McGILL UNIVERSITY

A FULL HOUSE: THE GAMBLERS, THEIR FAMILIES, AND FAMILY-BASED INTERVENTION STRATEGIES FOR PROBLEM GAMBLING

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Table of Contents

List of Tables and Appendices

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Introduction

Gambling can be defined as "a wager of any type of item or placing value upon a game or event of uncertain outcome in which chance, to varying extents, determines the outcome" (Murray, 1993, p. 271). It is an ancient activity practised by people in societies all over the world. Today in North America, where gambling opportunities exist in many forms, most people have gambled at some time in their lives. Years ago illegal gambling controlled the gambling domain, however, revenue from legal gambling endeavours are now used by governments and charities to fund a variety of economic goals. Legal and illegal gambling are not only big business, they represent a growth industry (Nova Scotia Lotteries Commission, 1993; Rosecrance, 1988). Gambling has become part of our social fabric.

The majority of Canadian adults regularly take part in some form of gambling. Most gamble for fun and recreation without complications, but for some, gambling becomes a problem. Canadian research studies have found that between 1.5% and 8.6% of the adult population are experiencing gambling related difficulties.

The diverse group of people suffering from problem gambling tend to experience multiple difficulties, the effects of which are also felt by family members, friends, and coworkers. It has been estimated that problem gambling not only affects the gambler but also impacts the lives of 10-17 of the gambler's significant others (Staff, 1995). Many lives are negatively affected by this socially promoted and accepted behaviour.

Public awareness of problem gambling and the difficulties endured by those affected is growing. A recent telephone survey of 1,500 Canadians found that 61% felt that problem gambling was of concern and 42% felt that it represented a significant

problem while 70% acknowledged it as a growing problem. Robertson (1994) reported that one in three Canadians sampled knew a problem gambler.

Canadian research on and treatment initiatives for problem gambling have been limited in the past; however, recently the issue has been receiving more attention. Provincial governments, such as Saskatchewan, Alberta, Manitoba, Nova Scotia, and Ontario have allocated monies obtained from gambling revenues to deal with problem gambling, although, British Columbia and Quebec have not (Downey, 1995).

It is the purpose of this paper to bring attention to problem gambling and the impact it has on many adult Canadian gamblers and their families. An attempt is made to provide a comprehensive picture of the complex situation faced by the gambler and the family when gambling becomes a problem. Family-based interventions are described in an effort to aid social workers who work with the gambler's family. Using a systems-based perspective, recommendations derived from the literature review are presented as a guide to facilitate a positive intervention process and a successful outcome.

Four research questions motivate this study -- What is problem gambling? What are the characteristics of adult problem gamblers? How does problem gambling affect the gambler's family members? and, What family-based interventions approaches are employed in treatment?

Research Method

Data collection for this project includes a review of relevant literature from books, journals, and government documents. The focus of the literature review is on Canadian references, supplemented by international references, particularly that of the United States. A case study obtained through an interview with a problem gambler is included.

Chapter 1: Problem Gambling

1.1.0. Definition of Terms

Several terms have been used to identify gambling related difficulties. Terms, such as compulsive, pathological, and problem gambling differ in meaning from one investigator to the next (Rosenthal, 1989). Moreover, these terms are at times used interchangeably in the literature (Murray, 1993). It is difficult to get an agreed upon definition of problem gambling.

For the purpose of this paper the term problem gambler will be used to refer to people who demonstrate compulsive, pathological or problem gambling. The terms compulsive and pathological gambling will be used with reference to literature citations.

1.1.1. Compulsive Gambling

Compulsive gambling is used to describe the behaviour of persons having problems resulting from gambling. A compulsion can be defined as "an irresistible urge to a form of behaviour, especially against one's conscious wishes" (Allen, 1990, p. 235). Thus, according to the compulsion model, the problem gambler does not necessarily want to gamble but has no control over gambling behaviour.

Gamblers Anonymous (GA) has given specific meaning to the term compulsive gambling. It is described in the GA literature as a progressive, chronic illness. The compulsive gambler is a person "whose gambling has caused growing and continuing problems in any department of his or her life" (Gamblers Anonymous (GA), 1993, p. 9). According to GA compulsive gambling can be identified by the twenty-item questionnaire in Table 1.

Table 1: The Twenty Questions of Gamblers Anonymous

1.	Did you ever lose time from work due to gambling?
2.	Has gambling ever made your home life unhappy?
3.	Did gambling affect your reputation?
4.	Have you ever felt remorse after gambling?
5.	Did you ever gamble to get money with which to pay debts or otherwise solve financial difficulties?
6.	Did gambling cause a decrease in your ambition or efficiency?
7.	After losing did you feel you must return as soon as possible to win back your losses?
8.	After a win did you have a strong urge to return and win money?
9.	Did you often gamble until your last dollar was gone?
10.	Did you ever borrow to finance your gambling?
11.	Have you ever sold anything to finance gambling?
12.	Were you reluctant to use "gambling money" for normal expenditures?
13.	Did gambling make you careless of the welfare of yourself and your family?
14.	Did you ever gamble longer than you have planned?
15.	Have you ever gambled to escape worry or trouble?
16.	Have you ever committed, or considered committing, an illegal act to finance gambling?
17.	Did gambling cause you to have difficulty in sleeping?
18.	Do arguments, disappointments or frustrations create within you an urge to gamble?
19.	Did you have an urge to celebrate any good fortune by a few hours of gambling?
20.	Have you ever considered self destruction as a result of your gambling?

Note. From GA (p. 15) by GA, 1993, California: GA International Service Office.

Answering "yes" to seven or more of the twenty questions is indicative of compulsive gambling (GA, 1993). However, it has been noted that GA's twenty questions produces a large number of false-negatives (Lesieur & Blume, 1987).

There is some movement away from the term compulsive gambling. Many authors feel that this term is wrongly applied as problem gambling does not have the same qualities as a classic compulsive neurosis. They argue that most problem gamblers want to gamble, and in fact, enjoy gambling at least initially (Walker, 1992).

1.1.2. Pathological Gambling

A term, used by proponents of the medical model, to describe problem gambling behaviour is pathological. Pathological refers to a disease or abnormality of or caused by a physical or mental disorder (Hawkins, 1990). Pathological gambling and its definition

described by the American Psychiatric Association (APA) are believed by some to be more descriptive of problem gambling behaviour than compulsive gambling (Lesieur & Rosenthal, 1991).

Definition and diagnostic criteria have evolved over time. Pathological gambling was first recognized as a diagnosable mental illness in the Diagnostic and Statistical Manual third edition (DSM-III), the APA's approved diagnostic manual of mental disorders, in 1980. Recently, a set of revised criteria were described in the DSM-IV (1994). Still categorized among impulse control disorders, pathological gambling is now viewed as being similar to psychoactive substance dependency (Rosenthal, 1989). This "persistent and recurrent maladaptive gambling behaviour that disrupts personal, family, or vocational pursuits" is diagnosed when at least five (American Psychiatric Association (APA), 1994, p. 609) of the empirically derived criteria depicted in Table 2 are met (Walker, 1992).

Table 2: DSM-IV Diagnostic Criteria for Pathological Gambling

(1)	is preoccupied with gambling (e.g., 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 dysphoric 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, therapist, 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

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

Note. Adapted from Diagnostic and Statistical Manual of Mental Disorders DSM-IV (p. 618) by APA, 1994, Washington, DC: APA.

A distinction is drawn between social and professional gamblers and pathological gamblers, as pathological gamblers form a categorial group separate from other gamblers. The social gambler usually gambles for entertainment with friends or co-workers for a limited amount of time and with a predetermined amount of acceptable losses. The professional gambler takes limited risks in a controlled fashion (APA, 1994).

1.1.3. Problem Gambling

Some authors prefer to use the term problem gambling. The term problem gambling can be defined as "the losing of excessive amounts of money through gambling, whereby the individual's financial situation determines how much is excessive" (Rosecrance, 1988, p. 117). This term is preferred particularly because it is more descriptive of gambling behaviour witnessed in natural settings and it allows for the consideration of a range of harmful behaviours (Lesieur & Rosenthal, 1991; Rosecrance, 1988).

The range of gambling behaviour can be described as existing on a continuum from no problems to serious problems. Gamblers are not categorized in either problematic or non-problematic groups. As such, problem gambling is applied to "all behaviour which may compromise, disrupt or damage family, personal or vocational pursuits" (Lesieur & Rosenthal, 1991, p. 7). Social learning, not illness, affects the individual's place on the continuum (Rosecrance, 1985, 1986, 1988).

1.2.0. Theories

There are two major schools of thought delineating the development of problem gambling: 1) the phase or stage theories and, 2) the continuum or dimensional theories.

Phase theory dominates the literature. This medical model is based on data obtained from self-reports made by problem gamblers and on clinical interpretations of those reports obtained from either treatment facilities or GA. Continuum theory is based on data obtained in natural gambling settings (ARF, 1995).

1.2.1. Phase Theory

One model that comprises phase theory was originated by Custer (1984) and depicts the development and recovery from problem gambling. Of relevance here, are the phases that are believed to be representative of the development and progression of problem gambling - winning, losing, and desperation. The gambler is believed to pass inexorably through the phases.

The Winning Phase begins with gambling that starts as an occasional recreational activity. Some people experience a "big win". This is thought to be crucial as it often leads to increased excitement and unrealistic expectations resulting in a rise in gambling. The individual believes that more wins will occur; consequently, larger risks are taken. When winning self-esteem is enhanced (Custer, 1984). Other people report gambling to "escape" from problems (Lesieur & Rosenthal, 1991). When gambling, euphoria is experienced. The ability to escape, combined with the euphoria resulting from gambling has been depicted by many who gamble to escape as "an anaesthetic which hypnotizes" (Lesieur & Rosenthal, 1991, p. 13). This disoriented state has been referred to as "dissociative" and is characterized by such things as "memory blackouts" and "trances".

In the Losing Phase gambling behaviour begins to dominate life. The gambler begins to "chase" losses, an increase in betting accompanied by a sense of urgency to

recoup losses. Gambling continues with optimism but losses increase to the point where financial resources become depleted; chasing continues. For many, the social aspect of gambling is lost. Covering up and lying occurs as the gambler tries to hide gambling behaviour. Family and work life suffer. Accumulated debt leads the gambler to seek out financial help or take part in illegal activity. A "bail out" occurs whereby the gambler obtains money to pay back debts. Promises to cut down on gambling are often short lived. Many begin to wager more heavily (Custer, 1984; Lesieur & Rosenthal, 1991).

