Massachusetts Department of Public Health's

Practice Guidelines for Treating Gambling-Related Problems

An Evidence-Based Treatment Guide for Clinicians

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Developed by the Massachusetts Council on Compulsive Gambling

January, 2004

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Introduction: The Purpose of Practice Guidelines

Sackett reminds us that evidence-based practice is the conscientious, explicit, and judicious use of current "best evidence" in making decisions about delivering care to an individual (e.g., patient/client) or group (e.g., family). Working in an evidence-based practice means that clinicians integrate personal clinical expertise with the best available external clinical evidence from systematic research (Sackett, Rosenberg, Grey, Haynes, & Richardson, 1996).

This treatment guide is intended to assist clinicians with the *identification, assessment and treatment* of disordered gambling. Specifically, we have developed this set of practice guidelines for professionals within the Commonwealth of Massachusetts who provide counseling for adults at-risk, affected by, or suffering from health-related gambling problems. In addition, this document addresses the following three areas of clinical concern: (1) **counseling issues with special populations**, (2) **intervention strategies in differing practice settings**, and (3) the **role of pharmacotherapy** in the treatment of gambling disorders.

While clinical investigators search for the most effective and specific clinical techniques for dealing effectively with gambling-related problems, it is essential to remind readers that non-specific or common factors account for a considerable amount of treatment outcome (e.g., Frank, 1961; Hubble, Duncan, & Miller, 1999). For example, Hubble et al. (1999) advise that common factors significantly influence treatment outcome. In addition to the specific effects associated with the treatment model or techniques, they suggest that non-specific to treatment technique factors include: (1) the extra-therapeutic attributes that clients bring with them to treatment (e.g., education, family support, etc.); (2) relationship factors displayed by the treatment provider (e.g., empathy, caring, warmth, etc.); and (3) the hope, expectancies and placebo effects that often associate with the start of treatment. A full discussion of the non-specific factors that influence treatment outcome is beyond the scope and intent of this guide. However, there are many useful resources for readers interested in the factors common to successful treatment (e.g., Frank, 1961; Havens, 1989; Hubble et al., 1999; Imhof, Hirsch, & Terenzi, 1984; Maltsberger & Buie, 1974; Miller, 2000; Miller et al., 1995; Polanyi, 1967; Schon, 1983; Shaffer, 1994; Shaffer & Robbins, 1991, 1995). We encourage clinicians to review this material, cultivate their non-specific treatment skills and examine these skills within the context of clinical supervision and consultation. Integrating non-specific treatment skills with gambling-specific treatment strategies holds the potential to maximize treatment benefits.

We also encourage readers to remember that this document represents practice guidelines and not agency program standards for professional service administration. Practice guidelines are designed for clinicians working with individuals or groups during a clinical encounter. Alternatively, program standards provide a framework for accountability between agency program managers and their funding sources through compliance measurement of a range of financial, personnel, and service indicators. Program standards also provide a vehicle for program quality improvement.

It is important to note that practice guidelines represent only one available tool to promote and shape optimal treatment. For example, in addition to program standards previously mentioned, other structural influences that shape the conduct of clinical practice include society's conceptualization of illness, ethical frameworks often promulgated by professional organizations, funding support, professional credentialing and continuing education. Practice guidelines provide a foundation for more multifaceted and knowledgeable clinical interventions, and thus have the potential to improve the quality of care and health recovery outcomes for people seeking help for their gambling and its adverse consequences.

Further, this document represents an evidence-based approach to practice guidelines for gambling-related problems. Consequently, it reflects contemporary efforts throughout health care to integrate the art and science of therapy (Sackett, Strauss, Richardson, & Haynes, 2000). A central feature of evidence-based practice is the identification and appraisal of original systematic research related to the specific clinical condition. With respect to treating gambling-related disorders, the situation is particularly challenging and complex because this is a nascent field of research; consequently, there is a paucity of gambling treatment outcome studies available to guide clinical practice. In addition, there is the strong temptation to extrapolate clinical outcome evidence from the broader, more mature and rigorously investigated addictions and mental health domains.

Inclusion Criteria for Gathering Evidence

Under this condition of uncertain and developing research, to evaluate the effectiveness of an intervention and compare treatments to determine those most worthwhile for clinical practice, the authors considered research criteria in four primary areas: (1) types of studies; (2) participants; (3) interventions; and (4) outcome measures (Oakey-Browne, Adams, & Mobberley, 2001). In general, studies eligible for inclusion in this report were published in peer-reviewed journals, reports from prominent agencies and only occasionally conference proceedings. **Randomized trials** were weighed with maximum importance. Randomized clinical trials of gambling treatments are few in number but engender a high degree of confidence to guide clinical practice because this study design minimizes systematic bias due to design influences, sample selection biases, or sample attributes. Despite these methodological advantages, randomized clinical trials can reflect unrealistic clinical circumstances. Therefore, this review also incorporates published gambling **case reports** and **case control studies** that offer a moderate degree of confidence. Participants in these studies were predominately adults; the instruments for diagnosis in these studies were those based on one of the recent editions of the Diagnostic and Statistical Manual of the American Psychiatric Association (e.g., American Psychiatric Association, 2000). The eligible interventions were psychological and pharmacological treatments. Treatment outcomes included gambling abstinence or moderation and a range of associated psychological and social behaviors. Finally, these guidelines include research that focused on substance use disorders. Although these substance abuse and dependence studies are well regarded in the broader addiction field, it is possible that research on treatment for substance use disorders does not apply to gambling treatments. Therefore, this body of research must be viewed with a certain level of skepticism as to the value of this research for gambling treatment providers; consequently, this evidence requires further gambling-specific study.

Classifying the Evidence

The guidelines that follow reflect a broad framework for clinical decision-making; this framework organizes supporting research by ***classifying evidence into strong, moderate or weak categories***. In addition, we synthesized this body of evidence with advice from clinicians and researchers who are expert in the treatment and study of treatment outcomes of gambling-related problems. Consequently, the latter exercise incorporated clinical material only where strongly advised, judged to be appropriate and footnoted in the text. Taken together, these criteria strike the right balance at this stage of maturity in the gambling treatment field, and have the potential to strengthen clinical decision-making and enhance clinical care.

Gambling, Gambling Disorders and Gambling Treatment: An Introduction

During recent years, there has been a relatively rapid and profound expansion of legalized gambling within Massachusetts and throughout the United States and Canada. Residents of Massachusetts have access to a wide range of gambling opportunities. Although not all forms of gambling are licit in the Com-

monwealth of Massachusetts (e.g., casinos or video slot machines are not currently licit), these other games of chance are legal in abutting states. Consequently, residents of Massachusetts have relatively easy access to casinos, slot machines, video lottery terminals (VLTs), pari-mutuel wagering, bingo and lotteries.[1] By using the Internet, Massachusetts' residents also have ready access to gambling in virtual casinos that also provide them with the opportunity to bet on sports. Massachusetts' citizens have access to risky day-trading in financial markets. Each type of gambling opportunity presents its own special and shared risks. Consequently, while the level of possibility varies, individuals who gamble are at some risk for a variety of physical health problems. For example, patients with gambling problems can suffer from repetitive movement disorders, other orthopedic problems, sexual dysfunction, gastro-intestinal distress, and circulatory difficulties or other physical maladies (e.g., Daghestani, 1987a; Pasternak & Fleming, 1999; Petry, 2000a).

Throughout this document, the term ***disordered gambling*** is intended to describe the spectrum of gambling-related health problems that can present in clinical practice; the word ***disorder*** reflects the status of gambling within the psychiatric nomenclature (i.e., the Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1994, 2000). These conditions deserve the attention of mental health and addiction clinicians as well as primary care practitioners (e.g., Daghestani, 1987b). The terms ***problem and pathological gamblers*** are widely used, though problem gambling is not currently identified as a disorder within the diagnostic nomenclature. Nevertheless, disordered gambling is a term that reflects both pathological gambling and its subclinical counterpart, problem gambling.

The estimated prevalence rates in the general adult population are stable throughout the world. Regardless of research strategy and researcher, the prevalence of the most serious form of gambling disorder (i.e., pathological gambling) is about 1% throughout the world (Shaffer & Korn, 2002). However, this prevalence has evidenced a slow but upward trend. For example, comparing Shaffer and Hall's prevalence estimates for studies up to 1999 with their earlier estimates up to 1997, past year mean prevalence estimates of level 3 gambling, clinically termed pathological gambling, rose from 1.14 to 1.46, a 28% increase (Shaffer & Hall, 2001). However, when outliers were removed from this analysis, the estimated rate remained at 1.1%. Among youth, college and institutional groups the estimated prevalence is significantly higher than their general population adult counterparts, but it has held steady during the past several decades (Shaffer & Hall, 2001; Shaffer, Hall, & Vander Bilt, 1997; Shaffer, Hall, & Vander Bilt, 1999; Shaffer & Korn, 2002). Given the considerably higher prevalence rates among certain population segments, Korn and Shaffer have noted the need for concern about the impact of gambling on vulnerable groups and populations with special needs (David A. Korn, 2000; Korn & Shaffer, 1999; Korn & Skinner, 2000). Later in this paper, in the section focusing on special populations, we will examine in more detail a variety of population segments that evidence increased vulnerability to gambling-related problems or distinctive treatment needs. For now, clinicians should note that there is a potential higher risk for gambling disorders among those seeking treatment for a variety of mental disorders—even if the treatment seeking is apparently unrelated to gambling.

Approach to Practice Guidelines

The development of clinical strategies for the effective treatment of disordered gambling is in its very early stages. The National Research Council noted the lack of available clinical research to inform clinical decisions (National Research Council, 1999). Many questions remain to be answered. What treatment modalities are effective, for which group of people, in what combination, by which practitioners, for what length of time, in which setting and at what cost? Despite the paucity of answers, we believe, and this

[1] Although casino and video lottery gambling is not legal in Massachusetts at this time, Massachusetts' residents are proximate to states with these forms of gambling holding legal status.

documents reflects, that Nathan (1998) was correct when he noted that we will not return to the pre-guideline era and "...efforts are best spent on establishing as firmly as possible the empirical base for psychosocial practice guidelines" (p. 290). Despite Nathan's view that practice guidelines are not yet ideal, many clinicians and health care organizations are requiring their programs to use guiding principles for practice. During a think tank meeting held during 2000, representatives from programs that were state-funded to deliver gambling-related treatment gathered in Boston. At this meeting, there was agreement on the need for practice guidelines despite the youthful nature of the field (Massachusetts Council on Compulsive Gambling, The Massachusetts Department of Public Health, & The Division on Addictions at Harvard Medical School, 2001). Consequently, it is likely that practice guidelines are here to stay, even if they are not mature or well-developed. The guidelines included in this monograph represent the first review of evidence based clinical suggestions for gambling treatment; therefore, these guidelines should be considered preliminary and are subject to change as the rapidly emerging evidence in gambling studies evolves.

Even in very basic areas of practice, guidelines can serve a useful purpose. For example, most clinicians working in the addictions do not have access to weekly clinical supervision or in-service training (Hall, Amodeo, Shaffer, & Vander Bilt, 2000; Hall, Shaffer, & Bilt, 1997; Vander Bilt, Hall, Shaffer, & Higgins-Biddle, 1997; Vander Bilt, Hall, Shaffer, Storti, & Church, 1997a, 1997b); practice guidelines can suggest that supervision and training are regular aspects of clinical settings. We agree with Nathan that it is unlikely that we will return to the pre-guideline era. Consequently, it seems to make sense to begin the process of developing guidelines with a conservative and critical perspective on practice, recognizing that today's truths can become tomorrow's myths.

Given the increasing demand for treatment guidelines, but keeping Nathan's caveat in mind, we offer these practice guidelines only as a starting point, based upon the current state of empirical knowledge and clinical experience in the gambling treatment field. As noted previously, these guidelines rest upon:

1. Research on gambling treatment efficacy, effectiveness, efficiency and impact[2];
2. Advice of recognized experts in gambling treatment that have influenced the usual and customary standards of practice;
3. Evidence-based practices (EBP) from related domains of substance abuse and mental disorders.

Finally, despite our intention to support the following guidelines with the best available, though evolving, body of evidence, there is a lure to consider this work as the "best" practice guidelines—as if the current evidence provided enduring insight into what is best for clinical practice. The field of science in general (e.g., Casti, 1989; Cohen, 1985; Kuhn, 1970) and health care for addictive disorders in particular is filled with a history of surprising twists and turns (e.g., Gambino & Shaffer, 1979; Havens, 1982; Levine, 1978; Shaffer, 1986b, 1991; Shaffer & Gambino, 1979; Shaffer & Robbins, 1991). Therefore, rather than smugly assume that we have arrived at our destination for guiding treatment, like Nathan, we believe that it is premature to consider these guidelines as ***best*** practices. Consequently, the following guidelines represent a current starting point for a developmental process that likely will evolve for many years to come.

[2] Efficacy answers the question "can it work?" Treatment efficacy refers to the net positive effects and duration of treatment. Effectiveness answers the question "Does it work with individuals in clinical settings?" Efficiency examines the economic questions of unit cost of intervention and cost effectiveness. Impact addresses the public health matter of which intervention has the more significant outcome on a disorder in a defined population or community. Treatment impact is a function of efficacy and patient participation numbers.

Guiding Principles for Clinical Interventions

"The general approach to addiction treatment can be described as breaking a big task into manageable bits, each tailored to the needs of the individual patient. Because of addiction's complexity and pervasive consequences, treatments typically involve many components. Effective treatments must attend to the multiple needs of the individual…" (Leshner, 1999, p.1315). While this general statement is straightforward, fulfilling this goal is more complex. For example, Leshner suggests that there are core activities that are integral to comprehensive addiction treatment. In addition to the non-specific factors described briefly at the beginning of this article, Table 1 below describes the clinical care components that might be provided during the course of treatment.

Table 1: ***Components of Comprehensive Addiction Treatment****

Core Elements
• Intake processing and/or assessment • Treatment plan • Pharmacotherapy • Behavioral therapy and counseling • Substance use monitoring • Self-help and peer support groups • Clinical and case management • Continuing care
Associated Services
• Mental health services • Medical services • Educational services • Acquired Immunodeficiency Syndrome (AIDS) & human immunodeficiency virus (HIV) services • Legal services • Financial services • Housing and/or transportation services • Family services • Child care services • Vocational services
*Derived from Leshner (1999) and modified from Etheridge RM, Hubbard RL. Conceptualizing and assessing treatment structure and process in community-based drug treatment programs. *Substance Use Misuse*, in press.

