Chapter 9

A Treatment Approach for Adolescents with Gambling Problems

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As indicated in previous chapters, it is not uncommon for an adolescent to be participating in one form of gambling or another, be it the lottery, card playing for money, sports wagering, or gambling on electronic gambling devices. The results of the National Research Council's (NRC) (1999) review of empirical studies suggest that 85% of adolescents (the median of all studies) report having gambled during their lifetime, with 73% of adolescents (median value) reporting gambling in the past year. This raises serious mental health and public policy concerns (Derevensky, Gupta, Messerlian & Gillespie, in this volume; NRC, 1999).

Meta-analyses (Shaffer & Hall, 1996) and a review of more recent studies (see Jacobs, in this volume) confirm that between 4–8% of youth are experiencing very serious gambling-related problems, with another 10–15% at-risk for the development of a gambling dependency. More recent debates have raised the question as to the accuracy of prevalence rates of problem gambling amongst youth. Some have recently argued that our current instruments and screens are not accurately assessing pathological gambling amongst adolescents but are over-estimating the prevalence rates (i.e, Ladouceur et al., 2000; Jacques & Ladouceur, 2003). Yet, in a comprehensive discussion of the arguments, Derevensky, Gupta and Winters (2003) and Derevensky and Gupta (in this volume) suggest that many of the assertions raised have little merit. Nevertheless, while this debate plays itself out in the research community and

the search for the *gold standard* instrument continues, it remains clear that a small but identifiable number of youth actually develop serious gambling-related problems. While the need for treatment of youth who gamble problematically is evident, little progress has been made in understanding the treatment needs of this population, a conclusion also reached by the NRC (1999) review. Treatment studies reported in the literature have generally been case studies with small sample sizes (Knapp & Lech, 1987; Murray, 1993; Wildman, 1997) and have been criticized for not being subjected to rigorous scientific standards (Blaszczynski & Silove, 1995; Nathan, 2001; National Gambling Impact Study Commission, 1999; NRC, 1999).

A critical review of treatment issues pertaining to pathological gambling highlights the stringent and rigorous criteria that treatment outcome studies must meet in order to be considered an *Empirically Validated Treatment* (EVT) approach (Toneatto & Ladouceur, 2003) or falling within the parameters of *Best Practices.* Both models base their criteria upon recommendations put forward by the American Psychological Association (Kazdin, 2001), SAMSHA and CSAT. Along with replicability of findings, randomization of patients to an experimental group, the inclusion of a matched control group, and the use of sufficiently large enough samples are viewed as the minimum requirements necessary to validate effective treatment paradigms. Unfortunately, the treatment of adolescent pathological gamblers has not yet evolved to the point that treatment evaluation studies have met the criteria for EVT or Best Practices.

There are several reasons to explain why more stringent criteria, scientifically validated methodological procedures, and experimental analyses concerning the efficacy of treatment programs for youth have not been implemented. Primarily, these reasons include the fact that there exist very few treatment programs prepared to include young gamblers amongst their clientele and few underage problem gamblers actually present themselves for treatment in centers with trained personnel. This small number of young people seeking treatment in any given centre results in the difficulty of obtaining matched control groups. Matched controls are even more difficult to obtain when considering that young gamblers often present with a significant number and variety of secondary psychological disorders. Another obstacle to treatment program evaluation is that treatment approaches may vary within a center and may be dependent upon the gamblers specific profile, developmental level, or therapist's training orientation. Given the lack of empirically based treatment in the field of pathological gambling, this therapy issue is relatively new compared to existing treatment models for youth with other addictions and mental health disorders. There nevertheless remains a growing interest in identifying effective treatment strategies to help minimize youth gambling problems.

Existing Treatment Approaches

Treatment paradigms used for adults have in general been based upon a number of theoretical approaches. These paradigms fundamentally include one or more of the following orientations: psychoanalytic or psychodynamic (Bergler, 1957; Miller, 1986; Rosenthal, 1987; Rugle & Rosenthal, 1994), behavioral (Blaszczynski & McConaghy, 1993; Walker, 1993), cognitive and cognitive-behavioral (Bujold, Ladouceur, Sylvain, & Boisvert, 1994; Ladouceur & Walker, 1998; Toneatto & Sobell, 1990; Walker, 1993), pharmacological (Grant, Chambers & Potenza, in this volume; Grant, Kim & Potenza, 2003; Haller & Hinterhuber, 1994; Hollander, Frenkel, DeCaria, Trungold, & Stein, 1992; Hollander & Wong, 1995), physiological (Blaszczynski, McConaghy, & Winters, 1986; Carlton & Goldstein, 1987), biological/genetic (Comings, 1998; DeCaria, Hollander & Wong, 1997; Hollander et al., 1992; Saiz, 1992), addiction-based models (Lesieur & Blume, 1991; McCormick & Taber, 1988), or self-help (Brown, 1986, 1987; Lesieur, 1990) (For a more comprehensive overview of these models the reader is referred to the reviews by Griffiths, 1995; Lesieur, 1998; NRC, 1999; Rugle, Derevensky, Gupta, Winters & Stinchfield, 2001).

