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## GAMBLING PRACTICES AMONG YOUTH: ETIOLOGY, PREVENTION AND TREATMENT

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Even though state-regulated forms of gambling are permitted only to those of legal age (the age varying between jurisdictions and on the type of gambling), children and adolescents are gambling for money in record numbers. If loosely defined as wagering money on the outcome of a game or event, with the hopes of winning larger sums of money, youth gambling participation is ramped. Gambling is not just about going to the casino or racetrack, or playing the lottery; one need not look much further than the home, where card games played for money, and sports wagering, are very commonplace.

Our team at the International Centre for Youth Gambling Problems and High-Risk Behaviors at McGill University in Montreal, Quebec, Canada has been involved since the early 1990s in understanding the complexities involved in youth gambling, treating adolescents and young adults with gambling problems, and preventing youth gambling problems. While youth gambling problems can be viewed as another adolescent risky behavior, it is only recently that it has gained the attention of policy-makers. This chapter is designed to provide an overview of what is currently understood about the correlates, risk factors and protective factors associated with youth gambling and problem gambling, as well as to touch upon prevention and treatment considerations.

## GAMBLING PARTICIPATION AMONG YOUTH

There is ample research suggesting that children often start gambling young, usually around 9 or 10 years of age. They frequently report engaging in card-playing with family and friends for money; purchasing and playing lottery products; playing bingo in bingo halls; and wagering on their own activities, including sports and video games (Derevensky and Gupta, 2004). Even before the mass expansion of gambling, Ladouceur and his colleagues conducted a study among 1320 primary school students and found that among their sample 86 percent of children reported some form of gambling for money, and 37 percent admitted to having wagered an object that was very dear to them. They further concluded that a large number of youth were gambling at least once per week, even under the ages of 9 and 10 (Ladouceur *et al.*, 1994a). A smaller sample of elementary students (fourth to sixth grades, age 10–12) in Quebec found similar rates of participation, with 70 percent of respondents reporting having gambled for money, 53 percent doing so at least once per week (Derevensky *et al.*, 1996). While these respondents are not individuals with severe gambling problems, these earlier studies reveal that gambling behavior patterns establish themselves very young, thus confirming retrospective studies where adult pathological gamblers report an early age of onset (Livingston, 1974; Custer, 1982; Productivity Commission, 1999).

More recent investigations have revealed that gambling, or wagering on a myriad number of games, is a relatively common and popular activity among adolescents (Jacobs, 2004). Studies conducted in Canada (Gupta and Derevensky, 1998a; Dickson *et al.*, 2002), the US (Shaffer and Hall, 2001), Australia (Delfabbro and Thrupp, 2003) and New Zealand (Clarke and Rosen, 2000) have consistently identified that between 60 and 80 percent of young people aged 13–17 years gamble at least once per year, and that between 3 and 6 percent display many of the behaviors indicative of adult problem gambling (Gupta and Derevensky, 1998a). These behaviors include an excessive preoccupation with gambling, chasing after losses, lying to peers and parents, and abandonment of important commitments like school work and peer relationships to pursue gambling. It could be argued that adolescents misuse gambling more frequently than adults, since they experience higher rates of problem gambling (Shaffer and Hall, 1996; Stinchfield and Winters, 1997; National Research Council, 1999). The most common locations where gambling takes place include the home, school, and friends' homes. Less frequently, youth report gambling in arcades, corner stores, cruise ships, with some managing to gain access to casinos and bars where electronic machines are frequently located (Gupta and Derevensky, 1998a). Prevalence rates of gambling are often contingent upon the availability and age prerequisites for youth, depending upon their jurisdiction and legal statutes. Of particular concern are the newer forms of electronic gambling, including electronic gambling machines (EGMs, VLTs, slots, Pokies), Internet

wagering, mobile gambling, and trends associated with the heavy advertising of gambling (e.g., poker tournaments, Internet websites).

### SOCIETAL TRENDS AND INFLUENCES

The activities of today's youth are very much dictated by societal trends and influences. As an example, more youth than ever are spending increased amounts of time in their homes during spare time, either watching television or chatting with friends online via their personal computers. In years past, children were more likely to be playing outside after school or on weekends. Such generational changes can possibly be attributed to a societal trend toward keeping one's children safe (i.e., away from people who could do them harm), increased homework loads assigned by schools, and society's technological advancements with respect to video-gaming, Internet-chatting, increased television programming particularly attractive to youth, and the relatively low cost of home personal DVD and VCR machines. Such societal trends and influences, by changing the way youth use their recreational time, has resulted in public health concerns such as obesity (Stettler *et al.*, 2004; Vandewater *et al.*, 2004) and diabetes rates (Pontioli, 2004) increasing in young children and adolescents.

Similar arguments can be made in regards to gambling and youth, with increased offer and societal acceptance of gambling resulting in increased public health concerns (Korn and Shaffer, 1999; Derevensky *et al.*, 2004a; Messerlian *et al.*, 2004). Gambling, once considered one of society's sins and vices associated with underground activities, has now taken center stage in many communities, being promoted by governments throughout the world as *gaming* – a change in terminology eliminating the negative connotation that once existed. Once relegated to international centers associated with gambling (such as Las Vegas, Reno, Atlantic City, Monte Carlo), more and more governments have either established their own casinos, electronic gaming machines, lotteries, Internet-gaming, etc., or at the very least have licensed these forms of gambling with heavy regulation and taxation. Growing up in a culture populated with state-sanctioned gambling opportunities and rich in advertisement, it is not surprising that the public has embraced such activities as a socially acceptable form of entertainment.

