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By

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SCREENING FOR PROBLEM AND PATHOLOGICAL GAMBLING: AN EXPLORATORY STUDY

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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This dissertation is dedicated to my mother,
Sandra

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ABSTRACT

Problem and Pathological Gambling are serious issues that may be difficult to identify in clients because of a lack of overt symptoms and the frequent presence of feelings of shame related to the problem. It is therefore imperative that clinicians utilize effective screening procedures and use accurate diagnostic resources when screening for problem and/or pathological gambling. This study sought to understand how mental health professionals screen for and assess pathological gambling/gambling disorder. Utilizing a general qualitative research design, semi-structured interviews with 10 licensed mental health professionals were analyzed and the results grouped into 7 themes. These themes represented important factors in the process of screening for and assessment pathological gambling/gambling disorder as identified by participants, which included 1) accounting for client shame and denial, 2) assessing for client motivation or stage of change, 3) conceptualizing comorbid disorders, 4) changes from the DSM-IV to the DSM-V, 5) comparing and contrasting pathological gambling/gambling disorder and other addictions, 6) using assessments in a nuanced way, and 7) the impact of relationship discord.

CHAPTER 1

INTRODUCTION

Gambling can be defined as "risking of an item of value on the outcome of an event determined by chance" (Nower & Blaszczynski, 2008). Gambling activities can include electronic gaming devices (slot machines, video draw poker, and blackjack), casino-type table games (roulette, blackjack, poker, and baccarat), numbers (lotteries, lotto, and scratch-card lotteries), wagering (horses and greyhounds), and sports betting; these activities can take place in legally sanctioned establishment, such as a casino or racetrack, or on the internet in the form of online gambling (Nower & Blaszczynski, 2008).

Opportunities for and access to legalized gambling has increased in the United States, and so have the rates of gambling participation and gambling-related problems (Nower et al., 2011). Although a vast majority of people are able to gamble without problems, researchers have found that up to 12 million people in the United States experience gambling related problems (Lynch et al., 2004). In a nationally representative survey of households in the United States, Kessler et al. (2008) found that nearly 4 out of 5 people had gambled at least once in their lifetime, while over half had gambled more than 10 times, a quarter had gambled more than 100 times, and 1 in 10 had gambled more than 1000 times. They found relatively low rates for problem and pathological gambling, however, with a lifetime estimate of problem gambling (which they defined as meeting one

DSM-IV-TR Criterion A symptom of pathological gambling) at 2.3% and a lifetime estimate of pathological gambling at 0.6%. Other researchers have found higher occurrences of problem and pathological gambling, with prevalence rates ranging from 1.1 to 1.6% for pathological gambling and from 2.8 to 3.8% for subclinical problem gambling for adults (Nower et al., 2011; Sacco et al., 2008).

Problem and pathological gambling are serious public and mental health concerns, significantly impacting not only the individuals themselves, but also their families and communities. Therefore, it is imperative that mental health professionals have effective assessment instruments and evaluation practices at their disposal to aid in the evaluation and treatment of pathological gambling. Problem and Pathological Gambling are serious issues that may be difficult to identify in clients because of a lack of overt symptoms and the frequent presence of feelings of shame related to the problem (Tolchard, Thomas & Battersby, 2007). It is therefore imperative that clinicians utilize effective screening procedures and use accurate diagnostic resources when screening for problem and/or pathological gambling.

Typical assessments used to screen for problem or pathological gambling include the South Oaks Gambling Screen (SOGS), the DSM IV-TR criteria for pathological gambling, and the Gamblers Anonymous Twenty Questions (20Q) (Toneatto, 2008). There is a need for more research on how these well-known assessments are being used, as well as which items are perceived to be most and least helpful. This would facilitate an understanding of the role assessments

currently play in screening for problem and pathological gambling. Furthermore, given the recent introduction of the DSM-V reclassification of pathological gambling to the Substance Use and Related Disorders section as gambling disorder, this study will provide valuable qualitative information regarding clinicians' experiences in this time of diagnostic transition.

This study is designed to provide a clearer understanding of how mental health care professionals are utilizing resources to screen for problem or pathological Gambling, and it seeks to explore mental health care professionals' perceptions and evaluations of those screening resources. The study also aims to explore and describe the process being utilized by mental health care professionals to screen for problem and pathological Gambling, as well as mental health care professionals' perceptions of common or key aspects of the Problem or Pathological Gambling screening process.

While there appears to be a significant amount of research investigating the properties and effectiveness of various problem gambling assessments, there is a dearth of research investigating the process by which clinicians assess for problem or pathological gambling. Furthermore, there also appears to be a dearth of problem gambling research using qualitative methodology. These two trends are likely related, as the process of assessment can be best captured through qualitative methodology. Clinicians seem to use an array of different techniques, tools, and thought processes when making a diagnosis of Problem or Pathological Gambling, and this study would aim at exploring and understanding these

different approaches. This study could potentially be beneficial to mental health care administrators attempting to institute or evaluate a standardized screening process, as well as any mental health care professional who may find themselves screening for problem or pathological gambling. Given the recent adoption of the DSM-V, this study could also be helpful for assessment creators in conceptualizing, adjusting, and/or updating their instruments. The question this study seeks to answer is how do mental health care professionals screen for problem gambling? What resources do they utilize, and how do their various approaches compare? The participants in this study will be mental health professionals with significant experience in the treatment and/or research of problem or pathological gambling.

1. How do mental health practitioners use the DSM-IV criteria to diagnose pathological Gambling?

2. How would mental health practitioners characterize the transition from the DSM-IV to the DSM-V for assessing pathological gambling or gambling disorder?

3. What resources and approaches do mental health practitioners typically use when screening for problem or pathological gambling?

CHAPTER 2

REVIEW OF THE LITERATURE

Terminology

Researchers have used many terms to describe gambling-related problems, but the most prevalent and ubiquitous terms in recent research have been problem gambling, pathological gambling, and gambling disorder. It is important to understand what is meant by each of these terms and how they are typically used in research.

The term pathological gambling generally refers to those individuals whose gambling behavior meets at least five of the ten diagnostic criteria outlined in the APA's Diagnostic Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR; APA 2000). In the DSM-IV-TR, pathological gambling is classified as an Impulse Control disorder. In the DSM-V, however, the term pathological gambling was replaced with disordered gambling, which is classified under Substance-Related and Addictive Disorders. As the DSM-V changes are recent (i.e. 2013) and a vast majority of the relevant research for this study utilizes the construct of pathological gambling, this paper will focus on pathological gambling and the DSM-IV-TR classification and criteria. The term problem gambling is more broad and is generally meant to communicate a subclinical gambling disorder that would fail to meet the criteria for pathological gambling or gambling disorder. Some researchers reserve the term problem

gambling for those individuals whose behavior meets three of the DMS-IV-TR diagnostic criteria for pathological gambling (Fisher and Harrison, 2009).

Pathological gambling and gambling disorder represent the more severe cases of gambling addiction, and they are generally conceptualized in black and white terms as one either meets the criteria for these disorders or does not. Problem gambling (estimated between 1-2% U.S. adults), on the other hand, conceptualizes gambling on a spectrum, and it typically describes people who have gambling issues that can harm to themselves and/or others but in less severity and/or frequency than is seen in Pathological Gambling (Toce-Gerstein, Gerstein & Volberg, 2009; Tolchard & Battersby, 2010). Problem Gambling can also be defined as an "inability to resist recurrent urges to gamble excessively despite harmful consequences to the gambler or others" (Maclaren et al., 2010).

Although problem gambling, pathological gambling, and gambling disorder are the primary terms used in the literature to refer to gambling-related disorders, other terms are also occasionally used. The term compulsive gambling is most frequently used by laypersons such as members of Gamblers anonymous; however, the criteria associated with compulsive gambling do meet the diagnostic criteria for pathological gambling. Additionally, the terms disordered gambling and gambling addiction are also sometimes used in the literature to identify problem and/or pathological gambling behavior.

DSM-IV Pathological Gambling

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) is a widely used diagnostic tool for mental health practitioners from a variety and fields and settings. Along with pyromania, kleptomania, trichotillomania, and intermittent explosive disorder, pathological gambling is currently classified in the DSM-IV as an "impulse control disorder not elsewhere specified," and the diagnosis of Pathological Gambling requires that the client meet any 5 of the 10 listed criteria (APA 2000). The DSM-IV (APA 2000) diagnostic criteria for pathological gambling are as follows:

A. Persistent and recurrent maladaptive gambling behaviors as indicated by five (or more) of the following:

   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 relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, or depression)

   6. after losing money gambling, often returns another day to get even (chasing ones losses)

   7. lies to family members, therapists, 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

B. The gambling behavior is not better accounted for by a manic episode

Although the 10 diagnostic criteria for Pathological Gambling listed in the DSM-IV were developed largely on clinical experience, researchers have since studied their psychometric properties to confirm their relevance and utility in diagnosing Pathological Gambling. The ten diagnostic criteria for Pathological Gambling of the DSM-IV have found to be reliable, valid, and accurate in the classification of Pathological Gambling, although it has also been found that weighting the criteria and reducing the minimum criteria necessary for diagnosis from 5 to 4 may further improve accuracy (Lakey et al., 2007; Stinchfield & Firsch, 2005).

Changes to DSM criteria in DSM-V

There have significant changes to the classification and diagnostic criteria in the next version of the Diagnostic and Statistical Manual, the DSM-V, which will have a significant impact on the screening and assessment of Pathological Gambling. Rather than being classified as an Impulse Control Disorder, it was proposed and enacted that the Pathological Gambling be grouped in the Substance Related and Addiction Disorders section, which correlates to the Substance and Related Disorders section in the DSM-IV (Mitzner et al., 2011). This proposed reclassification of Pathological Gambling was predicated on the similarities between Pathological Gambling and Addiction Disorders, such as "clinical presentation, comorbidity with Axis I and II disorders, association with

personality factors, neurotransmitter involvement, genetic transmission, and treatment options" (Mitzner et al., 2011).

Furthermore, there was debate among researchers concerning whether or not to alter the withdrawal symptoms listed as criterion 4 of the DSM-IV. Cunningham-Williams et al. (2009) proposed that the conceptualization and potential criteria revisions in the DSM-V should expand beyond the two symptoms of restlessness and irritability included in the DSM-IV. They found that only about one fourth of a sample of adult gamblers (n = 312) reported experiencing restlessness and irritability as gambling withdrawal symptoms, while 41% of the sample reported experiencing withdrawal symptoms when anger, guilt, and disappointment were added to restlessness and irritability (Cunningham-Williams et al., 2009). This suggests the potential need for a more comprehensive and inclusive set of withdrawal symptoms in the DSM-IV.

Petry et al. (2012) investigated the viability of some of the proposed changes of the DSM-IV criteria of pathological gambling for the DSM-V reclassification. They examined the proposals to remove the criterion related to committing illegal acts and to reduce the threshold for diagnosis from five to four criteria, particularly how these proposed changes may impact estimation of prevalence rates and classification accuracy. It was found that that eliminating the criterion related to committing illegal acts had negligible impact on the diagnostic accuracy of the criteria set, and they found that reducing the number of

met criteria to qualify for diagnosis from five to four seemed to result in a more consistent diagnostic system (Petry et al., 2012).

