LETTER TO THE SECRETARY, DEPARTMENT OF HEALTH AND MENTAL HYGIENE

December 31, 1990

The Honorable Adele Wilzak, Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Madam Secretary:

Enclosed is a copy of the Final Report of the Task Force on Gambling Addiction in Maryland. On behalf of the Task Force, we request your urgent review of its findings and recommendations.

As charged, this report discusses the prevalence of problem gambling in Maryland, its economic and social costs to the citizens of the State, the current state of responses to the problem, and the relationship between pathological gambling and other psychiatric and addictive disorders. The Task Force recommends specific steps to better coordinate, add to and effectuate state, local and private sector responses to this problem. It suggests alternative funding resources to support and expand gambling specific-programs.

The original research undertaken by this Task Force indicates that the policy of treating addicted gamblers under the same roof as other substance abusers may be inappropriate. The study reveals that there is an inverse relationship between severity of gambling addiction and abuse of alcohol and other drugs. Although gamblers report histories of substance abuse, those individuals whose gambling addiction is most severe are not currently abusing substances. Certain characteristics make gambling addiction different from other substance abuse addictions, and we believe those differences cannot be adequately addressed solely by employing the treatment model for traditional addictions.

This report strongly recommends that the network of counselors and therapists at state-sponsored community mental health centers and substance abuse treatment programs be clinically trained to recognize and diagnose problem gambling as a front-line approach, but refer such patients for intensive gambling-specific treatment to specialized programs and, possibly, then monitor the necessary aftercare.

In addition, this report recommends the establishment of a Legislative Advisory Commission on Gambling Addiction and the creation of a new Office on Gambling Addiction within the Department of Health and Mental Hygiene to monitor the potential adverse health effects of gambling on the citizens of the State and assist in appropriate responses.

Although the Task Force is now officially terminat-

ed, the co-chairs and its individual members remain committed to assist you in the execution of these recommendations.

We thank the Secretary for the opportunity to develop and present this report. If you have any questions or need additional information, please do not hesitate to contact us.

Sincerely yours,

Valerie C. Lorenz, Ph.D

Robert M. Politzer, Sc.D.

Co-Chairs
Maryland Task Force
on Gambling Addiction

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INTRODUCTION

Fact Sheet

Untreated pathological gambling costs Maryland billions of dollars, and affects hundreds of thousands of lives

There are 50,000 pathological gamblers in Maryland

There are another 80,000 problem gamblers in Maryland

Pathological gamblers cost Maryland and its citizens about $1.5 billion annually in lost work productivity and embezzled, stolen or otherwise abused dollars

The total cumulative indebtedness of Maryland's pathological gamblers exceeds $4 billion

Over 850,000 people in Maryland are affected by pathological gamblers (i.e., 17 people for each gambler)Selected Comments of Survey Respondents

"We are on the verge of a real crisis in this country with the widespread acceptance and dependence on gambling."
-- a GA survey respondent

"Gambling is a devastating disease, as overwhelming as cancer, but nobody talks about it. People don't realize the many forms of gambling or how insane the disease is. Some people can ruin their lives even on lottery tickets or bingo. It isn't just Las Vegas or Atlantic City."
-- a GamAnon survey respondent

"Gambling is a terminal disease -- it is a family disease that progressively kills each and every member of the family."
-- a GamAnon survey respondent

"We need more public awareness of gambling as an addiction, and financial support for education and rehabilitation of those affected."
-- a GA survey respondent

"We need support services, family counseling, crisis intervention and follow-up, social and mental health services."
-- a GamAnon survey respondent

"For me the gambling addiction was the strongest of my three addictions -- alcoholism, drug addiction and compulsive gambling. The gambling brought me to my knees and I questioned my sanity."
-- a GA survey respondent

"The damage that gamblers do spreads far wider than just the direct family members. Much more white collar criminal activity goes on than is made public. My own opinion is that the gambling illness is looked at as a weakness as opposed to a sickness that can be treated."
-- a GA survey respondent

"Have as much advertising for treatment as they do for the state lottery."
-- a GA survey respondent

Establishment and Purpose of the Task Force

In December 1988, Lloyd Sokolow, Ph.D., then director of the Alcohol and Drug Abuse Administration, became concerned that compulsive gambling might constitute an under recognized health problem in Maryland.

Dr. Sokolow invited about 15 people, ranging from researchers and gambling treatment providers from private programs, to legislators, reporters and lay people, all with some exposure to compulsive gambling, to look into the situation in Maryland. Most responded positively and enthusiastically. Others offered to help, but could not commit themselves to what was expected to be six months of monthly meetings.

The charge to the group, which met for the first time in January 1989, was to help determine appropriate state responses or policies, if, indeed, such responses were warranted.

Dr. Sokolow asked the Task Force to review the following items:

1. A definition of the current compulsive gambling problem in the State of Maryland;

2. The current state of responses to multiple problems in prevention, treatment and law enforcement areas;

3. Goals needed to better organize, coordinate, add to, and effectuate these responses;

4. The specific steps and conditions necessary to achieve these goals;

5. Determination of funding resources to support and expand gambling-specific programs;

6. The relationship between pathological gambling and other psychiatric and addictive disorders;

7. Appropriate local, state, and private sector responsibility with respect to these responses; and

8. Such matters which the Task Force might consider relevant and appropriate to its mission.

Membership of the Task Force

Co-Chairs

Robert M. Politzer, Sc.D.
Director of Research

Washington Center for Pathological Gambling
3700 Berwyn House Road
College Park, MD 20740
301-443-5794 (workday);
301-345-6623 (Center)

Valerie C. Lorenz, Ph.D.
Executive Director National Center for Pathological Gambling, Inc.
651 Washington Blvd.
Baltimore, MD 21230
301-332-1111
Liaison

William B. Lowry, Jr.
Department of Health and Mental Hygiene, Alcohol & Drug Abuse Administration
201 W. Preston St.
Baltimore, MD 21201
301-225-6873
Secretary

Ralph B. Duane
Businessman and compulsive gambling peer counselor
Brookeville, MD
Psychiatric Consultant

Eugene M. Caffy, M.D.
Veterans Administration Board of Veterans Appeals
Bowie, MD
Statistical Consultant

Robert A. Yaffee, Ph.D.
Academic Computing Facility,
Courant Institute for Mathematical Sciences
New York University

Membership of the Task Force (continued)

