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DEFINING THE “DEFINED”—PROBLEM GAMBLING, PATHOLOGICAL GAMBLING, AND GAMBLING DISORDER: IMPACT ON POLICY AND LEGISLATION

*Sarah A. Hinchliffe**

INTRODUCTION

For many people, gambling is a legitimate part of their leisure and recreation activities. While most people who gamble do so in a responsible manner and enjoy gambling as entertainment, for some it is a cause of problems for themselves, their families, and the community.

This paper highlights the shifts in regulatory priorities and identifies that, with the emergence of more complicated methods of gambling and related activities, coupled with an affluent health policy sphere (*vis-à-vis* with respect to mental health and disability law), and consumer protection laws, regulation of gambling providers has become a logistical nightmare for both problem gamblers and providers alike. Drawing on cross-disciplinary intercepts between law and psychology, this paper highlights the deficiencies and strengths that exist in an attempt to classify pathological gambling,¹ and the recently renamed gambling disorder,² as a disability. At present, this intercept is underrepresented in research, and yet is paramount for the purpose of legislative and policy development.

While the gambling industry is heavily regulated in many respects, the legal profession may overlook a full appreciation of the scientific grounding and psychological classification of problem gambling and compulsive gambling, as distinguished from pathological gambling. The significance of this classification is even more profound following the recent renaming of “pathological gambling” to “gambling disorder.” In particular, it reinforces the evolving landscape of this area—both from a scientific and legal perspective. While the motivation for

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1. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 663 (4th ed. text rev. 1994) [hereinafter DSM-IV-TR] (classifying “Pathological Gambling” as a type of “impulse-control disorders not elsewhere classified”).

2. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 585 (5th ed. 2013) [hereinafter DSM-V] (listing “Gambling Disorder” as a behavioral addiction. While located near substance abuse disorders, such as alcoholism and drug addiction, the DSM-V specifically labels it as a “non-substance related disorder”).

renaming pathological gambling to gambling disorder is noted,³ the author argues that it does not materially alter the legal hypothesis drawn in this paper.

This paper outlines the select methods that facilitate typifying pathological gambling and gambling disorder from the general reference to problem gambling. The author advances arguments that—from both a legal and economic perspective—there is merit in classifying pathological gambling, and gambling disorder, as a disability under the Americans with Disabilities Act.⁴

Notwithstanding such occasional opposition, gambling has not only become legitimated in the past four decades, it has become an integral component of governmental activities through revenue generation, policy plans, and the discursive construction and regulation of gambling as a social activity.⁵ Consequently, gambling activities are viewed—from a pragmatic perspective—as replacing moral concerns with technical and economic considerations.⁶ That is one view. Economic considerations, however, fail to take into account the harm caused and the cost to rehabilitate problem gamblers.⁷ This paper argues that there is an increasing need for governments, venue operators, and policy-makers to, at the very least, consider ways to reduce the impact of harm, particularly with respect to pathological gamblers and persons diagnosed with gambling disorder.⁸

The author highlights some deficiencies in the methods of classifying pathological gambling, particularly prior to the *DSM-V*, and whether pathological may (and should) be classified as other than an impulse disorder. It is proposed that classification of the former would continue to limit the application of disability discrimination legislation with respect to compulsive⁹ and problem gambling,¹⁰ but

3. Reference to “pathological gambling” in this paper, unless otherwise specified, may incorporate reference to “gambling disorder.”

4. 42 U.S.C. § 12101 (2014) [hereinafter the ADA].

5. See generally Fayette Martin et al., *A Longitudinal Study: Casino Gambling Attitudes, Motivations, and Gambling Patterns Among Urban Elders*, 27 J. GAMBLING STUD. 287, 290–92 (2011) (describing why gambling is a social activity in which older adults participate, and how casino activities relate to participants’ mental health); Rochelle Zaranek & Elizabeth Chapleski, *Casino Gambling Among Urban Elders: Just Another Social Activity?*, 60 B. J. GERONTOL. SOC. SCI. 74, 74–81 (2005) (using “Activity Theory” as a conceptual framework, the authors refer to casino gambling as a “newer social activity”); David Korn, Roger Gibbins, & Jason Asmier, *Framing Public Policy Towards a Public Health Paradigm for Gambling*, 19 J. GAMBLING STUD. 235, 242–43, 248 (2003) (examining the public policy value of looking at gambling from a public health perspective, and quantifying the public health factors of gambling that will substantially contribute to a public shift toward a public health frame); David Korn & Howard Shaffer, *Gambling and the Health of the Public: Adopting a Public Health Perspective*, 15 J. GAMBLING STUD. 289, 305–12, 324–26, 352–55 (1999) (identifying major public health issues, and how gambling can affect individuals, families, and communities); Howard Shaffer & David Korn, *Gambling and Related Mental Disorders: A Public Health Analysis*, 23 ANN. REV. PUB. HEALTH 171, 179–81 (2002) (identifying the expansion of gambling in North America and the psychological, economic, and social consequences for the public’s health and considers both the costs and benefits of gambling).

6. See Jim Cosgrave & Thomas R. Klassen, *Gambling Against the State: The State and the Legitimation of Gambling*, 49 CURRENT SOC. 1, 4 (2001).

7. See COMMITTEE ON THE SOCIAL AND ECONOMIC IMPACT OF PATHOLOGICAL GAMBLING, PATHOLOGICAL GAMBLING: A CRITICAL VIEW, *infra* note 132 at 171.

8. There is a higher threshold required to classify pathological gamblers as opposed to “problem gamblers.” See *infra* Part III of this paper.

9. See generally Einat Peles et al., *Stroop Task Among Patients with Obsessive-Compulsive Disorder (OCD) and Pathological Gambling (PG) in Methadone Maintenance Treatment (MMT)*, 19 CNS SPECTRUMS 509, 511–13 (2013) (discussing differences in individuals’ interference levels between those with pathological gambling and those with obsessive-compulsive disorders); Benjamin Morasco & Nancy Petry, *Gambling*

not pathological gambling nor disordered gambling.¹¹ The method of achieving this and its purported lateral impact will be discussed.

Part I provides a historical account of the legitimization of gambling in North America and outlines the economic validation and impact, from a consumer, a gambling provider, and a government, regarding gambling activities.¹² Part II outlines the important role that scientific literature plays in understanding the scope of problem gambling, compulsive gambling, and pathological gambling in a legal context. This section details the development of medical and scientific factors since the 1980s that exist to distinguish problem gambling and pathological gambling. The author discusses the scope of the new classification of gambling disorder under the *DSM-V*, and the impact that an incoherent approach to diagnosing a gambling-related condition can have on future legislative reform. In particular, the author outlines the importance of shifting from classifying certain gambling conditions as an impulse-control disorder to an addictive disorder. Part III continues to define

Problems and Health Functioning in Individuals Receiving Disability, 28 *DISABILITY AND REHAB.* 619, 620–21 (2006) (evaluating gambling behavior among participants receiving disability; identifying the rates and correlates of disordered gambling); Benjamin Morasco et al., *Severity of Gambling is Associated With Physical and Emotional Health in Urban Primary Care Patients*, 28 *GEN. HOSP. PSYCHIATRY* 94, 96–98 (2006) (suggesting that disordered gambling is common in primary care settings, and gambling severity is associated with decreased health functioning); Jon Grant & Marc Potenza, *Compulsive Aspects of Impulse-Control Disorders*, 29 *PSYCHIATRIC CLINICAL N. AM.* 539, 544–46 (2006) (suggesting that there is a similarity between impulse-control disorders (ICDs), which are characterized by repetitive behaviors and impaired inhibition of these behaviors, and the frequently excessive, unnecessary, and unwanted rituals of obsessive-compulsive disorder (OCD)).

10. See *DSM-IV-TR*, *supra* note 1; *DSM-V*, *supra* note 2. See also George Anderson & Iain Brown, *Real and Laboratory Gambling, Sensation-Seeking and Arousal*, 75 *BRIT. J. PSYCHOL.* 401, 405–07 (1984) (explaining that sensation-seeking and arousal are two conditions of problem gambling behavior); Nady el-Guebaly et al., *Compulsive Features in Behavioural Addictions: The Case of Pathological Gambling*, 107 *ADDICTION* 1726, 1730 (2011) (suggesting that there are some commonalities across disorders).

11. See Nadia Kuley & Duran Jacobs, *The Relationship Between Dissociative-Like Experiences and Sensation Seeking Among Social and Problem Gamblers*, 4 *J. GAMBLING BEHAV.* 197, 197–98 (1988) (identifying the difference between “pathological gamblers,” and “probable compulsive gamblers”); Robert Ladouceur et al., *Concordance Between the SOGS-RA and the DSM-IV Criteria for Pathological Gambling Among Youth*, 19 *PSYCHOL. ADDICTIVE BEHAV.* 271, 271–76 (2005) (discussing possible differences in the classification of adolescent gamblers when using the South Oaks Gambling Screen-Revised for Adolescents (SOGS-RA) versus a clinical interview that was based on Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for pathological gambling); Otto MacLIn et al., *A Computerized Slot Machine Simulation to Investigate the Variables Involved in Gambling Behavior*, 31 *BEHAV. RES. METHODS, INSTRUMENTS, & COMPUTERS* 731, 731–34 (1999) (identifying a number of potential variables involved in gambling behavior); Maria de Oliveira et al., *Pathological Gambling and its Consequences for Public Health*, 42 *REV. SAUDE PUBLICA*, 542, 545–46 (2008) (characterizing pathological gambling and showing the main consequences of this disorder. The authors note that “[t]he prevalence of this disorder is higher in countries that have legalized gambling and in Brazil, there is evidence of growth in the number of pathological gamblers.”); Rachel Volberg, *The Prevalence and Demographics of Pathological Gamblers: Implications for Public Health*, 84 *AM. J. PUB. HEALTH* 237, 239–40 (1994) (outlining the potential impacts of continued gambling legalization on the overall rate of gambling problems in the general population, and on specific at-risk groups, including women, minorities, and children); Don Ozga & John Brown, *Pathological Gambling. Identification and Treatment*, 40 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 22, 27–29 (2002) (discussing that social gamblers view gambling as a form of entertainment or recreation and gamble with no harmful effects, whereas problem gamblers’ behavior causes disruption or harm to themselves or others in major life areas. Pathological gamblers fail to resist the impulse to gamble, with the resulting loss of control in their gambling behavior. The authors classify pathological gambling as a primary mental health disorder of impulse control.); James Langenbucher et al., *Clinical Features of Pathological Gambling in an Addictions Treatment Cohort*, 15 *PSYCHOL. ADDICTIVE BEHAV.* 77, 78 (2001) (referring to descriptive psychopathology of pathological gambling).

12. In this paper, gambling providers are primarily casinos unless otherwise expressly stated. Discussions concerning online gambling fall outside the scope of this paper.

this categorical pattern by illustrating results of surveys undertaken, which distinguish problem and compulsive gamblers from pathological gamblers in the United States, United Kingdom, and Australia. Parts IV and V outline the strength of being able to classify pathological gambling, and recently categorized gambling disorder, as a disability within the scope of requisite health and disability legislation, primarily in the United States. The author summarizes the role that such classification may have on reasonable accommodation, and also the duty and standard of care owed by a gambling provider.

This paper concludes in Part VI by suggesting how policy makers, not only in the United States, could strike a balance between economic incentives (i.e., commercial or private-rights of a gambling provider), and broader socio- or public-rights through advancement of human rights, and promotion of rights for persons who are pathological gamblers or otherwise persons with gambling disorders or those classified as having a disability.

I. BACKGROUND OF GAMBLING: HISTORY AND LEGITIMIZATION IN NORTH AMERICA

“Each of the gambling industries has a unique history and regulatory structure. Some policy issues are common to all industries in the sector, while others are unique to the particular form of gambling.”¹³

“For the past two centuries, most forms of gambling were illegal in North America, Britain, Australia, and many other western countries reflecting social attitudes grounded in particular religious and economic ethics that viewed gambling as a problematic activity, if not a moral vice.”¹⁴

Throughout the 19th century and into the 20th, Puritan values held sway over social morality in North America and Britain with moral reformers attacking gambling and other forms of so-called immoral behavior.¹⁵ While lotteries existed in the 18th and 19th centuries, primarily as a taxation system used to fund public projects in emerging capitalistic economies, they were controversial, causing governments to eventually declare them, along with other forms of gambling, illegal in the late 19th century.¹⁶

In North America, the societal legitimization of gambling has expanded dramatically since the 1960s, when government-operated and regulated lotteries

13. Melissa Schettini Kearney, *The Economic Winners and Losers of Legalized Gambling* 2 (Nat'l Bureau of Econ. Res., Working Paper No. 11234, 2005), available at <http://www.nber.org/papers/w11234.pdf>.

14. Cosgrave & Klassen, *supra* note 6, at 2; ANN FABIAN, CARD SHARPS, DREAM BOOKS & BUCKET SHOPS: GAMBLING IN 19TH CENTURY AMERICA 17, 57 (1990); CHARLES CLOTFELTER & PHILIP COOK, SELLING HOPE: STATE LOTTERIES IN AMERICA 3-4, 45, 97 (1989) (referring to gambling and lotteries as a “social craze,” and discussing the influence of religion on gambling activities). *But see* WILLIAM THOMPSON, GAMBLING IN AMERICA: AN ENCYCLOPEDIA OF HISTORY, ISSUES, AND SOCIETY 202-05 (2001) (discussing that certain forms of gambling are still illegal in some countries, including Japan).

15. *See* CLOTFELTER & COOK, *supra* note 14, at 221 (discussing that critics dismiss gambling as “immoral”).

16. *Id.* at 15 (One of the arguments against the use of lotteries was that the development of modern forms of taxation and the expansion of banking provided alternatives to lotteries as methods of generating revenue.).

were reintroduced as methods of revenue generation.¹⁷ “Until 1964, lotteries were illegal in the United States, and until the early 1990s, casinos were only found in two states.”¹⁸ Table 1 outlines the number of casinos worldwide by country in 2011.

Table 1: Casinos Worldwide by Country in 2011¹⁹

Region or Country	Casino Number
North America	1623
Western Europe	682
Eastern Europe	479
South America	199
Africa	157
Caribbean	124
Far East	103
Central America	93
Central Asia	42
Oceania	25
South Asia	15
Middle East	5

“By the end of the 1990s, lotteries were operating in two-thirds of the states and casinos in more than half of the states.”²⁰ Table 2, below, outlines the number of commercial casinos in the United States as of 2011.²¹

17. Will Eadington, *The Economics of Casino Gambling*, 13 J. ECON. PERSP. 173, 173–92 (1999) (providing a historical account of the operation of casinos in North America); William Evans & Julie Topoleski, *The Social and Economic Impact of Native American Casinos* (Nat’l Bureau of Econ. Res., Working Paper Series No. 9198, 2002) (providing a review of the history of Native American casinos); see also U.S. GEN. ACCT. OFF. REP. CONG. REQUESTERS, *Internet Gambling: An Overview of the Issues*, GAO-03-89 Dec. 2002 (2002).

