Adolescents with Gambling Problems: From Research to Treatment

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Abstract

Considerable interest in the area of youth gambling has prompted an increase in empirical investigations examining the correlates associated with youth experiencing severe gambling problems. Based upon the current state of knowledge and our clinical experience, the development of the treatment program for youth with serious gambling problems employed at the McGill University Youth Gambling Research and Treatment Clinic is described. The major tenets, underlying philosophy and therapeutic processes are presented. A case study is included to illustrate the therapeutic approach. The authors present the need for greater funding for more basic and applied research and the necessity for further scientifically validated treatment and prevention programs.

As a result of recent research advances, media coverage, and federal and parliamentary commissions, the issue of youth gambling has been pushed to the forefront. The fact that adolescents are active gamblers and that a small but identifiable percentage of youth actually go on to develop serious gambling-related problems has been well established (see Jacobs, 2000; NRC, 1999; Shaffer & Hall, 1996). While the issues of identification and instrumentation are still contentious (see Derevensky & Gupta, 2000; Ladouceur, Bouchard, Rhéaume, Jacques, Ferland, Leblond & Walker, in press), two other important clinical issues remain unanswered; (a) how to best attract adolescents identified with significant gambling problems to seek treatment (the authors readily acknowledge that some might argue for self-recovery as a preferred modality), and (b) the type of therapeutic approach that would be most effective for diminishing or eliminating compulsive gambling behaviors among youth.

There remains little doubt that gambling is a popular activity engaged in by underage adolescents (see Jacobs, 2000, this issue). The results of the National Research Council's review of empirical studies suggest that 85% (the median of all studies) of adolescents report having gambled during their lifetime. The fact that 73% (median value) of adolescents report gambling fairly recently raises serious mental health and public policy concerns (NRC, 1999). Meta-analyses (i.e., Shaffer & Hall, 1996) and recent studies confirm that between 4-8% of youth have very serious gambling problems with another 10-15% at-risk for the development of a serious gambling problem.

Youth Gambling Treatment Programs

Given the magnitude of youth experiencing gambling related problems, it is surprising that little progress has been made in understanding the treatment of this disorder or the characteristics of individuals seeking help; a conclusion also reached by the NRC (1999) review. Treatment studies reported in the literature have generally been case studies with small sample sizes (Knapp & Lech, 1987; Murray, 1993; Wildman, 1997) and have been criticized for not being subjected to rigorous scientific standards (Blaszczynski & Silove, 1995; National Gambling Impact Study Commission, 1999; NRC, 1999).

There are likely several reasons to explain why more stringent criteria, scientifically validated methodological procedures, and experimental analyses concerning the efficacy of treatment programs for youth have not been implemented. Several plausible reasons include:

- Difficulty in attracting comparable control groups.
- There exist very few treatment programs for youth with serious gambling problems.
- Treatment facilities, where available, report few adolescents seeking help. As such, large-scale controlled outcome studies are difficult to conduct.
- Within a given center there may be no unified treatment approach for youth.
- Treatment approaches may vary within a center and may be dependent upon the gambler's profile (e.g., sports betting vs. VLT players), duration, intensity and severity of the individual's gambling-related problems.
- Age and gender considerations are likely important factors in the frequency, duration and types of treatments provided. Considering the wide developmental differences amongst youth present in treatment programs (i.e., 14-20 year-olds), it is difficult to compare the treatment process and efficacy studies require different measures.
- Treatment programs for adolescents with multiple addictions will require broader and different outcome measures.
- Youth with gambling problems often present with other primary or secondary psychological disorders requiring intervention. As such, matched control groups are difficult to acquire.

Treatment approaches

Treatment paradigms for adults have in general been based upon a number of theoretical approaches. These paradigms fundamentally include one or more of the following orientations: psychoanalytic or psychodynamic (Bergler, 1957; Miller, 1986; Rosenthal, 1987; Rugle & Rosenthal, 1994), behavioral (Blaszczynski & McConaghy, 1993; Walker, 1993) cognitive and cognitive-behavioral (Bujold, Ladouceur, Sylvain, & Boisvert, 1994; Ladouceur & Walker, 1998; Toneatto & Sobell, 1990; Walker, 1992), pharmacological (Haller & Hinterhuber, 1994; Hollander, Frenkel, De Caria, Trungold,

& Stein, 1992; Hollander & Wong, 1995; Moskowitz, 1980), physiological (Blaszczynski, McConaghy, & Winters, 1986; Carlton & Goldstein, 1987), biological/genetic (Comings, 1998; Decaria, Hollander & Wong, 1997; Hollander et al., 1992; Saiz, 1992), addiction-based models (Lesieur & Blume, 1991; McCormick & Taber, 1988), or self-help (Brown, 1986, 1987; Lesieur, 1990) (for a more comprehensive overview of these models the reader is referred to the reviews by Griffiths, 1995; Lesieur, 1998; Lesieur & Rosenthal, 1991; López Viets & Miller, 1997; NRC, 1999; Wildman, 1997).

The resulting treatment paradigms have in general incorporated a rather restrictive and narrow focus depending upon one's theoretical orientation of treatment (see Blaszczynski & Silove, 1995 for their analyses of the limitations of each approach). Blaszczynski and Silove (1995) further suggest that there is ample empirical support that gambling "involves a complex and dynamic interaction between ecological, psychophysiological, developmental, cognitive and behavioral components" (page 196). Given this complexity, the need to address each of these components should to be adequately incorporated into a successful treatment paradigm. While Blaszczynski and Silove addressed their concerns with respect to adult problem gamblers, a similar multidimensional approach may be necessary to address the multitude of problems facing adolescent problem gamblers.

