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Original article

Exploring Psychological Distress and Coping Styles in Spouses of Male Patients with Gambling Disorder

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ABSTRACT

Background: Gambling Disorder (GD), recognized as a behavioural addiction in DSM-5 and ICD-11, has received comparatively less research attention than substance use disorders, despite its profound effects on individuals and families. Its concealed nature often delays recognition until significant harm1 arises. Spouses of those affected commonly experience emotional distress, financial burden, and psychological strain. Coping responses vary and significantly influence their mental health and well-being. This study aimed to assess the relationship between the severity of gambling behaviour in males and the psychological distress, coping styles, and well-being of their spouses.

Methods: This cross-sectional study was carried out at Indlas Hospital, Vijayawada, and included 100 spouses of male patients diagnosed with gambling disorder. A purposive sampling technique was employed, wherein participants were selected based on the predefined inclusion and exclusion criteria to ensure that the sample was representative of the study objectives. The study was conducted over a period of 6 months, between January and June 2025. The Problem Gambling Severity Index (PGSI) was used to assess gambling severity in husbands. Spouses completed the Kessler Psychological Distress Scale (K10) to assess psychological distress, the Brief-COPE Inventory to evaluate coping styles, and the Personal Wellbeing Index-Adult (PWI-A) to measure well-being. Descriptive and inferential statistics were used to examine associations.

Results: Statistically significant associations were found between spouses' psychological distress and the severity of gambling in their husbands ($p < 0.001$), psychological distress and coping styles ($p < 0.05$), and coping styles and well-being ($p < 0.05$).

Conclusion: The study highlights strong associations between psychological distress, maladaptive coping, and poor well-being among spouses of individuals with gambling problems. Greater distress was linked to more severe gambling and reliance on emotion-focused or avoidant coping, which corresponded with poorer well-being. Early interventions promoting problem-focused coping may improve outcomes for affected families.

Key words: Gambling disorder, spouses, caregivers, psychological distress

INTRODUCTION

Gambling disorder (GD), also known as pathological gambling or ludomania is repetitive gambling behaviour despite harm and negative consequences. Pathological gambling was first included in DSM-III in 1980 under the "Impulse-control disorders" category. The DSM-5 published in 2013 renamed it as gambling disorder and placed under "Addictions and related disorders" category acknowledging its similarities to other substance use disorders. [1] ICD-10 followed a similar pattern. Gambling disorder was classified in ICD-10

as pathological gambling under "Habit and Impulse Disorders" (F63), which was redesignated as Gambling disorder (6C50) in ICD-11 under "Disorders due to Addictive behaviours". It also distinguished between online and offline gambling. [2]

Gambling has been mentioned since ancient times, but it wasn't until recently that it was formally recognized as a mental and behavioural disorder. Approximately 0.2-5.3% of adult's experience gambling disorder at some point in their life time. [3] By 2028, the worldwide financial cost of harm caused by gambling is expected to hit approximately 700 billion dollars. [4] In contrast to substance use disorders, which have garnered substantial attention and research, gambling disorder has been relatively understudied. One key factor contributing to this disparity is the secretive nature of gambling disorders. Unlike substance use disorders, which often manifest through visible signs of intoxication or physical symptoms, gambling disorders can remain hidden until the consequences become catastrophic. The financial losses incurred by individuals with gambling disorders often come as a shock to their families, who may have been unaware of the extent of their loved one's struggles.

Despite the growing awareness of its impact, there remains a significant dearth of research on gambling disorder and its far-reaching implications for both patients and their caregivers. The impact of gambling disorder on families can be particularly devastating. Many individuals with gambling disorder promise their families financial security but repeatedly relapse into destructive behaviour, leading to feelings of betrayal and helplessness among loved ones. Furthermore, the financial burden of gambling disorder can lead to a higher risk of suicide among both patients and their family members, compared to those affected by substance use disorders. [5]

Gambling Disorder is increasingly recognized as a serious behavioural addiction that can have profound implications not only for affected individuals but also for their families. The spouses of males with gambling disorders often bear the emotional, psychological, and financial burdens associated with the illness, making them a critical group for clinical attention and support. Chronic exposure to the unpredictable and adverse outcomes of gambling behaviour can lead to significant distress and strain within marital relationships, often resulting in elevated levels of depression, anxiety, and general psychological distress. [6]

Coping styles play a pivotal role in determining how spouses respond to the ongoing challenges posed by their partner's gambling behaviour. Coping Orientation to Problems Experienced Inventory or The Brief COPE inventory identifies three primary coping styles – problem-focused, emotion-focused, and avoidance coping, which vary in their effectiveness and long-term impact on well-being.

