

CHAPTER 4

ADOLESCENT PROBLEM GAMBLING

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Introduction

Many research papers refer to the higher prevalence of gambling problems among adolescents compared to adults (Hardoon et al, 2003; Gupta & Derevensky, 2000; Derevensky & Gupta, 2000). A number of overseas studies conclude that the problem gambling rate for adolescents is generally in the range of two to four times that of adults, with 85% of all adolescents having participated in gambling (Gupta & Derevensky, 2000; Shaffer et al, 1997). A recent New Zealand study identified that this higher risk also applied to a sample of over 500 high school students (13-18 years), with ethnic minority pupils attending lower socio-economic schools occupying the highest risk category (Sullivan & Beer, 2001). Two-thirds of the total student sample had participated in some form of gambling in the previous 12 months. Many of the gambling modes reported were legally restricted to ages above that of the students, suggesting that adolescents can readily access many forms of gambling, despite age limits. New Zealand's recently enacted Gambling Act 2003 legislates a minimum age of 18 years for most forms of gambling (20 years for casinos), together with increased penalties for both the gambling provider and underage player who breach the law. The effects of such legislation has yet to be determined, but overseas experiences demonstrate that vigilant enforcement of the law may still not ensure its success in eliminating all adolescents from gambling premises.

There may be a number of factors underlying the increased risk of gambling problems by adolescents in comparison to adults. Recently Chambers et al, (2003) attributed this higher risk to impulsivity increases arising from normal age-related neurodevelopment. They state that poor decision making arises from impulse control problems that adolescents

experience due to central nervous system changes. Other explanations may be more psycho-social, such as young people wishing to demonstrate support for sporting role models (through wagering on their success), familiarity with electronic systems and the strong reliance of modern gambling on such systems (internet gambling and video gambling machines), poorer awareness of the chances of winning, and enhanced reinforcing effects of smaller wins (which occur more often) on those with fewer financial resources. It is important to remember that “this is the first generation of youth spending their entire lives in an environment in which gambling is sensationalised, advertised, and government supported and endorsed” (Gupta & Derevensky, 2000, p.338).

Some support for these different hypotheses is provided by recent New Zealand research. To support the thesis that there is lower awareness of the possibility of winning, one in four students reported by Sullivan and Beer (2001) believed that gambling machines could be beaten using skill, compared with just 6% of adults. For students who were regular video game players, this percentage encompassed two-thirds of the sample.

In respect of a reduced awareness of their risk of gambling problems, two-thirds of the students considered that other adolescents were either unlikely to have gambling problems or had less chance than adults of developing them. This contrasts with the consistently higher adolescent risk identified in worldwide research findings.

Nevertheless, over 80% of the students considered that information about the risk of problem gambling would be useful in their education. With a dangerous combination of low awareness of risk coupled with a mistaken belief in the effectiveness of skill on the most problematic mode of gambling (gambling machines), the implied invitation may be an opportunity to address these important issues.

Age for ‘adolescents’

Although the age group that constitutes ‘adolescence’ can be vague, the focus for the purpose of gambling problems is the teenage years, especially those 14-17 years of age. These young people are underage for most continuous forms of gambling under the Gambling Act 2003. The Sullivan and Beer (2001) study average age was 14.8 years ($SD = 1.5$) with a range of 12-18 years. This relatively narrow age group possesses specific challenges not found in younger or older ‘young’ people. Quite aside from restrictions in legally accessing gambling, both males and females

aged 12-18 years are experiencing stressful biological, as well as psychological and social changes (Chambers et al, 2003; Hardoon et al, 2003).

Adolescent participation in gambling

In New Zealand, youth appear to participate in gambling at about the rates found in overseas studies. The Sullivan and Beer (2001) study found two-thirds of students had participated in some form of gambling in the previous 12 months. No rate of gambling was surveyed, although many students identified a range of gambling modes they had participated in during that period. Female students participated in gambling at a rate lower than that of male students (58% compared with 72%), a finding reflected in overseas studies, but rates were relatively similar.