Until relatively recently, theories of gambling problems amongst adolescents have had little empirical support. Ladouceur and his colleagues have long argued for a cognitive-behavioral approach to treating both adults and youth with gambling problems (e.g., Bujold et al., 1994; Ladouceur, Boisvert & Dumont, 1994; Ladouceur, Sylvain, Letarte, Giroux & Jacques, 1998; Ladouceur & Walker, 1996, 1998). The central assumption underlying the cognitive-behavioral approach is that pathological gamblers will continue to gamble in spite of repeated losses given they maintain an unrealistic belief that losses will be recovered. This perspective assumes that it is the individual's erroneous beliefs (including a lack of understanding of independence of events, their perceived level of skill in successfully predicting the outcome of chance events, and other illusions of control) which foster their persistent gambling behavior (Ladouceur & Walker, 1998).

In one of the few empirically based treatment studies with adolescents, Ladouceur et al. (1994), using four adolescent male pathological gamblers, implemented a cognitive-behavioral therapy program. Within their program five components were included; information about gambling, cognitive interventions, problem-solving training, relapse prevention, and social skill training. Cognitive therapy was provided individually for approximately 3 months (mean of 17 sessions). Ladouceur and his colleagues reported clinically significant improvements with respect to the individual's beliefs about the perception of control when gambling and a significant reduction in severity of gambling problems. Following termination of treatment, after a one-month period, one adolescent was reported to have relapsed. Three and six months after treatment the remaining three adolescents sustained therapeutic treatment gains and were abstinent, with none of the adolescents meeting the DSM criteria for pathological gambling at the last follow-up assessment. Ladouceur and his colleagues concluded that the treatment duration necessary for adolescents was relatively short compared to that required for adults. They further concluded that the positive gains resulting from the cognitive therapy represents "promising new avenues for treatment." This therapeutic approach is predicated upon the belief that adolescents (a) persist in their gambling behavior in spite of repeated losses as a result of their erroneous beliefs and perceptions, and (b) that winning money is central to their continued efforts.

More recently, we presented data showing strong empirical support for Jacobs' General Theory of Addiction for adolescent problem gamblers (Gupta & Derevensky, 1998a). Adolescent problem and pathological gamblers were found to have exhibited evidence of abnormal physiological resting states, exhibited greater emotional distress in general, reported significantly higher levels of dissociation when gambling, and had higher rates of comorbidity with other addictive behaviors. As well, problem and pathological gamblers, based upon scores on the DSM-IV-J, were found to have higher depression scores, low self-esteem, and higher excitability scores. More recently, a preliminary study by Gupta, Marget and Derevensky (2000) also found that adolescent problem and pathological gamblers differ on their ability to successfully cope with daily events, adversity and situational problems.

Risk Factors For Youth With Serious Gambling Problems

While our current state of existing empirical knowledge of adolescent problem gambling has been described elsewhere (see Derevensky & Gupta, 1998, in press; Griffiths & Wood, 2000), a brief overview of those findings provides the necessary foundation for our conceptual approach to treating these youth. There is substantial empirical support indicating the following:

- Gambling is more popular amongst males than females (Derevensky, Gupta & Della-Cioppa, 1996; Fisher, 1990; Govoni, Rupcich & Frisch, 1996; Griffiths, 1989; Gupta & Derevensky, 1998a; Ladouceur, Dubé & Bujold, 1994; NORC, 1999; NRC, 1999; Stinchfield, 2000; Stinchfield, Cassuto, Winters & Latimer, 1997; Volberg, 1994, 1996, 1998; Wynne, Smith & Jacobs, 1996).

- Probable pathological gamblers are greater risk-takers (Arnett, 1994; Breen & Zuckerman, 1996; Derevensky & Gupta, 1996; Powell, Hardoon, Derevensky & Gupta, 1999; Zuckerman, 1979, 1994; Zuckerman, Eysenck & Eysenck, 1978).

- Adolescent prevalence rates of problem gamblers are 2-4 times that of adults (Gupta & Derevensky, 1998a; Jacobs, 2000; NRC, 1999; Shaffer & Hall, 1996).

- Adolescent pathological gamblers have lower self-esteem compared with other adolescents (Gupta & Derevensky, 1998b).

- Adolescent problem gamblers have higher rates of depression compared to both adolescent social gamblers and non-gamblers (Gupta & Derevensky, 1998a, 1998b; Marget, Gupta & Derevensky, 1999).

- Adolescent problem gamblers dissociate more frequently when gambling as compared with adolescents who gamble occasionally and have few gambling related problems (Gupta & Derevensky, 1998b; Jacobs, Marsten & Singer, 1985).

- Adolescents between the ages of 14-17 with serious gambling problems are at heightened risk for suicide ideation and suicide attempts (Gupta & Derevensky, 1998a).

- Quality friendships and relationships are often lost and are replaced by gambling associates (Derevensky, 1999).

- Adolescent problem gamblers remain at increased risk for the development of another addiction or multiple addictions (Gupta & Derevensky, 1998a, 1998b; Kusyszyn, 1972; Lesieur & Klein, 1987; Winters & Anderson, 2000).

- Adolescent problem gamblers score higher on excitability, extroversion, and anxiety and lower on conformity and self-discipline personality scales (Gupta & Derevensky, 1997b, 1998a; Vitaro, Ferland, Jacques & Ladouceur, 1998).

- Adolescents with gambling problems have poor general coping skills (Marget, Gupta & Derevensky, 1999; Nower, Gupta & Derevensky, 2000).

- Adolescent problem gamblers report beginning gambling at earlier ages (approximately 10 years of age) as compared with peers without gambling problems (Gupta & Derevensky, 1997a; 1998b; Wynne et al., 1996).

- Among adolescents there is a rapid movement from social gambler to problem gambler (Derevensky & Gupta, 1996, 1999; Gupta & Derevensky, 1998a).

- Problem and pathological gambling amongst adolescents has been shown to result in increased delinquency and crime, the disruption of familial relationships and decreased academic performance (Gupta & Derevensky, 1998a; Ladouceur & Mireault, 1988; Lesieur & Klein, 1987; Wynne et al., 1996).

