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The problem gambler in Las Vegas: Quantitative and qualitative explorations

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THE PROBLEM GAMBLER IN LAS VEGAS: QUANTITATIVE AND QUALITATIVE EXPLORATIONS

by

Bo Jason Bernhard

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ABSTRACT

Problem Gamblers in Las Vegas: Qualitative and Quantitative Explorations

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Problem gambling behaviors among the adult population in the city of Las Vegas, Nevada are analyzed using both quantitative and qualitative methodologies. Responses to problem gambling questions from 1992 and 1995 telephone surveys are examined. On the 1992 survey, which focused on lifetime problem gambling behaviors, 5.8% of local residents indicated that they had a gambling problem. On the 1995 survey, which inquired about past-year gambling problems, 6.6% of the local population indicated that they had a gambling problem. Demographic information on the self-identified problem gamblers in the surveys is presented as well. Because survey methodology is limited in its ability to access sensitive information, ethnographic accounts of problem gamblers in local treatment centers will also be presented. Special attention is given to the phenomena of video poker gambling and public and private stigmatizaton of this population. In addition, recommendations for future research and policy directions are discussed.

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CHAPTER I

INTRODUCTION

The story of Las Vegas is, quite literally, a tale of *two* cities, both of which exist, of course, within the same geographic boundaries. Most familiar is the popular version, which exudes -- indeed screams -- gaudiness, superficiality, money, and unfettered leisure time activity, all within the gratifying confines of Sin City. The less-familiar "second city" jurisdiction is starting to receive more attention (usually for its unparalleled growth), but still remains an enigma for a large number of Americans, who have a hard time imagining the constitution necessary to live in this locale.

Too often -- indeed, even among the most esteemed of critics -- the "professional" analysts themselves fall into a trap of superficiality by examining only the familiar, glitzy version while neglecting entirely the latter, more pedestrian side of this community. Numerous sociological theorists and cultural critics have hailed Las Vegas as a bizarre new mecca, unique in its ability to reveal us at our most shallow, as Americans act out their urges to succumb to a blind quest for amusement.

Often, this tendency manifests itself as a lament, as commentators frown on the "Las Vegasization" of America, implying that the community of America had in effect adopted the neon ethos. Seldom have social researchers chosen to move beyond the popular media

portrayals of Las Vegas. Even Neil Postman, the renowned cultural critic, makes some fairly startling claims in his seminal *Amusing Ourselves to Death*:

> Today, we must look to the city of Las Vegas, Nevada, as a metaphor of our national character and aspiration, its symbol a thirty-foot high cardboard picture of a slot machine and a chorus girl. For Las Vegas is a city entirely devoted to the idea of entertainment, and as such proclaims the spirit of a culture in which all public discourse increasingly takes the form of entertainment"(italics added, page 3).

Postman (1985:3) goes so far as to proclaim Las Vegas as *the* most symbolic of late 20th-century American cities, shaping the cultural landscape of an entire nation in much the same way that Boston did in the late eighteenth century (a period during which even Virginians became "Bostonians at heart"), and in the same way that New York did in the mid-nineteenth century (crafting a national image of a melting pot, welcoming the world as it disembarked on Ellis Island), and in the same way that Chicago did in the early twentieth century (as the symbol of the dynamic and adventuresome entrepreneurial spirit that defined that particular day).

However, unlike those city-symbols, the residents of this locale during their "defining era" don't have as much of a say in their city's symbolic value as, say Bostonians, New Yorkers, and Chicagoans, all of whom forged a *Zeitgeist* using their own life-experiences as the shining example. When we think of Las Vegas, we don't think of Las Veg*ans* in the same way we think of Bostonians of the 18th century, New Yorkers of the 19th century, or Chicagoans of the 20th century. In fact, we hardly think of Las Vegans at all. The popular and educated perception of Las Vegas rests upon assumptions based on a *tourist culture*, rather than an informed examination of the lifestyles of the city's inhabitants.

Of course, all of this would appear to represent little more than petty hair-splitting,

but in fact, a great deal is missed when we accept the same portrayal of the city that Hollywood does. Las Vegas is a fertile locale for sociological and psychological study for the same reason that it serves as such a poor one for astronomical study -- the literal (and figurative) "bright lights" and their impact on the community that lurks quietly outside of their reach.

The state of Nevada decided -- in large part due to the onset of the Great Depression -- to become the first state to officially legalize casino gaming in the United States in 1931. This work will discuss some of the social impacts of that decision on the community of Las Vegas today, in 1999, using both qualitative and quantitative analyses.

To date, Las Vegas has been relatively neglected in the field of problem gambling studies. The accounts that follow represent the first comprehensive attempt to describe the population of problem gamblers living in Las Vegas. In this paper, the results of the 1992 and 1995 Las Vegas Poll surveys will be studied in order to assess the prevalence of problem gambling and the composition of population of problem gamblers living in Las Vegas. However, survey research alone cannot always provide a comprehensive description of rare sub-populations, especially when the questions asked of respondents are sensitive in nature. As Volberg, the leading demographer in the field of problem gambling studies, points out:

> ... many of the questions now being asked about gambling and problem gambling cannot be answered by single surveys ... As we move forward, it will be important to use a variety of methods to provide insights that no single approach can yield. Since all scientific methods contain biases, multiple research techniques (including experimental, clinical, historical, ethnographic and survey approaches) are needed to resolve puzzles and discrepancies as well as to provide a much-needed depth of perception to the field of gambling studies (1996:126).

To supplement the analysis of the surveys, an ethnographic study will present a more

in-depth account of the emotional experiences, social and familial relationships, and gambling activities of problem gamblers who have checked into treatment centers in Las Vegas.

This multi-method approach is advantageous for a number of reasons. After all, no matter how advanced our telephone survey methodologies become, we ultimately have to rely on the respondent to honestly and accurately assess his or her own problematic gambling behaviors — no small demand when the targeted individuals (problem gamblers) spend a large portion of their time creating an intricate series of stories designed precisely to *hide* these activities. At the same time, it is impossible to assess what kinds of patterns are emerging in the population as a whole by merely observing individuals who are acknowledged problem gamblers in treatment settings.

Before we proceed, a note on the epistemological approach of this paper is probably necessary in order to elaborate a bit on the ways this information has been collected. My undergraduate background is in sociology and psychology, and I have been fortunate enough to be able to continue to spend my time split neatly between the two fields. For a good portion of the last five years, this has meant that I have spent my days at the sociology department at the University of Nevada, Las Vegas, and my nights the Intensive Outpatient Program for compulsive gamblers at Charter Hospital and the Trimeridian treatment centers. More importantly, perhaps, this existence has meant that I spend half of my day with sociologists who study the prevalence and effects of problem gambling in the greater Las Vegas area, and the other half in the company of psychologists and problem gamblers themselves in order to obtain a more intimate glimpse of their lives.

On the one hand, much of my work in the sociology department at the University of

Nevada, Las Vegas has focused on examining macro-level goings-on in the Las Vegas community as a whole. It is this work that will be primarily reflected in the quantitative sections of this paper. On the other hand, my hundreds of evenings in the company of the problem gambling patient population in the Intensive Outpatient Program at Charter Hospital and Trimeridian treatment centers form the basis for the qualitative analysis presented in the second section of this paper.

Thus far, this cooperative arrangement has already paid invaluable dividends: the practices at the clinic are now informed by the subtleties of community "demand" (as measured by the polls conducted in UNLV's Cannon Center for Survey Research), and at the same time, those of us in the "ivory towers" are hopefully less divorced from the faces and social realities occurring outside of our university walls. This partnership has allowed us to explore gambling issues in Las Vegas with a far greater depth than we had been able to before, as we now have the capacity to weigh anecdotal "unscientific" evidence from the clinic and compare them with precisely measured variables in the general population.

Practically speaking, this has allowed us to minimize the potential for bias on both ends. On one hand, there is certainly a bias which inevitably results from hearing only the sad stories of the problem gamblers in treatment. In spending significant amounts of time with problem gamblers in these settings, I have found that it can be easy to forget the overwhelming majority of individuals for whom problem gambling does not become an issue. On the other hand, sitting at a computer terminal examining sociological data gives you no real sense of the depths of despair experienced by the small percentage of problem gamblers.

Empirically speaking, the sociologists among us have learned volumes about the

questions our surveys ask. One of our most obvious and basic assumptions of survey research holds that our respondent is answering in a candid fashion. For people who are living an act, we have to wonder, again and again, whether they will be forthright in their responses to a total stranger over the phone.

Finally, theoretically, we have been able to refine our interpretations of these individuals' lives by examining our assumptions in light of the evidence. For the psychologists in the clinic, this has on occasion meant dropping their ideas about the "widespread" nature of social phenomena when the data did not support their original notions. For the sociologists in the survey center, this has resulted in an evolving understanding of the ways that survey research should be conducted with this population.

At the end of the day (literally, in my case) what I have been striving for is a more comprehensive evaluation of complex behaviors in perhaps the most developed gambling laboratory of them all. It is my hope that we are arriving at something like a more responsible science, sensitive to both clinical and survey research issues pertaining to the sub-population of problem gamblers in Las Vegas.. This research, then, represents an attempt to delve into the one of the vital social issues swimming subtly beneath the water in Las Vegas, as opposed to the more blatant occurrences on the surface of the sea.

CHAPTER II

LITERATURE REVIEWS

Quantitative Literature

At no time in history has the phenomenon of problem gambling been studied with more rigor or enthusiasm than it is today. Although advances are to be expected in any maturing field of study, the recent expansion of gambling into new jurisdictions and the resultant governmental and medical attention given to the phenomenon has led to an exponential increase in the amount of attention paid to problem gamblers by scholars from a variety of fields.

Indeed, within the past two years, the two most comprehensive quantitative studies ever conducted on problem gambling behaviors in America have been completed: the Harvard Medical School Division on Addiction's meta-analysis of 120 prevalence studies of problem gambling behaviors (Shaffer, Hall, and Vander Bilt 1997), and the National Gambling Impact Study Commission's research report (conducted by the National Opinion Research Center at the University of Chicago).

Whether one agrees with the findings or the interpretations of the authors of these studies, it is impossible to dispute that the metaphorical bar has been raised in problem gambling research. Indeed, it is difficult to envision any problem gambling project today

which would not of necessity acknowledge and incorporate these two studies.

Harvard Medical School's Meta-Analysis

Shaffer, et al. (1997) conducted a comprehensive meta-analysis of the prevalence studies that have already been conducted in North America. They conclude that the construct which they refer to as "disordered gambling" represents:

> ... an apparently robust phenomenon that research can identify reliably across a wide range of investigative procedures that vary in quality of method. Robust phenomena tend to be reliable, occurring in almost all study settings; these phenomena may be found with almost any research methodology, even those that are widely disparate (ii).

After examining 125 prevalence studies in jurisdictions across the United States and Canada, the authors conclude that the phenomenon of problem gambling is far from an illusion: in fact, in study after study -- and regardless of methodology, setting, or population -- this phenomenon has proven to be a widespread societal problem that large numbers of individuals experience in the everyday (ii).

In order to incorporate all of the different prevalence studies Shaffer, et al. implement a 3-level typology which distinguishes between various manifestations of normal and problem gambling activity. "Level 1 gamblers" are individuals who "gamble with little or no consequences." These gamblers comprise the majority of individuals in North America (ii). Among individuals who have experienced problems with their gambling activity, level 2 gamblers are those who have had problems, but who possess "sub-clinical levels of gambling disorders" (iii). This level is variously defined in different studies, depending on the diagnostic threshold of the instrument in use. Finally, level 3 gambling "refers to disordered gambling that satisfies 'diagnostic' criteria and, therefore, is clinically

meaningful" (iii). These are individuals who surpass the various diagnostic thresholds of the instruments in these studies.

The study found that 1.60% of the the adult general population in American were lifetime level 3 gamblers, while 1.14% fell into the past-year level 3 category. Among individuals in the same populations, 3.85% qualified as lifetime level 2 gamblers, while 2.80% were classified as past-year level 2 gamblers (Shaffer, et al. 1997:iii).

Theoretically, Shaffer's study relies a "relativistic" approach, which recognizes that instrumentation and assessment are inherently social and emergent processes:

> Since prevalence estimates are a direct reflection of the research methods and strategies scientists develop and implement to measure a particular phenomenon, debate and controversy are regular consequences of prevalence estimation projects... This methodological debate results in confusion among the legislators, health care providers and public health program planners who use these estimates to make policy, funding, and treatment decisions... To minimize controversy and yield the most useful estimates of gambling-related problems, this project employed a meta-analytic strategy to develop estimates of gambling-related disorders across an array of differing estimation methodologies and populations (1).

Of course, to suggest that the meta-analysis would be less than controversial was probably optimistic. For all of these attempts to "neutralize" problem gambling terminology, the authors do not acknowledge that their own choice of terms (e.g., "disordered" or "level 1, 2, or 3 gambling") -- like any labels -- are far from neutral. In fact, some have contended that by avoiding terms like "problem" or "pathological," the true depths of the disorder are no longer conveyed (Volberg and Gerstein 1999).

Shaffer, et al. justify their meta-analytic approach by citing the rationale of Smith and Glass, who claim that:

> Mixing different outcomes together is defensible. First, it is clear that all outcome measures are more or less related to 'well being' and so at a

> general level are comparable. Second, it is easy to imagine a Senator conducting hearings on the NIMH appropriations or a college president deciding whether to continue funding the counseling center asking, 'What kind of effect does therapy produce — on anything?' Third, each primary researcher made value judgments concerning the definition and direction of positive therapeutic effects for the particular clients he or she studied. It is reasonable to adopt these value judgments and aggregate them (Smith and Glass 1977:753, cited in Shaffer, et al. 1997:5).

Shaffer et al. then argue that legislators and researchers are seeking broad answers to basic questions about problem gambling as well, and that the relative consistency of "value judgments" among problem gambling researchers allows for a synthesis of the diverse methods that have been used to measure these behaviors (1997:5). The authors continue by asserting that it is the very nature of their relativistic approach which allows for such a combination of methods:

> From this standpoint, scientists *manufacture* prevalence estimates... Instead of simply assuming that a "true" prevalence estimate awaits our capacity to accurately identify it, we believe that a dynamic interplay of factors influences and determines every prevalence estimate: which instrument, with which population, with which sampling strategy, with which administrative procedure, at which historical point in time, under the direction of which scientists all influence the outcome of an effort to estimate prevalence (6).

Hence, problem gambling prevalence rates -- or for that matter, any kind of prevalence rates -- are strongly influenced by the cultural and the sociological. Interestingly, this brand of "relativism," while recognizing the socially constructed nature of prevalence estimates, does not allow for estimates based on assessments by the population itself. In other words, despite the attempt to debunk the myth of pure scientific precision, no suggestion (or even mention) is made relevant to any attempt to strip *scientists* of their authority to ultimately determine the official categorizations. In effect, medico-scientific assessments are called into question, but this does not mean that the labeling privilege is to

be extended to lay persons.

In addition, the authors do not always adhere to their professed belief in the relativistic nature of prevalence studies. In some cases, potentially profound nuances are ignored in order to fit their data into more easily-classifiable categories. For instance, despite the claims that the unique aspects of various sub-populations need to be recognized and emphasized, the authors proceed in the next section to present "regional data," (Shaffer, et al. 1997:58, 107-111) in which locales as diverse as Las Vegas, Nevada, Provo, Utah, and Los Angeles, California are included within the same unit of analysis (the "Southwestern region").

Shaffer, et al. proceed to recommend that future studies endorse and utilize their "label typology" in order to simplify and unite future research projects (1997:81). The NORC nationwide survey commissioned by a the National Gambling Impact Study Commission, however, decided that another assessment method was needed.

The National Opinion Research Center's National "NODS" Survey

In April of 1998, the National Gambling Impact Study Commission hired the National Opinion Research Center (NORC) to conduct a nationwide poll to track gambling behaviors in the American adult population. NORC used telephone survey methods to interview a "nationally representative" sample of 2,417 adults (NORC 1999:1). Because it was expected that a survey of this size would not identify enough problem gamblers to conduct any significant statistical analysis, NORC supplemented this research with another survey of 500 randomly selected "patron interviews" in various gambling locations. This second follow-up survey administered "170 interviews in lottery ticket outlets (not including

locations with video lottery terminals only), 125 in Nevada and New Jersey casinos, 65 in riverboat casinos, 65 in Indian reservation casinos, 40 in para-mutuel locations, and 40 in locations with video lottery terminals" (22).

The fact that NORC had to survey "higher-risk" populations in order to obtain sufficient numbers of respondents for analysis of problem gamblers is significant. Shaffer, et al. (1997:3) estimate that in a single local sample, "a minimum of approximately 7,000 initial interviews (are necessary) to obtain a sample of disordered gamblers that provides adequate power for the important comparisons of interest." They go on to point out that a single 20- to 40- minute survey costs approximately $75.00 to administer (1997:3). What Shaffer, et al. (and NORC, for that matter) do not directly address are the labor hours involved in conducting these types of inquiries. The meta-analytic study lists three primary authors and another 39 "advisors" who are listed as having contributed significant amounts of work to the project (Shaffer et al. 1997:v-vi). The NORC study lists no less than 17 "authors" on its introductory page, and another 58 "staff members" and "advisory committee" members (NORC 1999:v-vii). In sum, the costs involved in locating and interviewing significant numbers of problem gamblers — or any relatively rare sub-population, for that matter — are often prohibitive.

The NORC survey points out that the majority of the instruments used in prior prevalence research are based on Lesieur and Blume's (1987) South Oaks Gambling Screen (SOGS), an outdated (the latest revision relies on DSM-III-R diagnostic criteria) measure that possibly overestimates problem gambling rates in America (1999:14-15). Although the SOGS has served as a foundation for most of the problem gambling prevalence studies conducted in this field, it would appear that the time has come to employ newer instruments

based on more recent developments in the rapidly-advancing field of problem gambling studies. Hence, the authors of the NORC survey claim that an entirely new instrument needed to be developed, incorporating the latest advances in the rapidly expanding field of problem gambling studies.

NORC addresses this issue by developing, testing, and implementing its own new instrument for problem gambling assessment: the NODS (short for the NORC DSM Screen for Gambling Problems). This new instrument follows the most recent DSM-IV criteria for problem gambling diagnosis (see Table 1 below). The NODS contains 17 items measuring both past-year and lifetime gambling activity: when respondents indicate that they have engaged in the behavior in the past year, they are then asked about their lifetime behaviors (1999:18). The questionnaire operationalizes the DSM-IV criteria as follows:

Table 1. DSM-IV Criteria and NODS Questions

DSM-IV Criterion	Question Number	Question
Preoccupation	1	Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets? OR
Preoccupation	2	Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about ways of getting money to gamble with?
Tolerance	3	Have there ever been periods when you needed to gamble with increasing amounts of money or with larger bets than before in order to get the same feeling of excitement?
Withdrawal	4	Have you ever tried to stop, cut down, or control your gambling?
Withdrawal	5	On one or more of the times when you tried to stop, cut down, or control your gambling, were you restless or irritable?
Loss of Control	6	Have you ever tried but not succeeded in stopping, cutting down, or controlling your gambling?
Loss of control	7	If so, has this happened three or more times?
Escape	8	Have you ever gambled as a way to escape from personal problems? OR
Escape	9	Have you ever gambled to relieve uncomfortable feelings such as guilt, anxiety, helplessness, or depression?
Chasing	10	Has there ever been a period when, if you lost money gambling one day, you would return another day to get even?
Lying	11	Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?
Lying	12	If so, has this happened three or more times?