In addition to the core activities of addiction treatment, there are fundamental principles that guide clinical work. For example, the National Institute on Drug Abuse (NIDA) published an important and widely distributed document entitled *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse, 1999). This document outlines 13 principles of effective treatment for drug addiction (see Appendix 1). Several of these NIDA principles have direct relevance for the treatment of gambling problems. These include:

- TREATMENT NEEDS TO BE READILY AVAILABLE

- AN INDIVIDUAL'S TREATMENT PLAN MUST BE ASSESSED CONTINUALLY AND MODIFIED AS NECESSARY TO ENSURE THAT THE PLAN MEETS THE PERSON'S CHANGING NEED
- ADDICTED OR DRUG-ABUSING INDIVIDUALS WITH COEXISTING MENTAL DISORDERS SHOULD HAVE BOTH DISORDERS TREATED IN AN INTEGRATED WAY

In the following discussion, we will consider six primary principles to guide clinical interventions in the gambling field.

1. RESPONSIBILITY: Individuals are encouraged to accept personal responsibility for their choices and actions appropriate to their level of impairment and stage of recovery. Professional efforts focus on seeking solutions to problems that have arisen. A therapeutic partnership between the individual and clinician that fosters shared responsibility is encouraged.
2. HARM REDUCTION: These interventions are directed towards minimizing or decreasing the adverse health, social, and economic consequences of gambling behavior on individuals, their family, and their community (Single et al., 1996). Harm reduction efforts target individuals with mild, moderate and severe problems. Treatment goals include, but are not limited to the moderation of the gambling behavior. Harm reduction recognizes the perspective that total abstinence from gambling is not the only therapeutic option (G. A. Marlatt, 1998).
3. PREVENTION: Preventive programs and services are can target a variety of levels (U.S. Preventive Services Task Force, 1996). Professional awareness and early identification of gambling problems in a range of clinical and community settings broadens the base of treatment. Primary prevention efforts enhance both professional and public awareness; primary prevention efforts focus on people not experiencing gambling-related health problems. Secondary prevention strategies focus on screening people for gambling problems and offering assistance, including referral to specialized resources, in order to minimize these problems. Tertiary prevention refers to measures undertaken during gambling treatment (e.g., mental health, financial and family services) to prevent complications arising from the disorder.
4. STAGES OF CHANGE: Quinn (1891) and Custer (e.g., Custer, 1981; Custer, 1982) were early proponents of a stage change approach to understanding the emergence of gambling problems. More recently, stage change has emerged as a ubiquitous transtheoretical model for understanding behavior change and recovery from a variety of addictive disorders (G. Alan Marlatt, Baer, Donovan, & Kivlahan, 1988; Miller & Rollnick, 1991; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 1994; Rollnick & Morgan, 1995; Shaffer, 1992, 1997; Shaffer & Robbins, 1995). Stage change strategies that have been utilized in smoking and substance abuse treatment can be adapted to the gambling field. This approach to treatment conceptualizes different stages through which individuals progress to initiate and sustain new health behaviors (Prochaska et al., 1992; Prochaska et al., 1994; Shaffer, 1997; Shaffer & Robbins, 1995). Once an individual's stage of change has been identified, then appropriate intervention strategies for that stage can be implemented (e.g., Prochaska et al., 1994; Shaffer & Robbins, 1995).
5. TREATMENT MATCHING[3]: Clients have a range of problems, preferences, expectations and recovery needs that should be taken into consideration in deciding the most appropriate

[3] To date, there is a shortage of empirical research suggesting the extent to which treatment matching actually works. For example, in a comprehensive comparison of interventions in the alcohol field, project MATCH found that all three interventions (i.e., motivational counseling, cognitive behavioral therapy, and twelve step facilitation) yielded similar outcomes (Project Match Research Group, 1997). However, psychiatric severity was associated with treatment outcome; those with more severe disorders had poorer outcomes than those who were healthier at the outset of treatment. Since comorbidity is a commonly observed circumstance among gambling treatment seekers pre-

treatment plan. Individuals can be matched to stage of change, problem severity and associated comorbidity. At the same time, it must be acknowledged that treatment choices are ultimately guided by the availability of resources within the community and the accessibility to the individual.

6. INFORMED AND SHARED DECISION-MAKING: One of the major challenges for clinicians in the gambling field is negotiating common ground regarding clinical management issues. It requires engaging the treatment seeking person in the complex process of treatment planning. We believe that finding common ground is the crux of client-centered care. The clinician's challenge is to offer the best evidence for treatment benefit so that clients can utilize it to make their decisions. This paradigm requires that the treating professional accepts the client as an equal partner in the treatment process and respects the experiences and preferences of every patient (e.g., Hubble et al., 1999; Taber, 1985; Weston, 2001).

These six broad principles serve as the strategic landscape against which the tactics of treatment are juxtaposed. These tactics reflect treatment objectives and conceptual models that guide our understanding of the etiology, maintenance and resolution of addiction in general and gambling disorders in particular.

Treatment Objectives

Health recovery is usually the stated primary goal for individuals seeking help for gambling problems. The World Health Organization (World Health Organization, 1984, 1986) defines health as the extent to which an individual is able, on the one hand, to change and cope with their environment and, on the other hand, to satisfy needs and realize aspirations.

For disordered gamblers this goal means ceasing or reducing gambling. The specific intent of treatment interventions is fourfold:

a) Minimize the harmful consequences of gambling to the gambler and others (e.g., family, friends, colleagues);
b) Avoid or reduce the risks associated with gambling environments (e.g., opportunities, associates and venues);
c) Cope effectively with negative mental states (e.g., anxiety, depression, loneliness, stress) through new strategies and life skills; and
d) Satisfy needs for entertainment, social connectedness and excitement through less destructive and more balanced leisure activities.

Concepts that Shape Treatment Interventions

A variety of conceptual perspectives shape the strategies and tactics of gambling treatment. These models provide the foundation against which clinicians judge the efficacy and impact of clinical practice. The following discussion will consider five commonly held perspectives that influence the treatment process.

Public Health Model: A Framework for the Spectrum of Gambling Behavior

People's gambling behavior can range from none to a great deal and observers can characterize this activity as ranging from healthy to unhealthy. At many points along this continuum, people can experience

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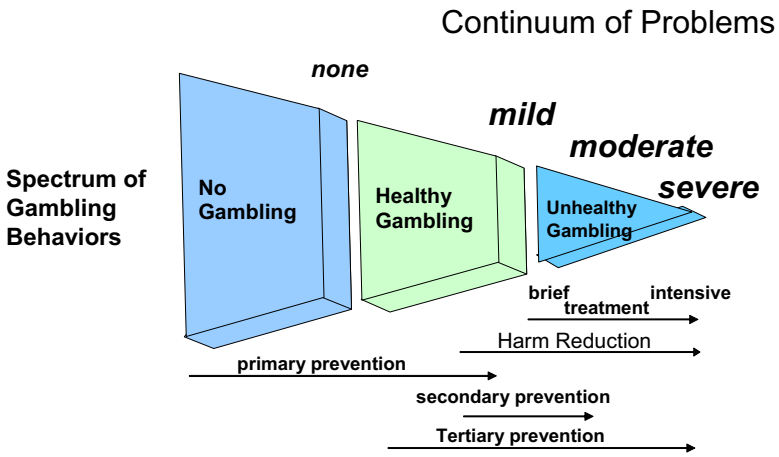
senting for treatment (Crockford & el-Guebaly, 1998b; National Research Council, 1999; Shaffer & Korn, 2002), we suggest that it is essential to treatment planning considerations. Perhaps, the empirical evidence is weak simply because tactically we have not yet learned how to do this matching with sufficient precision.

problems associated with their gambling, though these difficulties tend to emerge more among frequent gamblers who wager at higher levels and for longer periods of time. Figure 1 reflects the s*pectrum of gambling behavior* and illustrates a gambling problem continuum (Figure 1 is derived from, Korn & Shaffer, 1999; Shaffer & Korn, 2002). The point of demarcation between mild, moderate and severe problems is not precise and reflects cultural variation and individual attributes. In addition, this figure shows where the range of prevention, harm reduction and treatment interventions reside on the spectrum. By understanding the full range of gambling and its potential consequences, health professionals can develop and implement treatment systems that can optimize resource utilization and clinical care.

Figure 1: Public Health Framework for Gambling and Gambling-related Problems



Gambling Addiction

While there are a variety of perspectives on intemperate gambling, the consideration of excessive gambling as an addictive disorder has a long history and considerable following (Korn & Shaffer, 1999). An addiction perspective considers gambling disorders as characterized by a continuous or periodic feeling of loss of control over gambling, preoccupation with gambling and money with which to gamble, irrational thinking about odds and winning, and continuation of gambling despite adverse consequences to self, family, and work.[4]

Pathways into Disordered Gambling

The determinants of disordered gambling reflect a complex interaction among the biological, behavioral and psychological profile of the individual, the characteristics of the games themselves, as well as the gambling setting and local environment (Korn & Shaffer, 1999). *Money or something of value is the vehicle that transforms gaming into gambling*. People can develop gambling problems through a variety of pathways. These trajectories are influenced by genetic predisposition, maladaptive coping strategies to unpleasant thoughts, feelings or events, psychiatric comorbidity (e.g., associated with depression, substance abuse or other mental disorders), education, and financial status. Social environmental factors such as family, community, and cultural beliefs, values and attitudes also can influence peoples' relationship to gambling and affect their risk of developing gambling problems (Blaszczynski, 2000; National Research Council, 1999; Shaffer & Korn, 2002).

[4] This definition is a modification derived from the policy document of the Canadian Centre on Substance Abuse (Topp et al., 1998).

Natural History of Pathological Gambling

Pathological gamblers have been described as moving through a linear sequence of phases as the gambling behavior becomes increasingly problematic over time (Custer, 1982; Quinn, 1891). This view suggests that disordered gamblers initially experience a winning or positive consequences phase that reinforces gambling involvement. This experience is followed by the statistical inevitability of a losing phase. Prolonged losing yields a phase of desperation and hopelessness. Recent empirical and prospective research suggests that patterns of gambling are more dynamic than previously thought: there is considerable movement across the categories of pathological, problem, and non-problematic gambler even among those with full access and exposure to gambling (e.g., Shaffer & Hall, 2002).

Framework for Selecting Clinical Interventions

Choosing a treatment strategy can be a complex task. When clinicians select the level and type of treatment for an individual, they should make this decision within the context of a broad public health framework. This paradigm offers an array of treatment options by integrating the notion of healthy and unhealthy gambling behavior, a problem severity continuum reflecting mild, moderate and severe problems, as well as a range of prevention, harm reduction and treatment strategies (Korn & Shaffer, 1999; Shaffer & Korn, 2002). For example, healthy gambling represents informed choice on the probability of winning, a pleasurable gambling experience in low risk situations and wagering in sensible amounts. Healthy gambling sustains or enhances a gambler's state of well-being. Along with non-gamblers, healthy gamblers are a target group for primary prevention. Conversely, unhealthy gambling refers to the various levels of gambling problems experienced by some gamblers resulting in adverse consequences. The latter group of unhealthy gamblers benefits from brief or intensive treatment, secondary and tertiary prevention as well as harm reduction interventions.

Assessment of Pathological Gambling and Related Disorders

The following section will discuss the process of assessment and the tools often used for screening and diagnosing gambling disorders. In addition, this section of the guidelines will consider four related components that are central to the assessment process. These include an evaluation of 1) a person's readiness to change, 2) co-occurring mental health and substance use disorder(s), 3) severity of gambling problems, and 4) suicidality. Finally, we will examine the nature of treatment planning within the context of assessment.

Assessment, Diagnosis and Treatment: General Considerations[5]

Treatment for a gambling disorder begins at first contact with a clinician. Assessment is the critical and complex initial step in the process and involves both the art and science of clinical practice. Assessment has a number of components and is an ongoing and dynamic element in the treatment process (Shaffer & Freed, in press). Although it is seemingly straightforward, assessment reflects a complex set of multidimensional activities that both drives the formulation phase of treatment and informs the entire treatment process. The assessment process provides a foundation for developing an alliance with the individual, an understanding of the gambling problem and the person, a blueprint for treatment planning, and a reference point for treatment monitoring and continuing care. Assessment is a broad concept that represents screening, evaluation and diagnostic activities.

Conceptually, one important issue for clinicians to consider is whether they are assessing problems or people (Shaffer, 1986a). For example, is the evaluative task to identify excessive gambling patterns and

[5] See Appendix 8, Special Notes on Taking Drug & Gambling Histories.

the consequences of these activities or is it to understand the nature and dynamics of the excessive gambler? As one moves from screening to problem assessment to personal assessment, the extent of information developed is greater but the costs of assessment also increase. Performing a sequential assessment ensures that further information is actually necessary to the treatment process and its outcome goals and justifies the increased cost and time (Institute of Medicine, 1990, p. 250).

In the case of disordered gambling, a clinical assessment process explores the history of gambling behavior including current gambling activity; the impact of gambling on individual, interpersonal and social functioning; educational background; financial circumstances; individuals' readiness to change; their mental and physical health status including risk of suicide; past and present mental disorders including addiction, medication and substance use patterns as well as their relevant family history and social environment. Information can be gathered through a variety of formal and informal methods including free form interviews, structured interviews and screening tools (e.g., Shaffer & Freed, in press; Taber, 1985).

Screening

Screening is a form of secondary prevention that identifies individuals with mild to moderate gambling problems. It represents a self or other analysis of gambling patterns to identify gambling problems. Screening typically involves responding to a series of brief, often self-administered, questions for people not in gambling treatment to determine if they might have the disorder. By screening groups of asymptomatic people in the community or health care settings, health care professional try to identify the problem or disorder so that early intervention is possible. In health care settings, routine gambling screening of all patients/clients (i.e., case finding) provides an efficient opportunity to identify individuals for further evaluation and a consideration of options. Typically, in an optimal clinical system, once someone has screened positive for a gambling-related problem, the screener refers the person to a gambling clinician for more extensive evaluation. Ultimately, people can address their circumstance through self-help, professional assistance, a combination of these or other resources.

