FACING ADDICTION WITH HOPE AND UNDERSTANDING

The Hidden Patients: Understanding the Psychological Burden and Coping Strategies of Families Affected by Gambling Disorder

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When we speak of addiction, we speak most often of the person in its grip — the one whose brain has been rewired by compulsion, whose choices have narrowed to a single devastating channel. But behind every person struggling with gambling disorder, there is almost always another person: a spouse lying awake at 2 a.m., a parent quietly covering another debt, a sibling making excuses to extended family, a child learning to read the household atmosphere before asking for anything at all. These people — the Affected Others, or AOs, as researchers have begun to call them — are the hidden patients of addiction. They absorb enormous psychological, social, and economic harm, and yet they have received a fraction of the clinical and research attention devoted to the person with the disorder itself.

A significant new study published in *Frontiers in Psychology* by Guillén-Guzmán and colleagues (2026) takes direct aim at this gap. Examining the sociodemographic and clinical characteristics of patients receiving treatment for gambling disorder and their Affected Others, the research compares how psychological burden and coping strategies differ according to family relationship type and gender, and explores what best predicts global psychological distress in AO populations. The findings are not merely statistical. They constitute a portrait of what it means to love someone whose life is being consumed by compulsive gambling — and they carry urgent implications for how families should be supported, not as secondary concerns, but as primary ones.

The Scope of a Hidden Harm

Gambling disorder is frequently misunderstood as a financial problem rather than a mental health condition. This mischaracterization carries real consequences. If the harm is framed as primarily economic, then the human and psychological toll on everyone in the immediate orbit of the gambler is rendered invisible. Guillén-Guzmán et al. push back against this invisibility directly, framing their study around a clear premise: gambling disorder "generates substantial psychological, social, and economic harm not only for affected individuals but also for the relatives who support them" (Guillén-Guzmán 2026). The word "support" is worth pausing on. These relatives are not passive bystanders. They are active, often exhausted, caregivers — managing finances, monitoring behavior, absorbing emotional volatility, and frequently carrying the dual weight of grief for what the relationship once was and fear for what it is becoming.

The research highlights that evidence regarding the psychological burden and coping strategies of AOs "remains limited" (Guillén-Guzmán 2026). This is a remarkable admission given how long gambling disorder has been recognized as a clinical entity. It speaks to a broader pattern in addiction science: families are asked to participate in treatment — to attend family therapy sessions, to attend support groups, to modify their own behavior — while receiving comparatively little study of what they are actually experiencing and what strategies are genuinely helping them cope.

Who Are the Affected Others?

One of the most valuable contributions of the Guillén-Guzmán study is its attention to how psychological burden and coping strategies differ based on *who* the Affected Other is in relation to the person with gambling disorder, and whether gender shapes these differences. This is not a trivial distinction. A spouse or intimate partner experiences gambling disorder in a fundamentally different register than a parent does. A parent may carry guilt — the particular anguish of wondering what they did or failed to do. A spouse may carry a complex mixture of love,

betrayal, and financial terror. A sibling may carry ambivalence about involvement at all. The study's effort to map these distinctions matters because it resists the temptation to treat "family" as a monolithic category.

Gender differences, too, are a crucial dimension. Research in broader addiction literature has consistently found that women in relationships with people who have substance or behavioral disorders tend to internalize stress, experiencing higher rates of anxiety and depression, while men may be more likely to externalize through disengagement or anger. By examining these gender-based differences specifically within gambling disorder AO populations, this study begins to build the granular picture that effective clinical support requires.

Coping Strategies: The Difference Between Surviving and Disintegrating

Perhaps the most clinically actionable dimension of this research is its analysis of the associations between coping strategies and psychological distress. Not all coping is equal. In fact, coping is one of the most consequential variables in whether an Affected Other maintains enough psychological stability to continue functioning — as an individual, as a parent, as a partner — and ultimately whether their presence in the life of the person with gambling disorder remains a resource rather than an additional source of conflict.

