

Difficulties to differentiate mood disorders co-occurring with compulsive gambling. Discussion based on a case study

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Summary

Contemporary literature does not take a clear position on the issue of determining civil and criminal liability of persons diagnosed with pathological gambling, and all the more so in case of possible comorbidity of or interference with other mental disorders. Diagnostic difficulties are demonstrated by a clinical picture of a patient with problem gambling who underwent forensic and psychiatric assessments to evaluate the process of making informed (and independent) decisions in view of numerous concluded civil law (mainly financial) agreements. The patient had been examined 5 times by expert psychiatrists who, in 4 opinions, diagnosed her with bipolar affective disorder, including 1 diagnosis of rapid cycling of episodes. Based on the current state of scientific knowledge about the relationship between problem gambling and mood disorders, bipolar affective disorder was not confirmed. Diagnostic difficulties, resulting both from diagnostic haziness and unreliable information obtained during patient interview, that emerged in the course of case study point to the need for multi-dimensional clinical diagnosis of persons with suspected mood disorders and behavioral addictions.

Key words: forensic-psychiatric evaluation, mood disorders, gambling disorder

Case description

A female aged 67, married, one grown-up child. She worked for most of her adult life (until early retirement) and advanced her career. Without much difficulty, she reconciled her work duties, household chores and child-raising. She had no criminal record. She denied problematic alcohol intake and/or use of any potentially addictive substances. Until the first serious financial difficulties became apparent due to her gambling (at 63), she had not underwent any psychiatric consultations or treatment. Her files lack any information directly indicating that the patient suffered from any

mental disorder when she was younger. During her employment, for majority of her adult life, she efficiently coped with both domestic responsibilities and work duties related to her managerial position. The first problems with mental health began at the end of her professional career, when her company started having financial problems and working atmosphere became uneasy. The change of management caused conflicts. The defendant felt used, harassed and subjected to mobbing. She experienced symptoms of depression and anxiety, which may be considered to be adjustment disorders caused by work-related stress. Conflicts at work and poor wellbeing resulted in early retirement (before 60). Her husband informed of persistent depressive symptoms: apathy, sadness, lack of interest, and sleep deprivation, present over the subsequent months. At that time, the patient did not undertake any treatment.

It is known that for couple years before her retirement, she was interested in numbers games, dedicating to them a lot of time and attention. At work, she would take short-term loans when short on money to make bets on numbers. In the following years, being work-free, she reduced her household duties to a minimum and turned her attention to numbers games, fruit machines, toto-lotek, and other forms of lottery games. The period covered by charges is the time when her focus on gambling reached its peak. The defendant's behavior, statements and interests, as described by case witnesses, are compatible with a pattern typical for a person with problem gambling. She used to talk persistently about her gambling experiences, the ways to get money, she was not able to concentrate for an extended time on any other topic. When experiencing difficulties to meet her gambling needs, she would become anxious and irritated. After fulfilling them, she would become overexcited and tend to behave "too freely", as vaguely described in the files.

After numerous letters from banks and collectors had been disclosed, the patient was prompted by her family to meet with a psychiatrist. At that time, she felt sad and experienced sleep problems. Following medical assessment, she was diagnosed with adjustment disorder occurring in a person addicted to gambling. Only after consultation with the patient's husband, the psychiatrist concluded that the patient suffered from affective disorder allowing to diagnose a bipolar affective disorder with so-called rapid cycling. According to the husband, over the last years, she suffered from long-lasting (ca. 3 weeks) periods of depressed mood characterized by decreased activity, limited interests, reclusion and self-neglect alternated with periods when she was active, animated, restless, with majority of time spent outside the house. The psychiatrist recorded only 1 episode of excessive talking and increased wellbeing. There is no data on episodes of increased activity or other symptoms that would allow to assume a manic episode lasting longer than 7 days. The defendant, at the same time, systematically visited her family physician. Her medical history and her doctor's testimony indicate no noted changes in her behavior and/or appearance that could possibly confirm any cyclicity of mood changes.

Psychiatric opinions relating to court proceedings

The conclusions of 3 forensic-psychiatric evaluations present diagnosis of bipolar affective disorders with rapid cycling and gambling addiction. It was concluded that due to her mental condition, the patient had a limited ability to independently manage her behavior and handle her affairs (opinion following the husband's petition to determine incapacity) and that due to mood and behavior swings and hard to overcome gambling episodes, she was concluding loan agreements at the time when she was unable to make informed and independent decisions and/or declare her intent (opinions following banks' request relating to conclusion of civil law agreements). The author of the fourth forensic and psychiatric opinion, an expert psychiatrist, stated that on the dates of concluding loan agreements, the defendant was sound of mind due to remission of mental illness at that time (he diagnosed bipolar affective disorder), whereas at the moment of the act itself she was driven by so-called gambling craving, i.e., an uncontrolled impulse to get money for gambling at any cost. According to the expert, the impulse was uncontrolled, but it did not eliminate sanity because, despite her addiction, the defendant recognized or could predict the results of her actions. He concluded that her ability to make informed and independent decisions and/or express her intent relating to conclusion of loan agreements was, therefore, sustained.