18. Cosgrave & Klassen, *supra* note 6, at 3.

19. ERNST AND YOUNG, GLOBAL GAMING BULLETIN (2011).

20. See EDWARD MORSE & ERNEST GOSS, GOVERNING FORTUNE: CASINO GAMBLING IN AMERICA 1–12 (2007) (describing the regulatory environment of gambling at the federal, state and tribal levels); PATRICK PIERCE & DONALD MILLER, GAMBLING POLITICS: STATE GOVERNMENT AND THE BUSINESS OF BETTING 2–4 (2004) (outlining the politics behind the growth of legalized gambling in the United States, especially in regard to the states’ role in promoting gambling as a revenue source); NAT’L. GAMBLING IMPACT STUDY COMM’N FINAL REP. at 3-3, 3-5 (June 1999), available at <http://govinfo.library.unt.edu/ngisc/reports/fullrpt.html> [hereinafter NATIONAL GAMBLING IMPACT STUDY COMMISSION] (outlining the rapid expansion of legalized gambling in the United States); Joyce Miskell, *Lotteries in State Revenue Systems: Gauging a Popular Revenue Source After 35 Years*, 33 ST. & LOC. GOV. REV. 86, 88–89 (2001) (outlining the expansion of lotteries and gambling across particular North American states).

21. See AUSTRAL. GAMING COUNCIL, A DATABASE ON AUSTRALIA’S GAMBLING INDUSTRY: GAMBLING AROUND THE WORLD 13–20 (2010) (describing that, in 2011, the commercial casino industry in the United States consisted of 492 casinos in 22 states. A wider casino market also existed in the United States, including the 47 racetrack casinos in 13 states and 459 tribal casinos across 29 states.).

Table 2: Commercial Casinos in the United States (2011)²²

State (US)	Number of Casinos	Casino Description
Colorado	40	Land-based
Delaware	3	Racetrack
Florida	5	Racetrack
Illinois	10	Riverboat
Indiana	13	Riverboat, land-based, and racetrack
Iowa	18	Riverboat, land-based, and racetrack
Kansas	2	Land-based (State owned)
Louisiana	18	Riverboat, land-based, and racetrack
Maine	1	Racetrack
Maryland	2	Land-based
Michigan	3	Land-based
Mississippi	30	Dockside and land-based
Missouri	12	Riverboat
Nevada	256	Land-based
New Jersey	11	Land-based
New Mexico	5	Racetrack
New York	9	Racetrack
Oklahoma	2	Racetrack
Pennsylvania	10	Land-based and racetrack
Rhode Island	2	Racetrack
South Dakota	35	Land-based
West Virginia	5	Racetrack and land-based
Total	492	

In addition, from 1976 to 1997, revenues from legal gambling grew more than 1,600% and “gambling expenditures more than doubled as a percentage of personal income.”²³ Lotteries have become one of the largest operations run by state governments,²⁴ with citizens spending \$78 billion on them in 2012.²⁵

22. AM. GAMING ASS'N, 2012 STATE OF THE STATES: THE AGA SURVEY OF CASINO ENTERTAINMENT 5 (2012), available at http://www.americangaming.org/sites/default/files/uploads/docs/sos/aga_sos_2012_web.pdf.

23. See Kevin Brady & John Pijanowski, *Maximizing State Lottery Dollars for Public Education: An Analysis of Current State Lottery Models*, 7 J. EDUC. RES. POL'Y STUD. 20, 21–22 (2007).

24. In Canada, by comparison, the impetus for amending the Criminal Code was to allow lotteries to be used to raise funds for the Olympic Games held in Montreal in the summer of 1976. Since then, the variety of state-sanctioned and state-operated forms of gambling has grown to include sports betting, casino gambling, electronic bingo, video lottery terminals, scratch-and-win games, and related games of chance. The total percentage of government revenues derived from gambling rose from nearly zero in the early 1970s to in excess of 4 percent in some provinces by the late 1990s. For the nation as a whole, profits by governments from gambling increased by 167 percent during 6 years, between 1992 and 1998. See Katherine Marshall, *Update on Gambling*,

Table 3: Consumer Spending on Casino Gaming (2011)²⁶

State (US)	Gross-Revenue US\$ million (2011)
Colorado	750.1
Delaware	552.4
Florida	381.7
Illinois	1,480
Indiana	2,720
Iowa	1,420
Kansas	48.5
Louisiana	2,370
Maine	59.5
Maryland	155.7
Michigan	1,420
Mississippi	2,240
Missouri	1,810
Nevada	10,700
New Jersey	3,320
New Mexico	248.9
New York	1,260
Oklahoma	106.2
Pennsylvania	3.02
Rhode Island	512.9
South Dakota	100.9

In its numerous forms, gambling may be described as a casual, communal, and sometimes a surreptitious activity. Gambling activities have still been frequently regulated—at least when not prohibited by religious and state authorities—particularly during the second half of the 20th and into the 21st century.²⁷ Through the implementation of lotteries to finance public projects and raise government

12 PERSP. ON LAB. & INCOME, 29, 31 (2000); *see also* Katherine Marshall, *The Gambling Industry: Raising the Stakes*, 10 PERSP. ON LAB. & INCOME 7, 7–11 (1998).

25. *See infra* Table 3. Consumer spending on casino gaming in the United States was highest in Nevada and lowest in South Dakota. *Id.*

26. AM. GAMING ASS'N, *supra* note 22.

27. Cosgrave & Klassen, *supra* note 6, at 4.

revenue, gambling was a state-licensed activity.²⁸ Table 4 outlines the taxation collected from casino gambling profits in 2011 in the United States.

Table 4: Taxation Collected from Casino Gambling Profits in the United States²⁹

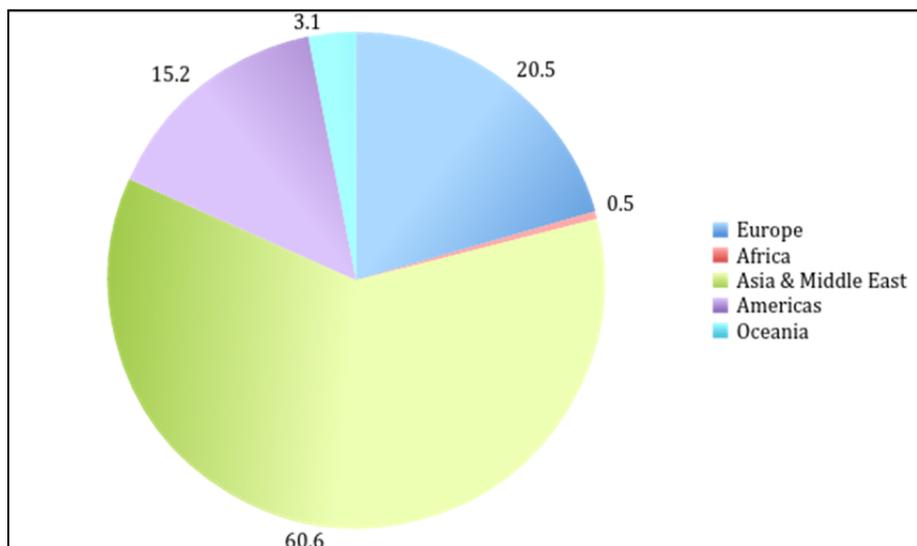
State (US)	Taxation US\$ million (2011)
Colorado	102.2
Delaware	230.2
Florida	143.6
Illinois	489.4
Indiana	846.4
Iowa	321.5
Kansas	13.1
Louisiana	573.2
Maine	29.1
Maryland	89.6
Michigan	320.7
Mississippi	274.4
Missouri	484.8
Nevada	865.3
New Jersey	277.6
New Mexico	64.7
New York	593.4
Oklahoma	18.3
Pennsylvania	1456
Rhode Island	308.7
South Dakota	16.4
West Virginia	406.5

28. CHARLES CLOTFELTER ET AL., STATE LOTTERIES AT THE TURN OF THE CENTURY 6 (Duke University: Report to the National Gambling Impact Study Commission 1999); *see also* NATIONAL GAMBLING IMPACT STUDY COMMISSION, *supra* note 20, at 3-1, 3-3, 3-4.

29. AM. GAMING ASS'N, *supra* note 22.

Despite the attempt by governments to stimulate local economies by introducing casinos into communities or the sale of lottery tickets,³⁰ opposition to gambling still exists.³¹ Organized Protestantism, it could be said, lies at the heart of moral criticism to gambling (including electronic gaming machines)³²—an activity that, it has been acknowledged, some religious groups oppose.³³

Diagram 1: Number of gaming machines worldwide (%)³⁴



30. CLOTFELTER ET AL., *supra* note 28 at 7–8, 19.

31. See Cosgrave & Klassen, *supra* note 6, at 4; LENNART HENRIKSSON & RICHARD LIPSEY, SHOULD PROVINCES EXPAND GAMBLING?: PAPER PREPARED FOR COALITION FOR EDUCATION AND RESEARCH INTO GAMBLING EXPANSION 5, 9–10 (Canadian Institute for Advanced Research, 1998) [hereinafter CERGE] (observing that “new gambling is not likely to have a significant effect upon economic activity or employment in British Columbia,” but concluding that, “for the economy as a whole . . . , while some new revenues and jobs are created, these are largely offset by the loss of jobs and revenue in other sectors”); see also JOHN HANNIGAN, FANTASY CITY: PLEASURE AND PROFIT IN THE POSTMODERN METROPOLIS 150 (1998) (stating that “[r]iverboat gambling was the final piece in an economic revitalization strategy that, in the 1980s, had seen the legalization of lotteries and of horse and dog tracks in a state that had been battered by recession, manufacturing losses, and plummeting farm income”); Ann Miyazaki et al., *A Longitudinal Analysis of Income-Based Tax Regressivity of State-Sponsored Lotteries*, 17 J. PUB. POL’Y & MKTG. 161, 161 (1998) (stating that “the primary governmental objective of state lotteries is revenue generation”); Charles Clotfelter & Phillip Cook, *Implicit Taxation in Lottery Finance*, 40 NAT. TAX J. 533, 542–43 (1987) (inferring that there is great interest by stakeholders in the distributional effect of the lottery as a fiscal device, and observing that lottery creation and taxation together produce net welfare gains).

32. Cosgrave & Klassen, *supra* note 6, at 4.

33. *Id.* at 3; see also GERDA REITH, THE AGE OF CHANCE—GAMBLING IN WESTERN CULTURE 108–10 (1999); MARY MURRELL, WHY PEOPLE GAMBLE: A SOCIOLOGICAL PERSPECTIVE 84 (David Lester ed., 1979).

34. See AUSTL. GAMING COUNCIL, *supra* note 21. With more than 4 million machines, the Asia and Middle East region accounted for 61% of gaming machines worldwide, followed by Europe (21%) and the Americas (15%). Oceania and Africa accounted for only 3.1% and 0.5% of the worldwide total respectively. *Id.*

Table 5: Number of Gaming Machines Worldwide by Region³⁵

Region	Number of Machines
Oceania	220,779
Americas	1,067,773
Asia and Middle East	4,250,243
Europe	1,439,295
Africa	33,218
Total	7,011,308

Clotfelter has acknowledged the amount spent on gambling activities was “exceeded only by education, public welfare, highways and health . . . ,”³⁶ and that it was “greater than the total that all states—including states without lotteries—spent on corrections, or on parks and natural resources.”³⁷ Cosgrave and Klassen observe that in Australia, for example “gambling expenditure has increased dramatically since the 1970s with the percentage of household disposable income spent on gambling doubling over a twenty-five year period.”³⁸

Australia’s first casino opened in 1973, and was quickly advanced by others in each territory and state.³⁹ Different forms of gambling also contribute differently in each state. EGMs comprise the single largest source of gambling tax revenue for all states and territories except Western Australia.⁴⁰ Although not expressly highlighted in Table 6, below; in five states and territories, EGMs from clubs and hotels alone provide more than 50% of such revenue.⁴¹

35. *Id.*

36. CLOTFELTER ET AL., *supra* note 28, at 7.

37. *Id.*

38. Cosgrave & Klassen, *supra* note 6, at 3.

39. *Id.* In 2008–09, state taxes (not including the Goods and Services Tax) accounted for 26 percent of gambling expenditure. Gambling provides on average one-tenth of own-state tax revenue across Australia. Although, the states that rely more heavily on gambling revenue are not necessarily those with the largest industries. For instance, while gambling consumption was \$90 more per adult in New South Wales than in Victoria in 2008–09, the Victorian industry contributed \$94 more tax revenue per adult. This reflects the fact that each state has different effective tax rates and, in this sense, the profitability of the gambling industry is different in each state. Jurisdictions with the largest gambling industries, as measured by aggregate expenditure, also record the largest amounts of gambling tax revenue. However, per capita gambling tax revenue does not vary in accordance with per capita expenditure. *Id.*

40. Joe Hirschberg & Jenny Lye, *Gambling with Stimulus Payments: Feeding Gaming Machines with Federal Dollars* (Dep’t of Econ., Research Paper No. 1166, 2013).

41. AUSTL. PRODUCTIVITY COMM’N, AUSTRALIA’S GAMBLING INDUS. REP. NO. 10 (1999) [hereinafter APC Report]; *see also* IBISWORLD, CASINOS IN AUSTRALIA INDUSTRY MARKET RESEARCH REPORT, ANZSIC R9201 34–38 (2013) (observing that, following three consecutive years of low revenue growth, the industry has improved since 2012–13, as it benefited from more robust domestic and international economic growth. Industry revenue is expected to increase 8.2% in 2012–13 to \$5.65 billion. Over the five years through 2012–13, industry revenue is expected to increase at an annual rate of 2.9%. However, new challenges are emerging, particularly from interest rate rises and intensifying competition from new casino establishments opening across Asia.).

