

Journal Information

Journal ID (publisher-id): jgi

ISSN: 1910-7595

Publisher: Centre for Addiction and Mental Health

Article Information

© 1999-2003 The Centre for Addiction and Mental Health

Received Day: 15 Month: August Year: 2002

Accepted Day: 28 Month: March Year: 2003

Publication date: October 2003

Publisher Id: jgi.2003.9.9

DOI: 10.4309/jgi.2003.9.9

Gamblers Anonymous: A critical review of the literature

Peter Ferentzy, PhD

Affiliation: Centre for Addiction and Mental Health, Toronto, Ontario, Canada, E-mail: pferentzy@earthlink.net

Wayne Skinner, MSW, RSW

Affiliation: Centre for Addiction and Mental Health, Toronto, Ontario, Ca

Peter Ferentzy is a research fellow in the concurrent disorders program at Ontario's Centre for Addiction and Mental Health. His first book, How Addiction Became a Disease, was provisionally accepted by the University of Toronto Press. He currently conducts research on mutual-aid solutions to compulsive gambling and co-occurring substance abuse problems.

Wayne Skinner, MSW, RSW is the clinical director of the concurrent disorders program and the problem gambling service of the Centre for Addiction and Mental Health in Toronto, Canada. He has over twenty-five years experience as a clinician, supervisor, researcher, consultant and educator. Wayne is an assistant professor in the department of psychiatry at the University of Toronto. He also directs and teaches in the addiction studies certificate program in continuing education at the University of Toronto. He is presently co-investigator on several research studies involving problem gambling and is editing a clinical handbook on the treatment of co-occurring addiction and mental health problems.

Abstract

This study surveys existing literature on Gamblers Anonymous (GA) and issues that help to contextualise our understanding of this mutual aid association. While GA has been the subject of investigation by social scientists, it is still understudied, with a notable shortage of research on issues facing women and ethnic minorities. A need exists for large-scale assessments of GA's effectiveness, more detailed accounts of GA beliefs and practices, increased knowledge of the ways in which GA attendance interacts with both formal treatment and attendance at other mutual aid organisations, and a better understanding of the profiles of gamblers best (and least) suited to GA, along with a clearer grasp of what GA was able to offer those

gamblers that it seems to have helped. This assessment of the current state of knowledge underscores the embryonic state of our collective inquiry into the nature of GA, and the authors emphasise that significant advances have been made. Notably, important targets for study are being identified.

Introduction

Founded in the 1950s, or a little earlier by some accounts ([Browne, 1994](#)), Gamblers Anonymous is a mutual aid fellowship based on 12-step principles. GA has groups in most North American communities, and has established itself worldwide as a resource for people struggling with gambling problems. GA has a unique culture of recovery that in certain ways distinguishes it from fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The most obvious difference may stem from the crippling financial difficulties many gamblers face: GA devotes much time and energy to counselling members on financial and legal challenges.

GA can be distinguished from formal treatment in that it involves peer support rather than professional intervention, yet its objectives are similar: to help members stop gambling and address character “defects,” such as self-centredness, which are purported to have led to the excessive gambling ([Custer & Milt, 1985](#)). However, what really distinguishes GA from formal treatment is not only the power of group dynamics, which institutions often provide, but that practitioners have no involvement. Since gamblers only receive help from other gamblers at GA, both the terms “self-help” and “mutual aid” are salient concepts for understanding this distinction. Part of a larger mutual aid and self-help movement based upon the 12 Steps of AA, and focussed upon compulsive behaviour that need not involve psychoactive substances, GA provides an excellent example of how the 12-step movement has been extended well beyond alcoholism to include other behaviours which can disrupt people's lives.

GA's effectiveness: How it works

When discussions of GA were in their infancy, endorsements were often less guarded than in current assessments ([Custer 1982b](#); [Custer & Milt, 1985](#); [Winston & Harris, 1984](#)), though GA's inability to deal with certain psychiatric issues has long been acknowledged ([Custer & Milt, 1985](#)). Since then, more researchers have come to perceive GA as helpful but incomplete and likely to be more effective in conjunction with other interventions. Such assessments are often based on three considerations:

1. greater attention to the significance of co-occurring substance addictions ([Lesieur & Blume, 1991a](#));

2. 2. more attention to GA's inability to address other special needs ([Rosenthal, 1992](#));
3. 3. concerns about the small percentage of gamblers who achieve abstinence after trying GA ([Lesieur and Blume, 1991a](#); [Petry, 2002](#)). (For example, [Stewart and Brown \(1988\)](#) found that out of a sample of 232 attendees 8% had remained completely abstinent and active in the fellowship one year after their first meeting, and about 7% after two years.

There are also questions pertaining to the type of gambler for which GA is effective. [Blaszczynski \(2000\)](#) has claimed that GA is suitable only for gamblers free of other compounding issues, meaning gamblers who are essentially “normal” save for the gambling problem itself. Yet [Blaszczynski \(2000\)](#) also claims that such gamblers, being relatively well adjusted, are good candidates for moderation instead of abstinence goals, throwing into question their suitability for a program that insists on abstinence. Brown (1986, 1987a, 1987c) has found that gamblers able to moderate their gambling activity are unlikely to stay for long at GA. Further, Brown has argued that GA may suit only the most severe cases as the GA ideology involves the need to “hit bottom” (often called one's “personal low” in GA) and demands abstinence, which, as both Brown and Blaszczynski state, may not be necessary for less troubled gamblers. Brown (1987a, 1987b, 1987c) found that precisely those gamblers who perceived themselves as less troubled were more likely to leave GA. [Stirpe \(1995\)](#) has also argued that GA is appropriate mainly for severe cases. In short, the ideology of “hitting bottom” insists that one must be at the brink — not just financially, but also emotionally — and tends to alienate those who simply cannot relate. Conversely, Blaszczynski's point is that a compulsive gambler with pressing psychiatric difficulties may require more serious intervention than a non-professional society can offer.

This brings to light why the term “effectiveness” in the literature often refers to more than just gambling cessation. Browne (1991, 1994) has discussed GA's lesser emphasis on the 12 Steps and spirituality than AA, and GA's more pragmatic focus upon the gambling itself and issues such as debt. For this reason, Browne considers GA less effective than AA, which puts more focus on the whole self, as an overall therapy. [Browne \(1991\)](#) has also suggested that the relative absence of spiritual and introspective therapies may alienate women and certain minorities. Yet, according to [Browne \(1991\)](#), “12-step consciousness” can be found among GA members affiliated with other 12-step fellowships. [Lesieur \(1990\)](#) has made similar observations. This adds weight to suggestions that GA is incomplete on its own ([Lesieur & Blume, 1991a](#); [Rosenthal, 1992](#); [Petry, 2002](#)) and should be judged on how it can complement other interventions.

Many have argued that a program can be “effective” even if it reduces gambling activity without achieving long-term abstinence ([Blaszczynski, McConaghy &](#)

[Frankonova, 1991](#)), and despite philosophical discrepancies, there is no reason to presume that GA could not play a role in such outcomes. It has long been recognised that GA may have a positive effect even on those who attend only once or twice ([Allock, 1986](#)).

