An Overview of

Pathological Gambling: Methods of Treatment and Prevention

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Pathological Gambling: Methods of Treatment and Prevention

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Methods of treatment and prevention for pathological gambling are relatively new topics that raise more questions than answers. It was only in 1980 that pathological gambling was classified as a psychological disorder in the Diagnostic and Statistical Manual of Mental Disorders (Reilley, 1990; Custer & Milt, 1985), and since that time there has been increasing concern over this little-understood addiction. A Harvard university literature review concluded that approximately 1.6% of the adult population are pathological gamblers (Shaffer et al., 1997), but many researchers and clinicians think that this may be an underestimation (Looney, 1998; Lorenz, 1998; Walker, 1996; Lesieur, 1994). In addition, the frequent association of pathological gambling with crime, depression, marital conflict, drug abuse, and alcoholism makes this psychological disorder difficult to examine as a separate psychopathology (Ciarrocchi, 1987; Rugle, 1980). This also poses difficulties for treatment, in that persons suffering from pathological gambling often have other serious needs that require immediate attention (Lorenz, 1998).

A general understanding of pathological gambling is necessary before discussing treatment and prevention. Thus, we should first focus on the definition and symptoms of pathological gambling. Next, methods and costs of treatment will be examined. The paper will conclude with a discussion of current prevention methods and their limitations.

It must be noted that the scientific literature on this topic is limited. In other words, it is an under-researched area that tends not to be cumulative. For that reason, this paper is intended to be neither comprehensive nor final, but simply an introduction to the topic.

Definition and Classification of Pathological Gambling

Pathological gambling is a chronic and progressive illness that affects social, marital, financial, and occupational life. By meeting at least five of the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders IV (1994), one is clinically diagnosed as a pathological gambler. The criteria are: 1) preoccupied with gambling, 2) needs to gamble with significantly increasing amounts of money, 3) has repeated unsuccessful efforts to control or stop gambling, 4) restless, insomnia, headaches and other physiological symptoms when attempting to stop gambling, 5) gambles as a way of

escaping from problems or relieving feelings of guilt, anxiety, depression, 6) after losing money, often returns another day to get even, 7) lies to conceal the extent of involvement with gambling, 8) involves in illegal acts to finance gambling, 9) jeopardized or lost significant relationship, job, educational, or career opportunity, and 10) reliance on other or institutions to provide money to relieve desperate financial situation caused by gambling (APA, 1994; Rosenthal & Lesieur, 1992; Custer & Milt, 1985).

In addition, gambling is usually classified into different phases or stages reflecting the intensity and severity of gambling behavior: 1) the winning phase, 2) the losing phase, 3) the chasing phase, and 4) the desperation stage (see Appendix A). Depending on the individual, each phase differs in its time span--from a few days to 15 years or more (Custer & Milt, 1985). The pathological gambler starts as a casual gambler during the winning phase, finding gambling as an exciting experience that gives the player a sense of control and power. During the losing phase, the gambler experiences uncomfortable feelings and anxiety, and frequently returns to relieve these feelings. During the chasing phase, financial problems, gambling frequency and thoughts increase, and the player is unable to think clearly. During the desperation stage, the player may need medical intervention or hospitalization for suicidal ideation, depression, and other maladaptive behaviors that require intensive care and treatment (Lorenz & Politzer, 1990; Custer & Milt, 1985).

Characteristics and Symptoms of Pathological Gamblers

Many pathological gamblers have other serious needs and problems that are associated with their gambling addiction. For instance, pathological gamblers have been found to have a high incidence of other mental health disorders such as depression (Becona et al., 1996; Ciarrocchi, 1987). A survey of Gamblers Anonymous (GA) members found that 32.4% of the members had suicidal thoughts and 13% actually attempted suicide (Frank et al., 1991). It has also found that GA members tended to grow up in dysfunctional families, and that 21% had a parent who was a pathological gambler (Rosenthal, 1992). Further, other studies report that many pathological gamblers are reared in families that place strong emphasis on the importance of money. They also report a high incidence of physical, verbal or emotional abuse during early childhood (Jacobs, 1998; Becona et al., 1996; Lorenz, 1993; Custer & Milt, 1985).

