

Group Therapy Can Help Pathological Gamblers

BY ELAINE ZABLOCKI
Contributing Writer

SPARKS, NEV. — Pathological gambling is a serious and increasingly prevalent addiction, but it is treatable—particularly with group therapy, Denise F. Quirk said at the annual meeting of the American College of Preventive Medicine.

During the last decade, restrictions on gambling have eased substantially. Today, the only states that do not have some form of legalized gambling are Utah and Hawaii. At the same time, Internet-based “casinos” have dramatically increased accessibility.

This can be particularly problematic for young people who would otherwise en-

counter age restrictions, said Ms. Quirk, who is a certified problem gambling counselor and the assistant clinical director of the Problem Gambling Center in Reno.

For many patients, psychotherapy combined with active participation in Gamblers Anonymous has proved effective, Ms. Quirk said.

Only 8 or 10 states offer inpatient or intensive outpatient treatment for pathological gambling. Ms. Quirk refers patients who need residential treatment to the Center of Recovery in Shreveport, La. “I have sent several clients there and they’ve done well,” Ms. Quirk said in an interview. “They have state funding, so most clients can get 4 weeks of residential treatment for about \$3,000.”

Intensive outpatient treatment typical-

ly takes 2.5 hours a day, 4 days a week, for 6 weeks. Patients meet for group therapy, with a few individual appointments included. Cognitive-behavioral therapies are effective, she said, and “group therapy works very well for these patients,” she said.

“There are so many delusional and irrational beliefs associated with gambling, and those patterns must be confronted during therapy. Another gambler can sniff out irrational thinking and say directly: ‘You’re slipping; you want to get back into the action.’”

Two questions are helpful for screening someone with a suspected problem: “Do you lie about any aspect of your gambling?” and “Have you bet more than you intended?” said Ms. Quirk, who is

also an advisory board member of the Nevada Council on Problem Gambling.

For a more detailed screening, she recommended using the DSM-IV criteria for pathological gambling (see box).

Families dealing with an Internet-based problem should put the computer in a public space, so it’s relatively easy to see how people are using it.

Parents should check the browser history, so they can see what sites have been visited, Ms. Quirk suggested. “They should pay a reasonable degree of attention to their credit card usage, so they notice any unusual debts,” she said.

In any year, about 1% of the U.S. population experiences a condition known as “pathological” or “compulsive” gambling, a progressive addiction characterized by an

increasing preoccupation with gambling, a need to bet more money more frequently, and restlessness or irritability when attempting to stop.

A national survey found that about 14% of adults have never gambled; 75% are low-risk, social gamblers; nearly 8% are at risk; and 1.2% are pathological gamblers. Problem gamblers, who meet one or more of the criteria for pathological gambling and are experiencing problems due to their gambling behavior, constitute another 1.5% of the adult population.

Problem gambling typically results in difficulties in personal, social, and work lives and can lead to depression, anxiety, and stress. For example, one study found that 32% of pathological gamblers and 36% of problem gamblers had been arrested, compared with 4.5% of those who had never gambled.

In another comparison, 53% of pathological gamblers and 40% of problem gamblers had been divorced, compared with 18% of those who had never gambled. Approximately 19% of pathological gamblers and 10% of problem gamblers had had mental health treatment, compared with 4% of those who had never gambled. ■

To find local treatment resources for gamblers, Ms. Quirk suggested calling a 24-hour national helpline, maintained by the National Council on Problem Gambling, at 800-522-4700. For more information, she recommends the National Council on Problem Gambling’s Web site, www.ncpgambling.org, and that of the Nevada Council on Problem Gambling, www.nevadacouncil.org.

