A publication of the Centre for Addiction and Mental Health

Issue 4 May 2001 ISSN: 1494-5185

eGambling

THE ELECTRONIC JOURNAL OF GAMBLING ISSUES

contents ISSUE 4 MAY 01

Submissions

eGambling
THE ELECTRONIC JOURNAL OF GAMBLING ISSUES

Go to Current Issue

intro

Intro
Feature
Policy
Research
Profile
Case Study
First Person
Review
Letters
Submissions
Links
Archive
Subscribe

Issue 4, May 2001

From the Editor

Anniversaries can be exciting, and we are elated that this fourth issue marks our first year anniversary of electronic publishing. One of our goals is to offer international coverage of gambling issues. We are glad to have articles about developments in gambling treatment and policy in Switzerland, northern Cyprus and Australia as well as from the USA and Canada.

A new section for Case Conferences begins in this issue (it's listed in the sidebar at left as **Case Study**). Alex Blaszczynski describes a case from his practice, a client whose severe back pain was relieved by gambling intensely and chasing his losses. Three other clinicians comment on the case and its ramifications for treatment in general, and Dr. Blaszczynski concludes with an overview of the discussion.

This issue presents some new ideas on how gambling can fit into our communities in a healthy manner. One article offers developments in the concept of a public health approach to both help assess the benefits of gambling and prevent and treat its negative effects (Feature; David Korn). Another describes how Swiss gaming policy requires that potential casino operators compete to offer better prevention, treatment and research facilities in order to win the right to run casinos (Policy; Daniela Dombrowski and colleagues). Another article takes the case of poor gaming policy and questions the ability of jurisdictions to manage gaming policy effectively by

examining these issues in a centre-periphery context, that of northern Cyprus (Research; Julie Scott).

I invite readers who enjoy these articles to tell their friends about the *Electronic Journal of Gambling Issues: eGambling*, and I ask those who would like to write to contact me. Please tell us what you think of our journal.

Phil Lange, Editor

E-mail: phil_lange@camh.net

Statement of Purpose

The *Electronic Journal of Gambling Issues: eGambling (EJGI)* offers an Internet-based forum for developments in gambling-related research, policy and treatment as well as personal accounts about gambling and gambling behaviour. Through publishing peer-reviewed articles about gambling as a social phenomenon and the prevention and treatment of gambling problems, it is our aim is to help make sense of how gambling affects us all.

The *EJGI* is published by the Centre for Addiction and Mental Health and is fully funded by the Ontario Substance Abuse Bureau of the Ministry of Health and Long-Term Care. We welcome manuscripts submitted by researchers and clinicians, people involved in gambling as players, and family and friends of gamblers.

issue 4 – may 2001

Go to Current Issue

intro | feature | opinion | research | service profile | first person accounts | reviews | letters | archive | submissions | subscribe | links

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Go to Current Issue

Intro
Feature
Policy
Research
Profile
Case Study
First Person
Review
Letters
Submissions
Links
Archive
Subscribe

feature

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Examining Gambling Issues From a Public Health Perspective

By David A. Korn, MD, CAS, DTPH
Department of Public Health Sciences
University of Toronto
Toronto, Ontario, Canada

E-mail: david.korn@utoronto.ca

Abstract

Public health has a tradition of addressing emerging and complex health matters that affect the whole population as well as specific groups. AIDS, environmental tobacco smoke and violence are examples of contemporary health concerns that have benefited from public health analysis and involvement. This article encourages the adoption of a public health perspective on gambling issues.

Gambling has been studied from a number of perspectives, including economic, moral, addiction and mental health. The value of a public health

viewpoint is that it examines the broad impact of gambling rather than focusing solely on problem and pathological gambling behavior in individuals. It takes into consideration the wider health, social and economic costs and benefits; it gives priority to the needs of vulnerable and disadvantaged people; and it emphasizes prevention and harm reduction.

This paper looks at the public health foundations of epidemiology, disease control and healthy public policy, and applies them to gambling. Major public health issues are analyzed within a North American context, including problem gambling trends amongst the general adult population and youth, and their impact on other specific populations. There is significant opportunity for public health to contribute its skills, methodologies and experience to the range of gambling issues. By understanding gambling and its potential impacts on the public's health, policy makers, health practitioners and community leaders can minimize gambling's negative impacts and optimize its benefits.

Key Words: Gambling, public policy, prevention, public health issues, community health

Competing Interests: none

Introduction

Public health initiatives achieved remarkable successes in the last century, reducing morbidity and mortality from childhood infectious diseases such as diphtheria and measles; identifying modifiable risks associated with heart disease and cancer; and promoting healthy lifestyles and environments. At the beginning of this new millennium, public health has the opportunity to contribute understanding and solutions to a range of complex health and social issues that affect the quality of life of individuals, families and communities. The unprecedented expansion of legalized gambling is one such challenge that can benefit from a public health perspective.

In North America during the early part of the 20th century, most types of gambling were considered criminal, and legal gambling was highly restricted. Recently, an unprecedented expansion of legalized gambling has occurred within a new, expanded public policy framework. The primary driving force behind the explosion of gambling in North America is the economic necessity

of states, provinces and local governments. Organizations in the United States promote the leisure and recreational aspects of gambling, whereas in Canada, the social benefits to charities, non-profit and community service agencies are emphasized (Campbell & Smith, 1998).

Historically, gambling has been understood from moral, mathematical, economic, social, psychological, cultural, and more recently, biological perspectives. Within the health care field, interest has come primarily from mental health and addiction professionals. Until recently gambling was not viewed as a public health matter. (Wynne, 1996; Productivity Commission, 1999; Korn, 2000). The value of a public health perspective is that it applies different lenses for understanding gambling behaviour, analysing its benefits and costs as well as identifying multilevel strategies for action and points of intervention. note 1 Policy makers, researchers and practitioners in the gambling field can incorporate a public health framework to minimise harmful consequences, enhance quality of life and protect vulnerable people.

Why Use a Public Health Perspective?

A public health approach incorporates various elements that make it an attractive frame for addressing gambling issues. It offers a broad viewpoint on gambling in society — not focusing solely on individual problem and pathological gambling. It conceptualizes a range of gambling behaviours and problems at points along a health-related continuum, which is similar to the approach taken in alcohol studies.

Public health goes beyond biomedical and narrow clinical models to address all levels of ***prevention*** note 2 as well as treatment and recovery issues. It offers an integrated approach that emphasizes multiple strategies for action and points of intervention within the health system and community. A public health approach emphasizes ***harm reduction*** note 3 strategies to address gambling-related problems and decrease the adverse consequences of gambling behaviour. It addresses not only the risk of problems for the gambler but also the ***quality of life*** note 4 of families and communities affected by gambling.

Public health action reflects values of social justice and equity, and attention to vulnerable and disadvantaged people. Public health professionals often play an advocacy role or act as a bridge between local citizens and policy

makers on particular issues such as environmental tobacco smoke. One example where they play a similar role is the issue of government gambling policy acting like a regressive tax on lower income socio-economic groups.

Public health agencies exist at municipal, regional, provincial or state and federal levels. They are well suited to developing surveillance systems to track trends in problem and pathological gambling as well as the indicators to monitor social and economic impacts of gambling on communities and population groups. A public health position recognizes both costs and benefits associated with gambling. By appreciating the health, social and economic dimensions of gambling, public health professionals can foster strategies that minimize the negative effects of gambling while recognizing its potential benefits.

Public Health Foundations for Gambling

1. Gambling and Health

Public Health embraces the World Health Organization (WHO) characterization of health as the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change and cope with their environment (World Health Organization, 1984). Health is viewed as a dynamic process and as a resource for living rather than an end in itself. It is a positive concept emphasizing social and personal resources as well as physical capacities. Building on this broad definition, gambling can be conceptualized as either *healthy* or *unhealthy*.

Healthy gambling entails informed choice, including an awareness of the probability of winning, a low-risk pleasurable experience (i.e. legal, safe, regulated) and wagering sensible amounts. Healthy gambling sustains or enhances a gambler's state of well-being. Conversely, unhealthy gambling refers to various levels of gambling problems. This terminology complements the notions of healthy people, families and communities.

2. Gambling and Public Policy

During roughly the same period that gambling was beginning to be seen as health issue in the 1980s and 1990s, there was a growing interest in *healthy public policy*. This expression was embedded in the WHO Ottawa Charter for Health Promotion in 1986, followed by the Adelaide Statement on Healthy Public Policy in 1988 (World Health Organization, 1986; World Health Organization, 1988). Healthy public policy refers to the WHO's thrust that policy initiatives *in every sector* should promote health-sustaining conditions.

In Canada, gambling is regulated under federal law, the Criminal Code of Canada, adopted in 1892. Only governments can "manage and conduct" gaming ventures or authorize charitable gaming under license. Private sector ownership is prohibited. Over the years, periodic amendments to the sections on gambling have permitted its growth, but only since the 1970s have lotteries and casinos been operating legally. In 1985, computer, video and slot devices were legalized and the provinces were given exclusive control of gambling. Stakeholder and social policy groups have raised concerns about the role of government policy in encouraging gambling, while at the same time, protecting the public interest.

3. Gambling and Public Health Research

Public health is the study of the distribution and determinants of health, disease and mortality in a defined population and the of related public policy measures to prevent, eliminate or control its occurrence and spread.. Epidemiology is its central empirical research tool. Prevalence estimates of gambling-related problems in the general adult population have been carried out in numerous North America jurisdictions. Fewer epidemiological reports have described the impact of gambling on vulnerable and specific populations such as youth, women, older adults and Aboriginal people. To date, no Canadian national prevalence study of problem and pathological gambling has been commissioned. There remains a need for research on the incidence of pathological gambling and longitudinal studies on its natural history in gamblers.

A review of existing prevalence studies by the Harvard Medical School Division on Addictions revealed that 152 gambling prevalence studies have been conducted in North America as of 1997, including 35 in Canada (Shaffer, Hall et al., 1999). The estimated lifetime prevalence in the general adult population for problem and pathological gambling combined (levels 2 and 3 in Harvard study nomenclature) was reported at 5.5%. There were no significant differences in prevalence rates between the United States and Canada. Male sex, youth and concurrent substance abuse or mental illness placed people at greater risk of a gambling-related problem. Studies carried out by the United States National Research Council and the National Opinion Research Center at the University of Chicago as part of the National Gambling Impact Study Commission generally support these prevalence estimates (National Gambling Impact Study Commission, 1999; National Research Council, 1999).

4. Gambling, Public Health Theory and Practice

The communicable disease control paradigm of public health is instructive to the gambling phenomenon. It describes the causal factors and interactions of host, agent and environment that contribute to a particular infectious disease, such as AIDS, and the strategies necessary to control its spread (see Figure 1). This model resembles the addictions paradigm of drug, set and setting that illustrates the interactions amongst these components which lead to a particular drug use experience and a range of possible outcomes (Zinberg, 1984).

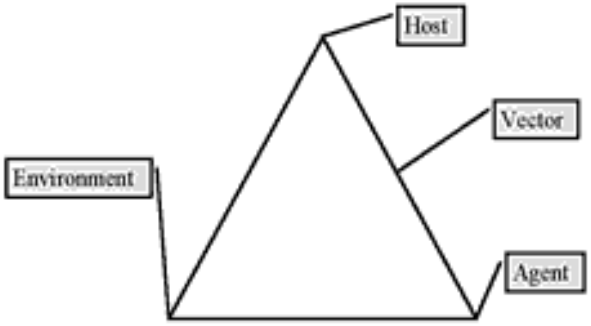

Figure 1: A Public Health Model of Communicable Disease

As applied to gambling (see Figure 2), the model can describe the multiple determinants of gambling problems and their complex interrelationships (Korn & Shaffer, 1999). The host is the individual who chooses to gamble, and who may be at risk for developing problems depending on their neurobiology, genetics, mental health and behaviour patterns. The agent represents the specific gambling activities in which players engage (e.g., lotteries, slot machines, casino table games, bingo, horse race betting). The vector can be thought of as money, credit or something else of value. The environment is not only the gambling venue but also the family, socio-economic, cultural and political context within which gambling occurs (e.g., whether it is legal, its availability and whether it is socially sanctioned or promoted). This public health paradigm invites a broad range of prevention and treatment interventions directed at various elements in the model.

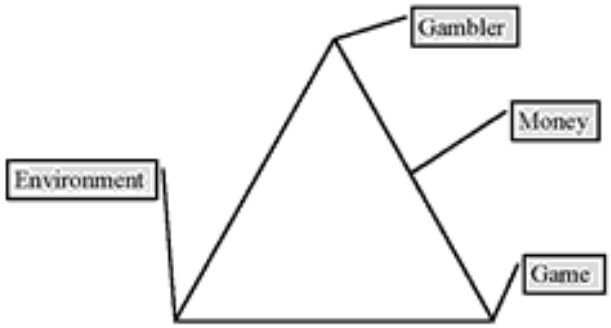

Figure 2: A Public Health Model of Gambling

Major Public Health Issues

A public health issue goes beyond consideration of the individual and their personal health to matters that affect groups of people who share common characteristics, geography or interests. The recent, dramatic growth of legalized gambling and its widespread acceptance raises concerns about its impact on the public's health and well-being. There are a range of public health issues related to populations at risk for gambling problems, suffering from gambling disorders or affected by the gambling practices of others. In addition, public policy decisions on gambling have implications for communities.

1. Gambling Expansion and Problem Gambling Trends in the Adult Population

In the last decade before the millennium, an unprecedented expansion of government-sanctioned gambling occurred throughout North America. The dominant concern is the emergence of gambling addiction, which may be stimulated by increased availability and promotion of casinos, lotteries and

VLTs. Currently, the estimated lifetime prevalence rates for problem and pathological gambling combined in the general adult population in both the United States and Canada is low; however, the Harvard meta-analysis of available studies shows that over the past 25 years there has been a rising trend.

