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Addictive Behaviors 28 (2003) 933–946

Empirical measures vs. perceived gambling severity among youth Why adolescent problem gamblers fail to seek treatment[☆]

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Abstract

A comparison of empirical measures and perceived gambling severity among youth was conducted. Participants ($N=980$), mean age of 18.6 years, completed several widely accepted measures of pathological gambling [Diagnostic and Statistical Manual of Mental Disorders-IV-Juveniles (DSM-IV-J), South Oaks Gambling Screen-Revised for Adolescents (SOGS-RA), and Gambler's Anonymous 20 Questions (GA 20)] and a questionnaire assessing gambling behavior. Findings revealed that while the DSM-IV-J, SOGS-RA, and GA 20 identified between 3.4% and 5.8% of participants as probable pathological gamblers, only 1.1% of individuals classified themselves as such. Further, 3.3% of the population reported that they considered themselves problem gamblers and 66% reported being social gamblers. It appears as though either youth are grossly underestimating the severity of their gambling problems or the gambling screens are overestimating prevalence rates. The clinical implications and future directions for research are considered.

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Keywords: Youth gambling; Addiction; Empirical measures; Treatment; Problem gambling

1. Introduction

Today's youth are growing up in a time of legalized and socially/culturally approved gambling that has not come without costs (Stinchfield & Winters, 1998). Legalized gambling

[☆] This is a revision of a poster presented at the Annual Conference of the American Psychological Association, Boston, MA, August 1999.

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venues can be found in the majority of states and provinces in North America. There is evidence that problem gambling causes personal and financial difficulties in at least 1–2% of the adult population in various countries throughout the world (Ladouceur & Walker, 1996).

Much of the past research on youth gambling has focused on prevalence rates and has found that pathological gambling rates for adolescents appear to range anywhere between two to four times that of adults (Gupta & Derevensky, 1998; Jacobs, 2000; Shaffer & Hall, 1996). Current rates of adolescent pathological gambling indicate that between 4% and 8% of adolescents exhibit seriously adverse compulsive or pathological patterns of gambling activity. Furthermore, between 9.9% and 14.2% of adolescents are at-risk of developing or returning to serious gambling problems (Shaffer & Hall, 1996). In addition, retrospective studies reveal that adult problem gamblers report that they began gambling in late childhood and adolescence, often between 10 and 19 years of age (Custer, 1982; Dell, Ruzicka, & Palisi, 1981). Recent studies have found that adolescent probable pathological gamblers report beginning gambling at 9 or 10 years of age (e.g., Gupta & Derevensky, 1998; Wynne, Smith, & Jacobs, 1996). These findings are extremely worrisome given the widespread availability of legalized gambling venues, necessitating significantly more research in the field of youth gambling behavior.

Not only is gambling prevalent but there is also ample evidence that it remains a socially acceptable activity. Results of several studies, in a number of countries, have indicated that the majority of youth *gamble for money* with family members and friends (Gupta & Derevensky, 1997; Moore & Ohtsuka, 1997). In fact, it has been found that 86% of children who gamble regularly for money do so with family members and 75% of children have gambled in their own homes (Gupta & Derevensky, 1997). As children get older, they tend to gamble less with their parents and more with their friends in their friends' homes and at school (Gupta & Derevensky, 1997). The high level of social acceptability by children is reflected in the finding that only 10% of Grade 8 students (age 14) fear being caught while gambling for money (Gupta & Derevensky, 1997). Furthermore, parents appear to show little concern over their children's gambling behavior. Between 80% and 90% of parents report knowing that their children gamble for money and 84% do not object (Arcuri, Lester, & Smith, 1985). It is important to note that in the aforementioned studies, participants were considered to have gambled if they reported engaging in one or more of the following activities in the past 12 months *for money*: card games, sports betting, sports lottery, lottery, wagering on videogames, bingo, slot machines, and/or games of skill.

Given the high prevalence rates of severe adolescent gambling problems, it is important to determine why adolescent problem gamblers are not presenting themselves for treatment. One hypothesis is that given the high level of social acceptability of gambling, combined with the lack of awareness of the possible harms associated with gambling, adolescents exhibiting problem and/or pathological gambling behaviors may not be aware of the severity of their gambling-related problem (for a more comprehensive discussion, see Gupta & Derevensky, 2000).