The Sullivan and Beer (2001) study also found that some students reported exceeding the participation in gambling of adults (internet gambling, gambling on sports, on cards, 0900 telephone competitions, and Daily Keno), although some gambling may have included student-to-student gambling rather than commercial venues (e.g. cards, sports) (see Table 4.1). Many age-restricted modes of gambling were accessed by students below that age requirement, indicating either the need for stronger enforcement processes, or the difficulty of age assessment faced by gambling vendors.

Of concern was the relatively high percentage of adolescents (10% compared with 18% of adults) who had participated in the most problematic form of gambling, namely playing gambling machines. Gambling machines currently account for at least 80% of the problems identified by problem gamblers seeking help from specialist treatment providers (Paton-Simpson, Gruys & Hannifin, 2003).

Adolescents at risk

Some findings from overseas research raise concerns. With adolescents, there is often a rapid escalation from social to problem gambling, while those who develop gambling problems have higher rates of depression and suicide attempts, and an increased risk of other addictions (Gupta & Derevensky, 2000; Chambers et al, 2003).

Help-seeking low for youth

Few adolescents appear to seek help for gambling problems. In New Zealand, less than 2% of callers to the Gambling Problem Helpline in

2002 were under 20 years of age, and this percentage rose only marginally in face-to-face treatment (3.4%) (Paton-Simpson et al, 2003). In order to counter this apparent barrier, a youth helpline service has recently been developed (personal communication with the Gambling Problem Helpline, March 25, 2004). However it is too early to ascertain its ability to attract calls from adolescents with problem gambling issues. The Sullivan and Beer (2001) study identified that problem gambling students preferred to seek help from friends or parents, while barely one in five would choose a specialist counsellor or telephone helpline. It is also possible that help-seeking is low for youth because of confidentiality issues, overconfidence in self-control and eventual recovery, guilt, poor awareness of the extent of youth behaviour, a belief that they are 'bulletproof,' and negative perceptions of counselling.

Interventions for adolescents with gambling problems

Current standard practice

Many of the factors discussed above indicate that health promotional strategies may provide important approaches to addressing adolescent gambling problems, but when difficulties do develop, therapeutic approaches should address aspects particularly relevant to youth. The first choice of youth for assistance in the Sullivan and Beer (2001) study was their friends, indicating the importance of understanding and acceptance, and perhaps age-matching or culture-matching where possible.

In New Zealand, apart from the youth help-line strategy, there is no specialist service available for treatment of problem gambling among adolescents. Some counsellors in specialist problem gambling treatment agencies may elect to receive adolescent gamblers, and may provide generic strategies to address the problem gambling.

The McGill intervention programme

The pre-eminent centre for youthful problem gambling management is the Canadian McGill Youth Research and Treatment Clinic. Although its approach has good face validity, the small sample of treated adolescents in the programme has made it challenging to clearly demonstrate whether the McGill approach is the optimum stratagem for reducing harm amongst this age group. It follows well-supported approaches that focus not only on the gambling behaviour, but also on issues that are common among problem gamblers of all ages and which appear to be particularly relevant to adolescents.

Its approach is to consider that many underlying difficulties contribute to the development of gambling problems, and that gambling may provide an escape from stress in the short term. Underlying difficulties that might lead to the development of a gambling problem include learning difficulties, anxiety, family concerns, poor self-esteem and low coping skills. However, even when this perspective is applied, the gambling behaviour is still addressed as the initial and most important issue, unless crisis matters such as suicidal ideation or serious depression take precedence.