In the Desperation Phase the individual becomes consumed by gambling. Relationships continue to be negatively impacted. Often more bail-outs occur. If there is involvement in criminal activity it continues and may be rationalized as a loan or may be somehow justified. Still the gambler remains optimistic, believing that a big win is close by. Stress felt throughout the phases escalates. The gambler becomes increasingly restless and irritable. Regular sleeping and eating patterns are disturbed. Feelings of helplessness and hopelessness are experienced. Often the gambler suffers physical and psychological exhaustion. Some fantasize about starting life over with a new identity. At this point, many consider suicide. Even at this stage the desire to gamble persists (Custer, 1984; Lesieur & Rosenthal, 1991).

The hopeless or giving up phase, recently added by Rosenthal, is not reached by all gamblers. In this phase gambling proceeds regardless of the consequences. The pleasure and excitement derived from being "in action" is all that matters. The gambler at this stage often gambles to the point of exhaustion (Lesieur & Rosenthal, 1991).

1.2.2. Continuum Theory

Continuum theory offers another explanation for the development of problem gambling. Theorists adhering to this model argue that the unyielding phase-like process has not been found in natural settings. A distinct category of pathological or compulsive gamblers does not exist. The compulsion/medical model is believed to be largely a social and political creation (Blaszczynski & McConaghy, 1989a; Rosecrance, 1985, 1986, 1988).

Rosecrance (1988) attempted to place problem gambling within a conceptual model. He related that there is not one behavioural pattern of problem gambling -- it is characterized by an assortment of patterns having the common denominator of the loss of excessive amounts of money. Gambling behaviour exists on a continuum ranging from problem free to problem dominated; any individual who gambles can move along the continuum. The development of problem gambling can be altered and stopped because as Brown (1987) noted, although erratic, systems of self-monitoring, self-control, and self-evaluation exist.

Continuum theorists view problem gambling as a product of social learning. Often the gambler learns the behaviour through friends. The social context affects frequency of play and amount wagered. Strategies of play, beliefs about gambling, method of managing finances, and coping methods impact on the individual's position along the continuum (Blaszczynski & McConaghy, 1989a; Sharpe & Tarrier, 1993). If gambling provides an adaptational function for the individual, often as a means to stimulate or escape, large losses result and lead to chasing. Strategies to obtain gambling money are

developed. Life crisis resulting from gambling leads to increased gambling which eventually levels out. Cues such as people, places, events, and situations impact the gambler's behaviour resulting in losses, chasing, and increased losses.

These two models of problem gambling serve to define and guide practice (Shaffer, 1993). Generally, when working with problem gamblers proponents of the phase theory opt for the goal of abstinence, while proponents of the continuum theory opt for the goal of controlled gambling (McGurvin, 1992).

Chapter 2: Problem Gamblers

2.1.0. Incidence

Gambling has existed in many cultures for thousands of years. McGurvin (1992) noted that gambling has been around since the beginning of civilization. Cross-cultural archaeological finds such as artifacts and records establish gambling among Babylonian (3000 B.C.), Etruscan, and ancient Chinese cultures. Furthermore, throughout the ages gambling behaviour has been accompanied by problem gambling (Orford, 1985). Gambling and problem gambling are not new phenomena.

Most adults in Canada have gambled. Canadian studies have yielded a large variance in the incidence of adult gambling. Table 3 illustrates the gambling behaviour of adult Canadians.

Table 3: Lifetime Incidence of Adult Gambling in Canada

Province	Participation %	Author(s)/Date
Alberta	70%	Bland, Newman, Orn & Stebelsky, 1993
	93%	Wynne Resources Limited, 1994
Ontario	67%	Insight Canada Research, 1993
Quebec	88%	Ladouceur, 1991
New Brunswick	87%	Baseline Market Research, 1992
Nova Scotia	80%	Omnifacts Research Limited, 1993

These rates represent a sharp increase from previous years. For example, the proportion of adult Canadians who gambled in 1949 was 57%. By 1980 the rate had risen to 78% (Ladouceur & Mireault, 1988). Changing attitudes and legislation have led to a substantial rise in the rate of gambling behaviour in the last two decades (Wynne Resources Ltd., 1994).

Cross country Canadian studies on the prevalence of problem gambling give a patchwork impression of its extent. Table 4 summarizes recent Canadian studies comparing the incidence of problem and pathological gambling (see Table 4, p. 14).

Although limited, studies to date show significant differences in the incidence of problem gambling within Canadian jurisdictions. In Canada the reported range for current problem gambling is 2.6% to 7.7%, while the reported range for current pathological gambling is 0.23% to 1.5%. If we consider the lifetime rates of problem gambling and pathological gambling, then the scope of the problem becomes even larger. Additionally, the gambler's significant others are affected by the gambler's behaviour (Lorenz & Yaffee, 1988). Even assuming the lower limits, a small but significant portion of Canadians are currently affected.

There are problems inherent in Canadian epidemiological studies. Consistency of data reported varies between studies. For example, Bland et al. (1993) noted that some studies did not specify the period that the interviews were conducted (i.e., Ladouceur, 1991). Furthermore, studies are difficult to compare as assessment tools used in obtaining and categorizing information vary (i.e., Bland et al., 1993; Ladouceur, 1991).

The tools used to detect problem gamblers are not free of problems. Culleton (1989) argued that the South Oaks Gambling Screen (SOGS), a dependency scale, may lead to an over-estimation of the incidence of pathological gambling due to problematic baseline rates (see Appendix A for a copy of the SOGS). The validity and reliability of the SOGS has been questioned in cross-cultural studies; some respondents have been found to answer questions in a culturally-defined fashion (Lesieur, 1994). As well, some

researchers have modified the SOGS (i.e., Omnifacts Research Ltd., 1993) thus reducing its ability to be used for comparative incidence rates.

Different strategies of obtaining information yield different results. For example, self-reported data having questionable reliability leads to possible methodological problems. Some researchers believe that problem gamblers, known to deny or lie about gambling behaviour, may participate more reliably in telephone interviews due to the anonymity provided (Bland et al., 1993). Others believe that individuals feel more uncomfortable when personal questions are asked over the telephone. The situation is further complicated because problem gamblers having large debts may not have telephones and consequently may be under-represented. There have been large non-response and refusal rates for telephone surveys. Non-responses may occur because the individual is busy gambling. Refusals may result from the avoidance of calls due to debtors seeking payment (Lesieur, 1994). Language also presents a barrier; people who are not proficient in the language in which the survey is conducted are more apt to decline participation (Wynne Resources Ltd., 1994). Therefore, the results of incidence studies must be evaluated carefully.

2.2.0. Demographic Profile

The stereotypical image of the high rolling, big spending, middle-aged male problem gambler is changing. Studies are beginning to demonstrate a demographic picture of individuals at risk. The data from several demographic categories differ according to the setting from which they are obtained; *general population* or *treatment population.* Therefore, both the general population and the treatment population of problem gamblers will be examined.

Table 4: Current and Lifetime Problem and Pathological Gambling in Canada

Author(s)		sample size	tools	Lifetime Incidence Problem Gambling	Lifetime Incidence Pathological Gambling	Current Incidence Problem Gambling	Current Incidence Pathological Gambling	Total Lifetime Incidence Problem & Pathological Gambling	Total Current Incidence Problem & Pathological Gambling
Omnifacts Research Ltd., 1993	NS	810	Adapted SOGS	3.1%	1.7%	-	-	4.8%	-
Baseline Market Research Ltd., 1992	NB	800	Adapted SOGS	4.0%	2.0%	3.1%	1.4%	6.0%	4.5%
Ladouceur, 1991	QC	1002	SOGS	-	-	2.6%	1.2%	-	3.8%
Insight Canada Research, 1994	ON	1200	SOGS	-	-	7.7%	0.9%	-	8.6%
ARF, 1995	ON	2600	-	-	-	2.6%	1.5%	-	4.1%
Gemini Research, 1993	MB	-	-	-	-	1.3%	-	-	-
Wynne Resources Ltd., 1994	AB	1803	SOGS-R	5.8%	2.7%	4.0%	1.4%	8.5%	5.4%
Bland et al., 1993	AB	7214	DIS	-	0.4%	-	0.2%	-	-
BC Ministry of Health, 1995	BC	1200	-	6.0%	1.8%	2.4%	1.1%	7.8%	3.5%

Note: Diagnostic Interview Schedule (DIS), South Oaks Gambling Screen - Revised (SOGS-R)

2.2.1. Age

An inverse relationship exists between age and gambling behaviour. For example, in 1989, a random telephone survey of 1,011 Iowa residents was conducted by Mok and Hraba (1991). Using the Gambling Behaviour Scale they found that the oldest (85 years or older) and the youngest (18-24 years) had the lowest and highest gambling behaviour scores, respectively. Furthermore, gambling behaviour gradually decreased from the 18-24 age category to the 55-64 age category. It then decreased at a progressively faster rate with the 65-74, 75-84, and 85 years plus age groups. After controlling for variables such as social class, marital status, employment status, gender, and religion the relationship between age and gambling behaviour weakened but still existed. The authors hypothesized that these findings may be due to the historical increase in the acceptance of gambling, as well as diminished experimentation with gambling for self-identity and self-preservation in older individuals.

Canadian community-based studies often indicate that young adults are more apt to be problem gamblers. For example, Ladouceur's (1991) Quebec study found that while 31% of the entire sample (1,002) were between 18 and 29 years old, 46% of the problem and pathological gamblers were in this age group. Eighteen percent (18%) of the sample aged between 40 and 49 years accounted for 34% of the problem and pathological gamblers. Problem gamblers 50 years of age and older represented 20% of the problem gambling population. A similar situation existed in Western Canada according to Wynne Resources (1994). They found that while 27% of the entire sample (1,803) were between 18 and 29 years old, almost half (46%) of the current problem and pathological gamblers

fell into this age category. Fifty-four percent (54%) of problem gamblers were over 30 years old, compared to 73% of the entire sample. A secondary analysis reported that female problem gamblers were more than twice as likely to be under 25 years of age when compared to female non-problem gamblers (Alberta Alcohol and Drug Abuse Commission (AADAC) & Wynne Resources Ltd., 1994).

American studies show that in general, young adult problem gamblers are under-represented in treatment and self-help programs. This seems to hold true when considering the average age for the samples of many professional treatment and self-help based studies (Lesieur and Rosenthal, 1991). For example, Johnson, Nora, & Bustos (1992) conducted a profile survey of 108 primarily male GA members in New Jersey. Questionnaire respondents met the criteria of the DSM-III-R for pathological gambling. Researchers reported that the sample varied in age from the early 20's to the late 60's, averaging 41 years. A slightly higher mean age was reported by Lesieur (1988) when studying 50 female pathological gamblers in GA. The study was conducted between 1983 and 1986 via face-to-face and telephone interviews in the U.S.A. The age range of the respondents was 25-73 years old. The average age was 44 years. Population surveys indicate that problem gamblers tend to be relatively young in age. In contrast, data from treatment settings indicate that problem gamblers in treatment tend to be middle-aged.