A study of Indiana adult offenders (Westphal et al, 1998) concludes that addictive levels of alcohol and drug behavior are high among pathological gamblers. The "dually-addicted" gamblers who are both addicted to gambling and chemical substances are more difficult to treat than a person who is just chemically dependent (Rosenthal, 1992; Ciarrocchi, 1987). In addition, many pathological gamblers have impaired physical health that results from maintaining a high level of stress. For example, they may suffer from hypertension, back pain, migraines or gastrointestinal complications (Looney, 1998; Lorenz, 1993; Rosenthal & Lesieur, 1992).

A study presented before an international conference on risk and gambling (Rugle & Melamed, 1990) reports that childhood history of hyperactivity, distractibility, and compulsivity constitute risk factors for the development of gambling addiction. Impulse control deficit is another risk factor relevant to gambling addiction. Limited neurobiological studies suggest that imbalance of chemicals in the pathological gambler's brain may contribute to the addiction (Hollander et al., 1998; Hand, 1998). The serotonergic system, which regulates mood, compulsivity and impulsivity may be implicated. Additionally, the excess release of chemicals that relate to intense arousal or pleasure-seeking behaviors like dopamine could possibly be linked to pathological gambling, as well as to other addictive behaviors (Concetta et al., 1998).

A study designed by Griffiths (1994) links gambling addiction with cognitive distortion. For example, the pathological gambler may believe that he or she has control over the game and think that after a run of losses a win is due. Further, the gambler considers his or her gambling skills above average, but blames others for failures (Griffiths, 1994). A controlled study in Canada (Ladouceur et al., 1997) found that pathological gamblers develop a belief that they can control events that are actually governed by chance. In fact, some would argue that self-deception characterizes pathological gamblers since they deceive both themselves and others, and fantasize about their own powers (Rosenthal, 1986).

Youth and adolescents are especially vulnerable to pathological gambling. In fact, pathological gambling is more prevalent among young people than among the adult population (Stinchfield & Winter, 1998; Shaffer et al., 1997). According to a New Mexico survey on gambling behavior, approximately 12.7% of the adolescent population were reported to be pathological gamblers (NM Department of Health, 1996). A study in Indiana (Westphal et. al, 1998) diagnosed 22.8% of juvenile offenders as pathological gamblers, and a survey on Texas adolescent gambling behavior classified 12% as pathological gamblers (Wallisch, 1995). Shaffer's meta-analysis (1997) identified approximately 4% of adolescents from the general population as pathological gamblers.

Gender does not differentiate susceptibility to gambling addiction, and thus women are as susceptible to becoming pathological gamblers as are men (Francis & Bolger, 1997; Rosenthal 1992). In Texas, 46% of pathological gamblers are women (Wallisch, 1995), and in Maryland 41% are women (Lorenz & Politzer, 1990). On the other hand, senior citizens appear to be vulnerable to pathological gambling. Many are retired and/or widowed, and can be financially insecure and lonely. They may gamble to escape feelings of insecurity and loneliness. In Minnesota, 8% of those who called the hotline for help were 63 and over (Gambling Problems Resource Center, 1997; Lorenz, 1993). The Florida Council on Compulsive Gambling reports that 17.8% of those calling for help were 55 and over (Fowler, 1997).

Pathological gambling is also prevalent among diverse ethnic groups such as in New Mexico, where 71% of the pathological gamblers are Hispanics (NM Department of Health, 1996). In the city of Detroit, 64% of pathological gamblers are African Americans (Social Systems Research Institute Associates, 1998).

Methods of Treatment for Pathological Gambling

Each pathological gambler's specific characteristics and symptoms must be carefully examined to develop an effective treatment plan. Treatment will vary depending on the severity of the problem, the availability and cost of treatment, and the patient's characteristics. For example, inpatient treatment is considered for pathological gamblers at risk to harm themselves, but a person already in recovery may simply be referred to Gamblers Anonymous. Unfortunately, the current scientific literature on the methods and effectiveness of treatment is very limited. This is an under-researched field among mental health treatment topics.

