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# Is Gambling an Addiction Like Drug and Alcohol Addiction?: Developing Realistic and Useful Conceptions of Compulsive Gambling

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## Abstract

As compulsive gambling and problem gamblers attract continued and increasing attention — due to state reliance on gambling for revenues and government and private marketing of the gambling experience — conceptions of compulsive, or addictive, gambling have evolved. The disease model of alcoholism and drug addiction, which predominates in the U.S. and North America, has generally been widely adopted for purposes of understanding and addressing gambling problems. However, this model fails to explain the most fundamental aspects of compulsive drinking and drug taking, so it can hardly do better with gambling. For example, people regularly outgrow addictions — often without ever labelling themselves as addicts. Indeed, gambling provides a vivid and comprehensible example of an experiential model of addiction. Elements of an addiction model that gambling

helps to elucidate are the cycle of excitement and escape followed by loss and depression, reliance on magical thinking, failure to value or practice functional problem solving and manipulative orientation towards others.

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*News Item*

*On May 9, 2000 the seven-state "Big Game" lottery provided a prize of $366 million. The odds of winning were 76 million to 1. In the days before, the lottery sales outlets were overrun with people buying hundreds of dollars worth of tickets. The weekend before the lottery was held, 35 million tickets were sold. Annually, Americans spend $36 billion on lotteries*.

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## Introduction — The Purpose and Development of Addiction Theory

In 1975, I proposed a general theory of addiction in *Love and Addiction* (Peele & Brodsky, 1975/1991): that any powerful experience in which people can lose themselves can become the object of an addiction. The result of this immersion is deterioration of the person's engagement with the rest of his or her life, which increases the person's dependence on the addictive object or involvement. Certain people are far more prone to form such addictive involvements — those with tenuous connections to other activities and relationships, and whose values do not rule out antisocial activities.

Initially, both scientists and people who misused alcohol and drugs thought that the expansion of the addiction concept to incorporate such non-substance based activities cheapened and minimized the idea of addiction. At the same time, the popularity of the idea of non-drug addictions grew through the 1980s and beyond. This trend was fueled by the growing claims by many people who gambled destructively: they were equally unable to control their habit and suffered just as much pain and loss in their lives as those destructively devoted to drugs and alcohol (and quite a few of these individuals shared gambling and substance addictions).

Since 1980, successive editions of the *Diagnostic and Statistical Manual* of the American Psychiatric Association have recognized compulsive (called "pathological") gambling, although the definitions have continued to evolve. Nonetheless, for many, the idea that gambling comprises an addiction is hard to accept; along with notions that gamblers undergo withdrawal like heroin users and that people who gamble excessively at one point in their lives are necessarily afflicted with a lifetime malady. In fact, gambling sheds light on the fundamental

dynamics of all addictions: (1) addiction is not limited to drug and alcohol use, (2) spontaneous remission of addiction is commonplace, (3) even active "non-recovered" addicts show considerable variability in their behavior, (4) fundamental addictive experiences and motivations for addiction are readily apparent in compulsive gambling, and (5) gambling even helps to clarify the motivations of drug and alcohol abusers.

In an effort to make sense of addiction, gambling researchers and theorists often fall prey to the reductionist fallacy that typifies theorizing about drugs and alcohol. Blaszczynski and McConaghy (1989), for example, referred to data showing that there is not a specific kind of pathological gambler, but rather that gambling problems occur along a continuum. This is an indication that a disease model of gambling addiction is inadequate. They then cited some preliminary findings of physiological differences that might characterize pathological gamblers as potentially strong support for the disease model. Blaszczynski (2000), in this journal, posited a typology of pathological gambling including one type that is genetically caused and incurable.

The logic that dictates that an activity must be shown to be biological or genetic in its nature to be genuinely addictive is exactly backwards — for drugs, alcohol, and gambling. If a model does not begin to explain the behavior in question, then any number of associations with biological mechanisms and measurements will fail to provide an explanation (and, by extension, a solution) to the problem. Science is built on accurate and predictive models, not laboratory exercises to demonstrate, for example, how drugs impact neurochemical systems. No work of this kind will ever explain the most basic elements of addiction; particularly that people addicted at a certain time and place cease to be addicted at a different time and place (Klingemann et al., in press/2001; Peele, 1985/1998; 1990).

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## Gambling is addictive; it is not a disease

### Defining addiction

Saying gambling is addictive but not a medical disease begs for definitions of "addiction" and "disease." The essential element of addiction to gambling is that people become completely absorbed in an activity and then pursue it in a compulsive manner, leading to extremely negative life outcomes. These individuals often describe a sense of loss of control in which they believe they are incapable of avoiding or stopping gambling.

