers see luck as occurring in “wave form” that cannot be predicted but that can be detected or felt. The art of the game is to catch the crest of the wave which is the lucky period. Early detection, that is, the realization that you are in a lucky period, is considered to be part of the skill of the game.

### *Flukes and Hindsight bias*

When gamblers' predictions turn out to be wrong and they can no longer entertain their illusion of control over chance-determined events, they may resort to other means of distorting the reality of the situation. They may re-evaluate their losses to minimize their importance and recast them in a more favourable light. Thus, many pathological gamblers have a tendency to formulate "hindsight evaluations" of outcomes which allow them to rationalize their losses. Hindsight bias frequently occurs in situations in which losses can be explained away as "flukes" caused by random, uncontrollable external factors rather than failures of the gamblers' own expertise or instincts. Hindsight bias fosters persistence despite heavy losses because it enables gamblers to continue to justify the erroneous betting strategies or "systems" in which they have come to believe.

### *Superstitious beliefs and ritual performance*

Many gamblers believe that various superstitious behaviours and rituals performances can also influence their present luck and enhance their ability to win. The choices of many gamblers are influenced by the "omens" they encounter in license plates, newspapers, and radio announcements they see or hear on their way to the track. Many lotto players select their lucky numbers on the basis of astrology, dream books, telephone numbers, zip codes, computer programs and the birthdates of their loves ones. This belief in the power of thought is what keeps the gamblers working at games or investing in lotteries when it is well known that they are constituted so as to give bad returns. Gamblers may be well aware that the large body of gamblers as a whole must lose but they think that their own special powers will make them, as individuals, win.

### Action gamblers

During the compulsion phase action gamblers still continue to gamble, not because they want to, but because they “need” to – because they are addicted – and feel that they are beyond help. The gambler often has an outward appearance, even at this stage, of being in control. He is still convinced that everyone believes his lies and even becomes angry when they don’t. Outwardly he blames everyone but himself for the unfortunate circumstances now occurring. Inwardly, the gambler is in severe anguish. He truly loves his family and wants things to be like they used to be. He wants respect and stability, but he has to gamble. He can’t tell you why, but he has to gamble. He has to be in action. He is living in a dream world, knowing that he cannot win but hoping that this big miracle will save and rescue him from all his problems. Punishing himself, he wants it to end. He thinks often about self destruction and probably more often, has attempted suicide. He has to gamble because it is the only way he can relieve the pain – the action gambler has now turned into an escape gambler. If he is still in a marriage or a relationship, the gambler’s significant other’s pride and lack of knowledge about the disorder will not allow her to face the fact that she must take action. It may take something like an arrest of the gambler, a suicide attempt, or some other traumatic event to take place before she finally offers an ultimatum, plans an intervention, or takes the children and leaves the gambler. When an action gambler enters a self-help recovery program, he often believes that his family should immediately rally to his aide, expecting them to forgive him instantly for his misdeeds. He frequently still blames others for his actions, and usually does not face the facts squarely. Often he wears the fact that he has stopped gambling as a badge of honor and his ego is once again inflated. Not taking the recovery program seriously, he only stops gambling. He may not involve himself in the recovery program and before long, after a few meetings, after he has convinced his family that he is once again a “hero”, he stops attending the program. Before long, he may be back out gambling and back in action on a progressive slide downward, right where he left off. After this relapse, again out of money, he may return to the

recovery program and finally take his gambling addiction seriously. When this occurs, he has a better chance at recovery. Yet, often the action gambler attends meeting, gambles, returns to meetings and gambles again. This cycle may last for years. This type of periodic recovery and periodic compulsive gambling often leads to criminal activity and imprisonment or even death.

### Escape gamblers

Once the gambler is in this phase, it would seem that everything bad had occurred. However, in this hopeless phase, both types of pathological gamblers have “given up”. They believe nothing can help and they do not care if they live or die. In fact, for many the latter is the preference. They may all consider suicide during this phase. Most will commit actions which place them in jail or prison. Clinical depression is a given. In their minds, no one cares, no hope is available. However, the prognosis for the escape gamblers, after having committed themselves to a recovery programme, seems to be better than those for the action gamblers. Often, when there was an underlying mood disorder or codependency present with the escape gambler – and this has been effectively dealt with in treatment – this gambler may have a better chance at staying gambling free.

## 5.6 DISTORTED SENSE OF SELF

Gambling not only makes people feel better by decreasing their existential fears and insecurities, but it also leads to a distortion of their perception of self. According to Walters (1994) these cognitive patterns do not represent relatively permanent personality traits, but temporary thought processes that constantly change with different situations. These elements, which come into play once the gambling life-style is firmly established, serve to excuse, rationalize and justify the gambler's behaviour despite its adverse consequences. Many of the cognitions can be seen to function as sophisticated and advanced psychological defense mechanisms that aid in the gambler's denial of any problem and include the following:

### Omnipotence

Omnipotence is the feeling of being all-powerful and is a defense against feelings of helplessness. The sense of omnipotence that all gamblers cultivate is most apparent in their wishful thinking - the conviction that they will win simply because they have to win. Since this feeling is born out of the gambler's desperation, it is strongest when the gambler is experiencing the greatest difficulties. At these times, gamblers will engage in provocative acts by taking even greater risks merely to test their omnipotence and to prove to themselves that they really are in control of the situation.

### Entitlement

Entitlement refers to the conviction of many pathological gamblers that they are different from other people and therefore warrant special treatment. For example, embezzlement might be justified on the grounds that it is not really stealing since they intend to pay the money back. Walters (1994) claims that the idea of pathological gambling as an uncontrollable disease is another example of entitlement since it gives gamblers permission to think that they are powerless to control their addiction. It is therefore the means by which they give themselves permission to gamble.

### Power orientation

Power orientation refers to the need of many gamblers to feel "in control" in order to have a positive self-image. When they are losing this feeling evaporates and their sense of self-worth is threatened. In an effort to eliminate their feelings of powerlessness, many gamblers attempt to gain control over other people and other situations.

### Sentimentality

Sentimentality refers to the ploy of doing good things for others so that they can disavow the consequences of their life-style and maintain a positive self-image.



By giving to charities or lavishing their spouses and others with money or expensive gifts, for example, they are able to preserve and project an image of themselves as good people who do nice things for others.

### Discontinuity

Discontinuity refers to the ability of many gamblers to compartmentalize their lives and act as two entirely different people. On the one hand they may act as respectable and honorable pillars of the community; on the other hand they may also be resorting to criminal activities to support their gambling habit. Inconsistent or uncharacteristic behaviour is a key indicator of discontinuity.

### Splitting

Splitting refers to self-idealization and self-devaluation and is a defense mechanism akin to compartmentalization. It refers to the gambler's tendency to think of himself as two separate people, one who is all good – a winner – and one who is all bad – a loser. By simultaneously holding these two self-conceptions, gamblers often make entirely contradictory statements without seeming to be aware of the discrepancy. By mentally separating the contradictions in reality that they so often experience, gamblers are able to avoid the conflict that these discrepancies would otherwise generate. The over-idealized self-image of winner contributes to the gambler's sense of omnipotence through the fanciful images of personal strength and power over others that it creates. The power to control others is something all gamblers may attempt to realize.

### Self-ascension

Self-ascension characterizes those who seek altered senses of identity and consciousness that committed gamblers achieve through the rapid and dramatic emotional shifts they continually experience. Rapid mood swings from despair at losing to elation at winning and back again are responsible for the gambler's

growing reliance on and deepening commitment to gambling to solve all of life's problems.

### 5.7 THE ESCAPE PHASE

Gambling as an institution has social rewards, including membership in a gambling sub-culture, which counteract the monetary losses and provide the gambler with an *identity*, a language and like-minded peers. The gambler in effect retreats to this sub-culture when the wider social structure is perceived as threatening. As the gambler loses more and more money, the commitment to gambling is reinforced, as this is the only milieu which provides comfort and a sense of security to the gambler, thus exacerbating the problem. The problem may be seen as not only a loss of control, but also an inability to cope with the complexities of the world outside the gambling context. The money which is used in gambling can become a vehicle through which power, security, competence, sexuality, or any other illusional quality the gambler wishes to project onto it can be symbolically displayed. Gambling therefore offers an easy escape from reality that, for some, is preferable to facing the "existential void" they feel in daily life. Instead of learning more appropriate ways of dealing with it, those individuals who cannot accept what life has to offer may find that the spiritual transcendence they experience through gambling lends order and meaning to a chaotic, incomprehensible world which they feel powerless to control. Not only do pathological gamblers struggle in vain to gain an edge against fate but they also chase magical dreams at the expense of their psychological development.

According to Brown (1987) gambling, like alcohol and other drugs, has bi-phasic effects since it can act as both a stimulant and a tranquilizer and is therefore used to satisfy both needs either simultaneously or consecutively. Like other addicts, gamblers experience arousal while they engage in their addictive behaviour and become depressed when they stop. With continual play, their moods and arousal levels actually become more depressed than they were

initially, which are referred to as the rebound effect or withdrawal. Withdrawal symptoms are a rebound of the negative emotional state gamblers attempt to reduce through gambling, drinking or drug use and which they alleviate by repeating whichever behavioural response they have learned. It is therefore also used as a way of mood management. Thus, addictive behaviours serve not only to induce pleasant emotional states but also to relieve unpleasant ones.

Gambling and other addictive behaviours reduce an emotional drive that is experienced as stress, anxiety and/or depression. Since gambling, alcohol and other drugs serve as analgesics which act to reduce these unpleasant emotional states and replace them with enjoyable ones, persistence is thought to be negatively reinforced by the reward of tension- or anxiety-reduction they provide. Thus excessive drinking, drug use and gambling, which some theorists believe to be functional equivalents since they often accompany or substitute for one another, are said to be acquired drives or bad habits that are learned as coping mechanisms in attempting to diminish the intensity of any unpleasant emotional condition. Thus, it has been frequently suggested that drinking, drug use, overeating, gambling and other patterns of self-indulgence are all variants of a common maladaptive coping strategy for the alleviation of chronic stress or anxiety (Brown, 1987).

Gambling caters to the need for immediate relief and gratification and can be used to regulate affect, arousal or self-esteem. When people are overwhelmed with feelings of helplessness and uncertainty about life they find a ready solution to their problems in gambling, since it gives them a feeling of omnipotence by providing the illusion that they have the ability to control the uncontrollable. The attraction of gambling is not risk but certainty; it becomes an escape into order.

Dysphoric mood states have been associated with increased persistence among high frequency gamblers and pathological gambling is believed to develop when gambling becomes the preferred means of offsetting the chronic dysthymia

induced by stress (Brown, 1987). Thus, gambling appears to be maintained at different times by excitement as well as depression. The quest for stimulation rather than money becomes the ultimate cause. Gamblers seek out the excitement or action in gambling and all else become irrelevant. Excitement and action becomes the gambler's drug and since excitement is all that matters, winning and losing are relatively inconsequential. Money is necessary only because it provides access to the game and winning is desirable only because it sustains the action. Because the euphoria that gambling provides is so fleeting, the experience must be repeated frequently and sometimes losing can be just as exciting as winning. The thrill and excitement are so pleasurable that they are virtually addicting. There is also a thrill in the expectation of the consequences when one loses. Being in jeopardy from creditors, some of whom are bent on doing the gambler physical harm, intensify the excitement. It is this charged-up feeling, a mixture of super confidence, enthusiasm, fear and guilt that seems to drive the gambler toward the gambling table. Gambling is not really a money-oriented activity anymore, although money is a visible passport to gambling action. Gambling seems to be a way of feeling good – of feeling alive - at least temporarily - and money is only a vehicle. The gambler's fear is not of losing money but of being unable to gamble.

In addition, persistence during this phase may result from the inconsistency of gambling in successfully manipulating one's optimal hedonic state. The very unreliability of the chosen method of manipulation by the pathological gambler, superior though it is to the relatively amateurish chaos of the normally conducted search for high positive hedonic tone, give rise to an intermittent schedule of reinforcement and so makes for great resistance to extinction and tendency to ready reinstatement, not just in gambling, as is well known, but in all addictions by their central nature.

## 5.8 THE DEVELOPMENT OF A DISTORTED REALITY WITH CHARACTER AND COPING DEFECTS

Rosenthal (1986) emphasized the distorted reality and various defense coping mechanisms that pathological gamblers routinely employ throughout their gambling career – all of which are closely intertwined. Together they encompass the pathological gambler's distortion of reality including a series of lies, fantasies, illusions, and delusions through which the gamblers fools both himself and others, and include the following:

### Cut-off

Cut-off refers to the attempt of distancing one's self from the reality of the consequences that would normally deter further gambling. Some might use alcohol or other drugs to nullify the impact of such deterrents as an angry spouse or unpaid bills. Others might reason that they have already lost so much that a little more will not make any difference. The phrase most commonly employed to express this attitude is "fuck it".

### Cognitive indolence

Cognitive indolence refers to the gambler's tendency to look for short cuts in solving their problems and attaining their goals. Rather than assessing their plans in a realistic and rational fashion, they seek out and take the seemingly quickest and easiest route to success. Unfortunately, this is often the most dangerous choice since it results in very poor money management which sets the stage for imminent failure.

### Super-optimism

Super-optimism refers to the belief that gamblers can escape the consequences of their behaviour indefinitely. It originates in the initial success they often have in surviving various gambling-related crises. They may reinforce this notion by obsessively learning as much as possible about their preferential form of

gambling and perhaps developing an infallible system for winning. Chasing one's losses is one of the more common results of super-optimism.

### *Pseudo-responsibility*

Pseudo-responsibility describes the pretense of responsibility that many gamblers are able to maintain. They do so, for example, by holding steady jobs, paying most of their bills and avoiding arrest. These external appearances are false, however, since in reality they are unable to meet the emotional needs of their families, friends, and other important people in their lives. Like the drug addict, however, the gambler's ability to maintain a pseudo-responsible behavioural style diminishes as the gambling problems becomes more severe. The reason that drug abuse, crime and gambling occur together so often is because they have overlapping life-styles.

### *Hyper-competitiveness*

Hyper-competitiveness refers to those who need to crush their opponents whether they are other card players, bookies, dealers, croupiers, slot machines, or video games. The intense feelings of power, domination and satisfaction that winning induces provide the "action" that gamblers crave. For gamblers, the "rush" of winning is similar to the high that drug addicts feel and the excitement that criminals experience when committing and getting away with crimes.

### *Social rule breaking/bending/distorting*

This is typical of those whose commitment to gambling overrides all other commitments and obligations. Gambling has become so important to them that they will do anything it takes to be able to gamble even if it means suspending normative rules of social conduct. Experts at lying and deception, this personifies the quintessential self-serving con-artist.

### Idealization and devaluation

Idealization and devaluation of others serves as a defense against intimacy. Gamblers rarely see the important people in their lives as equals but tend to regard them as either flawless or useless. Their estimation of any person often alternates between these two views. “There is no easier way of keeping another person at a distance than to put them on a pedestal”. It would be equally difficult to become intimate with someone who is held in contempt.

### Projecting

The gambler develops and maintains these attitudes by projecting his feelings about himself onto others. Moreover, the attitudes he holds of others at any time change according to the feelings he has about himself at that time. Thus, he either identifies with others or feels threatened and harassed by them. When he feels persecuted he sees himself as not only being controlled by others but also as the victim of their unreasonable and exploitative demands – a situation he finds intolerable. Conversely, by fantasizing that he is in control of others the gambler feels as though he is controlling the things about himself that he has projected onto them. The result is dysfunctional interpersonal relationships.

In splitting, however, some individuals idealize the bad things about themselves and devalue the good. This reversal further complicates relationships with others onto whom they have projected the features they see in themselves. Such individuals are genuinely masochistic in that they idealize their own ruin. They seem to be thinking, “if I can’t do anything creative or beneficial for myself, at least I can be destructive, and I can hurt myself far better than anyone else can”. Patients often speak of “carrying suicide around in my back pocket” as a way out of any situation. Ideation of this sort enables them to maintain their fantasies of power and control.

### Denial

Denial, perhaps the most primitive of all defense mechanisms, refers not only to the gambler's habitual lying to others but also to his continued refusal – despite all evidence to the contrary – to admit the reality of his situation even to himself. In the words of one patient; “Whether I am telling the truth or not doesn't matter. Even when I am telling the truth I accuse myself of bullshitting. After all, I have lied in the past so I can always bring that up against myself”. While lying to others represents another way of avoiding intimacy with them, the simultaneous denial of reality on one hand while retaining some knowledge of it on the other is the key to splitting.

Thus, the ultimate purpose of lying is not to deceive others so much as it is to deceive one's self. In many cases, pathological lying precedes the onset of pathological gambling. Treatment success hinges on therapists awareness of these defense mechanisms and their importance to the patient. Since deception is so routine for pathological gamblers, many patients will lie to the therapists not only out of habit but also in an effort to control them along with the other important people in their lives. Treatment can therefore be successful only if the therapist knows how to avoid being misled by the patient's system of deception and how to confront the patient about it.

#### 5.8.1 Character defects

Gamblers may develop certain character defects and may undergo a personality change during the cycle of problem gambling as a result of the impact of their pathological gambling behaviour, which may manifest in the following:

#### Inability and unwillingness to accept reality

Inability and unwillingness to accept reality may create a desire to escape into the dream world of gambling. When faced with personal failures in life, problem gamblers may cope with the frustrations of day-to-day living through escape and fantasy. They seek relief from their poor self-image by dreaming of a Monte



Carlo-type existence filled with friends, new cars, jewelry, penthouses and rubbing elbows with the “right people”. However, there never seems to be a big enough win to make even the smallest dream come true.

### Emotional insecurity

Problem gamblers may find that they are emotionally comfortable only when in “action”. It is not uncommon to hear a GA member say: “The only place I really felt like I belonged was sitting at the poker table. There I felt secure and comfortable. No great demands were made upon me. I knew I was destroying myself, yet at the same time, I had a certain sense of security”. In their struggle to relate to others, coupled with a low self-esteem, gambling gives them the opportunity to create an “image” they have always dreamed about. There seems to be a strong inner urge to be the “big shot” and they may be willing to do anything (often of an anti-social nature) to maintain the image they want others to see.

### Immaturity

A common characteristic of problem gamblers seems to be to have a desire to have all the good things in life without any great effort on their part. Gambling seems to offer an easy solution to some of life’s most pressing problems; insufficient money, little prestige or self-esteem, feeling of boredom or failure, hopelessness and defeat. Many gamblers may accept the fact that they are unwilling to grow up. Subconsciously they may feel that they could avoid mature responsibility by wagering on the spin of a wheel or the turn of a card and so the struggle to escape responsibility finally becomes a subconscious obsession. They may also have a tendency to set unreasonable and unrealistic goals for themselves which, in frustration, they are never able to reach. They may expect too much from those around them as well as from themselves and may be extremely controlling persons.

### Lack of responsibility

Gambling becomes a priority to such extent that everything else is neglected – family, friends, employment and finances. Problems with absenteeism at work, loss of productivity, focus and concentration are commonly experienced. Resignation is a step taken by many to avoid being detected or prosecuted for misappropriation, embezzlement or theft from their employer.

### Lying and deceit

The further the gambler moves towards the pathological phase of gambling the greater is the pressure to conceal his/her behaviour so that lying becomes an automatic part of everyday living. Lies become more frequent as the gambler attempt to explain unaccounted time away from the family or work, lack of money to pay bills, mood swings and phone calls from creditors. Lying, cheating, planning, scheming and manipulating become part of his daily conduct.

### Crime

During the later phases gamblers may resort to crime – fraud, embezzlement and theft and alternative ways of funding his/her gambling addiction. Gamblers commit criminal offences when legal sources of funds are totally exhausted. To enable them to continue the gambling habit they attempt to recoup losses, repay monies borrowed and repay debts and to cover up losses to avoid detection by their partners, employers, families or friends. In gamblers with a high risk taking element in their personality, criminal activities may become just another way of satisfying this “need”.

In addition, depression, suicidal thoughts or attempts, anxiety and anger, alcohol consumption, cognitive impairment and a deterioration of physical health are common consequences of pathological gambling.

## 5.9 CONCLUSION

It would seem that gamblers are first influenced by situational factors, for example the availability, legislation and policy of gambling establishments. During the middle phases of problem gambling development, there are many factors which heavily influence the maintenance of gambling behaviour including various schedules of reinforcement and cognitive biases. It would seem as if the physiological effects of gambling (e.g. arousal or relaxing/escape) are cognitively mediated. Initially gambling is maintained by classical and operant conditioning. Excitement and escape, occasional monetary gains and the consequences generated by gambling encourage further gambling. If gambling continues cognitive mechanisms become more important. Links between environmental cues, arousal and gambling-related cognitions are strengthened.

Whether or not the gambler gambles once the urge develops or to the point where it is problematic seems to be related to the gambler's coping skills. Beliefs which discount losses and encourage undue optimism come to be triggered by arousal and/or environmental cues. Once the gambling behaviour has become habitual and the gambler encounters gambling-related stimuli, the gambler experiences a behaviour completion mechanism. This means that in response to familiar stimuli the body takes over and neuronal links within the arousal system trigger the heightened arousal that is the usual response to the stimuli. Once the behaviour has been triggered, it must be completed, or the tensions aroused become very uncomfortable for the gambler – a compulsion – with devastating emotional, social and financial consequences. In order to cope with the negative consequences of his pathological gambling behaviour the gambler needs to escape from his daily chaotic existence into an existence of “order” – returning to gambling - as this has become the only way for him to cope with the contradictions and inconsistencies of a distorted reality created by his gambling addiction.



## CHAPTER SIX

### TREATMENT CONSIDERATIONS

#### 6.1 INTRODUCTION

In this chapter I will focus on individualized treatment considerations and approaches for patients with a gambling addiction. In doing so I will attempt to relate treatment to individual patients' gambling characteristics, as previously described.

#### 6.2 BIOPSYCHOSOCIAL ASSESSMENT IN TREATMENT

Optimal treatment for pathological gambling requires a careful diagnostic evaluation and targeting of associated, or co-morbid, conditions that may influence gambling. These co-morbid conditions may be present currently or could have occurred within the patient's lifetime. Pathological gambling co-occurs with a number of psychiatric disorders and is highly co-morbid with substance use, mood, anxiety and personality disorders. Effective treatment should ultimately target all symptom domains in individual patients. This suggests that treatment for one condition should involve assessment and possible concomitant treatment for co-morbid conditions (Rosenthal, 2004). Without a comprehensive biopsychosocial assessment, there is a risk of treating the wrong set of problems, or failing to provide any intervention for some problems. The biopsychosocial assessment delineates causative influences, types of gambling and related health, social and behavioural factors. Although problem gamblers and families impacted by gambling have certain experiences in common, each patient is unique. Effective intervention with the gambler should begin with a comprehensive biopsychosocial history with the focus on the

gambling behaviour. The individuality of each patient should be respected and treatment plans should be tailored to meet patients' needs.

A comprehensive assessment process consists of several stages including initial screening, comprehensive assessment, treatment plan and appropriate interventions and is described by Clark and Stoffel (1992) as follows:

1. Initial screening

Screening refers to brief procedures used to determine the presence of a problem, precipitating risk factors, substantiate that there is reason for concern, or identify the need for further evaluation (Clark & Stoffel, 1992). Several screening instruments and types of interviews can be used to attempt to get gamblers to reveal information about their gambling habit. Usually structured questionnaires, interviews and self-assessments are used for this purpose including a GA 20 question gambling screen, a codependency screening tool and a DSM-IV diagnostic inventory. Assurance of confidentiality is an important factor that enhances self-reporting. Where possible though, collaborative information needs to be obtained from significant others as denial is a common facet of addictive disorders including problem gambling. Individuals (and often also their significant others) tend to minimize both the nature and amount of time and money spent gambling.

2. Comprehensive assessment

Assessment is a process used to determine the nature and complexity of the individual's spectrum of gambling behaviour and related problems. A comprehensive assessment should focus on the following areas:

- medical status and problems;
- psychological status and possible psychiatric disorders;
- social functioning;
- family and peer relations;

- educational and job performance;
- criminal or delinquent behaviours and legal problems;
- socio-economic status and problems.

Self-reports, interviews and collateral contacts should be used for information gathering. Standardized testing instruments, interviews and/or self-administered tests can also be used during the assessment process. Multiple instruments have been developed in response to a need to detect and measure problem gambling. Existing instruments require additional psychometric evaluation – particularly with regard to specific population groups (such as seniors, for which new or modified instruments might be optimal (Grant & Potenza, 2004). Once information is gathered, it is interpreted for use in decision making.

### 3. Treatment plan and appropriate interventions

The data derived from the assessment process form the basis of an individualized treatment plan. The treatment plan should be comprehensive and contain information about the following:

- identified problems to be addressed;
- goals and objectives of the treatment process;
- resources to be applied;
- person responsible for certain actions and interventions;
- time frame within which certain activities will occur;
- expected benefits for the person/s who will participate in the treatment experience.

I used the comprehensive standard biopsychosocial assessment form, prepared and prescribed by the National Responsible Gaming Programme (Meyer, 2001), during the intake and assessment process. This was done in a private individual therapeutic setting and the following patient information was obtained:

- *Demographic information* (name, age, male/female), sufficient identification of the referral source and date, general practitioner, psychologist.
- *Marital position* including duration, current state of relationship, divorce, children, chemical or gambling dependency of spouse.
- *Biological family history* including chemical dependency or gambling dependency in family (siblings and parents).
- *Residential situation* and whether this has been affected by the gambling problem.
- *Occupation* including current employment, employment history, schooling/qualifications, special interests.
- *Medical history* including surgery, active medical problems, current medications, nicotine addiction.
- *Psychiatric history* including diagnosis, depression, attention deficit hyperactivity disorder (ADHD), bipolar affective disorder (BAD), previous admissions, previous or current counseling/therapy, suicide attempts related and not related to gambling, current medication.
- *Criminal record* including criminal activity (theft, fraud, embezzlement), charges pending, disciplinary actions.
- *Chemical history* including current drug of choice and relationship to gambling, current usage (pattern, quantity), other addictive behaviours, chemical dependency treatment history.
- *Gambling history* including first gambling episode (age, situation, nature of game memorable consequences), biggest early win, biggest loss, current game of choice, pattern of gambling (frequency, duration), average loss per session, superstitions about play, playing strategies, other games played, total current debt and extent of disruption and loss of control, adverse consequences, physical health and household financial impacts, personal consequences, criminal activities and social costs.



- *Motivation for treatment* including any significant past attempts to stop gambling, reasons for failure, pre-treatment motivational crisis, reason for wanting treatment now.

Internal motivation (e.g. spiritual, financial concerns, incompatible with desired self-image or goals, rational appraisal of odds, negative emotions, rock bottom, familial influence, fear of future consequences, cognitive appraisal).

External motivation (e.g. legal reasons, lack of financial resources, support, confrontation, environmental influence, out of awareness).

### 6.3 STAGE-CHANGE MATCHING IN THE TREATMENT OF GAMBLING ADDICTION

Stage-change concepts have emerged as an important force in the treatment of addictive behaviours and addiction clinicians should be familiar with these concepts. Stage-change theory suggests that an evaluation of a person's readiness to change and determination of that person's stage of change are important steps in formulating appropriately matching treatment strategies. According to Shaffer and Robbins (1995) stage-matching includes the following stages:

1. Initiation and positive consequences.
2. Emergence of adverse consequences.
3. Awareness of adverse consequences.
4. Turning points and an orientation to change.
5. Active quitting: Taking action for change.
6. Relapse prevention and change maintenance.

According to Shaffer and Robbins (1995) therapists have relatively specific tasks at each of the different phases in treatment. For example, during the early stages of treatment, therapists should raise doubt about the effectiveness of their gambling addiction to achieve personal goals. Once patients consider

changing, clinicians must exercise ambivalence and stimulate motivation to change by identifying reasons to change and risks of the status quo. Approaches which could be helpful during this stage are motivational interviewing, psycho-education and solution-focused therapy. Once ready to change, patients will need help in choosing the best plan. When there is an agreed-upon plan, therapists need to teach the patient skills that support change and prevent relapse. Approaches helpful during this stage, depending on the type of gambling, may be the 12-step approach, cognitive-behavioural therapy and motivational interviewing. Finally, once a patient has made changes, clinicians must help him or her practice these new behaviours and reframe relapses as an ongoing learning process. Observers often incorrectly think that changes occur in a linear and progressive fashion. In reality, changing addiction is a recursive process with many opportunities to revisit earlier struggles; these turns provide the opportunity to practice the tasks of recovery necessary to grow as a person and rebuild one's life.

#### 6.4 COMPONENTS OF TREATMENT IN PROBLEM AND PATHOLOGICAL GAMBLING

There are a variety of treatment pathways that can lead to recovery (Grant & Potenza, 2004). These routes include formal treatments specifically focused on gambling cessation, such as residential programs, outpatient groups, informal groups and individual counseling. Regardless of the recovery pathway that an individual chooses to travel, similar change strategies and treatment components may be used. The majority of these strategies fall under the rubric of cognitive-behavioural mechanisms, and many are the focus of cognitive-behavioural interventions (Grant & Potenza, 2004). Addiction is a syndrome with common and unique elements. The common attributes, such as anxiety and depression are shared with other mental disorders. The unique elements such as compulsion, tolerance and withdrawal are exclusive to addiction. Addictive behaviours, and especially addictive gambling have many treatment targets and may respond best to a comprehensive biopsychosocial approach

where clinicians can combine medications and various forms of psychotherapy and counseling to address a range of problems (Grant & Potenza, 2004).

#### 6.4.1 Pharmacotherapy

According to Petry (2005) there are a number of research studies that point toward the importance of biological factors in gambling addiction; a genetic blueprint, high impulsivity, deficits in the serotonergic, dopaminergic and noradrenergic systems (see also biological vulnerability in chapter 2 for further research references). For the clinician, practical considerations argue for using medication. Medication can help to achieve abstinence and can help provide the much-needed structure and support necessary to maintain some patients in treatment. The continuation of gambling, with its potential for large, sudden financial losses, illegal activities that lead to incarceration, attempted suicide and other serious consequences, can disrupt or threaten treatment. One cannot treat a patient who fails to show up. Even when the gambler is physically present, if still actively gambling he or she may be emotionally unavailable, dissociated or cognitively impaired. According to Rosenthal (2004) medication is appropriate for:

1. the difficult-to-treat end of the spectrum;
2. those patients who are multi-impulsive;
3. who have multiple addictive and other co-morbid disorders;
4. who have severe and intractable cravings, and
5. who act out or are non-compliant.

Some promising research results have emerged from pharmacological treatment studies, particularly placebo-controlled studies of serotonin reuptake inhibitors, opiate antagonists and mood stabilizers (Grant & Potenza, 2004). However, medication should be thought of as an adjunct to the treatment of pathological gambling as most gamblers can be treated successfully without it. Even when medication is prescribed, it is still necessary to help the patient identify and

express feelings, confront difficult situations, develop social skills and deal with codependent and relationship problems. In fact, medication is given in the context of a relationship. Although medication may become a very important part of treatment, it should not replace counseling but could enhance the effectiveness of counseling by allowing the therapist to focus on reconstructing the client's life (removing the negatively reinforcing aspects of gambling) rather than dealing with cravings per se. However, if problem/pathological gamblers ask for medication, they are likely looking for a quick fix. Unfortunately problem gamblers do tend to be fond of the quick fix (just one more win and then!). Their unrealistic belief systems need to be addressed (Rosenthal, 2004).

There are also economic considerations that argue for using medication, including limited or non-existent medical insurance coverage, and the already overburdened finances of most pathological gamblers. Therapists treating gamblers are hard pressed to make do with what is available. For example, in many parts of the country Gamblers Anonymous (GA) may meet only weekly or not at all, and may not conform to patients' needs with regard to gender, age, ethnicity, or even language. Medication, again, helps to provide the structure and support needed for abstinence and recovery (Rosenthal, 2004). Clinicians will always have to make choices based on what they are trying to accomplish. When choosing to medicate a pathological gambler, clinicians must consider what they are medicating, and in which pathological gambler will a given medication be effective. The role of the counselor is important in this regard to inform the practitioner of the symptoms that need medicating.

There are a number of models that have potential for helping the clinician tailor specific medications to individual patients (Rosenthal, 2004). These include treatment strategies that address pathological gambling in terms of:

1. neurotransmitter depletion/imbalance
2. kindling

3. withdrawal
4. cravings
5. co-morbidity
6. sub-typing

While prolonged use or exposure to an addictive substance or activity may cause depletion of dopamine or other neurotransmitters, it is also possible that the deficiency occurred first and created the vulnerability for addiction. This primary deficiency could be related to genetic factors, early trauma or other environmental conditions, or another disorder such as depression.