In view of inconclusive opinions the court turned to experts from the F Department of Forensic Psychiatry of the Institute of Psychiatry and Neurology. Due to extensive stroke suffered by the defendant, which resulted in paralysis and aphasia, it was decided to issue opinion based solely on the case files, without patient examination.

Based on the facts covered by case files, the defendant was diagnosed with problem gambling and reactive mood disorder related to increased financial problems.

1. The patient was found to display symptoms characteristic for problem gambling. The defendant, typically for persons with gambling addiction, concealed her problems from her family members, especially the extent of gambling-related financial problems. For 2 years, she took out numerous loans using money to finance gambling expenses while being certain of her ability to repay the debts with the expected winnings. She was aware of the commitments made and, at the initial stage, tried to pay the installments, consolidate debts, and respond to payment reminders. Then, she started losing control over her commitments. She started to hide bank correspondence and stopped replying to the reminders. She thought she would be able to solve her problems later, when she wins the anticipated cash pay-out. Such conduct exemplifies well-thought-out defensive behaviors aiming to conceal obvious commitment-related damage.
2. In the course of growing financial problems she developed depressive symptoms that never exceeded sub-threshold depression. Based on a neighbor's testimony

it was concluded that the defendant periodically experienced anxiety and distress over the possibility that her financial commitments would be exposed to her family. However, she felt no guilt and did not think about abstaining from such behavior in future. She was diagnosed with being prone to react to negative events in her life.

3. Except for one note on a slightly elated mood, the documentation does not provide any information confirming diagnosis of manic or hypomanic episodes, particularly lasting longer than 7 days, which is one of the criteria for diagnosing bipolar affective disorder.
4. No evidence was found for bipolar disorder with rapid cycling. The described symptoms were characteristic for mood instability and changeability, dysphoria, rather than for a cycle of episodes. Interpretation of dysphoric symptoms as hypomanic seems incorrect. The patient was observed to suffer from episodes of irritation or agitation when her behavior caused reaction on the part of her family. This is fairly typical for persons suffering from addictions at the time when they willingly succumb to impulses. When the person encounters obstacles in the form of criticism from family members, it often results in dysphoric reactions or even self-aggressive behavior, such as demonstrative suicide attempts. The patient's suicide attempts always took place in the presence of a family member, during conflict situation, and they took a form of unusual, not life-threatening acts (such as ostentatious drinking of flower fertilizer). There was no cyclicity determined in reference to mood disorders or gambling activity. Witness testimonies confirm a rather stable interest in gambling for several years. The described personality traits and the late onset of mood disorders are one of the indications to call into question the diagnosed bipolar disorder.

Discussion

Gambling and its consequences have been recognized for centuries, but opinion on the related psychopathology have significantly evolved over the last hundred years [1]. Until recently, the nosology of problem gambling was unclear and although addiction and dependency theories prevailed, some researchers and clinicians noted certain similarities to compulsion, impulse control disorder and other groups of disorders [1]. It is the latest DSM-5 classification [2] that unambiguously includes problem gambling in the group of "substance-related disorders and addictions" stressing, however, their distinctiveness (inclusion in the subcategory of addictions). This position results in significant consequences for forensic and psychiatric opinions in civil and criminal proceedings. The new approach has not been conceptualized enough with respect to court opinions or rulings. In addition, due to political, economic and cultural reasons,

the growing wave of problem gambling reached Poland with delay. Expert psychiatrists, psychologists and courts usually do not have sufficient experience in giving opinions and rulings in cases relating to this type of disorders.

Until recently, the issue of problem gambling in the context of forensic and psychiatric opinions was of marginal interest in Poland. Also the scientific knowledge of clinicians in this regard seems insufficient.

The availability of scientific knowledge about mood disorders in the course of problem gambling is inadequate in relation to knowledge about mood disorders of other etiology. In fact, there is even no term for gambling-related depression. Still, depression and other mood disorders are an immanent part of gambling-related disturbances. Even though the relation between problem gambling and affective disorders is diversified and complex, dominant are reactive disturbances as a reaction to objective factors (such as financial losses and their consequences) and subjective factors (such as the feeling of having problems that cannot be solved in any way, the feeling of powerlessness and helplessness). The above factors may contribute to over-diagnosis of mood disorders that are well known and to under-diagnosis of less known mood disorders caused by gambling.

