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The case of the bleak blackjack bettor: Clinical depression and pathological gambling

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Welcome back to the **Clinical corner**. This section 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. All cases and materials presented in this section are peer-reviewed.

Case presentation

Mr. B is a 28-year-old single Asian male with no children. He is an only child and lives with his mother. His father committed suicide 15 years ago when Mr. B was 13 years old. Mr. B finished high school and completed one year of a three-year bachelor of arts degree before dropping out of academics because he felt “sad and directionless.” He is currently supported by his mother but does odd jobs for family friends. He declared bankruptcy last year after racking up gambling debts of $60,000. Mr. B has been a regular at his local casino, where he has played blackjack for the last six years, which has overtaken most of his life. He has been unable to stop gambling despite his best efforts. He had been chasing his loses with increased betting, which resulted in his financial situation. Mr. B has great shame over this, especially after borrowing money from his mother for food.

Ever since his recent bankruptcy, Mr. B has been feeling sad and racked with guilt over his gambling. Three months ago, he began to tell his mother that he sometimes thinks about “ending it all.” Feeling concerned, his mother brought him to her family doctor. After hearing about the current situation, the family doctor told Mr. B, “Stop gambling and you'll feel better,” and sent him home.

Starting about two months ago, he found that gambling no longer brought him any pleasure, although gambling used to help him deal with stress and sad emotions. His motivation to look for work and maintain his hygiene dropped and he began to isolate himself at home. His mother would find Mr. B crying throughout the day. He barely ate and his mother watched him slowly waste away. Mr. B found he couldn't sleep well and would wake up in the mornings with a feeling of hopelessness about his future.

One month ago, Mr. B took an overdose of benzodiazepines and antidepressant medication he found in his mother's medicine drawer. His mother found him unconscious at home and called for an ambulance. Luckily, Mr. B was able to be medically stabilized, and was then admitted for psychiatric observation. The psychiatrists at the hospital determined that Mr. B was suffering from a major depressive episode (MDE) and started him on an antidepressant. They verified that he had no substance use disorders (such as alcohol dependence). He was kept in hospital for three weeks and was

released to follow-up with his family doctor once his mood had stabilized. Before he left, he asked the psychiatrist how he could get help for his gambling. The psychiatrist told him, “Don't worry—you were likely gambling as a coping mechanism for dealing with depression. Just keep taking the medication and things will be fine.”

Within a week, Mr. B had returned to the casino and begun to gamble again. This led to more financial losses, and two weeks later he quit taking his medication, feeling that it did not help him. He quickly began to get into dark moods and was having suicidal thoughts, and thus returned on his own to the hospital emergency room.

- What aspects of this case raise concern over the assessment and treatment of Mr. B?
- What additional information do you need to determine a treatment plan?
- What further complications could arise if the treatment plan remains the same?

Depressive disorders

In any given one-year period, at least one in six Canadians will suffer from major depression (Weissman et al., 1996). The social cost of this condition is high, but the cost in human suffering cannot be estimated. Depressive illnesses often disable functioning and cause pain and suffering not only to those who have the disorder but also to those who care about them. Most people with a depressive illness do not seek treatment. This is often due to stigma (people thinking that the person is “lazy,” that it's “just their personality,” or that they're “just faking”). Certain cultural factors can also come into play; e.g., some Asian cultures see mental illness as something that must be kept secret, as it would be shameful for a family to have this discovered.

A depressive disorder is an illness that has physical, emotional, and cognitive impacts. Unless one has suffered from this illness, one cannot appreciate what it truly feels like. Clinical depression is an abnormal mood state; it is not just extreme sadness. People feel very different from usual, describing depression as a qualitatively different experience from extreme sadness, e.g., feeling shot through with lead, living in hell, or feeling their insides rotting. It can rob people of feeling any pleasure in life and fill them with guilt; hopelessness; decreased energy, coupled with loss of motivation, resulting in an inability to perform basic daily functions; and suicidal thoughts as well as attempts. It affects the way a person eats and sleeps by either causing loss of appetite and sleep (melancholia) or the opposite (increased eating and increased hours of sleep). It is not a sign of

personal weakness, or a condition that can be willed or wished away. One cannot "snap out of it." Without treatment, symptoms can last for weeks to years.