Members

Clark J. Hudak, Jr., ACSW
Director, Washington Center for Pathological Gambling
College Park, MD

Christina R. Schauble, B.Sc.
Writer/Editor
Baltimore, MD

Joseph Ciarrocchi, Ph.D.
Director, Addictions Services
Taylor Manor Hospital
Ellicott City, MD

Alternate for J. Ciarrocchi:
Joanna Franklin, M.S., CAC
Taylor Manor Hospital

Richard Richardson

Maryland Council on Compulsive Gambling, Inc.
Baltimore, MD

Richard L. Feldman, LCSW
U. S. Probation Office
Baltimore, MD

Robert G. Goodman, B.Sc.
Glenwood Life Drug Treatment Center
Baltimore, Md

Thomas T. Truss, Ph.D.
Clinical Psychologist
Annapolis, MD

Judy Mulcahy
Community Member
Bel Air, MD
Special Volunteers

Barbara Turner
Maryland Gazette
Glen Burnie, MD

James Blumner, Esq.
Community Member
Baltimore, MD

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For distributing, collecting and encoding data in the surveys of Gamblers Anonymous and GamAnon members and for voluntarily recording, editing and distributing the minutes of Task Force meetings: Ralph B. Duane;

For his extensive analysis of the various data available to the Task Force, his skills in bringing the "dry figures" to life,

and his donated time: Robert A. Yaffee, Ph.D.;

For their authorship of the principal sections of this report and its appendices: Valerie C. Lorenz, Ph.D., Robert M. Politzer, Sc.D, and Robert A. Yaffee, Ph.D.;

For their additional contributions to the writing of this report: Christina R. Schauble and Joanna Franklin; and

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Work of the Task Force

The first meeting of the statewide Task Force on Compulsive Gambling was held on January 17, 1989, at the Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore. Members spoke of the range of their knowledge and interest in the subject of gambling addiction. Some of these Task Force members had been part of the original professional counseling and research team a decade earlier when Maryland established the nation's first residential center for the treatment of compulsive gamblers. They, and the other Task Force members, were aware that other states have surpassed Maryland's efforts in responding to compulsive gambling treatment needs.

Members were also aware that the National Institute of Mental Health was funding an epidemiological study into the prevalence of compulsive gambling in Maryland and four other states.

The membership of the Task Force realized they had a broad subject area to study, encompassing the scope of the compulsive gambling problem and its repercussions, analyzing what is being done and what ought to be done, and recommending funding resources. Compulsive gambling in Maryland is still not commonly recognized as an illness, similar to, yet unlike, other forms of addictive behavior. Compulsive gambling in Maryland involves both legal and illegal forms of gambling. Although state law forbids gambling absent a permissive local ordinance, and thus the state may be said to have a policy against gambling, numerous counties have persuaded the Legislature to grant exceptions. These counties have legalized slot machines and casino nights. There is no uniform state policy. Thus, the Task Force considered its role to collect and compile, as well as to disseminate information to major decision-makers, legislators, judges and the general public regarding these inconsistencies and needs.

The Task Force continued to meet each month, alternating meeting sites among the Health Department, the Washington Center for Pathological Gambling in College Park, Taylor Manor Hospital in Ellicott City, and The National Center for Pathological Gambling in Baltimore, until May 1990, when the final report was in preparation. During that time, it changed its official title to "Task Force on Gambling Addiction," which it felt was more readily understood than terms like pathological gambling or compulsive gambling. The Task Force had no official standing other than as an ad hoc advisory group to the Alcohol and Drug Abuse Administration. Members volunteered their time and services.

Originally, the Task Force was anticipated to have a life expectancy of six months. However, early on the members agreed to identify the problem of gambling addiction in Maryland in terms of demographics and statistics. They believed statistical analysis should not only include estimates of numbers of addicted gamblers, but also figures on how the community is affected by them -- a social and economic cost.

In order to obtain valid data, the Task Force agreed the only realistic method available to them was to extrapolate from existing data. This meant drawing a profile of the compulsive gambler through the patient data and questionnaires used by the private

therapists. In addition, the National Center for Pathological Gambling had records of telephone calls to its Compulsive Gambling Hotline (1-800-332-0402).

The Task Force also agreed to obtain data from individual members of the self-help groups Gamblers Anonymous and GamAnon. (The groups themselves do not participate in or endorse such surveys.) The Task Force developed two research surveys which would fill in some of the gaps from the patient and telephone data. The report of a pre-test of the survey with a limited number of GA and GamAnon members revealed that the survey took four to ten minutes to complete, was well-received, and generated interesting comments. GA members were concerned about maintaining confidentiality of participants. The Task Force agreed to proceed with the survey, but destroy the questionnaires as soon as statistical analysis was completed.

At the July 1989 meeting, the Task Force agreed to send all patient data and survey data to Robert A. Yaffee, Ph.D., a prominent computer and statistical analyst who has worked on other research projects in the field of compulsive gambling. Dr. Yaffee agreed to donate his time.

Compiling and coding the available information was a lengthy process. The patient data had to be culled for information on Maryland residents only. Some specificity of data were lost; for instance, one treatment program used a range for income -- $15,000 to $20,000, and another used the actual amount, $17,250. Thus, to be able to use the data, it was necessary to translate some of it into broader terms. Data were available from almost 300 compulsive gamblers. Similarly, coding and checking for accuracy of the information from the nearly 100 GA surveys and the 23 GamAnon surveys took many more hours than originally anticipated.

While Dr. Yaffee was developing a unique statistical approach to the information, the National Institute of Mental Health/Volberg prevalence study was completed and released. That information was not only included in the Task Force study, but further expanded and analyzed. The information gleaned from the different sources began to outline a profile of a Maryland compulsive gambler which sometimes confirmed and sometimes surprised the professional therapists on the Task Force. For instance, it challenged the concept of dual addiction. The most severely addicted pathological gamblers were not concurrently abusing other substances; the gambler who is embroiled is not engaging in escape through the abuse of other substances.

Finally, the Task Force had hoped to hold a public hearing in order to have community input, so that compulsive gamblers and their victims could tell their stories and that gaming interests, such as the state lottery, racing industry and bingo parlors, could present their views of gambling. However, the Task Force had no budget in order to arrange such a hearing. Task Force members concurred that such a hearing, and more study, is needed.

The following conclusions and recommendations are made by the Task Force on Gambling Addiction.