The McGill approach is similar in process to much of the generic New Zealand problem gambling therapy, but with youth-focused aspects. It comprises 20-50 sessions, and involves:

- Programme information provision to the adolescent, including requirements and goals.
 - A comprehensive assessment using a semi-structured interview. This includes identifying the mode and frequency of gambling, gambling strategies, preferred venues and accumulated debt. The employment or educational situation, family issues and social functioning are also covered. The assessment also identifies other addictive behaviours (e.g. alcohol, other drugs, tobacco), mental health issues (e.g. depression, suicide risk), and coping and self-esteem.
 - Treatment plan and goals based on the assessment and gambling abstinence is included (or irrational beliefs may remain).
 - Establishment of trust – all therapy is one-to-one.
 - Acceptance that gambling is causing problems – many present ambivalent about stopping completely.
 - Addressing personal issues using psychotherapy.
 - Development of coping skills, structuring free time, developing a healthy lifestyle, debt repayment arrangements if necessary.
 - Family involvement.
 - Cognitive restructuring.
 - Relapse prevention strategies.
- (Gupta & Derevensky, 2000).

Possible variations for New Zealand

Appropriate New Zealand treatment will include local cultural norms and will avoid perspectives not fully supported by research. In North America for example, there has been strong support for the 12-step

programme and the accompanying belief that abstinence must be the goal in the treatment of addictive behaviour. Others have been even more vehement in their belief that there are risks associated with controlled gambling behaviour (lack of acceptance of possible consequences, financial ruin and suicide risk). However, there appears to be no proof of this consequence, and many adolescents prefer a goal other than abstinence. The McGill programme providers note “approximately 60% of clients are initially ambivalent about abstinence” (Gupta & Derevensky, 2000, p 326).

In New Zealand there is a strong focus on client-centred therapy; controlled gambling can be anecdotally successful, and it can be instrumental in raising awareness of the need for abstinence when designed appropriately. The relatively small number of clients seen in the McGill youth programme (36 individuals aged 14-21 years over a five year period), when considered in combination with the need for ‘acceptance of the problem’ encouraging abstinence, may suggest the need for modification of this part of the programme for New Zealand. It is acknowledged that the McGill programme does not require acceptance of the abstinence goal before entering treatment, but that it is the preferred outcome.

Motivational Interviewing (MI) has a strong following in the treatment of addictive behaviour in New Zealand, and although no one approach is required under this strategy, the ambivalence noted in the McGill programme around a goal of abstinence suggests that an initial strategy may be MI followed by therapies that match the adolescent’s readiness to change. DiClemente et al, (2000) suggest that this approach both personalises and potentiates the intervention with adolescents.

Screening and assessment

A youth screen for problem gambling can assist with raising awareness and determining assessment issues to be addressed in therapy (treatment plan). The Eight Screen-Y (youth version) was developed with the assistance of youth focus groups and may be an alternative to the DSM-IV criteria when diagnosis of gambling pathology may be the goal (see Figure 4.1) (Sullivan, 2003).

Provision of information around the statistics of winning may also assist. Feedback during the development of the Eight Screen-Y was that an important motivator for change was the realisation that youth were being ‘ripped off.’ The very poor odds of winning, together with feedback

from the High School Study demonstrating poor understanding of probability theory (and willingness to learn), would support this approach.

The focus of the McGill programme is on adolescents with serious gambling problems. The availability of a simple screen and minimal training, brief intervention skills and awareness of referral resources, plus knowledge of problems that co-exist with gambling problems, offer an opportunity to identify and intervene early in the progression of gambling problems. Early intervention is not only less resource intensive, but can be more effective and cause less harm. In the High School Study almost one in six students identified a school counsellor or teacher as a preferred help-provider for gambling problems, suggesting one possible avenue for screening and early intervention.

In addition, a brief anxiety screen may assist with the identification of problem gamblers because anxiety, in addition to depression, is common amongst this population group. Two-question depression and anxiety screens are currently being trialled in New Zealand by a problem gambling treatment service, and these could be modified for youth (Sullivan, 2003).

Family/whanau

The preference to access family and friends for assistance found in the Sullivan and Beer (2001) study emphasises the importance of involving family/whanau in therapy. This may involve joint sessions, as well as separate sessions where the family can receive general information and develop skills in dealing with the adolescent problem gambler. In many cases older adolescents will have left their family and will be isolated socially. In this situation, group therapy (therapeutic support) can provide a socialising substitute. The family does participate in the McGill programme, and this may best be seen not as a variation, but as an emphasis.

