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Gambling disorder in older adults: A cross-cultural perspective

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Abstract

Introduction: Gambling disorder (GD) in older adults is significantly increasing and became an important public health issue in different countries. However, little is known regarding GD in older adults. The prevalence and acceptance of gambling vary among different cultures and this raises the question of how and to what extent culture affects older gamblers. The majority of the important studies regarding GD in older adults have been conducted mainly in Anglo-Saxon cultures and little information is available regarding GD in other cultures. The objective of this paper is to perform the first standardized cross-cultural comparison regarding older adults presenting GD.
Methods: The total studied sample involved 170 subjects: 89 from the Brazilian (BR) sample and 81 from the American (US) sample. It consisted of 67 men and 103 women (average age = 64.42, standard deviation = ±3.86). They were evaluated for socio-demographics, gambling behavior variables and psychiatric antecedents.
Results: Overall, there were significant differences between BR and US older adult gamblers in marital status, onset of gambling activity, onset of GD and urge scores.
Discussion: This study showed that there are important differences in gambling course, gambling behavior and personal antecedents between two samples of older adults presenting GD from countries with different social-cultural background. It weakens the possibility of generalization of results found in Anglo-Saxon countries to other cultures and reinforces for the need for development of research on GD in older adults outside the Anglo-Saxon culture.

1. Introduction

Gambling is an ancient behavior that exists in almost every culture [1]. There are reports that older adults – subjects aged 60 or older according to the World Health Organization [2] – who gamble recreationally could potentially have greater well-being relative to non-gamblers [3]. However, there is strong evidence suggesting that gambling disorder (GD) in this age range is increasing and became an important public health issue in different countries [4–6]. GD arises when the gambling behavior is persistent, recurrently problematic and leads to clinically significant impairment or distress [7]. Several factors contribute to the increased prevalence of GD in older adults such as the aging of the world population [6] and the larger gaming availability worldwide [5].

Despite its importance, little research has focused specifically on GD in older adults [4–6]. Research to date has suggested that older adults with GD may have unique clinical presentations (i.e. older age of onset, greater rates of anxiety disorders), may have different motivations for gambling, and different consequences from gambling compared to younger gamblers [6,8–10]. Therefore, older adults may require a special approach due to their particular general and mental health needs. [6,11]. However, apparently GD has different presentations depending on sociocultural factors [1].

As a result of this cultural influence, the prevalence and acceptance of gambling vary among different cultures [1],

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and this raises the question of how and to what extent culture affects older gamblers. Thus, evaluating individual variables related to GD in the elderly across cultures may be useful in identifying possible differences in GD psychopathology and thereby may enhance treatment outcomes [1]. The majority of the important studies regarding GD in older adults have been conducted mainly in Anglo-Saxon cultures (i.e., United States, United Kingdom, Canada and Australia) and relatively little information is available regarding GD in other cultures [12]. Therefore, the majority of our knowledge regarding diagnostic, psychopathology and treatment of GD in older adults comes from Anglo-Saxon cultures but we don't know how replicable are they in other parts of the world.

The objective of this paper is to perform the first cross-cultural study that compares different countries regarding older adults presenting GD. Our goal is to investigate in a standardized way the socio-demographics, gambling behavior and psychiatric antecedents among samples collected in Brazil and a United States, two countries that have differences in cultural and social background as well distinct legal status of gambling. Our hypothesis is that there are significant differences between GD in the older adults in those countries and that this comparison can lead to a better understanding of cultural influences of GD in this age group and can potentially suggest cultural adaptations for better therapeutic approaches.

2. Methods

2.1. Ethics

All data collection was approved by the ethics committee of the Clinical Hospital of Medical School of the University of São Paulo (BR), by Institutional Review Board of University of Chicago (US) and by the Institutional Review Board of the University of Minnesota (US). Written informed consent was obtained from all individuals. This study followed the principles of the World Medical Association Declaration of Helsinki, which guides experimental procedures with human subjects.

2.2. Participants

The total studied sample involved 170 subjects: 89 from the Brazilian (BR) sample and 81 from the American (US) sample. It consisted of 67 men and 103 women (average age = 64.42, standard deviation = ±3.86).

The BR sample included patients who voluntarily sought treatment at the Gambling Outpatient Unit of University of São Paulo Hospital. The recruitment was made by advertisements (Internet, radio, gamblers anonyms) that invited patients to clinical treatment and to clinical trials. A minor proportion came by external referral from low-complexity health services in the metropolitan area of São Paulo city. Subjects were recruited from 1996 to 2014.

The US sample consisted of older adults who were treated in the outpatient gambling unit at the University of Minnesota (n = 17; 21%) and from clinical trials that were conducted between 2000 and 2014 at the University of Minnesota and the University of Chicago. They were also recruited by media advertisements (newspapers, Internet, public places).

Exclusion criteria were: [1] unstable medical illness or participants who needed emergency care [2], clinically significant abnormalities on physical examination [3], individuals who had less than 5 years of formal education [4], patients who presented psychotic symptoms and [5] subjects who refused to participate in the study.

2.3. Measures

2.3.1. GD diagnostic

The GD diagnostic was made using the Structured Clinical Interview for Pathological Gambling, which is based on the criteria of the Diagnostic and Statistical Manual Fifth Edition (SCI-PG-DSM-5). Trained psychiatrists performed all diagnostic interviews. The different criteria collected before the release of DSM 5 were electronically saved and, then, a retrospective processing of the data for a proper adaptation to DSM 5 GD criteria was conducted.

2.3.2. Socio-demographic data

The two samples were evaluated for the socio-demographic variables gender, age, race, marital status and educational level.

2.3.3. Gambling behavior

All the participants were assessed for GD course variables: age of onset of gambling activity, age of onset of GD, lag onset of gambling activity and onset of GD; GD severity that was measured by the total number of DSM-5 criteria endorsed, which according to APA is related to different levels of severity [7]. The subjects were also evaluated for urge to gamble in the past week, which can be reliably measured by the score of the first 4 questions of the Gambling Symptoms Assessment Scale, G-SAS [13], and for the main forms of gambling used. According to Grant and Potenza (2008) all the measures evaluated in this section (Gambling Behavior) are clinically important and could help to better understand the presentation of GD [14].

We highlight that the variables "urges" and "gambling disorder severity" were not collected in American outpatients and, thus, the final values for these two variables in the US sample refer only to clinical trials participants (n = 64).

2.3.4. Psychiatric antecedents

Participants underwent a psychiatric interview using the Mini International Neuropsychiatric Interview (M.I.N.I.), a semi-structured interview that assessed the past existence of main comorbidities of "Axis I". This instrument is usually performed in approximately 45 minutes and was applied by professionals after a brief clinical training. Additionally, we assessed the past history of repetitive risky behaviors such as excessive sex, excessive buying and stealing. For this purpose, we used the criteria respectively of compulsive