Multi-modal Approach

Gamblers Anonymous (GA) is a self-help group modeled after Alcoholics Anonymous. GA is the only national voluntary organization for pathological gamblers, and was founded in 1957 (Custer & Milt, 1985). It does not rely on licensed, trained counselors since there is no professional infrastructure or central policy-making organization. Rather, GA relies on strategies of mutual respect, honesty, and encouragement. Gamblers learn to view pathological gambling as a lifetime disease and are encouraged to confront problems without depending on gambling. In addition, the "Twelve-Steps" program (see Appendix B) as adopted from Alcoholics Anonymous is used to alleviate the burden of pathological gambling by encouraging members to admit their limits, and rely on one another. The GA also encourages family members to join, and includes couple's programs as well (Tepperman, 1985). Although the abstinence rate for GA members--7.30% to 7.53% (Viets & Miller, 1997)--is relatively low, many treatment programs refer their patients to GA.

The Taylor Manor Hospital Gambling Treatment Program--the first pathological gambling treatment center--treated both inpatients and outpatients. It used a team approach designed by the Johns Hopkins Compulsive Gambling Counseling Center in which a recovered pathological gambler and an experienced professional counselor worked together to treat the patient (Franklin & Ciarrocchi, 1987). The recovered pathological gambler provided immediate assistance regarding "reality" issues such as financial and legal problems, and the professional counselor provided education and psychological support. The treatment center also had intensive residential care that provided an average of 40 hours of therapy per week for an average of six months. After treatment, 80% to 90% of the pathological gamblers abstained from gambling for an average of six months (Politzer et al, 1985).

There are other gambling treatments centers like the Taylor Manor Hospital Gambling Treatment Program that treat both inpatients and outpatients. For example, the Naval Addictions Rehabilitation and Education Department in the Naval Hospital is a program that provides services to individuals and families in the military that suffer from addictions; including pathological gambling. The residential inpatient treatment program

for pathological gambling focuses on overcoming the pathological gambler's denial of the problem and helping the patient to develop functional coping mechanisms rather than to resort to gambling.

Gambler's Choice in Minneapolis—a state-funded gambling treatment program—integrates the GA's 12-step program into its group therapy sessions. Many of the counselors at Gambler's Choice are recovered pathological gamblers who build rapport during the early sessions in order to minimize the dropout rate, which can range from 10% to 40% (Ladoucer & Walker, in press; Reilley et al., 1990). The program also offers treatment for dually-addicted gamblers who suffer from both pathological gambling and chemical dependency. Pathological gamblers attend 39 sessions while dually-addicted patients attend 52 sessions of group therapy. Six and twelve months follow-up measures showed that those who completed the treatment program significantly reduced the level and frequency of gambling activities compared to those who did not receive treatment. In addition, the treated pathological gamblers were more likely to get a job, and less likely to face bankruptcy and legal entanglements than untreated pathological gamblers (Rhodes et al, 1997).

The Compulsive Gambling Center in Baltimore is the only treatment program that offers residential care in a non-hospital setting. Patients are taught to prove their accuracy of thoughts and beliefs, and alter their thinking. In addition, the pathological gambler and family members are educated on topics such as guilt, boredom, and overcoming procrastination (Lorenz, 1993).

A study in Australia (Dickerson et al, 1990) reports that pathological gambling can sometimes be reduced even with minimal intervention. Pathological gamblers were sent self-help manuals that contained: 1) information on pathological gambling, 2) how to self-monitor, 3) goal or limit setting, 4) self-reinforcement, and 5) how to maintain gains in the longer term. This study did not target abstinence, but simply reduction in levels of gambling, and did not report outcome data. Nevertheless, the study suggests that this may be an inexpensive method of treatment for those in need of help.

Symptom-oriented Approach

A cognitive treatment designed by Ladoucer and Walker focuses on correcting the gambler's cognitive distortions. This treatment educates the pathological gambler with basic information on gambling and on the probability of gambling outcomes, so as to impede the player's motivation to gamble (Ladoucer & Walker, 1996). The patient also receives assertiveness training so that the gambler can say "no" to gambling in social gatherings and thus avoid relapse. Other relapse prevention methods involve identifying high-risk situations such as loneliness, having cash in the pocket, and lack of social activities that can lead the patient to resort to gambling. Patients are also taught to cope with stress and develop problem-solving techniques. For example, problem-solving training teaches the pathological gambler to have better control over spending, and paying off of debts. Patients who received treatment (17-30 hours) showed clinically

significant improvement compared with gamblers who received no treatment. Furthermore, 86% of those who received treatment was no longer considered pathological gamblers at the end of the cognitive treatment (Ladoucer et al., 1997).