DSM-IV Criteria For Pathology

The patient who has a diagnosis of pathological gambling:

- Is preoccupied with gambling. He or she relives past gambling experiences, plans the next venture, or thinks of ways to get gambling money.
- Needs increasing amounts of money for gambling to achieve the desired level of excitement.
- Loses control (has made repeated unsuccessful efforts to reduce or stop gambling).
- Is restless or irritable when attempting to reduce or stop gambling.
- Gambles to escape problems or relieve feelings of helplessness, guilt, anxiety, or depression.
- After losing money, returns another day to get even (known as “chasing” one’s losses).
- Lies to family members, therapists, or others to conceal the extent of the gambling.
- Has committed illegal acts (forgery, fraud, theft, or embezzlement) to finance gambling.
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- Seeks bailouts or relies on others to provide money to relieve a desperate financial situation caused by gambling.

‘Adaptive Design’ Promoted for Alcoholism, Depression Treatment

BY DAMIAN McNAMARA
Miami Bureau

BOCA RATON, FLA. — Clinicians treating alcohol abuse or depression could improve outcomes by adopting a strategy gaining popularity among psychiatry researchers, according to several presentations at a meeting of the New Clinical Drug Evaluation Unit sponsored by the National Institute of Mental Health.

With “adaptive design,” patients agree to begin a particular treatment with preset time points for gauging response or remission.

This “operationalization” of clinical trials has increased enrollment, improved patient engagement in their treatment, and allowed researchers to switch more patients to a better outcome by study end, Dr. David W. Oslin said.

A protocol that dictates initial treatment duration and when to switch patients to a different

treatment removes some clinician judgment. This may make some physicians uncomfortable at first, said Dr. Oslin, Hazelden Research Co-Chair in late life addiction at the University of Pennsylvania, Philadelphia.

For example, Dr. Oslin and his associates are using adaptive design for a trial of naltrexone for alcohol abuse. “We chose 8 weeks. Patients had to make it to 8 weeks to be considered responders. This caused a considerable amount of angst.

The reason? Clinicians were not used to not making the decision of when to determine response,” according to Dr. Oslin.

“Alcoholism is the example, but you can substitute depression if you treat patients who are depressed,” Dr. Oslin said.

Adjusting treatment requires knowledge about when to change, how to define when (for a responder or nonresponder), and what to change to. “It’s not

trivial deciding when to give up on a particular agent,” Dr. Oslin said.

In the naltrexone study, about 40% of participants were drinking or not having a robust response in the middle of the trial. Changing their treatment resulted in about half of those in the poor outcome group switching

Under adaptive design, patients agree to begin a particular treatment with preset time points for gauging response or remission.

to a good outcome by 8 weeks, Dr. Oslin said.

Responders in the naltrexone study are randomized to prescription plus telephone disease management and follow-up at 4 months, or prescription and follow-up at 4 months. Nonresponders receive combined behavioral intervention and medical management and are randomized to

either naltrexone or placebo, Dr. Oslin said, “to essentially answer the question about benefits of continuing naltrexone.”

“If we adapt treatment at the point that people relapse, you retain more people and keep them longer in the program,” Dr. Oslin said.

“There may also be a spillover effect to the people who really did not engage at all or would have dropped out early.”

An unexpected finding was an increased willingness of patients to participate in the naltrexone study because of its design. Dr. Oslin said this finding makes sense.

“Most of us would be more willing to start in a program if we know treatment will be adapted depending on how we are doing, versus knowing someone is going to flip a coin and randomly assign us.”

“When we give a patient a medication or psychotherapy, we

are doing an experiment. Often, we have to take a second step, third step, and fourth step,” said Dr. A. John Rush Jr., Rosewood Corporation Chair in biomedical science and Betty Jo Hay Distinguished Chair in mental health, University of Texas Southwestern Medical Center, Dallas.

With adaptive design, each treatment may inform the next step, Dr. Rush said at the meeting, which was cosponsored by the American Society for Clinical Psychopharmacology.

In addition, a treatment that appears best initially may not be the best in the long term, said Susan A. Murphy, Ph.D., who is H. Robbins Professor of statistics and senior research scientist at the Institute for Social Research at the University of Michigan, Ann Arbor.

Therefore, using adaptive design makes sense because it collects intermediate outcomes that can guide for whom each treatment works the best, Dr. Murphy added. ■