A Case of Pathological Gambling – Its Features and Management

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ABSTRACT

Pathological gambling (PG) represents the end spectrum of gambling behaviours. It is characterised by constantly recurring gambling behaviour which is maladaptive. This case illustrates how an Asian woman pathological gambler progresses through the different stages of development of the gambling habit, and how a multi-modal treatment approach has helped her regain psychosocial function. In addition, the maintenance factors, typical and atypical associated features, and difficulties in the management of such a case are highlighted.

Keywords: Pathological gambling, Asian woman, Features, Treatment

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INTRODUCTION

Pathological gambling (PG) is a disabling disorder that has been found to affect 1%-3% of the population[1]. The essential feature consists of constantly recurring gambling behaviour that is maladaptive in that personal, familial and/or vocational endeavors are disrupted[2]. Although it has been characterised as an impulse control disorder in the DSM IV, it has also been associated with compulsivity. Some regard it as a non-substance addiction and adopt treatment principles of an addictive disorder[2,3]. Local data on the prevalence of problem and pathological gambling and are still lacking, while presentation and referral tend to be late due to general lack of awareness.

CASE REPORT

The patient is a 32-year-old Asian housewife referred by a general practitioner for treatment of her compulsive gambling. Her gambling began since the age of twenty when she became pregnant with her first child and felt bored. Initially only card games involving small bets were played with friends at leisure but the gambling slowly worsened. She began to increase the frequency of gambling and the amount of her bets, which further escalated her losses. Even under close supervision by her husband, she would break the lock, sneak out of the house, sometimes bringing the children along; and she would return home only when she had lost everything and in complete exhaustion. She gambled in several gambling dens which constantly changed venues to avoid detection by the authorities. At each gambling session, which could last up to three days, she easily spent up to ten thousand dollars or more. When short of money, she would arrange for immediate loans with the loan sharks operating at the dens or pawn away her jewellery on the spot.

She described an irresistible urge and a pre-occupation to gamble and would succumb to this impulse. Once she started, she had great difficulty stopping and her longest abstinence lasted only five days. She found her own behaviour inexplicable as the thrill of gambling caused her to lose her sense of time and responsibility totally. She resented her husband's persuasion for her to stop and remained totally unconcerned about the pain that her behaviour had brought upon her spouse and family.

Her severe gambling resulted in physical, psychiatric and social complications. She skipped meals frequently and neglected her sleep when she became engrossed with her gambling, and would remain tired and lethargic for a few days after returning home from gambling. Psychologically she experienced frequent guilt about her gambling, especially in the initial phase. The losses affected her mood in that she would feel frustrated, lose sleep and her appetite reactively. Though dysphoric, she was however never clinically depressed. Just prior to psychiatric consultation, she was emotionally numbed to the effects of such losses and oblivious to the sufferings of the family while remaining pre-occupied with chasing the game and recovering the losses. Socially, her family life was suffering too. Her two children were neglected as they were often left alone in the house. Sometimes she would bring them along with her for days. Housework was either left undone or done hurriedly. In the one year prior to the consultation, she incurred escalating debts amounting to her husband's entire savings. There

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were frequent marital discords over her gambling. Her husband became depressed and needed psychiatric treatment. In an attempt to stop her gambling the family persuaded her to convert her religion and was bailing her out repeatedly. They even resorted to locking her up at home but even this failed to prevent her from going out at times.

She grew up in a village and lived a life of poverty. Her farmer father, also a problem gambler, squandered away whatever little that the family owned through his excessive gambling. Although her marital relationship was satisfactory, she felt bored and needed company. There was no history of other illicit drug abuse. Premorbidly, she was described to be an introverted and homely person, loving towards the family and her children.

Mental state examination during the first consultation revealed an adult lady who was shy and reticent. Despite her multitude of problems she remained apathetic. There were no depressive or psychotic features. The motivation to change was lacking and she was in denial of the complications of her gambling. She scored 14 points on the South Oaks Gambling Screen (SOGS) (More than five was suggestive of a pathological gambler) and also satisfied seven of the 10 criteria for the diagnosis of PG according to DSM IV classification.

TREATMENT

A combination of psychotherapeutic techniques and pharmacological therapy were employed in the entire treatment process. The essential components of treatment included: surveillance of her gambling activity, cognitive restructuring, family work, relapse-prevention and pharmacotherapy.

Regular sessions, sometimes at weekly intervals with interim telephone reporting, were arranged for surveillance of her gambling activities. An open and truthful attitude of confiding in the therapist and the family about her urge and gambling activities was encouraged.

Cognitive therapy centred on exploring her cognitive distortions about gambling such as her unrealistic ideas about the probability and the exercise of skill in gambling; and understanding how she would become entrapped in situations where excessive gambling may occur. The goal was to help her inculcate and maintain insight and motivation, and to realise the negative and adverse effects of gambling on her life.