A relatively new and under-researched method of treatment for pathological gambling is pharmacological treatment. With this approach, pathological gambling can be treated either as a primary disorder or as secondary to other psychopathological disorders. For example, lithium carbonate was given to a patient who primarily manifested symptoms of bipolar disorder (manic/depressive) but also manifested pathological gambling symptoms. Though the extent of reduction was not specified, lithium mitigated impulsivity and reduced gambling behaviors (Viets & Miller, 1997). In addition, medications such as fluvoxamine, typically used to treat obsessive-compulsive disorder, are sometimes used to treat pathological gamblers. A study found that ten patients who completed an 8-week fluvoxamine trial self-reported that they were abstinent from gambling (Hollander et al., 1998). On the other hand, some pharmacological treatment integrates other treatment programs such as cognitive or 12-steps program.

Behavioral treatment focuses on changing the pathological gambler's behavior using imaginal desensitization and relaxation therapy. In imaginal desensitization therapy, the pathological gambler is asked to pair cues for gambling with cues such as feelings of boredom, to reduce excitement. Further, relaxation therapy is used to counteract the patient's urge to gamble. A study found that 43% of patients receiving imaginal desensitization improved, and 30% improved from relaxation therapy (Walker, 1992).

Couples therapy for both the pathological gambler and the spouse is recommended even after a successful treatment. Because of debt and other long-term financial and legal consequences, spousal resentment can continue long after the gambler's abstinence from gambling (Rhodes et al, 1997; Heineman, 1987). In addition, disruption of marriage is considered both a causal factor and a possible effect of pathological gambling. Couples therapy prevents relapse by having the spouse support, understand, and be aware of the patient's effort (Reilley & Guida, 1990).

Another potentially helpful method of treatment is family therapy. In Detroit, 16% of pathological gamblers were reported to physically abuse their family members (Social Systems Research Institute Associates, 1998). Family therapy addresses such family issues that may exacerbate pathological gambling, and focuses on direct confrontation between the patient and family members (Rhodes et al, 1997).

The available research on the various treatment methods discussed above is based on samples that range from one to 250 patients, and on length of treatment that ranges from 40 hours to 3 years. These few studies on treatment effectiveness generally report positive outcomes, but the quality of their data are highly variable (Christensen, 1998; Moore, 1998; Ladoucer et al., 1997). Nonetheless, patients who complete treatment programs generally report being satisfied with the service provided. For example,

patients' satisfaction in Oregon ranged from 76.2% to 87.3% (Moore, 1998). Treatment may lead to other positive outcomes as well, such as employment, improved marital relationship, and elevated self-esteem and self-control. Currently, advances in treatment are hindered by the lack of uniformed and research-based outcome measures. Further, the diverse characteristics and symptoms of pathological gambling make it difficult to reach a consensus on the best practices for treatment selection and implementation.

Cost of Treatment

Pathological gamblers who seek help are usually at the point where they are unable to pay for treatment programs. All legal access to funds may have been exhausted. Thus, accumulated debt and legal problems often hinder the pathological gambler from even considering treatment. According to a study in Oregon, gambling debt can range from an average of $14,422 to a maximum of $1,000,000 (Moore, 1998). Average gambling debt in Nebraska was found to be $38,000 with 19% filing for bankruptcy (Christensen, 1998). Consequently, the pathological gambler is often unable to receive treatment without having some kind of help from the state, the gambling industry, and/or insurance companies.

Costs to treat pathological gambling can range from $63-$125 per hour for outpatient care, and from $683-$3,000 a day in residential treatment centers (Lorenz, 1998). For example, Sierra Tucson hospital in Arizona estimates an average cost of $16,500-$19,300 for a twenty-six day treatment plan that includes family therapy (Sierra Tucson, 1998). In general, however, treating pathological gambling is considered to be less expensive than treating persons with drug or alcohol addiction (Fulcher, 1994).

