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opinion

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Why don't adolescents turn up for gambling treatment (revisited)?

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Abstract

In a previous issue of the *Electronic Journal of Gambling Issues,* Griffiths (2001) raised 10 speculative reasons as to why so few adolescents enrol for treatment programs when compared with adults. This paper explores the issue a little further with another 11 possible reasons. These are (i) adolescents don't seek treatment in general; (ii) adolescents may seek other forms of treatment, but gambling problems are less likely to be seen as requiring intervention; (iii) treating other underlying problems may help adolescent gambling problems; (iv) a dolescent gambling 'bail-outs' can mask gambling problems; (v) a ttending treatment

programs may be stigmatising for adolescents; (vi) adolescents may commit suicide before getting treatment; (vii) a dolescent gamblers may be lying or distorting the truth when they fill out survey questionnaires; (viii) a dolescents may not understand what they are asked in questionnaires; (ix) screening instruments for adolescent problem gambling are being used incorrectly; (x) adolescent gambling may be socially constructed to be nonproblematic; and (xi) adolescent excesses may change too quickly to warrant treatment.

Introduction

It has been well established that prevalence rates of pathological gambling are reportedly higher among youth than adults (e.g., Shaffer & Hall, 1996; Shaffer, Hall, & Vander Bilt, 1999; Jacobs, 2000). In a previous issue of the *Electronic Journal of Gambling Issues,* Griffiths (2001) outlined 10 speculative reasons as to why adolescents may not seek out help for their gambling problem. Very briefly, the possible reasons were

- denial by adolescents of having a gambling problem
- adolescents not wanting to seek treatment even if they admit to themselves that they have a problem
- the general lack of adolescent treatment programs available for adolescents
- treatment programs not being appropriate and/or suitable for adolescents
- the occurrence of spontaneous remission and/or maturing out of adolescent gambling problems
- the possibility that adolescents are constantly being 'bailed out' by parents
- the negative consequences experienced by adolescents not necessarily being unique to gambling
- lying or distortion by adolescents on self-report measures when being researched
- the possibility of invalid screening instruments for measuring problem adolescent gambling specifically
- the possibility that some researchers may be exaggerating the adolescent gambling problem to serve their own career needs

Griffiths (2001) concluded that there did not appear to be any

empirical evidence for at least three of the speculations (i.e., denial by adolescents of having a gambling problem, adolescents not wanting to seek treatment, and researchers exaggerating the adolescent gambling problem to serve their own career needs). Of the remaining speculations, some were not unique to adolescents (e.g., invalid screening instruments for measuring problem gambling, lying or distortion by participants on self-report measures, denial of having a gambling problem, and not wanting to seek treatment). What was quite clear was that there is no single speculation that provides a definitive answer to the question of why adolescents don't seek treatment. In this paper, we present some other reasons and observations related to this issue.

Adolescents don't seek treatment in general. In the previous paper by Griffiths (2001), all of the speculations were drawn from within the gambling field. However, there is also the broader perspective. Why — in general — don't adolescents seek treatment? One might say that, apart from life-threatening traumas and extremely severe acne, young males will rarely contemplate seeking treatment for anything. Young females are a little more likely than young males to consult health professionals (especially for gynaecological reasons). The reasons why adolescents in general do not consult health professionals are their perceived invincibility, invulnerability, and immortality. In addition, adolescents are constantly learning and want to resolve their own problems rather than seek help from a third party. Who better than themselves knows what to do with their lives and whatever problem they are facing? They might experience more denial then adults, but come to the conclusion that others (usually adults) do not understand them. Ultimately, if adolescents rarely present themselves for any kind of treatment, it would be surprising to see them turn up for very specific treatments such as for problem gambling.

Adolescents may seek other forms of treatment, but gambling problems are less likely to be seen as requiring intervention. Adolescent problem gambling is associated with many comorbid behaviours, e.g., alcohol and drug abuse (Griffiths, 1994; Griffiths & Sutherland, 1998; Griffiths, Parke, & Wood, 2002; Chevalier, 2003). Therefore, the few adolescents who do seek treatment may do so for a comorbid behaviour rather than for problem gambling. In most Western societies, gambling is not perceived as a real problem, especially when compared with problems related to alcohol or substance abuse.

Treating other underlying problems may help adolescent gambling problems. Gambling problems could be (and quite often are) symptomatic of an underlying problem (e.g., depression, dysfunctional family life, physical disability, lack of direction or purpose of life) (e.g., Griffiths, 1995; Darbyshire, Oster, & Carrig,

2001; Gupta & Derevensky, 2000). Therefore, if these other problems are treated, the symptomatic behaviour (i.e., problem gambling) should disappear, negating the need for gambling-specific treatment.

Adolescent gambling 'bail-outs' can mask gambling problems. Griffiths 's previous paper speculated that adolescent problem gamblers may be constantly 'bailed out' of trouble and therefore do not require treatment. To add to this, adolescents are bailed out and forgiven when young. The older someone gets the less likely this is to happen. Turner and Liu (1999) highlighted differences between treatment seekers and problem gamblers who do not seek treatment. This shows that people seek treatment when the consequences of their behaviour are more severe, especially with regard to their finances and their families. Adolescents are protected from many consequences (no mortgage or rent to pay, no angry spouse or kids to support), and have not had the time or the resources to build up the kind of debt that brings people in for treatment. Young people will automatically be less likely to be in treatment, considering the average amount of time people have had a problem before they seek treatment.

