

**Disservice: A Narrative Review of Gambling Disorder Assessment and Treatment Gaps
Among US Military Veterans**

Dario Grant

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ADSC 501- Foundations in Addiction Science

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December 1, 2025

Abstract

Veterans exhibit higher rates of gambling disorder than the general population; however, assessments and treatment of the disorder are not uniformly applied across the Department of Defense and the Department of Veterans Affairs. This narrative review aims to identify the prevalence of GD, explore the age-related differences among clinical presentation, gambling modality, and impulsivity, suicidality/comorbidity, among service members and veterans, and the barriers to assessments, treatment, and continuity of care. A semi-structured narrative review was conducted using the University of Southern California's digital library, focusing on research from the DSM-5 era, in English, and peer-reviewed. The search identified 266 scholarly articles that underwent title and abstract screening; after applying inclusion and exclusion criteria, 18 were included in the final analysis. Veterans across studies showed a higher prevalence of gambling disorder and problem gambling than the general population, with younger and middle-aged veterans more likely to fall into at-risk or problem gambling categories and to present with greater symptom severity and psychiatric comorbidity. Younger adults in both general and veteran samples tended to exhibit more gambling-related harms, higher levels of depression and anxiety, and cognitive distortions that predicted persistence of disordered gambling, while inpatient VA cohorts were characterized by extreme gambling severity, high impulsivity, and heavy co-occurring PTSD, mood, and substance use disorders. We see that suicidality and suicide attempts were common among veterans receiving inpatient gambling treatment. Lower resilience associated with more frequent gambling and greater psychological distress in current and former service members was commonly observed. Across the Department of Defense and Department of Veterans Affairs, gambling disorder was rarely documented, screening was inconsistent, clinicians reported limited training and low use of validated tools, and yet both

patients and providers viewed mobile and digital interventions as acceptable ways to support assessment, engagement, and continuity of care. Overall, these findings indicate that gambling disorder in veterans is under-detected, highly comorbid, and concentrated among younger adults, underscoring the need for earlier and more consistent screening, improved clinician training, and age-tailored interventions that incorporate digital tools and address fears about career consequences of seeking help.

Keywords: Veterans, Problem Gambling, Gambling Disorder, Suicidality, Screening

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Gambling Disorder (GD) is the only Non-Substance-Related disorder in the Substance-Related and Addictive Disorders in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Text Revision (DSM-5TR). The DSM-5TR lists its diagnostic features as “risking something of value in the hopes of obtaining something of greater value”, often leading affected individuals to chase losses by placing larger, more frequent bets. For a clinical diagnosis of GD, four or more of the nine markers must be present over a 12-month period. With a national prevalence rate of 0.4% - 1.0% for lifetime rates of GD (American Psychiatric Association et al., 2013; Stefanovics et al., 2017), veterans are more susceptible to lifetime rates of GD, with a 2.0% lifetime pathological gambling rate in a clinical sample of VA patients. As high as 9.0% for at-risk problem gambling (Etuk et al., 2020). Active-duty service members, reservists, and National Guard members who have served in any of these components and have been discharged or released from service, regardless of discharge status, will be considered veterans for this review. As a special note, we are not concerned with their discharge status, despite that being a condition of accessing the VA health care system upon completion of their service obligation. Veterans affected by GD experience increased rates of depression, anxiety, Substance Use Disorders (SUDs), co-occurring psychiatric disorders, and even increased rates of suicidality. Despite recent legislation, Section 733 of Public Law 115-232, H.R. 5515, the John S. McCain National Defense Authorization Act for Fiscal Year 2019, mandates screening for GD in annual military fitness exams within the Department of Defense (DOD). Screening remains fragmented and is not standardized across the DOD and VA, and clinical social workers lack knowledge and rarely use existing screening tools (Etuk et al., 2020; Nower et al., 2023). When looking at the

risk factors that affect people affected by GD, they include age, gender, trauma exposure, homelessness, psychiatric comorbidity, depression, anxiety, and increased rates of suicidality. The research shows this playing out in both veteran and general populations. For the purpose of this review, we examine age-related differences in clinical presentation among veterans (Stefanovics & Potenza, 2022; Stefanovics, Potenza, Tsai, & Pietrzak, 2023).