Psycho-education and relapse prevention strategies were given emphasis throughout the treatment. Close attention was also given to help identify the urge and cues for gambling and to develop techniques of avoiding tricky situations. The inculcation of new leisure activities such as going on outings, travelling and cooking new dishes was encouraged. Assertive training to refuse invitations to gambling activities was rehearsed.

Regular family sessions were incorporated to work through the husband's co-dependent and rescuing behaviours and his grievances. Collaboration with her husband's psychiatrist became necessary at times. Budgeting, an essential component of the treatment, was planned with the husband's help. The husband took over the budget control until such time when she could gradually assume responsibility towards financial matters.

Fluvoxamine of up to 150 mg Nocte was prescribed after a series of relapses, both to relieve her secondary dysphoric symptoms and as a pharmacological adjunct to the ongoing psychological therapy.

Despite initial resistance and hence multiple slips of gambling, she began to make progress and gain insight. Soon she became motivated to keep her own abstinence and to subscribe to the regimen of the programme including being totally honest about her feelings and struggles. Her abstinence became sustained with consequent improvement in her social functioning. Her children were well looked after, her husband's depression remained in remission and the marital relationship improved.

DISCUSSION

Women problem gamblers are on the rise as part of the recent trends in developed countries. Among them, gambling appears to fill a need in their lives and they tend to report unhappiness, boredom and loneliness[4]. In addition, more women are also presenting with heavy debts as a result of excessive high-turnover gambling.

The acquisition, development and maintenance of PG is an area that is continually disputed. The exact causes and reasons for continuing gambling behaviour seem to be dependent upon the individual, but there seems to be some general underlying factors and re-occurring themes best explained by an integrated big-psycho-social model[5].

People with gambling problems often have a history of heavy gambling in close relatives (Bolen & Boyd 1968, Moran 1970). The Taq A1 variant of the human DRD2 gene (D2 A1 Allele) may play a role in pathological gambling[3,6]. Preliminary neurobiological studies implicate Serotonergic dysfunction in pathological gamblers[2]. Other neurotransmitter systems implicated include the Dopaminergic and the Nor-adrenergic systems. While the former may mediate positive and negative rewards, and is important for aberrant substance seeking or impulsive-

addictive-compulsive behaviour[7,8], the latter possibly mediate selective attention[9].

The accessibility and availability of gambling outlets is an important factor in the number of people being adversely impacted by gambling[10]. Early exposure to an environment of heavy gambling appears important too as excessive participation in gambling frequently results from social pressures. Gambling is often used by certain individuals to cope with crisis and major stresses as the building up and release of tension associated with risk taking can be thrilling, cathartic and pleasurable. Mere occasional gambling can therefore become pathological.

Development of gambling addiction proceeds in stages as illustrated by this case. She appeared predisposed in terms of the familial history, her lack of social support and her boredom. Her initial stage was characterised by a series of initial gains and encouragement from peers of a similar gambling background. As she entered the developing stage, her self-esteem soared as she saw herself as a smart and lucky gambler, and thereby increasing her bets and frequency of gambling. The thrill associated with winning propelled her into the losing phase when she began to lose money and suffer a blow to her self esteem, which led to chasing and acceleration of the losses. When she presented during the desperation phase, social and psychiatric complications with more bail-outs and impairment in her control were apparent.

Being a complex bio-psycho-social phenomenon, PG is associated with high rates of other clinical and comorbid conditions such as affective disorders, anxiety disorders and phobia, substance abuse and suicidality[2]. There are also higher rates of other impulse control disorders such as compulsive buying, compulsive sexual behaviour, kleptomania and attention deficit disorder[11]. However these were absent in this patient. On the other hand, she did exhibit alexithymia, which is found to be increased in PG and may be a risk factor for PG in some population[12].

The fact that PG is multi-factorial in etiology means that its treatment has implications far wider than just the activity of gambling. It also involves that person's entire lifestyle and the impact of social factors, particularly public policy on gambling. In a clinical setting, treatment has to be carried out in stages and often face limitations. Assessment should be detailed and the need for honesty set right from the start as the patient tended to develop a pattern of dealing with problems by untruthfulness.

Cognitive behaviour therapy has been found to be effective in reducing the frequency of gambling behaviour in clients[13] as well as maintaining the therapeutic gain[14]. On the other hand, aversive therapy and covert / imaginal desensitisation have not been found useful. Involvement of family is essential. Social assistance such as dealing with marital problems, leisure activities and legal assistance may also be indicated. A warm, empathic, non-judgemental and enthusiastic therapist with a strong sense of treatment boundary plays a pivotal role in moving the patient through the steps of change. With better therapeutic alliance, other relevant aspects of management such as dealing with low self esteem, ambivalence and fluctuating motivation to stop gambling; and applying the appropriate intervention based on the stage of gambling habit become easier.

Treatment of pathological gambling is very much in its infancy stage locally. Self-help groups may need to be developed with increased awareness and service demand. This case illustrates that though treatment can be long and frustrating, success is possible with appropriate approach in treatment and support.

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