Depressive disorders include the following:

- **Major depressive disorder**: A person has recurrent MDEs (*Diagnostic and Statistical Manual of Mental Disorders* (Rev. 4th ed.) (APA, 2000)). (See the DSM-IV-TR symptoms and signs of an MDE in Table 1.) Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime.
- **Dysthymia**: A person has long-term chronic symptoms that do not disable as much as an MDE, but keep one from functioning well or from feeling good. Many people with dysthymia also experience MDEs at some time in their lives (which one would then call "double depression"—dysthymia with recurrent MDEs).
- **Bipolar disorder**: This is also called manic-depressive illness (see the first Clinical Corner (Ballon, 2005)); a person has a combination of manic episodes and MDEs.

There are different specifiers for the conditions (e.g., with psychosis, melancholic features, etc.), but these details are not needed for the purpose of this article. (Those interested can find them all listed in the DSM-IV-TR.)

Causes of depression are numerous. Often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder. For a full account of depressive illness, see http://www.psychdirect.com/depression/d-resources.htm.

The first step to getting appropriate treatment for depression is a physical examination by a physician. Certain medications as well as some medical conditions can cause the same symptoms as depression. A good diagnostic evaluation will include a complete history of symptoms. The doctor should ask about alcohol and drug use (many substances can induce depressive symptoms) and whether the patient has thoughts about death or suicide. Further, a history should include questions about whether other family members have had a depressive illness and, if they were treated, what treatments they may have received and which were effective.

Treatment choice will depend on the outcome of the evaluation. There are a variety of antidepressant medications and psychotherapies that can be used to treat depressive disorders. Depending on the patient's diagnosis and severity of symptoms, the therapist may prescribe medication and/or one of the several forms of psychotherapy that have proven effective for depression. Electroconvulsive therapy (ECT) is useful, particularly for individuals whose depression is severe or

life threatening or who cannot take antidepressant medication (CPA and CANMAT Depression Work Group, 2001).

Patients are often tempted to stop medication too soon. They may feel better and think they no longer need the medication. Or they may think the medication isn't helping. Once the individual is feeling better, it is important to continue the medication for at least four to nine months to prevent a recurrence of the depression. For individuals with bipolar disorder or chronic major depression, medication may have to be maintained indefinitely. Antidepressant drugs are not addictive. However, as is the case with any type of medication prescribed for more than a few days, antidepressants have to be carefully monitored to see if the correct dosage is being given. The prescribing doctor (GP, family doctor, or psychiatrist) will regularly check the dosage and its effectiveness.

Two of the short-term psychotherapies that research has shown to be helpful for some forms of depression are interpersonal therapies and cognitive/behavioural therapies (CBTs). Interpersonal therapists focus on the patient's disturbed personal relationships, which both cause and exacerbate (or increase) the depression. Cognitive/behavioural therapists help patients change the negative styles of thinking and behaving often associated with depression.

Pathological gambling and depression

As we already know, pathological gambling often co-occurs with other mental health and addiction issues, especially depression (Specker, Carlson, Edmonson, Johnson, & Marcotte, 1996; Petry, 2001). A major depressive disorder is likely to occur in 76% of pathological gamblers, with recurrent depressive episodes likely to occur in 28% of pathological gamblers (Becoña, 1996). Pathological gamblers have increased rates of suicide and suicidal ideation, and an increased number of negative life events and increased severity of self-reported depressive symptoms (Bourget, Ward, & Gagné, 2003; Newman & Thompson, 2003; Maccallum & Blaszczynski, 2003). Gamblers reporting suicidal ideation were more likely to be depressed than nonsuicidal pathological gamblers and did not report more gambling problems. It is thus important for clinicians always to screen for depression and suicide risk when dealing with someone suffering from pathological gambling.

There are a few hypotheses on the question, “which comes first?” (i.e., gambling or depression), to link the two conditions. One is that pathological gamblers find that the escape from stress and the excitement and stimulation related to these activities alleviate negative mood. Others contend that gambling behaviours are used to fend off a severe or impending depression. Others hypothesize that gambling induces depression instead of depression leading to gambling problems.

