Journal Information
Journal ID (publisher-id): jgi
ISSN: 1910-7595
Publisher: Centre for Addiction and Mental Health

Article Information

Publication date: December 2005
Publisher Id: jgi.2005.15.8
DOI: 10.4309/jgi.2005.15.8

Pharmacological approaches

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Role: Presenter

Proceedings of the 19th annual conference on prevention, research, and treatment of problem gambling. June 23–25, 2005, in New Orleans, Louisiana. National Council on Problem Gambling, Washington, DC.

Session III: Critical issues in treatment

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*(Introduction.)***Ken Winters**: In the words of Peter Nathan, “We've had a long history, but a short past.” Those of us who've been involved in treatment outcome studies know that a portion of the short past has been in pharmacological therapy approaches and the introduction of medications to our treatment toolbox.

And that leads us to our next presentation, with Dr. Jon Grant, who is currently —although not for long—at Brown University Medical Center at Brown and Butler Hospital. He's going to move to the University of Minnesota in a couple of weeks. So he'll be part of a growing corps of researchers in Minnesota.

I'm looking forward to this talk. This is about some of the more cutting-edge technologies available in the arena today. Jon?

Jon Grant: I want to preface my comments by what I always tell my patients when I talk with them about medication. There's nothing FDA approved for the treatment of pathological gambling. So everything that's been studied and everything that's been used clinically by some of us is sort of off-label. You have to let people know that this isn't for that indication.

I always tell people that I own no stocks in any of this. And, the reason why I say this is that a patient came in one time and said, “Well, I had a doctor who kept telling me they prescribed this medication, and when I asked why the doctor said, ‘Because I own stock in that company.’” *(Laughter.)*

Which is honest, I guess. And the other thing is my grandmother does not make any of this in her basement, so if people don't like these things I don't really care. I

don't have any personal investment. *(Laughter.)*

The pharmacological literature is really growing and that's pretty exciting. One thing that should be kept in mind is that there's a difference between these studies that I'm going to talk about which have been done, and up until now the published studies, medication studies.

They're not comparison studies. They're not using therapy with it. And I think most people who use medications clinically are responsible enough that they use it in combination with therapy. I don't think of any one thing as the perfect treatment.

I would even go so far as to say that even though we call these medication studies and we say there's no therapy in them, I don't completely buy that. And, as I'll point out later, I think that's one of the issues that's complicated the way that we understand these studies.

When patients come in and tell you all about their gambling problems and you're doing a study, you can't help but do some supportive therapy; you might do some motivational enhancement therapy, unbeknownst to you. Just because you're human and somebody's sitting there telling you these things.

I think, also, that the disclosure therapy aspect of when people tell you the first time, maybe, that they've got this problem, and that you're the first person that they had ever told, brings a huge therapeutic improvement in their lives, independent of the medication.

So we kind of play this game that these are medication studies, but I don't really know, legitimately, and that there's often an element in these studies that they're medication-plus. Whatever that may be.

One way to think about medication—and this is also from a clinical perspective, as well as what we know from the studies—is, what are we looking at? What are we trying to improve with medication? And which one would we pick?

I mean, there are a bunch of them out there. I think one of the issues has often been trying to see each individual as an individual, and realize that what drives behavior in one person may, even if they can check off all the DSM criteria, not be what drives that behavior in another and is often qualitatively very different in other people.

There are people who come in and say, “I gamble because I can't deal with stress. I mean, it's the place I run to when I want to get away from stress. I'm so depressed in my marriage; I'm so depressed in my life; I go gamble.”

In some ways pathological gambling almost becomes a symptom of other

underlying issues. This may also determine our choice. This is where we have the selective serotonin reuptake inhibitors, commonly known as antidepressants, and this is the world of Prozac and all the “Prozac children” that have come out since then.

These medications are often very helpful, particularly if people are saying, “I'm obsessed with gambling; I'm thinking about it all the time; I can't get it out of my mind; I go when I'm anxious; I go when I'm depressed.” Clinically, I think, this may be a very helpful option for people who gamble due to anxiety, obsessions, or depression.

Another class of medications are the mood stabilizers and they tend to be medications that are FDA approved for epilepsy. They keep people from becoming too impulsive. Because what we often see in many people with pathological gambling is, obviously, comorbid bipolar disorder or manic depressive disorder. But I would say that even that misses the point. Some people have what I would refer to as subclinical mania, or hypomania. They're generally impulsive in many avenues of life. Even though, from a strict DSM sort of checklist view, they might not actually be bipolar, they've got a quality that often drives their gambling.