DSM-V Gambling Disorder

As mentioned above, in the DSM-IV pathological gambling was classified under the "Impulse Control Disorders Not Elsewhere Classified" section, along with Compulsive Hair Pulling (Trichotillomania); Intermittent Explosive Disorder; Kleptomania; and Pyromania. In the *DSM-V* pathological gambling has been moved to the category "Substance-Related and Addictive Disorder" and renamed gambling disorder. The name was changed to gambling disorder to reduce the stigma associated with the term pathological (Petry, Blanco, Stinchfield, & Volberg, 2013).

Research has increasingly indicated that pathological gambling and substance use disorders share common elements and similar etiologies. In fact, pathological gambling or gambling disorder has been referred to as a "drugless" substance use disorder, in that several of the predominant symptoms in pathological gambling seem to overlap with common symptoms of substance use disorders, including cravings, tolerance, withdrawal symptoms, and propensity for relapse (Conversano et al., 2013).

As mentioned in the research above, a major change from the DSM-IV criteria for pathological gambling to the DSM-V criteria for gambling disorder is the elimination of the criterion "has committed illegal acts such as forgery, fraud theft or embezzlement to finance gambling." Researchers have not only found that

there is a the low prevalence of this behavior among individuals with pathological gambling or gambling disorder, they have also found that that its elimination would have little or no effect on prevalence rates in research and little effect on diagnosis of gambling disorder in clinical work (Denis, Fatseas, & Auriacombe, 2011). In other words, no studies have found that assessing criminal behavior helps distinguish between people with a gambling disorder and those without one.

Some of the language in the criteria was changed in the DSM-V as well. For example, "Is preoccupied with gambling" has been changed to "Is often preoccupied with gambling" to clarify that one need not be obsessed with gambling all of the time to meet this diagnostic criteria. Furthermore, "Gambles as a way to escape from problems" has been changed to "Gambles when feeling distressed." Lastly, the text accompanying the criteria, "chasing one's losses" has been clarified to frequent, and often long-term, "chase" that is characteristic of gambling disorder, not short-term chasing (Denis, Fatseas, & Auriacombe, 2011) .

Furthermore, while the cutoff score to quality for pathological gambling in the DSM-IV is 5 criteria, the cutoff score for gambling disorder in the DSM-V is 4 criteria. Research has indicated that reducing the cutoff score for diagnosis leads to improvements in classification accuracy, as well as a reduced rate of false negatives (Petro, Blanco, Stinchfield, & Volberg, 2013). In order to diagnose a gambling disorder in the DSM-V, the critiera present in the individual must occur within a 12-month period, contrasting with the DSM-IV, which does not provide a

time period for symptoms. All symptoms required for diagnosis, therefore, must have been present within the past year, theoretically decreasing potential false positives.

Demographic Differences

Problem and pathological gambling can affect individuals of different racial and ethnic backgrounds, socioeconomic groups, geographic regions, ages, genders, and sexual orientations. Problem and pathological gambling appears to be most prevalent, however, in non-hispanic black males of low socioeconomic status (Hershberger et al., 2005). Men represent approximately 68% of pathological gamblers in the United States and seem to gamble earlier and more frequently throughout their lifespan than do women (Ladd & Petry, 2002).

Research into gender-related differences of problem and pathological gamblers that several differences emerged between men's and women's gambling behavior. Potenza et al. (2001) found gender-related differences in numerous areas, including reported patterns of gambling, gambling-related problems, borrowing and indebtedness, legal problems, suicidality, and treatment for mental health and gambling problems. It is important to note that this study utilized participants from a gambling help-line, and it was thus inclusive of only treatment seeking gamblers and does not address non-treatment seeking gamblers. They found that compared to treatment-seeking female gamblers, treatment seeking male gamblers were more likely to be younger, have a higher income, and were less likely to be African American (Potenza et al., 2001).

Potenza et al. (2001) also found other significant gender-related gambling differences. They found that male gamblers reported longer lifetime durations of gambling than did female gamblers. They also found significant differences between genders in the type of problematic gambling activity reported. Male gamblers were far more likely to report problems with "strategic" gambling activities, i.e. cards or sports betting, while female gamblers were more likely to report problems with "non-strategic" gambling activities. Male and female gamblers were both likely to report perceived gambling-related depression, but female gamblers were more likely to report perceived gambling-related anxiety and suicide attempts. Looking at legal concerns, male gamblers were more likely to report gambling-related arrest, while female gamblers were more likely to report illegal activity in the absence of arrest related to gambling behavior. Financially, both genders reported high rates of indebtedness, women were more likely than men to report a high level of gambling-related debt. Furthermore, male gamblers were more likely to report indebtedness to a bookie or loan shark, as opposed to female gamblers, who were more likely to report credit debt. Both genders were likely to report problems with alcohol (20% of males, 14% of females), but males were more likely than females to report drug abuse issues.

Ladd and Petry (2002) also investigated gender-related differences among treatment-seeking pathological gamblers. They confirmed the findings of Potenza et al. (2001) that male gamblers were more likely to report a longer lifetime duration of problematic gambling behavior, were more likely to be younger than

female treatment-seeking gamblers, were more likely to prefer action-oriented gambling activities, e.g. sports betting, to passive gambling activities, e.g. slot machines, and were more likely to have a higher income. In fact, they found that men initiated gambling, began gambling regularly, tried to stop gambling, and first entered gambling treatment at a younger age than women. They also found that female gamblers had fewer alcohol related difficulties and fewer legal complications than male gamblers, again largely confirming the findings of Potenza et al. (2002).

Gonzalez-Ibanez et al. (2005) examined differences in personality, psychopathology, and treatment response according to age, utilizing a sample of treatment seeking pathological gamblers ranging in age from 17 to 69 years old. The participants were divided into three groups; the first group being composed of participants with ages ranging between 17 and 26 years old, the second group being composed of participants with ages ranging between 27 and 43 years old, and the third group being composed of participants aged 44 years or older. Each participant was administered an array of questionnaires, including the DSM-IV criteria for pathological gambling, the Minnesota Multiphasic Personality Inventory, Zuckerman's Sensation Seeking questionnaire, and the Symptom Checklist Revised. Gonzalez-Ibanez et al. (2005) found important differences between the three age groups, which were largely consistent with previous research. They found that while the two older groups tended to show elevated levels of psychopathology, the younger group tended to stay within the normal

range, which is perhaps indicative of the progressive negative impact of pathological gambling over the course of the gambler's life. They also found that younger gamblers reported higher sensation seeking and a less favorable response to treatment than the two older groups. These findings are highly relevant to the assessment and treatment of pathological gambling, as the most beneficial time to intervene, i.e. while the gambler is young, also appears to be the most difficult time to intervene.

Blinn-Pike et al. (2010) conducted a review of literature focused on gambling in youth of ages ranging from 9 to 21 years. Through their review of 103 quantitative, 8 qualitative, and 26 non-empirical research studies, they found several concerning issues with adolescent gambling research in general, namely that 1) the research is limited to a relatively small group of researchers in Britain, Canada, and the United States; 2) comorbidity studies tend to be limited to alcohol abuse; 3) it has few developmentally appropriate, valid and reliable screening instruments, and 4) it lacks racially diverse samples. Despite these limitations, Blinn-Pike et al. (2010) were able to identify consistent themes in the adolescent research. For example, it appears that adolescent males gamble more than adolescent females. It also appears that not only is problem or pathological gambling more prevalent in adolescents, they are also less likely to seek treatment, consistent with the findings of Gonzalez-Ibanez et al. (2005). The research suggests that adolescent problem gamblers are at an increased risk for problems with alcohol or drugs. Lastly, it seems that adolescents involved in

problem gambling are more likely to be involved in crime, have poor family relationships, and have poor school performance.

Tse et al. (2012) conducted a systematic review of 75 empirical studies to examine issues related to problem and pathological gambling in older adults. The studies included in the review focused on problem or pathological gambling issues with participants aged 50 years and older. Notably, the authors found a range of prevalence rates for both Problem and Pathological Gambling, with the lifetime prevalence for problem gambling in older adults ranging from 0.2% to 12.9% and the lifetime prevalence for pathological gambling in older adults ranging from .3% to 2.4%. The also identified several motivations for gambling in older adults, including the food served at gambling venues, the excitement, chances to give to charity, chances to have an inexpensive holiday, to be a quick-fix solution for financial problems, a way to exercise the mind, a safe way to do something "bad," and getting a break from taking care of other people (Tse et al., 2012). They also identified some important risk factors for problem or pathological gambling in older adults, including lower income, having no vocational or tertiary qualifications, unemployment or retirement, single or widowed status, poor self-rated health, low level of optimism, poor quality of social support network, and limited access to the public transportation system.

Researchers have also investigated gambling differences across other demographic variables, including race and sexual orientation. For instance, Hershberger and Bogaert (2005) utilized survey data to examine differences in

gambling behavior in various sexual orientations. They found that heterosexual men gambled more often than homosexual men, and also that homosexual women gambled more often than heterosexual women. This difference was explained via the prenatal hormone biological explanation of sexual orientation development, i.e. the feminization of prehomosexual males and to the masculinization of prehomosexual females through sex-atypical patterns of hormone exposure during prenatal development. Problem and pathological gambling appears to be more prevalent in the Native American population than in the caucasian population of American, and this prevalence discrepancy appears most pronounced in women (Volberg & Abbott, 1997; Wardman, El-Guebaly, & Hodgins, 2001). Furthermore, maternal gambling appears to have a significant, negative impact on Native American children, particularly boys (Momper & Jackson, 2007). It should be noted, however, that the higher prevalence of gambling problems among the Native American population is best considered in the context of gambling access. Native American populations often have greater access gambling opportunities. Research has also shown differences in gambling behavior between Caucasion and African American populations in the United States. African Americans appear to be more likely to have problem or pathological gambling, as well as exhibit a stronger relationship between gambling issues and comorbid mood issues, hypomania, and substance use disorders (Barry et al., 2010).

Comorbidity

Psychological comorbidity can be defined as the presence of two or more mental disorders in an individual. Problems and pathological gambling often presents with one or more co-morbid disorders, notably substance use disorders, mood disorders, anxiety disorders, and personality disorders (Lorains et al., 2010; Holdsworth et al., 2011; Cunningham-Williams et al., 2000). It has been estimated that as much as 85% of pathological gamblers present with a co-morbid psychological disorder (Odlaug et al., 2012). The presence of a co-morbid disorder with pathological gambling has significant implications for onset of PG, course, severity, treatment-seeking behavior, course of treatment, and recovery.

In their systematic review and meta-analysis of 11 peer reviewed articles pertaining to the prevalence of comorbid conditions in problem and/or pathological gamblers, Lorains et al. (2010) found nicotine dependence, substance use disorders, mood disorders, and anxiety disorders. It is widely believed by researchers that pathological gambling and addictive disorders are influenced by many of the same factors, including genetic, environmental, and social predispositions, and Lorains et al. (2010) found nicotine dependence and substance abuse disorders to be the most common comorbid disorder with pathological gambling, with each co-occurring in over half of cases. Similar to pathological gambling, substance abuse disorders often present with comorbidity, as well as facilitating personality characteristics such as impulsivity (Slutske et al., 2005).

