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In the United States, DSM-IV represents the contemporary psychiatric manual for classifying mental illness for most clinicians; it is used as a guide to "diagnose, communicate about, study, and treat people with various mental disorders" (American Psychiatric Association, 1994, p. xxxvii). Evidence suggests, however, that some mental disorders do not always require treatment. For example, many individuals experience a "natural recovery" from alcohol, tobacco, and other substance use disorders (Carey, Kalra, Carey, Halperin, & Richards, 1993; Mariezcurrena, 1996; Sobell, Ellingstad, & Sobell, 2000; Stall & Biernacki, 1986; Vaillant, 1966). Recently, the WAGER examined a preliminary yet compelling review of research suggesting that a large number of individuals might experience "natural recovery" from gambling related problems as well (WAGER 8(48): "Paths to Recovery – Using Natural Recovery Research on Alcoholism to Inform Pathological Gambling Research"). Though many assume that individuals who qualify for treatment based on DSM-IV or other screens should seek professional treatment, evidence suggests this might not be the case. This WAGER discusses some problems related to the assumption that positive diagnosis is synonymous with a need for formal treatment.

Instrumentation Immaturity. Researchers, clinicians and public policymakers have considered the problems associated with epidemiologic prevalence rates of psychiatric disorders and the implied need for treatment. Hardoon, Derevensky and Gupta (2003) recently found that many instrument-identified cases were not accompanied by the self-perception of a gambling disorder. Like many other mental disorders, people might not experience their gambling-related symptoms as clinically significant (Narrow, Rae, Robins, & Regier, 2002; Regier, 2000; Regier et al., 1998). This lack of clinical significance might be due, in part, to the immaturity of the field's diagnostic tools. As diagnostic scholars have noted, there are important limitations associated with screening instruments, diagnostic criteria and the necessity for treatment (Regier et al., 1998). Specifically, with one exception (i.e., Shaffer, LaBrie, Scanlan, & Cummings, 1994), screening

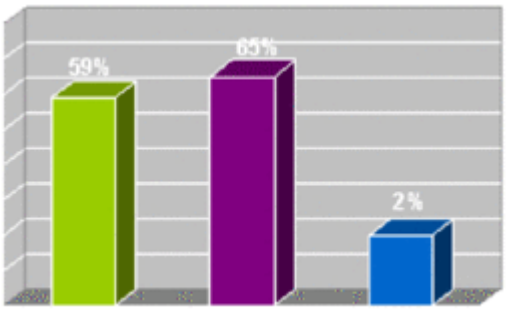
instrument items and the DSM diagnostic criteria are not weighted. Each item or criterion is valued equally. To illustrate, for the DSM, any five of the 10 current criteria will satisfy the basic requirement for a diagnosis; so, it is possible for clinicians to diagnose someone as a pathological gambler in the absence of a seemingly important symptom such as preoccupation with gambling. In addition to the absence of criteria or item weighting, there also is a failure to include symptom severity gradients. Therefore, in contemporary screening instruments, some symptoms that might be more intense and troublesome for one individual are weighted equally to other symptoms which are less troublesome. Under these circumstances, it is very difficult to estimate accurately the number of people who are in need of formal treatment based upon an estimate of how many people in the community meet diagnostic criteria (Regier, 2000).

Symptom Stability. Another complication in treating those diagnosed with pathological gambling revolves around the natural history of gambling related problems. The DSM-IV states,

> *"The gambling problem may be regular or episodic and the course of the disorder is typically chronic. There is generally a progression in the frequency of gambling, the amount wagered, and the preoccupation with gambling and obtaining money with which to gamble" (American Psychiatric Association, 1994, p. 673).*

This statement signals to clinicians that at-risk or moderate gambling related problems likely will be the precursors of more severe gambling related problems. Recent research suggests that this might not be the case. Just as Shaffer and Hall demonstrated for casino employees in one of the first multi-year prospective studies of gambling disorders (Shaffer & Hall, 2002), a recent study by Wiebe (2003) suggests that, perhaps more commonly, the majority of moderate and at-risk gamblers "improve" over time. This study followed 448 at-risk, moderate, or severe gamblers, as identified by the Canadian Problem Gambling Index (CPGI), over a period of one year. During this follow-up time, over half (59%) of the at-risk gamblers became either non-problem gamblers or non gamblers; similarly, over half of the moderate gamblers reduced the severity of their gambling related problems to qualify as at-risk (38%) or non-problem gambling (26%) (see Figure 1). Likewise, Slutske (2003) found that college students with gambling related problems reported fewer problems over time.

Figure 1. Percentage of improvement in one year for individuals with different levels of gambling related problems (Wiebe et al., 2003).



It is possible that studies relying on self-report (e.g., Slutske (2003), Shaffer (2002), and Wiebe (2003)) might not accurately reflect the severity of an individual's gambling related problems over time. Moreover, the assessments used in these studies (e.g., the CPGI, the DIS based on DSM-III and DSM-IV, and the SOGS) might not reliably or validly evaluate gambling related problems. However, a number of separate studies do provide substantial evidence challenging the conventional notion that all gambling disorders are progressive (Abbott, 2001; Winters, Stinchfield, Botzet, & Anderson, 2002). As scientists expand the focus of gambling studies from treatment seekers to the community at large, they may observe important differences between these groups including the rates of recovery for individuals with gambling related problems. Also, future findings from longitudinal research may alter how we view gambling. As seen in the studies cited above, research that captures a gambler's diagnostic progression over time yields a broader perspective on the course of gambling related problems.

Comments on this article can be addressed to Michael Stanton.

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