Yet, given the existing state of knowledge, GA's appropriate role is still open to speculation. While most North American gambling treatment programs use GA as an adjunct, a comprehensive understanding of GA's inner workings — its recovery culture and the types of narratives it employs — is lacking. This is due to a dearth of direct observational accounts of GA meetings. There is no shortage of attempts to evaluate GA in various ways ([Abt & McGurrin, 1991](#); [Allock, 1986](#); [Brown, 1985](#); Canadian Foundation of Compulsive Gambling (Ontario), 1996; [Custer, 1982b](#); [Petry, 2002](#); [Potenza, 2002](#); [Preston & Smith, 1985](#); [Rosenthal, 1992](#); [Steinberg, 1993](#); [Stewart & Brown, 1988](#); [Turner & Saunders, 1990](#); [Walker, 1992](#)). Yet [Petry \(2002\)](#) grants that evaluations of GA's efficacy remain tenuous given the current state of knowledge, and argues that large-scale controlled studies of various interventions are necessary for a clearer grasp of what really works for pathological gamblers (though [Brown \(1985\)](#) has discussed some of the difficulties involved in attempting to assess an anonymous fellowship such as GA). GA members have also been studied outside GA to gauge psychological and other issues ([Getty, Watson & Frisch, 2000](#); [Kramer, 1988](#); [Lorenz & Yaffee, 1986](#); [Whitman-Raymond, 1988](#)); however, little descriptive work has been done on the workings of GA itself.

[Livingston \(1971\)](#) provided information that by today's standards is introductory. [Brown \(1986, 1987a, 1987b, 1987c\)](#) has carried out some of the most useful work on the subject of GA, especially regarding the question of why some members drop out. As might be expected, he found that those who left were more likely to consider the talk at meetings to be “meaningless” and were more critical of GA literature than those who remained ([Brown, 1987b](#)). [Brown \(1986\)](#) also found that those who were overly elated at their first meeting were more likely to become disenchanted later on than those with a more balanced initial impression.

Yet these studies relied upon interviews without accompanying observation of GA meetings, so no detailed account is given of what exactly was dismissed as meaningless. Further, since a solid descriptive base is lacking, we are left with speculative evaluation. For example, [Brown \(1987a, 1987c\)](#) found that only gamblers with the most severe problems, or at least those who perceived their problems as most severe, were likely to remain in GA. Possible explanations for this remain unverified: [Brown \(1987a\)](#) speculates that perhaps some members take pride (possibly competitive pride) in the extreme nature of their gambling careers, with the corollary that many members must either embellish their own stories or be unacknowledged and socially sidelined. Direct observation accompanied by interviews would be needed to verify the existence of such a

cultural dynamic and describe its workings.

The study of GA's effectiveness is best understood as a work-in-progress, with important advances identifying better research targets yet still haunted by gaps in available knowledge. When Brown began his studies of GA, little observational work on GA had been done ([Cromer, 1978](#); [Livingston, 1971](#); [Scodel, 1964](#)), and both Cromer and Scodel delivered mainly interesting theoretical discussions and only brief empirical accounts of GA's workings. [Preston and Smith \(1985\)](#) claimed that AA is more effective with people with alcohol problems than GA with gamblers, partly because AA's physical disease conception of an "allergy" to alcohol facilitates "re-labelling," thereby helping to deflect guilt and shame.

While providing valuable insight into the importance of belief systems in mutual aid, [Preston and Smith \(1985\)](#) were nonetheless operating on the premise that the AA and GA programs were virtually identical. Later, Browne (1991, 1994) explored the differences between AA and GA. While this involved some discussion of GA's "consciousness" (1991), such as the lesser importance attached to discussing one's feelings than in AA, little attention was paid to how much feelings are actually addressed in GA because Browne's studies are to a large extent comparative. They are also more evaluative than descriptive, containing (beyond criticisms already mentioned) a critical account of GA's version of its own history ([Browne, 1994](#)). Browne's work does contain some important descriptive material based on direct observation, but does not provide a detailed account of what transpires at GA meetings.

Similar limitations apply to the account given by [Turner and Saunders \(1990\)](#) after a one-year observational study. Critical of the medical model, these authors discuss the moral and emotional implications of GA narratives and practices. They also mention GA's confrontational style as alienating to many newcomers. ([McCown & Chamberlain \(2000\)](#) also describe GA as more confrontational than AA.) Still, the narratives and practices are discussed primarily in terms of their negative implications rather than their actual content. It is possible to appreciate a commentary on the ways in which the medical model alienates those who do not conform to it, yet still question the validity of a critique that hinges largely upon the unattainability of an "ideal self" to which members aspire. The latter, after all, could be said of most spiritual and psycho-emotional endeavours. In any event, despite some significant descriptive observations, one is left mostly in the dark about how GA actually operates.

GA's own literature gives some vindication to Browne's (1991, 1994) contention that "GA consciousness" is pragmatic. The "pressure group," for example, sets GA apart from substance use-oriented mutual aid societies in that GA members take newcomers to task over financial and other issues to help them to "get honest" with their spouses and get their affairs in order (GANSO, 1978). [Browne \(1991\)](#)

discusses GA's "Page 17 consciousness," referring to a set of practical (rather than spiritual or psychological) principles found in GA's most important text (GAISO, 1999).

Overall, the available literature does vindicate GA in other, less direct ways. GA's collective wisdom has demonstrated some scientific merit: the 20 Questions GA poses to help gamblers determine whether they need help compares favourably with other, professionally developed diagnostic instruments ([Ursua & Uribe Larrea, 1998](#)). As well, commentators generally appreciate that GA provides social support that professionals could rarely imitate ([Rugle & Rosenthal, 1994](#)). [Ogborne \(1978\)](#) has argued that modalities are less important to success than the stability and support (such as family networks) a client brings to treatment, and gamblers with social support have been found to achieve longer term abstinence than those without it ([Stein, 1993](#)). [Davison, Pennebaker and Dickerson \(2000\)](#) found that AA members lacking outside support adhere more closely to AA's program, and that alienation from one's normal support networks may lead people to mutual aid; that mutual aid can alleviate isolation through peer support and encouragement. [Walker \(1992\)](#) claims that GA's main strength lies in its collective belief that compulsive gambling can be beaten.

These endorsements of the mutual aid approach are not unique to GA, and stem from a growing awareness of the importance of social support in general. Involvement in mutual aid has also been associated with better results with biological afflictions such as breast cancer ([Davison et al., 2000](#)). Little is known about what, if anything, GA offers beyond peer support. Whether GA's recovery program has merit in and of itself, and if so, for which type of gambler, remains undetermined.

To further complicate matters, questions concerning effectiveness are often laden with assumptions. For example, the answer to whether GA's insistence on abstinence is the best approach, good for some but not for others — or even potentially harmful — hinges upon ideas about the nature of compulsive gambling itself. We now turn to this issue.

The nature of problem gambling

Pathological gambling has been called a "pure" addiction because people feel compelled to pursue and continue the gambling activity even though no mind-altering drugs are involved ([Rosenthal, 1992](#)). GA uses the disease model, and the way GA is perceived is greatly affected by the extent to which this model is accepted. The most prominent view of pathological gambling, at least in North America, is the standard disease model of addiction, the so-called medical model. Even if the DSM IV (APA, 1994) calls pathological gambling an impulse control

disorder, its description of the problem is quite compatible with (and indeed embedded in) the medical model.

The disease conception of addiction involves a few major tenets:

1. Addiction is a primary disease, the cause rather than the symptom of other difficulties.
2. Addiction is progressive, meaning that untreated it can only get worse.
3. Addiction is chronic, meaning that it can be arrested but never cured (hence, abstinent subjects must forever remain on guard).
4. Abstinence is the only solution (Alcoholics Anonymous World Services Inc., 1976; GAISO, 1999; [Peele, 1989](#); World Service Office (WSO) Inc., 1982).

Despite the designation “primary disease,” medical model proponents in the alcoholism field have pointed out that disease primacy need not involve chronological priority. Even if an addiction emerged due to other factors, it can be “primary” once it has taken effect, in the sense that alleviating the initial causes alone would not arrest the addiction ([Flavin & Morse, 1991](#)). According to this view, the main consideration is that “active addiction” is not merely a symptom of other difficulties. The disease model (and by implication GA) can, therefore, be compatible with psychodynamic, psychobiological and other explanations for the problem's onset.

