The WAGER Vol. 9(24) – Reasons for Leaving Gambling Treatment

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Patient retention is a goal of both physical and mental health treatment providers. Recent research reports that disordered gambling treatment providers experience patient drop-out rates between 40% and 80% (Grant, Kim, & Kuskowski, 2004). Although treatment providers have come to expect that a certain proportion of their patients will drop-out, little is known about how such drop-out rates might be prevented. This week the WAGER reviews new research by Grant and his colleagues (2004), which asked drop-outs why they left before completing a gambling treatment program.

The authors defined a study cohort of 50 adult outpatients in the principal author's clinical practice who met DSM-IV criteria for pathological gambling. They contacted and surveyed 21 of 24 who had been in treatment for at least 60 days but left treatment before discharge. Patients in the treatment program received an antidepressant if they reported gambling to alleviate depression or naltrexone if they had difficulty dealing with urges to gamble. Patients also had the opportunity to engage in supplementary Cognitive Behavioral Therapy or Psychodynamic Therapy and could attend Gamblers Anonymous meetings. Grant et al. contacted the drop-outs by telephone and asked the former patients about their reasons for leaving treatment, current disordered gambling symptoms, and current gambling-related difficulties.

Table 1: Reported Reasons for Leaving Disordered Gambling Treatment (Grant, Kim, & Kuskowski, 2004) (N=21)

Reasons	N (%)*
Miss the thrill of gambling	10 (47.6)
Hoped winning would ease financial difficulties	6 (28.6)
Hopeless about getting better and had no support	4 (19.0)
Felt they could stop on own	3 (14.3)
Side effects from medication	3 (14.3)
Wanted to try other treatments	3 (14.3)
No Current gambling symptoms	1 (4.8)

Those who left treatment were less likely than those remaining in treatment program, to report at intake that they had a support system of friends and family. Social support predicted treatment continuation, but other characteristics did not (i.e., gender, age at treatment initiation, age at disorder onset, marital status,

gambling urges, preoccupation with gambling, or psychiatric comorbidity.) Clinical rating of improvement at the first chart review 60 days after admission was related to continuing in treatment. All but one continuing patient showed improvement at that time compared to roughly half (58%) of the drop-outs. This finding was not statistically significant (OR, 6.00; p = .04) because an appropriate adjustment for multiple comparisons established statistical significance at p = .0056 or less. At follow-up, researchers did not report if DSM-IV criteria were met for those who dropped out, but one patient reported no current gambling symptoms. As Table 1 shows, most discontinuers reported that they left treatment because they missed the thrill of gambling or hoped winning would ease financial difficulties.

Grant et al. (2004) provide some information about why patients leave treatment. Such research is important because it could ultimately lead to better designed treatment that attends to treatment needs. These needs can become frequent reasons for leaving. In this study, nearly half the drop-outs left treatment because they missed the thrill of gambling; an implication from this study might be the need to design interventions that pay more attention to coping with thrill-seeking. This area could benefit from further studies with larger samples of patients receiving diverse types of treatment that prospectively examine risks for failure to continue treatment and precipitating reasons for dropping out.

Comments on this article can be addressed to Michael Stanton or Debi LaPlante.

References

Grant, J. E., Kim, S. W., & Kuskowski, M. (2004). Retrospective review of treatment retention in pathological gambling. Comprehensive Psychiatry, 45(2), 83-87.