The relationship between access to gambling and gambling problems is widely debated. A significant number of replication studies associated with the introduction of new gambling opportunities in states such as New York, Iowa, Minnesota and Texas demonstrate an increase in problem and pathological gambling (Volberg, 1995; Miller & Westermeyer, 1996; Volberg, 1996; Wallisch, 1996). Research done in the United States shows a higher prevalence rate in states with higher per-capita lottery sales and in areas within 50 miles (80 km) of casinos (Volberg, 1994; Gerstein, Murphy et al., 1999). These findings support the general conclusion that gambling expansion is associated with related to increases in problem and pathological gambling.

2. Youth and Underage Gambling

Youth is a development stage associated with experimentation, novelty and sensation seeking. However, the current youth generation is the first to grow up within a society where gambling is widely available and government sanctioned. The implication of this societal change for youth gambling behaviour and risk of developing gambling problems as adults is unclear.

Surveys in Massachusetts, Minnesota, Nova Scotia and elsewhere point to a high prevalence of problem and pathological gambling among youth, estimated to be two to three times higher than in the general adult population (Winters, Stinchfield et al., 1993; Shaffer, LaBrie et al., 1994; Poulin, 2000). A meta-analysis showed that the estimated lifetime prevalence for both problem and pathological gambling in the adolescent study population was 13.3% (14.0% for the college population), a proportion that has been relatively steady over the past 25 years (Shaffer, Hall et al., 1997). This high prevalence of gambling and gambling-related problems among youth, including sports betting at colleges and universities, is cause for concern and invites innovative approaches to prevention.

3. The Impacts of Gambling on Special Populations

A number of special populations have been identified for focused attention because of their financial vulnerability, health status or distinct needs. This review of special populations examines people from lower income socio-economic groups, women, Aboriginal people and older adults, but it is not inclusive. Other groups that deserve consideration include ethnocultural minorities, incarcerated populations, substance abuse and mental health treatment groups and gambling industry employees. In general, gambling research within special populations is in an early phase, and these groups deserve further systematic study before conclusive statements can be made.

a. **Socio-Economic Status**

There has been considerable interest in the relation between gambling and socio-economic status. Recent Statistics Canada reports indicate that although gambling participation rates and actual expenditures tend to increase with household income, lower income households spend proportionately more than do higher income households (Marshall, 1998; Marshall, 2000). For example, in households in which at least one person was involved in gambling, those with incomes of less than $20,000 spent an annual average of $296 on gambling pursuits. This sum represented 2.2% of total household income, whereas those with an income of $80,000 or more spent $536, only 0.5% of total income. Given the share of gambling revenue in Canada and elsewhere that goes to government, these data suggest that gambling expenditures may be regarded as a voluntary but regressive tax that has a proportionately greater impact on lower income groups.

2. **Women**

Women appear to have distinct gambling behaviours; and they are gambling more now than in previous years. In the United States, the percentage of women who have ever gambled rose between 1975 and

1998 from 22% to 82%. In the same period, the percentage for males increased from 13% to 86% (Gerstein, Murphy et al., 1999). Female gamblers prefer slot machines, VLTs and bingo to action table games and horse racing. Compared to males, females gamble more to escape, reduce boredom or relieve loneliness than for excitement, pleasure or financial gain (Coman, Burrows et al., 1997).

3. **Aboriginal People**

   Aboriginal Peoples deserve attention because of the evolution of gaming policy and its potentially positive economic impact on Aboriginal communities through revenue generation and employment. At the same time, Aboriginal Peoples may be particularly vulnerable to the negative impacts of gambling for a variety of complex health and social reasons.

4. **Older Adults**

   There has been considerable interest but little empirical research into the gambling behaviour of seniors who are a sizable and growing proportion of the adult population (North American Training Institute, 1997; Gerstein, Murphy et al., 1999; McNeilly & Burke, 2000). Seniors appear to be disproportionately represented at bingo halls, charitable gaming activities and day excursions to casinos. Although seniors are generally considered low risk-takers, there are concerns about their vulnerability to gambling problems springing from fixed incomes, social isolation and declining health. However, seniors may also receive health benefits from gambling activity and its impact on social connectedness. Research that examines the impact of gambling on depression, physical mobility and quality of life would enhance our understanding of the risks and benefits of gambling for seniors.

4. Effects of Gambling on Family Life

Gambling-related family problems deserve to be positioned centrally as important public health issues. A healthy family is integral to developing and sustaining individual self-worth, meaningful interpersonal relationships, mutual respect and personal resiliency. Robert Glossop of The Vanier Institute of the Family recently noted, "Families are perhaps the central determinant of health, the central influence in the lives of individuals that determine their health status and their chances of survival" (Avard, 1999). When family

members are problem or pathological gamblers, they can adversely affect their relatives and significant others. To date, researchers in the gambling field have described a range of negative health and social consequences for family members associated with adult disordered gamblers. These effects have been identified in spouses (Lorenz & Yaffee, 1988), siblings (Lorenz, 1987), children (Jacobs, Marston et al., 1989) and parents (Heineman, 1989; Moody, 1989). Family issues include dysfunctional relationships, loss of family income, neglect, violence and abuse. Both the general public and health professionals need to be better informed of these potential consequences and elaborate a full range of family support interventions.

5. Gambling Sites and Community Quality of Life

When jurisdictions face the opportunity to establish a gambling facility or expand gambling activities, there is often extensive, heated community debate regarding the social costs and economic benefits. Ideally, a community gambling assessment is shaped by consideration of local community needs, community values, strategic plans and research findings on community impact. Active participation of its citizens, involvement of key stakeholder groups and transparent decision-making are characteristics of a successful community process.

The outcome of this process should preserve or enhance the quality of community life; sustain or improve the overall health status of its members; and demonstrate local economic vitality as a result of either the presence or absence of gambling. Ongoing monitoring and impact analysis is necessary to evaluate the decision over time and to make appropriate adjustments.

6. Emerging Gambling Trends with Public Health Implications

The Internet provides a new and virtual environment for gambling. It has experienced explosive growth in the numbers of gambling Web sites, players and revenues (Adiga, 2000). It is unregulated in North America; operating offshore, it offers sports betting and casino-style gambling opportunities to individuals possessing a computer modem and a credit card. It attracts gamblers because it provides access to gambling activities at anytime in the privacy of their home or office. Underage gambling is difficult to monitor.

Technology has become a significant dimension of gambling in general. Concerns have been expressed about the wide availability and addictive potential of VLTs. On the positive side, computer- and Web-based technologies can incorporate personal risk assessment tools for gambling problems, and innovative prevention programs and monitoring instruments. One type of gambling that has received little attention to date is gambling that occurs in the financial world. Economic well-being is a significant determinant of population health. Thus, high risk or impulsive financial speculation, such as day trading, can have profound impacts on health status and social institutions.

Creating a Public Health Framework for Action

What is done to resolve a particular societal matter depends on how it is framed. Approaching gambling from a public health perspective offers a strategic vantage point to address its broad health challenges and inform related public policy.

Three primary principles guide and inform decision-making. The first is to ensure that preventing gambling-related problems is a community priority, along with the appropriate allocation of resources to primary, secondary and tertiary prevention initiatives. The second is to incorporate a mental health promotion approach to gambling; one that builds community capacity, incorporates a holistic view of mental health (including its emotional and spiritual dimensions) and addresses the needs and aspirations of gamblers, individuals at risk of gambling problems and those affected by them. The third principle is to foster personal and social responsibility for gambling policies and practices.

These principles in turn inform a set of public health goals:

- to *prevent* gambling-related problems in individuals and groups at risk of gambling addiction
- to *promote* informed and balanced attitudes, behaviours and policies

towards gambling and gamblers both by individuals and by communities

- to *protect* vulnerable groups from gambling-related harm.

An action agenda based on these public health goals and principles has been proposed. **note 5**

In conclusion, this public health perspective on gambling issues offers policy makers, researchers, health practitioners and community leaders a focus for public accountability and the opportunity to minimize gambling's negative impacts while balancing its potential benefits.

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Acknowledgements

I express my appreciation to my colleague Professor Harvey Skinner, Chair, Department of Public Health Sciences, University of Toronto, for his support and interest in this work.

This article was peer-reviewed.

Submitted: November 6, 2000
Accepted: February 27, 2001

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David Korn is an addiction specialist and public health physician. He holds a faculty position in the Department of Public Health Sciences at the University of Toronto and maintains a clinical practice in addictions and behavioral health. Recently he was a visiting professor at Harvard University, Department of Psychiatry.

issue 4 —may 2001

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Go to Current Issue

policy

Intro
Feature
Policy
Research
Profile
Case Study
First Person
Review
Letters
Submissions
Links
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Brief Policy Report

Casino Gambling in Switzerland – The Legal Situation, Politics and Prospects for Prevention and Harm Reduction

By Daniela Dombrowski
Addiction Research Institute, Zurich, Switzerland

Ambros Uchtenhagen
Addiction Research Institute, Zurich, Switzerland

Jürgen Rehm
Addiction Research Institute, Zurich, Switzerland
University of Toronto, Toronto, Canada
Centre for Addiction and Mental Health, Toronto, Canada

Abstract

In April 2000, a new law came into effect in Switzerland that permits casino gambling with unlimited stakes for the first time since 1921. Casinos can now be run only with a concession granted by a newly established federal agency. In addition to economic and administrative information, each casino applying for a concession has to submit a fully developed "social concept" that includes detailed prevention measures for dealing with people with gambling problems, staff training and evaluation research, which an independent advisory board will control. In the fall of 2001, the first casino concessions will be granted based on the quality of each applicant's overall proposal.

The new legislation is creating a unique situation in Switzerland. To reduce the potential harm for gamblers that is associated with new forms of gambling, the legislation should be standardized and continuously optimized. These new measures require evaluation and government control.

The Legal Situation

On April 1, 2000, the new *Federal Law on Games of Chance and Casinos (Bundesgesetz über Glücksspiele und Spielbanken, 1998*) came into effect in Switzerland. The law is specified by the *Federal Casino Decree (Bundesrätliche Spielbankenverordnung)* and was ratified by the federal government on February 23, 2000 (see <http://www.admin.ch/> for information on Swiss legislation). note 1 This law permits gambling with unlimited stakes in Switzerland. In the corresponding decree, detailed guidelines specify the conditions under which gambling in Switzerland may take place. According to the Swiss legislative process, this law was made possible by a referendum in 1993; three-quarters of the electorate voted in favor of re-establishing casinos with high stakes (a 1920 referendum disallowed gambling in casinos where it had been allowed before 1921). In 1920, 55% of the population had supported the closing of casinos. This change in voting behavior between the 1920s and the 1990s reflects a general trend in market economies to emphasize individual liberties and decision making, which has also affected attitudes toward other public health policies (e.g., alcohol policy) .

Until the Federal Law on Games of Chance and Casinos came into effect, the maximum stake in gambling had been limited to CHF five per game. Slot machine gambling had different cantonal note 2 (state) laws that controlled the management of the amusement arcades (facilities with only machines) and small casinos. This led to a total banishment of gambling in some cantons (e.g., Zurich) while a relatively high number of machines were distributed to small casinos, amusement arcades and public places such as bars and restaurants in other cantons (e.g., Ticino). Additionally, many grand casinos note 3 in France, Italy, Austria and Germany are situated alongside the Swiss border.

This new federal law distinguishes between two kinds of gambling:

- games of skill (e.g., card games like poker, as well as machine games where the outcome depends to some degree on the skill of the player)

- games of chance that cannot be influenced by the skills of the gambler (e.g., slot machines or one-armed bandits; in the following text they are referred to as "chance amusement machines").

Games of chance will be strictly limited by law to special resorts like casinos and amusement arcades. Every person or legal entity wanting to run a gambling enterprise must apply for a concession from the federal government. The newly formed Federal Swiss Casino Commission note 4 will review the applications and make recommendations to the federal government.

The deadline for applications was September 30, 2000. The commission has promised to take about a year to review and make a decision on the applications. Two different types of concessions will be granted: Type A concessions for grand casinos (these will be taxed less), and Type B concessions for smaller casinos (these will be taxed more). Type A casinos will be allowed to offer 14 different table games with unlimited stakes, jackpots and maximum winnings at all machines. Type B casinos will only be allowed to offer three kinds of table games with limited stakes, jackpots and maximum winnings at all machines.

Taxation will be regulated as follows: Casinos of Type A pay 40% of their revenues up to CHF 20 million, and for each additional million the taxation rises by 0.5%. Casinos of Type B pay 40% of their revenues up to CHF 10 million, and for each additional million the taxation rises by 1%. The plan is to evenly distribute the concessions across Switzerland. Type A casinos will only be permitted within a catchment area of a million people or more. Overall, the intended result is to have about two to six Type A casinos and 15 to 20 Type B casinos all over Switzerland.

Gambling via telecommunications, especially the Internet, is forbidden. In Switzerland however, there are no models for prosecution in case of violation, nor does the law or the decree provide any. Cantonal law will control machines offering games of skill (in contrast to machines that solely depend on chance).

A five-year transitional law came into effect on April 1, 2000 for amusement machines depending solely on chance in both public places (restaurants, bars, waiting lounges, etc.) and amusement arcades, as well as for casinos that already exist. On April 1, 2005, operation of all games of chance amusement machines run by persons or legal entities that have not been granted a concession will be stopped.

The Social Concept – A Nationwide Approach

The legal basis for a social concept

In order to obtain a concession on the recommendation of the Swiss Federal Gambling Commission, each applicant is required to meet certain standards concerning

- measures for prevention and harm reduction of pathological and problem gambling,
- proper training of the casino staff, and
- provision of data for research.

Each applicant must describe in detail in a *social concept* how these criteria will be fulfilled.

These very strict requirements laid down by federal law create a peculiar situation; systematic, preventive and harm reduction measures have to be introduced nationally and at the beginning of grand casino gambling in Switzerland. To our knowledge, these are unique prerequisites in a nation

legalizing gambling.