There are four current approaches to the pharmacotherapy of pathological gambling. Medication is used to: (1) treat comorbidity, (2) target symptoms, traits or specific symptom clusters, (3) reduce negative affects, and (4) reduce cravings. Problems with compliance are significant, but are reduced when medications are used in conjunction with psychotherapy and other psychosocial approaches (Rosenthal, 2004). At this point, given that no pharmacotherapy for pathological gambling has received approval from the Food and Drug Administration, research indicated that the most conservative and safest recommendation may be to treat concomitant psychiatric disorders with medication (Petry, 2005). Thus, if a gambler presents to treatment with concurrent major depressive disorder, then serotonin reuptake inhibitors may be a reasonable option. If a gambler presents for treatment with bipolar features or cyclothymia, then mood stabilizers such as lithium or valproate may be justified, whereas fluvoxamine may exacerbate the symptoms. A patient with concurrent alcohol dependence and pathological gambling may respond to naltrexone treatment, although the necessary doses may be high and require frequent safety monitoring for liver functioning (Petry, 2005).

#### 6.4.2 Cognitive and behavioural treatment approaches

Treatment approaches vary in their relative focus on cognitive versus cognitive and behavioral change techniques. In the cognitive approach, gambling is seen as arising from the individual's beliefs and attitudes about control, luck, prediction and chance (Ladouceur & Walker, 1996; Toneatto, 2002). The goal of therapy is to identify and change cognitive distortions that are maintaining gambling. In more broad-based cognitive-behavioral approaches, gambling is thought to be maintained by both cognitive and behavioral factors, with treatment utilizing both types of techniques. Gamblers Anonymous incorporates a number of cognitive and behavioral strategies that can be used alone or with other approaches, as well as specific behavioral strategies such as self-exclusion policies and financial management (Nowatzki & Williams, 2002).

##### Cognitive therapy approaches

Observational studies in which gamblers verbalize their cognitions reveal more than 70% of gambling-related thoughts are illogical (Griffiths, 1994; Ladouceur & Dube, 1997). Correcting one's core beliefs about gambling and about the chances of winning is crucial to overcoming uncontrolled gambling. According to Grant and Potenza (2004) cognitive therapy comprises four major components: education, increasing awareness about cognitive errors, raising doubt about the validity of irrational cognitions and cognitive restructuring. Challenging the gambler's view about gambling and enabling him to understand the true reason underlying his motivation to gamble, can radically alter the desire to continue gambling. The aim with cognitive therapy is to assist the gamblers in setting about systematically identifying distorted or irrational thoughts, challenging these faulty assumptions and replacing them with appropriate styles of thinking (Aasved, 2002). The goal of the therapist is to maintain an interested and collaborative stance and to use Socratic-type questioning to help patients begin to doubt their cognitions.

Cognitive-experiential processes include *raising consciousness*, which consists of recalling negative information about gambling and think about financial problems from gambling. Another process is *self-reevaluation*, getting upset when thinking about one's gambling or being ashamed of one's own gambling behaviours. *Dramatic relief* is exemplified by being frightened by situations in which one finds oneself because of gambling and feeling scared about the strength of one's urges to gamble. *Social liberation* refers to noticing societal recognition of the dangers of gambling via advertisements or news stories and recognizing others who have stopped gambling. Last, *encironmental reevaluation* is related to thinking about how one's gambling has caused problems for friends or family members (Petry, 2005).

By the time many people enter treatment for problem gambling they often have amassed debt and done considerable damage to their interpersonal relationships. Early interventions might be successful in averting a large number of such crises. Cognitive behaviour treatment for early stage problem gamblers can include the following (Robson, Edwards, Smith and Colman, 2002):

- 1) Reducing gambling and money spent; and
- 2) reducing conflict experiences by the gambler at home, work, and in the community.

Key components of the above include:

- 1) discussing readiness to change;
- 2) using a decisional balance approach;
- 3) identifying risk triggers and coping strategies;
- 4) recording all gambling, and
- 5) examining potential gambling misconceptions.

Earlier uncontrolled case reports suggested that treatment focusing on modifications of cognitions could lead to cessation or reduction of gambling (Sylvain & Ladouceur, 1992; Toneatto & Sobel, 1990; Walker, 1992). However, the treatment intervention did not represent a pure cognitive therapy intervention. It included four components; in addition to cognitive therapy, participants received problem-solving training, social skills training and relapse prevention.

### Education

In terms of education, many gamblers lack awareness about the random nature of gambling. Basic information about gambling may increase patients' awareness of how specific cognitive errors influence their habit (Toneatto, 2002). Game information – how gambling works – is important information for all gamblers for the purpose of prevention, early intervention and treatment. Knowing this information can help gamblers make informed, conscious choices about gambling. Education is necessary and can be extremely useful with gamblers in all four vulnerability subgroups – biological, psychological, codependent and psychosocial. Much problem gambling is a product of various kinds of ignorance, including false beliefs about how gambling works (randomness, probabilities, odds), superstition, lack of money management and other life skills such as stress management. The therapist should be able to educate the uneducated ignorant psychosocial problem gambler in all these areas. Broadly speaking, for full-blown gambling addicts, the central problem is an impulse control disorder, a recognized medical condition. For the much larger number of excessive or problem gamblers, the central problem is various kinds of ignorance related to gambling, especially among the poor and uneducated. Education can be very helpful during the early stages of treatment especially in the ambivalence stage (Grant & Potenza, 2004). However, it is imperative that therapists educate themselves very well with regard to the how, what, when and where of gambling before confronting an action gambler in denial who may have an amazing ability to intellectualize about his gambling



behaviour. Some patients may be hardened gamblers, have had many failed attempts at abstaining and usually have very little faith in the therapeutic process. They may very often test and gamble with the “ability” of the therapist.

There are many treatment clients who would find how electronic gaming machines operate interesting, but not relevant to their treatment. For these clients this is not a useful treatment piece. However, there are also other clients where this is a necessary part of their treatment. Hence, the point is that this is one tool for clinicians to put in their toolkit. It is not for everyone. As previously indicated, one of the clinician’s roles is to ensure that they do a thorough assessment of the client’s needs at intake.

#### *Cognitive-behavioural approach*

Whereas the cognitive model focuses on cognitions, other models are more broadly based. Sharpe and Tarrier (1993) provided an integrative model describing the maintenance of problem gambling by both cognitive and behavioral factors. According to this model, stimuli that become associated with gambling over time can develop into triggers for gambling. These stimuli can be external (situations, times, places) or internal (affect, cognitions). Once a trigger is encountered, it leads to an involuntary response of heightened autonomic arousal that is accompanied by gambling-related cognitions (e.g. “I feel lucky today”) and urges to gamble.

#### *Coping and problem solving skills*

Whether or not the gambler gambles once the urge develops, or to the point where it is problematic, seems to be related to the gambler’s coping skills. In this context coping skills mean the ability to control heightened arousal, to analyze irrational thoughts, the ability to delay decision-making, to delay reinforcement, and the ability to apply problem-solving skills. The development of problem solving skills can assist individuals struggling against their impulses to gamble excessively to feel improved control over their gambling risks and

consequences. Problem solving strategies address therapeutic themes that include dealing with gambling urges, deciding about limits on the time and money spent gambling, resolving difficulties with family members and finding suitable solutions to gambling debts. The problem solving process involves a number of steps: identifying the problem accurately, collecting specific information about the problem, generating different options, exploring consequences by listing advantages and disadvantages for each, and then implementing and evaluating the preferred solution (Goldfried & Davison, 1976). There is also a range of social and life skills that can benefit a gambler in recovery. These include communication, assertiveness, numeracy skills, refusal skills, as well as the self-management of stress, anger and anxiety. Therapeutic life skills training also includes relaxation, physical activity and meditation.

Individuals with poor coping skills are more likely, therefore, to have their gambling behaviour become problematic as they are unable to resist gambling once a trigger for the behaviour is encountered. It has been noted that gamblers in treatment, for instance, used significantly more avoidant and impulsive coping styles (Scannel, Quirk, Smith, Maddern and Dickerson, 2002). The fact that there is a high proportion of compulsive gamblers who also report drug or alcohol abuse, supports the idea that they tend to have problems with coping skills (Bulwer, 2003). The poor coping skills hypothesis for the development of problem gambling is taken one step further where gamblers lack certain elements in their internal psychological structures. This results in gaps in identity and ego constructs, and inadequate cognitive and emotional frameworks. These gaps imply that it is difficult for the gambler to manage many aspects of his life, including interpersonal relationships, intimacy, behavioural consistency and negative affect. Impaired control over gambling might be influenced by certain problem coping strategies. These strategies include problem-focused coping, defined as active problem solving and conflict resolution and emotion-focused coping, centering on escape or avoidance of a particular problem or conflict (Scannel, Quirk, Smith, Maddern and Dickerson,

2002). A cognitive-behavioural treatment approach can be an effective tool in all four vulnerability groups and with both the escape and action gambler.

Using Sharpe and Tarrrier's (1993) cognitive-behavioural model of problem gambling, a clinician can create a treatment plan that can help a problem gambler focus on gambling-related behaviour and thoughts, decrease autonomic arousal and increase coping skills. A basic technique of cognitive-behavioural therapies is the functional analysis. It consists of identifying triggers or precipitants to gambling. Certain events, days, times, people and emotions have been paired with gambling in the past and may precipitate gambling episodes or urges. Gambling episodes are broken into triggers and are then evaluated for both positive and negative consequences. Financial counseling is often included in cognitive-behavioural programmes with the rationale that financial pressures are a common trigger to gambling. Other aspects of cognitive-behavioural therapy include increasing reinforcement derived from non-gambling sources (e.g. rewarding leisure activities) to compete with the reinforces associated with gambling. Gamblers can also be taught to brainstorm for new ways of managing both expected and unexpected triggers and to handle cravings and urges to gamble. They may also be taught other behavioural techniques such as assertiveness training or relaxation training. These cognitive-behavioural strategies can be delivered either alone or in conjunction with cognitive therapy (Grant & Potenza, 2004). Cognitive-behavioural therapy treats emotional disorders by changing negative patterns of thought. Irrational beliefs and locus of control orientations strongly influence gambling behaviour and different forms of gambling are likely to have different motivations. Thus, principles of reinforcement theory may be more appropriate in accounting for slot machine gambling, while those of cognitive theory may be more applicable to racetrak betting. In many cases, a cognitive-behavioural mix in the form of distraction, reminders of consequences and substituting other leisure activities can be successful.

Correcting one's core beliefs about gambling and about the chances of winning is crucial to overcoming uncontrolled gambling. Challenging the gambler's view about gambling, coming to understand the true reason underlying his motivation to gamble and recognizing what the activity is really all about can radically alter the desire to continue gambling. However, there are a number of other factors that need to be taken into account and modified. The gambler needs to be taught how to control the urge to gamble once it arises. The use of relaxation-based techniques (e.g, imaginal desensitization to reduce or eliminate the compelling urge to gamble) is important in treatment (Petry, 2005). In one study, McConaghy, et al. (1993) compared aversion therapy and imaginal desentization in a randomized design and found that both groups improved. Where depression occurs, one must take steps to reduce the low mood in order to increase motivation, the chances of compliance with treatment instructions and the hope that gambling and gambling problems could be overcome and solved. Strategies to avoid exposure to gambling triggers may need to be applied. For those who suffer from an additional alcohol problem or drug dependence, it is imperative that some help is directed to overcoming this problem, because it will determine how successful the gambler's efforts will be to regain control over gambling.

According to Petry (2005) five behavioural processes are reported in the literature on overcoming addictive behaviours. The first of these, *helping relationships*, means having people to talk with about gambling and related problems. *Stimulus control* refers to avoiding people or places associated with gambling and controlling access to money. *Counterconditioning* is keeping oneself busy to avoid gambling, distracting oneself, or doing exercise when urges arise. *Reinforcement management* means spending time with people who reward or make one feel good for not gambling, or rewarding oneself for not gambling. *Self-liberation* is making a commitment to not gamble, using willpower, and reminding oneself that one does not need to gamble to feel good.

A few case studies have shown reduction in gambling following cognitive-behavioural therapy (Arribas & Martinez, 1991; Bannister, 1977; Sharpe & Tarrier, 1992). The cognitive-behavioral therapy reduced gambling behaviours to a greater degree than GA referral alone. Other case studies of successful reductions in gambling after cognitive-behavioural therapy have been noted in several reports (Arribas & Martinez, 1991; Bannister, 1997; Sharpe & Tarrier, 1992). These same investigators also used relapse-prevention intervention to help training participants to identify and cope with relapse precipitants, including social pressure, negative affect, and interpersonal conflict. Over a 12-month follow-up period, 86% of the individual and 78% of the group intervention participants did not relapse, compared with 52% of the group who received no further treatment. In summary, controlled outcome data support the effectiveness of a cognitive-behavioural intervention that includes stimulus control and response prevention, as well as cognitive therapy combined with problem-solving, social skills training and relapse prevention (Sulvain, Ladouceur & Boisvert, 1997).

#### 6.4.3 Solution-focused therapy

This approach is heavily dependent on the expert knowledge of the professional who diagnoses the problem, makes the connection between problem and solution, prescribes the remedy and then follows up with an evaluation of whether the remedy was carried out and whether it worked. It focuses on a desirable future state of being rather than understanding what went wrong. It builds on strengths, rather than shoring up personal deficits (Berg & Briggs, 2002). This approach begins with a client's view and criteria for what is a desirable state of being and the therapist sets the stage for goal negotiation. Once the goal is negotiated, the next step is to learn about the client's frame of reference; that is, what is this person's unique way of orienting himself or herself in this world? For example, does this person view the world as hostile or friendly? Does the person view the problem as solvable or hopeless and

beyond solution? A host of other information can guide us toward understanding what might be a useful way to work with the client.

The third step is to discover the client's ability to find solutions: that is, the client's experience of exceptions to problems. For example, times when he or she could have gambled but somehow managed to stay away from it. These exceptions become the building blocks for tailoring solutions to fit a particular client. As treatment progresses, clients are asked to assess their own progress until they feel confident to carry out daily tasks in a manner they consider satisfactory. The solution-focused approach is driven by the client's view of his or her daily life in the real world outside of the therapy room. This approach further assumes that clients not only have ideas about what is good for them but also possess the beginning to their solutions, which is significant, however small. It becomes apparent why client resistance is a minimum, thus treatment moves along rather quickly and without the need to confront denial. According to Berg and Briggs (2002) therapists using this approach:

1. employ goal-driven activities negotiated with the client;
2. recognize that only the client can change (since we follow what the client is interested in changing);
3. are highly respectful of clients' own expertise in their own life circumstances based on personal history and life experiences; and
4. build on resources already existing in the client's life, rather than filling in or eliminating deficits and the treatment becomes short-term and long-lasting because we are working with the client's resources, not her or his deficits.

The solution-focused approach is a time sensitive, cost-effective approach that meets relevant criteria for efficient, effective and collaborative ways of working with clients short term. This approach tends to be effective with a non-pathological gambling problem, the psychosocial vulnerable subgroup and with

clients that presents with resistance to therapy. Because brief solution focused therapy was developed inductively in a clinical setting (Berg, 1994; DeJong & Berg, 1998; 2001) rigorous research that shows its effectiveness is only starting to come forth. Many informal studies have been conducted worldwide in a variety of settings. However, rigorous studies with pre- and post-measurements using controlled and experimental populations are difficult to develop and are just beginning to emerge. Recently, Gingerich and Eisengart (2000) reviewed the research literature on brief solution focused therapy as it was being refined as a viable treatment model with results that revealed similar and even better outcomes than traditional approaches. Further studies are needed to assess the effectiveness of the solution focused brief therapy approach with different client populations and several such research projects are currently underway in many corners of the world (Berg & Briggs, 2002).

#### 6.4.4 Motivational interviewing approach

Motivational interviewing is a client-centered approach that is designed to assist individuals in resolving their ambivalence about change. The methods are primarily active non-confrontational empathy and summarizing feedback to assist the client to move forward in a process of change. There seems to be tendency for counselors to move away from the concept of denial and the principles of motivational interviewing have taken its place. The aim is to help clients to identify for themselves what their concerns might be and thus to develop motivation as part of their own experience and priorities, not to foster resistant behaviour by insisting or implying that they have a problem but just will not admit it (Miller & Rollnick, 1991).

People with gambling problems often first seek help under pressure from significant others, or the courts. Under such circumstances, it may be difficult to make a therapeutic contract with the client. In addition, such clients are likely to be impatient and resistant. This would indicate that a motivational interviewing approach may be most productive to begin with (Miller & Rollnick, 1991). It may

lead to a behavioural probability and it is the function of counseling to facilitate the process leading to this probability. In general, the more the counselor insists on change, the more the client is obliged to resist. The counselor has a significant influence in determining outcome, dropout, retention and adherence and should be able to express empathy, develop discrepancy, avoid argumentation and roll with resistance and support self-efficacy. Therapists are more likely to be successful if they begin change from a position of self-acceptance than of self-loathing and have the client presents the reasons for change. Offering the client feedback in the form of summaries is one of the most powerful strategies in early motivational interviewing. Clients have seldom, if ever, reviewed chunks of their lives. Summarizing can assist the client in the beginning to make motivating connections between specific behaviours and unwanted experiences and sensations. Motivational interviewing approach may be successful in brief sessions, with high risk populations and with clients who are ambivalent about change (Miller & Rollnick, 1991).

A recent randomized study of 40 gamblers suggests that motivational interviewing techniques can improve outcomes when combined with cognitive-behavioural therapy (Milton, Crino, Hunt & Prosser, 2002). Motivational interventions in combination with cognitive-behavioural therapy appear to have some beneficial effect in case reports and descriptive studies (Petry, 2005). One randomized study showed potential advantages of these techniques relative to a wait-list control condition and workbook-only condition (Petry, 2005).

#### 6.4.5 Gamblers Anonymous 12-step programme

Gamblers Anonymous (GA) is one of the most popular interventions for pathological gamblers and is a self-help fellowship modeled after Alcoholics Anonymous (Grant & Potenza, 2004). GA proposes that pathological gambling is a disease that can never be cured but only arrested by complete abstinence from gambling. As in Alcoholics Anonymous, 12 principles or steps are followed, and members “work the steps”. These steps include accepting their



problem and powerlessness over gambling and surrendering to a “higher power”. Although it is not theoretically based, GA utilizes a number of behavioural techniques. First, members provide one another with positive reinforcement for refraining from gambling. Members state their duration of abstinence at each meeting and special rewards are provided for abstinence anniversaries, such as pins, certificates, or special meetings. Second, Gamblers Anonymous provides an alternative social activity to compete with gambling itself. Sponsors and call lists are utilized so that a gambler can telephone another member and receive social support and encouragement 24 hours a day, 7 days a week. Finally, the notion of taking one day at a time encourages the gamblers to make behavioural decisions on truncated time frames within which self-controlled decisions may be more likely. The programme is supported entirely by member contributions (Petry, 2001).

Although over 1,000 Gamblers Anonymous chapters exist in North America alone, little published literature exists on its efficacy. Researchers who have done observational work concur that most Gamblers Anonymous attendees do not become actively involved in the fellowship (Taber & Chaplin, 1988; Turner and Saunders, 1990). In a review of the number of meetings attended by new participants, Stewart and Brown (1988) found that of 232 attendees only 7.5% obtained a one-year abstinence pin. Almost one-quarter of new attendees never came back for a second meeting and almost three-quarters attended ten or fewer meetings.

Some data suggest that the effectiveness of Gamblers Anonymous can be enhanced by participation in professional treatment programs. Russo, Taber and McCormick (1984) evaluated 124 patients who completed a Veterans Administration program that combined individual and group psychotherapy with Gamblers Anonymous attendance. Of the 60 patients who completed the follow-up evaluation, 33 (55%) reported abstinence. Attendance at Gamblers Anonymous meetings and engagement in professional therapy were each

associated with long-term abstinence. More recently, research done by Petry, (2003) showed that Gamblers Anonymous attendees in professional treatment sessions had a higher rate of gambling abstinence than those who did not attend professional treatment sessions (48% vs. 36%). Also, the number of Gamblers Anonymous meetings attended was significantly and independently associated with abstinence. Although these results suggest potential effectiveness of Gamblers Anonymous when combined with professional therapy, the data do not demonstrate the efficacy of Gamblers Anonymous in reducing gambling, because random assignment procedures were not used. These outcome data simply suggest that gamblers who choose to attend Gamblers Anonymous (and receive professional treatment) do better than those who present for professional treatment but do not become actively engaged in either treatment modality.

Research done by Bulwer (2003) in South Africa indicated that after attending a six-week outpatient gambling treatment programme belonging to Gamblers Anonymous assisted treatment seekers to relapse less. The more likely they were to belong to Gamblers Anonymous the less likely they were to have any relapses. A negative correlation was also found between fulltime gambling during any stage and Gambling Anonymous participation.

According to Petry (2005), GA attendance seems to be associated with improved outcomes, but controlled studies are needed to further confirm these impressions. In terms of treatment recommendations, referral of gamblers who present for professional treatment to also attend GA may assist in maintaining abstinence, but at the same time therapists should recognize that only a minority of patients, and only those with abstinence-oriented goals, are likely to become involved in the 12-step programme.

#### 6.4.6 Self-exclusion (banning)

In some jurisdictions, local government or casino policy allows individuals to voluntarily ban themselves from gambling venues such as casinos and racetracks (Grant & Potenza, 2004). Typically, the exclusion is for a defined time period lasting from six months to a lifetime. The person may be excluded from one facility or from all facilities in the jurisdiction. When an individual enrolls in the programme, his or her photograph is circulated to the security officers of the facilities. The individual is also typically provided with information about local treatment resources. Sanctions for being caught on the premises can range from a formal request to leave to fines or legal charges of trespassing. Winnings are sometimes confiscated.

In principle, self-exclusion programmes are designed to eliminate gambling behaviour by preventing access to gambling venues. In this context, the ultimate criterion for successful outcome is abstinence as opposed to controlled gambling. Given that the explicit intent is simply to set barriers in place to prevent access to gambling venues rather than addressing irrational cognitions or psychological factors contributing to impaired control, self-exclusion should not be misconstrued to represent a method of psychological treatment. In this regard, the gaming industry's reliance on self-exclusion as the primary option for the management of problem gambling has been criticised by counseling service providers (O'Neil, Whetton, Dolman, Herbert, Giannopolous & Wordley, 2003). According to them there are three potential aspects related to the assessment of individuals seeking self-exclusion: (1) suitability for the programme; (2) need for concurrent counselling interventions, and (3) determining risk for self-harm. Self-exclusion is not a clinical or counselling intervention in its own right. While it is acknowledged that imposing a barrier to access gaming venues is sufficient for an unknown proportion of self-excluded gamblers, self-exclusion should be considered a procedure that supplements other treatment interventions. Referral to specialist gambling counsellors, clinicians and mental health services may be necessary to deal with factors that may contribute to chronic gambling

urges, comorbid disorders, marital dysfunction and personal issues and a appropriate mental health interventions can reduce the risk for relapse.

A review of self-exclusion programmes concluded that participants are typically male and have gambling problems and significant financial debts (Nowatzki & Williams, 2002). However, evidence is limited on the effectiveness of such programmes. Ladouceur, et al. (2000) focused on a small group of gamblers who were seeking their second exclusion from a Quebec casino. In this group, 64% had not entered the casino during their first exclusion (six to twelve months), and 30% had stopped gambling. Those who had violated the ban did so a median of six times. Only 10% had sought treatment. According to research done by Bulwer (2003) over a one year period self-exclusion seemed not to have had much of an effect on the number of relapses during the first half of the one year period. However, in the last half of that period a negative correlation was found which indicated that if treatment seekers had banned themselves they were less likely to relapse. In summary, more research is required to understand the role that exclusion policies can have in helping pathological gamblers overcome their problems.

#### 6.4.7 Medical/disease model approach

Although the debate continues whether pathological gambling is a medical/disease or a social problem, the American Psychiatric Association decided in its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994), to regard pathological gambling as a psychiatric condition but was not fully in favour of considering it a true addiction because there was no external substance involved. As a compromise, the decision was reached to include pathological gambling in the category of "Disorders of Impulse Control Not Elsewhere Classified" alongside a range of seemingly unrelated problems such as intermittent explosive personality, compulsive shoplifting (kleptomania), fire-setting (pyromania) and hair pulling (trichotillomania). Importantly, however, the

diagnostic criteria for pathological gambling were deliberately and directly based on those used for the substance abuse disorders (Blaszczynski, 1998).

There are three main features which distinguish disorders of impulse control. These are:

- The repeated failure to resist an urge to carry out a behaviour that is
- preceded by an increasing sense of tension and
- result in an experience of pleasure, gratification or release following its completion (Blaszczynski, 1998).

Loss of, or impaired control (powerlessness), is the key diagnostic feature and it is treated as a primary condition in and of itself, not secondary to other psychopathology. According to this model problem gambling is a “disease of unknown origin” with a probable but unproven neurobiological basis and an incurable, although treatable condition, but a progressive condition that gets worse with time. It is treated as a condition with a poor prognosis if untreated. This view is held by Gamblers Anonymous and health professionals who advocate classifying gambling as an addictive disorder. The medical model of gambling is, arguably, the dominant one in North America at the moment. (Aasved, 2002). The qualitative difference seen as central to the model may be due in part to some physiological factor which predisposes the individual to compulsive gambling (Jacobs, 1986) or to a mental illness such as obsession or compulsion (Brown, 1987), or to a combination of factors, including environmental circumstances. Pathological gamblers are seen, in some measurable way, as different even from other gamblers who experience serious gambling problems. Blume and Lesieur (1987) have differentiated the “disease” of pathological gambling from other forms of gambling by suggestion that it must be reliably and repeatedly harmful for the individual, and/or others. It must represent a characteristic pattern for the individual and be outside of the individual's conscious control.

The aspect of the involuntariness of compulsive gambling behaviour is also a key one. Pathological gambling is not a chosen route, but rather something which happens to an individual. It is a problem in and of itself and not a symptom of another disease. Further, it is not an unconscious habit, which can be changed by focusing an individual's attention on the behaviour. The disease follows a recognizable course, common to others with the same problem and is manifested through characteristic signs, symptoms and stages of development. Rosecrance (1986) summarizes the major components of the disease model as:

1. There is a single phenomenon that can be called "compulsive gambling".
2. Compulsive gamblers are qualitatively different from other gamblers.
3. Compulsive gamblers gradually lose control and are eventually unable to stop gambling.
4. Compulsive gambling is a progressive condition and one with an inexorable progression.

According to Blume (1987) the medical approach of gambling is a positive development which allows the problem gambler to shun the excessive guilt and defining oneself as "sick". The "sick" role requires that the patient accept the label applied and work toward recovery. Those who refuse to accept the label and the constraints of the sick role are seen as in "denial". This "sick" role and its attendant labeling do not mean that the "sick" person is a passive recipient of expert assistance, but rather can and should be an active part of the recovery process. While the model does not hold an individual responsible for contracting the disease, the individual is responsible for doing everything possible to recover. It strongly avoids a moral or judgmental stance even though many gamblers engage in criminal activities or socially unacceptable behavior as a result of the compulsion. The fact that the individual sought help is evidence of the desire to recover. As this approach is widely used by GA, therapists should

be familiar with this approach, whether it is used in individualized treatment or not (Blaszczynski, 1998).

Existing evidence from neurobiological, pharmacological, neuroimaging, neuropsychological, and genetic studies suggests that pathological gambling shares characteristics with substance use and impulse control disorders (Chambers & Potenza, 2003; Potenza, 2001). This growing body of evidence supports the role of multiple neurotransmitter systems (i.e. serotonergic, dopaminergic, noradrenergic, opioidergic) in pathological gambling. These findings allow for the generation of models that can be used as the foundation for future investigations into the neurobiology of pathological gambling. For example, a model incorporating impaired frontal cortical inhibitory mechanisms, largely serotonergic in nature, and increased promotivational drive, largely dopaminergic in nature, has been proposed as underlying increased vulnerability to addictive processes (Chambers & Potenza, 2003). Research done by Bulwer (2003) revealed that treatment seekers who had undergone a six-week outpatient treatment programme based on the medical model with a 12-step facilitation proved to have a 75% success rate after a one-year follow-up period.

#### 6.4.8 Codependency treatment approach

Codependency is an addiction to self-defeating behaviours (Sullivan, 2000). It is about focusing outside of the self for self-definition and self-worth. The reality in co-dependents' lives is that codependency is a deeply rooted compulsive behaviour and that it is borne out of sometimes moderately, and sometimes extremely dysfunctional family systems. Recovery from codependency is based on increased self-esteem – a self-esteem which can be gained by increased self-knowledge, a person's strong points and their weak points, and a full acceptance of themselves. This model tries to foster a basic self-love which is then carefully nurtured and expanded. Clients are encouraged to get in touch with their feelings and attitudes about every aspect of their personality, including

their sexuality, appearance, beliefs and values, body, interests and accomplishments. They begin to validate themselves rather than searching for a relationship to give them a sense of self-worth. Because codependency is usually rooted in a person's childhood, treatment often involves exploration into early childhood issues and their relationship to current destructive behaviour patterns through the use of psychoanalytic psychotherapy. Treatment thus focuses on helping patients getting in touch with feelings that have been buried during childhood and on reconstructing family dynamics (Stafford & Hodgkinson, 2000). The goal is to allow patients to experience their full range of feelings again. According to the psychoanalytic theory, once a person better understands the reasons for gambling, defenses can be confronted of which denial is a common defense. In addition, treatment includes education, confronting denial patterns, experiential groups and individual and group therapy through which co-dependents rediscover themselves and identify self-defeating behaviour patterns. Rather than seeing therapy as a means of simply avoiding the pain, therapists should enable clients to live through their own inner reality and make peace with their feelings, their past and their inner selves.

According to Sullivan (2000) patients need to be helped to examine their real life experience so that they can acknowledge the true impact of their compulsive codependent behaviour. Once they are more in touch with themselves and their lives, they may need to explore the root cause of the behaviour and then go through a process of letting go, or forgiveness of themselves, others, and their pasts. Unresolved codependency or family of origin issues are a chief cause for relapse for the unaware gambling addict. Becoming aware of the way these self-defeating personality styles interfere with the recovery process is an important part of understanding relapse. Tim Sullivan's six stages of recovery from codependent symptoms can be quite effective with the action gambler and especially with the escape gambler instead of the 12-step recovery programme and briefly includes the following (Sullivan, 2000):



1. First, clients need to acknowledge and become aware, consciously aware, of the self-defeating patterns of behaviour or the things that are not working in their lives. They need to put a name on the things they do that prevent them from getting what they want. These are the behaviours they are addicted or overly attached to.
2. The second step is detachment. After identifying the negative, self-defeating behaviours clients need to stop acting out the behaviour. They need to stop reacting. They need to learn how to be still and calm their minds.
3. The third step is to change the behaviour. Do something different which will break the personal and interpersonal patterns of self-defeating behaviour that occur when the thoughts and feelings that precede the self-defeating behaviour are realized and acted upon accordingly.
4. The fourth step is the social (empowerment). As a result of clients changing their behaviour, all of the social systems they are involved in are changed systems. They need to understand that this may cause conflicts but the change and benefits are well worth the effort. The above stages outline the processes necessary to repair the biopsychosocial damage caused by the development of a self-defeating personality style.
5. The fifth stage of recovery is the experience of psycho-spiritual transformation (a reconnection with the self). When clients became gambling-free, they had a psychological transformation but now a spiritual transformation is needed because the damage to the personality was done when the personality was developing and their soul was unfolding.

6. The sixth and final stage is continued growth and development. Maintaining again the gains made and reaching greater levels of self-actualization.

Codependency has been viewed with suspicion by outside observers as a fanciful term that lay counselors socialized in the narratives of a 12-step culture. Harkness, et al. (2003), however, conducted a research study amongst substance-abuse counselors and found valid and reliable professional consensus on the “diagnosis” of codependency. If replications of their study confirm their findings that addiction-counselor assessment of codependency are reliable and valid, then diagnostic criteria for codependency can be as a putative mental disorder from established disorders in the DSM-IV, laboratory studies, follow-up research, and family studies (Robinson & Guze, 1970). According to Stafford and Hodgkinson (2000) addiction studies have indicated that all forms of compulsive behaviour – eating disorders, compulsive gambling, sexaholism, alcoholism, spendaholism – are external manifestations of underlying codependency. Little research has investigated treatment outcomes and no listed studies have examined the efficacy of psychoanalytic or psychodynamic treatment of pathological gamblers. Instead, the use of these therapeutic techniques has been described within the context of treating gamblers. Today, some treatment programmes for gamblers continue to use these techniques and frameworks through an eclectic approach that may also incorporate GA, family therapy, and cognitive-behavioural techniques (Petry, 2005).

## 6.5 CONCLUSION

In this chapter I reviewed research studies evaluating different therapeutic approaches for treating pathological gamblers. Research data seem to suggest the efficacy of cognitive-behavioral techniques in treating these gamblers. However, due to the multi-dimensionality of addictive gambling, research suggests that treatment outcomes are improved when clinicians combine different therapeutic interventions within a comprehensive treatment plan. The

stage-change concept, which helps us to appreciate the natural history of addiction, underscores the importance of matching appropriate interventions with patients based on where they are in the process of addiction and recovery. In addition to stage-matching, this research study endeavors to clarify issues such as how to best match specific treatments with individual patients in order to enhance long-term outcomes. Thus, formulating appropriate matching treatment strategies should be based on not only the stage of change but also on the phase in the psycho-structural model, as well as the underlying vulnerability. From this a comprehensive gambling disposition profile can be completed with proper intervention matching approaches.