A cursory glance at the literature could easily give the false impression that the medical model is out of favour: it would seem to have more critics than champions. This is mainly a sign of the model's dominance. Its adherents do not necessarily defend it directly, often preferring to vindicate all or most of its tenets explicitly or implicitly. Critics of this model rarely deny that it dominates; instead, argue that it should not ([Abt & McGurrin, 1991](#); [Peele, 1989, 2001](#); [Sartin, 1988](#); [Turner & Saunders, 1990](#)). Also, it is common for researchers critical of aspects of the disease model to support other tenets and advocate co-operation with GA and its disease orientation. For example, [Whitman-Raymond \(1988\)](#), while at odds with the notion of disease primacy, as it downplays the importance of psychoanalytic determinants, believes that psychoanalysts should collaborate closely with GA. Authors with more sympathy for the medical model of compulsive gambling have even pointed out that newly abstinent gamblers can experience physical withdrawal ([Rosenthal & Lesieur, 1992](#)). Blume (1986, 1987) sidesteps questions concerning the disease model's scientific validity by simply claiming that it has proven useful for treatment.

[Walker \(1992\)](#) claims that problem gambling research has been overly reliant on data obtained from GA members and other gamblers in treatment who may have internalised the medical model and may, therefore, be likely to reconstruct their past experiences in accordance with its tenets. [Moreyra, Ibanez, Liebowitz, Saiz-](#)

[Ruiz and Blanco \(2002\)](#) argue that most research suggests that pathological gambling more closely resembles a substance use disorder than an obsessive-compulsive disorder, but mention that the addiction and obsession-compulsion models are not mutually exclusive. They also mention that since most research on pathological gambling has come from the substance use treatment field, many findings could be biased in that direction. Given that substance addiction treatment in North America generally operates along disease model lines and that the late 20th-century trend was to view a host of psychobehavioral ailments in this fashion (often in reference to AA's alcoholism model) ([Peele, 1989](#)), it is not surprising that problem gambling theory and practice have followed suit. This trend has been challenged, of course, often because of its propensity to reduce all pathological gambling to one formula ([Blaszczynski & McConaghy, 1989](#)).

The existing literature does offer alternatives to the medical model. It has been argued that, since problem gamblers score high for both impulsivity and obsessionality, “obsessive-compulsive spectrum disorder” would be a better designation ([Blaszczynski, 1999](#)). Some have argued in favour of an overall propensity to addiction, insisting that problem gambling is simply a subset and should not be treated as an independent problem ([Jacobs, 1987](#); [Jacobs, Marston & Singer, 1985](#)) while others have challenged that view ([Blaszczynski & McConaghy, 1989](#); [Briggs, Goodin & Nelson, 1996](#); [Rozin & Stoess, 1993b](#)). Pathological gambling has been associated with risky sexual behaviour ([Rozin & Stoess, 1993a](#)) and with impulsivity ([Blaszczynski, 1999](#); [Castellani & Rugle, 1995](#)), yet, at least, the latter view has been challenged ([Allock & Grace, 1988](#)). Many view compulsive gambling primarily in psycho-emotional terms ([Sartin, 1988](#); [Taber, Russo, Adkins & McCormick, 1986](#)). [Brown \(1993\)](#) has argued that a non-substance addiction such as gambling requires more focus on purely psychological processes and, thus, could steer understanding of other addictions in similar directions.

Despite the medical model's primacy, there seems to be a trend toward identifying subtypes of problem and compulsive gamblers, which connotes that the medical model — and by implication GA's approach — could not apply to all cases ([Blaszczynski, 2000](#); [Blaszczynski & Nower, 2002](#); [Peele, 2001](#); [Potenza, 2002](#)). The emphasis on typology involves, among other things, the view that two individuals might exhibit similar behaviours for completely different reasons. [Blaszczynski \(2000\)](#) can be taken as an exemplar when he divides gamblers into three types: those whose gambling is rooted in genetic difficulties, those with underlying emotional difficulties, and those who are essentially “normal” save for the gambling problem itself. Brown (1986, 1987a, 1987b, 1987c) was already pointing to the importance of subtypes when attempting to determine what type of gambler is likely to remain in GA. Along these lines, some have argued that the complexities of problem gambling suggest that it is a syndrome rather than a single

disorder ([Griffiths, Parke & Wood, 2002](#); [Shaffer & Korn, 2002](#)). [Berger \(1988\)](#) has discussed different personalities attracted to different games of chance whereas [Dickerson \(1993\)](#) has argued that different games produce different types of compulsion.

Perhaps the most controversial implication of the different views on the nature of compulsive gambling is an issue in approaches to other addictions as well: is abstinence the only solution?

The abstinence principle

GA insists upon abstinence; hence, debates over this principle apply directly to evaluations of GA's program of recovery. Arguably the medical model's most important tenet, the abstinence principle has many critics. Some have argued that the call for abstinence has both positive and negative features (Murray, 2001) while others have been unequivocally critical ([Peele, 2001](#); [Rosecrance, 1988](#); [Sartin, 1988](#)). Most common is the claim that abstinence should not be considered the only solution ([Blaszczynski, 2000](#); [Blaszczynski et al., 1991](#); [Blaszczynski & McConaghy, 1989](#); [Peele, 2001](#); [Walker, 1992, 1993](#)); it has long been argued that GA's call for abstinence may alienate those who do not have the same view ([Brown, 1987b](#)).

As a subset of the medical model, the abstinence principle might appear to have more detractors than supporters, but that would be inaccurate. Many in the field do not defend abstinence explicitly; however, as the dominant solution, abstinence is often the primary or exclusive measure of recovery success rather than the achievement of less harmful gambling patterns ([Johnson & Nora, 1992](#); [Maurer, 1985](#); [Rosenthal & Rugle, 1994](#); [Taber, McCormick, Russo, Adkins & Ramirez, 1987](#)). [McCown & Chamberlain \(2000\)](#) provide a more up-to-date defence of abstinence as a goal in which they discuss reduced gambling activity, though primarily with reference to clients who target abstinence.

There is little in the gambling literature on the virtues or drawbacks of abstinence to distinguish it from more thoroughly developed discussions of these ideas related to substance use problems. [Rankin \(1982\)](#) has argued that since physical dependence is often the criteria for suggesting abstinence in cases of alcoholism, the application of this principle for gamblers is tenuous. [Viets and Miller \(1997\)](#) have pointed out that, in the problem gambling field, even definitions of abstinence hinge upon definitions of gambling. For the most part, however, ideas about abstinence are not specific to gambling, and the gambling literature would benefit from greater attention to theoretical discussions of the abstinence principle's role in recovery.

Many perceive the abstinence principle in terms of its ideological function. While critics such as [Turner and Saunders \(1990\)](#) consider GA members' internalisation of the medical model to be comparable to collective brainwashing, the designation "ideology" need not be derogatory. Rather than attacking or defending the belief in abstinence, many researchers prefer to study the ways in which the principle operates. The acceptance of abstinence by a person with an addiction has been viewed as part of a larger belief system regarding the nature of, and solution to, the problem in question. [Antze \(1979\)](#) has discussed the ways in which mutual aid depends upon mutual identification and internalisation of the group's belief system. [Valverde \(1998\)](#) has claimed that abstinence in AA is not so much a tyranny over desires but a pragmatic reconstruction of habits rooted in strands of 20th-century philosophy as well as ancient, pre-scientific wisdom. In their study of the 12-step-based (AA and NA) Minnesota Model, [Keene and Rayner \(1993\)](#) found the approach favoured those with compatible belief systems (e.g. agreement with the medical model, positive attitudes toward spirituality). Keene and Rayner recommended that clients be served by approaches and theories consistent with their own ways of thinking. There is some evidence for "cognitive profiles" applicable to many AA members ([Ogborne & Glaser, 1981](#)), suggesting that similar work could be done on the personality and cognitive profiles of GA members: Are they field-dependent? Do they demonstrate authoritarian attitudes and an often accompanying need for simple, clear answers, such as abstinence? Work already done on AA members could help researchers in the gambling field move ahead more quickly than AA research pioneers were able to in this area.

