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JOURNAL OF GAMBLING ISSUES

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Clinical corner

Welcome to the first case presentation in the **Clinical corner**. This new offering from the *Journal of Gambling Issues* focuses on difficult situations that clinicians face when dealing with individuals suffering from pathological gambling. Sample composite cases will be presented to illustrate important points in conceptualizing how concurrent mental health factors interplay with the symptoms of pathological gambling. In some cases, the focus will be on a clinical condition, such as attention deficit hyperactivity disorder, or a therapeutic approach, such as mindfulness therapy. We invite readers to e-mail the editor (Phil_Lange@camh.net) to suggest future topics or to submit a clinical case for publication. The case below can be used as a template for submissions. All cases and materials presented in this section are peer reviewed.

The case of the sleepless slot-machine supplicant: Bipolar disorder and pathological gambling

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Case presentation

Ms. S is a 44-year-old Caucasian woman, married for twelve years with no children. She finished high school and took a year of college courses. She is a homemaker, although she used to do clerical work until she married. She is supported by her husband's income. She has had no legal problems in her past. She currently owes $11,000 in gambling debts she has kept secret from her husband. Ms. S has been gambling on slot machines for the last five years, starting when a casino opened near her home. In the last two years, because Ms. S reported spending sprees, staying up all night, agitation, mood instability, and depression, her family doctor thought she might have bipolar disorder. She consulted with a psychiatrist who also

thought this was the case, and she was started on a variety of mood stabilizing, antipsychotic, and antidepressant medications. She quickly developed a variety of side effects from them and so she wanted to know if she really needed all these medications. The medications also did not seem to have any impact on her moods or gambling behaviours.

When asked to explain her symptoms in further detail, Ms. S described staying up for one to two days at a time without sleep when absorbed in gambling on slot machines. Her spending sprees were all in the pursuit of getting tokens to play the slots. She denied spending money on items such as fancy clothes, extravagant phone bills, or food. Her mood instability connected to all the stresses of financial debt, ongoing difficulties keeping the debt secret from her husband, and concerns about what she was doing with her life. Her moods were never so low that she ever felt the urge to self-harm (i.e., to cut herself, etc.) or to contemplate suicide. Her appetite has remained unchanged through the last few years.

Ms. S's early history includes a chaotic family upbringing. She had difficulty with relationships, often failing to develop close intimacy. She married her husband to get away from her family, but for her this relationship also seemed to lack intimacy. She felt cut off from the world and alone. She says she started gambling to "escape" and feel alive. She denied any problematic substance use history. Family history was negative for bipolar or other mental health or addiction issues.

Recent blood work done by her family doctor demonstrated normal blood and electrolyte indices. Her thyroid functions were also normal. A urine toxicology screen was negative for substances of abuse (e.g., amphetamines, cocaine, etc.).

- What aspects of this case make you concerned over the diagnosis of bipolar disorder?
- What additional information do you need to determine what the problem is?
- What further complications could arise if her diagnosis is inaccurate?

Bipolar disorders

Bipolar disorder (BP), previously known as manic-depressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. The prevalence rate is ~1.2%, e.g., three million adults in North America alone. The

condition usually develops in late adolescence or early adulthood, but there are variant forms that begin in early childhood or later in life (Hales, Yudofsky, & Talbott, 1999).

The symptoms are often not recognized ("just a wild guy/gal"), and people may suffer for years before the disorder is properly diagnosed and treated. They are often misdiagnosed as suffering from attention deficit hyperactivity disorder (ADHD), substance use disorders (SUD), and personality disorders (PD) such as borderline personality disorder (BPD) (Hirschfeld, 2001). In addition, conditions such as substance use, trauma (and resultant post-traumatic stress disorders (PTSD)), and mood disorders often coexist with people suffering from BP (Hales, Yudofsky, & Talbott, 1999).

Bipolar disorder is a chronic illness that must be carefully managed throughout a person's life. There is no single cause for the condition and scientists speculate that a genetic basis combines with multifactorial vulnerabilities for the condition to manifest. Brain imaging tests have shown slight abnormalities in only some people with the condition and this supports the contention that BP represents a heterogeneous group of conditions (Soares, Mann, 1997).

People with the condition may alternate between "manic episodes" (ME) and "major depressive episodes" (MDE). This is called "Bipolar I." Some people have only mild forms of mania—i.e., they manifest symptoms, but these are not severe enough to interfere with their functioning in life. Such manifestations are called "hypomanic episodes"; having them with alternating episodes of MDE is classified as "Bipolar II." Then there are people who manifest sub-clinical depressive episodes with hypomanic episodes, and this is called "cyclothymia." People who have at least four episodes (manic or depressive) in a year are classified as "rapid cycling." In fact, the normal course of the illness is that the frequency and intensity of episodes increase as time goes on. As this occurs, sometimes people can develop "mixed" episodes where they have symptoms of mania and depression simultaneously (e.g., they are both full of energy and suicidal) (American Psychiatric Association Diagnostic and Statistical Manual-IV-TR, 2000).