Method

A narrative review combined with a structured database search, giving attention to veteran populations with gambling disorders, age-related differences in clinical presentation, and psychiatric comorbidity. Attention paid to gambling modalities, strategic vs. non-strategic, and emerging modalities and treatment, help-seeking, program design, and continuity of care. A limited number of non-veteran age-comparison studies have been included to provide context for PG.

Search Strategy

Using the USC Library digital catalog's search anything interface, which unites the major databases (e.g., PubMed, PsycINFO, etc.), limiting results to January 1, 2015, through current, with the intent of focusing on DSM-5 era work, in English and peer-reviewed journal articles. Six conceptual buckets were used with each of the terms joined by OR and the buckets joined by AND: Population: "veteran", "military", "service member", "armed forces", "VA Patient", "veterans affairs" Gambling: "gambling disorder", "problem gambling", "pathological gambling", "compulsive disorder", "gambling addiction", "gambling related harm" Age: "55 plus", "18 to 44", "age cohort", "age differences", "older adult", "older veteran", "aging veteran", "elderly veteran", "senior veteran", "younger veteran", "young adult veteran" Modality: "lottery", "scratch off", "scratchers", "table game", "casino gambling", "horse racing",

“dog racing”, “online gambling”, “internet gambling”, “mobile gambling”, “sports betting”, “online casino”, “digital gambling”, “fantasy sports”, “app based gambling”

Clinical/comorbidity: “clinical presentation”, “symptom severity”, “comorbidity”, “psychiatric comorbidity”, “PTSD”, “TBI”, “post traumatic stress”, “depression”, “anxiety”, “substance use disorder”, “cannabis use disorder”, “alcohol use disorder”, “suicidal ideation”, “suicidality”, “suicide risk”, “self harm”, “mental health correlates”, “behavioral health” Service: “treatment uptake”, “help seeking”, “service utilization”, “program design”, “outreach”, “intervention planning”, “behavioral health services”, “addiction treatment”

Additional Targeted Author Search

In addition to the broad search outlined above, a search for peer-reviewed articles, regardless of the year published, in which either Dr. Heather Chapman of the VA Northeast Ohio Healthcare system or Dr. Richard Rosenthal of the UCLA Gambling Studies program was involved. Both have published extensively on the subject of problem gambling generally and within the veteran population.

Inclusion and Exclusion

The result yielded 266 results, all of which were scanned for appropriateness based on veteran populations, gambling disorders, age, clinical presentation, comorbidity, or treatment themes. If the title appeared to align with the scope, the abstract was reviewed using the same criteria. Articles were determined to be excluded if they focused primarily on international populations with no direct link or reference to American veterans, treatment, or any logical connection or comparison to be made against American veterans or treatment. A limited number of non-veteran pathological gambling studies were retained if they explicitly examined age-

related differences in clinical course to provide a comparative context. Additionally, articles related to internet gaming and internet addiction, but not gambling, editorials, opinion pieces, and single case reports were also excluded. The process eliminated 166 results, retaining 100 as eligible and selecting 18 for detailed synthesis.

Data inclusion and exclusion

In reviewing the remaining articles, 18 provided sufficient information to code and build an evidence matrix from which the study design and population, age-relevant findings, gambling modality, clinical presentation, psychiatric and medical comorbidities, suicidality/mortality, barriers, help seeking and treatment, implications for age-tailored program design, and continuity of care. Original PDFs were annotated. No quantitative meta-analysis was attempted due to the heterogeneity in populations, measures, and outcomes; the aim was to conduct a conceptual and clinical synthesis, not pooled effect estimation. The data were then synthesized narratively by theme.

