

Comments from the Trenches: Proposed Changes to the DSM-V Classification of Pathological Gambling

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Abstract The proposed DSM-V changes related to the pathological gambling diagnosis hold far-reaching implications, yet these modifications have been met with little public attention. This letter addresses the three changes proposed including the diagnosis' reclassification alongside other addictive behaviors, the lowering of the pathological gambling threshold to the endorsement of 4 symptoms, and the removal of the "illegal acts" criterion. Support for the initial change is well documented, but there is evidence to suggest that the latter two changes should be reconsidered.

Keywords Pathological gambling · Diagnostic changes · DSM-V

After reviewing the proposed changes to the "Disordered Gambling" DSM-V diagnosis (American Psychiatric Association 2010), our research group would like to convey several reactions. First, we are in agreement that the diagnosis should be grouped with other addictive behaviors in the Addiction and Related Disorders section (formerly, Substance and Related Disorders) versus other organizing schemes. Researchers have alleged that as pathological gambling has been classified as an Impulse Control Disorders disorder, it belongs on the obsessive-compulsive disorders spectrum (e.g., Decaria et al. 1998); and reason that act of gambling may be conceptualized as the compulsive behavior that follows obsessions about the next gambling opportunity. In their review however, Potenza et al. (2009) examined this argument and concluded that the current evidence does not support this claim.

Rather, pathological gambling has evolved from what was a consequence-based disorder in DSM-III (American Psychiatric Association 1980) to an addiction diagnosis, embodying dependence criteria as well as those unique to the behavior such as "chasing" or needing a bailout (American Psychiatric Association 1994). Research has documented that pathological gambling bears additional similarities to substance-based addictions in its

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clinical presentation, comorbidity with Axis I and II disorders, association with personality factors, neurotransmitter involvement, genetic transmission, and treatment options (Petry 2006; Potenza 2006). Further, this trend has not been realized for other impulse control disorders, suggesting that pathological gambling behavior is more like substance use than other disorders of impulse control; and it appears a logical step that pathological gambling be reclassified with other addictive behaviors. We believe this move will also bolster pathological gambling's conceptualization as an addiction to be viewed side by side with substance use disorders in the treatment setting. Researchers and clinicians have found utility in using addiction models to treat gambling problems (e.g., Petry 2005; Whelan et al. 2007) and appreciating the parallels between behavioral and chemical addictions should facilitate the identification of their differences. This in turn may provide more opportunities for the study of pathological gambling, which would contribute to its understanding, development, and treatment.

The second proposed change regarding the lower threshold for the pathological gambling diagnosis is an interesting one. Some researchers have supported the validity of the DSM-IV diagnosis (e.g., Beaudoin and Cox 1999). More recently others have found that a 4 symptom diagnostic cutoff rather than the current 5 symptom cut point better discriminates individuals who have the disorder, and its associated correlates and consequences, from those who do not (Stinchfield 2003).

This debate is related to the methods historically used to conceptualize pathological gambling. Unlike other addictive behaviors, the DSM-IV diagnosis did not feature the two-component abuse versus dependence model of pathology. The creation of a uniform pathological gambling category influenced mental health professionals to develop variations in gambling behavior severity. Abbot et al. (2004) list 14 terms used to describe problematic gambling ranging from "at-risk" to "compulsive" to "probable pathological gambling." Public health scientists have adapted a model of gambling and its associated harm occurring along a continuum, from no problems to severe problems (Korn and Shaffer 1999). Researchers and clinicians have also viewed the variability in gambling behavior as fitting into three tiers (e.g. NRC 1999; Shaffer et al. 1999). Despite the terminology one uses, it appears that the proposed reduction in the pathological gambling threshold would not address the need to sub-classify gamblers and do little to remedy the confusing nomenclature.

As such there seem to be unresolved questions when reconciling this change with other proposed DSM-V changes. For instance, since diagnoses in the Addiction and Related Disorders section will now feature a uniform "Substance Use Disorder" classification requiring the endorsement of two symptoms, with moderate and severe specifiers, why not apply these criteria to Disordered Gambling? Just as addiction researchers have found it practical and responsible to identify varying intensity of use, so too have those studying gambling felt it important to be able to recognize and track sub-clinical gamblers. The application of this threshold denotes that individuals scoring a 2 or above on the DSM-V would be classified as having Disordered Gambling, Moderate, and those endorsing 4 or more symptoms would meet criteria for Disordered Gambling, Severe. This classification scheme would incorporate research documenting a tiered or continuous view of gambling severity, maintain a 4-symptom association with pathological gambling, and add to the consistency of the Addiction and Related Disorders section.

In our community outpatient gambling treatment center, we have analyzed the DSM-IV symptom counts of our treatment-seeking gamblers. We found that our clinic gamblers ($N = 234$) report an average of 6.7 DSM-IV items ($SD = 1.9$) at intake. It is apparent that these gamblers occupy the pathological end of the continuum and they would be

appropriately diagnosed Disordered Gambling, Severe. As one moves 1–2 standard deviations below the mean, the symptom count approaches the recommended DSM-V criteria for all substance use disorders. This suggests that a cutoff of 2 should prove useful when grouping treatment-seeking gamblers with moderate to severe symptoms, as it would identify those traditionally viewed as “at-risk” or problem gamblers.