Assuming these empirical findings, adolescent problem gamblers frequently have a multiplicity of pre-existing problems, with gambling being used as an unsuccessful solution to their underlying problems. Contrary to public opinion, and the tenets of the cognitive-behavioral approach, our research and clinical work suggests money is not the predominant reason why adolescents engage in these behaviors (see Gupta & Derevensky, 1998b). Rather, it appears that money is merely used as a means to enable youth to continue gambling. Through play, either with gambling machines, sports betting, cards, casino playing, or other forms of gambling, these adolescents exhibit a number of dissociative behaviors; escaping into another world, often with altered egos and repressing unpleasant daily events. When gambling, adolescents with serious gambling problems report that all their problems disappear. They report that betting on the outcome of a sports event or watching the reels of a VLT spin makes their adrenaline flow, their

heart rate increase, and their excitement intensify. These same physiological responses are reported whether they win or lose (the near miss phenomenon).

Our clinical experience suggests that for an adolescent with a gambling problem, a good day is when the money he or she has lasts all day while gambling. A bad day is when the same amount of money lasts for only a short time. Once all money is lost, their pre-existing problems (e.g., parental, familial, academic, legal, vocational, peer, personal) reappear with additional gambling-related problems only compounding existing problems. The initial claim by adolescents with gambling problems is that they gamble primarily for the excitement and enjoyment, with winning money being the third most frequently endorsed response. However, in discussions with these young problem gamblers, they quickly realize money won is used merely as a means to access further gambling opportunities. Even after a big win and recouping losses, few adolescents with gambling problems can resist the temptation and level of excitement and enjoyment resulting from gambling. As one adolescent said, "there is nothing in the world that is as exciting as gambling to me, not drugs, not alcohol or even sex."

To date, very little is known from an empirical perspective with respect to the short-term and long-term treatment effects for adolescents with serious gambling problems. Few clinicians specialize in providing treatment for youth with serious gambling problems and those who are prepared and willing to do so report that very few adolescents present themselves for treatment. It is clear that this issue is relatively new compared with the number of treatment centers and clinically based research studies focused upon treatment for youth with other addictions. There remains a growing interest in identifying effective treatment strategies to help minimize youth gambling problems.

This paper serves to add to the growing body of literature focused upon youth gambling problems. In particular, we have sought to provide a review of the literature, delineating some of the limitations of the current knowledge base, and will demonstrate how the McGill treatment program is conceptually linked to, based upon, and derived from existing empirical knowledge.

The McGill Youth Research & Treatment Clinic

The paradigm to be presented serves to illustrate the approach used at the McGill University Research and Treatment Clinic in the treatment of youth with serious

gambling problems. While there are sufficient outcome measures to point to the program's success, the treatment program has not been empirically validated with stringent matched control groups. At this point in time there have been an insufficient number of youth to establish matched control groups and the priority has been to immediately treat those youth presenting with severe gambling problems. The treatment approach itself is predicated upon the empirical research and clinical data suggesting that gambling problems often develop partially as a result of the need to escape other underlying problems (e.g., attentional problems, conduct disorders, oppositional defiant disorders, learning problems, anxiety disorders, poor problem solving and coping skills, relational and familial problems, low self-esteem, etc.). This is not to suggest that adolescents should not be classified as having a pathological gambling disorder and that most manifest gambling merely as a secondary epiphenomena of some other primary disorder. Rather, it suggests that many adolescents are experiencing concurrent problems, with gambling behavior being used as a mechanism of escaping daily stressors, be they personal, familial, academic, legal or work related. While these concurrent issues and psychological problems ultimately need to be addressed in therapy, the pathological gambling behavior and gambling-related problems must be initially directly addressed. The treatment approach will be illustrated with the help of a case study.

Since the inception of the McGill treatment clinic, we have worked with 36 youth, over a five-year period, ranging in age from 14-21. It may be argued that this is not a sufficiently large number of clients upon which conclusions can be drawn. Nevertheless, based upon empirical findings and clinical observations with these individuals, their reported success in remaining abstinent, and their improvement in their psychological well-being, the approach adopted in our clinic appears to have been successful in assisting youth overcome their gambling and gambling-related problems. While it is difficult to accurately report a success rate as no matched control groups have been employed, we know of only one adolescent who did not respond well to the treatment intervention (the authors readily acknowledge that adolescents seeking treatment may not be representative of the general population of youth problem gamblers). This particular adolescent experienced two relapses and has not returned for treatment despite repeated phone calls indicating his desire to return to the clinic. Furthermore, while several

adolescents decided to terminate treatment before completion they returned after being unable to control their gambling. To the best of our knowledge (all information consists of self-report data and that acquired from peers, girlfriends or family members) all other adolescents who participated in the treatment program were abstinent at least one year after terminating treatment, and were not experiencing problems with other addictive-type or compulsive behaviors. While we attempt to closely monitor these youth for at least one-year post treatment, many become difficult to contact after this point in time. Several call periodically to report their progress, especially with respect to their accomplishments.

It is also important to note that several youth enter treatment immediately after stopping their gambling, requesting assistance in maintaining abstinence and dealing with the concomitant gambling-related problems. This raises an interesting research question; Would they have maintained abstinence without intervention? The authors readily acknowledge that only studies with matched control group comparisons can adequately answer this question.

The outcome measures used for success include abstinence for a six-moth period (a score of 0 on the DSM-IV-J during the last six months), a healthy lifestyle (e.g., improved socialization with non-gambling friends, a return or improvement in school or work), improved peer and family relationships, and no marked signs of depressive symptomatology, delinquent behavior or excessive use of alcohol or drugs.

The clinical information provided, based upon the empirical research, is designed to help practitioners and clinicians working with adolescents with serious gambling problems.