The resulting treatment paradigms have in general incorporated a rather restrictive and narrow focus depending upon one's theoretical orientation of treatment (see Blaszczynski & Silove, 1995 for their analyses of the limitations of each approach). The application of theory and research findings to clinical practice has been similarly limited. Ladouceur and his colleagues have long argued for a cognitive-behavioral approach to treating both adults and youth with gambling problems (Bujold et al., 1994; Ladouceur, Boisvert & Dumont, 1994; Ladouceur, Sylvain, Letarte, Giroux & Jacques, 1998; Ladouceur & Walker, 1996,1998). The central assumption underlying the cognitive-behavioral approach is that pathological gamblers will continue to gamble in spite of repeated losses given they maintain an unrealistic belief that losses can be recovered. As such, this perspective assumes that a number of erroneous beliefs (including a lack of understanding of independence of events, perceived level of skill in successfully predicting the outcome of chance events, and illusions of control) result in their persistent gambling behavior (Ladouceur & Walker, 1998).

In one of the few empirically-based treatment studies with adolescents, Ladouceur et al. (1994), using four adolescent male pathological gamblers, implemented a cognitive-behavioral therapy program. Within their treatment program five components were included: information about gambling, cognitive interventions, problem-solving training, relapse prevention, and social skills training. Cognitive therapy was provided individually for approximately 3 months (mean of 17 sessions). Ladouceur and his

colleagues reported clinically significant gains resulting from treatment, with 3 of the 4 adolescents remaining abstinent three and six months after treatment. They further concluded that the treatment duration necessary for adolescents with severe gambling problems was relatively short compared to that required for adults, and that cognitive therapy represents a promising new avenue for treatment for adolescent pathological gamblers. This therapeutic approach is predicated upon the belief that adolescents (a) persist in their gambling behavior in spite of repeated losses primarily as a result of their erroneous beliefs and perceptions, and (b) that winning money is central to their continued efforts. However, their limited sample (four adolescents) while somewhat informative, is not sufficiently representative to depict a complete picture.

Research with adolescents suggests that the clinical portrait of adolescent problematic gamblers is much more complex than merely that of erroneous beliefs and the desire to acquire money. Our earlier research demonstrates strong empirical support for Jacobs' *General Theory of Addictions* for adolescent problem gamblers (Gupta & Derevensky, 1998a). Adolescent problem and pathological gamblers were found to have exhibited abnormal physiological resting states (resulting in a tendency toward risk-taking), greater emotional distress in general (i.e., depression and anxiety), reported significantly higher levels of dissociation when gambling, and had higher rates of comorbidity with other addictive behaviors. More recently, a series of studies have uncovered that adolescent problem and pathological gamblers differ on their ability to successfully cope with daily events, adversity and situational problems (Gupta & Derevensky, 2001; Gupta, Derevensky & Marget, in press; Hardoon, Gupta & Derevensky, in press). The empirical knowledge of the correlates and risk-factors associated with adolescent problem gambling has been described in more detail elsewhere (Derevensky & Gupta, 2004; Griffiths & Wood, 2000; Hardoon & Derevensky, 2002; Stinchfield, in this volume). Furthermore, contrary to common beliefs and the tenets of the cognitive-behavioral approach, our research and clinical work suggests money is not the predominant reason why adolescents with gambling problems engage in these behaviors (see Gupta & Derevensky, 1998b). Rather, it appears that money is often perceived as a means to enable these youth to continue gambling.

Blaszczynski and Silove (1995) further suggest that there is ample empirical support that gambling involves a complex and dynamic interaction between ecological, psychophysiological, developmental, cognitive and behavioral components. Given this complexity, each of these components needs to be adequately incorporated into a successful treatment paradigm (to achieve abstinence and minimize relapse). While Blaszczynski and Silove addressed their concerns with respect to adult problem gamblers, a similar

multidimensional approach appears to be necessary to successfully address the multitude of problems facing adolescent problem gamblers.

This chapter serves to add to the growing body of literature focused upon youth gambling problems. In particular, we seek to provide an example of our treatment approach which is conceptually linked to, based upon, and derived from existing empirical research. Nonetheless, it is important to note that we have not empirically tested our approach to the standards set forth by SAMSHA or APA due to the lack of a sufficiently large control group. It is our contention that placing youth requesting treatment on a waiting list for an extended period of time is problematic due to the high level of distress evidenced by these youth, the belief that if they remain in a control group their problems will escalate, and the concern that they will no longer seek treatment after waiting in a control group. As such, to date, we have elected to provide immediate treatment to all youth requesting services.

Finding a Treatment Population

Adolescents with gambling problems in general tend not to present themselves for treatment. There are likely many reasons that they fail to seek treatment including (a) fear of being identified, (b) the belief that they can control their behavior, (c) adolescent self-perceptions of invincibility and invulnerability, (d) the negative perceptions associated with therapy by adolescents, (e) guilt associated with their gambling problems, (f) a lack of recognition and acceptance that they have a gambling problem despite scoring high on gambling severity screens, and (g) their inherent belief in natural recovery and self-control (for a more detailed explanation see Derevensky, Gupta & Winters, 2003; Derevensky & Gupta, 2004).

Referrals from parents, friends, teachers, the court system, and the local *Help/Referral Line* are the primary sources through which we acquire our treatment population. As part of an effective outreach program, posters and brochures are distributed to schools, media exposure and media campaigns are frequent, and workshops are provided for school psychologists, guidance counselors, social workers, teachers, and directly to children and adolescents. As a result of this outreach program, we receive a number of calls from adolescents directly requesting treatment. Interestingly, our Internet site has generated several inquiries for on-line help and assistance.

Research and our clinical experience suggests that adolescent problem gamblers develop a social network consisting of other peers with gambling problems (Wynne, Smith & Jacobs, 1996). This results in clients recommending their friends for treatment. Once an adolescent accepts and realizes that he/she has a serious gambling problem, they become astutely aware of

gambling problems amongst their friends. Eventually, some successfully convince their peers to seek help as well.

