



Pathological gambling is an underestimated risk factor for pilfering and suicide in Ghana: a case report

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Received June 2023; Revised September 2023; Accepted November 2023

Abstract

Background: Gambling is a game of chance that involves putting money or something of value at risk to gain something better. Currently, in Ghana, sports betting is a growing public health concern. We present a case report of a 29-year-old accountant who presented with a year duration of recurrent suicidal thoughts, two years of depressive symptoms, and a four-year history of pilfering due to obsessive internet gambling. His symptoms were successfully managed at the Psychiatry Department of Korle-Bu Teaching Hospital. Pathological gambling is an underestimated risk factor for theft, depression, and suicide in Ghana. However, most people are unaware that it is a psychiatric condition that is manageable in the hospital. Advocacy, education, and publicity of pathological gambling as a psychiatric condition are needed to create awareness in the general public.

Keywords: Pathological gambling; Suicidal thought; Mental illness; Theft

Cite the publication as Majeed NS, Dei-Asamoah R, Agorinya J, Appiah-Pippim S, Marfo NAA, Twum WL, Dellor D, Apio E, Fiagbe DK (2023) Pathological gambling; an underestimated risk factor for pilfering and suicide in Ghana: a case report. HSI Journal 4(2):568-571. <https://doi.org/10.46829/hsijournal.2023.12.4.2.568-571>

INTRODUCTION

Gambling is a game of chance that involves putting money or something of value at risk to gain something better [1,2]. Currently, it is a growing public health concern globally [2-4]. The advent of internet gambling and easy access to mobile phones and televisions have made gambling easy [5], with more youth of the working age group getting involved [5-9]. It is legal to engage in online sports betting in Ghana according to the Gaming Act of 2006. Although the Gaming Act of 2006 made the Ghana Gaming Commission responsible for regulating sports betting [10], there are no legal requirements for gambling besides verifying the gambler's age [11], and there are no provisions to restrict where and when betting companies carry out their advertisement. Also, there is no law to protect the interests of the gambler.

This suggests that gamblers in Ghana gamble at their own risk since betting companies are not legally bound to protect the interests of the gambler. Moreover, the rising prevalence of gambling among youth in Ghana and Africa at large [6] suggests that more efforts are needed to promote responsible gambling. Sports betting is reported to be the most common form of gambling among Ghanaian youth [12]. One of the significant driving forces encouraging gambling behaviours is social difficulties from family [12]. Poverty has been indicated as one of the major risk factors of gambling in Africa [13]. However, other risk factors such as peer influence, availability and accessibility of gambling to the youth were also reported [5]. Therefore, with the rising cost of living and youth unemployment in Ghana due to the impact of the COVID-19 pandemic on the economy [14] and the surge of numerous sports betting companies in Ghana [15], more youth are likely to engage in gambling such as sports betting as a source of income. This case study aims to raise awareness that compulsive gambling is a psychiatric condition that can be managed in a hospital, and

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it also highlights the impact of pathological gambling as a risk factor for pilfering and suicide.

CASE

The patient, Mr. Y, is a 29-year-old Ghanaian who worked as an accountant in a company. He reported voluntarily for psychiatric evaluation and management in the company of his sister. He presented with a four-year history of excessive gambling on the internet, two years of depressive symptoms and recurrent suicidal thoughts for one year. After securing a job as an accountant, he began to bet casually on his favourite football team. He began with 500.00 Ghana cedis (GHS) and won about 1000 GHS on his first try. He felt excited and started using the company's money for sports betting, hoping to replace it after winning. However, because he had lost some of the company's money to betting, he decided to make more money by rolling over the money he had won. Gradually, he started betting on virtual games and increased the amount of money and number of times he bet in a day, even during working hours. After exhausting the company's account he had access to, he started borrowing money from his siblings and friends and lied about what he wanted the money for. The highest stake he ever placed on betting in a day was about 30,000 GHS, and the highest amount he had ever won was about 50,000 GHS. He tried several times to stop, but he could not. He lost his job after an audit showed he had stolen about 1.4 million GHS. He was arrested and detained till his family bailed him. He dropped out of his postgraduate studies to make more time for gambling. After four years of gambling, he realised he had never won enough money and was indebted to his friends and the company. He felt restless and had difficulty sleeping if he did not gamble for a day and would only be relieved after he had gambled. He became depressed and decided to die by suicide via starvation. His close friend, who had not seen him in a while, called him several times and raised the alarm about his whereabouts when he did not get a response. He was found in his room frail and was rushed to the hospital. After the suicidal attempt, he got another job but lost it because he stole about 15,000 GHS for betting. He started having depressive symptoms and suicidal thoughts again as he could not stop his gambling behaviour, which was affecting his socioeconomic life. After an initial consultation with a doctor, they were advised to seek further management with the Department of Psychiatry, Korle-Bu Teaching Hospital. Interestingly, when asked for the reason for his visit, he indicated that his suicidal ideation was the main reason for their visit. On direct questioning, it became evident that gambling was a significant precipitant of his suicidal ideation. They were surprised when they were told that gambling addiction was also a psychiatric condition that could be managed.