CONCLUSIONS AND RECOMMENDATIONS - SUMMARY

CONCLUSION 1: The Task Force recognizes that the problem of gambling addiction is on a disturbing rise in Maryland. The prevalence of pathological gambling is conservatively 1.5 percent of the adult population or about 50,000 addicted gamblers. These figures represent a near doubling of the estimated prevalence in the mid-1970s. An additional 2.5 percent or 80,000 people are problem gamblers. Although Marylanders suffer from other health problems, such as alcohol abuse, intravenous drug abuse and AIDS, public policy at the federal, state and local levels has addressed these latter issues. In contrast, solutions to the problem of the present rise in gambling addiction have not kept pace with the increased availability of legalized gambling or the increased legitimization of previously illegal forms of gambling and their subsequent promotion.

RECOMMENDATION 1: The State Legislature, the State Department of Health and Mental Hygiene, and the gambling industry should work together to address the adverse effects of gambling addiction on the citizens of the State. In 1978 the State of Maryland, in House Bill 1311, recognized the social responsibility to help those who are suffering from gambling addictions. The Task Force recommends that the State of Maryland re-acknowledge its social and economic commitment to this task.

CONCLUSION 2a: Most pathological gamblers note that as teenagers they were exposed to an addicted person as their role model. Recent data on treatment of addicted gamblers reveal that gambling onset is beginning at an earlier age.

CONCLUSION 2b: Although no substance is ingested by the addicted gambler, a substance is nevertheless abused -- money. Since the acquisition of gambling funds involves the manipulation of many individuals, the abuse of money for gambling renders many citizens victims of this disorder.

CONCLUSION 2c: Since the substance abused by the addicted gambler is money, over many years, gambling addiction is the most expensive addiction per addict known to society, costing Maryland citizens approximately $1.5 billion annually. Although addicted gamblers have had histories of stress-related disorders which have been costly to treat, gambling addiction is a purely psychological disorder for which appropriate treatment is relatively inexpensive and which does not require extensive medical intervention. Since no substance is ingested, addicted gamblers can maintain their addiction for long periods without discovery. This "silent" addiction is a severe burden to work productivity as the gambler pursues gambling and obtaining money at the expense of gainful employment. Thus, appropriate intervention for the primary and secondary prevention of gambling addiction is inherently cost-effective.

RECOMMENDATION 2: Health education of elementary and high school students currently includes significant information on alcohol abuse and other illicit drug abuse; it should also include gambling addiction. The State Department of Health and Mental Hygiene should work with the Department of Education, the school districts and their superintendents to include in the curriculum in appropriate grades information about the disorder, its

early detection and its prevention.

CONCLUSION 3: The study of gamblers attending Gamblers Anonymous revealed that the common notion that many gamblers abuse alcohol at the same time they are gambling, is not accurate. Those individuals suffering currently from gambling addiction and who report an alcohol abuse problem have previously learned to cope with their alcohol abuse -- perhaps they have already sought treatment. Moreover, addicted gamblers in treatment show a similar negative relationship with drug abuse. Although some elements of treatment for traditional addictions apply to gambling addiction, the treatment model for traditional addictions is insufficient for treating pathological gambling. Therefore, addictions counselors and other therapists whose patient populations comprise substance abusers as well as patients with gambling addiction cannot rely solely on the traditional substance abuse treatment model as an analog for gambling addiction. Furthermore, referrals of patients with gambling problems to drug or alcohol treatment programs when they do not have a drug or alcohol problem might be analogous to putting a cast on an arm when the patient has a broken leg. It is a disservice to the patient, the community, and the health profession to send a compulsive gambler or family member to a mental health treatment provider not specifically trained in treating this very complex psychiatric disorder.

RECOMMENDATION 3a: The Department of Health and Mental Hygiene should require that all therapists and certified addictions counselors in state-certified community mental health centers and state-certified substance abuse treatment programs receive, as a condition of certification and licensure, comprehensive training in gambling addiction. Both conventional training programs leading to certification and continuing education programs for practitioners should include this training. At a minimum, the training should include a definition of the problem of pathological gambling, an explanation of the unique interaction of addicted gamblers and their gambling environment, an understanding of the victimization of family and community, and a thorough knowledge of appropriate referral sources -- including the self-help groups of Gamblers Anonymous and GamAnon. A multi-disciplinary team of experts in gambling and gambling addiction with direct experience with problem gamblers in the clinical setting should administer this training.

RECOMMENDATION 3b: The Department of Health and Mental Hygiene should create a network of mental health providers and programs that can effectively address gambling addiction by recognizing problem gamblers, referring them to specialized centers for intensive treatment directed towards gambling addiction, and monitoring their ongoing aftercare.

RECOMMENDATION 3c: The State Legislature should mandate that the Department of Health and Mental Hygiene establish a separate Office on Gambling Addiction, with its own director, staff, goals, and budget, independent of the Alcohol and Drug Abuse Administration. This office would serve as a central focus to monitor the

proliferation of gambling in the state and its potential health effects, oversee and direct establishment and certification of gambling treatment programs, develop educational programs for the certification of practitioners, and conduct research and evaluation.

RECOMMENDATION 3d: The Maryland Legislature should create a permanent State Advisory Commission on Gambling Addiction to appropriately advise the Department of Health and Mental Hygiene on the establishment of the proposed Office on Gambling Addiction, and on other matters relating to the potential adverse health effects of gambling. This Commission should include members of the Legislature, Department of Health and Mental Hygiene, the Office of the State Attorney General, law enforcement, the different gambling industry components, the gambling treatment programs, religious groups, and public educators, among others. This Commission should meet at least quarterly and should receive an appropriation from the Legislature.

RECOMMENDATION 3e: In order that citizens of Maryland who suffer from gambling addiction may receive proper treatment at bona fide gambling addiction treatment programs, the Department of Health and Mental Hygiene, working together with the Commissioner of Insurance and the independent third party payors, should cooperate in making available, as part of standard health insurance packages, provision for the treatment of pathological gambling. Such benefits should be at least comparable to those provided for other addictive behaviors and mental health problems, and should allow for treatment on an inpatient and outpatient basis.

RECOMMENDATION 3f: The Department of Health and Mental Hygiene should work with the State Legislature to establish a fund to pay for treatment for those problem gamblers and their families who have limited or no health insurance and lack the means to pay for treatment. The Department of Health and Mental Hygiene, Office on Gambling Addiction, would dispense these funds on a case-by-case basis to compulsive gambling treatment programs providing treatment to these patients and/or their families. Programs would be held fiscally accountable. Addicted gamblers in recovery would be required to repay these funds, in whole or in part, as a part of their treatment/restitution plan.