It is important to note that adolescence, as a developmental period, is a time of increased risk-taking and is associated with perceived feelings of invincibility and invulnerability. Arnett (1992a, 1992b) suggests that certain developmental characteristics, namely sensation

seeking and egocentrism, make risk-taking behavior more likely during the adolescent years. According to Jessor and Jessor (1977), adolescents actively seek out activities that involve risk-taking. They suggest that risky behaviors permit adolescents to take control of their lives, deal with anxiety, frustration, inadequacy, and failure, and readily gain admission to peer groups. Moreover, the psychological literature on risk-taking suggests that males are greater risk-takers than females and that adolescents tend to be greater risk-takers than adults (Arnett, 1994). In addition, it is widely accepted that adolescents engage in risky behaviors, for example, smoking, substance abuse (drug and alcohol), fad diets, unprotected sexual practices, and dangerous driving (Galambos & Tilton-Weaver, 1998; Moore & Rosenthal, 1993). The positive consequences of these behaviors appear to be pleasure, peer acceptance, and satisfaction of needs, in spite of the fact that the negative consequences have been highly publicized and widely understood (Galambos & Tilton-Weaver, 1998; Moore & Gullone, 1996).

Gambling may be conceptualized as yet one more risky behavior engaged in by adolescents that has potentially serious negative consequences. Adolescents, particularly males, see risk-taking as a form of bravado and courage. Furthermore, they experience a sense of mastery due to the false sense of control that is perceived while gambling (Gupta & Derevensky, 1996). Given that gambling activities in and of themselves involve risk-taking, it is reasonable to assume that adolescents take greater risks on gambling tasks and are at increased risk for the development of multiple addictions (Derevensky & Gupta, 1997). In a study of gambling and risk-taking amongst university students, risk-taking was found to be positively correlated with degree of gambling involvement and was primarily male oriented (Powell, Hardoon, Derevensky, & Gupta, 1999). Given the data suggesting that adolescents are more likely to gamble and engage in risky behaviors, the implications of their perceptions of their own gambling behavior and related problems are of extreme importance.

The present study sought to examine perceived severity of gambling involvement compared with gambling involvement assessed by three gambling screens [Diagnostic and Statistical Manual of Mental Disorders-IV-Juveniles (DSM-IV-J), South Oaks Gambling Screen-Revised for Adolescents (SOGS-RA), and Gambler's Anonymous 20 Questions (GA 20)]. More specifically, the purpose of this study was to assess whether an individual's perception of their gambling involvement corresponded to their level of gambling involvement determined by self-report gambling screens. This serves to ascertain whether individuals possess an accurate awareness of the seriousness of their gambling problems. Furthermore, the present study seeks to clinically address the implications of either overestimating or underestimating the severity of one's gambling involvement.

2. Method

2.1. Participants

Students ($N=980$; 599 females and 381 males) from four CEGEPs (junior colleges) in the greater Montreal region participated in the present study. CEGEP is a 2-year post-high school

program that includes trade schools and academic programs. It is equivalent to Grades 12 and 13 and must be completed prior to enrolling in a Quebec university undergraduate program. The mean age of participants was 18.6 (S.D.=1.69). Participants were recruited from all sectors and areas of specialization within the CEGEP as well as from four different CEGEPS located in various districts of the greater Montreal region in order to minimize any biases. Participants were enlisted for participation via a research assistant entering their classrooms, explaining the study, and requesting participation. All participants volunteered to partake in the present study.

2.2. Instruments

The *Gambling Activities Questionnaire* (GAQ; Gupta & Derevensky, 1996) is a brief questionnaire designed to ascertain the frequency and type of gambling activities engaged in, with whom individuals gamble, and perceived severity of gambling involvement. More specifically, participants were asked to self-classify their gambling behavior by rating themselves on a Likert scale from 1 to 7 as Social Gamblers (1), Problem Gamblers (4), or Pathological Gamblers (7). Participants were classified as social gamblers if they indicated 1 or 2, as gamblers with some problems if they indicated 3–5, and as probable pathological gamblers if they selected 6–7 on the scale.

The *SOGS-RA* (Winters, Stinchfield, & Fulkerson, 1993), modified from the *SOGS* (Lesieur & Blume, 1987), is a 20-item scale used to determine the presence or absence of pathological gambling. A *SOGS* score of 0 is indicative of having no problems, 1–4 of having some problems, and 5 or greater of being a probable pathological gambler. The internal consistency reliability of the *SOGS-RA* was found to be .80.