Table 6: Taxation Collected from Gambling Profits in Australia⁴²

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
	AUS million					
New South Wales	1,653	1,576	1,652	1,706	1,757	1,815
Victoria	1,508	1,595	1,649	1,632	1,652	1,731
Queensland	825	889	922	927	945	996
South Australia	422	415	407	401	404	411
Western Australia	164	162	180	176	191	215
Tasmania	82	89	92	96	98	100
ACT	63	52	52	53	55	57
Northern Territory	56	68	74	71	-	-

By comparison, in European countries where governments may rely on numerous sources of revenue (e.g., Germany, Hungary, Czech Republic), tension to bolster “games of chance”⁴³ are less than in North America and Australia. In fact, gambling has been viewed as comprising a dichotomy—particularly in western countries—between its vogue, and its aberrance. McMillen suggests that sociology has habitually fallen short of identifying the ingénue of the state in spawning “gambling deviance.”⁴⁴ Furthermore, authors such as Cosgrave, Klassen, and McMillen note that, “by definition, state intervention conventionally is seen in the liberal sense as neutral and necessary to sustain the preconditions of social order and conformity—the central concerns being gamblers’ behavior and the precise mode of regulation.”⁴⁵ They go on to say that, “[t]he legalization of a variety of forms of gambling has contributed, at least tacitly, to the social acceptance of gambling activity, and for many citizens, lottery players, and sports betters.”⁴⁶

Gambling has, for example, metamorphosed into a quotidian part of life. Yet, coupled with an increased social acceptance of gambling activity and economic benefit derived by not only gambling providers, but governments through the impost of a number of taxation regimes,⁴⁷ there is a need to strike a balance that works in favor of problem gamblers.⁴⁸

42. 5506.0 – *Taxation Revenue, Australia, 2012-13*, AUSTRALIAN BUREAU OF STATISTICS (May 28, 2014, 11:30 AM), <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/5506.0Main%20Features22012-13?opendocument&tabname=Summary&prodno=5506.0&issue=2012-13&num=&view=>.

43. Cosgrave & Klassen, *supra* note 6, at 3.

44. See also Jan McMillen, *Understanding Gambling: History, Concepts and Theories*, in *GAMBLING CULTURES: STUDIES IN HISTORY AND INTERPRETATION*, 240–41 (Jan McMillen ed., 1996).

45. Cosgrave & Klassen, *supra* note 6, at 4.

46. *Id.* at 3.

47. See Terance Rephann, *Casino Gambling as an Economic Strategy*, 3 *TOURISM ECON.* 161, 177 (1997) (explaining that casinos generally stimulate economic growth—as measured by earnings and employment—and development—as measured by per capita income. Crime, while stimulated in some multi-casino counties, is not noticeably affected elsewhere. On the downside, earnings in state and local government sectors are not definitively

II. DEFINING THE UNDEFINED – GAMBLING, PROBLEM GAMBLING, PATHOLOGICAL GAMBLING, AND GAMBLING DISORDER

Broadly speaking, most forms of writing—articles, reports, and even legal judgments—are written with some portion of prevarication. The difference between problem gambling and pathological gambling is one such prevarication that is seldom addressed in legal literature.

The following section outlines the scientific methods for determining (and therein, distinguishing) problem gambling and compulsive gambling from pathological gambling and gambling disorder. The importance of this is two-fold: first, to demonstrate the importance that science plays (in this context) in legal policy development and legislative understanding; and second, to highlight the gaps that result when applying science to legal concepts and policies. Specifically, an understanding of these terms forms a necessary foundation for examining, amongst other matters, the degree to which requisite classifications could impact the standard of care owed by gambling providers and to discuss the interaction between disability law and consumer protection. This part involves (and notes the limitations of) an interdisciplinary examination of the intercept between science (i.e., psychology) and law.

A. Gambling

Construing the term “gambling” seems, at first glance, a straightforward task. On the one hand, it may describe outcomes of events determined by a level of skill or chance. For example:

staking of money on the outcome of games or events involving chance or skill; [s]taking money on uncertain events driven by chance; gambling, the act of staking money or some other item of value on the outcome of an event determined by chance; the exchange of property (usually money but sometimes other property including slaves, ears and fingers) on the outcome of an event largely, if not solely, determined by chance; wagering money or other belongings on chance activities or events with random or

accelerated. Most income generated by casinos is seeped through avenues to those who reside outside the county. Additionally, not all counties are poised to benefit equally from casino development. Multi-casino and more spatially isolated counties fare better than other counties in accruing employment benefits from casino development.); *see also* ROBERT GOODMAN, LEGALIZED GAMBLING AS A STRATEGY FOR ECONOMIC DEVELOPMENT, 9 (1994) (outlining six major sectors of the legal gambling industry); William Eadington, *The Legalization of Casinos: Policy Objectives, Regulatory Alternatives, and Cost/Benefit Considerations*, 34 J. TRAVEL RES. 3, 7 (1996).

48. *See, e.g.*, AUSTL. PRODUCTIVITY COMM’N, AUSTRALIA’S GAMBLING INDUS. REP. No. 50, at 5.35 (2010) (citing supportive evidence from Canadian provincial surveys that estimated the proportion of gambling revenues derived from problem gamblers to lie between nineteen percent and thirty-three percent).

uncertain outcomes; the betting or wagering of valuables on events of uncertain outcome⁴⁹

But, legitimate gambling comprises “a greater degree of chance than skill.”⁵⁰ In its pellucid form (such as pushing buttons on EGMs) no skill is necessary. By comparison, the application of skill to investment activities (such as purchasing stock where the outcome is also uncertain) utilizes skill to effect an increased probability of engendering a positive return.

Smith and Wynne postulate four observations concerning the above definitions of gambling:

- (1) an element of risk is involved;
- (2) someone wins and someone loses money, property or some other items of value change hands;
- (3) at least two parties must be involved in the activity—a person cannot gamble against him/herself; and
- (4) gambling is a conscious, deliberate, and voluntary activity.⁵¹

Some scholars, such as Shaffer and Korn, view public policy debates on gambling through a variety of frames.⁵² For example, that gambling is a matter of individual freedom; an entertainment or recreational; a source of government revenue; a tool for economic development through increased tourism and employment; an addiction that should be treated within a medical model; a cultural artifact intensely embedded in certain cultures; perhaps a means for some to escape class constraints through increased wealth; also a matter for public accountability, public responsibility, and public health.⁵³ The above aspects pose as the anatomy of questions concerning and affecting problem gamblers.

B. What is Problem Gambling?

While the definition of gambling is relatively settled, the same cannot be said for “problem gambling.” There is in fact much controversy surrounding the

49. PENNY NEAL, PAUL DELFABBRO & MICHAEL O’NEIL, PROBLEM GAMBLING AND HARM: TOWARDS A NATIONAL DEFINITION, 4 (2005) (citations omitted).

50. Peter Slade & Chris McConville, *The Problem with Problem Gambling: Historical and Economic Concerns*, 8 J. ECON. & SOC. POL’Y, 8 (2003).

51. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 4. Neal, Delfabbro and O’Neil expressed that:

Gambling, by its very nature, involves the voluntary assumption of risk. Risk-taking is reinforced by positive emotional experiences: relief from boredom, feelings of accomplishment, and the “rush” associated with seeking excitement. Those activities with the highest potential pay-offs tend to generate the most excitement and serve to stimulate greater risk-taking activity.

Id.

52. See David Korn et al., *Framing Public Policy Towards a Public Health Paradigm for Gambling*, 19 J. GAMBLING STUD. 235, 236 (2003).

53. See generally Howard Shaffer & David Korn, *Gambling and Related Mental Disorders: A Public Health Analysis*, 23 ANNU. REV. PUB. HEALTH 171, 171 (2002).

numerous definitions.⁵⁴ Literature uses surfeit terms to depict problem gambling. For example: “‘problem,’ ‘pathological,’ and ‘compulsive’ being the most common—but ‘addictive,’ ‘excessive,’ ‘disorderly,’ ‘Level 2’ and ‘Level 3,’ ‘at-risk,’ ‘in-transition,’ ‘degenerate,’ and ‘potential pathological’ are also used.”⁵⁵ This paper focuses on the differences between problem, compulsive, pathological, and gambling disorder for the purposes of public policy, legislative regulation, and development.

Generally, “problem gambling” is commonly used in North America to signify a caliber of gambling, which is at an elemental period, or which leads to more minimal issues than the developed stage “or more severe problems, or caused by those gamblers who are clinically diagnosed as pathological gamblers.”⁵⁶ “Problem gambling is an urge to gamble despite harmful negative consequences or a desire to stop.”⁵⁷ References to compulsive gambler and problem gambler are often used interchangeably, which is significant for the purposes of legislative reference, discussed below.⁵⁸ Although the favored term is “compulsive gambling” among many medical professionals, few people actually experience “compulsions” in the clinical sense of the word.⁵⁹

In Australia, by comparison, the term problem gamblers tends to encompass gamblers who are experiencing problems but who do not meet the diagnostic criteria, as well as encompassing gamblers who are clinically diagnosed as problem or pathological gamblers.⁶⁰ Often, problem gambling is not defined by the gambler’s own behavior, but rather by whether harm is *experienced* by the gambler or others.⁶¹ To date there have been several key reviews that critically analyze the definitions of problem gambling.

Many definitions of problem gambling tend to fall into one of a number of categories: problem gambling as a medical disorder or mental health problem; “as an economic problem; as lying on a continuum of gambling behavior;” expressed “in terms of harm to the individual and to others; and as a social construct.”⁶²

These categories (as opposed to methods of identifying a problem gambler) are not, however, mutually exclusive. For instance, one could look at the development of problem gambling using a continuum model as identified by Neal, Delfabbro,

54. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 4.

55. *Id.* at v.

56. *Id.*

57. Seyed Jazaeri & Mohammad Bin Habil, *Reviewing Two Types of Addiction—Pathological Gambling and Substance Use*, 34 INDIAN J. PSYCHOL. MED. 5, 6 (2012).

58. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 5.

59. See Jazaeri & Bin Habil, *supra* note 57, at 6.

60. See Henry R. Lesieur and Robert J. Rosenthal, *Pathological Gambling: A Review of the Literature* 7 J. GAMBLING STUD. 5, 6–8 (1991); M. WALKER, *THE PSYCHOLOGY OF GAMBLING* (1992); MARK DICKERSON ET AL., *DEFINITION AND INCIDENCE OF PROBLEM GAMBLING, INCLUDING THE SOCIO-ECONOMIC DISTRIBUTION OF PROBLEM GAMBLERS*, VICTORIAN CASINO AND GAMING AUTHORITY, VICTORIA (1997); Jackie Ferris, et al., *MEASURING PROBLEM GAMBLING IN CANADA, DRAFT FINAL REPORT FOR THE INTER-PROVINCIAL TASK FORCE ON PROBLEM GAMBLING*, CANADIAN CENTRE FOR SUBSTANCE ABUSE (1999); APC Report, *supra* note 41, at 190.

61. See Jazaeri & Bin Habil, *supra* note 57, at 6.

62. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 5.

and O’Neil, and in reference to problematic behaviors.⁶³ At the same time, it is recognized that a generic definition of problem gambling that meets the needs of all stakeholders in a diverse range of contexts will probably need to be referenced to both individual gambling behaviors and to harms, and as so may draw on several conceptualizations of problem gambling.⁶⁴ These are outlined below.

1. Is Problem Gambling a Disease?

Those who view problem gambling as a “mental health problem,” tend to describe problem gambling as pathological, addictive, or compulsive.⁶⁵ Understanding an individual’s underlying pedagogy and the scope of each of these categories based on medical models will reveal that it is a fallacy to refer to these terms interchangeably. Pathological gamblers are not the same as compulsive gamblers, but compulsive gamblers (but not all problem gamblers) have an addictive behavior.

Compulsive gambling is seen as a disease—a medical pathology.⁶⁶ It should be noted, however, that compulsive gambling is not the same as pathological gambling. Referring to Rosecrance’s summary of the major components of the disease model, these elements include that there exists a sole phenomenon referred to as compulsive gambling. The stages that a compulsive gambler experiences are best described as the following:

- Antecedent success (or a “big score”) that feeds quixotic expectations of future winnings and a heightened gambling activity.⁶⁷
- Increased gambling activity parallels limited success, and leads to gradual loss of financial resources.⁶⁸

63. See *id.*; see also Renee M. Cunningham-Williams et al., *Taking Chances: Problem Gamblers and Mental Health Disorders—Results from the St Louis Epidemiologic Catchment Area Study*, 88 AM. J. PUB. HEALTH 1093 (1998); Henry R. Lesieur & Sheila B. Blume, *The South Oaks Gambling Screen (SOGS): A New Instrument for the Identification of Pathological Gamblers*, 144 AM. J. PSYCHIATRY 1184, 1184 (1987).

64. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at v; see also Jennifer Borrell & Jacques Boulet, *Culture and the Prevention of Problem Gambling, in CULTURE AND THE GAMBLING PHENOMENON* 14 (Alex Blaszczyński ed., 2001).

65. See, e.g., John W. Welte et al., *Risk Factors for Pathological Gambling*, 29 ADDICTIVE BEHAV. 323, 323–25 (2004).

66. See JACKIE FERRIS ET AL., MEASURING PROBLEM GAMBLING IN CANADA, FINAL REPORT, PHASE 1, INTER-PROVINCIAL TASK FORCE ON PROBLEM GAMBLING, 3.2.2, (1992) (suggesting that the pathology approach implies that there is an identifiably separate group of gamblers who are different from other gamblers); DSM-IV-TR, *supra* note 1 (stating that “Pathological Gambling” is classified as a type of “impulse-control disorders not elsewhere classified”); DSM-V, *supra* note 2 (listing “Gambling Disorder” as a behavioral addiction. While located near substance abuse disorders, such as alcoholism and drug addiction, the DSM-V specifically labels it as a “non-substance related disorder”); see also Nancy M. Petry, *Should the Scope of Addictive Behaviors Be Broadened to Include Pathological Gambling?*, 101 AM. PSYCHIATRIC ASS’N, 152 (2006) (examining the advantages and disadvantages of expanding addictive disorders to include pathological gambling).

67. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 7 (citing FERRIS ET AL., *supra* note 66, at 1733).