Results

Prevalence and clinical presentation among veterans

In a national representative sample of US Veterans ($n = 3,157$), 35.1% identified as recreational gamblers, while 2.2% represented as at-risk/problem gamblers (ARPG). Factoring for age in a multivariate analysis, non-gambling vs. recreational gambling and non-gambling vs. ARPG gamblers, each year of age skewed more towards recreational gambling with the expected odds ratio of 1.011 per year, whereas ARPG had the inverse effect, skewing to younger veterans with an expected odds ratio of 0.966. ARPG does not meet full DSM criteria for GD; however, gambling-related harm and impairments are common, making it clinically relevant. Both

recreational gamblers and ARPG in this study have higher odds of SUDs, anxiety, depression, trauma history, and PTSD than the nongambler group (Stefanovics et al., 2017).

Using data extracted from the Global Health & Wellbeing Survey which is an online self-report survey, (n = 10,765 eligible respondents) a total of 394 veterans, and 337 active duty (731 combined military) supports what veterans generally being at higher prevalence and frequency of gambling in the last 12 months as compared to the general population (Milton et al., 2020).

In a large-scale Vietnam Era Twin Registry (n = 8169), consisting of all males, with a mean age of 42 years old, reported a history of at least one psychiatric disorder in 61.1% of the respondents. Furthermore, 23.4% met criteria for one disorder in the previous 12 months. The sample also had a lifetime GD rate of 2.3%. (Eisen et al., 2004)

In a sample of veterans receiving treatment for GD in an inpatient VA program (n = 603), 44.27% reported a history of suicide attempts. Additionally, 53.7% presented with a current mood disorder, 47.1% presented with PTSD, 36% reported a SUD (Valle Frias et al., 2025).

Age-related differences in presentation

According to the DSM-5TR (2013), GD is more prevalent among younger and middle-aged men. GD is more common in men than in women. A study examines gambling severity, gambling-related harms, and depression and anxiety in an online representative sample of Israelis (n = 3,244). The sample consists of emerging adults ages 18-29 (n = 740) and adults ages 30+ (n = 2,504). An ANOVA shows the emerging adult cohort's problem gambling severity was 0.47 vs 0.37 for older adults. The emerging adult cohort also demonstrated higher levels of gambling-related harms 0.81 vs 0.63) and depression and anxiety at higher levels 3.84 vs 3.20. Depression and anxiety fully mediated the association between age group and both

gambling-related harms and problem gambling severity (Gavriel-Fried et al., 2024). The Gavriel-Fried study demonstrates that younger adults in the general population experience more severe gambling problems, generally explained by depression and anxiety.

According to a sample of non-veteran, non-treatment-seeking PG (n = 105), two groups were studied: a younger adult group (ages 18-40; n = 57) and an older adult group (ages 60+; n = 48). According to Black and Allen (2021), the following are broad constructs that are independent predictors of remaining in the disordered gambling group: BDI total (depression severity), PG-YBOCS (baseline PG severity), MOS Physical role (lower physical role functioning = more risk), DBC Total and DBC superstition (cognitive distortions related to games of chance), and Childhood neglect. For each unit of increase in PG severity, expect to see a 2.58-fold increase in the odds of remaining in the disordered gambling group. Some predictors showed significant interactions with age group, meaning their association with persistent disordered gambling was different in older vs. younger adults, whereas others were associated with risk across both groups.

In a national representative sample of US Veterans (n = 3,157), factoring for age in a multivariate analysis, non-gambler vs. recreational gambling and non-gambler vs. ARPG gamblers, each year of age skewed more towards recreational gambling with the expected odds ratio of 1.011 per year, whereas ARPG had the inverse effect, skewing to younger veterans with an expected odds ratio of 0.966. Both recreational gamblers and ARPG in this study have higher odds of SUDs, anxiety, depression, trauma history, and PTSD than the nongambler group (Stefanovics et al., 2017).