Finding a treatment population

Adolescents with gambling problems tend not to present themselves for treatment. There are likely many reasons that they fail to seek treatment including (a) fear of being identified, (b) the belief that they can control their behavior, (c) adolescent self-perceptions of invincibility and invulnerability, (d) the negative perceptions associated with therapy by adolescents, (e) guilt associated with their gambling problems, (f) a lack of recognition and acceptance that they have a gambling problem despite scoring high on

gambling severity screens (Hardoon, Herman, Gupta & Derevensky, 1999), and (g) their belief in natural recovery and self-control.

Referrals from parents, friends, teachers, the court system, and the local *HelpLine* are the primary sources through which we acquire our treatment population. As part of an effective outreach program, posters and brochures are distributed to schools, and workshops are provided for school psychologists, guidance counselors, teachers, and directly to children and adolescents. As a result of this outreach program, several adolescents call directly requesting treatment. Interestingly, our Internet site has generated several inquiries from the U.S. for on-line help.

Our clinical experience has been that adolescent problem gamblers develop a social network consisting of other problem gamblers. This results in clients recommending their friends for treatment. Once an adolescent accepts and realizes that he/she has a serious gambling problem, they become astutely aware of gambling problems amongst their friends. Eventually, some successfully convince their peers to seek help as well.

Since adolescents with gambling problems have little access to "extra money," and many initially seek treatment without their parent's knowledge, it is important to provide treatment at no cost. While this is not practical for treatment providers in independent practice, State or Provincial funding (or support by insurance providers when available) is fundamental when treating adolescents with serious gambling problems.

The location of the treatment facility plays an important role in the successful work with youth. Concerns about being seen entering an addiction center, mental health facility or hospital may discourage some youth from seeking treatment. Accessibility by public transportation is essential since most young clients do not own cars or have money for taxi fare. Although our clinic is adjacent to a University counselling centre, it operates as a self-contained clinic exclusively for work with youth with serious gambling problems.

The Treatment Procedure

Intake assessment

The intake procedure includes a semi-structured interview covering the DSM-IV criteria for pathological gambling as well as other pertinent gambling behaviors (e.g., preferred activities, frequency, wagering patterns, accumulated losses, etc.). Current familial situation, academic and/or work status, and social functioning are ascertained. Information concerning alcohol or drug use, the presence of other risk-taking behaviors, self-concept, coping skills, and selected personality traits are also collected. An evaluation for clinical depression is included as well as a history of suicide ideation and attempts.

An explanation of our procedures, requirements and goals are provided. Client expectations and personal goals are also ascertained. Most youth report that they desperately want their unbearable situation to improve. However, approximately 60% of clients are initially ambivalent about abstinence.

All therapy is provided individually by a program staff member. Initially, therapy is provided weekly, however if the therapist deems more frequent sessions are required, appropriate accommodations are made. All clients are provided with a pager or cell phone number for emergency contacts. The number of sessions varies significantly with the range being between 20 and 50. The therapeutic process includes the following components:

Establishing mutual trust
Acceptance of the problem
Identification of underlying problems
Psychotherapy addressing personal issues
Development of effective coping skills
Restructuring of free time (sports and leisure activities)
Development of a healthy lifestyle
Involvement of family
Cognitive restructuring
Establishing debt repayment (where necessary)
Relapse prevention

Establishing mutual trust

Mutual trust and respect is fundamental. Total honesty is emphasized and a non-judgmental therapeutic relationship is provided. Since treatment is provided at no cost, clients are required to respect the therapist's time. This involves calling ahead to cancel and reschedule appointments, as well as attending sessions on time.

Therapeutic process

The therapeutic process incorporates the previously mentioned components. However, depending upon secondary presenting problems specific therapeutic goals are established. For example, an adolescent who presents with serious depression will not be approached in the same manner as one who does not evidence depressive symptomatology. If a client presents with a severe depression, this becomes the initial therapeutic objective while the gambling problem becomes a secondary objective. Interestingly, for many youth, once gambling has stopped depressive symptomatology actually increases as youth report that their only source of pleasure, excitement and enjoyment has been eliminated.

An important factor influencing the therapeutic approach relates to the client's current willingness to make significant changes in their life. Initially, most adolescents are reluctant and are not convinced that they really want to stop gambling completely. Rather, most state that they believe in *controlled gambling* and they hold onto their irrational beliefs. Some individuals seek basic information but remain open to the idea of making more permanent changes. Others have decided that they really must stop gambling but are unable to do so without assistance and support. Finally, there are adolescents who made the decision to stop gambling prior to their first session but require support in maintaining abstinence. These three examples depict adolescents in different stages of the process of change (see DiClemente, Story & Murray, 2000).

While there are a multiplicity of approaches taken depending upon one's severity of gambling problems, underlying psychological disorders or problems, age, and risk factors, the therapeutic approach used with those adolescents who are most representative of our client population is provided. The case study that will be presented reflects our therapeutic approach and philosophies.

A profile of adolescent gamblers seeking treatment

It has often been argued that those individuals who present themselves for treatment are distinct. For this reason, it is important to describe the profile of the adolescents who have sought and treatment within our clinic. To date, all of the adolescents we have treated were males. We are currently working with our first female client. Their profiles include:

- Overt signs of anxiety and/or attention deficit disorder. Excessive fidgety behavior, nail biting, sleep disturbances, stomach disorders, and an inability to focus on schoolwork are common.
- Approximately 30% of the adolescents meet the criteria for clinical depression (in varying degrees) upon intake. Another 20% develop symptoms of depression after they have stopped their gambling participation.
- Most of these adolescents score high on measures of risk-taking.
- Severed or stressed familial and peer relationships are always present. While many reside at home, those with severe problems are often living independently but are supported by their families. Those remaining at home report high levels of stress in their household due to their repeated lying, theft, disappointment and lack of trust.
- Most of their friendships prior to their gambling no longer exist (peers are not very accepting of theft, deceit, and failure to repay loans). Their current friends consist of fellow gamblers, bookmakers, and loan sharks.
- The activities most problematic for these youth include sports betting, casino playing (either poker or blackjack are preferred activities), and video lottery terminals. Sports lottery tickets are also highly problematic. Almost all of these young gamblers have obtained their introduction to the gambling through scratch lottery tickets and subsequently progress to other forms of gambling activities.
- By the time most adolescents seek treatment, they are experiencing serious financial difficulties, with debts frequently ranging from $3,000 to $25,000. Most of these youth have already previously had their debts, or a

part of their debt, paid by their parents at least once since the beginning of their gambling problems.