Experiences in other countries

Most countries that allow large-scale gambling lack systematic, nationwide regulation for preventive measures. Though internationally there has been an increase in gambling policy development in both public and private sectors, the level of interest and the funds available for education, prevention and treatment have not kept pace with increases in legal gambling revenues or in the availability of gambling .

In some Canadian provinces, in Germany, Sweden and the U.S., as well as in some states in Australia, the government grants money for prevention, treatment and research. For instance, two U.S. federal health agencies: the National Institute of Health, and the Substance Abuse and Mental Health Services Administration have allocated funds for research and services. However, "the level of funding is often minuscule compared to similar programs for mental health, substance abuse, and other human services."

In other countries, governments do not engage in funding prevention and harm reduction measures at all. There may be some private funding either in addition to or instead of public funding. In the U.S. and the Netherlands, the private enterprises running casinos have started several initiatives. In the U.S., the gaming industry became active in the field of underage and problem gambling during the 1990s. The American Gaming Association (AGA) founded and financially supports the National Center of Responsible Gaming (NCRG), which grants funds to research projects carried out by academic institutions in North America, and to organizations providing counseling for underage and problem gambling.

In the Netherlands, gambling was legalized in 1975 and the government granted Holland Casino's exclusive rights to run casinos in the Netherlands. Part of the corresponding regulations asked for a prevention concept. Holland Casino's and VAN (the Dutch amusement machine industry) are co-operating with Jellinek Consultancy (a counseling and prevention service linked to the Amsterdam Institute for Addiction Research – Jellinekhuis) to provide prevention and harm reduction measures.

Together, they worked out a prevention plan that includes

- the display of brochures with guidelines for responsible gambling

- information about the odds of winning and losing in the casinos
- the possibility of suspending people who have gambling problems, and
- a training program for casino and amusement arcade employees, social workers and relatives on how to deal with those who have gambling problems.

In addition to the legal casinos, there are an estimated 40 to 50 illegal casinos ; most of the gambling in Dutch casinos remains uncontrolled. Furthermore, innumerable slot machines are located in eating establishments and amusement arcades throughout the Netherlands. In an attempt to reduce uncontrolled gambling opportunities, the number of amusement machines in public places was reduced, but interestingly, the number of lotteries rose at the same time. Preventive measures for amusement machines, lotteries and illegal casinos are carried out in a non-standardized way, if they are carried out at all: meaning, they do not co-operate with the Jellinek Consultancy.

The Dutch example seems to indicate that government funding for prevention and harm reduction may not be necessary and could be replaced by funding provided by the sector itself. Such efforts have to be regulated; however, it is not only government regulations that are important, but also their enforcement. If most of the casinos are not participating in a standardized, national approach, the result will not be effective.

The implementation of social concepts in Switzerland

There will probably not be a standardized concept for all casinos in Switzerland as the applicants for a concession had to submit a fully developed social concept of their own. Until the concessions are granted in fall of 2001, the applicants are effectively in competition with each other, which makes exchanging concepts and ideas highly unlikely. However, each submission is bound to contain what's required by law since the granting of the concessions will be based on quality, along with other factors such as location, local traffic and size of the catchment area. Because competition is tough, it is expected (and hoped by some) that a well-planned social concept could mean winning the bid.

For each casino or for each company representing several casinos, a social

advisory board will supervise the translation of its concept into action. Depending on the concept, its members will often be independent experts from the therapy, social services and research fields, but will also sometimes include casino executives. The advisory boards will report directly to the Swiss Federal Casino Commission.

Last but not least, the law in Switzerland creates a unique chance to collect research; providing data for research is part of the social concept. Implementing grand casinos in a country where gambling had been strictly limited has been rarely evaluated until now (see Room, Turner & Iolamiteanu, 1999 for an exception) and could be especially interesting for other countries that also wish to legalize gambling. Furthermore, comparing development in cantons where gambling had been totally abolished, and development in cantons where gambling had already taken place might prove to be interesting. However, most evaluations will require baseline data (e.g., the current level of problem gambling) in order to be able to interpret results and make valid conclusions. Unfortunately, such data has been lacking so far.

An Example of a Social Concept in Switzerland: The Social Concept of Grand Casino SA

The Addiction Research Institute in Zurich has developed a social concept that the Grand Casino SA and its partners (ACE Admiral Casino & Entertainment AG, Escor AG, German Casino Management Group) will use to apply for concessions for 10 different casinos (two of Type A, eight of Type B) all over Switzerland. To obtain a concession, the casinos have agreed to subscribe to this social concept outlined below.

After the legal requirements, the social concept has the following components:

- preventive measures
- plans for dealing with problem gambling
- training program for staff

- research
- social advisory board.

The preventive measures are divided into primary and secondary prevention. Key elements for primary prevention include information and sensitization campaigns for casino customers and the public, a Web site with relevant information, media prevention campaigns, information on odds and pathological gambling, and contact information for professional help. Information brochures and advice on responsible gambling will be openly available in the casinos. Advertising for gambling will be strictly limited. In addition, structural changes to the casino will be made: an ID control at the entrance will prevent the admission of adolescents under 18 or suspended problem gamblers. Although credit cards will be accepted, no cash dispensers will be placed in the casino and no loans will be granted to customers. To prevent staff from relying on tipping, a relatively high fixed wage will be administered, increasing their monthly allowance and allowing them to be freer and less biased when intervening with those who have problems.

As part of secondary prevention, checklists for self-diagnosis will be displayed and combined with the offer of counseling by specially trained staff in each casino. A toll-free, 24-hour telephone hotline will provide the caller with information (e.g., where to obtain professional help). Customers who feel in danger of losing control will be able to have themselves suspended from either their favorite casino or every casino across the country.

To help deal with those who have gambling problems, staff will be trained to speak with customers who are obviously having trouble. A first counseling session may be held in the casino and contact information for professional help will be provided. Problem gamblers can be suspended nationwide, even if they do not agree to that intervention. A fund supplied by the casinos' revenues and managed by the social advisory board will be established for people with gambling problems with financial problems, who wish to immediately enroll in therapy.

All casino staff will be trained in a three-day workshop before starting their job. Training will include information about pathological gambling, risk and protective factors, different types and stages of gambling problems, preventive measures and therapy for problem gamblers. Potential problematic

behaviors because of any addiction will be thoroughly examined, and social competencies in dealing with problem gamblers will be practised in role-playing. Staff will be retrained annually. Additionally, at least one supervisor will receive extra training in how to interact with problem customers. He or she will also receive regular professional supervision.

Research will focus on data collection and interpretation of gambling frequencies, the socio-demographic characteristics of casino customers, the frequencies and circumstances of suspensions, and customer turnover in the casinos. Ideally, there would be national or even international monitoring, which however, depends on the co-operation of the other casinos and government regulations. Furthermore, the effectiveness of the preventive measures and social consequences in regions around the casinos will be evaluated by studying hotline usage, co-operating therapy and counseling centers, social services and crime rates.

The social advisory board will consist of seven independent experts from the prevention, therapy, social services and research fields. Up to two casino executives will be allowed to participate in the meetings (without the right to intervene or vote). The board's main function will be to supervise the implementation and realization of the social concept and to report regularly to the Swiss Federal Casino Commission. It will examine, authorize, order and control the preventive measures, training, research and public relations. It will decide upon suspensions and have authorization to grant funds for therapeutic aids for pathological and problem gambling.

Until now, the phenomenon of problem gambling has hardly been studied in Switzerland on a large scale. With the financial support of Loterie Romande and Romande des Jeux SA (i.e. representatives of the gaming industry in the French-speaking part of Switzerland), one major study was carried out in 1998 that estimated the existing prevalence of pathological and problem gambling in Switzerland . The authors screened a representative sample of the adult population for each Swiss region with the SOGS for current problem gambling and found that 0.8% of the Swiss population were probable pathological gamblers and another 2.2% were potential pathological gamblers. These prevalence figures are slightly higher than the corresponding Swedish figures . This comparison is justified as Sweden is also about to open casinos, with the first expected to be opened in spring 2001.

In addition, the Swiss study also found a relationship between gambling and alcohol problems; the latter screened by the CAGE . The study showed a positive relationship between the availability of gambling and the prevalence of problem gambling: the higher the relative density of amusement machines per 1000 inhabitants, the higher the prevalence of probable and potential

pathological gamblers.

When comparing those with gambling problems to the total population these statistics emerged; for all sets of figures, the first percentage is that of problem gamblers and the second percentage is for the total population: 73% of the group with gambling problems were male, while only 49% of the total population was male. Those under the age of 29 were 43% of those with gambling problems, but only 20% of the total population; 76% of problem gamblers were employees compared to 55% of the total population; full time workers composed 79% of the problem gamblers compared to 52% of the total population. Among people with gambling problems 18% were of non-Swiss nationality, compared to being 8% of the total population; and 48% of the problem gamblers were unmarried, compared to 30% unmarried among the total population. A smaller group of gamblers with problems was in the low-tax category (13% vs 29%), Protestant (28% vs 46%) or spoke French as their mother tongue (7% vs 18%) compared to the total population.

The number of probable pathological gamblers in Switzerland is estimated to be between 33,000 and 78,000; the number of potential pathological gamblers is between 107,000 and 180,000. These numbers are at the lower end of the international problem gambling statistics (Evans & Hausamann, 1998), (Henriksson in press), (Petry & Armentano, 1999), (Shaffer, Hall & Vander Bilt, 1999), (Ladouceur, 1996), (Volberg, 1996), (Osiek, Bondolfi, et al., 1998), although grand casino gambling has not yet started in Switzerland. Thus, problem gambling already exists in Switzerland despite the strict restrictions that have been in force until now.

Although there are exceptions, international and Swiss results show higher rates of problem gambling in regions with more gambling opportunities. This leads to the expectation that there will be rising numbers of problem gamblers following the implementation of grand casino gambling in Switzerland. We believe that a well-founded harm reduction policy should be in place to deal with this expected increase.

Conclusion

The new legislation has created a unique situation in Switzerland regarding grand casino gambling. While gambling with unlimited stakes will become daily business in Switzerland in the near future, the casinos themselves will be legally required to implement effective prevention methods and to establish a network of consultation and therapy for problem gambling. The Swiss law

limits gambling activities strictly to casinos and forces each of the casinos to implement and carry out a social concept with detailed *a priori* stated prevention measures, measures for dealing with problem gamblers, training of staff, and associated evaluation research. An independent social advisory board will control the actual implementation and realization of the measures.

In spite of these precautions, an increase in the prevalence of pathological gamblers is expected in Switzerland. So far, this prevalence rate is at the lower end of the international statistics, but national and international research has shown that the number of people with pathological levels of gambling problems tends to rise with more gambling opportunities.

This calls for a thorough harm reduction approach. To optimize its effectiveness, standardization of the measures and strict evaluation will be very important. It also requires commitment from the government to continue the regulation and control of all the steps. As we learned from the Dutch example, not only will control and regulation be necessary, but also enforcement of the regulations.

There are currently different social concepts in Switzerland that may differ in their effectiveness. It would be in the interest of the Swiss government to put the onus on the casinos to provide evidence for the effectiveness of their concepts. This seems to be particularly possible in a situation when a new law is being implemented.

Traditional medicine and public health have often encountered the problem that evidence of effectiveness is often established *post hoc*, taking into account many historical aberrations. These problems could be avoided if evidence of the effectiveness of countermeasures is presented at the beginning of the implementation. By routine monitoring and conducting standardized comparative evaluations of the effectiveness of different social concepts, such concepts could be shaped, and ineffective concepts could be abandoned or improved. Therefore, social and public health problems related to gambling in Switzerland might be less dramatic than would otherwise be expected.

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This brief policy report was peer-reviewed.

Submitted: November 6, 2000
Accepted: March 16, 2001

Address for correspondence:
Daniela Dombrowski
Addiction Research Institute
Konradstr. 32
Postfach 1617
8031 Zürich, Switzerland

Phone: ++41/1 448 11 69
Fax: ++41/1 448 11 70

E-mail: dombro@isf.unizh.ch

Daniela Dombrowski, Dipl.-Psych., graduated in clinical and pedagogical psychology from the University of Constance, Germany. She has worked with delinquent adolescents, at a graduate school of business administration and in several research projects. Since 1999 she is a project manager at the Addiction Research Institute in Zurich, Switzerland. She and her colleagues developed the social concept for the Grand Casino S.A., Switzerland.

Ambros Uchtenhagen, MD, PhD, Professor Emeritus in social psychiatry at Zurich University, is chair of the Board for the Addiction Research Institute at Zurich University. He is a member of the WHO Expert Panel on Drugs, and a board member of the European Association on Substance Abuse Research. He has numerous publications in the fields of social psychiatry and the addictions and is co-editor in chief of European Addiction Research.

Jürgen Rehm, PhD, is currently research director at the Addiction Research Institute at Zurich, Senior Scientist on a part time basis at the Centre for Addiction and Mental Health and professor at the Public Health Sciences Department of the University of Toronto. He has published widely on epidemiology, policy and the economics of substance use and abuse.

issue 4 – may 2001

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"Everything's Bubbling, But We Don't Know What the Ingredients Are" —Casino Politics and Policy in the Periphery

By Julie E. Scott
Research Fellow, Centre for Leisure and Tourism Studies
University of North London
London, UK
E-mail: j.scott@unl.ac.uk

Abstract

With the global spread of commercial gambling, the casino industry is fast establishing itself in many of the world's peripheries —economically and politically marginal locations, simultaneously remote from, but dependent on metropolitan centres of finance and decision-making. Using the case of northern Cyprus, this paper examines the political and economic context of decisions by such peripheries to embark on casino tourism as a

development strategy and explores some of the problems faced in attempting to regulate and control the sector. The paper suggests that it is the condition of dependency, rather than simple resource constraints, which is the major obstacle to establishing an adequate policy and regulatory framework.