Furthermore, research examining the differences between lifetime and past-year prevalence rates would gain from these changes to the Disordered Gambling diagnosis. Gambling behavior has been documented to be a changing phenomenon (Slutske et al. 2003). Hodgins et al. (1999) found that 36–46% of lifetime pathological gamblers and 32–46% of lifetime problem gamblers did not retain their respective classification during the past year. As these transient gamblers had reduced their symptom counts, often without formalized treatment, they were considered “resolved.” In another study examining gamblers from two national population surveys, Slutske (2006) reported that 66% of 141 lifetime pathological gamblers no longer met past-year diagnostic criteria, but still endorsed 1 or more symptoms. Collectively, these data suggest that as gamblers have been documented to reduce symptoms over time, epidemiologists and clinicians would benefit from more fluid diagnostic criteria. Lifetime Disorder Gambling, Severe patients may present clinically as past-year Disordered Gambling, Moderate, a classification that appears more practical and informative than simply “recovered.” The use of these groupings with transitory gamblers is consistent with the latent continuum of addictive behaviors presupposed by those studying gambling (e.g., Korn and Shaffer 1999; Strong and Kahler 2007) as well as other addictions (Kahler and Strong 2006; Langenbucher et al. 2004).

The last proposed change is the removal of the “illegal acts” criterion (APA 2010). In reading the literature on the hierarchy of gambling symptoms and their differential prevalence, one may conclude that this symptom occurs so infrequently that its removal would not affect prevalence rates, considering individuals who endorse the symptom likely also endorse at least 5 “less severe” symptoms (Toce-Gerstein et al. 2003; Strong and Kahler 2007). However, the elimination of the symptom may be misguided for two reasons. The first is from our work of treating individuals who met criteria for pathological gambling. Our clinicians report frequently treating clients who have committed an illegal act related to their gambling. On intake, we ask clients whether they have committed several criminal behaviors such as shoplifting, theft, fraud, assault, and prostitution. Across our sample of over 250 individuals seeking treatment, these illegal acts were endorsed by 1–9% of our clients. The interesting aspect of this discussion was the realization that gambling problems typically predate these criminal acts. It appeared that once their gambling had begun to take an extreme financial and emotional toll, they became willing to break the law in order to relieve a desperate situation. Accordingly, research on the relationship between gambling problems and decision to commit a criminal act warrants further attention.

Our second reason for retaining this criterion relates to the samples used in these gambling prevalence studies. Participants in all of these samples were over the age of 18, and no data regarding adolescent symptom presentations were incorporated into this decision. National prevalence studies have consistently documented that adolescent problematic gambling rates are higher than those of adults (Moore and Ohtsuka 1999; Shaffer et al. 1999). Further, there is increasing evidence that gambling and criminal behavior co-occur in youth (Barnes et al. 2005; Vitaro et al. 2001). It is therefore important to understand to what extent adolescents commit illegal acts related to their gambling.

Watson et al. (2010) examined the gambling behavior of adolescents recruited at an urban community organization that provides job training for economically disadvantaged young people ($N = 159$). Briefly, ages ranged from 16 to 21 years ($M = 18.4$,

SD = 1.18), with 62.3% ($n = 99$) male and 90.6% ($n = 144$) African Americans. Based on self-reported data, approximately 79% of participants reported gambling at least once in their lifetime and 63% reported past year gambling. Of past year gamblers, 27% were identified as problem gamblers, a rate higher than typically found among adolescents. Gambling and crime were highly associated among this population. Of those who gambled and committed crimes in the past year, 43% reported engaging in some form of crime in order to gamble or pay off gambling debt (37% vandalism; 37% theft; 46% sold drugs; 57% physical violence; 77% delinquent acts). Within this cohort of adolescents who committed crimes for gambling purposes, rates of problem gambling (43%) were substantially higher than the total sample. These findings suggest that the illegal act symptom is useful in conceptualizing the gambling behavior of some adolescents, and that its removal may be premature.

Alternatively, some evidence suggests that illegal acts could be combined with the bailout criterion. As previously reported, our clinicians observed that gamblers committed crimes in order to relieve a desperate financial situation. This may be viewed as an illegal type of bailout. In a separate analysis, we correlated the DSM-IV symptoms of 269 treatment seeking gamblers with one another and found that the illegal acts and bailout criteria were significantly associated ($r = .27$, $P < .001$). Toce-Gerstein et al. (2003) also found that bailout had one of the highest association values with illegal acts ($\phi = .30$). Though preliminary, the illegal acts symptom could be considered for merging with the bailout criterion. It is evident however, that more data supports independently retaining the symptom for further study.

The pathological gambling diagnosis has evolved since its entry into the DSM and we are pleased to find that empiricism is guiding the proposed changes. We hope the dialogue among professionals researching and treating gambling problems can shed light on other aspects of these changes and further inform the decision making process.

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