Some episodes are so intense that people can develop psychotic features (i.e., hallucinations and delusions) or even catatonic features (abnormal movement states) during the episode's course. Sometimes episodes can be triggered by the stress of childbirth and arise in the postpartum period as well (APA DSM-IV-TR, 2000).

The classic DSM-IV-TR symptoms and signs of a manic episode

are listed in Table 1 and of a major depressive episode in Table 2

Table 1
Manic episode DSM-IV-TR criteria

A) A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)
B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
    1) inflated self-esteem or grandiosity
    2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    3) more talkative than usual or pressure to keep talking
    4) flight of ideas or subjective experience that thoughts are racing
    5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
    6) increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation
    7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C) The symptoms do not meet criteria for a Mixed Episode
D) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features
E) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism)

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I disorder

Table 2
Major depressive episode DSM IV TR criteria

A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
4) insomnia or hypersomnia nearly every day
5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6) fatigue or loss of energy nearly every day
7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B) The symptoms do not meet criteria for a Mixed Episode

C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation,

psychotic symptoms, or psychomotor retardation

Table 3
Pathological gambling DSM IV TR criteria

A) Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
   1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
   2) needs to gamble with increasing amounts of money in order to achieve the desired excitement
   3) has repeated unsuccessful efforts to control, cut back, or stop gambling
   4) is restless or irritable when attempting to cut down or stop gambling
   5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
   6) after losing money gambling, often returns another day to get even ("chasing" one's losses)
   7) lies to family members, therapist, or others to conceal the extent of involvement with gambling
   8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
   9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
   10) relies on others to provide money to relieve a desperate financial situation caused by gambling

B) The gambling behavior is not better accounted for by a Manic Episode

"Mimicry" of bipolar disorder by pathological gambling

Interestingly, according to the DSM IV-TR, one of the exclusion criteria for making the diagnosis of pathological gambling (PG) (see Table 3) is that the behaviours are not "better accounted for by a Manic Episode" (i.e., the gambling is only a small manifestation in the overall plethora of behaviours being manifested by someone in the throes of mania).

Another thing to consider is that pathological gambling often co-occurs with other mental health and addiction issues. According to recent studies, BP is <u>not</u> very common compared to ADHD, SUD,

and PD (Specker, et al., 1996; Petry, 2000).

As well, behaviours (and their consequences) arising from PG can "mimic" other mental health issues, e.g., staying up all night to indulge in gambling, committing illegal acts such as stealing for money to gamble, spending their money only on gambling, emotional reaction to losses, dealing with relationships that are impacted by the gambling, and other problems. Often this may lead to depressive symptoms and, for those vulnerable, a major depressive episode. When gambling problems are treated usually many "psychiatric" symptoms vanish as well. If the symptoms do not resolve, or they get worse, then it becomes clear that there is a co-occurring/underlying psychiatric condition to be dealt with.

So, what are the possibilities in this case?

Possibility 1. Gambling behaviours in the context of bipolar disorder

If this were the case, we would expect Ms. S to have behaviours consistent with mania beyond just gambling. Gambling would most likely be merely one of the pleasurable activities someone would pursue while "high"—e.g., sex, spending sprees on all sorts of items, recreational drug use, running up telephone bills. The gambling would be just part of the many goal-directed activities engaged in, combined with poor judgment. Ms. S would demonstrate a grandiosity not just about her skills as a "great gambler" but about a great number of other things as well. You would also expect Ms. S to be in an energized state, needing little sleep for at least a week whether she was in the casino or not. Pressured speech (rapid, continuous, hard to interrupt) and flights of ideas (rapid shifting between usually related thoughts) occur in a manic state and not in pathological gambling. Similarly, a person does not develop psychotic symptoms if she is only engaging in pathological gambling! The clinician needs to get an understanding of the person's behaviours, signs, and symptoms inside and outside the gambling context.

Possibility 2. Pathological gambling disorder alone

How can this condition end up mimicking bipolar disorder? As mentioned already, people may be "driven" to gamble by many factors, but often they are releasing various neurochemicals (which give them pleasure and energy) during the act of gambling. This is why people can stay up for long periods of time—but eventually "crash" into exhaustion. They usually can't go a full week of being energized like someone in a manic state. Also, the "spending spree" is like in other addictions—the money is going into the pursuit of their gambling and very little else. This is not really a

spending spree, then, but just part of the typical behaviour of pathological gambling. The gambler's affects and moods can be variable but are usually reactive to situations, e.g., feeling joyous while playing, ecstatic when winning, anxious when losing, depressed when in debt. In fact, one criterion for pathological gambling is "becoming restless and irritable" (see Table 3) when trying to cut down the behaviour. These shifting moods are not sustained abnormal mood states as described above in bipolar disorder. However, someone under enough stress and with the right amount of genetic vulnerability could develop a major depressive episode. The clinician needs to look at all mental health issues and behaviours and see if they always manifest within or due to the gambling behaviours, or are occurring outside of them as well. If the former, the behaviours can all be explained purely by a pathological gambling disorder.