A recent study in Minnesota reports that the state primarily pays for gambling treatment programs (Stinchfield & Winters, 1996). However, the first state-funded pathological gambling treatment center--Taylor Manor Hospital Gambling Treatment Program--had to close due to lack of funding (Lorenz & Politzer, 1990). Further, the capacity of these inpatient pathological gambling treatment facilities is very limited. For instance, the capacity of Gambler's Choice is only 50 patients (Rhodes et al., 1997).

Insurance companies usually are reluctant to pay for treatment for pathological gambling since they do not classify it as a medical problem (Price et al., 1994). In fact, it is by and large not recognized as a treatable disease (North American Think Tank on Youth Gambling Issues, 1995). Furthermore, the gambling industry does not pay directly for treatment but they may indirectly contribute to councils on pathological gambling that offer services for pathological gamblers (Grinols & Omorov, 1996). For example, in Missouri portion of riverboat revenues goes to the Missouri Council on Problem Gambling Concerns to help fund outpatient centers (AGA, 1998; Volberg et al., 1996).

The cost generated by pathological gambling not only includes treatment, but also social costs that must be taken into consideration. Such costs may include:1) bad debts, 2) incarceration costs, 3) regulatory costs, 4) lost productivity in workplace, 5) lost

productivity of spouse, 6) lost funding for college education for gambler's children, and 7) spousal and child abuse costs (Thompson et al., 1997; Grinols & Omorov, 1996; Kindt, 1995). For example, social costs for one pathological gambler in Wisconsin were estimated to be $9,469 (Thompson et al., 1997). In Maryland, total cumulative indebtedness of pathological gamblers exceeds $ 4 billion (Lorenz & Politzer, 1990). Overall, the total cost that pathological gambling generates—estimated to be $39-$145 billion annually—is almost equal to that of drug addiction and alcoholism (Grinols & Omorov, 1996).

Prevention of Pathological Gambling

Despite the rising cost and prevalence of pathological gambling, there has been little exploration of prevention methods in the United States. According to the DSM-IV, pathological gambling is similar to other addictions (see Appendix C). Nevertheless, compared to the public awareness of alcoholism and drug addiction, pathological gambling is hardly recognized. Thus, education and increased public awareness could help reduce the cost of pathological gambling to society as a whole by stimulating prevention efforts.

Education

If pathological gambling is detected early on before reaching the most serious phase-- desperation stage—the cost of treatment could be minimized. However, such detection can only be possible based on a sound knowledge of pathological gambling, especially in the workplace. Several studies report that most pathological gamblers are employed. In Oregon, 59.7% were found to have full-time jobs (Moore, 1998), and one study estimated that more than 86% of the nation's pathological gamblers are employed (Fulcher, 1994). Some employers are beginning to promote education for recognizing pathological gambling symptoms in the workplace, such as: 1) regular talking about gambling, 2) frequent and unexplained absence, 3) borrowing from coworkers, 4) abusing the credit union system, 5) poor job performance, 6) dramatic mood swings, 7) bragging about wins, 8) stealing, and 9) use of corporate credit for cash advances (Ramsay, 1995; Fulcher, 1994). The early detection and treatment of pathological gambling could prevent some or all of these outcomes in the workplace.

A school-based prevention program for pathological gambling could help as well, considering the higher prevalent rate of pathological gambling among adolescents. In Canada, a prevention program was tested among five different schools in Quebec city. Small group activities, video tapes and quizzes were used, and the students studied different aspects of gambling such as legal aspects, economic aspects and symptoms of pathological gambling (Volberg et al., 1996).

The North American Training Institute, a division of the Minnesota Council on Compulsive Gambling, conducts training for educators to prevent gambling among adolescents through a curriculum designed to improve the student's critical thinking.

Within the context of math, language, and other diverse activities, the educators are trained to inform students about gambling. The Minnesota Institute of Public Health (Svendsen & Griffin, 1996) also provides education programs to parents and adolescents through group discussions on pathological gambling, guidelines for low-risk gambling, and guidelines to help pathological gamblers. It also conducts a Southeast Asian youth gambling prevention program. Unfortunately, there are no outcome data on these efforts yet.