Despite its popularity, many researchers are coming to the conclusion that while the abstinence principle may be helpful for some gamblers it could be harmful to others. Given that such questions are nowhere close to settled even in the substance addiction fields, we should not expect consensus among gambling researchers anytime soon.

GA in conjunction with other interventions

Despite the range of opinions about GA's effectiveness and appropriate function, one would be hard-pressed to find critics claiming that GA should have no place at all. GA's cost-effectiveness will ensure that it continues to play a role even if other approaches are found superior ([Walker, 1993](#)). Also, GA is recognised as the most widely available option for problem gamblers on this continent ([Viets & Miller, 1997](#)).

All this may help to explain why many efforts have been made to demonstrate GA's compatibility with certain professional approaches, which is not to suggest that compatibility studies are simply self-serving. Often such studies are guided by a belief that co-operation should replace ideologically rooted competition (Toneatto,

n.d.). Some have argued for the compatibility of GA with cognitive and cognitive-behavioural approaches (Problem and Compulsive Gambling Advanced Workshop, 1986; Toneatto, n.d.). Arguments have also been made regarding GA's compatibility with psychoanalytic methods ([Maurer, 1982](#); [Rosenthal & Rugle, 1994](#); [Rugle & Rosenthal, 1994](#); [Whitman-Raymond, 1988](#)). Overall, compatibility studies have raised points worthy of further exploration. For example, “denial” has long been the main target of both addiction treatment and psychoanalysis; and cognitive therapy, while diverging with 12-step recovery in some respects, also involves deference to certain principles and shares the disease model's emphasis on rooting out self-destructive thought patterns (Toneatto, n.d.).

Overall, studies have suggested that GA attendance in conjunction with professional therapy can yield positive outcomes. [Lesieur & Blume \(1991a\)](#), [Russo, Taber and Ramirez \(1984\)](#) and [Taber et al. \(1987\)](#) followed up clients who had completed such combined programs and each study found abstinence rates of over 50% among clients contacted at various points after discharge. While agreeing that these results suggest that GA in combination with professional therapy produces better results than GA alone, [Petry \(2002\)](#) claims that the studies contain methodological flaws: “One problem is therapy was not specifically described, so replication is not possible.” [Petry \(2002\)](#) concludes that more work needs to be done in this area.

Because some other mutual aid groups share a common grounding in the disease model and a recovery architecture built on the 12 Steps, GA's potential interaction with these groups emerges as an issue for consideration. Unfortunately, little work has been done on GA members who also attend AA, and NA has received even less attention, though [Lesieur and Blume \(1991a\)](#) do discuss a treatment program that made use of client specific combinations of GA, AA and NA. Both [Browne \(1991\)](#) and [Lesieur \(1990\)](#) have mentioned that concurrent attendance at other mutual aid groups can have a positive effect on some gamblers. [Lesieur \(1988\)](#), aware of the many issues that often accompany compulsive gambling, laments the way most self-help societies discourage talk of multiple addictions, and even suggests that an anonymous fellowship be created for that purpose.

There is enough in the literature to suggest that NA should be studied as an option for filling the void Lesieur identified ([Peyrot, 1985](#); [Rafalovich, 1999](#); [Wells, 1994](#)) even though it could only be of use to gamblers with substance use problems. Whereas AA has been inconsistent in its toleration of discussions of problems other than alcohol use, NA may be the only large-scale mutual aid society designed expressly for members to discuss all their obsessions and compulsions (WSO, 1982). While most mutual aid movements cut from the AA mould are focused, like GA, on a single issue (alcohol, eating, gambling, cocaine), NA promotes the broader concepts of “addict” and “addiction.” Unlike AA, NA has no

substance-specific conception of physical addiction; it is rooted in a notion of personality traits similar to an addictive personality concept ([Peyrot, 1985](#); WSO, 1982).

Since researchers have argued that GA works best in conjunction with other interventions ([Lesieur & Blume, 1991a](#); [Rosenthal, 1992](#); [Petry, 2002](#)), and since most treatment programs make use of GA, though some researchers ([Browne, 1991, 1994](#); [Lesieur, 1990](#)) have criticised its lack of attention to emotional issues, the ways in which GA attendance interacts with other approaches presents itself as a research priority.

Gambling and co-occurring substance addictions

It is hard to tell what percentage of GA members have co-occurring substance use issues, though it is safe to assume that levels are considerably higher than in the general population. For example, a study of female GA members found their rate of substance use problems to be two to three times as high as that of the general female population ([Lesieur & Blume, 1991b](#)). Studies have suggested that slightly over half of GA members have abused either alcohol or other drugs at some point ([Lesieur, 1988](#); [Linden, Pope & Jonas, 1986](#)). But work done so far has been preliminary ([Linden et al., 1986](#); [Lesieur & Blume, 1991a, 1991b](#)) and, since there is good cause to believe that GA's membership has undergone recent changes, even the little available knowledge must be considered dated.

While estimates vary, researchers agree that problem gamblers have higher rates of substance use problems than the general population ([Crockford & el-Guebaly, 1998](#); Canadian Foundation of Compulsive Gambling, (Ontario), 1996; [Griffiths et al., 2002](#); [Lesieur & Heineman, 1988](#); [Spunt, Dupont, Lesieur, Liberty & Hunt, 1998](#)). The only comprehensive study on drinking problems among problem gamblers in Ontario ([Smart & Ferris, 1996](#)) suggested that potential alcohol (and other drug) problems be taken into account when gamblers are being assessed. Yet this same study pointed to large discrepancies between different prevalence estimates. And even if varying definitions of substance use problems are taken into account to explain these discrepancies, some researchers have identified the need for harder data (preferably based on meta-analysis) of the overall prevalence of substance use problems among problem gamblers (*The Wager, 2002*). To be blunt, while everyone agrees that problem gamblers (and by implication GA members) are prone to substance use difficulties and that this fact should be taken into consideration during assessment, we are nowhere close to providing solid numbers. One short-term approach may be to take substance use findings and then work “backwards” in order to get a sense of the situation. For example, [Steinberg, Kosten and Rounsaville \(1992\)](#) found that 15% of cocaine users under study were pathological gamblers. [Spunt et al. \(1998\)](#) interpreted the available

evidence to suggest that problem gambling rates among people with substance use problems are four to 10 times that of the general population, but they point to a shortage of research in this area as well

One can only speculate about the current prevalence of co-occurring substance difficulties among GA members. Yet [Blaszczynski and Nower \(2002\)](#) may provide a clue. They argue that problem gamblers without serious psychiatric and other difficulties are less likely to have substance use issues than more troubled gamblers, and claim that this kind of gambling pathology is almost entirely dependent upon availability and accessibility of gambling venues. Given the growing number of legal gambling options, one might expect a higher percentage of this type of gambler. Hence, it is at least possible that a growing percentage of new GA members are free of compounding issues such as substance use problems.