2.2.2. Gender

Many studies report that problem gamblers are most likely men. For example, Ladouceur's 1991 Quebec study, Baseline Market Research Ltd.'s 1992 New Brunswick

study, and Bland et al.'s 1993 Edmonton, Alberta study all found that male problem and pathological gamblers outnumbered female problem and pathological gamblers by about 3 to 1. However, Blackwell's 1994 report of a Windsor, Ontario study cited a male to female ratio for problem gambling of 2 to 1. An even lower ratio was found by Wynne Resources' 1994 Alberta study. Women were just as likely as men (1 to 1) to have a current gambling problem (AADAC & Wynne Resources Ltd., 1994). The stereotype of the male problem gambler has become a myth; females, in growing numbers, are also at risk.

The numbers of women suffering from problem gambling are not reflected in treatment and GA studies. Ladouceur, Boisvert, Pepin, Loranger, and Sylvain (1994) reported on 60 pathological gamblers attending a treatment program or GA in Quebec. Typical gender related findings were revealed. The proportion of males exceeded that of females by 13:1 (93% male and 7% female).

2.2.3. Race, Ethnicity, and Religion

Canadian studies show a heterogeneous population of problem gamblers. Insight Canada Research (1993) reporting on ethnicity and race, found that in Ontario the groups most likely to be problem gamblers were of Southern and Northern European, Native American Indian and Canadian descent. Furthermore, those most likely to be probable pathological gamblers were from Canadian, French or Irish backgrounds. Unfortunately, in this study ethnic categories tended to be somewhat ambiguous. Wynne Resources (1994) found problem and pathological gamblers in Alberta were significantly more likely to be non-caucasian. While 7% of the general population under study were non-

caucasian they represented 19% of the problem and pathological gambling population. Although Canadian data regarding race and ethnicity is sparse and religion-based findings seem non-existent, a picture has emerged. That is, some racial and ethnic diversity exists among problem gamblers in the community.

Conversely, pathological gamblers involved in U.S.A. treatment programs show consistency according to race, ethnicity, and religion. Blackman, Simone, and Thoms (1989) reporting on their GTC sample of 128 patients revealed that Catholics comprised 59% and Jews comprised 29% of the group. Furthermore, 95% of the sample were caucasian compared to 76% of the center's total population of clients. The authors did not present information regarding the racial and religious composition of the community served by the clinic. Uniform results were found by Johnson et al. (1992). Most participants in this GA sample were Catholic (46%), Jewish (32%), and Protestant (14%). Furthermore, there were high numbers of people from Italian (23%), Irish (21%), and German (13%) backgrounds. These results were reflected in Strachan and Custer's 1989 sample of 52 female compulsive gamblers attending 14 GA groups in Las Vegas, Nevada. Questionnaire results indicated that most of the sample (83%) were caucasian. Thirty-nine percent (39%) were Catholic, 31% were Protestant, and 6% were Jewish. Comparisons with the general population were not provided by the authors; therefore, it is difficult to determine how this client population compares to the general population of Las Vegas.

The number of caucasian members of GA tends to be reflective of the U.S.A. population at large (World Almanac, 1995). However, Jews would seem to be over

represented in GA when considering that they represent 2.5% of the US population (Ciarrocchi and Richardson, 1989). U.S.A. treatment samples tend to consist of a homogenous group of gamblers; many are white and either Catholic or Jewish.

2.2.4. Marital Status

Canadian community-based studies show that a high number of problem gamblers are not married. Ladouceur (1991) found that 46% of the entire Quebec sample were not married while 63% of the problem and pathological gamblers were not married. Wynne Resources (1994) indicated that while 38% of the general population were not married, 52% of the problem and pathological gamblers fell into this category. Female problem gamblers were two times more likely to be single than the group of female non-problem gamblers (AADAC & Wynne Resources Ltd., 1994).

U.S.A. treatment programs tend to have fewer married gamblers than GA. For instance, the Taylor Manor Hospital study showed that of the sample 41% were married, 35% were divorced or separated, and 23% were never married (Ciarrocchi & Richardson, 1989). In comparison much higher rates of marital status for problem gamblers were found in predominantly male GA samples. In Johnson et al.'s (1992) study the authors found that 73% were married, 11% were divorced, 10% were single, 4% were separated, and 2% were widowed. However, Lesieur's (1988) study of female GA members showed that the number of married members dips when considering female GA members only. Most members sampled were single being either never married (16%), separated (6%), divorced (30%), or widowed (2%) and the rest were either married (42%) or living with a partner (4%). It seems that more male GA members have family supports than female

GA members. In turn, GA members tend to have more family supports when compared to problem gamblers in community and treatment surveys.

2.2.5. Income

A bimodal division along income lines exists for individuals at risk of problem and pathological gambling. For example, a study of Ontario residents indicated that those most likely to be problem gamblers had annual household earnings which exceeded $90,000. Whereas, those most likely to be probable pathological gamblers had annual household incomes between $20,000 and $29,000 and between $50,000 and $79,000 (Insight Canada Research, 1993). Similarly, Ladouceur (1991) found that while 20% of the entire Quebec population had an annual income between $15,000 and $25,000, 38% of the problem and pathological gamblers were in this group. Furthermore, while 24% of the population made between $35,000 and $50,000 a year, 44% of the problem and pathological gamblers were in this group. However, female problem gamblers were more likely than their female non-gambling counterparts to fall into the group of individuals with household earnings less than $15,000 or more than $50,000 (AADAC & Wynne Resources Ltd., 1994).

Income divisions within U.S.A. treatment facilities seem to reflect population survey findings. In Ciarrocchi and Richardson's (1989) sample of pathological gamblers from Taylor Manor Hospital in Maryland, 31% earned less than $20,000 annually and 16% earned more than $50,000 annually. The mean income was $24,885 and the median income was $23,460. During the same year, Blackman et al. reported that in their GTC New York State sample the median annual income was $15,600 while the median annual

family income was $18,200. The income of problem gamblers in treatment seem to vary substantially.

2.2.6. Education

Typically, within Canadian population surveys, problem gamblers have lower levels of education. For example, problem and pathological gamblers in New Brunswick (Baseline Market Research, 1992) and Alberta (Wynne Resources Ltd., 1993) were less likely than the general population to have graduated from high school. Insight Canada Research's (1993) Ontario study analyzed findings according to dependency level. The education level of problem gamblers did not differ significantly from the general population. However, pathological gamblers were more likely to have a high school education or less.

The educational trend obtained from Canadian population surveys does not seem to exist in U.S.A. treatment and GA programs at least for men. For example, McCormick, Russo, Ramirez, and Taber (1984) examined 50 male patients meeting DSM-III criteria for pathological gambling admitted to the inpatient treatment program of Cleveland's Veterans Administration Medical Center during 1981 and 1982. Findings revealed that 12% of the subjects had less than 12 years of education, 76% had between 12 and 15 years of education, and 12% had 16 or more years of education. A similar situation existed in Johnson et al.'s GA study (1992). Of the sample, 7% had some high school, 20% had completed high school, 32% had some college, and 41% had completed college. However, a different situation existed in Lesieur's (1988) study of female GA members. Half (50%) of the sample had a high school education or less, while 42% had

attended college and 8% had graduated from college. Comparison figures for the general population were not provided in these studies; however, according to World Almanac (1995) 71% of Americans graduate from high school. It would seem that treatment and GA programs tend to be largely comprised of male persons with more than a high school education. When considering female GA members the rate of education drops substantially.

An understanding of the Canadian experience is limited due to the lack of empirical research, particularly for treatment based studies. While the U.S.A. experience may not be directly comparable with the Canadian experience, U.S.A. studies were included to help provide a more in depth understanding of individuals who seek treatment when their gambling becomes a problem.

Unfortunately, there are difficulties incumbent when generalizing from some of these studies. Small sample sizes obtained from limited geographic areas, regional differences, a predominance of male dominated samples from an over-representation of samples obtained from U.S.A. professional treatment settings and self-help settings, as well as vague findings and limited comparisons with the general population make it difficult to gain an accurate picture.

Although Canadian studies are in their infancy, a demographic profile of the problem gambler is becoming clearer. Stereotypes are being challenged. Community-based surveys indicate that young, single individuals from various cultural and racial groups as well as various economic groups having relatively low levels of education are significantly involved in problem gambling behaviour.

Conversely, as noted by Lesieur and Rosenthal (1991), professional treatment and self-help mediums appear to be representative of only a subgroup of problem gamblers. Typically, white, middle-aged, middle-class, well-educated, Catholic or Jewish men are found in treatment. That is, a relatively homogeneous group are receiving help.

2.3.0. Coexisting Factors

Evidence suggests that the problems of pathological gamblers are not limited to their gambling behaviour. For some, psychiatric and physical disorders, criminal activity, employment and financial difficulties coexist with problem gambling. These serve to further complicate the situation of the gambler and the family. In this section empirical data is compiled to illustrate the complex situation faced by the gambler, the family, and the people who try to help them. International studies will be used to provide a glimpse into the lives of problem gamblers.

2.3.1. Affective Disorders

The coexistence of affective disorders and anxiety somatoform disorders with pathological gambling have been found in the general population. Bland et al. (1993) interviewed 7,214 Edmonton residents finding 30 pathological gamblers. Lifetime prevalence rates for pathological gamblers and non-problem gamblers indicated that 33% vs 14% had affective disorders (panic episode, major depressive episode, and dysthymia) and 27% vs 9% had anxiety somatoform disorders (phobias, obsessive compulsive disorder). Unfortunately, the number of females in the sample of pathological gamblers was small as was the sample of pathological gamblers in general, making it difficult to generalize findings. The study indicates that there is increased pathology among

pathological gamblers when compared to non-problem gamblers.

A high rate of co-morbity with affective disorders also exists among male problem gamblers in treatment programs. For example, McCormick et al. (1984) examined affective disorders and schizophrenia among 50 inpatients in the Cleveland Veterans Administration Medical Center, in Ohio. Findings derived from a battery of tests indicated that 76% had a major depressive disorder and 38% had a hypomanic disorder (26% qualified as having both), 8% had a manic disorder (about 6% of those had a major depressive disorder), and 2% had a schizoaffective disorder, depressed type. Many of these disorders were masked by other presenting problems (i.e., cross-addiction, family, and employment difficulties).

Consistency is evident in studies of GA members. For example, Linden, Pope, and Jonas (1986) studied 25 male GA members using the Structured Clinical Interview for DSM-III. Of the sample, 72% had experienced a depressive episode, 52% had experienced recurrent depressive episodes, and 20% had experienced panic attacks. Female GA members are not exempt from experiencing a high number of affective disorders. In Lesieur's study of 50 female GA members 26% of the sample had experienced serious depression prior to their gambling problems (Lesieur and Blume, 1991a). That is, a subgroup of problem gamblers has been found to experience depression.

