EDITORIAL

Problem gambling: what can psychiatrists do?

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Summary Psychiatrists rarely recognise or treat problem gambling, despite its high comorbidity among psychiatric patients. Early interventions, as in other psychiatric disorders, offer the potential for improving outcomes in problem gamblers. In this editorial, we make the case for why psychiatrists should do more to help problem gamblers, and discuss in detail how they can offer screening and brief psychological interventions.

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Seventy-three per cent of British adults gambled in the past 12 months.[1] Most of them did so recreationally, without any negative consequence to themselves or others. Nevertheless, akin to substance use, gambling behaviours exist on a continuum of escalating severity and adverse consequences, ranging from no gambling, to normal/recreational gambling, through 'at risk' gambling to problem gambling (Fig. 1).

The 2010 British Gambling Prevalence Survey[1] found that 7.3% of adults fell into the 'at risk' group, i.e. those who gamble problematically and who are at risk of developing more severe gambling problems. The survey also found that an additional 0.7% of British adults were problem gamblers.

Problem gambling has long been underrecognised in Britain. Consensus is now emerging that gambling is a potentially addictive behaviour, similar to psychoactive substance use.[2] In the USA, problem gambling is currently referred to as pathological gambling, but the name will change with DSM-5 to gambling disorder and will be re-classified under the category of addictive disorders.[3] In Britain, the term most often utilised is problem gambling. In this paper, we use the term problem gambling to mean 'gambling that disrupts or damages personal, family or recreational pursuits'.[4]

Why should psychiatrists do more?

Psychiatrists should assist in identifying and treating problem gamblers for several reasons. The first relates to the comorbidity between problem gambling and psychiatric disorders. The vast majority of problem gamblers also have one or more co-occurring psychiatric disorders, such as depression, anxiety, substance misuse and personality disorders.[5] Thus, patients seeking treatment for psychiatric disorders are much more likely than the general population to have a gambling problem. For example, the prevalence of gambling problems among treatment-seeking substance misusers has been estimated to be between 5 and 30%.[6]

Despite such high rates of comorbidity, gambling problems often go undetected and unaddressed. In our experience, this is due to two main reasons: patients' reluctance to discuss gambling behaviours (owing to shame, stigma and guilt) and psychiatrists' lack of awareness and knowledge of the condition.

Problem gambling, if untreated, can have wide-ranging negative impacts. The adverse consequences related to the individual include physical[7] and psychiatric disorders,[5] as well as obvious financial difficulties. Problem gambling also has an impact on the family; it is associated with interpersonal relationship difficulties,[8] domestic violence[9] and negative effects on children.[10] Further, it affects society at large, and is related to absenteeism at work and criminal activities.

There are easy-to-use screening tools and brief psychological interventions for problem gambling that can be readily applied in mental health settings. As in other psychiatric disorders, early interventions hold the potential for improving outcomes. In particular, brief interventions may assist some problem gamblers in ceasing gambling completely or in reducing gambling to the point at which it is causing no problems.[11,12] Given these issues, we call on psychiatrists to do more to help their patients with gambling problems.

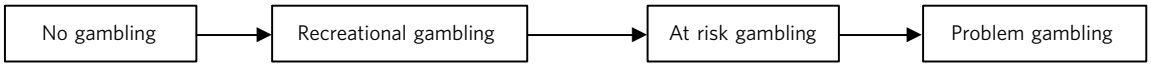

Fig. 1 The gambling continuum.

What can psychiatrists do?

In our view, psychiatrists can and should attempt to screen their high-risk patients for problem gambling. When patients screen positive for gambling, psychiatrists should offer brief interventions when possible; when brief interventions are unlikely to be sufficient, psychiatrists should refer such patients to more intensive specialist services.

Screening for problem gambling

There are several screening tools available, but there is no single 'gold standard' in assessing gambling problems. We briefly highlight two tools.

The NODS-CLiP[13] contains three questions: 'Have you ever tried to stop, cut down, or control your gambling?', 'Have you ever lied to family members, friends or others about how much you gamble or how much money you lost on gambling?' and 'Have there been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences, or planning out future gambling ventures or bets?' A positive response to any one question is considered a positive screen, which should be followed by a more extensive diagnostic interview. The advantages of this instrument are that it is very short, and two comprehensive studies[13,14] have been published on its psychometric properties, both of which demonstrated adequate reliability and validity in a range of populations from epidemiological samples to patients seeking treatment for substance use and medical disorders.