GA and gender

GA has been described as a predominantly male fellowship, both in composition and in attitude ([Mark & Lesieur, 1992](#)). Research on GA has, perhaps unintentionally, reflected this bias as little work has been done on female GA members. Twenty years ago, [Custer \(1982a\)](#) reported that only about four per cent of GA members were women. Yet, more recently, [Strachan & Custer \(1993\)](#) noted that, at least in Las Vegas, more than half of GA members were women. While available information is probably dated, it is safe to assume that GA remains predominantly male but that the number of women members is increasing. This is partly due to demographics: while most pathological gamblers have traditionally been male, the number of female pathological gamblers has been growing ([McAleavy, 1995](#); [Spunt et al., 1998](#); [Volberg, 1994](#)). Further, an increasing sensitivity within GA to the concerns of women has been noted (Murray, 2001).

While GA plays a major role in the treatment of problem gambling, its approach to gender issues has been identified as especially significant. Since many (possibly a majority) of clients are referred to gambling treatment through GA, it has been argued that GA's exclusion of women has inhibited women's participation in formal gambling treatment as well ([Spunt et al., 1998](#); [Volberg & Steadman, 1989](#); Volberg; 1994).

Browne (1991, 1994) has suggested that GA's neglect of spirituality and interpersonal and psycho-emotional issues inhibits women's involvement. [Lesieur \(1988\)](#) has argued that the opportunity to discuss a host of compulsions (rather than merely the targeted addiction) is important to women. Since then, studies have confirmed these suspicions. [Crisp et al. \(2000\)](#) found that male gamblers were more likely to report "external concerns" (employment, legal) as important

whereas women reported more concerns with physical and interpersonal issues. These results suggest that women may require more supportive counselling and psychotherapy whereas men seek information-sharing and cognitive restructuring. [Hraba and Lee \(1996\)](#) found that whereas alcohol was more likely to trigger problem gambling in men, women were more influenced by social issues, such as estrangement from conventional lifestyles and immersion in social settings that involve gambling.

While one can argue that GA's effectiveness is limited to clients without “special needs” ([Rosenthal, 1992](#)), to whatever extent women's concerns are considered special needs is simply a measure of their exclusion. Differences have been noted between male and female GA members. [Getty et al. \(2000\)](#) found that women in GA have higher rates of depression than men. In a study of women from GA, [Lesieur and Blume \(1991b\)](#) found that women were less likely to have begun gambling for the thrill; instead, they were seeking ways to escape problems in their lives.

Despite the dearth of material on women who gamble, we are discovering that much of what we know about women with other addictions (and their differences from men) may apply to women who gamble. This is not a substitute for direct knowledge of female gamblers, but it permits us to extrapolate until further research takes place and should help to guide further research. [Tavares, Zilberman, Beites and Gentil \(2001\)](#) found that, as with other addictions, compulsive gambling progresses more quickly in women than men. [Toneatto and Skinner \(2000\)](#) found that, compared to males, female gamblers reported more use of psychiatric medications, notably antidepressants and sedatives. Further, whereas men were more likely to consume alcohol in the month prior to seeking treatment, there were no significant gender differences with illicit substance use. [Toneatto and Skinner \(2000\)](#) point out that overall these ratios are consistent with gender differences throughout the general population, even if the prevalence of use was higher. [Mark and Lesieur \(1992\)](#), critical of GA as male dominated, argue that its tendency to produce a “men's club atmosphere” should be taken into account by researchers. They suggest, for example, the sharing of “war stories” (graphic, often ugly recollections of a person's history of addiction), by male GA members may alienate women. This suggestion is clearly indebted to our experience with the treatment of other addictions. Many drug treatment settings, along with a number of NA and AA groups, have long discouraged “war stories,” “drunk-alogues” and the like — at least in part because of how they affect women.

In fairness, GA has a history of acknowledging women's needs in at least one respect. GA's recovery culture reflects the template that originated with AA through the emergence GamAnon, a support fellowship for spouses, family members and other individuals whose lives have been negatively affected by someone with

gambling problems. A review of the GA meeting list for Ontario indicates that these groups typically meet at the same time and location as GA groups. This format of double meetings suggests that GA and GamAnon might be more interdependent than similar mutual aid groups in other domains.

Significantly, female gamblers who attend GA have received less attention than female members of GamAnon, which deals with (predominantly female) spouses or partners of GA members ([Adkins, 1988](#); [Bellringer, 1999](#); Canadian Foundation of Compulsive Gambling (Ontario), 1996; [Ciarrocchi & Reinert, 1993](#); [Heineman, 1987, 1992](#); [Lorenz & Yaffee, 1985, 1986, 1988](#), 1989; [Maurer, 1985](#); [Moody, 1990](#); [Steinberg, 1993](#); [Zion, Tracy & Abell, 1991](#)). As it stands from a research perspective, women have received more attention as wives and partners of GA members than as GA members themselves.

GA and ethnicity

If GA's alienation of women also interferes with their likelihood of attending formal treatment ([Spunt et al., 1998](#); [Volberg & Steadman, 1989](#); Volberg; 1994) then this would apply to excluded ethnocultural groups as well.

The available literature is not very helpful on GA and ethnicity, though it has been discussed ([Ciarrocchi & Manor, 1988](#); [Custer & Milt, 1985](#); [Livingston, 1971](#); [Sagarin, 1969](#)). [Browne \(1991\)](#) has suggested that GA's rejection of inner searching could alienate certain ethnocultural groups, and has commented (1994) on how many members of GA are either Jewish or Italian. While it has been argued that cultures where drunkenness is relatively uncommon (e.g. Jewish) have been more prone to gambling ([Adler & Goleman, 1969](#)), little work has been done on the implications of and reasons for GA's ethnocultural composition. Further, given that the world of gambling has been changing in recent years due to the proliferation of legal gambling venues, the available knowledge in these areas is probably dated.

Conclusion

A review of the literature on Gamblers Anonymous points out the paucity of knowledge we have about this approach to recovery despite its pivotal role in our overall efforts to assist people with gambling problems. GA remains a black box about which we know too little. There would be real benefits to a detailed and sophisticated understanding of the processes and events of GA that contribute to its success with some individuals and its lack of success with others. Such a knowledge base would require qualitative and ethnographic research methods, involving respect for GA as a positive social site of human interaction where meaning is constructed for and by those who participate. Large-scale, controlled

studies of GA's efficacy (alone and in conjunction with other interventions) are also an important priority. Such studies could also provide knowledge of GA's ethnocultural and gender composition as well as rates (and implications) of substance use problems among GA members. Since formal treatment programs normally suggest (and often insist upon) GA attendance, the ways in which GA can compliment — or hinder — various types of treatment is an immediate concern.

Issues pertaining to overall effectiveness, co-ordination with other interventions, gender, substance use and appropriate GA member profiles have all been identified in the literature as key targets of inquiry. Surprisingly, however, the research community has had less to say about the need to explore GA's ethnocultural composition and the need to observe GA directly. Nonetheless, since major gaps in our current knowledge of GA have been identified, we can now point with more clarity to the ways in which future studies of this fellowship ought to proceed.

Acknowledgements:

The authors acknowledge with gratitude the Ontario Problem Gambling Research Centre for their support of this research initiative. The opinions expressed are those of the authors and not necessarily those of the Centre for Addiction and Mental Health.