Cunningham-Williams et al. (2000) investigated the link between pathological gambling and comorbid disorders, particularly substance use disorders, in a substance-use treatment setting population. These researchers examined two samples, one recruited from drug treatment settings (n = 512), and one recruited from the community (n = 478). Interestingly, there were no statistically significant differences in number of cases of pathological gambling in each of the samples, with the overall prevalence of problem gambling at 22% and the overall prevalence of pathological gambling at 11%. They did find a strong relationship, however, between pathological gambling and antisocial personality disorder, consistent with the pathways model proposed by Blaszczynski and Nower (2002). Furthermore, they found a distinct etiological relationship between antisocial personality disorder and pathological gambling, with the onset of antisocial personality disorder occurring on average 11.4 years before the onset of pathological gambling.

Kessler et al. (2008) also examined the relationship between pathological gambling and various DSM-IV disorders, finding several significant associations. They utilized a nationally representative U.S. household survey to assess gambling symptoms, pathological gambling, and a variety of potential comorbid psychological disorders. They also found strong evidence for the prevalence of comorbidity in pathological gambling, with a vast majority of their participants (96%) qualifying for a comorbid DSM-IV disorder. The strongest association they found between pathological gambling and a comorbid disorder was between

pathological gambling and substance use disorders. They also found associations between pathological gambling and various anxiety disorders, post-traumatic stress disorder, depression, and impulse-control disorders. Furthermore, they examined the chronological relationship between pathological gambling and various comorbid DSM-IV disorders, hoping to elucidate the etiological relationships between them. Using age of onset data, these researchers found that in a significant majority of cases, anxiety disorders, depressive disorders, substance use disorders, and impulse control disorders pre-dated the onset of comorbid pathological gambling.

Winters and Kushner (2003) proposed four possible etiological relationships between pathological gambling and a comorbid disorder; 1) the comorbid disorder is directly caused by the pathological gambling, 2) the pathological gambling is caused by the comorbid disorder, 3) the comorbid disorder and the pathological gambling are both caused by a common etiological factor, or 4) there is no etiological relationship between the pathological gambling and the comorbid disorder. They acknowledge, however, that it is difficult to show that one psychological disorder is the clear and direct cause of another, but it is still important to understand any causal relationship present, to whatever degree manifested. It is also important to recognize that when considering population rates of various psychological disorders, one would expect to find multiple disorders in the same individuals, regardless of etiological relationship.

Despite the difficulty in ascertaining a clear etiological relationship between pathological gambling and a comorbid disorder, uncovering these relationships would not only help researchers to more accurately understand pathological gambling, but also help clinicians to more effectively diagnose, conceptualize, and treat pathological gambling in their clients. Winter and Kushner (2003) posit that when two diagnostic states covary, one must consider the possibility that one diagnosis may be is some way causing the other. They apply the three possible etiological relationships mentioned above to pathological gambling comorbidity specifically. Firstly, they examine the possibility that pathological gambling may predispose certain vulnerable individuals to develop one or more comorbid disorders, as they suggest may be the case with substance use and alcohol abuse disorders. Secondly, they discuss the possibility that certain psychiatric disorders may promote the development of problem or pathological gambling in vulnerable individuals. Thirdly, they discuss the possibility of pathological gambling and its comorbid disorder(s) sharing a common etiological factor or cause. These discussions are not meant to be definitive, but instead outline possible etiological relationships for further exploration. For instance, In addition to significant temporal relationships described above, Kessler et al. (2008) found that in almost 75% of participants with one or more comorbid DSM-IV disorders, at least one of the participant's comorbid disorders began at an earlier age than did pathological gambling.

In a qualitative study conducted by Holdsworth et al. (2011), half of the therapists interviewed believed that alcohol or substance use disorders generally occur before the development of pathological gambling, although nearly all therapists interviewed agreed that temporal sequencing of co-morbid disorders with pathological gambling depends on the individual. Most of the therapists interviewed also agreed that the most common co-morbid disorders with pathological gambling were depression, anxiety disorders, substance use disorders, and personality disorders (Holdsworth et al., 2011). This study is particularly relevant and noteworthy because it represents one of the few problem/pathological gambling related research studies conducted with qualitative methodology and involving mental health experts with experience treating pathological gambling. The authors collected data via two procedures, with one study using a forum of 33 gambling counselors and related professionals, and the other study using 25-30 minute telephone interviews with generalist counselors who had some experience with pathological gambling. The results of this study were largely consistent with the results of arguably the most extensive comorbidity research study to date, conducted by Kessler et al. (2008), demonstrating the viability of qualitative methodology in assessing pathological gambling issues.

Models and Etiology

No one single theory has been developed that can fully explain the onset and maintenance of disordered gambling. Pathological gambling is understood as

a complex, multifaceted, and multidimensional phenomenon, and it is generally considered a heterogeneous disorder in which multiple variables interact in multiple manners. Current research demonstrates that biological, psychological, and social factors are all relevant to the development of problematic levels of gambling (Sharpe 2002). While individuals share a number of common ecological factors, (i.e. cognitive distortions, behavioral contingencies of reinforcement, access to gambling opportunities, et cetera), they differ with respect to other biopsychosocial factors (Nower & Blaszczynski 2008). Based on these dissimilarities, Blaszczynski and Nower (2002), for example, posited three distinct groups of gamblers: (1) behaviorally conditioned problem gamblers, (2) emotionally vulnerable problem gamblers, and (3) antisocial, impulsivist problem gamblers.

Nower and Blaszcynski (2002) called this the Pathways model, which introduced an integrated model for pathological gambling that incorporates biology, personality developmental, cognitive theory, learning theory, and environmental factors into a comprehensive theoretical framework.

Nower and Blaszcynski (2002) proposed a first pathway composed of behaviorally conditioned gamblers. Pathway 1 represents a subset of gamblers who largely lack any premorbid psychopathology but sometimes technically meet the DSM-IV criteria for pathological gambling. The authors describe Pathway 1 gamblers as the least severe subtype, explaining the lack many of the frequent characteristics of more severe pathological gamblers. Pathway 1 gamblers, for

example, seem to lack not only premorbid psychopathology, but also substance abuse, impulsivity, and erratic or impulsive behaviors. Age of onset seems to be highly varied for this subtype, and these gamblers are described as the most responsive to treatment.

The pathway 2 subtype of gamblers proposed by Nower and Blaszcynski (2002) represents a more severe type of gambler than the pathway 1 subtype. These gamblers have the same ecological determinants, conditioning processes, and cognitive schemas of Pathway 1 gamblers, but they also present with premorbid anxiety and/or depression, have a history of poor coping and problem-solving skills, and have "negative family background experiences, developmental variables and life events." These gamblers described as influenced by a family history of pathological gambling, which represents a significant risk factor when exposed as children. Pathway 2 gamblers use gambling to relieve negative emotional states via arousal or escape, and they are emotionally vulnerable due to a combination of biological and psychosocial factors. This subtype of gambler is less responsive to treatment than the Pathway 1 gambler, and effective treatment must address not only the problem gambling, but also the underlying emotional vulnerabilities.

Nower and Blaszcynski's (2002) pathway 3 represents the most severe subtype of pathological gamblers, who present with features of impulsivity, attention deficit, and/or antisocial personality disorder. These gamblers display significant maladaptive behaviors and impulsivity across a broad array of

psychosocial contexts, including but not limited to pathological gambling, substance abuse, suicidality, irritability, low tolerance for boredom, and even criminal activity. This subtype is characterized by several troubling indicators not found in pathways 1 or 2, namely conflicted or poor interpersonal relationships, substance abuse with multiple drugs and alcohol, non-gambling related criminal behavior, and a family history of antisocial traits and alcohol problems. These individuals often begin gambling at an early age, and their pathological gambling behavior intensifies rapidly in early life. This subtype is the least responsive to treatment, and is not only unmotivated to seek treatment, but may respond poorly to any form of intervention.

There appears to be significant research evidence suggesting the existence of the 3 types of gamblers delineated by Blaszczynski and Nower (2002) via their Pathways model. Ledgerwood and Petry (2006) used the Gambling Experience Measure (GEM) to provide support for problem or pathological gambler subtypes; they found evidence to support two of the three subtypes suggested by the Pathways model, namely the emotionally vulnerable (pathway 2) and antisocial impulsivist (pathway 3) subtypes. Furthermore, Milosevic and Ledgerwood (2010) bolstered the evidence for the Pathways model subtypes in their comprehensive review of the existing literature on the subtyping of pathological gamblers based on psychopathology, personality, and motivation for gambling. Their review of the literature uncovered that three relatively distinct subtypes of problem or pathological gamblers seem to consistently emerge across various

studies. Much like the 3 subtypes suggested by the Pathways model, the subtypes discovered by Milosevic and Ledgerwood (2010) appear to be differentiated based on their motivations for gambling, psychopathology, and personality presentations.

The first type of gambler they found by Milosevic and Ledgerwood (2010) was characterized by elevated depression and/or anxiety; this type of problem or pathological gambler appears to be motivated to gamble in order to alleviate or escape their negative emotional state or dysphoric mood. This type of gambler appears strikingly similar to the second pathway subtype of the Pathways model (Blaszczynski and Nower, 2002). The second type of gambler found via Milosevic and Ledgerwood's (2002) review of the literature was characterized by impulsivity, sensation-seeking, emotional instability, and antisocial traits; this type of problem or pathological gambler appears to be motivated to gamble in order to decrease boredom or create an increased state of arousal. This type of gambler appears to closely parallel the third pathway subtype of the Pathways model (Blaszczynski and Nower, 2002). The third type of gambler found by Milosevic and Ledgerwood (2002) was characterized by a lack of psychopathology, impulsivity, or sensation-seeking; this type of problem or pathological gambler appears to be motivated by behavioral conditioning, social, or cultural factors. This subtype appears to resemble the first pathway subtype of the Pathways model (Blaszczynski and Nower, 2002).

Gonzalez-Ibanez et al. (2003), in an effort to classify pathological gamblers according to their psychopathology, sensation-seeking, and sociodemographic variables, also discovered 3 clusters or subtypes of gamblers which closely parallel the subtypes of Blaszczynski and Nower's (2002) Pathways model. The first cluster they found was characterized by relatively low psychopathology and moderate sensation seeking, as indicated by lower scores on the Symptom Checklist 90 – Revised (SC90-R), and thus bears resemblance to the first pathway/subtype of the Pathways model. It is important to note that although this first cluster was characterized by less psychopathology than the other two, gamblers falling into this cluster were near the clinical cutoff for several psychopathology subscales of the SC90-R, including depression, psychoticism, anxiety, interpersonal sensitivity, and obsessive-compulsiveness. This may suggest that even the milder groups/subtypes of pathological gambling involve elevated rates of psychopathology when compared to a non-clinical population. The second cluster found by Gonzalez-Ibanez et al. (2003) was characterized by high psychopathology and low sensation seeking; this cluster seems to resemble the second pathway/subtype of the Pathways model. The third cluster found was characterized by high psychopathology, with high scores on the hostility and paranoid ideation subscales of the SC90-R being unique to this cluster, and high sensation seeking; this cluster appears to be similar to the third pathway/subtype of the Pathways model.