The South Oaks Gambling Screen (SOGS)[15] is perhaps the most widely used. This is a lengthier 20-item, self-administered questionnaire, and a score of 5 or above indicates a 'probable problem gambler'. It has been applied in numerous samples and translated into many languages. However, the main disadvantage of this instrument is that it appears to overdiagnosis gambling problems. Thus, similarly to other screening instruments, a diagnostic assessment is often indicated following a positive screen.

Other instruments are under development and many others have been described in the literature; for a detailed review of the literature on this topic, we refer the reader to the guidelines from Monash University.[16] Regardless of the instrument chosen for screening, psychiatrists should provide either a referral or an intervention for individuals who screen positive for a gambling problem.

Brief interventions for problem gambling

Brief interventions were designed for people who use addictive substances or engage in problematic behaviours (such as gambling) but who have not yet developed a full-blown addiction. They are also appropriate for patients who are unwilling to seek formal or more intensive treatment for their disorder. The rationale for administering brief interventions is that they may prevent the progression of an addictive disorder (Fig. 1). Further, they are low-cost, high-volume interventions that may be applicable in a range of settings. Brief interventions in the field of alcohol misuse are well validated, and a simple 5- to 10-minute intervention has been shown to be very effective in reducing drinking in some contexts.[17] Despite brief interventions having been developed and evaluated in the USA and Canada to help problematic gamblers, Britain has lagged behind.

Petry[6] developed a very brief gambling intervention that has evidence of efficacy. This intervention takes no more than 10–15 min to deliver and consists of three simple steps. In step 1, the concept of the gambling continuum and the meaning of these terms are explained. Then, a pie chart demonstrates how people gamble; this includes the relative breakdown of non-gamblers, recreational gamblers, at-risk gamblers and problem gamblers in the general population. Step 2 involves discussing the harms associated with problem gambling, including financial harms, family harms, health harms and negative impact on work. Step 3 consists of discussing simple and practical measures to reduce gambling such as limiting the amount of money one spends gambling, reducing the amount of time and days spent gambling, not viewing gambling as a way of making money, and spending time on non-gambling activities.

Brief interventions have yielded success in decreasing gambling. For example, in a randomised trial, Petry *et al*[18] compared a brief 10-minute intervention with an assessment-only control, one session of motivational enhancement therapy (MET), and a session of MET plus three sessions of cognitive–behavioural therapy (CBT). The one session of MET was the only intervention to yield clinically significant reductions in gambling at 9 months follow-up. The brief 10-minute intervention evidenced some reductions in gambling compared with the control condition, as did the MET plus CBT condition; however, none of the 'active' interventions differed significantly from one another. Hence, brief interventions were successful in reducing gambling behaviours, although the optimal length may range from 10 min to up to a more traditional 50-minute session. Importantly, participants in this study[18] were not seeking treatment for their gambling problems, emphasising the usefulness of brief interventions when used opportunistically. Additional studies of this brief intervention are ongoing in the USA and in Britain.

More intensive gambling treatments

Although the focus of this editorial has been on brief interventions that can be offered to gamblers in mental health settings, there may be instances in which such interventions are not sufficient. Individuals who are actively seeking interventions, or those whose lives have been substantially affected by gambling, may require more intensive treatment. Additionally, some persons may have already received brief interventions for gambling and not benefitted. Such cases would warrant referral to specialist gambling treatment services.

However, treatment provision for problem gamblers in Britain is at best patchy and at worst non-existent.[19] There is only one such specialist service in the National Health Service (NHS) in Britain – the National Problem Gambling Clinic.[20] Nevertheless, patients can also be signposted to other non-NHS gambling treatment agencies that take self-referrals, for example GamCare and Gamblers Anonymous. GamCare (www.gamcare.org.uk) is a charity that 'provides support, information and advice to anyone suffering

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through a gambling problem'. Based in London, it offers services (themselves or through their partner agencies) in most regions of Britain. Services offered by GamCare include a telephone helpline, internet line, forums, chat rooms, counselling (face to face and online), psychotherapy, group therapy and support for families. Gamblers Anonymous (www.gamblersanonymous.org.uk) is a self-help group modelled on Alcoholics Anonymous: it is based on the '12-step model' and sees total abstinence as the treatment goal.

Conclusions

We hope that we have made a strong case for why psychiatrists should do more to help problem gamblers and what types of interventions psychiatrists can deliver in mental health settings. Screening for problem gambling and administering brief interventions is very much within the psychiatrist's repertoire. In our view, the Royal College of Psychiatrists ought to take the initiative in expanding gambling screening and intervention services.