Keywords: casino tourism, dependency, periphery, policy, politics, northern Cyprus

Introduction

The title of this paper is taken from a comment made to me by the Turkish Cypriot manager of a casino in northern Cyprus during fieldwork in 1999. What was bubbling was northern Cyprus's casino sector, 20 casinos having recently opened, with another 20 applications pending in a territory with an area of 3,355 sq. kilometres (1,295 sq. miles) with a permanent population of about 250,000. His comment reflected double perplexity: firstly, that of a casino manager operating in a climate of enormous uncertainty; secondly, the concern of a Turkish Cypriot concerned at the effects he observed of the casino industry on his home. From both a professional and a personal point of view, he confessed to grave doubts about the sustainability of the sector.

In this paper I want to try to describe this bubbling mixture and identify its ingredients. I shall argue that the problems and dilemmas faced by northern Cyprus, as it seeks to come to grips with its new industry, are representative of the problems faced by peripheral regions in general when they engage in casino tourism development. And for a number of reasons, it is precisely in such peripheral regions that much of the casino development of the past decade has been concentrated. On the one hand, locating casinos in physically peripheral regions effectively isolates gambling activity, rationing the gambling opportunities for the residents of metropolitan centres and shifting many of the associated problems and costs elsewhere (Stansfield, 1996; Felsenstein & Freeman, 1998).

On the other hand, the economic marginality of many peripheral areas may make them eager to cash in on the growing demand for casino gambling. In doing so, they can turn their location into a comparative advantage, whether they are an urban economy in need of regeneration in the aftermath of industrial and economic restructuring (Goodman, 1995;

Deitrick, et al., 1999); an emerging former Soviet-bloc state seeking the means to kick-start post-communist economic activity (McMillen, 1996a; Thompson, 1998); or a small, offshore island with limited development options. Northern Cyprus, in the eastern Mediterranean, is one such island.

Northern Cyprus

The Turkish Republic of Northern Cyprus (TRNC) could be considered perhaps the quintessential peripheral location. Recognised politically and diplomatically only by Turkey, this northern third of the island of Cyprus has been literally cut off from the rest of the world since its partition in 1974, following an attempted coup engineered by the military junta in Athens and subsequent military intervention by Turkey. Boycotts put in place by the United Nations ensure that all post and telecommunications to northern Cyprus must be routed through Turkey, and there are no direct international flights to the north.

These problems of accessibility and negative image render the north artificially remote from the mass tourism markets of northern Europe, the mainstay of the Greek Cypriot tourism industry in the south. They make them triply dependent on mainland Turkey, which is their gateway to the rest of the world, the main source of aid and investment in the north, and also, the main tourist market (Scott, 2000a). The primary attractions of northern Cyprus for Turkish tourists are sun, sea, sand, shopping, and the opportunity for casino gambling.

The Development of the Casino Sector in Northern Cyprus and Turkey

Research in northern Cyprus's casino sector was undertaken as part of a wider project looking at diversity and sustainability in tourism development. The author, an anthropologist at the Business School of the University of North London, worked in collaboration with Turkish Cypriot colleagues at Eastern Mediterranean University, Famagusta, Cyprus. Using a combination of survey, interview and participant observation methods, our research explored the relationship between northern Cyprus's conventional tourism product and the casino tourism sector (Scott and Asikoglu,

forthcoming), and the impact of casinos on traditional gambling (Scott, 2000b).

At the commencement of fieldwork in spring 1999, 20 casinos were operating in northern Cyprus. All were attached to, or located within, hotels, holiday villages or other tourist accommodation, and eight were in town centre locations, the majority of these in the main tourist resort town of Kyrenia (Girne). By far the largest is the Emperyal Casino, with 22 gaming tables and 377 slot machines. This compares with an average of 10 tables and 70 slot machines per casino, although the smallest has only seven tables and 18 machines (Ministry of Tourism, 1998). The main games played are American and French roulette, Las Vegas craps, Black Jack, poker, chemin-de-fer, punto banco, baccarat and keno. However, a number of other games are also permitted on casino premises, including chug-a-lug, wheel of fortune, rummy, backgammon, and betting on horse and dog races and football matches. Casino opening hours are subject to government regulation, and operation is currently permitted from early afternoon to early morning, with seasonal adjustment from winter to summer. Alcoholic drinks are available free of charge, and may be consumed at the gaming tables. At the time of writing, citizens of northern Cyprus and students, regardless of nationality, are not permitted to gamble on casino premises (nor, technically, in any other location).

The scale of the current level of casino activity has caused enormous local controversy, yet casinos themselves are nothing new in northern Cyprus. A law permitting the licensing of premises for betting and gambling was first passed in 1975, to encourage tourism investment and diversify the north's fledgling tourism product in the aftermath of the island's partition. Casino operators were required to meet tourist bed/night targets as a condition of their licence, but this requirement was soon dropped when it became clear that none of the casinos had been able to meet their targets, and that all would face heavy penalties (Yesilada, 1994). In the face of the low level of demand, would-be operators who had received permission to open casinos bided their time. By 1991, only four small premises were in operation, although permission had been granted for 10 casinos to open.

Throughout the 1990s, however, the licensing and opening of casinos gathered pace. The development of the Israeli "casino junket" market began to ensure a steady stream of weekend gamblers, but posed enormous logistical problems in the absence of direct flights to and from Israel. Turkey presented a much more accessible and potentially much larger market.

Although casino gambling was legalised in Turkey in 1983 —again with the aim of stimulating investment in tourism and attracting overseas tourists — Turkish citizens were initially barred from the live game areas of casinos. High rollers were obliged either to play the slot machines —where some individuals would lose as much as US $2,000 to 3,000 on a daily basis (Kent-Lemon, 1988:409) —or to visit casinos outside Turkey, with northern Cyprus a convenient location only one hour by air from Istanbul or Ankara.

By 1995, a further eight casinos had been licensed in northern Cyprus, but with the liberalisation of gaming laws in Turkey, allowing Turkish nationals access to the gaming tables, the Cypriot casinos again found themselves struggling to survive. However, by 1997 the tide of public opinion in Turkey was turning against the casinos, fuelled by an apparent increase in widespread problem gambling (Duvarci, et al.,1998) as well as stories linking casinos with organised crime and corrupt politicians. The electoral success of the Islamic Welfare Party, who opposed gambling on religious and moral grounds, hastened their demise, so that by autumn 1997, Turkey's 78 casinos had been closed down.

For the biggest casino operators, however, the closure represented only a temporary hiatus. As early as March 1997 *Sabah* newspaper reported on plans to shift casino operations to locations outside Turkey —to Poland, the Czech Republic, Russia, Slovenia, Azerbaijan and France. Furthermore, six operators announced their intention to move to northern Cyprus (*Sabah*, 1997). By 1998, the Turkish Cypriot Ministry of Tourism had granted a further six casino licences, bringing the total to 24, but many more were waiting in the wings, eager to capitalise on the Turkish market for casino gambling where it had become an essential leisure activity. By the spring of 1999, a further 20 entrepreneurs were lobbying hard for casino licences. If all were successful, the total number of casinos in northern Cyprus would reach well over 40, a situation that raised a number of dilemmas for the new minister of tourism.

Policy Dilemmas

While on the one hand, giving the go-ahead to all of the casino applications might have provided a pragmatic short-term solution to many of the problems besetting northern Cyprus's tourism industry, the wholesale licensing of casinos holds threats and uncertainties for the long term.

Partisans of gambling tourism and casino expansion argued that the casinos had raised the demand for hotel accommodation and would potentially increase the demand for other tourism services, such as travel agencies, restaurants, car hire, entertainment, etc. Even some of the smaller hotels that did not have a casino claimed they had improved their chronically low occupancy rates by accommodating the overspill from the larger casino hotels. Furthermore, the casinos themselves would provide a source of local employment. Indeed, to promote this objective, legislation passed in the mid-1990s required that the proportion of foreign nationals employed in any casino should not exceed 30 per cent. Taxes and licence fees levied on casinos, it was argued, could provide a lucrative source of income for the government. Finally, from 1994 onwards, casino licences were granted only to hotel premises with a minimum four-star rating and 200 to 250 beds. After 1996, this was raised to five-star premises with a minimum of 500 beds, with the intention that casino investors should improve the level and quality of hotel stock in the north.

In addition to fears that the casinos would lead to increased crime and rates of problem gambling (the anecdotal evidence for which is so far unverified by definitive research; c.f. Scott, 2000b), critics of the casinos identified a number of negative impacts on existing tourism and its future prospects. These criticisms had two major themes: firstly, that the benefits of casino tourism were exaggerated and unevenly distributed; and secondly, that casino tourism was distorting the north's tourism product and introducing a dangerous element of dependency on the casinos.

Who benefits?

There is no doubt that large flows of money have accompanied the establishment of casinos in northern Cyprus. The casino iInvestors and operators own association estimates their annual contribution to the local economy to be in the region of US $65,000,000 (*Kibris*, 20/6/99). But it is far from clear who is benefiting from these flows, and it seems likely that the gains to the public purse are extremely modest. Certainly, the issuing of casino licences is proving less lucrative for the government (which grants two-year licences for an annual fee of between $80,000 and $100,000 US) than it is for the licence-holders who then illegally sell their (supposedly non-transferrable) licence to third parties for much larger amounts; according to one casino manager, amounts up to $2,000,000 US.

Hotel owners renting out casino premises are also reported to be charging an average rent of $100,000 US a year, although during fieldwork, amounts of up to $35,000 US *per month* were also mentioned. In the eyes of many,

this speculation in casino licences and rents functions as a secret subsidy to hoteliers, which has ensured their economic survival and enabled them to refurbish and maintain their properties in the absence of either established tourism or adequate financial assistance from the cash-strapped government. Yet it has also reinforced the casino sector's status as a largely hidden and secretive industry, and weakened central government's grip on development and their capacity to exercise effective controls.

The lack of effective government control is reflected in their inability, so far, to enforce local employment quotas. Despite the legal requirement that a minimum of 70% of the casino personnel should be local, research carried out by the Ministry of Tourism in 1998 indicated that this requirement was honoured more in the breach than in the letter. Thirteen out of 18 casinos surveyed employed fewer than 50% local staff, and four employed fewer than 20%. Only two either met or exceeded the 70% target (Ministry of Tourism, 1998). The majority of the staff are from either Turkey or Eastern Europe.

Far from boosting business for local shops, bars and restaurants, many of them claim to be suffering as a result of the casinos. Restaurateurs complain that the casino tourists seldom venture out to sample the local restaurants. What is worse, they also claim that their local business (i.e. their Cypriot clientele) is influenced by the free food, drink and entertainment offered in the casinos. This particularly hits alcohol sales, where local restaurants derive most of their profits. Although no official statistics have been gathered, anecdotal evidence from the restaurateurs' association suggests that restaurant closures have increased with the upswing in casino activity.

Relationship to tourism

Despite the fact that rents and illegal income from selling off licences provide a 'hidden subsidy' to hotels in northern Cyprus, this income benefits only a small proportion of the hotels trying to make a living from tourism. Only four- and five-star hotels are allowed to have casinos, yet 85% of the membership of the hoteliers' association is made up of one- and two-star hotel owners. Small-scale hoteliers complain that their traditional market is being squeezed out by the priority given to casino tourism. The president of the hoteliers' association claims that tour operators have stopped actively promoting northern Cyprus as a "family market," thereby changing its tourist profile. Travel agents point out that casino tourism is exacerbating the transportation bottlenecks to which the north is subject by monopolising

scarce aircraft seats at the expense of other tourists. There is also evidence that the local tourist supply chain is being distorted by the trend for casinos to deal directly with tour operators in Turkey and elsewhere, thereby cutting out local travel agents. This practice is technically illegal, but appears to be increasingly rarely policed.

A Policy Stand-Off?

The casino sector in northern Cyprus is characterised by uncertainty and lack of clarity, at least a partial consequence of the stop-and-go, contingent nature of casino tourism in northern Cyprus and its extreme dependency on developments in Turkey. The government has been criticised for being too reactive and ad hoc in relation to the casino sector. But some casino operators go further and accuse politicians of deliberately prolonging the state of uncertainty surrounding the casinos and exploiting the polarisation of public opinion for political capital. In a public statement in June 1999, the head of the Association of Casino Investors and Operators claimed: "The government does not accept us as a sector, they have classified us in the same category as gambling houses, whore houses and seedy coffee shops. Their goal is to shut us down" (*Cyprus Today*, 19/6/99, p. 2). According to this view, the government's failure so far to establish a gaming control board is symptomatic of its unwillingness to seriously engage the casino sector.

The pressures on the government to grant new licences have become so great, however, that it is finally being forced to take a position, which is proving to be no easy matter. Personal interests flourished in the previous laissez-faire climate and casino operators are now unwilling to bow to stricter regulation by government. The publication in June 1999 of a draft bill amending the Gambling Establishments, Casinos and Gambling Prevention Law provoked a strong reaction from casino operators. The bill proposed tightened restrictions on entry into casinos and an entry fee of $10 US. The bill also provided for more vigorous action against "illegal gambling" (i.e. by citizens of northern Cyprus and students), with increased fines and up to two years' imprisonment for individuals, and even stiffer penalties (fines, three years' imprisonment and possible closure) for casino management who permit illegal gambling on their premises. The Association of Casino Investors and Operators, which had been moribund up to this point, responded with a full-page public announcement in *Kibris* newspaper (20/6/99) denouncing the proposals, and threatened to close

down all of the casinos over the summer season "so it is understood how much this sector affects tourism and the economy" (*Cyprus Today*, 19/6/99: p. 2). The amendments were watered down, and the threatened closures did not occur.

Conclusion

Eadington (1995) has pointed out that places eager for the economic benefits of casino tourism development often overlook the associated costs of establishing and maintaining an adequate policy and regulatory framework. Resource constraints alone, however, do not fully explain the experience of northern Cyprus. As McMillen (1996b) points out, to approach casino tourism development solely from the angle of costs, benefits and technical management solutions ignores the radical transformations in social, cultural and economic relations into which casino tourism destinations are thrust, and in which the state, out of necessity, plays a central part as the source of legitimation, legislation and public policy. The history of northern Cyprus's involvement with casino tourism provides a telling illustration of McMillen's further observation, that governments are "constrained and complex forums for competing ideas, rather than the autonomous and single-minded organisations assumed from a paradigm of economics and public choice" (1996b: 31).