The very popular and highly publicized game of poker currently represents a social trend that is largely impacting the gambling behaviors of the general public. Celebrity and international poker tournaments, found on many television channels, have placed the game front and center, and have caught the attention and interest of old and young alike. Sports networks are now televising poker tournaments as a *sport*, resulting in yet another cultural shift. The promotion of a gambling activity as a sport carries several concerns, primarily because most people are of the belief that sports are safe and promote health and well-being.

Children and adolescents are not immune to social trends and influences, as well as the negative consequences associated with excessive gambling. While it

is still unclear what the social costs are in reality, many now better understand the need to include gambling prevention alongside those of other adolescent addictive and high-risk behaviors (Jessor, 1998; Ghezzi *et al.*, 2000; Dickson *et al.*, 2004). Nevertheless, it still remains that many youth and parents are unaware that what begins as an enjoyable, exciting activity can quickly escalate to impaired control when gambling, with serious social, personal, interpersonal, legal and economic negative consequences. There are so many mixed messages about gambling that many youth, parents and educators are confused and not properly informed. Through our continued work with youth, we have come to understand that many conscientious teens make choices to avoid excessive alcohol and drug use, and elect to gamble instead, believing that they are acting responsibly and in their best interest. Unfortunately, youth who are unaware of the warning signs and potential risks inherent in excessive gambling could unknowingly be placing themselves in harm's way. As a result, the benefits of a *harm-minimization* approach in minimizing gambling problems warrant serious consideration (Dickson *et al.*, 2004) and will be discussed later in this chapter. This approach is nested in the belief that the vast majority of teens are gambling and will continue to do so, that society will continue to readily recognize many forms of gambling as an acceptable form of entertainment, and consequently the best way to help youth is to sensitize them to the risks and raise issues around responsible gambling.

Technology is an ever-evolving phenomenon which inevitably brings with it social change. Today, the majority of people in many jurisdictions around the world have ready, affordable access to computers and to the Internet. Children and teens, even more than adults, are very adept at using and entertaining themselves via Internet access from their homes or Internet cafés, often unsupervised. Griffiths (1999) has long argued that technology will continue to play a meaningful role in the evolution of gambling practices. Griffiths and Parke (2002) explain that patterns of family leisure activities are changing, with the more sophisticated home entertainment systems resulting in a cocooning effect instead of families going out and being active. They argue that these family trends may ultimately affect the choices teens make with regard to the use of their leisure time, with many preferring technologically-based activities. This shift lends itself well to increased gambling involvement, especially when brought into the home via the Internet. In a recent publication, Griffiths *et al.* (2006) address in more detail the impact of technology, highlighting the salient characteristics that could lead to a serious rise in gambling participation by youth. These factors include easy accessibility, anonymity, and convenience amongst others. Gambling has now come to be understood as an activity that individuals engage in for purposes of escape and/or stimulation (Gupta and Derevensky, 1998b), and Griffiths and his colleagues (2006) argue that Internet gambling allow for both. Couple this with adolescents' perceived enjoyment and excitement from gambling, their belief that gambling is a relatively harmless activity, and the potential to win money, and it is no wonder that gambling is enticing.



### EFFECTS OF PARENTING ON YOUTH GAMBLING PARTICIPATION

A small-scale study conducted by Magoon and Ingersoll (2006) concluded that parental gambling was associated with levels of gambling amongst adolescents, as well as an increased likelihood of their children being identified as problem gamblers. Higher levels of parent-child attachment were associated with lower levels of adolescent gambling, while strained parental trust and communication was associated with increased problem gambling amongst the teens. Measures of parental monitoring and supervision found similar outcomes in that increased monitoring and supervision resulted in lower levels of adolescent gambling. Their study also suggests that peer influences could be moderated by parental influences. Vachon *et al.* (2004), using a community sample of adolescents, yielded similar conclusions. Their results showed that adolescent gambling frequency was related to both parental frequency of gambling participation and problems. Furthermore, adolescent problem gambling was linked only to fathers' severity of gambling problems. They also examined the impact of parental monitoring and disciplinary practices on the behavior of adolescents. As might be predicted, they concluded that low levels of monitoring and higher levels of discipline inadequacies both adolescents' risk of both getting involved in gambling activities and developing related problems. Other research has consistently pointed to higher rates of problem gambling in adolescents who report excessive parental gambling (Gupta and Derevensky, 1998a; Jacobs, 2000, 2004; Felsher *et al.*, 2003; Langhinrichsen-Rohling *et al.*, 2004).

Parenting style can have an effect on problem gambling even when not modeling the behavior itself. A retrospective study requiring adult pathological gamblers and controls to recall how they were parented found that those reporting lower maternal and paternal care were more likely to be pathological gamblers. In terms of parental bonding patterns based on a combination of care and protection, the pathological gamblers reported low rates of optimal parenting and high rates of neglectful parenting (Grant and Kim, 2002). In another study examining the relationship between parenting styles, family environment and gambling behavior, it was concluded that parenting styles indirectly influenced the gambling behavior of teens via the family environment. More specifically, poor family environments which were characterized by high levels of conflict and low levels of cohesion were found significantly to increase the likelihood of gambling problems among the youth residing in those homes (Ste-Marie, 2006).