Some gambling industries are making efforts to educate their employees on pathological gambling. For example, casino floor employees may be encouraged to suggest breaks from playing and offer information on pathological gambling and treatment centers to their customers. Further, some gambling industry employers distribute brochures, post posters, and send out newsletters with articles related to pathological gambling (AGA, 1998).

Clearly, more scientific research on pathological gambling is needed to identify effective prevention and treatment methods. The National Center for Responsible Gaming (NCRG) funds research on these issues, and the National Institute of Mental Health has begun doing likewise (AGA, 1998). But it will take awhile for researchers to begin accumulating a consistent body of scientific literature on this topic.

Legal Responsibilities

Some gambling companies and state governments are contributing to treatment and prevention programs, yet without legal obligation. A few states do have legislation that requires allocation of gambling revenues to funding of treatment and prevention programs, but these are very limited. For example, Louisiana passed a law in 1993 that required the Department of Health to establish a hotline for information and referral services funded by the state lottery. And in Nebraska, 1% of lottery profits are allocated to fund treatment and prevention programs (Volberg et al., 1996).

In addition to educating adolescents on pathological gambling, some argue that the minimum age for gambling should be increased to 21 (Lorenz, 1998; Arizona State Senate, 1998). Depending on the gambling activity, the minimum legal age may vary, but overall the minimum age for gambling is 18 (AGA, 1998). In Arizona, a bill that proposed the increasing of the minimum age for gambling from age 18 to 21 was introduced on January 12, 1998. Although the bill passed the House Committees and the Senate Committee on Rules, it failed to pass the Senate Committee on Judiciary. Further, according to the fact sheet presented with this bill, the Arizona Lottery stated that an increase of the minimum age would reduce lottery sales by four percent, or a loss of $3 million annually to the state (Arizona State Senate, 1998).

Conclusion

There are many promising methods of treatment and prevention for pathological gambling. However, the diverse characteristics and symptoms of pathological gambling make it difficult to reach a consensus on the best practices for treatment and prevention. Furthermore, it is unclear who should pay for these services—insurance, the state, or the gambling industry. For policymakers to be informed as they address these issues, there is a clear need for consistent and well-funded research.

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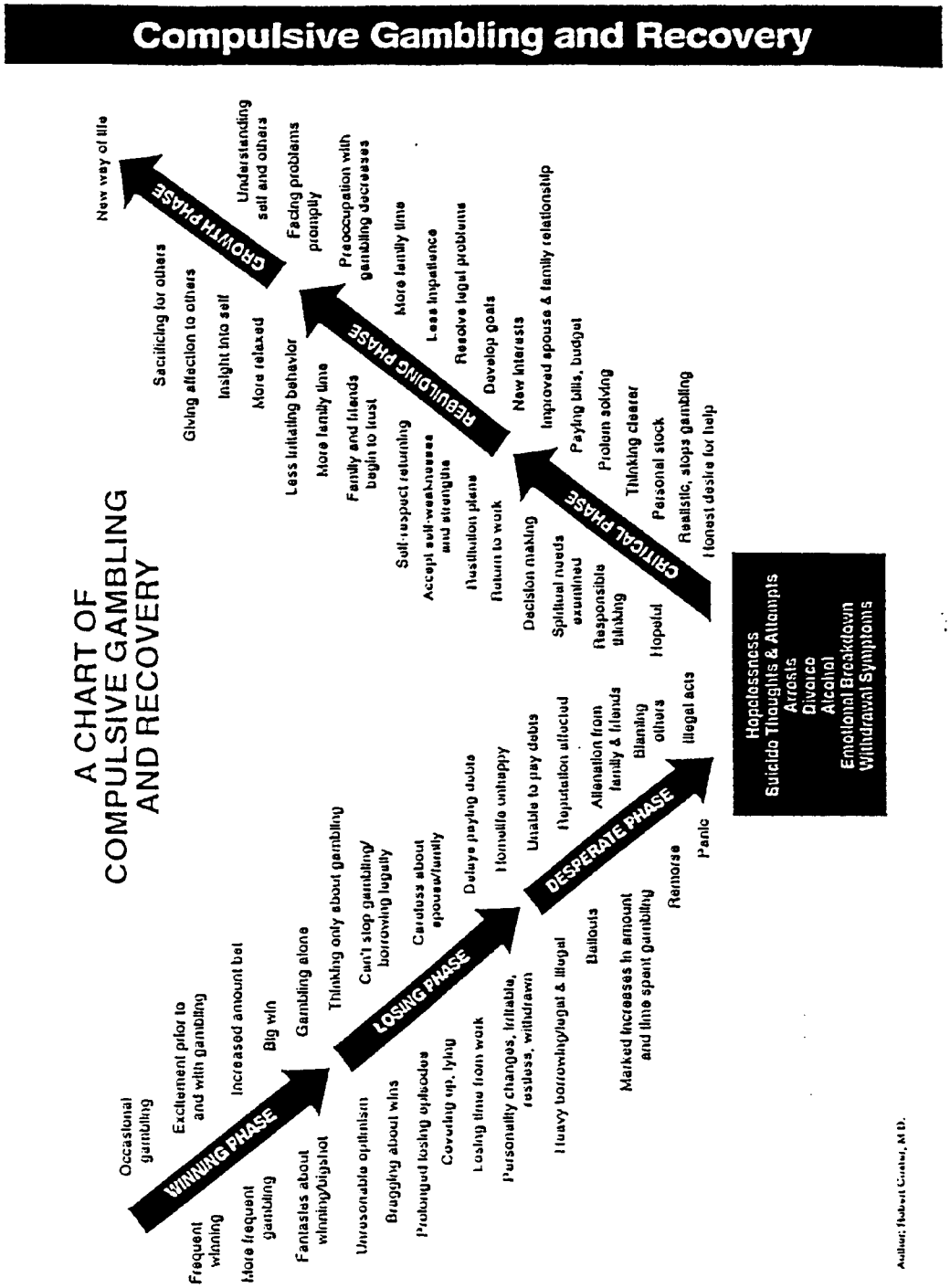
Appendix A