Illegal Acts	13	Have you ever written a bad check or taken money that didn't belong to you from family members or anyone else in order to pay for your gambling?
Risked Significant Relationship	14	Has your gambling ever caused serious or repeated problems in your relationships with any of your family members or friends? OR
Risked Significant Relationship	15	ASK ONLY IF RESPONDENT IS IN SCHOOL: Has your gambling caused you any problems in school, such as missing classes or days of school or your grades dropping?
Risked Significant Relationship	16	Has your gambling ever caused you to lose a job, have trouble with your job, or miss out on an important job or career opportunity?
Bailout	17	Have you ever needed to ask family members or anyone else to loan you money or otherwise bail you out of a desperate money situation that was largely caused by your gambling?

Source: NORC 1999:18

The NODS addresses concerns about the tendency of prior instruments to overestimate problem gambling rates by making its criteria "more demanding and restrictive" (NORC 1999:18) than those used in previous studies. On occasion, more than one question was needed in order to best capture the desired concepts (19). In field tests prior to the nationwide administration, the NODS proved to be a valid measurement, as individuals clinically diagnosed with gambling disordered were overwhelmingly classified as pathological or problem gamblers according to the NODS typology (20). Furthermore, the instrument displayed strong test-retest reliability and internal consistency, though the performance of the "lifetime" series of questions were slightly more reliable (20).

The NODS is scored using a unique terminology, which is determined by the respondents' scores on the instrument. Scores corresponded with the DSM-IV system, and ranged numerically from zero to ten (NORC 1999:21). Respondents answering in the affirmative to one or more of the DSM-IV criteria were labeled as follows:

Table 2. Criteria for Classifying Respondents using the NODS

At-risk Gambler	One or two DSM-IV criteria
Problem Gambler	Three or four DSM-IV criteria
Pathological Gambler	Five or more DSM-IV criteria

Source: NORC 1999:21

Gamblers scoring a one or two on the NODS instrument are classified as "at-risk" gamblers. Those who answer "yes" on three or four DSM-IV criteria are labeled as "problem gamblers." Finally, those scoring a five or higher on the NODS are classified as "pathological gamblers." NORC then presented the results of their surveys in three separate

formats: the first format displayed the findings of the RDD survey alone, the second examined the patron survey findings alone, and the third format looked into the results when the two surveys were combined (NORC 1999:21). This format yielded the results tabulated in Table 3.

Table 3. Percentages of Selected Gambling Types Based on Lifetime and Past-year NODS Scores

	RDD Survey	RDD Survey	RDD Survey	RDD Survey	Patron Survey	Patron Survey	Patron Survey	Patron Survey	Com-bined	Com-bined	Com-bined	Com-bined
	Lifetime (%)	Past year (%)	Lifetime (n)	Past year (n)	Lifetime (%)	Past year (%)	Lifetime (n)	Past year (n)	Lifetime (%)	Past year (%)	Lifetime (n)	Past year (n)
TOTAL	100.0	100.0	2,417	2,417	100.0	100.0	530	530	100.0	100.0	2,867	2,867
At-risk	7.9	2.3	183	55	17.9	14.3	95	76	7.7	2.9	267	125
Problem	1.3	0.4	30	9	5.3	4.9	28	26	1.5	0.7	56	33
Patholo-gical	0.8	0.1	21	3	7.9	5.3	42	28	1.2	0.6	57	27

Source: NORC (1999:25)

Based on lifetime and past-year scores, 7.9 percent of respondents in the RDD survey alone qualified as lifetime "at-risk" gamblers, while 2.3% qualified for that category in the past year. In the "patron survey," 17.9% qualified as lifetime at-risk gamblers, while 14.3% met the criteria for at-risk gambling activity in the past year. The RDD survey and the patron survey combined yielded a percentage of 7.7% lifetime and 2.9% past-year at-risk gamblers.

In the RDD survey, 1.3% of respondents qualified as lifetime "problem" gamblers, while 0.4% were labeled as past-year problem gamblers. In the patron survey, 5.3% met the lifetime criteria for problem gamblers, while 4.9% fell into this category based on past-year activity. The RDD survey and the patron survey combined yielded percentages of 1.5% lifetime and 0.7% over the past year.

Finally, lifetime "pathological" gamblers comprised 0.8% of the RDD sample, while past-year pathological gamblers comprised 0.1% of the sample. In the patron survey, 7.9% qualified as lifetime pathological gamblers, while 5.3% met the criteria for pathological gambling based on past-year activity. When the two surveys were combined, lifetime rates of 1.2% and past-year rates of 0.6% were obtained.

Within certain demographic subgroups, "risk factors" for problem gambling were developed. Risk factors are calculated by determining the percentages of individuals within a certain group (i.e., males) who develop a gambling problem. The results of these tabulations, which are based on the RDD survey data and the patron survey data combined, are displayed in Table 4:

Table 4. Prevalence of Gambling Problems Among Selected Populations

Demographic	Problem Gambling (n=56)	Pathological (n=67)
	Lifetime/Past Year	Lifetime/Past Year
Gender		
Male	2.0 / 0.9	1.7 / 0.8
Female	1.1 / 0.6	0.8 / 0.3
Race		
White	1.4 / 0.6	1.0 / 0.5
Black	2.7 / 1.7	3.2 / 1.5
Hispanic	0.9 / 0.7	0.5 / 0.1
Other	1.2 / 0.5	0.9 / 0.4
Age		
18-29	2.1 / 1.0	1.3 / 0.3
30-39	1.5 / 0.8	1.0 / 0.6
40-49	1.9 / 0.7	1.4 / 0.8
50-64	1.2 / 0.3	2.2 / 0.9
65+	0.7 / 0.6	0.4 / 0.2
Education		
Less than High School	1.7 / 1.2	2.1 / 1.0
High School Graduate	2.2 / 1.1	1.9 / 1.1
Some College	1.5 / 0.8	1.1 / 0.3
College Graduate	0.8 / 0.2	0.5 / 0.1

Source: NORC (1999:26-27)

It appears from these data that males are more likely than females to develop gambling problems in both "lifetime" and "past-year" time frames. Among racial and ethnic groups, black respondents were more likely to develop gambling problems of all types

relative to other groups. Members of the youngest age group (18-29) developed gambling problems at the highest rates. Respondents with different educational levels displayed relatively few differences in problem gambling activity.

Though the NODS instrument appears to represent the most advanced tool available for identifying gamblers, the foundation for the decision to base the instrument on the DSM-IV is perhaps less stable than NORC suggests. NORC justifies its use of the DSM-IV by claiming that two separate international think tanks arrived at the conclusion that "the field needed to move fully into the new 'DSM-IV era'" (NORC 1999:16). However, I was invited to participate in one of these two think tanks, and my recollection of the meeting was that the group arrived at less than a "consensus" regarding the DSM-IV and in fact pointed out some of the deficiencies inherent in the DSM-IV criteria. The "consensus," if any, was that continued improvements needed to be made in future DSM versions, and that the field remained without a "gold standard" for assessment and diagnosis.

Of course, it is probably the case that the field will never arrive at a "consensus" on these matters, as even NORC concedes: "... the presence of competing concepts and methods is not uncommon among emerging and even mature scientific fields. Nevertheless, disputation among experts has led to some degree of public confusion and uncertainty about the impacts of legal gambling on society" (1999:13). As such, NORC was forced to proceed given the best possible means available — a research strategy shared by this study of Las Vegas gambling patterns.

NORC's implicit rejection of the typology suggested by the meta-analysis, however, was not overlooked by the authors of the meta-analysis. During their recent presentation at the National Conference on Problem Gambling in Detroit, Michigan, two of the principal

investigators of the NORC study were questioned by representatives of the authors of the meta-analysis about their choice of instruments (Volberg and Gerstein, 1999). The NORC authors indicated that they did not use the meta-analysis' typology because they did not feel that it fit the way that this affliction was conceptualized among the broader public (a public which, of course, NORC had to answer to in providing the NGISC, Congress, and President Clinton with a reliable measure of problem gambling behaviors in the entire country).

I mention these apparently minor distinctions and debates only to illustrate that the field of problem gambling studies is still characterized by much debate over how, exactly, to measure this problem. Furthermore, I mention these approaches by way of introducing a new method that is utilized in the surveys that will be examined in this thesis, the Las Vegas Polls. While the Las Vegas Poll construct is broadly conceptually parallel to those of the NORC and meta-analytic studies, the primary difference relative to all other studies conducted previously is that the individuals themselves are allowed to do the conceptualizing. Respondents in the surveys that follow were asked to personally assess their own (and others') gambling and problem gambling behaviors.

Other Relevant Prevalence Studies

Surprisingly few prevalence studies have been conducted in the Las Vegas valley. Literature searches at the University of Nevada, Las Vegas Special Collections library (which collects both published and non-published gambling studies from around the world) were only able to locate four additional studies which specifically targeted Nevadans and their problem gambling behaviors. In some of these works, the methodology employed was questionable, while in others, the target population focused on non-adult (non-general)

populations. None of the works examined adult populations in Las Vegas using rigorous survey methods.

A University of Michigan study (Kallick, Suits, Dielman, and Hybels 1976), commissioned by the first federal committee established to study gambling, examined gambling behaviors in three counties in the state of Nevada (Washoe, Nye, and Clark). This study (somewhat) randomly surveyed adults using phone methods, but other characteristics of the study make it inappropriate for the purposes of this analysis. The study was eventually formally released in 1977, but the actual survey was conducted in 1975, measuring gambling behaviors which took place in 1974. Needless to say, vast changes that have taken place in Nevada since 1975, so interpretations based on these data should be used with extreme caution.

Notably, in examining gambling behaviors, the authors of the study decided to screen out individuals "who moved to Nevada in order to gamble," (Kallick, et al. 1976:361). In addition, the instrument used to identify "probable or potential compulsive gamblers" is fundamentally different from the ones in widespread use today. For one thing, the instrument is not specific to gambling activities: a scale was created using scores on a variety of psychological variables, including such items as "I would be willing to invest my money in a new uranium mining venture," and "Sometimes at elections I vote for men about whom I know very little" (Kallick, et al. 1976:432-433). While these questions may seem completely inappropriate, and even humorous, to those familiar with the phenomenon of problem gambling as viewed through our current lenses, it must be kept in mind that referring to the field of problem gambling studies in 1975 as "in its infancy" might be overstating the case. That said, this study provided the first official estimate of problem gambling activity in the

history of the Las Vegas valley. It was estimated that 2.62 percent of Nevadans were "probable compulsive gamblers," while another 2.35 were "potential problem gamblers."

Another work which targeted a population in Nevada was authored by Lesieur, et al. in 1991. In this study, a student sample was used, so extrapolations for purposes of estimating the prevalence rate of the local adult population are not easily made. Unfortunately, the study does not indicate where *within* the state of Nevada the figures were gathered. While these types of "sub-distinctions" are rarely made in problem gambling research, they can in fact represent important clarifications. We can be certain, for instance, that gamblers in rural Nevada are faced with a very different series of gambling options relative to those who reside in Las Vegas. For that matter, the state's two largest cities currently, Reno and Las Vegas, represent potentially different gambling environments. This presents a challenge for prevalence researchers interested in problematic gambling activities as opposed other types of prevalence researchers. While alcohol, for instance, is available in a virtually uniform fashion in different areas across the United States, we cannot say the same thing about gambling opportunities. At this stage in the field of problem gambling studies, we are as yet unable to determine whether this is an activity unaffected by even subtle community differences such as these.

It is probably safe to assume, however, that the Lesieur, et al. (1991) figures were obtained from the student population at the University of Nevada, Reno (where one of the authors, Gary Rubenstein, served on the faculty). This particular study used the South Oaks Gambling Screen. Among this sub-population of students, the authors estimated that 16 percent of students were "problem" gamblers (scoring 3 or 4 on the SOGS), while 4 percent were categorized as "pathological" gamblers (scoring 5 or higher on the SOGS).

In Southern Nevada, Oster (1992) completed a master's thesis on problem gambling rates based on studies conducted on students at the University of Nevada, Las Vegas. This work is commendable for its usage of three separate methods of assessment. Using the DSM III-R, the South Oaks Gambling Screen, and the DSM-IV (which was in development at the time) criteria, this study arrived at prevalence rates of 5.1%, 4.2%, and 11.2%, respectively (iii). However, unlike the Las Vegas Polls, studies examining problem gambling behaviors of student populations -- while certainly important in their own right -- do not contribute much to our understanding of problem gambling activity in larger populations.

Finally, in an unpublished master's thesis, Tekniepe (1997) examined problem gambling behaviors among the Las Vegas homeless (and low income) population. Once again, while this survey is certainly useful for determining problem gambling rates with a difficult-to-identify sub-population, it represents but one small sub-population among Las Vegas residents.

Using a survey handed out during the annual Stand Down for the Homeless (an organized event whose attendees may or may not be representative of the broader homeless population locally), Tekniepe examined the homeless population for problem gambling patterns. Among homeless individuals, Tekniepe found that 16.5% were "pathological" gamblers: that is, individuals scoring higher than a 5 using the DSM-IV criteria. He also found that another 25.4% were "problem gamblers," i.e., gamblers who scored between 2 and 4 using the DSM-IV criteria. Once again, while helpful in determining the problem gambling parameters within this subpopulation, these numbers contribute only slightly to our understanding of problem gambling in the entire Las Vegas population.

Qualitative Literature

Asylums Then and Now

Some of sociology's "classic" qualitative pieces can be fruitfully used to interpret the lives of problem gamblers in treatment. No sociological investigation of a mental institution would be complete without first paying homage to Goffman's monumental contribution to this field. However, reading Goffman's *Asylums* (1961) today is a bit like watching *One Flew Over the Cuckoo's Nest*: lens-altering, certainly, but the observer is left with the realization that the piece is also inextricably linked to its own era. Because mental institutions today indisputably offer a less oppressive environment than those in the 1950s did (at least on the dimensions described by Goffman), it is difficult to avoid the conclusion that mental hospitalization has come a long way since Goffman's day. Indeed, my own observations of a problem gambling treatment facility provide an appropriate illustration of this evolution.

In contrast to Goffman's "total" mental institutions in the 1950s, many types of treatment programs in mental hospitals today offer far less rigid and regulated *out*patient programs. In these environments, patients remain as full participants in their own "outside" lives during their treatment. As a result, a more humane treatment process emerges, in which a diversely-influenced new self is more democratically constructed by the patient and his or her friends, employers, peers, family members, and clinicians. This process takes place both inside and outside of Goffman's ubiquitous "walls." Furthermore, Goffman's observations of the authoritarian doctor-patient interactions in the 1950s contrast sharply with the similar processes I observe today. In the problem gambling treatment center, clinicians consciously "self-defang" by informing patients that the problem gambling is still in its infancy, and as

a result, the patients themselves are the truest of "experts."

Indeed, in pondering the continuing relevance of *Asylums* in today's world, it is worth questioning whether Goffman's total institutions exist at all anymore. At the very least, they are certainly a threatened species — in part due to the advent of developments Goffman couldn't possibly have envisioned. A new breed of white-collar criminals has led to a newer, more "user-friendly" breed of incarceration. In response to public pressures, certain military institutions have "softened" their training techniques, if the traditionalists are to be believed. In the medical field, insurance companies have refused to cover extended and intensive inpatient psychiatric hospital stays. In fact, it could well be that effective exposés not unlike Asylums itself have resulted in public sympathies and crackdowns on some of the more blatant violations of the rights of the institutionalized.

However, much as the *tools* -- if not the totality -- of the "classic" sociological theorists remain useful instruments for social theorists today, Goffman still provides us with effective dissecting devices for the *social* -- if not the physical -- world of the institutionalized. Put another way, while the machine may sputter, its cogs are still potentially sound.

To be sure, certain adjustments might be made — to determine whether virtual erasure of the entire self in order to reconstruct it has evolved into a treatment process that is better characterized nowadays as a reconstruction of one *aspect* of the individual's self, for instance. Other analytic constructs (such as the patient's retrospective reinterpretations, acceptance of the "deviant" label when no other labels seem readily available, the apologias, and the vicissitudes of the patient's life — especially upon hitting "rock bottom" and/or entering a treatment facility) need little more than a metaphorical "dusting off." It seems that

the more enduring legacy (and the legacy most likely intended by Goffman himself) of Asylums, then, can be found in its ability to locate the individual in the coldly institutional, instead of its broad characterizations of the total institution itself. In fact, these social constructs provide the foundation for a number of key theoretical issues that comprise the main theoretical arguments of Goffman's next study of marginalized populations, Stigma.

Stigma and the Problem Gambler

"I hope (admitted gambling addict) Gina Garcia read Dr. Laura Schlessinger's advice column in the Sun on (November 2)... Her gambling addiction sounds to me like the excuse for her 'lack of loyalty, loving, time, patience, thoughtfulness, to say nothing of ethics and morality,' as Dr. Laura so precisely put it."

-- Las Vegas Sun letter to the editor, 11/8/98

Indeed, if it were only so easy for problem gamblers. No less than 39 years after its original publication date, Erving Goffman's Stigma (1963) still provides a powerful analytic lens through which the lives of stigmatized individuals may be viewed and interpreted. Goffman's deconstruction of the discredited still speaks to us today because it reveals the ways in which our society remains comfortable with swift and often cruel stigmatization processes.

In the opening chapter of Stigma, Goffman describes a group of individuals stigmatized for "blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty" (1963:4), characterizations which sound all too familiar to problem gamblers today. In fact, in most cases, each of these accusations has been directed at problem gamblers at various points during their lifetime.

Problem gamblers are certainly accused being weaker of will than most: virtually all have heard the inevitable "Why don't you just *stop*?" response upon being "discovered." Theirs is also viewed as a "domineering or unnatural passion," as most who observe them cannot understand why they return to their gambling despite their repeated losses and consequent anguish. Many problem gamblers have also been accused of having "treacherous and rigid beliefs" and are often ridiculed for clinging to the apparently irrational belief that only by gambling *more*, not less, will they be rescued from their financial and personal distress. Finally, problem gamblers' dishonesty often reaches extreme levels, as increasing amounts of their energies come to be devoted to constructing an intricate web of lies designed to conceal their problems.

Unfortunately, as Goffman points out, the inability of our culture to acknowledge the complexity of stigmatization can and does result in a tragic series of events for the stigmatized. Goffman's recognition that stigmatization represents an (often-imbalanced) give-and-take exchange of interpretations between the self and the other represents one of sociology's most important contributions. His further distinction between those who are stigmatized as "discredited" and those who can be potentially discredited, or "discreditable" (1963:41) provides a useful framework for those interested in studying problem gamblers. Although Goffman spends most of his time discussing the characteristics of the discredited (especially those who are stigmatized because of their physical features), his theoretical ventures into the secret worlds of the discreditable, the individuals for whom "the issue is... managing information about his failing" (1963:42) also provide an insightful theoretical explanation for many of the apparently illogical behaviors of problem gamblers.