## CHAPTER SEVEN

### HENRY: A BIOLOGICAL VULNERABLE GAMBLER

#### 7.1 INTRODUCTION

Henry, a 38 year old single man, contacted the National Responsible Gambling Helpline (NRGP) three years prior to ask for assistance with his gambling problem. He was referred to me for outpatient counseling treatment after a telephonic assessment of his gambling problem by the NRGH.

When I met Henry his hair was curly and hanging on his shoulders. He was neatly dressed in a pair of jeans and a Manchester United T-shirt. When I shook his hand it was sweaty and shaky. Henry was clearly very nervous. As an “ice-breaker” I commented on his T-shirt and asked: “Are you a Manchester United fan?” He eagerly confirmed this. So we talked about soccer for a while. He became excited and showed a real passion for the sport. He further shared with me that he is also a passionate tennis player for which he received provincial colours as a child. As he started talking about his childhood he appeared more relaxed.

This is how our relationship of fourteen months started, lasting from February 2002 to April 2003.

#### 7.2 HENRY’S STORY

*I am Jewish by the way. I was born in the Jewish faith in a little town on the West Rand. I have two older sisters and one older brother – so I am the youngest of four children. My childhood was – well - not a particularly happy one I would say. First of all I was very shy. I also suffered from a stuttering*

*problem as a child and was teased and bullied much by the other kids at school because of this. I never really had any friends and was quite a lonely child. And – worst of all – I was the only Jewish boy in a predominantly Christian school! My parents were not very well-off and they could not afford to put us children in a private Jewish school. It was hell and I hated every minute of it. I never knew where I belonged and always felt very out of place. All I wanted was to fit in and be accepted by the other kids. On top of this I wasn't the sharpest pencil in the box either. I had enormous difficulty in concentrating at school and used to get very distracted and bored in the classroom – for which I obviously got reprimanded all the time. I actually had to repeat standard nine twice before eventually passing standard ten. I think the only way I survived at school was through my sport. I started playing tennis in primary school and really loved the game. Besides loving the game of tennis, the tennis court was a place where I felt comfortable and where I could make a few friends. Playing for the first team definitely gave me some acknowledgement amongst my peers.*

*When I was born my mother was 38 years and my father 50 years old. I never really had a relationship with my father. I think he was probably too old – but I always wanted him to notice me and approve of what I was doing. I also didn't see my father that often – he was working a lot..... Hell, that was another thing – I hated the work my father did! I was so ashamed of his job. He worked as a Security Officer at a large retail store. I was so afraid that someone would find out what he was doing and where he was working. My father's job didn't seem to faze anybody else in the family, not my brother or sisters nor my mom, and I could never really understand that. I guess my mother was just too happy that there was money for a plate of food for all of us. My dear Mom – that is exactly how she was – never really asked for much but was always ready to give and to hand out to others. I loved her so much. I shared a particularly strong bond with my mother. I adored her immensely. My mother got taken away too soon, as I still had so much to tell her and to share with her. There was so much I wanted to do for her and to make her proud of me. She was the kindest,*

warmest, friendliest, caring, loving Jewish “mommela” a person could ever wish to have. I guess, at the end of the day, my mother and father were pretty solid Jewish parents who did the best they could with the little they had. They didn't drink or gambled – unlike their own parents - my grandmother and grandfather who both had a serious gambling problem. I guess that is probably where I get it from – it's in the genes. Oh yes, and then there's my cousin. He had lost everything, and I mean all his material possessions, as a consequence of his gambling addiction. So yes, I guess gambling does run in the family.

I was always spoilt and protected by my brother and sisters and I used to get upset and angry if things did not go my way. I became the center of everybody's attention. My brother and sisters were much older than me and they really spoiled me. I did whatever I wanted to and could literally get away with murder. I knew I was my mother's favourite child and I slept in the same bed as my mother until I was eight years old. I wish I could have felt at school the way that I did at home. I felt so much protected and safe at home – I was confident and secure and I felt like I was in charge. I was also very manipulative at home as a youngster. But things changed as soon as I was away from home. It was like I became two different people. The minute I was away from home I would feel very insecure and scared. During my adolescence I was painfully shy and I had great difficulty in communicating with almost anybody, especially girls! I never went out with girls. I guess I was too shy and I never felt good enough for them - or - that I really fitted in anywhere. I had no money and nothing to offer a Jewish girl and I was not going to be accepted by a Christian family either. The only thing that I could do was to dream and have fantasies – sexual fantasies. I started having a lot of fantasies and dreams about spanking school girls and I would become sexually aroused by this. Creating these fantasies in my mind excited me and the more I had them, the more I felt I was OK – that things weren't that bad. I would dream about a world where I was in charge – where everybody respected and admired me. It was only in my dreams and fantasies that I felt comfortable and in control.

*I was nineteen, about two months into basics in the army, when my mom passed away. She had had a mastectomy but the cancer had spread to her liver. She had basically gone from being quite a healthy woman to a very sick lady in short period of time. Luckily I was in the army the first two months and didn't have to witness her rapid deterioration. But, I was there the weekend she died. I actually saw both my parents die with terminal illnesses. I was twenty-four when my dad died practically in front of me. He was 73 and had leukemia but he actually died of a stroke. This was hard for me, especially later on when the Jewish Festivals came along ..... I grieved much during those years. What's more, it was during that same period that my one sister emigrated in 1987 and my other sister in 1992. So I had lost both my sisters to Australia. My brother was still around but we didn't really communicate that well. It was during this time that I started gambling and probably had the biggest loss – materially of course. I guess I was trying to take out my grief via gambling. I just didn't care anymore and felt I had nothing else to lose.*

*After serving two years of national service in Pretoria, I started working at my uncle's motor vehicle garage for eleven months while still living at home. It was in fact during this time that my father had two strokes and developed Leukemia. I then decided to resign from my job and went back-packing through Europe for seven months. I was very pleased to leave the garage because I never felt comfortable about sharing with others where I was working and felt ashamed of the job that I was doing. When I returned to South Africa, I decided not to return to my old job at my uncle's garage and I enrolled on a trainee management course with one of the local restaurants. I didn't enjoy that either so I resigned after six months. I stayed at home for about two months doing nothing and then got a job as a junior clerk at one of the local banks. I was employed by the bank for about 5 years but was fired for committing company fraud - for a second time. I needed money to go back (to the casino) just one more time to get back what I had lost – I was going to put it back – but they discovered the missing*



*monies before I could replace it. Fortunately no charges were laid but I had to sign over a large portion of my inheritance to the bank to repay the money that I had taken and was then placed under administration. And then I couldn't care anymore. I just spent the rest of my inheritance on gambling. Always looking for a win, always thinking there was going to be a win, never thinking there would be a loss or anything like that. I was broke and with no job. My only option was to beg my uncle for my old job back – the job that I hated so much with a passion – and that's where I am still working today – hating it more than ever. I had no motivation or no ambition. I stole money from my uncle on numerous occasions to go gamble. It was discovered every time, but my brother would just bail me out all the time and I was back gambling two or three days later. This carried on for years.*

*While growing up and during my teenage years I never had relationships with the opposite sex. I had many sexual fantasies about younger school girls. During my army training I started sexually experimenting with other male partners even though my first real sexual experience was at the age of 21 years – with a woman of colour - who was also a sex worker. I was calling the shots now with the sex workers and it felt great.*

*I enjoyed spending time with the “ladies of the night”. It was so exciting and I started living a double secretive life that nobody around me was aware of and I called it my “dark side”. I spent a lot of time and money on this other life of mine and it became more difficult to go through a night without speaking to, or having one of these ladies. I also spent a lot of time on porn websites to pass the time – mostly S&M (sadism and masochism). I love to spank and cane a women dressed in sexy, silky clothes and I don't think there is anything sinister or weird about this. However, sex has cost me a lot of money, gray hairs and abortions.*

*I started gambling when I first visited a casino with friends, outside the South African borders in 1989 and won R3 000 in the first few hours of playing Black Jack. I was hooked almost instantly and was back gambling the same week. I actually started going to illegal casinos very early on. I loved gambling – any type of gambling – horses, dice, lotto, slots, internet, black jack, roulette – all of them. I was upgraded to a Prive Player fairly quickly and loved the excitement and thrill of the games. I wanted to be a “high roller”. Gambling and sex made me feel so much alive! If for instance I had a good win in one evening, I would celebrate by spending much of my winnings on buying two or three hookers at once and entertaining everybody for the evening in a hotel room – the ultimate thrill – I am telling you – the ultimate thrill with food and liquor in abundance! If I had lost, I would then only get one hooker for the night..... I guess..... maybe to make me feel better – and I would then drown my sorrows. I actually started drinking quite a bit – the alcohol was just always flowing.*

*I would spend my entire salary month after month on gambling and hookers – I just couldn't stop. I still remember clearly – I maxed three credit cards and a substantial overdraft facility and all my accounts and rent were in arrears. I was borrowing from all over - micro lenders, loan sharks, banks, family and friends. I even sold my computer and stereo set for gambling and sex money. Many times I asked my family for help and was bailed out by my brother and sister on the condition that I stop gambling – they weren't aware of the ladies (prostitutes). I would stop for about three weeks but was then back gambling the same as before – even worse. I would just run out of money every time and there was nobody left to borrow from. It was then that I took a company cheque from the bank - just to tie me over for a short while. Unfortunately this got completely out of hand and I wrote up approximately R10 000 worth of guaranteed company cheques at one of the casinos over a period of time. This was soon discovered by the bank and I was given a warning and it was arranged for me to repay the monies. I guess it was just too easy, but I was also in too deep. I couldn't stop gambling and I couldn't stop the ladies, and the bank*

*was the only place where I was able to obtain money – just to tie me over. When I started taking company cheques again – about R33 000 - I was caught and fired.*

*I had to beg for my old job back - the very job that I hated so much. I had lost all motivation and ambition and had become very lazy. I didn't feel like doing anything but gambling and sex. When I was not involved with gambling or the ladies, I would look for anything exciting such as great sporting events, sensational news events, reality television or even pornographic websites. During this time I had a win at the casino of R64 000. I decided to take my winnings and went to the Far East on a six week holiday. I spent most of my money there and the rest when I returned. When I returned, things just continued in the same manner – as if I was never away. In fact, I had several large wins of R30 000, R50 000 and R60 000, but it was never enough - I always needed more. I had many big wins. My biggest dream was to become a professional gambler and spending each day at a glitzy casino in an exotic place – driving a fancy car and spending money on sexy hookers. Before I knew it, about five years later, I had lost about R250 000 of which was inheritances and salaries. In the process I also lost my job and contemplated killing myself.*

*When the dollars were flowing I used to walk around with R30 000 in my pocket and it made me feel so good. At the table I would place R4 000 on one single bet and would just love everybody's attention and surprise. If I had a good win I would give the waitress a R500 tip - throwing the money to her over my shoulder without even looking at her. But, before I knew it, I was dry again. After having worked at my uncle's garage for several years I reckoned that he owed me more than just a lousy salary and I took a R8 000 company cheque. When my uncle discovered the missing monies he threatened me with criminal charges. Fortunately my brother came to the rescue and I was again bailed out by him on the condition that I get help from Gamblers Anonymous. I then started attending GA for six months and then stopped attending. In fact, even though the*

*gambling became much less, I never really stopped gambling while attending GA, and most of my money then was spent on the ladies.*

*My family was never aware of my great sexual appetite. After a few months I had found myself in financial trouble again and I once again committed company fraud of R13 000. I was again bailed out by my brother and sister. They then decided I had a serious psychological problem and took me to a psychiatrist who diagnosed me with Bipolar Disorder. I was prescribed Lithium and sleeping tablets.*

*Even though I promised to stop gambling yet again, I was back at the casino two days later and over a period of five months I had managed to be up R60 000. All of this, and more, went quickly back into gambling and the ladies. I was expecting the medication to make a difference in my behaviour, but it didn't. I had lost everything and was seriously contemplating suicide. I lived on the 16<sup>th</sup> floor in Berea and I worked out the measurements to see if I would die jumping out of the window. I committed another R20 000 company cheque fraud and was bailed out by my angry and traumatized brother and sister once again, on the condition that a life time self-exclusion order be taken out by myself which could only be lifted by my brother, and that I go for professional help with a qualified gambling counselor - and here I am.*

### 7.3 ASSESSING HENRY'S GAMBLING PROBLEM

Problem or pathological gambling is such a multi-dimensional disorder that in many cases it is very difficult for me, as a therapist, to make a fully comprehensive accurate assessment of all the underlying vulnerabilities in any problem gambler in only one session. In the majority of cases long term treatment is necessary to complete an ongoing assessment process. In order for me to be clear about a gambler's assessment, I developed a "Personal Gambling Disposition Profile" that acted as an effective working tool for tailoring an individualized treatment approach (Annexure 4). I used the Personal

Gambling Disposition Profile in the ongoing assessment of Henry's problems during the fourteen month treatment period. The result of this assessment is given in Annexure 5.

The following methods were used in assessing Henry's gambling problem:

1. DSM-IV Classification (Annexure 1)
2. GA 20 Questions (self-evaluation) (Annexure 2)

Family counseling was unfortunately not possible in Henry's case as he was single, both his parents were deceased, both his sisters had emigrated to Australia, and he was left with a very angry and bitter brother who was not prepared to get involved in Henry's life any further. In addition, I strongly recommended psychometric evaluation. Unfortunately Henry was very deep in debt and had no funds available for these tests and did not want to ask his brother for any further financial assistance.

#### 7.4 ANALYSIS OF HENRY'S GAMBLING ADDICTION

On assessment, Henry, a 42 year old single Jewish male, presented with all the symptoms of a pathological gambling problem in the desperate phase (APA, 1994). His score on the DSM-IV was 10/10 and on the GA 20 Questions was 20/20. He presented as an action gambler who punted mostly on games of skill with the belief that he could beat the system. Henry's vulnerability to developing a gambling problem started in childhood as follows:

Henry, who was Jewish, grew up and went to school in a Christian community – which he hated - as his parents did not have the financial means to send the children to a private Jewish school. Already in childhood money started taking on a significant meaning in Henry's life and he started associating money with emotional happiness and acceptance. As a child he never felt that he belonged – not in the Jewish faith and not in the Christian faith and felt rejected by both

these two cultures. According to McCormick, et al. (1989) personal vulnerability is linked to childhood experiences of inadequacy, inferiority and low self-esteem. This is where his lack of identity started. This also led to a low self-worth of not feeling accepted or good enough because they did not have additional financial means. He started attaching his own self-worth to the value of money and was resenting his father for being a security officer and not being able to financially provide more sufficiently for the family. Throughout his whole life he didn't like who and what he was when he was with others. He was an inferior, shy, introverted boy who was teased and bullied by his peers for his speech impediment. He even hated his own name.

Henry was the youngest of 4 children and spoiled a great deal by his mother and three older siblings. The only time he was happy was when he was being spoiled and taken care of by his family at home – the centre of everyone's attention. This was where he felt in control and powerful and where he could manipulate them to get whatever it was that he wanted – materially or emotionally. As Henry got older he felt a more severe lack of belongingness and self-worth in the external world and it became more and more important for him to be acknowledged, spoiled and taken care of by his family. Henry became very needy and needed the constant attention and reinforcement of his family members to make him feel that he was worthwhile. He quickly learned that he could manipulate them into taking over some of his responsibilities and make them feel sorry for him – taking on the victim role. He learned to play the victim role early on in his life and not to take responsibility for his actions. He never considered or had to deal with any consequences of his actions and Henry became impulsive and insisting on instant gratification at home.

At this early age Henry lived and experienced two extreme opposite emotions – one of being totally in control of a situation, confident and feeling accepted (at home) to one of being totally out of control, no confidence and feeling rejected (at school). He coped with the negative feelings of lack of control and

confidence and feelings of rejection by slipping into being a different person (identity) when he was around his family – which gave him an illusion of being in control, confident and accepted.

Henry never got involved with the opposite sex in his adolescent years. He was a lonely child and he had difficulty in concentrating and focusing at school and got bored very quickly. According to Henry he had an excellent relationship with his mother but did not have a good relationship with his father. Early parental deprivation and neglect while growing up and an ambivalent relationship with one's father are frequently noted in the psychoanalytic literature as significant aspects of problems gambler's childhoods (Rosenthal & Rugle, 1994). When both his parents died respectively and his sisters emigrated he was left emotionally distraught and traumatized, but enjoyed the attention that he as the "baby" in the family received – now all on his own, he became the "victim". Henry then looked for solace in the arms of a sex worker of colour and loved the attention, the excitement, sense of belonging, and feelings of being in control and power with which this provided him with. This indicates the lack of emotional coping skills that manifested with Henry in a time of crisis. Henry escaped pain and responsibility – looking for the easy way out. According to Jacobs (1988) problem gambling develops out of the need to obtain relief from a stressed state, be it noxious feelings of inferiority, guilt, rejection, and/or inadequacy, recurring dysphoria/depression and chronic under stimulation, or a combination thereof. Dickerson (2003) found that those who maintain control over their gambling use significantly less of the type of coping strategies traditionally thought of in the literature as maladaptive, than those players who do not maintain control over their gambling. People who have high levels of control over their gambling activities prefer coping strategies that deal with the problem they are facing.

During this time Henry started experimenting with gambling and found a very similar thrill, sense of belongingness and excitement to the ones experienced

with his promiscuous sexual behaviour. Gambling legitimized the time spent in the company of others and provided a sense of belongingness, social support and group solidarity through engagement in a parallel activity with other players (Dickerson, 2003). Henry started visiting the casino and won R3 000 in the first few hours of playing Black Jack. He felt hooked almost immediately and was back gambling the very same week to try and win some more. According to Turner, Littman-Sharp, Zengeneh and Spence (2003) winning is frequently linked to problem gambling and wins lead people to believe that they can beat the odds. As Henry had several large wins in the beginning this belief was continuously reinforced. Henry, who was depressed, emotionally vulnerable and had a great need to feel special (a severe undernourished ego) was easily seduced by the power of a win (Turner, et al. 2003). For Henry this was easy money and a way of getting rich quick and he tried his luck on many different games. He wanted to be a “high roller”. In addition, gambling provided a powerful escape in which Henry could dream about his life being turned around “magically”. He loved the rush of gambling. He loved feeling in control. But, most of all, gambling provided Henry with a fantasy world where everything was possible. Henry was a dreamer - he hated reality – he did not want to live in everyday reality because that meant that he had to take responsibility for himself – and – Henry did not know what responsibility was as he had hardly ever taken responsibility for his actions throughout his life. He was lazy and constantly looking for the easy way out. Cognitive indolence refers to the gambler’s tendency to look for short cuts in solving their problems and attaining their goals. Rather than assessing their plans in a realistic and rational fashion, they seek out and take the seemingly quickest and easiest route to success. Unfortunately, this is often the most dangerous choice since it results in very poor money management which sets the stage for imminent failure (Aasved, 2002).

Both gambling and sex showered Henry with attention and sensation and made him feel that he belonged somewhere and was accepted for he was. It made



him feel powerful and in control and it was this image that he wanted to portray to everybody. Henry was also very aware of his image and physical appearance with clear narcissistic traits (Aasved, 2002). Henry's addictive gambling and sexual behaviour soon spiraled out of control and he was spending huge amounts of money on his addictions. On many of these occasions he managed to lie and manipulate his brother and sisters into bailing him out worth tens of thousands of Rands. Henry had become a master manipulator who became reckless and greedy and started gambling with everything and everybody around him. Even when he was stealing large amounts of money from his then employer he was able to get away with no criminal charges. This became another gamble for Henry – with how much could he actually get away with before getting caught – and if caught – who was he going to manipulate into bailing him out this time? The theft and fraud that he committed became another way of satisfying this high-risk element in his personality – constantly living on the edge. Everything became a gamble to him. Henry was even gambling with his own life – and with death. According to Walters (1994) super-optimism as a cognitive distortion refers to the belief that gamblers can escape the consequences of their behaviour indefinitely. It originates in the initial success they often have in surviving various gambling-related crises. Henry was testing fate with all his multiple sexual partners and running the risk of contracting HIV. He did not want to live in reality because reality meant that he had to start taking responsibility for himself and stopped depending on others. He loved living two lives. He loved living a fantasy and he wanted the easy life without any real effort. Henry would also latch onto people and family who he thought he could get something from.

Henry continued working at his uncle's garage for a meager salary despite the fact that he hated this job, hoping and praying that his uncle would die soon so that he might inherit some money. This type of pseudo-responsibility describes the pretense of responsibility that many gamblers are able to maintain. They do so, for example by holding steady jobs, paying their bills and avoiding arrest.

These external appearances are false, however, since in reality they are unable to meet the emotional needs of their families, friends, and other important people in their lives (Walters, 1994). Henry waited for this big miracle that would save him one day in the same way that he was always saved and rescued by his family as a child. When Henry was diagnosed with Bipolar Disorder it gave him an acceptable excuse for his behaviour. An interesting fact is that even though Henry was on medication for months for this condition, it did not seem to make a difference to his erratic obsessive gambling and sexual behaviour. Henry also had several attempts at abstinence during his seventeen years of gambling before he reached rock bottom. During this period Henry's had many large wins. According to Turner, et al. (2003) the memory of these past wins encourages the gambler to keep trying in spite of subsequent losses. This phenomenon is consistent with an operant conditions model of problem gambling (Skinner, 1953).

The most important thing in Henry's life was to obtain money to continue with his gambling and sexual addictions. He had no friends and no social life and during the day at work he presented as a shy and reserved character. He started seeing a social work counselor at the local community center to assist with his problems. He attended sessions for over two years but continued to engage in his gambling and sexual addictions. All his spare time outside of work was spent gambling and with prostitutes and he lived a second "dark" life that nobody was aware of. His *"biggest dream was to become a professional gambler and spending each day at a glitzy casino in an exotic place – driving a fancy car and spending money on sexy hookers."* Henry wanted the best of everything with the least effort. He had a very low self-worth and was desperately looking for an identity - a sense of belongingness and acceptance – and he found this in the gambling subculture. The longer he gambled the more cognitively distorted he became. Henry developed the ability to compartmentalize his life and acted as two entirely different people (Walters, 1994). On the one hand he acted as a respectable and honorable person and

on the other hand he resorted to gambling-related criminal activities and promiscuous sexual behaviour, including intermittent alcohol abuse, that he referred to as his “dark side”. Gambling provided the opportunity for Henry to take on an exciting role, that of the “high roller” and provided him with social rewards, including membership in a gambling sub-culture which counteracted the monetary losses and provided him with an identity, a language and like-minded peers – something which he longed for his whole life (Walters, 1994). This was what he loved and wanted more than anything else – the feeling of acknowledgement/acceptance, power, control and respect. Henry retreated to this sub-culture when his wider social structure was perceived as threatening. As Henry lost more and more money, his commitment to gambling and sex was reinforced as this was the only milieu which provided comfort and a sense of security to him, thus exacerbating the problem. Henry’s problem was not only one of loss of control, but also an inability to cope with the complexities of the world outside the sex and gambling context. Gambling and sex became the way through which Henry felt he had control in his life, even though it was only an illusion of control.

Henry’s sexual identity confusion most probably started in childhood when he experienced difficulty in relating to a father figure. Henry also could not relate or identify with his older brother. He was surrounded by female figures that attended to his every whim and his emotional insecurity manifested in him sharing his mother’s bed until he was eight years old. Even though he loved his mother and sisters dearly, he was able to control and manipulate them extensively. When Henry was 12 years old he witnessed his school teacher spanking one of the girls in his class on her behind and became excited and sexually aroused by this. As he reached adolescence, Henry was very shy and never made an attempt to get involved with girls. He spent much time reading pornographic magazines and fantasizing about sex workers in stockings and high heels. During his army training Henry started feeling sexually attracted to other males and had a few sexual encounters with other men which included

only sexual play, but no intercourse. At the age of 21 years Henry had his first sexual intercourse experience with a white lady friend who left him feeling extremely inadequate and insecure – like he used to feel at school and he hated this feeling. He then had a sexual encounter with a black sex worker – and he almost became instantly addicted to the “ladies of the night”. This experience excited him and made him feel so much in control - *“I was calling the shots now.”* Besides the sex workers, Henry left a string of unstable short term relationships behind him – all with black women. Young black women excited Henry and in the early apartheid years he said he felt good and in control of such secretive relationships on his terms. In his young adulthood Henry developed a preference for black women as they did not reject him and made him feel wanted and accepted.

Henry started engaging more and more in sexual activities with prostitutes to the point where he became obsessed - *“When I would meet somebody new, I would call her about 20 – 30 times per day and engage in talk of a sexual nature – I just couldn’t stop myself from phoning. I ran up cell phone bills of thousands of Rands.”*

It eventually became impossible for Henry to go through one night without a prostitute or any sexual activities and it developed into a compulsion. As a consequence of his deviant sexual behaviour he contracted two venereal diseases. In addition, he had to financially help aborting two unwanted pregnancies with two of his regular sex workers respectively. Unable to sustain intimate, romantic or social contacts due to his compulsive secret sexual life, Henry felt isolated and frequently suffered bouts of depression and anxiety which left him feeling hopeless, shameful and guilty. He also spent much time on the pornographic sites of the internet. When Henry was not gambling he was engaging in some or other sexual related activity. He also became deeply involved in sadistic and masochistic (S&M) activities after encountering it on the internet and this compulsion cost Henry many thousands of Rands. Thus,

during the day Henry would work as a sales person in his uncle's garage and at night he would engage in this dark secretive night life that nobody was aware of – gambling and sex.

Henry's secretive sexual acting out behaviours included prostitution, masochism and sadism, pornography, telephone sex/cyber sex and conducting multiple anonymous sexual affairs with women he had met on the Internet and elsewhere. Sexual addiction and compulsivity can be defined as sexual behaviours which involve “escalating patterns of sexual behaviour with increasingly harmful consequences”. These consequences include (<http://www.sexualrecovery.com>):

- Social – loss of marriage/primary relationship, friendships, social networks due to sexual preoccupation and behaviours.
- Emotional – depression or anxiety are common due to the shame, secrecy and lowered self esteem of sexual addicts.
- Physical – injury due to frequency and type of behaviours, sexually transmitted diseases are common.
- Legal – Arrests for sexual crimes (voyeurism, lewd conduct), loss of professional stature or licenser for sexual misconduct or sexual harassment.
- Financial – costs of pornographic materials, use of prostitutes, phone/computer sex lines. The loss of productivity, creativity and employment.

Henry did not associate sex with intimacy. For Henry sex with prostitutes was a type of action that was exciting and where he felt in control, especially when he was paying for it. With these ladies he felt a sense of belongingness/attachment and acceptance – and – no rejection. This is where he felt in control and experienced instant gratification. Though Henry experienced an internal sense of decreased self worth, continuously returning to his secretive sexual activities

became another escape from reality. He feared emotional intimacy and committing to a healthy relationship as he might be rejected once they knew him and all his secrets. Henry was also self-centered, immature and emotionally insecure with an undernourished ego (Blaszczynski, 1998).

## 7.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS

The multi-dimensionality of Henry's gambling addiction is evident and the assessment identified avenues that needed to be explored further. Henry's personal psychological profile revealed that he was an biologically vulnerable gambler (action gambler) in the pathological stage, but also gambled for escape reasons (Blaszczynski, 1998). Henry's gambling was an activity that was known to everybody and something that he often boasted about. His scores on the GA 20 Questions gambling screen and the DSM-IV classification indicated all the symptoms of pathological gambling in the desperate to hopeless stages with criminal activities and severe financial and emotional depletion (APA, 1994).

An assessment of Henry's gambling history indicated that his problem was not isolated to only one game, but included several games of skill. Besides the actual primary gambling addiction that needed immediate attention, the assessment revealed another primary addiction – compulsive sexual behaviour.

In addition, Henry was previously diagnosed with bipolar mood disorder (query) and intermittent alcohol abuse. The fact that Henry was previously diagnosed with Bipolar Mood Disorder potentially eliminated the diagnosis of pathological gambling. According to APA, (1994) bipolar mood disorder has to be ruled out before a diagnosis of pathological gambling can be made. It became important to query this condition as there was minimal change in Henry's mood states and gambling and sexual behaviour after being put on Lithium medication for approximately eight months. I referred him back to his psychiatrist as I suspected that Henry's gambling was not only related to his mood disorder.

Henry refused any further pharmacological treatment and I informed him of the risks in refusing medication. Henry's assessment was ongoing and later revealed a possible attention deficit disorder (query) with personality traits including histrionic, narcissistic, anti-social, dependent, risk taking, boredom proneness, impulsivity and excitement seeking. Suspected neuropsychological impairment in the form undiagnosed attention deficit-related symptoms reflecting traits of impulsivity (e.g. limited attention spans, impulsive behaviour, inability to delay gratification and insensitivity to punishment) were possibly present at childhood and predated the onset of pathological gambling behaviour (Blaszczynski, et al. 2002).

#### 7.5.1 Initial phase of treatment

Henry's reason for seeking treatment was internal and external. When he arrived for his first session he had hit rock bottom. After a family confrontation, internally an extreme low point was reached where he felt that he could not continue gambling and hurting and abusing the people that he loved the most – his family – and was experiencing stress, anxiety and guilt. He was forced by his family to have himself banned from all casinos and to phone the NRGP for specialized treatment for his gambling problem. Externally, Henry had also reached a saturation point where he had exhausted all his resources which made it difficult for him to continue his sex and gambling habit. He revealed that it was both the gambling *and* the sexual behaviour that contributed to his emotional, financial and social depletion, that they were intertwined and that the one could not be successfully addressed without the other. It is not uncommon for problem gamblers to have a sex addiction or to engage in promiscuous sexual activities (Bulwer, 2003). Henry's preference was to get his gambling addiction under control first and then to address his sex addiction. Even though Henry's family forced him to take out a self-exclusion order, I was not convinced about his responsibility and commitment to recovery. As with any addiction assessment and treatment model, careful interviews and discussion should always consider the possible involvement or history of drug and alcohol abuse

or dependency, eating, exercise, spending or gambling. It is not uncommon for this population to switch addiction during treatment (Petry, 2005). I was concerned about an increase in Henry's deviant sexual behaviour when trying to abstain from gambling.

When Henry began to recognize his addictive gambling and sexual activities as the primary cause of his problems, he began to consider the possibility of addressing these issues. According to Shaffer and Robbins (1995) the major clinical challenge is to address patients' ambivalence about whether they wish to alter their addictive behaviour and deal with the associated problems and tip the balance in favor of change. The primary approach to stimulating the desire to change is to acknowledge that addiction provides positive as well as negative consequences. I acknowledged that modifying the pattern of behaviour that caused Henry's problems would require relinquishing some existing activities. I decided to use a decision balance exercise that explores the pluses and minuses of maintaining the behaviour and the gains and losses of changing. For Henry this was the major vehicle for resolving the ambivalence about the value of curbing his addictive behaviour.

During this initial phase I focused on Henry's cognitive distortions, psycho-education, financial pay-back plan, denial patterns and his unmanageability and powerlessness related to his gambling behaviour. One very important question that I was confronted with was the following:

*"Henry was an action skill gambler who believed that he could beat the system. Was he simply a player who has poor level of skill or does he suffer from false beliefs about his abilities?"*

According to Nigel and Fritz (2002) a person could be reasonably good, and yet, in the long term, still lose money. A problem gambling counselor might conclude that a problem gambler has a distorted belief about his own skill, but the reality may be subtler. I realized that a slightly different approach was needed for



Henry. Telling him, for example, that he cannot win because winning is random, would not sit well with him who knows he has the skills. His self-appraisal might have been, in fact, reasonably accurate. But Henry did not realize just how skilled he would have to be to beat the house edge and the edge of other players (especially in horse racing). However, I directed the focus instead on how the house rake and better players take their cuts, which lead to a better understanding. What is of vital importance here is that if I did not consider the games that Henry frequented, I would not have been able to help him understand how even skilled play does not guarantee winning the long run. Showing Henry how dismal his long-term prospects were facilitated a re-evaluation of his gambling behaviour and he felt ready to start attending GA.