There are a variety of clinical tools available to mental health and substance abuse treatment providers that identify gambling-related problems. New assessment instruments for gambling disorders are appearing regularly. The most common clinical screening instrument is the South Oaks Gambling Screen (SOGS) for adults introduced in 1987 for use with clinical populations (Lesieur & Blume, 1987). The SOGS is based upon the DSM-III-R. The Massachusetts Gambling Screen (MAGS) is the first instrument introduced that was based wholly on DSM-IV criteria (Shaffer, LaBrie, Scanlan, & Cummings, 1994). Further, this is the first instrument to introduce weighted items to gambling assessment; that is the MAGS recognizes that some symptoms are more important than others. Consequently, the MAGS is responsive to growing criticisms of the DSM-IV (Beutler & Malik, 2002). It includes a short and long form: the short form (i.e., MAGS 7) and was validated on a sample of adolescents. These screening devices have demonstrated reliability[6] and validity; in addition, these screens are readily interpretable. However, each of these instruments is valid only within certain parameters. In addition, Gamblers Anonymous has available a self-assessment questionnaire (GA 20) based on 12 step principles and practices (Gamblers Anonymous, 2001). However, it has not been well validated nor widely used in clinical settings.

There are many new instruments that have been used for general population screening; in 1997, 27 different screening instruments had been identified (Shaffer et al., 1997). More are in the development stages. However, most of these instruments have not been subject to peer review and their psychometric charac-

[6] The MAGS was designed to evidence lower Chronbach's alpha than most other scales since its short form requires that each question efficiently burden independent evaluative dimensions; longer scales inherently evidence higher internal consistency since multiple questions measure the same underlying dimensions.

teristics remain uncertain. One of the most promising of the new instruments for identifying gambling and comorbid psychiatric disorders is the Composite International Diagnostic Interview (CIDI) (Kessler, 2000); this measure is endorsed by the World Health Organization and is now part of a United States national comorbidity survey.

Pathological gambling can coexist with substance abuse, mental illness and other addictive disorders, although these relationships and the pathogenesis are incompletely understood. Nevertheless, it is prudent for clinicians to consider and screen for other mental disorders such as alcohol and drug problems, mood, anxiety and stress disorders as well as suicide risk. A referral to an appropriate mental health specialist for in-depth clinical assessment of a possible comorbid condition may be required. Appendix 2 contains a resource for some commonly used screening instruments.

Diagnosing Pathological Gambling

In 1980, the American Psychiatric Association incorporated "pathological gambling" into its diagnostic and statistical manual (American Psychiatric Association, 1980). This development legitimated disordered gambling as a psychiatric illness within the mainstream mental health field. DSM-IV requires 5 of 10 criteria to be satisfied for clinicians to make a diagnosis of pathological gambling (American Psychiatric Association, 1994). In addition to making a diagnosis of pathological gambling, DSM-IV requires that the presence of a manic condition not provide a better explanation of the gambling behavior. Table 2 below summarizes these 10 diagnostic criteria. The DSM-IV emphasizes impaired ability to control gambling-related behaviors, adverse social consequences of gambling, as well as tolerance and withdrawal.

Table 2: *Diagnostic Criteria for Pathological Gambling*

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

(1) is preoccupied with gambling (e.g., is preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)

(2) needs to gamble with increasing amounts of money in order to achieve the desired excitement

(3) has repeated unsuccessful efforts to control, cut back, or stop gambling

(4) is restless or irritable when attempting to cut down or stop gambling

(5) gambles as a way of escaping from problems or of relieving a dysphonic mood (e.g., feelings of helplessness, guilt, anxiety, depression)

(6) after losing money gambling, often returns another day to get even ("chasing" one's losses)

(7) lies to family members, therapists, or others to conceal the extent of involvement with gambling

(8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling

(9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling

(10) relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode.

Although the Diagnostic and Statistical Manual (DSM-IV) includes pathological gambling, it does provide an unusual *cautionary statement*. This statement notes that "...inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency" (American Psychiatric Association, 1994, p. xxvii). This statement is confusing. Although this perspec-

tive implies that this diagnosis might not be wholly relevant to certain judgments, the use of "wholly" also suggests that it might be partly relevant. This perspective of the American Psychiatric Association raises a number of conceptual, ethical and professional issues but nonetheless is important to acknowledge.

Assessing Motivation and Readiness for Change

Motivational assessment gives the clinician conceptual and practical tools to identify the person's *readiness for change* (e.g., not ready, unsure or ready). It also can be used to determine and score individuals' perception as to the *importance of changing* and their *confidence in their ability* (i.e., self-efficacy) to initiate and carry out the challenge (Prochaska, 1996; Prochaska et al., 1992; Prochaska et al., 1994; Shaffer, 1997; Shaffer & Robbins, 1995; Shaffer & Simoneau, 2001; Skinner, 2001). However, it should be noted that the majority of research on readiness to change has been carried out in the tobacco and alcohol fields; consequently, there is considerable need for more gambling-specific research with longitudinal follow-up.

Assessing the Severity of Disordered Gambling

To reflect the underlying continuum of gambling problem behavior, Shaffer and Hall have suggested a universal system for clinicians to assess problem severity beyond a simple dichotomy (Shaffer & Hall, 1996). In addition to avoiding pejorative and often misleading language, this system also is consistent with a public health perspective on population prevalence and resource allocation. In this system, level 0 represents the prevalence of non-gamblers; level 1 represents respondents who do not report any gambling-related symptoms (i.e., not experiencing any gambling problems). Level 2 represents respondents who are experiencing sub-clinical levels of gambling problems and level 3 represents respondents who meet diagnostic criteria for having a gambling disorder. It is important to note that level 2 gamblers can move in two directions: they can progress to a more disordered state (i.e., level 3), or they can move to a less disordered state (i.e., level 1). New research suggests that these gamblers progress to level 3 less than expected and move toward level 1 more than the conventional wisdom would predict (Shaffer & Hall, 2002).

Formulating a Treatment Plan

Treatment plan development should be a joint undertaking between the client and clinician. The treatment plan reflects their shared understanding of the nature of the problem, the desired outcomes and the preferred interventions. Since clients are heterogeneous in a number of clinically significant ways, treatment plans should differ according to the client's goals, psychobiology and social context. Because expectancy is an important predictor of successful outcome, clinical interventions should be congruent with the client's informed beliefs about the likely effectiveness of treatment (e.g., Frank, 1961; Havens, 1982; Havens, 1989; Hubble et al., 1999; Menninger, 1963; Miller, 2000; Rollnick & Morgan, 1995; Shaffer & Robbins, 1991; Silver & Shaffer, 1996; Walitzer, Dermen, & Connors, 1999; Weiner, 1975). Ultimately, treatment plans must address the goal and specific objectives of treatment, the psychological interventions and particular modalities, medications where appropriate, other supportive strategies, length of treatment, setting and cost.

Treatment Modalities & Settings

Caring for a Syndrome

Gambling disorders have both unique and shared elements (Shaffer & Korn, 2002). For example, pathological gambling has unique elements (e.g., betting increasing amounts of money); it also shares signs and

symptoms with other disorders (e.g., anxiety, depression, impulsivity, substance abuse). Consequently, pathological gambling is best thought of as a syndrome. Since syndromes are multidimensional, these disorders typically do not respond favorably to a single treatment modality. From this perspective, the most effective treatments for gambling problems reflect a multimodal approach that rests upon patient-treatment matching. Multidimensional treatments include various combinations of psychotherapy, psychopharmacology, financial, educational and self-help interventions. These various treatment elements within a continuum of care model are both additive and interactive, a circumstance necessary to deal with the multifaceted nature of gambling disorders.

Treatment settings include primary care, residential (e.g., hospital and non-hospital), day programs and outpatient treatment (i.e., hospital and non-hospital) as well as community counseling clinics. These settings most often are associated with mental health and addiction services. The variety of settings provides an array of service modalities that vary in cost, professional expertise, therapeutic resources, and treatment philosophy. Not all settings offer all treatment modalities. For example, primary care settings tend to offer broad contact for screening, early identification, brief treatment and referral. Alternatively, residential or comprehensive day treatment settings often provide multimodal programming. Severely disordered gamblers might initially require in-patient care for psychiatric stabilization and safety during period of initiating cessation from their gambling activities. Outpatient settings, (e.g., community mental health, social service and addiction treatment clinics) are the most accessible but might have limited options, relying on careful selection of appropriate counseling interventions. Further, outpatient settings often require linkages with other community resources. Because of the complex relationship between clinical setting and modality, treatment planning requires careful matching of these care components.[7]

Counseling Interventions

Counseling for individuals with gambling problems is the most common clinician intervention. The widespread use of counseling in the addictions suggests that it is central to achieving the goal of health recovery. In the mental health and addiction field, there is a spectrum of psychological interventions potentially available in an individual, family or group format. Based on the clinical research literature, we will highlight empirically supported psychotherapeutic treatments for disordered gambling; in addition, we will describe interventions that derive from relevant addiction and mental health research.

As we described before in the section on gathering evidence, the research criteria for including evidence in this guide were derived generally from the model developed by The Cochrane Library, which addresses four methodological areas: 1) types of studies, 2) participant profile and numbers, 3) interventions utilized, and 4) outcome measurements (Oakey-Browne, Adams, & Mobberley, 2001).

Strength of Evidence

To help evaluate the efficacy of specific counseling modalities, techniques and strategies, the following discussion classifies counseling approaches by the strength of the scientific evidence that is available to support the use of these methods (Chambless & Ollendick, 2001). Although randomized clinical trials have long represented the "gold standard" of treatment outcome studies and the strongest form of evidence regarding the efficacy of treatment, in the field of gambling studies, randomized clinical trials are few. In addition, the existing randomized clinical trials have limited their focus to cognitive and behavioral therapies; further, these studies have tended to include small samples. Finally, the absence of a randomized clinical trial does not mean that other treatment approaches have little or no utility. Rather, this evidence simply is the best available research supporting these methods. Given the nascent state of gam-

[7] See Appendix 7 Criteria for Patient Placement, Adapted from Giulliani and Schnoll (1985).

bling research, currently, the shortage of clinical trials usually suggests that investigators simply have not yet studied most available clinical methods.

There are a variety of ways to classify evidence (Chambless & Ollendick, 2001). This document organizes the evidence into three general categories: strong, moderate and weak. S***trong evidence*** reflects the availability of randomized clinical trials, typically with 6 to 12 month follow-up period, clear outcome measures and adequate sample sizes. ***Moderate evidence*** represents interventions and treatment protocols that are fully documented and tested within a strong research design that includes a control group, adequate subject follow-up and carefully measured treatment outcomes. ***Weak evidence*** reflects the absence of studies or studies with poor designs, weak methods, small samples, the absence of control or comparison groups, and inadequate periods of follow-up. Unpublished reports, manuscripts of clinical efficacy that have not been subject to peer review, conference presentations and proceedings are considered weak evidence. In addition, controversial techniques reflecting questionable ethics have been classified as having weak evidence to support their use—not necessarily because empirical treatment efficacy is absent, but instead simply because the clinical methods are questionable on ethical grounds. Using this sorting system, Table 3 summarizes counseling and self-help intervention methods by the nature and extent of the available evidence.[8] With respect to the strong evidence category, the Cochrane Library review (Oakey-Browne, Adams, & M., 2001) noted that until the year 2000, they identified only seventeen gambling outcome studies, and merely four were randomized clinical trials (Echeburua, Baez, & Fernandez-Montalvo, 1996; McConaghy, Armstrong, Blaszczynski, & Allcock, 1988; McConaghy, Blaszczynski, & Frankova, 1991; Sylvain, Ladouceur, & Boisvert, 1997).

Table 3: *Classifying the Evidence*

Strength of Evidence	*Interventions*
Strong Evidence	• Cognitive Behavioral Therapy • Behavioral Therapy
Moderate Evidence	• Relapse Prevention
Weak Evidence	• Psychodynamic Psychotherapy • Aversion Therapy • 12-step (e.g., Gamblers Anonymous; self-help) • Self-Exclusion (self-help)

Promising Interventions and Complementary Services

Before examining each of the interventions described in the table above, it is useful to consider the promise evidenced by empirically supported interventions from related mental health and addiction fields (Chambless & Ollendick, 2001) that have been widely transported to gambling treatment. These applications appear theoretically attractive, are widely used by the gambling treatment practitioners. Although they show great potential to the gambling field, to date, this adaptation phenomenon has occurred without research into their efficacy and effectiveness for disordered gamblers. Brief therapy, strategies to enhance motivation, stage change matching and twelve-step facilitation are promising interventions included in this document and the following discussion because these four methods have significant implications for future research and represent promising applications to gambling practice. In addition, financial counseling and the use of leisure programs serve as complementary treatment strategies that hold promise for the treatment of gambling disorders.

[8] Readers should note that weak evidence does not mean that the existing evidence fails to support the efficacy of these interventions; rather, it most likely indicates that there is little evidence available.

Interventions: Strong Evidence

Cognitive Behavior Therapy and Related Techniques

Cognitive Behavioral Therapy (CBT) is based on the principles of social learning theory (Bandura, 1986; Bujod, LaDouceur, Sylvain, & Boisvert, 1994; Ladouceur, Sylvain, Boutin, & Doucet, 2002; Ladouceur, Sylvain, Letarte, Giroux, & Jacques, 1998; Ladouceur & Walker, 1998; Sylvain et al., 1997). This type of psychotherapy attempts to change the thoughts and behaviors that are fundamental to maintaining a disorder. Disordered gambling is a highly cognitive condition. Despite the need for additional treatments and the likelihood that these will emerge, based upon current empirical evidence, CBT is the primary psychotherapeutic modality for the treatment of disordered gambling; currently, it also is the most broadly utilized primary counseling modality that is supported by randomized controlled clinical trials demonstrating efficacy and improved clinical outcomes (Bujod et al., 1994; Sylvain et al., 1997). Despite the strength of evidence that is available to support the use of CBT, it is important for readers to note that this research often has limited subjects that complete the course of treatment (Montori & Guyatt, 2001).