- Academic failure is very common. Their preoccupation with gambling (the most frequently endorsed item on the DSM-IV-J by youth problem gamblers) precludes them from concentrating and focusing on school assignments and exams. They may be either still enrolled in school and failing or dropped out. Those with part-time jobs often have not fulfilled their responsibilities, and subsequently lose their jobs. Most of these adolescents have a significant amount of free time with nothing to do, nowhere to go, and are preoccupied with seeking money in order to continue gambling.
- All have sold personal possessions, with most having stolen money from their homes. Still further, many are involved in delinquent criminal activities outside their home to support their gambling (e.g. shop lifting, check forgery).

Therapeutic philosophy

Adolescents experiencing serious gambling problems continue gambling in the face of serious consequences because of their need to dissociate and escape from daily stressors. Without exception, adolescents report that when gambling they enter a "different world," a world without problems and stresses. They report that while gambling, they feel great, they are admired and respected, and that time passes quickly. They report being oblivious to all negative events in their lives while gambling. They describe it as "the ultimate escape." In light of empirical research (Gupta & Derevensky, 1998a; Jacobs, 1998; Jacobs, Marsten & Singer, 1985) and clinical findings, one primary treatment goal is to identify and treat the underlying problems that are producing stress. These in general include one or more of the following problems: personal (e.g., low self-esteem, depression, ADHD, oppositional defiant disorders), familial, peer, academic, vocational, and legal. Through traditional therapeutic techniques these problems are addressed and alternative approaches to problem solving are supported while sublimation, projection, repression and escape are discouraged.

The need to escape one's problems usually occurs more often among individuals who have poor coping skills. Using gambling or other addictive activities to deal with daily stressors is an example of maladaptive coping. Recent research efforts have confirmed these clinical observations, where adolescents who meet the criteria for pathological gambling demonstrated poor coping skills as compared to peers who do not have a gambling problem (Gupta et al., 2000; Marget et al., 1999; Nower et al., 2000). A primary therapeutic goal involves building and expanding the coping abilities of adolescents with a gambling problem.

It has been well established that avid gamblers experience multiple cognitive distortions (Ladouceur & Walker, 1998; Langer, 1975). They are prone to believe that they can control gambling events (illusion of control), they underestimate the amount of money lost and over-estimate the amount won, they fail to utilize their understanding of the laws of independence of events, and they believe that if they persist at gambling they will likely win back all money lost (chasing behavior). The reversal of these cognitive distortions remains another treatment goal.

Common consequences of a serious gambling problem involve impaired relationships with friends and family members. Helping the adolescent rebuild these crucial relationships constitutes an important goal of therapy. Philosophically, we contend that these youth will be happier and will be more able to abstain from gambling if they feel supported by family and friends. The inclusion of family members and friends in therapy sessions and is strongly encouraged.

Effective money management skills are typically lacking in adolescents who have a gambling problem. Therapeutic goals involve re-teaching them the value of money, helping them develop effective and reasonable repayment plans for debts, and building money management skills. Many of the youth in treatment view money directly in terms of their gambling activities (e.g., the cost of a dinner or taxi to the casino is half a blackjack hand or one fourth a wager on baseball).

Despite a lack of strong empirical evidence, our clinical work suggests that abstinence from gambling is a necessity in order to prevent a relapse. We also maintain that if an individual has succumbed to one addictive behavior, they are vulnerable to other addictions as well (see Winter & Anderson, 2000). As a result, treatment is not

viewed as complete or successful until the individual's underlying problems have been resolved and coping/problem-solving skills are improved. Unless these goals are met, cessation of gambling may result in individuals seeking alternative addictive behaviors. These beliefs are directly communicated to the client and play a major role in the therapeutic process.

The outcome measures used to assess termination are that the adolescent is required to be abstinent from gambling for six months with the adolescent not meeting any of the criteria for pathological gambling, the individual must be either working and/or in school, no longer lying or engaging in other delinquent or antisocial behaviors, and free of excessive alcohol or drug use. They should be on amicable terms with parents and some friends, and living a relatively healthy lifestyle.

Therapeutic techniques

The following case study illustrates the treatment approach. It is important to note that many of the objectives and goals of treatment are approached simultaneously and that the actual therapeutic process will vary somewhat depending upon the nature and severity of the individual's clinical diagnosis and gambling related problems. However, all components previously described are applied to each individual in treatment.

Case Study

Background information

Angelo was an 18-year-old adolescent when he initially presented himself for treatment. He comes from a large extended Italian family and resides with his mother and two older brothers, aged 23 and 26. Angelo's father died after a prolonged illness when Angelo was 14 years old. His mother now runs the family business with her eldest son. She lives her life with a pervasive sadness and feelings of loss, never having sought help to successfully cope with the death of her husband. Their extended family, including aunts, uncles and cousins, is very close to Angelo's family unit and provides a valuable source of support.

Angelo reported having a close relationship with his family but also indicated feeling alienated and misunderstood. His older brothers were very frustrated, unsympathetic and angry concerning Angelo's gambling behaviors. As a result, they

became extremely judgmental, critical and punitive. While adopting the role of surrogate parent after their father's death, Angelo's oldest brother seemed unable to cope with his gambling and gambling related behaviors.

Angelo's girlfriend, Sonya, was very devoted and actively supported him through his gambling recovery. They had been dating for approximately two years and reported being very committed to each other. Sonya frequently accompanied Angelo to treatment as a form of moral support.