Problem-focused coping involves taking direct action, such as setting financial limits, seeking professional help, or planning solutions, and is generally linked to better psychological outcomes and long-term resilience. Emotion-focused coping helps regulate distress through strategies like acceptance, emotional support, or religious faith, offering emotional stability when the problem feels uncontrollable. In contrast, avoidance or dysfunctional coping, such as denial, self-blame, or behavioural disengagement tends to worsen psychological strain and damage relationship quality. [7] Unhealthy coping and limited support can lead to greater harm, especially when the GD is severe. [8] Understanding the interplay between these coping strategies and the degree of psychological distress experienced by spouses can offer valuable insights into the dynamics of marital resilience and vulnerability.

Although a growing body of literature has examined the psychological consequences of gambling disorders, research focusing specifically on spouses and how their coping styles relate to their distress and overall well-being remains limited, especially in the Indian context. The present study aims to address this gap by exploring the association between gambling severity in males, distress levels in their spouses, coping styles adopted by the spouses, and their well-being. By doing so, this research hopes to contribute to a more holistic understanding of the ripple effects of gambling disorder and support the development of targeted interventions for both patients and their families.

MATERIALS AND METHODS

Study design, population, and setting

This was a cross-sectional, observational study conducted at Indlas hospital, Vijayawada. The study aimed to assess the relationship between the severity of gambling behaviour in males and the psychological distress, coping styles, and well-being of their spouses.

Sample size

A total of 100 patients with gambling disorder and spouses of these patients were recruited for the study. Participants were selected through purposive sampling method from outpatient and inpatient settings.

Inclusion and exclusion criteria

The inclusion criteria comprised males diagnosed with gambling disorder and their spouses (aged between 18 and 54 years). Eligible spouses were those who had been living with the patient for at least one year and were willing to provide informed consent to participate in the study. Prior to obtaining consent, the objectives and procedures of the study were explained in detail to both the patients and their spouses, and any queries were addressed to ensure voluntary participation.

The exclusion criteria included spouses with a known psychiatric illness predating the onset of the patient's gambling behaviour, as well as those who were unwilling to provide informed consent for participation.

Ethical considerations

Ethical clearance for the study was obtained from the Indlas Ethics Committee (Approval Number: INDIEC04/January/2025). The study was conducted over a period of 6 months, between January and June 2025.

Measures

A semi-structured pro forma was used to collect socio-demographic data of the spouses. The following scales were

used, which took 25-30 minutes for completing all the scales. The scales were translated to Telugu, and then back to English to ensure the accuracy and equivalence of the scales.