Coping strategies in this context can be broadly understood along a spectrum from tolerant or accommodating approaches (where the AO essentially adapts their life to manage the consequences of the gambling) to more engaged or assertive strategies (where the AO seeks to influence the situation more directly), to withdrawal strategies (where the AO creates emotional or physical distance). Each carries different psychological costs and benefits, and importantly, none of them are inherently right or wrong. They arise from a context — from the severity

of the gambling, from the history of the relationship, from the AO's own psychological resources, from the presence or absence of children, from financial dependency, from hope and from exhaustion.

The study's exploration of predictors of global psychological distress in AOs is particularly valuable because it moves the conversation from description to mechanism. Understanding *what* predicts distress — whether it is the severity of the gambling, the type of relationship, the coping strategy employed, or some interaction among these — gives clinicians something to work with. It suggests that interventions aimed at shifting coping strategies, rather than simply offering emotional validation, may have measurable impact on AO wellbeing.

The Moral Imperative of Attending to Families

There is a compelling ethical argument embedded in this research, one that aligns directly with the philosophy underlying FAHU's work. When families are left to cope in isolation — without evidence-based guidance about what helps, without acknowledgment that their own distress is real and clinically significant, without support that is specifically calibrated to their relationship type and their gender and their particular psychological profile — they are more likely to adopt coping strategies that are ultimately harmful: to themselves, and sometimes to the person with the disorder as well.

The instinct to shield, to cover, to protect the person with gambling disorder from consequences is profoundly human. It springs from love. But research increasingly suggests that accommodating behaviors, while emotionally understandable, can inadvertently sustain the conditions that allow a disorder to continue unchallenged. This is not a reason to blame families — quite the opposite. It is a reason to offer them much better, more tailored, more evidence-based support so that their love can be channeled into strategies that genuinely serve recovery rather than inadvertently impeding it.

This is precisely the insight that animates a hope-and-understanding framework. Judgment does not help families cope better. Shame does not produce healthier coping strategies. What works — what the Guillén-Guzmán research is beginning to map with greater precision — is understanding: of the disorder itself, of the family's specific relational dynamics, and of the coping strategies most likely to protect both the AO and create conditions more conducive to the person with gambling disorder actually seeking and sustaining treatment.

Toward a Family-Centered Model of Gambling Disorder Treatment

The implications of this research for clinical practice are significant. Treatment programs for gambling disorder have historically been organized around the individual patient. Family involvement, when it occurs, is typically framed as supportive to that individual's treatment rather than as a treatment need in its own right. The Guillén-Guzmán study implicitly challenges this model. If AOs are experiencing substantial psychological distress — if their coping strategies can be meaningfully characterized and studied as predictors of outcome — then they are not merely helpers in someone else's treatment. They are people in need of care themselves.

A family-centered model would involve several shifts. It would include systematic screening of AOs for psychological distress, not as an afterthought but as a standard component of gambling disorder treatment intake. It would involve evidence-based intervention for AOs that goes beyond attending a few family sessions, calibrated to their relationship type, gender, and psychological profile. And it would mean developing a body of research — of which the Guillén-Guzmán study is a welcome early contribution — that can guide these interventions with the same rigor we bring to individual treatment.

Conclusion: Naming the Hidden Patients

The family members of people with gambling disorder have been the hidden patients of addiction medicine for too long. Their suffering is real. Their coping strategies matter — not only for their own wellbeing, but for the recovery ecology of the person they love. Research like that of Guillén-Guzmán and colleagues (2026) begins to bring them into full clinical view, to ask the right questions, and to generate the kind of evidence that can translate into better, more compassionate, more effective support.

Facing addiction with hope and understanding means refusing to let anyone in that story be invisible. It means recognizing that the spouse, the parent, the sibling, the child sitting in the waiting room are not accessories to someone else's crisis. They are people whose pain deserves to be seen, whose coping strategies deserve to be understood, and whose wellbeing — alongside the wellbeing of the person they love — is a legitimate and urgent clinical priority. That is not sentimentality. It is science, and it is the only approach that does justice to the full human cost of this disorder.

Works Cited

Facing Addiction with Hope and Understanding — facingaddictionwithhope.com
Every source above is listed with a direct link to the original publication.