#### 7.5.2 Middle phases of treatment

A number of vulnerabilities were drawn from our sessions and the following were identified as themes of risk in his gambling behaviour:

##### Power and control orientation

- Personal achievement as a result of gambling
- Belief that he can control winning or luck
- Distorted concept of controlled gambling
- Winning as an accomplishment
- Erroneous beliefs
- Needs to appear in control
- Manipulates and takes advantage of others' inadequacies
- Difficulty with authority figures

##### Emotional states

- Low self-worth (undernourished ego and facade of self-confidence)
- Emotional immaturity
- Difficulty with intimacy
- Strong denial patterns

- Unhappiness
- Depression
- Suicide ideation
- Guilt
- Aggressive codependency
- Gambling to escape
- Faulty coping system
- Lack of direction in life
- Unresolved childhood issues

#### Personality traits

- Impulsivity (instant gratification)
- Boredom proneness (action-oriented)
- Restlessness (hyperactivity)
- Competitiveness
- Narcissism
- Risk-taking
- Anti-social
- Challenge/sensation seeking
- Obsessive compulsive
- Extremist (knows no balance)
- Hypermanic
- Being dissatisfied with things in general (e.g. work)
- Procrastinates
- Lack of responsibility (easy way out)

#### Social factors

- Gambling as a major social activity
- Unrealistic expectations of others

After eight weeks of weekly counseling, Henry had reached a turning point and developed an orientation to change his gambling behaviour. On a mental and emotional level Henry had moved towards accepting the notion that changes are necessary and worthwhile (Shaffer & Robbins, 1995). Henry needed the tools and skills to equip himself to stay abstinent from gambling. Certain cognitive-behavioural techniques, warning signs, denial manifestations, relapse triggers and more functional coping mechanisms were identified and taught to him (Blaszczynski, 1998). A main challenge was to help him with alternative behaviours as he experienced an increased need for his deviant promiscuous sexual activities. Identifying and substituting a different leisure activity for the time spent on sex and gambling was an important component of his recovery. Activities that address the need for being in control, action, boredom proneness, impulsivity, risk-taking, challenge-seeking and competitiveness were brainstormed with Henry.

Three prominent elements in Henry's life that came to the fore and which we started dealing with in counseling were the following:

### Action

Henry thrived on any type of action and got bored very quickly. He was impulsive, thrill and excitement seeking and was an "adrenaline junkie" who loved a challenge of any kind. Therefore, even our counseling sessions needed to be stimulating and filled with "action" as he had a limited attention span. I also gave Henry weekly assignments to complete which form part of our sessions. Firstly, it was difficult for Henry to sit still in one position for an hour during counseling. He tended to get bored, impatient and restless very quickly. He wanted to be challenged and wanted to know about practical solutions to his problems – in a quick way - the quick fix. Henry had a tendency to look for short cuts in solving his problems and attaining his goals. Rather than assessing his plans in a realistic and rational fashion, he sought out and took the seemingly quickest and easiest route to success. This is why I did not use solution-

focused therapy with Henry. For me, as Henry's therapist, it became quite a challenge to help him reduce his pace, to teach him about his responsibilities, how to face it, and to still keep him interested. In addition, it was necessary to find an alternative activity which included a high level of action.

### Ego

As an action gambler Henry continually needed to find ways to feed his undernourished ego which manifested in constant attention seeking behaviour. He presented with an inflated sense of skill in general, was very narcissistic and egotistical, competitive and constantly felt he had to prove himself to essentially hide an underlying low self-worth of "I am not good enough". He needed recognition, approval and respect from others to feed his emotional insecurity and had a great fear of rejection. I was aware of his sensitive and fragile ego and external locus of control. Henry loved talking about himself and I capitalized on this. However, I had to be certain not to join in his fantasies. I constantly had to do a reality check with Henry. I had to bring across the message that he was not this helpless creature who needed to be saved and rescued by everybody anymore – especially not by me – but that it is time that he learns how to take responsibility for himself and his addictions. This was quite a challenging task with Henry since I was dealing with an extremely fragile self-worth and he could easily have felt rejected, in which case he would not have returned to therapy. It became quite a challenge to keep Henry staying in reality and to teach him about reality testing, self awareness and setting limits.

### Profit

For Henry it was all about chasing, winning, gain and money. It was only when he won that he felt worthwhile and emotionally satisfied, even though it was only short term. Henry was constantly looking for some kind of external reinforcement to make him feel that he was good enough. Henry believed that money, which he could obtain easily and quickly through gambling, provided him with the emotional benefits of power, control and status, which in turn lead to

gaining respect and acceptance in other areas of his life (Blaszczynski, 1998). I explored the meaning of money (as an external reinforcement) with Henry as it was also related to his sense of recognition and emotional security. I came to the conclusion that Henry was not just chasing his lost monies through continuous gambling, but he was also chasing a desire – one of power and control – and at the same time running away from pain, fear and vulnerability – thus – escaping (Rugle, 2004). Henry continued to try to chase happiness by seeking something, someone or some experience outside of himself. Moreover, I appreciated the pressure Henry experienced to continue the chase. It was difficult for him to accept that happiness, serenity and satisfaction were not somewhere “out there” just beyond reach, but rather that these feelings are found within, here and now. His gambling and deviant sexual behaviour was mindless and emotionless acts. In fact, it became the goal of Henry’s treatment and recovery to help him become increasingly “mindful” of himself and the reality of the world around him. This mindfulness involved the willingness to recognize craving, the desire to chase, and to tolerate the discomfort of not acting on that desire (Rugle, 2004). By being willing to listen to desires and to deeply understand it, Henry was able to learn a true sense of empowerment and started learning to have control over his own life. Henry also needed some sort of direction in his life that would help him to recover from his addictive gambling which included a new job, job improvement, general life improvement and having plans and goals.

#### 7.5.2.1 Addressing Henry’s deviant sexual behaviour

Henry disclosed the nature of his sexual acting out at the beginning of our clinical relationship – almost as if he wanted to shock or entice me. It was his preference to first treat the gambling addiction and then his deviant sexual behaviour. After approximately three months of weekly counseling Henry verbalized that he was feeling more comfortable with his abstinence from gambling but was concerned that he was spending large amounts of money on sexual activities. I suggested that Henry see a specialist in this field but he

refused. He said that he did not want to start all over again with a stranger and if I could help him with his gambling addiction he felt confident that I could help him with this. I approached Henry's deviant sexual behaviour similar to his gambling addiction.

Like alcoholics, drug addicts and compulsive gamblers, sexual addicts employ typical defenses such as denial, rationalization and justification in order to be able to continue to engage in their behaviours, while blaming others for the resulting problems. Diagnosis and subsequent treatment can be skewed by a patient's minimization or outright denial of the type, amount or consequences of their sexual activity (<http://www.sexualrecovery.com>). I had to directly confront Henry's denial regarding his sexual activities to create an awareness of the severity of his problem. Even though Henry thought that he was enjoying his secret double life with the "ladies of the night", he had difficulty in admitting the shame and stress of living a double life. Unable to sustain intimate romantic or social contacts due to his compulsive secret sexual life, Henry frequently suffered bouts of depression and anxiety which left him feeling hopeless and shameful which a great deal of emotional isolation.

Gambling and sex did not only make Henry feel better by reducing his existential fears and insecurities, but it also led to a distortion of his perception of self. He developed many psychological defense mechanisms that aided in his denial of his problems. One significant cognitive factor was his power orientation which was his intense need to feel in control in order to have a positive self-image (Walters, 1994). When he lost at gambling this feeling evaporated and his sense of self-worth became threatened. In an effort to eliminate his feelings of powerlessness, he attempted to gain control over other people (prostitutes) and situations (gambling). Henry also started abusing alcohol to nullify the impact of his sex and gambling addictions and to cut himself off from the reality of the consequences of his addictions. He also developed super-optimism and started believing that he could escape the consequences of his behaviour indefinitely.

This distortion originated in the initial successes he often had in surviving various gambling-related and sex-related crises. I decided to divide the process of treatment into three major stages:

- Identification of the problem – I utilized the PROMIS sexual addiction screening tool (Lefever, 1988), close questioning and observation to help both Henry and me to identify the specific behaviours which made up his problematic addictive pattern.
- Behavioural contracting – We defined in clearly written terms specific problem sexual behaviours which were to be eliminated. The contract also included tasks assigned to encourage the use of alternative coping mechanisms, i.e. daily journaling and attendance at 12-step meetings.
- Relapse prevention – Working to identify and reduce patterns of experience and interaction which supported or triggered the acting out behaviours,

Approaches that I used with Henry during this phase were cognitive-behavioural (Grant & Potenza, 2004; Sharpe & Tarrier, 1993), self-exclusion (O’Neil, et al. 2003), motivational interviewing (Miller & Rollnick, 1991), disease model approach (APA, 1994), gamblers anonymous, 12-steps and his unmanageability and powerlessness related to his deviant sexual behaviour (<http://www.gamblersanonymous.org.recovery.html>)

### 7.5.3 Middle to end phases

Ongoing assessment of Henry’s behaviour revealed a lot of stress and a lack of direction in his life. There seemed to be quite a significant relationship between his addictive behaviour and boredom susceptibility, impulsivity, depression and interpersonal anxiety (low self-worth and power and control orientation). Gambling and his deviant sexual behaviour provided Henry with a powerful

escape in which he could dream about his life being turned around almost “magically”. Henry was using his addictions to make him feel empowered and in control.

After approximately one year, and attending GA on a weekly basis, Henry managed to totally abstain from gambling. He managed to build up a support system and started socializing with other GA members. For Henry it was important to find other activities to replace his gambling and sexual activities with. He decided that he wanted to take up photography – something that he had experimented with in the past and really enjoyed. After experimenting with this for a few weeks a family friend suggested that they needed a photographer at one of the local school’s football game and asked Henry if he would be prepared to do this. He felt very uncertain and could not believe that his work was good enough for others to become interested. He eventually agreed but was very scared and anxious. This is how Henry started getting involved in action photography. It seemed that it was easier for Henry to relate to the outside world through the lens of a camera. As a demand developed for Henry’s “action photos” at the local schools and elsewhere, Henry’s self-esteem and social life started increasing. Even more so when he sent one of his action photographs to one of the local news papers. They were so impressed with the photograph that they offered Henry money to publish it on a billboard. This made Henry feel that his work was special and good enough. Even though he was still a loner, it became easier for him to start relating to other people as he stated: *“It feels so good to feel normal and not so worthless all the time”*. Henry would often bring his photos to our sessions – wanting to know from me whether it was good enough – still looking for approval.

As Henry started spending more and more time and energy on his newly acquired hobby, he had less time and less money to spend on prostitutes. During this period, two to three weeks would sometimes pass without Henry engaging in prostitution. The obsessive phone calls also started reducing.



Henry needed money to upgrade his camera equipment and I spent much time teaching Henry about money management skills – on how to save, how to plan, how to balance and how to delay impulsive buying (delay gratification). After one year Henry had managed to save R5 000. Seeing his money grow acted as a great motivating factor in Henry's life. Henry's photography also thought him about taking responsibility for himself and his actions.

One of Henry's main concerns was that, at the age of forty, he had no material possessions and had accomplished nothing. He had always been undecided as to what to do with his life. Henry furthermore realized that he needed to empower himself with knowledge and education if he wanted to leave his uncle's garage and earn a decent salary. As Henry was interested in computers he enquired about a Certificate in Computer Technologies at a Technical College and was informed that a ten week course would cost R6 175. He applied for assistance at the Hebrew Trust and was granted a bursary that covered the entire fee, on the condition that he passes.

As Henry started attending the course he had to spend much time studying the material as he had great difficulty in focusing and concentrating and could not afford to refund the bursary money.

Henry started making friends at college. He befriended a young lady in his class and for the first time Henry asked a lady out for coffee, without any ulterior motives or intentions of a sexual nature. Henry had real difficulties with intimacy and it was a major step for him to emotionally try to connect with a lady.

I had to give Henry much support and guidance on what normal relationship interaction was and on how to conduct himself in a relationship. With Henry's fear of commitment and responsibility he had difficulty with this. Henry's involvement with prostitutes had drastically reduced to approximately once in

four weeks and he admitted that it was not as excited as it used to be in the past.

As Henry started becoming emotionally stronger, he started to make amends to the people that he had hurt through his addictions. Even though Henry's family was never aware of his deviant sexual behaviour, they certainly were severely hurt and damaged – emotionally and financially – through his gambling. Henry was carrying much guilt and regret about hurting his family and decided it was time to face his brother – who was prepared to see and listen to him. Henry realized that a great deal of damage had been done and that it was going to take time for his family to start trusting him again – but he was prepared to wait.

#### 7.6 MY RELATIONSHIP WITH HENRY AND ROLE AS HIS THERAPIST

Henry came into treatment at a turning point with an orientation to change. Active quitting of his addiction and taking action for change happened during the beginning to middle phases of our relationship and I responded to the stage he was at (Shaffer & Robbins, 1995). Henry was not ready to take immediate action of his sexual problem and I needed to work with him on motivation and other issues that were in the way. My aim was to make sure he was fully informed and had thought the issues through.

I personally will tell clients honestly if I think what they are hoping to do is highly risky and will discuss the history, the benefits and consequences and the possible outcomes. But in the end it is their decision. I will not refuse to work with someone because they are not conforming to my own ideas of what they should do. Sometimes, attempts at moderation represent a stage on the way to abstinence.

My role as Henry's therapist was to help him to stop gambling and to help him develop ways of coping with his gambling and sex addiction. To provide Henry, as a sexual addict, with appropriate and genuinely helpful treatment initially

placed challenges on me that left me uncomfortable and unfamiliar. Regardless of clinical training and background, it can be disquieting to initiate discussions about the most intimate and personal details of a patient's sexual life and practices, particularly in early treatment phases. This however became easier as I took on an approach with Henry that was directive and reality based. It was important to provide clear intervention, direction and resources to aid him in addressing his sexual acting out behaviours. I encouraged him to take direct action to change his behaviour and to protect his own health and those of his sexual partners. Our early sessions focused minimally on the transference aspects of the relationship or upon childhood injury, and I utilized a clear directive focus on the here and now. Although an established positive and trusting clinical relationship is essential, my initial role was directive, applying a task oriented and accountability based approach, while always maintaining containment of his gambling and sexual behaviour as the primary mutually agreed upon therapy goal.

In addition, I provided help in understanding some of the underlying reasons why gambling has become a problem and addressed related issues that were causing harm or damage. Help should be provided in developing a productive and healthy life without problem gambling. According to Petry (2005) it is important for the therapist to recognize that gambling addiction is particularly gender and culture specific. The therapist should recognize that every client is unique. I therefore helped and supported Henry to reach his personal goals, taking into account his individual economic, educational and social conditions. Henry's family members were not included in his treatment and I and GA supported him in regaining responsibility for his own life, including his right to self-determination. It was important that Henry understood the motivations behind his gambling and sex addiction to improve his life-style and regaining his sense of self-worth.

Henry was an action gambler and a biologically vulnerable gambler and I was dealing with an illusion of power and control. He presented with certain personality traits which included impulsiveness, boredom proneness, competitiveness, dominance, aggression, control, manipulative, assertive, persuasive, confident and intelligent – which also manifested in the therapeutic situation. I felt that initially Henry did not take the counseling sessions seriously and that he saw it as just another game – a challenge and competition which he tried to beat and control – and he was very good at controlling. Initially Henry was trying to shock, entice, control and manipulate me and the challenge for me was not to fall into the “control-trap” but to stay assertive, directive, firm and challenging. It also became obvious that Henry had major problems with trust and tested me in many ways. Henry started his sexual fantasies at a very young age and his emotional development was extremely impoverished. He lived in a fantasy dream world – waiting for a big miracle that was going to save him – a quick and easy way out of all his problems. Henry manifested a severe lack of functional coping mechanisms. His ability for self-deceit and denial had become extremely sophisticated and he tried to manipulate me into his way of thinking. Constant reality testing and confronting of denial was an ongoing therapeutic task with Henry as he tended to be the “eternal optimist”. Henry had a high intelligence level and figure ability and for me to be able to challenge the denial related to his gambling, I needed to have a good understanding of randomness, probabilities and the different gambling games and their odds.

## 7.7 CONCLUSION

Upon assessment Henry presented with all the signs of a pathological gambling problem in the desperation phase with suicidal ideation. In addition, he presented with a biological, psychological and psychosocial vulnerability. To complicate matters, Henry was previously diagnosed with bipolar mood disorder and was put on medication. While on medication there was no change in his behaviour which made me query this diagnosis. In addition, he presented with symptoms of an adult attention deficit problem. As Henry had limited finances,

he refused any further psychiatric evaluation. Henry struggled with an alcohol abuse problem and one other serious addiction – compulsive deviant sexual behaviour. As our sessions were progressing Henry manifested major problems with power and control orientation and low self-worth, which was closely associated to his childhood and addictive behaviours. During this time I also queried anti-social and aggressive codependency traits. Henry gambled because he felt compelled to gamble and because he believed he could beat the system and get rich quick. Money meant success, power, control, respect, acceptance and emotional happiness. Developing insight into his gambling addiction enabled him to achieve total abstinence. Henry's alcohol abuse problem was closely linked to the stress of his gambling and sex addictions. When he started abstaining from gambling and reduced his deviant sexual activities, there was a major reduction in his alcohol consumption. While he developed much insight into his deviant sexual behaviour he was not able to totally abstain from that. However, it had decreased to approximately once every four weeks. When Henry started valuing and affirming himself he was able to learn to relate to others in a much more functional way. He became motivated through his photography to further his education – which was very hard for Henry as he had problems with learning and concentration.

As Henry's therapist I had relatively specific tasks at different phases of his treatment. It took eight weeks of counseling before Henry felt ready to commit himself to abstaining from gambling. Approaches helpful during this stage were motivational interviewing, relapse prevention, self-exclusion, 12-steps, psycho-education and cognitive-behavioural. Then it was time to address Henry's deviant sexual addiction, which was initially quite a challenge for me. However, as I used the same treatment strategy as with gambling, it much improved. As Henry had very limited functional coping skills much time was spent on teaching him proper functional emotional coping strategies including taking responsibility, confronting negative emotions, money management skills and preventing a

relapse. He also had to learn how to value himself to start building his self-worth.

For treatment purposes Henry's case study offers strong insights into the complexity of problem gambling. Treatment matching, was of the utmost importance. Priority was given to Henry's addictions and then to address his underlying biological, psychological and psychosocial vulnerabilities. In addition, it became clear that Henry's gambling and deviant sexual behaviour were influenced by a combination of vulnerabilities rather than only one vulnerability, and each of these vulnerabilities had to be matched with a specific treatment approach.

## CHAPTER EIGHT

### TINA: A PSYCHOLOGICAL VULNERABLE GAMBLER

#### 8.1 INTRODUCTION

Tina, a 58 year old divorced woman, contacted the National Responsible Gambling Helpline (NRGP) four years prior to ask for help with her gambling problem. She was referred to me for evaluation and outpatient counseling treatment after a telephonic assessment of her gambling problem by the NRGF.

After completing the NRGF treatment sessions, Tina started off attending outpatient counseling sessions once per week for approximately one year. After one year it was changed to once every second week and during the third and fourth year Tina had her sessions once per month. As Tina had been charged with fraud, sequestrated, and having lost her job, I felt that it would have been unethical to drop Tina from counseling after completing the NRGF free sessions as she was not in a position to pay for further counseling sessions. I treated Tina's case as pro-bono work and as an opportunity to give back to the community.

When I met Tina she could hardly speak. Being overwhelmed with shame, guilt and remorse she could not make eye contact. She was anxious, embarrassed and very emotional, crying almost the entire session. She kept on saying: *"Please help me, please help me, I don't know what I am going to do. I am so ashamed by what I have done"*. Her pleading sounded like a mantra and touched me profoundly. Tina was desperate and helpless. She had lost her job and had been charged with committing company fraud to the amount of R900 000. She claimed that all this money was used to fund her gambling habit.

Tina's lawyer instructed her to undergo psychological evaluation to assist with her legal case. This evaluation would be the first step on the road leading her away from her terrible addiction.

Our relationship of four years, lasting from January 2002 to January 2006, started when Tina told me her life story.

### 8.1 TINA'S STORY

*I was born in Johannesburg in 1947 and am the youngest of four sisters. As a child I had Polio and I suffered a lot – it was hard for me – always to the doctor and back. Besides the Polio, I would say I had a happy childhood. Even though our parents were strict, they loved us dearly. They taught us the importance of having good morals and values and that it was very important to always help other people where we could. They always taught us what the right thing was to do. My father was employed as a fitter and turner and my mother was a housewife. We didn't have a lot of money – in fact – I would say that we were quite poor. There wasn't money for fancy luxuries but we never went hungry for one day and we were able to amuse ourselves with the little we had. Mom was always cooking, cleaning and ironing and dad was working long hours to feed a wife and four hungry children. I didn't really enjoy school that much – I struggled a bit at school and decided to leave after completing standard nine and started working in 1964.*

*Working has always been very rewarding for me. Between 1964 and 1985 I held six positions at different subsidiary companies in Office Administration. My reason for leaving each of these positions was for better prospects. I was never asked or forced to leave – I resigned every time because I was offered better positions. People knew me and they knew that I was loyal and hardworking - I was good at my job. I liked my jobs and I liked the people that I worked with. I looked forward going to work in the morning and I worked hard, sometimes until*



late. When I was at work I could forget about all my problems. I always gave 100% and I really enjoyed all my jobs. My jobs meant very much to me and my hard work was acknowledged by my superiors – which made me want to go the extra mile. However, at the beginning of 1999 things changed dramatically – it was then when everything started going wrong. The company that I was working for at the time underwent a major restructuring and many of my fellow workers were retrenched. This was a terrible time for us all – I was so scared – not knowing whether I was going to be next. I needed my job desperately. I could not afford to lose my job – it was the only income my family had. I had to hold on to my job – not just for the money, but for my own sanity as well. Then came that terrible day when my boss called me in to tell me that he had been retrenched – I can remember it so clearly - what a shock – him instead of me! He was gone the very same day. After that things changed on a daily basis – not knowing from one day to the next what to expect going to work. How could they treat us this way? How could they treat me this way – after everything that I had given and done for that company? I started feeling very angry and resentful and wanted out, but I couldn't because I needed my salary to survive. I continued going to work everyday, but hated each minute I was there. My motivation was very low and I wasn't really all that productive. I became extremely unhappy at work and started hating my job – the same way I hated being at home with a drunken husband. Two months ago I was fired from this job after I was caught and charged with company fraud. I was out on bail with no job or no income. I had to find a job immediately so that my dogs and I could eat. I was fortunate to find a temporary position in telesales but the pay was in fact very poor – about R1000 per month – but it was better than nothing.

I married John in 1968. We were both 21 years old and I was so in love. I knew that he was drinking when we married but I never thought it was that bad. I also knew that his father, brother and sisters all had a severe drinking problem, but I thought that John would change once we were married. How damn naïve can you get! I fell pregnant soon after we married and our two boys were born

early in the marriage. I thought that this might change things, but John's drinking just became worse and worse. In fact, he has actually been a chronic alcoholic for the past 35 years. I had threatened to leave him so many times but each time I did he would sober up for a while and promised to stay clean "this time" – all just empty promises. And also, since childhood I was made to believe that divorce is wrong. You make things work between you and your husband doesn't matter what. My life existed around empty promises. While he was not drinking he would actually be a nice person. He would help me around the house, help with the children and in the kitchen – which made me thought that this time around it might be different – but it never was. The last straw was when he again pawned some of our household stuff for drinking money. I then just had had enough and I had him arrested. I became so outraged that night that I physically attacked him in his drunken state. Oh, how I hated him then. And this is how things carried on. We didn't have a family life. Our family life deteriorated to such an extent that I just could not take it anymore. I thought I was going insane. It was hard for me, but I eventually got the courage together to divorce him in 1983 – after being married to him for 15 years – 15 years too long.

Even though we were divorced, John refused to leave the house and continued to live with me and the boys. I would literally chase him out of the house and off the property like a dog and lock him out, but he would manage to climb over the fence during the night and sleep on the patio. Then, on my way to work the next morning, I would find him lying there reeking of alcohol. I would again chase him away but he would continue to sit outside the front gate – then I would feel guilty for chasing him away and let him back in. On more than one occasion he broke into my house, either to steal something to sell, or to find a place to sleep. Believe me when I tell you that even having him arrested did not change things. I just eventually gave up. I was tired of fighting – I couldn't anymore.

The resentment and bitterness in Tina's voice was clear when she stated: *He (John) was never there for me and the boys – he was like a child – neither the boys nor I could ever rely on him for anything. My boys, especially the younger one was extremely supportive of me, but both of them started staying out with friends more and more and spent less time at home. During the times that John abstained from drinking for brief periods of time he substituted the alcohol with over-the-counter medication and became dependent on Sinutab. He was taking approximately 200 Sinutab per month. John was in and out of rehabs and I was in and out of Alanon (Alcoholics Anonymous). He had eight inpatient rehabilitation treatment committals over a 35 year period, with an average stay of approximately four to six weeks per stay. Each committal cost on average between R3 000 to R6 000 per stay for which I paid to try and help him to rehabilitate himself from his alcohol addiction. I wanted him to recover so that he could help with supporting our children and that he could be a father to our two boys. But he was a chronic alcoholic and, because of this, he was never able to function properly anywhere – never mind a job.*

*John was constantly fired from whatever job he managed to get at the time. He was a trained Motor Service Technician and fired from 8 jobs due to his excessive drinking. He just continued with his excessive drinking – whatever the consequences. John never worked for eighteen years and insisted on living with us in the house even after the divorce – because he had nowhere to go. I did not know from one day to the next what to expect from my husband – what has he been up to today or what has he pawned today. I was constantly scared and anxious. I poured many bottles of alcohol down the drain and often screamed and shouted at him that I actually thought I was going insane. The only thing that seemed to bring some kind of relief was when I was cooking or eating – you know I eat when I am nervous – oh yes, and my dogs and the voluntary work I was doing for the SPCA and Cerebral Palsy Foundation – I love sharing and giving to the less privileged. I would return from work and he (John) would be unconscious from the alcohol. He had drunk himself into a stupor and the house*

*was reeking of urine and alcohol - where he had wet himself while under the influence (possible seizures). The only people that were aware of what I was going through were my parents.*

*My mother died in 1972 when I was 25 years old and my father died in 1983 when I was 36 years old. Both died of cancer of the lungs. The only person I could talk to about all my problems was my father. I loved my dad very much and spent a lot of time with him – I could talk to him for hours. I had no other support. I knew that he (dad) was not able to do anything about my situation – that I was the only one that could change things – but he would always listen and I always felt better afterwards. Things really became very difficult for me when he died. My dad was my friend, the only friend who I could really trust and who never judged me. I had friends at work – good friends – but I never discussed my problems with them. They never really knew what I was going through and things really became very difficult for me.*

*I started going to the casino at the beginning of 1999. It was very close to home and I would stop off there after work – I guess to pluck up some courage to go home. Thinking back now, I don't think I even wanted to go home at all. I played slots and video poker machines. I loved those machines. I loved going the casino. I didn't have to think or feel when I was there – not about John... not about work... not about my dad. It made me forget about all my problems. I could sit there for hours and hours and just play. I was in another world when I was gambling. Winning money provided me with a way out of all my problems and misery. I even started planning in my mind that when I win the "big one" I would have John committed to an institution and start a new life for myself where he will never find me – away from him and all the problems. It was the only place (casino) where I was happy. I started making new friends there and often I would sit chatting with a few ladies. Looking back, I don't even recall how everything (theft and fraud) started. All I can remember is that I started running out of money – even though I had won many jackpots, I needed more money to*

go and play. My credit card was maxed and I had borrowed from family and friends. I didn't know where to turn anymore. I just had to be there (at the casino), I just had to gamble. I didn't want to go home. Many times I would play right through the night and quickly just go and have a bath before going to work the next morning. But then..... there was no more money. The thought of not having money to gamble with was so, so, terrifying. It was during this time that I discovered some unallocated share certificates at work which nobody had claimed in years..... and I decided to sell them. I knew that I was not suppose to do what I did, but I was not really stealing the money because I was going to replace the Rand values when I win. I only needed a bit of revolving credit to get me through a difficult time. At first I only sold a few but as time went by I started selling more and more every month. I just had to have money. I was so scared and nervous of being caught but the urge to go and gamble was so strong that I couldn't control it. I felt guilty and the need to replace the money became very strong, but in order to start replacing the money that I had taken, I needed to place bigger bets until everything spun completely out of control. I made a few attempts at depositing cheques back into the different accounts but the amounts I owed were too big. The guilt and shame was killing me. I couldn't sleep at night and I couldn't stop thinking about it. The only place where I could forget was at the casino.

I decided to make an appointment with a firm of Attorneys in Roodepoort and came clean about everything with the lawyer. I told him about the stolen shares and he promised to help me locate the lost shareholders and start repaying what I had taken. But still, even after all of this, I couldn't stop myself from going to the casino. I still didn't think that I had a gambling problem. To me it was a money problem that needed to be resolved which was possible through gambling. I couldn't make the repayments arranged by the lawyer and continued gambling for another four months until that one dreadful day when the police walked into my office. Apparently the missing share certificates were discovered through an internal audit. I was first interrogated by a few police

*officers and I just admitted everything immediately. I wanted to come clean – I couldn't live with the lies and secrecy anymore. I was then taken to the local police cells for the night – an experience that traumatized me immensely. I am still haunted by that night every single day. I was charged with R900 000 company fraud and I am out on R5 000 bail. My lawyer advised that I go for a comprehensive psychological evaluation – and this is why I am here. But besides that, please help me, please help me to stop gambling.* When Tina ended her story with an honest plea for help, tears were uncontrollably rolling down her cheeks that touched me in a profound way.

### 8.3 ASSESSING TINA'S GAMBLING PROBLEM

As in the other cases, I used the Personal Gambling Disposition Profile in Tina's assessment that acted as an effective working tool for tailoring an individualized treatment approach (Annexure 4). Assessment of Tina's problems was an ongoing process during the four year treatment period. The results of this assessment are given in Annexure 6. Records of her gambling at several casinos were obtained and studied. In addition, psychometric evaluations were performed on Tina by an independent psychologist. The following methods were used in assessing Tina's gambling problem:

1. DSM-IV Classification (Annexure 1)
2. GA 20 Questions (self-evaluation) (Annexure 2)
3. Psychometric evaluation (16PF and MCMI)
4. Records of gambling at several casinos (casino printouts)
5. Spann-Fischer Codependency Scale (Annexure 3)
6. Family counseling

### 8.4 ANALYSIS OF TINA'S GAMBLING ADDICTION

Tina started visiting the casino at the beginning of 1999 – only a few kilometers away from her home with small amounts of her own salary and played slot and video poker machines. Over a period of three years Tina progressed through

the different stages from being a recreational gambler to a pathological gambler in a very desperate stage where she was dismissed and charged with fraud of company funds by her employer. On assessment Tina presented with all the symptoms of a pathological gambling problem which is recognized as a medical disorder (Impulse Control Disorder) by the American Psychiatric Association (APA, 1994). Her scores on both gambling screens were in the pathological range. Tina lost control over her gambling behaviour with damaging personal, social and financial effects and consequences including a chronic inability to resist, in this case, the act of gambling, despite harmful consequences. According to two casino printouts Tina had spent approximately R1.8 million on slot and video poker machines. According to Blaszczynski (1998) the pathological gambler very often suffers from legal problems. In Tina's case it is clear her criminal behaviour (fraud) was a direct consequence of her gambling addiction and not of a deceptive nature of her personality.

Besides the possibility of making money, gambling made Tina feel empowered and in control, something that she had not felt in more than 30 years being exposed to her husband's chronic alcohol dependency and continuous verbal, emotional and financial abuse. Blaszczynski (1998) calls this an "illusion" of power and control. No win was however big enough to fulfill her dreams and she started relying more and more on gambling to meet her emotional and financial needs. Tina's gambling however was not about money, even though she justified her gambling as just that. She needed her "escape" (her "fix" – very similar to the drug addict's psychoactive high) to cope with her life on a daily basis. She used gambling as a way of self-medicating, to numb the pain she was feeling inside. Gambling became a dysfunctional emotional coping mechanism – it became her drug of choice – and it was the only way in which she could cope with her daily unhappiness. When she became unhappy in her job after a company restructuring 1999, her only functional coping mechanism disappeared and she severely struggled to cope on an emotional level, until she decided to visit the casino one day. At the beginning of 2000 her gambling had

progressed to becoming out of control and she needed more and more money to gamble with. She became obsessively pre-occupied with gambling and ways to obtain money as gambling became the only way for her to cope with her ever increasing problems. The fact that she was able to obtain money from her employer catapulted her into severe addiction. As her tolerance to money increased, she spent larger amounts of money more frequently. Total loss of control was evident. Like most gamblers Tina was so caught up in the process that she was unable to see the reality of her situation.

Due to the severe delusional belief system and cognitive distortions that are clear symptoms of a gambling addiction (Walker, 1992), Tina rationalized taking money from her employer as “borrowing” money that would be returned when she wins the “big” one. Her intention was not stealing, but borrowing the money. She also experienced severe guilt after taking the money and made several attempts to repay the monies taken. She admitted and disclosed her actions to a firm of attorneys a couple of months before she was caught and started actions to repay the money taken. She also contacted a broker to enquire about the possibility of buying back ten shares per month to return to the company. Her situation however was so desperate that she could not continue with this as she had run out of resources *“there was just no more money”*. Finally it was outside intervention in the form of a crisis that forced her to see that her gambling was out of control and was the root cause of her problems. When she was charged with fraud by her employer she could no longer deny the problem. It is clear that Tina has progressed through all the stages of addiction, from the acquaintance stage to the desperate stage. The only stage left is the hopeless stage in which incarceration or death by suicide occurs. In terms of the diagnostic criteria for pathological gambling (APA, 1994), Tina has manifested every one during her active addiction.