1. The Problem Gambling Severity Index (PGSI) by Ferris & Wynne (2001) was used rate the severity of GD. [9] This is a brief, 9-item self-report measure of problematic gambling behaviours. Each item is scored on a 0-3 likert scale, with a total score ranging from 0-27. Scores of 0 are considered to be a severity of none, scores of 1-4 are considered low, scores of 5-7 are considered moderate and scores of 8 and above are considered to be problematic severity. [10] This scale is well validated with good internal consistency (Cronbach's alpha = 0.84) and adequate test-rest reliability (r = 0.78).
2. Kessler's psychological distress scale (K10) was used to rate psychological distress in spouses of male gamblers. It is a popular tool used to screen psychological distress in general population. K10 comprises ten items, rated on five-point likert scale, which indicate the degree of psychological distress prevalent among persons in the past 4 weeks. It has an excellent internal consistency and reliability (Cronbach's alpha = 0.93). [11] The 2001 Victorian population health survey adopted the following cut-off scores to rate the severity of distress: Scores of 19 or less –no distress, scores of 20-24 mild distress, scores of 25-29 moderate distress, and scores of 30 and above severe distress. [12]
3. Coping Orientation to Problems Experienced Inventory (Brief-COPE) by Carver (1997) was used to measure the coping styles of wives of patients with GD. It is a self-report questionnaire designated to measure effective and ineffective ways to cope with a stressful life event. [7] Scores are presented over three overarching coping styles as average scores, indicating the degree to which the respondent has been engaging in that coping scale. The three styles are Problem-Focused Coping (PFC), Emotion-Focused Coping (EFC) and Avoidant Coping(AC). [13] A high score on PFC, EFC and low scores on AC indicate adaptive coping. [14] It has a good internal consistency and reliability (Cronbach's alpha=0.86).
4. Personal Wellbeing Index- Adult (PWI-A) 5th edition developed by International Wellbeing Group, Melbourne (2013) is a 9-item self-reported questionnaire to rate the satisfaction in life. It contains total 9 items where items 1 and 9 are optional items. Each item is scored on a likert scale of 0-10. Standard scores are computed by dividing the raw scores by 7(items 1 and 9 are not included in scoring), times by 100. Higher scores are indicative of higher levels of personal well-being, quality of life and mental health. [15] Individual scores on the PWI can be interpreted using the following guidelines:70 and above- normal levels of subjective wellbeing, 50-69-compromised levels of subjective wellbeing, 49 or less-challenged level of subjective wellbeing. [16] This scale has shown an excellent internal consistency and reliability in our study (Cronbach's alpha = 0.90).

Statistical analysis

Data entry and analysis were performed using Microsoft Excel (2021) and R environment version 3.4.4 (Vienna, Austria). Quantile-quantile (QQ) plots were used to assess the normal distribution of the data. Continuous variables were reported as mean with standard deviation (SD) and categorical variables were reported as a number with the percentage of the total. The Chi-square test was used to study the relationship between the variables in the study. For all analyses, the probability level considered to indicate statistical significance was set at $p < 0.05$.

RESULTS

In our study sample, over half (52%) were young adults (18–34 years), and the rest were middle-aged, with slightly more working women (60%) than homemakers (40%). Most lived in nuclear families (64%), and the majority had graduated from college or higher (56%). In terms of religion, Hindus comprised 54% of the group, followed by Christians (20%), Muslims (10%), and those identifying as non-religious (16%).According to the PGSI scores, which rate gambling severity in husbands, more than half (58%) were scored in the severe range, 40% in the moderate range, and only 2% in the mild range. When we looked at the mental health status of the spouses, we found that many were struggling. The Kessler Distress Scale revealed that 60% were experiencing severe distress, 24% moderate distress, 12% mild distress, and only 4% fell into the well range. In terms of coping styles, most participants (54%) used problem-focused coping, followed by emotion-focused coping (34%), and a smaller group (12%) used avoidance coping. The PWI–A Well-Being Scores revealed that only 4% of participants felt well, 40% were in a "compromise" range, and the majority (56%) felt "challenged" in their overall well-being. [**Table 1**]

The chi-square analyses revealed significant links between psychological distress, coping styles, gambling severity, and overall well-being.

First, a chi-square test examined the association between Kessler Distress levels in the wives and the severity of gambling (PGSI) in their husbands. The results were highly significant ($\chi^2 = 50.31$, df = 6, $p < 0.001$). Higher levels of psychological distress were clearly associated with more severe gambling behaviour. As distress increased, the proportion of participants in the moderate and severe gambling categories rose sharply. Secondly, an examination of coping styles across Kessler Distress categories also revealed a significant association ($\chi^2 = 16.93$, df = 4, $p < 0.05$). At the well range of distress, participants exclusively used avoidance coping. At mild distress levels, avoidance and emotion-focused coping dominated. Meanwhile, for moderate and severe distress, emotion-focused coping became increasingly common, suggesting a shift towards less active coping as distress grew. Finally, an association was tested between coping styles and well-being status (PWI-A), which also showed a statistically significant relationship ($\chi^2 = 13.55$, df = 4, $p < 0.05$). In other words, well-being status was not independent of coping style, highlighting that how a person copes with stress has a direct link to their overall psychological well-being. [**Table 2**]

Table 1: Socio-demographic data and scores of study variables of the subjects.