The goal of CBT for gambling is to ***identify and change "cognitive distortions and errors" that are associated with intemperate gambling and its adverse sequelae.*** For example, beliefs in an eventual big win, being unrealistically lucky, superstitious behavior, as well as selective and distorted memory are characteristics of cognitive distortions that often are associated with disordered gambling (e.g., Ladouceur et al., 2002; Ladouceur & Walker, 1998). Perceptions of self include how money links to self-esteem, social status and power. ***The "illusion of control" over gambling outcomes is a core cognition that influences disordered gamblers.*** This sense that ***one has the "omnipotent skill" necessary to beat the odds*** is an enduring characteristic of pathological gamblers. Finally, CBT attends to the effect of gambling on others and attempts to minimize the negative impact on family, work and personal finance.

Ladouceur and colleagues at Laval University in Quebec (Bujod et al., 1994; Ladouceur et al., 2002; Ladouceur et al., 1998; Ladouceur & Walker, 1998; Sylvain et al., 1997) have developed a treatment program model based on cognitive behavioral principles that includes four components: (a) correcting cognitive distortions about gambling; (b) developing problem solving skills; (c) teaching social skills; and (d) teaching relapse prevention. These key CBT techniques central to gamblers are outlined below.

Cognitive Restructuring

Cognitive restructuring for gambling disorders reflects interventions that are directed toward changing unhealthy gambling behavior by correcting distorted thoughts, beliefs and attitudes about playing and winning games of chance. It begins by enhancing gamblers' awareness of specific gambling thought distortions and errors in judgment so that they can begin to make better decisions and choices. This goal can be achieved by thoroughly reviewing a person's gambling experiences, strategies and expectations as well as by monitoring their current gambling behavior. This will provide clinicians with the opportunity to describe, assess and evaluate a gambler's cognitive pattern of activities. For example, one of the commonly observed distortions among disordered gamblers is known as the "Gambler's Fallacy." This cognitive distortion represents a gambler's belief that they can predict future randomly determined gambling outcomes based on their observations and analysis of past random gambling events.

By examining the specific gambling thought processes that support distorted ideas, beliefs, reasoning and decisions and then correcting and reframing them, clinicians can effect change in disordered gambling behavior. Cognitive restructuring interventions correct distortions in thinking regarding numeracy, games played, betting systems, superstition, selective memory, attribution and causality.

For example, through a process of hypothesis testing the problem gambler in treatment can validate their predictions in a variety of gambling simulated or actual scenarios that test mathematical and logical think-

ing. Subsequently, they can evaluate their outcome predictions of coin tosses, picking lottery numbers, as well as slot and electronic gaming machines patterns. The new learning focuses on understanding and applying concepts of randomness, probability, luck and skill to gambling situations and decisions.

We encourage interested readers to review the following resources for additional information for a more detailed description of cognitive problems, treatments and restructuring strategies (Ladouceur, Paquet, & Dube, 1996; Ladouceur et al., 2002; Ladouceur et al., 1998; Ladouceur & Walker, 1998).

Problem Solving Training

The development of problem solving skills can assist individuals struggling against their impulses to gamble excessively to feel improved control over their gambling risks and consequences. Problem solving strategies address therapeutic themes that include dealing with gambling urges, deciding about limits on the time and money spent gambling, resolving difficulties with family members and finding suitable solutions to gambling debts.

The problem solving process involves a number of steps: identifying the problem accurately, collecting specific information about the problem, generating different options, exploring consequences by listing advantages and disadvantages for each, and then implementing and evaluating the preferred solution (e.g., Goldfried & Davison, 1976).

Social and Coping Skills Training

There is a range of social and life skills that can benefit a gambler in recovery. These include communication, assertiveness, numeracy skills, refusal skills, as well as the self-management of stress, anger, and anxiety. Therapeutic life skills training also includes relaxation, physical activity and meditation. CBT tactics applied to disordered gamblers often incorporate **role play** (e.g., practicing refusal skills), **imaging** (e.g., anticipating an effective coping sequence, re-experiencing a disastrous gambling event and creating a more acceptable outcome), **goal setting** (e.g., deciding limits on gambling occasions, time & amount of money spent), **psycho-education** (e.g., learning the signs and symptoms of problem and pathological gambling), **impulse management** (e.g., controlling urges to gamble), and **self-monitoring** (e.g., money and time spent gambling).

A detailed discussion of this broad area is beyond the scope of these guidelines. Interested practitioners are encouraged to examine relevant materials from the alcohol field (e.g., Project MATCH manual) and the cocaine literature (e.g., NIDA's cognitive behavioral manual for cocaine addiction) as a basis for exploring specific topic areas and selected exercises (Monti, Abrams, Kadden, & Cooney, 1989; National Institute of Drug Abuse, 1998; National Instituted on Alcohol Abuse and Alcoholism, 1995).

Behavioral Therapy

A variety of behavioral therapeutic approaches have been applied to problem and pathological gamblers. These methods include: 1) aversion (e.g., Barker & Miller, 1968; Koller, 1972; Seager, 1970), 2) individual stimulus control and cue exposure with response prevention (Echeburua et al., 1996), 3) systematic imaginal desensitization strategies incorporating both imaginal relaxation (IR) and imaginal desensitization (ID) techniques (McConaghy, Armstrong, Blaszczynski, & Allcock, 1983; McConaghy et al., 1988; McConaghy et al., 1991), as well as 4) self-exclusion or avoidance strategies (Ladouceur, Jacques, Giroux, Ferland, & Lebond, 2000).

Imaginal Desensitization Technique

Imaginal techniques are used as a desensitization tactic. These treatment tactics derive from a behavioral completion approach that has been found to decrease gambling urges and behaviors (McConaghy et al., 1983; McConaghy et al., 1988; McConaghy et al., 1991).

Systemic imaginal desensitization (ID) is a useful method to reduce or eliminate the compelling urge to gamble. After the induction of relaxation, it involves exposure to specific gambling cues or triggers and subsequent response prevention (McConaghy et al., 1988). This treatment strategy incorporates both imaginal and other relaxation-based techniques. Research incorporating a randomized clinical trial design has demonstrated significant and favorable differences between desensitization techniques and other behavioral procedures as evidenced by decreased anxiety and gambling behavior (McConaghy et al., 1991). Although there are variations, the desensitization technique involves learning a progressive muscle relaxation procedure that reduces physical tension; once relaxed, the relaxed person then imagines urges and or opportunities to gamble while maintaining the relaxed state. For a more thorough description of this approach, interested readers should see "Controlling Your Urge Using a Relaxation Technique" in *Overcoming Compulsive Gambling* (Blaszczynski, 1998). This technique is well suited for use alone or in combination with cognitive behavioral and other therapies that need to integrate stress and tension reduction techniques.

Interventions: Moderate Evidence

Relapse Prevention and Recovery Training

Relapse prevention and recovery training are modalities designed to increase a person's ability to identify and cope with **high-risk situations** that commonly create problems and precipitate relapse. The techniques have been well developed and widely used in the alcohol and drug treatment field (H. Annis, 1986; G. Alan Marlatt & Gordon, 1985; McAulliffe & Ch'ien, 1986). More recently, these strategies have been applied to gambling treatment. The gambling risk situations identified include environmental settings (e.g., casinos, lottery outlets), intrapersonal discomfort (e.g., anger, depression, boredom, stress) and interpersonal difficulties (e.g., finances, work and family). The goal is to develop coping methods to deal effectively with these specific high-risk situations without relying on unhealthy and maladaptive gambling behavior. To date, other than its incorporation into program outcome studies of Ladouceur and colleagues (e.g., Ladouceur et al., 1998) there has been a paucity of research addressing the effectiveness of relapse prevention in the gambling field.

A promising application of the relapse prevention model for gambling is in the late stage of development (e.g., Littman-Sharp, Turner, Stirpe, & Liu, 1999). The instrument, *Inventory of Gambling Situations* (IGS), builds on earlier similar tools, the Inventory of Drinking Situations (IDS) and Inventory of Drug-Taking Situations (IDTS) (H. Annis, M,, 1985; H. Annis, M., 1982). The IGS identifies an individual's high-risk situations for disordered gambling behavior by assessing the areas that have been problematic during the clients' life and which might place them at risk of relapse into unhealthy gambling during their recovery.[9] By identifying potential risk situations, this instrument can be used to teach recovering gamblers new coping strategies for use during their continuing care and aftercare experiences. In addition, this instrument can be used during the early phase of treatment to enhance awareness of the role gambling

[9] The Inventory of Gambling Situations includes eleven items: Negative Affective Situations (negative emotions, conflict with others), Temptation Situations (urges and temptations, testing personal control), Positive Affect Situations (pleasant emotions, social pressure, need for excitement), Gambling Cycle Situations (worried about debt, winning and chasing loses, confidence in skill, need to be in control).

plays in maladaptive coping. To date, the instrument has been validated but not published in a peer-reviewed journal.[10]

Interventions: Weak Evidence

Psychodynamic Psychotherapy

This therapeutic modality has been used widely with gambling clients prior to the dominance of cognitive-behavioral approaches. It is likely that this is still the most common form of psychotherapy with gambling as well as other addictive disorders. However, there is a paucity of psychodynamic research in the gambling field and sparse evidence in the outcome literature to support its effectiveness. The purpose of psychodynamic psychotherapy is to assist the individual to gain insight into the emotional origins and meaning of their gambling behavior. It frames disordered gambling as a repetitive activity that is functional. For example, it exists to satisfy some need that typically remains unconscious or poorly understood. Although psychoanalytically oriented treatment can be lengthy, continue over several years and might be best suited for individuals with comorbid personality disorders, psychodynamically oriented treatment also offers strategies and techniques that can be used in brief treatment and supercede any particular treatment model (Bergler, 1957; Galdston, 1951; Gustafson, 1995; Khantzian, Halliday, & McAuliffe, 1990; Levin, 1987; Perry, Cooper, & Michels, 1987; Rosenthal, 1997; Rosenthal & Rugle, 1994; Weiner, 1975). Rosenthal and Rugle provide clinicians and interested readers with a comprehensive review and treatment approach for gambling problems based on psychodynamic principles (Rosenthal, 1997; Rosenthal & Rugle, 1994).

Self-Help: Gamblers Anonymous

Originally founded in 1957, Gamblers Anonymous (GA) is a commonly, but not always readily available, self-help fellowship that provides mutual support group for individuals experiencing gambling problems. GamAnon is a related fellowship for family members affected by compulsive / pathological gamblers. Like Alcoholics Anonymous and Al-anon, these gambling self-help fellowships are based on 12-Step principles. As fellowships, these programs are not treatments, though for many participants these interventions are therapeutic. Since 12-step groups like GA are not treatments, it is improper to consider these widely available, highly variable and free activities as a treatment or practice component.

Nevertheless, GA has strong roots and a well-developed conceptual strategy that guides its activities. For example, deeply rooted in this approach is the perspective that disordered gambling (e.g., pathological, problem, compulsive) is a spiritual and medical disease. The major goal of this fellowship is to garner from its members a commitment to abstinence from gambling and a lifelong commitment to the principles of GA and participation in GA meetings. There is no professional facilitation, organizational affiliations or fee. Despite its status and purpose as a fellowship, there has been a paucity of research directed to evaluating its effectiveness. Outcome studies of Gamblers Anonymous have reported first year dropout rates as high as 70 percent (Stewart & Brown, 1988) with abstinence rates of 8 percent after one year (R. I. F. Brown, 1985). However, many formal treatment programs and professional therapists require, or at least encourage, troubled gamblers to be involved in GA as a component of a comprehensive treatment and aftercare plan. Information on groups and meetings can be obtained through the local telephone directory or the Internet.

[10] The Inventory of Gambling Situations is available on disc from the Centre for Addiction and Mental Health, 1-800-661-1111 or e-mail: marketing @camh.net

Aversion Therapy

Though it is used for the treatment of certain forms of depression, clinicians consider aversion therapy, using electric shock as a punishment, as an unacceptable choice of therapy for the treatment of addictive disorders; consequently, it is used rarely in contemporary settings. However, imagining distressing situations is used as an aversive device (Barker & Miller, 1968; Koller, 1972; Seager, 1970).

Self-Exclusion

An interesting policy approach to reduce and avoid disordered gambling exists in some jurisdictions. Self-exclusion programs represent a voluntary opportunity for gamblers to avoid casino or racetrack gambling by arranging their own exclusion from entering these settings for a fixed time. Under this strategy, the casino corporation assumes responsibility for implementing the program within a particular jurisdiction and for a defined period, including a lifetime. The program does not extend to other forms of gambling that might be problematic for the self-excluded person. However, this program raises a number of thorny legal issues (e.g., Napolitano, 2003). Despite these legal concerns, it represents a unique type of behavioral intervention, although its long-term effectiveness as a harm reduction strategy requires more study (Ladouceur, Jacques, Giroux, Ferland, & Leblond, 2000)

Interventions: Promising and Complementary Services

Promising Interventions

A number of other psychotherapeutic interventions are available for clinicians to utilize during the treatment of disordered gambling. Typically, these clinical strategies and tactics originated in addictions and mental health practice. Some of these treatments have empirical support, while others remain controversial in the absence of sufficient evidence for the treatment of gambling disorders. Consequently, the interventions presented in the following discussion were selected because these have shown varying degrees of promise in the gambling field. Nevertheless, it is important to emphasize that we believe more empirical validation must be completed before we can draw meaningful conclusions about the efficacy and impact of these procedures (e.g., Chambless & Ollendick, 2001).

Brief Therapy

Solution-focused brief therapy (SFBT) was developed for use with substance abusers and has been adapted to gambling. This treatment rests upon cognitive behavioral principles and represents a paradigm shift in clinical strategies from more medically oriented problem solving to client-centered solution building (I. Berg, K,, 1995; I. K. Berg & Miller, 1992). Since research on this treatment is in its early stages, the effectiveness of this approach has not been fully demonstrated. However, cost considerations and client satisfaction make this a potentially attractive and important option (Lee, 1997).

Therapists can apply (SFBT) to both individual and family counseling. The central frame is brief treatment offered either as a single contact or a series of brief and intermittent episodes throughout the recovery process. The main tactics are creating options using a decision balance format and setting achievable goals. The decision balance exercise develops a therapeutic cost benefit analysis through an exploration of the positive and negative implications of continuing the problem behavior and comparing this outcome to the benefits and loses of adopting a new and healthier behavior. The client and practitioner cooperatively formulate and negotiate specific goals. This process emphasizes solution building, small but steady gains, and the development of a sense of control. Clinicians can view SFBT as a form of harm reduction (e.g., Brownson, Newschaffer, & Ali-Abarghoui, 1997; David A. Korn, 2000) that might be most useful for early stage problem gamblers.

