Pathological Gambling -
A Clinical Overview

Abstract
The nationally representative British Gambling Prevalence Survey of 2010\(^1\) indicates 0.9% of individuals in Britain meet the criteria for problem gambling, equating to approximately 451,000 adults. However, individuals who are problem gamblers are known to present to their GPs with associated problems without disclosing the underlying condition\(^2\) (Sullivan, Arroll, Coster & Abbott, 1998). Pride, shame and denial are factors that non-treatment seeking problem gamblers identify as barriers against them seeking treatment.\(^3\) \(^4\) This disorder is therefore hugely challenging for professionals to identify and respond appropriately to. This article will outline the current DSM-IV criteria for Pathological Gambling, describe a simple, easy to administer screening tool, and explain common co-morbidities. Treatment is then discussed in terms of empirically supported approaches and what is currently available in the UK.

Keywords
Problem gambling, screening, treatment, support, pathological gambling.

**DSM-IV Criteria and Update (Table 1)**
The American Psychiatric Association (APA) defines Pathological Gambling in the DSM-IV\(^5\) as ‘persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or vocational pursuits’. Importantly, a diagnosis cannot be made if the presentation is ‘better accounted for by a Manic Episode’. Pathological Gambling is currently listed as an ‘Impulse Control Disorder, Not Otherwise Classified.’ However, with the upcoming release of the DSM-V, the APA proposes to reclassify it under ‘Substance Related Disorders’, which in turn will be renamed ‘Addiction and Related Disorders’ (American Psychiatric Association, 2010).\(^5\) The current 10 DSM-IV criteria for Pathological Gambling make up the main instrument used by trained professionals to diagnose Pathological Gaming. A client who concurrently meets 3 or 4 of the criteria is classified as a ‘Problem Gambler’ whilst a score of 5 or more indicates a probable ‘Pathological Gambler’.

<table>
<thead>
<tr>
<th>Table 1: DSM-IV Criteria.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:</strong></td>
</tr>
<tr>
<td>- Preoccupation</td>
</tr>
<tr>
<td>- Tolerance</td>
</tr>
<tr>
<td>- Recurrent relapses</td>
</tr>
<tr>
<td>- Withdrawal</td>
</tr>
<tr>
<td>- Emotional coping</td>
</tr>
<tr>
<td>- Chasing losses</td>
</tr>
<tr>
<td>- Concealment</td>
</tr>
<tr>
<td>- Illegal acts</td>
</tr>
<tr>
<td>- Loss or damaged to relationship/career</td>
</tr>
<tr>
<td>- Financial reliance on others after gambling</td>
</tr>
<tr>
<td><strong>B. The gambling behaviour is not better accounted for by a Manic Episode.</strong></td>
</tr>
</tbody>
</table>

**Correspondence:**
Phoebe Kaspar
Central North West London NHS Trust,
National Problem Gambling Clinic,
4th Floor,
Soho Centre for Health and Care,
1 Frith Street,
London W1D 3HZ,
UK
Email: gambling.cnwl@nhs.net

Phoebe Kaspar\(^1\)
Bsc (Hons)

Sophie Mitter\(^1\)

Henrietta Bowden-Jones\(^1,2\)
MRCPsych, BA(Hons), DOccMed.

\(^1\) The National Problem Gambling Clinic
\(^2\) Imperial College, London
Screening

There are numerous tools available to screen potential Problem gamblers, but the General Practitioner requires a brief, easy to administer tool that reliably distinguishes the Pathological gambler from the ‘social’ gambler. An example is Johnson et al’s ‘Lie-Bet’ questionnaire, a screening tool made up of only two items derived from a questionnaire based on the 10 DSM-IV diagnostic criteria.

The first item questions lying:

Have you ever had to lie to people important to you about how much you gambled?

The second investigates the client’s experience of tolerance:

Have you ever felt the need to bet more and more money?

Because of its brevity, this screening tool is particularly clinically practical and requires no training to administer—a positive answer to at least one of the questions identifies a potential problem gambler, in which case it is recommended a more detailed screening tool such as The Problem Gambling Severity Index be administered. This 9 question screening tool is easily found online, and can be completed by the patient. Rather than a dichotomous yes/no answer to items, respondents can choose from ‘never’, ‘sometimes’, ‘most of the time’ and ‘almost always’. A score of 8 and above indicates a Problem Gambler, appropriate for referral to a specialist gambling treatment service.

Who to screen?

Whilst patients may be reluctant to voluntarily admit to having a gambling problem, certain client groups are known to have elevated rates of problem gambling. Professionals can therefore routinely screen these individuals when they encounter them to facilitate identification of a potential problem gambler. This may help promote early identification of the gambling problem, which is known to optimize the individual’s prognosis and limit the extent to which adverse consequences can prevail.8

Depression and Anxiety

Major depression and anxiety are frequently linked to problem gambling6, 10 and problem gamblers have been found to present to their GP with these co-morbidities without disclosing their underlying gambling problem.2 Therefore clinicians should be mindful of problem gambling when encountering an individual with non-specific anxiety and/or depression who may either be reluctant to expose their underlying addiction or unable to recognise the link between them.