Gambling may serve to relieve distress. McCormick et al. (1984) noted that gambling in their patients seemed to serve as an "antidepressant". It was the only activity that would elevate severely depressed patients.

To explore whether anxiety and depression were important determinants in the maintenance of gambling behaviour Blaszczynski and McConaghy (1989b) studied 70 males and 5 females assessed for a psychiatric inpatient pathological gambling treatment program in Australia between 1984 and 1986. All subjects met the DSM-III criteria for pathological gambling. Through interviews and the Gambling History Questionnaire, Beck Depression Inventory, and Speilberger's State-Trait Anxiety Inventory findings indicated that stress and depression often resulted in an escalation of gambling behaviour. It was confirmed that gambling may be used as an antidepressant by some gamblers. Gambling acted as a maladaptive coping strategy.

2.3.2. Trauma

Stress and depression resulting from traumatic experiences may be a factor leading to problem gambling. Taber, McCormick, and Ramirez (1987) studied 44 male patients successively admitted to the inpatient gambling treatment program at the Cleveland Veterans Administration Medical Center (1983-1984), meeting DSM-III criteria for pathological gambling. Results obtained via client autobiographies, the Minnesota Multiphasic Personality Inventory, and the Millon Clinical Multiaxial Inventory found that many (23%) of the subjects reported severe trauma, 16% reported moderate-heavy trauma, 30% reported less severe trauma, and 32% reported no serious trauma during their lives. Those gamblers experiencing severe trauma had more depression and anxiety than the gamblers experiencing no trauma. In 90% of the cases with severe trauma pathological gambling was preceded by traumatic event(s). As they were all veterans, the sample may not have been typical since the participants may have

experienced more trauma than other groups. Also, the retrospective nature of the tests may have affected the data.

Some problem gamblers have experienced negative events as children which may put them at risk for problem gambling. For example, Ciarrocchi and Richardson (1989) found that the 172 male and 14 female pathological gamblers in their study reported life stressors which included experiencing the death of a parent before 18 years of age (23%) and child abuse perpetrated by parents (82% of the females and 24% of the males out of 140). Additionally, in Lesieur's (1988) all female sample 12% reported a disruption in their childhood due to World War II. These findings were all higher in the treatment population than in the general population.

Alternatively, depression and stress-related disorders may be the result of difficulties experienced by problem gamblers as a consequence of gambling behaviour. Custer, Lorenz, and Linnoila (1988) compared 14 (13 male, 1 female) gamblers meeting DSM-III criteria for pathological gambling and major depressive episode with 41 normal controls (16 male, 25 female) to determine the relationship between life events and gambling. The gamblers were examined using the Hamilton Depression Scale and the Paykel 64-item Recent Life Event Interview. The Schedule for Affective Disorders and Schizophrenia and a series of physical tests were given to the control group. Depressed gamblers were found to have experienced significantly more life events as well as undesirable life or exit life events six months antecedent to depression. Almost two-thirds of the life events evaluated were rated dependent on gambling, a significantly higher amount of life events were rated independent of gambling, thus indicating that depression

in some problem gamblers may result as a consequence of gambling behaviour. Gambling as a coping mechanism for affective disturbances resembles a double edged sword for some gamblers in that is has been found to create and/or dissipate depression.

2.3.3. Attempted Suicide

Attempted suicide rates are higher among problem gamblers than among the general population. In 1969, Moran investigated the association between attempted suicide and pathological gambling in 75 (72 male and 3 female) American GA members finding that 20% of the men and 67% of the women had attempted suicide. In total 22% of the GA members had attempted suicide. These early findings were substantiated by Ciarrocchi and Richardson (1989) in their sample from a community clinic. They found that out of the 141 gamblers (130 men and 11 women) responding to the question of suicide attempts, 15% of the men and 50% of the women, had attempted suicide. That is, 17% of the clients studied had attempted suicide.

Empirical data has demonstrated that a high rate of attempted suicide exists among Canadian problem gamblers in the general population as well. Bland et al., 1993 found that 13% of the pathological gamblers in the community reported attempting suicide. Data related to suicidal ideation and gender were not included.

Suicide attempts or suicidal ideation is often a response by problem gamblers to multiple difficulties. Frank, Lester, and Wexler (1991) sent questionnaires to 500 GA members in the U.S.A. and received 162 responses (152 men, 10 women) in an attempt to obtain information on the gambler's history of suicide. Of the 132 who answered this particular question, 13% had attempted suicide, 48% had considered suicide, and 21%

had never considered suicide. Gamblers with a history of suicidal behaviour (98) were more likely than gamblers with no history of suicidal behaviour (34) to: have started gambling before 17 years of age; have relationship difficulties; have substance addicted relatives; and, have committed gambling related crimes. The authors did not break down results by gender. Generalization of results to the general population is hindered by the self-selected nature of the sample.

2.3.4. Antisocial Personality Disorder

There is overlap between pathological gambling and anti-social personality disorder. For example, in Bland et al.'s (1993) population survey they discovered that 40% of problem gamblers compared to 3% of non-problem gamblers and non-gamblers had an antisocial personality disorder.

Features of antisocial personality disorder may be directly linked to gambling. Blaszczynski and McConaghy (1994) studied 306 pathological gamblers (152 from a hospital-based treatment program and 154 from GA), meeting DSM-III criteria for pathological gambling, in Australia. Both groups (271 males and 35 females) were demographically similar. Results from a semi-structured interview schedule including DSM-III criteria and the California Psychological Inventory revealed that 15% (47) of the males had an antisocial personality disorder, a significantly higher rate than males in the general population (5%). None of the females met the full requirements of antisocial personality disorder. Criminal offenses were found to be committed independently of the disorder by the majority of participants. For some, antisocial personality traits were concluded to emerge in reaction to repeated efforts to hide gambling behaviour and

subsequent gambling-related debts.

2.3.5. Multiple Addictions

Another issue confronting a substantial number of problem gamblers is substance abuse. In Bland et al.'s (1993) Canadian epidemiological survey findings revealed that 63% of problem gamblers abused or were dependent on alcohol and 23% abused or were dependent on other drugs. This was a higher rate than in the general population.

U.S.A. treatment and GA studies have also exhibited large numbers of cross-addicted problem gamblers. For example, when studying 186 pathological gamblers Ciarrocchi and Richardson (1989) reported that 34% abused alcohol, 6% abused other drugs, while 31% abused alcohol and other drugs. Male and female members of GA show almost equivalent amounts of lifetime substance abuse rates. Lesieur and Blume (1991) reported that half (50%) of the 50 female GA members sampled had abused alcohol or other drugs while Linden et al. (1986) reported that just over half (52%) of the 25 male GA members sampled had abused alcohol or other drugs. Multiple addictions seem to be present in the lives of many problem gamblers.

The pattern is also apparent among individuals in treatment for substance abuse. Lesieur, Blume, and Zoppa (1986) questioned 458 (324 male and 134 female) inpatients in a substance abuse treatment facility in New York about gambling behaviour during 1984. Nine percent (9%) of patients met the criteria for pathological gambling and 10% met the criteria for problem gambling. A breakdown of the sample according to substances abused indicated that signs of pathological gambling were found in 5% of patients abusing alcohol, 12% combining alcohol with other drugs, and 18% abusing

drugs other than alcohol. When examining the interaction between gambling and drug use, 34% gambled while consuming alcohol or other drugs occasionally and 5% gambled frequently or consistently while consuming alcohol or other drugs. Examination of the relationship between drug use and gambling found that 28% consumed alcohol or other drugs occasionally while gambling and 16% consumed alcohol or other drugs frequently or consistently while gambling.

The overlap existing between substance abuse and problem gambling tends to signify compound difficulties. For example, 12 male chemically dependent participants meeting DSM-III criteria for pathological gambling attending an addictions program in a private psychiatric hospital were compared with 12 (11 male and 1 female) chemically dependent participants having similar demographic and substance abuse characteristics. Via the Addiction Severity Index both groups showed similar results involving employment functioning and legal problems; however, the chemically dependent pathological gambler group showed higher impairment in the areas of medical, relationship, and psychiatric difficulties (Ciarrocchi, 1987).

Moreover, McCormick (1994) revealed that subjects with a dual diagnosis of substance abuse and pathological gambling abused more substances, showed more negative affect, and were more impulsive than non-gamblers. Additionally, coping skills were more depleted in the dual diagnosis subjects. Substance abuse combined with problem gambling complicates an already complex situation.

Research has indicated other addictive behaviours among both male and female problem gamblers. Lesieur (1988) found that of the 50 female GA members in his study

24% reported compulsive shopping and 20% reported compulsive overeating. Twelve percent (12%) of the women also reported possible sexual addiction. Furthermore, Wynne Resources (1994) found that problem gamblers were more likely to be cigarette smokers than non-problem gamblers.

2.3.6. Physical Health

Problem gambling takes a toll on the gambler's physical health. Wynne Resources (1994) revealed that problem gamblers in Alberta experienced more stress-related health problems than non-problem gamblers.

A variety of physical disorders are suffered by problem gamblers. Focusing on the desperation and recovery phases of the gambling process Lorenz and Yaffee (1986) explored psychosomatic problems encountered by 206 gamblers (97% male and 3% female) attending three GA conferences in Chicago, New York, and Pittsburgh during 1983-1984. Questionnaire results indicated that many respondents suffered psychosomatic illness during the height of gambling. The most frequently mentioned illnesses were: depression (46%); stomach problems (i.e., knotted stomach, loose bowels, excessive gas, constipation, colitis or ulcers) (51%); insomnia (35%); headaches or migraines (29%), asthma (18%), high blood pressure (17%), backaches (17%); and, angina, heart pains, and palpitations (16%). Many respondents felt that health problems were associated with gambling related issues such as a desperate need for money (62%), depressed feelings (39%), guilt feelings (35%), isolated feelings (22%), and fearful feelings about losing a job or being caught participating in criminal activity (12%). Some respondents suffered illness after abstinence, however, the numbers were lower and

could not be linked with gambling.

2.3.7. Criminal Activity

Criminal activity is quite common among problem gamblers. Bland et al. (1993) found that pathological gamblers were involved in more criminal activities than the general population. Of the 30 pathological gamblers: 60% had been involved in borrowing or stealing money to gamble; 30% had been arrested for non-traffic offenses; 27% had been in trouble for drinking and driving; and, 28% had been convicted of a felony. Unfortunately the authors did not provide any further detail regarding the total number of problem gamblers committing crimes, types of crimes or genders of respondents. In addition, the categories delineating crimes were not consistent with other studies thus making them difficult to compare.