Motivational Enhancement Strategies

Motivational enhancement strategies (e.g., motivational counseling, resistance reduction) are brief therapeutic strategies designed to lower resistance and enhance motivation for change. During the last decade, a variety of clinicians began to encourage treatment for substance use and other "addictive" disorders that focused on treatment matching (e.g., J. M. Brown & Miller, 1993; Miller & Rollnick, 1991; Prochaska et al., 1992; Prochaska et al., 1994; Shaffer & Robbins, 1991, 1995; Shaffer & Simoneau, 2001). From this perspective, matching clients to the developmental stage of their addictive disorder with a particular therapeutic approach was the algorithm that has started to guide clinical practice. Knowing stages and processes of change have helped therapists evaluate where their clients were on the change continuum and allowed for targeted treatment plans (e.g., Rollnick & Morgan, 1995; Shaffer & Robbins, 1991, 1995). Consequently, instead of pursuing a more distant and difficult complete resolution to the problem of addiction, clinicians began working to enhance motivation to help clients advance incrementally toward the next developmental stage of change. Motivational enhancement strategies rapidly grew in popularity, promising better clinical outcomes by stimulating, provoking or otherwise enhancing client motivation.

Motivational enhancement strategies augment pre-existing motivation by improving the therapeutic alliance. This is accomplished by recognizing that clients are, at best, ambivalent about experiencing personal change (Miller & Rollnick, 1991; Orford, 1985; Rollnick & Morgan, 1995; Shaffer, 1994, 1997). With improved therapeutic relationships, clients are more willing to consider and explore their ambivalence. Miller and Rollnick (1991) noted that ambivalence is at the heart of treatment for addictive disorders. Shaffer (1992; 1994; 1997; 1995) simultaneously speculated that painful ambivalence was responsible for stimulating denial and the appearance of intractability among people struggling with addictive disorders. By attending to the dynamics of ambivalence, clinicians improve the quality of treatment by providing a therapeutic context that resonates with the client's mixed motivations. Motivational interviewing strategies presume that the level of motivation necessary for change is lacking and insufficient to stimulate and sustain change. If at all present, the motivational interviewing strategy (Miller & Rollnick, 1991) suggests that motivation to change is inadequate and has to be energized (charged), like a weak battery. If motivation to change is absent, according to enhancement strategies, clinicians need to fashion and nourish motivation during the treatment process. Consequently, treatment providers have been focusing on motivational deficiencies to improve treatment outcomes.

Focusing on clients' resistance to change is another important way for clinicians to improve the motivational status of clients who seek treatment for addictive disorders (Shaffer & Simoneau, 2001).[11] Resistance is at the core of what makes it difficult for people, even the most healthy, to achieve consistently "good" mental health (Ellis, 1987; Shaffer & Simoneau, 2001). Based upon psychodynamic principles, resistance reduction assumes that internal and external obstacles dilute or weaken existing levels of motivation for change that can *already be sufficient* to drive the change process. Resistance reduction strategies encourage therapists to validate present, apparently self-destructive, behavior as a legitimate choice by asking clients about the perceived benefits of these activities (e.g., gambling) rather than exclusively focusing on the costs (e.g., losses). Within this safe context, clients can more freely explore <u>all</u> of the costs and benefits associated with a pattern of addictive activity. Since a resistance reduction strategy does not ask clients to give up anything, patients also have less need to resist therapeutic interventions. With little need to resist treatment, previously inhibited motivation is released for clients to use in changing seemingly intractable behavior patterns.

[11] Although this article primarily focuses on addictive behaviors, the discussion and its application are not limited exclusively to the addictions. Many of the treatment strategies and techniques described in this article also will apply to other clinical problems.

Resistance reduction and other motivational enhancement strategies are not mutually exclusive. Clinicians should consider employing the full range of motivational enhancement approaches to advance the treatment objectives and the health of disordered gamblers. A decision balance is the major technique used in motivational enhancement strategies. At every stage of treatment, motivational strategies ask patients to address the pros and cons of their current behavior and value of staying the same or changing.

Matching Motivational Strategies to Stage of Change

Stage change concepts have emerged as an important force in the treatment of addictive behaviors (Crowley, 1999; Prochaska et al., 1992; Prochaska et al., 1994; Quinn, 1891; Rollnick & Morgan, 1995; Shaffer, 1992, 1994, 1997; Shaffer & Robbins, 1995). Derived originally from work with tobacco dependence, stage change thinking has evolved into a ubiquitous and transtheoretical map for the treatment of addictive behaviors. As we mentioned previously, an evaluation of a gambler's readiness to change and determination of their stage of change are important steps to formulating treatment strategy (Shaffer & Robbins, 1995). Motivational enhancement techniques can facilitate this process and guide intervention strategies. It is important to ensure that clinical interventions match appropriately to the stage of change.

Winning: Precontemplation

At this initial stage, because they are unaware of the relationship between their gambling and their problems, gamblers do not consider changing their behavior. Gambling is viewed as a positive experience; most people who have experienced only winning do not seek treatment. However, few regular gamblers only win. Statistical probability takes its toll and this stage is characterized by lack of awareness that excessive gambling can be or is the cause of any personal problems that are evident in a person's life. The major challenge or themes of this stage are to **enhance awareness** of adverse consequences and reduce **resistance** to change (Shaffer & Simoneau, 2001). A psycho-educational strategy initiates the change process. The counselor provides information on the clinical syndrome of pathological gambling and describes the continuum of mild, moderate and severe gambling problems that can arise. Individuals are encouraged to examine their own gambling patterns, risky situations and impact on others. They are requested to self-monitor their gambling and document urges to gamble. To date, other than its incorporation into treatment outcome studies of Ladouceur and colleagues (e.g., Bujod et al., 1994; Ladouceur et al., 1996; Ladouceur et al., 1998; Ladouceur & Walker, 1998; Sylvain et al., 1997) there has been a paucity of research addressing its effectiveness in the gambling field.

Adverse Consequences and Losing: Contemplation

During this stage, there is recognition of gambling-related problems and some receptivity to the possibility of addressing them. The major clinical challenge is to address a person's **ambivalence** about whether they wish to alter their gambling behavior and deal with the associated problems. Since ambivalence reflects concurrent positive and negatives feelings about an object, affect or behavior, clinicians need to acknowledge that gambling provides positive benefits but also costs (Miller & Rollnick, 1991; Shaffer, 1994; Shaffer & Simoneau, 2001). The counselor acknowledges that modifying the gambling will require relinquishing some current activities. A decision balance exercise that explores the pluses and minuses of maintaining the gambling behavior and the gains and loses of changing is the major vehicle for resolving the ambivalence about the value of curbing their gambling. A seminal event such as the loss of a large sum of money or job loss, often referred to as a **turning point,** clearly marks the decision to commit to major changes.

Turning Points: Preparing for Change

During this stage the gambler accepts that changes are necessary and worthwhile. The major challenge is **making choices** and the key activity is planning. Efforts are directed to clinical goal setting and treatment planning. The individual and counselor together explore therapeutic options and appropriate action steps. Parameters to be considered include type of setting, program philosophy, level of care, kind and variety of therapeutic modalities, group or individual format, professional profile, and cost. Matching is the important principle. Success at this stage is often linked to honoring the person's preferences and validating the acceptability of their choices.

Action: Making Changes

During this stage, the major theme is active **learning**. The treatment strategy during action is to encourage the gambler to initiate a range of **new behaviors** based on the acquisition of new knowledge, insight, attitudes and skills. Identifying and substituting a different leisure activity to replace the time spent gambling is an important component of a healthy recovery. Solution focused brief therapy for problem gamblers is being utilized and holds considerable promise. It has been implemented, successfully in the substance abuse field, however research in gambling treatment is highly limited (Dickerson, Hinchy & Legg-England, 1990). The introduction of a support program such as the fellowship of Gamblers Anonymous can be highly beneficial.

Relapse Prevention or Change Maintenance

To achieve treatment goals, the focus at this stage is to **practice** the new competencies in order to sustain a balanced, healthy lifestyle. Adult learning theory recognizes that developing and mastering new behaviors requires training and repetition. Relapses can occur and attention to situational risk is a critical component of relapse.

Clinicians have noted that the clinician's task at each stage are relatively specific (Brosky, 2001; Shaffer, 1997; Shaffer & LaPlante, in press; Shaffer & Robbins, 1995). For example, when treatment seekers are unable or unwilling to recognize the influence that gambling has on their day-to-day experience, clinicians need to help them experience doubt about the current behavior and exercise their ambivalent feelings about change. Once aware of how gambling influences their life, clinicians need to help people by having them consider the costs and benefits associated with their current behavior patterns and consider similarly the costs and benefits associated with change. During the active change stage of any addictive behavior, but gambling in particular, it is important to teach new skills and support existing skills that provide for alternative activities that are incompatible with gambling and therefore support change. During relapse prevention and change maintenance, gamblers in recovery need to practice their new behaviors and skill sets; they need to revisit their ambivalence about change and determine that the new behavior patterns are worthwhile; they need to grieve their loss and separation from gambling; finally, they need to reframe any lapse or relapse experiences as opportunities for learning.

There is one major caveat regarding the stage change model and motivational enhancement counseling. Observers often incorrectly think that changes occur in a linear and progressive fashion. In reality, the change process is recursive with many opportunities to revisit earlier stages and successfully navigate the tasks of recovery necessary to grow as a person and rebuild one's life (Shaffer, 1992, 1997; Shaffer & Robbins, 1995).

Complementary Services

Services complementary to psychological counseling are available. These community resources offer an opportunity for a change in lifestyle, financial well-being and a balanced approach to health recovery.

Financial Management

Financial counseling can assist people with gambling-related debt to initiate a financial plan, learn budget management and develop a payment plan (National Endowment for Financial Education & National Council on Problem Gambling, 2000). This counseling support should be made available to both gamblers and those affected by their gambling debt. Since a preoccupation with money and credit is central to the disordered gamblers' experience, it is essential to address their financial obligations and responsibilities during treatment. By diminishing these very real and pressing problems, treatment can reduce the stress and anxiety associated with financial debt. By developing a carefully and realistically crafted financial plan, people with gambling problems can stimulate and maintain a sense of personal control and the consequent sense of hopefulness that it encourages.

Leisure Substitution

To date, there are no empirical studies in the gambling literature that specially address this strategy. However, for many individuals who reduce their problem gambling, there is a need to fill time otherwise occupied with gambling. In addition, physical activity through aerobic exercise (e.g., jogging, swimming or bicycling), as well as weight and flexibility training can improve mood, decrease anxiety and provide socialization (Hays, 1999; D. A. Korn, 2000; Sachs & Buffone, 1984; United States Department of Health and Human Services, 1996). Since there is the potential for significant health and social benefit and minimal risk of harm, it seems prudent to encourage this new use of leisure time and support further study as to its effectiveness.

Twelve Step Facilitation

As mentioned before, twelve-step facilitation is a fellowship based on the principles of Gamblers Anonymous (GA) and is not a professional treatment. During treatment, however, many clinicians actively encourage individuals to attend GA meetings and to maintain journals of their attendance and participation. Typically, clinicians place primary emphasis during treatment sessions on GA steps 1 through 5. The twelve-steps of GA are summarized in Table 4. In addition, clinicians sometimes assign readings from the GA literature to complement materials introduced during therapy. Nevertheless, it is important to emphasize that these activities are not considered treatment but are complementary services.

Table 4: *The GA Twelve Steps*[12]

1. We admitted we were powerless over gambling - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to a normal way of thinking and living.
3. Made a decision to turn our will and our lives over to the care of this Power of our own understanding.
4. Made a searching and fearless moral and financial inventory of ourselves.
5. Admitted to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have these defects of character removed.
7. Humbly asked God (of our understanding) to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Make direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having made an effort to practice these principles in all our affairs, we tried to carry this message to other compulsive gamblers.

Other Psychological Therapies

In addition to supportive, family and group psychotherapy, a number of other therapeutic approaches have been tried with disordered gamblers; however, case control or randomized clinical trials have not been sufficiently applied to determine the effectiveness of these modalities. Other treatments for gambling problems have tied, for example, eye movement desensitization and reprogram (EMDR) (Henry, 1996), acupuncture, hypnosis, meditation and biofeedback. However, to date there are only professional opinion and clinical experience to guide a clinician's intervention choice and outcome expectation.

Psychopharmacology

There is no specific pharmacotherapy protocol currently approved specifically for the treatment of disordered gambling. A variety of drug treatments, however, are being tested for application to gambling-related disorders. Since gambling typically co-occurs with other mental problems (Crockford & el-Guebaly, 1998b; Shaffer & Korn, 2002), physicians treating mental illness and addiction (e.g., psychiatrists, primary care physicians, addiction and behavioral medicine clinicians) do prescribe various psychotherapeutic agents for problem and pathological gamblers as complementary or adjunctive therapy. The use of pharmacological agents for pathological gamblers rests upon clinical experience with treating other mental disorders that share similar symptomatology or have overlapping theoretical and neurochemical considerations. As with other disorders, treatment should begin at the least invasive level. Therefore, clinician facilitated psychotherapy and counseling (e.g., cognitive and behavioral therapy) in combination with a support group is the typical first treatment option. When clinicians determine that prescription drugs are a potentially useful adjunct to this treatment plan, pharmacotherapy should be implemented in combination with counseling and other psychosocial interventions.

A role for pharmacotherapy during the treatment of disordered gambling shows significant promise (e.g., Eric Hollander, Buchalter, & DeCaria, 2000). Neurobiology research reveals the involvement of serotonin (Moreno, Saiz-Ruiz, & Lopez-Ibor, 1991), norepinephrine (DeCaria, Begaz, & Hollander, 1998; Siever,

[12] (Gamblers Anonymous, 2002).

1987) and dopamine (Bergh, Sodersten, & Nordin, 1997; Blum et al., 2000; Comings, 1998) in various expressions of gambling behavior. These neurotransmitters have been associated with the expression of urges, impulsivity, risk-taking and the brain's reward system. The development of specific pharmacotherapy for use with pathological gamblers is currently an area of active clinical research. The following discussion will review the primary drug classes and possible agents that are among the leading candidates for emerging pharmacotherapeutic protocols (Grant, Kim, & Potenza, 2003).