For problem gamblers not yet "discovered" (and hence still unstigmatized), Goffman

rears his theoretical head at virtually step in his or her "career" (1963:32). As Goffman predicts (42), in this phase, gamblers go to great lengths to hide their potentially stigmatizable behaviors. These individuals become adept at pulling off the appearance of a "normal" lifestyle while surreptitiously engaging in excessive and destructive activities. However, Goffman's description of the hiding process reveals one of the most important differences between alcohol and gambling addicts, a difference unaccounted for by Goffman's framework. Because excessive and problematic gambling activity is not always as obvious to friends and loved ones as excessive drinking or drug use, gamblers are able to erect a far more elaborate facade of lies, and with fewer challenges to its legitimacy. One female alcoholic and problem gambler told me once that when she was drinking heavily, even her 3-year-old daughter was able to quickly discern between her "good mommy" and her "bad mommy." With gamblers, the mother pointed out, these distinctions are less easily made. This "blessing," however, only lasts for so long; it appears that this phenomenon of oblivious ignorance makes for an even more dramatic (and potentially *traumatic*) discovery and/or intervention episode.

When this intervention episode does occur, again it does so just as Goffman predicts, but with certain limitations. Upon discovery, problem gamblers, unable to come up with an alternative explanation for their destructive behaviors, are forced to accept their stigmatizing labels. Again, however, Goffman's grouping of all addicts into a single theoretical category misses some of the differences between the stigmatization processes inherent in each. As it turns out, the stigmatizing/labeling process is somewhat different for gambling addicts than it is for their counterparts with alcohol or drug problems. None of this is to suggest that these individuals' suffering is any less intense: certainly those with drug and alcohol

problems present excruciating and potentially tragic challenges to those who are trapped in their grasp. However, subtle (but potentially vital) differences need to be acknowledged: "at least with drugs and alcohol you have a better idea of what you have," as another dual addict told me once. In other words, at least a previously-constructed sets of assumptions exist regarding the nature of alcoholism and drug addiction, and at least most people have some idea that treatment for these afflictions exist.

Problem gamblers, on the other hand, are rarely labeled (nor do they *self*-label) as "sick" and in need of a treatment that can potentially rectify a destructive situation. Instead, they leap to the "I am *evil*" or the equally-popular "I must be possessed" conclusion, and these views are often endorsed enthusiastically by those close to him or her. Despite recent public developments which have increased the visibility of problem gamblers, these types of awareness problems continue to plague their attempts to adjust to a social world willing and able to attach damaging labels to their problematic activities.

As a result, gamblers, labeled as uniquely evil and having broken the bonds of trust with nearly all of those whom they care about, often feel they have nowhere to turn. The staff at Charter Hospital reports that problem gamblers there attempted suicide at a rate surpassing all other groups within their psychiatric hospital -- no small feat considering those suffering from major depression, drug addiction, and schizophrenia are also included in that sample. I have heard more than a few problem gambling patients cite the stigmatization process and the inability of their social circles to incorporate a (Goffmanian) understanding of the potentially tragic labeling process into their reactions as one of the explanations for these tragic phenomena.

To combat these social processes in treatment, the clinicians in the treatment center

I observe regularly hold a "family and friends" night. These meetings of the "labeling powers that be" are particularly revealing to those who have read Goffman. A vital component of the treatment program involves an "educating" of significant others so that they won't lapse into their old (and presumably destructive) labeling behaviors. These others are told that they are not to fault the gamblers entirely for having their problem, as some recent literature (Comings 1998, Comings 1999) suggests that a biological predisposition partially contributes to certain addictive behaviors, including problem gambling. However, upon recognizing (read: labeling) their problem, if the gambler then *continues* to engage in destructive behaviors or miss treatment meetings (akin to an ill individual refusing to acknowledge his or her "illness" or refusing to take his or her medicine), then, they are told, they may "get mad" at them. In other words, the specter of stigma looms hauntingly over the head of the gambler -- who knows its powers well -- to motivate him or her to "work the program."

Finally, just as Goffman suggests, after graduating from the treatment program, problem gamblers, armed with their newly-acquired knowledge and identity, set out to reduce their own stigma as well as the stigma of others similarly afflicted. On occasion, problem gamblers' new interpretations allow the patients to counter-stigmatize their old labelers as simply ignorant or uninformed. In fact, many problem gamblers then set out to work on "publicizing" (25) by reaching out to educate the public about their affliction.

Perhaps the greatest contribution of Goffman's work in clinical treatment settings lies in his ability to empathically interpret the apparently irrational behaviors of the marginalized. Goffman's attempts to understand the lives of the "insane" has contributed in no small way to the vast and humane changes in treatment facilities across the United States. His attempts

to seek a "gentler" understanding of a group unaccustomed to such treatment will be incorporated into the ethnographic accounts that follow.

Douglas and Investigative Sociology

An approach informed solely by Goffman's empathic approach, however, could potentially falter when listening to subjects who may respond in a less than honest fashion. Toward that end, it is necessary to incorporate an approach which views its subjects with an appropriate skepticism.

The somewhat jaded view of Douglas seems particularly fitting when studying individuals for whom life has been transformed into one giant facade. Douglas' approach:

> ... is based upon the assumption that profound conflicts of interest, values, feelings and actions pervade social life. It is taken for granted that many of the people one deals with, perhaps all people to some extent, have good reason to hide from others what they are doing and even lie to them. Instead of trusting people and expecting trust in return, one suspects others and expects others to suspect him. Conflict is the reality of life; suspicion is the guiding principle (Douglas 1976:55).

While Douglas certainly had broader populations in mind when he formulated his approach, it would appear that it would be particularly appropriate for problem gamblers. Douglas argues for an "investigative" (56) approach to get beyond stage management or "fronts" that are inevitably created (and perhaps *especially* created) by this population, which finds itself so desperately in need of a cover.

However, while Douglas' words convey a healthy and appropriate skepticism, Douglas' *tone*, which stresses the negative and almost muckraking nature of this investigative practice, could perhaps prove a bit excessive. A process which emphasizes that "any suspicious lover can suddenly turn into a dedicated (practitioner)" (56) would seem to

miss opportunities to reveal the positive and the powerful swimming innocuously beneath the well-documented ugly surface.

To borrow the sociolinguist Deborah Tannen's elegant argument, too often -- and too quickly -- a "critiquing" role becomes an unnecessarily and automatically "critical" one (1998). Citing the media and academia's tendency to polarize, Tannen points out that academic and popular critics alike often slip into knee-jerk adversarial positions. In doing so, Tannen argues, the very quality of the critique is compromised. It is not the critical nature of this phenomenon that Tannen calls into question, but rather the *"automatic* nature" (7) that proves problematic.

This would not present so much of a problem were it not for the unique social positioning of problem gamblers. After spending countless hours with these individuals, it has become apparent to me that the "ugly" has indeed been pointed out to them in graphic detail by those in their own social circles. What is sometimes needed, then, is an interpretation of their behaviors which takes into account the often "sensical" or rational behaviors in which they have been engaging.

Early Qualitative Accounts: Custer

From the earliest literature on problem gambling (spanning back to the 1970s; "historical" pieces in this field remain relatively young), universalizing explanations of these behaviors have been the norm. In fact, one of the first "classic" texts in the field -- authored by a psychiatrist -- possesses a certain optimistic insistence upon relatively straightforward explanations. Of course, as is often the case with early attempts to explain befuddling behaviors, the intentions of the author were noble, and the insights presented were

extraordinary. Unfortunately, however, these early positions continue to exert undue influence on the ways that the public — and even the *informed* public — perceive these issues today.

The late Dr. Robert Custer, the widely-acknowledged "founding father" of problem gambling treatment, describes the "typical" problem gambler by a series of psychological traits. In his seminal work, When Luck Runs Out (1985), Custer relates the life stories of a number of his problem gambling patiehts. Custer identifies the following as common characteristics of problem gamblers: "generally male, superior intelligence, energetic, craves excitement, loves risk, assertive, persuasive, confident, and competitive" (1985:57-61). While these types of characteristics were probably common during Custer's career (in the 1970s and 1980s in Cleveland), they have all but disappeared from the Las Vegas problem gambling scene in 1999. Custer did not recognize that these traits -- all characteristic of classic "gambling hall" gamblers -- might not translate well into other jurisdictions and time periods. For instance, the video poker addict today looks nothing like this description. To be fair, Custer found himself in a Durkheimian dilemma, seeking certitude in order to achieve recognition for a young and fledgling field. However, when viewed from a "current" perspective (only 14 years later), the differences between "his" problem gamblers and the problem gamblers in Las Vegas in 1999 are striking.

Toward a Medically-Informed, Socially-Constructed Understanding

More importantly, the approaches of Custer bring up a theoretical issue which cannot be ignored when examining problem gamblers in treatment. As is the case in many fields involving studies of deviant behavior, the medicalization of the phenomenon has been called

into question by some who doubt this model's theoretical and practical efficacy.

In particular, the works of Rosecrance (1988) and Vatz and Weinberg (1993) merit further attention here. In contrast to both Custer and Lesieur, both of whom invested their careers in the notion that this is a treatable problem that belongs at least partially within the realm of medically diagnosable disorders, Rosecrance and Vatz and Weinberg disagree with the "medical model."

Rosecrance (1988:106-121) argues that problem gambling is a phenomenon which is historically and socially constructed. As such, its "existence" can be attributed to "more of a social accomplishment than a scientific achievement" (116). He goes on to propose a new model in which problem gambling as a purely medical phenomenon be rejected, as well as the notion that "troubled" gamblers need standardized approaches to treatment (119). Rosecrance also proposes a new model, in which these objections are addressed and diverse manifestations of problem gambling behavior are recognized and "treated" (117-119). Finally, Rosecrance questions the ability of the body of research on problem gambling to accurately depict these phenomena, especially since the researchers base their conclusions on observations of Gamblers Anonymous meetings (111).

Vatz and Weinberg (1993), who call this phenomena "heavy gambling," claim that those adhering to a medical model do so without the support of the empirical evidence that exists. They argue that "there is no credible evidence whatsoever of any neurochemical or neuropsychological status causally linked to heavy gambling" (168). They also question the efficacy of treatment modalities (171) as well as the degree to which problem gamblers engage in destrutive behaviors despite their devotion to their families: "many heavy gamblers... simply don't care so much about their families... Most compulsive gamblers are

not committed family men, with or without their gambling" (172). They conclude by arguing that we must "stop all special consideration for those whose excuses are sympathy-provoking only because they bear the unscientific 'disorder' imprimatur of psychiatry" (174).

These observations and conclusions are not to be treated lightly. Indeed, they present some important challenges to the ways problem gambling as a societal and medical phenomenon have been conceptualized. In the past, I have felt that the field of problem gambling studies -- historically dominated by clinicians -- often finds itself in desperate need of a "sociological imagination," as it were. Many of my own conclusions relative to these instances of excessive universalization and standardization are presented in this paper.

However, I have also found that the field of problem gambling studies is making strides toward accepting a more sociological conceptualization of these phenomena. As has been pointed out in the quantitative section of this paper, Harvard Medical School's meta-analysis relies primarily on a culturally-based, relativistic approach to the definitions of problem gambling. In fact, I have become familiar with the treatment practices of most of the prominent clinicians in this field over the past few years, and none have espoused an approach which conceptualizes this as a purely medical phenomenon independent of social influences.

The socially-constructed nature of this phenomenon is obvious, in my view, and indisputable. In fact, as I have already stated, it has been my experience that those adhering to a "medical model" generally accept this as self-evident. Furthermore, treatments of problem gambling have certainly evolved over the years, and currently incorporate a wide variety of treatment approaches which cater to diverse populations. In addition to group treatment settings, treatment approaches now regularly incorporate individual sessions,

financial sessions (where the inevitable economic problems are addressed), "friends and family" sessions (including sessions in which the family members *only* are allowed to attend), and legal sessions (for individuals who engaged in criminal activity in order to acquire funds to support their habit). The current treatment "model" need not be standardized, as Rosecrance (1988:118) accurately pointed out, and in the years since this observation was made, it appears that treatment professionals have recognized this.

These developments in treatment centers have also inevitably affected the ways researchers have gone about examining these phenomena. Instead of having to rely solely on data gathered in Gamblers Anonymous (GA) meetings, researchers can now investigate problem gamblers who have been caught in a number of diverse "safety nets" established by employers, psychologists, legal systems, and other service-oriented institutions. In the past year alone, I have advised groups who are currently attempting to identify problem gamblers in nonprofit centers (such as Consumer Credit Counseling Services, a United Way group involved in advising individuals who are in serious debt), medical offices serving a broader population (such as family pratitioners, who may have overlooked symptoms of problem gambling activity in the past), social work offices, legal offices, and even the Secret Service (assigned to track counterfeiting activity in the United States; predictably, some counterfeiting activity can be traced to problem gambling activities on the part of the perpetrator). As such, it is no longer defensible to label problem gambling research as dependent solely upon GA data. In the future, the field of problem gambling studies should continue to attempt to learn about problem gamblers who do not show up in treatment studies.

Referring to these activities as "heavy gambling" (Vatz and Weinberg 1993) also

misses out on a crucial point. It appears that the vast majority of gamblers who gamble heavily never develop a gambling problem. Conversely, I have observed a number of self-admitted problem gamblers in the treatment center whose losses have been surprisingly minimal. In fact, frequency (in terms of both time and money) of gambling activities do not appear to determine whether an individual develops a gambling problem or not. At the very least, the two phenomena (frequency and problem gambling) need to be treated as separate until the evidence supports a different approach.

Finally, in the qualitative stories that follow, it is evident that family matters *matter* tremendously to the problem gamblers I observed. In fact, the new family treatment program at Trimeridian was provided precisely because problem gamblers in treatment insisted that their family members were at least as deserving of attention as they were. Claiming, as Vatz and Weinberg do, that we can conclude that these individuals "simply don't care so much about their families" (1993:72) would appear to be premature and is not supported by my observations.

Of greater theoretical importance is the observation that pointing out that problem gambling -- or deviance in general, for that matter -- is socially constructed does not preclude us from accepting a model which incorporates medical advances and understandings in this field. A phenomenon can be simultaneously socially constructed to a certain degree and still explained partially by a "medical model." Indeed, it would appear that this would hardly be the time to ignore the medical field: in recent years, more and significant evidence has surfaced which suggests that a medically-informed model may help aid our collective understanding.

The research of Comings (1998, 1999) counters Vatz and Weinbeg's contention that

little evidence has been gathered supporting medical conceptualizations of problem gambling. Comings, director of medical genetics at the City of Hope Medical Center, has recently turned his attention to problem gamblers. He believes that:

> As with most addictions, the common perception is that people should be able to control their involvement and those who overindulge have only themselves to blame. While it is important for individuals to take responsibility for their own behavior, it is equally clear that biological and genetic factors can play a role in increasing the risk of becoming a pathological gambler (1998:27).

At the same time, Comings is no biogenetic determinist, claiming that it appears that "problem gambling is a multifactorical disorder, caused in part by environmental factors and in part by genetic factors, and the genetic part is polygenic in nature" (28). He goes on to posit that "there is no single cause or single gene for problem gambling and a person who happens to carry the relevant set of risk factors (environmental and genetic) is not inevitably doomed to become a pathological gambler" (28).

Certainly, the work of one of the nation's leading medical geneticists should not be ignored. In fact, Comings' very involvement with the field of problem gambling studies indicates that this field of study is more biologically and genetically complex than "pure" labeling theorists might contend.

Furthermore, medical corporations have recently begun investing large amounts of money in the notion that this biochemical and physiological factors can at least partially explain some of these problematic behaviors. Eli Lilly, the developers of Prozac, has sponsored research designed to determine the efficacy of certain drug treatments among members of this population. It seems, then, that members of pharmaceutical fields are convinced enough about biochemical explanations to begin expensive explorations of this possibility.

To be fair, many of these developments have taken place since these criticisms were first directed at problem gambling researchers and clinicians. At the very least, however, we seem to have entered a new era in problem gambling studies, in which sociological, psychological, biological, and even genetic explanations are more cooperatively offered in order to understand a more diverse assortment of problem gambling activities.

In sum, I agree with the spirit of the "soft deterministic" approach offered originally by Lesieur (1984:246), which accepts a degree of a "loss of control" (which may be influenced by medical and biochemical factors), but also recognizes that these phenomena can be profoundly influenced by more classically sociological variables such as gender and culture. Of course, Lesieur argued that this kind of multilayered approach would be most appropriate long before these more recent advances took place. Interestingly, he did not always support medically-informed approaches:

> In my student days, I was convinced that there was no such thing as mental illness; this was because of the influence of the 'labeling' school of deviance. At best, mental illness was a 'label' which enabled the medical establishment to justify its control over and attempts to modify the behavior of deviants... My views were to be transformed... I met psychologists, social workers, psychiatrists and others connected with the medical model. I found that they were compassionate persons who knew in their own mind that what they were doing was helpful to the gamblers... In addition, I met literally hundreds of gamblers who praised the work that these professionals were doing. I heard statements like: "Dr. Kramer saved my life." "If it wasn't for Dr. Taber, I would have killed myself two years ago" (1984:xiv).

I also found myself convinced by the genuine compassion of the treatment professionals I met and the efficacy of their treatments. In fact, I heard many of the same types of testimonials from problem gamblers, some of which referred to the same practitioners Lesieur originally cited. In the end, I was convinced that these professionals were working "in the trenches" to better the lives of individuals in desperate need of help.

Indeed, it is rare that sociologists find themselves in a position to directly effect this kind of positive change. Hence, this theoretical approach, which recognizes the socially constructed nature of labels while accepting and learning from recent medical advances, will be incorporated into the more specific methodological foundations of the research that follows.

CHAPTER III

METHODOLOGY

Quantitative Methodology

This thesis, then, represents the first attempt to assess problem gambling behaviors among the adult population in Las Vegas in a systematic way. Any number of significant implications of such a venture might be suggested here. For one thing, according to the National Opinion Research Center, problem and pathological gambling rates within 50 miles of a casino are roughly double the rates found elsewhere (1999:27). Of course, Las Vegans not only fall well within the 50-mile radius of casinos, they probably have more and easier access to a greater variety of gambling venues than any other locale in the country. As such, another potential benefit of this study needs to be considered: it would be imprudent to ignore the developments in Las Vegas as gambling availability grows nationwide — in effect, "Las Vegas-izing" communities by introducing diverse forms of gambling.

The Las Vegas Polls, which were conducted in 1992 and 1995 under the direction of Dr. Frederick Preston, also represent the first attempt to move beyond Shaffer, et al.'s (1997) level of "relativism." Individuals residing in a unique "gambling community" are asked to self-assess their problem gambling behaviors (as well as assess potentially problematic gambling behaviors among their friends and loved ones). Certainly, there are problems

inherent in self-assessment methods as well. For one thing, because public awareness of this problem is so low, it may be that few individuals possess the knowledge to properly assess the extent or existence of a gambling problem. However, this research is not presented as an attempt to establish a "gold standard" method, but rather to contribute to the ongoing debate about the best means of identifying problem gamblers in the general population.

As mentioned previously, defining problematic gambling behaviors has proven to be a difficult exercise among researchers in this field. The term used most commonly in everyday usage, "compulsive gambling," evokes frustration on the part of clinicians, who point out that those suffering from compulsions engage in repetitive activities (such as hand washing or door locking) because of a persistent "nagging" urge which triggers these actions. Problem gamblers, meanwhile, do not necessarily display any of these behaviors. The clinicians at the treatment center I observed for five years prefer the term "addiction," because of the affliction's similarities to those suffering from alcohol and drug dependence. In addition, this term has recently received support from research conducted by City of Hope geneticist David Comings (1998), who suggests that those who suffer from gambling, alcohol, and/or drug problems tend to possess similar biochemistries. It could well be that in the future, as we learn more about the "nature" of these problems, one term or another will prove appropriate. For now, however, a definition is needed.