What is most striking in the northern Cyprus case are not the financial barriers to achieving regulatory efficiency, but the state's inability to reconcile conflicting internal and external political and ideological pressures (exacerbated by its symbiotic relationship with Turkey and dependence on developments there); its failure to send out clear signals to the competing interest groups and the general public and its unwillingness to engage the casino sector seriously, from a position of strength. The example of northern Cyprus suggests that the obstacles to economic development which characterise peripheral regions, and which are rooted in conditions of dependency, vulnerability and uncertainty, are likely to be intensified rather than alleviated by the relationship with the footloose, global casino industry.

Acknowledgements

Fieldwork was funded by the Development and Diversity programme of the University of North London. My thanks to colleague Sahap Asikoglu for his invaluable collaboration, and to Dr. Turgay Avci of Eastern Mediterranean University for the generous research facilities made available. I am also grateful to the anonymous reviewers for their comments.

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This article was peer-reviewed.

Submitted: October 16, 2000
Accepted: March 1, 2001

Julie Scott is a social anthropologist at the Centre for Leisure and Tourism Studies of the University of North London. For the past ten years she has carried out research into various aspects of tourism in northern Cyprus and the Mediterranean, where casino tourism has, of late, assumed a growing importance. Her interests lie in using qualitative research methods to explore the social, cultural, economic and political contexts of gambling activity.

issue 4 —may 2001

Go to Current Issue

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Case Conference Responses
Author's Response to Reviewers' Comments and References

Case Conference Report

Gambling-Induced Analgesia: A Single Case Report

By Alexander Blaszczynski, PhD
School of Psychiatry, University of New South Wales
Kensington, Australia
E-mail: a.blaszczynski@unsw.edu.au

Fiona Maccallum, MPsych (Clinical)
South Western Sydney Area Health Service, Liverpool Hospital,
Liverpool, Australia

Abstract

This paper describes a single case study of analgesia induced by gambling. The subject is a 48-year-old male diagnosed with pathological gambling

problems, suffering chronic back pain resulting from a road trauma. The reported intensity of arousal associated with slot machines and roulette produced a state of dissociation or distraction that temporarily reduced levels of pain. Consistent with an operant conditioning model, this reduction in pain was a negative reinforcer that acted to elicit further gambling whenever the pain reached a certain level of discomfort. In the absence of any effective analgesic medication, he used gambling as his predominant strategy to manage pain. He began to enjoy gambling, and within a relatively short period, lost more than he intended and commenced chasing losses. Pain levels decreased following chiropractic interventions, but his gambling continued. The additional, positive reinforcing effects of the excitement generated by the slot machines and roulette gaming became sufficient to maintain persistence in gambling independent of pain experienced. This case highlights the possibility that psychological factors involved in establishing a gambling habit may differ from those involved in maintaining persistence.

Introduction

Several authors have suggested that the need to escape negative emotional states partially explains the motivation for persistent gambling in a proportion of participants (Blaszczynski & McConaghy, 1989; Jacobs, 1989; Wynne, 1994). The central concept underlying this view is that gambling is capable of producing sufficient arousal to induce a state of narrowed attention, or an altered state of consciousness characterised by amnesic episodes, trance and dissociation. It is argued that this state of consciousness permits a person who is gambling to temporarily 'switch off' from stressful thoughts, reduce boredom (Blaszczynski, McConaghy & Frankova, 1990), escape emotionally from their current situation or cope with feelings of inadequacy or rejection. Although imprecisely defined, the phenomenon of dissociation, the cornerstone of Jacobs' *General Theory of Addictions* (1989), is claimed to mediate this process.

Studies demonstrate that gambling is associated with subjective and physiological indices of arousal (Anderson & Brown, 1984; Leary & Dickerson, 1985; Dickerson & Adcock, 1987; Roby & Lumley, 1995) and high scores on measures of dissociation (Kuley & Jacobs, 1988; Brown, 1997; Gupta & Derevensky, 1998). Empirical data offered by Diskin and Hodgins (1999) demonstrate the ability of gambling to engross participants during play. The authors demonstrated that reaction time in response to visual stimuli during a laboratory session of gambling was slower and scores on a dissociative scale

higher among 12 people with pathological gambling problems who played video lottery compared to 11 occasional players.

We present an interesting case of a male for whom arousal associated with gambling invoked a dissociative-like state (or level of distraction) that induced analgesia for chronic back pain. His gambling rapidly escalated as it was an effective strategy that distracted him from his chronic back pain. According to principles of operant conditioning, removal of pain negatively reinforced gambling and led to the development of a gambling habit. However, consistent with the behaviour completion mechanism model (McConaghy, 1980; McConaghy, Armstrong, Blaszczynski & Allcock, 1983), once his gambling became a habit, he acknowledged that he played independently of pain. He enjoyed gambling for the excitement it generated, and in response to urges triggered by stresses of any nature or source.

Case history

Mr. S.M. was a 48-year-old married, self-employed businessman. He referred himself for treatment because, for one year, he played slot machines and roulette excessively. He reported a mean net expenditure of AUD $500 to $800 per session (on infrequent occasions, more than AUD $1,000), frequently playing twice a week for two hours. He endorsed seven of 10 DSM-IV criteria and obtained a South Oaks Gambling Screen (Lesieur & Blume, 1987) score of 11. Mr. S.M. produced bank statements verifying recurrent withdrawals of AUD $200 from gambling venues.

Mr. S.M. consented to publication of this case study.

Personal details

Mr. S.M., second youngest of four boys, was born in Germany in 1950, went to school, and then migrated to Australia with his family at age 20. His father, a cabinetmaker, died 20 years ago from a heart condition and his mother lives near his residence. His developmental milestones were normal and his childhood unremarkable. The family was close and he maintains irregular contact with his brothers.

In Australia, he commenced but did not complete a diploma in chemistry. He was employed as a technical assistant in a painting and printing research and

development laboratory. He subsequently embarked on a relatively successful career as a self-employed businessman, importing goods and earning approximately AUD $240,000 per annum. He is a gregarious and talkative person.

At age 21, he married a nurse and they had three children. He described the relationship as "good." In 1984, because they both worked long hours, they experienced marital difficulties, which resulted in a two-month separation.

Mr. S.M. denied the presence of a family or premorbid history of psychiatric illness, alcohol dependency or illicit drug use. He consumed alcohol socially; less than two standard drinks per day on average; although, because of a car accident, he drank more when he experienced severe pain. There was no evidence suggesting a personality disorder, thought disorder, antisocial or conduct-behavioural problem, nor was there evidence of any significant medical illness prior to the injuries sustained in the accident.

History of physical injuries

In June 1997, Mr. S.M. was involved in a motor vehicle accident and sustained severe bruising, soft tissue whiplash injuries and a fractured spine and sternum but did not lose consciousness. He continued to suffer significant back pain and psychological changes characterised by increased irritability, anger and depression. His back pain was located in the lumbar regions L1 and L2 and upper neck and shoulder area. He described it as severe fluctuating episodes lasting a day or two with continual moderate pain. Using the McGill Pain Questionnaire (Melzack, 1975), his pain was rated at a score of three; which is distressing because of its intensity. Using the rank value method, the following pain scale scores were obtained: sensory, 6; affective, 16; evaluative, 10; and miscellaneous, 13; giving an overall total Pain Rating Index of 45. He stated that he was unable to stand or sit for any length of time and said this had hampered his ability to function at work.

Taking analgesic medication such as Panadeine Forte and Efexor (300 mL) daily temporarily alleviated pain but did not eliminate it completely. When the pain was severe, he would consume several glasses of alcohol over a few hours.

Mr. S.M. became depressed due to the pain, which interfered with his capacity to work and restricted his quality of life. He consulted a psychiatrist for counselling and a hypnotist for pain management and he initiated

compensation because of his injuries.

Gambling history

Mr. S.M. commenced gambling at 17, infrequently betting AUD $5 on horse races at off-track betting venues. He also began playing slot machines socially, and infrequently attended a casino with friends and or his wife. There was no reported loss of control over the 15-year period prior to 1998.

In March 1998, Mr. S.M. attended a casino with his wife and won AUD $4,500. Significantly, he noted that gambling (and winning) produced a state of excitement —powerful enough to act as an effective analgesic for his pain. The excitement altered his mood and self-confidence: "Nothing but happy thoughts, I'm on cloud nine."

As a result, Mr. S.M.'s gambling escalated rapidly over the following three months after learning that gambling was effective in reducing his chronic back pain. Whenever the pain increased, he gambled to reduce its intensity. All other concerns and physical sensations were excluded from conscious awareness:

> "…the concentration on the gambling is so intense that I don't feel anything. I talk with people at the roulette table and become very happy and relaxed. The concentration is on the gambling. Very important, when gambling just small amounts it becomes boring and the pain becomes noticeable. To chase gives full concentration. The pain disappears. This does not work without real [meaning substantial amounts] money."

On the Jacobs (1989) four-item dissociative scale, he failed to endorse depersonalization ("…ever felt like you were outside yourself watching…") and reported only occasional memory lapses. The remaining two items were rated as frequently: "I'm really into it [gambling], everybody is a shadow when I am playing" and "I feel totally happy, invincible."

The negative reinforcing effects of gambling led to a cycle where gambling represented a costly approach to pain management. He lost substantial amounts and, given his restricted capacity to earn money, was forced to sell investment properties to cover expenses. He began to chase losses and developed erroneous beliefs about his skills and probability of winning. Over three months, he lost approximately AUD $20,000 and made repeated,

unsuccessful efforts to cease gambling.

Between March and September, Mr. S.M. was offered imaginal desensitisation (McConaghy et al., 1983) and cognitive therapy designed to correct erroneous perceptions. He reported an estimated improvement of 60 to 90 per cent (as assessed by frequency and amount used to gamble).

Chiropractic manipulation partly contributed to this positive outcome of pain reduction, and his back pain stabilised to tolerable limits. In September 1998, he reported that he gambled less frequently, reduced the amount substantially, and that current gambling sessions were not motivated by the need to induce analgesia. His gambling patterns changed significantly and he often gambled within controlled limits motivated by social enjoyment. He made the conscious decision to play for excitement in weekly one-hour sessions with a net expenditure of $100. However, there were additional binge episodes that were triggered by a range of stresses or depressed moods related to worries over his compensation proceedings and inability to work. At these times, he spent more than intended, losing up to AUD $250 to $350 per session.

At his October 1999 follow-up, he reported continued improvement of approximately 80 per cent from pre-treatment levels of amount and frequency of gambling. However, he still had intermittent lapses during the intervening 12 months in which he lost up to $400 (amounts significantly less than those lost in earlier binge episodes). On one occasion, he was under considerable pressure and decided to gamble despite the efforts of his friends to contain him. He acknowledged awareness of his actions but felt the need to release pent-up stresses and the overwhelming drive to gamble. In another episode, conflict with barristers and anxiety associated with the preparation of compensation reports provoked a serious episode where he gambled AUD $1,000 but aborted the session despite having access to money.

When last seen, in December 1999, he reported no subsequent episodes of excessive gambling. On several occasions he entered gambling premises with his wife, but either did not gamble or limited his gambling to a small amount with no difficulty, deciding to cease despite having AUD $2,000 or more in cash. He acknowledged a persistent underlying urge to gamble but claimed it was controllable. Given his fluctuating pattern of improvement, his prognosis was regarded as positive, but uncertain in the longer term. Cognitive therapy and counselling continued to be offered.

Discussion

It makes intuitive sense to argue that gambling represents an exciting activity capable of generating sufficient levels of arousal. Gambling offers an opportunity for emotional escapism by narrowing a player's attention, and altering his or her state of consciousness and sense of disconnection from self and environment. From a behavioural learning perspective, the reduction in aversive mood states is a negative reinforcer. Once immersed in gambling, all extraneous aspects of a person's life can be excluded from conscious thought, while attention and concentration are directed at the single task of winning, anticipating the next outcome and the powerful, ego-boosting fantasy associated with winning.

A number of authors have underscored the desire to escape stressful situations, memories and aversive mood states as a primary motivation for continued participation in gambling. Anderson and Brown (1984) first hypothesised that the physiological arousal and subjective excitement associated with gambling could sufficiently narrow attention to allow participants to escape from their current state of emotional distress.

Jacobs (1989; 1998) incorporated this concept as a central feature of his *General Theory of Addictions*, arguing that such arousal was comparable to dissociative-like phenomena. He has produced convincing empirical data to show that people who gamble experience blurred reality, shift in persona, depersonalisation and amnesia for events occurring during gambling (Jacobs, 1998). According to Jacobs, addiction is defined as "a dependent state acquired over time by a predisposed person in an attempt to relieve a chronic stress condition" (Jacobs, 1989, p. 35). Addiction to gambling specifically arises from an interaction of two predisposing variables: an abnormal state of physiological hyper- or hypo-arousal and negative childhood experiences invoking rejection, inadequacy and low self-esteem.

In this model, the potential to induce a dissociative-like state that diverts attention from chronic aversive arousal states, deflects thoughts of self-perceived inadequacies from consciousness and fosters the emergence of wish-fulfilling fantasies that give gambling its "addictive" qualities. Gambling represents a problem-solving method that permits psychological escape through mechanisms of dissociation.

> "[It is a] normal…defence we all use against distractions in everyday life. We also use dissociation as a defense when high levels of psychological distress, physical pain, or sense of helplessness caused by a traumatic incident or a continuing

> aversive condition overwhelms a person's resources for coping with the stress it engenders" (Jacobs, 1998, p. 4).

