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Special populations and treatment for gambling problems

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Session III: Critical issues in treatment

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*(Introduction.)***Ken Winters**: Next up is Dr. Lori Rugle. She is someone who has helped with the long past and the recent history. Or is it the long history and the recent past? She has been there. One of the eminent clinicians and researchers, she got the field started in looking at treatment issues before I think this came under a bigger spotlight, and has also helped move the field in these recent years to a more rigorous point.

Lori's going to talk about specialized populations.

Loreen Rugle: When I talk about working with special populations, I always think of the variety of ethnic, cultural, and social backgrounds everyone in the audience comes from, and I think of my own background.

My ethnic background is Slovenian. Anybody know where Slovenia is? *(Laughter.)* Many people don't. It's part of the old Yugoslavia, kind of nudged between Italy and Austria in a little tiny corner there. And the joke about Slovenians is, how does a Slovenian double her money? Anybody know? She folds it and puts it in her pocket. *(Laughter.)* We're not known as the most financially risky group, ethnically. If we're prone to any addiction, it's probably work, which is certainly true for me. But I think all of us come from different backgrounds, with different attitudes, values, practices, in terms of gambling.

There is not a great deal of research that has been completed regarding the treatment of special populations, yet we do know that different ethnocultural groups

have differential prevalence rates for problem gambling.

We don't necessarily know why this is. It's not necessarily anything particularly inherent in that ethnic group. You may speculate, “Is it because they're economically disadvantaged in any particular culture?” It is not the same ethnic group across cultures, across states of the United States, across countries, that exhibits higher risk for problem gambling. It seems to be whatever group is most marginalized, culturally and economically, in that particular area that's the factor that puts them at risk for problem gambling.

Is it an issue of social and economic hope and mobility? Is it that gambling is seen as the only option that particular group sees for advancing and integrating and becoming enculturated in that society?

Is it because gambling is a way of maintaining a cultural identity when individuals are coming into an area where they are not familiar with the majority culture's traditions and values? They may not know or understand how to fit into the majority culture, but they do know that they gamble with their family, with people in their cultural group. They have their own games and it's a way of identifying and holding onto that sense of fitting in and belonging.

So there are many things we don't know about why those differences in problem gambling prevalence exist across different groups.

Perhaps the reason for the higher prevalence rates is just that they don't have access to resources; that they get turned down for loans more frequently and gambling seems like a way of making needed money?

Let's look at women as a special population. We know that male gender remains a risk factor, but women are catching up in terms of problem gambling rates. We know that men may start earlier, and this may be a cohort effect. Younger women, younger cohorts of women, may be starting to gamble at younger ages. Currently, the data still show that men start at younger ages, but women seem to progress faster in developing problems.

Again, is this something inherent in female gender, or is it a lack of economic resources? Or a lack of understanding about the game? We don't know what the cause is.

Women seem to come in with higher rates of trauma and abuse history, as with substance abuse. There may be gender differences in terms of illegal activities. Debt and poor family support, for example, are fairly common, so that women coming into treatment are more likely to be divorced and not have a supportive spouse than are men coming into treatment. So there are issues there.

Women are underrepresented in treatment research. When we talk about the research, we come head-on to this issue. Ethnic groups, cultural groups, and women have been severely underrepresented in treatment outcome studies.

I think that's very significant. I hope we can talk later about the issue, which is one of my questions to this group: not, “Are the criteria for empirically validated studies too strict?” but, “Are they not good enough?”

I have some ideas in terms of what is “not good enough” because we haven't taken the next steps of applying those criteria to real-world populations and settings. I think we need more criteria for what are really evidence-based effective treatments, rather than fewer criteria.

Service delivery and perceptions of successful outcome may differ based on gender. This is a really intriguing finding from one study, in terms of clinicians' perception of treatment effectiveness. And clinicians perceive treatment to be more effective for women than for men, even though, when you look at the concrete qualitative-quantitative outcome measures, there wasn't any significant difference.

But the clinicians perceived that the women were doing better than the men. So there are gender differences along those lines that may affect the types of services available based on gender, the length of services, and the need and perception of the need for additional services.

Significant issues, in terms of these special populations, are isolation and alienation. Groups in our society that are isolated, that are alienated, that have no hope, are clearly at higher risk.

