Pathological gambling and impulsivity: an Italian study

DONATELLA MARAZZITI, MICHELA PICCHETTI, STEFANO BARONI, GIORGIO CONSOLI, DIANA CERESOLI, GABRIELE MASSIMETTI, MARIO CATENA DELL’OSSO

E-mail: dmarazzi@psico.med.unipi.it

Dipartimento di Medicina Clinica e Sperimentale, Section of Psychiatry, Università di Pisa

SUMMARY. Aim. Although the precise nature of pathological gambling (PG) is still elusive, currently it is considered an impulse-control disorder that shares several features with substance dependence, such as deficit in self-regulation and impaired impulsivity. The aim of this study was to evaluate the impulsivity of PG patients by means of the Barratt Impulsivity Scale, version 11 (BIS-11), as compared with healthy control subjects, and to explore the possible correlations with gambling severity. Methods. Thirty-five outpatients (all men) with a diagnosis of PG were recruited at their first psychiatric interview in a psychiatric outpatient ward, and compared with a similar group of healthy control subjects. The severity of PG was assessed by means of the South Oaks Gambling Screen (SOGS). Results. The results showed that the BIS-11 total score, as well as the scores of different factors (motor impulsivity and cognitive complexity) and subscales (motor and non-planning impulsivity) were significantly higher in PG patients than in control subjects. In addition, positive correlations were detected between the SOGS and the BIS-11 total scores, and the attention and cognitive instability factor scores, or the attentional and motor impulsivity ($r_s=0.459$, $p=.021$) subscale scores. Conclusions. These findings support the notion that impulsivity represents a core element of PG linked to the severity of the clinical picture.

KEY WORDS: pathological gambling, addiction, impulsivity, SOGS, BIS-11.

INTRODUCTION

According to the previous edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR)\(^1\), pathological gambling (PG) is an impulse-control disorder, characterized by persistent and maladaptive gambling behaviors, that shares similarities with substance abuse disorders. In fact, the core features of PG are craving, tolerance, withdrawal symptoms, frequent relapse, loss of control, and disruption of life, until the point of loss of job, divorce, deterioration of patrimony or even criminal behavior\(^2,3\). Nowadays, a large agreement exists that deficits in self-regulation and impaired impulsivity represent the most salient features of both impulse control disorders, such as PG, and substance dependence\(^4\). This notion has led to the inclusion of PG amongst substance use disorders in the latest DSM edition (DMS-5)\(^5\). Therefore, according to several authors, PG should be considered a form of “behavioral or drug-less addiction” characterized by high impulsivity\(^6\). Nevertheless, an alternative model of
PG considers it related to obsessive-compulsive disorder (OCD), closer to the impulsive pole of an impulsivity-compulsivity dimensional axis. In any case, some studies cast doubt about the significant association between PG and OCD. Subsequently, impulsivity has been considered mainly as an endophenotype of individuals at risk for both PG and substance use disorder and, not surprisingly, in the next edition of DSM PG will be reclassified into the “addiction and related disorders”.

Impulsivity has been variously defined as a swift action without forethought or conscious judgment, behavior without adequate thought, and the tendency to act with less forethought than do most individuals of equal ability and knowledge. The most exhaustive definition of impulsivity is perhaps that given by the International Society for Research on Impulsivity (ISRI), which considers it as “a human behavior without adequate thought, the tendency to act with less forethought than do most individuals of equal ability and knowledge, or a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to negative consequences of these reactions”. Impulsivity may be viewed as a state or a trait, first referring to a transitory state in response to a peculiar event, while the other refers to a stable personality feature.

A great bulk of evidence suggests that impulsivity is widely implicated in the development and maintenance of both addictive behaviors and of PG that would arise from an impairment of inhibitory control and self-regulation.

When comparing PG patients with control subjects, some studies reported high levels of impulsivity in the first group, or no difference. Part of the controversies might be related to the inclusion of heterogeneous samples of PG patients, but also to the use of different instruments for assessing impulsivity, such as neurocognitive tests or self-report questionnaires. Some authors, while using some neurocognitive tests, such as the Stop Signal Task, the Stroop task, the Wisconsin Card Sorting Test, the Tower of London and a few others, described low impulsivity in PG. It should, however, be underlined that these instruments assess state impulsivity. On the contrary, this dimension resulted high on self-report tests, such as the Barratt Impulsivity Scale, version 11 (BIS-11), and the Eysenck Impulsiveness Questionnaires, assessing trait impulsivity. Similar findings were obtained also with neuropsychological measures of trait impulsivity, such as the reaction time and number of errors at Go/No-Go tasks, while highlighting the impact of this dimension in the clinical picture of PG and, perhaps, in the development of the disorder itself.