Opioid Antagonists (OA)

Naltrexone, a competitive narcotic antagonist, blocks opioid receptors and the production of endogenous opioids. It has been recently approved for the *treatment of alcohol dependence* where it reduces alcohol **cravings** and reduces the **pleasurable effects** of alcohol when ingested (O'Malley et al., 1992). The recommended starting dose for alcohol treatment is 25mg daily for two days followed by the usual dose of 50mg daily, continued for six months. Similar effects are postulated for gambling (Crockford & el-Guebaly, 1998a). Researchers at the University of Minnesota recently reported significantly reduced gambling urges among pathological gamblers and theorize about its usefulness in treating pathological gamblers (Kim, Grant, Adson, & Shin, 2001). It is generally well tolerated but can cause mild gastrointestinal upset. Naltrexone should be used carefully in people with any degree of liver disease and the implementation of a monitoring protocol for hepatotoxicity is recommended. An adequate dose of 100mg/day or more for 4-6 weeks for the treatment of pathological gambling is often necessary before symptom relief is evident (Grant et al., 2003).

Selective Serotonin Reuptake Inhibitors (SSRIs)

This class of drug is indicated for the treatment of *obsessive-compulsive disorders, other anxiety disorders* and *depression* (E. Hollander, 1998; Eric Hollander et al., 2000). Members of this group comprise fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), sertraline (Zoloft), and citalopram (Celexa). Each of these agents varies in the ability to inhibit serotonin, noradrenaline, and dopamine uptake and produce a booster effect with these neurotransmitters. The rationale for using these medications with gamblers relates to their **obsessive preoccupation** with gambling and the money with which to gamble; in addition, disordered gamblers evidence a repetitive and **compulsive** pattern of activity (E. Hollander, 1998; Eric Hollander et al., 2000). **Depression** or **anxiety** also tends to accompany a treatment seeker's clinical profile. From this perspective, we conceptualize pathological gambling to reside towards the compulsivity end of a compulsivity-impulsivity continuum.

Fluvoxamine (Luvox) shows promise as a drug treatment for pathological gamblers. For example, a study of 10 pathological gamblers demonstrated decreased gambling urges and behavior at the end of a 16-week trial (E. Hollander, 1998). Further research utilizing randomized design, larger sample size, and longer periods to measure outcomes to validate these findings has begun (Eric Hollander et al., 2000).

The doses of these SSRIs required to treat pathological gambling appear to be higher than the average dose generally required to treat depressive disorders but similar to the dosage typically utilized during the treatment of obsessive compulsive disorder. For example, fluvoxamine at 200 to 300 mg/day or paroxetine at 40 to 60 mg/day for 10 – 12 weeks may be required before symptom relief is evident (Grant et al., 2003).

Mood Stabilizers

Mood stabilizers, for example, amitriptyline (Elavil) and divalproex (Epival), which are used in the treatment of bipolar disorder, also have a theoretical rationale for use with gambling disorders. For example, the American Psychiatric Association considers a manic episode accounting for excessive gambling as an exclusionary criterion for the diagnosis of pathological gambling (American Psychiatric Association, 2000). Carbamazepine (Tegretol), showed significant clinical benefit during a 30-month treatment period with a single case report of a chronic pathological gambler (Haller & Hinterhuber, 1994). Lithium carbamate also was reported effective in treating three pathological gamblers with concurrent mood disorders (Moskowitz, 1980). Since mania and depression can often co-occur among disordered gamblers (Shaffer & Korn, 2002), mood stabilizers represent a potentially important treatment resource.

Other Drugs

Olanzapine (Zyprexa), an atypical anti-psychotic medication, currently is undergoing a clinical trial with pathological gamblers (Rugle, 2000). Other drugs that theoretically might be helpful in the treatment of pathological gambling include ondasetron (Zofran), a selective serotonin receptor antagonist (SSRA) that recently has been demonstrated effective in a randomized clinical trial during the treatment of early onset alcohol dependency (Johnson et al., 2000). Bupropion (Wellbutrin), a norepinephrine dopamine modulator (NDM), has demonstrated efficacy as an anti-craving medication during the treatment of nicotine dependence even though the mechanism of action in smoking cessation is not well understood. Methylphenidate (Ritalin) has been used in the treatment of attention deficit disorder, which has impulsive characteristics similar to pathological gambling. Finally, in a case report, Baclofen (Lioresal), a GABA agonist and muscle relaxant, was described as able to reduce cocaine cravings and block the cocaine high. Monetary reward in a gambling-like experiment produced brain activation similar to that observed in cocaine addicts (Breiter, Aharon, Kahneman, Dale, & Shizgal, 2001).

Integrated Treatment Strategies: Combining Psychotherapy and Pharmacotherapy

Since gamblers seeking treatment often present with dysthymia and depression, clinicians should consider the potential value of a treatment strategy that addresses depression. In an important carefully conducted randomized clinical trial of pharmacotherapy (i.e., Nefazadone) versus cognitive behavior therapy compared with a combination of these treatments, Keller et al. (2000) demonstrated that the combination of pharmacotherapy and cognitive behavioral therapy yielded meaningfully higher rates of recovery from depression than either of these treatments alone. While clinical trials of combination studies are few, this research provides strong evidence suggesting that clinicians consider the potential benefits of adjunctive treatments. Further, it is likely that other combinations of pharmacotherapy and psychotherapy also will yield improved treatment outcomes compared with each of these treatments. However, without evidence from carefully controlled clinical trials to provide support for combining a particular psychotherapy with a specific pharmacotherapy, it is premature to recommend specific combinations of treatment.

Treatment of Disordered Gambling in Special Populations

Special population segments represent groups of individuals with particular or distinctive treatment needs. These needs might be related to the influence of culture, gender, age, or social economic status as these alone or in combination apply to their gambling behavior, mental well-being and overall health recovery. Special populations are an emerging area of public health interest from both a prevention and treatment perspective (Korn & Shaffer, 1999). As practitioners and researchers gain experience with these diverse groups, improved treatment strategies likely will evolve reflecting scientifically validated research. How-

ever, at this early stage of our understanding, we encourage clinicians to develop enhanced awareness of the complexity and variability of gambling beliefs, practices and vulnerabilities amongst these various peoples; by developing an improved assessment and understanding of these factors, we expect that clinical practice, treatment programs, service design and research strategies will benefit.

Youth[13]

Youth are at-risk for gambling problems (e.g., Shaffer, Hall, Vander Bilt, & George, 2003). Prevalence estimates of disordered gambling among youth reveal rates that are two to four times that of the general adult population (e.g., Shaffer et al., 1997; Shaffer et al., 2003; Shaffer & Korn, 2002). Screening instruments exist that are specific to the adolescent population. For example, the SOGS-RA (Winters, Stinchfield, & Fulkerson, 1993), based on the DSM-III, and the MAGS (Shaffer et al., 1994), based on the DSM-IV, are widely used instruments (see Appendix 2). Risk factors for youth problem gambling include low self-esteem, conformity and self-discipline, sensation seeking and associated significant anxiety, feelings of depression and substance abuse. Cognitive behavioral interventions in a non-randomized study involving a small number of adolescents have demonstrated clinically significant improvements for perception of control and severity of problem (Ladouceur, Boisvert, & Dumont, 1994). Recently, a model describing how young people might develop and stop gambling problems targets interventions to adolescent stages of change. This strategy notes the importance of recognizing that how a young person becomes a problem gambler might be very different from how they stop this pattern of behavior (DiClemente, Story, & Murray, 2000). Based upon work in the substance abuse treatment field (e.g., Prochaska et al., 1992), this new work holds promise but will require more support through extensive research before we can claim with confidence that it is an evidence-based intervention. Gupta and Derevensky describe the basic tenets of treatment with adolescents (Gupta & Derevensky, 2000a). The treatment process in general and with young people in particular includes clinical components that focus on themes such as acceptance of the problem, establishment of mutual trust, involvement of family and restructuring of leisure time (Gupta & Derevensky, 2000a).

Older Adults

Seniors represent a sizable and growing proportion of the adult population. In addition, this segment of the population appears to be represented disproportionately at bingo halls, charitable gaming activities, and day excursions to casinos. Although seniors generally take fewer risks compared with their younger counterparts, there is concern about their vulnerability to gambling problems springing from their fixed incomes, social isolation and declining health. Clinicians need to be cognizant that older adults can experience a sense of loss related to health, independence, purpose in life and friendships, and might turn to gambling to satisfy those unmet needs. In addition, older adults might experience various levels of cognitive impairment and concurrent mental disorders including substance abuse that might adversely influence their pattern and frequency of gambling (McNeilly & Burke, 2000). However, seniors also might receive health benefits from their gambling activity (Korn & Shaffer, 1999; Shaffer & Korn, 2002). For example, gambling among older adults provides a social experience and the opportunity to connect to their peers; similarly, like low level alcohol use, the excitement and activity associated with gambling likely has cardiovascular benefits. Therefore, treatment efforts with older adults require a careful assessment of the costs and benefits of gambling. A clinical assessment with this population segment, for example, should

[13] A special issue of the *Journal of Gambling Studies* focusing on youth gambling recently has been published. It represents an important resource for more detailed material about youth and gambling with important content and references (Gupta & Derevensky, 2000b).

at the very least examine the impact of gambling on depression, physical mobility and quality of life before deciding on intervention strategies and treatment goals.

Women

Women are gambling more than in previous years. In the United States, the percentage of all women who have ever gambled rose between 1975 and 1998 by 22%, from 60% to 82%. During the same period, the percentage for males increased by 13%, from 73% to 86% (National Gambling Impact Study Commission, 1999). Though there is little scientific evidence to support this perspective, clinicians often view women as having distinct gambling behaviors, often described as "escape" gambling. The clinical tradition suggests that they prefer to gamble in casinos and bingo halls that are perceived to be safe. Female gamblers favor games such as slot machines, VLTs and bingo that are not skilled based. Compared to males, females gamble more to reduce boredom, escape form responsibility and relieve loneliness than they do for excitement, financial gain or pleasure. Despite the absence of evidence to support these views, these perspectives have endured. In addition to these clinical issues, treatment professionals need to be sensitive to the possible history of trauma, difficult economic realities, and a preference for women specific setting and programming and as well as group format for counseling.

Aboriginal People / Indians / First Nations

These people may be particularly vulnerable to the negative impacts of gambling for a variety of complex health and social reasons. In general, Indians report relatively high rates of problem and pathological gambling, significant unemployment, and poor mental health status indicators as well as higher rates of substance-related problems than does the general population (Elia & Jacobs, 1993; National Steering Committee, 1999; Office of Public Health, 1999; Wardman, el-Guebaly, & Hodgins, 2001). This potential problem might be exacerbated by the growth of gambling opportunities in or around Indian reservations and the higher rates of gambling problems observed among casino employees (Shaffer & Hall, 2002; Shaffer, Vander Bilt, & Hall, 1999). Counselors should be sensitive to tribal beliefs and traditional healing practices when formulating treatment strategies.

Ethno-cultural Minorities

Perceptions of gambling differ across cultures. Recent immigrants may be particularly vulnerable to gambling problems because of low socio economic status, financial pressures and sense of marginalization. Clinicians should consider the use of an interpreter to understand both culture and language and offer interventions in a culturally sensitive manner.

The Homeless

The first studies of homeless treatment seekers reveal that, like other psychiatric population segments, community service recipients in general and the homeless in particular evidence elevated rates of gambling disorders (Lapage, Ladouceur, & Jacques, 2000; Shaffer, Freed, & Healea, 2002). For example, evaluating 171 consecutive treatment seekers, Shaffer and Freed reported past year prevalence rates at intake of level 2 and 3 gambling disorders (i.e., 12.8 and 5.4, respectively) that were significantly higher among this population than among the general adult population (Shaffer et al., 2002). Issues of access to treatment resources are a key consideration in designing and funding services for the homeless at a community and practitioner level.

Gambling Disorders Among Patients with Comorbid Mental Disorders

The various versions of the DSM that have included pathological gambling as a distinct disorder also have drawn attention to the possibility that other disorders might coexist with pathological gambling (American Psychiatric Association, 1980, 1987, 1994, 2000). A variety of mental disorders occur at disproportionately high levels among disordered gamblers (Crockford & el-Guebaly, 1998b; Shaffer & Korn, 2002). These include substance use disorders, mood disorders, anxiety disorders, personality disorders and impulse disorders. Despite this observation, there is a paucity of empirical prevalence and treatment research about the comorbidity of gambling and other psychological disorders (G. W. Hall et al., 2000; Lesieur & Blume, 1990; Lesieur, Blume, & Zoppa, 1986; Petry, 2000b; Shaffer, Vander Bilt et al., 1999; Slutske et al., 2000; Westphal, Rush, & Stevens, 1998). Given the extent of comorbid mental disorders among treatment seekers with gambling disorders, future treatments are increasingly more likely to involve the use of psychoactive medications.

Families

Gambling-related family problems deserve to be positioned centrally as an important issue for clinicians. When family members are problem or pathological gamblers, they can adversely affect their relatives and significant others. Researchers in the gambling field have described a range of negative health and social consequences for family members associated with adult disordered gamblers. These effects have been identified in spouses, siblings, children, and parents (e.g., Korn & Shaffer, 1999). Family issues include dysfunctional relationships, loss of family income, neglect, violence and abuse. The health and human service professionals need to be aware of these potential consequences and elaborate a full range of family supports interventions. Family therapy and couples therapy are important therapeutic modalities when gambling-related relationship difficulties arise.

Gambling Treatment Emergencies

The primary psychiatric emergency that might be associated with gambling disorders is the risk of suicide. Suicidal ideation, attempts and completions among disordered gamblers are mentioned as associated with disordered gambling. However, the research evidence demonstrating a causal relationship is inconclusive (General Accounting Office, 2000; National Research Council, 1999; Shaffer & Korn, 2002). Not withstanding, clinicians working with disordered gamblers need to be vigilant to this possibility. For example, the threat of suicide can arise when losses lead to intense feelings of hopelessness, desperation and conflict or when other conditions such as substance abuse, depression or major mental illness coexist. Teenagers, older adults, and Indian /First Nation peoples are vulnerable groups at special risk. Urgent evaluation of risk and etiology followed by prompt treatment or referral is required.