Currently, prevalence research estimates tend to use the terms "pathological gambler," meaning an individual with diagnostic or severe problems, as well as "problem gambler," which refers to individuals who are at "sub-clinical" but nevertheless dangerous levels. As I mentioned earlier, Shaffer, et al. (1997) use a "level system," which corresponds to this kind of typology, but removes the terminologies often found in common usage.

In the 1992 and 1995 Las Vegas Polls, the term "problem gambler" was used. Following NORC's (1997) lead, it is assumed by this research that this is the term most meaningful to the layperson. Furthermore, it would seem to be very unlikely that respondents would differentiate between "problem" or "pathological" gambling—especially since the surveys took place before these distinctions were commonly made in the literature. Hence, in this research project the "defining of terms," as it were, is done not by the academics who observe and analyze the subjects of study, but by the subjects themselves. At this stage, it is not possible to determine what the parameters of the various response categories: for instance, "probably" categories probably indicate a lack of certainty on the part of the respondent himself or herself.

While limitations need to be acknowledged here at the outset, it is difficult to determine how these kinds of "self-assessments" -- of the individuals themselves as well as individuals within various social circles -- will affect the data. Certainly problem gambling remains a highly stigmatized behavior, and as a result, individuals may not readily admit to these types of behaviors. In fact, many problem gamblers in the treatment setting I observed indicated that they would not even indicate that they *gambled*, so as to avoid the inevitable follow-up questions.

It could well be, however, that those around the problem gambler may be more willing to identify them than they are themselves. On the other hand, in many instances, I know from my experiences with problem gamblers in treatment settings that quite often, even close friends and family members are left in the dark about the extent (or existence) of a gambling problem. As such, it may be that while individuals around the problem gambler may be *willing* to make an assessment, they may not be *able* to do so based on the limited

presentation that they see from the problem gambler.

Certainly the ways that the public conceptualizes this affliction are important. Furthermore, self-identification techniques are not without precedent in this field. This is, in essence, a 12-step type of assessment. After all, Gamblers Anonymous (like Alcoholics Anonymous before it) requires only that members identify themselves as having a problem. These types of assessments predate the professional ones by several years. In the future, it would be interesting -- not to mention useful for policymakers and clinicians alike -- to use survey research to determine how "layperson" assessments differ from professional ones.

The 1992 and 1995 surveys used random digit dialing (RDD) techniques to randomly sample households in the Las Vegas Valley. Respondents were then sampled within households by using "most recent birthday" techniques. Individuals participating in the survey were asked questions pertaining to a range of issues relevant to life in Las Vegas.

Due in part to time and cost considerations, the Las Vegas Polls interviewed a sample of 513 respondents in 1992 and 453 in 1995. Although these numbers are certainly sufficient for analyzing the issues of broader interest in the Las Vegas valley that the polls were originally designed for (such as local political issues or opinions about community needs), they are less than ideal when studying characteristics of rare sub-populations. Because of these limitations, the statistical analyses of the problem gambling behaviors identified in the Las Vegas Polls will be kept simple. Although powerful interpretations will not be offered, it should be considered that to date, no better assessment of problem gambling behaviors in Las Vegas is available, and these numbers may certainly be used as a springboard for future research protocols.

In 1992, the sample yielded a total of 30 individuals who answered "yes" or

"probably" to the question, "Have you ever had a gambling problem?" Within this subgroup, 10 individuals answered "yes," and 20 answered "probably" to this question. In 1995, 29 respondents answered "yes, definitely," or "yes, probably" to the question "Have you had a gambling problem during the past year?" Within this subgroup, 19 individuals answered "yes, definitely," and 10 individuals answered "yes, probably."

Because these subgroups are so small, especially when further variables are added for analysis, only frequencies will be presented here. Although the statistical means for analysis are limited, these remain the strongest prevalence figures available for Las Vegas, and furthermore, it is hoped that in conjunction with qualitative explorations (presented in the second section of this work), a more comprehensive understanding of the lives of problem gamblers locally can be achieved.

Qualitative Methodology

I first started researching the lives of problem gamblers five years ago, for a project which evolved into my undergraduate thesis. As is often the case with long-term research endeavors, the contrast between the "findings" of my explorations in 1994 (when I started thinking about these issues as an undergraduate) and the manifestations of the research today could hardly be more pronounced. In my case, however, this reflects not only a "chiseling away" at my patent ignorance of the field, but also a shifting set of understandings and beliefs as to the how my qualitative explorations of that field should be constituted. As a result, today my outlook is inevitably and significantly different than it was five years ago: instead of relying solely on the opinions of the "experts" I encountered in my literature reviews (and everyday interactions with other problem gambling researchers and clinicians),

I have also begun to seek the expertise of those who experience gambling problems in the everyday. As such, the "voices" I focus on have changed significantly over the years.

On a more practical level, this has meant that my gaze has shifted from every word of the doctor-experts, to every word (as well as every gesture, glance, intonation, broken promise, tear, shared moment, and so on) of the patients themselves. While in the beginning, I was overwhelmed by the opportunity to hear Big Names lecture in the treatment center, in the end I have begun to listen a different breed of "experts" as well. The observations that follow, then, generally reflect the experiences of the more recent patients in the treatment centers I observed, who had the fortune — good or bad — to join the program after I began shifting my attention.

All of which is not to say that there remain no substantial similarities between the "old days" and today, of course. Then, as now, the questions I had were the predictable ones, and they all revolved around a single query: what are their *lives* like? Today, for the most part, that question remains the same; the permutations, however, have grown considerably more complex.

To answer these questions, the theoretical approaches of Goffman and Douglas will play a central role. In essence, this ethnography will lean on the empathic understanding of Goffman, while relying on the critical skeptical approach of Douglas as well. In sum, it is my hope that my approach will allow me to get at "misinformation, evasions, lies, and fronts" (Douglas 1976:57) as well as the (Goffmanian) less stigma-worthy behaviors of the gamblers while they are "in action." Rather than simply detailing the apparently egregious wrongdoings in these individuals' lives, I hope to go beyond the damage to examine the destructor. This empathic, skeptical approach has informed my thinking throughout my work

on this qualitative piece.

Of course, I have had a great deal of help on this journey. I doubt one could find a more cooperative and eager group of individuals to investigate. Soon after my first visits to the treatment centers, I learned that I was in the company of similarly-minded individuals in a very important sense: like the social researcher, these patients *constantly* asked their most prodding questions, and sought answers to explain behaviors that had been baffling them.

As it turns out, few patients surrender to this malady without concern for the "whys": As Julie, a reserved thirty-year old former cocktail waitress, told me after a meeting one day, "I remember sitting there at the machines saying to myself, 'I just want to know, Why am I doing this? I don't even *want* to be doing this...'"

In the treatment center, these amorphous questions are directed at the therapists, the researcher, the other patients, themselves, their family members -- in short, of anyone expressing an interest (or angry *dis*interest, even) in their plight. Ultimately, I found that the patients' willingness to explore the deepest abscesses of their damaged souls was among the most rewarding aspects of this ethnographic research. In the work that follows, I have tried to put our collective critical and social imaginations to work as best as I could, in order to better understand their lives and the lives that may enter that room in the future.

Before proceeding with the stories, a brief description of the scenery is probably necessary. Inside the treatment room, groups of 10-12 gather to speak with treatment professionals and each other about their peculiar affliction. During my visits, I observed the interactions of over 200 patients who had checked into these treatment centers because of their gambling problems. Before I started observing these individuals, the human subjects committee in the department of sociology at the University of Nevada, Las Vegas approved

these investigations.

The interactions I observed were characterized by a sort of affectionate cynicism, as patients called into question each others' tales. For instance, whenever a patient would attempt to claim that last night's "slip" consisted of an accidental dropping of his or her change into the slot machine at 7-11, the room would soon have the patient conceding that the true extent of his or her relapse had been far more substantial. I heard on more than one occasion that this was a room where "bullshitting is not allowed," for the simple reason that the people inside found themselves in the company of seasoned and professional bullshitters -- the "best of the best," as they mockingly claimed. Because "you can't smell the cards on our breath and we don't go around bumping into things," as a favorite Gamblers' Anonymous saying goes, these individuals had been able to craft intricate webs of deceit which eventually "caught" all within their social circles. Only here, in this room, would the "real" story come out, I was promised.

I was game.

I would soon realize, as all ethnographers likely do at some point, that it is at precisely this moment -- when the subjects promise you that *this* is when and where you're going to hear the truth -- that we need to sharpen the focus of our own critical "lenses." Hence, as often as possible, I will relate these tales as best as I can (given my note taking limitations -- which I tried to counter by going over my scrawled notes as quickly as possible in a nearby office after the meetings concluded) and include my own interpretations where appropriate.

As for the more concrete details of the "room," a brief discussion of its merits and limitations is in order. The research presented here was collected in both the Trimeridian and

Charter Hospital Intensive Outpatient Program. A few points about these centers are especially relevant. According to its founders, the program as it stands today reflects an evolutionary process which has taken place since its inception over a dozen years ago. Sharp cuts in health insurance coverage dictated that what was once an intensive *in*patient program became reincarnated as an outpatient program. However, this newer, distilled version of treatment, the patients are assured, is by no means a watered-down one. Patients come for three hours a night, four nights a week, for six weeks. Daily sessions usually incorporate one of three separate treatment strategies.

The first session type is a therapeutic one, which is run by a "traditional" psychologist and deals with the inevitable emotional and relationship distress felt by the patients. The second type of treatment strategy incorporates the 12-step model, and is led by "Phil T." (not his real name), a Gamblers' Anonymous member with over 10,000 days of abstinence. This segment focuses on the day-to-day vicissitudes of a problem gambler's life -- a sort of nuts-and-bolts "how-to" guide for staying clean.

The final component involves "educational" discussions. These presentations are given by the founder of the program, Dr. Robert Hunter. Along with Dr. Robert Custer, Dr. Hunter founded the problem gambling treatment program at Charter Hospital in 1986. In his sessions, Hunter relates the historical and the what-we-know-now aspects of the field of problem gambling. It is this latter subsection that I attend, primarily because it fit into my schedule most conveniently. I usually attend one or two meetings a week, each about two hours in length. Dr. Hunter has been extremely generous in allowing unfettered and unstructured interactions with the patients both in the treatment center and outside its walls when the program ends for the evening.

Inside the center, the treatment room is sparsely decorated, with a dry-erase board serving as the most visible backdrop. Patients, treatment professionals, family members (when their attendance is appropriate -- they are invited once a week), and researchers alike are seated in a circle inside of the room. Interaction almost always begins unspectacularly. Most patients, familiar with the 12-step tradition, fall into the famous pattern where they state their name first, and then admit their problem by its label: "My name is Bob, and I'm a compulsive gambler." Before long, however, this lighter fare is abandoned, and the dramatic tales begin to unfold. On many nights, the speakers soon have to raise their voices to be heard over the chorus of loud sobbing.

The final point is a sociological one, and one that needs to be addressed with some care: the institution currently charges for its services (an often tragically ironic reality which is not lost on its patients, who are seeking help in large part *because* of their financial dire straits). While the services used to be offered free of charge (as a "public service" of Charter Hospital), Trimeridian Inc.'s recent buyout has meant that the program has started to seek a profit. Because of this, one can only wonder what types of patients we are *missing* in this newer sample. For instance, it is impossible not to notice that in its current incarnation, females no longer comprise the vast majority of patients in the center. Although Trimeridian is too new an entity to explore this phenomenon further here, it would be interesting to examine the differences between for-profit and nonprofit or donated treatment programs for problem gamblers.

CHAPTER IV

RESULTS

Quantitative Results

The 1992 Las Vegas Poll Data

In 1992, individuals were questioned about their own lifetime problem gambling behaviors as well as those of individuals within various social circles of the respondent. Respondents were asked whether they felt that they had any coworkers, close friends, or family members who had "ever had a gambling problem." They were then provided with the response categories "yes," "probably," and "no." In this analysis, on a number of occasions the "yes" and "probably" categories will be combined (the "combined" category) by looking at the cumulative percentages.

In any case, the findings of the 1992 poll suggest that many Las Vegans are dealing with problem gambling on a very intimate level. Respondents were questioned about their coworkers, close friends, and family members. In Table 5, the results of the "close friend prevalence" question are tabulated:

Table 5. Coworker with a Gambling Problem, 1992

Coworker with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes	204	41.2	41.2
Probably	53	10.7	51.9
No	238	48.1	100.0
Total	495	100.0	

41.2% of the respondents indicated that they felt that at some point in their life, they had a coworker with a gambling problem. An additional 10.7% of respondents felt that they "probably" had a coworker with a problem, so taken together, over half of those responding to this question felt that they have had (or probably have had) a coworker with a gambling problem over the course of their lifetimes. Of course, lifetime coworker rates could well include a number of individuals who are no longer working with the respondent.

Respondents were then asked if they have had a close friend who has ever had a gambling problem. Results are displayed in Table 6.

Table 6. Close Friend with a Gambling Problem, 1992

Close Friend with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes	169	33.3	33.3
Probably	40	7.9	41.2
No	298	58.8	100.0
Total	507	100.0	

Once again, this survey suggests that large numbers of Las Vegans feel that they have had personal experiences with problem gamblers. Exactly one-third of Las Vegans surveyed answered "yes" to the question, "Has a close friend ever had a gambling problem?" Another 7.9 percent felt that a close friend has "probably" had a gambling problem. Combined, the "yes" and "probably" respondents make up 41.2% of the sample.

The next question asked about and even more intimate social group: the families of the respondents. Once again, the findings suggest that large numbers of Las Vegans feel that they have come in close contact with this phenomenon (see Table 7):

Table 7. Family Member with a Gambling Problem, 1992

Family Member with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes	88	17.2	17.2
Probably	22	4.3	21.4
No	403	78.6	100.0
Total	513	100.0	

Once again, the evidence here suggests that according to Las Vegans responding to this poll, problem gambling is a problem that many in the Las Vegas valley have experienced. 17.2 percent of those surveyed answered "yes" to the question "Has a member of your family ever had a gambling problem?" When those answering that a member of their family "probably" had a gambling problem are added, over one in five (21.4%) locals indicated that they had experienced this problem on an intimate basis.

Finally, the question was posed to the respondent him or herself: "Have you ever had a gambling problem?" (Table 8, below). Although prevalence rates listed here cannot be compared with prevalence rates obtained elsewhere using clinical instruments, this remains the best indicator currently available on current problem gambling phenomena in Las Vegas. Furthermore, if Shaffer, et al.'s "relativism" is accepted, "conceptual equivalence" is of prime concern. As such, these numbers are broadly comparable, as it is assumed that the "concept" of problem gambling is stable on a general public level. Again, these should be viewed as preliminary numbers, but at the very least, the problem does appear to be significant.

Table 8. Self-reported Gambling Problem Frequencies, 1992

	Frequency	Valid Percent	Cumulative Percent
Yes	10	1.9	1.9
Probably	20	3.9	5.8
No	483	94.2	100.0
Total	513	100.0	

On the self-assessed problem gambling question, 1.9 percent of Las Vegans surveyed answered "yes" to this question, while another 3.9 percent answered that they "probably" had a gambling problem. Taken together, 5.8 percent of Las Vegans in the survey fell into the "combined" category, that is, indicated that they were probable problem gamblers or actual problem gamblers.

Further analysis was conducted in order to determine problem gambling "risk factors" among certain subgroups within the Las Vegas valley. Because the total number of problem gamblers was not large enough to conduct complex statistical analyses of the demographic breakdown of the "problem gambler" group, only frequencies will be displayed. These frequencies reflect the percentage of individuals within certain categories who admitted to a gambling problem.

This approach is consistent with both the NORC study and the Harvard Medical School meta-analysis, both of which argued that percentaging in this direction represented the only viable method. Shaffer, et al. argue convincingly that

> Rather than reporting, for example, that males make up 80% of the group of pathological gamblers, we recommend that investigators report gender-specific prevalence rates. For example, *"4.3% of the males in the sample were pathological gamblers compared to 1.2% of the females in the sample."* The former approach

> is an indication of the proportion of the entire sample that is male, and confounds an understanding of the relationship between gender and disordered gambling; the latter approach is a better index of a specific risk factor (e.g., gender) for disordered gambling. Data reported in this manner will stimulate an improved understanding of the factors that contribute meaningfully to the phenomenon of disordered gambling (1997:57) .

In most instances, analysis was only conducted with subgroups (e.g., college graduates, males, casino employees) reflecting the responses of over 50 individuals, though in a handful of occasions, categories with less than 50 respondents are presented as potential "guideposts" for future research. Finally, though the data that follow still reflect the best current estimations of problem gambling behaviors in Las Vegas, it remains important that the reader interpret these figures as approximate, "ballpark" figures which will hopefully lead to further research and discussion.

Problem gambling prevalence rates among certain demographic groups

Although these numbers are not large enough for purposes of generalization, the data suggest that a larger proportion of males have gambling problems in Nevada. Interestingly, in Table 9 below, it appears that these patterns are similar to those found in the NORC survey (1999:26-27).

Table 9. Gender and Gambling Problems, 1992

	Gender	
Problem Gambler?	Male (n=254)	Female (n=258)
Yes	2.4% (6)	1.6% (4)
Probably	4.7% (12)	3.1% (8)
Total	7.1% (18)	4.7% (12)

In Table 10, the sample of problem gamblers was broken down into age groups:

Table 10. Age and Gambling Problems, 1992

	Age Group				
Problem Gambler?	18-29 (n=93)	30-39 (n=125)	40-49 (n=91)	50-64 (n=119)	65+ (n=85)
Yes	3.2% (3)	0.8% (1)	1.1% (1)	2.5% (3)	2.4% (2)
Probably	2.2% (2)	2.4% (3)	7.7% (7)	3.4% (4)	4.7% (4)
Total	5.4% (5)	3.2% (4)	8.8% (8)	5.9% (7)	7.1% (6)

Although the data are relatively evenly distributed in this table, it appears that when the "yes" and "probably" groups are combined, the age groups that are most "at risk" are 40-49 year old individuals and 65+ individuals. It would seem that the 65+ age group would need to be monitored closely in the future, as the local retirement communities continue to grow in size.

Table 11. Educational Level and Gambling Problems, 1992

	Educational Level			
Problem Gambler?	Less than High School (n=38)	High School Graduate (n=181)	Some College (n=197)	College Degree + (n=95)
Yes	2.6% (1)	2.2% (4)	2.0% (4)	1.1% (1)
Probably	5.3% (2)	5.0% (9)	3.6% (7)	2.1% (2)
Total	7.9% (3)	7.2% (13)	5.6 (11)	3.2% (3)

It appears that those with less than a high school education have are at the greatest

risk of developing a gambling problem, although the small cell counts in this response category should be taken into consideration. Within this sample, those who have a high school diploma or less have more than twice the risk factor relative to those who have at least a college degree.

Table 12. Race/Ethnic Background and Gambling Problems, 1992

	Race/Ethnic Background			
Problem Gambler?	Black (n=42)	White (n=413)	Hispanic (n=36)	Asian (n=10)
Yes	2.4% (1)	1.7% (7)	2.8% (1)	10.0% (1)
Probably	4.8% (2)	3.4% (14)	0% (0)	40.0% (4)
Total	7.1% (3)	5.1% (21)	2.8% (1)	50% (5)

Although white respondents were by far the most common racial group represented in the survey, it would be interesting to pursue certain subgroups within the Las Vegas valley, in order to determine if any of these numbers would hold up with larger numbers. For instance, further research might delve into the problem gambling rates of Black and Asian Las Vegans, to see if the proportions of problem gamblers remain above those of White and Hispanic respondents.