References

- Abt, V., McGurrin, M.C.. (1991). The politics of problem gambling: Issues in the professionalization of addiction counseling. In Eadington, W.R.. & Cornelius, J.A.. (Eds.), *Gambling and Public Policy: International Perspectives* (pp. 657–659). Reno: University of Nevada.
- Adkins, B.J.. (1988). Discharge planning with pathological gamblers: An ongoing process. *Journal of Gambling Behavior*, 4 (3), 208-218.
- Adler, N., Goleman, D.. (1969). Gambling and alcoholism; symptom substitution and functional equivalents. *Quarterly Journal of Studies on Alcohol*, 30, 7333-7336.
- Alcoholics Anonymous World Services Inc. (1976). *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. New York: Author.
- Allock, C.C.. (1986). Pathological gambling. *Australian and New Zealand Journal of Psychiatry*, 20, 259-265.
- Allock, C.C., Grace, D.M.. (1988). Pathological gamblers are neither impulsive nor sensation-seekers. *Australian and New Zealand Journal of Psychiatry*, 22, 307-311.
- American Psychological Association (APA). (1994). *DSM IV: Diagnostic and Statistical Manual of Mental Health Disorders* (4th ed.). Washington, DC: Author.
- Antze, P.. (1979). Role of ideologies in peer psychotherapy groups. In Lieberman, M.A.. & Borman, L.D.. (Eds.), *Self-Help Groups for Coping with Crisis: Origins, Members, Processes, and Impacts* (pp. 272–304). San Francisco: Jossey-Bass Publishers.
- Bellringer, P.. (1999). *Understanding Problem Gamblers*. London: Free Association Books.

- Berger, H.L. (1988). Compulsive gamblers: Relationships between their games of choice and their personalities. In Eadington, W.R.. (Ed.), *Gambling Research:Proceedings of the Seventh International Conference on Gambling and Risk Taking*, Vol. 5 (pp. 159–179). Reno: University of Nevada.
- Blaszczynski, A.. (1999). Pathological gambling and obsessive-compulsive disorders. *Psychological Reports*, 84, 107-133.
- Blaszczynski, A.P. (2000, March). Pathways to pathological gambling: Identifying typologies. The Electronic Journal of Gambling Issues: eGambling [On-line serial] 1. Available: <http://www.camh.net/egambling/issue1/feature/index.html>
- Blaszczynski, A.. McConaghy, N.. (1989). The medical model of pathological gambling: Current shortcomings. *Journal of Gambling Behavior*, 5 (1), 42-52.
- Blaszczynski, A.. McConaghy, N.. Frankonova, A.. (1991). Control versus abstinence in the treatment of pathological gambling: A two- to nine-year follow-up. *British Journal of Addiction*, 86, 299-306.
- Blaszczynski, A.. Nower, N.. (2002). A pathways model of problem and pathological gambling. *Addiction*, 97 (5), 487–499.
- Blume, S.B. (1986). Treatment for the addictions: Alcoholism, drug dependence and compulsive gambling in a psychiatric setting - South Oaks Hospital, Amityville, New York. *Journal of Substance Abuse Treatment*, 3, 131-133.
- Blume, S.B. (1987). Compulsive gambling and the medical model. *Journal of Gambling Behavior*, 3 (4), 237-247.
- Briggs, J.R.. Goodin, B.J.. Nelson, T.. (1996). Pathological gamblers and alcoholics: Do they share the same addictions?*Addictive Behaviors*, 21 (4), 515-519.
- Brown, R.I.F.. (1985). The effectiveness of Gamblers Anonymous. In Eadington, W.R.. (Ed.), *The Gambling Studies: Proceedings of the Sixth National Conference on Gambling and Risk Taking*, Vol. 5. (pp. 258–284). Reno: University of Nevada.
- Brown, R.I.F.. (1986). Dropouts and Continuers in Gamblers Anonymous: Life-Context and Other Factors,*Journal of Gambling Behavior*, 2 (2), 130–140.
- Brown, R.I.F.. (1987a). Dropouts and continuers in Gamblers Anonymous: Part 2. Analysis of free-style accounts of experiences with GA. *Journal of Gambling Behavior*, 3 (1), 68-79.
- Brown, R.I.F.. (1987b). Dropouts and continuers in Gamblers Anonymous: Part 3: Some possible specific reasons for dropout. *Journal of Gambling Behavior*, 3 (2), 137-152.
- Brown, R.I.F.. (1987c). Dropouts and continuers in Gamblers Anonymous: Part 4. Evaluation and Summary. *Journal of Gambling Behavior*, 3 (3), 202-210.
- Brown, R.I.F.. (1993). Some contributions of the study of gambling to the study of other addictions. In Eadington, W.R.. & Cornelius, J.A.. (Eds.), *Gambling Behavior and Problem Gambling* (pp. 241–272). Reno: University of Nevada.
- Browne, B.R.. (1991). The selective adaptation of the Alcoholics Anonymous program by Gamblers Anonymous. *Journal of Gambling Studies*, 7 (3), 187-206.
- Browne, B.R.. (1994). Really not God: Secularization and pragmatism in Gamblers Anonymous. *Journal of Gambling Studies*, 10 (3), 247-260.
- Canadian Foundation of Compulsive Gambling (Ontario). (1996). *Vision of and Role in the Province of Ontario's Comprehensive Strategy for Combating Problem and Compulsive Gambling*. Queen's Printer: Ontario Ministry of Health, Substance Abuse Bureau.
- Castellani, B.. Rugle, L.. (1995). A comparison of pathological gamblers to alcoholics and cocaine misusers on impulsivity, sensation seeking and craving. *The International Journal of the Addictions*, 30 (3), 275-289.

- Ciarrocchi, J.W.. Manor, T.. (1988). Profile of compulsive gamblers in treatment: Update and comparisons. In Eadington, W.R.. (Ed.), *Gambling Research: Proceedings of the Seventh International Conference on Gambling and Risk Taking*, Vol. 5 (pp. 1–25). Reno: University of Nevada.
- Ciarrocchi, J.W.. Reinert, D.F.. (1993). Family environment and length of recovery for married male members of Gamblers Anonymous and female members of GamAnon. *Journal of Gambling Studies*, 9 (4), 341-351.
- Crisp, B.R.. Thomas, S.A.. Jackson, A.C.. Thomason, N.. Smith, S.. Borrell, J.. , et al. (2000). Sex differences in the treatment needs and outcomes of problem gamblers. *Research on Social Work Practice*, 10 (2), 229-242.
- Crockford, D.N.. el-Guebaly, N.. (1998). Psychiatric comorbidity in pathological gambling: A critical review. *Canadian Journal of Psychiatry*, 43, 43-50.
- Cromer, G.. (1978). Gamblers Anonymous in Israel: A participant observation study of a self-help group. *The International Journal of the Addictions*, 13 (7), 1069-1077.
- Custer, R.. (1982a). An overview of compulsive gambling. In Carone, P.A.. , Yolles, S.F.. , Kieffer, S.N.. , Krinsky, L.W.. (Eds.), *Addictive Disorders Update: Alcoholism/Drug Abuse/Gambling* (pp. 107–124). New York: Human Sciences Press.
- Custer, R.. (1982b). Gambling and addiction. In Craig, R.J.. & Baker, S.L.. (Eds.), *Drug Dependent Patients: Treatment and Research* (pp. 367–381). Springfield, IL: Charles C. Thomas.
- Custer, R.. Milt, H.. (1985). *When Luck Runs Out: Help for Compulsive Gamblers*. New York: Facts on File Publications.
- Davison, K.P.. Pennebacker, J.W.. Dickerson, S.S.. (2000). Who talks? The social psychology of illness support groups. *American Psychologist*, 55 (2), 205-217.
- Dickerson, M.G.. (1993). Internal and external determinants of persistent gambling: problems of generalizing from one form of gambling to another. *Journal of Gambling Studies*, 9 (3), 225-245.
- Flavin, D.K.. Morse, R.M.. (1991). What is alcoholism? Current definitions and diagnostic criteria and their implications for treatment. *Alcohol Health & Research World*, 15, 4.
- Gamblers Anonymous International Service Office (GAISO). (1999). *Gamblers Anonymous*. Los Angeles: Author.
- Gamblers Anonymous National Service Office (GANSO). (1978). *The Pressure Group Meeting Handbook*. Los Angeles: Author.
- Getty, H.A.. Watson, J.. Frisch, G.R.. (2000). A comparison of depression and styles of coping in male and female GA members and controls. *Journal of Gambling Studies*, 16 (4), 377-391.
- Griffiths, M.D.. Parke, J.. Wood, R.T.A.. (2002). Excessive gambling and substance abuse: Is there a relationship? *Journal of Substance Abuse*, 7, 187–190.
- Heineman, M.. (1987). A comparison: The treatment of wives of alcoholics with the treatment of wives of pathological gamblers. *Journal of Gambling Behavior*, 3 (1), 27-40.
- Heineman, M.. (1992). *Losing Your Shirt: Recovery for Compulsive Gamblers and Their Families*. Minneapolis, MN: CompCare.
- Hraba, J.. Lee, G.. (1996). Gender, gambling and problem gambling. *Journal of Gambling Studies*, 12 (1), 83-101.
- Jacobs, D.F.. (1987). A general theory of addictions: application to treatment and rehabilitation planning for pathological gamblers. In Galski, T.. (Ed.), *The Handbook of Pathological Gambling* (pp. 169–194). Springfield, IL: Charles C. Thomas.
- Jacobs, D.F.. Marston, A.R.. Singer, R.D.. (1985). Testing a general theory of addictions: Similarities and differences between alcoholics, pathological gamblers and compulsive overeaters. In Sanchez-Sosa, J.J.. (Ed.), *Health and Clinical Psychology* (pp. 265–310). Proceedings of the XXIII International Congress of Psychology of the International Union of Psychological Science.