The Natural History of Gambling Treatment: Stages of Events and Activities

Figure 2 below reflects the natural history of treatment and major intervention options that are typically associated with a treatment episode (Shaffer & LaPlante, in press). These events often repeat and no single treatment episode should be interpreted to represent a complete treatment history. With gambling and other addictive disorders, it is common for treatment seekers to experience multiple treatment episodes. Multiple treatment experiences do not seem to portend treatment failure; rather multiple treatments simply represent a longer journey to a destination which others arrived at more rapidly. In addition, Figure 2 is not intended to represent a detailed algorithm for clinical decision-making. Although not addressed in this practitioner's guide, avenues for self-assessment and self-care also are acknowledged.

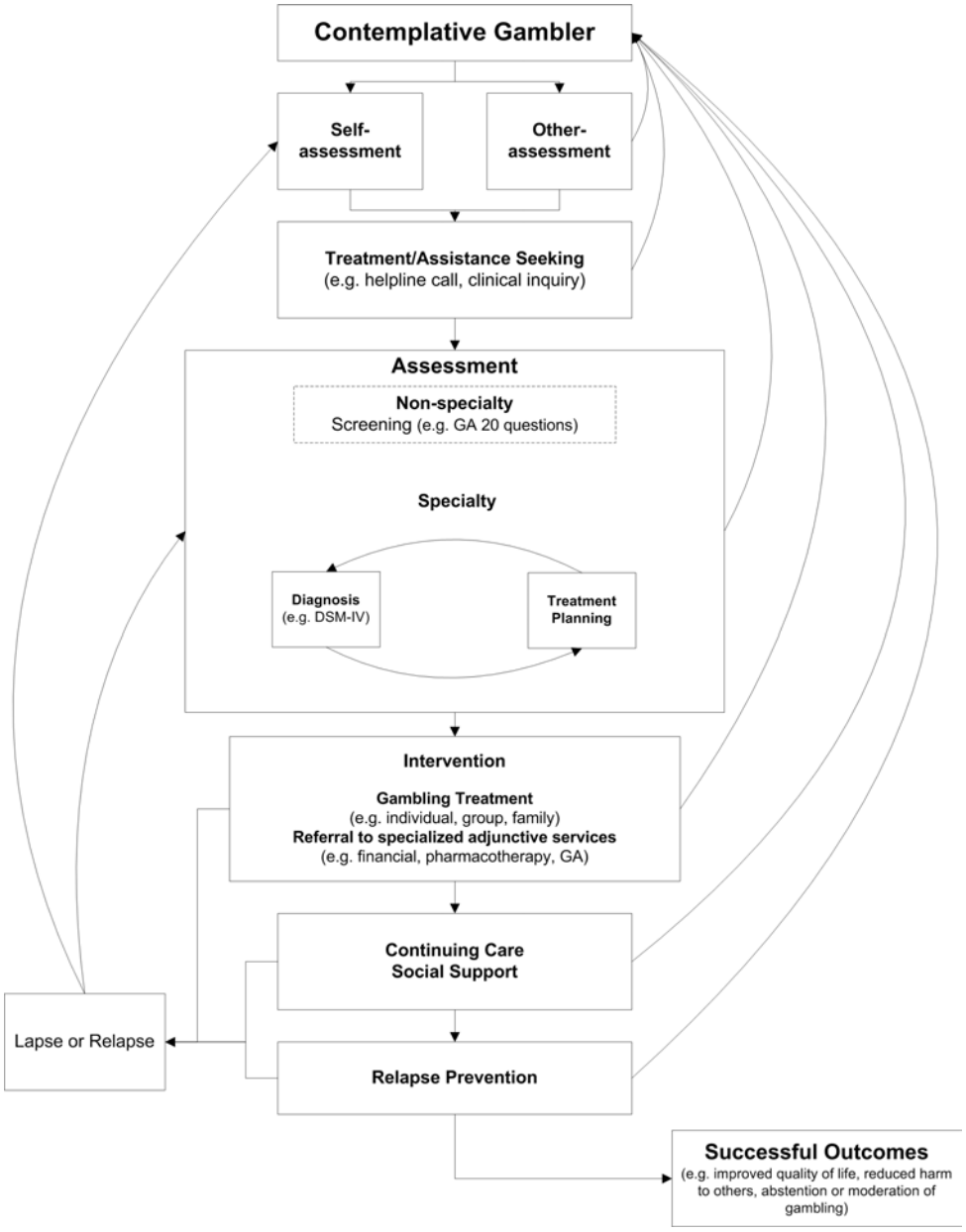


Figure 2: The Natural History of Treatment for Gambling Disorders

Administrative Matters for Clinicians

There are a number of conventional professional matters with respect to clinician and client responsibilities and rights that also apply to gambling treatment. These issues are imbedded in professional standards, program policies and client handbooks. Framers of these documents intend them to ensure quality care and a safe professional environment. For example, informed consent must be obtained prior to initiating a therapeutic process. Confidentiality and privacy of shared information is always central to treatment except when there is written consent to release clinical material or when required by law to report. A written treatment agreement or contract assures that there is a clear understanding of the responsibilities

and expectations between the participants in a treatment process. Clinicians should consider increasing the intensity of treatment when clients fail to progress at a lower level of care. Similarly, clinicians have an option to terminate treatment when in the clinical setting there is evidence of threats to the safety of others, disruptive or violent behavior, or illegal activity on the premises. There always should be an administrative provision for a review process of therapeutic care and closure.

Acknowledgements

Developing practice guidelines is a daunting task. Limited resources that necessarily restrict the scope of work complicate this effort by forcing us to make difficult choices. Clearly, this work represents a starting point and cannot be all things to all clinicians. For the shortcomings of this work, we accept responsibility. However, many people have contributed to this project. We want to extend special thanks to Kathleen Scanlan for her vision to establish this project and shepherd it through many obstacles. Thanks for their comments and contributions to earlier drafts of this article are extended to Rachel Kidman, Richard LaBrie, Debi LaPlante, Laura Vander Leeden, Christopher Freed and Marlene Warner. We also want to extend a very special thanks to Harvey Skinner for his thoughtful guidance and contributions to this project.

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APPENDICES

Appendix 1: Principles of Drug Addiction Treatment: A Research-Based Guide

1. NO SINGLE TREATMENT IS APPROPRIATE FOR ALL INDIVIDUALS.
2. TREATMENT NEEDS TO BE READILY AVAILABLE.
3. EFFECTIVE TREATMENT ATTENDS TO MULTIPLE NEEDS OF THE INDIVIDUAL, NOT JUST HIS OR HER DRUG USE.
4. AN INDIVIDUAL'S TREATMENT AND SERVICES PLAN MUST BE ASSESSED CONTINUALLY AND MODIFIED AS NECESSARY TO ENSURE THAT THE PLAN MEETS THE PERSON'S CHANGING NEEDS.
5. REMAINING IN TREATMENT FOR AN ADEQUATE PERIOD OF TIME IS CRITICAL FOR TREATMENT EFFECTIVENESS.
6. COUNSELING (INDIVIDUAL AND/OR GROUP) AND OTHER BEHAVIORAL THERAPIES ARE CRITICAL COMPONENTS OF EFFECTIVE TREATMENT FOR ADDICTION.
7. MEDICATIONS ARE AN IMPORTANT ELEMENT OF TREATMENT FOR MANY PATIENTS, ESPECIALLY WHEN COMBINED WITH COUNSELING AND OTHER BEHAVIORAL THERAPIES.
8. ADDICTED OR DRUG-ABUSING INDIVIDUALS WITH COEXISTING MENTAL DISORDERS SHOULD HAVE BOTH DISORDERS TREATED IN AN INTEGRATED WAY.
9. MEDICAL DETOXIFICATION IS ONLY THE FIRST STAGE OF ADDICTION TREATMENT AND BY ITSELF DOES LITTLE TO CHANGE LONG-TERM DRUG USE.
10. TREATMENT DOES NOT NEED TO BE VOLUNTARY TO BE EFFECTIVE
11. POSSIBLE DRUG USE DURING TREATMENT MUST BE MONITORED CONTINUOUSLY.
12. TREATMENT PROGRAMS SHOULD PROVIDE ASSESSMENT FOR HIV/AIDS, HEPATITIS B AND C, TUBERCULOSIS AND OTHER INFECTIOUS DISEASES, AND COUNSELING TO HELP PATIENTS MODIFY OR CHANGE BEHAVIORS THAT PLACE THEM OR OTHERS AT RISK OF INFECTION.
13. RECOVERY FROM DRUG ADDICTION CAN BE A LONG-TERM PROCESS AND FREQUENTLY REQUIRES MULTIPLE EPISODES OF TREATMENT.

(National Institute on Drug Abuse, 1999)

Appendix 2: Commonly Used Screening Instruments

This appendix provides a resource guide to commonly used and readily available screening instruments by providing a list of measures. This list is not intended to be exhaustive; rather, the instruments presented here are representative of screening devices commonly used in clinical practice and research across a variety of settings and content areas confronted during the treatment of gambling and other addictive disorders. To help identify screening and assessment instruments, we required each measure under consideration to have been published. We operationally defined publication as successfully completing a scientific peer review process; reports released by commissions and institutions failed to meet the requirements of scientific peer review.

Before selecting an instrument for use, we encourage clinicians to consider the psychometric properties of screening and other assessment instruments against the purpose for which they are used and the objectives of the instrument. Since the purposes of screening and assessment shift over time and across settings, the psychometric properties also change. Consequently, clinicians must choose instruments carefully and interpret them cautiously. The following instruments represent a variety of different areas of behavior and experience that often are associated with addiction. We also encourage readers to consider using the American Psychiatric Association's resource book on psychiatric measures (2000) as a resource.

PROBLEM GAMBLING

South Oaks Gambling Screen (SOGS)

Lesieur HR, Blume SB: The South Oaks Gambling Screen (SOGS): a new instrument for the identification of pathological gamblers. Am J Psychiatry 144:1184–1188, 1987

Lesieur HR, Blume S: Revising the South Oaks Gambling Screen in different settings. Journal of Gambling Studies 9:213–223, 1993

South Oaks Gambling Screen-Revised for Adolescents (SOGS-RA)

Winters, K. C., Stinchfield, R., & Fulkerson, J. (1993). Patterns and characteristics of adolescent gambling. *Journal of Gambling Studies, 9*(4), 371-386.

Massachusetts Gambling Screen (MAGS)

Shaffer, H. J., LaBrie, R., Scanlan, K. M., & Cummings, T. N. (1994). Pathological gambling among adolescents: Massachusetts gambling screen (MAGS). *Journal of Gambling Studies, 10*(4), 339-362.

Diagnostic Interview Schedule (DIS)

Robins LN, Helzer JE, Croughan J, et al: National Institute of Mental Health Diagnostic Interview Schedule. Arch Gen Psychiatry 38:381–389, 1981

Robins LN, Marcus L, Reich W, et al: Diagnostic Interview Schedule, Version IV. St. Louis, MO, Department of Psychiatry, Washington School of Medicine, 1996

The DIS-IV is available from:
Dr. Lee N. Robins

Washington University School of Medicine
Department of Psychiatry
4940 Children's Place
St. Louis, MO 63110-1093
Phone: 314-362-2469

Composite International Diagnostic Interviewing (CIDI)

Robins LN, Wing J, Wittchen H-U, et al: The Composite International Diagnostic Interview: an epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. Arch Gen Psychiatry 45:1069–1077, 1988.

World Health Organization: Composite International Diagnostic Interview, Version 2.1. Geneva, World Health Organization, 1993.[14]

Available from:
American Psychiatric Press
1400 K Street, NW
Washington, DC 20005
Phone: 800-368-5777
Internet: www.appi.org

READINESS TO CHANGE

University of Rhode Island Change Assessment (URICA)

McConnaughy EA, DiClemente CC, Prochaska JO, et al: Stages of change in psychotherapy: a follow up report. Psychotherapy 26(4):494–503, 1989

The measure is available in McConnaughy et al. (1989) or from:
Jan Prochaska
Department of Psychology
University of Rhode Island
Kingston, RI 02881
Phone: 401-874-2830

SUICIDALITY

Beck Scale for Suicide Ideation (BSS)

Beck AT, Steer RA: Beck Scale for Suicide Ideation Manual. San Antonio, TX, Harcourt Brace, 1991

The BSS is copyrighted and was published in 1991 by:

[14] This version does not have gambling included. The newest version, not yet available for widespread use, will be released soon from the University of Michigan.