Gambling modality, impulsivity, and age in veteran inpatient samples

Strategic gambling leverages skill and decision-making and can include activities such as card games and sports betting, whereas non-strategic gambling is entirely based on chance and includes electronic gaming machines, lotteries, roulette, and similar games. Using nonstrategic gambling as the baseline, in a sample of US Veterans receiving inpatient treatment for GD in a VA program ($n = 401$), those who preferred strategic gambling tended to be younger, with an odds ratio (OR) of 0.968. Veterans with nicotine use disorder or PTSD have lower odds of being in the strategic gambling group, with ORs of 0.47 and 0.539, respectively (Grubbs et al., 2023).

In a separate study using the same VA inpatient population for GD treatment, gambling cognitions and impulsivity were explored using the UPPS and gambling expectancy measures, J. Connolly et al. (2025) introduces a mixed preference group (both strategic and non-strategic $n = 164$), which scored 4.16 highest of the three groups with non-strategic gambling scoring 3.93 followed by strategic at 3.66 for gambling expectancies. Male veterans in this inpatient sample show higher sensation seeking (Cohen's d about .714), positive urgency (Cohen's d about 0.345), and interpretive bias (Cohen's d about 0.224) than did female veterans. Cognitive distortions (e.g., gambling expectancies and interpretive bias), along with positive urgency and sensation seeking, are positively associated with greater gambling severity.

Another study of non-veteran, treatment-seeking problem gamblers in Florida and California compared adults with ADHD ($n = 39$) and those without ADHD ($n = 87$). Reid et al. (2020) find the onset of gambling problems was earlier in the ADHD group 5% reported onset before age 18, and 54% between ages 18 and 30, compared with 0% and 30% respectively in the non ADHD group. The ADHD group also showed greater overall gambling severity, larger gambling-related debts, higher rates of bankruptcy, and more domestic violence related to gambling. These findings imply that when a high impulsivity neurodevelopmental condition,

such as ADHD, is present, gambling problems start earlier and follow a more harmful course. Given that veterans in inpatient VA GD programs also show marked impulsivity and distorted gambling cognitions, it is plausible that similar financial and interpersonal harms are present in veteran GD populations even though ADHD specific comparisons have not been tested directly.

Suicidality, mortality, and severe outcomes

In a longitudinal registry study of individuals with GD ($n = 2,099$) in Sweden, Karlsson and Hakansson (2018) observed elevated levels of mortality resulting from suicide. During the mean surveillance period of 4.7 years, a total of 67 people died, with suicide being the number one cause of death 31% in this subset of the sample. The leading comorbidities with this population were 41% presenting with SUDs, 51% depression, and 60% with anxiety disorders. (Karlsson & Hakansson, 2018). The study reflects similar findings in veterans seeking inpatient GD treatment, where Valle Frias et al. (2025) report greater than 40% attempted suicide and have similar comorbidities.

Every day, an average of 17 veterans die by suicide, making it the 13th leading cause of death for veterans. In a sample of veterans seeking inpatient GD treatment in a VA program ($n = 603$), 44.27% reported a history of suicide attempts. The leading comorbidities reported were SUDs at 36% of the sample, 47.1% presented with PTSD, and 53.7% presented with a mood disorder. Additionally, the South Oaks Gambling Scale (SOGS) was used to measure gambling severity and risk level, with scores ranging from 0 to 20. A score of five or more suggests probable GD. The increase in score is associated with increased severity of GD; the sample population had a mean score of 16.2 ($SD=2.96$). Higher severity of GD is associated with a history of suicide attempts (Valle Frias et al., 2025). Milton et al. (2020) use The Global Health & Wellbeing Survey which is an online self-report survey, ($n = 10,765$ eligible respondents) a

total of 394 veterans, and 337 active duty (731 combined military) to demonstrate the negative correlation between lower resilience and higher gambling frequency, simply stated resilience which is higher with in the combined military partly explains the link between gambling frequency and psychological distress specifically and suicidality.