The *DSM-IV-J* (Fisher, 1992) is a 12-item screen for pathological gambling during adolescence modeled after the *DSM-IV* criteria for diagnosis of adult pathological gambling. The *DSM-IV-J* internal consistency reliability was reported to be .78. Each endorsed item is given a score of 1, with a total score of 4 or greater being the scoring criteria for severe gambling problems. An individual who receives a score between 1 and 3 has some gambling-related problems and a score of 0 has no gambling-related problems.

The *GA 20 Questions* is a brief screening instrument that is primarily used to help gamblers and their families to assess the existence and severity of a gambling problem. A score of 0 suggests no gambling problems, between 1 and 6 is indicative of a gambler with some problems, and 7+ is indicative of being a pathological gambler.

2.3. Procedure

The instruments were group administered to classes of 20 to 30 students and were presented in a randomized order. A research assistant was present to answer any questions, and the total time necessary to complete all instruments was between 30 and 50 min.

3. Results

3.1. Probable pathological gamblers

3.1.1. Instrument classification

With respect to instrument classification, the DSM-IV-J identified 3.4% ($n=33$) of the participants as probable pathological gamblers. The SOGS-RA identified 4.0% ($n=39$) of participants as probable pathological gamblers, while the GA 20 Questions identified 5.8% ($n=57$) of the youth as experiencing serious gambling-related problems. The DSM-IV-J was found to be the most stringent gambling screen, while the GA 20 was the least conservative. These findings have been previously reported in greater depth (Derevensky & Gupta, 2000).

3.1.2. Self-classification

As mentioned, individuals were asked to rate themselves on a Likert scale from 1 to 7 from Social Gamblers to Probable Pathological Gamblers. Participants were classified as social gamblers if they indicated 1 or 2, as gamblers with some problems if they indicated 3–5, and as probable pathological gamblers if they selected 6–7 on the Likert scale. Only 1.1% ($n=10$) of the total sample classified themselves as being probable pathological gamblers (see Table 1), indicating a large discrepancy (ranging from 2.3% to 4.7% depending on the instrument used) between the perception of pathological gambling and actual classification of pathological gambling on the gambling screens.

Table 1

A comparison of participants who self-classified and those classified by the varying classification instruments

Instrument		Nongambler (%) ^a	Gambler: no problems ^b (social gambler; %)	Gambler: some problems ^c (%)	Probable pathological gambler (%)
DSM-IV-J	Female	36.6	56.9	5.8	0.7
	Male	16.5	53.3	22.6	7.6
	Total	28.8	55.5	12.3	3.4
SOGS-RA	Female	36.6	46.9	15.7	0.8
	Male	16.5	42.5	32.0	8.9
	Total	28.8	45.2	22.0	4.0
GA 20s	Female	36.6	28.7	31.6	3.2
	Male	16.5	20.3	53.2	10.0
	Total	28.8	25.4	39.9	5.8
Self-classification	Female	36.6	60.8	1.0	0.3
	Male	16.5	74.1	6.8	2.2
	Total	28.8	66.0	3.3	1.1

^a Nongamblers did not complete the gambling screens. Thus, percentages are the same.

^b In self-classification, participants indicated that they were social gamblers.

^c In self-classification, participants indicated that they were gamblers with some problems.

3.2. Individuals with some gambling-related problems

3.2.1. Instrument classification

The DSM-IV-J identified 12.7% of individuals experiencing some gambling-related problems, while the SOGS-RA identified 24% of participants experiencing several gambling-related problems and the GA 20 Questions identified 46.6% experiencing some problems directly as a result of their gambling.

3.2.2. Self-classification

Overall, only 3.3% of the youth reported being gamblers with some problems while 66% classified themselves as social gamblers (see Table 1). Again, it can be seen that there is a large discrepancy between the perception of gambling-related problems and the actual classification of such individuals according to the measures employed. It should be noted that the difference between self-classification vs. measure classification in the problem gambling category is greater than in the pathological gambling category.