### RECREATIONAL GAMBLING VS PROBLEM GAMBLING

When addressing the issue of gambling and youth, it is important to make the distinction between problem gambling and general gambling participation (Winters and Anderson, 2000). As is the case with other high-risk activities such as alcohol consumption and drug use, most adolescents experiment with gambling activities while experiencing few or no negative consequences. The majority of young people who gamble do so for enjoyment and excitement, and

have no difficulty limiting their participation to social occasions. They gamble only what they can afford to lose, spend a reasonable amount of time doing so, gamble relatively infrequently, and report experiencing considerable fun and entertainment. However, a small but meaningful percentage of teens lose control of their gambling behavior, and as a result of an inability to set or maintain limits or having difficulty stopping, they experience significant gambling-related negative consequences. It is believed that problem gamblers are different from non-problem gamblers in many ways. Nevertheless, it should be noted that not all youth gamblers are problematic. In fact, there is evidence that most youth gamble responsibly, at low levels, with no appreciable problems. However, it is clear that between 4 and 8 percent of adolescents have severe gambling problems, with another 10–15 percent at risk for developing problems (Shaffer and Hall, 1996; National Research Council, 1999).

Youth in detention centers, psychiatric facilities and rehabilitation programs yield pathological gambling rates that are significantly higher than the norm (Winters and Anderson, 2000; Magoon *et al.*, 2005). This is mainly accounted for by the fact that similar risk factors underlie problem gambling as well as other high-risk behaviors, such as substance abuse. Winters and Anderson (2000) highlight that the origins of adolescent problem gambling frequently point to co-morbidity, often established between drug use and pathological gambling. It could thus be argued that multiple high-risk behaviors, in particular those characterized as addictive behaviors, share similar etiological processes. Data from two longitudinal studies, using general population household samples, link gambling to substance use and delinquency, but the association was not found to be strong (Barnes *et al.*, 2005). The lack of a strong association is most likely due to a failure to examine large numbers of problem gamblers.

### RISK FACTORS/ETIOLOGY

Risk factors consist of personal attributes, environmental context, or a situational condition that increases the chances of a person engaging in a high-risk behavior. Jessor and colleagues (1995; Jessor, 1988) have identified a host of risk factors that seem to be common to numerous adolescent high-risk behaviors (see Derevensky and Gupta, 2004; Dickson *et al.* 2004; and Dickson-Gillespie *et al.*, 2007 for a comprehensive examination of common high-risk behaviors). Such high-risk behaviors include low self-esteem, depressive mood, being a victim of physical and sexual abuse, poor school performance, a history of delinquency (poor impulse control), being male, having a parental history of addiction, and community and family norms that endorse or facilitate access to gambling venues. More recent research has substantiated this list of risk factors and has identified several additional factors, such as parenting style, a lack of connection to the school community, and the presence of learning problems in earlier educational years (Dickson *et al.*, 2003; Hardoon *et al.*, 2004; Felsher, 2006; Ste-Marie, 2006). Personality traits unique to adolescent problem gamblers

have also been identified (Gupta *et al.*, 2006). Utilizing discriminant analysis, Gupta and colleagues found that high levels of disinhibition, boredom susceptibility, cheerfulness and excitability, as well as low levels of conformity and self-discipline, were strongly associated with the function that best predicts the problem gambling severity level. Their findings lend additional support to the premise that certain types of individuals are more susceptible than others to developing a gambling problem.

Jacobs (1987) has long theorized that the severity of gambling in an adolescent is associated with increased stress and inability to cope with negative life events. From this perspective, gambling becomes a maladaptive solution or a coping response to difficult life situations (Gupta and Derevensky, 1998b; Gupta *et al.*, 2004; Haroon *et al.*, 2004; Bergevin *et al.*, 2006). Co-morbidity may also represent a risk factor. Gambling has been widely correlated with other high-risk behaviors, with adolescent gamblers being more likely to smoke tobacco, drink alcohol and use drugs (Potenza *et al.*, 2000). Adolescents identified as problem or pathological gamblers were more likely to drink alcohol on a weekly basis, to consume drugs or to smoke, compared with those who gambled very little or not at all (Gupta and Derevensky, 1998a; Derevensky and Gupta, 2004).

Experts suggest that risk factors not only play a central role in the initiation and maintenance of gambling behavior, but should also be taken into consideration when targeting interventions, since they consist of complex biological, psychological and sociological factors (DiClemente *et al.*, 2000; Derevensky *et al.*, 2004b, 2004c).

### PREVENTION OF UNDERAGE PROBLEM GAMBLING

The issue of gambling prevention programs designed for youth has been gaining considerable attention in recent years. As society and policy-makers become more aware of the risks and negative consequences associated with underage gambling, the movement towards addressing this issue as both a mental and a public health issue has grown, and substantiates the need for effective prevention initiatives (Korn and Shaffer, 1999; Messerlian *et al.*, 2004). Empirically, while little is known about the science of prevention as it pertains to youth gambling, there is a growing body of literature addressing this issue. Prevention experts have often relied heavily upon existing practices common to the prevention of other high-risk and addictive behaviors, as well on the current youth gambling research findings, when developing prevention materials. Based upon theoretical and empirical evidence of common risk and protective factors across adolescent risky behaviors (Battistich *et al.*, 1996; Galambos and Tilton-Weaver, 1998; Jessor, 1998; Loeber *et al.*, 1998; Costello *et al.*, 1999), including problem gambling (Gupta and Derevensky, 1998b; Jacobs, 1998; Dickson *et al.*, 2002, 2004), many have argued the benefit of developing prevention initiatives that target multiple high-risk behaviors (Derevensky *et al.*, 2004b, 2004c). Such comprehensive

prevention materials have yet to be developed, but surely represent the future trend in prevention.