A mental state examination on the day of his presentation showed a well-groomed young man. His affect was depressed, and he had some perceptual disturbance (auditory hallucination). He was ruminating over suicide

but appeared to have full insight into his condition after psychoeducation. He was ready to stop gambling and go back to his everyday life. Mr Y was diagnosed with severe gambling disorder using the Diagnostic and Statistical Manual of Mental Disorders - 5th Edition (DSM-5) [16] and severe depressive episodes with suicidal ideation. Yale-Brown Obsessive Compulsive Scale adapted for Pathological Gambling (PG - YBOCS) [17], Hamilton Depression Rating Scale (HDRS) [18] and Columbia Suicide Severity Scale (CSSRS) [19] were used in assessing him. Mr Y scored 9 points on the DSM-5 and 30 out of 40 on the PG-YBOCS, suggesting severe pathological gambling. He also scored 25 on 52 on the HDRS, suggesting severe depression. Also, his rating on the CSSRS showed he had moderate suicidal risk. An APA (American Psychiatric Association) Personality Inventory for DSM5 [20] revealed moderate traits of anhedonia, anxiety, deceitfulness, depression, impulsivity, irresponsibility, manipulateness, perseveration, risk-taking, restricted affection, submissiveness, and suspiciousness. His cognitive distortions about gambling were also assessed.

He was admitted to the Department of Psychiatry at Korle-Bu Teaching Hospital. The management was multidisciplinary with a biopsychosocial approach, including psychiatrists, psychiatric nurses, clinical psychologists, occupational therapists, addiction teams, social workers, and community psychiatric nurses. He was put on suicide watch and monitored while on the ward by psychiatric nurses. The psychiatrist prescribed antidepressants, and he was started on them to help with his depressive symptoms and decrease the urge to gamble. Mr. Y and his relation were psycho-educated on his condition. The clinical psychologist managed his preoccupation with gambling and cognitive distortions with cognitive behavioural therapy. He also had motivational interviewing to resolve any indecisiveness and uncertainties to motivate him to make a positive behavioural change. Insight-orientation therapy was used to help him understand how events in his past affect his current behaviour and lead to emotional challenges to help him develop coping mechanisms, boost self-esteem and increase self-awareness. Family therapy was also employed to educate the family about the client's condition, to help resolve family conflict, and to improve family relationships with him. The Occupational therapist managed the aspects of his life that were affected by the gambling, i.e. his reputation, education, work, finances, relationship with family and his brushes with the law. In addition, daily routine planning and leisure engagement were discussed with the client, who was encouraged to return to school and how to get a new job post-discharge. Mr Y agreed to join the Gambling Anonymous Group after a discussion with the Addiction team to help him sustain his sobriety as he interacts with like-minded persons who have been in remission. This will ultimately forestall another relapse. After 22 days of inpatient management, his preoccupation with gambling

and depression had decreased significantly. He scored 0/40 on PG-YBOCS and 4/52 on HDRS. He was discharged to continue his medications and report for review in 2 weeks. The Community Psychiatric Team visited Mr. Y and his family two days post-discharge, and he was found to have a normal mental state following examination. He had not gambled since he got home and was looking for a job. He was also observed to be using a phone that did not allow him to gamble online. Mr Y and his family were counselled on relapse prevention and the need to continue with rehabilitation.