Since adolescents with gambling problems have little access to discretionary funds and many initially seek treatment without parental knowledge, treatment is provided without cost. While this is not practical for treatment providers in independent practice, State or Provincial funding (or support by insurance providers when available) appears to be fundamental when treating these adolescents.

The location of the treatment facility plays an important role in successfully working with youth. Concerns about being seen entering an addiction center, mental health facility or hospital may discourage some youth from seeking treatment. Accessibility by public transportation is essential since most young clients do not own cars or have money for taxi fare. Although our clinic is adjacent to a University counseling centre, it operates as a self-contained facility exclusively for work with youth experiencing gambling problems.

The McGill Treatment Paradigm

This treatment approach has been refined through our continued work over a seven-year period with over 50 young problem gamblers, ranging in age from 14–21. While not a sufficiently large number of clients upon which to draw firm conclusions, it nevertheless has provided us with sufficient diversity of experience to appreciate the broad applicability of our approach considering the variability of the age range of clients and the concomitant cooccurring problems often accompanying their gambling problems. Based upon empirical findings and our clinical observations with these individuals, their reported success in remaining abstinent, and their improvement in their overall psychological well-being, the approach adopted in our clinic is generally successful in assisting youth to resume a healthy lifestyle.

The criterion by which to evaluate success differs from one treatment facility and approach to the next. In a recent review of treatment literature, Toneatto and Ladouceur (2003) suggest that several different outcome measures have traditionally been used when assessing treatment effectiveness; these being personal ratings of urges, reduction of gambling involvement, and gambling cessation. Our treatment philosophy is predicated upon the assumption that sustained abstinence is necessary for these youth to recover from their gambling problem and that their general overall psychological well-being and mental health must be improved (this also includes improvement in their coping skills and adaptive behaviors). During the past seven years, we have observed a large percentage of youth in

treatment who initially had as their primary goal controlled gambling. Our clinical work suggests that while controlled gambling (ability to respect self-imposed limits) can be an interim goal, abstinence is eventually necessary. Attempts are made to closely monitor these youth for at least one-year post treatment, however it becomes difficult to maintain contact with many of these youth after this point in time. Several youth call periodically beyond the one-year follow-up period to report their progress, but we remain acutely aware that youth who may have relapsed may be unwilling to contact the treatment centre unless they are prepared to re-enter treatment. There is also some recent evidence with adults that pathological gamblers who have successfully completed treatment and who have relapsed often fail to return to the same treatment centre for assistance but are more likely to seek treatment elsewhere (Chevalier, Geoffrion, Audet, Papineau & Kimpton, 2003).

For the most part, our treatment philosophy is predicated upon the work of Jacobs' *General Theory of Addictions* and the work of Blaszczynski and his colleagues' *Pathways Model* (see Nower & Blaszczynski, in this volume, for a comprehensive discussion of the model and an adaptation of the *Pathways Model* for youth problem gambling). This model presupposes that there are three different subtypes of pathological gamblers—each subtype having a different etiology and different accompanying pathologies. It is further assumed that these different subtype pathological gamblers would by necessity require different types of intervention (with different emphases) and that the duration for treatment will likely differ. While there is some overlap between the two models, with both describing the etiology, trajectory and psychology of the addicted gambler, Jacobs' model primarily describes the *Pathway 3* gambler articulated by Nower and Blaszczynski. The commonalities lie in the belief that these youth have a combination of emotional and/or psychological distress coupled with a physiological predisposition toward impulsively seeking excitement. This subset of problem gamblers represents our most typical young clients who seek therapy: those tending to gamble impulsively primarily for purposes of escape and as a way of coping with their stress, depression, and/or daily problems. Longitudinal data recently published following young boys aged 11 to 16 suggests that early indicators of gambling problems include indices of anxiety and impulsivity (Vitaro, Wanner, Ladouceur, Brendgen & Tremblay, 2004). Recent research has also replicated earlier findings that adolescent problem gamblers are more likely to be exposed to peer and parent gambling, are more susceptible to peer pressure, are more likely to exhibit conduct problems and antisocial behaviors, engage in substance use, and have suicide ideation and indicate more suicide attempts (Langhinrichsen-Rohling, Rhode, Seeley, & Rohling, 2004). Such a constellation of correlates and risk-factors are sure to result in different profiles of young problem gamblers.

A General Profile of Youth Seeking Treatment

It has been suggested that those individuals who present themselves for treatment are distinct, representing a minority of young pathological gamblers. It is important to note that while our clients voluntarily come for treatment a number may be less than motivated to participate at first. A considerable number attend because of parental pressure, mandatory referrals from the judicial system, or are strongly encouraged by significant others (i.e., boyfriends, girlfriends) and comply for fear of losing relationships.

The youth that do present for treatment tend to share a similar constellation of behaviors. Other than the psychological variables of depression, anxiety, impulsivity and poor coping abilities previously mentioned, it is not uncommon to see youth who have a history of academic difficulties (usually due to a learning disability and further compounded by their gambling preoccupation and gambling behavior), stressed interpersonal relationships with family members and old friends, involvement with unhealthy peer groups, and are engaging in delinquent criminal behaviors to support their gambling (e.g., shoplifting, cheque forgery, credit card scams). Despite these commonalities, individual differences exist resulting in three distinct profiles.

The following represents a brief synopsis profile of the three predominant types of young gamblers we have treated in our practice, with those fitting in Nower and Blaszczynski's Pathway 3 being most representative of the majority of youth with whom we have worked.