Prevention efforts addressing adolescent risky lifestyles have traditionally been aimed towards non-users (primary prevention), screening for potential problems (secondary prevention), and treatment (tertiary prevention) for those who have developed problems (e.g., alcohol use and abuse, substance abuse, smoking). In terms of primary prevention, the goal is avoiding or postponing the initial use of substances or activities such as gambling. Considering the far-reaching consequences that result from a gambling problem in adolescence, the importance of primary prevention administered to youth who have not yet gambled or experienced problems related to their gambling cannot be disputed. Research highlights that age of onset of gambling behavior represents a significant risk factor, with a younger age of initiation being correlated with the development of gambling-related problems (Wynne *et al.*, 1996; Gupta and Derevensky, 1998a; National Research Council, 1999; Jacobs, 2000, 2004; Dickson *et al.*, 2004). Thus, delaying the age of onset of gambling experiences would be fundamental in a successful prevention paradigm for youth in primary school, since many have not yet started engaging in gambling behavior.

The question of whether the traditional approach of promoting non-use amongst adolescents is optimal has been an ongoing topic of discussion (Beck, 1998; Thombs and Briddick, 2000), especially in the field of alcohol use and gambling (Dickson *et al.*, 2004), as it is well understood that the majority of high school students have already engaged in these behaviors at some point in their development. The adoption of a harm-reduction paradigm in the prevention of problem gambling may represent the most logical approach for adolescents who have already initiated gambling behaviors. Even though underage youth are prohibited access to government-regulated forms of gambling and venues, research clearly indicates that early gambling experiences mostly occur with non-regulated forms of gambling amongst peers or family members (e.g., playing cards for money, placing bets on sports events, wagering on games of skill, or parental gambling with their children) (Gupta and Derevensky, 1998a; Jacobs, 2000, 2004). With 70–80 percent of children and adolescents reporting having gambled during the previous year (Gupta and Derevensky, 1998a; National Research Council, 1999; Jacobs, 2000), it could be argued that it would be unrealistic to expect youth to stop gambling completely, especially since it is exceedingly difficult to regulate access to gambling activities organized amongst themselves. And while we remain concerned about the occurrence of serious gambling problems amongst youth, it is also recognized that the majority of youth are able to gamble without developing any significant gambling-related problems, as evidenced in the prevalence rates of underage gamblers who are not meeting the criteria for problem or pathological gambling.

Harm-reduction strategies of all types seek to help individuals without demanding abstinence (Riley *et al.*, 1999; Mangham, 2001). Included in such an approach would be secondary prevention strategies, based upon the assumption



that individuals cannot be prevented from engaging in particular risky behaviors (Cohen, 1993; Baer *et al.*, 1998); tertiary prevention strategies (DiClemete, 1999); and a "health movement" perspective (Denning and Little, 2001; Heather *et al.*, 1993; Messerlian *et al.*, 2004). As well, strategies designed as harm-minimization would include the promotion of responsible behavior; teaching and informing youth about the facts and risks associated with excessive gambling; changing erroneous cognitions, misperceptions and beliefs; along with enhancing skills needed to maintain control (setting and adhering to time, frequency and money limits) when gambling. If these skills are encouraged and reinforced through children's formative years, it is plausible that they may become less vulnerable to the risks of a gambling problem once gaining legal access to gambling forums. Given the proliferation and socially accepted practice of gambling, the utility of a harm-reduction approach as a means to prevent problem behavior remains promising. The International Centre for Youth Gambling Problems and High-Risk Behaviors at McGill University ([www.youthgambling.com](http://www.youthgambling.com)) has developed a number of prevention initiatives based upon a harm-minimization approach, such as *The Amazing Chateau* and *Hooked City* (two interactive CD ROM games for children and adolescents aged 11–18); prevention workshops (PowerPoint) for children aged 11–18; and *Clean Break* (a DVD/VHS docudrama designed for adolescents aged 13–18).

#### ISSUES PERTAINING TO THE TREATMENT OF ADOLESCENT GAMBLERS

Adolescents with gambling problems in general tend not to present themselves for treatment. There are likely many reasons that they fail to seek treatment, such as a fear of being identified, and the negative stigma often associated with treatment. Adolescents tend to hold self-perceptions of invincibility and invulnerability, and thus rarely recognize their own problems. Also, those who do realize they are in trouble often believe that no one can help them to control their behavior. Inherent in their thinking is the belief in natural recovery and eventual self-control (for a more detailed explanation, see Gupta and Derevensky, 2000, 2004; Derevensky *et al.*, 2003; Derevensky and Gupta, 2004).

Empirically, not very much has been learned about the treatment of young pathological gamblers. We know that a certain percentage of adolescents develop very serious gambling problems, but only a small minority of those individuals present themselves for treatment in facilities where addiction therapists trained to deal with pathological gambling are located. As such, it is very difficult to develop empirical treatment efficacy studies without access to clinical populations, and even more difficult to conduct Empirically Validated Treatment (EVT) designs or Best Practices (Toneatto and Ladouceur, 2003). Minimum criteria for Best Practices include the replicability of findings, randomization of patients to an experimental group, the inclusion of a matched control group, and the use of sufficiently large numbers of participants. Unfortunately, the treatment of

adolescent pathological gamblers has not yet evolved to the point that treatment evaluation studies have met such rigorous criteria.

Apart from limited access to adolescent clinical populations, there are several other reasons to explain why more stringent criteria, scientifically validated methodological procedures and experimental analyses concerning the efficacy of treatment programs for youth have not been implemented. Primarily, there exist very few treatment programs prepared to include young gamblers amongst their clientele, and the small number of young people seeking treatment in any given center results in the difficulty of obtaining matched control groups. Matched controls are even more difficult to obtain, considering that young gamblers often present with a significant number and variety of secondary psychological disorders. Another obstacle to treatment program evaluation is that treatment approaches may vary within a center, and may be dependent upon a gambler's specific profile or developmental level, or the therapist's training orientation. Given the lack of empirically-based treatment in the field of pathological gambling (for both adolescents and adults), this issue is relatively new compared with existing treatment models for youth with other addictions and mental health disorders. As such, there remains a continuing and growing interest in identifying effective treatment strategies to help minimize youth gambling problems.