Table 13. Casino or Related Industry Employment and Gambling Problems, 1992

	Type of Employment			
Problem Gambler?	Work in Casino Industry (n=112)	Work in Closely Related Industry (n=69)	Combined (in Casino or Related Industry) [n=181]	Neither Casino nor Related Industry (n=329)
Yes	3.6% (4)	2.9% (2)	3.3% [6]	1.2% (4)
Probably	6.3% (7)	4.3% (3)	5.5% [10]	3.0% (10)
Total	9.8% (11)	7.2% (5)	8.8% [16]	4.3% (14)

Of all of the variables measured in the 1992 Las Vegas Poll, this particular one might tell us the most about the unique experience of living and working in a city where gambling serves as a dominant economic force. From these numbers, it appears that those who work in the casino industry or in a closely related industry have higher problem gambling rates compared to those who do not work in the casino or a closely related industry. Of course, at this stage, causal interpretations would be premature: it could well be, for instance, that these types of employment opportunities attract individuals who turn out to be problem gamblers for one reason or another.

Table 14. Marital Status and Gambling Problems, 1992

	Marital Status				
Problem Gambler?	Married (n=303)	Single (n=68)	Divorced (n=82)	Cohabiting (n=6)	Widowed (n=49)
Yes	1.3% (4)	1.5% (1)	3.7% (3)	33.3% (2)	0% (0)
Probably	3.3% (10)	2.9% (2)	7.3% (6)	0% (0)	4.1% (2)
Total	4.6% (14)	4.4% (3)	11.0% (9)	33.3% (2)	4.1% (2)

Among those indicating their marital status, a couple of patterns emerge from the data. In all of the problem gambling categories, divorced individuals displayed twice the problem gambling rates that married or single individuals have. Once again, however, caution must be taken in making any causal inferences, as it is impossible to discern from these numbers whether problem gambling behaviors or marital problems were causal: in fact, as is often the case, it is likely that the two interact to a significant degree.

Table 15. Employment Status and Gambling Problems, 1992

	Employment Status			
Problem Gambler?	Employed (n=291)	Unemployed (n=91)	Student (n=10)	Retired (n=116)
Yes	2.1% (6)	2.2% (2)	0.0% (0)	1.7% (2)
Probably	3.8% (11)	4.4% (4)	0.0% (0)	4.3% (5)
Total	5.8% (17)	6.6% (6)	0.0% (0)	6.0% (7)

Interestingly, employment status variables revealed no significant problem gambling

patterns in the Las Vegas population. Though the student subsample was too small to make any inferences about its makeup, it appears that individuals who are employed, unemployed, and/or retired have similar rates of problem gambling behaviors.

Finally, problem gamblers' social circles were examined by looking into the problem gambling patterns of their coworkers, close friends, and family members.

Table 16. Coworker Gambling Problems and Respondent Gambling Problems, 1992

	Coworker Gambling Problem?			
Respondent Gambling Problem?	Yes (n=204)	Probably (n=53)	Combined Yes and Probably (n=257)	No (n=238)
Yes	4.4% (9)	1.9% (1)	3.9% (10)	0.0% (0)
Probably	5.4% (11)	11.3 (6)	6.6% (17)	0.8% (2)
Total	9.8% (20)	13.2% (7)	10.5% (27)	0.8% (2)

Of those who indicated that they had a coworker who had a gambling problem, 4.4% indicated that they, too, had a gambling problem, while another 5.4% indicated that they probably had a gambling problem. Predictably, both of these numbers exceed those found in the general population (in which 1.9% felt they had a gambling problem and 3.9% felt they probably had a gambling problem, and 5.8% fell into one of the two problem gambling categories). In addition, when those who indicate that they had a coworker who "probably" had a gambling problem are added to those in the "yes" category (see the third column above), the problem gambling rates remain relatively higher (3.9% indicated that they had a gambling problem, 6.6% indicated that they probably had a gambling problem, resulting

in a 10.5% combined rate). Even more significant, perhaps, is the observation that only 0.8% of individuals who have not had a coworker with a gambling problem developed a gambling problem themselves. From this data, then, it appears that those who identify co-workers with a gambling problem do in fact report higher rates of gambling problems themselves.

Table 17. Close Friend Gambling Problems and Respondent Gambling Problems, 1992

	Close Friend Gambling Problem?			
Respondent Gambling Problem?	Yes (n=169)	Probably (n=40)	Combined Yes and Probably (n=209)	No (n=298)
Yes	4.7% (8)	2.5% (1)	4.3% (9)	0.3% (1)
Probably	5.9% (10)	17.5% (7)	8.1% (17)	1.0% (3)
Total	10.7% (18)	20.0% (8)	12.4% (26)	1.3% (4)

Of those who indicated that they had a close friend with a gambling problem, problem gambling rates were higher than the rates found in the general population. 4.7% of those who indicated that they had a close friend with a gambling problem indicated that they, too, had a gambling problem, while 5.9% of those with a problem gambler close friend felt that they "probably" had a gambling problem. Taken together, 10.7% of those indicating that a close friend had a gambling problem had a probable or actual problem gambling themselves. Once again these numbers exceed those found in the general population (in which 1.9% felt they had a gambling problem and 3.9% felt they probably had a gambling problem, and 5.8% fell into one of the two problem gambling categories). They also are far higher than those of individuals who indicated that they had no close friends with gambling

problems: only 1.3% of these individuals developed gambling problems themselves.

When those who indicated that they had a friend who "probably" had a gambling problem were combined (see column 3 above), the rates remained relatively high. 4.3% of individuals with actual or probable gambling problems indicated that they had a gambling problem, while 8.1% indicated that they probably had a gambling problem themselves.

Once again, it appears that individuals who have friends who gamble to excess are more likely to do so themselves, though causal inferences cannot be made. It is not clear from this data whether individuals have close friends who gamble, which leads them to excessive behaviors themselves, or if problem gamblers are attracted to other problem gamblers in their social relationships.

The final "social circle" question asked about problem gambling activities in the respondents' families.

Table 18. Family Member Gambling Problems and Respondent Gambling Problems, 1992

	Family Member Gambling Problem?			
Respondent Gambling Problem?	Yes (n=88)	Probably (n=22)	Combined Yes and Probably (n=110)	No (n=403)
Yes	5.7% (5)	0.0% (0)	4.5% (5)	1.2% (5)
Probably	6.8% (6)	40.9% (9)	13.6% (15)	1.2% (5)
Total	12.5% (11)	40.9% (9)	18.2% (20)	2.5% (10)

Once again, the problem gambling rates among those who have a family member with a gambling problem are higher than the figures taken from the general population. Of individuals who indicated that they had a family member with a gambling problem, 5.7% indicated that they also had a problem, while 6.8% felt that they "probably" had a gambling problem. Recall that both of these numbers exceed those found in the general population (in which 1.9% felt they had a gambling problem and 3.9% felt they probably had a gambling problem, so that 5.8% were self-identified actual or probable problem gamblers).

When those who felt that they had a family member who "probably" had a gambling problem were added to the analysis, the rates remained high once again: 4.5% indicated that they had a gambling problem, 13.6% indicated that they probably had a gambling problem, and 18.2% (the highest combined rate in any of the "social circle" problem gambling categories) fell into the combined categories. Finally, these rates are far higher than the rates of individuals who have no family experience with problem gamblers: only 2.5% of those individuals indicated that they had a gambling problem. Once again, however, it is necessary to caution against overenthusiastic causal analysis: it cannot be determined whether problem gambling patterns in the family are causal, or whether, for instance, those with gambling problems create family problems which lead to higher problem gambling rates.

Finally, another possibility is that certain respondents are simply more likely to identify a gambling problem in *any* individual. It could be, for instance, that an overenthusiastic "problem gambling identifier" would more readily self-identify *and* identify others as having a problem. Without further study of the ways in which individuals identify and self-identify problem gambling behaviors, it is difficult to know what accounts for these apparent tendencies.

In any case, it could well be that these findings could have applications in treatment settings. Although it cannot be said that certain social backgrounds *cause* problem gambling behavior, there certainly appears to be a correlation. At the very least, problem gamblers may be advised to consider the social situations in which they gamble, and how these types of situations may contribute to their excitement or their escape while gambling. It could well be that many problem gamblers have relationships with certain "trigger" individuals, and that these types of relationships need to be addressed in order to help the problem gambler. The social situations in which problem gamblers engage in gambling activities are further explored in the qualitative section of this paper.

Las Vegas Poll 1995 Data

The 1995 Las Vegas Poll differed from the 1992 Poll in two crucial respects. For one thing, individuals were questioned regarding their problem gambling behaviors *in the past year* rather than over their lifetimes. While both approaches are valid and have their defenders, recall from the previous discussion that certain issues need to be kept in mind which may affect the ways that this problem gambling population differs from the one examined in 1992. It is my view that while the numbers of problem gamblers in both polls is too small to conduct a comparative statistical analysis, examining both approaches in different years is commendable. Perhaps in the future, both approaches might be used in the same survey to better determine how past-year and lifetime rates differ in the Las Vegas valley. For now, comparisons between the 1992 data (measuring lifetime rates) and the 1995 data (measuring past-year rates) should not be made.

Remarkably, Shaffer, et al. (1997:24) indicate that over one third (37.3%) of the studies used in their meta-analysis "failed to indicate the time frame for their prevalence studies." This appears to be another example of a distinction that has evolved as this field of study matures. In the future, however, neglecting this potentially useful distinction would be irresponsible.

Secondly, because of the inherent vagueness of the "probably" problem gambling categories in the 1992 survey, individuals were asked to answer in the affirmative to all problem gambling questions. Response categories, then, allowed individuals to give the following responses: "Yes, definitely," "Yes, probably," and "No." Although further research would certainly be necessary in order to derive any definite conclusion from the findings that follow, it is likely that the response categories of "yes, definitely" and "yes,

probably" categories represent higher thresholds than "yes" and "probably" categories respectively. At the very least, the responses became more specific than those offered in the last Las Vegas Poll.

In 1995, all respondents were asked about past-year problem gambling behaviors among certain individuals within certain social circles of the respondent. The categories were adjusted somewhat: in 1995, respondents were asked about "acquaintances" in order to determine how many Las Vegans felt they knew an individual with a gambling problem. In addition, the "family member" category was made more specific: in 1995, respondents were asked whether they felt that an "immediate" family member had a gambling problem.

Table 19. Acquaintance with a Gambling Problem, 1995

Acquaintance with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes, definitely	197	46.4	46.4
Yes, probably	40	9.4	55.8
No	188	44.2	100.0
Total	425	100.0	

From the evidence observed in the overall sample, it appears that many — perhaps even a majority — of Las Vegans know of someone who has had a gambling problem in the past year. 46.4% of those responding indicated that they "definitely" knew someone who had a gambling problem, while another 9.4% indicated that they "probably" knew someone who had a gambling problem. Taken together, 55.8% answered in the affirmative, meaning that

it is possible that half of the residents of Las Vegas in 1995 felt that they knew someone with a gambling problem.

When respondents were questioned about the problem gambling behaviors of close friends, once again substantial numbers of Las Vegans felt that they had encountered this problem on a personal level.

Table 20. Close Friend with a Gambling Problem, 1995

Close Friend with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes, definitely	144	32.7	32.7
Yes, probably	27	6.1	38.8
No	269	61.1	100.0
Total	440	100.0	

In the 1995 survey, 32.7% of those responding indicated that they "definitely" had a close friend with a gambling problem. Another 6.1% felt that they "probably" had a close friend with a gambling problem. When these "yes" categories are considered jointly, 38.8% of Las Vegans responding felt that they had a close friend with a gambling problem.

Respondents were then asked about their "immediate family members" and the problem gambling activities in which they may have engaged. Immediate family member problem gambling rates are displayed in Table 21.

Table 21. Immediate Family Member with a Gambling Problem, 1995

Immediate Family Member with a Gambling Problem?	Frequency	Valid Percent	Cumulative Percent
Yes, definitely	76	17.2	17.2
Yes, probably	15	3.4	20.6
No	350	79.4	100.0
Total	441	100.0	

In 1992, respondents were asked about "family member" problem gambling behaviors, but the apparently high rates created some skepticism among the study's principal investigators. In 1995 respondents were asked about their "immediate" family members in hopes that a more specific idea of the nature and extent of problem gambling behaviors within these groups could be identified. In this sample, 17.2% of Las Vegans indicated that they "definitely" had an immediate family member with a gambling problem, while 3.4% indicated that they "probably" had an immediate family member with a gambling problem. If both of the "yes" categories are added together, 20.6% of Las Vegans surveyed in 1995 indicated that they had an immediate family member who had a gambling problem in the past year.

Despite the fact that these are tentative numbers, it is difficult to avoid the conclusion that problem gambling is a pervasive problem in the Las Vegas valley. It should also be kept in mind that because the general public is still lacking in knowledge about this affliction, it could well be that many indicators of problem gambling behaviors among acquaintances, close friends, and immediate family members go undetected. Of course, it could also be that

individuals "over-diagnose" — that is, identify false positives — but this would seem to be a less likely scenario, especially when the sensitive, stigmatizing nature of these labels are considered.

Table 22. Self-reported Gambling Problem Frequencies,* 1995

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, definitely	19	4.4	5.2	17.2
Yes, probably	10	2.2	2.7	20.6
No	337	6.6	7.9	100.0

* Individuals who indicated that they had never gambled were not asked if they were a problem gambler.

In 1995, only individuals who indicated that they had gambled in their lifetime were asked about problem gambling activity. This shift allowed for another distinction, advocated by Shaffer, et al. (1997), to be made:

> Nearly every study in this meta-analysis conceptualized prevalence rates in the same way: Prevalence was calculated by dividing the number of respondents experiencing disordered gambling by the total number of respondents in the study.
>
> Expressing prevalence rates as the percentage of the "general population" that experiences the phenomenon in question is a standard practice in epidemiological research. However, in the gambling research field, there are benefits to including a second method of calculating prevalence rates: in this second method, prevalence rates would be calculated by dividing the number of respondents experiencing disordered gambling by the number of respondents *who are at risk for developing disordered gambling* (e.g., those in the total population who have gambled in their lifetime). This conceptualization of prevalence is based on the premise that if one never gambles, there is no active or practical risk of becoming a pathological gambler. Similarly, if one never drinks alcohol, there is no risk of developing alcohol dependence (65).

The authors go on to point out that this approach is not without precedent. In assessing side effects with a certain drug, for instance, only individuals who have actually taken the drug are examined for side effects. Hence, "this group is used as the reference group among which prevalence is calculated" (65).

Fortunately, in the 1995 survey we may consider this alternative method of assessing problem gambling prevalence because individuals who had not gambled in their lifetime were not asked about problem gambling activities. Hence, the contingency question "Have you ever gambled?" allows us to filter respondents into "lifetime gambler" and "lifetime non-gambler" categories.

In the 1995 survey, the "total population" prevalence rates were as follows: 4.4% indicated that they "definitely" had a gambling problem in the past year, while 2.2% indicated that they "probably" had a gambling problem within the same time frame. Overall, 6.6% of respondents answered affirmatively to the question "In the past year, have you had a gambling problem?"

Of course, when the "eligible population" (i.e., those who have gambled) is used for the calculations, the numbers increase: 5.2% of those who have gambled indicated that they "definitely" had a gambling problem, while 2.7% of those who have gambled indicated that they "probably had a gambling problem. Taken together, 7.9% of Las Vegans indicated that they were problem gamblers using the "eligible population" model.

In the 1995 survey as in the 1992 survey, problem gambling prevalence rates were calculated among certain subgroups in the Las Vegas valley, allowing for a "risk factor" calculation. In the tables that follow, risk factors are calculated for various demographic groups, and results are presented as percentages of these groups (e.g., 40-49 year old

respondents) who indicated that they had developed a gambling problem in the past year.

Prevalence of Gambling Problems among Certain Demographic Groups

Once again, further analysis on specific demographic groups was conducted on the respondents to the 1995 survey.

Table 23. Age and Gambling Problems, 1995

	Age				
Problem Gambler?	18-29 (n=77)	30-39 (n=123)	40-49 (n=74)	50-64 (n=83)	65+ (n=96)
Yes, Definitely	7.8% (6)	4.9% (6)	1.4% (1)	2.4% (2)	4.2% (4)
Yes, Probably	1.3% (1)	3.3% (4)	0.0% (0)	4.8% (4)	1.0% (1)
Total	9.1% (7)	8.1% (10)	1.4% (1)	7.2% (6)	5.2% (5)

Interestingly, in this survey, the age data appear to be distributed in something of a "reverse bell curve" fashion. That is, younger and older groups appear to have higher rates of problem gambling activity, while the lowest rate was found in the middle (40-49 year old) age category. The highest rates of problem gambling were observed in the 18-29 category (9.1% combined "yes, definitely" and "yes, probably"), followed by the 30-39 category (8.1% combined), and the 50-59 category (7.2% combined).

Table 23. Educational Level and Gambling Problems, 1995

	Educational Level			
Problem Gambler?	Less than High School (n=41)	High School Graduate (n=121)	Some College (n=154)	College Degree + (n=125)
Yes, Definitely	9.8% (4)	3.3% (4)	5.2% (8)	1.6% (2)
Yes, Probably	2.4% (1)	0.8% (1)	2.0% (3)	4.0% (5)
Total	12.2% (5)	4.1% (5)	7.1% (11)	5.6% (7)

When respondents' educational backgrounds were examined, a few patterns emerged. Although the number of "less than high school" respondents is lower than ideal, out of 41 individuals who fell into this category, five (12.2%) answered that they definitely or probably had a gambling problem. Meanwhile, 4.1% of those who earned only a high school diploma answered in the affirmative to the problem gambling question, while 7.1% of the "some college" group and 5.6% of the "college degree or higher" group did so.

Table 25. Gender and Gambling Problems, 1995

	Gender	
Problem Gambler?	Male (n=205)	Female (n=248)
Yes, Definitely	5.4% (11)	3.2% (8)
Yes, Probably	2.4% (5)	2.0% (5)
Total	7.8% (16)	5.2% (13)

Once again, males had higher rates of problem gambling than females in all

categories. 5.4% of males surveyed indicated that they "definitely" had a gambling problem, while 2.4% indicated that they "probably" had a gambling problem. Overall, 7.8% of males indicated a "yes" category when this question was posed. Among females, 3.2% indicated that they "definitely" had a gambling problem, while 2.0% indicated that they "probably" had a gambling problem. 5.2% of females surveyed fell into one of the two combined "yes" categories.

Table 26. Race/Ethnic Background and Gambling Problems, 1995

	Race/Ethnic Background					
Problem Gambler?	Black/ Af-Am (n=42)	White/ Caucasian (n=343)	Hispanic/ Mexican (n=34)	Asian/ Pacific Isle (n=12)	Other (n=4)	Native American (n=10)
Yes, Definitely	2.4% (1)	4.1% (14)	2.9% (1)	8.3% (1)	0.0% (0)	10.0% (1)
Yes, Probably	0.0% (0)	2.9% (10)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	2.4% (1)	7.0% (24)	2.9% (1)	8.3% (1)	0.0% (0)	10.0% (1)

Among racial and ethnic groups, once again the preponderance of white respondents presents a problem. While the numbers for other racial and ethnic groups are not as high as we might prefer, a couple of patterns emerged which might prove interesting for future inquiries. Although the proportion of African American respondents who indicated that they had a gambling problem in the past year was lower than that of whites (relative to the 1992 survey examining "lifetime" problem gambling rates), the proportion of Asian and Pacific Islander respondents who indicated that they had a gambling problem remained high.

