

# The WAGER, Vol. 16(6) - What is the worst gambling strategy? A study about preferred forms of gambling among pathological gamblers

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It is important to understand clinical characteristics (e.g., betting pattern, emotional states, gambling preferences) of pathological gambling to provide insight for developing effective prediction, prevention and treatment initiatives. This week's WAGER reports results of a study that examined how gambling preferences (i.e., strategic versus non-strategic) relate to clinical characteristics among people who suffer with gambling disorder (Odlaug, Marsh, Kim, & Grant, 2011).

## **Method**

- Participants (N = 440, age  $\geq 18$ , 54% females) were patients with a current DSM-IV diagnosis of pathological gambling (PG) and no psychotic or bipolar disorders. The researchers recruited participants who were enrolled to one of several clinical trials that investigated PG treatment during 2000 through 2008.
- Investigators assessed participants using the following measures:
- Psychiatric assessment - The Structured Clinical Interview for DSM-IV Axis Disorders (SCID-I; Williams et al., 1992) and the Structured Clinical Interview for Pathological Gambling (SCI-PG; Grant, Steinberg, Kim, Rounsaville, & Potenza, 2004).
- Demographics and features of PG - The researchers assessed participants' gender and age. The semi-structured clinical interview asked for the preferred types of gambling.
- PG symptoms severity - The Yale-Brown Obsessive Compulsive Scale Modified for Pathological Gambling (PG-YBOCS; Pallanti, DeCaria, Grant, Urpe, & Hollander, 2005) and the Clinical Global Impression Severity

scale (CGI-S; Guy, 1976).

- Based on the participants' reported preferred gambling type, the researchers assigned participants to one of three groups: *strategic gamblers* (e.g., those who prefer poker, blackjack, dog and horse racing, sports betting, and craps/dice games; N = 56); *nonstrategic gamblers* (e.g., those who prefer slot machines, pull tabs, bingo, and keno; N = 200); and, *both* (those who reported no preference; N = 184).

## Results

- Table 1 shows that the nonstrategic gamblers reported no more relationship, financial or work-related problems than strategic gamblers.
- The nonstrategic gamblers were older than strategic gamblers when they started gambling (mean age 34.1 vs. 22.5) and when gambling became a problem (mean age 42.6 vs. 30.6). Nonstrategic gamblers were also less educated (60.4% with at least some college education vs. 79.6%) and more likely to be women (71.5% vs. 30%) than strategic gamblers. All differences are statistically significant at  $p < .01$ .
- There were no differences between the groups in terms of PG symptoms severity and psychiatric comorbidity.

**Table 1. Self-reported gambling related problems among gamblers who prefer *strategic*, *nonstrategic* and *both* types of gambling - N (%)**

Group	Nonstrategic N = 200	Strategic N = 56	Both N = 184
Problems due to gambling			
Financial	151 (75.5)	40 (71.4)	153 (83.2)
Relationship	37 (18.5)	4 (7.1)	23 (12.5)
Work-related	92 (46.0)	20 (35.7)	79 (42.9)

*Note:* These are the measures with no significant difference between groups.

## Limitations

- This is a self-reported study. The self-reported preference to play a specific type of game might not identify the game type that is associated with problems or is actually the most often played game.

- The study included only treatment seeking gamblers.

## **Conclusion**

The study found that gambling type preference is confounded with age, education, and gender differences. Specifically, gamblers that prefer nonstrategic games are older, less educated, and more likely to be women than those that prefer strategic games. However, because female gamblers tend to be older than male gamblers (Nelson, LaPlante, LaBrie, & Shaffer, 2006) further studies should examine if the age and education differences remain when the gender is controlled. The study did not find differences in the severity of PG symptoms among the groups. However, using treatment-seeking PGs as participants necessarily reduces the variance in symptom severity, and might work against finding differences in associated measures.

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What do you think? Please use the comment link below to provide feedback on this article.

## **References**

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