3.3. Are problem gamblers aware of the severity of their problems?

3.3.1. DSM-IV-J

Of those individuals who were identified as being pathological gamblers according to the DSM-IV-J [score ≥ 4 ; $n = 33$ (3.4%)], 37.5% classified themselves as social gamblers and 43.8% classified themselves as gamblers with some problems, while only 18.8% ($n = 6$) recognized that they had a probable pathological gambling problem (Table 2).

3.3.2. SOGS-RA

Of those individuals who were identified as being probable pathological gamblers according to the SOGS-RA [cutoff scores ≥ 5 ; $n = 39$ (4%)], 50% classified themselves as social gamblers and 36.8% classified themselves as gamblers with some problems, while only 13.2% ($n = 5$) recognized that they had a probable pathological gambling problem (Table 2).

Table 2
Self-classifications made by probable pathological gamblers

Self-classification	Instrument classification: probable pathological gambler					
	DSM-IV-J (4+)		SOGS-RA (5+)		GA 20s (7+)	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Probable pathological gambler	18.8	6	13.2	5	8.9	5
Gambler with some problems	43.8	14	36.8	14	32.1	18
Social gambler	37.5	12	50.0	19	58.9	33
Total <i>N</i>		33 ^a		39 ^a		57 ^a

^a One individual did not complete the self-classification item.

3.3.3. GA 20

Of those individuals who were identified as being probable pathological gamblers according to the GA 20 Questions [$n=57$ (5.8%)], 58.9% classified themselves as social gamblers and 32.1% classified themselves as gamblers with some problems, while 8.9% ($n=5$) recognized that they were probable pathological gamblers (Table 2).

Across all instruments, pathological gamblers were found to be more likely to classify themselves as social gamblers rather than probable pathological gamblers. An examination of performance on the DSM-IV-J revealed that a larger percentage of individuals classified as probable pathological gamblers are reporting that they are gamblers with some problems (43.8%) rather than social gamblers (37.5%).

It is important to note that there were six individuals who self-classified themselves accurately according to DSM-IV-J criteria. Five of these individuals accurately self-classified themselves according to the SOGS-RA and GA 20 Questions criteria. However, the SOGS-RA and the GA 20 had four individuals in common, with one individual differing in each group. Based upon the number of individuals identified as probable pathological gamblers, the DSM-IV-J was found to be the most conservative measure. In addition, a larger percentage of individuals are reporting to be problem gamblers as opposed to social gamblers. Perhaps the items included in the DSM-IV-J, modeled upon the DSM-IV, are more accurately reflective of gambling problems as experienced by adolescents and young adults based upon self-report scores. Finally, it appears as though both the SOGS-RA and the GA 20s may be over identifying probable pathological gamblers.

3.4. Gamblers who self-classified

Several variables were examined in an attempt to determine how DSM-IV-J pathological gamblers who self-classified ($n=6$) differed from those who did not ($n=27$). It should be noted that these comparisons were limited by small cell sizes and reported differences did not reach statistical significance. However, they are presented from a qualitative perspective. The first variable that was examined was the current age of the gamblers as it was thought that individuals who accurately self-classified might be older, more cognitively aware, or experiencing more difficulty as a result of their gambling. An independent-samples *t* test revealed that those who self-classified did not differ in age ($M=18.50$, $S.D.=2.35$) from those who did not ($M=18.41$, $S.D.=0.89$). Probable pathological gamblers who self-classified and those who did not were also compared on total DSM-IV-J score. It was thought that accurate self-classifiers might have higher scores (more gambling-related problems) on the DSM-IV-J, resulting in an increased awareness of their severity of gambling-related problems. However, results revealed that there were no statistically significant differences of DSM-IV-J score means between accurate self-classification ($M=7.33$, $S.D.=2.80$) and instrument-classified pathological gamblers ($M=5.48$, $S.D.=1.48$). Finally, largest amount wagered reported by participants were compared for these two groups. Results, while not statistically significant, revealed that individuals who accurately self-classified themselves had placed the largest bets ($M=2134.00$, $S.D.=4399.80$; range US\$20–10,000) compared to those individuals who were solely instrument classified ($M=569.33$, $S.D.=1176.88$; range US\$20–5600). The large

Table 3
Comparison of accurate self-classifiers and instrument classified individuals