Possibility 3. Combined bipolar and pathological gambling disorders

Of course, there is the possibility that both are occurring at the same time. There are a few ways this could look, including:

a. *Starting with a pathological gambling disorder*. Pathological gambling behaviours are ongoing but there are discrete episodes of hypomania, mania, or major depression occurring when a history is carefully taken. It could be during these episodes that the gambling behaviour worsens, but other symptoms of bipolar disorder are also present.

b. *Starting with a manic episode*. A person with the potential for gambling difficulties enters into a manic episode, and takes up gambling as part of the illness. Once the episode begins to decrease in intensity, the person continues to gamble. If the person starts to slip towards a major depressive episode, he or she may increase the gambling behaviour as a way to self-medicate their mood (a method which is usually doomed to failure).

c. *Starting with a major depressive episode*. The person starting to develop a depressive episode begins to "treat" him- or herself with the "highs" of gambling and develops the pathological gambling disorder due to a vulnerability to that condition. The gambling continues but worsens when a manic episode arrives.

The key again is taking a careful longitudinal history of the different symptoms to see how they match up temporally.

Possibility 4. None of the above

Although it is beyond the scope of this article to go into in detail, bipolar disorder diagnoses are sometimes misdiagnoses of ADHD, BPD, SUD, and trauma-related conditions. Medical conditions such as hyperthyroidism can create equivalent manic behaviours. In Ms. S's case above, there seems to be no history of learning problems or difficulties at school or attention problems (although this makes ADHD merely unlikely, but does not rule it out), and no overt trauma history (although emotional trauma may have occurred in her upbringing). Self-reported history and urine toxicology screen are negative (although, for example, cocaine can be undetectable a few days after use unless you use the proper lab tests), and her thyroid levels are normal. For simplicity in this article, let us go along with the working hypothesis that all these possibilities have been ruled out for now (although a good clinician always keeps fall-back hypotheses!).

What do we need to know?

So, to get the proper context to understand what is going on, the clinician needs to know at least the following:

- Behaviours inside and outside the gambling environment
- Onset and pattern of gambling and psychiatric symptoms, and how they relate to each other temporally (it helps to draw this out as a chart). This chronology of symptoms can include developmental history, periods of abstinence, etc.
- Addiction conditions (either ruled out or, if present, put into the temporal relationship chart)
- Medical conditions (either ruled out or, if present, put into the temporal relationship chart)
- Medication use—is it helping with any of the symptoms?
- General functioning in the following domains:
    - School/Vocational functioning
    - Family functioning
    - Social/Peer relationships
    - Leisure activities
- Family history of mental health issues, e.g., mood disorders, anxiety disorders, gambling problems, addiction problems, etc.

The case revisited

Based on the information on the case, and assuming there are no underlying issues of ADHD, trauma, or addiction, etc., most of Ms. S's behaviours can be explained by the pathological gambling condition alone. There are likely some interpersonal issues that predate the gambling problem and may have originally led her to use gambling as a self-soothing, maladaptive coping mechanism, but further history would be required to solidify this theory. Although she is currently suffering from some mild depression, it does not appear to be a major depressive episode. Thus the medication she is taking may be unneeded. Cognitive behavioural therapy (CBT) can address gambling and depressive cognitions simultaneously. If the mood symptoms remain or worsen, then one can consider re-examining the situation to see if Ms. S has developed a MDE and could benefit from combined CBT and/or medication treatment.

Final thoughts

Context is key. Symptoms don't exist in a vacuum.

It often takes time to truly unravel a diagnosis, especially when many conditions have overlapping symptoms.

Being misdiagnosed with bipolar disorder when instead the condition is pathological gambling has serious implications:

- The person has to live with the "label" and all the consequences that go with it
- Would-be parents must consider the possibility of having children who inherit a psychiatric condition
- The person must maintain a certain lifestyle to prevent triggering an episode (i.e., going to bed on time, etc.)
- The pathological gambling often can be overlooked and "lumped" into being only a manifestation of a manic episode, and thus the person does not receive the proper treatment for PG
- The person may be put on medications which can cause unwanted side-effects and possible long-term problems induced by the medication
- This also speaks to the question of whether most mental health clinicians are aware of the presentation and manifestation of pathological gambling to help prevent misdiagnosing BP

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