The rate of criminal activities engaged in to support gambling tends to vary according to the type of sample being studied. When comparing groups of problem gamblers Lesieur (1987) noted that almost all incarcerated problem gamblers and almost two-thirds of non-incarcerated problem gamblers (GA and treatment samples) had been involved in an assortment of illegal activity to support gambling. Table 5 (see page 33) shows this trend by comparing the criminal activity of problem gamblers from a variety of settings and displaying the wide range of financially motivated crimes engaged in by problem gamblers in order to fund gambling endeavors.

Table 5: Illegal Activities Engaged in by Problem Gamblers to Support Gambling

Type of Activity	Blaszczynski, McConaghy & Frankova (1989) Treatment & GA, Male & Female	Ladouceur et al. (1994) Treatment & GA, Male & Female	Lesieur & Klein (1985) Prison, Male	Lesieur & Klein (1985) Prison, Female	Jacobs & Pettis (1988) GA, Male	Lesieur (1988) GA, Female
Loan Fraud	-	-	13%	6%	41%	44%
White Collar Crime						
Check Forgery	-	-	28%	59%	33%	44%
Forgery	-	10%	19%	35%	18%	24%
Embezzlement & Employee Theft	-	-	13%	21%	38%	24%
Tax Evasion	-	-	6%	3%	28%	12%
Tax Fraud	-	-	1%	-	18%	6%
Signed Cheques with Insufficient Funds	-	33%	-	-	-	-
Insurance Fraud	-	3%	-	-	-	-
Larceny	48%	-	22%	24%	21%	26%
Burglary	12%	17%	57%	29%	15%	2%
Armed Robbery	7%	3%	21%	15%	4%	2%
Shop Lifting	7%	17%	-	-	-	-
Pimping	-	-	19%	12%	2%	0%
Prostitution	-	-	3%	41%	-	12%
Drug Trafficking	3%	-	54%	54%	9%	2%
Fencing Stolen Goods	-	7%	37%	41%	14%	4%
Gambling System Connected Crime						
Bookmaking & Working in an Illegal Game	-	-	13%	24%	-	28%
Hustling at Sports	-	-	51%	50%	-	8%
Hustling at Cards or Dice	-	-	50%	35%	-	8%
Running a "Con Game" or Swindling	-	-	50%	29%	-	14%
Engaged in Any Type of Activity Above	59%	68%	97%	97%	-	66%

Note. Adapted from "Pathological Gambling: A Review of the Literature" by H. Lesieur and R. Rosenthal, 1991, Journal of Gambling Studies, 1(1), p. 25.

Problem gamblers involved in criminal activity tend to have multiple difficulties. For example, when comparing female problem gamblers from GA and prison samples, Lesieur (1993), found that substance abusing female problem gamblers committed more crimes that non-substance abusing female problem gamblers. Meyer and Fabian (1993) found that problem gamblers committing offenses were more excessive in their gambling behaviour, experienced more satisfaction through gambling, and experienced more psychosocial difficulties especially with reference to partnerships, friendships, and employment.

2.3.8 Employment Difficulties

Employment difficulties are familiar to pathological gamblers. For example, in Ladouceur et al.'s (1994) study, many participants reported problems occurring at work. Due to gambling patterns, 61% had been late for work, 60% had missed work, 59% were irritable and had concentration difficulties at work, 43% had asked for paycheck advances, 37% had stolen money from their employers, 50% had almost lost jobs, and 36% had lost jobs.

McCormick et al. (1984) found that pathological gamblers with affective disorders were more likely to miss work. Of the depressed gamblers studied, 25% had missed one month or less of work. Twenty-eight percent (28%) of the sample had missed from one month to one year of work. Additionally, 31% had missed between two and three years of work. In some cases (15%), this added up to four or more years of missed work.

2.3.9. Financial Difficulties

The financial situation of the gambler is often compromised. Gambling related debt averages between $53,000 and $90,000 US for samples largely composed of men in treatment (Lesieur & Rosenthal, 1991). Conversely, the average debt for female GA members was estimated at $15,000 US (Lesieur & Blume, 1991a).

Money to fund gambling and gambling related debt is obtained by problem gamblers from a variety of sources. For example, Ladouceur et al. (1994) reported that of the pathological gamblers sampled, 90% used their paychecks or family savings and 83% borrowed money (62% borrowed money from friends or relatives and 25% borrowed money from loan sharks) to fund gambling endeavours. Twenty-eight percent (28%) of the gamblers had filed for bankruptcy.

Difficulties exist in generalizing from these studies. These difficulties are due to small sample sizes, self-selected samples, biased data selection, an over representation of men, and limited gender based results.

Chapter 3: Impact of Problem Gambling on the Family

The entire family system is detrimentally affected by problem gambling. Family members are at risk of experiencing a wide-range of difficulties which include interpersonal conflict, abuse, alienation, as well as emotional and physical complications.

3.1.0. The Partner

Social and psychological stresses are encountered by partners of problem gamblers. Lorenz and Shuttlesworth (1983) used a questionnaire to obtain information from 250 members of Gam-Anon (G-A), a self-help fellowship of and for the family members and friends of compulsive gamblers. Of the 144 respondents, most (98%) were females married to compulsive gamblers (94%). Demographically they resembled the typical GA member profile. Common problems associated with spousal gambling behaviour were: marital conflict; social isolation resulting in declining self-worth; frequent confrontations with creditors; and, frustration due to the lack of community-based assistance. As a result of these difficulties, 84% of the sample felt that spousal gambling behaviour had made them emotionally ill.

Stress related illnesses are endured by the gambler's partner. Lorenz and Yaffee (1988) examined psychosomatic, emotional, and marital difficulties among 215 G-A members during the desperation phase. The respondents were attending three GA conferences in Chicago, New York, and Pittsburgh between 1983-1984. All of the respondents were females ranging in age from 22-76 years. Most (94%) were married to, or living with a gambler and 89% had children. The self-administered questionnaire found that during the height of gambling 80% of the respondents reported that the

husband's gambling resulted in feelings such as anger, guilt, isolation, depression, and suicide. Health difficulties associated with these feelings included: chronic or severe headaches (41%); irritable bowels, constipation, diarrhoea (37%); dizziness or excessive perspiring (27%); breathing problems (23%), and backaches (18%). Some women experienced more than one of these illnesses simultaneously.

A high rate of spousal abuse exists among the problem gambling population. Bland et al. (1993) found that 23% of the pathological gamblers in Edmonton had hit or thrown things at a spouse or partner. Moreover, Lorenz and Shuttlesworth (1983) found that almost half (43%) of the spouses in G-A reported verbal, emotional, and physical abuse. In these samples, spousal abuse among problem gamblers was higher than among the general population.

The financial situation of the gambler's partner is often poor. Lorenz and Shuttlesworth (1983) noted that financial problems were reported by 99% of Gam-Anon members.

The partner's perception of the problem gambler is compromised. Lorenz and Shuttlesworth reported that all of the G-A respondents in their 1983 study believed that the gambler was emotionally ill. Characteristics ascribed to the gambler in most cases were dishonest, irresponsible, uncommunicative, insincere, and impulsive.

Family dissolution rates vary according to the population studied. Despite the difficulties the gambler's marriage often remains intact, at least among female dominated G-A members. Lorenz and Shuttlesworth (1983) found that the majority (94%) of G-A members sampled remained married to the gambler. In Lesieur's (1987) study of female

GA members, 22% were divorced as a consequence of gambling. Jacobs et al. (1989) studied 844 adolescents in four high schools in California. The adolescents were studied via an anonymous Health Survey. Of the sample, 52 (6%) reported that at least one parent had a gambling problem. Over one-third (37%) of adolescents with problem gambling parents experienced family break-ups due to divorce, separation, and death.

Dysfunctional responses are used by some partners to cope with gambling related difficulties. Fifty percent (50%) of the respondents in Lorenz and Shuttlesworth's (1983) female dominated sample took part in excessive drinking and/or smoking, undereating or overeating, and impulsive shopping. Additionally 12% had attempted suicide. In Lorenz and Yaffee (1988) the attempted suicide rate among G-A members was 14%. These rates were substantially higher than the rate in the general population. A complex situation exists between the spouse's emotional and physical well-being and gambling. The partners of problem gamblers are susceptible to experiencing multiple problems.

3.1.1. The Children

Children of problem gamblers are also in jeopardy of experiencing psychosocial difficulties. The children in the problem gambling parent group of Jacobs et al.'s (1989) study were apt to rate the quality of their lives as poor. They reported experiencing broken homes, unhappy teen years, and criminal justice problems with increased frequency when compared with their peers in the non-problem gambler parent group. The children of problem gamblers were also more likely to report being insecure, unhappy, depressed, and suicidal.

Children of problem gamblers with multiple addictions tend to experience even

more difficulties. Using a modified version of Jacobs' Health Survey (1986), Lesieur and Rothschild (1989) surveyed 105 children of Canadian and American GA members and pathological gamblers in treatment settings (1986). Most of the respondents were males (55%) between the ages of 12-60, averaging 17 years of age. Almost all (95%) reported having a problem gambling father while 3% reported having a problem gambling mother. The respondents were divided into two groups: children of compulsive gamblers (46%) and children of multiple addicts (54%), defined as having concurrent problems with gambling and substance abuse and/or overeating. Children of parents with multiple addictions were more likely than children of compulsive gamblers to smoke tobacco, drink alcohol, overeat, sleep "worse than most people", and feel unhappy, insecure, inferior, or inadequate.

Children's feelings concerning parental gambling are often negative. The children in both of Lesieur and Rothschild's groups reported similar feelings. Of the entire sample, 44% felt angry most or all of the time and 26% felt angry less than half of the time while 30% never felt angry about parental gambling. Children also reported feeling sad (68%), hurt (60%), depressed (56%), confused (59%), pity (46%), hate (45%), shame (44%), helpless (42%), isolated (34%), abandoned (31%), and guilty (26%). Only 17% of the children reported occasionally feeling happy about their parent's gambling; some children indicated that they liked their problem gambling parent better when the parent was gambling.

A high rate of parental abuse and neglect is experienced by the children of problem gamblers. Bland et al. (1993) found that of the pathological gamblers studied,

17% reported physically abusing their children and 10% reported leaving their children unattended, 17% reported spending money on themselves and running out of food and money for children, and 13% reported that their children had been taken in or fed by neighbours. This was higher than the rate of abuse and neglect experienced by children in the general population. Lesieur and Rothschild (1989) found that GA children also experienced more parental violence than the general population. Moreover, GA children from multi-problem families, problem gambling combined with substance-abuse and/or overeating, were more violent and were more likely to use violence than either children of problem gamblers or children in the general population.

Addictive behaviours are widespread among the children of problem gamblers. The children in Jacobs et al.'s 1989 study having a problem gambling parent showed more tobacco, alcohol, and other drug use than the control group. These children also took part in more frequent gambling and overeating. For most, participating in these activities served as a means of "stimulation" or "relaxation". However, 20% more children of problem gamblers indicated that "escape" from tension or unhappiness was their goal. They experienced more dissociative reactions when using alcohol, other drugs, or overeating and gambling. Addictive behaviours, for some children of problem gamblers, seem to be a means of coping with unhappy life circumstances.