Bonnaire et al. (2009) studied depression, alexithymia, and sensations seeking in a population of French gamblers to identify potential subtype classifications utilizing these constructs. Their results supported the idea that problem and pathological gamblers are a heterogeneous group, necessitating classification and differentiation into subtypes. The subtypes found not only corresponded with Blaszczynski and Nower's (2002) Pathways model subtypes, they appeared to be differentially associated with certain kinds of gambling activities. The first subtype identified was characterized by high sensation-seeking, high alexithymia scores, need for arousal, more frequent gambling, and a preference for more action oriented gambling activities, e.g. racetrack betting. This subtype lines up with the antisocial impulsivist (pathway 3) subtype of the Pathways model. The second subtype identified was characterized by low sensation-seeking, high depression, high dependency, and a preference for continuous, passive gambling activities that require no skill or ability, e.g. slot machines. This subtype bears resemblance to the emotionally vulnerable (pathway 2) subtype of the Pathways model. The third subtype identified was characterized by low sensation-seeking, low alexithymia, low depression, and a preference for gambling activities involving strategy and skill, e.g. roulette. This subtype appears to parallel the behaviorally conditioned (pathway 1) subtype of the Pathways model.

Personality Correlates

MacLaren et al. (2011) conducted a meta-analytic review of 44 studies that involved personality traits of pathological gamblers and a non-pathological gambling control group. Interestingly, they found that the personality profile of a pathological gambler has notable overlap with that of Borderline personality disorder and substance use disorders. All three of these personality profiles seem to involve Negative Affect, Unconscientious Disinhibition, and Disagreeable Disinhibition. In the studies reviewed, Negative Affect was often measured by the Neuroticism scale of the NEO PI-R or by Harm Avoidance on the TCI, Disagreeable Disinhibition was often measured by the Agreeableness scale of the NEO PI-R or Cooperativeness on the TCI, and Unconscientiousness Disinhibition was often measured by the Conscientiousness scale of the NEO PI-R or by Novelty Seeking on the TCI. The authors did not find a substantial effect size for positive affect, typically measured in the reviewed studies as Extroversion on the NEO PI-R or by Reward Dependence on the TCI.

Certain personality factors have been shown to be associated with problem or pathological gambling. Bagby et al. (2007) utilized the Five Factor Model of Personality to investigate differences between non-treatment-seeking pathological gamblers and non-pathological gamblers. They found that the personality profile of the pathological gambler is characterized by high impulsivity, emotional vulnerability, and a high level of excitement-seeking. These findings represent an amalgam of 2 of the the pathological gambling subtypes espoused by Blaszczynski and Nower (2002) in their Pathways model, namely the emotionally

vulnerable subtype and the antisocial impulsivist subtype. Based on this personality profile, the authors postulate that pathological gambling results from maladaptively coping in order to regulate affect or mitigate the effects of high neuroticism.

Myrseth et al. (2009) examined personality factors as predictors for problem or pathological gambling, and they also utilized the Five Factor Model of Personality. An adjusted regression analysis of demographic data and scores on the NEO-FFI of both pathological and non-pathological gamblers revealed 4 personality traits emerging as significant predictors of pathological gambling, namely neuroticism, openness, impulsivity, and stimulus intensity. Although these traits can serve as predictors of the development of pathological gambling, the relationship may be bidirectional in that the negative consequences or problem gambling behavior may influence the manifestation of these personality characteristics. A highly neurotic individual, for example, may be drawn to gambling to relieve a state of negative affect, but the negative consequences of pathological gambling, e.g. financial problems, relationship conflict, or legal difficulties, may heighten the presentation of neurotic tendencies (Blaszczynski & Nower, 2002; Myrseth et al., 2009).

While there seem to be certain associated personality factors, there also seem to be certain personality disorders that frequently co-occur with pathological gambling. Research has shown personality disorders to be a common co-morbid concern with problem or pathological gambling; it is estimated that between 23

and 92% of pathological gamblers have at least one personality disorder, while approximately 20% have two or more personality disorders (Odlaug et al., 2012). The most common personality disorders that seem to co-occur with pathological gambling are obsessive-compulsive, borderline, narcissistic, antisocial, and dependent personality disorders (Odlaug et al., 2012).

Although many personality disorders have been associated with problem and pathological gambling, the association between with of these personality disorders weakens when self-report measures are removed (Bagby et al., 2008). The personality disorder shown to have the strongest association with problem and pathological gambling, regardless of inclusion of self-report measures, is Borderline personality disorder (Bagby et al., 2008; Sacco et al., 2008). This finding is particularly intriguing, given that Blaszczynski and Nower's (2002) antisocial impulsivist subtype would suggest a strong association between Antisocial personality disorder and pathological gambling. The strong association between pathological gambling and Borderline personality disorder, however, can also be conceptualized via Blaszczynski and Nower's (2002) Pathways model, which theorized that many problem and pathological gamblers are motivated by impulsivity and affect regulation. This would explain problematic gambling behavior as a maladaptive means of coping with the characteristic impulsivity and emotional dysregulation of Borderline personality disorder (Bagby et al., 2008).

Assessment

As mentioned above, Problem and Pathological Gambling are serious issues that may be difficult to identify in clients because of a lack of overt symptoms and the frequent presence of feelings of shame related to the problem (Tolchard, Thomas & Battersby, 2007). Symptoms of PG may be assessed as part of a clinical diagnostic interview or by psychometrically validated self-report scales . Typical assessments used to screen for Problem or Pathological Gambling include the National Opinion Research Center DSM-IV Screen for Gambling Problems (NODS) (Gerstein et al., 1999), the South Oaks Gambling Screen (SOGS) (Lesieur & Blume, 1987), the Gamblers' Anonymous Scale (GA20) (Ursua & Uribelarrea, 1998), the Canadian Problem Gambling Severity Index (PGSI) (Ferris & Wynne, 2001), or simply the DSM-IV criteria. There appears to be diagnostic consistency between the SOGS and the DSM-IV criteria, and although there are distinct differences in the content assessed by the two diagnostic tools, research has shown that the South Oaks Gambling Screen and the DSM-IV criteria "appear to measure the same underlying core [Pathological Gambling] construct" (Slutske et al., 2011, p. 749).

As mentioned above, assessing for problem and pathological gambling can present a challenge for both researchers and clinicians, as many gamblers may be too ashamed or embarrassed to reveal the full extent of their gambling-related difficulties (George & Murali, 2005). Without an effective evaluation and classification system, however, therapeutic intervention, as well as problem and pathological gambling research efforts, will be limited in their effectiveness and

applicability. The clinical assessment process should assist not only in making a diagnostic decision, but also in creating and structuring an effective treatment plan from which to refer and intervene. Given the feelings of shame and guilt often present in the problem or pathological gambler, it is important to gather information from multiple sources to properly evaluate the client. Along with a strong clinical interview, financial records, and interviews with family members (with permission from the client), an important piece of the clinical evaluation process is the administration of assessment instruments to enhance diagnostic accuracy and inform treatment.

The South Oaks Gambling Screen is a 20-item questionnaire which was originally based on DSM-Ill criteria for pathological gambling. It was designed to be a convenient means to screen clinical populations of alcoholics and drug abusers, as well as general populations, for probably pathological gambling, although it was developed using hospitalized patients (Lesieur & Blume, 1987). The authors of the South Oaks Gambling Screen defined probable pathological gamblers as individuals who score 5 or more. Researchers have also sometimes used two additional categories, namely occasional or non-problem gamblers with a score of 2 or less and potential and problem gamblers with a score of 3 or 4 (Lacoceur et al., 2000). It is important to recognise that the scale was not designed for use in epidemiological research but was given a major role in prevalence studies in the absence of appropriately designed alternatives. The South Oak Gambling Screen's short, easy to understand format allows for many forms of

administration, including interviews conducted by either experts or nonexperts, computer, or even self-administration. This convenience and efficiency contributed to the South Oaks Gambling Screen becoming the predominant instrument for measuring problem or pathological gambling in research (Goodie et al., 2014).

The South Oaks Gambling Screen has not been without criticism, however. One criticism is that it overestimates prevalence rates in various populations when compared to the DSM-IV criteria (Stinchfield, 2002). Stinchfield (2002) conducted a study to examine the reliability, validity, and classification accuracy of the South Oaks Gambling Screen in a general population sample and a gambling treatment sample. The South Oaks Gambling Screen was administered to participants along with the DSM-IV criteria, which served as the standard against which the classification accuracy of the South Oaks Gambling Screen was evaluated. The author found satisfactory reliability and validity for the South Oaks Gambling screen in both the general population and the gambling treatment sample, but its classification accuracy varied by sample. The South Oaks Gambling Screen was found to have excellent classification accuracy with the gambling treatment sample, but it was found to have a 50% false positive rate with the general population sample (Stinchfield, 2002).

Lacoceur et al. (2000) investigated three possible factors contributing to this pattern of false positives, hypothesizing that 1) clients and participants utilizing the South Oaks Gambling Screen may have difficulty understanding

some items of the South Oaks Gambling Screen, (2) problem gamblers and probable pathological gamblers may be more likely to interpret items incorrectly than would non-problem gamblers and, (3) assuming that the first two hypotheses were accurate, clarification of these items would decrease the number of clients and participants identified as problem gamblers or probable pathological gamblers. Results indicated that many participants did find certain items on the South Oaks Gambling Screen to be unclear, and they found that providing clarification for those items decreased the likelihood of obtaining a false positive diagnosis of probable pathological gambler (Lacoceur, 2000).

Other means of reducing the rates of false positives found by the South Oaks Gambling Screen have been investigated, including increasing the score required to qualify as a probable pathological gambler. Goodie et al. (2013) investigated the relationship between the South Oaks Gambling screen and both the DSM-IV criteria and the DSM-V criteria, particularly the propensity of the South Oaks Gambling Screen to produce false positive according to each set of criteria. When used in conjunction with the DSM-IV and DSM-V criteria, the South Oaks Gambling Screen was found to be a useful tool for research screening but not as useful as a diagnostic instrument for diagnostic purposes clinical settings. Consistent with previous research, the South Oaks Gambling Screen was found to produce a high number of false positives with both set of criteria (Stinchfield, 2002; Goodie et al., 2013). The authors suggested raising the South Oaks Gambling Screen cut-off score from 5 to equalize the ratio of false positives

to false negatives. It was suggested that the cut-off score be raised from 5 to 10 for DSM-IV criteria. It was also suggested that when used with the DSM-V criteria, the cut-off score be raised from 5 to 8 for research screening purposes and from 5 to 12 for clinical diagnostic purposes (Goodie et al., 2013).