Problem gambling is often accompanied by other disorders, among which mood disorders feature prominently [1, 3–8]. It is estimated that mood disorders occur in ca. 37.9% of gamblers [9]. Division by the type of affective disorder shows that the prevalence of problem gambling is 8-time higher with bipolar disorder and 3-time higher with recurrent depression. In addition, there has been noted comorbidity of problem gambling with mixed episodes of bipolar disorder. The co-occurrence of bipolar disorder may cause significant diagnostic difficulties because manic episodes may favor behaviors such as gambling (unjustified optimism about the chances to win, ignoring consequences of losing, the feeling of empowerment, attributing oneself with above-normal luck, etc.). This approach allows mania to be interpreted as the cause of secondary problem gambling. There is a possibility of accidental co-occurrence of manic episodes and problem gambling, or that the episodes are precipitated by the mere fact of gambling, winning, losing and emerging problems.

According to majority of modern diagnostic systems (ICD-10, DSM-III, DSM-IV, DSM-IV TR, DSM-5) [2, 10–12,] the diagnosis of symptoms of mania during gambling episodes excludes the diagnosis of problem gambling – criterion B of DSM-5 relating to problem gambling: “the gambling behavior is not better explained by a manic episode” [2] and ICD-10 for pathologic gambling F63.0: “diagnosis excludes: excessive gambling by maniac patients (F30.–)”[10]. However, comments to DSM-5 provide for numerous thoughts on the relationship between bipolar disorder and problem gambling as well as provide diagnostic tips for their differentiation.

For the purpose of differential diagnosis, the authors of DSM-5 suggest to focus on:

- periodicity – meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months;
- duration – experiencing continuous symptoms, to meet diagnostic criteria for multiple years;
- the disease becomes more severe over the course of assessment;
- quality of remission – when remission is diagnosed, it is necessary to specify whether the remission is sustained (none of the criteria for gambling disorder have been met during a period of 12 months or longer) or early (none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months). This means that regression of symptoms, even in full, over a period of less than 3 months does not allow to diagnose remission. In case of doubt it is advised to rigorously verify possible diagnosis of bipolar disorder using modern diagnostic criteria [2].

The analyzed case forms an example of diagnostic and forensic difficulties in a situation where recurring mood disorders are comorbid with problem gambling, and some of the symptoms of both disorders overlap. It should be pointed out that the diminished emotional control of the patient correlated with emotional disturbances and self-aggressive behavior. Problem gambling played a key role in the period of alleged unlawful acts (conclusion of over a dozen of loan agreements and failure to pay the debt back). In the sphere of mental health, the key consequence of gaming is pathological gambling, the feeling that one “must” gamble. It is manifested through impaired control over time and money spent. The impairment of control is the biggest consequence of gambling because it may lead to subjecting all spheres of life to gambling. Something that was supposed to be fun becomes a dominant life activity. For the gambler, the possibility to continue gambling is worth committing acts that violate social and legal norms. Problem gambling is often accompanied by depressive symptoms of different intensity or other unacceptable behaviors identified by some psychiatrists as within the spectrum of bipolar affective disorders.

For the described case, it was necessary to conduct a multi-dimensional analysis of long-term incidence and intensity of mental disturbances as well as their comorbidity with often mutually modulating mental symptoms and experiences. Diagnosing the patient with affective disorders, emotional instability and diminished emotional control is characteristic for addicted persons. They do not meet any of the criteria necessary for diagnosing bipolar affective disorder.

A significant feature is the fact of giving interviews, intentionally or not, by family members who may be interested in obtaining the diagnosis that would affect the court’s ruling by diminishing the sentence. In addition, the discussed case poses a significant ruling problem because a person previously committing unlawful acts tries

to invalidate them justifying her actions with poor mental state at the time of the act which resulted in subsequent unfavorable consequences. In such situations, the experts should be highly careful in their opinions because the patient may, during assessment, adopt defensive attitude, for example, simulate or aggravate the symptoms of mental illness. The experts must, therefore, first reproduce the mental state of the patient at the moment of committing alleged unlawful acts and only then express their opinion on the awareness and independence of decision and intent [13].