3.1.2. The Parents

Parents of problem gamblers tend to experience emotional difficulties related to the problem gambling pattern of their children. Heineman (1989) studied 126 parents of male pathological gamblers who were admitted to an inpatient treatment program in New York.

Findings revealed that anger, fear, and guilt were pervasive among the parents. Often parents linked these feelings to anticipating a child's losses related to gambling (i.e., employment, housing, family, and freedom) and being blamed for poor parenting by the gambler.

The mothers and fathers of problem gamblers often take different approaches to dealing with the gambling behaviour of children. In Heineman's (1989) study most of the fathers (80%) were reported to have distanced themselves from the gambler; however, the mothers seldom did so. In fact, the mothers tended to move closer to the gamblers.

The marital relationship is compromised as a result of the child's problem gambling. The different approaches taken by parents tended to lead to the spouses blaming one another for the child's gambling pattern. Mothers, in Heineman's study (1989), were often manipulated by sons into funding gambling endeavours. Husbands tended to blame wives for enabling gambling by funding bail-outs, while wives blamed husbands for distancing themselves and refusing to help change the problem gambling behaviour.

Parents of gamblers in treatment programs and GA often have addiction problems. For example, Ciarrocchi and Richardson (1989) found that of the 186 pathological gamblers in their study 41% reported that their fathers and 18% reported that their mothers either abused or were dependent on alcohol. Many of the fathers (27%) and mothers (12%) showed signs of pathological gambling. In Lesieur's (1988) female sample, 28% reported having had alcoholic fathers and 10% reported having had alcoholic mothers. Twenty percent (20%) of the sample had fathers showing signs of

compulsive gambling and 4% had mothers showing signs of compulsive gambling.

Several limitations are incumbent in these studies. Only a small amount of empirical data related to the family members of problem gamblers are available. Most samples only focus on the wives and children of male problem gamblers (i.e., Lorenz and Yaffee, 1988, 1989). In some cases, male spouses were included but the numbers were small. Even so, gender based results were not presented (i.e., Lorenz and Shuttlesworth, 1983). Furthermore, same-sex couples and siblings have rarely been represented in the studies. Samples tend to be derived from either treatment, GA or G-A groups. This makes it unsuitable to generalize findings to the entire population (i.e., Heineman, 1989). In addition, sampling flaws may skew the findings (i.e., Lesieur and Rothschild, 1989).

Chapter 4: Family-Based Interventions

Family members are often the first persons to seek assistance to deal with the effects of problem gambling. Working with the family members helps them to deal with the difficulties they experience when gambling becomes a problem. The family can work together in an attempt to motivate the gambler to take part in the change process and work together to foster a positive outcome. This section draws on multiple ways to intervene with the family of the gambler with or with out the gambler.

4.1.0. Family Intervention

Family intervention is a method used in motivating the gambler's significant others and the gambler to accept treatment. Heineman (1994) described the goal of family intervention as getting 'someone' into treatment. A supportive network is assembled and assisted in confronting the gambler in a non-judgemental and non-defensive manner. The gambler's significant others are helped to understand the dynamics of problem gambling and to work together to change the way they relate with the gambler.

Heineman (1994) detailed stages in orchestrating the process of successful family intervention. The stages include: initial contact, consultation, preparation, intervention, and follow-up. The following is a modified version of Heineman's suggestions for facilitating a family intervention.

The initiators of contact with the worker are often the gambler's significant others. The first contact with them typically occurs over the telephone. At this stage, information about the gambler and the impact that problem gambling has had on the family is gathered. As the professional is often approached in response to a crisis situation it is

helpful to listen to the caller's feelings and concerns and to provide the caller with support, encouragement, and information. The caller is instructed to bring one other concerned person to the consultation session. This additional person helps to provide support and supplementary information.

During the consultation more information about the gambler is gathered. Both the family's and the gambler's suitability for this type of intervention is assessed. The family is instructed to contact the gambler's medical doctor or therapist to discuss the plan for intervention and to obtain information regarding the appropriateness of confronting the gambler in his/her present mental state. Strategies are used to empower the persons present to express the effects that gambling has had on them. They are supported in exploring and verbalizing their feelings. Self-help options, such as G-A, are discussed and participation is encouraged. An informal support network, consisting of concerned significant others is built to form the intervention group.

Several preparation sessions take place to ensure that the intervention group members are equipped for the intervention. During session one, each member of the intervention group shares their perception of the gambler's problem situation. After everyone has had an opportunity to express their view point, any unrealistic perceptions held by the members are confronted by the worker. The concept of problem gambling as a family issue is discussed, and links are made with the experiences described by family members. The members of the support network are encouraged to continue in the change process, whether the gambler accepts help or not. Letters are written by the members to present at the intervention. The goal of the letters is to convey that gambling

has caused a distancing in the relationship, and that the gambler is missed and wanted. The focus of the first letter is the writer's feelings directly related to the gambling behaviour. A second letter is written to be used only if the gambler declines participation. It states the ways that the relationship between the gambler and the writer will change if the gambler does not accept help.

In the second preparation session, new intervention group members are introduced and a review takes place. Members, who have attended previous meetings, read their letters to the group. Constructive comments are made about the letters - all criticisms or lectures should be removed. The member's feelings about the letters and their perceptions about how the gambler will react are explored.

Preparation session three provides the group with an opportunity to practice the intervention. Encouragement is given to members to continue receiving support even if the gambler does not opt for treatment. A plan is established to invite the gambler to the next session; the intervention. In case the gambler refuses this invitation, a back-up plan is prepared, whereby the intervention takes place in the home of one of the group members.

During the intervention the worker's role revolves around guiding and facilitating the confrontation ensuring that it proceeds in a supportive and non-judgemental manner. After the members have read their letters, the helper summarizes the statements and requests that the gambler participate in treatment. The definition of treatment and available options are discussed and decided upon by the gambler and the helper.

The follow-up session gives the intervention group members a chance to share

their feelings and deal with the outcome of the intervention. Encouragement is provided to members to continue working toward change whether the gambler has chosen to be involved in treatment or not.

Heineman did not give any indication of treatment effectiveness other than indicating that "more often than not, one or more of the concerned persons agrees to continue in treatment so they can recover" (Heineman, 1994, p. 75).

4.2.0. Marital/Family Counselling

Even if the gambler does not participate in treatment the gambler's partner or significant others can be helped to affect change. Walker (1985) reported on marital intervention using a brief therapy approach. Marital therapy took place with the wife of a problem gambler through individual counselling.

Brief therapists believe that "a problem's existence is maintained by precisely those measures intended to solve it" (Walker, 1985, 3). Therapy centered around assisting the complainant, the wife of the gambler, to change the methods that she was using to influence her husband's gambling behaviour.

Initially, the worker sought out the wife's perception of the problem situation and her perception of what she would like the situation to be like. Past coping methods were discussed. This helped to foster an understanding of the couple's pattern of interaction as well as an understanding of what had been tried to solve the problem. Exploration took place regarding what she was willing to do to change the situation. Tasks were directed at working with the wife's perception of the situation and changing the couples pattern of interaction. Role playing and rehearsal were utilized. A reduction occurred

in the wife's resistance to her husband's behaviour. This resulted in the gambler realizing the impact that his gambling behaviour was having on his wife. Instead of feeling that he was being forced to change, a situation was created that led him to choose to change for his wife's sake.

Walker related that three follow-up sessions took place with the wife from six weeks to six months after treatment. Consistently, she reported that her husband had not returned to gambling.

Steinberg (1993) asserted that there is a need for family and intergenerational assessment and intervention with clients who are experiencing difficulties related to problem gambling. Derived from Steinberg's practice with male gamblers and their family members, the following is an approach to working with the couple/family during the assessment and treatment process.

It is Steinberg's belief that the gambler's partner and key significant others should be included as early as possible in the assessment process. Initially, interviewing the gambler's significant others alone, facilitates the development of rapport, and the assessment of mental and emotional functioning. It aids in the determination of a group of significant others to include in treatment sessions. Steinberg feels that children should be included early in the assessment phase. The children can be included in treatment after the couple relationship has stabilized. Provisions are made to include children earlier in the treatment phase only if marital dissolution is expected, if the children request inclusion, or if the children are experiencing serious difficulties.

Steinberg's work focuses primarily on intervening with the couple. Working with

the couple initially focuses on getting them to discuss the issue of problem gambling and its impact. Goals for the relationship, as well as individual goals are identified and negotiated. The ultimate goal is the survival of the relationship. If necessary, conjoint sessions are supplemented with individual sessions. Goals for individual sessions include the building of trust and the identification of issues for change.

The couple can be helped to strengthen their relationship through the resolution of emotional issues and the improvement of their ability to relate positively to one another. Treatment issues for couples experiencing problems related to gambling and strategies to address them are outlined in the following list adapted from Steinberg (1993):

- Commitment. Does commitment and love still exist for the couple? Help the couple to explore their feelings and options.

- Addictive Behaviour. Are the gambler and their partner engaging in other addictive behaviour(s)? Consider the need for multiple interventions including self-help options.

- Relapse Prevention. Help identify and avoid triggers resulting in relapse. Assist clients in developing a plan of action to employ if urges to gamble develop or gambling occurs. Use stress-reduction techniques, assertiveness training, and other forms of skill development. Aid the gambler's partner to clarify boundaries within their relationship with the gambler. Address issues of codependence with the couple to reduce enabling behaviour (i.e., bailouts).

- Finances. What financial difficulties exist? Financial management strategies include issues such as budgeting, financial restitution, and debt management (loan consolidation, bankruptcy, gifts (bailouts)). If needed, refer to GA, G-A, or financial management consultants.

- Control and Power Issues. What control and power issues exist? Help the couple negotiate change in role expectations. Foster the expectation that the gambler assume a fair share of responsibilities. Defuse power struggles by reframing and interpreting the situation. Help the couple accept and value one another's view points, as well as strengthen and utilize negotiation skills in making joint decisions.

• Anger. Is the couple expressing anger in unproductive ways? Assist in strengthening their ability to defuse and express anger in direct constructive ways. Help them change reactions to one another by assisting them in recognizing and understanding internal and external triggers for anger and responding in a positive manner.

• Emotional Intimacy. How have relationships been affected? A genogram can be used to show intergenerational issues such as patterns of behaviour and communication. Foster trust, mutual vulnerability, and sharing. Facilitate the identification and communication of feelings, as well as sensitivity to each others feelings and needs. Help the couple to plan ways to spend time together that do not include gambling. Reinforce positive behaviours using techniques such as role playing and problem solving.