Substance Misuse

Sufficient research has been conducted to urge clinicians to screen for problem gambling when encountering other addictions. Literature has consistently found elevated levels of alcohol dependence in those who gamble problematically compared to the general population.11, 12, 13 Those who use alcohol are more likely to experience gambling related problems14, 15 and importantly, the number of these problems increases in proportion to the average amount of alcohol consumed.16 Hence, clients presenting with alcohol misuse problems may be considered an ‘at risk’ population especially when consumption is particularly high. Non-alcohol related substance misuse must also be considered; rates of problem gambling in samples of substance users are dramatically higher than those observed in the general population.17, 18 Up to 21% of methadone maintenance patients have been found to have co-morbid problem gambling.19 Reported figures are even higher for cannabis users at up to 24%,18 and cocaine users at up to 30%.20

Domestic Violence

Research has linked problem gambling with an increased risk of Intimate Partner Violence (IPV). Muelleman et al21 interviewed women admitted to a hospital Emergency Department and identified a significant association between problem gambling and IPV: women who reported their partner was a problem gambler were significantly more at risk of experiencing IPV than those without a partner who problematically gambled. Afifi, Brownridge, Macmillan & Sareen23 found dating and marital violence as well as child maltreatment were associated with problem gambling, with the severity of the violence increasing in line with the severity of the Problem gambler. Those who commit violence in the home may therefore be considered an ‘at risk’ client group eligible for automatic screening for problem gambling.

Treatment and Support

Treatments with cognitive-behavioural elements have been shown to be the most beneficial for problem gamblers, in terms of a sustained statistical and clinical improvement in gambling behaviours.23 Sylvain, Ladouceur & Boisvert24 found highly significant changes in a ‘treatment group’ given a cognitive-behavioural intervention (including cognitive correction, problem solving training, social skills training and relapse prevention). Therapeutic improvements continued to be highly significant at 6 and 12 month follow up. Ladouceur et al25 suggested a cognitive treatment package alone, that identifies and corrects erroneous perceptions around gambling, can be successful in significantly reducing scores on measures of problem gambling. Again the longevity of the improvement is shown by maintenance of treatment gains at follow up. Hodgins, Currie and el-Guebaly26 show even minimal cognitive-behavioural interventions can significantly reduce gambling behaviour, as demonstrated by participants who received a self-help manual in the post, and no other formal therapeutic intervention, showing sustained improvements in gambling behaviours at a year follow up.

There is increasing support for the use of the opiate antagonist Naltrexone in the treatment of problem gambling. Grant et al27 used a double blind placebo controlled study to demonstrate significant improvement in gambling urges and behaviours in samples of problem
gamblers given 50, 100 or 150mg/day of Naltrexone compared to a placebo group. Such pharmacological treatment is yet to be widely available in the UK, however the UK National Problem Gambling Clinic will shortly trial the prescription of Naltrexone for individuals presenting with the highest severity symptoms.

Impact on Others
Practitioners must be mindful of other individuals likely to be impacted by problem gambling. Research is limited in this area, but it is estimated that 5–10 people are negatively impacted by an individual’s problem gambling. Studies have shown that Concerned Significant Others are at increased risk of suffering from anxiety and depression and experience significant distress, particularly when living with the gambler. Even ‘minimal’ interventions such as a self-help workbook have been found to significantly reduce relationship and personal distress, as reported by CSOs.

The National Problem Gambling Clinic
Set up in 2008 by Dr Henrietta Bowden-Jones, the National Problem Gambling Clinic is the first and only National Health Service facility that provides evidence based treatment to problem gamblers and their families. Individuals can self refer, or be referred by a GP or other professional to this service, and will undergo a comprehensive screening and assessment process before being assigned to an appropriate Cognitive Behavioural Therapy (CBT) treatment programme. The support offered to family members and friends affected by problem gambling includes a 5-step handbook specifically written for those affected by someone else’s gambling, attendance at a monthly psycho-educational group, and family therapy with an experienced family psychotherapist. The clinic now has a specialised group for female problem gamblers and a ‘remote’ CBT option can be offered to those unable to travel to the clinic regularly, in which treatment is delivered mainly over the phone. To refer, a referral form must be completed, which can be found on the clinic’s website: http://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic/

GamCare
GamCare is a charity offering face-to-face counselling support to individuals and their families who are affected by problem gambling. Instant support can be accessed over the phone by using The GamCare Helpline, or on the internet using The Netline, where individuals can message trained advisors for support and advice. This can be accessed at http://www.gamcare.org.uk/

The Gordon Moody Association
This is a specialist service providing residential treatment to problem gamblers. Individuals can apply to be accepted into treatment by completing application forms, available on their website: http://gordonmoody.org.uk/Default.aspx

Gamblers Anonymous (GA)
Based on the twelve step programme originally advocated by Alcoholics Anonymous, GA holds meetings across the UK, with some offering a separate support group, ‘Gam-Anon’, for family and friends of problem gamblers. GA meetings can be attended on a ‘drop in’ basis, and given the number of locations, is a readily accessible forms of support for individuals affected by gambling. Meeting locations can be found at http://www.gamblersanonymous.org.uk/

Conflict of Interest
All authors have no conflict of interest to declare. No extraneous funding was obtained.

Further reading

References