RECOMMENDATION 3g: Gambling addiction produces signifi-cant losses to worker productivity. Because it can serve as a role model to private employers, the Department of Health and Mental Hygiene should initiate an intervention program specific to gambling addiction for its own employees. In addition, the permanent State Advisory Commission on Gambling Addiction should supplement the efforts of the Department of Health and Mental Hygiene by pursuing all potential public and private funding sources for prevention, treatment and research to reduce loss of work productivity.

CONCLUSION 4a: The extent of the public health problem of gambling addiction only begins with the addicted gambler. Unlike other addictions, problem gambling can only be sustained by the continued bilking of many companies and individuals over long periods of time. Thus the network of victims of this disorder progressively encompasses family, friends, clients, employers, banks, insurance companies, credit card companies, and social welfare systems. Intervention at the secondary level must be directed at the continued victimization.

CONCLUSION 4b: The study of members of Gamblers Anonymous revealed that those pathological gamblers whose gambling debt relative to their income was highest, tend to abstain from alcohol, tend to gamble in casinos, tend to seek public assistance, and report that they considered or attempted suicide. Thus, addicted casino gamblers cost society not only in the amount of money they obtain from friends, family and others, far in excess of their own resources, but also in social costs when they turn to public assistance or attempt to take their own lives.

RECOMMENDATION 4a: The Department of Health and Mental Hygiene should work with the State Advisory Commission on Gambling Addiction to persuade the legislature to impose greater restrictions on credit and lending; in particular, betting on credit should not be extended to any type of gambling, including bingo, casinos, horse racing, lottery, slot machines, and other forms of gambling.

RECOMMENDATION 4b: The Departments of Health and Mental Hygiene and Human Resources should promote public education and prevention programs to stem the continued victimization of spouse and family. Courses on marital relationships, effective communication, family relationships, assertiveness training and household budgeting are appropriate in educating about gambling addiction.

RECOMMENDATION 4c: The Department of Health and Mental Hygiene, through its Office on Gambling Addiction, should initiate public service announcements and other advertisements with warnings about gambling addiction at all legal gambling establishments including, but not limited to, bingo halls, charitable casinos, lottery vendors, race tracks, establishments with slot machines, and buses that transport Marylanders to casinos in Atlantic City.

RECOMMENDATION 4d: The State Legislature should require lottery, racetracks, bingo parlors, and any other forms of gambling entities that advertise in Maryland or promote its games, to spend five percent, or an alternate percentage, of its advertising on caution messages, e.g. "Bet with your head, not over it" or "Help is available for those with a gambling addiction" or "Social gambling is fun for most, but for those who cannot gamble in moderation, it may be devastating." (This is similar to the public relations work that the liquor industry uses in its advertising.)

CONCLUSION 5a: Further analysis of the prevalence of problem gambling in Maryland revealed a significant problem among non-whites in Baltimore City, Baltimore County, and Prince Georges

County. It is clear from the treatment data, the Hotline data, and the results of the Gamblers Anonymous survey of the Task Force that the limited treatment now available is not reaching the non-white community.

CONCLUSION 5b: Other data reveal that female problem gamblers also are not being reached.

RECOMMENDATION 5: The Department of Health and Mental Hygiene, with the assistance of the State Advisory Commission on Gambling Addiction, should establish a network of care providers for the treatment of minority and female problem gamblers. Care providers in existing community mental health centers, pastoral counselling centers, domestic violence centers, and community based organizations that already treat chemical dependency and other health problems should be adequately trained to recognize problem gambling, especially in non-whites and women. Counselors and therapists as well as local community workers should be recruited and trained to diagnose and refer minority and female patients with gambling problems to treatment centers. Existing treatment programs for problem gambling within the state should be approached to organize and establish cross-cultural training programs for therapists and counselors.

CONCLUSION 6: The examination of patient data collected by the treatment programs in Maryland revealed that information is lost when data are not comparably compiled.

RECOMMENDATION 6: The Task Force agrees that patients would be better served if a uniform instrument were available for research purposes. The Office on Gambling Addiction, with assistance from the State Advisory Commission on Gambling Addiction, should develop a uniform patient data collection instrument for use by treatment programs throughout the state. This uniform coding should be required of all state-supported gambling treatment programs.

PATHOLOGICAL GAMBLING

Compulsive gambling is the layman's term for "pathological gambling." Twenty years ago compulsive gamblers attending Gamblers Anonymous (GA) typically were white, middle aged, middle-class men (Livingston, 1974, Custer, 1977). Today a compulsive gambler may be a teenager or a retired senior citizen, male or female, a businessman, blue collar or white collar worker, military member, student or housewife, of any level of socioeconomic status, highly educated or illiterate, of any racial or ethnic group, or of any religious inclination. In short, many groups are represented in Gamblers Anonymous.

Compulsive gamblers in the past most often were casino, racetrack or sports bettors, with more than an occasional stock, options, or commodities gambler. Currently, however, trends identify younger and older compulsive gamblers, and more women, underemployed, and lower socioeconomic status level players, many

of whom are addicted to either poker machines, lotteries, bingo, or a combination of these forms, such as poker machines and the lottery (Lorenz, 1984). In Maryland, which recently legalized slot machines in some jurisdictions, the first slot machine addict was reported a few months later. Slot machine addicts also appear to be more common among military personnel stationed in Maryland.

For some as yet unknown reason casino, racetrack and sports bettors appear to be able to maintain their gambling behavior for many years at a controlled level, before eventually succumbing to the chronic and progressive urges to gamble which lead to loss of control and fully established mental illness.

This final stage may be the last two to five years of the illness, marked by repeated attempts to stop gambling, illegal acts to support the addiction and to pay off debts, attendance and dropping out of Gamblers Anonymous, and "bottoming out" financially, physically, and emotionally. One possible explanation of this ability to "stay in action" longer may be the gambler's greater access to money; however, this is not yet supported by strong data.

Slot machine, poker machine, lottery and bingo addicts tend to "bottom out" in less time than other types of gamblers, usually within two to three years of starting to gamble on this particular gambling activity. A possible reason for this may be attributed to this latter group having less money from the onset. It takes money, after all, to support the gambling addiction. Another possibility may be that slot machine, poker machine and bingo addicts resort to these forms of gambling more as a means of avoiding painful issues in their lives, rather than in the hopes of winning large sums of money with which to solve their problems.

