

# The WAGER, Vol. 13(2) - Chickens, Eggs, and Psychiatric Comorbidity Among PGs

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People with gambling-related problems also are likely to qualify for other psychiatric disorders (McIntyre et al., 2007; Shaffer et al., 2007). Understanding the temporal sequence of PG and comorbid disorders can provide information about how PG relates to other disorders and suggests causal links. Unfortunately, there is little research that clarifies how the onset of PG relates temporally to the onset of other disorders. This week's WAGER reviews a large epidemiological study by Kessler, Hwang, LaBrie, Petukhova, Sampson, Winters & Shaffer (2008), which investigated comorbid disorders among people with PG. In addition, this study examined the temporal onset of PG and the onset of other disorders.

The National Comorbidity Survey Replication (NSC-R), a nationally representative sample of 9,282 English speaking adults (Kessler & Merikangas, 2004), used the Composite International Diagnostic Interview (CIDI; Kessler & Ustun, 2004) to assess DSM-IV criteria (American Psychiatric Association, 1994) for Axis I disorders, and age of onset (AOO; i.e., the age at which people first reported the first symptom of a given disorder) for those with disorders.

**Table 1. Lifetime psychiatric comorbidity among participants with lifetime PG (adapted from Kessler et al., 2008)**

| Disorder                     | Prevalence of disorder among those w/ PG | Temporal Sequence<br>(for those with PG and other disorder) |                      |                    |
|------------------------------|------------------------------------------|-------------------------------------------------------------|----------------------|--------------------|
|                              |                                          | PG first                                                    | Other disorder first | Onset at same time |
| Any mood disorder            | 55.6%*                                   | 23.1%                                                       | 65.1%                | 11.7%              |
| Any anxiety disorder         | 60.3%*                                   | 13.4%                                                       | 82.1%                | 4.5%               |
| Any impulse control disorder | 42.3%                                    | 0.0%                                                        | 100%                 | 0.0%               |
| Any substance use disorder   | 42.3%*                                   | 36.2%                                                       | 57.4%                | 6.4%               |

\* Prevalence significantly greater among PGs compared to the rest of the sample ( $p < .05$ ).

**Note:** Any mood disorder = major depressive disorder or dysthymia and bipolar disorder. Any anxiety disorder = phobias, generalized anxiety, panic, and post-traumatic stress disorder. Any impulse control disorder = oppositional-defiant, conduct, attention deficit hyper activity, and intermittent explosive disorders. Any substance use disorder = alcohol or drug abuse, dependence, and nicotine

dependence.

The lifetime prevalence of pathological gambling (PG) within the sample was 0.6%. Almost all participants who had lifetime PG also had another lifetime disorder (96.3%) and 64.3% suffered from three or more disorders. Table 1 shows that mood disorders, anxiety disorders, and substance use disorders were significantly elevated among participants with PG, and that other disorders were more likely to precede PG than to occur afterward or begin at the same time. In fact, 74.3% of participants with PG and another disorder experienced the other disorder before PG.

These results provide important information about the temporal relationships among disorders. However, this study cannot conclusively determine whether any disorder caused PG, or PG caused another disorder. Furthermore, the data in this study derived from retrospective self-report; consequently, AOO might not be accurate because of recall errors. However, the results suggest that PG rarely exists alone. This study adds important new data about typical pattern of onset. The study also illuminates the need for mental health and medical professionals to assess PG along with the variety of other disorders with which it is often comorbid.

What do you think? Comments can be addressed to Leslie Bosworth.

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