Source: Svendsen, R. & Griffin, T. (1996). *Improving Your Odds.* Anoka, MN: Minnesota Institute of Public Health.

Appendix B

Gamblers Anonymous Twelve Steps

Source: Custer, Robert & Milt, Harry. (1985). *When Luck Runs Out.* New York, NY: Facts on File.

1. We admitted we were powerless over gambling—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to a normal way of thinking and living.

3. Made a decision to turn our will and our lives over to the care of this Power of our own understanding.

4. Made a searching and fearless moral and financial inventory of ourselves.

5. Admitted to ourselves and another human being the exact nature of our wrongs.

6. Were entirely ready to have these defects of character removed.

7. Humbly asked God (of our understanding) to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out.

12. Having made an effort to practice these principles in all our affairs, we tried to carry this message to other compulsive gamblers.

Appendix C

Comparison of DMS-IV Criteria for Substance Dependence and Pathological Gambling

Psychoactive Substance Dependence	Pathological Gambling
1. Frequent preoccupation with seeking or taking the substances.	1. Frequent preoccupation with gambling or getting money to gamble.
2. Often takes the substance in large amounts or over a longer period than intended.	2. Gamble with increasing amounts of money or over a longer period than intended.
3. Tolerance: need for increased amounts of the substance to achieve intoxication or desired effect, or diminished effect with continued use of the same amount	3. Repeated unsuccessful efforts to control, cut back, or stop gambling
4. Characteristic withdrawal symptoms	4. Restlessness or irritable when attempting to cut down or stop gambling
5. Relief substance use: often takes the substance to relieve or avoid withdrawal symptoms	5. Gambles as a way of escaping from problems or of relieving distressful mood
6. Persistent desire or repeated efforts to cut down or control substance use	6. After losing money gambling, often returns another day to get even
7. Often intoxicated or impaired by substance use when expected to fulfill social or occupational obligations, or when substance use is hazardous	7. Often gambles lying to family members and others
8. Has given up some important social, occupational, or recreational activity to seek or take the substance	8. Has jeopardized or lost a significant relationship, job, or education or career opportunity because of gambling
9. Continuation of substance use despite a significant social, occupational, or legal problem or a physical disorder that the individual knows is exacerbated by the use of substance	9. Committed illegal acts to finance gambling
	10. Relies on others to provide money to relieve desperate financial situation caused by gambling

Sources: American Psychiatric Association. (1994). *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders.* Washington, D.C.: Author.
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