Like all conditions in psychiatry, most disorders are heterogeneous; i.e., one person's mood and gambling problems might meet the same criteria for diagnosis, yet the manifestation and factors associated with them might be completely different. The clinician would do better to assume that the two disorders are combined and interacting with each other—and both need to be treated simultaneously!

As for “snapping out of it"—clinical depression and pathological gambling are both essentially chronic illnesses. If it were possible to “snap out of it,” a person would! Clinicians need to understand the multifactorial nature of these conditions and to provide appropriate treatment, thereby allowing a person to evaluate his or her situation, make healthy decisions, and deal with his or her conditions. This may take some time and usually requires matching treatment intensity to the intensity of the condition. Misunderstanding the chronic nature of depression and pathological gambling often leads to poor, uncoordinated treatment and to stigmatizing the person, who is seen stereotypically as being solely to blame for not getting “better.” Instead, it is vital to realize that the system needs to provide the care suitable to a chronic disorder.

As assessment and treatment continue, it becomes clearer how clinical depression and pathological gambling are linked for any given individual. Treatment can then be adjusted accordingly.

Four possible scenarios for concurrent depressive and gambling symptoms are:

1. clinical depression leading to pathological gambling,
2. pathological gambling leading to clinical depression,
3. both conditions occurring because of an underlying third cause (e.g., trauma issues), and,
4. none of the above.

Possibility 1. Clinical depression leading to pathological gambling

One can lean to this option when the person has a history of MDEs before the gambling behaviour ever started and/or a family history of depression or suicidal behaviours. Even if this history cannot be obtained, if the person has clear mood dips into depression despite the continuation of the gambling behaviours at a fairly constant rate, this again suggests a preexisting MDE. Often, gambling begins as a maladaptive coping mechanism to deal with the horrible emotions felt by the individual. However, once a person begins to engage in gambling at a pathological level, he or she has now developed a new condition that needs treatment and that usually does not go away just because the depression has been treated. Pathological gambling may be maintained by psychosocial factors (and perhaps an underlying common factor in some cases; see Possibility 3, below). The person

would require concurrent treatment of both conditions. In Mr. B's case, there seems to be a history of depressive symptoms (dropping out of university) before gambling behaviours emerged, as well as a family history (his father's suicide). In addition, focusing on only one condition at a time allowed the other condition to go unabated, resulting in relapses of both conditions for Mr. B. The clinician needs to get an understanding of the person's behaviours and symptoms inside and outside the gambling context.

Possibility 2. Pathological gambling leading to clinical depression

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, and depressed when in debt. However, someone under enough stress and with the right amount of genetic vulnerability could develop an MDE. Not everyone who is a pathological gambler will develop an MDE from the consequences of his or her actions—although he or she might develop an “adjustment reaction disorder” (basically, a time-limited condition that develops in people due to the impact of a large stressor). However, it is a mistake for a clinician to jump to the conclusion that a person is only adjusting to the sequelae of his or her actions, and that once the gambling is treated the depression will go away. The key message to remember is that, if a person still meets the criteria for an MDE, then *that person needs to be treated for it as well*! If not, the clinical depression will likely interfere with the therapy for the gambling.

It should be noted that CBT can be used for both conditions (the pathological gambling and the resulting clinical depression). If a person cannot engage in therapy because he or she is too depressed, one should consider offering the person an antidepressant; it won't suddenly make the situation better, but it will allow the person to engage in the needed therapy to help cope with gambling and depression. Mr. B may have intensified the depressive symptoms he already had by using gambling to cope with his symptoms, which eventually worsened when he lost at the casino. It might also be the case that he had subclinical symptoms of an MDE (e.g., dysthymia), and once he declared bankruptcy, the stress may have interacted with an underlying vulnerability for him to develop a full-blown MDE.

Note that double depression is where a person suffers from ongoing dysthymia and has a breakthrough MDE as well. These individuals often require more intense psychological, social, and biological treatments to effect symptom remission. Also, as we see that depression and pathological gambling often intertwine, double depression should have the clinician's warning bells ringing to investigate if gambling (or another maladaptive behaviour) is present.