Angelo was no longer attending school when he began treatment, although he was officially enrolled in CEGEP (a post secondary school equivalent to a junior college). He reported being incapable of attending class, with his mind constantly preoccupied by gambling issues. He expressed serious concern regarding the permanency of school transcripts reflecting poor academic performance and failures as he indicated wanting to return to school once his gambling problem was resolved.

Gambling history

Angelo reported initially beginning gambling at the age of 13, at approximately the time that his father's illness required his first hospitalization. At that time he discovered sports betting via a sports pool lottery ticket (Mise-O-Jeu), sold in Quebec (equivalent to Sports Select). This game permits the player to wager varying amounts of money on the outcome of sporting events. Angelo quickly found himself purchasing multiple tickets at a time and that the amounts wagered were escalating. Angelo's greatest satisfaction came from the time spent watching the sports events on which he wagered. He explained that when thoroughly engrossed in the game he could easily forget about his father's illness and his belief that his family was "falling apart." Eventually, Angelo discovered bookmakers and spreadsheets, and switched from legalized sports betting to illegal betting as bookmakers extended credit. If Angelo would win, he would play again; if he lost, he would place another bet on credit hoping to recover his losses and repay his debt. Angelo started betting $50 or $75 on a game but this progressed to betting $500 to $2000 on a single event. He was quickly introduced to others his age that were also gambling and soon was adopted by these individuals into their "family," with whom he spent his evenings and weekends in cafés watching games. Angelo reported that this newfound excitement and sense of belonging significantly

improved his life. As the youngest member of the family, he was not in included in decisions regarding his father, nor was he permitted to sit by his father's bedside for extended periods of time. His older brothers assumed all familial responsibilities as well as ensuring the success of the family business. As a result, Angelo had little guidance and supervision during this period. He quickly found a rewarding, social milieu that catered to his emotional and psychological needs.

Angelo's father's condition worsened and his mother and other relatives remained constantly at the hospital. They told Angelo, age 14, that his responsibility was to attend school. As both his gambling and debts increased, he found it exceedingly difficult to concentrate and focus on schoolwork. Preoccupied with gambling, trying to chase his losses, and his desire to spend time with his dying father, Angelo was frequently truant from school. Since his entire family was at the hospital, he would merely erase messages left by the school or remove school correspondence from the mail. As sports events only took place on evenings and weekends, he found his days were filled with a void. It was during this period that Angelo discovered video lottery terminals (VLTs). He found several establishments that allowed him to play the machines. Although the legal age for playing was 18, these vendors reportedly seemed unconcerned that he was playing and not attending school.

At this point in time, in order to cover sports betting losses and to help fund his VLT playing, Angelo began stealing money from the family business, friends and family members, and was selling personal possessions and stolen items. Family members were too absorbed by the seriousness of his father's illness and as a result Angelo's behavior patterns went unnoticed. Not long after he began VLT playing Angelo's father died, resulting in a stronger need to continue gambling and for longer periods of time. Family members, consumed with their own personal grief, were unable to comprehend Angelo's emotional needs resulting from the loss of his father and guilt associated with his gambling.

Angelo returned to school after his father's death but his academic performance significantly deteriorated. At age 16 he met Sonya, and he reduced his gambling in order to be with her, although she often enjoyed accompanying him to the cafés where he would continue to gamble. It was not until Angelo's eldest brother realized that someone

was stealing money from the family business that surveillance cameras were installed. Angelo, now 18 years old and unaware of the surveillance cameras, was videotaped stealing from the cash register.

Angelo presented himself for therapy accompanied by his aunt who had learned of our treatment services via a referral center. She initially made the appointment with his consent. Angelo attended therapy weekly and was often accompanied by either a family member (aunt, mother, uncle) and/or his girlfriend.

Angelo admitted gambling on a daily basis. The greatest amount of money he reported losing in one day was $6000. Upon entering therapy, he reported an outstanding debt of $9200. He readily admitted that his gambling and life seemed totally out of control and was terribly ashamed of all the "immoral" acts he had committed in order to fund his gambling. He readily admitted stealing from the family business, family members, friends, and neighbors. He even reported having stolen a watch that belonged to his friend's deceased father, an item that held significant personal and sentimental value.

Angelo reported believing that he had severed all ties with his oldest brother and several aunts and uncles as a result of his dishonesty and thefts. He expressed remorse over the pain he was causing his mother and expressed a fear of eventually losing his girlfriend if he did not succeed in stopping gambling. Despite the multitude of problems resulting from his gambling, Angelo was ambivalent about stopping his gambling completely and preferred controlled gambling. He was informed that our treatment goal involves eventual abstinence from gambling.

Angelo completed the intake instruments, scored high on the risk-taking indices and low on the measures of self-esteem. On the depression scale, Angelo's responses did not reach clinical significance, although he did indicate feeling helpless. Angelo responded positively to 11of 12 items on the DSM-IV-J gambling screen ($\geq$ 4 is indicative of a significant gambling problem).

Goals of Therapy

1) **Understanding the motivations for gambling**.

Angelo was required to reflect upon his motivations for gambling. After his second therapy session, he was asked to write a paragraph, as a homework assignment, explaining the reasons he gambled. He responded,

> The reason why I gamble is because I love the feeling it gives while I'm watching the game I'm betting on. It gives me a feeling that I have no worries other than the game I am watching. I feel that nobody could bother me, like I am in another world. I feel I need that because I have a lot of things on my mind and it helps me forget them. I get a great sense of excitement.

Angelo explained that he originally thought his primary motivation for gambling was money but other motivations became more apparent as his gambling problems worsened. Angelo was gambling as a form of both escape and a way to seek excitement. He readily admitted to having multiple personal problems, but he was unable to clearly identify them at this point in time.