Help seeking, treatment, and continuity of care

Why veterans (to include active duty service members) do or do not access GD treatment can be partially explained by the barriers that make accessing treatment more difficult. These barriers can be placed in two categories: internal and external. Internal barriers involve ambivalence or low motivation to treatment, thinking that if they increase their gambling and have a big win, it can solve their past gambling problem, also known as denial, and fear of what asking for help could mean to their careers. External barriers include limited access to trained professionals, a lack of GD treatment in the areas where they are stationed or currently living, and financial constraints, including inadequate insurance coverage. These are just a few of the internal and external barriers veterans face. In a purposeful sample ($n = 28$) of active-duty service members and veterans, a qualitative descriptive survey explored two themes: emotional suppression in military culture and structural ignorance of gambling problems (Vana et al., 2025).

Military culture, starting in basic (aka boot camp for enlisted and OCS for officers), instills a belief that in all situations, one must maintain one's military bearing. (Vana et al., 2025) describe this concept as the necessity to “restrain vulnerabilities, and maintain discipline in the context of high-stress environments.” In their interviews with the respondents, we see there is a fear of getting help because “[you] are expected to carry your shit,” and the associated fear of punishment should you seek help. Punishment could range from losing a security clearance to

being placed on a “Do Not Arm” list, which makes many military occupations, especially law enforcement roles, impossible to perform. Possibly the biggest challenge for the respondents was how normalized gambling activities were, from playing poker and shooting dice all night into the morning in the barracks after a day in the field, to the prevalence of EGMs on base and the close proximity of casinos to many installations. The normalization of a gambling culture in the military gave a false sense that the activities they were engaging in were not harmful to them.

Respondents discuss receiving endless briefings on topics such as sexual assault, off-limit areas while on liberty, to other routine military issues, but nothing on the harms of GD. The precursor to Public Law 115-232, H.R. 5515, the John S. McCain National Defense Authorization Act, was the Gambling Addiction Prevention Act, which ordered the DOD to develop and implement programs to assess the severity of the problem and limit the negative consequences of GD across the ranks. Prior to the act, the Government Accountability Office (GAO) reported that only .03% of DOD and Coast Guard members’ medical records have a diagnosis of GD, and a large sample of over a million veterans using VA mental health services .2% had a GD diagnosis (Etuk et al., 2020). In settings where veterans are actively seeking treatment for a substance or behavioral addiction, screening shows that the prevalence rates are much higher, suggesting there is a lack of screening in settings where veterans are accessing primary health and mental health care. Vana et al. (2025) found that when the screening is done, it is not taken seriously and described it as being asked if you have a gambling problem the same way you would ask if someone normally wears their seatbelt when driving. The level of care during screening is partially explained by the shortage of competent mental health providers. As of Nower et al. (2023), only one school of social work in the United States offered GD training. Clinicians outside of addiction treatment settings often feel unprepared to use the spiderweb

screening tools and effective treatment modalities based on the sociodemographic traits of the person presenting with potential GD/PG symptoms, partially explaining the underreporting of the prevalence of GD.

Despite the lack of screening, both people with GD and providers are open to using technology such as SMS-based communication and mobile phone apps. In a study examining mHealth or digital interventions. Based on ecological momentary assessments and interventions (EMIs/EMAs), providers and patients can address issues and concerns in near real time within the patient's natural environment. The approach has been tried in a cohort of tobacco smokers. In the sample of 1,705, 30% quit smoking, compared with 13% in the control group (Rahman et al., 2020). Additionally, 98% of individuals enrolled in an outpatient substance abuse treatment program expressed interest in receiving support through their mobile phone. In a sample of 20 patients seeking treatment for GD and 20 providers providing the treatment 80% of the patients (n = 16) report they would use the app daily as part of their course of treatment and 70% of the providers (n = 14) would check in on their clients multiple times per week, and the remaining 30% of the providers (n = 6) would use it daily suggesting there is high acceptability of such assessments and interventions. mHealth as is the case with most health care there needs to be a level of attunement between the provider and the patient, to truly be effective.