68. *Id.*

- The gambler is motivated to be in “action”—an act driven by aberrant optimism about winning, leading to an all-consuming compulsion for the need to gamble.⁶⁹
- Money is perceived as an object to facilitate the act of gambling.
- As a result of unresolved guilt that encourage the act, the gambler suffers psychological distress.⁷⁰
- The gambler chases his “losses” in a bid to win back his lost money. This feeds the gambler’s need to obtain money by any means possible, including through illegal avenues.⁷¹
- Spells of bingeing and self-castigation are preceded by a period of rationalization and then resume to the ritualistic act of gambling.⁷²

The fact that compulsive gamblers steadily lose control is qualitatively different from other gamblers. It is recognized that compulsive gambling is a progressive condition.⁷³ Eventually, they are unable to stop gambling, leading to compulsive gambling being characterized as a permanent and irreversible condition.⁷⁴ The only cure is complete sobriety.⁷⁵ It has been recognized that the disease view of problem gambling is reflected in the Gamblers Anonymous definition: “Compulsive gambling is an illness, progressive in its nature, which can never be cured, but can be arrested.”⁷⁶

Neal, Delfabbro, and O’Neil identify the existence of other definitions derived from a “medical model.” They highlight that these focus on the “progressive nature of the ‘disease’, [sic] a psychologically uncontrollable preoccupation with gambling and pathological gambling as an impulse control disorder that ultimately disrupts personal relationships, family life, and vocational pursuits.”⁷⁷

The definition offered by Rosenthal provides a good foundation to defining problem gambling, “particularly because it is broadly accepted by psychiatrists, many psychologists, and Gamblers Anonymous members.”⁷⁸ It resides as the foundation for the influential *Diagnostic and Statistical Manual’s* criteria for problem gambling, namely: “A progressive disorder characterized by a continuous or periodic loss of control over gambling; a preoccupation with gambling and with

69. *Id.*

70. *Id.*

71. *Id.* at 8.

72. *Id.*

73. *See Stages of Compulsive Gambling*, ELEMENTS BEHAVIORAL HEALTH (Oct. 19, 2009), <http://www.elementsbehavioralhealth.com/addiction/stages-of-compulsive-gambling/>.

74. *See* NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8.

75. *See id.*

76. *See id.*; *see also Questions and Answers About Gamblers Anonymous*, GAMBLERS ANONYMOUS, <http://www.gamblersanonymous.org/ga/content/questions-answers-about-gamblers-anonymous> (last visited Mar. 9, 2015).

77. *See* NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8.

78. *See* Jazaeri & Bin Habil, *supra* note 57, at 7.

obtaining money with which to gamble; irrational thinking; and a continuation of the behavior despite adverse consequences.”⁷⁹

Problem gambling has previously been regarded as an addiction or medical problem.⁸⁰ Due to the initial similarities to alcohol and other drug problems, this conceptualization was regarded as a familiar framework for both policy makers and clinicians.⁸¹ This observation, as will be discussed, is significant. Categorizing a condition as an impulse-control disorder may be viewed as central in differentiating pathological gambling from gambling disorder, compulsive gambling, or problem gambling under disability-discrimination legislation—in particular, the ADA.

“Many of the definitions in the medical disorder [or] mental-health category focus on the individual being unable to control his [or] her impulse to gamble.”⁸² Impulsivity is also referred to as “disinhibition,” or a “deficit of inhibitory control.”⁸³ There appears to be a link between sensation seeking and gambling; however, one cannot be certain that it is, in fact, sensation seeking, per se, or if sensation seeking is related to the “true” determinant(s) (e.g., alcohol use, unemployment, or other unmeasured variables).⁸⁴ The cause for the relationship remains unclear: why and how the relationship exists and the underlying mechanisms responsible for that relationship remain a mystery.⁸⁵ The literature

79. Richard Rosenthal, *Pathological Gambling*, 22 *PSYCHIATRIC ANNALS*, 72, 74 (1992); see also DSM-V, *supra* note 2; Jazaeri & Bin Habil, *supra* note 57, at 7. Jazaeri and Bin Habil explained that:

This definition, like the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria, is behaviorally based, and sees gambling as a disorder that one either has or does not have. It captures most of the important behaviors that are seen with severe problem gambling, but only indirectly includes the consequences of gambling. Of course, it is because of the consequences that most gamblers end up in treatment. In addition, by calling gambling a “disorder” the definition suggests that those who have gambling problems are in some qualitative way different from those who do not. The literature suggests that this is not true.

Id.

80. *Id.*

81. Jackie Ferris, *How Do You Define Gambling?*, PROBLEM GAMBLING INST. OF ONTARIO, <http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/Howdoyoudefinegambling.aspx> (last visited Feb. 20, 2014).

82. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8.

83. See Robert B. Breen & Marvin Zuckerman, ‘Chasing’ in *Gambling Behavior: Personality and Cognitive Determinants*, 27 *PERSONALITY & INDIVIDUAL DIFFERENCES* 1097, 1099 (1999) (discussing impulsivity as “spontaneous or unintentional behavior where one acts without thought or self control,” which is consistent with other definitions of impulsivity in the literature); see also Namrata Raylu & Tian P.S. Oei, *Pathological Gambling A Comprehensive Review*, 22 *CLINICAL PSYCHOL. REV.* 1009, 1023 (2002) (noting that the author does not speak directly to impulsivity’s connection to disinhibition, but expands of the definition of impulsivity). See generally MARVIN ZUCKERMAN, *BEHAVIORAL EXPRESSIONS AND BIOSOCIAL BASES OF SENSATION SEEKING* 389–92 (1994) (outlining a 40-item self-report measure of impulsive sensation seeking).

84. See generally Jonathan W. Roberti, *A Review of Behavioral and Biological Correlates of Sensation Seeking*, 38 *J. RES. IN PERSONALITY* 256, 268 (2004) (discussing the risky and non-risky choices made by sensation seekers to acquire stimulation).

85. See generally *id.* at 261 (outlining the strong relationship between the scores on sensation seeking questionnaires with alcohol use, use of other drugs, promiscuous sexual activities, gambling, high-risk sports, and other forms of recreation).

linking impulsivity to gambling behavior is abundant and generally consistent.⁸⁶ Many recent studies have found that problem or excessive gamblers tend to have higher scores on impulsivity measures when compared to low-frequency or non-gamblers.⁸⁷ Impulsivity also predicts gambling severity,⁸⁸ loss of control when gambling, and discriminates “chasers” (i.e., individuals who will continue to bet or bet more after a series of losing bets) from “non-chasers.”⁸⁹

Studies have hypothesized that impulsivity may be connected to the initial decision to gamble as opposed to within-session gambling decisions.⁹⁰ Although most support the relationship between sensation seeking and gambling, there are a number of issues that arise.⁹¹ For instance, these studies often rely on retrospective self-reported gambling behavior, which may be susceptible to recall error or other

86. See, e.g., Frank Vitaro et al., *Impulsivity Predicts Problem Gambling in Low SES Adolescent Males*, 94 ADDICTION 565, 565–67 (1999) (outlining previous tests that are “abundant”).

87. See, e.g., R. Michel Bagby et al., *Pathological Gambling and the Five-Factor Model of Personality*, 43 PERSONALITY & INDIVIDUAL DIFFERENCES, 873, 875 (2007); Nancy M. Petry, *Pathological Gamblers, with and without Substance Use Disorders, Discount Delayed Reward at High Rates*, 110 J. ABNORMAL PSYCHOL. 482, 483–86 (2001); Nigel Turner et al., *The Experience of Gambling and its Role in Problem Gambling*, 6 INT’L GAMBLING STUD. 237, 249–250 (2006) (discussing differences between the groups); Frank Vitaro, Louise Arseneault & Richard E. Tremblay, *Dispositional Predictors of Problem Gambling in Male Adolescents*, 154 AM. J. PSYCHIATRY 1769, 1769–70 (1997); Marc A. Zimmerman et al., *Measurement and Structure of Pathological Gambling Behavior*, 49 J. PERSONALITY ASSESSMENT 76, 78–79 (1985); See also Lia Nower et al., *The Relationship of Impulsivity, Sensation Seeking, Coping, and Substance Use in Youth Gamblers*, 18 PSYCHOL. ADDICTIVE BEHAVIORS, 49, 53 (2004).

88. See, e.g., Peter L. Carlton & Paul Manowitz, *Factors Determining the Severity of Pathological Gambling in Males*, 10 J. GAMBLING STUD. 147, 148–49 (measuring impulsivity of gambler and correlation with an index of the social and familial disruption engendered by past gambling. In contrast, a measure of one facet of the gamblers’ cognitive style (the TF subscale of the Myers-Briggs Inventory) did correlate with this index of gambling-induced disruption but did not differentiate gamblers from controls); see also Hae Woo Lee et al., *Impulsivity in Internet Addiction: A Comparison with Pathological Gambling*, 15 CYBERPSYCHOLOGY BEHAV. SOC. NETWORKING 373, 376 (explaining that those suffering from Internet addiction showed increased levels of trait impulsivity, which were comparable to those of patients diagnosed with pathological gambling. Additionally, the severity of Internet addiction was positively correlated with the level of trait impulsivity in patients with Internet addiction. Results state that Internet addiction can be conceptualized as an impulse control disorder and that trait impulsivity is a marker for vulnerability to Internet addiction.)

89. See generally Breen & Zuckerman, *supra* note 83 (examining within-session chasing as opposed to between-session chasing in light of impulsivity, sensation seeking, and attitudes and beliefs about gambling. The finding that chasers played more trials than non-chasers indicates that chasers exposed themselves further into the sequence of increasing losses, thus indicating the inability to moderate responses. Chasers were higher in impulsivity than non-chasers suggesting that impulsivity constitutes sensitivity to signals of reward relative to a general insensitivity to signals of punishment).

90. See, e.g., Damien Brevers & Xavier Noël, *Pathological Gambling and the Loss of Willpower: A Neurocognitive Perspective*, 3 BRAIN & ADDICTION 1, 6 (2013) (describing how structural factors (the contingency of loss and reward, near misses, providing gamblers with choice, and the casino-related context) could promote the repetition of gambling experiences and bias learning mechanisms to such an extent that vulnerable individuals may become unable to control their gambling habits); Ellen J. Langer, *The Illusion of Control*, 32 J. PERSONALITY & SOC. PSYCHOL. 311, 318 (1975) (illustrating how perceived control can actually cause subjects to reject a genuine opportunity to increase their chances of winning); Luke Clark et al., *Physiological Responses to Near-Miss Outcomes and Personal Control During Simulated Gambling*, 28 J. GAMBLING STUD. 123, 133–34 (2012) (observing that illusory perceived control can also modulate the impact of near-misses).

91. A. Blaszczynski et al., *Impulsivity in Pathological Gambling: The Antisocial Impulsivist*, 92 ADDICTION 75–76 (1997); see also Breen & Zuckerman, *supra* note 83; Paul Delfabbro, *The Stubborn Logic of Regular Gamblers: Obstacles and Dilemmas in Cognitive Gambling Research*, 20 J. GAMBLING STUD. 1, 2 (2004); Paul M. Delfabbro & Anthony H. Winefield, *Predictors of Irrational Thinking in Regular Slot Machine Gamblers*, 134(2) J. PSYCHOL. 117, 125 (2000); Mark D. Griffiths, *The Role of Cognitive Bias and Skill in Fruit Machine Playing*, 85 BRIT. J. PSYCHOL. 351, 363 (1994).

reporting biases.⁹² Indeed, risky gambling has been linked to “biases,” or preferences in cognition.⁹³ More importantly, these studies tend to focus solely on exploring the variables that differentiate pathological gamblers from social or non-gamblers,⁹⁴ as opposed to how and why these relationships among factors exist.

To date, very few studies in this area involve novel experiments. Studies with community samples tend to use naturally occurring groups and do not control for demographic variables, such as socioeconomic status (SES), marital status, employment status, religion, and other psychopathology.⁹⁵ Similarly, these naturalistic studies do not take context effects into account (e.g., alcohol/substance use, fatigue, noise, other players, etc.).⁹⁶

It should be conclusively determined, however, whether a direct link between impulsivity and within-session gambling behavior exists, and therein clarify the role of impulsivity to gambling while controlling for potential confounding factors.

2. Problem Gambling as a Spin-off of Compulsive Gambling, not Addictive Behavior?

Impulse control disorders are not an addiction or addictive disorder *per se*, but are rather categorized under the obsessive-compulsive disorder spectrum. On the other hand, problem gambling is classed according to whether harm is experienced by the gambler (or by others), as opposed to the gambler’s behavior.⁹⁷

The definition of problem gambling used for research in Australia and endorsed by Gambling Research Australia (GRA) states that “problem gambling is characterized by difficulties in limiting money and/or time spent on gambling, which leads to adverse consequences for the gambler, others, or for the community.”⁹⁸ Based on the GRA definition, a classification of problem gambling is appropriate when the individual has both problems limiting the time and money

92. See Breen & Zuckerman, *supra* note 83, at 1098.

93. See Natalie V. Miller & Shawn R. Currie, *A Canadian Population Level Analysis of the Roles of Irrational Gambling Cognitions and Risky Gambling Practices as Correlates of Gambling Intensity and Pathological Gambling*, 24 J. GAMBLING STUD. 257, 271 (2008).

94. See, e.g., Bagby et al., *supra* note 87, at 873; Kenny R. Coventry & Iain F. Brown, *Sensation Seeking, Gambling and Gambling Addictions*, 88 ADDICTION 541, 551 (1993); Nadia Kuley & Durand F. Jacobs, *The Relationship Between Dissociative-Like Experiences and Sensation Seeking Among Social and Problem Gamblers*, 4 J. GAMBLING BEHAV. 197, 199–201 (1988) (discussing findings that examined the relationships among dissociative experiences, sensation seeking scores, and gambling behavior that differentiate pathological gamblers from social or non-gamblers); See also Mark W.J. Langewisch & G. Ron Frisch, *Gambling Behavior and Pathology in Relation to Impulsivity, Sensation Seeking, and Risky Behavior in Male College Students*, 14 J. GAMBLING STUD. 245 (1998); Adrian Parke et al., *Personality Traits in Pathological Gambling: Sensation Seeking, Deferment of Gratification and Competitiveness as Risk Factors*, 12 ADDICTION RES. & THEORY 201, 209 (2004).

95. See generally Bagby et al., *supra* note 87, at 879 (explaining that socio-economic elements—status, education, ethnicity—were not controlled for in the experiment; however, age and gender are more likely to be taken into account).

96. See Kenny R. Coventry & Anna C. Norman, *Arousal, Sensation Seeking and Frequency of Gambling in Off-course Horse Racing Bettors*, 88 BRIT. J. PSYCHOL. 671 (1997).

97. Emir Aly Crowne-Mohammad & Meredith A. Harper, *Rewarding Trespass & Other Enigmas: The Strange World of Self-Exclusion and Casino Liability*, 1 UNLV GAMING L.J. 99, 101 (2010).

98. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 1.

spent gambling (thus causing excessive gambling) and problems resulting from the excessive gambling, a view similar to that of Dickerson.⁹⁹

Ferris, Wynne, and Single . . . suggest that the medical or disease model is arguably the dominant paradigm in North America at the moment, possibly because psychologists and psychiatrists have tended to dominate the problem gambling discourse there. This may also be due, in part, to the system of health insurance where a diagnosis of pathological gambling may be required so for health insurance to be used for treatment costs.¹⁰⁰

Broadly, problem gambling is measured using psychological screens—tested and validated questions that relate to gambling behaviors and beliefs—that are administered to survey populations.¹⁰¹ “There are numerous screens worldwide that have been developed to identify the extent of gambling problems within the community and/or to assess the severity of an individual’s gambling problem.” These include:

- South Oaks Gambling Screen (SOGS)
- Gamblers Anonymous 20 Questions (GA-20)
- Massachusetts Gambling Screen (MAGS)
- Diagnostic Interview for Gambling Schedule (DIGS)
- *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (*DSM-IV*)¹⁰²
- *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (*DSM-V*)¹⁰³
- Problem Gambling Severity Index (PGSI)¹⁰⁴
- Gambling Treatment Outcome Monitoring System (GAMTOMS)
- National Opinion Research Center *DSM-IV* Screen for Gambling Problems (NODS or NORCDSM IV)

99. See DICKERSON ET AL., *supra* note 60.

100. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8. See generally JACKIE FERRIS ET AL., THE CANADIAN PROBLEM GAMBLING INDEX: FINAL REPORT, CANADIAN CENTRE OF SUBSTANCE ABUSE 2 (2001) [hereinafter CPGI Final Report].

101. See RACHEL A. VOLBERG & ROBERT J. WILLIAMS, DEVELOPING A BRIEF PROBLEM GAMBLING SCREEN USING CLINICALLY VALIDATED SAMPLES OF AT-RISK, PROBLEM AND PATHOLOGICAL GAMBLERS 1 (2011).

102. AUSTR. GAMING COUNCIL, *supra* note 21; DSM-IV-TR, *supra* note 1; see also, David R. Strong & Christopher W. Kahler, *Evaluation of the Continuum of Gambling Problems Using the DSM-IV*, 102 ADDICTION 713, 713 (2007).

103. DSM-V, *supra* note 2. In the *DSM-V*, which has just been released, “Gambling Disorder” is now listed as a substance abuse disorder, alongside alcoholism and drug addiction. *Id.*

104. See *Problem Gambling Severity Index*, PROBLEM GAMBLING INSTITUTE OF ONTARIO, <http://www.problemgambling.ca/EN/ResourcesForProfessionals/pages/problemgamblingseverityindexpgsi.aspx> (last visited Mar. 10, 2015). See generally *Clinical Tools: Problem Gambling*, PROBLEM GAMBLING INSTITUTE OF ONTARIO, <http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/ClinicalToolsProblemGambling.aspx> (last visited Mar. 10, 2015) (explaining that based on the CPGI, the Problem Gambling Severity Index (PGSI) was developed as a diagnostic tool for use by health care professionals).

- Lie/Bet
- Canadian Problem Gambling Index (CPGI)¹⁰⁵
- Gambling Behaviour Interview (GBI)
- Structured Clinical Interview for Pathological Gambling (SCIP)
- Victorian Gambling Screen (VGS)
- The Maroonah Assessment Profile for Problem Gambling (G-MAP)
- Diagnostic Interview Schedule (DIS)
- HARM
- Gambling Symptoms Assessment Screen.¹⁰⁶

Results are then weighted and extrapolated to provide adult population estimates.¹⁰⁷ Part IV of this paper sets out select results of certain studies undertaken in the United Kingdom, Canada, the United States of America, and Australia outlining the application of commonly used psychological screening tests to determine the proportion of problem as opposed to pathological gamblers.¹⁰⁸

Viewing problem gambling as a medical disorder or mental health problem, Neal, Delfabbro, and O’Neil observe, primarily arose from the work of Robert Custer who defined compulsive gambling as: “[A]n addictive illness in which the subject is driven by an overwhelming, uncontrollable impulse to gamble.”¹⁰⁹

“Compulsive gambling” was included as a “new mental disorder” in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders III* as a result of Custer’s work.¹¹⁰ Compulsive gambling was defined as:

[A] progressive disorder in which an individual has a psychologically uncontrollable preoccupation and urge to gamble. This results in excessive gambling, the outcome of which

105. See Katherine Marshall & Harold Wynne, *Fighting the Odds*, PERSP. ON LABOUR & INCOME, Dec. 2003 at 7, 7 (2003); see also Crowne-Mohammad & Harper, *supra* note 97, at 101; *infra* part IV of this paper (highlighting that the CPGI is a 9-item instrument that assesses several domains of gambling problems, including guilt or anxiety, criticism from other people, financial problems, and chasing previous losses and which includes 46 variables. Developers of the CPGI divided scores into 4 categories (0, 1 to 2, 3 to 7, and 8 or over) to indicate increasing levels of gambling problems.).

106. AUSTL. GAMING COUNCIL, *supra* note 21; see also Suck W. Kim et al., *The Gambling Symptom Assessment Scale (G-SAS): A Reliability and Validity Study*, 166(1) PSYCHIATRY RES. 76, 77 (2009).

107. See, e.g., Howard J. Shaffer et al., *Estimating the Prevalence of Disordered Gambling Behavior in the United States and Canada: A Research Synthesis*, 89 AM. J. PUB. HEALTH 1369, 1373–74 (1999) (explaining that the test results from the sixteen measures for lifetime level three gambling among adults ranged from 1.5% to 1.6%).

108. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STAT. MANUAL OF MENTAL DISORDERS (3rd. ed. text rev. 1980) [hereinafter DSM-III].

109. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8.

110. See Christine Reilly & Nathan Smith, *The Evolving Definition of Pathological Gambling in the DSM-5*, NAT’L CENTER FOR RESPONSIBLE GAMING 1, 2 (2013), http://www.ncrg.org/sites/default/files/uploads/docs/white_papers/ncrg_wpdsm5_may2013.pdf; see also NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 9 (noting that “Custer’s background was as a psychiatrist in treating alcoholics, and this background influenced his perceptions of problem gambling, as did his primary sources of information who were clients of Gamblers’ Anonymous, since shown to be unrepresentative of problem gamblers in the general population”); David Crockford et al., *Prevalence of Problem and Pathological Gambling in Parkinson’s Disease*, 24 J. GAMBLING STUD. 411, 412 (2008).

compromises, disrupts or destroys the gambler's personal life, family relationships or vocational pursuits. The problems in turn lead to intensification of the gambling behavior. The cardinal features are emotional dependence on gambling, loss of control and interference with normal functioning.¹¹¹

The *DSM-III* criteria inaugurated a statement about the individual experiencing increasing loss of control, and emphasized disruption or damage to the individual's personal circumstances such as family and money-related issues. Following revisions to the *DSM-III* criteria in 1984, pathological gambling was depicted in the *DSM-III-R* as agnate to other addictions, such as substance dependence.¹¹²

Jacobs¹¹³ refers to the *Standard Medical Dictionary* definition of "addiction" as "the state of being given up to some habit, especially strong dependence on a drug," emphasizing that it is a habit that is central to addiction rather than ingestion of a substance.¹¹⁴ Even though problem gamblers may display similar symptoms to persons with other addictions (such as alcohol and drug dependence), problem gambling itself seems not to be physiologically addicting.¹¹⁵ This is not to say, necessarily, that classification as a problem or that a compulsive gambler should be placed at a higher plateau to alcohol or drug dependence for legislative or policy development.

Notably, there is a difference between "addiction" and "compulsive." The nexus between addiction and certain kinds of compulsive or impulsive behavior is a source of definitional confusion. To avoid confusion (although perhaps unsuccessfully), the terms substance dependence and substance abuse are used as opposed to "addiction" in the *DSM-IV*.¹¹⁶ One definition of addiction is,

111. Robert Custer, *An Overview of Compulsive Gambling*, in ADDICTIVE DISORDERS UPDATE 107, 110 (Pasquale Carone et al eds., 1982); see also NEAL, DELFABBRO & O'NEIL, *supra* note 49, at 5.

112. See Henry R. Lesieur & Robert L. Custer, *Pathological Gambling: Roots, Phases, and Treatment*, 474 ANNALS AM. ACAD. POL. & SOC. SCI. 146, 147 (1984).

113. Durand F. Jacobs, *A General Theory of Addictions: A New Theoretical Model*, 2 J. GAMBLING BEHAV. 15, 18 (1986); see also Anna E. Goudriaan et al., *Neurocognitive Functions in Pathological Gambling: A Comparison with Alcohol Dependence, Tourette Syndrome and Normal Controls*, 101 ADDICTION 534, 535 (2006); See generally Rachel A. Volberg, *The Prevalence and Demographics of Pathological Gamblers: Implications for Public Health*, 84 AM. J. PUB. HEALTH 237 (1994) (discussing that the Brief Bisocial Gambling Screen (BBGS) was created to assess past year experiences of withdrawal, deception, and bailout. The BBGS was developed using the National Epidemiologic Survey on Alcohol and related Conditions (NESARC)).

114. See generally U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTES OF HEALTH, THE NATIONAL INSTITUTE ON DRUG ABUSE MEDIA GUIDE HOW TO FIND WHAT YOU NEED TO KNOW ABOUT DRUG ABUSE AND ADDICTION 1 (2014) (defining addiction as a "chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences").

115. See BORRELL & BOULET, *supra* note 64, at 288.

116. See DSM-IV-TR, *supra* note 1, at 671-74. Notably, since 1980, psychology and psychiatry increasingly diagnosed problem gambling as an addiction but the DSM-IV definition that, until recently, was used to define pathological gambling in the United States, moved the focus from addiction to loss of control as the central experience. See Alex Blaszczynski & Lia Nower, *A Pathways Model of Problem and Pathological Gambling*, 97 ADDICTION 487, 492 (2001). Additionally, the DSM-IV noted that the excessive gambling behavior might be an indication of a manic episode, and, therefore, bipolar disorder would be the primary diagnosis. See Michael Walker & Mark Dickerson, *The Prevalence of Problem and Pathological Gambling: A Critical Analysis*, 12 J. GAMBLING STUD. 233, 239 (1996).

“compulsive behaviors that persist despite serious negative consequences for personal, social, or occupational function.”¹¹⁷

Characterizing the problem gambler as an addict is perceived as being based on a characterization of gambling behaviors such as, “preoccupation with gambling, gambling longer and with more money than intended, increasing tolerance to larger bets or longer odds in order to create the desired excitement, and frequent unsuccessful attempts to cut down or quit without attempting to draw etiological hypotheses about the origins of those behaviors.”¹¹⁸

By comparison, pathological gambling has been viewed as a “behavioral or non-clinical addiction.”¹¹⁹ By 1994, the *DSM-IV* definition had carved out a measure of guidance to clinically diagnose pathological gambling.¹²⁰ It emphasized the demise, loss, or impairment of control as a central event,¹²¹ and highlighted the essential feature of an impulse control disorder as being “[t]he failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or others.”¹²²

Equating “problem gambling” with “loss of control,” Neal, Delfabbro, and O’Neil observe, relates in part to the “underlying notion of an addictive personality.”¹²³ The updated *DSM-IV* included a diagnosis of pathological gambling within the section “Impulse Control Disorders not elsewhere classified,” where it is defined as “persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.”¹²⁴

Persistent, maladaptive gambling is expressed by a patient satisfying at least five of the following criterion, which represent three facets of behavior, namely:

- Damage or disruption, loss of control, and dependence.
- Strong desire to wager increasing amounts of money to experience the thrill of excitement.
- Adopts gambling as a means of escape from problems, or to cope with anxiety, depression or guilt.
- Repeated (but failed) attempts to control or stop gambling.
- Experiences restlessness or irritability when trying to restrain gambling.
- Being engrossed with gambling.

117. Ronald Pies, *Should DSM-V Designate “Internet Addiction” a Mental Disorder?* 6(2) *PSYCHIATRY* 31, 32 (2009) (this use of the term ‘compulsive’ is somewhat different than the classical, psychodynamic understanding of obsessive-compulsive symptoms).

118. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 8.

119. *Id.* at 9. *See also* GOUDRIAAN ET AL., *supra* note 113, at 534.

120. *Contra* APC Report, *supra* note 41, at 20 (explaining that Australian researchers, on the other hand, have tended to reject definitions of problem gambling such as this that contain reference to mental health, addiction, or disease for several reasons: insufficient evidence for underlying etiology and absence of reference to a contextual basis in diagnosing problem gambling. There is, however, research currently being conducted by the University of Adelaide, Australia.).

121. *See* DICKERSON ET AL., *supra* note 60, at 26.

122. *DSM-IV-TR*, *supra* note 1, at 609.

123. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 9.

124. *See* DICKERSON ET AL., *supra* note 60, at 13.

- Frequently attempts to redeem losses.
- Lies to cover up extent of gambling.
- Jeopardizes job, career, or personal relationship.
- Engages in criminal or fraudulent activities to finance gambling.¹²⁵
- Has had to rely on others for money to fuel or relieve the consequences of gambling.¹²⁶

As already noted, the *DSM-IV* definition (or other very similar definitions) is used in the United States.¹²⁷ As will be discussed, clarification of the scope of terms, the degree to which they differ, and their respective definitions are important for the purposes of identifying the standard of care owed by gambling providers and the potential for certain classifications (e.g., pathological gambling and gambling disorder) to be categorized as a disability.

3. Pathological Gambling

The most widely used measures of pathological gambling worldwide have been the South Oaks Gambling Screen (SOGS) and the diagnostic criteria listed in the *DSM*.¹²⁸ Both correlate highly and are acceptable methods of assessing the presence of pathological gambling.¹²⁹ As illustrated in Part IV of this paper, these methods have been widely used in measuring the population prevalence of pathological gambling.¹³⁰

American Psychiatric Association *DSM-IV* outlines diagnostic criteria for 312.31 Pathological Gambling as:

- A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
1. is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble);
 2. needs to gamble with increasing amounts of money in order to achieve the desired excitement;
 3. has repeated unsuccessful efforts to control, cut back, or stop gambling;

125. See Strong & Kahler, *supra* note 102, at 713 (explaining that certain criterion—inclusive of this one—have been omitted in the *DSM-V*. The rationale for this change is the low prevalence of this behavior among individuals with gambling disorder. In other words, no studies have found that assessing criminal behavior helps distinguish between people with a gambling disorder and those without one.)

126. APC Report, *supra* note 41, at 18; see also NEAL, DELFABBRO & O'NEIL, *supra* note 49, at 10; DSM-IV-TR, *supra* note 1, at 618.

127. See NEAL, DELFABBRO & O'NEIL, *supra* note 49, at 10.

128. See DSM-IV-TR, *supra* note 1, at 674; DSM-V, *supra* note 2, at 585–86.

129. See NEAL, DELFABBRO & O'NEIL, *supra* note 49, at 70.

130. See Stephanie Stucki & Margret Rihs-Middel, *Prevalence of Adult Problem and Pathological Gambling between 2000 and 2005: An Update*, 23 J. GAMBLING STUD. 245, 247 (2007).

