Pathological Gambling in Relation to Anxiety and Identity Status

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Abstract

Pathological gambling represents the end spectrum of gambling behaviors. This behavior affects the gambler's family and friends and the most obvious consequence of gambling problems is a poor private economy. This study examines the connection between pathological gambling, anxiety and identity status. A group of 50 patients diagnosed with pathological gambling which joined this research filled in the South Oaks Gambling Screen, the STAI-Form Y Anxiety Inventory and the Identity status measure EOM-EIS-2. The results were compared to those obtained by a control group. The clinical group shown higher level SOGS scores and higher anxious symptomatology compared to the control group. Concerning the identity status in the clinical group, it was shown that moratorium and diffuse identity were prevalent.

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1. Problem statement

The DSM-IV (American Psychiatric Association, 2000) defines pathological gambling as "persistent and recurrent maladaptive gambling behavior that is not better accounted for by a manic episode".

There are some social critics that even question whether problem gambling is merely a moral problem that has been recently medicalized to excuse decadent behaviors (Castellani, 2000). Identification of risk factors and determining the nature and relative strength of their influence is important to advance understanding of problem gambling and develop effective interventions to assist problem gamblers and prevent problem onset and progression. The main risks factors that surface along with the pathological gambling are as following:

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age, gender, depression and anxiety, impulsive behavior, abusive consumption of alcohol, drug and cigarettes, emphasized personality traits, intolerance to boredom, illusion of control over game, availability to play (Welte, Barnes, Wieczorek, Tidwell, & Parkera, 2004).

A more recent study (Toce-Gerstein & Volberg, 2003) brought out the need to recognize the pathological form of gambling and its connection to the severe depressive-anxious symptomatology.

Epidemiological studies support the idea that gamblers with a persistent and recurrent pathological disadaptive behavior have extensive emotional vulnerabilities: more than 40% have suffered from anxiety disorder at least once in life and about 23% have a specific cluster B personality disorder (Kessler et al., 2008, Petry, Stinson, & Grant, 2005).

Similarly, gamblers with persistent and recurrent pathological behavior suffer from generalized anxiety disorders (Crockford & el-Guebaly, 1998, Hodgins et al., 2005, Rizeanu, 2012a), and up to 17% have a comorbidity of cluster B personality disorder, antisocial and anxiety disorders (Pietrzak & Petry, 2005).

The issue of identity status (Marcia et al., 1993) has a double source: individual and social. The identity formation process and its continuation from adolescence to adulthood (Kroger, Haslett, 1991) requires the person to experience inner incongruity, loss and the crisis of sense and to be able to find a solution by himself and in relation with others.

Literature identifies four states which comprise a series of amendments: identity acquisition (psychosocial development, self-actualization, high adaptation and overall high level of ego development, social cognition and efficiency, tendency to succeed in various activities), the moratorium status (increased level of anxiety, capacity to represent the overall situation, constant social dissatisfaction, high self-awareness that is related to vulnerability and exposure), the foreclosure identity (authoritarianism and rigidity, poor psychosocial development, lack of self-actualization, low adaptability, lack of analytical thinking and predisposition to commit errors) and diffuse identity (subject oriented towards exterior, impulsivity, tendency to psychopathology, overwhelmed by the social environment, lack of tolerance of frustration, tendency to conceal, etc.).

2. Purpose of study

The objective of the present study was to investigate the relationship between pathological gambling, anxiety-state, anxiety-trait and identity status.

In agreement with the data and observations presented above our hypotheses are the following:

Participants diagnosed as pathological gamblers show higher anxious symptoms scores compared to the persons in the control group;

We expect that participants from the clinical group, diagnosed as pathological gamblers, to present a diffused identity status.

3. Research methods

We used two groups with an equal number of participants and perform according to design research on the grounds of age and education level. The clinical group consisted of 50 outpatients diagnosed with pathological gambling disorder by medical staff of the Department of Psychiatry at the Al. Obregia Hospital, based on DSM-IV-TR (2000), 40 males and 10 female aged between 22 years and 38 years, (M age = 27.7), with various educational level. The control group consisted of 50 participants, Hyperion University students, 14 males and 36 female, individuals with secondary and higher education. Selection was random as the criteria were related to age and educational level. We used the following measures:
The South Oaks Gambling Screen (SOGS, Lesieur and Blume, 1987) includes 16 items related to the practice of gambling. A score of 5 or more points is considered specific for a potentially pathological gambler. For the present study the coefficient of internal consistency was 0.82.

STAI-Form Y Anxiety Inventory (Spielberger et. al., 1983) consists of two self-assessment scales for measuring two distinct concepts of the state of anxiety (A-state) and anxiety as a trait (A-trait). Scale (A-state) consists of 20 descriptions based on how people express they feel overall. Scale (A-trait) also consists of 20 descriptions, but the instructions require subjects to indicate how they feel at some point. The STAI state scale is scored on four levels of anxiety intensity from 1='not at all' to 4='very much' and with a sum score between 20 and 80. It is usually administered as a self-completion questionnaire.

In research field and psychiatry the scale (A-state) can be used in determining current levels of anxiety, or as an indicator of the level of self-control.

Identity status measurement scale (The Extended Objective Measure of Ego Identity Status, EOM-EIS-2, Bennion & Adams, 1986) aims to auto-evaluate the level of development of individual identity status. EOM-EIS-2 has a total of 64 items that are built in the Likert system, starting 1 = strongly agree to 6 = strongly disagree. The scale contains four subscales: identity acquisition, foreclosure identity, moratorium and diffused identity. Scores range from 16-96 points. During this research global statuses distributed in the four subscales were used. Cronbach alpha coefficient for this study showed good internal consistency (.84).