#### 8.4.1 Tina's syndrome of codependency

Tina tried to help her husband with his alcohol dependency and had him committed to eight inpatient rehabilitation centers over several years – which Tina paid for. Due to the chronic nature of John's alcohol problem he continued to rely on Tina for support, even after she divorced him in 1983 and despite several attempts from Tina to have him physically removed from the property, and laying charges against him. During these years Tina had to endure verbal, mental, emotional and financial abuse from her alcoholic husband. Tina developed many traits of a codependency syndrome which made her vulnerable and predisposed her on a psychological level to developing a gambling addiction.

As John's alcohol problem and lifestyle deteriorated, his daily functioning became more and more unpredictable. Tina often confronted him with her scorn, anger and disgust. As John's abusive drinking increased, so did the deterioration process within Tina. During the early stages of codependency Tina learned how to cope with John's drinking through rationalization of his behaviour and constantly tried to help her husband out. During the middle stages she started taking on more financial, social and emotional responsibility at home which enabled her husband's addictive behaviour. During the last stages, Tina, in frustration, tried to control more and more aspects of her husband's drinking behaviour in an attempt to regain some feelings of worth. She began to pour out or hide any extra liquor she found in the house, pleaded with him, locked him out of the house and assumed responsibility for all family affairs. On several occasions she also contacted the police to physically remove him from the premises, but she always felt regret and guilt and allowed her husband back in. Accustomed to lack of love in a relationship, co-dependents are willing to wait, hope, and try harder to please (Stafford & Hodgkinson, 2000), which was exactly what Tina did.

While constantly being exposed to emotional and verbal abuse from John, Tina's feelings of self-worth progressively declined. She became desperate in her attempts to cope with her husband's excessive drinking and increasingly experienced uncontrollable and inappropriate mood swings. She fluctuated from extended periods of deep depression ending in hours of lonely crying, to violent outbursts of rage and hostility. This left her feeling bewildered and thinking that she was about to slip into insanity. Tina consulted with her practitioner and was formally diagnosed with depression in 1997 and given appropriate medication. Due to the chronic nature of John's alcohol problem he continued to rely on Tina for support, even after their divorce, despite her continuous efforts to remove him from her existing environment and life. She experienced constant guilt feelings when she stood up for herself instead of giving in to him or others. Tina found herself caught in a downward spiral. She had therefore become trapped in a progressively worsening situation that developed into the syndrome of codependency.

Codependency is often the result of living in a home affected by alcoholism or drug addiction (Stafford & Hodgkinson, 2000). This is clear in the case of Tina, where her husband's alcohol dependency caused much stress and anxiety for her family. As a result she developed habitual self-defeating coping mechanisms (compulsive eating, compulsive spending and compulsive gambling) in an attempt to survive her husband's emotional and verbal abuse. When Tina's father died there was no-one to share her pain with and she had to hide her feelings about her traumatic marriage from others and from herself. She had lost the ability to see or express her feelings, because it hurt too much. She had lost all sense of self-worth and confidence – and in the process – had moved towards an overdeveloped sense of responsibility where she focused on others' needs while neglecting her own. This was also clear in all the charity work that she was engaged in at the time. It was easier for her to be concerned with others, rather than herself, because it enabled her not to look too closely at her own problems. It was extremely important for Tina to gain approval from

others, to the point where she lost her own identity. Since she was so concerned with what others expected she lost touch with her own needs and became very confused about her own personal boundaries. Codependents experience excessive dependency on external cues and a disconnection from many of their inner thoughts, feelings and needs. They struggle with their basic sense of self and have a hard time knowing what they want (Stafford & Hodgkinson, 2000).

Tina came from a dysfunctional long term marital relationship in which her emotional needs were not met. In this relationship she did almost anything to keep it from dissolving. This is because Tina was terrified of abandonment and her religious beliefs and kind-heartedness prevented her from considering leaving her husband for many years. Tina was so fearful of being abandoned, ignored, or shamed, that she continually looked to others or things outside of herself for cues to tell her what she should be like or what she needed to do. At the same time Tina had an excessive need for control as a consequence of a deep sense of powerlessness she experienced because she was living with a man who was completely out of control. Since Tina was blaming her husband for her unhappiness, she assumed that she had a right to try and change him. According to Stafford and Hodgkinson (2000) codependents may be predisposed emotionally and often bio-chemically to becoming addicted themselves to drugs, alcohol, shopping and/or certain foods – in Tina's case it was food, shopping and later on gambling – and also have a tendency towards episodes of depression – with which she was formally diagnosed with in 1997.

#### 8.4.2 Tina's motivation for gambling

Tina's initial main motivation for gambling was for escape reasons and winning was an extra bonus to supplement her income. With John's alcohol dependency and unstable working history, Tina took control as main provider for the family and struggled financially, with no or very little assistance from her husband.

Tina also took on extra working responsibilities in an effort to supplement the family's income.

According to Blaszczynski (1998) escape gamblers, most typically women, only become vulnerable to developing a gambling addiction once a predisposing factor appears. Throughout her working career Tina was always happy and enjoyed her jobs. Going to work provided her with an escape from the problems at home – this was how she coped. The death of Tina's father left her isolated and lonely. Always being happy and content in her place of employment provided her with a functional emotional coping mechanism. This also provided and emotional escape from the severe difficulties she had to face at home which became worse when she discovered that her oldest son was also developing an alcohol problem. Her work became her sole place of "happiness" and Tina worked long hours to avoid being at home. Tina found much encouragement and support from her youngest son, but when he left home to get married in 1999, Tina felt even more isolated and lonely. Her world literally started falling apart when the company that she was employed with at the time underwent a restructuring with many retrenchments and she started feeling uncertain and insecure of her position at work. During this period her workplace changed from a happy, fulfilling place which provided her with a functional emotional coping mechanism and escape, to an unhappy, unfulfilling place that she dreaded.

With the company restructuring she became uncertain of her position at work. She was now unhappy both at work and at home, which caused added stress and anxiety, and had nowhere to escape to. Her two children had also left home and she felt disempowered, insecure, lonely, anxious, isolated and depressed. In an effort to try and find some distraction and escape from her unhappiness she started visiting the casino on her own, only a few kilometers from home. Here she found herself in a fantasy world – away from reality and all its problems. Here she could forget about all her heartache, make new friends, find a new life. According to Griffiths (1995) it is not uncommon for gamblers to

experience a hypnotic state when playing the slot and poker machines and become psychologically addicted to the anesthetizing quality of these machines *"I was in another world when I was gambling"*. Gambling also provided her with excitement and fun, something that she had not known for years and winning money was an extra bonus that assisted her financially, which she so desperately needed. Fantasizing and dreaming about a better future became part of her daily thought patterns. What started out as an innocent escape from the daily verbal and emotional abuse that Tina had to endure for many years from her chronic alcohol dependent husband, ended up as a full-blown gambling addiction.

#### 8.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS

From the description of Tina's story the multi-dimensionality of her gambling addiction is evident and the assessment identified avenues that needed to be explored further. The initial assessment revealed a major crisis in the form of being caught by her employer for embezzling company funds (R900 000) and being criminally charged and interrogated with an immediate dismissal. She claimed that she used the money to gamble. Her scores on the GA 20 Questions gambling screen and the DSM-IV classification indicated all the symptoms of pathological gambling in the desperate to hopeless stages with criminal activities and severe financial and emotional depletion (APA, 1994). An assessment of Tina's gambling history determined that her problem was isolated to one game – slot/poker machines. Besides the actual primary gambling addiction that needed immediate attention, I strongly suspected the presence of all four underlying vulnerability pathways. I suspected an underlying biological vulnerability, several underlying psychological vulnerabilities, a co-dependent vulnerability, psychosocial vulnerabilities and several negative experiential factors. This was later on confirmed through psychometric testing.

Tina's personal psychological profile revealed that she was an escape gambler in the pathological stage. Tina's gambling had been a closet activity with no family or friends being aware of the problem. The escape closet gambler in the ambivalence stage might be quite a challenge for the therapist. Even though I, as Tina's therapist, encouraged openness and honesty about her behaviour, she was initially not prepared to disclose her gambling behaviour to anyone and tried to deal with the problem on her own – with me as her only lifeline. As a clinician, I have found that during this early stage it was important to include measures of time as well as money spent to help Tina realize what she was doing was harmful. Elaborate rationalizations can be built up around the financial losses, but looking at the time spent gambling where her friends, families and other interests were being neglected brought her to other insights.

Assessment with some psychometric instruments can identify if a person has a personality disorder, a tendency of lying, is likely to be aggressive, and can also determine sub-types of gambling problems (escape from negative emotions, action seeking, impulsive, bored). It all depends on what instruments are used (Dickerson, 1993). A diagnosis of depression for example would tell the therapist to approach the patient differently than a diagnosis of ADHD. The problem of course is that to do it properly often requires too many assessment tools and the assessment itself becomes very costly, time consuming and aggravating, but assessment (if done well) can be very beneficial to clinical planning and therapeutic intervention. In Tina's case it was vital for all the necessary tests to be carried out to assist in her court case. I felt concerned about Tina's depressed mood and anxious desperation and seriously recommended inpatient rehabilitation, which Tina resisted. She did however commit herself to an outpatient rehabilitation programme. According to Meyer (2001) inpatient rehabilitation should seriously be considered where outpatient treatment has previously failed, concurrent active alcohol or drug abuse making outpatient treatment impossible, or in cases of strong suicidal ideation.

### 8.5.1 Initial phase of treatment

Tina's reason for seeking treatment was internal and external. When she entered outpatient treatment she had hit rock bottom – internally an extreme low point was reached where she felt she could no longer go on with the way things were going. She was experiencing negative emotions associated and caused by gambling such as extreme stress, fear, depression, guilt and shame (Griffiths, 1995). Externally she was forced to stop gambling because of legal reasons. I felt that she was ready to change (stage-matching) and needed help in choosing the best options in dealing with her gambling addiction (Shaffer & Robbins, 1995). When ready to change, the major theme is active learning. The agreed-upon treatment goal was to get her gambling addiction under control as this was the cause of her major financial and emotional crisis at the time. Tina was also experiencing intense negative emotions in the form of shame, guilt and remorse which made her vulnerable for relapsing. As Tina suffered a pathological gambling problem, the only realistic treatment approach was abstinence, as she was not capable of controlled gambling in any sense. The first step was to help Tina put certain immediate safety nets in place that would support change and prevent relapse which included weekly counseling, self-exclusion, GA support group, handing over of finances and family counseling. I engaged her younger son (as he was the only one supporting her) in counseling and provided him with information about addictive gambling and associated problems.

During these early phases of treatment I helped Tina to better understand the pattern of her gambling behaviour and to identify her triggers. Tina experienced great difficulty in understanding and accepting what she had done as a consequence of her gambling addiction and cried as she stated: *“How could I have done this. This is not me. I was always the one that preached to everyone about honesty and integrity..... I have never taken or stolen anything from anybody before this..... I have always been so honest.”*

Tina had great difficulty in coming to terms with the fact that it was actually her that committed the fraud and her remorse, guilt and shame was overwhelming: *“I feel so terribly, terribly ashamed – if I could only turn back the clock.”* She could not identify with “Tina the gambler” that manifested cognitive distortion symptoms such as dissociation, splitting and compartmentalization as explained by Walters (1994). During the beginning stages of counseling I felt that it was important to focus primarily on learning about the addiction including its nature and consequences (psycho-education). According to Shaffer and Robbins (1995) psycho-education can help to start the change process. Tina was ready to quit gambling and the major theme became active learning. My treatment strategy was on encouraging Tina to initiate a range of new alternative behaviours based on the acquisition of new knowledge, insight, attitudes, and skills. This was the beginning of Tina’s psychological detoxification and restoration. In order for Tina to make some kind of progress in counseling she had to understand the power of her addiction and her own character defects and personality changes that occurred as a result of her gambling addiction. I tried to help her understand by stressing that *“the Tina that gambles and the Tina that doesn’t gamble is not the same person.”*

Addressing principles of reinforcement theory (Aasved, 2002) and correcting her core beliefs about gambling and her chances of winning (e.g. entrapment, illusion of control, flexible attributions and representativeness bias) was crucial in overcoming her uncontrolled slot machine gambling. Tina had also become totally desensitized to the value of money. Denial and relapse prevention are important concepts and I felt that even though Tina had acknowledged that she had a gambling problem, she still had a long way to go in accepting that she had a very serious gambling addiction. When I discussed self-exclusion with her as a safety net, she was adamant that it was not necessary as she will never gamble again – and I did not force her. I requested that she self-monitor her behaviour and document any urges to gamble. As we continued with our sessions – approximately the seventh session – Tina stated: *“I have decided to*



*ban myself. I think I realize now that I am leaving the back door open – and you have shared with me - you leave the back door open for only one reason. To be honest with you, I had an urge this week. I just could not cope with all the stress and uncertainty anymore..... I just had this enormously strong need to sit in front of that machine and not to think about anything. I could not understand that after everything that gambling caused in my life that I still wanted to go back. That really scared me.”*

During this part of treatment I also questioned Tina about what her gambling addiction is doing *for* her, not just what it is doing *to* her. By exploring patients' perception of the benefits and advantages of their gambling addiction for them, clinicians are in a better position to develop realistic treatment plans that consider alternative behaviour patterns that can fulfill as many of the same addiction objectives as possible without having to engage in the addictive gambling. Taken together, these early treatment activities exercise the ambivalence associated with behaviour change and gently diminish denial and resistance (Shaffer & Robbins, 1995). Tina had to be equipped and taught certain skills to be able to prevent a relapse, including certain stress management skills and relaxation techniques. I gave her certain written assignments on denial and relapse prevention devised by Meyer (2001) to be completed as part of her safety nets and helped her to practice new behaviours in order to sustain her abstinence. I also taught her certain techniques on how to deal with urges and cravings including strategies to avoid exposure to gambling triggers. I helped Tina with developing insight into what “needs” the gambling fulfilled in her life and brainstormed certain replacement leisure activities that would address these needs.

Approaches that I used during Tina's early counseling were supportive, psycho-educational, motivational, solution-focused, cognitive-behavioural and relapse prevention. It was clear that Tina's motivation for gambling was to combat feelings of depression, anxiety, insecurity, low self-esteem and powerlessness

initiated by her husband's chronic alcohol problem as well as her own codependency. I felt that it was directly related to her mood management, stress relief and freedom. Not only did gambling make her feel better, but it also lead to a distorted self-image that minimized the extent of her involvement and the consequences of her behaviour. Gambling reduced her stress, anxiety and depression – it was her drug of choice - and coming to this realization radically altered her desire to continue gambling. For Tina, her poorly managed stress added to poor decision making, poor listening, poor problem solving and interpersonal conflict. Strategies that I used in helping her cope with her stress included stressor-focused coping and self-focused coping. The use of relaxation-based techniques (e.g. imaginal desensitization to reduce or eliminate the compelling urge to gamble) added to her success (Blaszczynski, 1998). I also provided her with information and reading materials to futher improve her insight into her gambling addiction.

#### 8.5.2 Middle phases of treatment

During the early stages of treatment it became clear to me that Tina was suffering a chronic underlying depression which was most probably initially rooted in her passive codependent behavioural style and, later on, exacerbated by her gambling addiction. In fact, after I requested her to complete a codependency screening tool it became clear that much of her psychological vulnerabilities, including depression, poor self-esteem, social isolation, unproductive coping skills (e.g. avoidance), controlling and perfectionist characteristics and obsessive compulsive behaviours (eating and shopping) were possibly rooted in her codependency behavioural style. This was confirmed through psychometric evaluation performed by an independent psychologist.

Results on a Sixteen Personality Factor Questionnaire (16 P.F. - 2<sup>nd</sup> order factors) revealed that Tina tended towards introversion, dependency, insecurity, higher anxiety levels, lower reaction time, frustration, depression, more subdued

and compulsive behaviour. Results on a Millon Clinical Multiaxial Inventory-II (MCMI-II) revealed that Tina tended towards Axis II (Cluster C) personality patterns of schizoid, avoidant, self-defeating, compulsive, with clinical syndromes of anxiety, dysthymia, thought disordered and delusional behaviour. There were, however, no signs of any anti-social traits on either test which confirmed that Tina's criminal behaviour was a direct consequence of her gambling addiction and not of a deceptive nature of her personality.

With Tina's underlying depression it was important to take steps to reduce her low mood in order to increase her motivation and compliance with treatment instructions. I referred her for medication to address the predominant symptoms and traits which included depression, anxiety and obsessive compulsive behaviour. According to Rosenthal (2004) Tina could be categorised as multi-compulsive with other co-morbid disorders. One might infer that she has low levels of serotonin and would respond to an SSRI. As Tina had very little income and no medical aid, she was forced to make use of the state hospital facilities and was prescribed Cerapax and Valium.

Once Tina's gambling addiction was under control - after approximately three months of weekly therapy sessions - I decided to start working with her codependency issues. I helped her to examine her real life experiences to enable her to acknowledge the true impact of her compulsive codependent behaviour. Tina's codependency was borne out of a very strict childhood and her dysfunctional marriage with a chronic alcoholic husband where she had been desperately searching for ways to overcome the dilemmas and conflicts in her marriage relationship. She was suffering an extreme low self-worth and needed to validate herself rather than searching for a relationship to give her a sense of self-worth. Tina was poor at self-care and feeling guilty and selfish about taking time for herself. She lacked a healthy balance between caring for her own needs and caring for others and needed a shift away from caretaking and into self-care and personal enrichment (Stafford & Hodgkinson, 2000).

Treatment in this regard included education, enabling and detachment issues, needs assessment, confronting denial patterns, and identifying self-defeating behaviour patterns.

Helping Tina build her self-worth was challenging for me in the light of all the adversities but it started developing through self-affirming meditations, encouraging messages of self-appreciation, self-acceptance and appreciations, forgiveness of self and changing beliefs about herself. I felt that good progress had been made when Tina managed to detach from her ex-husband's alcohol addiction after he harassed her again and she managed to have him arrested and jailed with a court interdict. This left her feeling empowered, motivated and more in control of her life. According to Stafford and Hodgkinson (2000) unresolved codependency or family of origin issues can be a chief cause for relapse for the unaware gambling addict. Becoming aware of the way these self-defeating personality styles interfere with the recovery process is an important part of understanding relapse. Tim Sullivan's six stages of recovery from codependent symptoms were used with Tina instead of a 12-step recovery programme. Tina also started attending a Gamblers Anonymous support group meeting where it was reinforced that gambling will not solve her problems. The fellowship of GA represented a source of comfort, friendship and social activities to Tina and she had no problem in embracing the spiritual emphasis. It is important for therapists to take note that Gamblers Anonymous treatment approach may in some cases not be advisable for the psychological vulnerable (escape) gamblers due to its emphasis on powerlessness. Due to the criminal charges against Tina it was however important that she engaged herself in an intensive outpatient rehabilitation programme, which included GA, as an optional support and safety net in her attempt at rehabilitation.

During this process Tina was sequestered, lost her pension and all material possessions and went to live with her sister in an old wendy-house on a deserted plot. I felt that Tina needed help and support in dealing with the life

transition events and enormous losses she was experiencing at the time – the loss of her home of 26 years and her job, her children leaving home, her own dignity and self-respect, family and friends – and - the loss and consequences of her gambling addiction. She was able to find temporary work (telesales) with very little income. Tina felt that she had nothing to live for at the time but stated that she never had any suicidal ideation as this was against her religious belief. She had enormous difficulty in forgiving herself for what happened and suffered much guilt and shame, and was morally judging herself very harshly. Her own betrayal, deception and loss associated with the gambling incurred a deep wound inside her. She also had great difficulty in even considering her gambling addiction as a disease that affected her behaviour at the time as she held strong moral convictions about her ex-husband's alcohol addiction.

During the four years of counseling Tina became empowered even in the face of very adverse conditions. She developed insight into her codependent and self-defeating behavioural styles and learnt more productive coping and problem solving skills. She started positively confronting her problems instead of avoiding them. She started putting certain boundaries in place, learnt how to positively deal with conflict in a relationship and became assertive and focused on her own needs and self-preservation.

#### 8.6 TINA'S OTHER COMPULSIONS

Tina started suffering from two other compulsions/addictions shortly after she got married – many years before her gambling started. Tina started to find much comfort in shopping and eating. It seemed that through the years Tina's compulsive spending and eating patterns became a balm for the depression, anxiety, anger and loneliness she was experiencing. She was compulsively eating and spending for the exact same reason she was compulsively gambling – *“it just made me feel so much better for a while.”* It provided her with temporarily relief from the negative emotions – the regrets and pain, stress and her problems of daily living. During treatment I helped Tina to start addressing

her compulsive spending through certain behavioural techniques (e.g. sticking only to items on a grocery list, purchases from daily cash allowance only, only taking limited amounts of money to shops, no watching of television shopping channels). It was clear that Tina had become desensitized to the value of money as a consequence of her gambling and spending behaviour. Through teaching her certain budgeting and other money management skills she started developing an improved appreciation for the value of money. Tina was later on forced to limit her spending when he was sequestered and left without a job or any income and her youngest son had to assist her financially.

Another one of Tina's addictions to cope with daily stresses and problems in her life was compulsive overeating which resulted in obesity. She felt guilty for not being "good enough" and shame for being overweight with a very low self-esteem. With a low self-esteem and often constant need for love and validation she turned to obsessive episodes of bingeing and eating as a way to forget the pain and the desire for affection. I noticed a direct association between her moods and her food intake and her nutritional well-being became a concern. Tina could not financially afford to consult a dietician and I had to help her with healthy weight management strategies. During treatment Tina's compulsive eating however still remained a problem and it seemed that this was related to her fears regarding the uncertainty of the outcome of the court case and a possible imprisonment.

#### 8.7 TINA'S GAMBLING ADDICTION AS SUBSTANTIAL AND COMPELLING CIRCUMSTANCES IN HER COURT CASE

Tina's gambling addiction was used in her court case as substantial and compelling circumstance. I was requested by Tina's attorney to prepare a comprehensive psychosocial court report in her defense where I explained Tina's gambling as a mental illness (impulse control disorder) that severely affected her behaviour and rational thought processes at the time. I also explained in the report that during the late stages of her gambling addiction she

became cognitively distorted and delusional which was exacerbated by the gambling as well as the extreme levels of stress that she was enduring at the time – with symptoms similar to a drug-induced psychosis. The way in which Tina was able to split and compartmentalize her life and personality (cognitive distortions) (Walters, 1994), may be indicative of a psychosis where she lost complete touch with reality. Her ability to make sense of her thoughts, feelings and external information was seriously affected, and she became very frightened and perceived her world differently than normal. Tina's intention was not "stealing" and she rationalized her behaviour as "borrowing" the money, to be repaid once she has won the big jackpot. In addition, Tina made several attempts to actually repay the monies that she allegedly stolen. In fact, she could not resist the impulse to "borrow" (steal) the money to feed her addiction.

During the three and a half years that Tina was in therapy, she had to attend several court appearances and was facing the strong possibility of a fifteen year jail sentence which caused her much stress and anxiety. Due to the theft amount being R900 000 (more than R500 000), she was informed by her attorney that the law on minimum sentencing would come into operation – which is 15 years imprisonment. Even though her gambling addiction was taken into consideration by the court in sentencing Tina, she was still sentenced to five years imprisonment (instead of 15 years according to the magistrate and the law on minimum sentencing). Tina has subsequently appealed against the sentence and outcome is awaited.

Tina was a first offender who had never broken the law until she developed a serious psychological illness. She had no previous conviction or criminal intention of any kind and was totally committed to rehabilitating herself from her gambling addiction. Tina had made excellent progress in recovery. She also expressed sincere guilt and remorse and was motivated to make amends. I also believed that Tina was of no threat or danger to society. Tina was sequestered as a consequence of the crime that she committed - as a result of her addictive

gambling behaviour - and lost all her possessions. Her house was sold (approximate value R200 000) as part repayment of her debt and she also lost her pension fund of R60 000 to repay her debt to her employer. The sum of approximately R640 000 was still owed to her employer. Gambling had ruined her financially and damaged her psychologically. Tina had taken responsibility for her illness and will long be punished through suffering the losses and consequences of her actions. Her crime was specific to her gambling addiction and was not part of her normal code of behaviour. This was confirmed through an external psychometric evaluation. With proper rehabilitation and the cessation of her gambling, I believe Tina is capable of being a responsible citizen and participates constructively in society.

Throughout the three and a half years since Tina started counseling treatment she managed to stay gambling free without a relapse and took responsibility for her own recovery by putting the following safety nets in place:

- Tina stopped gambling when she entered counseling and made a sincere effort in recovery and had not returned to gambling.
- She had been attending counseling sessions with me for three and a half years to assist in the rehabilitation of her gambling addiction as well as assistance with her other compulsive and co-dependent behaviour. She never missed an appointment.
- As part of her rehabilitation, Tina voluntarily applied for a self-exclusion (banning order) for life from all casinos nationwide from the Gauteng Gambling Board.
- She also joined Gamblers Anonymous support group and had been actively involved in these support group meetings on a weekly basis.
- She made excellent progress with her codependency behaviour and ways to empower herself. She became emotionally much stronger and much more in control of her life and learnt to focus on herself and



attending to her own needs and stress in a much more functional way. She also managed to find temporary employment.

## 8.8 MY RELATIONSHIP WITH TINA

When I met Tina for the first time I was surprised at how overweight she was. Tina was not just overweight but suffered an obesity problem which made it difficult for her to move around easily – she even struggled to get up from the couch in the reception room. Even though Tina had a serious weight problem she was always very neatly dressed with impeccable personal hygiene – which fitted her obsessive personality traits. Tina also suffered many health problems – most probably as a consequence of her obesity - which include a leg that is in chronic pain as a result of a fall (for which she uses crutches) and chronic colon problems with much bleeding and, episodes of epilepsy.

I experienced her as polite and co-operative and an instant rapport developed between us. Even though Tina initially had difficulty in making eye contact she spoke openly and freely and I felt that she was honest in the description of herself and her situation and did not appear to be fabricating any of her history. Compulsive lying is part of gambling addiction and very often the lying and dishonesty continues even when the gambler has stopped gambling. Throughout the years Tina and I had built up a close therapeutic relationship as she did not feel judged by me. I became her only confidant as she isolated herself from society, friends and family as she stated: *“I am so looking forward to coming here every week.”* As Tina showed many symptoms of codependency, I had to be aware of the fact that she could become codependent on me as her therapist and I had to keep a delicate balance between supporting her and keeping the therapeutic relationship boundaries.

My role and approach as Tina’s therapist was determined by the assessment I made of her and her problems. Doing a thorough assessment is a way of listening to a client’s story in a way that helps the therapist understands their

experiences so that he can help them reach their goals (Clark & Stoffel, 1992). Doing a thorough assessment brought out avenues that neither myself nor Tina thought about exploring. Tina showed definite signs of being an escape gambler with a longstanding depression and codependency, and used gambling to self-medicate the pain she was feeling. Tina had needs as both a woman and a pathological gambler. She had become powerless in the face of all her adversities and I had to help her to start feeling empowered and free again without her gambling addiction. This was a very challenging task in light of all the (legal) uncertainties around her. There were times that she felt so utterly hopeless, scared and ashamed that all I could do was just to be there for her and carry her, if only for an hour in session. When Tina started seeing the connections between all of her difficulties, she seemed more motivated to start taking action with all her underlying concerns. Tina had enormous difficulty in forgiving herself, was very hard on herself and needed help in setting realistic goals. I was there to help her developing ways to control her gambling behaviour and to deal with her underlying vulnerabilities that were causing harm or damage. I was dealing with Tina as an escape gambler and I spent more time looking at what there was in Tina's environment and her past that she was running/escaping from.

## 8.9 CONCLUSION

When Tina committed herself to long-term treatment it afforded me the opportunity to not only help her in addressing her gambling addiction, but also her underlying biological, psychological, psychosocial and codependent vulnerability, including all existing co-morbidities. Tina struggled with other problematic behaviors in addition to the gambling, including compulsive eating and compulsive spending. She had difficulty with anger, assertiveness and setting relational boundaries which became a vital topic to be addressed in treatment. Though Tina did initially gamble for fun, excitement and entertainment her gambling behaviour became more directly an attempt at autonomy, mood management, rebelling and stress relief. Developing insight

into her compulsions and her absolute commitment and determination enabled her to achieve total abstinence in the face of extreme difficult conditions. In dealing with the pain from her traumatic experiences with an alcoholic husband she started feeling relief and at greater peace with herself. She was able to start affirming and valuing herself. Tina developed a strong commitment to her well-being and a clear roadmap for ongoing recovery. In addition to much improved coping with various stressors in her own life, she chose to reach out and offered support to others who have a gambling problem. She experienced stronger feelings of self-esteem and self-worth and her life was more balanced.

As Tina's therapist I had relatively specific tasks at different phases of her treatment as set out by Shaffer and Robbins (1995). During the early stages of treatment, I raised doubt about the effectiveness of her gambling addiction to achieve personal goals. Once Tina considered changing, I exercised ambivalence and stimulated motivation to change by identifying reasons to change and risks of the status quo. Approaches helpful during this stage were motivational interviewing, psycho-education and solution-focused and support therapy. Tina was ready to change and needed help in choosing the best plan. Once there was an agreed-upon plan, I needed to teach Tina certain skills that supported the change and prevented a relapse. Approaches helpful during this stage were cognitive-behavioural therapy and motivational interviewing. Finally, once Tina had started making changes, I helped her to practice these new behaviours and reframed relapse as an ongoing learning process.

Observers often incorrectly think that changes occur in a linear and progressive fashion. In reality, changing addiction is a recursive process with many opportunities to revisit earlier struggles; these turns provide the opportunity to practice the tasks of recovery necessary to grow as a person and rebuild one's life (Shaffer & Robbins, 1995). However, in Tina's case, only considering stage-change matching was not sufficient for long-term abstinence success. In formulating appropriately matching treatment strategies I based it on: (1) the

phase in the psycho-structural model, (2) the stage of change, and (3) the underlying vulnerability/needs.

Treatment-matching was of the utmost importance. Even though Tina had developed a pathological gambling problem and the addiction did receive priority in treatment, it was the underlying biological, psychological, psychosocial and codependent problems that were the initial motivating factors for her multiple compulsions/addictions. It was extremely important that these underlying vulnerabilities be addressed otherwise abstaining from gambling would possibly only be temporarily, or cross-addiction would occur. During Tina's counseling treatment a combination of stage-matching, supportive, pharmacotherapy, psycho-educational, solution-focused, motivational, Gamblers Anonymous, self-exclusion, cognitive-behavioural, relapse prevention, functional coping skills and codependency treatment approaches were used. In dealing with Tina's gambling pathology it became again very clear to me that each of these mentioned treatment approaches had a definite place in assisting with Tina's recovery.

## CHAPTER NINE

### SANTJIE: A PSYCHOSOCIAL VULNERABLE GAMBLER

#### 9.1 INTRODUCTION

Santjie, a 49 year old divorced woman, contacted the National Responsible Gambling Helpline (NRGP) two and a half years ago to ask for help with her gambling problem. She was referred to me for outpatient counseling treatment after a telephonic assessment of her gambling problem by the NRGF.

On receiving the fax referral from the NRGF, there was a footnote that read “caller disabled”. I immediately felt concerned about the extent of her disability as our offices were not wheelchair friendly and decided to phone her without delay. Her cell phone was on voice mail and I left a message. Approximately two hours later Santjie returned my call. She was very apologetic about not being able to take my original call and said that she needed to see me as soon as possible. She added that she was paraplegic and permanently bound to a wheelchair. She enquired about the stairs at our office park and when she discovered that it was *only* four, she said that it should not be a problem and that her son would bring her. I did not feel comfortable with this arrangement and stressed that we were only three females in the practice and physically not strong enough to help her up and down the stairs. I suggested that we meet outside in the office park under one of the trees, but Santjie assured me that she and Bennie (her son) had done this many times before and we set a date for our appointment for the same week.

Santjie arrived for her appointment. Her son Bennie, who was tall and thin, tried to pull his severely overweight mother, who could hardly fit in her wheelchair up

the stairs. Our secretary, Carol, became very concerned that Santjie would fall and came to call me. When I arrived at reception, Bennie and his mother were screaming at each other whilst trying to keep their balance.

With one last scream and pull he managed to get Santjie to the top. She profusely apologized for the commotion.

I introduced myself to Santjie and saw that she had a severely deformed back and dressed in an old worn out skirt and jersey.

When she introduced me to Bennie, her son, I noticed that he appeared white and she coloured. Bennie greeted me abruptly.

This chilling, chaotic and confusing scene provided me with a metaphor of Santjie's life. Our relationship lasted approximately thirteen months.