That people who gamble obtain elevated scores on measures of dissociation has been found repeatedly; (Gupta & Derevensky, 1998; Kuley & Jacobs, 1988) although with some contrary results. For example, Diskin and Hodgins (1999) found that a small sample of people diagnosed with pathological gambling problems had higher dissociative scores than people who gambled occasionally, but neither differed from normative scores.

However, dissociation is a complex concept that lacks a single framework. It is variously conceptualised as a non-integrated mental module or system, an alteration in consciousness resulting in a disconnection from self or environment, or a psychological defence mechanism (Cardena, 1994). In Jacobs' model, dissociation is used with various meanings with no attempt made to distinguish it from altered states that emerge as correlates of ordinary "distraction." As Cardena (1994) cautions, labelling any simple disconnection between self and perceptions, or emotions and thought as dissociative weakens the utility of the construct. The term should be retained for circumstances where there is a qualitative disconnection from ordinary modes of experience. We are suggesting that there are many normal activities that engross the participant wherein they become so focused they lose perceptions of external and internal stimuli. These activities are enjoyable and participation is sought recurrently. Examples are sporting contests, computer play, reading and board games. Gambling can be conceptualised in the same vein without recourse to more complicated concepts of dissociation.

In the present case study, Mr. S.M. was so engrossed in gambling that he was distracted from pain, which led directly to increased participation. It should be noted that distraction is used effectively in pain management strategies without recourse to dissociation as an explanatory process. Once the habit was established, other factors superseded the analgesic effects as the primary reasons for participation, notably, excitement and erroneous perceptions surrounding the likelihood of winning.

Blaszczynski and McConaghy (1989) adopted a similar position. They argued that gamblers experiencing anxiety selected low-skill games, while dysphoric gamblers chose high-skill games to modulate mood states and achieve optimal levels of physiological arousal (Zuckerman, 1979). However, adopting a neo-Pavlovian, behaviour completion mechanism model, McConaghy and his colleagues (McConaghy, 1980; McConaghy et al., 1983) did not consider dissociation or negative childhood experiences a necessary component of the aetiological process. Rather, a wide range of current external or internal stresses was considered sufficient to trigger the drive to gamble once a

gambling habit was established. This behaviour completion mechanism would drive the person to engage in and complete the sequence of behaviours underlying the urge. The person would experience this as a persistent preoccupation and urge to engage in the behaviour and to carry it through until satisfactorily completed. Attempts to impede this process would lead to an aversive state of increased tension and continued drive to complete the behavioural sequence.

In addition to the operant reinforcing qualities of the excitement of winning, the reduction in aversive arousal associated with the urge to carry out a habitual behaviour to completion and aversive emotional state were seen to represent important negative reinforcers. In the case of Mr. S.M., when the physical pain overwhelmed his coping resources, he gambled as a means of temporarily reducing pain through distraction. Once this became a habitual pattern, this strategy was applied to escape negative emotional states.

This client case presentation was peer-reviewed.

Submitted: July 17, 2000
Accepted: September 13, 2000

Correspondence:

Alexander Blaszczynski, PhD
School of Psychiatry
Psychiatry Research and Teaching Unit
Level 4, Health Services Building
Liverpool Hospital
Liverpool, NSW 2170, Australia.
E-mail: a.blaszczynski@unsw.edu.au
Fax: +61 (2) 9828 4910

Case Conference Responses

Response to a Case of Gambling-Induced Analgesia

By Durand F. Jacobs, PhD, ABPP
Clinical Professor of Medicine (Psychiatry and Behavioral Sciences)
Loma Linda University Medical Center, California, USA

"In our work with young gamblers..."

By Rina Gupta
Youth Gambling Research and Treatment Clinic
McGill University, Montreal, Quebec, Canada

Further Specifying Our Models of Problem Gambling

By David Hodgins
Coordinator, Program Development and Research
Foothills Medical Centre, Calgary, Alberta, Canada

Author's Response to Reviewers' Comments

References

issue 4 – may 2001

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intro | feature | opinion | research | service profile | first person accounts | reviews | letters | archive | submissions | subscribe | links

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First Person
Review
Letters
Submissions
Links
Archive
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First Person Account

[This First Person Account tells how a high school student used the challenge and opportunity of a class assignment to explore gambling among her peers. Note: OAC classes referred to in this article are university preparation courses for students in Ontario secondary schools.

This article prints out to about six pages.]

The Evolution of Discovery: Finding Out the Truth for Myself

By Jennifer Zechmeister
Hamilton, Ontario, Canada
E-mail: jlzechme@uwo.ca

Gambling has become, over the years, an increasingly popular and socially acceptable way for us to spend our leisure time; at the same time, it has become a significant problem for many people. We, as a society, generally tend to focus more on the entertainment value of gambling and fail to fully recognize the negative side, which shows that 10%* of us Ontarians struggle with severe gambling addiction and losses every day. With gambling problems there are no physical remnants to be found by loved ones, as there are with

alcohol or drug addictions. With problem gambling, there is nothing to hide except guilt, shame and, especially, secrets to keep. It is a painful addiction, which can be cleverly covered up by those who want to hide it, and one that destroys the lives of many. It is the hidden addiction.

After personally experiencing how problem gambling can affect others, I have come to a point where I can look at gambling no longer with fear, but with courage. I have chosen to join the battle of awareness and discovery surrounding a problem more severe than the average person imagines. In the past, I was naive enough to believe gambling was merely for fun, and like many, I believed gambling was just another silly gimmick to try to get rich quick. But I've seen the power and control such an addiction possesses. I was left with many questions about gambling that I had never considered before I saw its effects, and many of the questions began with "why?"

In January 2000, I was given the opportunity to search for the answers to my questions. The OAC (Ontario Academic Credit) class called Families in Canadian Society (fancy terminology for sociology) was how I was given this chance. It was simple. Do a research project on an issue or topic that focuses on "the family." Naturally, I jumped at the chance to research the one thing that had torn apart people close to me and the one thing I failed to understand. I read all about gambling: the characteristics and symptoms of a compulsive gambler, his/her family and their own related problems, what help is available —all the while picking out more and more parallels to my own situation. I realized how serious gambling addictions really are. For example, how many people know that compulsive gambling is recognized by the American Psychiatric Association as a mental illness? Compulsive gamblers commonly experience difficulties with drug and alcohol addictions and are more likely to suffer from depression, hyperactivity, agoraphobia and compulsive disorders. They are also more likely than the general population to commit suicide and to smoke; they often suffer more from stomach ailments, insomnia, ulcers, colitis, high blood pressure, heart disease, migraines and skin problems.

After reading information like this, I began to realize how dangerous problem gambling can be and, I began to worry about the gambling practices of children and teenagers (the people who society needs to be most responsible for). In my library visits, I found a multitude of books on teen gambling and statistics that explained why there were so many teens with gambling problems. I found out some startling pieces of information. For example, teens who are involved in gambling are four times more likely to develop addictions than their adult counterparts. As with alcohol or substance addictions, the children of compulsive gamblers are more likely to develop problems with gambling in later years. I realized that via such means as the Internet, children and teens have access to gambling pretty much whenever they want it.

Here's where the problem lies. There are plenty of statistics and studies out there proving over and over how vulnerable teens are to gambling, yet the authorities who are responsible for informing them of this weakness, fail to do so. Furthermore, these authorities promote gambling by advertisements and positive slogans that lead teens to believe that there can't be a negative side to gambling. Teens know that if they drink alcohol or do drugs they do so at their own risk. Because of advertisements and programs at school, many are aware that they may develop addictions due to such behaviours. Are they also aware that the very same adverse effects can come from gambling? Or are they too naive, like I was, thinking that gambling is just a game, for fun, or just something to do?

In my sociology class, I had an opportunity to ask these questions myself. Our assignment was to experience the process of primary research by polling the students in our school with a questionnaire. The goal of the assignment was to learn to appreciate the time and hard work put into the studies we were using everyday as secondary research. I aimed to discover my peers' views about gambling and what their gambling practices were.

For a number of reasons, I went into the assignment with my own opinions and assumptions about my peers' attitudes towards gambling. The secondary school I attended at that time was in a predominantly white, middle-class location, a fair distance away (about an hour) from a large-scale gaming institution. I believed that because of their age most of the students would be unaware of the negative effects of gambling. Most cannot legally gamble.

Age was actually a large factor in my questionnaire. I decided that from the range of students I could access, I would interview OAC (Grade 13) students (N = 37) who were at least 18 and could legally gamble, and Grade 9 students (N = 42) who were 14 or 15 and were the youngest students in our school and too young to legally gamble. I naturally hypothesized that the OAC students, due to their age, would gamble more often and would be more aware of the

negative aspects of gambling.

I administered most of the questionnaires in classrooms and with their teachers' written permission. Others were given randomly to students in the halls or cafeteria. I was always present to explain that all information was strictly confidential and to answer any questions or address any concerns.

My first question was basic. I asked whether gambling is best defined as a good source of entertainment, a good way to get rich quick or a possibly harmful addiction. Surprisingly, over half of the students surveyed (55% of Grade 9 students and 51% of OAC students) believe gambling is best described as "a possibly harmful addiction." I was impressed that students think of gambling in this way. Due to advertisements and our social acceptance of gambling, I believed the majority of students would perceive gambling as "a good source of entertainment"; 38% of the Grade 9 students and 41% of the OAC students did, in fact, choose that answer.

My second question worked with the first in addressing the effect gambling has on our society. Although about half of the students believe gambling is best described as a harmful addiction, 64% of the Grade 9 students and 46% of the OAC students say that gambling has a neutral effect on our society, while 31% of the Grade 9 students and 30% of the OAC students believe gambling has a negative effect on our society. If gambling is best described as an addiction, isn't it natural that it would have a negative effect on us? Perhaps, the students don't see gambling addictions as serious, or perhaps the entertainment value of gambling is too strong to ignore. Only 5% of the Grade 9 students and 22% of the OAC students believe gambling has a positive effect on our society. I expected the answers of the Grade 9 students compared to the OAC students to be drastically different because of the age difference. Yet, looking at the statistics, they are similar, showing an impressive level of awareness by the younger students.

Another question brought similar responses from the two age groups. However, this time the results weren't as positive. First, I gave them a commonly used definition of gambling:

> "Gambling means placing a bet, whether for money or not, where the outcome of an event is uncertain or depends on chance, and in which the player may or may not be able to improve the chances of winning because of his or her skill."

Then I asked them to keep this definition in mind while answering if they gamble or have ever gambled. Eighty-three per cent of the Grade 9 students and 92% of the OAC students (only 9% more) answered this question in the

affirmative.

About 40% of the Grade 9 students who gamble report that they do so approximately once a year; half of these 14 to15 year old teenagers gamble at least once a month; 6% gamble at least once a week and 6% gamble more than once a week. Should we worry about the 12% who are gambling on such a regular basis?

Yet again, their responses show little difference between the two age groups. Of the OAC students who gamble, 56% report themselves as yearly gamblers; only 35% are monthly gamblers; 6% gamble once a week and 3% gamble more than once a week. These older students can gamble legally and only 9% do so on a regular basis. Comparing the statistics, Grade 9 students, who are illegal gamblers, are more regular gamblers than the OAC students, who are legal gamblers.

Since the Grade 9 students are not permitted to enter casinos or any other large-scale gaming institution, or to purchase lottery tickets, the statistics show that their gambling tends not to be institutionalized. When asked what forms of gambling they participate in, over half (57%) report they play cards for money and 51% contribute to sports pools or other types of pools. Forty per cent of these students report having played lottery tickets and 40% played bingo. Do their parents buy them lottery tickets? Do they go to family bingo? Are the people they trust the most treating these actions as harmless?

The students were also asked what they win when they gamble. The results were age-appropriate: the Grade 9 students report winning such things as tickets to movies, candy, bicycles; whereas the OAC students only report winning money. This reinforces the fact that the younger students are participating in small-scale, non-institutionalized gambling. But does this necessarily mean that they are participating in harmless gambling? Are these innocent gambling practices of their youth creating potentially dangerous attitudes for adult behaviour?

Over all, from both age groups, the students reported that 71% of their parents gamble, and that 23% gamble yearly, 34% monthly, 34%gamble weekly and 9% gamble more than once a week. These numbers suggest most parents are social or casual gamblers as opposed to problem gamblers. However, in this day and age, are casual gamblers giving children and teenagers the impression that gambling is acceptable to the point where teens see no wrong in gambling more than once or twice a week? Is this setting the teens up for future problems? How will they differentiate between safe and problem gambling practices?

Thirty eight per cent of all students surveyed know or have known somebody with a gambling problem. Twenty-seven per cent of the students report the gambler to be under 20 years of age. This suggests to me that they are friends of the students; 7% of the students report the gambler to be between 21 and 30; 13% between 31 and 40; while 43% report the problem gambler to be between 41 and 50 (the probable ages of their parents); and 10% report the gambler to be over 51. Seventy per cent of the students report that the people they know or have known who have gambling problems have not yet recovered and still struggle with the illness. This suggests that some students are regularly exposed to gambling problems through their friends, parents, and relatives. Isn't it time they learned how to help their loved ones?

After doing my own research and analyzing all of this for myself, I am still left with many questions. However, I have started to answer many of them, and hopefully have made others start thinking as well. It is important to understand that what we do as children, more often than not, influences our actions as adults. Things that may seem innocent and harmless, like playing cards for money, may do more long-term damage than we even care to imagine. Ten per cent of us currently have problems with gambling. I would be willing to bet money that 10% of us believe scratching lottery tickets as young children cannot possibly have adverse effects later in life. I'm not a social scientist with multiple degrees attached to my name, so take my opinions and statistics for what they are worth to you. Do your own research, question what the advertisements say and join the battle of awareness and discovery. It's time to expose the hidden addiction. Thank you.