Another criticism of the South Oaks Gambling Screen is that the items do not align closely enough with the DSM-IV criteria (Goodie et al., 2013). For example, nearly half o the items of the South Oaks Gambling Screen refer to sources of borrowed money for gambling activities, while only 2 of the 10 DSM-IV criteria address this issue (Lesieur & Blume, 1987). Therefore, if a client who has borrowed money from numerous sources, he/she could score above the South Oaks Gambling Screen cut-off score of 5 to be identified as a probably pathological gambler. The same client could score well below the DSM-IV diagnostic cut-off of 5 and fail to meet the criteria for a diagnosis of pathological gambling.

One proposed explanation for this and the high false positives phenomena is that the South Oaks Gambling Screen and the DSM-IV criteria are actually measuring different severity levels or stages of problematic gambling behavior (Stinchfield, 2002). The South Oaks Gambling Screen, according to this argument, measures a less severe, earlier stage of problem gambling than does the DSM-IV criteria, and thus it leads to a high rate of false positives. If the South Oaks Gambling Screen measures an earlier, less severe state of pathological gambling, it should have a higher level of sensitivity than the DSM-IV criteria

and screen for issues more pertinent to the early stage problem gambler. This argument notwithstanding, it is important to note the differences in item coverage and sensitivity between the South Oaks Gambling Screen and the DSM-IV criteria for pathological gambling, particularly how those differences impact the screening context, i.e. research or clinical diagnosis.

Another popular problem and pathological gambling assessment instrument, the National Opinion Research Center Diagnostic Screen for Gambling Problem (NODS), has been shown to be highly correlated with the SOGS; the NODS, however, appears to yield lower prevalence rates than the SOGS (Wickwire et al., 2008). The NODS was developed via a Congressional commission to create a DSM-IV criteria based screening tool for pathological gambling. The NODS involves 17 items aimed at assessing the presence of gambling-related problems within in the past 12 months, and is utilized in research, in the assessment of problem and pathological gambling, and in the evaluation of treatment of problem and pathological gambling (Ladouceur & Jacques, 2005).

The NODS has been demonstrated to be a reliable and valid instrument for evaluating pathological gambling; it demonstrated a high level of internal consistency, as well as adequate levels of concurrent and discriminant validity relative to the SOGS (Wickwire et al., 2008). A strong correlation with the SOGS has been demonstrated, but there are significant diagnostic differences between the two assessment instruments. Primarily, the NODS appears to be less sensitive

to gambling problems than is the SOGS, and therefore it is less likely to classify an individual with probably pathological gambling. This can be viewed as either an advantage or a disadvantage. While the NODS may not recognize certain gambling problems that the SOGS may identify, this may be considered advantageous in the context of the frequent criticism that the SOGS overestimates prevalence rates of pathological gambling (Wickwire et al., 2008). It should be noted that although the NODS has been shown to be more conservative than the SOGS in its estimation of prevalence rates, it has been shown to be more sensitive to gambling problems than a clinical interview based on DSM-IV criteria (Ladouceur & Jacques, 2005).

Perhaps the simplest and shortest commonly used assessment instrument for problem and pathological gambling is the Lie/Bet Questionnaire, a 2-item questionnaire which was developed from the DSM-IV criteria for pathological gambling. The Lie/Bet Questionnaire has been shown to be a useful and effective screening tool for pathological gambling; it was shown to have high positive and negative predictive capabilities, i.e. it accurately identified the presence of pathological gambling as well as the lack of pathological gambling (Johnson et al., 2007). The Lie/Bet Questionnaire has also been found to have moderate congruence with the SOGS in the classification of problem gambling (Rosso & Molde, 2006). Therefore, while the Lie/Bet Questionnaire does correlate moderately with the SOGS, both the Lie/Bet Questionnaire and the SOGS show a

higher correlation with the DSM-IV criteria for pathological gambling than they do with each other (Rosso & Molde, 2006).

One of the oldest commonly used assessment instruments for problem and pathological gambling is the Gamblers Anonymous 20 Questions, which was developed within the Gamblers Anonymous organization during the 1950's. Although the Gamblers Anonymous 20 Questions have been a popular screening tool for problematic gambling for several decades, there appears to be a relative lack of research into its usefulness and accuracy in this function. A score of 7 on the Gamblers Anonymous 20 Questions has been found to indicate subclinical pathological gambling or problem gambling, while a score of 14 has been found to indicate pathological gambling (Toneatto, 2008). The Gamblers Anonymous 20 Questions have also been shown to be reliable and valid in the assessment of pathological gambling (Toneatoo, 2008).

Another commonly used instrument for assessing problem and pathological gambling is the Canadian Problem Gambling Severity Index (PGSI), which is a nine item scale designed to measure the severity of gambling problems in the general population. The PGSI has been predominantly used for research purposes, and it has become the "gold standard" in Canada and Australia and has become popular throughout the world (Miller, Currie, Hodgins, & Casey, 2012). The PGSI classifies participants into four gambler types, namely non-problem, low-risk, moderate-risk and problem gamblers. Of these four subtypes, however, only problem gambler category underwent validity testing during the scale's

development; this represented a significant initial weakness for the PGSI, as over 95% of gamblers fall into the non-problem, low-risk, and moderate-risk categories combined (Currie, Hodgins, & Casey, 2013). Research has indicated that although the PGSI appears to be strongly valid in assessing more severe gambling problems, it may be significantly weaker in assessing mild or moderate gambling problems (Miller, Currie, Hodgins, & Casey, 2012).

CHAPTER 3

METHODS

Theoretical Framework

This study is grounded in the constructionist epistemological stance, which Crotty (1998) explains as the position that "truth, or meaning, comes into existence in and out of our engagement with the realities of our world" (p. 8). This research will thus be conducted and interpreted through the lens that the mind creates and constructs meaning from its environment and that "there is no meaning without the mind" (Crotty, 1998, p. 8-9). It will be assumed that no two people view the world in exactly the same way, and one's particular perspectives or schemas seem to be influenced by a number of factors, including past experiences, neurological health, mood, state of important relationships, education, culture, et cetera.

This study will utilize several philosophical assumptions. Firstly, it is assumed that the relevant phenomena, in this case experiences with screening for and assessing problem and pathological gambling, will be consciously perceived and experienced by participants (van Manen, 1999). Secondly, it is assumed that those experienced essences of the relevant phenomena will then be described and interpreted rather than analyzed and explained (Moustakas, 1994). Thirdly, it is assumed that each participant will uniquely construe their own realities and experiences, which will formulate and foster an interpretivist-constructivistic paradigm. Finally, it is assumed that it is through their efforts to understand and

describe the lived experiences of participants that this study's researchers will create its complex and meaningful data (Creswell, 2007).

Research Design

This study utilizes a general qualitative approach. Qualitative research involves the use of interpretive techniques which seek to describe, decode, translate and come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world. It assumes that knowledge and reality are constructed in and out of interaction between human beings and their world. Meaning is constructed by human beings as they engage with the world they are interpreting.

This study involves the collection, organization, and analysis of data according to a general qualitative design. The general qualitative design of this study can be summarized in six broad steps. 1) The researchers identified a problem after exploring naturally occurring phenomena regarding assessment, i.e. it was found that there is a dearth of research concerning the process of screening for and assessing problem and pathological gambling. 2) In reviewing the literature the researchers identified a gap and justified why the study was important, offering rationale for the study, i.e. gambling problems are underreported and often difficult to diagnose. 3) Researchers specified a purpose for the study, considering the how, what and why questions regarding the topic, i.e. this study seeks to understand mental health practitioner's experiences in screening for and assessing problem or pathological gambling. 4) In considering

participants, a small number were identified who might offer expert information related to the study, i.e. licensed mental health clinicians with experiences treating problem or pathological gambling. 5) In analyzing and interpreting the data, researchers attempted to objectively consider interviewee ideas and knowledge as it emerged, without imposing given meaning upon it. Description and interpretation drew upon interviewees interpretations of the information they presented in the interviews as well as tentative interpretations of the researchers. For instance, interviewee interpretive language was utilized. 6) In writing up the report and providing an evaluation of the work, researchers engage in reflexivity in order to counter natural biases.

The data collected from participant interviews were transcribed, and the analyses of this data was approached inductively. Transcripts were also sent to participants to ensure accuracy. The data was coded, with significant statements, beliefs, or events being marked. The coded data was grouped into categories based on common elements, and these categories formed the themes through which the results of this study have been be organized and presented.

This research study aligns with what Haverkamp and Young (2007) would describe as a practice-oriented investigation, or a study designed to inform practice by providing full, elaborated descriptions of specific processes or concerns within a specified context, in this case the screening and assessment of problem and pathological gambling. This can be contrasted with construct-oriented and action-oriented investigations, which seek to better understand a

theory/construct or facilitate some kind of change based on social values, respectively. Some researchers argue that qualitative research should be approached from a broad generalist position and without strong preconceptions, but at the same time, they note the impracticality of approaching a topic without existing beliefs and ideas (Haverkamp & Young, 2007). This research study embraces the importance of a thorough understanding of the phenomenon through existing literature in order to develop a study's purpose, rationale, research questions, and contribution to the field (Morrow, 2005).

Participants

10 participants who are licensed mental health professionals with experience treating or screening for problem and pathological gambling were recruited for this study. Because this is an exploratory, qualitative study aimed at gathering information related to participants' experiences in screening for and treating problem or pathological gambling, finding mental health professionals who have robust professional experience with problem and pathological gambling in a clinical setting facilitated richer, more salient results. Although no specific exclusion criteria for experience were set, researchers with little or no clinical experience with problem and pathological gambling were not recruited for this study.

The mean age of the 10 mental health professionals participating in this study was 47.5 (Range = 35 – 67). While there were no geographic exclusion criteria for these participants, 8 of the participants were mental health

professionals working in the state of Oklahoma. One participant works in the state of Texas, and one participant works in the state of Mississippi. The corresponding limitation in generalizability will be discussed in the limitations section. While all participants were licensed mental health professionals, they possessed a variety of licensures, including state licensure of professional psychology, licensed professional counselor, and licensed social worker. 6 of the participants were male while 4 were female, and 9 were Caucasian while 1 was African American. The level of clinical experience of the participants ranged from 9 years to 31 years. 3 of the participants engaged in problem gambling focused clinical work, while 7 engaged in generalist clinical work.

This study utilized purposeful and snowball sampling to obtain the necessary number of participants. From existing social networks, two people with significant experience and expertise in assessing for and treating problem and pathological Gambling were recruited, and their knowledge of other potential participants was used recruit to more mental health practitioners with Pathological Gambling experience. All participants who choose to participate in this study and were given a consent form, which was reviewed and signed before the interview took place.

Interviews

Each participant was administered a 30-60 minute, semi-structured interview, of which 6 were face to face and 4 were via telephone. Interview protocols were used with interview questions designed to solicit participants'

thoughts, experiences and feelings regarding screening clients for and assessing problem and pathological gambling. Interviews were audio-recorded and transcribed. In order to protect the confidentiality of the participants, pseudonyms were used and data was stored in a password-protected computer. Interviewee information was deleted upon completion of study.

The interviewees were informed that the principal researcher is attempting to understand 1) how mental health professionals evaluate and utilize the 10 DSM-IV criteria for Pathological Gambling, 2) how mental health professionals experience the transition from the DSM-IV criteria for pathological gambling to the DSM-V criteria for gambling disorder, 3) how mental health professionals typically screen for and assess problem and pathological gambling, and 4) how mental health professionals typically recognize problem and pathological gambling. The questions asked were general and abstract, and the interviewees were asked further probing questions and were asked to volunteer additional information if they wished.