The literature describes different reasons which may form the basis for invalidating declaration of intent made. One of them is mental state described in Article 82 of the Polish Civil Code: "A declaration of intent made by a person who, for any reason, is in a state which precludes the conscious or free making of a decision and declaring of intent is invalid. This applies in particular to mental illness, mental retardation or other, even temporary, mental disorder" [14]. Inability to make a valid declaration of intent is interpreted differently. Some researchers believe that even minor mental disturbances may, in some cases, form a premise for ruling out the ability to make declaration of intent. Other conclude that only serious disturbances, such as acute psychotic state, significant mental retardation and dementia at the time of declaring the intent result in its legal invalidity [13].

It is beyond any doubt that mental illness, such as bipolar disorder, may eliminate the ability to make legally bounding decisions, but only during the incidence of obvious symptoms typical for psychosis. The mere fact of diagnosis of bipolar disorder may not form the basis for drawing conclusion regarding legal incapacity at all times and in each situation. The very definition of the illness provides for episodic nature of its course. It has been recognized that the periods of recurrence have different intensity and length. They are alternated by periods of remission lasting couple years or more. Even in case of rapid cycling, there are periods of remission. The literature shows that in case of hypomania, the elimination of ability to conclude legal acts is a matter of discussion and not all experts believe it is correct [14]. In addition, if an act is continuous or recurring many times in the same circumstances, it is necessary to analyze the relation between the act and the mood disorders, attitude of the patient, and/or criticism at the time of committing the act.

For problem gambling, as best conceptualized among behavioral addictions, it is necessary to consider the complexity of processes related to addictive behaviors. These processes are understood on many levels, both biological, including molecular, related to dysregulation of many neurotransmitter systems (mainly dopamine pathways) and functional, such as impairment in many social spheres. Biological context for the group of behaviors co-occurring with gambling shows clear difficulties in specifying which act constitutes a direct stimulus responsible for involvement in gambling; most probably it is an individually variable/dependant factor. The difficulties in categorizing the act

and its legal consequences (understanding the addiction in civil and criminal terms, responsibility, awareness, sanity, source of intoxication and the intoxication-induced state) have been presented in experts' opinions discussed above.

One more issue was noted while analyzing the files, which has a direct impact on the results of assessment, namely a lenient interpretation of legal regulations by experts and arbitrary interpretation of mental disorders. In one of the opinions, the expert stated that in the course of her activities the patient was under the influence of so-called gambling craving, i.e., an uncontrolled impulse to get money with which to gamble at any means. The impulse was uncontrolled but it did not eliminate sanity because, despite the addition, the patient was able to predict the consequences of her behavior. It seems that this conclusion shows the addictive nature of excessive borrowing, not gambling, when the impulse, and the need to act on the impulse, by taking a loan, is the equivalent of being drunk. The patient, therefore, just as a drinking person who is aware of the consequences of getting drunk, was supposed to take responsibility for concluding a loan agreement. It is probable that the expert assumed that addictive gambling should be treated just as any other substance addiction and gave opinion in line with a "clear case" addiction regulated by Article 31 § 3 of the Polish Penal Code: "The provisions of § 1 and 2 shall not be applied when the perpetrator has brought himself to a state of insobriety or intoxication, causing the exclusion or reduction of accountability which he has or could have foreseen". This conclusion arises from a wrong application, in opinions prepared for criminal proceedings, of the criteria for limiting or eliminating sanity, which results in exclusion of liability for any civil and criminal decisions. At the same time, it allowed to recognize the acts such as accumulating funds by a gambler as the symptoms of craving and meeting the drive. It is worth to note that the consequences of excessive liberty in the interpretation of evidence, or arbitrary use of terminology, by the experts result in contradictory conclusions, which are incomprehensible to courts. It is difficult for the court to compare and assess different opinions, thus it often happens that another team of experts must be appointed.

The case discussed in this paper presents diagnostic difficulties encountered by experts when dealing with co-occurrence of symptoms characteristic for different disorders. This is relevant especially when they are uncritical about diagnosis based on assessments made in outpatient clinic conditions. The assessments are often hampered with intentional acts of family members seeking the explanation for difficult to accept behavior of their loved ones. While appreciating the information found in medical files, it is important to be genuine in the assessment of the entire period relating to the alleged unlawful acts in the context of the patient's life events. Special attention should be drawn to the need for in-depth examination of symptoms of mental illness before the onset of any disorders resulting from the addiction. It should also be stressed that

bipolar disorder is episodic in its nature, therefore, it must be remembered that during remission patients experience change of criticism and attitude toward their behavior in the period of increased mood. For the conclusions to be accurate it is important for the evidence to come from different sources and be confirmed both by the patient's biographical data and the diagnoses made by individual experts involved in the case. Only multi-dimensional approach and establishment of a common diagnosis, based on in-depth analysis, allows for reliable and objective assessment of personal and social functioning of a given person, especially in complex cases, when symptoms of different disorders overlap.

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