Pathway 1: Behaviorally-Conditioned Problem Gamblers

Joe, a 17-year-old male, is primarily a blackjack casino player (in spite of legal prohibitions). On one of his early visits to the casino, Joe reportedly won over $200 leading him to believe that gambling could provide a good and easy source of revenue. Personal accounts suggest he played, on average, between $300–$500 per week before seeking treatment. Joe also revealed that he had lost up to $2,000 on several visits to the local casino. He attends a post secondary business school, but was failing due to his problem gambling and preoccupation with gambling debts. He presents with occasional drug use and antisocial behaviors related to his gambling behaviors.

Motivation for gambling. Joe reports that gambling is very rewarding as it makes him feel exceptionally good. He revealed that gambling is highly exciting and he perceives it to be the ultimate challenge to outsmart the casino, recoup his losses, and to win large amounts of money.

Financial resources. Joe works part-time in father's company while attending school. He takes money from the company coffers, steals money from family members, and has even stolen and cashed alimony checks sent to his

mother to enable him to gamble. He reportedly has borrowed money from friends and while he does his best to repay them he remains in constant debt.

Therapeutic objectives. Joe entered treatment reporting that he could stop gambling by himself but likes the support and supervision therapy provides. He acknowledged his need for an outlet to deal with the frustration and agitation resulting from his gambling withdrawal. The primary therapeutic objectives were to gradually help him reduce his gambling participation by setting frequency, time, and money limits on his activities while simultaneously addressing his erroneous beliefs about wagering and winning. Restructuring his time was essential to ensure he had minimal free time to think about gambling. This included helping him prioritize school work, seeking and developing healthy peer relationships, and minimizing his use of drugs.

Pathway 2: Emotionally Vulnerable Problem Gamblers

Candice, a 17-year-old female, primarily wagers on sports and casino playing (blackjack was her preferred game of choice). She reported wagering on average between $500–$1,500 per week. She generally plays until all her funds are depleted. She readily understood that the gambling cycle involves wins and losses, with the casino holding the edge over the player. Upon entry into treatment she was enrolled in the first year of CEGEP (Junior College), but was rarely attending as she spent much of her time at the casino. She also held a part-time job that she approached in a responsible manner.

Motivation for gambling. Candice reports gambling primarily to make herself feel special, impress friends, become closer to her father (also a pathological gambler), and as a way of dealing with depression, low self-esteem, agitation, and anxiety. She indicates that she had always experienced academic difficulties and preferred to spend time at the casino versus attending class and completing assignments.

Financial resources. Since all of her expenses were paid by her family (pocket money, car expenses, clothing, cell phone), the money Candice earned from her job was used almost exclusively for gambling. In addition, she would regularly take cash advances on her credit card (approximately $300 per week), which was readily paid by her father.

Therapeutic objectives: The primary goals established for Candice focused upon the identification of her underlying stressors and unresolved issues, addressing the underlying depression and anxiety, and improving her coping skills and adaptive behavior. There was also a need to directly address her gambling behavior and determine her willingness to abstain from gambling. This was accomplished through the gradual introduction of limit setting (money spent, time and frequency spent at the casino).

Pathway 3: Antisocial Impulsivist Problem Gamblers

Sonny, an 18-year-old male, is primarily a casino card player. He reports playing on average between $300–$600 per week depending on his success at the casino. He acknowledges being a thrill-seeker and was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at the age of 12. He frequently engages in drug use, primarily cannabis to "take off the edge." Sonny has a family history of depression, meets the criteria for a mild chronic depression (dysthymia), and reports having repeated suicidal ideations.

Motivation for gambling. Sonny reports that while he is unhappy about his inability to control his gambling it provides him with such a thrill and escape that he can't stop. He has also calculated that the casino "owes" him $7000, and that it would be easier to stop once he wins back that money (a frequent form of logic seen with our clients). When explained that he would be unlikely to recoup the money lost, he acknowledged that most people lose money over time when gambling but that he is the exception to the rule. His erroneous belief system about his ability to control the outcomes of random events was pervasive. Sonny gambled primarily for escape, excitement, and to recoup lost money.

Financial resources. Sonny has little access to gambling funds as he was attending school and only holds a small part-time job. His parents are divorced and he works in his father's company on the weekend. His psychological profile indicates antisocial tendencies, often stealing money from his father's company. He also reports repeatedly lying to and manipulating his mother and friends to obtain money to gamble.

Therapeutic objectives. Sonny's impulsivity was underlying his inability to control his gambling. Thus, controlling impulsive tendencies (ADHD) and finding more appropriate ways to channel them were primary objectives. Sonny also met the criteria for a mild depression that required treatment and monitoring. His lying, stealing and manipulation of his family and friends were without remorse, representing an important treatment goal. Sonny's peers were perceived to be a negative influence and as such fostering a healthier choice of peers was important. The treatment plan also included a gradual reduction of his gambling participation and modifying erroneous cognitions.

The Treatment Procedure

Intake Assessment

The intake procedure includes a semi-structured interview using the DSM-IV criteria for pathological gambling as well as other pertinent gambling

behaviors (e.g., preferred activities, frequency, wagering patterns, accumulated losses, etc.). Current familial situation and relationships, academic and/or work status, and social functioning are ascertained. Information concerning alcohol or drug use, the presence of other risk-taking behaviors, self-concept, coping skills, and selected personality traits are ascertained through a variety of instruments and clinical interviews. An evaluation for clinical depression as well as a history of suicide ideation and attempts is included.