However, regardless of the form of gambling or length of time involved, the legal and financial problems, medical and mental health complications, and impact on the gambler, family member, employer or community, makes pathological gambling a devastating, costly illness -- but one which is treatable and preventable (Lorenz, 1988, 1989; Lorenz & Yaffee, 1986, 1988, 1989).

Types of Gamblers

In confronting the problem of compulsive gambling, it is important to be able to differentiate between types of gamblers. Basically, there are four types of gamblers. Most frequent is the Social Gambler, who gambles for recreation or diversion from everyday stresses. Losses are viewed as entertainment, and gambling does not interfere with normal family, social or vocational interests, with the gambler's physical or emotional health, or with the gambler's sense of values. Should the gambling interfere, the social gambler will limit the gambling in terms of frequency, time and money wagered, or turn to an activity which causes fewer problems and is more rewarding.

Examples of social gambling are betting on a Super Bowl game, a weekly poker game, or buying a daily lottery ticket. Frequency and amount are not the issue; rather, it is the gambler's reason for gambling and his or her ability to control the gambling that distinguishes among the types of gamblers.

The Professional Gambler views gambling as a business, earning his livelihood from gambling. The gambling is disciplined and controlled, with losses being carefully studied to minimize their recurrence. Wins, too, are carefully analyzed in order to increase the profit margin. The professional gambler does not seek to avoid emotional pain through gambling.

Some examples of professional gamblers are stock brokers, professional card players, such as "Amarillo Slim" and Kenny Huston, and dealers in gambling houses. These are persons who often gamble with other people's money, who may be staked by supporters, and who would not use the second mortgage on their own home to support the gambling or the industry. Nevertheless, the professional gambler is often at risk of losing control of his gambling and becoming a compulsive gambler.

The Criminal Gambler gambles to make money, even if this includes cheating or swindling, alone or in conspiracy with others. Losses are usually blamed on others and cheating is justified. Losing or cheating does not result in feeling guilty or remorseful; rather, it increases the criminal gambler's tendency to blame others for his misfortune and to seek revenge.

This type of individual develops problems early on in life with physical and sexual aggressiveness, poor school performance, truancy, lack of acceptable social skills, an inability to sustain close personal relationships, association with fringe groups, and a history of poor work performance.

The criminal gambler is usually well known to juvenile authorities and law enforcement agencies, being a "client" of these systems generally starting in childhood or adolescence, being in and out of foster homes and juvenile detention centers. Gambling is only one of his many socially unacceptable or illegal activities.

From a clinical perspective, this person most often may be diagnosed as suffering from Anti-Social Personality Disorder and may be labelled as a sociopath. Bookies and loan sharks often fall into this category. Recent data support the belief that some sociopaths may also become addicted to gambling.

The Pathological Gambler can be described as an individual who is above average in intelligence, honest, energetic, competitive, creative, athletic, hard working and motivated to achieve -- a citizen with a solid set of values concerning law and order, health, family, job and country.

Typically the pathological gambler is reared in a family environment in which there is a strong emphasis on money. Almost always there is a parental history of pathological gambling, alcoholism, or some other form of serious emotional disorder. The gambler's childhood is marked throughout with inconsistent parenting and discipline, and with a history of physical and/or verbal abuse. There is also a very strong emphasis on the importance of money in these families.

There are other forms of family dysfunction, such as an emotionally distant father and an "overly emotional" mother,

parental separation through death or divorce, or an early sibling death. Emotional deprivations and losses are not addressed, and the gambler fails to go through the natural grieving stages to recover from these traumas.

A history of being sexually abused or molested occurs frequently among male and female pathological gambles. Sexual abuse for them is an issue rarely addressed and even more rarely resolved. Data suggest that males suffered sexual abuse more often by persons outside the family, while females incurred sexual abuse more often by family members.

The Pathological Gambler is emotionally damaged. He or she grows up emotionally immature, a "loner" with poor self-image, lacking in self-confidence and self-esteem, easily bored, and with a low level of frustration tolerance. Many are painfully shy and fear close emotional relationships.

There is virtually always a history of additional painful, frightening or anger-provoking events during later stages of development. These are traumas which are unresolved and which continue to trouble the individual, often leaving the person in a state of dysphoria and vulnerability (Jacobs, 1987; Taber, 1987). Traumatic military experiences compound the pathological gambler's problems.

Gambling, and winning, give the pathological gambler a sense of action and excitement, a sense of confidence and accomplishment. Money and winning are seen as a means of gaining in esteem, attention and power; thus, gambling provides the pathological gambler with the opportunity to avoid facing pain and the harsh realities and discomforts of life.

Through gambling, reinforced by wins and attention from others, the gambler develops irrational patterns of thinking (Gaboury & Ladouceur, 1987). He is convinced of his superior gambling skills and luck. As this delusional thinking becomes more fully developed, the thought processes become marked by denial, rationalizations, self-deceptions, magical thinking and obsessive thoughts of gambling. The gambler fails to realize that he has lost control of his gambling and is unable to resist the urges to gamble. He seeks immediate gratification, without regard for the consequences (DSM IV). He does not view his bets as risky, and experiences less anxiety while gambling than do social gamblers (Kuly and Jacobs, 1988).

For the purposes of this report, the Problem Gambler is a person whose gambling is no longer a recreational pastime or leisure activity. His gambling exceeds his planned limits in time spent, money lost or both. Gambling has passed beyond casual involvement. The Problem Gambler is at risk of becoming a Pathological Gambler.

Clinical Definition

Pathological gambling was categorized in 1979 by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) under Impulse Control

Disorder, Section 312.31. It was updated in the DSM III, Revised, 1985, and has again been revised for the DSM IV.

Essential features of pathological gambling in the DSM IIIR are "a chronic and progressive failure to resist impulses to gamble and gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits. The gambling preoccupation, urge, and activity increase during periods of stress. Problems that arise as a result of the gambling lead to an intensification of the gambling behavior. Characteristic problems include extensive indebtedness and consequent default on debts and other financial responsibilities, disrupted family relationships, inattention to work, and financially motivated illegal activities to pay for gambling" (DSM III-R, 324-325).