• Sexuality. Is the couple's sexual relationship mutually satisfying? Foster communication and honesty between partners. Help them to see sexual expression as part of a loving relationship. If needed, obtain a sexual history and refer clients to a sex therapist.

This guideline was developed by Steinberg based on his work with approximately 50 couples. No results were given indicating the outcome of treatment; however, the author invited systematic research.

Heineman (1989) also indicated that intergenerational family education and counselling are required when gambling becomes a problem. Key points of intervention with the gambler's parents and grandparents outlined by Heineman are provided below in an adapted form.

• Inquire about family member's involvement in addictive behaviours in a supportive, non-judgmental fashion.

• Educate family members about problem gambling.

• Help family members to let go of the past. Eliminate blame and self-blame.

• Create a supportive, non-judgemental, empathetic environment for parents to vent (i.e., feelings of anger, guilt) in individual sessions.

• Involve all the family members in sessions to: share the way in which members were affected by the gambling; obtain a group commitment to

discontinue bail-outs; identify family dynamics; and, strengthen communication.

• Conjoint sessions involving the gambler and one parent at a time are recommended if one parent is acting as the "middle parent", separating the gambler from the other parent. Help to strengthen the relationship between the gambler and the distanced parent by discussing the manner in which the parent became distanced. Share feelings about the relationship and visions for change in the relationship. Enable the gambler to understand that they have a right to a relationship with both parents.

• Refer parents to a self-help group for ongoing guidance and support.

4.3.0. Professionally Led Groups

Marital couple group therapy was used by Boyd and Bolen (1970) in working with male gamblers and their wives who were experiencing severe martial difficulties. Problem gambling was viewed by Boyd and Bolen as a defense mechanism triggered by a crisis situation (i.e., the death of a relative, birth of a child). The authors also believed that gambling served as a maladaptive coping mechanism in a dysfunctional marriage.

Two groups consisting of four couples were formed to run for a year in an unstructured group context. A therapeutic contract usually consisting of goals related to understanding problem gambling, decreasing gambling, and improving the marital relationship was negotiated with each couple. In order to reduce feelings of anxiety and fear experienced by couples during the group process, they were asked not to make any major life changes during therapy (i.e., divorce).

Early in the group process, members discussed their common problem of gambling and its effects on them. Husbands (problem gamblers) tended to reminisce about gambling endeavours. Wives discussed negative experiences resulting from their husband's gambling behaviour. The wives saw gambling as their husbands problem; they

did not feel that they played a part in their husband's gambling behaviour. The therapists, at this stage, were non-directive.

Arguments, often unrelated to problem gambling, between the couples began to dominate group sessions. The therapists intervened by clarifying sources of the disputes, and by indicating that assumptions led to misunderstandings and arguments. Encouragement was given to the members to discuss issues in a direct manner, and to ask questions in order to facilitate understanding and to make communication more effective. The authors reported that as communication was enhanced the husbands began to show progress (decreased gambling and decreased depression). Conversely, the wives reportedly began to show increased depression as they explored their own situations and realized that the gambling was a shared problem manifested by marital difficulties. Crisis intervention was often necessary.

Turbulent group processes and crises led to the provision of extra-group contact (individual or conjoint therapy) with the therapists. A direct and at times authoritarian approach was used in intervention. Discussions focusing on present day issues were beneficial. Periodically, in an attempt to deal with unease related to change, disruptions occurred which required immediate intervention in order to deal with feelings of anxiety and vulnerability.

Boyd and Bolen reported their groups were quite successful. The authors claimed that a reduction of anxiety, depression, and ineffective communication occurred in the couples. Interactions between members became increasingly positive and revealed a growing ability to empathize, clarify, interpret, and problem solve. All couples realized a

reduction or cessation in gambling, and an improvement in their relationships.

Using the same rational for problem gambling as Bolen and Boyd (1970), Tepperman (1985) reported on short term conjoint group therapy with male pathological gamblers and their wives. Treatment goals included decreasing defensiveness and increasing compatibility and communication between spouses. Two groups consisting of 10 couples were assembled to serve as experimental groups. Twenty other couples were also assembled to serve as control subjects. All participants were members of GA and G-A. The experimental groups met once a week for twelve weeks and took part in a group program. The program was based on understanding the twelve steps of GA. Each session focused on one of the steps. Meetings began with members reviewing the step under discussion as a group. Members then voluntarily shared the significance that the step had in their lives.

Tepperman reported that half of the couples dropped out of the group process (six from the first experimental group and four from the second experimental group). Couples in the experimental groups experienced improved martial relationships and a reduction of depression. All but one couple elected to participate in an open-ended group. Upon follow-up, three years later, almost all of the experimental couples were involved in GA and the gamblers were abstaining from gambling. Conversely, all the members of the control group had dropped-out of GA.

4.4.0. Self-Help Groups

Gamblers Anonymous is a voluntary fellowship of people suffering from a common chronic illness; compulsive gambling. It is a twelve step program for recovery and

personal growth (see Appendix B for a copy of The Twelve Steps of GA). GA views gambling as the primary problem. Other difficulties result from gambling. Lesieur (1990, p. 239) related that GA's success stems from the gambler's "identification with a new reference group in a spiritual journey that members of GA reconfigure (relabel) their self-conceptions. The members are no longer "evil" or "stupid"; they are sick people in need of help from a higher power".

GA has several strengths. For example, the goal of abstinence is promoted as a life long process which proceeds one step at a time. Open and closed meetings serve as a forum for members to narrate life experiences before and after GA. Family members can attend open meetings with the gambler. Family attendance at GA meetings helps family members learn more about GA and compulsive gambling as well as support the gambler in the program. Through the group process GA members benefit by a sense of belonging, support, hope, and advice. GA members are encouraged to call one another. Sponsors, acting as friends and confidantes provide support and understanding. GA fosters the redirection and substitution of gambling. GA holds a "pressure-relief" group in which the new member and the member's significant others meet with seasoned GA members in order to assess the degree of financial difficulties and to establish a budget to repay debt.

The GA model has limitations. For example, while some people have been able to adhere to the twelve-step model, others have not. GA appeals to a select population such as caucasian, middle-aged men. It does not meet the needs of all problem gamblers. Although GA has been helping compulsive gamblers in recovery for many

years, the actual effectiveness has not been established (Steward & Brown, 1988). Evidence supporting GA's claims of success is so far anecdotal.

Gam-Anon is a self-help group comprised of relatives and friends of compulsive gamblers. The group focuses on helping the G-A member to change and not the gambler. In G-A, members take part in a spiritual group following a twelve-step format. Through the group process they experience a sense of hope and belonging, and are supported in coping with problem gambling. Support is given to increase understanding of compulsive gambling and the role that the member plays in the life of the gambler. In particular, the role of Gam-Anon revolves around helping family members to refrain from enabling the gambler (i.e., bail-outs, cover-ups) and refrain from attempting to control the gambler (Lesieur, 1990). Suggestions are provided to aid the gambler's significant others in coping with difficulties resulting from compulsive gambling. Members are helped to work through feelings such as guilt and responsibility related to the problem gambling.

Gam-A-Teen groups exist for the children of compulsive gamblers. Groups of adult children of compulsive gamblers have also been initiated in some places. However, they are both limited in availability. The effectiveness of G-A, Gam-A-Teen, and adult children of compulsive gambler groups in helping the family members cope with gambling related problems has not been evaluated.

Lesieur (1990) outlined several suggestions the worker can follow when encouraging clients to attend Gamblers Anonymous. Many of these suggestions can also be applied to facilitating Gam-Anon membership. For example, explore the option of self-help with the client(s). Provide information and answer questions. Encourage the

client(s) to shop around for a group where they are comfortable. Recommend that the client(s) attend three to four meetings each week for four months. Meet with the client's sponsor and work together as a team. Discuss the self-help program with the client on an on-going basis to monitor progress. If conflicts arise between the client and other GA members allow the client to express feelings and encourage them to stick with the program.

Chapter 5: Case Study

In this chapter a case study is used to illustrate some of the concepts under review in this paper. Paul, a problem gambler interviewed by the author, is a 35 year old single caucasian male. He is employed and has an undergraduate university degree. Both Paul and his family members have experienced difficulties in coping with Paul's problem gambling behaviour.

History of problem gambling and substance abuse. Paul was introduced to gambling by his father as they "would go to the track when I was a kid". He began betting occasionally while in high school. In his 20's Paul described forming a dependency on cannabis stating, "I was stoned for 5 years straight". When he was 25, after his father died, Paul spontaneously stopped smoking drugs but continued gambling occasionally. It was not long before Paul became preoccupied with gambling on "illegal poker and fruit machines" indicating that "gambling became my life". When he was not gambling he "fantasized about winning all the time". Paul "constantly felt pressure to find money to gamble" and indicated "feeling sick until having money to gamble". He described his relationship with gambling as an "obligation or chore" finding that he "couldn't stop gambling 'till the money was gone" at which point he could "relax". Another situation that provided him with relief was when experiencing "any type of win -- it would feel like getting a shot". These "rushes of adrenaline" were the strongest after a long period of losing but also occurred when he was "thinking about or planning to gamble". He would often gamble until physically exhausted, at times gambling for periods up to 18 hours straight. Over the past three years Paul has made several attempts to abstain from

gambling.

Family and Social History. Paul was the youngest of four siblings. He reported that his deceased father was a "compulsive gambler" who played the horses. Paul's father "was never able to control his gambling". In "retrospect" Paul realizes that his father's gambling had an impact on the family; however, he stated that he doesn't "reflect on that time". His mother lives in a rural area of New Brunswick. His siblings are "scattered all over" except for his sister Carolyn who lives close by. Paul explained that Carolyn experiences alcohol-related problems. None of his family members have received professional-help or self-help related to Paul's gambling.

Gambling "created a gap" in Paul's relationship with his family. His relationship with his brother was sporadic and conflictual. Paul indicated that his mother tended to "rescue me by bailing me out" and that for a long time he "wanted to be rescued". Conflict has ensued between Paul and his mother since he began working on controlling his gambling and paying back his debts. Despite his efforts to refuse, his mother constantly tries to bail him out. Paul tried to explain his gambling related difficulties and his efforts to change to his mother but found that "it was hard to feedback information". Carolyn tended to support Paul's efforts to change his gambling pattern. However, he stopped relying on her after finding that enlisting her support created difficulties for her, "I noticed that when I went to her for support she began to drink more".

Difficulties exist for Paul and his family members in coping with Paul's problem gambling. For example, Paul related that his mother tends not have confidence in his abilities to work on his gambling pattern stating that "my mom didn't believe it was

possible because my dad never could change". Recently after several conflicts with his mother due to her desire "to rescue me through bail-outs" he "finally gave up and took the money". Paul believes that the situation is hard for his mom to understand and noted that "she lives in a place where there aren't a lot of resources for the family members of compulsive gamblers".