An explanation of our procedures, requirements and goals are provided to each client in order to avoid any misconceptions. Client expectations and personal goals are also ascertained. Many youth report that they desperately want their unbearable situation to improve. However, approximately 60% of clients are initially ambivalent about abstinence.

Tenets of Therapy

A staff psychologist provides all therapy individually. Initially, therapy is provided weekly, however if the therapist deems more frequent sessions are required, appropriate accommodations are made. All clients are provided with a pager or cell phone number for emergency contacts. The number of sessions varies significantly with the motivation and degree of gambling severity of the client and the concomitant disorders. The number of therapy sessions generally range between 20—50 sessions.

The basic therapeutic process includes the following components:

Establishing mutual trust and respect. Mutual trust and respect are fundamental to the therapeutic relationship. Total honesty is emphasized and a non-judgmental therapeutic relationship is provided. This results in the adolescent not fearing reactions of disappointment if weekly personal goals are not achieved. However, since treatment is provided without cost, clients are required to respect the therapist's time. This involves calling ahead to cancel and reschedule appointments, punctual attendance at sessions, and a commitment to complete 'homework' assignments.

Assessment and setting of goals. Since the emphasis of different therapeutic objectives is tailored to the individual, a more detailed profile of the client is required. This is accomplished through comprehensive clinical interviews (beyond intake assessment), usually taking place over the first three sessions. The initial interview consists of the completion of several instruments primarily designed to screen for gambling severity, impulsivity, conduct problems, depression, antisocial behaviors, and suicide ideation and attempts. Their responses to these measures are followed up through more in-depth diagnostic interviews over the next few sessions and more details about the consequences associated with their gambling

(i.e., academic and/or occupational status, peer and familial relationships, romantic and inter-personal relationships, legal problems, etc.) are obtained.

This comprehensive evaluation allows for the therapeutic goals to be established. For example, an adolescent who presents with serious depression will not be approached in the same manner as one who does not evidence depressive symptomatology. If a client presents with a severe depression, this becomes the initial therapeutic objective while the gambling problem becomes a secondary objective. Interestingly, for many youth, once gambling has stopped depressive symptomatology actually increases as youth report that their primary source of pleasure, excitement and enjoyment has been eliminated. It is therefore important to periodically screen for depressive symptomatology throughout the therapeutic process.

Assessment of readiness to change. An important factor influencing the therapeutic approach relates to the client's current willingness to make significant changes in their life. Our experience suggests that most adolescents experiencing serious gambling related problems are reluctant and are not convinced that they really want to stop gambling completely. Rather, most state that they believe in *controlled gambling* and hold onto this belief for some time in spite of our reluctance. Some individuals seek basic information but remain open to the idea of making more permanent changes. Others have decided that they really must stop gambling but are unable to do so without therapeutic assistance and support. Finally, some adolescents have made the decision to stop gambling and do so prior to their first session but require support in maintaining abstinence. These three examples depict adolescents in different stages of the process of change (see chapter by DiClemente, Delahanty & Schlundt, in this volume, for a comprehensive discussion of the Stages of Change Model).

While there are a multiplicity of approaches taken depending upon one's severity of gambling problems, underlying psychological disorders or problems, age, and risk factors, the overall therapeutic philosophy remains similar, with different weightings of therapeutic goals placed where most needed.

Goals of Therapy

DiClemente, Story and Murray (2000) initially proposed a *Transtheoretical Model of Intentional Behavior Change* for adolescent gambling problems whereby they contend that paths leading from addiction to recovery involve interactions between biological, psychological, sociological and behavioral elements in a person's life (see also the chapter by DiClemente, Delahanty & Schlundt, in this volume). As such, a multimodal, multi-goaled

therapeutic approach is necessary. Within our treatment philosophy, the overall framework is to address multiple therapeutic goals simultaneously over time, tailoring the time allocated to each goal to the client. Some will require more emphasis on psychological issues, others on their physiological impulses, others on environmental / social factors while others will require examining their motivations to change. Nevertheless, each client receives individualized therapeutic attention in all areas to ensure they are achieving a balanced lifestyle.

The goals of therapy can be conceptualized as follows:

1) Understanding the motivations for gambling

Adolescents experiencing serious gambling problems continue gambling in the face of repeated losses and serious negative consequences as result of their need to dissociate and escape from daily stressors. Without exception, youth with gambling problems report that when gambling they enter a "different world," a world without problems and stresses. They report that while gambling, they feel invigorated and alive, they are admired and respected, that time passes quickly, and all their problems are forgotten, be they psychological, financial, social, familial, academic, work-related, or legal. As such, gambling becomes the ultimate escape.

Adolescents are required to write a short essay on why it is they feel they gamble, entitled, "What gambling does for me." We contend that the youth must be benefiting in some way from their gambling experiences, albeit temporarily, to continue playing despite serious negative consequences. This exercise is important for two reasons. First, it enables us, in a general way, to understand the individual's perceptions of the reasons underlying why they are gambling excessively. Second, and more importantly, it enables them to articulate and understand the underlying reasons why they gamble. The following are excerpts from their writings; the first one highlighting difficulties with interpersonal relationships and poor coping/adaptive skills, while the second example illustrates an individual's gambling to alleviate a depressed state and as a form of psychological escape:

> I always had trouble making friends, and never had a girlfriend. Gambling has now become my best friend and my one true love. I can turn to her in good times and bad and she'll always be there for me. (Male, age 18)