Individuals	Total instrument score			Largest bets (US\$)			Age (current)		
	Mean	S.D.	Range	Mean	S.D.	Range/median	Mean	S.D.	Range
DSM-IV-J and self ($n=6$)	7.33	2.80	4–12	2134.00	4399.80	20–10,000/200	18.50	2.35	17–23
DSM-IV-J only ($n=27$)	5.48	1.48	4–10	569.58	1176.88	20–5600/150	18.41	0.89	17–20
SOGS-RA and self ($n=5$)	9.00	2.74	5–12	2662.50*	4893.77	50–10,000/300	17.60	0.89	17–19
SOGS-RA only ($n=34$)	6.74	1.87	4–11	448.75	1038.27	20–500/100	18.32	0.81	17–20
GA 20s and self ($n=5$)	12.80	4.60	8–20	2134.00*	4399.80	20–10,000/200	18.80	2.49	17–23
GA 20s only ($n=52$)	8.90	2.50	7–19	354.46	896.66	20–5600/75	18.48	1.18	17–21

* $P < .05$.

standard deviation in largest bets placed by self-classifiers was likely due to a US\$10,000 bet placed by one individual. It is important to note that the same variables were examined for the SOGS-RA and for the GA 20 Questions and similar results were obtained (Table 3).

Other items that were examined comparing accurate self-classifiers to instrument-classified individuals included the types of gambling activities in which they engaged, chasing losses (i.e., returning to the game to win back money lost), seeking professional help, being able to control their gambling, and age of onset (Table 4). With respect to

Table 4
Comparison of accurate self vs. item only classified gamblers on regular^a involvement in various activities

Activities	DSM and self-classified ($n=6$)		DSM classified only ($n=27$)	
	%	n	%	n
Cards	50.0	3	51.9	14
Sports pools	50.0	3	40.7	11
Sports lottery	16.7	1	48.1	13
Lottery	16.7	1	22.2	6
Videogames/video poker	50.0	3	11.1	3
Bingo	33.3	2	11.1	3
Slot machines	50.0	3	14.8	4
Games of skill	33.3	2	14.8	4
Casino	50.0	3	25.9	7
Gambles more than wants	100.0	6	80.8 ^b	22
Sought professional help	16.7	1	7.7 ^b	2
Chases losses (all the time)	66.7	4	25.0 ^b	7
	Mean	S.D.	Mean	S.D.
Age began gambling	11.50	2.25	12.56	3.90

Similar results were obtained for SOGS-RA and GA 20 Questions.

^a Once a week or more.

^b These percentages were calculated from $n=26$ (one individual did not complete these questions).

gambling activities, it can be seen that the two groups differed in terms of the types of activities in which they engaged (e.g., sports lottery, lottery, video games/video poker, bingo, slot machines, games of skill, and casino play). While these differences are not statistically significant and remain limited by small cell sizes, they remain worthy of mention. More specifically, accurate self-classifiers play less sports lottery (16.7%) and regular lottery (16.7%) than DSM-IV-J only-classified individuals (48.1% and 22.2%, respectively). One possible explanation for this finding is that lottery is a widely accepted form of gambling and so much a part of our society that some individuals may not even consider the lottery a form of gambling or concomitant with problem gambling. Further, a greater percentage of accurate self-classifiers play videogames/video poker (50% vs. 11.1%), slot machines (50% vs. 14.8%), and casino games (50% vs. 25.9%). A greater percentage of self-classifiers also play bingo (33.3% vs. 11.1%) and wager on games of skill (33.3% vs. 14.8%) more than their nonaccurate counterparts (Table 4).

The finding that accurate self-classifiers appear to engage in a greater percentage of gambling activities may be a contributing factor in their greater level of awareness, as compared to nonaccurate gamblers who engage in fewer gambling activities, and have less of an awareness of the severity of their gambling-related problems.

Moreover, participants were asked whether they perceived that they gamble more than they intend. One-hundred percent (all six accurate self-classifiers) indicated that they gambled more than they wanted to compared with 80.8% (22 out of 26) of DSM-IV-J only-classified individuals (Table 4). Still further, a greater percentage (16.7%; only one of six) of accurate self-classifiers have sought professional help for a problem, compared with 7.7% (2 out of 26) of instrument (DSM-IV-J)-classified individuals. While a greater proportion of accurate self-classifiers sought help, this difference is not significant or meaningful given the small difference in sample size. Additionally, 66.7% of self-classified individuals reported that they chase their losses *all the time* compared with 25% of instrument only-classified individuals. Finally, the age of gambling onset was examined for both groups. Accurate self-classifiers began gambling approximately 1 year earlier ($M=11.50$, $S.D.=2.25$) than their instrument only-classified counterparts ($M=12.56$, $S.D.=3.9$; Table 4).