The disease model looks to an inescapable biological source for addictions; some neurochemical adaptation that accounts for compulsive behaviors. In addition, a disease model posits that these neurochemical adjustments lead to measurable tolerance and withdrawal. Because the biological systems underlying the addiction

are thought to be irreversible, the disease model includes the idea of a progressive worsening of the habit which requires treatment in order to arrest the addiction. According to the 12-step model of addiction and therapy presented by Alcoholics Anonymous, recovery from addiction requires lifetime abstinence, acknowledgment of powerlessness over the activity in question, and submission to a higher power.

Social psychological (or social cognitive) models of addiction (Orford, 1985/1995; Peele, 1985/1998) instead emphasize social causality, psychological dynamics and the behavioral definition of addiction — which is seen as a continuum of behavior. All of the elements said to define addiction–like compulsive pursuit and preoccupation with a substance or activity, and personal disorganization and desperation after cessation — are known through behavioral, experiential, and phenomenological observation and criteria. That is, no physiological measure defines the expression of continued need for a substance. Many post-operative patients, for instance, readily abandon large narcotic regimens without notable discomfort or the desire for more of a drug. My experiential model in particular (Peele, 1985/1998) focuses on the addict's sense of him or herself, the modification of the person's experience by the substance or activity, and the way this modified experience fits in with the rest of the individual's life.

My experiential model, while rejecting a disease formulation, creates an alternative model of addictive gambling, one which recognizes the undeniable realities that people do sacrifice their lives to gambling and that they assert or believe they cannot resist the urge to do so. At Gamblers Anonymous meetings compulsive gamblers attest to sacrificing everything for their addiction and claim they have no control over their habit, providing evidence of this subjective and lived reality. On the other hand, disease-model explanations for these phenomena may be questioned, and indeed, in many cases explicitly disproved. Yet, addiction theorists and gambling researchers err by discounting gambling's genuine addictive qualities even though gambling falls short of attaining medical disease status. While discounting gambling's genuine addictive qualities, they often assume that alcohol and drug addictions fulfil criteria for an addictive disease that gambling fails to meet.

**Diagnostic studies of gamblers in comparison with substance abusers**

Wedgeworth (1998) found that “patients coming into treatment do not fit the addictive disease conception of gambling behavior” (p. 5). He interviewed (both directly and through examination of autobiographies created for treatment) 12 patients admitted to a private inpatient treatment center who were diagnosed as pathological gamblers. Wedgeworth found the patients did not meet criteria of “compulsive” gambling. Rather, he found that individuals were diagnosed for practical purposes, in order to fulfill insurer criteria while allowing them to repair their personal relationships. Nonetheless, in a case extensively described, the

patient “had burned all his bridges” — separated from his wife, lost his job, and faced embezzlement charges (p. 10).

Patients who receive hospital treatment for addiction frequently do not meet all the criteria for addiction, but this does not distinguish gambling from alcohol and drug patients. For decades, research has found that intakes in heroin treatment centers often reveal negligible (or sometimes no) signs of opiate consumption, and that private drug and alcohol centers commonly admit anyone who shows up for intake in order to fill their treatment rolls. In 1999, the founder of the American Society of Addiction Medicine, G. Douglas Talbott, was found liable for fraud, malpractice and false imprisonment for coercing a physician into treatment who was not alcohol dependent (Peele, Bufe & Brodsky, 2000).

Orford, Morison, and Somers (1996) compared problem drinkers with problem gamblers. Orford et al. employed an attachment scale, which found that problem drinkers and gamblers were equally devoted to their habits. However, drinkers scored significantly higher on a severity-of-dependence scale including both psychological and physical components of withdrawal. For Orford, these findings call for a refocusing on subjective states rather than on withdrawal symptoms as indicators of addiction. Orford's view that addiction is best understood from an experiential and behavioral perspective is close to the position I take. However, I believe that symptoms of addiction, including withdrawal and tolerance, are simply behavioral manifestations of the same attachment that Orford et al. measured (Peele, 1985/1998).

There are reasons not to accept that withdrawal and tolerance are absent in gambling addiction, or at least any more so than they are in alcohol and drug addictions. Wray and Dickerson (1981) claimed that gamblers frequently manifest withdrawal, although their definition of withdrawal as restlessness and irritability might be questioned. However, classic studies of withdrawal have found that even heavy narcotic users manifest extremely variable symptoms, which are highly subject to suggestion and environmental manipulation (Light & Torrance, 1929). Moreover, the recent WHO/NIH Cross-Cultural Applicability Research Project found that withdrawal and other alcohol-dependence symptoms varied tremendously from cultural site to site (Schmidt, Room & collaborators, 1999, p. 454).