**The statistic of "10% of [adult] Ontarians" with gambling problems can be seen as an inflated figure. The source for this figure (Van Rijn, 1995) chose to include those who endorsed having even one gambling problem on the South Oaks Gambling Screen (SOGS). However, to be identified as having a clinically significant gambling problem, a person would have to endorse at least five items on the SOGS. Recent research on the prevalence of gambling problems offers a different view. A widely accepted meta-analysis by Shaffer, Hall and Vander Bilt (1999) describes lifetime prevalence rates of probable pathological gambling of 1.7% for adults and 4.3% for adolescents in the United States and Canada.*

—The editor

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Submitted: September 17, 2000

This account was not peer-reviewed.

Jennifer Zechmeister is a first-year student at the University of Western Ontario in London, Ontario. Currently in the Faculty of Social Science, Jennifer hopes to attain a post-graduate degree in journalism. Jennifer was born and raised in Hamilton, Ontario and graduated from her local high school with an award as an Ontario Scholar.

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Case Conference **Responses**

Response to a Case of Gambling-Induced Analgesia

By Durand F. Jacobs, PhD, ABPP
Clinical Professor of Medicine (Psychiatry and Behavioral Sciences)
Loma Linda University Medical Center, California, USA

I will attempt to cast the case of Mr. S.M. within the context of the *General Theory of Addictions* (Jacobs, 1982; 1986), key elements of which are summarized in the Discussion section of Dr. Blaszczynski's paper. From this perspective, I view the most devastating immediate and continuing result of the patient's accident as the loss of the psychological, social and financial rewards that stemmed from the business that he had created, and in which he had become so involved that at one time it even threatened his marriage.

In effect, the accident robbed this man of the essential substance and quality of his life, and left him virtually adrift from his previously established moorings.

His chronic and episodically severe pain further restricted his former, physically active work and social life. This combination of physiological and psychological stressors set the stage for his later, enthusiastic "discovery" that high

excitement while gambling actually provided an escape from all his stressors: from his preoccupation with feelings of low self-worth; from his worry about his failing business and attending money problems; as well as from his severe pain and its attending physical limitations. Moreover, he stated that he frequently experienced an altered, clearly dissociated, state of consciousness and identity while gambling. In this altered state, his mood and self-confidence were dramatically improved and he felt superior to others —invincible.

That his analgesic release from pain, while gambling, was only one component of the above dissociated experience is evidenced by the fact that his gambling "binges" continued long after the pain had become manageable. As Dr. Blaszczynski relates, the later gambling binges continued to be triggered by a range of situational stressors much like those I have described above.

The patient acknowledged that Dr. Blaszczynski's treatment of his erroneous perceptions and expectations regarding gambling had greatly reduced the frequency and amount spent per period of gambling. Yet, the patient also admitted that, despite his own and others' attempts to control his gambling, he still continued to rely on bouts of gambling to escape the build-up of intolerably frustrating stressors in his life that periodically peaked during the treatment period and continued one year after his treatment.

Fifteen months post-treatment, when last seen by Dr. Blaszczynski, the patient reported no binges during the previous three months but admitted that he had a "persistent, underlying urge to gamble," which he claimed he was controlling.

From the perspective of the *General Theory of Addictions* (and my own clinical experience), I don't believe one can talk or reason anyone with pathological gambling problems (or any person with an addiction) out of his or her chosen pattern of addictive behavior, while it is serving that person's needs. After all, in the case of Mr. S.M., pathological gambling was not the patient's "problem." For him, it was his best available solution to his long-standing underlying problems (Gupta & Derevensky, 1998) that were exposed by the physical and the functional disabilities caused by his accident. Until these underlying physiological (hypotensive) and psychological (self-worth) issues are ameliorated by whatever means, and until the patient acquires more effective coping skills for dealing with his daily stressors, I expect that his episodic gambling binges will continue.

I would like to offer a word about the differences between my view of dissociation and those expressed by Drs. Blaszczynski and Cardena. My

clinical experience and research findings consistently support the position that the phenomenon of (self-induced) dissociation constitutes an unbroken continuum of behaviors. This extends from simple, everyday forms of reverie or concentration or distraction to a middle ground, wherein a commonly held and extensively verified set of dissociative reactions are reported by people with addictions, while they are indulging (Jacobs et al., 1985; Jacobs, 1988). Towards the far end of this continuum are ever more extreme dissociative reactions, such as those reported by patients showing post-traumatic stress disorders, functional fugue states and dissociative identity disorders (Jacobs, 1982).

Consequently, I cannot agree with Cardena's argument (1994) that the concept of dissociation should be restricted to the more clinically abnormal circumstances "where there is a qualitative disconnection from ordinary modes of experience." He would thus relegate involvements with ordinary modes of experiences such as board games, computer play and reading to the (non-dissociative) realm of normal engrossments.

I believe it is far more parsimonious to view dissociation as the unbroken continuum described above. Within this conceptual framework, increases in the frequency and types of dissociative reactions reported would indicate the extent to which the person chooses to progressively separate himself or herself (via self-induced changes in thought, emotion, identity, time and/or memory) from ordinary, mildly challenging to highly aversive reality situations. For example, tables 1 and 2 reveal the progressively increasing use of five different dissociative reactions as direct correlates to the increasing extent of self-reported problems with gambling (Jacobs, 2000).

Table 1: Potential Effects of Gambling on Personality among Ontario Adolescents (N = 400)

Personality Effects (SOGS Scores)	No Problems (0)	Some Problems (1–2)	Some Problems (3–4)	Probable Pathological
Lost track of time while gambling	12%	36%	55%	65%

Felt like you were a different person	3%	10%	26%	53%
Felt like you were outside of yourself watching yourself gamble	2%	8%	9%	29%
Felt like you were in a trance	0%	8%	7%	24%
Experienced a memory blackout for things that happened while you were gambling	0%	3%	2%	12%

Compiled by D.F. Jacobs, PhD

Reprinted with permission of Insight Research Canada (1994).

Table 2: Potential Effects of Gambling on Personality among Alberta Adolescents

Dissociative State	% Non-Problem Gamblers (N = 430)	% At-Risk Gamblers (N = 148)	% Problem Gamblers* (N = 77)
Lost track of time while gambling	24%	56%	75%

Felt like you were a different person	7%	23%	29%
Felt like you were outside yourself, watching yourself gamble	2%	7%	26%
Felt like you were in a trance	1%	2%	27%
Experienced a memory blackout for things that happened while you were gambling	1%	6%	20%

** Classification of gambler categories based on SOGS scores.*

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As one knowledgeable about pain management strategies, I find it unacceptable to propose "distractions" as a freestanding entity arbitrarily and without supportive evidence. Distraction, via reading or meditation, is firmly included within the range of simple to more complex dissociation techniques (e.g., self-hypnosis) regularly taught to hospitalized patients reporting chronic, intractable pain (Jacobs, 1980; 1987).

This is a final comment about the respective motives for gambling, which Dr. Blaszczynski attributes to social and pathological gamblers. Overwhelmingly, both groups enjoy the excitement and opportunity to win money. What

separates them is that social gamblers typically set and hold to time and loss limits for a given playing session. When they win larger amounts, social gamblers tend to pocket their winnings and leave. Gamblers with pathological-level problems, like Mr. S.M., find it very difficult when stressed to set or maintain time or loss limits. They rarely pocket the money and leave even when they win very significant amounts. Their overriding motivation is to use winnings and other sources of money to keep playing. Their primary objective is to maintain and enjoy the dissociated, altered state of consciousness that results from gambling. In the words of one person with pathological gambling problems: "The next best thing to winning is losing – just so I stay in action!"

Submitted: November 6, 2000

Case Conference Response

"In our work with young gamblers…"

By Rina Gupta
Youth Gambling Research and Treatment Clinic
McGill University, Montreal, Quebec, Canada

It was a real pleasure reading the article "Gambling-Induced Analgesia: A Single Case Report," as it echoes what we see and experience in our treatment of adolescent gamblers.

The single case report describes a man in his late forties who turned to gambling as a way of escaping the pain of a back injury incurred from a serious car accident. Gambling, for him, resulted in analgesic properties allowing him to escape physical pain for brief periods of time. The article also reported that he experienced depression as a result of his pain, and that he would also engage in binge drinking as a means of escape. One must wonder if he was also intentionally escaping feelings of depression with his gambling and use of alcohol.

What is particularly interesting about this individual is that he continued his gambling despite an improvement in his physical condition, and he was aware

of gambling for reasons other than its analgesic effects; that is, primarily for the excitement. He continued to gamble beyond the limits he set for himself and recognized that the reasons causing him to begin gambling in a problematic fashion were not the same as those maintaining his gambling involvement.

In our work with young gamblers, we often encounter adolescents whose motivations underlying their gambling change over time. However, we are more likely to see youth who start gambling primarily for reasons of socialization and excitement, and then realize over time, the "escape" that gambling provides. Those who feel they benefit from the escape are more likely to continue gambling for this property and less for the excitement and socialization advantages that attracted them in the first place.

Our research efforts have consistently indicated a strong linear relationship between degree of gambling and reported degrees of dissociation experiences by youth while gambling. They report that gambling is a "whole different world" where "problems do not exist," where they "feel good." It is not uncommon for us to work with youth who are either mildly or seriously depressed, and they explain that only when gambling do they feel "not depressed" and "alive."

More likely than not, youth who experience gambling problems lack adequate problem-solving, coping and social skills. They often find themselves having friendships that lack depth and closeness, feeling as though they "don't belong" and as though they are incapable of successfully facing the challenges of adolescence. Most of our adolescents in treatment can reflect back on previous years and honestly admit to feeling dysfunctional in many ways —in terms of interpersonal relationships with friends and family, and often, with respect to their academic performance. More often than not, these youth are struggling with identity issues and issues of belonging.

Many of these youth are anxious or fidgety, and may only feel comfortable when engaged in highly stimulating activities. It is no wonder they quickly come to recognize gambling as a solution to their unhappy states of being; to recognize gambling as their new "best friend." This best friend keeps them busy, does not judge or criticize them, satisfies their need for high arousal and stimulation and allows them to forget that they are not functioning well in the outside world.

These words from an 18-year-old girl sum up what we have come to understand about the motivations underlying gambling very well:

" ..It was a whole fantasy life and I felt happier than I ever did before. I didn't

feel sad or bored, or as if I did not belong. I realized that I did not have any real friends, my whole life. I never really had a friend that I could confide in or cry with, or even really laugh with. Now, I felt satisfied and happy and I thought gambling was the best thing for me. …Now I can't stop. I need it to make me forget my problems at school and with my family, and the fact that I have no real friends."

We have not yet treated any youth who were gambling for analgesic reasons, but we have frequently worked with youth who gambled to numb emotional pain resulting from the death or loss of a parent as well as other traumas. While gambling they can feel good and let go of the pain, resulting in a very powerful situation where gambling serves as a negative reinforcer. Most youth, due to a lack of previous gambling involvement, are unaware that gambling will help them escape pain and unhappiness, but they latch onto gambling for these reasons through repeated exposure and their primary motivations for gambling seem to fall into the background.

In sum, we must acknowledge the strong analgesic and escape properties inherent in gambling participation, as well as the fact that reasons for gambling participation can change over time. This awareness will serve to develop better prevention messages and allow for more successful treatment outcomes.

Submitted: October 24, 2000

Case Conference Response

Further Specifying Our Models of Problem Gambling

By David Hodgins
Coordinator, Program Development and Research
Foothills Medical Centre, Calgary, Alberta, Canada

This 48-year-old German man living in Australia could easily be living in Calgary, Alberta, playing our infamous video lottery terminals, or he could be anywhere else in Canada or North America. I am struck by how the clinical presentation of gambling problems is so similar from country to country and continent to continent, despite the fact that our gambling venues, habits and

traditions vary considerably. In many ways, people with gambling problems in different countries seem more similar than different. Frequently, the person with gambling problems describes the functional role of gambling as escape from dysphoria. Grief, depression, relationship difficulties, and pain are commonly cited causes of the dysphoria. Also very common is the report of a "big win" early in the course of the development of the problem.

Various models and theories attempt to account for these aspects of problem gambling phenomena. The author draws upon concepts such as arousal, dissociation, excitement, narrowing of attention and operant conditioning among others. Specific reference is made to Jacobs' general theory and the behavior completion mechanism model. The concept of dissociation in the general theory is accurately identified as particularly fuzzy. It is interesting, however, that all these concepts can be invoked in the conceptualization of this case. None, however, seems necessary or sufficient. Our models are ripe for further development and integration, particularly with clearly specified, parsimonious and testable tenets.

Self-reports and observations of people with gambling problems have been helpful in developing our models. These retrospective reports can, however, be misleading. The challenge to theorists and researchers is to specify these models in a way that allows testable hypotheses that do not depend upon the retrospective reports from problem gamblers. Years ago, we believed that the etiology of Down's syndrome, now recognized as a chromosomal disorder, was related to stressful life events during pregnancy. We based these beliefs on research using retrospective reports of mothers who were struggling to understand a very stressful situation compared with mothers of babies without Down's syndrome (Brown & Harris, 1978). It is not surprising that they were more likely to recall stressful events during their pregnancies. Similarly, various self-medication models of substance abuse, albeit intuitively attractive, have failed to yield strong empirical support when prospective designs are used. Likewise, in the gambling area, we need to move away from sole reliance on retrospective reports as the major dependent variables, and instead, use prospective designs and/or non–self-report variables in studying our models.

I have a number of clinical observations about Mr. S.M.'s treatment. Cognitive therapy designed to correct erroneous perceptions appears to have played a central role in this man's treatment. This approach is curious given that the conceptualization of the case does not focus on erroneous perceptions. Mr. S.M.'s gambling was conceptualized as offering "emotional escapism" through distraction, dissociation or some type of narrowed attention. A logical treatment thus would involve training in alternative distraction techniques generally, and cognitive pain management techniques specifically.