> Gambling, well, it's strange to talk about the positive side because of how upside down it has turned my life, but I guess the pull of it is how it makes me feel so alive, so happy, and so much like I belong, but only when I am gambling. The low I feel after I realize what I did, and how much I have lost, is worse than anything I can explain. I guess I just need to feel good from time to time, it lets me escape the black hole that is my life. (Male, age 17)

2) Analysis of gambling episodes

Self-awareness is essential to the process of change. If individuals understand the underlying motivations prompting certain behaviors they begin to feel empowered to gain control and make change. Every person who repeatedly engages in a self-injurious pattern of excessive behavior can be guided through an analysis of their behavioral patterns. An awareness of their gambling triggers, their psychological and behavioral reactions to those triggers, as well as the consequences which ensue from this chain reaction is important to achieve. This type of analysis empowers the individual to make long-term successful changes to their behaviors. The following model provides an overview of the framework:

Triggers→Emotional Reactions and Rationalizations→Behavior→Consequences

Triggers. These can consist of places, people, times of day, activities, particular situations, and/or emotions. While initially many individuals are unaware of their specific triggers, they can be identified through discussions of prior experiences, as well as by examining written journals (i.e., a component within the therapeutic process). Once identified, avoiding or effectively dealing with the triggers becomes possible. For example, one of the most common triggers for gamblers is the handling of large sums of money. We therefore help them adopt strategies to minimize the exposure to this trigger, such as arranging for payment of something to be made by a third party, or to have the money replaced by a cheque, and limiting access to cash withdrawals from bank machines. In one case, a parent who was financially supporting his son made daily deposits into his account rather than weekly deposits. Other examples of triggers include gambling advertisements or landmarks, personal anxiety or depressed feelings, interpersonal difficulties, enticement of peers, stressful situations (i.e., exams), the need to make money quickly, or quite simply daydreaming of engaging in gambling. Sometimes, just having the awareness of one's triggers provides a person with a better ability to deal with gambling urges. Additional research is needed to better understand the relationship between triggers and mechanisms of self-control.

Gambling-free times. It is also important to properly understand the times in a person's day when they do not seem to have the urge to gamble. Identifying the circumstances, time of day, who they are with, their emotional state, activity levels, physical location, etc. is essential. By understanding the circumstances in which the urge to gamble is less or absent, it provides a set of guidelines by which the therapist can help recreate similar situations at other times in the day. For example, we have noted that many of the young gamblers undergoing treatment often report that when

actively engaged in playing sports with friends, bicycling, physical activity in gym, or rollerblading they felt better and had their minds clear of their gambling desires both during and after the activity. As a result, for these youth, when helping them to structure and organize their week, we attempt to include similar types of activities on a daily basis.

3) Establishing a baseline of gambling behavior and encouraging a decrease in gambling

Once the motivations for gambling are understood and an analysis of gambling patterns has been made, efforts are focused on making changes to the adolescent's gambling behavior. In order to set goals and measure improvements, it is useful and important to initially establish a baseline of gambling behavior. Adolescents are required to record their gambling behaviors in terms of frequency, duration, time of day, type of gambling activity, amount of money spent, losses and wins. When establishing goals for a decrease in gambling participation, individuals are guided to establish *reasonable* goals for themselves. Some elect to target multiple factors such as frequency and duration and amount spent simultaneously, while others may focus on one form of behavior (e.g., frequency or duration). For these individuals we encourage a decrease in frequency or duration of each gambling episode versus initially focusing on amount wagered. Some meet their goals immediately at which point we generally support decisions to maintain this decrease for several weeks while setting new goals immediately. Others struggle to meet their goals at which point goals are generally modified.

4) Addressing cognitive distortions

It has been well established that individuals with gambling problems experience multiple cognitive distortions (Ladouceur & Walker, 1998; Langer, 1975). They are prone to have an illusion of control and perceive that they can control the outcome of gambling events, they underestimate the amount of money lost and over-estimate the amount won, they fail to utilize their understanding of the laws of independence of events, and they believe that if they persist at gambling they will likely win back all money lost (chasing behavior). Addressing these cognitive distortions remains an important treatment goal. Furthermore, the analysis of their gambling behavior usually reveals the rationalizations they make to justify their gambling behavior, and these rationalizations need to be addressed, as they too represent distortions of reality. An example of a rationalization for gambling is, "If I gamble now, I will be in a good mood and I will be more able to have fun at my friend's party tonight," or "By gambling now, the

urge will be out of my system and I'll be more able to focus on studying for my exam." The overarching goal would be to ensure the individual comprehends that the gambling episode will likely result in a bad mood if they were to lose money, thus a negative mood at their party; or an inability to focus on studying for their exam. Ultimately, the goal of addressing many of the cognitive distortions is to highlight how their thinking is self-deceptive, to provide pertinent information about randomness, to encourage a realization that they are incapable of controlling outcomes of random events and games, payout rates, etc.

5) Establishing the underlying causes of stress and anxiety

In light of empirical research (Gupta & Derevensky, 1998a; Jacobs, 1998; Jacobs, Marsten & Singer, 1985) and clinical findings, a primary treatment goal is to identify and treat any underlying problem that results in increased stress and/or anxiety. These in general include one or more of the following problems: personal (e.g., low self-esteem, depression, ADHD, oppositional defiant disorders), familial, peer, academic, vocational, and legal. Through traditional therapeutic techniques these problems are addressed and alternative approaches to problem solving are supported while sublimation, projection, repression and escape are discouraged. For example, Candice was initially struggling with chronic depression, a learning disability, and poor coping skills. The combination of these factors resulted in significant anxiety when faced with school assignments and exams; all of which resulted in a poor self-esteem affecting her ability to establish and maintain healthy peer relationships. As a result of a clinical evaluation, Candice's depression and learning problems were addressed. Candice gained insight as to the reasons she needed to escape through her excessive gambling. Ultimately, she was relieved to have her primary problems addressed, her self-esteem gradually improved, and she was encouraged to develop a healthier lifestyle and more effective coping skills. In time, Candice found developed a very good friendship with someone in whom she could confide about her struggles with gambling. This friend assisted her in overcoming her gambling urges, kept her occupied with healthy activities, and became a good study partner. This friendship also helped Candice develop a stronger sense of self-worth and she came to better understand her value and potential.