## 9.2 SANTJIE'S STORY

*Things aren't easy for me. I am just so terribly tired..... I don't know if I can carry on like this for much longer. My life is just a constant battle and Bennie doesn't make it easier for me. But I need him to help me around..... like up the stairs and places that are difficult to reach. I must also apologize for Bennie being so rude. I am afraid he loathes social workers and psychologists – he had very bad experiences with them.*

*I phoned the helpline because my son said that if I didn't stop gambling he would leave me. He really got very angry when he found out that I had pawned our computer for gambling money. He was furious with me and I felt very bad and then promised to go for help. But what he doesn't understand that it is my gambling money that is keeping us alive. Bennie is nineteen now but will be twenty soon. I love that child more than life itself and he hasn't always had it easy..... I will do anything for that child of mine. But what hurts the most is*

*that he is blaming me for everything. It is not out of choice that I am a paraplegic, I was born this way. I had to learn to make do living in a wheelchair my whole life. I also didn't have a wonderful life and I came from an extremely poor family. I grew up in Cape Town in a small outside room in someone's backyard with five children – yea – two brothers and two sisters - plus my mother and father. There were times when we didn't have food to eat and went to sleep hungry. I was fortunate that the local church took pity on me and donated me a wheelchair; otherwise I don't know how I would have managed. Much of the time my mother wasn't there. She was suffering from some or other psychological problem and had many shock therapies. So, most of the time she was "out of it". I never really saw my father much either and my brothers and sisters all did their own thing and left home at a young age. So, from a very young age I had to learn to manage on my own – being paraplegic and all. I had to learn to fight for myself through life and when I was in my teens, the church managed to find me a place in a care centre. This at least gave me the opportunity to get some kind of education, even though it was only standard six. Later on they also helped me to apply for a disability pension of which the centre took a large portion. I was left with very little at the end of the day.*

*It was during the time that I lived at the care centre in Cape Town that I met Bennie's father, Charlie. He was half white and half coloured – his mother was white and his father coloured. When Charlie moved into the care centre, we became friendly quickly. He was such a charmer with the ladies and he really made me feel special. But I was so naïve at the time, thinking that it was only me. I would only later found out what he was really all about. He was bad – also – a real criminal and womanizer. Four months later I discovered that I was pregnant. You can just imagine how shocked and surprised I was. I never in my wildest dreams thought that I would ever be able to have a child. I was also very scared, not knowing how I was going to take care of a baby – being disabled and with very little income. When I told Charlie that I was pregnant he suggested that we marry and move out of the care centre. He wanted to move*

*to Durban. Now, thinking back, it was only to get his hands on my disability pension – because then he didn't have to work. But as stupid as I was, I just trusted him blindly and believed that we would be a happy family living in Durban. It was just after we had moved to Durban, shortly after Bennie's birth that everything started going horribly wrong.*

*We struggled to find a place to live in Durban. We had very little money. Charlie eventually managed to find us a place to live - in someone's garage. It was extremely difficult for me to take care of a little baby whilst living in a garage with no amenities. Then Charlie started disappearing for days. I never knew where he went or what he was doing. He would take my pension and told me that he needed it for rent and then I wouldn't see him for days. When he was home we would have terrible arguments – all in front of Bennie. This carried on for about two years before I decided to file for a divorce.*

*I divorced Charlie in 1983 – Bennie was two years old. After the divorce Bennie started behaving strangely. At times he would become very aggressive and destructive and then extremely quiet and emotional – crying much of the time. I was finished, not knowing what to do or who to ask for help. I took Bennie to the local clinic and he was put on medication. I then tried to find accommodation in a centre, but nobody was prepared to take both Bennie and I and my disability pension was not enough to pay rent somewhere else. I felt very alone and helpless. My only option then was to start “collecting” (begging). I had no choice but to take Bennie with me. I was doing well with the collecting and Bennie and I managed to get accommodation in an outside back room that we could afford. We survived like this for three years – on my disability pension and collection money – until one day when the welfare knocked on my door. I think somebody reported me. The welfare took my son away from me when he was six years old. It was the worst day of my life. I just wanted to die there and then. Bennie was in and out of foster homes for three years before he was returned to me. I knew that if I ever wanted my son with me again I had to find*



*some kind of stable income. I managed to find a job in administration at a firm of attorneys and worked there for six years. But still, my lifestyle was not good enough for Bennie to be returned to me.*

*It was during this time that I first started gambling – to try and make some extra money. I started gambling on the machines at a nearby little illegal casino after work. I was very lucky and kept on winning – and – I kept on going back – winning more and more. It was just so easy and I made quite a lot of money during that time. I found proper accommodation in a little garden cottage and managed to buy myself a little second hand Golf. The local church helped me in modifying it so that I was able to learn how to drive. For the first time in my life I felt proud and independent – thanks to gambling. Gambling took me off the streets. Gambling made it possible for me to get my child back. We were together and happy – until I was retrenched.*

*When I was retrenched I was a bit concerned but honestly thought that I could keep us going financially through my gambling money, which I did for a while. I looked for work but nobody would employ me. Bennie and I were slowly running out of money. We then decided to come to Johannesburg to see if the opportunities here would be better. But, the grass was not greener on the other side. Again, no centre would take both my child and me. I had no choice but to try my luck at gambling again. I would collect some money during the day and at night I would take that and go gamble. Sometimes I was lucky, sometimes I was not, but more often than not. I could feel it in my bones when my machine was going to pay out. I just felt so good when I won.*

*Things in Johannesburg were hard. We were living in the basement of an old empty building and sleeping on the floor. I asked for help at the local church again and took the donations they gave me to go gamble – to try and double it – but this time I kept on losing. I knew that my luck would turn..... I was only on a losing streak. We lived on collection money and donations and it just was not*

*enough for both of us and gambling was the only possible way of making a little extra. We would have our ups and downs. At one time I made R20 000 in three months. Bennie and I would then go and book in at a hotel for a week or so and I would buy him clothes and stuff. The gambling money also paid for Bennie's college fees – he is trying to do standard seven, eight, nine and ten through correspondence. He also needs to go for his license as soon as possible. He has been driving me around since the age of fifteen and the car is not licensed either. Nothing else matters in my life but my son. Next year he will be twenty-one and I am so scared that he will leave me. I also get very scared when he goes out. I cannot be on my own. I think at times he resents me for always having to rely on him being there. Sometimes we have huge fights over not having money and he would disappear for days. This would just send me straight to the casino and I can easily stay there the whole night – just gambling until everything is gone. Then, in order to get money again, I go and pawn the little that we have, to try my luck again. I am so tired of all the lies as well. This makes Bennie very angry. One time he left me stuck for three days in an apartment on the first floor. We have been blacklisted several times and I owe many people money. I also play the lotto all the time, hoping and praying that one day I will win. You know, he complains about the gambling only when I am losing, when I am winning, he is just all smiles. On several occasions he encouraged me to go to the casino to make some money.*

*I give Bennie everything I have, but sometimes I get very depressed and worried about him. He blames me for the position that we are in but I also don't see him making a plan to find a job. I feel bad upsetting him, but sometimes I feel so depressed about everything that I just need to get away. You know that I sometimes feel normal when I am at the casino. Nobody watches or stares at me; they are too busy gambling themselves. How will Bennie and I survive if I am not able to gamble anymore? I just feel so incredibly tired – tired of all the struggling – I cannot do this anymore..... I feel like just ending it all. Please, I need some help!*

When Santjie left with her son, they left with the same commotion that they arrived with – all the way down the stairs. It was at that moment, amongst all the commotion, that I felt overwhelmed with admiration and respect for a person that, against all odds, was still surviving – physically and emotionally.

### 9.3 ASSESSING SANTJIE'S GAMBLING PROBLEM

I used the Personal Gambling Disposition Profile in Santjie's assessment as an effective working tool for tailoring an individualized treatment approach (Annexure 4). The result of this assessment is given in Annexure 6. Assessment of Santjie's problems was an ongoing process during the thirteen month treatment period. The following methods were used in assessing Santjie's gambling problem:

1. DSM-IV Classification (Annexure 1)
2. GA 20 Questions (self-evaluation) (Annexure 2)
3. Family counseling

On assessment, Santjie presented with a thirteen year gambling history. Over a period of thirteen years she progressed through all the different stages from being a recreational gambler to a problem gambler – bordering on pathological – and finding herself in a desperate situation. Her score on the DSM-IV was 9/10 and on the GA 20 Questions was 16/20. She presented as a psychosocial vulnerable gambler.

### 9.4 ANALYSIS OF SANTJIE'S GAMBLING ADDICTION

Santjie is the youngest of five children and born a paraplegic. The family was coloured, poor and struggled to survive financially. According to Petry (2005) lower socio-economic status and non-white ethnicity are demographic characteristics that are rather consistently associated with increased rates of disordered gambling. Besides being poor and having to do with very little

material possessions, Santjie had an emotionally absent mother and father. Her siblings didn't seem very supportive either and all left home at a very young age. Santjie was then put into a care facility where she managed to educate herself up to standard six. Soon after meeting Bennie's father she fell pregnant and left the centre with her husband. Santjie could not believe that she was able to conceive a child. She was experiencing "normality" in her life – a husband, a child, a family of her own. These were the things that she only dreamt about – and then – her dreams came true. But, these dreams were soon shattered when she divorced Charlie.

Married people have lower prevalence rates of disordered gambling than divorced or separated individuals or those who never married (Petry, 2005). After her divorce, Santjie managed to find and hold down a job in administration for a period of six years. This job provided her with an income, independence, self-respect, dignity and social interaction. It made her feel empowered. When she was retrenched and left disempowered with no income, Santjie tried her luck at gambling, as she had a dependent and needed money to take care of her child. Income is an obvious and important starting point. Findings have consistently shown that people on low incomes and unemployed persons are vulnerable to gambling problems. Low earners have less disposable income available to spend on leisure pursuits than those who earn high salaries. As a result, problems emerge at a much earlier stage in proceedings and tend to persist over a longer period, because of the wage-earner's limited resources and restricted access to financial assistance (Blaszczynski, 1998). Thus, Santjie's psychosocial stressors manifested in the following ways: physical disability, lack of education, family problems, unemployment, poverty, ignorance, lack of life skills, disempowerment and lack of social stimulation.

Santjie faced enormously demanding psychosocial stressors on a daily basis. She was powerless and hopeless while struggling with severe physical disabilities and a system that failed her and her son. Winning money through

gambling became an opportunity to escape the reality of her daily stress and pain. Gambling became a constant option and an eternal spring of hope (Dickerson, 1993). Santjie was hoping for that big win to resolve her problems and improve her life situation. It meant that she could stop her begging and get off the streets. She believed that she could empower herself through gambling. Intermittent experiences of winning, exposure to other people's wins and promotions by the gaming industry reinforced her hope and strengthened her resistance to abstinence (Griffiths, et al. 2003).

Santjie's first gambling experience was on slot machines, in secret, at a nearby little backstreet illegal casino. Her initial motivation for gambling was purely to try and make extra money to supplement her meager income. According to Boughton (2003) money tensions are like depression, which can serve as both a cause and consequence of gambling and, how money is spent as well as a lack of money, are also sources of conflict in relationships. Santjie was desperate for money and she believed that it was her only chance of surviving. She had to increase her income and upgrade her standard of living in order to get her son back. The prospect of turning a meager amount of money into a fortune at the casinos exerted a powerful attraction and a quick-fix to a life-time of struggles and poverty. Santjie was not only physically challenged, but also socio-economically in dire straits. This led her to believe that she could only change her life through luck, rather than dealing with her challenges in a more constructive way. She became entangled in gambling as a way of trying to rise above her extremely difficult circumstances and came to believe that gambling was her only salvation.

When Santjie won her first jackpot, it opened a whole new world for her, as she kept on winning. According to Turner, et al. (2003) an early fairly consistent pattern of successes may lead to a skill attribution, which in turn leads players to expect future success. The more wins there are, the greater the comfort that is felt in the possibility of a next win. Winning, especially for the psychosocial

vulnerable gambler, who has a poor understanding of randomness and probability, can be a great risk in developing a gambling problem. When Santjie started losing, she believed that it was only temporary and that her luck would turn. Persistent gambling might be attributed directly to the uncertainty factor which is built into variable-ratio and variable-magnitude schedules of reinforcement, since it is characteristic of intermittent reinforcement that behaviour may be sustained over long periods with very little return (Aasved, 2002).

Santjie never dreamt or fantasized of becoming filthy rich through gambling. All she wanted was to be able to provide proper accommodation for her and her son and to provide him with education and opportunities that she as a person never had. For Santjie, money, obtained through gambling, gave her the opportunity to feel “normal” and to have some kind of independence and dignity. Gambling made her feel empowered (Boughton, 2003). If she didn’t have money, she couldn’t be a mother and provider to her only child. Santjie was trying her luck at gambling as she didn’t want to beg on the street corners – and – because she was quite lucky and won often in the beginning, gambling money took her off the streets and helped her to keep her child – but only temporarily. As she started losing control over her gambling habit she believed that she was only on a losing streak and that she would win again (Aasved, 2002). She started needing extra money to go and gamble to make more money – but she still kept on losing. She started borrowing money and pawning the little household stuff they had. She started staying for longer periods at the casino and would have many arguments with Bennie about her losing money. Santjie started collecting (begging) again, not to supplement her income this time, but to take her collections to try and double it at the casino. She would even take her donations from the local church to go and try her luck at gambling, but she was now losing more often than winning – chasing her losses. As she was losing more and more, she became pre-occupied with gambling and ways to obtain money (Blaszczynski, 1998). Her relationship with Bennie also started

deteriorating. In addition, Santjie came to believe that a big win would restore her to a central place in Bennie's life. Fueled by that belief, her gambling increased and became irresponsible and out of control. I doubted whether this could be classified as pathological gambling at the time, since there was a certain rationality to her belief, but it qualified as problem gambling without a doubt. However, the pathology started manifesting when Santjie experienced negative emotions as a consequence of her out of control gambling behaviour. She started feeling anxious, isolated, guilty and depressed. She also displayed signs of cognitive impairment and suicidal ideation. Besides providing her with the possibility of supplementing her income, gambling also started providing her with an emotional escape from all the negative feelings she started experiencing as a consequence of her gambling behaviour.

Santjie had by now turned into an emotional vulnerable gambler with mood disturbances, poor self-esteem, social isolation, lack of social support and unproductive coping, which in turn acted as a motivational factor (escape) in continuing gambling. Santjie became overwhelmed with feelings of helplessness and uncertainty about life and found a ready solution to her problems in gambling, since it gave her a feeling of empowerment by providing the illusion that she had the ability to control the uncontrollable. She was now suffering feelings of insecurity, low self-esteem and a sense of rejection. She developed feelings of personal unhappiness, low mood, anxiety and tension. Gambling had now become a means of emotional escapism, a means by which she could forget her problems through the distraction of excitement (Griffiths, 1990). The attraction to gambling now was not risk, but certainty; it became an escape into order.

#### 9.5 CLINICAL EVALUATION AND LONG TERM TREATMENT CONSIDERATIONS

Santjie's personal gambling disposition profile revealed that she was a psychosocial vulnerable gambler that had turned into a psychologically

vulnerable gambler – and – most probably into a biologically vulnerable gambler. Being coloured, semi-educated, unemployed and physically disabled, Santjie became enmeshed in gambling as a way of trying to survive the hard realities of a capitalist economic system. The initial assessment revealed a financial, emotional and relationship crisis as a consequence of her gambling behaviour. Her scores on the GA 20 Questions and the DSM-IV indicated symptoms of pathological gambling in the desperate phases with severe emotional and financial depletion. An assessment of Santjie's gambling history determined that her problem was isolated to machine gambling (slots, video poker and video lottery). Besides the actual primary gambling addiction that needed immediate attention, Santjie presented with relationship, family, residential, financial, medical, psychological, occupational and legally identified problems. Additional negative experiential factors were her forced dependency on others as a consequence of her paraplegia, lack of social support and unproductive coping skills. In addition, Santjie presented with a depressed mood, verbalizing suicidal ideation. I strongly suggested inpatient treatment which she vehemently resisted. Her main reason for resisting was that there would be nobody to take care of Bennie. She did however agree to outpatient treatment.

#### 9.5.1 Initial phase of treatment

On assessment Santjie presented with a depressed mood and suicidal ideation due to possible biochemical impairment (serotonin (mood regulation) and dopamine (reward regulation) deficiency) as a consequence of her gambling behaviour (Rosenthal, 2004). There was also a possibility of this preceding her gambling behaviour but worsened after a period of continuous gambling. Because dysphoric mood states prior to gambling have been associated with increased persistence among habitual or high-frequency gamblers, pathological gambling is believed to develop when gambling becomes the preferred means of offsetting the chronic dysthymia induced by stress, loneliness, anxiety, or trauma (Aasved, 2002). The inability to see a solution, coupled with the low mood of depression, results in a sense of hopelessness, isolation and despair,



while the deception and moodiness that go with pathological gambling put great strain on interpersonal relationships. This adds the fear that a partner or a family member will walk out, and anger and blame are directed toward oneself, weakening the self-esteem. Alcohol abuse can exacerbate these feelings, which may eventually lead to suicidal ideas (Blaszczynski, 1998). As Santjie was totally resistant to inpatient treatment, I referred her for pharmacological treatment. She was financially depleted with no medical aid and I had to do a professional referral to the Johannesburg General Hospital (a state hospital) for medication.

Santjie's reason for contacting the NRGPs was external. She was confronted by her very angry son and given an ultimatum. Santjie had also run out of financial resources which made it difficult for her to continue gambling. She also asked if the NRGPs would assist her financially – or anybody else for that matter. I had to put very clear boundaries immediately in place as far as money and bailing her out were concerned and stated that we were not able to help her financially, but will do anything in our power to help her emotionally. I was not sure, after having made this very clear, whether she would return to counseling, as Santjie was experiencing her gambling problem as a money problem. She didn't experience her problems as a *consequence* of her gambling behaviour, but experienced it as a *solution* to all her problems. Even though she was still experiencing her gambling as positive, it became more and more difficult to ignore the negative feelings surrounding her gambling. Still, Santjie was not ready to change. According to Shaffer and Robbins (1995) when people experience both positive and negative feelings about their gambling, they are ambivalent. This ambivalence can become painful and lead to denial. Consequently, my first major clinical challenge with Santjie was to enhance her awareness of the consequences of her gambling behaviour to overcome her resistance to change. This was not an easy task, as in Santjie's own mind, gambling was the only thing that she could turn to when she was in trouble. It always remained an option – not always a successful one – but an option that in

the past rescued her from utter desolation. Gambling was the only thing that gave her some kind of independence and made her feel empowered – emotionally and financially – and now she was asked to give up the very thing that provided her with power and independence.

The best option for Santjie was total abstinence, as she had lost control over her gambling. However, Santjie was not yet ready to change. We did however agree that she would not gamble while she was attending the NRGP six week counseling sessions. This gave me the opportunity to fully explore Santjie's perception of the benefits and advantages of her gambling problem. It put me in a better position to develop realistic treatment plans to consider alternative behaviour patterns that could fulfill as many of the same addiction objectives as possible, without having to engage in the addictive gambling. Taken together, these early treatment activities addressed the ambivalence associated with behaviour change and gently diminished her denial and resistance.

During the initial phase I focused on Santjie's distorted perceptions surrounding her gambling. This was not an easy task especially as Santjie was a very lucky gambler during her initial years of gambling. People's early learning experiences are responsible for their later personality development and related behaviour. In chance situations where people are, by chance, successful at early trials, it is likely than an attribution to personal causation will be made. On the other hand, in chance situations where the outcome is a loss early on, people will attribute the outcome to bad luck or some other external attribution (Aasved, 2002). Motivational interviewing and psycho-educational therapy became primary counseling approaches during the initial phases. Santjie was semi-educated and she had no idea of odds, probabilities and randomness. In addition, I made use of cognitive-behavioural strategies in challenging her irrational beliefs. Cognitive-behavioural approaches that I used included focus on gambling-related behaviour and thoughts, increase in coping skills, functional analysis, financial counseling, rewarding leisure activities, self-reevaluation,

dramatic relief, social liberation and environmental reevaluation (Grant & Potenza, 2004). It was also important to let Santjie understand how her denial system was manifesting and how much more unmanageable her life had become since her gambling became a problem. I felt it important to include Bennie in our family session as a support system for Santjie. Unfortunately, Bennie refused to be included in any family counseling sessions. According to Petry (2005) children of problem gamblers are portrayed as feeling angry, hurt, lonely, guilty and abandoned. These outcomes clearly are not limited to children of pathological gamblers, but they may be sequelae of growing up in a variety of adverse environmental conditions and with parents who have been diagnosed with any number of psychiatric conditions.

Santjie was not going to let go of her gambling habit as long as she was suffering from all the mentioned psychosocial stressors. For her, gambling was her lifeline in difficult times. Right from the start I had to take a holistic approach with Santjie as she had many psychosocial stressors that motivated her gambling behaviour. Solution-focused therapy then became the chosen approach. Firstly, she had no income as her disability pension was stopped when she had a full-time job. I had to help her to re-apply for her disability pension. Secondly, she needed proper accommodation. Thirdly, she needed a job. In other words, Santjie needed empowerment to restore her self-respect and dignity. If environmental stress is the ultimate cause of habitual gambling, then elimination of the stressors are sometimes believed to be the simplest way of eliminating the problem. The excessive machine gambling could be a secondary problem caused by the underlying main problem of feeling out of control in the social and family environment. By addressing the primary problem, the secondary symptoms might disappear (Aasved, 2002).

#### 9.5.2 Middle to end phases of treatment

Santjie religiously attended her six NRGP weekly sessions. During this time she started acknowledging her gambling problem and did not return to gambling.

However, Santjie failed to arrive for her seventh follow-up session two months later. When I contacted Santjie, she started crying and asked if I had an opening for her to come and see me that same day. Santjie arrived with her son for a late afternoon appointment. This was how the second phase of our relationship started.

*I am so sorry that I didn't even call you to cancel our appointment. I really feel so guilty. I have to be honest with you, I am sick of all the lying and dishonesty..... I went gambling again..... I couldn't stop myself..... I am so ashamed. It was pulling me like a magnet. It was after Bennie and I had another fight..... again about money. He just wants and wants all the time and gets very angry and aggressive if I am not able to give him what he wants. He is supposed to be studying for his exams, but he hasn't done a thing.... he sleeps all day and is surely going to fail. I just don't have the money to give to him anymore. The little that I collect during the day goes on buying us food and other necessary stuff. I am still waiting to hear about my disability pension, but until then, I have to watch my money very carefully. But Bennie doesn't understand this and got very angry and again disappeared and left me on my own for three days. I thought I was going to go crazy. At least when I can give Bennie money then things seems to be OK between us. The only place that I could possibly make some money, was the casino, so I took my collections to try and make some more money. But, nothing happened; I just quickly lost everything again. I went back home to fetch my microwave and pawned that. Still nothing, I just kept on losing. I stayed in the casino for two days, begging people to help me out with a few Rands..... I tried my luck with every last cent..... but I just kept on losing. I just couldn't care anymore, nothing mattered to me anymore, not even Bennie. All I wanted to do was to be at the casino..... I didn't even have to gamble..... I just wanted to be there..... but at the same time I was hating myself for being there. This really scared me..... I have to stop..... Please help me to stop gambling!*

According to Blaszczynski, et al. (1991), a significant majority of pathological gamblers relapse at least once while attempting to quit gambling and relapse tends to result in uncontrolled gaming behaviour that brings with it many deleterious consequences. When Santjie had her relapse, she had reached a point where she recognized her problem gambling as the primary cause of her problems and was ready to consider the possibility of addressing these issues. Her motivation to stop gambling after her relapse was more intrinsic. Research has found that intrinsic motivations to quit gambling were more predictive of successful cessation than were external motivations (Petry, 2005). This time around I was more convinced that Santjie was embarking on this programme for her own benefit and not to please others and, that her motivation stemmed personally from within and that she was committed to change. As Santjie had no income and definitely needed more support and counseling, I applied for a further six counseling sessions from the NRGP. After submitting a written motivation on Santjie's specific case, the NRGP agreed to a further six sessions.

During this time it became clear that her son, Bennie, had very much become part of Santjie's gambling problem. During the initial phases it was important to include Bennie in Santjie's recovery, but he refused. Bennie was encouraging Santjie to gamble when she was winning, to stop when she was losing and became manipulative when he needed money and Santjie was not able to supply him with money. He put much financial pressure on Santjie. Relationship difficulties may be attributed directly to the gambling but another possibility is that communication difficulties and even aggressive behaviours may predate the gambling (Petry, 2005). I suspected a great deal of latent anger and resentment in Bennie towards both his mother and father. According to Blaszczynski (1998) overcoming gambling is made easier when family members provide strong support and encouragement. Working in cooperation with close others is one excellent way of improving family relationships, as well as a source of strength in boosting commitment to change and maintaining momentum. The trustfulness and quality of one's relationships are vastly

improved as a result of open communication. Bennie was enabling Santjie's gambling behaviour and had to learn to detach from it. However, I had to be very discreet in my approach as Bennie loathed therapists in general. When Bennie was requested to join Santjie in a family session, Santjie asked if I could first talk to Bennie on his own – which he reluctantly agreed to. Bennie was abrupt and didn't look me in the eye. The mistrust was obvious and I was the enemy. I shared with him that in order to help his mother, I needed his help. Bennie made it clear to me that it was his mother with the gambling problem and not him and that he would bring her to the sessions, but did not want to be involved.

As Santjie started becoming aware of how her son was manipulating her, she realized how much she was enabling his behaviour. Bennie had become a constant reminder of her partial "normality" and this relationship gave meaning and value to her life. Santjie displayed symptoms of codependency and it was important for her to realize how she was putting Bennie's needs first, allowing too much of herself to be negotiable under pressure from their relationship.

According to Lesieur and Blume (1991) women are prone to de-self, may be poor at self-care and feeling guilty and selfish about taking time for themselves. Santjie needed a more healthy balance in caring for her own needs and caring for her son's needs. She needed a shift away from caretaking into self-care and we started addressing issues of personal enrichment and empowerment. It was time for Bennie to start becoming independent and taking responsibility for his own life and it was time for Santjie to let go. This was not an easy task for Santjie and she went through a period of loss and grief where she needed a great deal of emotional support and self-validation. Treatment in this regard included enabling and detachment issues and confronting denial patterns (Meyer, 2001), education (Toneatto, 2002), coping and problem solving skills (Berg & Briggs, 2002), needs assessment and identifying self-defeating behavioural patterns (Sullivan, 2000). However, I experienced a definite shift in

Santjies's mood state and behaviour when she was notified that her disability pension was reinstated. Then our search for a care facility started. Santjie was overwhelmed when she was notified after a few weeks that a care centre on the East Rand was willing to take her in. Santjie had become emotionally and financially empowered. I felt that good progress had been made when she was ready to contact her x-husband, Bennie's father, and informed him that Bennie would have to, from now on live with him, as she had found a new home in a care centre. He was initially resistant, but eventually agreed. Bennie, again, didn't seem to be too perturbed about where he would be living.

When the second series of six sessions came to an end, I felt that Santjie needed ongoing support and counseling. I felt that it would have been unethical to drop her from counseling after completing the NRGF free sessions as she was not in a position to pay for her counseling sessions. I treated Santjie's case as pro-bono work and as an opportunity to give back to the community and Santjie continued seeing me once per month with the assistance of one of the staff members in the care centre.

During the latter part of our therapeutic relationship Santjie came to a point where she displayed a great deal of contentment. She had not been gambling at all, was happy in her new found home and had made a few friends. We had covered behavioural processes such as helping relationships, stimulus control, counter-conditioning, reinforcement management and self-liberation (Sharpe & Tarrier, 1993). The anti-depressant was agreeing well with her and her anxiety and mood became more and more stable. Most anti-depressants do not reduce depression until several weeks after treatment begins (Petry, 2005). In Santjie's case, her initial skepticism about stopping gambling and the benefits of the therapy may have been related to this delayed onset of action. She also may have been on too low of a dose, or she may not have yet garnered the appropriate social resources to stop gambling. These, or other as-yet-unknown variables, may individually or collectively lead to gambling cessation.

Most likely, the reasons for long term cessation of Santjie's gambling behaviour were related to her feelings of empowerment. She managed to find herself a job as a consultant for a local cosmetic range and she was earning an honest commission income. Through her new found job and friends she experienced an increase in social stimulation. As Santjie had very little knowledge about how to deal effectively with her money, a fair amount of time was spent on teaching Santjie about financial management, including a budget plan, sensible spending and saving, and that there was no quick and easy way of making money. Part of Santjie's anxiety and pressure to gamble derived from the wish to win enough to have some kind of income and to repay debts. According to Petry (2005) a therapist must have adequate knowledge of loan consolidation, consumer credit bureaus, and bankruptcy so that he or she can refer the gambler as needed. Santjie was also having regular medical examinations (arranged through the care centre) and her back and thyroid problems were being attended to.

#### 9.6 MY RELATIONSHIP WITH SANTJIE AND ROLE AS HER THERAPIST

When I saw Santjie and her son the very first time, I was filled with fear, sympathy, confusion and admiration – all at the same time. Santjie was born a paraplegic and was permanently bound to a wheelchair since her childhood years. She was much overweight which made it difficult for her son to wheel her around. Throughout our sessions I developed a great deal of admiration for Santjie's courage and determination. She was a survivor, despite all the odds being against her. Santjie was only a mother trying to look after and care for her only child. She was tired of everybody else making decisions about her life and the life of her child. I allowed Santjie to express her feelings, fears and opinions and listened and reflected her thoughts which made her feel empowered. Even though Santjie came across as quite self-assured, it was a masked self-assurance to help her cope with her own forced dependency, fears and insecurities. I recognized Santjie's need to be able to function socially, emotionally and physically within a working environment and community at large



and validated her feelings of how difficult this could be. A great deal of therapy was based on solution-focused strategies. As Santjie had no access to any facilities and had become helpless and disempowered, I physically had to help her in making phone calls, enquired about placement in care centers and applying for her disability pension. She found herself in a deep dark pit and needed somebody to help her see the light again.

My initial approach with Santjie focused on abstinence. I was supportive and non-judgmental and at the same time confronted Santjie with the consequences of her behaviour and calling attention to inconsistencies in her stories. I endeavored in helping her better understand what gambling meant for her. I was working from the concept that whatever Santjie said and did was meaningful. The relationship between present statements and actions and underlying causal connections was uncovered in the context of therapy. I was seeking to provide a balance between pushing Santjie toward examining her emotional vulnerabilities and connections between past events and current behaviours and pro-actively managed her emotions and memories. I further helped Santjie identify adverse emotional states that may have been relieved by gambling to understand the defensive functioning of her gambling behaviour. Santjie's emotions and their relationship to gambling were also addressed within the context of cognitive-behavioural therapy. Cognitive and behavioural restructuring, motivational interviewing, solution-focused approach, coping and problem solving, social skills training, and relapse prevention were used in our individual sessions. Santjie's erroneous cognitions were not unique to her gambling; they were also noted in other aspects of her life that involved making decisions that had uncertain outcomes, and she needed someone to make her aware of these, without making her feel incompetent as a person (Petry, 2005).

Since Santjie started her recovery she never attended GA, no self-exclusion and no handing over of finances. The fact that she had very little safety nets in place was concerning, but as a consequence of her severe physical disability and lack

of social support, Santjie's safety nets were severely limited. I became Santjie's only safety net and lifeline and she achieved abstinence in the light of very difficult conditions.

## 9.7 CONCLUSION

Santjie, as a psychosocially vulnerable gambler, is typical of many South Africans who have been let down by the very system that was created to help them. Winning money through gambling, when there are no other income resources or options, becomes an option to survive financially. When Bennie gave his mother an ultimatum to stop gambling, Santjie was catapulted into an arena of confusing and conflicting emotions. Why would he want her to stop when gambling is the only thing that is actually keeping both of them alive? Santjie was not ready to stop and she also didn't trust the "system" that she again encountered through me. The only system that she trusted was the gambling system who she felt never let her down. Forming a trusting relationship with Santjie afforded me the opportunity to get to know her behind her mask and together we discovered her unique strengths and capabilities. I concentrated on being authentic with her and entered into a good relationship with her in order to understand her pain and turmoil.

Santjie suffered the following psychosocial stressors that made her vulnerable in developing a gambling problem:

- Lack of education (only standard six)
- Physical disability
- Unemployment
- Poverty
- Ignorance
- Lack of life skills
- Lack of social stimulation
- Disempowerment

Santjie tried to cope with the above through gambling and started seeing gambling as the solution to all her problems. Gambling made her feel in control, independent and empowered. However, it was important to let Santjie see that it was all just an illusion. This was not easy as gambling had become her only hope and lifeline. The following themes emerged in counseling:

- Uncertainty versus certainty
- Lack of control versus control
- Responsibility versus irresponsibility
- Information versus ignorance
- Illusion versus reality
- Enabling versus detachment
- Isolation versus support

What is clear in Santjie's case is that she started off as a psychosocially vulnerable gambler who turned into an emotionally vulnerable gambler, who in turn needed medication and became a biologically vulnerable gambler. Treatment matching and treatment approaches such as stage-change matching, motivational interviewing, supportive counseling, solution-focused approach, pharmacotherapy, relapse prevention, cognitive-behavioural and coping and problem solving skills were useful in the above case. What probably caused the biggest shift in Santjie's behaviour was the solution-focused approach. Only addressing Santjie's gambling problem was not enough to maintain abstinence. Santjie needed drastic concrete changes and solutions to her pressing psychosocial stressors and she needed to feel empowered and in control of her life. It was through our relationship that Santjie empowered herself and began to develop trust in her environmental system again.