Further sociological and anthropological research would appear to be necessary in order to determine whether individuals of Asian/Pacific Island descent do indeed have higher rates of problem gambling behaviors.

Table 27. Marital Status and Gambling Problems, 1995

	Marital Status			
Problem Gambler?	Married (n=250)	Single, Never Married (n=72)	Separated/ Divorced (n=86)	Widowed (n=36)
Yes, Definitely	4.4% (11)	4.2% (3)	3.5% (3)	2.8% (1)
Yes, Probably	2.0% (5)	1.4% (1)	4.7% (4)	0.0% (0)
Total	6.4% (16)	5.6% (4)	8.1% (7)	2.8% (1)

In the 1995 survey, few differences emerged among those who were married, single, or separated/divorced, although the latter category does appear to have the highest proportion of problem gamblers. Among married respondents, 4.0% indicated that they "definitely" had a gambling problem, while 2.4% indicated that they "probably" had a gambling problem, resulting in a 6.4% "combined" prevalence rate for these individuals. When "single and never married" respondents were asked about past-year gambling behaviors, 4.2% indicated that they had "definitely" had a problem, while 1.4% indicated that they "probably" did, for a combined rate of 5.6%. Meanwhile, divorced or separated respondents had the highest rates of all of the groups: 3.5% among "definites" and 4.7% among "probables," for a combined rate of 8.1%.

Table 28. Employment Status and Gambling Problems, 1995

	Employment Status				
Problem Gambler?	Employed (n=261)	Unemployed (n=43)	Student (n=7)	Homemaker (n=32)	Retired (n=101)
Yes, Definitely	3.4% (9)	4.7% (2)	0.0% (0)	9.4% (3)	4.0% (4)
Yes, Probably	2.7% (7)	2.3% (1)	0.0% (0)	0.0% (0)	2.0% (2)
Total	6.1% (16)	7.0% (3)	0.0% (0)	9.4% (3)	5.9% (6)

In 1995, no sizable differences in problem gambling rates among individuals with varying employment statuses were observed. Employed individuals had a 6.1% "combined" problem gambling prevalence rate (3.4% definite, 2.7% probable), unemployed individuals had a 7.0% "combined" rate (4.7% definite, 2.3% probable), and retired individuals had a 5.9% "combined" rate (4.0% definite, 2.0% probable). Intriguing is the category of "homemaker," which displayed a combined rate of 9.4%, all of whom indicated that they were "definitely" problem gamblers. Although the number of respondents in this subgroup is a bit low, it would seem that the risk factor for this group should be studied in the future.

Table 29. Gambling Location and Gambling Problems, 1995

	Gambling Location				
Problem Gambler?	Local Bar (n=32)	Supermarket (n=27)	Local Casino (n=234)	Visitors Casino (n=70)	Other Location (n=15)
Yes, Definitely	6.3% (2)	3.7% (1)	6.4% (15)	0.0% (0)	6.7% (1)
Yes, Probably	3.1% (1)	0.0% (0)	2.1% (5)	5.7% (4)	0.0% (0)
Total	9.4% (3)	3.7% (1)	8.5% (20)	5.7% (4)	6.7% (1)

One of the most controversial topics of recent debate in Las Vegas involves the location of various gambling activities. With the so-called "local casinos" sprouting up all over the valley, some locals have called for increased scrutiny of the effects this expansion will have on problem gambling rates. Of course, this analysis does not allow for any causal inferences to be made. However, a number of patterns did emerge. When asked about their favorite location to gamble, individuals who preferred local bars and local casinos had the highest overall rates of problem gambling activity. Among those who preferred to gamble at local bars, 9.4% answered in the affirmative to the problem gambling question (6.3% indicated that they "definitely" had a problem, while 3.1% indicated that they "probably" had a problem). These numbers should be considered with caution, however, as the total numbers of individuals who prefer to gamble in these locations was not as high as social researchers generally prefer for analysis.

It also appears from this data that among locals, gambling in "local" casinos is a different activity compared to gambling in "visitor" casinos. Among those who indicated

that they gambled in the visitor locations, 5.7% answered "yes" to the problem gambling question. Interestingly, however, all of those respondents indicated the less-severe "probable" gambling problem category. Within the "local casino" group, 6.4% indicated that they definitely had a gambling problem, while 2.1% indicated that they "probably" had a gambling problem. Taken together, this 8.5% prevalence rate is the highest observed among these groups.

Table 30. Type of Game and Gambling Problems, 1995

	Type of Game						
Problem Gambler?	Video Poker (n=172)	Slots (n=98)	Race/ Sports (n=15)	Bingo/ Keno (n=34)	Blackjack (n=31)	Dice/ Craps (n=15)	Other (n=14)
Yes, Definitely	5.8% (10)	4.1% (4)	6.7% (1)	0.0% (0)	0.0% (0)	6.7% (1)	21.4% (3)
Yes, Probably	3.5% (6)	1.0% (1)	0.0% (0)	2.9% (1)	0.0% (0)	6.7% (1)	7.1% (1)
Total	9.3% (16)	5.1% (5)	6.7% (1)	2.9% (1)	0.0% (0)	13.3% (2)	28.6% (4)

In 1995, another question was asked relative to game preference. Among groups with a number of respondents high enough to allow for analysis, video poker players had the highest proportion of problem gamblers. In order to conduct further analysis, the groups might be broken down even further:

Table 31. Type of Game Collapsed and Gambling Problems, 1995

	Type of Game		
Problem Gambler?	Video Poker (n=172)	Slots (n=98)	All Other Forms (n=109)
Yes, definitely	5.8% (10)	4.1% (4)	4.6% (5)
Yes, probably	3.5% (6)	1.0% (1)	2.8% (3)
Total	9.3% (16)	5.1% (5)	7.3% (8)

Once again, the video poker player group has the highest percentage of problem gamblers. However, based on my experiences observing problem gamblers in treatment over the past five years, I would suggest that these numbers might be a bit misleading. In my experiences in formal and informal interviews with problem gamblers and non-problem gamblers alike, I have found that a number of individuals say that they play the "slots" when they really mean the video poker machines. Because slot machines predate video poker machines by a number of years, when video poker machines became popular in the early 1980s, many people used the old terminology to label the new machines. Furthermore, the state of Nevada also categorizes video poker machines with slot machines in its analyses of gambling activities (Kanigher 1999:4D).

As such, when individuals are asked about the types of games they play, I would suggest that a number of problem gamblers who indicated that they are "slot" players are actually video poker players. This is based on my observations in the treatment center, where video poker players routinely make up over 90% of the individuals in treatment. Meanwhile, I cannot recall a single slot machine player in treatment since I started observing these groups. Some have suggested that video poker playing has a "perception of skill" component

— presumably critical to problem gamblers — that slot machines lack. These issues will be addressed further in the qualitative section of this paper. In any case, in the future, care should be taken to ensure that respondents are prodded on this subtle — but nevertheless vital — characteristic of our gambling vocabulary.

Finally, variables were added to the 1995 survey to determine why individuals moved to Las Vegas. Respondents were asked if they moved to Las Vegas because of the opportunities to gamble. While the number of respondents indicating that these opportunities were "very important" or "somewhat important" was relatively small, a few patterns did emerge.

Table 32. Moved to Las Vegas for Opportunities to Gamble and Gambling Problems, 1995

	Importance of Opportunities to Gamble			
Problem Gambler?	Very Important (n=28)	Somewhat Important (n=40)	"Very" and "Somewhat" Combined (n=68)	Not Important (n=200)
Yes, Definitely	10.7% (3)	7.5% (3)	8.8% (6)	2.0% (4)
Yes, Probably	7.1% (2)	10.0% (4)	8.8% (6)	1.0% (2)
Total	17.9% (5)	17.5% (7)	17.6% (12)	3.0% (6)

Among those indicating that gambling opportunities played a "very important" role in their decision to move to Las Vegas, 10.7% felt that they "definitely" had a gambling problem, while 7.1% felt that they "probably" had a gambling problem. Of those who indicated that these opportunities were a "somewhat" important factor in their decision, 7.5% indicated that they definitely had a problem, while another 10.0% indicated that they

probably had a problem. When the two groups are combined, 17.6% of the individuals for whom opportunities to gamble played a "very" or "somewhat" important role in their decision to move here indicated that they were definite or probable problem gamblers.

These numbers are interesting because if the problem gambling rates in Las Vegas are higher than those found in other areas, it appears that part of the reason could be that some of the people who move to the city do so because of the gambling opportunities. Of course, it is impossible to determine from these numbers whether their gambling problems developed in their location of origin or whether they developed them after they came to Las Vegas.

Again in 1995, risk factors were calculated relative to the types of gamblers within problem gamblers' social circles.

Table 33. Acquaintance with a Gambling Problem and Self Report Gambling Problems, 1995

	Acquaintance with a Gambling Problem?			
Respondent Gambling Problem?	Yes, Definitely (n=197)	Yes, Probably (n=40)	Combined "Yes, Definitely" and "Yes, Probably" (n=237)	No (n=188)
Yes, Definitely	7.1% (14)	10.0% (4)	7.6% [18]	0.5% (1)
Yes, Probably	3.0% (6)	2.5% (1)	3.0% [7]	1.6% (3)
Total	10.2% (20)	12.5% (5)	10.5% [25]	2.1% (4)

Of those who indicated that they had an acquaintance who definitely had a gambling

problem, 7.1% indicated that they, too, had a definite gambling problem, while another 3.0% indicated that they probably had a gambling problem. Taken together, 10.2% of those who "definitely" had a friend with a gambling problem indicated that they either "definitely" or "probably" had a gambling problem themselves.

Of those who indicated that they had an acquaintance who fell into either the "definite" or the "probable" categories, 7.6% indicated that they definitely had a gambling problem, and 3.0% indicated that they probably had a gambling problem, for a combined rate of 10.6%. This rate is much higher than the 2.1% rate found among those who knew no problem gamblers. It appears, then, that those who have acquaintances with gambling problems are more likely to self-identify as a problem gambler. Once again, it could well be that certain individuals are simply more likely to identify problematic gambling behaviors both in themselves and in others. Of course, this does not necessarily mean that these are erroneous assessments: it could be that these individuals are *correctly* identifying more problem gamblers in the general population.

Table 34. Close Friend with a Gambling Problem and Self Report Gambling Problems, 1995

	Close Friend with a Gambling Problem?			
Respondent Gambling Problem?	Yes, Definitely (n=144)	Yes, Probably (n=27)	"Yes, Definitely" and "Yes, Probably" Combined (n=171)	No (n=269)
Yes, Definitely	8.3% (12)	3.7% (1)	7.6% [13]	2.2% (6)
Yes, Probably	3.5% (5)	7.4% (2)	4.1% [7]	1.1% (3)
Total	11.8% (17)	11.1% (3)	11.7% [20]	3.3% (9)

The next question asked of respondents probed the problem gambling behaviors of close friends. Those who "definitely" had a close friend with a gambling problem had a 11.8% chance of falling into one of the affirmative categories. When those who indicated that they "probably" had a close friend with a gambling problem were added, the rate remained fairly constant: 11.7% of those in the "combined" close friend category indicated that they themselves had a gambling problem. Meanwhile, of those who did not have a close friend with a gambling problem, the rates were far lower: only 3.3% (2.2% definite, 1.1% probable) of those individuals indicated that they had a problem. It appears that predictably enough, individuals who are close friends with problem gamblers are more likely to have gambling problems themselves than those who do not have any close friends with gambling problems.

Table 35. Immediate Family Member with a Gambling Problem and Self Report Gambling Problems, 1995

	Immediate Family Member with a Gambling Problem?			
Respondent Gambling Problem?	Yes, Definitely (n=76)	Yes, Probably (n=15)	"Yes, Definitely" and "Yes, Probably" combined (n=91)	No (n=350)
Yes, Definitely	11.8% (9)	13.3% (2)	12.1% [11]	2.3% (8)
Yes, Probably	5.3% (4)	13.3% (2)	6.6% [6]	1.1% (4)
Total	17.1% (13)	26.6% (4)	18.7% [17]	3.4% (12)

Finally, respondents were asked about their immediate family members' problem gambling behaviors. Among individuals who indicated that they "definitely" had an immediate family member with a gambling problem, 11.8% said that they also "definitely" had a gambling problem. Meanwhile, 5.3% of those with "definite" family members said that they "probably had a gambling problem themselves. When the "yes, probably" close friend category was added to the "yes, definitely" category, the numbers were even more sizable: 12.1% of those indicating that they had an immediate family member with a definite or probable gambling problem felt that they "definitely" had a problem themselves, while 6.6% felt that they "probably" had a gambling problem. When all of the "yes" categories are added together, 18.7% of the individuals who felt that an immediate family member had a gambling problem indicated that they themselves had a gambling problem. Meanwhile, of those who did not have an immediate family member with a gambling problem, only 3.4% (2.3% definite, 1.1% probable) indicated that they had a gambling problem themselves.

It appears, then, that individuals who have immediate family members with gambling

problems are far more likely to develop a gambling problem than individuals with no problem gamblers among their immediate family members. Once again, however, these figures must be applied with caution: we are far from able at this stage to infer that certain environments are *causing* certain types of problematic gambling behavior. More research — likely using cohort techniques to isolate a population over time — will have to be conducted in order to better address issues of causality. At the same time, we are left with some of the same conclusions as the 1992 data suggest: it could be that certain social relationships can perhaps serve as powerful "triggers" for the problem gambler. At the very least, problem gamblers should be urged to consider this possibility, as well as the possibility that altering these relationships could help the problem gambler overcome some of their problems. Certainly problem gamblers can more readily examine and alter these "variables" relative to certain others (e.g., gender, age, education, etc.) in this analysis. Treatment programs might cite these types of statistics as support for the notion that regardless of the causal direction (or directions), social relationships apparently play a powerful role in the lives of many problem gamblers.

Qualitative Results

Stories from the Treatment Center

The qualitative stories depict the lives of a number of problem gamblers who shared the treatment room with me during my visits. Their names have been changed, but for the most part, their tales have not. The central characters, indexed alphabetically (alongside their game of choice and age):

Albert (blackjack; age 24): Albert has been recruited by Michael, who claims that

Albert's situation is dire. I only observe Albert for a few evenings, but his presence is memorable. Albert is an African American male with light brown eyes. He looks, to put it bluntly, like the metaphorical deer caught in the headlights. I later learn that he is lucky enough to have a family that still cares for him. He works, interestingly enough, as a blackjack dealer.

Andy (video poker; age 34): I probably felt more of a connection with Andy than I did with any of the other patients, but perhaps due to his dissociation, I cannot say that the feeling was mutual. Andy was a successful track and field athlete in high school, a skill which afforded him the opportunity to go to a big-name college in the Midwest on an athletic scholarship. His charming personality is difficult to resist, but the other gamblers, as well as the therapists, never seemed to get through to him. Though recidivism is relatively rare in the program, Andy has been through the system once already. Andy's family remains in his hometown in Oklahoma. He works in construction.

Barbara (video poker; age 34): Barbara is a mother of four, but by her own admission she hasn't been a very good one. In fact, she claims that her gambling often reflects a desire to "get away" from her family life, which in turn leads to a desire to get away from the realization that she's getting away. This spiraling process led to her participation in treatment after a co-worker suggested that she needed help. Barbara's husband is a roundish man of 45 or so, and his concern with her need for treatment worries her. Barbara is a homemaker.

Holly (video poker; age 48): Dawn was born in England, but has lived in Las Vegas for most of her adult life. She seems very together, even during her first few days (a period during which most patients walk around in a bit of a daze). However, like many of the

others, this "togetherness" is a facade. She once told me that she "feels like a duck": cruising along above the surface, but "kicking like mad" underneath in order to keep going. Although amounts of money are hardly ever discussed in the center, Holly once lets slip that she has lost over $50,000 (a figure which is not — by a long shot — the largest in the group). Holly's husband, however, remains largely unaware of the extent of her problem, and she still cannot bring herself to let him in on it. Holly works in a local bank.

Jerry (blackjack; age 56): Jerry is a classic New England smart aleck who always wears a Boston Red Sox baseball cap. I know him from a prior visit, but this time around he is noticeably more attentive. Just before entering the program again, Jerry spent three hours — "a record," according to Dr. Hunter — on the phone with a therapist from Trimeridian's central office in Indianapolis. He spent the entire phone call with a gun in his hand. At last, the therapist was able to talk Jerry down. His outwardly callous and aggressive demeanor aside, Jerry is one of the most fragile cases in the treatment center. Despite the groups' constant pleas to "get it all out," he has never mentioned his suicidal episode in the presence of his fellow members. Jerry is a contractor.

Julie (video poker; age 30): Julie is a former cocktail waitress who battled alcoholism and gambling addiction while she was working. She has a daughter from a failed marriage, but I have never met her. Although she is prone to the occasional outburst, Julie usually is reserved, taking in the advice and stories of the other gamblers in the center.

Katherine (video poker; age 67): Our popular notions of feminine beauty being what they are, I have met many elderly females about whom I have heard the descriptive phrase: "She must have been stunning when she was younger." If this is the rule, than Katherine is the exception: she remains absolutely stunning at 67 years young. Katherine's

flowing red hair, deep blue eyes, and generally strong exterior belie a truly remarkable — even by gamblers' standards — loss of control. The wife of a leading banker in town, and a former successful businesswoman herself, Katherine has seen her life deteriorate since she first began playing video poker two years ago — once she reached retirement age, in fact. Katherine's husband often brings her two young grandchildren along to pick her up after the meetings. When I first met her husband, she introduced me, and despite the fact my (accurate) assertions that I was a mere observer inside of the treatment room, he slapped the center of his chest and said, "from right here, I thank you all with everything I have."

Marcy (video poker; age 42): Marcy is a dual addict (she is also an alcoholic), and a very vocal member of the group. While she feels she is on her way towards a better life, she still is usually the second person in the group to start crying whenever the opportunity presents itself. I have probably grown closer to Marcy than I have to any of the other patients. Marcy is extremely friendly, but she has had vicious fights with her husband, who comes to the center and is generally very attentive. The couple has one daughter, who is 17. Marcy works as a legal assistant.

Michael (primarily video poker; age unknown): Michael appears 60 or so. He is an African American male who retired from the military ten years ago. He is soft-spoken, deep voiced, and carefully-articulating. He has quiet, penetrating eyes. One can't help but respect him. One also senses that he is aware of this, and so he works to debunk his own positive portrayals: "There are a lot of things I've done over the past few years that I'm *real* ashamed about." He came into treatment after his wife threatened to end their 30-year marriage.

Pete (video poker; age 32): If none of the people in the room appear more odd-

looking than normal, Pete looks *least* like an individual in need of psychiatric treatment. He is young, good-looking, and extremely successful. A lawyer by trade, he looks like one of the high-powered types from the TV dramas. Ironically, some of his best friends and business partners are in the gaming industry. They also are largely ignorant of his problems. Upon revealing the extent of his gambling losses to a lifelong friend, who also happens to own a casino in Southern Nevada, the friend implores, "Why didn't you tell me? We have a ton of those machines down in our basement at home. You can come over and play anytime." Pete tells this story often, in an effort to illustrate what he perceives to be the innocent -- but dangerous -- ignorance of individuals in positions of power locally.