Moreover, the combination of both BIS-11 and Iowa Gambling Task in a group of 42 PG patients compared with non-gambler subjects showed that the first were more impulsive than the second.

Given the lack of information in our country, in order to provide a further contribution on this topic, our study aimed to compare impulsivity, by means of the BIS-11 questionnaire, in Italian PG outpatients and healthy control subjects, and to explore the possible correlations between PG severity and impulsivity characteristics.

**MATERIALS AND METHODS**

**Subjects**

 Thirty-five outpatients (all men, mean age±SD: 46.23±11.6 years) with a diagnosis of PG, as assessed by the structured clinical interview for DSM-IV, patient version 2.0 (SCID-P). were recruited at their first psychiatric interview at the outpatient ward of the Dipartimento di Medicina Clinica e Sperimentale, Section of Psychiatry, University of Pisa, Italy. None suffered from any severe physical illness nor had ever taken psychotropic drugs, except for ten patients who had occasionally taken benzodiazepines for difficulty with sleeping or panic attacks. The severity of PG was assessed by means of the South Oaks Gambling Screen (SOGS, normal score <5): the total score (mean±SD) of the patients was 10.9±2.7. The age of onset of the disorder (mean±SD) was 30.8±13.2 years. The majority of the patients used multiple types of gambling: electronic machines, internet lotteries or casino and bingo.

Six patients were suffering also from simple phobia, three from panic disorder, three from bipolar disorder of type II, and two from generalized anxiety disorder. Twelve patients were heavy cigarette smokers (<20/die); three were suffering from cannabis abuse and two from alcohol abuse.

Twenty-three patients were single or divorced, ten married and two were widowed. Twenty-eight patients had completed a high school, four had a university degree and three had completed only the primary school.

The patients were compared with a similar group of healthy control subjects (35 men, mean age±SD: 47.19±13.4 years), who had no family or personal history of any major psychiatric disorder, as assessed by a psychiatric interview, carried out by a senior psychiatrist (DM) by means of the SCID. They were recruited amongst medical and nursing staff at the Department of Psychiatry, Neurobiology, Pharmacology, and Biotechnology, University of Pisa, Italy. These subjects were also free of any physical illness, as documented by a general check-up and by the normal blood and urine tests and were completely psychotropic drug-free for about 12 months. None of them were heavy cigarette smokers; none of the participants belonged to a high-risk HIV group, and none took any regular medication. All gave their informed consent to participation in this study, which was approved by the Ethics Committee of Pisa University.

**Impulsivity assessment**

The impulsivity was assessed by means of the BIS-11 questionnaire validated into Italian. The BIS-11 is a self-report scale developed to measure impulsivity as a stable characteristic, composed by 30 items, which are answered on a four-point scale; items are scored 1, 2, 3, 4, where 4 indicates the most impulsive response: the higher the total scores for all items, the higher the level of impulsivity. The total score range between 30 and 120, with no established cut-off point and is the result of the sum of three different subscales: attentional (rapid shifts of attention and impatience with complexity), motor (impetuous action), and non-planning (lack of future orientation) impulsivity. In addition, the 30 items form six factors determined by principal component analyses: attention, motor impulsivity, self-control, cognitive complexity, perseveration and cognitive instability.

**Statistical analyses**

The unpaired Student’s t test was used to compare parametric variables, such as the age. Since the BIS-11 scales, subscales and...
Pathological gambling and impulsivity: an Italian study

RESULTS

The BIS-11 total score (mean±SD) was significantly higher in PG patients than in control subjects (65.46±12.08 vs 57.34±11.04; Mann-Whitney test: Z=−2.50, p=.012).

As far as the BIS-11 factors were concerned, the “motor impulsivity” and “cognitive complexity” scores were significantly higher in PG patients than in control subjects (16.34±4.84 vs 11.26±3.40, Z=−3.88, p=.001; 13.73±2.75 vs 12.38±2.70, Z=−1.96, p=.050). The same was true for “motor” and “nonplanning” impulsivity subscale scores (23.96±5.17 vs 18.53±3.89, Z=−3.87, p=.001; 18.88±4.00 vs 16.58±4.11; Z=−1.90, p=.047) (Table 1). The comparison of the “self-control” factor scores showed a similar, albeit not significant, trend.

No differences were measured between patients suffering and not suffering from substance abuse, or between those with and without comorbid psychiatric disorders.

A significant and positive correlation was detected between the SOGS and the BIS-11 total scores (r=0.492, p=.012) and cognitive instability (r=0.461, p=.020) factor scores, or the attentional (r=0.405, p=.045) and motor impulsivity (r=0.459, p=.021) subscale scores.