Group therapy

Group therapy may also be appropriate. The McGill programme reports the proselytising roles of these young clients amongst problem gambling friends once their awareness is raised. It may well be that as treatment progresses, socialising, trust, coping skills, cognitive restructuring and relapse issues can be dealt with at least as well through the addition of group therapy. The programme length of 20-50 sessions is considerably above that normally involving New Zealand clients of all ages, and resources may be stretched without some adjustment. The group therapy

option, once client numbers for a youth group have been reached, may in part assist to counter limited resources while facilitating recovery and relapse prevention.

Information

Focus groups (Sullivan & Beer, 2001) identified that youth dislike being 'taken advantage of' or being misled. Conversely, they responded overwhelmingly that they would welcome information about problem gambling issues in their curriculum (Sullivan & Beer). It would appear that part of an adolescent programme should include information about chances of winning, psychological explanations around encouragements to continue participating even when losing, and developing critical appraisal of both industry and 'self-talk' messages to enhance resilience to such pressures.

Earlier intervention in non-problem gambling venues

Rather than specialist problem gambling treatment services being the only provider of help for problem gambling, the barriers to help-seeking arising from awareness of the extent of the gambling before help-seeking suggest that opportunistic screening and in-house interventions could be provided by services addressing higher likelihood co-existing disorders. The therapeutic connection and trust may already have been established, while the programmes provided by alcohol and other drug services are similar in content. From the viewpoint that problem gambling and misuse of drugs may both result from attempts to escape stress, client guilt can be assuaged through awareness that the co-existing disorders are not due to an 'addictive personality,' but rather to a learned response adopted during a time of biological, social and psychological change.

Results of interventions

Although generally the aim is abstinence from gambling, there is a growing focus on harm reduction, which can include controlled gambling. There is also the difficulty of verification of the behaviour change. In measuring outcomes, there is reliance on self-report by the gambler due to the lack of unambiguous symptoms for problem gambling which might otherwise enable objective assessments. For this reason a more appropriate measure of outcome status may be to gauge peripheral issues, as well as any self-reported gambling behaviour changes. Some approaches have been to seek feedback from other family members in order to verify changes. There

are some advantages and disadvantages here. Disadvantages are that the client may see their family as 'checking up' on them, or policing them, and this may not improve family interactions. Advantages are that a truer picture may be gained, since sometimes problem gambling clients are less able to monitor their improvements, especially as they develop increasing awareness of its costs. For example, the programme at McGill has found that "interestingly, for many youth, once gambling has stopped depressive symptomatology actually increases as youth report that their only source of pleasure, excitement and enjoyment has been eliminated" (Gupta & Derevensky, 2000, p.327).

This depression increase may in fact be an artefact of recovery and its relevance could be countered by an appropriate additional question when used as part of an outcome assessment. If the depression is persistent and related to a gambling lifestyle, this may also indicate the need for greater emphasis on the development of alternative lifestyle goals, further addressing of underlying issues to avoid relapse, and the need for cognitive restructuring.

Outcome measures

McGill's outcome measures focus on a six-month abstinence period with zero scored on a DSM-IV scale for youth, a healthy lifestyle measured by developing non-gambling friends and improved school grades, improved relationships with family and peer group, lack of depression or lack of excessive use of alcohol or drugs, and absence of delinquent behaviour (Gupta & Derevensky, 2000).

Currently baseline and post-treatment measures are being recorded from clients presenting at a large New Zealand specialist gambling treatment provider. Measures include depression, anxiety, anger, alcohol and other drug use, and motivation, as well as gambling behaviour (Sullivan, 2003).