Another example of a situation that resulted in difficulties for Paul and his family occurred last August. After being abstinent for five months Paul informed his family of his progress. At that time his mother and siblings did not acknowledge his success. A couple of weeks later the family had a surprise dinner party celebrating Paul's birthday and accomplishment of abstinence from gambling. The next morning Paul went on a gambling binge.

When Paul began gambling more frequently his circle of friends diminished until his friends "disappeared". He described a situation in which he "alienated" his friends by not following through on plans. This resulted in Paul's becoming "isolated", having relationships "not with people but with machines".

History of Emotional and Physical Difficulties. Paul reported being "depressed and angry a lot of the time" while on a binge. At times he considered suicide but never made any plans to attempt it. He also described mood swings occurring at work in which he vacillated between being "angry" and "calm", further describing his flat affect as "being monotone". At times he felt confused as he often hid his gambling with "an endless cycle of lying". Living behind a "barrier of lies" became difficult as he had to constantly "cover lies with more lies". During the height of Paul's gambling he experienced weight loss and

sleeping difficulties.

Work situation. Paul's work situation was impacted by his gambling difficulties. Inconsistent emotions were observed by his colleagues. "They nicknamed me Dr. Jekyll and Mr. Hyde" due to the "split personality" he exhibited. Although Paul reported being late for and missing work to gamble he always made up the time. He excelled in his career and received promotions stating that his "whole objective at work was to get money to gamble".

Financial situation. Most of Paul's money was spent on gambling. He often went without eating as his "money for food went to gambling". He sold his car and began "walking everywhere I went because I didn't have money for transportation". Paul estimates that he has lost up to $50,000 due to gambling over nine years.

Criminal activity. The desire to obtain money to gamble led Paul to commit white collar crimes. In one attempt to abstain, Paul asked his sister Carolyn to be a co-signer for a bank account as a safeguard against obtaining funds to gamble. This safeguard was ineffective as Paul "conned her by forging her name on the bank slips and emptying the bank account". He also "signed rent checks knowing that there would be no money in my account".

Treatment. Paul's gambling continued to a point that he felt that he could no longer go on with his life situation the way it was as "all I was doing was gambling and waiting to gambling - nothing else happened". Feeling that he needed help Paul contacted GA and attended meetings sporadically. Paul "never really felt part of GA"; however, he uses the twelve step format. After his experiences with GA, Paul discussed

his problem gambling with his supervisor at work. The supervisor instructed him to contact the company's EAP. The EAP counsellor referred him to counsellors who ran a two-week residential and twelve-week aftercare program in Quebec. Paul attended the program in 1992 and felt that it was beneficial.

Present situation. Since beginning to work on his gambling pattern in 1992 Paul has returned to gambling a couple of times. Currently, he has been abstinent for eleven months and is paying back his debts. Relations with his mother and siblings are slowly becoming stronger. He has started to build a small circle of friends.

The literature reviewed in this paper was helpful in carrying out an interview with and in understanding the life situation of a problem gambler and his family. For example, Paul fulfils the DSM-IV criteria for pathological gambling. His demographic characteristics are similar in many ways to the demographic make-up of problem gamblers in Canada. Paul's gambling, which began as recreational gambling at an early age, escalated after a traumatic event. Emotional and physical difficulties has been experienced by Paul as a result of his gambling. His financial situation has been negatively impacted. He and some of his family members have taken part in a variety of addictive behaviours. Paul's family system has experienced difficulties related to his gambling pattern and have attempted to deal with the situation by using coping methods that at times jeopardize Paul's progress and theirs. This interview shows how the life situation of a problem gambler and the family can be linked with empirical data. It also reveals the importance of involvement of the family system in the intervention process.

Chapter 6: Implications for Social Workers

The systems perspective, used by social workers, seems particularly applicable to working with people experiencing difficulties related to problem gambling. The approach includes considering the global picture. Rather than viewing problem gambling as an individual issue, social workers are in the position to view the systems that interplay in the situation (i.e., family). Helping the gambler's family provides help to the gambler and helping the gambler provides help to the family as change in one part of the system manifests change in other parts of the system.

Problem gambling and its effects on the gambler and the gambler's family system was illustrated by an interview, conducted by the author as part of the research study, with a problem gambler (Paul). In this case the family system was experiencing several gambling related problems. Paul has undergone individualized treatment. The literature demonstrates that Paul and his family may have benefited from a family-based intervention plan. Perhaps intervention methods similar to those proposed by Heineman (1989) and Lesieur (1990) may have increased the likelihood of a positive intervention process,and success for Paul and his family.

Based on the analysis of the literature and the case study the following recommendations have been developed to aid social workers when intervening with the family affected by problem gambling.

- Develop rapport and trust. Provide encouragement, support, and empathy in a non-judgemental atmosphere.

- Identify and build support system. If possible, include the gambler's significant others and the gambler in the assessment and the intervention process. Encourage family members to participate even if the gambler

doesn't.

- Conduct a thorough bio-psycho-social assessment.

    - Assess coexisting problems (i.e., depression).

    - Ascertain the family's legal and financial situation. Help the family system to organize a plan (i.e., refer to lawyers, financial counselling services, GA or G-A).

    - Obtain a history of the gambling pattern and other addictive behaviours from the gambler's family members and the gambler, if possible.

    - Identify and deal with crises.

- Link the gambler to GA and the gambler's significant others to G-A. Assist in considering self-help information and options. Support them in the process.

- Educate the family system about problem gambling.

- Assist in exploring the relationship the family members have with problem gambling and the ways it has impacted on their life situation(s).

- Affect change in the interaction process. Help family members to strengthen communication and relationships.

- Enhance and promote methods of coping with stress.

- Educate in prevention techniques. Help to identify cues and triggers leading to gambling. Formulate plans for the reduction or elimination of gambling. Work with members to prevent enabling. Explore and practice techniques with the family to prevent relapse. Stress the importance of learning from the experience of relapse.

- Follow-up referrals checking to see if the client followed through and if the help was suitable.

Conclusion

Problem gambling is an issue that many Canadian families are struggling with. It has destructive effects on both the gambler and the gambler's family. These families can be assisted by social workers who are sensitized to the possibility of the presence of problem gambling among their clients and who are aware of the dynamics of problem gambling.

In an effort to help family members deal with the consequences of problem gambling and to strengthen the natural support network of the gambler, the family system should be involved in treatment whether the gambler is or not. A variety of family-based intervention approaches such as brief focus therapy and marital conjoint group therapy can be used by social workers intervening with the family system when gambling has become a problem.

A case study, depicts a problem gambler's struggle to overcome his gambling related difficulties in his family context. It demonstrates several ways in which he and his family members were affected by, and attempted to cope with problem gambling.

The social worker intervening with the gambler and the family faces a complex situation. Implications for social workers and clinical recommendations to keep in mind when intervening with the family system suffering from the affects of problem gambling are outlined. Consideration of the entire family system in the intervention plan can positively affect the intervention process.

Appendix A

The South Oaks Gambling Screen

1. Please indicate which of the following types of gambling you have done in your lifetime. For each type, mark one answer: "not at all", "less than once a week", or "once a week or more".

a. _____ play cards for money
b. _____ bet on horses, dogs or other animals (at OTB, the track or with a bookie)
c. _____ bet on sports (parlay cards, with a bookie, or at Jai Alai)
d. _____ played dice games (including craps, over and under or other dice games) for money
e. _____ gambled in a casino (legal or otherwise)
f. _____ played the numbers or bet on lotteries
g. _____ played bingo for money
h. _____ played the stock, options and/or commodities market
i. _____ played slot machines, poker machines or other gambling machines
j. _____ bowled, shot pool, played golf or some other game of skill for money
k. _____ pull tabs or "paper" games other than lotteries
l. _____ some form of gambling not listed above (please specify)

2. What is the largest amount of money that you have ever gambled with on any one day?

___ never have gambled___ more than $100 up to $1000
___ $1 or less___ more than $1000 up to $10000
___ more than $1 up to $10___ more than $10000
___ more than $10 up to $100

3. Check which of the following people in your life has (or had) a gambling problem.

___ father___ spouse or partner
___ mother___ child(ren)
___ brother or sister___ another relative
___ grandparent___ friend or significant other

4. When you gamble, how often do you go back another day to win back money you lost?

___ never	(0 point)
___ some of the time (less than half the time I lost)	(0 point)
___ most of the time I lost	(1 point)
___ every time I lost	(1 point)

5. Have you ever claimed to be winning money gambling when you were losing?

___ never (or never gamble)	(0 point)
___ yes, less than half the time I lost	(1 point)
___ yes, most of the time	(1 point)

6. Do you feel you have ever had a problem with betting money or gambling?

___ no	(0 point)
___ yes, in the past but not now	(1 point)
___ yes	(1 point)

7. Did you ever gamble more than you intended to? ___ yes ___ no

8. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true? ___ yes ___ no

9. Have you ever felt guilty about the way you gamble or what happens when you gamble? ___ yes ___ no

10. Have you ever felt like you would like to stop betting money or gambling but didn't think you could? ___ yes ___ no

11. Have you ever hidden betting slips, lottery tickets, gambling money, IOUs or other signs of betting or gambling from your spouse/partner, children or other important people in your life? ___ yes ___ no

12. Have you ever argued with people you live with over how you handle money? ___ yes ___ no

13. (If you answered yes to question 12): Have money arguments centered on your gambling? ___ yes ___ no

14. Have you ever borrowed from someone and not paid them back as a result of your gambling? ___ yes ___ no

15. Have you ever lost time from work (or school) due to betting money or gambling? ___ yes ___ no

16. If you borrowed money to gamble or to pay gambling debts, who or where did you borrow from? (Check "yes" or "no" for each.)

    a. from household money
    b. from your partner
    c. from other relatives or in-laws
    d. from banks, loan companies or credit unions
    e. from credit cards
    f. from loan sharks
    g. you cashed in stocks, bonds or other securities
    h. you sold personal or family property
    i. you borrowed on your chequing account (passed bad cheques)
    j. you have (had) a credit line with a bookie
    k. you have (had) a credit line with a casino

Scores on the SOGS are determined by adding up the number of questions which show an "at risk" response. Questions 1, 2, 3, 12, 16j, and 16k are not counted. A "yes" answer for question 7-15 equals one point. A score of zero indicates "no problem", a score of one to four indicates "some problem" and a score of five or more indicates "probable pathological gambler".

Note. From "Revising the South Oaks Gambling Screen in Different Settings" by H. Lesieur and S. Blume, 1993, Journal of Gambling Studies, 9(3), p. 220-222.

Appendix B

The Twelve Steps of Gamblers Anonymous

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. Made 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.

Note. From GA (p. 4-5) by GA, 1993, California: GA International Service Office.

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