It is important to understand the intent and purpose of the qualitative interview, as it is aimed at uncovering a particular type of data. The goal of the interview is to gather detailed descriptions from participants concerning a particular lived experience relevant to the current research. The initial question is open-ended and asks that participants think of the experience and recall as much detailed information as possible about the event. From that point, the interviewer avoids leading questions as participants take charge of the interview and provide

descriptions of their experience. The conversation that follows serves to connect participants with the interviewer and to provide a frame of reference from which the interviewer may ask further questions for the purpose of gaining more details or clarification about the experience.

In contrast to many other research approaches, this particular approach is concerned with obtaining as much illumination as possible about the meaning of the experience for the participants. As much as possible, the interviewer avoids "why" questions that seek an explanation and utilizes "what" or "how" questions that allow for a richer, fuller description of the experience. The descriptions that emerge from this discussion allow for knowledge of the experience as a concrete representation of the phenomenon at hand that will be used in later analysis. The result of this interview process reveals what is meaningful to the person, and such meanings can be characterized as themes that capture a description of the phenomenon.

Validation Procedures

Multiple validation procedures were utilized to aid in establishing the trustworthiness, credibility, and authenticity of this study. The primary validation procedure used was investigator triangulation, i.e. a second researcher was invited examine transcriptions for significant statements, meanings, themes, and descriptions. This process was carried out independently from the primary researcher. Both researchers met for debriefing sessions, however, to discuss and corroborate findings. An external audit was also employed. An independent

consultant examined the research process and results for accuracy and assessed whether the findings were supported by the data (Creswell, 2007).

The primary researcher of this study is a 34 year-old, Caucasian, male doctoral student of Counseling Psychology at the University of Oklahoma. The second researcher is a Native American male professor of Counseling Psychology who has taught for over 17 years. The triangulation process involved each researcher independently examining the transcribed interviews, coding significant statement, categorizing those statements, and forming themes through which to present results. The researchers then combined independently formed themes and synthesized them into a single set, which are presented in the Findings section.

The researcher also employed the technique of bracketing, through which the researchers endeavor to set aside and suspend their own understandings of problem and pathological gambling screening as much as possible in order to perceive the phenomenon from a fresh perspective. This involved the acknowledgment and continual awareness of researcher biases, assumptions, and preconceptions related to gambling and to clinical assessment. Because qualitative research requires an unbiased perspective, certain preconceptions, such as the way the researcher, in his own clinical work, might assess for a DSM diagnosis, were deliberately set to the side in order to collect and describe results in the most objective manner possible. Researcher bias was also counteracted by providing quotes, long quotes when possible, to allow participants to describe experiences in their own words.

CHAPTER 4

FINDINGS

Theme 1: Shame/Denial

A recurring theme among interviewees was the importance of working with the client's shame and denial throughout the assessment process. This seemed to manifest in the interviewees' answers as references to a multifaceted barrier to obtaining an accurate assessment of gambling disorder with many clients. This referenced barrier typically implied an internal cognitive or emotional process manifested through shame, denial, defensiveness, ambivalence, and resistance. While these are all separate but related constructs, in can be argued that they are unified as mental processes of the client that impede the assessment of gambling problems.

Ordered from most used to least used regarding this "barrier" were the following terms: "denial," followed by "defensiveness," "ambivalence," "shame," and "resistance." These terms were used by participants in four different contexts. 1) They were used in reference to denial/shame as a barrier to the client seeking treatment in the first place, 2) to describe the client's resistance to treatment in a clinical setting, 3) in reference to obtaining an accurate assessment of client's gambling problems, and 4) in reference to a factor in the client's low motivation for treatment and recovery, i.e. pre-contemplative/contemplative stages of change. The common denominator of these four different contextual

references to this phenomenon is that in all cases the denial/shame of the client represents an impediment to the therapeutic process.

Shame/denial was mentioned by many participants as a barrier to the client seeking treatment. One participant, whose experience was largely in generalist counseling center settings, stated, "I don't think I've ever seen anyone come in here and say 'I have a gambling problem.'" This participant explained that his clients with gambling problems had always presented to therapy for other reasons, e.g. substance abuse, depression, or couple counseling. Other participants explained that shame/denial often prevented their client's from seeking therapy until they had transgressed into more severe stages of their gambling disorder, i.e. when relationships and/or finances have been significantly damaged. Several participants mentioned clients with gambling problems being brought in by a spouse. One participant said that they "don't buy that it's an addiction" and think "I shouldn't be doing this." Another participant remembered a client who had been brought in for therapy by a spouse, who reported:

> I had a husband who was, uh, whose wife brought him in, under some protest… and said "well I don't have a gambling problem," and I said "well let's see." I use the steps and the questionnaire that Gambler's Anonymous had developed, and this guy… I gave it to him and let him evaluate whether or not he had a gambling problem. And sure enough, he had a one hundred percent score on the thing, and I said "well, what are we going to do?" He wasn't willing to get in to therapy but he admitted he had a gambling problem.

Shame/denial was also mentioned by participants as a barrier to obtaining an accurate assessment of pathological gambling/gambling disorder. One participant referred to the assessment of gambling problems as an "art" due to the responsiveness and adaptability required to "work with their built in defenses and denial." This participant went on to describe his own assessment approach as "more conversational" and "less clinical," again per the necessity to subvert the client's shame and denial throughout the assessment process. He stated that the more formalized the assessment procedures are, the more likely the client will go into "denial mode." Another participant also described his own assessment approach as "conversational" and discussed the importance of adapting the assessment approach to the shame/denial, characteristics, and preferences of the client. Another participant explained that many of the clients with gambling problems he worked with wanted to "skirt" the issue of their gambling and deny the problem. One participant noted:

> Yes, but they never know they're doing it. I just do it conversationally and check it after the fact. And as feedback to the client, if they're ambivalent or in denial about the disorder… I'll give them that number… the number of criteria. You only need four of these to meet the criteria, and you've clearly got four, five, and six, or whatever the number might be… so they can see they have a gambling disorder. At least it plants that seed, as motivation for continued treatment.

Another context in which shame/denial was mentioned by participants was as a barrier or resistance to treatment and recovery. One participant described a client who was brought in by his spouse. He stated that by working with the

client's shame/denial in the assessment process he was able to help the client see that he had a problem with gambling, but he stated the client still refused treatment and would not agree to therapy. Another participant connected this phenomenon to the "confusion" clients feel and their difficulty understanding the cognitive, emotional, and behavioral processes underlying pathological gambling/gambling disorder, causing them to see the behavior as a personal fault or failure and slip further into shame/denial. He went on to explain that client's confusion about the nature of gambling disorder and the related denial can result in client's viewing treatment as unnecessary and that the solution to their problems, rather than getting treatment, is to "get back on a hot streak" and "to get back to the winning side of things, and everything will get better."

Participants also mentioned their client's shame/denial in relation to motivation for treatment or stages of change. One participant reported that assessment became particularly important with clients who are "in a very ambivalent stage about having a problem." He described a particular assessment with a client who was "in the denial phase," and he stated this client had a "dissociative" look on his face and was unlikely to comply with treatment. The theme of motivation and stages of change was discussed by several participants, not only in the context of client's denial/shame, but also as an important aspect of the assessment process.

While shame, denial, defensiveness, ambivalence, and resistance each represented a barrier to the pathological gambling/gambling disorder assessment

process, they also appeared to interact with one another. Specifically, the presence of shame appeared to influence the manifestation and intensity of the other constructs, i.e. more shame was associated with more denial, defensiveness, ambivalence, or resistance. Clients' therapeutic cooperation and acceptance of their gambling issues involved the management of shame.

Theme 2: Motivation/Stage of Change.

Another emergent theme among participants' comments was the importance of considering and gaging the client's motivation or stage of change when assessing for pathological gambling/gambling disorder. Closely connected to the denial/shame involved with gambling problems, gaging the client's motivation was described by participants as perhaps the most important task in the assessment process. Recognizing and gaging the client's level of motivation was discussed by participants primarily in three ways: 1) a factor around which the clinician must adapt the assessment process and procedures, 2) as an indicator of clients' likely treatment compliance and willingness to engage in the process of treatment, and 3) the first step in the treatment planning process.

Client motivation or stage of change was mentioned by participants as an important factor around which to structure assessment procedures. One participant noted that upon recognition of low motivation in his clients he employed motivational interviewing as part of his assessment process. He explained that with clients who display low motivation (for example, pre-contemplative or contemplative stages of change) he will often "give them…the

number of criteria" they meet of the DSM criteria "so they can see they have a gambling disorder." Another participant described a clinical situation with a particular client in a state of low motivation, stating he provided this client with the Gamblers Anonymous 20 questions and "let [the client] evaluate whether or not he had a gambling problem." This again represented an adaptation of the assessment process in response to the recognition of low motivation or stage of change. As one participant explained,

> I think finding their motivation for change is more important, using motivational interviewing skills and the stages of change. You know, just the simple part of what you say you want to stop gambling, on a scale of 0 to 10, how important to you is that… how motivated are you to stop. And then you simply try to assess, you know, are they in pre-contemplative, contemplative, or preparation stages… and then everything else is really geared around that.

Another way in which the clients motivation or stage of change was discussed by participants as an indicator of clients' likely treatment adherence and willingness to engage in the therapeutic process. One participant explained that he listens for "high desperation" when assessing clients for pathological gambling/gambling disorder, equating a higher level of motivation in these clients to "the gift of desperation." He described a connection between the amount of suffering the client has undergone and their level of motivation, stating:

> If you've suffered a lot and you're looking to get out of the hamster wheel, then willingness is usually associated. So when I tell you to do things like let's

> get on medicine, let's do counseling, let's do this, let's do that… you're willingness tends to be better, proportionally to the suffering you've undergone.

Two participants discussed the generally low motivation levels of problem gambling clients as a population. One of the participants related this to there being "no physical pain to count on as a motivator for treatment," which he contrasted to alcohol and drug addictions. He further stated that a problem gambling client's motivation typically does not significantly increase "until the banker or the employer…or the mate gets involved." Another participant also contrasted the dynamic of motivation in pathological gambling/gambling disorder with substance use addictions, stating that unlike clients with a substance addiction, problem gambling clients believe they are "one win away from changing their circumstance" and thus "motivation is lower."

Motivation and stage of change was also mentioned by participants as being the first step in their treatment planning process with clients. According to one participant:

> You know, because if they're in contemplation or pre-contemplation, they're probably not going to stop gambling even if they say they want to… so then we're more in an education mode. So we're already doing treatment before, you know, along with assessment…

This participant elaborated on the relationship between clients' shame/denial and level of motivation, stating that even when clients present for therapy "deeply in trouble and knowing they have a gambling problem" it

"doesn't mean they're ready to stop." He further explained that getting a client to "the action stage of thinking…takes quite a bit of time."