Abstinence from gambling is not a requirement for participation in the study. The feedback from others is not necessary, unless the need is to validate the client's responses for programme development reasons. Certainly self-reported improvements in grades, socialisation and behaviour are important; however one should also be aware that clients that continue to attend programmes may not be representative of the problem gambling (adolescent) population, and may be motivated to change their behaviour with or without the assistance of a counsellor.

Hence effectiveness may be demonstrated by increases in the number of adolescents that present to generic and specialist problem gambling services, as well as the numbers of adolescents who continue to remain in treatment.

Conclusion

Adolescents are not accessing problem gambling treatment providers in New Zealand or elsewhere in proportion to the prevalence of their gambling problems. An approach to remedy this disquieting fact for a recognised group of higher problem gambling risk individuals seems imperative. A holistic approach appears to be appropriate, starting with early education and recognising factors that may place adolescents at greater risk. Screening for and addressing issues that are also adult concerns appears to be appropriate. In addition, however, knowledge of and addressing stressors that are associated with developmental stages of an adolescent's life will be necessary, as will information around the gambling process itself, and the chances of winning. A structured assessment will ensure that most issues are covered, without a focus on gambling pathology. Delivery of a programme that incorporates adolescent culture and an understanding of technology, and involves family/whanau where possible, may be important to ensure that relevance, support, and a sufficient therapeutic connection exists. As electronic technology in accessing and the delivery of gambling increases, a field that many adolescents are comfortable with, so may the disproportionate numbers of adolescent problem gamblers increase. Services incorporating the elements described above may help to remove barriers to adolescents seeking help for gambling problems, encourage early help seeking, and improve outcomes for adolescents experiencing gambling problems.

Figure 4.1. Eight Screen-Y

Gambling is an entertainment that most adults enjoy, whether it's Lotto, playing the horses, gambling machines, or even going to a casino.

Young people can often access gambling, and as with some adults, it can become increasingly important in our lives.

Sometimes it can also start to affect our health.

To help us check your well-being please answer the questions on page 69 as truthfully as you are able from your own experience:

1. Sometimes I've felt down or stressed out after gambling.
 yes, sometimes no, never
2. Sometimes I've felt bad about the way I gamble.
 yes, sometimes no, never
3. When I think about it, gambling has sometimes caused me grief.
 yes, sometimes no, never
4. Sometimes I've found it better not to tell people, especially my friends, about the amount of time or money I spend gambling.
 yes, sometimes no, never
5. I often find that when I stop gambling I've run out of money.
 yes, sometimes no, never
6. I often feel like going gambling again to win back losses.
 yes, sometimes no, never
7. Some people have put me down about my gambling in the past.
 yes, sometimes no, never
8. I have tried to win the money that I owe others.
 yes, sometimes no, never

Scoring

Four 'yes' responses suggest that the adolescent is experiencing gambling problems. A score of three 'yes' responses can indicate hazardous gambling that may develop into problem gambling.

If positive, enquire if the responses reflect their current situation.

Table 4.1: Participation by students in modes of gambling during the 12 months previous to the survey (Sullivan & Beer 2001; n=525; 19 data missing) compared with gambling by the general population of New Zealand (Department Internal Affairs 2001; n=1,500)

Gambling mode	Students (Sullivan & Beer 2001) (n=525)	General population (Dept Internal Affairs 2001) (n=1,500)
Lotto	35%	75%
Instant Kiwi (all students)	35%	48%
Instant Kiwi (students under 16 years of age)*	32%	48%
Telebingo (TV Bingo)	13%	20%
Daily Keno (Bingo card)	7%	6%
Cards for money	24%	5%
0900 telephone gambling	7%	3%
Sports gambling**	17%**	8%
Track gambling	7%	17%
Internet gambling	4%	1%
Casino	5.5%	16%
Gambling machines	10%	18%

*Instant Kiwi was restricted to those 16 years of age or over until the Gambling Act 2003, which restricted participation to those 18 years and over.

**Sports gambling responses were not restricted to legal gambling through the TAB, as was the comparison general population survey.