## CHAPTER TEN

### CONCLUSION AND IMPLICATIONS

This chapter will present a general discussion of my research. This will be followed by the formulation of hypotheses that emerged from the study. To conclude, I will also consider the strengths and limitations of the study.

#### 10.1 GENERAL DISCUSSION OF THE STUDY

Exploring problem and pathological gambling as a biopsychosocial behaviour made it evident that individual differences and broader contextual factors should be considered and not ignored. Gambling is a complex, multi-dimensional activity that is unlikely to be explained by any single theory and a narrow focus upon one theoretical perspective in research and clinical intervention may, in many cases, not be justified. After having completed extensive research on problem gambling (Bulwer, 2003) the multi-dimensional nature of problem gambling became abundantly clear to me. Peoples' initial motivation for starting gambling (their biopsychosocial vulnerability), the choice of a gambling activity, the gambling space and the motivation behind gambling once a problem has developed, are highly important considerations in treatment approach and clinical management.

For the purpose of this study it was important to explore the existence of specific at-risk (vulnerable) subtypes of gamblers. Blaszczynski and Nower (2002) developed a pathways model with three distinct subgroups of gamblers and, though I agree with him in principle on these pathways, individual and especially cultural aspects need to be considered in the South African context. South Africa and its people have its own cultural uniqueness which cannot be ignored

when dealing with psychosocial problems like addictive gambling. In addition, I detected a shifting, multi-dimensional range of risks over the participants' lifetime.

This study had several objectives and I will discuss these objectives as they relate to the three participants respectively:

- To explore the underlying biopsychosocial vulnerabilities in three different subgroups of pathological gamblers.
- To integrate a detailed psychotherapeutic stage matching model to investigate certain biopsychosocial manifestations in the respective stages of pathological gambling.
- To focus on patient treatment matching for the different subgroups of gamblers.

## 10.2 EMERGING HYPOTHESES

A number of main hypotheses emerged from this study. Hammersley (1998) suggests that the most central task in an ethnographic study is to identify its main findings or hypotheses and the evidence presented in support of them. This is also called inductive data analysis according to Lincoln and Guba (1985). This means that these hypotheses and implications were developed as a result of working with the data rather than derived from previous hunches. This type of analysis, according to Creswell (1998), enables possibilities to emerge and understandings to develop and it enables the researcher to be playful with the data rather than confined. This does not imply constructing results that are not grounded in the data, but it allows a kind of mental freedom to think without restraint to bring sense to a larger picture.

The implications of these hypotheses according to Van Maanen (1995) could provide valuable information and in this particular study could serve as a guideline to those working with pathological gamblers. As the sample is small and unrepresentative, these hypotheses do not lead to findings that can be generalized to a larger population. I will now discuss these hypotheses. After each hypothesis, I will give an explanation of its implications which could be of value to further research in this field. Through these explanations I attempt, as suggested by Hammersley and Atkinson (1995), to discern pervasive patterns which occur in the different sub-types of problem and pathological gamblers.

### Hypothesis one

**A pathological gambler may present with all four underlying vulnerabilities instead of only one vulnerability pathway.**

In two of the three participants (Tina and Santjie) a manifestation of all four underlying vulnerabilities was present. Henry was an example of a **biologically vulnerable gambler**. He presented with signs of a *biochemical impairment*, when he was formally diagnosed with a bipolar mood disorder (serotonergic, noradrenergic and dopaminergic deficiency) and put on medication. While on medication there was no change in his behaviour which made me query this diagnosis. Henry's assessment was ongoing and later revealed a possible *neuropsychological impairment* in the form of a suspected ADD. Possible anti-social traits and attention deficit-related symptoms reflecting traits of impulsivity (e.g. limited attention spans, impulsive behaviour, inability to delay gratification and insensitivity to punishment) were possibly present at childhood and predated the onset of pathological gambling behaviour. In addition, Henry manifested histrionic, narcissistic, risk-taking, boredom proneness, competitive, challenge and sensation/excitement seeking traits. When I explored Henry's **psychological vulnerability** it became clear that his biological vulnerability was possibly linked to an *emotional vulnerability* in the form of negative experiential factors that started during his childhood (e.g. childhood disturbances, poor self-

worth, social isolation, father deprivation, unproductive coping skills, life stressors). Henry's personal vulnerability was linked to his childhood experiences of inadequacy, inferiority and low self-esteem. Furthermore, he manifested personality traits such as histrionic, narcissistic, risk-taking, boredom proneness, impulsive, and challenge and excitement/sensation seeking. In addition, Henry suffered from an alcohol abuse problem and compulsive sexual behaviour. As a result of his gambling addiction, Henry started manifesting a **psychosocial vulnerability** in the form of a distorted concept of controlled gambling, lack of money management skills, lack of social stimulation and viewing winning as an accomplishment. After an accurate assessment over a period of time it became quite clear that Henry was not just presenting with one, but with three underlying vulnerabilities – biological, psychological and psychosocial. What initially made Henry vulnerable in developing a gambling problem was his biochemical and neuropsychological impairment. As a consequence of his gambling addiction he became even more depressed and became psychologically and then psychosocially vulnerable. As Henry had now become a biopsychosocial vulnerable gambler, his motivation for continuing his pathological gambling behaviour was driven by a very powerful compulsion and the consequences of his gambling addiction, which, in return, needed appropriate and suitable treatment approaches.

Tina presented with an initial **psychological/emotional vulnerability** with pre-morbid anxiety and depression, poor coping and problem-solving skills, negative family background experiences, recent life transition events and many other identified stressors. Tina was an example of an emotionally vulnerable gambler. She manifested introversion, dependent, avoidant and obsessive personality traits as well as compulsive eating (obesity) and compulsive spending behaviour. Tina's husband suffered a chronic alcohol and over-the-counter-medication dependency and she presented with all the patterns of a **codependent style**, including denial, low self-worth, control, anger, compliance, repression, care taking, obsession, dependency, poor communication, weak



boundaries and lack of trust, sexual problems, depression and progressive symptoms. Furthermore, Tina experienced recent life transition events in the form of both sons leaving home, sequestration, loss of job, criminally charged, social isolation, lack of social support, ex-husband's and son's alcohol addiction, chronic physical pain, unproductive coping skills, life stressors, and negative emotions. In addition, identified problems related to Tina's primary relationships (codependent style), family (isolation), residential (lost house – sequestered), financial (no income and huge debt), medical (epilepsy, leg and colon problems), psychological (guilt, shame, remorse, loss), occupational (no job) and legal (criminal charges) needed to be addressed. Tina was previously diagnosed with a depression and higher anxiety levels and put on medication. This could possibly be an indication of the presence of a **biochemical vulnerability**. A biochemical impairment (serotonin (mood regulation and dopamine (reward regulation) deficiency) could possibly have been present preceding her gambling. Furthermore, she possibly suffered a prior dopamine deficiency that could have created a vulnerability for addictive behaviour (*related to a long standing codependent style*) and a possible worsening of deficits as a consequence of gambling. Further, a clear **psychosocial vulnerability** manifested further in the form of lack of education and ignorance with regard to gambling. Unemployment, disempowerment and a lack of social stimulation were further present.

Being coloured, semi-educated, unemployed, poor, ignorant, disempowered, physically disabled, with a lack of life skills and social stimulation, Santjie presented as a **psychosocially vulnerable gambler** who became enmeshed in gambling as a way of trying to survive the hard realities of a capitalist economic system. The initial assessment revealed a financial, emotional and relationship crisis as a consequence of her gambling behaviour. Besides the actual primary gambling addiction that needed immediate attention, Santjie presented with relationship, family, residential, financial, medical, psychological, occupational and legally identified problems. Additional negative experiential factors were her

forced dependency on others as a consequence of her paraplegia, lack of social support and unproductive coping skills. On assessment Santjie presented with a depressed mood and suicidal ideation due to possible biochemical impairment (serotonin (mood regulation) and dopamine (reward regulation) deficiency) as a consequence of her gambling behaviour. There was also a possibility of this preceding her gambling behaviour but worsened after a period of continuous gambling. Because dysphoric mood states prior to gambling have been associated with increased persistence among habitual or high-frequency gamblers, pathological gambling is believed to develop when gambling becomes the preferred means of offsetting the chronic dysthymia induced by stress, loneliness, anxiety, or trauma (Aasved, 2002). Her inability to see a solution, coupled with her low mood of depression, resulted in a sense of hopelessness, isolation and despair, while the deception and moodiness that go with pathological gambling put great strain on her interpersonal relationships. What is clear in Santjie's case is that she started off as a psychosocially vulnerable gambler who turned into an emotionally vulnerable gambler (with codependency traits), who in turn needed medication and became a biologically vulnerable gambler.

### Implications

When the above three participants entered treatment they all presented with a pathological gambling problem and manifested with three underlying vulnerabilities (biological, psychological and psychosocial). An underlying codependent vulnerability manifested with the two female participants (Tina and Santjie). I also queried an underlying aggressive codependency with Henry. In Tina's case it is very clear that what initially looked like a psychological vulnerability, ended up having elements of a biological impairment, codependent and psychosocial vulnerability – an all inclusive biopsychosocial vulnerability. One very clear underlying vulnerability was that of longstanding codependency traits. The existence of Tina's codependency was probably central in leading to her pathological gambling. This ought to increase the awareness of a possible

link between the two disorders. From my experience with problem gamblers I believed that there was a blind spot related to the biopsychosocial vulnerabilities of problem gamblers and I became more and more aware of the negative internal states as well as interpersonal difficulties of these gamblers. The manner in which the above participants experienced their lives and themselves in relation to others played a crucial role in the development and maintenance of their gambling. Negative interpersonal experiences in developing and maintaining problem gambling was a reality which could not be ignored. Interpersonal (relationship) difficulties with the participants became abundantly clear to me. I soon realized that these difficulties manifested in many gamblers' personal histories and necessitated long term treatment that address the underlying vulnerabilities, as well as the gambling behaviour. As I started addressing this with the participants, clear symptoms of codependency crystallized. In addressing the symptoms of codependency, the long term treatment outcome was positively surprising and I experienced the participants (Tina and Santjie) to be more committed to counseling treatment.

It seemed that the longer the participants gambled, the more severe their gambling problem became, and the more vulnerabilities they accumulated along the way. By the time the participants had developed a pathological gambling problem they had all developed multiple underlying vulnerabilities which contributed in maintaining the gambling problem. All these underlying vulnerabilities needed to be addressed in treatment.

### Hypothesis two

**A single-theory treatment approach may not be sufficient to address all four underlying vulnerabilities over a long term treatment period.**

As all three participants suffered a pathological gambling problem with comorbidity, the only realistic treatment approach was abstinence, as they were not capable of controlled gambling in any sense. Even though inpatient

rehabilitation was suggested, they were resisted to the idea. The first step was to help them put certain immediate safety nets in place that would support change and prevent relapse which included weekly counseling, self-exclusion, GA support group, handing over of finances and family counseling.

Henry had reached rock bottom, internally and externally, and the primary approach to stimulating the desire to change was to acknowledge that his addictions provided positive as well as negative consequences. I acknowledged that modifying the pattern of behaviour that caused Henry's problems would require relinquishing some existing activities. I decided to use a decision balance exercise that explored the pluses and minuses of maintaining the behaviour and the gains and losses of changing. For Henry this was the major vehicle for resolving the ambivalence about the value of curbing his addictive gambling behaviour. We started working on putting immediate safety nets in place in the form of attending a GA support group and self-exclusion (which he had already done). This was a sign that he was ready for active quitting. Approaches that I used with Henry during this phase were cognitive-behavioural (Grant & Potenza, 2004; Sharpe & Tarrier, 1993), self-exclusion (O'Neil, et al. 2003), motivational interviewing and reality testing (Miller & Rollnick, 1991), disease model approach (APA, 1994), Gamblers Anonymous, 12-steps (<http://www.gamblersanonymous.org.recovery.html>) and his unmanageability and powerlessness related to his deviant sexual behaviour. A further treatment approach with Henry was a psychiatric referral for pharmacological treatment for his mood disorder, obsessive and impulsive behaviour and possible attention deficit disorder. Henry refused any further psychological/psychiatric assessments and medications. In addition, during the initial phase, I focused on Henry's cognitive distortions, psycho-education, financial pay-back plan and subtle denial patterns related to his gambling behaviour. Treatment approaches that I used were productive coping and emotional management and social skills (Walker, 1992) (to assist with his boredom proneness, excitement seeking, impulsiveness, social isolation, life stressors and risk-taking behaviour),

motivational interviewing (Miller & Rollnick, 1991), cognitive-behavioural techniques (Blaszczynski, 1998) (to assist with the low self-worth) and 12-Step programme (Gamblers Anonymous, 2002) (to assist with the alcohol abuse and sex addiction). A main challenge was to help Henry with alternative behaviours as he experienced an increased need for his deviant promiscuous sexual activities. Identifying and substituting a different leisure activity for the time spent on sex and gambling was an important component of his recovery. Activities that addressed the need for being in control, action, boredom proneness, impulsivity, risk-taking, challenge-seeking and competitiveness were brainstormed with Henry. Treatment approaches used were psycho-education and cognitive-behavioural (Toneatto, 2002), social stimulation and money management skills.

Tina's reason for seeking treatment was internal (stress, fear, depression, guilt, shame) and external (legal reasons). She had been criminally charged with company fraud with an immediate dismissal. She was ready to change (stage-matching) and needed help in choosing the best options in dealing with her gambling addiction. Tina was ready to change and the major theme became active learning. Treatment approaches with Tina focused on cognitive-behavioural techniques, productive coping and emotional management skills (Blaszczynski, 1998) and intensive codependency treatment according to Sullivan's six stages (Sullivan, 2000). Treatment approaches that were used here were loss and grief (trauma debriefing), self-esteem building, cognitive-behavioural techniques for compulsive eating and spending and pharmacology (medication) for physical problems, depression and anxiety (Blaszczynski, 1998). Treatment approaches that were used were psycho-education (Blaszczynski, 1998), empowerment, resource facilitation and solution-focused therapy (Berg & Briggs, 2002). Tina was also experiencing intense negative emotions in the form of shame, guilt and remorse which made her vulnerable for relapsing.

On assessment Santjie presented with a depressed mood and suicidal ideation due to possible biochemical impairment (serotonin (mood regulation) and dopamine (reward regulation) deficiency) as a consequence of her gambling behaviour. I felt that Santjie was in urgent need of pharmacological treatment and did a written referral for her to the Johannesburg General Hospital for medication. Santjie's reasons for entering treatment were external. She was in the ambivalence stage, not yet ready to change (stage-matching) and in a state of denial. Thus, my first major clinical challenge with Santjie was to enhance her awareness of the consequences of her gambling behaviour to overcome her resistance to change. During the initial phase of Santjie's treatment I focused on her distorted perceptions surrounding her gambling. Motivational interviewing and psycho-education therapy became primary counseling approaches during the initial phases. Santjie was semi-educated and she had no idea of odds, probabilities and randomness. In addition, I made use of cognitive-behavioural strategies in challenging her irrational beliefs. Further cognitive-behavioural approaches that I used included focus on gambling-related behaviour and thoughts, increase in coping skills, functional analysis, financial counseling, rewarding leisure activities, self-reevaluation, dramatic relief, social liberation and environmental reevaluation (Grant & Potenza, 2004). It was also important to let Santjie understand how her denial system was manifesting and how much more unmanageable her life had become since her gambling became a problem. I felt it important to include Bennie (her son) in our family session as a support system for Santjie. Unfortunately, Bennie refused to be included in any family counseling sessions. Santjie's motivation to stop gambling after her relapse was more intrinsic and I felt more convinced of her commitment to change. Furthermore, Santjie displayed symptoms of codependency and it was important for her to find a healthy balance in caring for her own needs and caring for her son's needs. She needed a shift away from caretaking into self-care and we started addressing issues of personal enrichment and empowerment. She was also going through a period of loss and grief where she needed a great deal of emotional support and self-validation. Treatment in this

regard included enabling and detachment issues and confronting denial patterns (Meyer, 2001), education (Toneatto, 2002), coping and problem solving skills (Berg & Briggs, 2002), needs assessment and identifying self-defeating behavioural patterns (Sullivan, 2000).

During the latter part of our therapeutic relationship we covered behavioural processes such as helping relationships, stimulus control, counter-conditioning, reinforcement management and self-liberation (Sharpe & Tarrier, 1993). As Santjie had very little knowledge about how to deal effectively with her money, a fair amount of time was spent on teaching her about financial management, including a budget plan, sensible spending and saving, and that there was no quick and easy way of making money. Right from the start I had to take a holistic approach with Santjie as she had many psychosocial stressors that motivated her gambling behaviour. Solution-focused therapy then became the chosen approach.

### Implications

Each of the underlying vulnerabilities directed a long term treatment approach in each of the participants. The question that I, as a treatment professional, asked myself was: "What exactly am I dealing with?" A treatment professional will not be able to assist the problem gambler effectively if he-she does not know what it is that they are dealing with. Problem and pathological gambling is a complex and complicated addiction that cannot be pushed into a little black box. It requires the careful exploration of the different interconnected vulnerabilities to enable effective long term treatment.

Assessment with some psychometric instruments can identify if a person has a personality disorder, a tendency of lying, is likely to be aggressive, and can also determine sub-types of gambling problems (escape from negative emotions, action seeking, impulsive or bored). A diagnosis of depression for example would tell the therapist to approach the patient differently than a diagnosis of

ADHD. The problem of course is that to do it properly often requires too many assessment tools and the assessment itself becomes very costly, time consuming and aggravating. However, assessment (if done well) can be very beneficial to clinical planning and therapeutic intervention.

I realized that a single-theory treatment approach may not be sufficient to address all four underlying vulnerabilities over a long term treatment period. With this in mind, I developed the Personal Gambling Disposition Profile. For each vulnerability and personal attribute related to the gambling addiction there had to be a suitable treatment approach. After much previous investigating and experimenting, the following were identified as possible successful treatment approaches:

- Stage-change matching
- Pharmacotherapy
- Cognitive and behavioural treatment approaches
- Motivational interviewing approach
- Gamblers Anonymous 12-step programme
- Self-exclusion (banning)
- Solution-focused therapy
- Medical/disease model approach
- Codependency treatment approach

In developing the Personal Gambling Disposition Profile and using it right throughout the treatment period it became a constant reminder and stable working tool. I personally believe in *you have to know what it is that you are working with before you can deal with it effectively*. A single-theory model may be successful when an effective treatment approach is needed within a time-constraint period. Thus, the disease model gave the participants a powerful “kick-start”. However, after seven weeks of abstaining from gambling they were



ready to move forward and I allowed myself to be lead into the directions that they wanted to go in.

After having done the initial assessment with the participants I asked myself the question: “Exactly what am I presented with?” This question became very important because it determined my therapeutic approach, for example:

- Am I dealing with a pathological action gambler in the desperate stage who is considering active quitting, or;
- Am I dealing with an ambivalent problem escape gambler in the losing stage?

If I am dealing with a pathological/problem *action* gambler, I may be dealing with a *primary* gambling addiction. If I am dealing with a problem *escape* gambler, then care should be taken because I might be dealing with more of a *secondary* gambling problem. When I felt that I was dealing with an escape gambler as opposed to an action type gambler, I spent more time looking at what there was in the participants’ environment and/or their past that they could be running from. Sometimes it was a failing relationship, sometimes it was the chaos of a dysfunctional or disorganized home life or a history of physical or emotional or sexual abuse. While this did not change the diagnosis of problem/pathological gambler, and it did not change the need to maintain control and safety around the individual/family finances, it actually determined how quickly we were able to move in the direction of codependency therapy or whether I was going to adopt a linear or systemic model.

### Hypothesis three

**The different sub-types of gamblers present with different illusions, which dictate in part, the therapeutic approach.**

There were important differences between the escape (psychologically vulnerable) and action (biologically vulnerable) participants and understanding them assisted in accelerating their recovery. Due to Tina's codependency traits and overdeveloped sense of responsibility it became important for her to free herself, even if it was just for short periods of time, from all this responsibility. For Tina, there was too much control in their life, too much responsibility, too much stimulation and she had a need to loose control, loose responsibility, loose the stimulation and become numb and hypnotized and isolated. When I was dealing with Tina who presented as an escape gambler, I was dealing with an *illusion of freedom*. Tina wanted to escape into her gambling and become nobody. Tina was suffering from an overload of responsibilities and control in her personal life and gambling provided her with freedom from all of this. Gambling became a dysfunctional emotional coping mechanism also for issues like boredom and loneliness. At the casino Tina developed an *illusion of social interaction*. Even though she never really interacted with anybody at the casino it was enough for her just to have people around her which made her feel less lonely. Tina had been a nurturing, responsible individual for the majority of her adult life and became a victim of emotional abuse within a dysfunctional family that became the breeding ground for codependency. After an extended time in the throes of problem gambling, Tina as a female gambler entered recovery in a "haze". She stated: *"I used to be so responsible", "what happened to me?", "I feel like two different people"*. In early recovery Tina felt depressed, fearful, wounded and ashamed.

Gambling and sex did not only make Henry feel better by reducing his existential fears and insecurities, it also lead to a distortion of his perception of self. He developed many psychological defense mechanisms that aided in his denial of his problems. One significant cognitive factor was his power orientation which was his intense need to feel in control of everybody and everything in order to have a positive self-image. He loved controlling and manipulating people around him. Henry presented with a severe lack of control and power in his

personal life. His *illusion of control* was not only related to his gambling, but related to a constant chase in trying to gain control over issues in his life that he felt he had no control over. In other words, Henry felt so out of control in his personal life that he specifically looked for certain situations that would provide him with an element of control (e.g. gambling and prostitution). In addition, in dealing with Henry as a biologically vulnerable gambler, I was further dealing with an *Illusion of power*. Henry had a strong need and desire to be someone, which in reality was underpinned by an extreme low self-esteem. For Henry, winning money meant success, attention, power, respect and acknowledgement. This is why he initially chose games that required the involvement of other players as well as some kind of skill (e.g. black jack, roulette, horse race punting) and not an isolated slot machine game. External reinforcement was very important to him and he had an undernourished ego with a great need to control, to feel special and to be admired (in the same way that he admired and envied so many other people since childhood). Henry manifested major difficulties with power and control orientation and low self-worth, which was closely associated to his childhood and addictive behaviours.

Thus, in contrast to Tina as the psychologically vulnerable gambler, Henry presented with an underdeveloped sense of responsibility with no sense of personal control. He gambled to gain some personal control and because he experienced almost no personal control he became obsessed with the need to appear to be in control of everything and everybody else around him. Henry gambled for stimulation, for an identity, to meet his responsibilities, for respect and to improve his self-worth.

### Implications

Though I was dealing with one concept of control, I had to constantly be aware that the different sub-types of participants had different illusions of control. My role as the therapist in dealing with the different sub-types participants was a very versatile one and had to be adjusted to the different types of illusions and

problems that I was presented with. It was important to have a full range of approaches and options for the participants rather than trying to force them to fit into one specific treatment approach. I had to be multi-skilled and resourceful and needed to adjust my therapeutic style to the type of gambler and illusion I was dealing with. Even though I was dealing with one very powerful addiction, I was dealing with completely different illusions in different types of participants.

Tina gambled and played the slot machine with the intention of losing control – almost rebelling against all the control, stimulation and responsibility. I had to support and assist Tina in restructuring and eliminating all her responsibilities. In contrast to Tina, I had to teach Henry all about taking responsibility. Therapists should be aware that what very often appear as a lack of responsibility with the action gambler, may in some cases be more a fear of responsibility – Henry literally did not know how to take responsibility and had to be taught how to do so in practical terms.

Thus, with the biologically vulnerable action gambler (Henry) in a therapeutic situation, I was working towards a *sense of humbleness* and had to be firm and assertive with clear boundaries in dealing with this type of gambler. With the psychologically vulnerable escape gambler I was working towards a *sense of empowerment* in an empathic, uplifting and motivational manner. However, who exactly decides what is in the client's best interest? Participants brought to their experience of distress their own conceptualization of what was wrong and sought out solutions that seemed to fit that concept. I, as a clinician, further formulated my own beliefs about what was wrong and what would make it right. This was informed by my unique experience of the world. When the therapist's conceptualization is promoted as the "only truth" then there is no choice. Our understanding of gambling addiction is still evolving. It is essential that there is transparency in the treatment process to enable clients to make informed choices. Clients should have access to information that explains the full choice

of treatment options. This should include psychotropic medications if they have been found to be effective.

Tina and Santjie's recovery was greatly accelerated by recognizing and dealing with codependent issues. They became empowered by replacing gambling with other activities and regaining and developing functional coping skills. Part of many treatment programmes is for the gambler to admit powerlessness over their compulsion to gamble. Ironically, feeling powerless over all of the problems in their lives may have been a major factor that led these escape gamblers to gamble in the first place. What they needed was empowerment, which is just what the machine provided them with – a sense of having freedom from being powerless. Once in treatment these participants were asked to leave the one thing in their lives that gave them some sense of freedom, their machine. When they no longer had it, they believed they had nothing. I encouraged them to replace that illusion of freedom which the machine provided them with some other activities or coping skills.

It was my task, as their counselor, to provide support and a safe place for Tina and Santjie to open up. When appropriate, I involved family members of the participants in the counseling process. From counseling the participants learnt effective recovery strategies including combating urges and establishing and maintaining abstinence from gambling. During counseling both Tina and Santjie as female gamblers identified patterns of thinking and behaviour that stood in their way of long-term recovery. I provided them with training in how to prevent a relapse. It was important for the female participants to focus on alternatives to gambling and to learn new coping skills. Together, we explored spiritual development. I further assisted them in identifying unresolved issues, and with my help and support, they began to address and work through painful feelings they had avoided and numbed by gambling. Both Tina and Santjie, as female gamblers, have spent so much of their lives taking care of and pleasing others, they have lost sight of their own identities. I helped them explore and arrived at

a clear sense of self-identity. With Santjie we also had to address various issues such as career development or assertiveness in relationships in the process of self-exploration.

Hypothesis four

**Brief solution-focused treatment techniques may be less effectively for the biologically vulnerable gambler but may be more effective for the psychosocially vulnerable gambler.**

Henry tended to get bored, impatient and restless very quickly. He wanted to be challenged and wanted to know about practical solutions to his problems – in a quick way – “the quick fix”. Henry had a tendency to look for short cuts in solving his problems and attaining his goals – “the easy way out”. Rather than assessing his plans in a realistic and rational fashion, he sought out and took the seemingly quickest and easiest route to success. This is why I focused much less on the solution-focused therapy (Berg & Briggs, 2002) with Henry. It became quite a challenge to help him reduce his pace, to teach him about his responsibilities, how to face it, and to still keep him interested in the process. In addition, it was necessary to find an alternative activity which included a high level of action.

However, treatment matching and treatment approaches such as stage-change matching, motivational interviewing, supportive counseling, solution-focused approach, pharmacotherapy, relapse prevention, cognitive-behavioural and coping and problem solving skills were useful in Santjie’s case. Furthermore, what probably caused the biggest shift in Santjie’s behaviour was the solution-focused approach. Only addressing Santjie’s gambling problem was not enough to maintain abstinence. Santjie needed drastic concrete changes and solutions to her pressing psychosocial stressors and she needed to feel empowered and in control of her life. It was through our relationship that Santjie empowered herself and began to develop trust in her environmental system again.

### Implications

The solution-focused treatment approach might have been originally developed to cope with negativity and depression, but I find it tends to feed right into the unrealistic optimism. Henry was the kind of gambling addict which I call the “pathological optimist”. He tended to live for the moment, always looked on the bright side and always had another plan or scheme to get money or get out of whatever trouble he was in. He had fantastic defenses against any negative feeling and even treatment had become one of the things he was unrealistically optimistic about. Henry was right just often enough to feed his overconfidence and when he was wrong he saw it as a fluke. It bothered him for a day and then he shrugged it off and moved on to the next scheme. There might be connection here with ADHD, but not a simple one.

### Hypothesis five

**Not all sub-types of gamblers will manifest all the stages of the psycho-structural model of gambling in the same order.**

Henry manifested all the symptoms mentioned in the psycho-structural model of gambling. He went through all the stages, from the winning, losing, chasing and compulsion stage with many cognitive distortions like biased evaluation, illusion of control and hindsight bias. There is however a question mark related to his distorted sense of self. According to the psycho-structural model Tina appeared to be an escape gambler in the hopeless stages and charged by her employer with criminal activities. She suffered severe financial and emotional depletion. Tina’s gambling history determined that her problem was isolated to one game – slot/poker machines which produced a hypnotic emotional effect – a way of self-medicating the emotional pain she was feeling inside.

### Implications

As a consequence of Henry's gambling addiction he became even more depressed and gambling started becoming an emotional coping mechanism. After years of gambling, Henry eventually turned into a psychologically vulnerable gambler and started playing machines. In addition, the question that needs to be asked is whether Henry developed a distorted sense of self through the gambling or was the distorted sense of self already present before he started gambling compulsively? I suspected the latter. It was uncertain whether his character defects appeared as a result of his gambling behaviour or whether it had already been there before he started gambling – I suspected the latter. The question then remained whether I was not dealing with an anti-social gambler, which means that it was the anti-social traits that pre-disposed him to pathological gambling and related criminal behaviour. Unfortunately he was not willing to undergo further psychiatric evaluations or any psychometric testing and this could not be confirmed. Care should thus be taken that when you are in fact dealing with a biological vulnerable gambler, it may present with symptoms similar to a psychological vulnerable gambler (which it might be at that particular time period) and this will need a slight shift in the treatment approach. It is also very important that an anti-social personality disorder be ruled out, which in some cases could easily be the primary condition and the gambling pathology might be a symptom manifestation of a primary personality disorder. This in turn will severely affect the treatment approach.

Initially, for Tina her gambling was not about making money but numbing her deep seated emotional pain. According to the psycho-structural model, and when discussed with her, Tina did not go through a chasing phase before reaching the pathological stage. She did not care if she was losing; just as long as she could play – winning or losing – it did not matter to her. When she was losing, she was not intentionally trying to win it back for the sake of trying to win back what she had lost. Tina only started chasing *after* she had reached the pathological stage and committed a crime. Even though Tina and Henry's



motivation then looked similar, their motivations had actually switched. Tina became the “action” gambler who was chasing the money (to repay her employer what she had stolen) and Henry had become the “escape” gambler, using gambling as a dysfunctional coping mechanism. Tina felt very guilty about her criminal activities and was trying to return the monies that she had stolen and was trying to chase and recoup the monies through gambling. After Gambling had become her only coping mechanism in dealing with her daily troubles – she could not function properly without gambling. The treatment approach needs to acknowledge the shift in motivation for these two sub-types of gamblers.

#### Hypothesis six

**Pathological gambling is a stressful addiction and the way in which the sub-types of gamblers experience gambling-related stress are diverse.**

Gambling is an action-packed game that gets the adrenaline flowing, the heart beating and the blood boiling. At the same time gamblers can lose themselves in it, depending on the type of game that the gambler is playing. The real stress starts building when the gambler loses more and more and he/she becomes totally pre-occupied and obsessed, not just with gambling, but with ways to obtain money. Some gamblers thrive on the stress, others have great difficulty in dealing with it.

#### Implications

This hypothesis has important implications especially with regard to how our legal system views pathological gambling and gambling related crimes. It is clear from the above case studies that the participants’ motivations for gambling was very different and also changed over time. Gambling-related criminal activities become a major symptom in the desperate stages of this addiction and all pathological gamblers’ behaviour is driven by a very powerful compulsion which they are unable to control. However, I do believe that the motivation

behind sub-types of participant gamblers' gambling related crime is different and should be taken into consideration when a person has been charged with a criminal offence and sentencing is passed.

During ongoing assessment, Henry (as a biologically vulnerable gambler) also presented with suspected anti-social traits, a weak super-ego and a very high risk-taking element in his personality. It seemed that Henry's criminal behaviour (theft and fraud from his employers) started taking on very similar attributes to that of his gambling behaviour, and even started to take precedence over his gambling behaviour. It appeared as if his criminal behaviour had become the major challenge and very exciting in the sense of: "Can I get away with this. Can I beat or manipulate the "system"". This became the ultimate gambling challenge and the ultimate rush – not just to beat the gambling/casino system, but the overall "system" in general. This provided him with enormous feelings of power and control. He loved and thrived on the stress, anxiety, tension and adrenaline flow that he experienced in constantly "living on the edge" – it made him feel alive. In addition, Henry had an amazingly ability to block out any guilt feelings which reflected a lack of conscience and remorse. His cognitive distortions were limited to his gambling behaviour and did not seem to filter through to his everyday personal life. Henry was not just gambling at the casino or race tracks, he was gambling with everyone and everything – and even with his own life. Everything in Henry's life became a game – a gamble – pushing the limits and living on the edge wherever he went.