Thus Orford et al.'s view that dependence symptoms exist objectively and that factors such as treatment experiences and social learning do not determine their prevalence is not well founded (Peele, in press). Indeed, Orford and Keddie (1986) showed that a subjective scale of dependence, prior treatment and AA experiences yielded better predictive models of alcoholism treatment outcomes (particularly with regard to the achievement of controlled drinking) than did the same severity-of-dependence measure Orford et al. used for the purpose of differentiating

gambling from drinking problems. In the DSM-IV (American Psychiatric Association, 1994), the manifestation of tolerance and withdrawal is not essential for a diagnosis of dependence.

Thus, while I remain highly sympathetic to Orford and his colleagues' view that an essential element of addiction is the experience of attachment; I find the distinction they draw between an attachment-based definition of addiction and manifestations of withdrawal and tolerance unjustified and unnecessary.

**Distribution, continuity, and self-identification of addictive problems**

If there is a disease of alcoholism, or of compulsive gambling, some people should manifest a distinct addiction syndrome. Yet population studies (as opposed to clinical studies of individuals in treatment) of alcoholism, drug addiction, and compulsive gambling regularly reveal that different people display different types of problems, and that the number and severity of these problems occur across a continuum rather than forming distinct addict and non-addict profiles. Moreover, interview studies of general populations of drinkers (or of large populations of clinical alcoholics, like the Rand studies and Project MATCH) find tremendous movement and variability in severity of problems such that over time (sometimes quite brief periods), the severity of their problems shift — including substantial numbers who are no longer found to have a diagnosable problem (cf. Dawson, 1996 and Peele, 1998, in the case of alcohol; Shaffer, Hall & Vander Bilt, 1998, reviewed in Hodgins, Wynn & Makarchuk, 1999, provide similar data for gamblers).

Obviously, some people's gambling problems are worse than others. A person can have an unhealthy gambling habit that can be termed pathological without being a fully addicted (i.e. compulsive) gambler. Blaszczynski (2000) dealt with such differences by defining a three-part typology of gamblers. He based these types on an outcome study (McConaghy, Blaszczynski & Frankova, 1991) in which the three groups are characterized by non-abstinent recovery, abstinence from gambling, and continued pathological gambling. Blaszczynski posited that the first group of problem gamblers are “normal”: people who successfully reduce their gambling habits and who otherwise have normal personalities. The second group — “emotionally disturbed gamblers” — have pre-existing personality disorders to which pathological gambling is a response. The third and irremediable group of gamblers — whom Blaszczynski does not label — are highly impulsive and are hypothesized to have a strong biological component and a specific allele at the D2 receptor gene site (Comings, Rosenthal, Lesieur & Rugle, 1996).

But the Blaszczynski model shows the same weaknesses as other such models in regards to epidemiological, typological, and etiological data and theory. In the first place, it seems quixotic and visionary to imagine that outcomes of gambling treatment will be related on a one-to-one basis to gambling types. Certainly,

severity of pathological gambling could well be related to the likelihood of resumption of non-pathological gambling and of successful resolution of a gambling addiction. But that there are distinct demarcation points of severity that indicate distinct syndromes — and moreover that these are related to entirely distinct causal factors, genetic or otherwise — belies the kind of integrated bio-psycho-social model Blaszczynski (2000) endorses. And, indeed, McConaghy, Blaszczynski and Frankova (1991) did not find distinct personality differences to characterize treatment outcomes in their study. Rather, all such pathologic gamblers can be understood to use gambling as a response to some combination of personal, situational, and biological characteristics according to a social cognitive model.

Blaszczynski and his colleagues have focused on the personality trait of antisocial impulsiveness as being central to a key type of (one might say “genuine”) gambling addiction. This syndrome includes other emotional disorders (Blaszczynski, Steel & McConaghy, 1997; Steel & Blaszczynski, 1998). In this research, the gamblers studied are unable to curb their urges, disregard the consequences of their actions on others, use gambling as a response to dysphoria and emotional problems, and are predisposed to substance abuse and criminality. These individuals are manipulative and readily sacrifice personal relationships to their urges — stealing or diverting money from family and friends and carrying on campaigns of duplicity.