Would Mr. S.M.'s progress have been faster with a treatment more consistent with the conceptualization? Or was the conceptualization limited by the lack of integration of cognitive features? The author alludes to fantasies associated with winning and anticipations of the next outcome but does not appear to view them as central in either the development or maintenance of the problem. I am also curious about why this man developed a gambling problem versus an alcohol problem, or even a narcotic problem. He clearly used alcohol and antidepressant medications to cope with pain with at least some positive effect. Presumably these coping options were more accessible than gambling, but gambling became the "analgesic" that became generalized to coping with other aversive states. Why so? We have much to learn about this fascinating disorder.

Submitted: October 16, 2000

Author's Response to Reviewers' Comments

References

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Author's Response to Reviewers' Comments and References

By Alex Blaszczynski

In this article, we have presented an interesting case describing the development of pathological gambling and attempted to argue that factors instrumental in precipitating impaired control over gambling may no longer be relevant in its maintenance. David Hodgins correctly highlights the fact that there is currently no conceptual model that integrates the myriad factors underlying the development and maintenance of impaired control in pathological gambling.

One can only fully support Hodgins' view that most models make reference to concepts that are neither sufficient nor necessary to explain the onset and continuation of problem gambling behaviours, and that there is an imperative need to advance testable hypotheses and models that rely more on prospective designs, and less on retrospective or subjective reports. Sadly, most efforts to date are founded on the premise that those with pathological gambling problems constitute a homogenous group of individuals influenced by the same complex set of interacting variables. As a consequence, in an effort to explain the aetiological process underlying gambling, there is a tendency to force all gamblers into the one cast. Durand Jacobs' *General Theory of Addictions* models fit into this mould, whereas McConaghy's behaviour completion perhaps less so.

A consistently reported clinical observation is that stresses precipitate bouts of

gambling and that gambling represents a gambler's attempt to escape from emotional turmoil. Gambling produces heightened arousal, narrowed attention and an "altered state of consciousness" variably referring to the gambler as being in a state of dissociation or "in action." The fundamental drive underlying gambling is to maintain this state of arousal with winning as the means by which this state can be prolonged. I endorse Rina Gupta's and Durand Jacobs' views that many gamblers utilise gambling to cope with psychological distress and stresses, but argue that such an explanation applies only to a proportion of those with gambling problems.

Jacobs calls upon a set of predisposing stressors in interaction with hyper or hypo states of baseline arousal. Accordingly, two conditions need to be met in all pathological gamblers: pre-morbid stresses leading a sense of rejection, low self-worth and poor self-image, and a physiological resting state that requires either augmentation or reduction. The psychological motivation underlying gambling is the creation of a state of dissociation that provides temporary relief from psychic pain. Rina Gupta's experiences echo this perspective.

McConaghy's model, on the other hand, invokes the concepts of cortical neuronal substrates and behavioural completion mechanisms to account for recurrent patterns of gambling behaviour. The prerequisite requirements are the development of a habitual pattern of behaviour with no reference to the presence of premorbid psychopathology or negative life experiences. Once a habitual pattern of behaviour is established, a wide range of stressful internal and external events are capable of precipitating the drive to carry out the behaviour. The excitement of gambling distracts the gambler's focus of attention from aversive stresses and thus becomes negatively reinforcing.

I have long argued that it is limiting to conceptualise those with pathological gambling problems as a homogenous population subject to the same pathogenic processes. We must divide this population into at least three subtypes: "normal" pathological; emotionally vulnerable; and biologically disposed impulsive gamblers. Jacobs' model can be legitimately applied to the emotionally vulnerable gambler but falls short of accounting for the normal gambler. McConaghy's model can account for all three groups, and therefore, it is more comprehensive and parsimonious.

Durand Jacobs' clinical assessment that the back injury and resultant chronic pain exerted a profound impact on the client's quality of life, self-image and psychological functioning is not in dispute. But his interpretation that the "enthusiastic discovery that high excitement…provided an escape" through the mechanism of dissociation, while attractive on some levels, is limited in its ability to explain the phenomenon witnessed in this unique and unusual case.

Jacobs correctly observes that gambling is an inherently exciting activity for both social and problem gamblers. He advances the position that the pathological gambler's drive to induce a dissociated, altered state of consciousness is the end consequence of his or her attempt to deal with stresses, and that the primary objective is to maintain this state for as long as possible. This distinguishes the pathological from the social gambler.

However, it is noted that Mr. S.M. described a 15-year history of social gambling yet during this period he did not use the dissociation of gambling as a coping strategy in the context of other life stresses. Why so? If dissociation is to be invoked as the fundamental motivating component underlying impaired control over gambling, it is necessary to provide an explanation of the processes that lead from social to impaired gambling behaviour in individuals with a premorbid history of social gambling and stresses. At the same time, it is important to explain why, in the absence of stress or poor self-image or poor self-worth, a proportion of "normal" gamblers lose control over their behaviour only to regain mastery and resume participation in patterns of controlled gambling.

Part of my argument hinges on the pivotal role purportedly played by dissociation, the key construct forming the foundation of Jacobs' model. Notwithstanding Jacobs' disagreement with Cardena's argument, I must agree with David Hodgins' comments that dissociation is a particularly fuzzy concept.

But have we lost touch with considering the simpler possibility that gambling is an intrinsically exciting and enjoyable pastime pursued for its own sake, much the same as people seek out any other enjoyable activity such as chess, sports or watching movies? Jacobs alludes to this when he refers to the underlying motivation of a gambler as the need to "stay in action." Csikszentmihalyi (2000) defines such recreational activities as "autotelic experiences," ones in which there is no implicit external reward or goal beyond the pursuit of the activity and maximising enjoyment for its own intrinsic sake. Is this not so with gambling? The central feature of this experience is the funnelling of attention toward a limited stimulus field (narrowing of attention), loss of ego or self-consciousness and merging of awareness and activity. In other words, the person pursues the activity for its own sake because it is enjoyable, and in so doing, loses his or her perspective of time, self and environment. The gambler is in action.

The arousal associated with this enjoyment is of a sufficient level, in the case of Mr. S.M., to cause a distraction from pain, perhaps much in the same way that a sportsperson is oblivious to an injury sustained in the height of play, a level of arousal capable of greater distraction than reading or meditation. To call this dissociation imposes an unnecessary complexity on the

epiphenomenona.

Gambling is simply an exciting and enjoyable activity that engrosses one's attention. As such it falls along a dimensional plane as Jacobs suggests. However, in support of Cardena, I would argue that some states of dissociation do not represent an extreme position on a continuum, but a qualitatively different state of consciousness. Therefore, if the term dissociation is to be used in gambling, it is necessary to clarify the term used and to define its operational boundaries. Otherwise, let us just use the simpler term of *distraction* to describe the excitement or enjoyment experienced while gambling.

Hodgins raises a valid point when he questions why cognitive therapy was used rather than training in alternative distraction and pain management techniques. Although not described in the case study, the psychiatrist and hypnotherapist had applied a variety of pain management techniques that together with medication and alcohol use did not prove effective. I would hazard the guess that had such interventions been effective, Mr. S.M. might not have lost control over his gambling. By the same token, alcohol and medication, while ameliorating the severity of pain to some extent, did not match the same profound effect produced by gambling, hence causing gambling to became the effective "drug" of choice.

The inherent arousal produced by the enjoyment of gambling caused a significant reduction in pain, a comparatively greater reduction than was achieved by alcohol, medication or other interventions. Mr. S.M.'s gambling experiences shaped cognitive belief structures leading him to believe that he could eventually win and recoup losses. The cognitive intervention that was formulated and applied was justified on the grounds that, independently of the negative reinforcement produced by the analgesia, his experiences at gambling modified cognitive belief structures that acted to perpetuate further gambling.

Pathological gambling is a major public health problem that exerts a destructive influence on individuals, their families and society in general. To understand the behaviour we need to advance clearly articulated and testable conceptual models. In so doing, we need to be cognisant of several elements: people with pathological gambling problems are not a homogenous population; pathological processes leading to the development of the condition differ between cases; and variables relevant in the development of pathological gambling may not contribute to its persistence.

Submitted: February 1, 2001

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Profile
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First Person
Review
Letters
Submissions
Links
Archive
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Book Review

Gambling and Governments in Canada, 1969—1998: How Much? Who Plays? What Pay-off?

By François Vaillancourt and Alexandre Roy. (2000). Toronto, ON: Canadian Tax Foundation, Special Studies in Taxation and Public Finance, No. 2, xi, 72 pages. Price: $30.00 Cdn.
ISBN: 0-88808-156-1.

Reviewed by Len Henriksson
Faculty of Commerce, University of British Columbia
Vancouver, British Columbia, Canada
E-mail: len.henriksson@commerce.ubc.ca

With the ongoing growth of state-sponsored gambling throughout Canada and much of the western world, this study by Vaillancourt and Roy is of more than a passing interest. Following a brief history of gambling, the authors present a comprehensive overview of the level, composition and importance of government gambling revenues in Canada. The compendium of statistical tables drawn from a variety of domestic and international sources is a useful general reference for researchers in the field.

Three themes emerge from the statistical presentation that invite comment. First, the authors focus on government revenue from gambling and do not include non-government gambling activities in their analysis. While this was no doubt in the interest of simplicity, it may understate the true importance of gambling as a funding mechanism for traditional government responsibilities. For example, hospital lotteries have become a staple in many Canadian cities, while community service agencies have often come to depend on the proceeds of raffles and bingos to fund "off-loaded" activities.

Second, on a more technical note, the authors' breakdown of gambling revenue by source includes a specific designation for video lottery terminals (VLTs). As some readers may know, controversy surfaced over VLTs in several Alberta communities because of concerns about the "addictive" properties of these devices. The question of whether any meaningful distinction can be drawn between VLTs and slot machines represents a continuing challenge for the research community.

Third, using 1995 estimates, the authors show that Canadian government gambling revenues now constitute about two per cent of total government revenues. What I find interesting about this statistic is that it invites study on the relationship between the revenue and the expense side of government ledgers. A high proportion of Canadian provincial budgets is spent on health care. An aging population, technological advances and a competitive international market for health care practitioners will heighten cost pressures further. If governments expand gambling in ways that are later found to cause even tiny increases in health care expenditures, the revenue "growth" becomes illusory, particularly with the advent of intensified competition from offshore locations and the Internet.

The expense summary of provincial lottery corporations is nicely done. An interesting minor addition would be a detailing of marketing and promotion costs. Agencies such as the British Columbia Lottery Corporation rank among the largest advertising accounts in their provinces. It is important to maintain awareness of these expenditures into the future given the well-understood example of tobacco and alcohol marketing.

The authors then review family expenditure surveys using an impressive number of domestic and international sources. They present a multivariate analysis in order to identify the key determinants of purchasing decisions. Their evaluation of the incidence of gambling taxes reveals that they are second only to tobacco in terms of regressivity.

The final part of the study has attracted some interest in the popular press. It

finds that the benefits of gambling in Canada greatly outweigh the costs. The authors begin by reviewing the methodological issues. Appropriately, they point out the need for an "incremental" approach. In the case of problem and pathological gambling, for example, it is important to try to separate out the costs created by other illnesses such as alcoholism in order to get useful results. Unfortunately, the underlying causal linkages remain uncertain, and so, remain "problematic" for cost estimation projections. The difficulty is exacerbated by our limited knowledge of incidence, due to the inherent limitations of self-report data and poor (or unreported) response rates, evident in the two British Columbia incidence studies with which I am most familiar.

The authors' cost estimations include only "real" resource costs. What economists call "transfers" are not included. "Real resource costs ...do not include any form of transfers, including the proceeds of crime (theft), government transfers (welfare), inter-family transfers and bad debts (transfers from creditors to debtors), since transfers do not use additional resources" (p. 41). This is good economic practice but it is also a good reason why so many students of the overall effects of gambling dismiss economic studies that take this line as irrelevant. Such studies do tell us something, but they manifestly do not tell us *everything* about the social impacts of gambling.

To put the economist's definition of economic gain and loss into perspective, consider a tax of $100 on the 100,000 poorest people in the country, the proceeds of which are used to pay a lump sum to the richest person. This would be neither good nor bad (economically) as it merely transfers wealth from one set of people to another. Closer to the problem at hand, if gamblers are driven to embezzle money from others, and they seek out poorer and less well-informed people as the easiest victims, but the government does not respond with additional police and other resources that are costs to the justice system, there is no "loss" to be set against the gains of gambling.

Similarly, if an unemployed or retired person commits suicide because of insufferable gambling losses, there is no economic cost (in fact, there may be an economic gain in the sense that the person will not consume more medical and hospital resources). A cost is recorded only if the person who committed suicide is an employed person, and then, only if he is not replaced by someone who is employed (p. 41). Of course, it is interesting to uncover the narrowly defined economic costs of gambling (and I am not ridiculing the attempt), but as these examples show, the costs are much less than the social losses, many of which show up in economists' calculations as "mere" transfers. Thus, the authors' conclusion that gains from gambling exceed losses must be interpreted with extreme caution.

The "population health paradigm" —defined as a conceptual framework for

thinking about why some people (and hence, some societies) are healthier than others —will help shed more light on gambling as a desirable fiscal tool for governments. Vaillancourt and Roy's treatment of income distribution and socio-economic status is useful in this regard because both have been found to be important determinants of population health.

The authors' assertion that more research is needed to help understand provincial and regional issues associated with gambling expansion is well taken. Their conclusion suggests that the risks of expanded state-sponsored gambling in Canada can be justified by societal and government benefits. On that point, I must respectfully disagree (Henriksson, in press; Henriksson & Lipsey, 1999). That said, I found this study to be a useful contribution to the literature.

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The author thanks Professor Richard Lipsey for his insightful comments and suggestions.

This book review was not peer-reviewed.

Submitted: December 20, 2000

Correspondence:
Lennart E. (Len) Henriksson, PhD
Faculty of Commerce & Business Administration
University of British Columbia
2053 Main Mall, Vancouver, BC, Canada V6T 1Z2
Tel: (604) 822-8289
E-mail: len.henriksson@commerce.ubc.ca

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Centre for Addiction and Mental Health
33 Russell Street
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