Having acknowledged the limited number of treatment outcome studies, in one empirically-based treatment study Ladouceur and colleagues (1994b) implemented a cognitive-behavioral therapy program, using four adolescent male pathological gamblers. Five components were included within their treatment program – information about gambling, cognitive interventions, problem-solving training, relapse prevention, and social skills training. A mean number of 17 cognitive therapy sessions was provided individually over a period of approximately 3 months. Clinically significant gains were reported, with three of the four adolescents remaining abstinent 3 and 6 months after treatment. Ladouceur and colleagues further concluded that the length of treatment necessary for adolescents with severe gambling problems appeared to be relatively shorter than that required for adults, and that cognitive therapy represents a promising new avenue for treatment. It is important to note that this therapeutic approach is predicated upon the belief that (i) adolescents persist in their gambling behavior in spite of repeated losses primarily as a result of their erroneous beliefs and distorted cognitive perceptions concerning their gambling play, and (ii) winning money is central to their continued efforts. However, the limited sample, while somewhat informative, is not sufficiently representative to depict a complete picture.

Research and clinical accounts with adolescents (Gupta and Derevensky, 2000, 2004) suggest that the clinical portrait of adolescent problematic gamblers is much more complex than merely that of underlying erroneous beliefs and the desire to acquire money. As specified previously, our earlier research demonstrated strong empirical support for Jacobs' General Theory of Addictions for adolescent problem gamblers (Gupta and Derevensky, 1998b). Adolescent problem and pathological gamblers were found to have exhibited abnormal

physiological resting states (resulting in a tendency toward risk-taking), greater emotional distress in general (i.e., depression and anxiety), significantly higher levels of dissociation when gambling, and higher rates of comorbidity with other addictive behaviors. The fact that adolescent problem and pathological gamblers differ in their ability successfully to cope with daily events, adversity and situational problems (Gupta *et al.*, 2004; Hardoon *et al.*, 2004; Bergevin *et al.*, 2006) represents a critical component in our treatment approach. Furthermore, contrary to common beliefs and the tenets of the cognitive-behavioral approach, our research and clinical work suggests money is not the predominant reason why adolescents with gambling problems engage in these behaviors (see Gupta and Derevensky, 1998a). Rather, it appears that money is important in that it is merely a means to enable such youth to continue gambling.

Blaszczynski and Silove (1995) further suggest that there is ample empirical support that gambling involves a complex and dynamic interaction between ecological, psycho-physiological, developmental, cognitive and behavioral components. Given this complexity, it would be best to incorporate each of these components into a successful treatment paradigm designed to achieve abstinence and minimize relapse. While Blaszczynski and Silove addressed their concerns with respect to adult problem gamblers, a similar multidimensional approach seems appropriate to successfully address the multitude of problems facing adolescent problem gamblers.

### THE MCGILL TREATMENT PARADIGM

Over an 8-year period of time, we have developed a treatment approach for adolescents with serious gambling problems (for a comprehensive description, see Gupta and Derevensky, 2000, 2004). We have treated in excess of 60 young problem gamblers, ranging in age from 14 to 21 years. While not a sufficiently large number of clients upon which to draw firm conclusions, this nevertheless has provided us with sufficient diversity of experience. Based upon our clinical observations with these individuals, their reported success in remaining abstinent, and their improvement in their overall psychological well-being, the approach adopted in our clinic has been generally successful in assisting youth to resume a healthy lifestyle.

The criterion by which to evaluate success differs from one treatment facility and approach to the next. In a recent review of the gambling treatment literature, Toneatto and Ladouceur (2003) suggest that several different outcome measures have traditionally been used when assessing treatment effectiveness; these being personal ratings of urges, reduction of gambling involvement, and gambling cessation. Our treatment philosophy is predicated upon the assumption that sustained abstinence is necessary for these youth to recover from their gambling problem, and that their general overall psychological well-being and mental health must be improved (this also includes improvement in their coping skills and adaptive behaviors). It is important to acknowledge that a number

of individuals contend that *controlled* gambling for certain adults is a viable alternative to an abstinence approach. During the past 8 years, we have observed a large percentage of youth in treatment who, initially, had controlled gambling as their primary goal. Our clinical work suggests that while controlled gambling (the ability to establish and respect self-imposed limits) can be an interim goal, abstinence is eventually necessary for adolescents with gambling problems.

While our treatment approach is unique, its theoretical basis is predicated upon the principles outlined in Jacobs' General Theory of Addictions and Blaszczynski's Pathways Model (see Nower and Blaszczynski, 2004, for a comprehensive discussion of how the Pathways Model can be adapted to explain youth problem gambling). Both theories presuppose that the interaction of a combination of factors (emotional, psychological and physiological) has an important role in the acquisition and maintenance of a gambling problem. The Pathways Model further elaborates three different subtypes of pathological gamblers – each subtype having a different etiology and different accompanying pathologies. It is postulated and assumed that the different subtypes of pathological gamblers would by necessity require different types of intervention. While there is some overlap between the two models, with both describing the etiology, trajectory and psychology of the addicted gambler, Jacobs' model primarily describes the Pathway 3 gambler articulated by Nower and Blaszczynski. The commonalities lie in the belief that these youth have a combination of emotional and/or psychological distress coupled with a physiological predisposition toward impulsively seeking excitement. This subset of problem gamblers represents our most typical young clients who seek therapy; those tending to gamble impulsively primarily for purposes of escape and as a way of coping with their stress, depression and/or daily problems. Longitudinal data recently published following low-income young boys aged 11–16 years suggests that early indicators of gambling problems include indices of anxiety and impulsivity (Vitaro *et al.*, 2004). Recent research has also replicated earlier findings that adolescent problem gamblers are more likely to be exposed to peer and parent gambling, to be susceptible to peer pressure, to exhibit conduct problems and antisocial behaviors, to engage in substance use, and to have suicide ideation and indicate more suicide attempts (Derevensky and Gupta, 2004; Langhinrichsen-Rohling *et al.*, 2004).