4. is restless or irritable when attempting to cut down or stop gambling;
 5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression);
 6. after losing money gambling, often returns another day to get even (“chasing” one’s losses);
 7. lies to family members, therapists, or others to conceal the extent of involvement with gambling;
 8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling;
 9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling;
 10. relies on others to provide money to relieve a desperate financial situation caused by gambling.
- B. The gambling behavior is not better accounted for by a Manic Episode.¹³¹

In their Report, the Australian Productivity Commission noted advantages and disadvantages of the *DSM-IV* definition, noting that: “[T]he description of pathological gambling in *DSM-IV* [sic] characterizes pathological gambling in relatively precise operational terms; provides the basis for measures that are reliable, replicable, and sensitive to regional and local variation; distinguishes gambling behavior from other impulse disorders; and suggests the utility of applying specific types of clinical treatments.”¹³²

It was noted that, while the *DSM-IV* criteria appears to have worked well for clinicians in excess of a decade, there existed several shortcomings in classifying a person as a pathological gambler.¹³³ For example, while the *DSM-IV* offered a clinical description, it did so with little empirical support outside of a treatment environment.¹³⁴ Also, the *DSM-IV* only recognized the presence or absence of a clinical disorder.¹³⁵

131. See *DSM-IV-TR*, *supra* note 1, at 674.

132. COMMITTEE ON THE SOCIAL AND ECONOMIC IMPACT OF PATHOLOGICAL GAMBLING, *PATHOLOGICAL GAMBLING: A CRITICAL VIEW 2* (1999).

133. See *id.* at 2–3. See further Part IV of this paper. Because it is a clinical description with little empirical support beyond treatment populations, there still are problems with its use to define the nature and etiology of pathological gambling and when trying to estimate prevalence. *But see* Nancy Petry et al., *An Overview of and Rationale for Changes Proposed for Pathological Gambling in DSM-5*, 29 *J. GAMBLING STUD.* 493, 496–97 (2013).

134. See COMMITTEE ON THE SOCIAL AND ECONOMIC IMPACT OF PATHOLOGICAL GAMBLING, *supra* note 132, at 2–3. See also Christine Reilly & Nathan Smith, *The Evolving Definition of Pathological Gambling in the DSM-5*, *NAT’L CENTER FOR RESPONSIBLE GAMING*, 3 (2012) (noting that “the majority of pathological gamblers omit seeking formal treatment, and so a clinical description that is primarily based on observing those who do can be problematic, particularly when attempting to define the nature and origins of pathological gambling and trying to estimate its prevalence”).

135. See Reilly & Smith, *supra* note 134, at 3.

It is suggested that gambling problems exist on a “continuum” and that subclinical instances, namely those in lieu of noticeable clinical symptoms, of pathological gamblers are more prevalent.¹³⁶ Subclinical pathological gamblers, referred to as “problem gamblers,” have been defined as having difficulties as a result of their gambling. But, they fall short of fulfilling the five criteria for a diagnosis.¹³⁷

No doubt the significance of terms used can impact the application of certain legislation including the ADA, which specifically excludes compulsive gambling.¹³⁸ As already mentioned, however, such reference is to be distinguished from pathological gambling or gambling disorder, which are not expressly excluded under the ADA. This is discussed in Part V, below.

In the author’s opinion, however, it is pertinent to examine the substance of the disease as opposed to the form or terms (albeit general or generic) of classification. A further and more detailed analysis, as noted above, should be undertaken to accurately differentiate the problem gambler and compulsive gambler from the pathological gambler and gambling disorder. Research to date is inconclusively determinative.

4. Substance over Form: Problem Gambling Versus Pathological Gambling

The progressive nature of problem, or pathological, gambling is emphasized in a number of the medical disorder or mental health problem definitions. Letson¹³⁹ distinguished “problem” from “pathological” gambling, with the latter being defined as: “a progressive disorder in which an individual has a psychologically uncontrollable preoccupation with and urge to gamble, resulting in damage to vocational, family, and social interests. It is characterized by a chronic and progressive inability to resist the impulse to gamble.”¹⁴⁰

By comparison, the National Council on Problem Gambling in the United States defines problem and pathological gambling as follows:

Problem gambling is gambling behavior which causes disruptions in any major area of life: psychological, physical, social or vocational”Problem Gambling” includes, but is not limited to, the condition known as “Pathological”, or “Compulsive” Gambling, a progressive addiction characterized by increasing

136. See *id.*

137. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 14; see also Howard Shaffer et al., *Estimating the Prevalence of Disordered Gambling Behavior in the United States and Canada: A Research Synthesis*, 89 AM. J. PUB. HEALTH 1369, 1370 (1999) (outlining other labels used to describe this group such as “at-risk,” “level 2,” and “probable pathological”); see also Reilly & Smith, *supra* note 132, at 3.

138. See 42 U.S.C. § 12211(b)(2) (2014).

139. See Laura Letson, *Current Trends in Problem and Pathological Gambling*, Presentation at Bridging the Gap Conference, (May, 2000), available at [http://geo.ca/sites/default/files/documents/Letson%20\(2000\)Current_trends_in_problem_and_pathological_gambling.pdf](http://geo.ca/sites/default/files/documents/Letson%20(2000)Current_trends_in_problem_and_pathological_gambling.pdf).

140. NEAL, DELFABBRO AND O’NEIL, *supra* note 49, at 10.

preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, “chasing” losses, and loss of control manifested by continuation of the gambling behavior in spite of mounting, serious, negative consequences.¹⁴¹

Similarly, the Nevada Council on Problem Gambling defines problem gambling as:

[A] progressive behavioral disorder in which an individual has a psychologically uncontrollable preoccupation and urge to gamble. This results in excessive gambling, the outcome of which is the loss of money, time and self-esteem . . . gambling reaches a point at which it compromises, disrupts, and ultimately destroys the gambler’s personal life, family relationships, and vocational pursuits. These problems in turn lead to intensification of the gambling behavior . . . principal features are emotional dependence on gambling, loss of control, and interference with normal functioning.¹⁴²

The above characterization depicts a horizontal linear progression with respect to gambling problems—that being from less disorderly to more disorderly gambling.¹⁴³ The definitions additionally fixate on preoccupation with gambling, and for some people, discount episodic bouts of wagering, rather than uncontrolled wagering, can result in those people either identifying themselves, or being identified by others, as problem gamblers. Although linear progression may depict the behavior of many problem gamblers, Shaffer and Hall note that few studies have explored the potential for demise in problematic gambling behavior.¹⁴⁴ It is nevertheless apparent that there exists minimal evidence of linear progression.

Therein, many Australian definitions focus on loss of control. For example, according to the Australian Institute for Gambling Research (AIGR): “problematic gambling [is] . . . gambling that is frequent, is at times uncontrolled, and has resulted in some harmful effects.”¹⁴⁵

Other definitions concerning loss of control are noted by the Australian Productivity Commission: “Problem gambling may be characterized by a loss of control over gambling, especially over the scope and frequency of gambling . . .

141. *Id.* at 11.

142. *Id.* at 10–11.

143. *Id.* at 11.

144. *See id.*; *see also* Howard J. Shaffer and Matthew N. Hall, *Estimating the Prevalence of Adolescent Gambling Disorders: A Quantitative Synthesis and Guide Toward Standard Gambling Nomenclature*, 12 J. GAMBLING STUD. 193, 204 (1996).

145. Mark G. Dickerson & Ellen Baron, A CRITICAL EVALUATION OF TWO NATIONAL PREVALENCE STUDIES: THE CASE FOR ALTERNATIVE STRATEGIES 111 (Austl. Inst. Gambling Research eds., 1998).

level of wagering . . . amount of leisure time devoted to gambling . . . the negative consequences deriving from this loss of control.”¹⁴⁶ They go on to note that:

Problem gambling is used to refer to the wider group of people who show some but not all signs of developing that condition. . . . [P]roblem gambling are [sic] gambling behavior over which the person does NOT have control or which the person finds very hard to control and which contributes to personal, economic and social problems for the individual and family.¹⁴⁷

The definitions in Australia, unlike in the United States, fall short of representing problem gambling linearly or in a continuous fashion. Rather, the Australian definitions emphasize preoccupation with gambling.¹⁴⁸ In referring to loss of control as an elemental feature, the approach in Australia appears previously to have mixed pathological gambling with compulsive gambling. Where a gambler has displayed clear signs of loss of control, “pathological and compulsive gambling [are used] in an equivalent sense to describe [such] gamblers.”¹⁴⁹ The ACT Gambling and Racing Commission, for example, implicitly recognizes problem gambling as an impulse control disorder: “Problem gambling is characterized by a strong pull or compulsion towards gambling that becomes more and more difficult to resist [T]he urge to gamble . . . despite all the logical arguments they have against gambling, this urge will not go away until it is satisfied (by gambling).”¹⁵⁰

In its captious review of pathological gambling, the National Research Council recognizes broad support (particularly in the United States and in research literature) for pathological gambling or Level 3 gambling, which has been defined as: “[A] progressive disorder characterized by a continuous or periodic loss of control over gambling; a preoccupation with gambling and with obtaining money with which to gamble; irrational thinking; and a continuation of the behavior despite adverse consequences.”¹⁵¹

Similar to the United States, however, Australia instills the view that problem gambling is problematic because of the adverse consequences that arise from a person’s gambling behavior. For example, problem gambling has been described by the Australian Productivity Commission as involving, “[a] lack of control by the gambler over his/her gambling behavior; and/or adverse personal, economic and social impacts which result from a gambler’s actions—particularly the financial losses relative to the gambler’s means.”¹⁵²

146. See APC Report, *supra* note 41, at 6.2; see also NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 11.

147. APC Report, *supra* note 41, at 6.3.

148. See *id.*

149. See *id.*

150. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 12.

151. See APC Report, *supra* note 41, at 6.3.

152. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 12.

The Productivity Commission has generally viewed problem-gambling behavior as laying on a continuum of gambling behavior.¹⁵³ This essentially extends from where gambling does not escalate adverse impacts, to where the behavior leads to very severe consequences for the gambler and related third parties.¹⁵⁴ The continuum approach appears to eliminate the focus of problem gambling from the individual to society. In so doing, it does not truly fit in with the medical approach with its focus on the underlying pathology of the individual gambler.

C. Distinguishing the Distinguished? Pathological Gambling and Gambling Disorder

In 1998 and 1999, the Committee on the Social and Economic Impact of Pathological Gambling and Committee on Law and Justice in the United States launched a calumnious review of pathological gambling.¹⁵⁵ Of particular noteworthiness is its summary of the advantages and disadvantages of the *DSM-IV* definition of pathological gambling. It stated that the current description: “[H]as been found to characterize pathological gambling *in relatively precise operational terms*; to provide the basis for measures that are reliable, replicable, and sensitive to regional and local variation; to *distinguish gambling behavior from other impulse disorders*; and to suggest the utility of applying specific types of clinical treatments.”¹⁵⁶

It went on to observe that, although the criteria in *DSM-IV* seemed to work well for clinicians in the early 1990s, there were inherent limitations because it was a clinical description.¹⁵⁷ “[B]ecause it is a clinical description with little empirical support beyond treatment populations, there are still problems with its use to define the nature and origins of pathological gambling, and when trying to estimate prevalence.”¹⁵⁸

To date, no published studies have evaluated the reliability or validity of the diagnostic criteria when used in clinical assessment. In the author’s opinion, therefore, it appears difficult to identify what basis the claim that the *DSM-IV* criteria has functioned satisfactorily for clinicians is being made.

Researchers such as Shaffer and Korn have questioned the inclusion of pathological gambling under the impulse-control disorders classification, placing particular emphasis on key differences between the disorders.¹⁵⁹ Pathological

153. See *id.*

154. See *id.*

155. COMMITTEE ON THE SOCIAL AND ECONOMIC IMPACT OF PATHOLOGICAL GAMBLING, PATHOLOGICAL GAMBLING: A CRITICAL VIEW, *supra* note 132, at 17.

156. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 13 (citing Howard J. Shaffer et al., *Pathological Gambling Among Adolescents: Massachusetts Gambling Screen (MAGS)*, 10 J. GAMBLING STUD. 339, 341 (1994)).

157. See *id.*

158. *Id.*

159. See *DSM-IV-TR*, *supra* note 1, at 663 (pathological gambling was classified under the section titled, “Impulse Control Disorders Not Elsewhere Classified,” along with Compulsive Hair Pulling (Trichotillomania); Intermittent Explosive Disorder; Kleptomania; and Pyromania); see also Reilly & Smith, *supra* note 110, at 3.

gamblers, for example, “while in action often find their gambling enjoyable, and only after the gambling is terminated or losses are incurred, do pathological gamblers begin to feel distress.”¹⁶⁰

The ongoing desire to refine and redefine pathological gambling with precision (i.e., to achieve a more accurate diagnosis of gambling disorder) motivated the introduction of an amended threshold in the *DSM-V*.¹⁶¹ For example, in response to such concerns for ongoing clinical utility, pathological gambling was moved to the category Substance-Related and Addictive Disorders and renamed gambling disorder.¹⁶² It has been suggested that brain imaging studies and neurochemical tests were proven to be a strong method because “[gambling] activates the reward system in much the same way that a drug does.”¹⁶³ Although, in such a context, this reclassification of gambling disorders places it on par with alcohol and drug use disorders and potentially greater coverage for treatment of the disorder by health insurance providers. Reinforcing the desire to achieve a more accurate diagnosis of gambling disorder, the *DSM-V* provides a limited time period.¹⁶⁴ This essentially requires that symptoms be present during a 12-month time period, as opposed to an indefinite or undefined period of time.¹⁶⁵ The clinical description in the *DSM-V* also eliminated a previous criterion of having “committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling.”¹⁶⁶ The rationale for this change was the purported minimal prevalence of such behavior among individuals with gambling disorder.¹⁶⁷ It has been determined that the elimination of this criterion, in any event, would have minimal (if any) effect on diagnosis.¹⁶⁸ The text will, however, refer to illegal acts associated with the disorder, but illegal acts will not of itself be a single criterion for diagnosis.

Most gambling problems, although not all, are the result of gamblers spending in excess of their ability.¹⁶⁹ Although, this is only one aspect of problem gambling. The term most often used to define problem gambling when it is “characterized as an economic activity is excessive gambling.”¹⁷⁰ A typical definition is Blaszczynski, Walker, Sagris, and Dickerson’s definition: “Excessive gambling is

^{160.} Reilly & Smith, *supra* note 110, at 3 (observing that individuals with kleptomania and pyromania (both impulse control disorders) feel overwhelmed by an impulse to act and often report a sense of relief after having acted); see also Howard Shaffer & David Korn, *Gambling and Related Mental Disorders: A Public Health Analysis*, 23 ANN. REV. PUB. HEALTH 171, 181–94 (2002).