As with other addictions, compulsive gambling follows a pattern of progression:

1) Developing a tolerance toward gambling -- that is, gambling longer, more often, and with larger amounts of money in order to obtain that same level of excitement or "high."

2) Developing an intolerance for losing -- the "high" becomes an intolerable "low" as losses occur, resulting in periods of "chasing" losses, making reckless bets with larger amounts of money to recoup losses.

3) Preoccupation with gambling cravings -- gambling becomes an obsession, every waking hour of each day. The strong cravings or urges to return to gambling are reinforced by interpersonal conflict or emotional needs, to feel good and to avoid depression, and by environmental press.

4) Disregard for consequences of gambling or illegal activities to support the gambling -- the pathological gambler is suffering from a psychiatric disorder, which, by definition, makes it impossible for him to think logically, rationally, and sequentially while involved in gambling. In his distorted views of the world, illegal activities committed to obtain funds to support the addiction are seen as "temporary loans" to be replaced by the next win or as the only option available in his desperate state.

Just as nicotine addicts, alcoholics, drug addicts, and people with eating disorders ignore the medical effects of their addiction, so do compulsive gamblers fail to consider seriously the consequences of their actions regarding family or employer, or their illegal activities committed to obtain funds to continue the addiction or to resolve a desperate financial situation.

5) Withdrawal symptoms -- which most often result in headaches, stomach problems, sleep difficulties, and depression.

6) Slips and relapses -- most often after interpersonal conflicts, a constant need for money, or a desire to be a "normal" gambler again.

7) Cross-addiction -- most often becoming workaholic, or developing excessive eating, smoking or coffee habits.

The Stages of Pathological Gambling

Another view of the development of pathological gambling might be described as developing in three phases -- the Winning Phase, the Losing Phase and the Chasing Phase. Each phase may last from a few times of gambling to gambling for several years.

The Winning Phase starts when the casual, social gambler realizes that gambling can become a fast-action, exciting experience. He gambles carefully, studies the horses, teams, cards or numbers, and wins fairly frequently. The gambling is fun, is usually a social activity engaged in with a friend or two, and is a means of relaxing and getting away from daily pressures of work and family.

This phase is usually ended by repeated wins or a "big win," a win of money equivalent to several times one's weekly income, or more. These wins generate in the potential pathological gambler a false sense of optimism concerning luck and skill in gambling. Winning provides a sense of accomplishment: it is a boost to low self-esteem. It gives the pathological gambler new status, confidence, a sense of control and power.

The Losing Phase is generally marked by increased gambling and losses. Although the gambler has experienced a big win, or several big wins, or even a series of smaller wins, he will also eventually experience losses. These losses are very disturbing to the pathological gambler. It is not only a loss of money, but also an upset to a fragile sense of self-esteem. What had been fun is now very uncomfortable, making him feel anxious and depressed. Thus he immediately returns to gambling to rid himself of these feelings. He needs to gamble more often and with larger amounts to regain the previous level of action and excitement.

This stage is associated with attempts to hide the gambling, with lies about absences from home, about income not received, and missing monies, mail, and other ploys. Money is lacking and bills are late in being paid. The gambler may borrow from friends or colleagues hoping thereby to prevent a spouse or other family members from discovering gambling losses.

Personality changes occur such as becoming restless, irritable, defensive and argumentative. The gambler becomes more despondent, feeling guilty about his behavior towards others and angry with himself.

Repeated evidence of money missing and bills not paid on time result in increased arguments. He desperately wants his family to stop harassing him and berating him. Promises of abstinence are made.

The family is convinced that intentions to stop gambling are sincere and will provide the money to pay back loans and past-due bills. Unfortunately, this "bail-out" more often than not will become the first of many bail-outs, both financially and emotionally, by covering up for the gambler, through lies and other deceptions. The spouse or other family member may themselves become co-dependent or enablers of this illness.

Promises of abstinence are well-intentioned but short-lived.

As new pressures occur, as financial problems increase, the urge to gamble becomes stronger. The return to gambling is not with a $2 bet or one lottery ticket, but rather at the level where the gambling was left off previously. The gambling accelerates -- as do losses. The gambler becomes desperate, and starts "chasing" losses, gambling large amounts, recklessly, wagering with all available funds on a long-shot. Thus begins the Chasing Phase.

All thoughts are on gambling, constantly -- which team to play, how much to bet, how to pay off bills, how to get to the phone or track, to the action, how to block out discomforts and pressures.

The gambler borrows until all borrowing options are used up. Checking or savings accounts have long been depleted. Credit cards are overdrawn. Cash value on life insurance policies is spent. Loans from banks and financial institutions are no longer possible, and whatever could have been sold was, in fact, sold long ago.

He knows of only one way to escape from what many gamblers describe as "living in a gray zone, a fog." He needs one more big win -- a win that rides on the next bet, if only he can get the money to make it. He is convinced he will win. He "borrows" -- most often first from the family, then from his employer or elsewhere. Most gamblers start their "borrowing" by writing bad checks, forging a loan application, or using another's credit card.

He may "borrow" once, or he may "borrow" many times. There is no intention to injure anyone but rather, in the gambler's confused state of mind at this time, there is only the thought, "the next bet will come in, and all will be well." If the next bet does not come in, he will have to "borrow" again. He "knows" it is his turn to win; after all, he has done so before, many times. And the wins have been for very substantial sums.

He can't think clearly or concentrate. He is filled with a tremendous sense of anger, guilt, and anxiety. He works harder, but accomplishes less. He has become alienated from his spouse, family, friends and fellow employees. He feels isolated and alone. He may start drinking.

The gambler at this point in the development of the mental illness is also quite ill, physically (Adkins, 1988; Lorenz & Yaffee, 1987). He may briefly consider seeing a doctor, but that would cost money -- money which he needs for gambling.

He suffers physically from multiple somatic complaints. His head hurts constantly. He cannot eat, and often goes two or three days without food. His stomach feels like it is tied in knots, he is constipated or suffers from frequent diarrhea. His chest hurts, as does his lower back and his upper back. He may break out in a rash or other form of dermatitis. His breathing becomes difficult. He cannot sleep soundly, and often finds himself awake all night, suffering from increasing nightmares. At times his fingers or hands feel numb or he cannot lift his leg. He has no more energy.

This formerly honest, intelligent person now has only a very weakened intellectual understanding between right and wrong, of appreciating the consequences of his behavior, of considering that others are being hurt by his actions. But he does know that when

that urge to gamble comes upon him, he is virtually powerless. He is unable to fight off that urge.