Since adolescents rarely voluntarily seek treatment for gambling problems, a considerable number attend because of parental pressure, mandatory referrals from the judicial system, or are strongly encouraged by significant others (girlfriends, boyfriends, close peers) and comply for fear of losing relationships. As such, many are reticent about participating at first. The youth to whom we have provided treatment tend to share similar profiles. Other than the previously mentioned psychological variables of depression, anxiety, impulsivity and poor coping abilities, it is not uncommon to see youth who have a history of academic difficulties (usually due to a learning disability and/or attention deficit disorder and further compounded by their gambling preoccupation and gambling



behavior), have stressed interpersonal relationships with family members and friends, are involved with unhealthy peer groups, and are engaging in delinquent and criminal behaviors to support their gambling. The description of our treatment philosophy and approach is briefly provided to help individuals interested in working with young problem gamblers to acquire a better understanding of the different components necessary when working with these youth. Treating youth with severe gambling problems requires clinical skills, a knowledge of adolescent development, an understanding of the risk factors associated with problem gambling, and a thorough grounding in the empirical work concerning the correlates associated with gambling problems. By no means should this brief description substitute for proper training.

### Initial Process

There are three basic processes that are necessary to establishing a successful therapeutic experience:

1. *Establishing mutual trust and respect.* Mutual trust and respect are fundamental to the therapeutic relationship. Total honesty is emphasized and a non-judgmental therapeutic relationship is provided. This results in the adolescent not fearing reactions of disappointment if weekly personal goals are not achieved. However, since treatment is provided without cost, clients are required to respect the therapist's time. This involves calling ahead to cancel and reschedule appointments, punctual attendance of sessions, and a commitment to complete "homework" assignments.

2. *Assessment and setting of individual goals.* Since the emphasis of different therapeutic objectives is tailored to the individual, a more detailed profile of the client is required. This is accomplished through comprehensive clinical interviews (beyond intake assessment), usually taking place over the first three sessions. The initial interview consists of the completion of several instruments primarily designed to screen for gambling severity, impulsivity, conduct problems, depression, antisocial behaviors, and suicide ideation and attempts. Their responses to these measures are followed up through more in-depth diagnostic interviews over the next few sessions, and more details about the consequences associated with their gambling (i.e., academic and/or occupational status, peer and familial relationships, romantic and inter-personal relationships, legal problems, etc.) are obtained. This comprehensive evaluation allows for the therapeutic goals to be established. For example, an adolescent who presents with serious depression will not be approached in the same manner as one who does not evidence depressive symptomatology. If a client presents with a severe depression, this becomes the initial therapeutic objective while the gambling problem becomes a secondary objective. Interestingly, for many youth, once gambling has stopped depressive symptomatology actually increases as youth report that their primary

source of pleasure, excitement and enjoyment has been eliminated. It is therefore important to screen for depressive symptomatology periodically throughout the therapeutic process.

3. *Assessment of readiness to change.* An important factor influencing the therapeutic approach relates to the client's current willingness to make significant changes in his or her life. Our experience suggests that most adolescents experiencing serious gambling-related problems are reluctant to attend and are not convinced that they really want to stop their gambling completely. Rather, most state that they believe in *controlled* gambling, and hold on to this belief for some time in spite of our reluctance and experience. Some individuals seek basic information concerning pathological gambling, but remain open to the idea of making more permanent changes. Others have decided that they really must stop gambling, but are unable to do so without therapeutic assistance and support. Finally, some adolescents have made the decision to stop gambling, and do so prior to their first session but require support in maintaining their abstinence. These three examples depict adolescents in different stages of the process of change.

While there is a multiplicity of approaches taken, depending upon the individual's severity of gambling problems, underlying psychological disorders or problems, age, and risk factors, the overall therapeutic philosophy remains similar, with different weightings of therapeutic goals placed where most needed.

### Goals of Therapy

Within our treatment philosophy, the overall framework is to address multiple therapeutic goals simultaneously over time, tailoring the time allocated to each goal to the client. Some require greater emphasis on psychological issues, others on their physiological impulses and others on environmental/social factors, while others require examining their motivations to change. Each client receives individualized therapeutic attention, as an outpatient, in all areas to ensure they are achieving a balanced lifestyle. This approach is consistent with DiClemente and colleagues' (2000) Transtheoretical Model of Intentional Behavior Change for adolescent gambling problems, whereby they call for a multimodal, multi-goaled therapeutic approach.

The McGill Approach adopts the following goals of therapy:

1. *Understanding the motivations for gambling.* Adolescents experiencing serious gambling problems continue gambling in the face of repeated losses and serious negative consequences as result of their need to dissociate and escape from daily stressors. Without exception, youth with gambling problems report that when gambling they enter a "different world," a world without problems and stresses. They report that while gambling, they feel invigorated, excited and alive, they are admired and respected, that time passes quickly, and all their problems are forgotten, be they psychological, financial, social, familial,

academic, work-related or legal. As such, for these individuals gambling becomes the ultimate escape. Once we understand a person's primary and secondary reasons for gambling, we can try to replace the gambling activity for another that may approximate the same benefits.