^{161.} See *DSM-V*, *supra* note 2, at 585.

^{162.} See *id.* at 585.

^{163.} See Constance Holden, *Behavioral Addictions Debut in Proposed DSM-V*, 327 SCIENCE 935 (2010); see also Reilly & Smith, *supra* note 110, at 3 (discussing that pathological gamblers report cravings and highs in response to their stimulus of choice); see also Marc Potenza et al., *Shared Genetic Contributions to Pathological Gambling and Major Depression in Men*, 62 ARCHIVES OF GEN. PSYCHIATRY 1015–21 (2005) (observing that neuroscience and genetics research has played a key role in these determinations and concluding that it also runs in families, often alongside other addictions).

^{164.} See *DSM-V*, *supra* note 2, at 585.

^{165.} See *id.*

^{166.} See *id.* But see *DSM-IV-TR*, *supra* note 1, at 674.

^{167.} See Strong & Kahler, *supra* note 102, at 720 (There are no studies establishing that assessing criminal behavior helps distinguish between people with a gambling disorder and those without one).

^{168.} See *id.*

^{169.} See *DSM-V*, *supra* note 2, at 585.

^{170.} NEAL, DELFABBRO & O’NEIL, *supra* note 49, at vi.

used to describe a level of gambling expenditure . . . considered to be higher than can be reasonably afforded relative to the individual’s available disposable income and as a result produces financial strain.”¹⁷¹

As Neal, Delfabbro, and O’Neal observe, “it is usually financial problems that distinguish so-called problem gamblers from other gamblers whose gambling behaviors might otherwise be identical.”¹⁷² They observe that any definition of problem gambling should encompass this facet of gambling, especially if such a definition is to be more widely used other than in a clinical setting.¹⁷³

As identified in the section above, problem gambling has been viewed as a “continuum.” For example, Neal, Delfabbro, and O’Neal have suggested a range or spectrum ranging from social or recreational gambling (which entails no adverse impacts), to problem gambling where gambling results in adverse consequences, followed by pathological gambling where severe consequences ensue.¹⁷⁴ Those who do not favor the medical disorder or mental health approach to problem gambling may favor this approach to problem gambling.¹⁷⁵ The Australian Productivity Commission recognizes that problem gambling is a behavior that will present in varying degrees and forms.¹⁷⁶ Despite its recent efforts to investigate a possible definition of “problem gambling,” it favors problem gambling as being viewed as a “continuum,” stating that: “gambling involvement rests on a continuum from occasional non-problematic use through to extreme over-involvement, with a host of related problems that may be accompanied by a sense of impaired control.”¹⁷⁷

In order to effectively determine that a person is a problem gambler under the continuum approach to problem gambling, it is important to hypothesize which levels of severity are policy-relevant.¹⁷⁸ In other words, consideration should be made to the broader societal and policy impact of a classification in a present context. This is similar to the observation of Neal, Delfabbro, and O’Neal who highlight that it is the more commonly used approach because it is inclusive (individuals will fit somewhere on the continuum).¹⁷⁹ In the author’s opinion, the ability to classify persons on this “spectrum” may be useful to implement strategies (e.g., early intervention for at-risk gamblers, or targeted strategies for pathological gamblers) that address problem gambling. Definitions of problem gambling based on the continuum approach are, therefore, contextually based (i.e., factor into account cultural, social and environmental factors) and broad enough to entail

171. *Id.*

172. *Id.*

173. *See id.*

174. *See id.*; *see also* Strong, *supra* note 102, at 713.

175. *See id.*

176. APC Report, *supra* note 41, at 6.1.

177. *Id.*

178. *See* NEAL, DELFABBRO & O’NEIL, *supra* note 49, at vi.

179. *Id.* at 15 (noting that reference to “whole population” of gamblers for the purposes of the continuum approach refers to “those who have no gambling-related problems to problem and pathological gamblers who exhibit increasingly extreme gambling behaviors and gambling-related harms”).

those potentially classified as having a gambling problem.¹⁸⁰ They are also focused on inimical outcomes as opposed to purported foundational pathology.

But, there exist limitations in defining problem gambling in terms of a continuum that are also recognized by scholars such as Neal, Delfabbro, and O’Neal; however, this includes the purported inability to equip the construct of social policy, difficulty in facilitating effective diagnosis due to the absence of an objective measurement.¹⁸¹

There exists another option—the harm-based approach—for defining problem gambling. Practitioners and researchers in Australia appear to have favored this approach in recent years. This approach has been recognized by scholars including Neal, Delfabbro, and O’Neal, and is broadly described as defining problem gambling “in terms of the harms it gives rise to for the individual and to any other persons affected by that individual’s gambling behavior.”¹⁸² Although they are broader than definitions based on a clinical approach, harm-based definitions can be contextually based, encompass a clinical approach when necessary, distinguish problem gambling from social gambling, and are useful for service providers and those monitoring service usage.¹⁸³ On the flip-side, harm-based definitions instigate subjective criteria, cannot quantitatively measure or replicate research and are inept to assess the level of assistance an individual gambler may require for the purposes of public policy planning.¹⁸⁴

Several jurisdictions do, however, define problem gambling in terms of its harm. For example, in Australia and North America, problem gambling is presently defined (albeit broadly) in terms of its social impacts—not individual behaviors.¹⁸⁵ The primary harm-based definition used in Australia is that “[p]roblem gambling refers to the situation when a person’s gambling activity gives rise to harm to the individual player, and/or to his or her family, and may extend into the community.”¹⁸⁶

A strikingly similar harm-based definition to Australia’s, which reinforced the development of the Canadian Problem Gambling Index (CPGI), was advanced by the Canadian Inter-Provincial Task Force on Problem Gambling. Similarly, the Queensland Government Treasury’s definition of problem gambling also contains within it a definition of harm: “a range of adverse consequences where . . . the safety and wellbeing of gambling consumers or their family or friends are placed at risk, and/or negative impacts extend to the broader community.”¹⁸⁷

180. See David R. Strong & Christopher W. Kahler, *Evaluation of the Continuum of Gambling Problems Using the DSM-IV*, 102 ADDICTION 715 (2007).

181. *Id.*

182. *Id.*

183. NEAL et al., *supra* note 49, at vii.

184. *Id.* at 27.

185. *Id.* at vii.

186. AUSTRALIAN INSTITUTE FOR GAMBLING RESEARCH, AUSTRALIAN GAMBLING COMPARATIVE HISTORY AND ANALYSIS 2 (1999), available at <http://assets.justice.vic.gov.au/vcglr/resources/bb81f943-d854-40de-8bab-b09d8bbd610f/australiangamblingcomparativehistory.pdf>.

187. QUEENSLAND TREASURY, THE QUEENSLAND RESPONSIBLE GAMBLING STRATEGY 3 (2002), available at <http://publications.qld.gov.au/dataset/202496ee-ba88-479a-9c8e-7dc765133f21/resource/7c0d2522-e5eb-47a8-bd7b-41e0638c632e/download/0552orcodeofpracweb.pdf>.

The *New Zealand Gambling Act 2003* contains a specific definition of harm that encompasses broader social impacts:

Harm-

- (a) means harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and
- (b) includes personal, social, or economic harm suffered—
 - (i) by the person; or
 - (ii) the person’s spouse, partner, family, whanau, or wider community; or
 - (iii) in the workplace; or
 - (iv) by society at large.¹⁸⁸

These definitions, however, support only minimal measures in assessing the assistance that individual gamblers require from a public policy planning perspective.¹⁸⁹ While not explored in this article, it is noted that such a perspective could play a key role in negligence-based tort actions against casino providers.

D. Summary and Comment of Problem Versus Pathological Gambling

Volberg points to the difficulties in assessing problem gambling because of the broad range of stakeholders:

Policy makers, government agencies, gambling regulators, and gaming operators are concerned about the likely impacts of changing mixes of legal gambling on the gambling behavior of broad segments of the population as well as on the prevalence of gambling-related difficulties. Public health researchers and social scientists are concerned with minimizing the risks of legal gambling to particular subgroups in the population. Economists, financial institutions, and law enforcement professionals are concerned about the relationship between legal gambling and bankruptcies, gambling and crime, and the reliance of the gaming industries on problem gamblers for revenues. Treatment professionals, government agencies, and not-for-profit organizations are concerned about how to allocate scarce resources for the prevention and treatment of gambling problems.¹⁹⁰

188. Gambling Act 2003 (N.Z.) available at <http://www.legislation.govt.nz/act/public/2003/0051/latest/DLM207497.html>.

189. See CPGI Final Report, *supra* note 100 (explaining that important attempts have been made to measure the harm caused by gambling at the individual level, but, at this time, there appears to be no scale which measures the severity of problems caused by gambling across a representative array of domains in everyday life. It is under these circumstances that, in Canada at least, the GRA has recommended the use of the CPGI.)

190. RACHEL VOLBERG, CHANGES IN GAMBLING AND PROBLEM GAMBLING IN OREGON. RESULTS FROM A REPLICATION STUDY, 1997 TO 2000 (2001) A7–A8.

A solitary definition of problem gambling, that addresses requirements of the above stakeholders may be problematic to achieve. Stakeholders, for example, will likely favor definitions that focus on the nature of their individual professional interactions with problem gamblers, using whichever definition is of most practical use.¹⁹¹ In investigating the distribution among United States gamblers of the ten DSM-IV criteria for Pathological Gambling, Toce-Gerstein, Gerstein, and Volberg¹⁹² attempt to refine the definition and diagnosis of gambling disorders, concluding that:

[D]ependence in a bio-behavioral sense appears to be a hallmark of Pathological Gambling, but it marks only one threshold in a qualitative hierarchy of disorders beginning with a common subclinical behavior, chasing.

...

Withdrawal and Loss of Control, along with Tolerance, appear to play important, interrelated roles in Pathological Gambling.¹⁹³

This outcome provides a valuable facet to Blaszczynski and Nower's¹⁹⁴ characterization of pathological gambling as impaired behavioral control. Toce-Gerstein, Gerstein, and Volberg, however, campaign another approach to pathological gambling.¹⁹⁵ The authors expose broad acceptance of the *DSM-IV* definition in many countries where legalized gambling exists. They note, however, that there remains an outstanding contention about whether gambling disorders lie on a continuum, or include a sole, acutely distinguished pathological individual; or, alternatively, whether gambling problems encompass a ranking of logically comprised but qualitatively contrasting disorders.¹⁹⁶

Reference to "problem gambling" in existing literature (relating to the medical model) frequently characterizes those gamblers who meet not more than five of the *DSM-IV* criteria.¹⁹⁷ The *DSM-IV* definition, however, fails to adequately cater the need to describe individuals who fall short of being diagnosed as pathological gamblers, but who (as a result of their gambling behaviors) experience unfavorable consequences.¹⁹⁸

Some authors are, however, critical of the medical model of problem gambling. They tend to favor approaches that regard gambling as a continuum—which, as previously mentioned, are inclusive of the whole population of gamblers. One

191. *Id.*

192. *See* Mariana Toce-Gerstein, Dean Gerstein & Rachel Volberg, *A Hierarchy of Gambling Disorders in the Community*, 98 *ADDICTION* 1661, 1661–72 (2003).

193. *Id.* at 1661, 1669; *see also* Neal, Delfabbro & O'Neil, *supra* note 49, at 14.

194. *See* Blaszczynski & Nower, *supra* note 116, at 487.

195. *See* Neal, Delfabbro & O'Neil, *supra* note 49, at 14.

196. *Id.*

197. *See* Lesieur & Rosenthal, *supra* note 60.

198. *See id.*

drawback is that there is no clearly delineated cut-off point on the continuum that defines a person as a problem or pathological gambler. Problem gambling is generally referred to as an addiction. In other words, a person that has, at the very least, a sense of control over their behavior is distinguished. A person that has a sense of control leads to reliance on third parties to either manage or intervene to resolve the problem. Blaszczynski, Walker, Sagris, and Dickerson posit that categorizing problem gambling as an addiction is inappropriate. This is because gambling does not involve the ingestion of a substance as would be required by a strict interpretation of addiction.¹⁹⁹

Addiction comprises four key elements: withdrawal that leads to distressing physiological effects; chemical substance; a fix that results in an increased level of anxiety; followed by addiction when a person is incapable of coping in the absence of the thing.²⁰⁰ Notwithstanding this, the shortcoming of proving biological histology has not, it has been noted, obstructed “the psychiatric system from confidently defining pathological gambling as a psychiatric condition.”²⁰¹

A number of scholars have criticized the limitations of the *DSM-IV* criteria. For example, Law is principally critical of the *DSM-IV* criteria for diagnosing pathological gambling, stating that

the presence and identification of a behavior that constitutes a significant problem is neither *prima facie* evidence nor proof of the existence of pathology. These are not the same thing. . . . [T]he only basis on which these behaviors (which are without a biological etiology) are deemed to constitute a pathology is their presence in the *DSM-IV*.²⁰²

This highlights the need for a more certain and clearly defined approach and criteria, as already outlined, to make such a determination. Similarly, Neal, Delfabbro, and O’Neal identify that the *DSM-IV* criteria fails to distinguish true pathological gambling from non-disordered gambling.²⁰³ They refer to Wakefield’s criticism of substance abuse. Dickerson, McMillen, and Hallebone²⁰⁴ reiterate that the mental disorder conceptualization accentuates preoccupation, excitement, and escaping from problems, which may be otherwise common to persons other than problem gamblers.²⁰⁵ In arguing that problem gambling should be recognized as largely, but not solely, one of financial strain, Blaszczynski, Sagris, and Dickerson state that: “A subjective sense of impaired control is not a necessary attribute [of problem gambling].”²⁰⁶

199. Blaszczynski et al., *supra* note 42, at 11.

200. See Dickerson et al., *supra* note 60, at 57–58.

201. *Id.*

202. See Ian Law, *Problem Gambling and Therapy: Exploring Alternative Metaphors to ‘Addiction’*, 2 DULWICH CENTRE NEWSLETTER 54, 55–58 (1997).

203. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 15.