Amsterdam: Elsevier Science.

Johnson, E.E., Nora, R.M. (1992). Does spousal participation in Gamblers Anonymous benefit compulsive gamblers? *Psychological Reports*, 71, 914.

Keene, J., Rayner, P. (1993). Addiction as a "soul sickness": The influence of client and therapist beliefs. *Addiction Research*, 1, 77-87.

Kramer, A.S. (1988). A Preliminary Report on the Relapse Phenomenon Among Male Pathological Gamblers. In Eadington, W.R. (Ed.), *Gambling Research: Proceedings of the Seventh International Conference on Gambling and Risk Taking*, Vol. 5 (pp. 26-31). Reno: University of Nevada.

Lesieur, H.R. (1988). The Female Pathological Gambler. In Eadington, W.R. (Ed.), *Gambling Research: Proceedings of the Seventh International Conference on Gambling and Risk Taking*, Vol. 5 (pp. 230-258). Reno: University of Nevada.

Lesieur, H.R. (1990). Working with and understanding Gamblers Anonymous. In Powell, T.J. (Ed.), *Working with Self-Help* (pp. 237-253). Silver Spring, MD: NASW Press.

Lesieur, H.R., Blume, S.B. (1991a). Evaluation of patients treated for pathological gambling in a combined alcohol, substance abuse and pathological gambling treatment unit using the Addiction Severity Index. *British Journal of Addiction*, 86, 1017-1028.

Lesieur, H.R., Blume, S.B. (1991b). When Lady Luck loses: Women and compulsive gambling treatment. In Van Den Bergh, N. (Ed.), *Feminist Perspectives on Addictions* (pp. 181-197). New York: Springer.

Lesieur, H.R., Heineman, M. (1988). Pathological Gambling Among Youthful Multiple Substance Abusers in a Therapeutic Community, *British Journal of Addiction*, 83, 765-771.

Linden, R., Pope, H., Jonas, J. (1986). Pathological gambling and major affective disorder: Preliminary findings. *Journal of Clinical Psychiatry*, 47, 201-203.

Livingston, J. (1971). *Compulsive Gamblers*. Lafayette, IN: Purdue University.

Lorenz, V.C., Yaffee, R.A. (1985). Pathological gambling: Medical, emotional and interpersonal aspects. In Eadington, W.R. (Ed.), *The Gambling Studies: Proceedings of the Sixth National Conference on Gambling and Risk Taking*, Vol. 5 (pp. 101-108). Reno: University of Nevada.

Lorenz, V.C., Yaffee, R.A. (1986). Pathological gambling: Psychosomatic, emotional and marital difficulties as reported by the gambler. *Journal of Gambling Behavior*, 2 (1), 40-49.

Lorenz, V.C., Yaffee, R.A. (1988). Pathological gambling: Psychosomatic, emotional and marital difficulties as reported by the spouse. *Journal of Gambling Behavior*, 4 (1), 13-26.

Lorenz, V.C., Yaffe, R.A. (1989). Pathological gamblers and their spouses: Problems in interaction. *Journal of Gambling Behavior*, 5 (2), 113-126.

Mark, M.E., Lesieur, H.R. (1992). A feminist critique of problem gambling research. *British Journal of Addiction*, 87, 549-565.

Maurer, C.D. (1982). Challenges in dealing with pathological gambling in outpatient psychotherapy. In Eadington, W.R. (Ed.), *The Gambling Papers: Proceedings of the Fifth National Conference on Gambling and Risk Taking*, Vol. 1 (pp. 136-144). Reno, University of Nevada.

Maurer, C.D. (1985). An outpatient approach to the treatment of pathological gambling. In Eadington, W.R. (Ed.), *The Gambling Studies: Proceedings of the Sixth National Conference on Gambling and Risk Taking*, Vol. 5 (pp. 205-217). Reno: University of Nevada.

McAleavy, T. (1995, September 10). More women among problem gamblers. *The Bergen Record*, p. H3.

McCown, W.G., Chamberlain, L.L. (2000). *Best Possible Odds: Contemporary Treatment Strategies for Gambling Disorders*. New York: John Wiley & Sons.

Moody, G. (1990). *Quit Compulsive Gambling: The Action Plan for Gamblers and Their Families*. London: Thorsons.