Possibility 3. Pathological gambling and clinical depression arising from an underlying common factor

Sometimes an underlying condition may be the root of a variety of other clinical syndromes. Researchers are still investigating if there may be some genetic/biological factors, which raise the risk that a person may develop both clinical depression and pathological gambling. One group that clinicians commonly encounter are people with a trauma history. Often, physical, sexual, or emotional abuse affects a person's ability to regulate affect, maintain self-esteem, or self-sooth in an adaptive, healthy way. Instead, the person develops depressive symptoms and mood instability. These symptoms are often dealt with by using maladaptive coping mechanisms to help numb the person emotionally or to block "flashbacks." Developing substance use disorders or pathological gambling problems in this manner is common. It is again important to note that, in this particular group, dealing with the trauma alone won't suddenly eliminate the pathological gambling or mood disorders. In fact, it usually makes them worse. The person needs to be stabilized by *concurrent* treatment that addresses the mood and gambling problems and provides new coping skills to deal with dysphoric moods. Were such a person to engage in trauma therapy alone, he or she would almost certainly become retraumatized, and would quickly revert to using his or her usual maladaptive coping mechanisms to self-sooth. In the case of Mr. B, no information on his developmental history has been obtained as yet, so a trauma history cannot be ruled out. For example, we are not sure what the circumstances of his father's suicide were; e.g., did Mr. B witness it, or find the body?

Possibility 4. None of the above

Although unlikely, it is possible that the two conditions arose *de novo* (i.e., the person started gambling and developed pathological behaviours in between MDEs). However, it is hard to imagine that the two conditions would not interact once both developed. There is also a chance that the person is malingering for secondary gain (e.g., a psychopath wanting to avoid paying debts). Also, as mentioned above, a person may develop an adjustment reaction to the sequelae of gambling instead of a full MDE. Adjustment reactions need to be dealt with concurrently as well, but often will require supportive therapy as opposed to medications. In the case of Mr. B, none of these scenarios seems likely.

What do we need to know?

As always, context and time lines are key. The clinician needs to know at least the following:

- mood symptoms 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); can include developmental history, periods of abstinence, etc.;

- developmental history (abuse, a serious major life event, or other family factors);
- family history of mental health issues, e.g., mood disorders, anxiety disorders, gambling problems, addiction problems, etc.;
- substance use disorders, other psychiatric conditions, and medical conditions (either ruled out or, if present, put into the temporal relationship chart).

The case revisited

Mr. B seems to be suffering from concurrent major depressive disorder and pathological gambling. It appears that the depression may have come first, judging by his history and family background. The precipitating factor for Mr. B developing a full MDE seems to be his recent bankruptcy. However, it is still unclear if there are deeper issues such as trauma that may underlie these conditions. It is also worth exploring if cultural factors are interfering with Mr. B's treatment. (Being Asian, does he perceive mental illness as shaming himself and his family, and is he thus reluctant to engage in ongoing care, let alone accept that he may have clinical depression?) Even without cultural factors, many people stop their medications if they cause side effects or make them feel “cured.” Someone will need to discuss treatment compliance with Mr. B. However, his treatment plan has been hindered because his various caregivers are treating each of his conditions in isolation, and are not in communication with each other. This has led to relapses of both conditions. His treatment plan should be tailored for concurrent treatment whenever a possible therapy may help both conditions (e.g., CBT, Gamblers Anonymous, or a harm-reduction approach). Exploration of Mr. B's cultural issues, family psychiatric background, and emotional state from social factors (e.g., the shame feelings he endorsed originally) is essential for a proper understanding of this situation. For the treatment providers, Mr. B's case should illustrate the need to understand the true nature of pathological gambling and depressive disorders.

Final thoughts

- Concurrent disorders require concurrent treatment.
- Chronic conditions such as pathological gambling and major depressive disorder will require chronic care, matching treatment intensity to the person's intensity of need.
- Depressive symptoms in the context of pathological gambling are often judged as merely the just consequences of the gambler's actions. If a person has met criteria for an MDE, his or her depressive symptoms should be treated as an MDE.
- Gambling behaviours can sometimes be thought of as only a maladaptive coping mechanism a person uses to self-treat depressive symptoms. This is

often jumping to conclusions and can gravely affect the treatment outcome.

- Clinicians need to be aware of the presentation and manifestation of pathological gambling and mood disorders to provide the proper assessment and treatment plans.

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Tables

Table 1

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 (DSM-IV-TR, 2000).

Article Categories:

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