Some believe the only way out of the desperation and turmoil is to commit suicide. Research studies on compulsive gamblers indicate that almost 25% have attempted suicide (Custer & Custer, 1987). Others have felt incredibly relieved after being arrested. The long, desperate struggle is over.

Finally the gambler "hits bottom." Some may need to be hospitalized, either for depression, suicidal ideation, or any of the physical complications resulting from years of stress, anxiety, abuse, neglect or malnutrition. Others need to be removed from the environment to prevent further illegal activities. Withdrawal symptoms similar to those of alcohol or drug withdrawal may occur.

It is only after a period of abstinence that the compulsive gambler begins to recognize the irrationality of his behavior. It is not uncommon to hear a compulsive gambler in treatment utter over and over again, "I can't believe I did this, I can't believe I did this." Or, "My head kept racing, everything was so fast." Or, "My children are teenagers! I remember them as toddlers."

Unfortunately, the first "bottom" may not be the only one. Gamblers may experience several bottoms, with the financial bottom usually being the first. They may remain abstinent for a period of time, repay debts and other financial obligations, but eventually the hopes of "being normal", of being able to gamble responsibly again, will lead them back to the poker table, track, bookie, lottery vendor, or other form of action.

As family or job related stress or money pressures once again build up, the ability to think clearly diminishes. Problem solving skills and communication skills are still poor, and resources are fewer. The one-time slip ("to prove to myself I'm normal") becomes a relapse. Without treatment, not even the fear of a parole violation will suffice to intercept the gambling addiction. An outside intervention is necessary to break the destructive pattern.

Criminal Behavior

Crimes committed by compulsive gamblers vary, but typically are non-violent crimes such as writing bad checks (against insufficient funds, against a closed account, on a spouse's account), floating or kiting checks, forgery, fraud, embezzlement, failure to file IRS returns, submitting false financial statements to obtain loans, or other thefts by deception.

With the democratization of gambling and compulsive gambling, current trends indicate that all types of non-violent crimes are committed by compulsive gamblers during the desperate Chasing Phase, depending on the individual's circumstances. An attorney, for instance, may embezzle a million dollars from clients' trust accounts, a juvenile may steal from a parent's wallet, a housewife may shoplift or forge a husband's name on a credit application, a plumber may falsify invoices, or a businessman may fail to file income tax returns (Brown, 1987; Lorenz, 1984).

As the compulsive gambling population becomes more diverse, it

is anticipated so will the types of crimes. Several cases of bank robbery have been reported, although in almost all instances the weapon was nonfunctional -- a plastic or wooden gun, or a gun without bullets or a firing pin (Lorenz, 1987).

Others may resort to pimping, selling drugs, or prostitution (Lesieur, 1987) or hustling (Livingston, 1974). These numbers are small. Sports bettors may become bookmakers to support their own addiction.

Some will go to jail, where they continue to gamble. Incarceration will not cure this mental illness, and no professional gambling treatment is available within any state, local, or federal penal institution.

Treatment and Recovery

Pathological gambling is a treatable mental disorder. For those gamblers who are in serious distress, inpatient treatment may be indicated. For gamblers who are not suicidal or uncontrollably committing crimes to support their addiction, but who nevertheless are in serious distress or who may be under time constraints, intensive short-term therapy on an outpatient basis appears ideal. Both are followed with outpatient aftercare.

For others, less intensive therapy is sufficient. For all, a combination of individual and group therapy is recommended.

Abstinence from gambling during therapy is essential for recovery. Restitution is an integral aspect of treatment, and commitment to the Gamblers Anonymous program is vital.

The first year of abstinence is the most difficult for the gambler and for the family. In treatment, emphasis generally is first on resolving financial and legal conflicts. Rebuilding family cohesiveness, including developing more effective communications patterns, establishing trust, and rebuilding intimate relationships, is difficult, especially without the assistance of professional help, yet it is necessary to insure recovery.

Different types of treatment have been tried, such as long-term psychoanalysis, paradoxical intention, behavior modification, flooding, and electroshock therapy, or other aversive therapy, with poor results.

Incarceration, too, has been found to have little beneficial effect on overcoming this illness. Gambling in prison is common-place; thus incarceration merely changes the location of the gambling site and the medium of exchange. The compulsive gambler in prison gambles for food, goods or services instead of money (Jarvis, 1988). The illness itself is perpetuated.

Current evidence points to the effectiveness of a mix of psychodynamic, behavior, cognitive and rational-emotive therapy, with a mix of professional therapists and trained peer counselors, for the gambler and immediate family members. Gamblers respond well to therapy in a supportive, open environment, and tend to become defensive and resistant in a locked, psychiatric setting.

A common difficulty with obtaining professional care, however, is the gambler's inability to pay for services rendered. Mental health insurance coverage is inadequate in most instances, and in other cases the gambler may have neither a job nor insurance. Some, who are employed and who may have at least some health insurance, cannot take the time off from work without losing their pay, thus increasing the already severe financial pressures. Others lack the funds or means of transportation to go to a center where treatment may be offered.

Public Health Impact

Lawmakers throughout the nation face the question of whether to legislate state lotteries and other forms of gambling, while opponents argue that legalized gambling has done more harm than good (Indiana Citizens Against Legalizing Gambling, 1985; New Mexico Coalition Against Gambling, 1989). In 1986, state lotteries supplanted casino gambling as the largest American gambling industry, a feat just accomplished by casinos over horse racing in 1979 (Christiansen, 1987). Legislators in several states have looked to physicians, mental health professionals, epidemiologists, and public health analysts for the answers when they seek to determine the public health risks of legalized gambling (Politzer & Morrow, 1981; ICALG, 1985; NMCAG, 1989). One of the consequences of this increased exposure to gambling is the creation of a whole new group of problem or pathological gamblers (NMCAG, 1989).

Several theoretical models have been proposed to explain problem gambling including the medical or disease model (Blume, 1987), the social learning model (Brown, 1987), directive state theory (McCormick, 1987), economic theory (Eadington, 1987), and biological theory (Carlton & Manowitz, 1987). All have significant limitations. The medical model, which locates the source of deviant behavior within the individual, tends to be the dominant theoretical approach that guides our present knowledge (Blume, 1987). However, it is limited in that it focuses only on the agent or condition and virtually ignores the influence of environmental factors. Although social learning theory touches upon the opportunities afforded gamblers by their occupation, leisure habits, and other features of lifestyle, environmental factors are not at its central focus. Economic, directive state, and biological theories also focus primarily on observations of pathological gamblers to explain the phenomenon.