Scotty (video poker; age 50): Scotty is a light-skinned African American male. He wants desperately to figure out his affliction. As such, he often intellectualizes the goings-on and likes to keep me after the sessions to discuss the latest developments in the problem gambling literature. I like Scotty a lot, and tend to use his mind to bounce thoughts and observations off of. Scotty is divorced and works as an engineer.

Steve (video poker; age 40): Steve is an extremely bright — if socially awkward — individual. Although he generally keeps to himself, I found his analytic mind to be of use on a number of occasions. Steve rarely says much during the meetings, but when he does speak, he usually says something worth noting. He has spent almost ten years in various Gamblers' Anonymous programs, and his knowledge of that subculture is impressive. Steve is single, and works "in the computer industry."

Reasons for Gambling

Barbara's answer to the most obvious first question is fairly typical:

> Hi, I'm Barbara and I'm a compulsive gambler. I had to gamble to get back to my normal feeling. I wanted to get back... get to emotionally and financially *even*. It's like _____ says... it's just like those old Calgon bath commercials -- you know, where the dog is barking and the kids are racing around the house and the mailman is at the door, and the lady says 'Calgon, Calgon, *take me away...*' and then she goes into the bathtub and this nice music is playing and she's all relaxed -- *that's* why I gambled. It gave me that ability to get taken away.

Here, Barbara alludes to a distinction often referred to as the "escape/action" dichotomy. It is often claimed that problem gamblers seek either a high or an escape, and my experience in the treatment center certainly didn't do anything to dispel that contention. To the extent that the public pictures a pathological gambler, the so-called "action" gambler is probably the most common imagined embodiment of the affliction. These are individuals who tend to gravitate towards the table games, craps tables, or sports books. For these folks, the "rush" is the key: gambling gives them a high that they attempt to achieve in repeated gambling episodes.

Interestingly, while "action seekers" remain the dominant form as described in the literature (and, to be fair, probably represent the majority of gamblers in many, if not most, locales), they are a dying breed in the Las Vegas area. Fifteen years ago, when the treatment center at Charter Hospital first opened its doors, its patients were almost exclusively male, and their "games of choice" were the more "classic" casino games: blackjack, sports betting, and craps.

Nowadays, the gender breakdown is more balanced, and even the males have gravitated towards the video poker machines. Today in Las Vegas, the "escape artist" is far more common. Whereas treatment used to focus on finding alternative "rushes" for the action seekers, these gamblers are different. These are individuals who tend to play video

poker, and who "go somewhere" when they play. For these folks, a "zombie-like" affect is described, in which the feeling sought is not a "high," but rather a "nothingness."

It should be mentioned that this distinction is alluded to often in treatment and that this may have shaped Barbara's perspective on her own motivations. However, in my opinion, this distinction is a legitimate and useful one: having observed gamblers and problem gamblers "in escape" (as opposed to "in action") at video poker machines for four years, it seems apparent to me that these players do indeed "go somewhere" when they are playing. In fact, I cannot recall a single instance of an addicted video poker player declaring that they get a "high" out of gambling.

One evening, I asked the group (which happened to consist entirely of video poker players on that occasion) how many of them had experienced the "catatonia" or the "zombie" symptoms. Without prompting or prior discussion of these phenomena, every single individual volunteered that they had. Intuitively, this makes sense: displays of fist-pumping theatrics are rare at video poker machines. Far more common is the familiar sight of the "entranced" gambler -- himself/herself far less animated and lifelike than the beeping, fast-twitching machine in front of them.

In a sense, this comment by Barbara is typical: it broadly reflects some of the more pervasive ideas of both the 12-step model and the treatment model, but she also adds a flavor that she claims to be her own. The "Calgon" analogy, then, allows Barbara to use the language of the treatment center and the 12-step model while maintaining, to some degree, the uniqueness of her own experience. It appears that the group setting -- in which patients are focused on *both* individually and as a unit -- encourages this type of "mediated conformity."

In this comment, Barbara also alludes -- as she and others do quite often -- to the stressors present in her home life. I later learn that Barbara's husband is more than a bit skeptical about the concept of a problem gambling treatment program. During his visit the following week, Barbara relates that the two of them argue because he is "having trouble understanding the intimacy of the relationships" Barbara has developed with her fellow patients (whom she has known only for a couple of weeks). Her husband is obviously uncomfortable in the treatment setting, but a few weeks later, he somewhat begrudgingly concedes that "whatever you guys are doing, it's working: I've got my wife back now."

Other gamblers are more willing to embrace more biological explanations in the nature-vs.-nurture debate. Several gamblers I saw attribute their gambling addiction to their having been "wired for it at the factory." Marcy is one of these patients: "I've always had it, and I've known I've had it from the time I was a little kid. I've got 'em all. I'm also an alcoholic. And I'm *sorry*. Gambling has kicked my ass far worse than that ever did." I interject at this point and ask Marcy what was, in retrospect, an overly simplistic question:

"On a scale of 1-10, then, where would you rate gambling and alcohol in terms of that... ass-kicking?"

Marcy doesn't miss a beat: "About a 39. Compared to a 2 with the alcohol."

As per rule and tradition in both GA and the treatment center, Marcy starts by acknowledging her afflictions at the outset. As some (Smith and Preston 1984:325-348) have explicitly pointed out, labeling theorists would have a field day with these individuals, whose self-labeling processes occur early and often. By self-labeling as "pre-wired," gamblers are able to jettison some of the guilt commonly associated with this problem. They are also armed with a new explanation to accompany and counter the ever-popular "weak-

willed loser" interpretation that they will inevitably face.

I found it interesting that after she introduces herself, Marcy feels a need to apologize about her dual addictions. Her apology then evolves into an attack, although the target does not become clear to me until later. During the smoking break after our meeting, Marcy goes into a mini-diatribe about her social interactions since she has "come clean" about her gambling. She tells me that while "it was almost *cool* to be an alcoholic because people understood that," her current affliction baffles her friends and family. "They all have that attitude like 'Take responsibility and just *stop*!' and all that crap." While it certainly may be the case that Marcy's significant others are merely tiring of Marcy's debilitating breakdowns, Marcy feels like she is experiencing a different -- and unfair -- public reaction to her gambling problem relative to her previous battles with alcohol.

Dr. Hunter believes that this social reaction to the problem gambler is typical. He says that this intolerance and lack of awareness (especially in comparison to drug and alcohol addictions) is precisely what leads to the high suicide rate of his patients. Because the gambler generally lacks the knowledge to realize that s/he has a somewhat common and treatable problem (and therefore concludes that s/he is the only individual who has ever created this kind of destruction), and because his/her social circles are all too eager to concur in that diagnosis, the gambler often feels that s/he has nowhere to turn.

Suicide

Indeed, suicide stories are common in the center. On any given night, a handful of individuals readily admit to current suicidal thoughts, and virtually all admit that they have contemplated suicide in the past. One of the patients who elaborated her actual attempt in

detail during this period was Katherine. Her story is well worth relating here:

> My name is Katherine, and I'm a compulsive gambler. I've been in the program four weeks. Four weeks and one *day* ago I was sitting in my car at the bottom of Red Rock Canyon. I had my husband's handgun in my lap.
>
> *At this point, Katherine pauses and dabs her cheek with a tissue. She begins to sob uncontrollably, and her tears are soon shared by just about everybody in the room. Although I've become much better at projecting my professional front over the years, in this instance it is difficult to even choose to fight what promises to be a hopeless battle. I have found that the very young (the people belonging to my own generation) and the very old (the people who have "been around the block" and feel they should know better than to throw away their lives) are the most excruciating tales I hear...*
>
> *... (continuing, but still crying loudly, talking through the sobs)* and I put the gun right up to the side of my head. *(Stops).* I can still feel the pressure of the metal against my temple. It was my husband's gun, but he had no idea I was there. I was about to relieve him and everyone else in my family of their misery, though...
>
> I pulled the trigger. I pulled the trigger, and just then I realized that my husband always left the first case empty "just in case" one of the grandkids accidentally got a hold of it or something.
>
> *(Laughs softly).* As you might imagine, this sort of jolted me. For some reason, I looked down then, and I saw that I had my seatbelt fastened. *(Laughs again).* Isn't that crazy?
>
> The next day, I came here. And that was four weeks ago.

Obviously, these suicidal stories pose serious challenges to researchers and laymen alike who may be interested in effecting positive social change. One promising scenario would have public education and awareness programs creating a "safety net" of sorts beneath the potential problem gambler. By educating the masses about this affliction, it is hoped that gamblers will contemplate treatment options after the first missed music recital or soccer game, as opposed to the first failed suicide attempt. Furthermore, even if the problem gambler were not reached, a wider educational net might catch a few within their significant social circles, thereby improving their chances of more sympathetic interpersonal receptions.

It isn't often that those of us who are hooked on the sociological are able to play a direct role in a lifesaving process, but it certainly appears that by fighting for public service announcements and informed public educational programs, we can at least let gamblers (and those who know gamblers) know that they are not alone, and that treatment options do exist.

Problem Gambling and Alcoholism: Coping Strategies

Like Marcy, Julie is also a "double addict." Her comments about her battles with what she called her "two-headed monster" are often pointed and angry.

> And you can't tell me this is any different, either. It got to the point where I would say 'this shit isn't working the way it used to' -- I was building up a tolerance. I'd try to get my dosage up, but then it got to the point where I'd be playing as much as I could, and it still hurt like hell. I'd win a royal flush, and it still didn't get the effect. It really is a Jekyll and Hyde process -- it turns you into somebody different.

Many in the group are tormented by these dual addictions. In a later session, we continue talking about the differences between battles with drugs and alcohol and their current fight to stay abstinent from gambling activities. Jerry brings up a strategy that I had never come across before: "I knew I was an alcoholic, so I always gambled in the drug stores. I knew that no one would stop me and ask if I wanted drinks there."

It turns out Jerry has a lot of strategies. He has gambled since he was a young child, and he has spent most of that time trying to figure out ways to beat the system. A religious reader of card-counting books, Jerry spent an entire half-hour detailing his "system" with me after a session once.

Although it consists of mathematical permutations the likes of which I can never hope to understand, it also includes a dose of superstitious behaviors as well. He has, for instance, always felt like it is extremely lucky to bet with borrowed money, a tactic which has no doubt

contributed to his demise. Interestingly, Jerry's system is designed to outwit a microchip which is programmed at the factory to pay out jackpots at a certain rate. This apparent inconsistency, however, is lost on Jerry, who only begins to acknowledge after a great deal of encouragement from the group that perhaps he cannot "beat" the machine.

At this point, Barbara joins in with a truly bizarre story on superstitions: "I had a friend who took her best friend's ashes with her for good luck! I swear to God! She'd put 'em right there on the top of the machine for good luck..." The group soon erupts with bursts of shared experiences:

Pete: "I always thought that being watched jinxes you. I'd get *pissed* if someone tried to watch me play."

Marcy: "Yeah! I've felt that way too. Plus, if someone says 'good luck!' to you when they give you the change, it's horrible."

Katherine: "I always *knew* I was going to do good if I got a roll of quarters with heads on both ends!"

Although some might focus on these "magical" beliefs in and of themselves, in this instance I was more concerned with the social process that was taking place in the room as these tales were being related. Quite often, the gamblers engage in epiphanic exchanges, in which they all marvel at their stories' similitude. I believe that this process is as vital as any that take place within the walls of the center. Again, because the gamblers believe themselves to be uniquely flawed, the moments when they realize that there are others who have engaged in similar behaviors (as well as others who have inflicted far *more* substantial damage) are nothing short of a life-altering revelation.

Social Groups and Gambling Behaviors

While many in the treatment center started out as "social" gamblers, by the time they hit "bottom," none claimed to do so in the company of significant others. Pete said that "I decided I needed to be out, but I wanted to be alone. I just wanted to get away, but I didn't want to feel *all* alone."

Katherine's standing in the community is close to impeccable. This type of status is not uncommon in the treatment center; in fact, many of the patients are notable for their success in their business endeavors. I have encountered more prominent professionals than I can begin to count, including a number of doctors, lawyers, casino vice presidents, politicians, and even a distinguished local judge, who asked me after his first session to please keep his participation a secret from my father, who is a local attorney. "I sit in judgment of everyone from deadbeat dads to hardened criminals all day long, and meanwhile, nobody realizes that I am no better than any of them," he once told me.

Katherine told me once that "I wanted to be alone. I would always imagine how horrified I would be if my friends would walk up would see me like that -- and with all that money tied up in the machine." Marcy also preferred solitude, but for slightly different reasons: "My friends would always want to leave while I was hot, so I just stopped taking them."

Barbara, a large and outgoing woman who is difficult to miss, nevertheless sought a hiding place when he played: "I kept moving and changing bars or casinos. I guess that's why I liked the big casinos best, because you could just get lost in them and nobody's gonna pay you much attention -- especially when I played, which was usually around 9 in the morning."

Steve then chimes in with a tale that is met with resounding agreement. "I always thought that there is nothing worse than being next to someone who wants to *talk*. It's like, shut up and play, dammit! I got friends at home! I come here to be *alone*." Steve is a bit of an odd person, but the others in the group genuinely like him. He is famous in Gamblers' Anonymous circles, in part because of his unique "party trick." Because of his extensive video poker play, Steve suffers from carpal tunnel syndrome. He claims to have less than 15 degrees of movement in his left (playing) arm, and he shows off his limitation whenever asked.

Andy also alludes to the social situations he desired: "I just wanted to play somewhere where nobody would see me. I knew I had a problem, and I felt like everybody around me knew it too. That's when I started hitting the (video poker) machines heavily." I found myself drawn to Andy, probably because we had both come from athletic backgrounds. Andy was a muscular man who had thrown the discus in college. His intimidating appearance belied a calm and constantly calculating mind, however, that seemed battered by this second trip through the system. His eyes would often dart from other patients in the room and then back to me, as if it were imperative to convey to each individual the pain he had endured. Andy had survived a suicide attempt (though I never learned more about it), a sobering reality that scared him back into treatment. He often spoke of this of his "last chance," and lamented that his lapses had cost him his job, his wife, and all of his friends. "It's just so hard to go through this now when all you've ever had is gone," he once told me after a meeting. When reminded that he in fact had the services of dozens of fellow problem gamblers at his disposal, Andy was relatively unmoved: "I know, and you folks have saved my life, but I've just lost so much..." This was met with concerned

mumblings from a handful of other patients who had stuck around, suggesting that he would "get them back" in his life, but Andy seemed unconvinced.

Could it be that problem gambling (or even gambling as a whole) has become less of a social activity (especially with the increasing popularity of machine gaming)? Possibly. Is it therefore less of a *sociological* activity as a result? Absolutely, emphatically not. In fact, Andy's story reveals a great deal about why critical researchers need to pay attention to the social needs of these individuals. As problem gamblers approach "bottom," often their worlds become increasingly lonely places. They start to hide -- and just as importantly, because of the nature of their problem, it is often somewhat *easy* to hide -- and lose touch with the social world. When I went to the treatment center for the last time, Andy had not shown up for a week.

When I asked another female patient about him, she covered her mouth, got more than a little bit choked up, and informed me of Andy's most recent developments. Apparently, Andy had a relapse, and called a fellow GA member afterward. Unfortunately, the member wasn't at home. He came home, however, to hear a despondent Andy sobbing on his answering machine, detailing his recent slip, and talking about "taking off for good." No one, including his family back in the midwest, has heard from him since. Everyone, including his blood family as well as his "adopted" one in the clinic, feared the worst.

Politics Explode onto the Scene

This past fall, the biggest event ever to take place in a gambling treatment center in this town occurred. The National Gambling Impact Study Commission visited the city of Las Vegas, and chairperson Kay James requested a discreet private audience with the group

before the meetings commenced.

Marcy, however, was not impressed:

> They needed to get you in here *before*. There's just so much shame -- deep, deep shame. It just feels so different from anything else. The reason I got in here was because of my daughter. I guess one day when things were really goin' bad my daughter wanted to tell my husband. I said something like 'No, don't... I'd rather be dead than be so miserable.' My daughter got really scared *(starts crying pauses for a few moments, then continues to speak. Her voice is shaking)* and my husband asked her what had been botherin' her so much. She said 'No, mom's gonna kill herself if I tell you' He about went through the roof... and then he demanded she tell him and she said 'Mom's a compulsive gambler.'

As per tradition, we move around the room. We come to Holly, who hails originally from Manchester, England. This is her first night. Unbelievably, Holly is fresh off the street, only to be greeted by perhaps the single most important meeting in the history of problem gamblers in Las Vegas. Holly is visibly shaken by all of the turmoil, but collects herself admirably and begins with her introduction. Unlike most first-timers, who look positively shell-shocked, Holly is relatively composed as she gives the details of her problem:

> I've lived here in Las Vegas for 23 years. I never played a nickel. And you have to understand, when I set my mind to do something I do it. I smoked for over 20 years, and then just decided one day to quit and I went cold turkey and I haven't smoked a cigarette since. I've lost over 80 pounds and kept it off for ten years. I am not some weak-willed person who can't control herself -- I take *pride* in my ability to control myself. But I lost that control... I started going to the casinos with my sister. I've only been playing for the past two years, but I can*not* stop. I'd get my paycheck on Friday and go out with it and lose it all... then I'd be broke for two weeks and have to come up with things to tell my husband about the money -- it went for this or that, or I just told him I put it in the bank. I'd tell him I saw someone at the grocery store that I hadn't seen in years... when the whole time I'd been gambling.
>
> The funny things is, I *always* lose. I never win. I can't even say that I'm going for the big jackpots because I *know* I'm not going to win them. The other employees where I work, my friends, my family -- they have *no ... clue.* I told my husband a little bit of the story for the first time last night, just told him that I was going to learn more about gambling, but he thought it was some

> educational program where you learn how to gamble better. He said "why do you want to learn more about that?" And I couldn't tell him anything more...

Dangerous Myths, Dangerous Realities

During a later visit, Scotty recounts his own story to Dr. Hunter, who opens that evening by requesting that everyone give him an "update." Shuffling nervously, Scotty details his recent problems.

> This is my second -- and last -- shot. *(His eyes are glazing over -- it is difficult to tell whether they are tears or if he is dissociating)* I've stopped gambling before. I was going to GA, religiously even, and there were just a lot of questions that GA wasn't answering for me. And I'm very analytic, I need to know *why*. And I'm hoping *(pauses... chokes, swallows)*, that this program has given it to me, because I can't go anywhere else. I have no friends anymore, I have no family anymore -- at least none that trust me. And it's not that I'm totally financially devastated. But I am completely morally devastated, I am completely emotionally devastated.

When others relate their stories, it is common for other members of the group to nod knowingly, and smile, and even cry. Michael, a distinguished career military man who has become a leader of sorts within the group, takes over for Scotty and sympathizes:

> We've all been there, man. Mine all started when I was a little kid. I was always pitching pennies, nickels/quarters, I played the tables for years and years. I guess I just wasn't getting fulfilled there. I played house (poker) games for years and years with buddies. I'd just take my retirement check and spend it all. At the end stage it was video poker.
>
> *At this point Scotty cuts in:*
>
> That happened to me too! I used to be a blackjack player. The last time I played blackjack, though, it was just so boring. I was a counter, I felt like I could win, but I just got impatient with the games because they took so *long*. That was when my gambling really got bad *(pauses)*... and that was when me and my wife ended up getting the divorce.