DISCUSSION

One of the main results of the present study was that a sample of Italian PG patients showed higher levels of impulsivity, as measured by the BIS-11 total score, than control subjects. This finding is the first of this kind in Italy and supports the existence of the already and widely reported association between impulsivity and PG. In addition, it is in agreement with the notion that impulsivity may represent a core element of PG, perhaps related to a typical personality trait or structure that may predict the development of addictive and impulsive behaviors. Moreover, our findings, while highlighting the positive correlation between gambling severity, as assessed by the SOGS, and BIS-11 total and some factor/subscale scores, would support the assumption that a strict link may exist between PG severity and impulsivity, as already reported by using other questionnaires. However, some controversies do exist on this topic.

While comparing the scores of each BIS-11 factor and scale between patients and healthy control subjects, it turned out that PG patients showed higher scores than healthy individuals on the motor impulsivity and cognitive complexity factors, and on the motor and non-planning impulsivity subscales, with no differences either on the attentional impulsivity subscale or attention factor. Similar finding were reported recently in gamblers with different degrees of clinical severity, and in strategic and non-strategic gamblers assessed by neurocognitive tests. These data have been generally interpreted along the hypothesis that impulsivity in PG might originate from deficits of executive functions rather than of attention. We would add with cautions that this assumption is indirectly supported by our findings showing that the attention factor and the attentional impulsivity subscale scores were positively related to the severity of PG, as measured by the SOGS total scores.

Moreover, the perseverance factor was not different between the groups. This last aspect could be considered as consistent with some studies reporting no link with OCD or obsessional personality, as perseverance is a feature typical of these two conditions. We would add with cautions that this assumption is indirectly supported by our findings showing that the attention factor and the attentional impulsivity subscale scores were positively related to the severity of PG, as measured by the SOGS total scores.

Table 1. BIS-11 total, factor, and subscale scores (mean±SD) in PG patients and healthy control subjects

<table>
<thead>
<tr>
<th>BIS-11 factor</th>
<th>PG patients</th>
<th>Control subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIS-11 total score</td>
<td>65.46±12.08</td>
<td>57.34±11.04*</td>
</tr>
<tr>
<td>attention</td>
<td>8.88±3.01</td>
<td>9.85±2.92</td>
</tr>
<tr>
<td>motor impulsivity</td>
<td>16.34±4.84</td>
<td>11.26±3.40**</td>
</tr>
<tr>
<td>self-control</td>
<td>13.73±3.53</td>
<td>11.81±3.74</td>
</tr>
<tr>
<td>cognitive complexity</td>
<td>13.73±2.75</td>
<td>12.38±2.70***</td>
</tr>
<tr>
<td>perseverance</td>
<td>7.62±2.00</td>
<td>7.27±1.66</td>
</tr>
<tr>
<td>cognitive instability</td>
<td>5.15±1.57</td>
<td>4.77±1.63</td>
</tr>
<tr>
<td>BIS-11 subscale score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attentional</td>
<td>22.61±4.73</td>
<td>22.23±5.01</td>
</tr>
<tr>
<td>motor</td>
<td>23.96±5.17</td>
<td>18.54±3.80****</td>
</tr>
<tr>
<td>nonplanning</td>
<td>18.88±4.00</td>
<td>16.58±4.11*****</td>
</tr>
</tbody>
</table>

* significant: z=−2.50, p=.012; **significant: z=−3.88, p=.001.
*** significant: z=−1.96, p=.050.
**** significant: z=−3.87, p=.001.
***** nearly significant: z=−1.90, p=.057.

Riv Psichiatr 2014; 49(2): 95-99

97
by the fact that 14 patients were suffering from different co-
morbid psychiatric disorders and 17 from substance abuse, 
conditions that are all characterized by high levels of impul-
sivity. Interestingly, disinhibition, that often equates impul-
sivity, is considered an endophenotype of subjects at high 
risk for PG and substance abuse. Fourth, the gambling 
severity was assessed by the SOGS only. This scale was cho-
en because it is the most used in our country and can be use-
ful for comparing the results deriving from different centers. 
Fourth, our sample was composed almost entirely by men, so 
that we cannot exclude a gender effect on impulsivity, al-
though literature findings on this topic are controversial.

CONCLUSIONS

Taken together, the findings of the present study support 
the notion that impulsivity represents a core element of PG 
perhaps linked to the severity of the clinical picture. Howev-
er, further studies, carried out in larger samples of PG pa-
ients of both sexes with and without comorbid psychiatric 
disorders, and assessed by means of multiple neurocognitive 
tests and neuroimaging techniques, such as those used re-
cently, are necessary to explore the possible relationships 
between impulsivity and PG.