We talked earlier about the public health model, and about addressing these issues in our service delivery system because these groups feel isolated and alienated from the service delivery systems, not just generally isolated from mainstream culture.

There are often more significant issues of shame and guilt in these special populations. There are people who feel different from the majority culture to begin with, and to come into a treatment setting when they're already feeling different and alienated, where there may be a lot of shame and guilt inherent in a cultural perspective or in a value system, presents an incredible obstacle and barrier to accessing care.

We need to look at the route to success and independence. Is gambling viewed in this different group as the only route they have to success, as defined in that culture? As the route to financial success, social success, business success? If that's the only avenue that our society is providing, then we're in serious trouble.

Here is a modification from the 12-step programs of the acronym HOW. I thought it very appropriate here. Rather than Honesty, I start with Humility. As gambling treatment providers, professionals, policy makers, I think we need to start with humility in working with special populations. We can't tell any particular group how to do it. We need to learn from that group. We need to make our treatments fit into the context, the value systems, the understandings, the perceptions, of that culture.

We have something to offer, which is our understanding of problem gambling, but we also have a whole lot to learn and to be educated in, in terms of what works and what doesn't work for any particular group.

Next is Open-mindedness that our ideas might not work for any specific group. We must deal with the groups that we work with. I thought about Dr. Pursch and his presentation of the group he works with, where he has a 90-some percent success rate. Well, if he comes in to my VA population with that approach, it's not likely to work very well. What I was thinking was, “Gee, that's nice, but my guys don't even have a job.” So they're not even going to be motivated by keeping their job. Or they've had 20 jobs in the last five years, and they don't need any particular job because they can always go out and get another job.

So motivating factors are different. I think we have to be open-minded that what we may experience that works, or even what the empirically validated studies say works, may not work very well for any particular cultural group or different population.

And we need to involve, as David [Korn] said, all the stakeholders in the community. Actually, they may need to involve us. They don't have to. It's their community; it's their group. We're the outsiders. We have to prove our value to them, not the other way around.

So if we're fortunate enough and if we're open enough, we may be included as a stakeholder at the table when each community talks about how to deal with problem gambling within their group, within their community.

Finally, we have Willingness. Willingness to integrate community and program evaluation components to really study what works and why it works. Willingness to design program evaluations that address the complexity of a holistic and a community-based perspective.

This is not easy. It's not the simple answer. It's not a clearly defined, “We're going to study this one aspect of the problem; we're going to try this one narrow intervention.” It's about a very complex study that looks at a lot of different factors and tries to integrate them into what's going to work.

It's also a willingness for funders, policymakers, governments, funding sources, to fund these kinds of complex studies that are not easy to do and not cheap, and require resources. We barely have enough resources to provide minimal treatments for the broad culture. But to say we need more funding to provide services to special groups that maybe have very small numbers in the context of our state, of our nation? Policymakers aren't going to be happy with that. But we need to serve all people so we can all learn, and the willingness to provide the resources to reach out to every segment of the population is incredibly important.

We need to learn a lot. What are the barriers for special populations to accessing problem gambling services? What can we do about them? What are their help-seeking preferences and how can existing approaches mesh with different cultural traditions? Does treatment advocacy differ for various groups? Does pharmacological therapy work the same for all ethnic groups?

Just a couple of days ago I heard a news story about a high blood pressure medication that hadn't been found to be effective when applied to the broad culture. But recent studies have reexamined the data and it seems to be effective for African American men. Go figure. It may yet be approved for that segment of the population. We don't know what medications may act differentially for men, for women, for Hispanics, for African Americans, for Asian Americans, for Caucasians. This is intriguing information.

Do cognitive behavioral approaches work across cultures? Probably not in the same way. Do 12-step approaches work? It's been very hard in Ohio, in the Cleveland area, to have African Americans stick in GA. They don't feel welcome.

Fifteen years ago, it was women who wouldn't stick in GA, because they didn't feel welcome. A lot of work is needed to find out whether 12-step approaches work the same across cultures or whether we have to do other interventions to integrate different cultural groups into 12 steps or provide their own 12-step groups.

And the role of family and community is important. We haven't talked much about family interventions yet at this conference, but family can be so important in these different cultural groups. And how to utilize family as a resource, how family plays a role in engaging and repairing patients in treatment or in other interventions, is incredibly important.

So with that, I'll conclude, and thank you very much.

[End of session.]