The Frost et al. (2025) study shows that patients are generally fine with their health care providers (doctors or allied professionals) asking about their alcohol and substance use in a primary care setting. In the study, when asked if participants would be annoyed if their provider asked about their alcohol and drug use, 85.1% disagreed (n = 955), and likewise, over half (52.2%, n = 955) would be comfortable being asked face to face about their alcohol and drug use. An overwhelming majority would not be embarrassed (an element tied to shame and

stigma). With regards to the embarrassment, blacks agreed they would be embarrassed at 20.1% (n = 98) compared to the total sample at 10.4% (n = 959), and they would also be annoyed at higher rates than other races at 16.3% (n = 98) compared to 8.1% for the total sample (n = 959).

Discussion

At this point, it has become painfully clear that veterans suffer from GD at higher rates than the general population and experience comorbidities, whether physical, psychiatric, or otherwise, at higher rates as well (Eisen et al., 2004; Etuk et al., 2020; Stefanovics & Potenza, 2022; Stefanovics et al., 2017; Stefanovics, Potenza, Tsai, Nichter, et al., 2023; Stefanovics, Potenza, Tsai, & Pietrzak, 2023). In a country with an all-volunteer military, we rely on younger adults to fill the ranks that keep us safe. Current practices fall short of ensuring those selfless individuals are fully aware of the less obvious risks associated with service, specifically as they relate to GD. It is through this lens that, if we look at our general population, we should always be mindful that the men and women who keep us free and safe are disproportionately affected by these risks.

According to the DSM, GD is more prevalent among adolescents and young adults; it is more common in men than women. Younger adults also join the military at higher rates than older adults, making this a great concern in light of the emerging gambling modalities targeted at this segment of the population. In the (Gavriel-Fried et al., 2024) study, we see how emerging adults (18-29) had higher gambling severity, more gambling-related harms, and higher depression and anxiety scores than did older adults. Black and Allen (2021) found that, in a non-veteran sample, higher baseline PG severity, greater depressive symptoms, childhood neglect, and cognitive distortions related to PG predicted one's odds of remaining in the PG group. These general population findings suggest that younger veterans are also likely to present with

more severe, comorbid, and cognitively distorted gambling problems, which is consistent with the patterns seen in veteran samples.

Modality and personality factors further shape how gambling problems present in veteran samples. In an inpatient VA gambling treatment program, veterans who preferred strategic forms of gambling, such as cards and sports betting, tended to be younger than those who preferred nonstrategic games, while nonstrategic gambling was more common among veterans with nicotine use disorder and PTSD (Grubbs et al., 2023). Using the same inpatient cohort, (J. Connolly et al.) reported that a mixed preference group who engaged in both strategic and nonstrategic gambling showed the highest gambling expectancies, and that male veterans had higher positive urgency and sensation seeking than female veterans. Across this sample, greater urgency, sensation seeking, and stronger gambling cognitions were positively associated with higher gambling severity (J. Connolly et al., 2025). Non-veteran data from treatment-seeking gamblers with ADHD highlight the potential consequences of this profile, as high-impulsivity gamblers showed earlier onset of gambling problems, greater overall severity, higher gambling-related debts and bankruptcy, and more domestic violence than gamblers without ADHD (Reid et al., 2020). Although ADHD has not been systematically examined in veteran GD cohorts, the combination of extreme severity, impulsivity, and distorted cognitions observed in VA inpatient programs suggests a high risk of similar financial and interpersonal harms in younger veterans with GD.