The Epidemiologic Model

The epidemiologic model may be instructive in analyzing alternative strategies to reducing the health risk of pathological gambling. In applying the model to pathological gambling, the host is the gambler, the agent is the action of gambling, and the societal environment in this instance, is comprised of three sectors: family, community, and culture. The three components of the model interact in varied combinations to affect the incidence of pathological gambling, as depicted below.

Agent -- The Gambling Action

The agent is usually described as a substance or entity that is consciously ingested, unintentionally internalized, or directly linked to the change in health status of the host or victim. Recent publicity has focused on such ingestible agents as cholesterol, alcohol, illicit drugs, anabolic steroids, and tobacco. National attention has also focused on the human immunodeficiency virus. The abusive care-giver and a weapon in the hands of a perpetrator could also be considered agents.

For pathological gambling, no substance is ingested, and, unlike victims of abuse or violent crimes, gamblers exert some influence over their interaction with the gambling environment. Pathological gambling has been described as a purely psychological disorder (Custer & Milt, 1984).

Gambling action is the product of wagering on the ambiguous outcome of an event. This ambiguity creates the level of excitement and entertainment. The level of excitement, repetition of events, and extent of postponement of the outcome contribute to the height of action and consequently are the factors that contribute to risk of addiction. The degree of involvement and the setting also contribute to the excitement level. For example, horse racing at the track is viewed as more exciting than horses off track by some gamblers (Commission, 1976). Anticipation of the experience also demands attention and affords an escape from the problems of daily routine (McCormick, 1987).

Host -- The Gambler

The host is usually described as the individual manifesting a detectable change in health status, such as the alcoholic, the HIV-infected person, a person with coronary heart disease, an abused child, a substance abuser, a victim of a crime, a lung cancer patient, an anabolic steroid user. A closer look at the dynamics of the gambling disorder displayed by the gambler who manifests the pathological state reveals other competitive risk factors. In labeling pathological gambling as an impulse disorder, psychiatrists have characterized the host as immature, highly stressed, and depressed (Custer, 1984; Jacobs, 1986). Hence, an underlying psychological imbalance is a necessary risk factor for a potential host to manifest the disorder after obtaining the gambling "action." Experts have stated that the mental health status of the gambler is a significant predisposing risk factor to manifesting the disorder (Taber, McCormick & Ramirez, 1987). Addicted gamblers are loners with low frustration tolerance, easily bored, fear criticism and rejection, who demand immediate gratification and relief, and have low self-esteem and self-image (Lorenz, 1989).

Recent biological findings suggest that pathological gamblers suffer from an addiction like alcoholism. In a study of 22 subjects, it was found that 12 were driven by the need for the thrill which stimulated an under-active noradrenalin-ergic system (Roy & Linnoila, 1989). Some "extreme" gamblers were found to have basic flaws in applying otherwise useful habits of everyday decision-making and displayed difficulty in controlling impulses. Other researchers state that gamblers are victims of beliefs that lead them to overlook the laws of probability (Wagenaar, 1989).

Environment - The Family

The family structure of compulsive gamblers can be considered an environmental risk factor. For example, those families which permit their dominant and unlimited control of family finances are at increased risk of perpetuating the disorder (Custer, 1984). Dysfunctional family development also can be viewed as an environmental risk factor. Pathological gamblers are typically reared with strict but inconsistent discipline, in families which place a strong emphasis on money or materialistic possessions (Politzer & Morrow, 1980). Psychosocial histories indicate that addicted gamblers have experienced several psychological or physical traumas which have not been resolved (Taber, McCormick & Ramirez, 1987).

Researchers are uncertain as to why at-risk individuals choose gambling as their addiction as opposed to other behaviors. They do report, however, that these individuals not only have histories of parental absence or emotional deprivation, but they also have a familial history of gambling addiction, alcoholism or other psychiatric disorder (Ciarrocchi & Richardson, 1989). The addicted gambler is a victim of verbal, physical, or sexual abuse, or some combination (Lorenz & Yaffee, 1986; Ciarrocchi & Richardson, 1989). The gambling usually begins with imitation learning, perhaps copying a hero figure in adolescence, but more commonly learning from one's own social peers (Brown, 1987). Gamblers are inherently competitive and good with figures.

Environment - The Culture, Work, Leisure

The glamorizing and acceptance of gambling would represent a factor of the general societal environment or culture. The publicizing of lottery winners reflects this popularity. Other environmental factors such as work and leisure time activities play a role in the incidence and prevalence of pathological gambling. Experts report that addicted gamblers are often dissatisfied with their current employment (Hudak, Varahese & Politzer, 1989). In addition, credit policies have increased access to money. In essence, credit implies permission to spend someone else's money today to be repaid with interest in the future. This easier access to money places the impulsive, "relief-seeker" with a preoccupation for material wealth at even greater risk.

Researchers argue that the Protestant work ethic, a basic social tenet of our culture, is critically eroded when a government or a citizenry encourages profit or gain through chance rather than through work (Commission, 1976). It seems that we live for the moment and, unlike our forbearers, are quite willing to consume our wealth in immediate gratification. Currently, we save far smaller percentages of our income than we did in the past, even when discounting for inflation (DOC, 1988). Workers are consumers even in leisure when leisure should be escape to genuine opportunities for creative play. Institutional leisure has reduced our opportunities for genuine creative play. We rely on television to provide the creativity. We pay to be spectators and permit others to determine the opportunities for escape. Consequently, it appears that contemporary man is perpetually bored, dissatisfied, and looking for safe risks. These changes in culture have fostered an environment conducive to gambling and, for some, gambling

addiction (Abt et al., 1985).

Other investigators report that the stress of employment, coupled with child-rearing and household responsibilities felt by married women who have recently entered the labor force could explain, in part, the increase in the prevalence of alcohol and other substance abuse among women (DHHS, 1987). Such an explanation could also underscore the increase in the number of female pathological gamblers. One researcher found that female pathological gamblers, unlike their male counterparts, gamble for escape and relief from life's troubles (Lesieur, 1988).

In short, family dysfunction, life experiences, personality characteristics, biochemical imbalance, work dissatisfaction, social mores, and the prevalence of gambling all contribute to the development and increase of pathological gambling.

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