trodes attached to the wrist of one arm. Whenever he reaches the sporting page he receives a reasonably strong electric shock, painful although not in any way damaging. This is continued until the patient rejects the sporting page. He is asked to continue turning over the pages of the pile of newspapers. He thus receives some 15 shocks in a single session and sessions are repeated 2 or 3 times a week. A course of treatment takes about 6 weeks.

An alternative method is to project photographic slides of lists of runners, betting shops, racing cards and winning tickets and give the patient the shock in association with each of the slides. Interspersed with every two or three slides is a photograph of something which he associates with a reason to give up his gambling. These would be photographs of his wife and children, his house, his dog. With these he gets no shock and these are known as relief slides. Again he would receive some 15/20 shocks in one session and ideally sessions take place two or three times a week for about 6 weeks.

It is quite useless to consider giving this form of treatment to a patient against his will. It is in this way that such a treatment differs from punishment. Punishment is imposed upon the individual without reference to his own wishes but at the behest of the appropriate authority. This treatment is a learning process in which the individual co-operates because he recognises that he needs help in modifying his behaviour. Several patients have been *brought* for treatment by desperate wives but it has always been found that treatment is of no avail in this situation. It is only where the patient wishes to co-operate that he can be helped.

The problem of the compulsive gambler is a serious one with its effects on the individual, his family and his friends. Treatment holds out some hope of alteration in the patterns of behaviour. One cannot say which particular factor or combination of factors has played the most important part, but in a small number of patients a quarter remained free of gambling for at least a year after treatment, while one or two report three years' freedom.

While the purely psychological aspects of the treatment are important it cannot be denied that other important factors are at work. There is little doubt that the sympathy and support of the therapist is a factor in helping the patient to modify his behaviour and several patients have commented on the fact that this is the first time that anyone has taken an interest in his problem and understood that he is not being wicked or callous in his behaviour. He is unable to give up a pattern of activity even though recognising that it is harmful to himself and his family.

TAKING THE FINAL RISK

Risk is inherent in gambling and in a suicide bid. A correlation between the two is suggested by Dr. E. Moran, Hon. psychiatrist to Gamblers Anonymous. This article is based on his paper given at the 5th International Congress on Suicide prevention in October.

AN ESSENTIAL element of gambling is that the result depends on the outcome of a risky situation. In some types (roulette) it is all a matter of chance; in others (betting on horses) some skill is also involved in terms of knowledge of previous form.

Risk-taking is also inherent in the suicidal act. There is always a degree of uncertainty whether a suicide attempt will succeed or fail. It has been increasingly realised that chance factors in the environment, such as the arrival of another person on the scene, are often the most important in determining the outcome.

This was emphasised by Firth, an anthropologist who studied suicidal acts on Tikopia, a small Polynesian island. Here the usual method of suicide was to go out into the shark infested sea. This method of suicide was admired because of the attitude towards death in this society. So an attempt was usually made to rescue the individual by sending out a fleet of canoes. The chances of the rescue succeeding depended on many factors including the availability of the canoes, the weather and the time of day or night. The individual therefore knew that the outcome of his suicide attempt was uncertain even if he did not really wish to end his life but was making an appeal or a protest. From his observations, Firth concluded that 'involved in the suicide attempt is a distinct element of risk-taking. It is part of my

argument that such risk-taking may be built into the structure of ideas about suicide, and may then have a bearing on the sociological interpretation of the volume of suicide'.

Since both gambling and suicide attempts are types of risk-taking behaviour one would expect them to be frequently associated. Unfortunately, despite the scale of both, there are no detailed studies of their association. In an initial attempt to investigate this, 75 pathological gamblers who were members of Gamblers Anonymous, were asked to complete a questionnaire concerning their gambling habits. They were asked also whether they had ever attempted suicide and if so, whether it was related to gambling problems. A similar questionnaire was given to 47 spouses of pathological gamblers who were members of Gam-Anon.

The vast majority of this sample of gamblers (72 out of the 75) were men whose gambling was either horse or dog race betting or gaming. One in five of these gamblers had attempted suicide and the ones who had done so were all married. Consequently, if the single and the separated were excluded from the sample, the incidence of attempted suicide was one in four of married gamblers. This is very high but not as high as among the three female gamblers, two of whom had made suicide attempts. The incidence of suicide attempts among the wives of gamblers was one in eight.

This high incidence of suicide attempts among pathological gamblers and, to a lesser extent, among their wives requires further investigation. It appears that the obvious link is depression which is very common among pathological gamblers and is also known to be a frequent cause of suicide. The usual depression of pathological gamblers is a reaction to large financial losses after a bout of heavy gambling. Occasionally the depression may be primary and the gambling is then used to relieve the symptoms of tension much the same as in depressive shop lifting. In these cases, the gambling might also be self destructive, arising out of morbid guilt feelings which are very common in depression.

Both pathological gambling and suicide are types of self destructive behaviour. The American psychiatrist, Karl A. Menninger, in his book 'Man Against Himself', suggested that much deviant behaviour was a form of chronic suicide. This may be no more than an analogy but any one who has known a pathological gambler will find Menninger's comments very appropriate: 'Whoever studies the behaviour of human beings cannot escape the conclusion that we must reckon with an enemy within the lines. It becomes increasingly evident that some of the destruction which curses the earth is self-destruction; the extraordinary propensity of human being to join ranks with external forces in an attack upon his own existence is one of the most remarkable of biological phenomena.'

We know very little about the 'enemy within the lines' responsible for pathological gambling—it might be related to individual risk-taking characteristics. What Menninger failed to mention is that society often provides the tools for the self-destruction of the individual. This is certainly the case in pathological gambling. In our society liberalised laws and social pressures encourage excessive gambling and people predisposed towards it are exploited by inadequately controlled facilities. We need to realise that both the gambler and society are responsible for this problem if we are to do anything effective to relieve it.

A baize table in a pool of light, an absorbed group clustered around—the fashionable end of the gambling spectrum. *Photo: Syndication International*