4. Findings

Demographics of participants in the study shows us that the two groups have an equal number of participants and perform according to a research design that was held on two main criteria: age and education level (see tabel 1).

| Table 1 Demographics of participants (N=100, clinical group = 50; control group=50) |
|-----------------------------------------------|---|---|---|---|
| Clinical group                              | Control group           |
| M    | Sd   | M    | Sd  |
| Age  | 27.7  | 5.87  | 28.5 | 6.23 |
| Gender (%)                                  |                           |
| Male | Female | Male | Female |
| 80%  | 20%    | 28%  | 72%  |
| Education                                  |                           |
| M    | Sd    | M    | Sd   |
| 15.8 | 3.46   | 19.3 | 4.41 |

The South Oaks Gambling Screen was applied to the independent groups considered through the differential t test and assuming the homogeneity of variance (by Levene test).

The results obtained for a total group of 100 subjects (two groups of 50 subjects each) showed for the clinical group the mean of 21.13 and a standard deviation of 3.661, and for the control group a mean of 17.89 with a standard deviation of 4.568, where t(df=65)=5.183, p<0.002.

Thus we can say that while the scores were high for the clinical group (above 5), to reinforce the diagnosis - pathological gambling disorder - which selected participants of The Al. Obregia Hospital presented when included in the study, the scores registered by the control group didn’t match the pathological level.

In order to evaluate the anxiety and identity status, we calculated an independent samples t test comparing the mean score of participants who were in the clinical group and those in the control group.
The mean of 57.98 and a standard deviation of 14.316, which indicates a high level of anxiety-state, were obtained when applying STAI-Y through the differential t test, corresponding to assuming the variance homogeneity (verified by Levene test) to the clinic group (see tabel 2).

The mean of 30.06 and the standard deviation of 11.650, which indicate a slightly anxious state, were obtained for the control group.

The statistic calculation shows a $t(\text{df}=80)=8.163$, $p=0.001$, which demonstrates that the manifestations of anxiety symptomatology have been significantly registered within the clinic group, compared with the control group, where the score indicated a normal range anxiety.

<table>
<thead>
<tr>
<th>STAI-Y score</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>t test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control group</td>
<td>30.06</td>
<td>11.650</td>
<td>8.163</td>
</tr>
<tr>
<td>Clinical group</td>
<td>57.98</td>
<td>14.316</td>
<td>Sig. (2-tailed) $p=0.001$</td>
</tr>
</tbody>
</table>

Regarding trait-anxiety, an independent-samples t test was calculated and indicates a $t(\text{df}=80)=7.422$, $p=0.000$. The mean for the clinic group registered values $M=27.24$ and a standard deviation of 12.788. The control group registered a mean $M=27.24$ and standard deviation of 7.553. As we could observe in the case of anxiety-trait, the scores reported by the subjects had lower anxiety levels for both groups (see table 3).

<table>
<thead>
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<th>Mean</th>
<th>Std. Deviation</th>
<th>t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control group</td>
<td>27.24</td>
<td>7.553</td>
<td>7.442</td>
</tr>
<tr>
<td>Clinical group</td>
<td>55.47</td>
<td>12.788</td>
<td>Sig. (2-tailed) $p=0.000$</td>
</tr>
</tbody>
</table>

The EOM-EIS-2 results in the clinical group showed that the global identity statuses of the participants were distributed significantly differently in the four categories (subscales). The findings provide a significant difference (chi-square to degree of correspondence) $\chi^2 = 151.41$, $p <.03$ that comes from grouping global identity to the statuses of moratorium and identity diffuse type: 89.3%. Such is invalidated the part of the research hypothesis claiming that the clinical group participants (outpatients diagnosed with pathological gambling disorder) present mainly a diffuse identity status. The finding provides also that in terms of acquired foreclosure identity status the percent within the clinic group is very low, 10, 7%.

5. Conclusions

Clinical experience and statistical specific methods are designed for disclosing the specific symptoms that can show the world of turmoil that practitioners find in their patients.

Pathological gambling is a complex phenomenon that requires a permanent diagnostic investigation followed by further interventions or psychotherapeutic counseling. In this study we undertook an analysis of patients diagnosed with pathological gambling and identified a number of features that indicated co morbidity
with identified anxious symptomatology. More studies report the presence of a severe level of anxiety among pathological gamblers (Rizeanu, 2012b).

Another aspect investigated by this research was one that referred to the development and identification of the identity status for pathological gamblers: we showed that an empty and diffuse identity is associated with a higher likelihood of pathological gambling.

Application of such evidence in the investigation pathological gamblers may present a good opportunity to build support for a subsequent psychotherapeutic approach.

The process of self-definition that is experienced by the individual is an important factor in pathological gambling (Baumeister, 1991); it is encountered in the development of identity status, and its intersection with the reference system, with individual, community and social values (which are changeable in the case of diffuse identity) can be used for the comprehensive understanding of the patient facing pathological gambling issues.

In the future such analysis can be used in preparing the psychotherapeutic plan which begins from the stage of evaluating these factors. The evaluation process will also require the inclusion of interdisciplinary investigations carried out both transversely and longitudinally after psychopharmacological, psychotherapeutic intervention and social reintegration, each of these parts of the treatment specifically developing over time.

References