The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
Phone: 800-211-8378
Internet: www.psychcorp.com

Suicide Intent Scale (SIS)

Beck AT, Schuyler D, Herman I: Development of suicidal intent scales, in The Prevention of Suicide. Edited by Beck AT, Resnik HP, Lettieri DJ. Bowie, MD, Charles Press, 1974

The SIS is copyrighted and published by:
The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
Phone: 800-211-8378
Internet: www.psychcorp.com

Beck Hopelessness Scale (BHS)

The BHS is copyrighted and was originally published in 1988 by:
The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
Phone: 800-211-8378
Internet: www.psychcorp.com

ANXIETY DISORDERS

Manifest Anxiety Scale (MAS)

Taylor JA: A personality scale of manifest anxiety. Journal of Abnormal Social Psychology 48:285–290, 1953

Hamilton Anxiety Rating Scale (HARS)

Hamilton M: The assessment of anxiety states by rating. Br J Med Psychol 32:50–55, 1959

A structured interview format of the HARS is available from:
M. Katherine Shear, M.D.
Anxiety Disorders Prevention Program
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213

A computer-administered version has a high correlation with the clinician-administered version (r= 0.92) and has good psychometric properties. Individuals interested in the computer version should contact:
Kenneth A. Kobak
Dean Foundation for Health, Research, and Education
8000 Excelsior Drive, Suite 302
Madison, WI 53717-1914

Clinical Anxiety Scale (CAS)

Snaith RP, Baugh SJ, Clayden AD, et al: The Clinical Anxiety Scale: an instrument derived from the Hamilton Anxiety Scale. Br J Psychiatry 141:518–523, 1982

Beck Anxiety Inventory (BAI)

Beck AT, Epstein N, Brown G, et al: An inventory for measuring clinical anxiety: psychometric properties. J Consult Clin Psychol 56:893–897, 1988

The BAI is copyrighted by Dr. Aaron T. Beck. The measure costs $53.00 and can be obtained from:
The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-2498
Phone: 800-211-8378
Internet: www.psychcorp.com

Fear Questionnaire (FQ)

Marks IM, Mathews AM: Brief standard self-rating scale for phobic patients. Behav Res Ther 17:263–267, 1979

The scale may be obtained from:
Issac Marks, M.D.
Maudsley Hospital
Institute for Psychiatry
De Crespigny Park
London SE4 8AF
United Kingdom

DEPRESSIVE DISORDER

Beck Depression Inventory (BDI)

Beck AT, Ward CH, Mendelson M, et al: An inventory of measuring depression. Arch Gen Psychiatry 4:53–63, 1961

The scale is copyrighted and may be obtained from:
The Psychological Corporation

555 Academic Court
San Antonio, TX 78204-2498
Phone: 800-211-8378
Internet: www.psychcorp.com

Hamilton Rating Scale for Depression (Ham-D)

Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 23:56–62, 1960

Guy W: ECDEU Assessment Manual of Psychopharmacology —Revised (DHEW Publ No ADM 76-338). Rockville, MD, U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, NIMH Psychopharmacology Research Branch, Division of Extramural Research Programs, 1976

Inventory of Depressive Symptomatology (IDS)

Rush AJ, Giles DE, Schlesser MA, et al: The Inventory for Depressive Symptomatology (IDS): preliminary findings. Psychiatry Res 18:65–87, 1985

Copies of the measure and permission to use it can be obtained by writing:
A. John Rush, M.D.
University of Texas Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, TX 75235-9101

Raskin Scale (Three-Area Severity of Depression Scale)

Raskin A: Three-Area Severity of Depression Scale, in Dictionary of Behavioral Assessment Techniques. Edited by Bellack AS, Herson M. New York, Pergamon, 1988

Zung Self-Rating Depression Scale (Zung SDS)

Zung WWK: A self-rating depression scale. Arch Gen Psychiatry 12:63–70, 1965

SUBSTANCE USE DISORDERS

Alcohol Use Disorders Identification Test (AUDIT)

Babor TF, de la Fuente JR, Saunders J, et al: AUDIT, The Alcohol Use Disorders Identification Test: guidelines for use in primary health care (WHO Publ No PSA/92.4). Geneva, World Health Organization, 1992

Addiction Severity Index (ASI)

McLellan AT, Luborsky L, Woody GE, et al: An improved diagnostic evaluation instrument for substance abuse patients: the Addiction Severity Index. J Nerv Ment Dis 168(1):26–33, 1980

Copies of the interview, training, and reference materials are available from:
DeltaMetrics
One Commerce Square
2005 Market Street, 11th Floor
Philadelphia, PA 19103
Phone: 800-238-2433 or 215-665-2888
CAGE Questionnaire

Drug Abuse Screening Test (DAST)

Skinner HA: The Drug Abuse Screening Test. Addict Behav 7:363–371, 1982

Fagerstrom Test for Nicotine Dependence (FTND)

Fagerstrom KO, Schneider NG: Measuring nicotine dependence: a review of the Fagerstrom Tolerance Questionnaire. J Behav Med 12(2):159–182, 1989

Heatherton TF, Kozlowski LT, Frecker RC, et al: The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addiction 86:1119–1127, 1991

Michigan Alcoholism Screening Test (MAST)

Selzer ML: The Michigan Alcoholism Screening Test: the quest for a new diagnostic instrument. Am J Psychiatry 127(12):1653–1658, 1971

Selzer ML, Vinokur A, van Roojen L: A self-administered Michigan Alcoholism Screening Test (SMAST). J Stud Alcohol 36:117–126, 1975

Blow F: Michigan Alcoholism Screening Test —Geriatric Version (MAST-G). Ann Arbor, MI,University of Michigan Alcohol Research Center, 1991

Pokorny AD, Miller BA, Kaplan HB: The brief MAST: a shortened version of the Michigan Alcoholism Screening Test. Am J Psychiatry 129:342–345, 1972

Alcohol Dependence Scale (ADS)

Skinner HA, Allen BA: Alcohol dependence syndrome: measurement and validation. J Abnorm Psychol 91(3):199–209, 1982

The ADS is copyrighted and is available from:
Marketing Services
Addiction Research Foundation
Toronto, Ontario M5S 2S1, Canada
Phone: 416-545-6000

Obsessive Compulsive Drinking Scale (OCDS)

Anton RF, Moak DH, Latham P: The Obsessive Compulsive Drinking Scale: a self-rated

instrument for the quantification of thoughts about alcohol and drinking behavior. Alcohol Clin Exp Res 19(1):92–99, 1995

Brief Screen for Adolescent Substance Abuse (CRAFFT)

Knight, J. R., Shrier, L. A., Bravender, T., Farrell, M., Vander Bilt, J., & Shaffer, H. J. (1999). CRAFFT: a new brief screen for adolescent substance abuse. *Archives of Pediatrics & Adolescent Medicine, 153*(6), 591-596.

Appendix 3: Services of the MASSACHUSETTS COUNCIL ON COMPULSIVE GAMBLING

About the Massachusetts Council on Compulsive Gambling

The Massachusetts Council on Compulsive Gambling is a private, non-profit agency, founded in 1983, dedicated to reducing the harm caused by problem gambling. The Council provides the following services:

- ***Information and Public Awareness about Compulsive Gambling***
  Literature, posters, newsletters, resource library; www.THEWAGER.org, and a Web site: www.masscompulsivegambling.org
- ***Community Education***
  Workshops, conferences, in-service trainings, and an annual course for service providers: *Understanding, Assessing and Treating Compulsive Gambling*, and a New England Conference on Problem Gambling
- ***Capacity Building***
  With the Massachusetts Department of Public Health, Bureau of Substance Abuse Services and other agencies to increase their capacity to address gambling problems
- ***Advocacy***
  For services for compulsive gamblers and their families, and for responsible public policy
- ***Referral***
  Helpline: 1-800-426-1234 (in Massachusetts only), for those impacted by problem gambling or for professionals interested in learning more about problem gambling.

Massachusetts Council on Compulsive Gambling
190 High St., Suite 5, Boston, MA 02110-3031
Telephone: 617-426-4554
Fax: 617-426-4555
Helpline: 1-800-426-1234 (in Massachusetts only)
Email: gambling@aol.com
Website: www.masscompulsivegambling.org

Appendix 4: Selected Resources for Help with Gambling Problems

12 STEP SUPPORT GROUPS

Gamblers Anonymous

(For those with a gambling problem)
Eastern Massachusetts (617) 338-6020
www.newenglandga.com
Email: info@newenglandga.com
Western Massachusetts (888) 519-5059
Rhode Island (401) 553-1441
Connecticut (203) 777-5585
New Hampshire (603) 644-8097
Eastern New York (518) 292-0414
New York City (212) 903-4400
International (213) 386-8789
www.gamblersanonymous.org
Email: isomain@gamblersanonymous.org

Bettors Anonymous

(For those with a gambling problem)
(978) 988-1777; (781) 662-5199

Gam-Anon

(For family members and friends of problem gamblers)
(888) 644-8482
www.gam-anon.org
Email: info@gam-anon.org

Massachusetts Treatment Resources

The Massachusetts Department of Public Health operates 17 gambling treatment programs. These programs offer outpatient counseling for people experiencing gambling problems and/or their families at agencies that already provide substance abuse services. Various insurances are accepted, and fees for those without insurance are determined by ability to pay.

A call to the Massachusetts Council on Compulsive Gambling's office at 1-800-426-1234 (in Massachusetts only) or 1-617-426-4554, or a visit to the Council's Website: **www.masscompulsivegambling.org** can put you in touch with the most current information about specific support group meetings and/or counseling services.

National Treatment and Education Resources

The National Council on Problem Gambling can provide contacts to resources in many states in the United States.

National Council on Problem Gambling

208 G Street, NE
Washington, DC 20002
(202) 547-9204
Nationwide Help Line: 1-800-4700
www.ncpgambling.org
e-mail: ncpg@erols.com

Appendix 5: Certification for Treatment Providers: Recommendations and Resources

To assure that a minimum standard of care is met in providing treatment to compulsive gamblers and their families, the Massachusetts Council on Compulsive Gambling encourages and recommends that compulsive gambling counselors obtain a certification credential. Certification can be obtained by applying to one of the organizations described below. Regardless of the certifying organization, requirements include: an application, a fee, education, supervision, test taking, and references.

AMERICAN ACADEMY OF HEALTH CARE PROVIDERS IN THE ADDICTIVE DISORDERS

The American Academy is a non-profit organization; it offers the credential of Certified Addictions Specialist (C.A.S.) credential, which reflects clinical competency in the treatment of compulsive gambling and other addictive disorders (i.e., alcohol and other drug use disorders, eating disorders, sex addiction).

Contact: **The American Academy of Health Care Providers in the Addictive Disorders**
314 West Superior Street, Suite 702
Duluth, MN 55802
Phone: 218-727-3940
Fax: 218-722-0346
E-mail: info@americanacademy.org
Website: www.americanacademy.org

NATIONAL GAMBLING COUNSELOR CERTIFICATION BOARD

The National Gambling Counselor Certification Board, a division of the National Council on Problem Gambling, a non-profit organization, offers the credential of National Certified Gambling Counselor (NCGC) attesting to clinical competency in the treatment of compulsive gambling.

Contact: **National Council on Problem Gambling, Inc.**
208 G Street, NE
Washington, DC 20002
202-547-9204
Email: ncpg@erols.com
Website: www.ncpgambling.org

Appendix 6: Criteria for Treatment Matching

CRITERIA FOR ACUTE INPATIENT HOSPITAL CARE[15]

1. FAILURE TO PROGRESS IN LESS CONTROLLED AND INTENSE LEVELS OF TREATMENT.
2. HIGH-RISK CHEMICAL DETOXIFICATION, E.G., WITHDRAWAL THAT MIGHT BE ASSOCIATED WITH SEIZURES OR DELIRIUM TREMENS.
3. CHEMICAL DETOXIFICATION COMPLICATED BY HIGH LEVELS OF TOLERANCE TO MULTIPLE SUBSTANCES.
4. ACUTE EXACERBATION OF MEDICAL AND/OR PSYCHIATRIC PROBLEMS THAT RELATE TO CHEMICAL DEPENDENCE, E.G., CARDIOMYOPATHY, HEPATITIS, SEVERE DEPRESSION.
5. CONCOMITANT MEDICAL AND/OR PSYCHIATRIC PROBLEMS THAT POTENTIALLY COULD COMPLICATE TREATMENT, E.G., DIABETES, BIPOLAR AFFECTIVE DISORDER, HYPERTENSION.
6. SEVERELY IMPAIRED SOCIAL, FAMILIAL OR OCCUPATIONAL FUNCTIONING.

CRITERIA FOR NON-HOSPITAL RESIDENTIAL CARE

1. FAILURE TO PROGRESS IN LESS INTENSIVE LEVELS OF TREATMENT.
2. CHEMICAL DETOXIFICATION, IF NECESSARY, CAN PROCEED SAFELY WITHOUT CLOSE MEDICAL SUPERVISION.
3. THE PATIENT IS PSYCHIATRICALLY AND/OR MEDICALLY STABLE BUT REQUIRES DAILY SUPERVISION.
4. THE PATIENT'S SOCIAL AND/OR VOCATIONAL LEVEL OF FUNCTIONING REQUIRES SEPARATION FROM ASPECTS OF THEIR REGULAR ENVIRONMENT.
5. THE PATIENT'S INTERPERSONAL AND DAILY LIVING SKILLS ARE SUFFICIENTLY DEVELOPED TO PERMIT A SATISFACTORY LEVEL OF FUNCTIONING IN A MILIEU ENVIRONMENT.

[15] Adapted from Giuliani and Schnoll (1985).

CRITERIA FOR PARTIAL HOSPITALIZATION OR DAY TREATMENT CARE

1. CHEMICAL DETOXIFICATION, IF NECESSARY, CAN PROCEED WITHOUT CLOSE MEDICAL SUPERVISION.
2. THE PATIENT IS PSYCHIATRICALLY AND/OR MEDICALLY STABLE BUT REQUIRES SUPERVISION DAILY RATHER THAN WEEKLY OR BIWEEKLY.
3. THE PATIENT'S INTERPERSONAL AND DAILY LIVING SKILLS ARE SUFFICIENTLY DEVELOPED TO PERMIT AN AUTONOMOUS LEVEL OF FUNCTIONING IN A NON-RESIDENTIAL ENVIRONMENT.
4. THE PATIENT IS PSYCHIATRICALLY STABLE BUT MAY NEED SOME TO MODERATE SUPPORT.
5. THE PATIENT HAS A SOCIAL SYSTEM CAPABLE OF PROVIDING THE NECESSARY LEVEL OF SUPPORT, E.G., FRIENDS, FAMILY, WORK.

CRITERIA FOR OUTPATIENT CARE

1. THE PATIENT'S PSYCHIATRIC/MEDICAL PROBLEMS ARE STABLE (I.E., DAILY OR WEEKLY SUPERVISION IS UNNECESSARY).
2. THE PATIENT IS CAPABLE OF AN AUTONOMOUS LEVEL OF FUNCTIONING IN THE PRESENT SOCIAL ENVIRONMENT.
3. THE PATIENT CAN FUNCTION EFFECTIVELY IN INDIVIDUAL, GROUP, AND/OR FAMILY THERAPY ENVIRONMENTS.
4. MEDICAL SUPERVISION IS UNNECESSARY FOR WITHDRAWAL.
5. THE PATIENT IS WILLING TO PARTICIPATE IN A TREATMENT PROGRAM.

Appendix 7: Special Note on Taking a Substance Use or Gambling History

At the very least, clinicians should always cover the following areas when conducting a gambling or substance use history:

- the major categories of drug use or gambling activities
- amount, route of administration, frequency of use, and the duration of use or the type of game, and the pattern of play
- setting in which drug(s) are used or gambling is experienced
- how does patient acquire the drug(s) or gain access to gambling activities
- significant life issues related to drug use or gambling (e.g., precipitating crisis, hospitalization, etc.)
- any reports of drug overdose or binge gambling
- the specific subjective effects produced by the use of every drug reported or every game played