6) Evaluating and improving coping abilities

The need to escape one's problems usually occurs more frequently among individuals who have poor coping and adaptive skills. Using gambling, or other addictive activities to deal with daily stressors, anxiety or depression

represents a form of maladaptive coping. Recent research efforts have confirmed these clinical observations, where adolescents who meet the criteria for pathological gambling demonstrated poor coping skills as compared to same age peers without a gambling problem (Gupta, Derevensky & Marget, in press; Marget, Gupta & Derevensky, 1999; Nower, Gupta & Derevensky, 2000). A primary therapeutic goal involves building and expanding the individual's repertoire of coping abilities. This happens best by using examples of situations in the individual' life that were dealt with inappropriately and suggesting more appropriate ways of handling them. As adolescents begin to comprehend the benefits of effective coping abilities and their repertoire of coping responses expands, they are more apt to apply these skills to their daily lives. Examples of healthy coping skills include honest communication with others, seeking social support, and learning to weigh the benefits or costs associated with potential behaviors. Also included in the discussions and role playing exercises are ways to improve social skills (e.g., learning to communicate with peers, developing healthy friendships, being considerate of others, and developing trust).

7) Rebuilding healthy interpersonal relationships

Common consequences of a serious gambling problem involve impaired and severed relationships with friends and family members. Helping the adolescent rebuild these crucial relationships constitutes an important therapeutic goal. Often through lies and manipulative behaviors resulting from their gambling problem, friends and family members become alienated, leaving unresolved negative feelings. Once a youth has been identified as being a liar or a thief, it becomes difficult to earn back the trust of others and to resume healthy relationships. One needs to explain to family members and friends that these deceptive actions are part of the constellation of problematic behaviors exhibited by individuals who cannot control their gambling. Consequently, once the gambling is under control, family member and friends can anticipate being treated with more respect. Family members, peers, and significant others become important support personnel to help ensure abstinence and can take an active role in relapse prevention. We contend that youth with gambling problems will be happier and are more likely to abstain from gambling if they feel they belong to a peer group and are supported by family and friends. As a result, the occasional inclusion of family members and friends in therapy sessions can prove to be very beneficial.

As an example, Sonny, having stolen from his father's company, and having manipulated his mother with lies in order to obtain funds for gambling faced a difficult challenge in regaining the trust of his parents. Both

parents perceived him as being ruthless and were convinced that his antisocial criminal behaviors would not stop. Once he regained control of his gambling and was abstinent for several months, he came to understand how his behaviors were hurtful. As a result, he experienced significant remorse. Through inclusion of his parents in the therapeutic process, concomitant with improved communication skills and his willingness to accept responsibility for the emotional distress he caused his parents, he slowly regained the support and trust of his family members and peers. This process remains ongoing and often takes considerably longer than the client wants.

8) Restructuring free time

Adolescents struggling to overcome a gambling problem experience more positive outcomes when not faced with large amounts of unstructured time. Some adolescents in treatment are still in school and/or have a job, and as such their free time consists mainly of evenings and weekends. Others have dropped out of school and may have a part-time job while others are not working. For these youth, structuring their time becomes paramount as they initially find it exceedingly difficult to resist urges to gamble when they are bored. We frequently ask adolescents to carry an agenda with them where we have helped articulate ways of spending time with friends, family, school or work related activities. Other activities can involve participating in organized sports activities, engaging in a hobby, and performing volunteer work. The *success* of their week is evaluated on how they achieve their weekly goals as agreed upon, with their gambling-related goals (reduction or abstinence) being one part of the program. Thus, if an individual fails to meet their goals surrounding their gambling behavior, they still may achieve success in other areas. This approach tends to keep the young gamblers from being discouraged and motivates them to keep trying to attain a balanced lifestyle.

9) Fostering effective money management skills

These skills are typically lacking in adolescents who have a gambling problem. Therapeutic goals involve educating them as to the value of money (as they tend to lose perspective after gambling large sums), building money management skills, and helping them develop effective and reasonable debt repayment plans.

10) Relapse prevention

Despite a lack of strong empirical evidence, our clinical work suggests that abstinence from gambling is necessary in order to prevent a relapse of

pathological gambling behaviors. It should be noted that small, occasional relapses throughout the treatment process are to be expected. However, once gambling has ceased for an extended period of time (i.e., 4–6 months), an effective relapse prevention program should help these individuals remain free of gambling. Relapse prevention includes continued access to their primary therapist, the existence of a good social support network, engagement in either school or work, the practice of a healthy lifestyle, and avoidance of powerful triggers. Youth are contacted periodically via telephone for one year post treatment to ensure they are maintaining their abstinence and doing well in general. Support is offered if required. Gamblers representative of Pathways 2 and 3 are more apt to need additional support after the termination of therapy.