In that case, these medications can often be very helpful, not only for their mood stabilization but for gambling that often results from impulsiveness.

The third group are the atypical antipsychotic medications. What we find is, even though as a group most of them have come out FDA approved for the treatment of schizophrenia or psychotic disorders, as I said yesterday, these pills do more than any of us know and sometimes they do a heck of a lot less than any of us expect them to do. But even though they're primarily set up to focus on psychotic issues —delusions, paranoia, things such as that—they often deal with anxiety reduction, and particularly obsessional reduction in many folks. So they have a role, as well.

Finally, there are the opiate antagonists, which have been used in the treatment of alcohol and heroin and narcotics addictions, and they reduce cravings. So for pathological gamblers who have intense cravings, these offer a very reasonable alternative.

A good question is, “Is medication effective?” Even though medication has not been studied as long as some other interventions, there are already nine double-blind published studies, meaning, medication versus placebo or sugar pill: the most rigorous types of study design.

Eight of these have been positive studies, meaning that people that are on medication have done better than people who were just taking a placebo, for the most part. Now, response rates among people who are taking these different types

of medication in these studies are actually pretty high, at 70 to 79 percent, if you pool the studies.

And on the response, it's a little difficult because not all the studies are trying to measure exactly the same thing. The response in most of these studies is really referring to either very mild or nonexistent symptoms, often complete remission of symptoms, meaning no gambling, no thoughts, or mild thinking and some minimal gambling.

Again, as people have said, this has a lot to do with which scales you use, and not all the studies have used the same scales. So they're not directly comparable, but I do want to point out that when people come up with the idea of medication, I think we're seeing at least some glimmer that these have a role, and not just in a small percentage of the people who are taking them.

I would also point out that most of the people who have been in these studies often look quite severe, when you look at their measures of gambling severity. So it's not as if very minimal symptoms of pathological gambling are what these folks are reporting.

So I'm very encouraged by what we see. Although, again, I don't think any one pill is going to be amazing magic. The problem is sometimes the media get wind of these things and then I've had patients come in and say, “I want that magic pill.”

And I think, “Well, I wish I had a magic pill for you. I have some very good pills that may be beneficial. At the same time, they may have some problems.”

Some of the problems in medication studies include seeing high dropout rates. Now, interestingly enough, the dropout rates in some of the cognitive behavioral studies are also fairly high. But I do think that the medication studies suffer from higher rates because we don't do a lot of, in my opinion, the motivational enhancement that allows people to stay in treatment.

We are also seeing a fairly high percentage of people who aren't taking anything and they respond. And this is sort of baffling. People will go into a study for three months, four months, and at the end they'll say, “I'm not gambling any more. This has been great. Thanks for that pill.”

I open up the envelope. “You weren't on a pill. You were on a placebo.” Which is really interesting. And I think a lot of coming to see somebody weekly, or every two weeks, is a sort of hidden, not quantified, therapy element from which they may be benefiting.

The studies have been short: 8 to 16 weeks. There haven't been follow-ups of these studies, so that we don't really know how well these people are doing, say, a

year later. And that's obviously something we have to focus on.

The studies have also been really clean studies, in the sense that, up until recently, people who had clinical depression, clinical bipolar disorder, attention deficit disorder, and all these other things weren't included. So these are studies of pathological gamblers who have no other problems and you ask yourself, “My goodness, is that like any pathological gambler you've ever met?”

And maybe, maybe not. And one question is, maybe that's why we're getting such good rates of response in these studies is that we're not taking complicated people who reflect the real population better.

And then my thought is, does this really match clinical practice? Because I'm intrigued by how many patients are in treatment studies who do very well with responses of 70 percent. I treat several hundred gambling addicts now and I don't get 70 percent response rates within the first three months of treating them.

What is it about this patient population? Is it the lack of comorbid conditions or something else that makes people highly motivated when they enter a treatment study? I don't know, and we haven't really studied the difference between treatment study folks and clinic patients.

But I think the bottom line is that we're seeing some early evidence that medication may have a role. It may not be the answer, but it may have a role. And for which patients, how long, all of these other things are questions that we still have to figure out.

[End of session.]