- Moreyra, P., Ibanez, A., Liebowitz, M.R., Saiz-Ruiz, J., Blanco, C. (2002). Pathological gambling: Addiction or obsession? *Psychiatric Annals*, 32 (3), 161-166.
- Murray, R.D.. (Ed.). (2001). *Helping the Problem Gambler*. Toronto: Centre for Addiction and Mental Health.
- Ogborne, A.C.. (1978). *Patient Characteristics as Predictors of Treatment Outcomes for Alcohol and Drug Abusers*. Toronto: Evaluation Studies Department, Addiction Research Foundation.
- Ogborne, A.C., Glaser, F.B.. (1981). Characteristics of affiliates of Alcoholics Anonymous: A review of the literature. *Journal of Studies on Alcohol*, 42, 661-675.
- Peele, S.. (1989). *Diseasing of America: Addiction Treatment Out of Control*. Boston: Houghton Mifflin.
- Peele, S.. (2001, February). Is gambling an addiction like drug and alcohol addiction? Developing realistic and useful conceptions of compulsive gambling. *Electronic Journal of Gambling Issues: eGambling* [On-line serial], 3. Available: <http://www.camh.net/egambling/issue3/feature/index.html>
- Petry, N.M.. (2002). Psychosocial treatments for pathological gambling: Current status and future directions. *Psychiatric Annals*, 32 (3), 192-196.
- Peyrot, M.. (1985). Narcotics Anonymous: Its history, structure, and approach, *The International Journal of the Addictions*, 20 (10), 1509-1522.
- Potenza, M.N.. (2002). A perspective on future directions in the prevention, treatment, and research of pathological gambling. *Psychiatric Annals*, 32 (3), 203-207.
- Preston, F.W., Smith, R.W.. (1985). Delabeling and relabeling in Gamblers Anonymous: Problems with transferring the Alcoholics Anonymous paradigm. *Journal of Gambling Behavior*, 1 (2), 97-105.
- Problem and Compulsive Gambling Advanced Workshop (ARF). (1986). *Cognitive Treatment for Compulsive Gambling*. Sault Ste. Marie: Addiction Research Foundation.
- Rafalovich, A.. (1999). Keep coming back! Narcotics Anonymous narrative and recovering-addict identity. *Contemporary Drug Problems*, 26, 131-157.
- Rankin, H.. (1982). Control rather than abstinence as a goal in the treatment of excessive gambling. *Behaviour Research and Therapy*, 20, 185-187.
- Rosecrance, J.. (1988). Active gamblers as peer counselors. *The International Journal of the Addictions*, 23 (7), 751-766.
- Rosenthal, R.J.. (1992). Pathological gambling. *Psychiatric Annals*, 22 (2), 72-78.
- Rosenthal, R.J., Lesieur, H.R.. (1992). Self-reported withdrawal symptoms and pathological gambling. *The American Journal on Addictions*, 1 (2), 150-154.
- Rosenthal, R.J., Rugle, L.J.. (1994). A psychodynamic approach to the treatment of pathological gambling: Part 1. Achieving abstinence. *Journal of Gambling Studies*, 10 (1), 21-42.
- Rozin, P., Stoess, C.. (1993a). Gambling problems in substance abusers are associated with increased sexual risk behaviors. *Addiction*, 95 (7), 1089-1100.
- Rozin, P., Stoess, C.. (1993b). Is there a general tendency to become addicted? *Addictive Behaviors*, 18, 81-87.
- Rugle, L.J., Rosenthal, R.J.. (1994). Transference and countertransference reactions in the psychotherapy of pathological gamblers. *Journal of Gambling Studies*, 10 (1), 43-65.
- Russo, A.M., Taber, J.I., Ramirez, L.F.. (1984). An outcome study of an inpatient treatment program for pathological gamblers. *Hospital and Community Psychiatry*, 35, 823-827.
- Sagarin, E.. (1969). *Odd Man In: Societies of Deviants in America*. Chicago: Quadrangle Books.
- Sartin, H.G.. (1988). WIN THERAPY: An alternative diagnostic and treatment therapy for problem gamblers. In Eadington, W.R.. (Ed.), *Gambling Research: Proceedings of the Seventh International Conference on Gambling and Risk Taking*, Vol. 5 (pp. 365-391). Reno: University of Nevada.

- Scodel, A.. (1964). Inspirational group therapy: A study of Gamblers Anonymous. *American Journal of Psychotherapy*, 18, 115-125.
- Shaffer, H.J.. Korn, D.. (2002). Gambling and related mental disorders: A public health analysis. *Annual Review of Public Health*, 23, 171-212.
- Smart, R.G.. Ferris, J.. (1996). Alcohol, drugs and gambling in the Ontario adult population, 1994. *Canadian Journal of Psychiatry*, 41, 36-45.
- Spunt, B.. Dupont, I.. Lesieur, H.R.. Liberty, H.J.. Hunt, D.. (1998). Pathological gambling and substance misuse: A review of the literature. *Substance Use & Misuse*, 33 (13), 2535-2560.
- Stein, S.A.. (1993). The role of support in recovery from compulsive gambling. In Eadington, W.R.. & Cornelius, J.A.. (Eds.), *Gambling Behavior and Problem Gambling* (pp. 627–637). Reno: University of Nevada.
- Steinberg, M.A.. (1993). Couples treatment issues for recovering male compulsive gamblers and their partners. *Journal of Gambling Studies*, 9 (2), 153-167.
- Steinberg, M.A.. Kosten, T.A.. Rounsaville, B.J.. (1992). Cocaine abuse and pathological gambling. *The American Journal on Addictions*, 1 (2), 121-132.
- Stewart, R.M.. Brown, R.I.F.. (1988). An outcome study of Gamblers Anonymous. *British Journal of Psychiatry*, 152, 284-288.
- Stirpe, T.. (1995). *Review of the Literature on Problem and Compulsive Gambling*. Toronto: Addiction Research Foundation, Problem and Compulsive Gambling Project.
- Strachan, M.L.. Custer, R.L.. (1993). Female compulsive gamblers in Las Vegas. In Eadington, W.R.. & Cornelius, J.A.. (Eds), *Gambling Behavior and Problem Gambling* (pp. 235–239). Reno: University of Nevada.
- Taber, J.I.. McCormick, R.A.. Russo, A.M.. Adkins, B.J.. Ramirez, L.F.. (1987). Follow-up of pathological gamblers after treatment. *American Journal of Psychiatry*, 144 (6), 757-761.
- Taber, J.I.. Russo, A.M.. Adkins, B.J.. McCormick, R.A.. (1986). Ego strength and achievement motivation in pathological gamblers. *Journal of Gambling Behavior*, 2 (2), 69-80.
- Tavares, H.. Zilberman, M.L.. Beites, F.J.. Gentil, V.. (2001). Gender differences in gambling progression. *Journal of Gambling Studies*, 17 (2), 151-159.
- Toneatto, T.. (n.d.) A Cognitive Behavioral Analysis of Gamblers Anonymous. Unpublished manuscript.
- Toneatto, T.. Skinner, W.. (2000, March). Relationship between gender and substance use among treatment-seeking gamblers. The Electronic Journal of Gambling Issues: eGambling [On-line serial], 1. Available: <http://www.camh.net/egambling/issue1/research/index.html>
- Turner, D.N.. Saunders, D.. (1990). Medical relabelling in Gamblers Anonymous: The construction of an ideal member. *Small Group Research*, 21 (1), 59-78.
- Ursua, M.P.. Uribe Larrea, L.L.. (1998). 20 Questions of Gamblers Anonymous: A psychometric study with population of Spain. *Journal of Gambling Studies*, 14 (1), 3-15.
- Valverde, M.. (1998). *Diseases of the Will: Alcohol and the Dilemmas of Freedom*. Cambridge: Cambridge University.
- Viets, V.C. L.. Miller, W.R.. (1997). Treatment approaches for pathological gambling. *Clinical Psychology Review*, 17 (7), 689-702.
- Volberg, R.A.. (1994). The prevalence and demographics of pathological gamblers: Implications for public health. *American Journal of Public Health*, 84, 237-241.
- Volberg, R.A.. Steadman, H.J.. (1989). Prevalence estimates of pathological gambling in New Jersey and Maryland. *American Journal of Psychiatry*, 146, 1618-1619.
- Wager,, The. . (2002). Perfect Match? Co-Occurring Problem Drinking and Gambling *The Wager*, 7 (20), May 15. Available: <http://www.thewager.org/Backindex/vol7pdf/wager720.pdf>
- Walker, M.B.. (1992). *The Psychology of Gambling*. Oxford: Pergamon Press.

Walker, M.B.. (1993). Treatment strategies for problem gambling: A review of effectiveness. In Eadington, W.R.. & Cornelius, J.A.. (Eds.), *Gambling Behavior and Problem Gambling* (pp. 533–536). Reno: University of Nevada.

Wells, B.. (1994). Narcotics Anonymous (NA) in Britain. In Strang, J.. & Gossop, M.. (Eds.), *Heroin Addiction and Drug Policy: The British System*. Oxford: Oxford University.

Whitman-Raymond, R.G.. (1988). Pathological gambling as a defense against loss. *Journal of Gambling Behavior*, 4 (2), 99-109.

Winston, S.. Harris, H.. (1984). *Nation of Gamblers: America's Billion-Dollar-a-Day Habit*. New Jersey: Prentice-Hall.

World Service Office Inc. (WSO). (1982). *Narcotics Anonymous*. Van Nuys, CA: Author.

Zion, M.M.. Tracy, E.. Abell, N.. (1991). Examining the relationship between spousal involvement in Gam-Anon and relapse behaviors in pathological gamblers. *Journal of Gambling Studies*, 7 (2), 117-131.

Article Categories:

- Research: Ferentszy