Again, while these comparisons are limited by their small cell sizes and while differences were not statistically significant, these results appear to suggest that individuals who self-classified themselves as being probable pathological gamblers are likely qualitatively different.

3.5. Gender differences

In an effort to determine whether there were any gender differences involved in awareness of a gambling problem, data for males and females were examined separately. Results revealed that significantly more males 7.6% ($n=29$) than females 0.7% ($n=4$) were classified by the DSM-IV-J as having a probable pathological gambling problem ($P<.01$). Further, analyses revealed that significantly more males 2.2% ($n=8$) than females 0.3% ($n=2$; $P<.01$), overall, self-classified themselves as being probable pathological gamblers. It is

Table 5
Percentages of responses on DSM-IV-J items for gamblers with 4+ problems

DSM-IV-J items	4+ problems (<i>n</i> = 33)
Think about gambling all the time	90.9
Spend more and more money on gambling	57.6
Become tense and restless when trying to cut down	60.6
Gamble as a way of escaping from problems	51.5
Chase losses	84.8
Lie to family and friends about gambling behavior	69.7
Use other money (e.g., lunch money) for gambling	60.6
Taken money from family to gamble without telling them	24.2
Stolen money from outside family to gamble	12.1
Fallen out with family because of gambling behavior	21.2
Skipped school more than five times to gamble in the past year	27.3
Sought help for serious money worry caused by gambling	24.2

important to note that the two females who self-classified themselves as having a pathological gambling problem were not classified as such by any of the gambling screens. Closer examination of these individuals' questionnaires revealed that they obtained scores of 0 on both the DSM-IV-J and the SOGS-RA and a score of 1 on the GA 20 Questions. They did report gambling regularly but reported having no problems associated with their gambling on the gambling screens. It is likely that these individuals did not properly complete the questionnaire or the self-report measure. None of the females in the present sample appeared to have accurately self-classified themselves into the probable pathological gambling group. However, given the small number of females in the total sample who are pathological gamblers, this finding is not surprising.

3.6. Item endorsement

An examination of responses to the individual questions on the DSM-IV-J revealed that participants identified as probable pathological gamblers indicated that they think about gambling all the time (90.9%), spend increasing amounts of money on gambling (57.6%), chase their losses (84.8%), become restless and tense when trying to cut down (60.6%), gamble as a way of escaping problems (51.5%), lie to family and friends about gambling behavior (69.7%), and use other money (e.g., lunch money) for gambling (60.6%; see Table 5).

4. Discussion

The results of the present study indicate that the majority of gamblers with some problems and probable pathological gamblers, regardless of screening instrument used, describe their gambling behavior differently than preestablished criterion on the DSM-IV-J, SOGS-RA, and GA 20 gambling screens. More specifically, personally perceived gambling severity amongst

youth was inconsistent with the number of gambling-related behaviors and problems endorsed on the individual gambling screens, such that only 18.8% ($n=6$) of DSM-IV-J-identified pathological gamblers classified themselves as having a severe problem. One plausible explanation for the present findings is that the gambling screens themselves may be overestimating the prevalence of gambling severity amongst youth. However, given clinical evidence that the DSM-IV-J is one of the most conservative and stringent youth gambling screens (Gupta & Derevensky, 2000), it is likely that adolescents are likely underestimating the severity of their gambling behavior.

Other findings revealed that those individuals who accurately self-classify themselves are qualitatively different from those who fail to recognize that they have a gambling problem. For example, while not statistically significant, accurate self-classifiers appear to have placed larger wagers, have marginally higher total scores on gambling screens, engage in a greater number of gambling activities, have an earlier age of onset, have a greater tendency to chase their losses on a regular basis, report gambling more than they want to, and may have a greater likelihood of having sought professional help for other problems. However, it should be noted that even though a greater proportion of accurate self-classifiers sought help as compared to instrument only-classified individuals, this difference might not be meaningful given the small sample size.