The severity of gambling problems in these veteran samples is underscored by their association with suicidality and premature mortality. In a longitudinal registry study of individuals with diagnosed GD, all-cause mortality was elevated, and among those who died during follow-up, suicide was the most common cause of death, occurring in roughly one-third

of cases, in the context of high rates of co-occurring substance use, depression, and anxiety disorders (Karlsson & Hakansson, 2018). This pattern aligns with broader data showing that approximately seventeen US veterans die by suicide each day, making suicide a major cause of death in this population. Within an inpatient VA gambling treatment program, more than forty percent of veterans reported a history of suicide attempts, and over half met criteria for a current mood disorder, nearly half for PTSD, and more than one third for a substance use disorder, with higher gambling severity among those whose suicide attempts were directly related to gambling (Valle Frias et al., 2025). In a broader current and formerly serving military cohort, lower resilience has been linked to higher gambling frequency, while suicidal ideation and psychological distress are associated with lower resilience, suggesting that resilience may be an important pathway connecting mental health burden and harmful gambling behavior in this group (Milton et al., 2020). These findings together indicate that suicidality and severe psychiatric comorbidity are not peripheral complications, but central features of gambling disorder in veteran and military populations.

Despite the clear burden of GD among veterans, documented diagnosis and treatment remain rare in the systems that serve them. Analyses of DoD and VA health records have identified GD diagnoses in only a tiny fraction of active-duty personnel and VA mental health service users, far below the rates observed when veterans are systematically screened in research or clinical settings (Etuk et al., 2020). Qualitative work with service members and veterans suggests that this gap reflects both structural and cultural barriers: participants describe minimizing or denying gambling problems, fearing that disclosure will jeopardize their careers or security clearances, and operating in environments where gambling is normalized and emotional vulnerability is discouraged, while screening questions about gambling, when they are

asked at all, are often experienced as perfunctory (Vana et al., 2025). On the clinician side, most social workers and many other mental health providers report little or no formal training in problem gambling, infrequent use of standardized screening tools, and low confidence in their ability to assess and treat GD outside of specialized addiction programs (Nower et al., 2023). In contrast, survey data from primary care patients indicate that the large majority do not feel annoyed or embarrassed when asked routine questions about alcohol or drug use, although there are important racial differences in comfort levels, suggesting that well-designed behavioral health screening can be broadly acceptable if implemented thoughtfully (Frost et al., 2025). Emerging mobile health studies further show that both patients with gambling problems and their providers view smartphone and text-based support as acceptable and feasible, and that veterans with PTSD and harmful gambling can be recruited and engaged through social media and app-based platforms. These converging findings point to a structural problem of under-detection and limited provider preparedness, rather than simple reluctance among veterans to discuss addictive behaviors, and they highlight the potential role of technology in improving outreach and continuity of care.

The literature reviewed here has several important limitations that constrain the conclusions that can be drawn. Most studies of gambling disorder in veterans are cross-sectional, rely on treatment-seeking and predominantly male samples, and rarely provide detailed age-stratified analyses, which limits understanding of how the course and clinical presentation of GD differ across age cohorts. Very few studies have evaluated treatments specifically tailored to veterans with GD and comorbid PTSD, mood disorders, or substance use disorders, and data on the impact of emerging online and app-based gambling modalities in veteran populations are sparse. The present review is narrative rather than fully systematic, restricted to English-

language articles primarily from the DSM-5 era, and relies largely on self-report instruments and diagnostic codes reported in the original studies. Future research should therefore include age stratified longitudinal studies of veterans to clarify trajectories of onset, persistence, and remission; controlled trials of integrated interventions that explicitly address the complex comorbidity profiles observed in inpatient GD programs; and implementation studies that test routine GD screening and mobile health tools in VA and DoD clinical settings, with particular attention to younger veterans who are most exposed to digital gambling environments.

Conclusion

The available evidence indicates that gambling disorder in veterans is more prevalent than in the general population, is concentrated among younger and middle-aged adults, and is closely intertwined with PTSD, mood disorders, substance use disorders, and suicidality. Younger veterans in particular appear more likely to engage in strategic and mixed gambling, to exhibit higher impulsivity and distorted gambling cognitions, and to experience more severe and harmful courses of illness, yet GD remains markedly under-detected in DoD and VA systems. Addressing this burden will require earlier and more consistent screening, improved clinician training, and age-tailored interventions that account for military culture, comorbid psychiatric conditions, and the growing influence of online and app-based gambling, potentially leveraging mobile health technologies to improve outreach and continuity of care.

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