Concluding Remarks

The authors acknowledge that the treatment program's efficacy has not been empirically validated using the standards necessary for a rigorous, scientifically controlled study (i.e., no random assignments to a control group matching for severity of gambling problems and other mental health disorders, controlling for age, SES, frequency and type of gambling activity preferred, etc.). As such, more clinical research is necessary before definitive conclusions can be drawn. Nevertheless, based upon clinical criteria established for success (i.e., abstinence for six months post treatment, return to school or work, not meeting the DSM criteria for pathological gambling, improved peer and family relationships, improved coping skills, and no marked signs of depressive symptomatology, delinquent behavior or excessive use of alcohol or drugs), the McGill University treatment program appears to have reached its objectives in successfully working with youth with serious gambling problems.

The description of our treatment philosophy and approach were elaborated upon to provide clinicians and treatment providers with a better understanding of the different components necessary when working with young problem gamblers. Treating youth with severe gambling problems requires clinical skills, a knowledge of adolescent development, an understanding of the risk factors associated with problem gambling, and a thorough grounding in the empirical work concerning the correlates associated with gambling problems. By no means should this chapter substitute for proper training.

While we did not elaborate upon how to treat youth with multiple addictions in this chapter, it is clear that gamblers with concomitant substance abuse problems pose a greater challenge for treatment (Ladd & Petry,

2003). Youth with clinical levels of depression, high levels of impulsivity, and anxiety disorders are often referred to psychiatry to simultaneously undergo pharmacological treatment while undergoing our therapy. The use of serotonin re-uptake inhibitors tend to be effective in helping these youth manage their depression and anxiety, and preliminary research suggests that they may be useful in lowering levels of impulsivity which often underlie pathological gambling behavior (Grant, Chambers & Potenza, in this volume; Grant, Kim & Potenza, 2003).

The finding that several youth enter treatment immediately after stopping their gambling on their own, requesting assistance in maintaining abstinence and in dealing with the concomitant gambling-related problems and underlying issues, raises an interesting research and clinical question. Would these youth have maintained abstinence without intervention?

While the incidence of severe gambling problems amongst youth remains relatively small, the devastating short-term and long-term consequences to the individual, their families, and friends are significant. One adolescent, when discussing the severity of his gambling problem responded, "It's an all-encompassing problem that invades every facet of my life. I wouldn't wish this problem on my worst enemy, for it's way too harsh a punishment."

The vast majority of the youth seen in our clinic have a wide array of problems. Merely treating the gambling problem without examining the individual's overall mental health functioning will likely have limited results. The following is a text written by a young pathological gambler we treated, one year post-treatment:

> Gambling is an extremely addictive activity which can get unbelievably out of control. It can lead to a very horrible reality, one in which just getting out of bed can seem unthinkable. Unfortunately, I have lived this reality. I was eighteen when I began to fight for my life back. My future did not look very good. I was severely depressed, anxious and overweight, I wanted to disappear. Thankfully, with the support of an amazing team I have managed to overcome my addiction, lose thirty pounds and continue my schooling. 1 feel like I am relearning how to live. This continues to be a very long and emotionally painful process, however it does get easier with time. My memories of the gambling, the lies and unhappiness are slowly fading away … becoming part of the past. However I will never forget my struggle or how easy it was to lose control. In my gambling years I have seen and experienced first hand an incredible amount of heartache. I hope to never witness such avoidable pain again. Now at twenty years old, I am beginning a journey which holds an endless amount of opportunity. My dream to be a health-care professional seems closer than ever. Please let my story be a source of hope for anyone in a similar situation. I understand how bad life can seem, I've been there, believe me. You are not alone. Get the help you need, be true to yourself and start your own journey.

While it appears as though large numbers of adolescents who gamble problematically appear to resolve their gambling problems without therapeutic intervention (natural recovery), providing support for those in need remains essential. Our governments, private corporations, and charitable organizations, recipients of the revenues generated from gambling, need to help address this issue by providing funding for the establishment of treatment centers and training of professionals. Problem gambling, even for adolescents, can have devastating short-term and long-term consequences.

The youth briefly described, Joe, Candice, and Sonny, are all doing relatively well and are living happy productive lives. Joe has channeled his energies into starting his own business, always taking significant but well reasoned risks. Candice has successfully returned to her studies, and although she was unable to enter into the health science university program (she always envisioned herself as attending medical school) as a result of academic failures during her excessive gambling days, she nevertheless is happily enrolled in an alternative, related program. She remains highly motivated and committed toward building her career. Sonny has learned to manage his ADHD and his depression and has integrated full-time into the workforce. He has built a solid peer network of social support for himself and is working on repairing broken relationships with friends and family members.

In spite of gains in knowledge concerning the correlates and risk factors associated with severe gambling problems amongst youth during the past ten years a general lack of public and parental awareness exists. The fact that the prevalence rates for youth with severe gambling problems remain higher than that of adults is of significant concern. Whether maturation will result in individuals stopping their excessive gambling behavior by the time they become adults with additional responsibilities still remains an unanswered question (the issue of natural recovery remains a highly important issue in need of considerable research). As we have argued elsewhere, independent of whether or not individuals with severe gambling during adolescence become more responsible 'social gamblers' as adults, the personal costs and consequences incurred along the way often remain with them.

Gambling problems among youth will raise important public health and social policy issues in the 21st century. Greater emphasis on outreach and prevention programs is absolutely essential. Our governments must help fund more basic and applied research and be responsible for supporting and developing effective and scientifically validated prevention and treatment programs. The treatment of young problem gamblers is a complex, multi-modal process. While such an approach can take months or longer, the benefits to the individual and society outweigh the costs of funding such programs.

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