Relevant lessons were learned in the process of recognising substance addictions (drugs and alcohol) as a legitimate problem for psychiatrists to address. All psychiatrists are now trained in the assessment and treatment of alcohol and drug misuse. Similarly, training in the treatment of problem gambling ought to be incorporated into the core training curriculum of psychiatric trainees. Perhaps a starting point for our College might be to follow the path of the Royal College of General Practitioners, which in 2011 launched a 3-year training programme for general practitioners to support people with gambling problems, emphasising screening and brief interventions (www.rcgp.org.uk/professional_development/continuing_professional_development/gambling_awareness.aspx). They have also recently developed a problem gambling e-learning module for general practitioners. Similar efforts in the training of new and practicing psychiatrists may ultimately reduce the burden of problem gambling on patients, their families and society.

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References

1 Wardle H, Moody A, Spence S, Orford J, Volberg R, Jotangia D, et al. *British Gambling Prevalence Survey 2010*. TSO (The Stationery Office), 2011.

2 Orford J. *Excessive Appetites: A Psychological View of Addictions* (2nd edn). Wiley, 2001.

3 Petry N. Pathological gambling and the DSM-IV. *Int Gamb Stud* 2011; **10**: 113–5.

4 Lesieur HR, Rosenthal RJ. Pathological gambling: a review of the literature (prepared for the American Psychiatric Association Task Force on DSM-IV committee on disorders of impulse control not elsewhere classified). *J Gamb Stud* 1991; **7**: 5–39.

5 Petry NM, Stintson FS, Grant BF. Comorbidity of DSM-IV pathological gambling and psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry* 2005; **66**: 564–74.

6 Petry NM. *Pathological Gambling: Etiology, Comorbidity and Treatment*. American Psychological Association, 2005.

7 Morasco BJ, Pietrzak RH, Blanco C, Grant BF, Hasin D, Petry NM. Health problems and medical utilization associated with gambling disorders: results from the National Epidemiologic Survey on alcohol and related conditions. *Psychosom Med* 2006; **68**: 976–84.

8 Lobsinger C, Beckett L. *Odds on the Break Even: A Practical Approach to Gambling Awareness*. Relationships Australia, 1996.

9 Mulleman RL, Denotter T, Wadman MC, Tran TP, Anderson J. Problem gambling in the partner of emergency department patient as a risk factor for intimate partner violence. *J Emerg Med* 2002; **23**: 307–12.

10 Jacobs DF, Marston AR, Singer RD, Widaman K, Little T, Veizades J. Children of problem gamblers. *J Gamb Behav* 1989; **5**: 261–7.

11 Hodgins DC, Currie SR, el-Guebaly N. Motivational enhancement and self-help treatments for problem gambling. *J Consult Clin Psychol* 2001; **69**: 50–7.

12 Dickerson M, Hinchy J, Legg England S. An evaluation of a minimal intervention for media-recruited problem gamblers. *J Gamb Stud* 1990; **6**: 87–102.

13 Toce-Gerstein M, Gerstein DR, Volberg RA. The NODS-CLiP: a rapid screen for adult pathological and problem gambling. *J Gamb Stud* 2009; **25**: 541–55.

14 Volberg RA, Munck IM, Petry NM. A quick and simple screening method for pathological and problem gamblers in addiction programs and practices. *Am J Addict* 2011; **20**: 220–7.

15 Lesieur HR, Blume SB. The South Oaks Gambling Screen (SOGS): a new instrument for the identification of pathological gamblers. *Am J Psychiatry* 1987; **144**: 1184–8.

16 Problem Gambling Research and Treatment Centre (PGRTC). Guideline for Screening, Assessment and Treatment in Problem Gambling. Monash University, 2011.

17 Bien HT, Miller WR, Tonigan S. Brief interventions for alcohol problems: a review. *Addiction* 1993; **88**: 315–36.

18 Petry N, Weinstock J, Morasco BJ, Ledgerwood DM. Brief motivational interventions for college student problem gamblers. *Addiction* 2009; **104**: 1569–78.

19 George S, Copello A. Treatment provision for Britain's problem gamblers: present gaps and future opportunities. *Adv Psychiatr Treat* 2011; **17**: 318–22.

20 Bowden-Jones H, Clark L. Pathological gambling: a neurobiological and clinical update. *Br J Psychiatry* 2011; **199**: 87–9.

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