For Blaszczynski (2000), this type of gambling addiction is genetically determined by a gene claimed to cause alcoholism and other addictions. For many genetic researchers, this connection is not only unlikely but has already been disproved (Holden, 1994). Yet, many of the traits identified by Blaszczynski et al. (1997) resemble those found in alcohol and drug abusers — particularly antisocial impulsivity (Peele, 1989/1995). Likewise, drug abusers and alcoholics frequently demonstrate manipulative and alienated relationships. Such similarities in the lives of those addicted to disparate involvements indicate common addictive patterns and motivations with different triggering events, social milieus, and personal predilections leading individuals to one or another type of addictive object. At the same time, a given individual often alternates or substitutes from among a variety of addictions, including problem drinking and gambling. For such individuals, it is the experiential similarities in these involvements that link the activities.

The movement of individuals from one group or outcome to another refutes Blaszczynski's distinct gambling types — especially the incurable genetically based variety. Just because a person failed to benefit from treatment at one point does not mean he or she is doomed to gamble compulsively forever. Nor is the severity of a gambling problem a guarantee of its permanence. In the 12-step approach to alcohol, gambling and other addictions, the individual is required to admit that he or she is genuinely addicted. In my view such self-labeling is rarely helpful. For

example, when surveys objectively measure compulsive behavior in remission (subjects who in a lifetime prevalence measure score as addicted, but do not currently score as such), many such individuals say they have never had a gambling or other addictive problem.

The failure to identify or at least to treat alcohol dependence, accompanied by remission, is more common than not for those who have been alcohol dependent (Dawson, 1996). Likewise, Hodgins et al. (1999) surveyed over 1800 Canadians and identified 42 respondents who revealed a lifetime gambling problem but who had had no problem in the last year. “Only 6 of the 42 in the target sample acknowledged ever having experienced a problem with gambling …” (p. 93). This could be regarded as demonstrating the clinical symptom of denial. However, it may be a functional attitude when it permits people to leave a gambling or other addictive problem behind; perhaps more readily than if they identified themselves as addicts.

**The addiction cycle and the proclivity to addiction**

Some people have extremely destructive gambling experiences and some develop chronic gambling habits and problems. The individual loses more than she or he intended, feels bad about the losses, tries to recoup them by continuing to gamble — only to lose more, and good money follows bad. Even though the risk of gambling or the prospect of winning can be exhilarating, the aftermath of gambling losses are emotionally deflating and create increasing legal, job and family problems. At the same time, future gambling relieves the anxiety, depression, boredom and guilt that set in following gambling experiences and losses. At this point, the individual can come to feel that he or she only lives when involved in the gambling experience.

The addictive cycle is central to my experiential model of addiction (Peele, 1985/1998), and is described repeatedly in the gambling literature (cf. Lesieur, 1984). One critical element of the pathological gambling experience is money. For Orford et al. (1996, p. 47), the problem cycle begins with “negative feelings associated with gambling losses” in combination with the “person's positive experience of the gambling activity itself, shortage of money and the need to keep the extent of gambling a secret” (p. 52). The individual who is lost in this cycle relies on magical solutions — as do drug and alcohol abusers — to produce desired outcomes without following functional plans to achieve his or her goals (Marlatt, 1999; Peele, 1982).

Although Blaszczynski (2000) emphasized the diversity of pathological gambling, he identified “elements relevant to all gamblers irrespective of their subgroup.” These elements include the association of gambling with “subjective excitement, dissociation, and increased heart rate” often “described as equivalent to a 'drug-

induced 'high.'" Another common element is the "downward spiral of gambling …. When gamblers lose, they attempt to recoup losses through further chasing … Despite acknowledging the reality that gambling led them into financial problems, they irrationally believe that gambling will solve their problems." The subjective allure of the addiction and the self-feeding nature of the addictive process describe the addictive cycle and the predisposition to magical solutions central to the addiction experience.

## Conclusions: Gambling and Society

Unlike illicit drug use, which the state prohibits, and alcohol, which is manufactured privately, the state has a central role in gambling — both administering lotteries and other gambling venues, and licensing casinos, race tracks, gambling machines, etc. This direct relationship between the state and addictive gambling versus the state's indirect role in drug and most alcohol addiction has critical implications. For one thing, gambling venues continue to expand rapidly. Yet, the third element that Blaszczynski (2000) identified as central to all pathological gambling is that prevalence "is inextricably tied to the number of available gambling outlets." There is also a special temptation to think that addiction in this area is genetically determined, since this would minimize the responsibility of governments for the incidence of the problem. Modern thinking about drug addiction and alcoholism encourages this reductive view of gambling addiction. However, it is unfounded, not useful for understanding and ameliorating addiction, and leads (as it does in the case of gambling) to dysfunctional social policy.

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