REFERENCES

1. American Psychiatric Association. DSM-IV: Diagnostic and 
   Statistical Manual of Mental Disorders (4th ed.). Washington, 

2. Blum K, Braverman ER, Holder JM, et al. Reward deficiency 
syndrome: a biogenic model for the diagnosis and treatment 
of impulsive, addictive, and compulsive behaviors. J Psychoacti-

3. Blassczynski A, Nower L. A pathways model of problem and 

4. Goldstein RZ, Volkow ND. Drug addiction and its underlying 
   neurobiological basis: neuroimaging evidence for the involve-

5. American Psychiatric Association, DSM-5: Diagnostic and Sta-
   tistical Manual of Mental Disorders (5th ed.). Washington, DC: 

6. Potenza MN. The neurobiology of pathological gambling and 
   drug addiction: an overview and new findings. Philos Trans R 

7. Stein DJ, Hollander E. The spectrum of obsessive-compulsive 
   related disorders. Washington, DC: American Psychiatric Press, 
   1993.

8. Blassczynski A. Pathological gambling and obsessive-compulsi-

9. Black DW, Shaw M, Blum N. Pathological gambling and com-
   pulsive buying: do they fall within an obsessive-compulsive 


11. Tavares H, Gentil V. Pathological gambling and obsessive-com-
    pulsive disorder: towards a spectrum of disorders of volution. 

12. Verdejo-Garcia A, Lawrence AJ, Clark L. Impulsivity has a vul-
    nerable marker for substance-use disorder: review of findings 
    from high-risk research, problem gamblers and genetic associa-

13. Swann AC, Lijffijt M, Lane SD, Steinberg JL, Moeller FG. Trait 
    impulsivity and response inhibition in antisocial personality dis-

14. Lai FDM, Ip AKY, Lee TMC. Impulsivity and pathological 
    gambling: Is it a state or a trait problem? BMC Research Notes 
    2011; 4: 492.

15. Petry NM. Pathological gamblers, with and without substance 
    use disorders, discount delayed rewards at high rates. J Abnorm 

16. Aron AR, Monsell S, Sahakian BJ, Robbins TW. A component-
    tial analysis of task-switching deficits associated with lesions of 

17. Clark L, Roiser JP, Cools R, Rubinstein DC, Sahakian BJ, Rob-
    bins TW. Stop signal response inhibition is not modulated by 
    tryptophan depletion or the serotonin transporter polymor-
    phism in healthy volunteers: implications for the 5-HT theory of 

    characteristics and personality traits in pathological gambling. 

19. Sáez-Abad C, Bertolín-Guillén JM. Personality traits and disor-
    ders in pathological gamblers versus normal controls. J Addict 

20. Lawrence AJ, Luty J, Bogdan NA, Sahakian BJ, Clark L. Impul-
    sivity and response inhibition in alcohol dependence and 

21. Dannon PN, Shoenfeld N, Rosenberg O, Kertzman S, Kotler M. 
    Pathological gambling: an impulse control disorder? Measure-
    ment of impulsivity using neurocognitive tests. Isr Med Assoc J 

    Dell’Osso L. Pathological gambling. A systematic review of bio-
    chemical, neuroimaging and neuropsychological findings. Harv 

23. Alessi SM, Petry NM. Pathological gambling severity is associa-
    ted with impulsivity in a delay discounting procedure. Behav 
    Processes 2003; 64: 345-54.

24. Fuentes D, Tavares H, Artes R, Gorenstein, C. Self-reported and 
    neuropsychological measures of impulsivity in pathological 

    vity and compulsivity in pathological gambling. Psychiatry Res 

26. Steel Z, Blassczynski A. Impulsivity, personality disorders and 


28. Kertzman S, Lowengrub K, Aizer A, Vainder M, Kotler M, Dan-
    non PM. Go-no-go performance in pathological gamblers. Psy-

29. Glücksohn J, Zilberman N. Gambling on individual differences 

30. First MB, Spitzer RL, Gibbon M, Williams JWB. Structured Cli-
    nical Interview for DSM-IV Axis I Disorders-Patient Edition 
    (SCID-I P, Version 2.0, 4 97 revision). New York: Biometrics Re-
    search, New York State Psychiatric Institute, 1997.

31. Lesieur HR, Blume SB. The South Oaks Gambling Screen 
    (SOGS): a new instrument for the identification of pathological 

32. Fossati A, Di Ceglie A, Acquarini E, Barratt ES. Psychometric 

33. Odlaug BL, Chamberlain SR, Kim SW, Schreiber LR, Grant JE. 
    A neurocognitive comparison of cognitive flexibility and re-
    sponse inhibition in gamblers with varying degrees of clinical se-

34. Grant JE, Chamberlain SR, Schreiber LR, Odlaug BL. Neuro-
    cognitive deficits associated with shoplifting in young adults. 

Riv Psichiatr 2014; 49(2): 95-99

98
Pathological gambling and impulsivity: an Italian study