Unfortunately, the majority of adolescents do not seek treatment and fail to recognize that they have a gambling addiction until their problems are relatively severe (e.g., legal actions pending against them, being threatened by “bookmakers,” delinquent behaviors to pay for gambling debts, loss of friends, etc.). By the time youth are willing to seek treatment for a gambling problem, they are usually experiencing significant family, social, academic, and legal difficulties (Gupta & Derevensky, 2000).

Clinical experiences with adolescents have demonstrated that most youth with serious gambling problems often minimize the severity of their gambling problems. Even when in treatment, many adolescents fail to believe that they have serious gambling-related problems. Further, they often fail to tell the truth and their lying about gambling is not perceived to be a problem. Compounded by this fact is the reality that the severity of adolescent gambling problems differs from adult gambling problems. Often, adolescents do not have a job to lose or a spouse and children that are being neglected. Further, the total amount of money spent by adolescents on gambling activities is, in general, much less than their adult counterparts. This leads many teens to believe that because they are not spending large sums of money or incurring extraordinarily large debts, they do not have a significant gambling problem. Many even temporarily stop gambling after financial resources are depleted only to return to gambling activities as soon as they acquire additional funds (via working, stealing, and/or borrowing).

According to the DSM-IV-J scoring criteria, many of the youth with gambling problems indicated that they are engaging in problematic gambling-related behaviors but fail to recognize the severity of these behaviors. For example, more than half of the youth in the present sample identified as probable pathological gamblers report thinking about gambling all the time, spending increasing amounts of money on gambling, chasing their losses, and becoming restless and tense when trying to cut down. Further, they

reported gambling as a way of escaping problems. It is important to note that the accurate self-classifiers reported placing the largest bets. Perhaps the amount of money, more specifically the size of wagers, is a key factor in the perception of the severity of one's gambling problems.

The misperception of the severity of one's own gambling-related problems has been previously suggested. While between 4% and 8% of adolescents are reported to be probable pathological gamblers (Shaffer & Hall, 1996), less than 1% are in treatment (Gupta & Derevensky, 2000). Empirical support for the notion that adolescents minimize and underestimate the severity of gambling problems most likely accounts for the few youth seeking treatment (Gupta & Derevensky, 2000). Research has also demonstrated that adolescents with gambling problems are usually experiencing an underlying clinical depression (Gupta & Derevensky, 1998, 2000) and as such may not perceive the severity of their problems.

Other reasons for nontreatment include (a) fear of being identified, (b) the belief that they can control their behavior, (c) self-perceptions of invincibility and invulnerability, (d) negative perceptions associated with psychological help or therapy, (e) guilt associated with their gambling problems, (f) their belief in natural recovery and self-control, and (g) a lack of treatment facilities geared toward adolescents (Gupta & Derevensky, 2000). Another plausible reason is that adolescents are seeking treatment for other problems, which they perceive to be more pressing than their gambling problem. This is likely given the comorbidity of depression and substance abuse problems with a gambling problem. Perhaps while youth are seeking help for these other problems, their gambling problems are being minimized or going undetected.

Unfortunately, the consequences of a pathological gambling problem for an adolescent may not be perceived as acute by adolescents, their parents, and the general public. Given that they often fail to embezzle money, lose their spouse, their family, their job, etc., there is a widely held belief that youth gambling problems do not exist. Moreover, gambling is often referred to as the "hidden addiction," such that it is extremely difficult to identify, as there are no outwardly visible signs of the addiction. Nevertheless, the preoccupation with gambling and the concomitant negative consequences (loss of friends, delinquent and antisocial behaviors, poor academic performance, and disruption of social relationships) are devastating for the adolescent and have long-term consequences.

Future research needs to be directed at examining adolescents' perceptions of pathological gambling. Still further, focus should be placed on influencing adolescents to examine the reality of their own self-perceptions. For example, self-quizzes could be distributed in high schools in an attempt to enable youth to identify whether they have a gambling problem or are at-risk for the development of one. Given the small number of youth seeking treatment and the findings of the present study, this initiative is extremely important. If adolescents are taught that gambling can result in serious problems, then this may serve as a type of inoculation against potential gambling problems.

The present study has provided a possible answer to the question of why adolescents fail to seek treatment. However, the results presented are by no means a definitive answer to this question. More research in this area is needed.

Acknowledgements

This research was partially supported by a research grant from Loto-Quebec to Dr. J.L. Derevensky.

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