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Author's Response to Reviewers' Comments and References

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In this article, we have presented an interesting case describing the development of pathological gambling and attempted to argue that factors instrumental in precipitating impaired control over gambling may no longer be relevant in its maintenance. David Hodgins correctly highlights the fact that there is currently no conceptual model that integrates the myriad factors underlying the development and maintenance of impaired control in pathological gambling.

One can only fully support Hodgins' view that most models make reference to concepts that are neither sufficient nor necessary to explain the onset and continuation of problem gambling behaviours, and that there is an imperative need to advance testable hypotheses and models that rely more on prospective designs, and less on retrospective or subjective reports. Sadly, most efforts to date are founded on the premise that those with pathological gambling problems constitute a homogenous group of individuals influenced by the same complex set of interacting variables. As a consequence, in an effort to explain the aetiological process underlying gambling, there is a tendency to force all gamblers into the one cast. Durand Jacobs' *General Theory of Addictions* models fit into this mould, whereas McConaghy's behaviour completion perhaps less so.

A consistently reported clinical observation is that stresses precipitate bouts of gambling and that gambling represents a gambler's attempt to escape from emotional turmoil. Gambling produces heightened arousal, narrowed attention and an “altered state of consciousness” variably referring to the gambler as being in a state of dissociation or “in action.” The fundamental drive underlying gambling is to maintain this state of arousal with winning as the means by which this state can be prolonged. I endorse Rina Gupta's and Durand Jacobs' views that many gamblers utilise gambling to cope with psychological distress and stresses, but argue that such an explanation applies only to a proportion of those with gambling problems.

Jacobs calls upon a set of predisposing stressors in interaction with hyper or hypo

states of baseline arousal. Accordingly, two conditions need to be met in all pathological gamblers: pre-morbid stresses leading a sense of rejection, low self-worth and poor self-image, and a physiological resting state that requires either augmentation or reduction. The psychological motivation underlying gambling is the creation of a state of dissociation that provides temporary relief from psychic pain. Rina Gupta's experiences echo this perspective.

McConaghy's model, on the other hand, invokes the concepts of cortical neuronal substrates and behavioural completion mechanisms to account for recurrent patterns of gambling behaviour. The prerequisite requirements are the development of a habitual pattern of behaviour with no reference to the presence of premorbid psychopathology or negative life experiences. Once a habitual pattern of behaviour is established, a wide range of stressful internal and external events are capable of precipitating the drive to carry out the behaviour. The excitement of gambling distracts the gambler's focus of attention from aversive stresses and thus becomes negatively reinforcing.

I have long argued that it is limiting to conceptualise those with pathological gambling problems as a homogenous population subject to the same pathogenic processes. We must divide this population into at least three subtypes: “normal” pathological; emotionally vulnerable; and biologically disposed impulsive gamblers. Jacobs' model can be legitimately applied to the emotionally vulnerable gambler but falls short of accounting for the normal gambler. McConaghy's model can account for all three groups, and therefore, it is more comprehensive and parsimonious.

Durand Jacobs' clinical assessment that the back injury and resultant chronic pain exerted a profound impact on the client's quality of life, self-image and psychological functioning is not in dispute. But his interpretation that the “enthusiastic discovery that high excitement… provided an escape” through the mechanism of dissociation, while attractive on some levels, is limited in its ability to explain the phenomenon witnessed in this unique and unusual case. Jacobs correctly observes that gambling is an inherently exciting activity for both social and problem gamblers. He advances the position that the pathological gambler's drive to induce a dissociated, altered state of consciousness is the end consequence of his or her attempt to deal with stresses, and that the primary objective is to maintain this state for as long as possible. This distinguishes the pathological from the social gambler.

However, it is noted that Mr. S.M. described a 15-year history of social gambling yet during this period he did not use the dissociation of gambling as a coping strategy in the context of other life stresses. Why so? If dissociation is to be invoked as the fundamental motivating component underlying impaired control over gambling, it is necessary to provide an explanation of the processes that lead

from social to impaired gambling behaviour in individuals with a premorbid history of social gambling and stresses. At the same time, it is important to explain why, in the absence of stress or poor self-image or poor self-worth, a proportion of "normal" gamblers lose control over their behaviour only to regain mastery and resume participation in patterns of controlled gambling.

Part of my argument hinges on the pivotal role purportedly played by dissociation, the key construct forming the foundation of Jacobs' model. Notwithstanding Jacobs' disagreement with Cardena's argument, I must agree with David Hodgins' comments that dissociation is a particularly fuzzy concept.

But have we lost touch with considering the simpler possibility that gambling is an intrinsically exciting and enjoyable pastime pursued for its own sake, much the same as people seek out any other enjoyable activity such as chess, sports or watching movies? Jacobs alludes to this when he refers to the underlying motivation of a gambler as the need to "stay in action." Csikszentmihalyi (2000) defines such recreational activities as "autotelic experiences," ones in which there is no implicit external reward or goal beyond the pursuit of the activity and maximising enjoyment for its own intrinsic sake. Is this not so with gambling? The central feature of this experience is the funnelling of attention toward a limited stimulus field (narrowing of attention), loss of ego or self-consciousness and merging of awareness and activity. In other words, the person pursues the activity for its own sake because it is enjoyable, and in so doing, loses his or her perspective of time, self and environment. The gambler is in action.

The arousal associated with this enjoyment is of a sufficient level, in the case of Mr. S.M., to cause a distraction from pain, perhaps much in the same way that a sportsperson is oblivious to an injury sustained in the height of play, a level of arousal capable of greater distraction than reading or meditation. To call this dissociation imposes an unnecessary complexity on the epiphenomenona.

Gambling is simply an exciting and enjoyable activity that engrosses one's attention. As such it falls along a dimensional plane as Jacobs suggests. However, in support of Cardena, I would argue that some states of dissociation do not represent an extreme position on a continuum, but a qualitatively different state of consciousness. Therefore, if the term dissociation is to be used in gambling, it is necessary to clarify the term used and to define its operational boundaries. Otherwise, let us just use the simpler term of *distraction* to describe the excitement or enjoyment experienced while gambling.

Hodgins raises a valid point when he questions why cognitive therapy was used rather than training in alternative distraction and pain management techniques. Although not described in the case study, the psychiatrist and hypnotherapist had applied a variety of pain management techniques that together with medication

and alcohol use did not prove effective. I would hazard the guess that had such interventions been effective, Mr. S.M. might not have lost control over his gambling. By the same token, alcohol and medication, while ameliorating the severity of pain to some extent, did not match the same profound effect produced by gambling, hence causing gambling to became the effective “drug” of choice.

The inherent arousal produced by the enjoyment of gambling caused a significant reduction in pain, a comparatively greater reduction than was achieved by alcohol, medication or other interventions. Mr. S.M.'s gambling experiences shaped cognitive belief structures leading him to believe that he could eventually win and recoup losses. The cognitive intervention that was formulated and applied was justified on the grounds that, independently of the negative reinforcement produced by the analgesia, his experiences at gambling modified cognitive belief structures that acted to perpetuate further gambling.

Pathological gambling is a major public health problem that exerts a destructive influence on individuals, their families and society in general. To understand the behaviour we need to advance clearly articulated and testable conceptual models. In so doing, we need to be cognisant of several elements: people with pathological gambling problems are not a homogenous population; pathological processes leading to the development of the condition differ between cases; and variables relevant in the development of pathological gambling may not contribute to its persistence.

Article Categories:

- Case_Conference