2) **Establishing a baseline of gambling behavior and encouraging a decrease in gambling.**

Angelo was required to record his gambling behavior on a daily basis. He recorded locations, times, amount of money bet (overall in a gambling session), and final balance in a small notebook that he continuously carried in his pocket. At the beginning of the treatment sessions, Angelo reported gambling daily, although he did not always watch the games on which he wagered. The first week in treatment his losses were $300; the second week losses totaled $1000. In order to support these debts he admitted to stealing $2000 from his grandparent's home.

Each week, Angelo was encouraged to decrease his gambling, in terms of frequency, duration, and amounts wagered. Realistic, new goals were established weekly and Angelo met each of these goals. His girlfriend, Sonya, played an important role in helping him decrease his gambling by ensuring they participated in alternative activities during evenings and weekends (e.g., movies, dinners).

Angelo decreased his gambling behavior significantly after three weeks of treatment, but still insisted on playing VLTs or purchasing sports lottery tickets, believing that these were a harmless form of entertainment and represented forms of gambling that he could control. That behavior continued for another month, at which point he realized that any form of gambling placed him at risk for relapse into a vicious cycle of gambling. Angelo stopped gambling completely after two months of treatment.

3) Addressing cognitive distortions concerning gambling.

Most individuals who gamble excessively experience distorted perceptions about their gambling behavior. Angelo believed that when playing the VLT machines he could manipulate the outcome and make substantial wins by pressing the buttons on the machine in a specific way. He believed that if he touched the buttons while the reels were spinning he could control when and where they would stop (see the article by Griffiths & Wood, 2000 for more information concerning these illusions of control with respect to slot machines). He also believed that certain machines and games were better than others (easier to win more money), and that a machine would not pay out a jackpot if it had done so previously that same day. With his sports betting, Angelo's cognitive distortions were somewhat different, believing that his illusion of control was based upon factual knowledge concerning teams and players. Angelo believed that his intimate knowledge of factual information concerning players' abilities was certain to result in winning more money than those who know little about sports. Given his perceived knowledge, it was easy for Angelo to justify betting upwards of $1000 on a game since he believed he could readily predict the outcome.

Angelo's irrational cognitions concerning gambling were discussed at length and he had little difficulty accepting that these thought patterns were inaccurate. He explained that he was always aware of this fact at deeper levels of consciousness, but that his irrational thoughts permitted him to justify his playing. His open acceptance that he was thinking irrationally helped bring this knowledge to the surface and helped him resist gambling opportunities (see Ladouceur et al., 1994 and Ladouceur & Walker, 1998 for a more thorough discussion of modifying cognitive distortions).

4) Establishing the underlying causes of stress and distress.

This therapeutic goal is tackled simultaneously while encouraging a reduction in gambling behavior. Therapeutic sessions are focused upon identifying underlying emotional issues and stressors. Psychotherapy fostered Angelo's realization of unresolved issues concerning his relationship with his father and ultimately the acceptance of his death. Discussions focused upon his anger surrounding the lack of consideration and supervision he received during the final stages of his father's illness. He further realized the magnitude of his anger toward the way his family reacted to his father's death (Angelo was never given an opportunity to speak about his father, seek therapy, nor did he receive any psychological comfort from any family members). He had many unresolved feelings that subsequently affected his overall emotional well-being and ability to cope with daily events.

Angelo also freely discussed the difficulties he experienced as direct consequences of his gambling (e.g., financial debts, lack of trust by family and friends, academic problems, delinquent behavior). He began to recognize that those stressors were compelling him to gamble in order to "just forget for a short while." Angelo described the relationship between problems and gambling as a "viscous circle that sucks you in and never lets you out."

5) Addressing underlying depression.

When Angelo finally stopped gambling completely, approximately two months after therapy was initiated, he began to exhibit symptoms of clinical depression and expressed suicidal thoughts (i.e., "I wanted to drive my car into the wall when on the highway"). He began to have difficulty sleeping, was not eating properly, and reported feeling unmotivated to get out of bed in the morning. He expressed that he no longer had any activities that permitted him to "feel alive," and subsequently became uninterested in living. At this point in the therapeutic process his need to deal with his father's loss became intensified. Angelo was assessed as being clinically depressed and was placed on antidepressant medication. This was accomplished with careful monitoring by a consulting physician.

6) Evaluating and improving coping abilities.

An examination of past experiences allowed for an evaluation of Angelo's ability to handle difficult situations. After an analysis of multiple episodes the therapist concluded that Angelo dealt with difficulties and problems primarily through the defense mechanisms of escape and avoidance. Preferring to keep feelings to himself, Angelo experienced significant difficulties communicating with others, and had difficulty requesting and receiving help.

In daily life events, Angelo seemed to be using his existing, restrictive behavioral strategies resulting in unhealthy and unsuccessful coping patterns. He reported being incapable of sharing his inner most feelings with his girlfriend and was also unable to explain his predicament to his family nor could he effectively handle their anger and disappointment. Angelo admitted that his psychological pain and inability to deal with issues were his primary motivations for gambling. He began to realize the need to improve his general coping and adaptive skills.

Angelo expressed his need to share his inner feelings with Sonya although he lacked the skills to so. This goal was accomplished initially through role-playing with the therapist until he was confident that he could apply his new skills. Sonya was cooperative, and before long, he was able to share his feelings about his father. He was happy and greatly relieved about their ability to share personal issues, his ability to effectively communicate, and grateful for her support. For the first time in many years, Angelo expressed "not feeling alone." At this point, he became more confident in trying to improve his relationship with family members. After careful preparation, each family member was invited into the therapy session. During these sessions, Angelo apologized for his past actions and behaviors and explained the emotional pain he felt. His anger was expressed in a socially appropriate manner and he attempted to explain the reasons underlying his need to gamble. He expressed a strong desire to earn back their trust and respect and asked for their support throughout his recovery. He explained that he no longer wanted to avoid them out of a sense of fear and shame, but rather wanted to spend more time with each of them and to re-establish past relationships. Angelo felt empowered by this new ability to effectively communicate and seek their help.