Michael then proceeds by acknowledging Scotty's story (thereby assuring him that

his were by no means uniquely egregious wrongdoings) and then describing the effect his behaviors had on his family:

> Yup. I did it too, man. It got so bad then, it got to where my wife gave me an ultimatum. We've been married thirty years, and she told me either you quit and take charge of your life or I'm leaving... this one day she just comes in and she says 'are we going to get a divorce or are you going to fix this?'

I have observed many (mostly male) problem gamblers who gambled for twenty years or more, with periods of significant losses even, only to recently begin video poker play and experience more severe problems. From that point, it often seems, the fall is far more sudden. There appears to be a group of gamblers for whom video poker is the "final hurrah" or "grand finale" for a long history of problematic gambling behaviors.

Video Poker

Michael's and Scotty's tales both involve a downward spiraling once they (in Michael's words) "swapped poisons." Both have been gamblers for most of their lives, and both of them took a severe turn for the worse when they began playing video poker. For whatever reason, video poker does appear to be the most common game of choice within the treatment center: video poker players regularly comprise well over 90% of the participants in both GA (according to the patients) and treatment. These numbers are somewhat startling. Imagine if similar rates of, say, vodka use was observed in alchoholics.

This presents yet another troublesome challenge resulting from a lack of public education and awareness about problem gambling. Many people consider machine games the "go-carts" of gambling games -- a somehow safer, sanitized version of the "real thing." Policymakers in jurisdictions across the country are embracing forms of video poker while

rejecting "hard-core" gambling. Even in Las Vegas, we are seeing a sort of bizarre "deforestation" effect whereby video poker machines are "encroaching" upon spaces formerly occupied by table games. It is likely that right now, at this very moment, somebody somewhere in the city is taking apart a blackjack table and replacing it with a video poker machine. In a similar vein, it should be noted that Mayor Jan Jones' notorious recent convenience store "slot debate" was nothing of the sort: one would be hard-pressed to find a traditional slot machine in a local store.

Hopefully, we have evolved in our understanding of these phenomena to the point where we no longer need to treat gambling activities as monolithic in nature. While many pundits earn notoriety by warning about the perils of *gambling* sweeping the nation, it needs to be acknowledged that to some degree, it is *video poker* that is taking over here (as well as in Canada and Europe). As such, we would be well advised to take into consideration the apparently stark differences between video poker gambling and other forms.

Another myth surrounding the video poker machine is that it is in effect the "candy" game. Because it is a "low-stakes" game, many feel that it cannot possibly lead to substantial financial losses. However, those who observe video poker players regularly know that the *speed* at which these people play more than makes up for any reduction in per-hand stakes. No matter how many times I observe serious video poker players at play, I am always amazed at how quickly these players can process the information on the screen, complete the necessary calculations, and press the appropriate buttons. It has often occurred to me that I would have great difficulty keeping pace with these players were I to simply *randomly* play the game. Within the group, Steve's carpal tunnel syndrome is testament to the fact that, over time, the speed of play challenges even the limits of the human body.

In fact, the immediacy of video poker play is one of Dr. Hunter's key points in his "hierarchy of games" presentation to the gamblers. He often talks about what makes video poker unique among gambling games. According to Dr. Hunter, video poker "scores an A+" on all four of the dimensions which determine how problematic certain games can become for problem gamblers. In addition to the immediacy (or "the ability to find out *yesterday* if I win or not," according to Pete), video poker also allows the gambler to increase his or her play — in terms of time and money. The game also appeals to those who have a (false) belief in their own ability to "beat" the game; apparently this *perception* of skill makes video poker more appealing to problem gamblers than, say, traditional slot machines. The final (and most difficult to operationalize) dimension Dr. Hunter describes is the "escape" phenomenon. Recall that many of these problem gamblers allude to their desire and ability to "go somewhere" when they play. According to Dr. Hunter and the patients, no game permits the degree of dissociation that video poker does.

The nuances of the video poker players also suggest that one final myth about problem gamblers deserves a more critical look. The notion that problem gamblers are simply "greedy" individuals, who somehow attempt to circumvent the Protestant Ethic with their chosen get-rich-quick scheme, does not appear to be consistent with my observations of these gamblers. For one thing, not only do most of the problem gamblers play video poker (ignoring even the Megabucks machines), but almost all of the video poker players play a specific *subtype* of game that does not even award large jackpots. This game, "Double Double Bonus Poker," in fact has larger-than-normal *intermediate* payoffs, a fact that is not missed by the gamblers. These more-common rewards allow the gamblers to play *longer*. Scotty claims that he felt like he could "stay hooked up to the drug longer" with these

machines.

Recently, I spoke to this phenomenon in Edmonton, Alberta, at the first-ever conference devoted exclusively to video poker play. I expressed that while it was commendable that we were gathering to talk about a subtype of gambling games (whereas only a few years ago a *problem gambling* conference was virtually unheard of), in a way we still find ourselves behind the curve: while we are beginning to finally focus on video poker, *subtypes* of video poker games demand further attention. As such, further study needs to incorporate explorations of these "subtypes *of* subtypes."

Another interesting outburst in the center indicated to me that these individuals are motivated by something more complex than mere greed. Pete related that he got to a point where he became extremely frustrated whenever he *did* hit a jackpot. The problem, it seemed, was that the payout took time: "I would think to myself, 'Damn, I wish I hadn't hit that jackpot, *it's slowing me down!*'" This comment, too, was met by widespread agreement and instant understanding. Surely, if the jackpot represented the desired end, these types of behaviors would not be observed. At the very least, then, it seems we need to re-examine our notions of greed as it pertains to these types of players.

The Shame and the Healing

The shame tends to run deep, but the desire to help others apparently runs deeper: despite his status as a respected community figure, Michael (and many other patients) constantly share their stories. "Any time you would like me to go someplace to speak about this stuff, you let me know," Michael told me once. He says he has "lots of public speaking experience" (from his career as a high-ranking airman), "but this would be different."

Michael has been a gambler for most of his life, and he is convinced that the problem is more widespread than people think. "What you have is a whole lot of people who have a problem, but don't think they do. We need to get to them before it's too late."

Michael's critical imagination, as it were, may even have saved a life. During a recent meeting I observed, Michael practiced what he preaches: he brings in a new "recruit." Before the meeting, Michael told me about a "kid" who was "hurting real bad." About halfway into the meeting, we are greeted by Albert, and Michael's face lights up. Albert, however, looks far less convinced. He literally stumbles into the gathering. Predictably, Albert doesn't volunteer much during his first meeting. He only offers that his family is what matters most to him and his family is the reason why he is here.

After the meeting, I meet Albert as he leaves the room. I ask him if "it all seems like a blur," but he only nods and walks ahead. I then see what has caught his attention. On the front desk of the treatment center, there is a McDonald's bag with dinner inside. Taped to the bag is a photo of an adorable little girl who can't be more than three years old. Next to the photo is a note, obviously scrawled by someone other than the child: "To Daddy. We love you!"

Again I offer an altogether insufficient comment, and again, Albert is lost in thought. As I pass by the desk and head for the door, I notice that a tear is falling down his cheek.

And so, no matter how much I learn, at times the nature of this baffling affliction makes me wonder whether my ignorance knows any boundaries. More importantly, though, this final snapshot of Albert -- attempting to change his life, devastated, defeated, and yet fortunate, perhaps, to have found his way to the room -- serves as a powerful reminder of the work to be done among problem gamblers and those interested in researching their lives.

CHAPTER V

SUMMARY AND CONCLUSIONS

It is my hope that more than anything, studies such as these underscore the need to stop conceptualizing "problem gambling" as a monolithic activity. While the field of problem gambling studies could afford this oversight while it was in its infancy, the quantitative and qualitative analyses presented here reveal that the diversity (and patterns emerging from within that diversity) of problem gamblers today can no longer be ignored.

Although some psychological and biological explanations appear promising, we cannot begin to endorse them at the expense of explorations of the sociocultural. In fact, it appears that problem gamblers in Las Vegas could well differ from those living in other locales: for instance, because of the degree of community acceptance and historic presence of gambling opportunities, it could be that individuals who reside in Las Vegas are exposed to a greater number of individuals who have gambled or who have had gambling problems. This is potentially problematic because as the quantitative analysis in this paper showed, individuals who know problem gamblers are far more likely to be problem gamblers themselves than individuals who do not know any problem gamblers.

The field of problem gambling studies, then, has often suffered from an excessive

fascination with the macro. Too often "problem gamblers" are referenced as if they were a uniform group, even though recent advances in our understanding of this population have shown us that this is not so. In may academics' (often noble) quest to universalize this problem, many nuances of local communities have been overlooked, and New Orleans, Louisiana becomes Detroit, Michigan becomes Las Vegas, Nevada and so on. The resultant haze -- in which we can neither be certain of the micro *nor* the macro -- has plagued countless works over the years.

It does us no good, for instance, to speak of "problem gambling" when we really mean "video poker addiction," as the two labels potentially represent very different phenomena. What is more, as was pointed out in the qualitative section of this paper, just as we begin to examine video poker play, it appears that certain *subtypes* of video poker machines demand more attention. Continuing to use a "big tent" approach to incorporate all of these subtypes of problem gambling activities is no longer defensible in light of continuing observations that different types of gamblers potentially have very different experiences during their gambling and social activities.

At the same time, "hyper-specificity" will also get us nowhere. For those seeking easier explanations for problem gambling behaviors, such as those in Louisiana who are in the process of banning video poker machines, the answers provided here provide little support. On the contrary, if anything is apparent from these numbers and stories, it is that there are a number of different variables that need to be examined before we go about assessing "blame" in any real way to any singular (or even multiple) causes.

That said, it is my hope that at least some of this research can be fruitfully applied in other jurisdictions into which gambling has been introduced. Now that virtually all

Americans are within a day's drive of a gambling establishment, to completely ignore the test tube that is Las Vegas would appear to be a bit irresponsible, especially given the often tragic nature of the problem gambler's existence.

On a more practical level, a number of policy-oriented issues need to be addressed.For instance, changes need to be made in the way that insurance coverages work for these individuals. Because so many of them are deeply in debt, and because treatment costs can run high, it is imperative that coverage policies be expanded to include these people. In fact, a number of Las Vegas casinos are already including this coverage in their employee plans, a substantial development in a city where the gaming industry provides hundreds of thousands of jobs.

This was one of the issues discussed repeatedly during the meetings of the National Gambling Impact Study Commission (NGISC). In fact, this research may be used in the future to measure the ultimate effect of the NGISC. An optimist might foresee a day in which these types of stories represent a glimpse at the lives of problem gamblers before the quasi-revolutionary events associated with the commission took place. A more cynical future analyst might cite a work like this as "proof" that what followed was "business as usual," and that the commission was a nonevent, or at least one that created little actual change in their lives. Of course, the actual impact of the commission will probably fall somewhere in between these two extremes.

As discussed in the qualitative section of this paper, public education efforts, which up to this point have been relatively modest, need to be expanded. In fact, differences in public awareness remain key distinctions in the ways that gambling problems manifest

themselves in America today relative to drug and alcohol problems. The entire field of problem gambling studies lags far behind those of alcohol and drug abuse fields. In fact, two of the principal investigators involved in the NORC study estimate that the total federal expenditures on problem gambling studies over the past 25 years is equivalent to the weekly expenditures on drug abuse surveys (Volberg and Gerstein, 1999).

As I have mentioned elsewhere in this paper, research and education programs would appear to be the best starting point for future projects. The lack of county and state prevalence estimates is particularly disturbing and needs to be addressed quickly. These studies can be supplemented by ongoing research on treatment outcomes and approaches. As we have seen in the qualitative sections of this paper, information can be a powerful weapon against the perils of this affliction. Even if the problem gambler is not reached through educational programs, if just one individual in the problem gambler's social circles learns enough about the affliction to provide a "safety net," these individuals may receive attention and help before their problems become too severe. In the treatment center, few things are more frustrating than listening to problem gamblers whose downward spiral was accompanied by a complete lack of awareness of the potential financial, legal, and psychological help that is available to the public.

There are many ways we can educate the public about this affliction, and none need to make any sky-is-falling claims. More effective is an analogy with another popular recreational activity. In many ways, casino gambling truly is like a ski slope. Millions upon millions of people worldwide enjoy skiing and have a wonderful time shooting down the slopes. Skiing brings in all kinds of revenue to various economies. Skiing provides jobs.

Skiing can certainly rejuvenate a stagnant economy. However, skiing is not completely safe for all individuals. All of this does not come without a cost.

File it with the "sad but true:" while skiing, some people are bound to break their legs. Unfortunately, some people are also going to break their *necks*. What we have to make sure of is this: it is imperative that ski slopes have a well-trained ski patrol as well as a hospital (hopefully with a degree of expertise in broken legs and necks) at the base of the mountain to take care of the inevitably injured. And of course, care must be taken to make sure that the communication lines between the ski patrol, the lift operators, and the hospital is streamlined and top-notch. In effect, treatment professionals, casino operators, and researchers need to continue to cooperatively investigate the ways we can help this population. In Nevada, there is no reason that the state's "problem gambling model" should not be as widely hailed as the city's regulatory or operational ones are. Toward that end, the state and its most prominent industry need to support research focusing on the unique local populations.

The present sociopolitical climate relative to problem gambling is a dynamic one, and the years to come will no doubt bring more promising developments. At this point in time, Las Vegas' "slopes" remain a popular destination for both locals and tourists alike. What remains to be seen is whether the city will continue to serve the needs of the masses of recreational users as well as the individuals who fall.

BIBLIOGRAPHY

Comings, David E. 1998. "The Molecular Genetics of Pathological Gambling." CNS Spectrums 6:26-37.

Comings, David E. 1999. "Molecular Genetics of Personality Traits." Presented at the 13th National Conference on Problem Gambling, June 4, Detroit, MI.

Custer, Robert. 1985. When Luck Runs Out: Help for Compulsive Gamblers and their Families. New York:Facts on File.

Douglas, Jack. 1976. Investigative Social Research. Beverly Hills:Sage.

Goffman, Erving. 1961. Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. New York:Anchor.

Goffman, Erving. 1963. Stigma: Notes on the Management of Spoiled Identity. New York: Touchstone.

Kallick, Maureen, Daniel Suits, Ted Dielman, and Judith Hybels. 1976. "Survey of American Gambling Attitudes and Behaviors." Final Report Prepared for the Commission on the Review of the National Policy Toward Gambling.

Kanigher, Steve. 1999. "Playing the Percentages: Report Names Best Places for Gamblers to Play." Las Vegas Sun. July 11:1D, 4D.

Lesieur, Henry R., and Sheila B. Blume. 1987. "The South Oaks Gambling Screen (SOGS): A New Instrument for the Identification of Pathological Gamblers." American Journal of Psychiatry. 144(9):1184-1188.

Lesieur, Henry R., John Cross, Michael Frank, Michael Welch, Carolyn M. White, Garry Rubenstein, Karen Moseley, and Marie Mark. 1991. "Gambling and Pathological Gambling Among University Students." Addictive Behaviors. 16:517-527.

Lesieur, Henry. 1984. The Chase: Career of the Compulsive Gambler. Garden City:Anchor.

National Gambling Impact Study Commission. 1999. "National Gambling Impact Study Commission Final Report." Online. Available:

http://www.ngisc.gov/reports/fullrpt.html

National Opinion Research Center. 1999. "Gambling Impact and Behavior Study:Report to the National Gambling Impact Study Commission." Online. Available: http://www.norc.uchicago.edu

Oster, Steven L. 1992. "Parameters of Undergraduate Gambling." Master's thesis, Department of Psychology, University of Nevada, Las Vegas.

Rosecrance, John. 1988. Gambling without Guilt: The Legitimation of an American Pastime. Pacific Grove:Brooks/Cole.

Smith, M.L. and G.V. Glass. 1977. "Meta-analysis of psychotherapy outcome studies." American Psychologist 32:752-760.

Smith, Ronald and Frederick W. Preston. 1984. "Vocabularies of Motive for Gambling Behavior." Sociological Perspectives. 27:325-348.

Tannen, Deborah. 1998. The Argument Culture: Moving from Debate to Dialogue. New York:Random House.

Tekniepe, Robert J. 1997. "Prevalence of Problematic Gambling Behavior: An Exploratory Study of the Low Income Population of Las Vegas, NV. " Master's thesis, Department of Public Administration, University of Nevada, Las Vegas.

Vatz, Richard E. and Lee S. Weinberg. 1993. "Refuting the Myths of Problem Gambling." Pp. 167-173 in Gambling, edited by A. Riconda. New York:H.W. Wilson.

Volberg, Rachel A. 1996. "Prevalence Studies of Problem Gambling in the United States." Journal of Gambling Studies. 12(2):111-128.

Volberg, Rachel and Dean Gerstein. 1999. "Emerging Avenues: Results from the 1998 National Survey and Implications for the Future." Presented at the 13th National Conference on Problem Gambling, June 4, Detroit, MI.

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Presentations

"From Sociopath to Somebody: The Socio-historical Trajectory of the Gambling Addict." Presented at the Pacific Sociological Association meetings, Portland, OR, April 1999.

"Identifying the Problem Gambler." Speech delivered to Reno-area health professionals at the University of Nevada, Reno, Reno, NV, March 6, 1999.

"Revising the Safety Net: 'Catching' Problem Gamblers." Speech delivered to all

Las Vegas-area parole officers for the City of Las Vegas, March 2, 1999.

"Recognizing the Problem Gambler in Las Vegas." Opening address at the annual meetings of the Nevada Association of Social Workers, Las Vegas, NV, January 24, 1999.

"Treatment Options for the Problem Gambler." Speech delivered to the Nevada Association of Nurse Practitioners, Las Vegas, NV, January 8, 1999.

"Changing Patterns of Las Vegas Sports Betting: A Fourteen Year Perspective." Paper presented with Fred Preston and Paul Shapiro at the North American Society for the Sociology of Sport conference, Las Vegas, November 1998.

"Living in Las Vegas: Surveys over a Fourteen-Year Period." Paper presented with Frederick Preston at the National Conference on Problem Gambling, Las Vegas, NV, June 1998.

"Designing the Intensive Outpatient Program." Paper presented with Robert Hunter at the National Conference on Problem Gambling, Las Vegas, NV June 1998.

"Rodeo Cowboys: Frontstage and Backstage." Paper presented with Fred Preston and Troy McGinnis, Pacific Sociological Association meetings, San Francisco, CA, April 1998.

"Video Poker in Las Vegas." Address given to "Video Lottery Terminals (machine gaming devices): Issues and Impacts," University of Alberta, Canada, February 1998.

"Pain, Risk, and Injury: A Comparison of Football and Rodeo Subcultures." Paper presented with Jim Frey and Frederick Preston at the North American Society for the Sociology of Sport conference, Toronto, Canada, November 1997.

Publications:

Preston, Frederick W., Bo J. Bernhard, Robert E. Hunter, and Shannon L. Bybee. 1998. "Gambling as Stigmatized Behavior: Regional Relabeling and the Law." The Annals of the American Academy of Political and Social Science 556:186-196.

Preston, Frederick W., Troy A. McGinnis, and Bo J. Bernhard. "The Rodeo Cowboy: Pain Tolerance and Masculinity." Chapter in Revealing Male Bodies. University of Oregon Press. (Accepted, forthcoming).

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