There is another possibility somewhere between 'bail-out' and spontaneous remission. Problem gambling can be addressed by support (as self-help groups such as Gamblers Anonymous have demonstrated). Adolescents are more likely to get support than adults. For instance, parents often do not quit on their child and will give support whether or not it is needed or wanted.

Attending treatment programs may be stigmatising for adolescents. Adolescents might not seek treatment because of the stigma attached to such a course of action. Seeking treatment may signify that they can no longer participate in the activities by which they and their group define themselves. Furthermore, it may draw attention to a failure.

Adolescents may commit suicide before getting treatment. Suicide rates among adolescents are comparatively high (Duchesne, 2002; World Health Organization, 2002). Suicide is often attributed to adolescence itself (i.e., a host of reasons not always well defined by medical examiners) (Gould, 2003). Gambling might be one of the reasons associated with suicide without anyone ever realising the true cause.

Adolescent gamblers may be lying or distorting the truth when they fill out survey questionnaires. It has been asserted by Stinchfield (1999) that the prevalence rates for adolescent problem gambling are not real and are due to youth exaggerating their involvement in gambling. Furthermore, truths are multiple. It

could be that, while answering truthfully from their standpoint, they are giving researchers answers that we would not think suitable. An example could be in response to a question such as 'Did your gambling ever get you in trouble with your parents?' For instance, an adolescent boy might have a problem with parental curfews. One day he might be late because he missed the bus home, the next day he might be late because he went to a long film at the cinema. On the third occasion he might be late because he was gambling and lost track of time. If the parents told him off on this occasion, it would be an example of gambling getting the boy in trouble with his parents. However, is this response really a valid example of getting into trouble with parents due to gambling?

Adolescents may not understand what they are asked in questionnaires. Another reason that the prevalence rates of adolescent problem gambling are elevated may be due to measurement error. If adult instruments are administered to youth (which some researchers have done, including the second author!), they may endorse items they should not, doing so because they do not understand the item. For instance, Ladouceur et al. (2000) showed that many of the SOG-RA items were misunderstood, with only 31% of students understanding all of the items correctly.

Screening instruments for adolescent problem gambling are being used incorrectly. With measures developed for adolescents, as with those for adults, there may be incorrect use of screening instruments. Stinchfield (1999) asserts that this is one possibility for elevated prevalence rates. He further claims that there may be a lack of consistency in methodology, definitions, measurement, cut scores, and diagnostic criteria across studies, and particularly in the use of lenient diagnostic criteria for youth in some studies. For example, some studies use the SOGS but lower the cut score, and some studies use DSM criteria but lower the cut score, all of which tend to inflate the rate of pathological gamblers.

Adolescent gambling may be socially constructed to be nonproblematic. Problems, whether they are medical or otherwise, are socially constructed (Castellani, 2000). For example, denial may not be experienced because there is no perception of a problem. For instance, if the peer group, school class, and/or the family of the adolescent is progambling, actively engaged in gambling, and shows signs of problems, it may appear to the adolescent that it goes with the territory. Playing the guitar is hard on the fingers, playing football is hard on the shins, and playing poker is hard on cash flow, nerves, sleep, digestion, friends, mood, family, school, job, and much else. Therefore, it may not be perceived as a medical, psychological, and/or personal problem, but merely a fact of life.

Adolescent excesses may change too quickly to warrant treatment. Adolescence is sometimes about excess and many addictions peak in youth (Griffiths, 1996). It could be that transfer of excess is a simpler matter for adolescents. They might have an excess 'flavour of the month' syndrome, where one month it is binge alcohol drinking, one month it is joyriding, and one month it is gambling. Adolescents may not seek treatment not because of spontaneous remission in the classical sense, but because of some sort of transfer of excess.

Concluding comments

As with the previous speculations (Griffiths, 2001), many of the possibilities outlined here are also speculative and many of the original conclusions are applicable here as well. However, there are clearly some research questions that need answering. For instance, why do youths appear to be reluctant to seek help for gambling problems? What is the true prevalence of problem gambling among youth? Are the available statistics inflated by a lack of understanding of the survey questionnaire items, too liberal cut-offs, etc.? Where does problem gambling fit among the many difficulties young people face during the developmental process? Are the heightened rates of pathological gambling among youth the result of having grown up during times of such extensive availability (i.e., a cohort effect)? Or is it merely a reflection of adolescent experimentation that they will grow out of (or a combination of the two)?

Research needs to address directions and magnitudes of causality among problem-gambling behaviours and other health and social problems, such as cardiovascular disease, psychiatric disorders, and social problems (e.g., divorce, domestic violence, bankruptcy, etc.). The question of where problem gambling comes in the chain of negative events in the life of each case, such as before or after the onset of depression or drug abuse, needs to be studied. Such research would inevitably feed into the area of youth gambling. The evidence is overwhelming that most cases of problem gambling have their origins in the developmental period. One study asked patients to specify when their gambling and drug-taking began and it emerged that gambling follows some forms of drug abuse and appears to emerge simultaneously with others (Hall et al., 2000). Hall and his colleagues reported that gambling problems precede addiction to cocaine but seem to emerge simultaneously with opiate dependence. As can be seen, there is large scope for future research in this area. We hope that articles such as this may provide the impetus for such research.

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