2. *Analysis of gambling episodes.* Self-awareness is essential to the process of change. By understanding the underlying factors prompting certain behaviors, individuals feel empowered to gain control over their actions and ultimately to make behavioral changes. It is important to achieve an awareness of their gambling triggers, their psychological and behavioral reactions to those triggers, as well as the consequences which ensue from this chain reaction. The following model provides an overview of the framework.

Triggers → Emotional reactions and rationalizations → Behavior → Consequences

Triggers can consist of places, people, times of day, activities, particular situations, and/or emotions. While initially many individuals are unaware of their specific triggers, they can be identified through discussions of prior experiences, as well as by examining written journals (a component within the therapeutic process). Typical triggers include handling of large sums of money, gambling advertisements or landmarks, anxiety or depressive symptomatology, interpersonal difficulties, enticement of peers, stressful situations (e.g., academic failure, exams, a loss of some kind), the need to make money quickly, or quite simply daydreaming of engaging in gambling. Possessing an awareness of his or her triggers provides a person with a better ability to deal with gambling urges.

It is also important to properly understand the times in the individual's day when they do not seem to have the urge to gamble. Identifying the circumstances, time of day, who they are with, their emotional state, activity levels, physical location, etc., is essential. Understanding the circumstances in which the urge to gamble is minimal or absent provides a set of guidelines by which the therapist can help to recreate similar situations at other times in the day.

3. *Establishing a baseline of gambling behavior and encouraging a decrease in gambling.* Once the motivations for gambling are understood and an analysis of gambling patterns completed, efforts are then focused on making changes to the adolescent's gambling behavior. In order to set goals and measure improvements, we find it useful and important initially to establish a baseline of gambling behavior. Adolescents record their gambling behaviors in terms of frequency, duration, time of day, type of gambling activity, amount of money spent, losses and wins (it is interesting to note that adolescent problem gamblers, like their adult counterpart, consistently underestimate their losses).

When establishing goals for a decrease in gambling participation, individuals are guided to establish *reasonable* goals for themselves. Some elect to target multiple factors simultaneously (e.g., frequency, duration and amount wagered), while others may focus on one aspect of their behavior. For these individuals we encourage a decrease in frequency or duration of each gambling

episode versus initially focusing on amount wagered. Some meet their goals immediately, at which point we generally support decisions to maintain this decrease for several weeks while setting new goals immediately. Others struggle to meet their goals, at which point goals are generally modified.

4. *Challenging cognitive distortions.* It has been well established that individuals with gambling problems experience multiple cognitive distortions (Langer, 1975; Ladouceur and Walker, 1998). They are prone to having an illusion of control, and perceive that they can exert control over the outcome of gambling events; they underestimate the amount of money lost and over-estimate the amount won; they fail to utilize their understanding of the laws of independence of events; and they firmly believe that if they continue gambling they will likely win back all or most of the money lost ("chasing behavior"). Addressing these cognitive distortions and chasing remains an important treatment goal.

In addition to addressing the erroneous cognitions, it is important to also identify the rationalizations people make to justify their gambling behavior. These rationalizations also represent distortions of reality. An example of a rationalization for gambling is, "If I gamble now, I will be in a good mood and I will be more able to have fun at my friend's party tonight", or "By gambling now, the urge will be out of my system and I'll be more able to focus on studying for my exam". The overarching is to ensure the individual comprehends that the gambling episode will likely result in a bad mood if they are to lose money – and thus a negative mood at the party; or an inability to focus on studying for the exam.

Ultimately, the goal of addressing many of the cognitive distortions is to highlight how their thinking is self-deceptive, to provide pertinent information about randomness, and to encourage a realization that they are incapable of controlling outcomes of random events and games, payout rates, etc.

5. *Establishing the underlying causes of stress and anxiety.* In the light of empirical research and clinical findings, a primary treatment goal is to identify and treat any underlying problems that results in increased stress and/or anxiety. In general, these include one or more of the following problems: personal (e.g., low self-esteem, depression, ADHD, oppositional defiant disorders), familial, peer, academic, loss, vocational and legal. These problems are addressed through traditional therapeutic techniques, and alternative approaches to problem-solving are supported while sublimation, projection, repression and escape are discouraged.

6. *Evaluating and improving coping abilities.* The need to escape their problems usually occurs more frequently among individuals who have poor coping and adaptive skills. Using gambling or other addictive activities to deal with daily stressors, anxiety or depression represents a form of maladaptive coping. Recent research efforts have confirmed these clinical observations, where adolescents who meet the criteria for pathological gambling demonstrated poor coping skills as compared with same-age peers without a gambling problem (Nower *et al.*, 2000; Gupta *et al.*, 2004; Hardoon *et al.*, 2004; Bergevin *et al.*, 2006). A primary therapeutic goal involves building and expanding the



individual's repertoire of coping abilities. As adolescents begin to comprehend the benefits of effective coping abilities and their repertoire of coping responses expands, they are more apt to apply these skills to their daily lives. Examples of healthy coping skills include honest communication with others, seeking social support, and learning to weigh the benefits or downfalls of potential behaviors. Also included in the discussions and role-playing exercises are ways to improve social skills (e.g., learning to communicate with peers, developing healthy friendships, being considerate of others, and developing trust).

7. *Rebuilding healthy interpersonal relationships.* Common consequences of a serious gambling problem involve impaired and severed relationships with friends, peers, family members and employers. Helping the adolescent to rebuild these crucial relationships constitutes an important therapeutic goal. Often friends and family members have become alienated through lies and manipulative behaviors resulting from the individual's gambling problem, leaving unresolved negative feelings. Once a youth has been identified as being a liar or a thief, it becomes difficult to earn back the trust of others and to resume healthy relationships – something the adolescent has difficulty accepting once his or her gambling has stopped. It is important to explain to family members and friends that these deceptive actions are part of the constellation of problematic behaviors exhibited by individuals having difficulty controlling their gambling. Consequently, once the actual gambling is under control, family member and friends can anticipate being treated with more respect. Family members, peers, and significant others become extremely important support personnel to help ensure abstinence, and can take an active role in relapse prevention. We contend that youth with gambling problems will be happier and are more likely to abstain from gambling if they feel they belong to a peer group and are supported by family and friends. As a result, the occasional inclusion of family members and friends in therapy sessions can prove to be very beneficial.