The client reported for review on two occasions, two weeks post-discharge, where he was seen by a psychiatrist and six weeks post-discharge, to see a clinical psychologist. A mental state examination of Mr Y during the reviews did not reveal any abnormalities as he scored 0/40 on PG-YBOCS and 2/52 on HDRS two weeks post-discharge and had the same scores at six weeks post-discharge when he reported for review. However, the client did not report for subsequent reviews. Hence, subsequent follow-ups were done through phone calls. Mr Y and his family were contacted through a phone call four months post-discharge. He was doing very well and was looking for a job. However, he was still using a phone that did not allow him to gamble online. He had also deactivated his subscriber identity module (SIM) card from all online money transactions. Six months post-discharge, Mr Y was found to be doing very well and was still looking for a job. Ten months post-discharge, Mr Y had gotten a new job as a supervisor with no report of gambling when the family were contacted. He also mentioned that he was using an Android mobile phone but did not download any betting app on it, his SIM card was still deactivated from online mobile money transactions, and he was in a stable relationship with a lady and was preparing to write an exam to travel abroad to continue his education. His family confirmed the information provided by Mr Y. Additionally, no suicidal thoughts were noted at any point during the post-discharge follow-ups. He would continue the Gambling Anonymous Group meetings and report for scheduled reviews at the Psychiatric and Addiction Units.

DISCUSSION

As indicated by the instance described in this research, the rise in online sports betting companies in Ghana has contributed to the country's rising rate of vices and suicide. Several news outlets in Ghana have reported thefts and suicide cases due to sports betting. This includes the report of some students deferring their courses due to non-payment of school fees, with sports betting being cited among the reasons for non-payment of the fees [21]. Also, a 76-year-old chief and retired educationist reportedly died by suicide after losing 120,000 GHS on an AFCON bet [22]. Furthermore, an Accra-based electronics company employee was arrested for allegedly spending 1,079,728 GHS of the company's money on sports betting [23]. Despite the impact of these bets on crimes and suicide, little

or no attention has been given to curbing the situation in Ghana. Even though the Ghana Gaming Commission and the National Lottery Authority imposed an age limit of 18 and above for gaming to promote responsible gambling practices, several studies have revealed that young people under the age of 18 participate in gambling in Ghana [12,24,25], suggesting that little or no effort is being made to enforce legislative regulation of gambling in Ghana. The high frequency of gambling advertisements on radio, television and billboards contributes to irresponsible gambling in Ghana. In some European countries, gambling advertisement is highly restricted to protect minors [26]. For example, gambling advertisements are only allowed between 10 p.m. and 7 a.m. in Russia. It is restricted to only television and radio and in the locations where the gambling is held [26]. On the contrary, in Ghana, gambling advertisement is done on all media outlets without restriction on time zone and location. These suggest that more efforts are needed to promote responsible gambling in Ghana. Also, one of the significant challenges in addressing this issue will be the knowledge and attitude of individuals toward seeking remedies for pathological gambling. In Ghana, most people likely do not know that pathological gambling is a condition that can be managed in hospitals. The lack of knowledge can be attributed to little or no education, advocacy, and publicity about psychiatric conditions in the country. This status quo is worsened by few mental health professionals in the country [27].

Limitations

Mr. Y could not report for reviews as scheduled. He reported for review only at two weeks and six weeks post-discharge. Therefore, all the follow-ups after six weeks post-discharge were conducted through phone calls. Hence, assessments such as mental state examinations and monitoring scales that require the presence of Mr Y could not be done during the phone call follow-ups.

Conclusion

Pathological gambling is an underestimated risk factor for theft and suicide and a manageable psychiatric condition in Ghana. This study recommends that routine psychiatric screening of employees should be encouraged by employers. This screening will enhance early detection and prevention of psychiatric conditions that can lead to loss of resources. Advocacy, education, and publicity of psychiatric disorders should be improved to create awareness of psychiatric conditions that can be managed in Ghana. There is a need for research to understand the knowledge and attitude of pathological gamblers toward seeking remedies in Ghana.

DECLARATIONS

Ethical considerations

Informed consent was obtained from the patient, and all ethical issues and efforts have been made to keep his identity anonymous.

Consent to publish

All authors agreed to the content of the final paper.

Funding

None

Competing Interest

No conflict of interest was reported by the authors.

Author contributions

DKF and NSM participated in the conceptualisation and drafting of the manuscript. DKF, NSM, SAP, ANM, RDA, JA, WT, DD and EA participated in the management, review and final review of the manuscript.

Acknowledgements

A big thank you goes to all the staff of the Department of Psychiatry, Korle-Bu Teaching Hospital and the patient involved.

Availability of data

The data used for this article is available upon request to the corresponding author.

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