S. No	Study variable	Numbers (%)
1	Age	
	18-34 (Young adulthood)	52(52)
	35-54 (Middle adulthood)	48(48)
2	Education	
	No Formal education	24(24)
	High school education	20(20)
	Graduation and above	56(56)
3	Type of family	
	Nuclear	64(64)
	Joint	36(36)
4	Profession	
	Home makers	40(40)
	Working women	60(60)
5	Religiosity	
	Hindu	54(54)
	Christians	20(20)
	Muslims	10(10)
	Non-religious	16(16)
6	PGSI score	
	1-4 (Mild)	02(02)
	5-7 (Moderate)	40(40)
	8 and above(Severe)	58(58)
7	Kessler distress	
	10-19(well)	04(04)
	20-24(Mild)	12(12)
	25-29(Moderate)	24(24)
	30 and above(Severe)	60(60)
8	Brief-COPE styles	
	PFC	54(54)
	EFC	34(34)
	AC	12(12)
9	PWI-A well-being scores	
	70 and above (Normal)	04(04)
	50-69 (Compromised)	40(40)
	49 and below(Challenged)	56(56)

PFC: problem focused coping; EFC: emotion focused coping; AC: avoidant coping.

Table 2: Chi-Square Test of Association between key psychological variables.

S. No	Variable compared	Chi-Square	*p*-value
1	PGSI Score & K10	50.31	<0.001*
2	K10 & Brief-COPE	16.93	<0.05*
3	Brief-COPE & PWI-A	13.55	<0.05*

*$p < 0.05$ statistically significant.

PGSI: The Problem Gambling Severity Index; K10: Kessler's psychological distress scale; Brief-COPE: Coping Orientation to Problems Experienced Inventory; PWI-A: Personal Wellbeing Index-Adult.

DISCUSSION

These findings underscore the complex interplay between psychological distress, coping strategies, gambling behaviour, and overall well-being.

In our study, psychological distress in spouses increased with the increased severity of gambling disorder in the husbands. Holdsworth et al. (2013) in their study on impacts of gambling problems on partners found that it can cause significant emotional distress, frustration and fear. Gambling disorder creates undue financial stresses and strains that impacts partners' financial security and quality of their lives, physical health issues, relationship conflicts and in some cases even divorce. [17] Thus a husband's gambling behaviour can affect the well-being and quality of life of his spouse.

Our study found that people change how they cope with stress as their distress levels go up or down. When stress is low, people often use avoidant-coping and which helps as an early defence mechanism. But as stress gets worse, emotion-focused coping becomes more prevalent, especially in those with moderate and severe levels of psychological strain. This shift could reflect a growing difficulty in employing more active or problem-focused coping strategies as distress intensifies.

While our study confirmed a statistically significant association between psychological distress and coping styles, the observed patterns diverged from conventional expectations regarding adaptive coping. Traditionally, PFC had been associated with better psychological outcomes in stressful contexts. [7 ,8,18] However, in the context of uncontrollable, chronic stressors like spousal gambling, PFC may have limited impact on subjective well-being. Similar findings were reported by Hodgins et al. (2007), who found that spouses of individuals with gambling disorders often experienced significant emotional burnout and role strain, despite attempts to manage the situation constructively. [19]

Furthermore, studies by Orford et al. (2005) and Patford (2009) on the impact of addiction on family members highlight that coping style alone does not fully mediate distress or well-being. Emotional well-being was more strongly associated with social support, partner's recovery efforts, and the degree of perceived control in the relationship. [20,21] Our study supports these conclusions, suggesting that spouses may continue to struggle even when employing adaptive coping, due to external and relational factors beyond their influence.