Over time, Angelo rebuilt his social support network, a critical part of the treatment process. He brought into therapy examples of daily stressors and through careful coaching he acquired alternative coping skills. Of importance is that Angelo learned to generate several different alternative response options to each dilemma or conflict, and was able to discern the positive and negative aspects for each (see Folkman & Lazurus, 1990; Monat & Lazarus, 1991; Wolchik & Sandler, 1997 for more strategies and an understanding of coping mechanisms). Angelo soon experienced the benefits of directly addressing problems and subsequently felt enabled.

Establishing a debt repayment plan also constituted part of the coping skills training. During this phase of treatment, Angelo developed with guidance a reasonable repayment schedule. This involved assisting him evaluate his minimal financial needs and then allocating residual money for repayment. Emphasis on establishing priorities and developing a hierarchy of individuals to be repaid was accomplished. Angelo still had to effectively deal with individuals requesting their money be returned immediately. As such, assistance in developing effective coping skills for dealing with this anxiety and effective communication skills (i.e., honesty versus lying and deceit) were emphasized. This reflects a very important aspect of the therapeutic process since pressures from individuals collecting debts can result in the temptation to return to gambling in order to achieve a 'big win' as a solution for a quick repayment plan.

7) Restructuring free time.

Angelo was encouraged to find a job from the very first treatment session. He quickly acquired part-time employment driving a delivery truck. However, his time spent not working represented excessive free time, which is detrimental to individuals who are trying to overcome a gambling problem. Discussions involved the need to engage in healthy and productive activities. He was encouraged to join a softball team where he developed a healthy friendship with a teammate. As well, Angelo began a physical fitness regime at the local gym; attending a minimum of 5 days per week. In addition, he volunteered to spend more time assisting his brothers with the family business, which he found highly rewarding and therapeutic. Angelo also reported enjoying cooking and offered to make a special meal for his family twice per week. With limited extended free periods of time, his ability to abstain from gambling activities during the treatment phase

improved. These goals are essential not only during the therapeutic process but are necessary for the post treatment phase.

8. Outcome and relapse prevention.

In time, Angelo developed a renewed sense of confidence about himself and his abilities to effectively deal with daily problems and stressors. His relationship with his girlfriend and family member continued to grow stronger. His biggest difficulties remained earning and maintaining the trust of family members. For example, it was immediately assumed by family members that Angelo was responsible for a robbery at the family business, despite the fact that he was no longer gambling. After most suspicious occurrences, Angelo would become the focus of attention. This was exceptionally difficult for Angelo, nevertheless he readily accepted that trust is very difficult to earn back and that there are both short-term and long-term consequences of his gambling problems.

Angelo has completed payment of all debts. While he contemplated returning to school he felt incapable of handling the stress of studying for exams. As a result, he decided to attend a vocational program capitalizing upon his interests and enrolled in a professional culinary school. Angelo is presently working full time driving a delivery truck and regularly prepares gourmet meals for family and friends. He aspires to becoming a chef in a quality restaurant.

Angelo's therapy lasted for 5 months but relapse prevention occurred intermittently over the following six month period. During this time Angelo attended individual sessions on a monthly basis. Between sessions he would also call periodically to seek guidance or to inform the therapist of his progress. Phone contacts continue and one year later Angelo remains abstinent from gambling. He reports being happy, not gambling, and is empowered by his competence to effectively deal with the inevitable daily stressors affecting most youth.

Concluding Remarks

The authors acknowledge that the treatment program described does not meet the requirements for a rigorous, scientifically controlled study (i.e., not randomly assigning individuals to a control group, matching for severity of gambling problems, intake at different stages of the gambling problem, and controlling for age, SES, frequency and

type of gambling activity preferred) and that such an approach is necessary before more definitive conclusions can be drawn. Nevertheless, based upon the criteria previously established for success (i.e., abstinence for six months post treatment, return to school or work, not meeting the DSM criteria for pathological gambling, improved peer and family relationships, and no marked signs of depressive symptomatology, delinquent behavior or excessive use of alcohol or drugs, and improved coping skills), the treatment program at the McGill Clinic has reached its objectives in successfully working with youth having serious gambling problems.

Treating youth with severe gambling problems requires clinical skills, a knowledge of adolescent development, an understanding of the risk factors associated with problem gambling, and a thorough grounding in the empirical work concerning the correlates associated with gambling problems. Angelo was fortunate in that he already had considerable social support from his family and girlfriend. This type of support contributes significantly to a successful treatment program. In other cases, more time is spent rebuilding these relationships, often requiring weeks or months to establish some form of social support and for the development of new healthy friendships.

While the incidence of severe gambling problems amongst youth remains relatively small, the devastating consequences to those individuals, their families, and friends are enormous. As one adolescent told us when discussing the severity of his gambling problem, “It’s an all encompassing problem that invades every facet of my life. I wouldn’t wish this problem on my worst enemy, for it’s way too harsh a punishment.” A general lack of public and parental awareness that severe gambling problems exist amongst our youth, that adolescents perceive themselves as invulnerable, concomitant with the fact that there exist few treatment centers and that adolescents rarely present themselves for help raises serious mental health concerns.

The fact that the prevalence rates for youth with severe gambling problems are 2-4 times that of adults is also of great concern. Whether these individuals will stop their excessive gambling behavior by the time they become adults with additional familial and personal responsibilities still remains an unanswered question. And even if they become ‘social gamblers,’ what were the social and personal costs along the way? This is the first generation of youth spending their entire lives in an environment in which gambling is

sensationalized, advertised, and government supported and endorsed. As a society we are giving our youth two contradictory messages; study hard in school and you will become successful, or for a dollar….

Youth gambling problems will raise important public health and social policy issues in the 21st century. Greater emphasis on outreach and prevention programs is absolutely essential. Our governments must help fund more basic and applied research and be responsible for supporting and developing effective and scientifically validated prevention and treatment programs.

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