Theme 3: Comorbid Disorders

Participants frequently discussed the presence of comorbid DSM 4/DSM 5 diagnoses accompanying pathological gambling/gambling disorder. The presence of one or more comorbid disorders was mentioned by several participants as an important aspect of both the assessment process and the treatment process. Participant responses indicated that the presence of a comorbid disorder requires a clinician to adapt the assessment process to 1) determine the relationship between pathological gambling/gambling disorder and comorbid disorder(s) and 2) determine the primary focus of treatment. Participants also noted the most common comorbid disorders they found in clients with pathological gambling/gambling disorder.

The presence or potential presence of a comorbid disorder with pathological gambling/gambling disorder was mentioned by participants as a catalyst for adapting the assessment process. One participant reported that "assessment then becomes very, very important" with clients who may have co-morbid disorders because the assessment process "can get more complex." Participants described significant interactions between their clients' pathological gambling/gambling disorder and various comorbid disorders. One participant reported interactions between pathological gambling/gambling disorder, depression, and unresolved trauma related to grief and loss. Another participant

described a client whose pathological gambling/gambling disorder was complicated by issues with substance abuse. Participants noted particularly strong interactions between pathological gambling/gambling disorder and other addictions, which will be discussed further in another section. One participant described a former client with co-morbid depression, for example:

> I had a client who was doing very poorly in his classes, and having difficulty getting out. Really struggling academically, and he used to be an honor student. He was having trouble just getting out and getting to work on time…he was depressed because of the gambling. And he also admitted to having financial problems too.

Participants also discussed the importance of assessing for co-morbid disorders in treatment planning and determining the focus of treatment. Participants mentioned instances of comorbid disorders interfering with a client's recovery from pathological gambling/ gambling disorder. One participant described an assessment with a client who presented with comorbid depression and trauma, stating:

> …she had spending addiction problems, major depressive disorder, and a long standing history of trauma after losing her mother after caring for her for a long period of time…We started with the management of her dysphoria, so we got her on some Zoloft. What I usually tell patient is that you have this addictive disorder that tells you to do these things, so we have to reduce the drives that push you to do it. So for her, the first thing was to get this depression under control.

Another participant mentioned the impact of comorbid depression on assessment and treatment planning, explaining that depression "becomes the primary treatment modality." The interaction between pathological gambling/gambling disorder and a comorbid disorder was described by participants as either one disorder causing the other, e.g. gambling issues causing depression or vice versa, or as both disorders resulting from an underlying cause. Two participants mentioned "unresolved trauma" as the underlying cause for both pathological gambling/gambling disorder and their client's comorbid disorder, which was depression in one instance and substance abuse in the other.

Theme 4: Perceived Impact of DSM Reclassification and Diagnostic Changes.

A major theme discussed by participants was the perceived impact of the changes made from the DSM-IV diagnosis of pathological gambling to the DSM-V diagnosis of gambling disorder. Much of this discussion related to the impact of the diagnosis' reclassification from an Impulse Control Disorder Not Elsewhere Classified in the DSM-IV to a Substance-Related and Addictive disorder in the DSM-V. Participants discussed both the micro-context of clinical work and the macro-context of its impact on the sub-field of gambling related counseling, as well as the field of psychology as a whole. Participants also discussed changes to the criteria of the diagnosis, again discussing these changes in both the context of clinical work with clients and the impact on the larger field of psychology. They emphasized the impact of these changes from DSM-IV to DSM-IV, as well as the lack of significant clinical impact.

Participants noted several potential implications and possible effects of the reclassification of the gambling disorder diagnosis from Impulse Control Disorders Not Elsewhere Classified in the DSM-IV to Substance Related and Addiction Disorders in the DSM-V. One participant noted that "professionally, I think [gambling disorder] is now a more credible diagnosis, because it's along with the other addictions." Another participant expressed that he "like[d]" the reclassification from Impulse Control Disorders Not Elsewhere Classified to Substance-Related and Addiction Disorders on "practical grounds," stating "I think that's the only way gambling is ever going to be recognized by insurance companies for reimbursement." This was echoed by another participant, who asked, "Will insurance companies pay for it?" Another participant noted,

> I am very satisfied. I believe that changing how it is characterized and grouping it with substance abuse disorders better reflects the severity and course of this disorder. I also believe that this change will increase availability of therapeutic services due to more insurance companies reimbursing for this treatment.

Participants also discussed the reclassification and diagnostic criteria changes from the DSM-IV to the DSM-V in terms of its more accurate reflection of the clinical presentation of gambling disorder. One participant stated "when you look at the criteria and how it matches substance dependence now you see how similar they now really are." Another participant noted that "clinically, I think to say that gambling is an addiction is really appropriate." He went on to explain that,

> Yeh, gamblers tend to follow other addicts in many aspects of their lives. The patterns are the same. The thinking styles are the same. What they do in their relationships is somewhat similar, on and on. Compulsive gambling belongs in the category of addictions. And it needs to remain as distinct within that group, so that we don't get them confused… and think that we can treat gamblers the same as we treat other addicts.

It should be noted that while participants enumerated several benefits to the changes from the DSM-IV to the DSM-V, some emphasized that the changes were irrelevant to the clinical assessment and treatment of gambling disorder. As one participant explained, "I don't think any of us in the treatment field, uh, care, because it's not going to change our therapeutic approach, or motivational interviewing."

Theme 5: Pathological Gambling/Gambling Disorder Versus Other Addictions.

Another unifying theme in participants' responses was the comparison and contrast of pathological gambling/gambling disorder with other addictions, particularly substance-related addictions. This comparison and contrast extended from the nature, progression, and clinical presentation of the disorders themselves to the approach taken by experienced practitioners in addressing them in assessment and in treatment. This theme was typically manifest in participants' responses as a reference point for conceptualizing some aspect of the pathological gambling/gambling disorder assessment process. In order words, participants elucidated some aspect of a multifarious assessment approach via an ostensibly

more easily accessible example in substance use disorder assessment. As one participant explained,

> When you treat a gambling addiction, a lot of times, money is the ingredient that fuels the addiction. So somehow you have to find ways for them to not have control over money. Which is very, very different. With alcohol, you have to go out and purchase it, and you can keep it out of your house if you want to. But with gambling, the money is the commodity, so if they have money, they have a problem. So you have to find ways for them not to be able to manage their own money for a long time, which is very difficult to do with adults.

Participants discussed how pathological gambling/gambling disorder was similar in clinical presentation to substance use disorders in general. One participant noted, "We certainly see the connection between process addictions and chemical addictions with things like tolerance and mental preoccupation. It fits the paradigm nicely…" Another participant echoed this connection, stating, "Because it's all creating chemistry change in their brain… whether it's the behavior or the substance that's changing, uh, their thinking patterns into an action state of seeking, chasing phenomena…" Another participant echoed this, explaining that "gamblers tend to follow other addicts in many aspects of their lives. The patterns are the same. The thinking styles are the same. What they do in their relationships is somewhat similar, on and on." He went on to compare pathological gambling/gambling disorder to another type of addiction and stated that "sex addiction I think is a lot like gambling [disorder]." Another participant

provided a comparison when discussing resistance to treatment, stating, "It's like the kind of resistance you get with a substance abuse problem or eating disorder."

In addition to similarities between the two types of disorders, participants also noted several differences in clinical presentation between pathological gambling/gambling disorder and substance use disorders. One participant described the contrast as follows:

> There's not a whole lot of internal pain that goes on for gambling until he gets kickback for it. There's no physical pain to count on as a motivator for treatment. But the alcoholics… the guy gets drunk as gets left alone long enough, there's going to be pain there, like with drugs.

Another participant noted a similar contrast:

> And the problem with gamblers is there's not bottom. As long as they can find money they'll keep going. Whereas the substance was going to kill them, and in these two cases it was that dangerous to them, the gambling just doesn't have a bottom if they can keep getting money.

Participants also discussed the interaction between pathological gambling/gambling disorder and substance use disorder as it relates to the similarity between the two in clinical presentations. Specifically, this sub-theme was manifest as a transfer of behavioral, affective, and cognitive patterns from one type of disorder to the others. As one participant noted, "… instantly once he started gambling he transferred his addiction from substances to behavior… and you can see the same criteria affecting his life… the preoccupation with it, spending money, chasing the winnings, chasing the losses." He described this

transference across disorders, explaining, "he just went through the typical relapse pattern that you would from drugs and alcohol… it just happened to be the behavior this time instead of the substance."

Theme 6: Nuanced Use of Assessment Instruments.

Another emergent theme among participants was the minimal, but nuanced use of assessment instruments in the assessment of pathological gambling/gambling disorder. This nuanced use of assessment instruments was discussed in the context not only of how the instruments are being used in a clinical setting, but also when and under what circumstances they are being used. The assessment instruments mentioned by participants were the DSM 5 criteria, the DSM 4 criteria, the South Oaks Gambling Screen, the Gambler's Anonymous 20 Questions, and the Lie/Bet Questionnaire.

Participants emphasized a minimal use of assessment instruments in the assessment of pathological gambling/gambling disorder. One participant explained that in his clinical experience, assessment instruments "usually confirm" his clinical evaluation of a client's gambling issues. Another participant reported the Lie/Bet Questionnaire as a part of his intake procedures, but he stated that from there he often forgoes the use of assessment instruments. He reported this propensity has changed over time, stating that in the past he "was probably better about using those other assessments and the DSM-4 criteria." He stated, "in truth, once they answer yes to the Lie-Bet questions, they've met the criteria for a while…you're looking at the mid to late stages at that point."

Participants also repeatedly described a nuanced use of assessment instruments in response to the reportedly unique barriers to assessment with individuals with gambling problems. As one participant explained:

> I just, in my mind, develop quick questions that directly reflect the criteria, so that I can easily, just from my notes… I already have the answers to all criteria… and that way you get a better assessment without getting into the defensiveness of the client when they know they're being assessed.

He went on to further describe his approach:

> So, it's just a little trick that you get a better feel for… you know, you're using Motivational Interviewing skills to get them to teach you sort of how they gamble… and it becomes interesting to them… know you only want to do this once, because they're also getting a euphoric recall by telling you the secrets of their trade… you know, how they do it… but you've got a really good idea of what they're gambling looks like, and how it fits the criteria… by doing it conversationally.

Another participant described using similar tactics with his own clients, stating, "This was a country boy, and I thought he would blow me off if I gave him a stiff, clinical sounding measure." He went on to explain that he often did not use assessment instruments. He stated, "I don't have to do the Lie-Bet scale to find out if they are, even though… an exception to that is when I had a husband who was, uh, whose wife brought him in, under some protest…" This is indicative of situational factors that influence the utility of assessment instruments in assessing pathological gambling/disorders.

Theme 7: Relationship Discord.