Additionally, Gupta & Derevensky (2001) noted that spouses of gamblers often internalize guilt, shame, and social stigma, which may reduce the effectiveness of even proactive coping strategies. These emotional overlays unaddressed in purely skill-based coping models could explain why even "healthy" copers in our study remained psychologically vulnerable. [22]

Thus, our findings build on the existing literature by emphasizing that while coping style is important, its effectiveness is context-dependent, and must be considered alongside emotional, social, and relational dynamics — especially in situations involving repeated trauma or unresolved dependency, as is often the case with gambling disorders.

Strengths, Limitations, and Recommendations

This study offers important insights into the psychological impact of gambling disorder on spouses, particularly within the Indian context. Several strengths and limitations must be acknowledged to contextualize the findings and guide future research.

Strengths

One of the key strengths of this study is its novel focus on the spouses of individuals with gambling disorder in India—a population that remains significantly understudied and the use of multiple validated instruments, including the PGSI, K10, Brief COPE Inventory, and PWI–A, that allowed for a comprehensive examination of gambling severity, psychological distress, coping strategies, and well-being. The statistical analysis, particularly the use of chi-square tests, provided robust evidence for the associations among these variables. Overall, the study contributes valuable data to the limited body of literature addressing the ripple effects of gambling behaviour on family members.

Limitations

Despite its contributions, the study has several limitations. The cross-sectional design restricts the ability to draw causal inferences between variables. The sample size was not statistically calculated; instead, a fixed number of 100 participants were included based on feasibility. All data were collected through self-report measures, which may be subject to biases such as underreporting or over reporting due to social desirability. Furthermore, the sample was limited to female spouses of male gamblers, which reduces the generalizability of the findings to other affected family members, such as male spouses or same-sex partners. The absence of qualitative data also limited the opportunity to gain deeper insights into the subjective experiences of distress and coping in this group. Finally, more rigorous statistical analyses, such as regression analysis, could have provided a better understanding of the relationships among the study variables.

CONCLUSION

This study reveals a significant and multifaceted relationship between psychological distress, coping strategies, gambling severity in spouses, and subjective well-being among affected women. The findings demonstrate that higher levels of psychological distress are strongly linked to more severe gambling behaviour in husbands and to the use of less adaptive coping strategies, such as emotion-focused and avoidance coping. These maladaptive coping styles, in turn, are closely associated with poorer well-being outcomes.

Collectively, the data emphasize the need for comprehensive psychosocial assessments and targeted interventions for spouses of individuals with gambling problems. Promoting problem-focused coping strategies may serve as a protective factor, enhancing resilience and improving mental health and well-being. Early identification and intervention programs, especially those integrating mental health support and coping skills training, are crucial for breaking the cycle of distress and dysfunction in such families. This study underscores the urgent need for systemic mental health policies and family-centred care models to address the broader psychosocial impact of gambling disorders.

Recommendations for Future Research

Building upon the limitations of the present study, future research should adopt longitudinal designs to overcome the constraints of a cross-sectional approach and to better understand causal relationships between distress, coping styles, and well-being among affected spouses. Statistically calculated and adequately powered sample sizes are recommended to improve the robustness and reliability of findings. Including a wider range of participants, such as male spouses, same-sex partners, and other family members, will enhance the generalizability of results. To address the limitations of self-report measures, future studies could incorporate multiple methods of data collection, including clinician-rated assessments or collateral reports. Mixed-method designs, combining quantitative measures with qualitative interviews, are strongly encouraged to capture the depth of subjective experiences and coping narratives. Furthermore, incorporating culturally sensitive frameworks that account for regional, social, and religious variations in coping and help-seeking behaviours will add contextual relevance. Finally, intervention-based research evaluating the effectiveness of structured psychological support programs may provide practical insights into strategies that can strengthen problem-focused coping and reduce distress in this vulnerable group.

AUTHORS' CONTRIBUTION

Each author has made a substantial contribution to the present work in one or more areas, including conception, study design, conduct, data collection, analysis, and interpretation. All authors have given final approval of the version to be published, agreed on the journal to which the article has been submitted, and agree to be accountable for all aspects of the work.

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CONFLICT OF INTEREST

None.

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