During ongoing assessment, it became clear that the way in which Tina, (as a psychologically vulnerable gambler) experienced the acute and chronic stress brought on by her gambling addiction and related criminal behaviour, was very different than that of Henry. Psychometric testing revealed that Tina had a very strong super-ego, was depressed, dependent, avoidant, neurotic and highly guilt-prone – and not a person that deals particularly well with stress. Tina's motivation for gambling was initially purely emotional and was used to escape

her problems rather than confronting them directly. Her behaviour was not only driven by a very powerful gambling compulsion, but gambling had become her only emotional coping mechanism. As a consequence of the acute and chronic stress, she started developing delusions and cognitive distortions (e.g. illusion of control) related to her compulsive gambling behaviour which filtered through to her daily life. In order to survive emotionally, Tina had to continue gambling. As she could not identify with her gambling-related criminal behaviour, she rationalized her behaviour as “borrowing” the money and not stealing and would repay the stolen monies once she wins the jackpot. Tina’s thought processes became severely distorted and her crime became a direct result of a distorted mind. The stress, trauma and guilt that she was experiencing as a consequence of her gambling behaviour became too overwhelming and Tina started manifesting symptoms very similar to a type of psychotic behaviour – she became delusional and developed a distorted sense of self. Even though Tina was aware that her criminal behaviour was wrong and was able to distinguish between right and wrong, she rationalized it as “borrowing” the money from her employer that she would return as soon as she wins the jackpot. Tina had developed a *delusion* of control and had started chasing at the casino to replace the monies stolen from her employer.

The implications of this hypothesis are quite profound, particularly in the light of the actual *intention* behind the gambling-related criminal behaviour. It could be argued that Henry’s criminal behaviour was motivated by his anti-social personality traits and that the criminal behaviour was a by-product of his type of personality and only partially initially motivated by the gambling. It could be that Henry’s intention was conscious theft to see if he could outsmart that particular “system” as well, as this provided him with the ultimate challenge, thrill, power and risk-taking. In contrast, it could be argued that Tina’s intention behind her gambling related criminal behaviour was one of “borrowing” and not stealing as she was then chasing to repay what she had “borrowed”. She developed a type of psychosis (severe delusions) which immediately puts Tina in the category of

mentally impaired at the time of committing the crimes. If it can be proven that Tina became mentally impaired while committing the crimes as a result of extreme high levels of chronic stress induced by her gambling behaviour, then pathological gambling could be argued as substantial and compelling circumstances in a court of law.

### Hypothesis seven

#### **Gambling addiction is gender specific which has treatment implications.**

Both female participants, Tina and Santjie, had difficulties with anger, assertiveness and setting relational boundaries, which became vital topics that had to be addressed in treatment. Incidents of addiction/compulsions, codependency and mental health problems existed in the family systems of these women. They struggled with other problematic behaviours in addition to the gambling, including, compulsive or binge eating and compulsive spending. Co-morbidity in the form of depression, anxiety and suicidal ideation manifested. Themes in both Tina's and Santjie's history included marital and relationship problems, abuse, violence, trauma, caretaking and employment pressures. Though they initially gambled for fun, excitement and entertainment, it would seem that their gambling is more directly an attempt at autonomy, mood management and stress relief. They also complained at a lack of fun and alternative safe leisure choices.

Some of the unique emotional issues I saw Tina and Santjie bring to their problem gambling therapy concerned rebellion and autonomy. Almost as if gambling was in some manner a way of "letting go of their obligations", "rebellious", "doing what they want, finally", after taking care of everyone else in their lives. Both Tina and Santjie, as female gamblers, had experienced abusive relationships and lasting loneliness. The crux of the rebellion seemed to be the end result of feeling emotionally and physically responsible to others first and themselves last.

However, Henry, as a male gambler in treatment, had the goal of getting his finances in order first and his relationships second, which, alone, he considered as treatment success. On the other hand, the female participants not only had gambling related and financially related goals but also real, current and explicit concerns about dealing with underlying issues. Henry had difficulty in dealing with underlying issues, for example feelings invoked by encounters with his father, and the like. Tina and Santjie, again, felt they needed to deal with these issues, as their unresolved emotions were triggers to gamble. Tina and Santjie were able to see the connections between all of their difficulties, while Henry was more inclined to compartmentalize his problems – it was his gambling over here and his relationships over there. The lines of demarcation were rarely so black and white for the two female participants. Tina and Santjie on the other hand came to therapy with much less concrete goals and were much harder on themselves in evaluating success than Henry. This made working with both Tina and Santjie much more challenging. The treatment goals were more elusive and their own measure of success harder to establish.

### Implications

For the female participants, measures of success were typically so large that, clinically, it was one of the greatest challenges to help them formulate treatment goals that were achievable. It felt at times that all of the cognitive-behavioural techniques were not enough. They wanted good strategies from me as their counselor, but this was not what they demanded most. They seemed to want to know that I was there with them, to acknowledge that their pain was seen and that I was not afraid of them; that I could bear their stories and carry them, and that they would be attended to when they feel unworthy.

There seemed to be distinct risks and vulnerability factors for the female participants related to gambling. These warrant sensitive treatment approaches in working with the female gambling population. Female gamblers need to be

attended to as both women and as gamblers. Learning about a variety of personal and gambling issues seem to be helpful to support the female gambler to make changes. Changing gambling behaviour, including how to cope with urges, triggers, how to stop, learning how their denial system manifests seem to be helpful. Dealing with stress, disempowerment, low self-worth, depression, anxiety, guilt and shame are personal life issues that can make a difference in treatment. In cases of codependency issues such as caretaking, repression, obsessions, controlling, denial, dependency, poor communication, weak boundaries, lack of trust, anger and sexual problems may need to be addressed.

Santjie tended to be concerned about financial issues such as ways to increase income, resolving debts and proper money management. Financial and legal consultation can be useful in supporting the treatment efforts of the female gambler. Financial concerns are important to address in helping women rebuild and recover from gambling problems. Credit counseling training can help with consolidation, budgeting and debt repayment. Equally important is the therapeutic task of exploring the meaning, history, values and relational power dynamics attached to money for the female problem gambler.

Leisure issues such as having fun or doing something rewarding for themselves were themes that constantly surfaced with Tina and Santjie. They were separated and divorced and a lack of spousal support was a treatment issue. Especially Tina feared rejection in disclosing the extent of her gambling and tended to cloak her gambling in secrecy. Tina's son, as a male supporter had difficulty in relating to his mother's escape gambling. In addition, what was important to Tina as a female gambler were problems related to food and eating as well as body image. In addition, both Tina and Santjie had suffered a recent life transition event and relationship issues which needed to be explored in counseling.

In treating the female participants it was of critical importance to address issues of personal enrichment, for example, dealing with stress, self-esteem issues, empowerment, spiritual well-being, burn-out, having fun, meaningful use of free time, isolation and loneliness. Reconnecting socially and replacing gambling with satisfying, meaningful social and leisure alternatives were critical for them, but finding these alternatives was often a challenge. Dealing with relationship issues was valuable in the treatment of the female participants. However, in counseling them, care had to be taken not to collude with societal and internalized expectations and pressuring them to engage in yet more caretaking to fix problematic relationships. While skill training in areas such as assertiveness benefited the female participants, it was more essential to attend to and explore more effective means of self-care.

The implications of this hypothesis are quite profound with regard to how counselors approach treatment with female gamblers. I came to the conclusion that counselors need to validate a woman's right and need to "escape" but encourage her to find healthier ways than gambling to nurture and reward herself. Counselors working with female problem gamblers must be conscious of the layers of the addictive gambling behaviours and possible co-mingling with mental health issues, which are often accompanied by a history of abuse and trauma. Working with women means attending to the whole person and often involves addressing more than a specific focus on the gambling behaviours. To the extent that gambling is a coping or survival strategy to deal with psychological and physical pain, changes to behaviour will not occur without attention to underlying issues, either in treatment sessions or through appropriate referrals. Some therapies focus too narrowly on overt gambling behaviours or cognitions and too little on underlying factors, such as poor coping strategies or dysphoria. If for instance, a woman is gambling to escape loneliness, then counseling strategies that focus entirely on her gambling behaviour are unlikely to be successful in the long term. Even if problem gambling is successfully halted, it is possible that she may simply turn to another

form of avoidance, such as excessive shopping or eating to cope with her ongoing loneliness. It is important for counselors to identify the “needs” that are satisfied by gambling and to work with clients to find alternate methods of satisfying these needs.

Counseling Tina and Santjie as female gamblers required a feminist sensitivity to the reality of women’s lives. While not all women who develop gambling problems will fall into the psychologically and co-dependent vulnerable group, I believe that many may have some of the concerns mentioned. Further, Santjie presented with a psychosocial vulnerability where problem gambling occurred as a result of ignorance and poor judgment. Supporting her through a process of making changes to her gambling involved a variety of tasks in addition to relapse prevention: developing support systems, addressing relationship, leisure and job needs, working with financial issues, dealing with psychiatric concerns, codependency and the aftermath of abuse and trauma. Effective counseling for both Tina and Santjie as female problem gamblers, included an active search for underlying factors such as dysphoric mood or maladaptive coping strategies including an active search for underlying emotional problems. Both of them were gambling because of dysphoric emotions and I treated their overt behaviours as symptoms rather than the cause of problems.

### 10.3 STRENGTHS OF THE STUDY

Qualitative research is especially effective for studying the subtle nuances of attitudes and behaviours and for examining social processes over time (Rubin and Babbie, 1993). For these reasons, the chief strength of this study lies in the depth of understanding and insight it may permit into the lives of different sub-types of pathological gamblers. Developing deep insight and knowledge of the person and his/her gambling behaviour enabled me to discover real truths that would otherwise not have able to be obtained by an external party. “Being there” - with and for the participants was a powerful technique for gaining insights into the way in which they were experiencing their gambling addiction as



well as their rehabilitation and treatment process. I also identified and applied certain treatment approaches and the participants were able to give me feedback as to the effectiveness of the respective treatment approaches. Being able to present certain hypotheses, themes and conceptualizations in this study are valuable in their own right. In addition, they can provide the basis for further research – both qualitative and quantitative. The findings and insight from this study could be used as a valuable tool by other professionals and clinicians in the understanding and treatment of pathological gambling.

In qualitative research the complexity of human functioning is respected. This is unlike the positivist-empirical tradition which according to Lincoln and Guba (1985) produces research with human respondents that ignores their humanness, a fact that not only has ethical but also validity implications. In the present study I formed a close and respectful relationship with each participant. Participants were viewed as a most reliable source of information and as experts in the field of living with a pathological gambling addiction. Therefore qualitative research cannot be value free, which means that the researcher cannot, according to Lincoln and Guba (1985) and Hammersley (1998) assume an uninvolved and objective position.

In qualitative research the traditional reliability and validity is conceptualized in terms of trustworthiness (Lincoln & Cuba, 1985; Creswell, 1998). In this study, the techniques of prolonged engagement, triangulation and member checks were used for ascertaining trustworthiness.

Prolonged engagement requires the investment of sufficient time. The stories produced were the result of one hour individual counseling, once a week to once every second week, and then once per month. The shortest time span was with Santjie and lasted thirteen months. Counseling with Henry lasted fourteen months and Tina's counseling lasted three and a half years.

Triangulation, according to Denzin (1997) is achieved through multiple data sources and data collection methods. In this study this was achieved by using the information from the individual counseling sessions, journal writings, notes, further interviews with family members, a codependency screening tool and two respective gambling screening tools.

Member checks, whereby data, analytic categories, interpretations and conclusions are tested with members from whom the data were originally collected, is the most crucial technique for establishing credibility (Lincoln & Guba, 1985). During this study I analyzed information after each session and gave feedback to the participants to determine if I had captured their meaning accurately. The stories and the themes which emerged were also shared and negotiated with the participants. The participants agreed with my interpretations and when there was disagreement, outcomes were negotiated.

Transferability is the next issue in a qualitative inquiry. Transferability means whether the study is applicable. In quantitative research this would be called "external validity" and would be expressed in the form of statistical confidence limits. According to Lincoln and Guba (1985) the qualitative researcher cannot specify the external validity of an inquiry. The researcher can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility. Since this study is a unique exploration of the researcher as the human instrument it cannot be replicated for verification. This study provides stories and conclusions that are meant to be thought provoking. It will be up to the applier to determine which results and how well they apply to different contexts.

#### 10.4 LIMITATIONS OF THIS STUDY

This study presumes individual construction of reality. The constructions may be shared or idiosyncratic, but the assumption is that realities are multiple, i.e. there is more than one and they are constructed and holistic. From a traditional

perspective this would be viewed as a limitation as the diverse meanings articulated in this thesis are not the only meanings that could exist. My descriptions represent a reconstruction of the participants' constructions and according to Moon, Dillon and Sprenkle (1990) the mind tends to select data that confirms the meanings the researcher has identified.

The context of the present study may limit the applicability of the findings and the descriptive qualitative methods used means that this study cannot be verified by future research. The complexity of the context negates a linear model of cause and effect and the notion of variables which can be dissected and studied without connection to the context. This can be viewed as a limitation by traditional quantitative studies who, according to Lincoln and Guba (1985) select out for intense study one or a few variables while holding everything else constant.

A study of this kind involves intense personal interaction between the researcher and the participants which is not dispassionate and objective (Denzin, 1997). I selected a thesis of interest to me, one which fits my belief in the importance of the individual. The participants taught me a great deal and they too learned more about what they thought and about the realities they constructed for themselves. Reactions and interactions were a necessary part of this study. The limitation with this is that the connection between the researcher and participants is a very fragile one which raises important ethical issues (Moon, Dillon & Sprenkle, 1990). More generally, the conclusions drawn from this study can be regarded as suggestive rather than definitive. This is due to certain problems and subjectivity and generalizability. Unintentional bias and a lack of unique external objectivity in this study should be taken into account. An independent party with a fresh perspective might notice trends or conclusions that I, as the internal reviewer, might have missed because of familiarity with the findings and participants, and expectations about its value. However, having deep insight and knowledge of the participants and their gambling behaviour

enabled me to discover real truths that would otherwise not have been able to be obtained by an external party.

## 10.5 CONCLUSION AND IMPLICATIONS FOR BEST PRACTICES

This study is an exploration, through ethnographic and auto-ethnographic inquiry, of the personal world and gambling experiences of different sub-types of pathological gamblers and of my personal relationship and treatment of these gamblers. The aim of this study was further to explore the effect of certain identified treatment approaches with different sub-types of gamblers. Again, as was explored and experienced through this study, gambling is a complex, multi-dimensional activity that is unlikely to be explained by any single theory. Instead, it is best served by a biopsychosocial model that stresses the individual and idiosyncratic nature of the development of gambling problems and emphasis on the role of contextual factors internal and external to the process of gambling itself.

To date, there have been a small number of studies worldwide about the characteristics of problem gamblers in long term treatment services. The long term treatment of gambling related disorders, especially in South Africa, is at an early stage of development. Special population segments may represent groups of individuals with particular or distinctive treatment needs. Consequently, treatment providers may consider the descriptions and hypotheses in this study as part of a buffet of options to consider when treating a pathological gambler.

My role as therapist was to explore the gambling experience and personal world manifestations of the three participants. In addition, I strived to assist them in stopping and reducing the frequency of their problem gambling and to help them develop ways of coping with the problem gambling behaviour by matching their gambling disposition profile with certain treatment approaches. Thus, exploring the participants' worlds and the construction of realities was an ongoing process during long term counseling. This allowed me to formulate appropriate matching

treatment strategies that were based not only on the stage of change, but also on the phase in the psycho-structural model, as well as the underlying vulnerability. From this a comprehensive gambling disposition profile was completed with proper intervention matching approaches. In addition, I explored some of the underlying reasons why gambling had become a problem and addressed related issues that were causing harm or damage. It was important to provide help in developing a productive and healthy life without problem gambling. Therapists should help and support the addicted gambler to reach their personal goals, taking into account the individual economic, educational and social conditions of the clients. The therapist should help all problem gamblers, whatever age, be they men or women, to understand the reasons behind their gambling addiction, to regain responsibility for their lives, to improving their life-style and regaining self-esteem and to include the whole family in treatment.

In conclusion, therapists need to be aware of the gender differences associated with assessment and treatment, recognizing that women may enter the treatment system under different circumstances than their male counterparts. In addition, treatment professionals need to be sensitive to a preference for women-specific treatment settings and programming. Not only gender differences, but the respective underlying vulnerability pathways in developing a gambling problem seem to be an important factor in treatment matching.



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**ANNEXURE 1****DSM-IV DIAGNOSTIC CRITERIA FOR PATHOLOGICAL GAMBLING**

Persistent and recurrent maladaptive gambling behaviour should occur which causes disruption or damage to several areas of a person's functioning, including personal, family or vocational pursuits. The gambling cannot be explained by a psychiatric condition of mania or a manic episode. In addition, at least five or more of the following features need to be present (APA, 1994):

1. An excessive pre-occupation 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 or stop gambling.
4. Is restless or irritable when attempting to cut down or stop gambling.
5. Gambles as a way to escape from problems or relieve a dysphoric mood (i.e. feeling of helplessness, guilt, anxiety and depression).
6. After losing money, often return on another day to get even ("chasing" one's losses).
7. Lies to family members 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 educational or career opportunity because of gambling.
10. Relies on others to provide money to relieve a desperate financial situation caused by gambling ("bail-out").

## ANNEXURE 2

## GAMBLERS ANONYMOUS 20 QUESTIONS

1. Have you ever lost your sense of time while gambling? *yes/no*
2. Does gambling make your home life miserable? *yes/no*
3. Is gambling influencing your daily work? *yes/no*
4. Do you ever feel regret after gambling? *yes/no*
5. Do you ever gamble to make money in order to pay debts or solve other financial problems? *yes/no*
6. Does gambling decrease your efficiency? *yes/no*
7. When you lose, do you have the feeling that you have to go back as soon as possible to make good on your losses? *yes/no*
8. When you win, do you feel an urge to go back and win more? *yes/no*
9. Do you usually play until you have gambled away your last rand? *yes/no*
10. Do you sometimes borrow money in order to gamble? *yes/no*
11. Have you ever sold personal belongings to pay for your gambling? *yes/no*
12. Do you hate to use gambling money for normal expenses? *yes/no*
13. Does gambling make you careless? *yes/no*
14. Do you sometimes gamble for longer than you intended? *yes/no*
15. Do you sometimes gamble to escape problems or worries? *yes/no*
16. Have you ever thought about doing something illegal to finance your gambling fever? *yes/no*
17. Do you ever suffer from insomnia because of gambling? *yes/no*
18. Do frustrations, controversy, etc., create in you the urge to go gambling? *yes/no*
19. Do you get your main pleasure in life in gambling? *yes/no*
20. Do you ever consider suicide as an escape for your gambling problems? *yes/no*

## ANNEXURE 3

## THE SPANN-FISCHER CODEPENDENCY SCALE

Read the following statements and place the number in the spaces provided that best describes you according to the following list:

- 1 - Strongly disagree                      2 - Moderately disagree                      3 - Slightly disagree  
 4 - Slightly agree                              5 - Moderately agree                              6 - Strongly agree

- .....
1. It is hard for me to make decisions. ....
  2. It is hard for me to say "no". ....
  3. It is hard for me to accept compliments graciously. ....
  4. Sometimes I almost feel bored or empty if I don't have problems to focus on. ....
  5. I usually *do not* do things for other people that they are capable of doing for themselves. ....
  6. When I do something nice for myself I usually feel guilty. ....
  7. I *do not* worry very much. ....
  8. I tell myself that things will get better when the people in my life change what they are doing. ....
  9. I seem to have relationships where I am always there for them but they are rarely there for me. ....
  10. Sometimes I get focused on one person to the extent of neglecting other relationships and responsibilities. ....
  11. I seem to get into relationships that are painful for me. ....
  12. I don't usually let others see the "real" me. ....
  13. When someone upsets me I will hold it in for a long time, but once in a while I explode. ....
  14. I will usually go to any lengths to avoid open conflict. ....
  15. I often have a sense of dread or impending doom. ....
  16. I often put the needs of others ahead of my own. ....

TO OBTAIN A SCALE SCORE, REVERSE ITEMS 5 AND 7 AND SUM ALL THE ITEMS



**PERSONAL GAMBLING DISPOSITION PROFILE**

**SEVERITY OF GAMBLING PROBLEM**

- DSM-IV Classification Score : .....
- GA 20 Questions Score : .....
- Problem / Pathological : .....
- Phase : .....

**Treatment approach**

.....

**TYPE OF GAMBLER** (action/escape & game)

.....

**Treatment approach**

.....

**BIOLOGICAL VULNERABILITY** (onset and course)

.....

**Treatment approach**

.....

**EMOTIONAL/PSYCHOLOGICAL VULNERABILITY** (onset and course)

- Previous diagnoses : .....
- Mood/Anxiety disorder : .....
- Personality disorder : .....
- Substance abuse : .....
- Other compulsive behaviour : .....
- Codependency : .....
- Negative experiential factors : .....

**Treatment approach**

.....

**PSYCHOSOCIAL VULNERABILITY**

.....

**Treatment approach**

.....



IDENTIFIED PROBLEMS

- Primary relationship : .....
- Family : .....
- Residential : .....
- Financial : .....
- Medical : .....
- Psychiatric : .....
- Occupational : .....
- Legal : .....

**Treatment approach**

.....

STAGE OF CHANGE

.....

**Treatment approach**

.....

THERAPIST (CLINICAL) APPROACH

.....

## ANNEXURE 5

**PERSONAL GAMBLING DISPOSITION PROFILE: HENRY****SEVERITY OF GAMBLING PROBLEM**

- DSM-IV Classification Score : 10/10
- GA 20 Questions Score : 20/20
- Problem / Pathological : *Pathological (numerous illegal activities with no criminal charges, loss of employment, co-morbidity)*
- Phase : *Desperation phase with suicidal ideation*

**Treatment approach**

*Inpatient referral? motivational, abstinence (total loss of control), immediate safety nets (GA support group), referral for confirmation of Bipolar Disorder, query (adult) Attention Deficit Disorder?*

**TYPE OF GAMBLER** (action/escape & game)

- *Action gambler : black jack, roulette, horse race punting, dice, lottery*
- *Escape gambler : slots (dysfunctional coping strategy)*

**Treatment approach**

*Illusion of power and control, motivational and reality testing, cognitive-behavioural and directive (here and now).*

**BIOLOGICAL VULNERABILITY** (onset and course)

- *Possible genetic pre-disposition (grandparents were problem gamblers)*
- *Possible biologically based traits of impulsivity*
- *Possible deficits in the serotonergic (mood regulation), dopaminergic (reward regulation) and noradrenergic (mediating arousal)*
- *Possible neuropsychological vulnerability – attention deficit disorder*

**Treatment approach**

*Referral for pharmacological treatment for mood disorder, obsessive and impulsive behaviour and possible attention deficit disorder.*

**EMOTIONAL/PSYCHOLOGICAL VULNERABILITY** (onset and course)

- Previous diagnoses : *Bipolar Mood Disorder (medication: Lithium and Dormicum (sleeping tablets))*

- Mood/Anxiety disorder : *Bipolar Mood Disorder?*
- Personality disorder : *Traits: histrionic, narcissistic, risk-taking, boredom proneness, impulsive, excitement seeking, anti-social?*
- Substance abuse : *Alcohol abuse*
- Other compulsive behaviour : *Sex addiction*
- Negative experiential factors : *Childhood disturbances, poor self-worth, social isolation, unproductive coping skills, life stressors, loss*

### **Treatment approach**

*Productive coping and emotional management skills, motivational, cognitive behavioural techniques, 12 step programme and refer for medication.*

### **PSYCHOSOCIAL VULNERABILITY**

- *Distorted concept of controlled gambling*
- *Winning as an accomplishment*
- *Lack of money management skills*
- *Lack of social stimulation*

### **Treatment approach**

*Psycho-education, cognitive-behavioural, social stimulation and money management skills.*

### **IDENTIFIED PROBLEMS**

- Primary relationships : *Dependent and power orientation*
- Family : *Enabling, father deprivation, parents deceased*
- Residential : *Living in bachelor's flat, rent in arrears*
- Financial : *±R150 000.00 gambling debt, meager salary*
- Medical : *Sexually transmitted disease*
- Psychological : *Bipolar disorder? ADD? gambling and sex addiction*
- Occupational : *Fired from job due to company fraud twice (A-motivational syndrome)*
- Legal : *No criminal charges (numerous illegal activities) and administration order*

### **Treatment approach**

*Psycho-education, motivational interviewing, cognitive-behavioural techniques and 12-step programme, psychiatric referral, HIV referral, functional coping, family involvement and goal setting.*

**STAGE OF CHANGE**

- *Orientation to change* : *Gambling and sexual behaviour*
- *Active quitting* : *Taken action for change (Banned himself)*
- *Motivation for change* : *Internal (financial concerns, negative emotions, rock bottom, familial influence)*  
*External (lack of financial resources, confrontation)*

**Treatment approach**

*Motivational, abstinence and relapse prevention with a complete life-style change.*

**THERAPIST (CLINICAL) APPROACH**

*Firm, assertive, directive and reality based (here and now), task oriented, direction and resource based, accountability based, clear therapeutic boundaries and working toward a sense of humbleness.*

## ANNEXURE 6

**PERSONAL GAMBLING DISPOSITION PROFILE: TINA****SEVERITY OF GAMBLING PROBLEM**

- DSM-IV Classification Score : 10/10
- GA 20 Questions Score : 20/20
- Problem / Pathological : *Pathological (criminal charges, loss of job).*
- Phase : *Desperate phase (no suicidal ideation).*

**Treatment approach**

*Inpatient referral? total abstinence (addiction), immediate safety nets (self-exclusion order, GA support group, handing over finances, family involvement), psychometric evaluation, motivational, supportive, legal support and relapse prevention.*

**TYPE OF GAMBLER** (action/escape and game)

- *Psychologically vulnerable gambler (escape).*
- *Slot and poker machines.*

**Treatment approach**

*Productive coping and problem solving skills to eliminate avoidance coping. Cognitive-behavioural approach (challenging irrational beliefs). Psycho-education (odds, probabilities, randomness).*

**BIOLOGICAL VULNERABILITY** (onset and course)

- *Possible biochemical impairment (serotonin (mood regulation) and dopamine (reward regulation) deficiency) preceding gambling – possible prior dopamine deficiency that created vulnerability for addictions (related to a long standing codependent style) – also possible worsening of deficits as consequence of gambling.*
- *Possible lack of D2 receptors causing patient to seek pleasure-generating activities e.g. compulsive eating and compulsive shopping.*
- *Epilepsy - Temporal lobe epilepsy query?*
- *No suspected genetic predisposition.*

**Treatment approach**

*Referral for medical (scan) and pharmacological treatment for depression and obsessive and compulsive behaviour.*

**EMOTIONAL/PSYCHOLOGICAL VULNERABILITY** (onset and course)

- Previous diagnoses : *Depression (1997) (no medication at present)*

- Mood/anxiety disorder : *Higher anxiety levels*
- Personality disorder : *Introversion and dependent traits*
- Substance abuse : *Husband – chronic alcoholic and over-the-counter medication dependency*
- Other compulsive behaviour : *Compulsive eating (obesity) and compulsive spending*
- Codependency : *Presenting with all patterns of a codependent style: denial, low self-worth, control, anger, compliance, repression, care taking, obsession, dependency, poor communication, weak boundaries, lack of trust, sexual problems, depression and progressive symptoms*
- Negative experiential factors
  - Recent life transition event  
*Both sons leaving home, sequestration, loss of job, criminally charged, social isolation, lack of social support, ex-husband's and son's alcohol addiction, chronic physical pain, unproductive coping skills, life stressors and negative emotions.*
  - Personality traits  
*Depressive, dependent, avoidant and obsessive.*

#### **Treatment approach**

*Productive coping and emotional management skills, intensive codependency treatment (Sullivan's six-stages, enabling and detachment), cognitive-behavioural techniques and alternative behaviours to replace gambling.*

#### **PSYCHOSOCIAL VULNERABILITY**

*Lack of education and ignorance related to gambling, unemployment, disempowerment and lack of social stimulation.*

#### **Treatment approach**

*Psycho-education, empowerment, resource facilitation and solution-focused approach.*

#### **IDENTIFIED PROBLEMS**

- Primary relationships : *Codependent style (passive)*
- Family : *Isolation from family due to embarrassment*
- Residential : *Lost house - sequestered – living with sister in a back yard wendy-house on a plot*
- Financial : *No income – lost all possessions, son helping*

- out financially & R900 000 gambling charges
- Medical : Mild controlled epilepsy, damaged leg (on crutches and colon problems)
  - Psychological : Guilt, self-blame, remorse, depression, anxiety, dependent, avoidant, loss, compulsive spending and eating (obesity)
  - Occupational : Dismissed due to company fraud charge – temporary employment with minimal income
  - Legal : Criminal charges – court case pending

### **Treatment approach**

*Loss and grief (trauma) and low self-worth (self-esteem building).*

*Cognitive-behavioural techniques for compulsive eating and spending.*

*Medication for physical problems, depression and anxiety.*

### STAGE OF CHANGE

- *Orientation to chance* : *Gambling, compulsive eating and spending and codependency*
- *Active quitting* : *Taken action for change (forced quitting)*
- *Motivation for change* : *Rock bottom and legal reasons (internal and external – caught and criminally charged by employer)*

### **Treatment approach**

*Abstinence and relapse prevention with complete life-style change (including different leisure activities and needs assessment).*

### THERAPIST (CLINICAL) APPROACH

*Illusion of freedom, empowerment, uplifting, motivational and supportive.*



## ANNEXURE 7

**PERSONAL GAMBLING DISPOSITION PROFILE: SANTJIE****SEVERITY OF GAMBLING PROBLEM**

- DSM-IV Classification Score : 9/10
- GA 20 Questions Score : 16/20
- Problem / Pathological : *Problem bordering on Pathological*
- Phase : *Desperation phase with suicidal ideation*

**Treatment approach:**

*Inpatient referral? total abstinence (addiction), immediate safety nets (self-exclusion order, GA support group, family involvement), motivational, supportive and relapse prevention.*

**TYPE OF GAMBLER** (action/escape & game)

- *Psychosocial vulnerable (escape) gambler turning into psychological vulnerable gambler*
- *Machines (slots, video poker and video lottery machines)*

**Treatment approach**

*Psycho-educational (odds, probabilities, randomness), productive coping and problem solving skills, money management, cognitive-behavioural approach (challenging irrational beliefs).*

**BIOLOGICAL VULNERABILITY** (onset and course)

- *Possible biochemical impairment (serotonin (mood regulation) and dopamine (reward regulation) deficiency) as a consequence of gambling – also a possibility of this preceding gambling but worsened after a period of continuous gambling.*
- *Not certain of mother's psychological problems – possible genetic predisposition.*
- *Thyroid problems – possible link (query).*

**Treatment approach**

*Referral for medical and pharmacological treatment for depression/anxiety and thyroid problems.*

**EMOTIONAL/PSYCHOLOGICAL VULNERABILITY** (onset and course)

- Previous diagnoses : *None formally diagnosed*
- Mood/Anxiety disorder : *Depression/anxiety (onset query)*
- Personality disorder : *Dependent traits? Obsessive traits?*
- Substance abuse : *None*
- Other compulsive behaviour : *Obesity (query link to thyroid problems)*

- Codependency : Symptoms (query)
- Negative experiential factors
  - Paraplegia, partly dependent on others, physical medical problems, relationship problems with only son, no accommodation, no job, lack of social support, severe financial pressures, unproductive coping skills, life stressors and negative emotions.

#### **Treatment approach**

*Productive coping and emotional management skills, needs assessment, enabling and detachment, cognitive-behavioural techniques and alternative behaviours to replace gambling, 12-step programme and refer for medication.*

#### **PSYCHOSOCIAL VULNERABILITY**

*Lack of education and ignorance related to gambling, physical disability, unemployment, poverty, disempowerment, lack of coping, life and money management skills and lack of social stimulation.*

#### **Treatment approach**

*Psycho-education, empowerment, resource facilitation and solution-focused approach, coping and skill training and social stimulation.*

#### **IDENTIFIED PROBLEMS**

- Primary relationships : *Forced partial dependency as consequence of paraplegia*
- Family : *No contact – estranged from all family except son*
- Residential : *Living in basement of empty building*
- Financial : *No income – disability pension stopped*
- Medical : *Paraplegic in wheelchair, back problems, thyroid problems*
- Psychological : *Depression, anxiety, forced dependency, obsessive (query), obesity*
- Occupational : *Unemployed*
- Legal : *Blacklisted, judgments*

#### **Treatment approach**

*Solution focused, family involvement, resource facilitation, care centre possibilities, disability pension application, medication for physical problems, depression and anxiety, employment possibilities, cognitive-behavioural techniques, 12-step programme and motivational interviewing.*

STAGE OF CHANGE

- *Orientation to change* : *Gambling and codependency*
- *Motivation for change* : *Initially external (family confrontation)*  
*Initial ambivalence, denial, resistant*
- *Active quitting* : *Taking action for change after relapse*

**Treatment approach**

*Enhancement of awareness of the consequences of gambling, exploring of benefits and disadvantages of gambling, psycho-education and cognitive-behavioural strategies, abstinence and relapse prevention with complete life-style change and coping strategies.*

THERAPIST (CLINICAL) APPROACH

*Psycho-educational, supportive, empowering, solution focused and motivational.*