8. *Restructuring free time.* Adolescents struggling to overcome a gambling problem experience more positive outcomes when not faced with large amounts of unstructured time. Some adolescents in treatment are still in school and/or have a job, and as such their free time consists mainly of evenings and weekends. Others have dropped out of school and may have a part-time job while others are not working. For these youth, structuring their time becomes paramount as they initially find it exceedingly difficult to resist urges to gamble when they are bored. With the use of a daily agenda, we help them to articulate ways of spending time with friends, family, school- or work-related activities. Other activities can involve participating in organized sports activities, engaging in a hobby, and performing volunteer work. A successful week is measured not only by meeting their goals in regard to their gambling participation, but also by how they use their free time. This approach tends to keep the young gamblers from being discouraged, and motivates them to keep trying to attain a balanced lifestyle.

9. *Fostering effective money-management skills.* These skills are typically lacking in adolescents who have a gambling problem. Therapeutic goals involve

educating them as to the value of money (as they tend to lose perspective after gambling large sums), building money management skills, and helping them to develop effective and reasonable debt-repayment plans.

10. *Relapse prevention.* Despite a lack of strong empirical evidence, our clinical work suggests that abstinence from gambling is necessary in order to prevent a relapse of pathological gambling behaviors. It should be noted that small, occasional relapses throughout the treatment process are to be expected. However, once gambling has ceased for an extended period of time (i.e., 4–6 months), an effective relapse prevention program should help these individuals to remain free of gambling. Relapse prevention includes continued access to their primary therapist, the existence of a good social support network, engagement in either school or work, the practice of a healthy lifestyle, and avoidance of powerful triggers. Gamblers representative of Nower and Blaszczynski's (2004) Pathways 2 and 3 are more apt to need additional support after the termination of therapy.

### OTHER CONSIDERATIONS

While we have not elaborated upon how to treat youth with multiple addictions, it is clear that gamblers with concomitant substance abuse problems pose a greater challenge for treatment (Ladd and Petry, 2003). Youth with clinical levels of depression, high levels of impulsivity and anxiety disorders are often referred to psychiatry to simultaneously engage in pharmacological treatment while undergoing therapy. The use of serotonin re-uptake inhibitors tend to be effective in helping these youth manage their depression and anxiety, and preliminary research suggests that they may be useful in lowering the levels of impulsivity which often underlie pathological gambling behavior (Grant *et al.*, 2003, 2004).

### FINAL REMARKS

While the incidence of severe gambling problems amongst youth remains relatively small, the devastating short- and long-term consequences for affected individuals, their families and friends are significant. New forms of gambling have changed the landscape considerably. There is beginning to be evidence that more youth are engaging in online gambling, and that a high percentage of these youth are experiencing gambling-related problems (Derevensky *et al.*, 2006). While some governments (in particular the US government) are seeking to restrict Internet gambling, many others throughout the world are licensing, regulating or operating sites. Simultaneously, many other land-based forms of gambling are appearing daily, with significant increases in sports wagering, and lotteries, electronic gaming machines and casinos springing up in most countries.

Gambling has become a primary form of entertainment, and one of the fastest-growing industries throughout the world. The widespread acceptance of and

greater opportunities for accessing multiple venues are going to be a significant challenge. While these venues are primarily being developed for adults, the rate of gambling for young adults is amongst the highest for all age groups. Notwithstanding the operators' perspective and diligence to ensure that underage gambling is prohibited, underage youth have managed to be engaged in all forms of personal and state-sponsored and regulated gambling. In North America, some of the more highly rated television shows and movies have significant gambling themes. The adventuresome *James Bond* is one persona that youth admire.

Today's youth treat the winners of the World Championship Poker series as cult heroes who are known and admired. More and more international stars are sponsoring or have major stakes in Internet companies. The appeal, thrill of winning and lure of gambling are becoming increasingly attractive. The fact that few adolescents fear getting caught gambling and are often encouraged to play poker in their homes by their parents (gambling and poker is viewed as less problematic than most other addictive behaviors) without acknowledging any of the potential warning signs for excessive gambling is particularly problematic.

The fact that the prevalence rate for youth with severe gambling problems remains higher than that for adults is of significant concern. Societal trends continue to indicate that gambling is becoming more mainstream, and youth are being influenced and exposed through traditional media such as television, mobile phones and the Internet. The complete etiology of problem gambling among youth is unclear, but we do know that parenting style, acceptability, exposure, access to gambling venues, personality traits, impulsivity and emotional disposition all interact together to place certain individuals at increased risk at a very young age. It is important, now more than ever, that youth adopt healthy attitudes towards gambling, such that they recognize it is not a way to make money, nor is it a healthy way to escape from life stressors. As one teen told us, "Gambling is an equal opportunity destroyer. I wouldn't wish my gambling problems on my worst enemy as it is way too harsh a punishment". The implementation of prevention programs, as well as providing therapeutic support for those experiencing problems, remains essential.

While somewhat similar in many ways to other adolescent high-risk behaviors, gambling problems among youth have gone relatively unnoticed. Often referred to as the hidden addiction, all individuals working with adolescents are well-advised to understand and address this issue.

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