Another important theme throughout participant responses was the frequent presence of relationship or marital discord in clients with pathological gambling/gambling disorder. As one participant noted when he described one of his clients, "He began gambling and has burned so many bridges that, uh, you know, friends of his were calling me… so we kind of did an intervention on him last night." Several participants noted examples of clients being brought into therapy by a romantic partner. One participant stated, "if they're in couples counseling, their partner will out them." Another participant described this conflict from the perspective of a spouse:

> And he, uh, was also heavy into gambling and losing most of it. The wife was just… the wife had been raised in this very protected family, had never known that there were people in the world who did anything like her husband did… and she was mainly just appalled at all this and has trouble even now accepting that how could someone do this…

Another participant, in describing the more advanced stages of pathological gambling/gambling disorder, provided context, stating, "the spouse is gone, kids are upset." Another participant described the gambling problems of his client in the context of his romantic relationship as "a source of conflict for them." A different participant provided the following example:

> I had a patient that came in for marital issues. Financial issues were explored due to being a big part of the marital conflict. This was when

> gambling issues were discovered and a diagnosis was made based on DSM criteria.

This pattern was also reported by another participant, who stated,

> Most often we see spouses of problem gamblers but they come in to discuss marital issues. When the gambling is identified they seem to minimize it or distance themselves from focus on it. I notice it is a taboo topic still.

Therefore, clients' romantic relationships appear to have relevance in the pathological gambling/gambling disorder assessment process in the three following ways: 1) as a means of getting the gambler into therapy via couples counseling, 2) as evidence of the clients' gambling problem when disclosed by spouse or romantic partner, and 3) as a negatively impacted aspect of the clients' life and additional source of distress.

Summary

Participants discussed several factors influencing the procurement of an accurate assessment for pathological gambling/gambling disorder, the diagnosis and conceptualization of pathological gambling/gambling disorder, the development and implementation of a treatment plan, and the success of treatment. They provided insight from their direct experiences screening for and/or assessing pathological gambling/gambling disorder.

Specifically, the emergent themes from participant interviews were as follows: 1) the importance of working with the client's shame and denial throughout the assessment process, 2) the importance of considering and gaging

clients' motivation or stage of change when assessing for pathological gambling/gambling disorder, 3) the influence of comorbid disorders, 4) the impact of changes made from the DSM-IV diagnosis of pathological gambling to the DSM-V diagnosis of gambling disorder, 5) the relationship of pathological gambling/gambling disorder to other addictions, 6) the nuanced use of assessment instruments, and 7) the presence of relationship or marital discord in clients diagnosed with pathological gambling/gambling disorder.

Several of the themes were overlapping and closely related to other themes. Client's shame and denial, for example, was identified by participants as highly salient in the gaging of clients' motivation and stage of change. Likewise the influence of comorbid disorders was identified as relevant and important to the gaging of motivation, while motivation was identified as important in the nuanced use of assessment instruments. This overlap notwithstanding, the above themes were categorized as they were to represent distinct factors in the screening and assessment of pathological gambling.

CHAPTER 5

DISCUSSION

Introduction

Although pathological gambling/gambling disorder has been extensively researched, there seems to be a relative dearth of research investigating the process by which clinicians assess for problem or pathological gambling, as well as a relative dearth of research utilizing qualitative methodology. The results of this study, therefore, ostensibly address these seeming gaps in the pathological gambling/gambling disorder literature by exploring this assessment and screening process through a qualitative lens.

Some of the themes identified in participant responses, such as the impact of comorbid disorders or the connection between pathological gambling/gambling disorder and other addictions, have been addressed extensively in the existing research literature. Other themes, such as the impact of shame/denial or motivation/stage of change, appear to have been less extensively addressed in existing literature, perhaps due to their more therapeutic rather than theoretical salience. One theme, the use of assessment instruments in the assessment of pathological gambling/gambling disorder, has been covered extensively via quantitative research but not qualitative. At this point, because DSM changes have taken place so recently, there is yet to be substantial body of research to indicate its impact.

Relevance of Findings

This results of this study are highly relevant to the 1) development and administration of assessment instruments pathological gambling/gambling disorder, 2) conceptualization of pathological gambling/gambling disorder as a diagnostic construct, and 3) the creation and implementation of a treatment plan. The experiences of clinicians who have actively screened and assessed for pathological gambling/gambling disorder can be helpful in identifying gaps between conventional conceptual and procedural thinking and clinical work as it is practiced.

A major theme from participants' responses was the importance of working with client's shame and denial throughout the assessment process. Researchers have found a high level of shame and defensiveness in people diagnosed with pathological gambling, and participant responses indicated that this shame and defensiveness of clients with gambling issues frequently represented a barrier to effectively assessing and/or screening for pathological gambling/gambling disorder ((Tolchard, Thomas & Battersby, 2007; George & Murali, 2005). It would likely be beneficial to incorporate a measure of shame, denial, and/or defensiveness into the assessment instrument itself, as practitioners seem to currently rely on informal practices to account for this barrier to assessment and treatment of pathological gambling/gambling disorder. This may increase practitioners' confidence in directly pathological gambling/gambling disorder instruments.

Furthermore, pathological gambling/gambling disorder has also been shown to have a strong association with and present with similar patterns to other addictions (Kessler et al., 2008). Consistent with previous research, participants identified this strong association as an important factor in the reclassification of pathological gambling from an Impulse Control disorder in the DSM-IV to Substance Use and Other Addictions in the DSM-V (Mitzner et al., 2011). This is consistent with the conception of pathological gambling/gambling disorder as a "drugless" substance use disorder (Conversano et al., 2013). Furthermore, some participants reported that many of their clients had addictive patterns that had shifted from substance abuse to pathological gambling/gambling disorder and vice versa. It is suggested, therefore, that researchers, developers of diagnostic manuals, developers of assessment instruments, and clinicians continue along the current conceptual path of convergence between pathological gambling/gambling disorder and other addictions, with particular focus on a larger addictive patterns manifesting through various addictions.

Researchers have estimated that as much as 85% of pathological gamblers present with a co-morbid disorder, and participants in this study emphasized the importance of comorbid disorders in the assessment of and screening for pathological gambling/gambling disorder (Odlaug et al., 2012). They identified the most common comorbid disorders in their clinical experience as alcohol or drug abuse, depression, and previous trauma. Previous studies have identified both substance abuse and mood disorders as among the most common comorbid

disorders (Lorains et al., 2010; Holdsworth et al., 2011; Cunningham-Williams et al., 2000). Also consistent with previous research, participants emphasized the importance of determining relationship and causality between pathological gambling/gambling disorder and comorbid disorders (Winters and Kushner, 2003). All aspects of the pathological gambling/gambling disorder treatment process, therefore, would likely benefit from a more overt and focused integration of the impact and dynamic relationships of co-morbid disorders. Assessments should be repeated periodically during treatment to get a better appraisal of the impact of one disorder upon the others. For instance, if while in care a client has not taken substances for a given time, will he or she elevate score in the areas elevated previously?

It has also been found that pathological gambling/gambling disorder can have a negative impact on important relationships, i.e. romantic, friendships, family, coworker, et cetera (Blaszczynski & Nower, 2002; Myrseth et al., 2009). Participants' responses identified relationships, particularly romantic relationships, as an impactful factor in the assessment process, salient in the initial help-seeking and disclosure of pathological gambling/gambling disorder, as stressors or sources of support, and of unintended negative consequences of the gambling behavior. The status and dynamics of these important relationships should also be considered as potentially a more formalized aspect of the assessment and treatment process. For instance, marital satisfaction inventories

may provide vital information on these clients. Also formalized efforts should be taken to include spouses periodically in the therapy.

Taken in sum, the results of this study suggest that pathological gambling/gambling disorder is most effectively conceptualized, assessed, and treated within a larger context of relational and individual mental health. Participants identified powerful intrapersonal and interpersonal dynamics between the gambling patterns and other forces that are critical to the assessment and treatment process. Shame and denial, shifting addictive patterns, and co-morbid disorders are active within the client while their relationships with family, friends, coworkers, and romantic partners attenuate, intensify, aggravate, and/or perpetuate the pathological gambling/gambling disorder. Consequently, working on intra-psychic and personal belief system issues using psycho-dynamic approaches or deeply exploring client schema through cognitive approaches is warranted. At the same time, because systemic issues are involved Structural and Narrative approaches that include family and larger system interventions are likely to be beneficial.

Limitations and Implications for Future Research

While the results of this study may be valuable in the development and administration of assessment instruments and treatment plans for pathological gambling/gambling disorder, they should be considered and interpreted in the context of certain important limitations. Firstly, a majority of the participants were recruited from the state of Oklahoma. While this geographic specificity

limits generalizability of these findings to other states, it could also be viewed as a strength in the context of understanding and improving the assessment of pathological gambling/gambling disorder within the state of Oklahoma. Secondly, the results of this study provided little further insight into problem gambling subtypes, i.e. participants did not emphasize the importance of identifying a subtype in the assessment of pathological gambling/gambling disorder. Subtype categorization has been an important area in problem gambling research, and it was relatively unaddressed in these interviews. Thirdly, most of the participants in this study were Caucasian males, and none of the mental health professionals interviewed were directly affiliated with any Native tribes.

Much more research is needed into actual clinical practice of pathological gambling/gambling disorder assessment. Although it was not emphasized by participants, it would likely be beneficial to develop measures that incorporate and assess for problem gambling pathways/subtypes. Furthermore, research is needed in the following key areas of the assessment process identified by the study participants: 1) working with clients' shame and/or denial, 2) conceptualizing the complex dynamics between pathological gambling/gambling disorder and co-morbid disorders, particularly other addictions, 3) assessing clients' relational and interpersonal context, particularly romantic relationships.

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APPENDIX A

Interview Protocol

Thank you for time and willingness to participate. As you know, I am interested in exploring the manner in which mental health professionals screen for Problem or Pathological Gambling. Particularly, I am trying to understand 1) how mental health professionals evaluate the 10 DSM-IV criteria for Pathological Gambling, 2) how mental health professionals are transitioning from the DSM-IV diagnosis of Pathological Gambling to the DSM-V diagnosis of Gambling Disorder, 3) how mental health professionals utilize resources and assessments to screen for Problem or Pathological Gambling, and 4) how mental health professionals typically recognize Problem or Pathological Gambling. Please feel free to offer as much or as little as you would like, and thank you again for participating in this research.

1. Which DSM-IV criteria do you feel are most important to diagnose Pathological Gambling? Why?

    a. Do you feel all 10 criteria are necessary? Why or why not?
    b. What weights would you assign to each of the 10 DSM criteria? Why?
    c. How would you change the criteria if you could?

2. How would you characterize your transition from the DSM-IV to the DSM-V for assessing PG?

    a. How satisfied are you with the DSM-V changes and its diagnosis of Gambling Disorder?
    b. How useful are the DSM-V classifications of mild, moderate, and severe?

3. What resources do you typically use when screening for PG?

    a. Which assessments do you feel are most effective at screening for PG? Why?
    b. Are there any aspects of PG that you feel are not addressed by PG screening assessments? Why or why not?
    c. What items or sections of the assessments you use to screen for PG do you find most useful? Least useful?

4. How do you typically recognize PG?

    a. How do you differentiate between Problem Gambling and Pathological Gambling?

5. How would you characterize your experience screening and/or treating Problem and Pathological Gambling? Explain if necessary.

    a. What training have you had in the screening and assessment of problem or pathological gambling?
    b. Please describe a case in which you successfully screened and identified problem or pathological gambling.
    c. Based on your experience, what would be a better way to screen for problem or pathological gambling?

Closing
Thank you for your participation.