204. See Dickerson et al., *supra* note 60.

205. See *id.* at 15, 25; see also NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 14.

206. Blaszczynski et al., *supra* note 42, at 6–7.

They appear to regard impaired control as being linked to impulsivity, or “an inability to delay gratification, which, in turn, leads to excessive gambling.”²⁰⁷ Nevertheless, they suggest that problem gambling exists as a “mental disorder.” They also caution that the *DSM-IV* criteria for diagnosis is “over-inclusive” (particularly in the Australian context), a view that for reasons discussed above I similarly share. They also conclude that Dickerson, McMillen, and Hallebone et al., fail to put forward convincing empirical evidence.²⁰⁸

Neal, Delfabbro, and O’Neal refer to economists such as Slade and McConville, who are critical of the APA’s definition.²⁰⁹ In particular, they censure it as tautological, since failure to resist the impulse to gamble is deemed pathological.²¹⁰ They question the ability to transfer such definitions to other spheres of economic activity—for example, the failure to resist the impulse to set up a small business. Even when equipped with the knowledge that most small businesses fail, it could categorize the entity as possessing an underlying pathology.²¹¹ The AIGR has reflected on the Dickerson, McMillen, and Hallebone review of research into gambling as an addiction, a mental disorder, and as excessive behavior highlighting that industry representatives saw “the ‘mental health/addiction’ approach . . . as [being] too rigid and ‘scientific’ to validly define and measure problem gambling.”²¹²

The authors do, however, correctly note that the definitions of pathological and problem gambling were “a barrier to understanding gambling problems in ethnic communities,”²¹³ that it was not compatible with social perspective, and that it “may not be valid to have a universal definition.”²¹⁴ A view that the author shares.

IV. NUMBERS CAN MEAN MORE THAN ONE THING—THE STATISTICS

The availability of legal gambling has increased sharply in the past twenty years.²¹⁵ There is ongoing speculation that “the concomitant increase in gambling availability, and the promotion and widespread market penetration of new gambling forms, will lead to increased rates of problem gambling” or compulsive

207. *Id.*; see also NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 15.

208. See Dickerson et al., *supra* note 60; see also NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 15 (recognizing that a number of other authors are also critical of the APA definition arguing that no pathology has been demonstrated with respect to the *DSM-IV* definition, nor does the condition have the characteristics of classical neuroses).

209. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 16.

210. Slade & McConville, *supra* note 50, at 6.

211. See NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 15.

212. NEAL, DELFABBRO & O’NEIL, *supra* note 49, at 16.

213. *Id.*

214. *Id.*

215. From the outset, it should be noted that data represented in this section comprised a ten-item scale based on the fourth edition of the *DSM-IV* and/or the nine-item CPGSI, unless otherwise stated. Discussion about the forte and limitations of each study and importance in distinguishing ‘pathological gambling’ from ‘problem gambling’ appears later in this section. Given the lack of previous research, however, the current study was exploratory with no specific hypotheses advanced. See Howard Shaffer, Matthew Hall & Joni Vander Bilt, *Estimating the Prevalence of Disordered Gambling Behavior in the United States and Canada: A Research Synthesis*, 89 AM. J. PUB. HEALTH 1369, 1376 (1999).

gambling,²¹⁶ a higher threshold of pathological gambling,²¹⁷ and now gambling disorder.²¹⁸

Therein, estimating the degree of problem gambling-related harm has been a focal point in problem gambling prevalence research over the previous decades, reflecting the emergence of problem gambling as a public health issue in a culture where gambling is a common and generally acceptable activity.²¹⁹ By examining the difference between problem and at-risk gamblers, taking into consideration the use of land-based gambling,²²⁰ the author seeks to illustrate the delineating line between problem (or compulsive) gamblers and pathological gamblers. In so doing, this paper makes an argument that, with the increased ability to more accurately determine the difference between these requisite classifications, coupled with the vagueness of definitions under statutory legislation for covering persons with disabilities, there is an increasingly stronger argument that such legislation would apply to protect persons deemed to be pathological gamblers. It is proposed that the methodologies and hypotheses instituted in this paper will be central to strengthening the relevant role that science (in particular, psychiatry) plays in statutory and policy development—particularly with respect to health and disability law.

A. United States

It has been estimated that 1.5% of adults in the United States, at some time in their lives, have been problem gamblers.²²¹

As previously stated, problem gambling is a more inclusive term than pathological gambling.²²² Welte, Barnes, Wiczorek, Tidwell, and Parker,²²³ for example, found that the prevalence of problem gambling in the United States is 3.6% based on a SOGS score of 3+.²²⁴ The prevalence of pathological gambling in

216. See Sally M. Gainsbury et al., *The Impact of Internet Gambling on Gambling Problems: A Comparison of Moderate-Risk and Problem Internet and Non-Internet Gamblers*, 27 *PSYCHOL. ADDICTIVE BEHAV.* 1092, 1093 (2013).

217. “Pathological gambler” is to be distinguished from “problem gambler.” See *supra* Part III.

218. See DSM-V, *supra* note 2, at § 312.31 (outlining criteria to determine “gambling disorder”).

219. See Sanju George & Vijaya Murali, *Pathological Gambling: An Overview of Assessment and Treatment*, 11 *ADVANCES IN PSYCHIATRIC TREATMENT* 450, 450 (2005).

220. As opposed to a combination of internet and land-based gambling, discussed in a subsequent paper. The specific objectives of this research were to compare internet and non-internet gamblers on gambling behavioral patterns, gambling-related problems, and help-seeking behavior between those identified as problem and moderate-risk gamblers. The current study aims to examine differences between problem and at-risk gamblers, taking into consideration use of internet in addition to land-based gambling. Therefore, we examined overall patterns of gambling behavior to determine the contribution of each form to gambling problems and to clarify factors associated with Internet gambling problems. Given the lack of previous research, the current study was exploratory with no specific hypotheses advanced.

221. *Socio-Economic Costs*, CASINO TYRE, <http://www.casinofreetyre.com/costs.html> (last visited Feb. 26, 2015).

222. An individual can be classified as a problem gambler, but not a pathological gambler, based on a SOGS score of three or four. See *supra* Part III.

223. See John Welte et al., *Alcohol and Gambling Pathology Among U.S. Adults: Prevalence, Demographic Patterns and Comorbidity*, 62 *J. STUDIES. ON ALCOHOL* 706 (2001).

224. *Id.*

the same jurisdiction is slightly less than 1%.²²⁵ However, using the CPGI with a cut-off of eight, as recommended in the manual,²²⁶ a surprising result is found: the prevalence of problem gambling based on the CPGI is typically less than the prevalence of pathological gambling based on the SOGS.²²⁷

Research undertaken in the United States have utilized a variety of screens to, such as *DSM-IV*,²²⁸ *NODS*,²²⁹ *SOGS*,²³⁰ *SOGS-R*²³¹ to measure the significance of problem gambling.²³² Given the differences stated, the variety of sample sizes and the age of some studies, comparisons between United States jurisdictions should only be made with caution. For the purposes of this paper, however, the data represented is illustrative of (1) the increasing prevalence of problem gambling globally;²³³ (2) the accepted methods used to categorize problem gamblers and pathological gamblers;²³⁴ and (3) therein, the ability to distinguish between these requisite classes.²³⁵ However, it is submitted that further research should be undertaken to conclusively and accurately define the scope of pathological gambling and the extent to which it may be categorized as an impulse control disorder.

The National Research Council has estimated that in the United States in a given year, approximately 0.9% of adults (or 1.8 million) are pathological gamblers.²³⁶ It notes that a higher percentage of males fall into this category.²³⁷ In addition, the ratio of pathological gamblers is higher amongst adolescents (as many as 1.1 million adolescents between twelve and eighteen) than it is among adults.²³⁸ However, “adolescent measures of problem gambling are not always comparable to adult measures, and [that] different thresholds for adolescent gambling problems

225. Thus, without thinking the logic through, it might be expected that a similar difference would be observed in Australia.

226. See CPGI Final Report, *supra* note 100, at 41.

227. *Id.* at 34.

228. See *DSM-IV-TR*, *supra* note 1.

229. See *supra* Part III.B.ii.

230. See generally Lesieur, *supra* note 63, at 1184 (providing an overview and explanation of the South Oaks Gambling Screen (SOGS)).

231. Jamie Wiebe & Brian Cox, *Problem and Probable Pathological Gambling Among Older Adults Assessed by the SOGS-R*, 21 J. GAMBLING STUD. 153 (2005).

232. AUSTL. GAMING COUNCIL, A DATABASE ON AUSTRALIA’S GAMBLING INDUSTRY: CHAPTER 10—PROBLEM GAMBLING 25 (2013/14), available at https://www.austgamingcouncil.org.au/system/files/AGCPublications/AGC_DB_2013-14_CHP_10.pdf [hereinafter *Database on Australia’s Gambling*].

233. See Gainsbury, *supra* note 216, at 1093.

234. See *supra* Part III.

235. See *id.*

236. NATIONAL RESEARCH COUNCIL, *PATHOLOGICAL GAMBLING: A CRITICAL REVIEW 3* (Nat’l Academy Press, 1999), available at <http://www.nap.edu/catalog/6329.html>.

237. *Id.*

238. *Id.*

may exist.”²³⁹ Such demographics may play an important role in the development of legal policy and prevention of opening any litigation floodgates.²⁴⁰

With the increased availability of gambling and new gambling technologies, problem gambling has the potential to become even more widespread. Pervasive methodological problems prevent firm conclusions about the social and economic effects of gambling or problem gambling on communities; nor, can it be accurately said whether problem gamblers contribute disproportionately to overall gambling revenues. In addition, because the existing research on other subgroups in the population is less developed,²⁴¹ determining the degree to which other groups, such as elderly people and poor people, have disproportionately high rates of problem gambling may be undeterminable. Similarly, the data is inconclusive as to how legalized gambling affects community or national rates of suicide and crime.²⁴²

B. United Kingdom

In Britain, by comparison, three British Gambling Prevalence Surveys (BGPSs)—carried out in 1999–2000, 2006–2007, and 2009–2010—employed both of the above-mentioned problem gambling screening instruments.²⁴³ These surveys produce an estimated proportion of the adult population who are thought to have been above the threshold for problem gambling during the prior twelve months.²⁴⁴

Orford has noted that the:

[P]revalence estimates from the 2010 British Gambling Prevalence Survey (BGPS10) data were, according to the DSM-IV scale 0.9% (+/– 0.3) and according to the PGSI, 0.7% (+/– 0.3). . . . In percentage terms, the problem gambling prevalence estimates from BGPS10 are even larger still if the roughly one-quarter of the population who report having engaged in no gambling at all in the previous twelve months are excluded (1.3% and 1.0% according to the DSM-IV and PGSI scales respectively).²⁴⁵

He goes on to observe that “[t]hese are arguably large figures in public health terms,” equating to approximately one-third or a half-million adults in Britain.²⁴⁶ It

239. *Id.* Given various ways in which problem gambling has been operationalized in prevalence studies among adolescents, this estimate should be viewed with caution.

240. *See generally* Joseph M. Kelly & Alex Igelman, *Compulsive Gambling Litigation: Casinos and the Duty of Care*, 13 GAMING L. REV. & ECON. 386 (2009) (discussing the development and purpose of self-exclusion and other policies to address the increase in litigation by gamblers against casinos).

241. Subgroups refer, for example, to minors, elderly, retired etc.

242. Patricia L. Janes & Jim Collison, *Community Leader Perceptions of the Social and Economic Impacts of Indian Gaming*, 8 UNLV GAMING RESEARCH & REV. J. 13, 14 (2012).

243. *See* Jim Orford, Heather Wardle, & Mark Griffiths, *What Proportion of Gambling is Problem Gambling? Estimates from the 2010 British Gambling Prevalence Survey*, 13 INT’L. GAMBLING STUDIES 4, 4 (2013).

244. *See id.* For the most recent 2010 survey, the survey comprised a ten-item scale based on the DSM-IV and the nine-item CPGSI. *Id.*

245. *Id.* at 5.

246. *Id.*

should be emphasized that these measures comprise a singular approach to determine the scale of gambling that is problem gambling.²⁴⁷ For instance, the percentage of individuals in the general populous who have recently experienced gambling problems does not empirically mirror the proportion of the clientele of gambling establishments who have gambling problems.²⁴⁸ In other words, it seems plausible that problem gamblers visit gambling establishments more frequently than non-problem gamblers. Accordingly, the proportion of attendances made by players who have gambling problems would be greater than the proportion of problem gamblers in the general population. For example, a study undertaken by Fisher examining a representative sample of forty British casinos, approximated that of those patrons who frequented British casinos at any time in a single year, around 7% had gambling problems.²⁴⁹ This reflects a statistic that, according to Orford, is approximately ten times greater than the “1999/2000 BGPS general population estimate of the prevalence of problem gambling among all adults.”²⁵⁰ Fisher also estimated that approximately 16% of patrons present in the casinos at any one time were likely to have a gambling problem.²⁵¹

It is acknowledged that additional studies are required to advance understanding of these important matters. A greater understanding of this problem through scientific research is critical. Recent methodological and theoretical advances in epidemiology, medicine, and the social and behavioral sciences should aid this understanding.

C. Australia

Data collected in Australia concentrated primarily on electronic gaming machines (EGMs)—which are widespread in most Australian states and territories.²⁵² Gambling opportunities in Britain and the United States are, by comparison, “very diverse and it must be surmised that answers to the question posed here will vary considerably from one form” of wagering to another.²⁵³ “It might be supposed, for example, that problem gambling and problem gamblers would be more prominent in table game casino gambling than gambling on a bi-weekly lottery draw.”²⁵⁴

In utilizing the SOGS, the Australian Productivity Commission estimated that between 1997 and 1998, 2.1% (or approximately 292,737) of Australian adults experienced a form of problem gambling.²⁵⁵ Following the 2009 and 2010 review

247. Orford, *supra* note 243, at 5.

248. *Id.*

249. *Id.*; see also Susan Fisher, *Measuring the Prevalence of Sector Specific Problem Gambling: A Study of Casino Patrons* 16 J. GAMBLING STUDIES 25, 34 (2000).

250. Orford, *supra* note 243, at 5.

251. *Id.*

252. Jim Orford, *Consultation on Proposals for Changes to Maximum Stake and Prize Limits for Category B, C and D Gaming Machines*, GOV.UK, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/248941/Gambling_Watch_UK.docx.docx (last visited March 8, 2015).

253. *Id.*

254. *Id.*

255. *Database on Australia's Gambling*, *supra* note 232.

of gaming in Australia,²⁵⁶ the Productivity Commission concluded “that there are between 80,000 and 160,000 Australian adults suffering [from] severe problems due to their gambling (0.5 - 1.0% of adults).”²⁵⁷ The Productivity Commission estimated that, in addition, between 230,000 and 350,000 Australians (or 1.4 – 2.1% of adults) could be classified as falling into a “moderate risk group,” in turn placing them at a higher risk of progressing into problem gambling.²⁵⁸

D. Summary

In general, empirical findings underscore public health concerns about the social costs likely to accompany the rapid and prolific expansion of new forms of legalized gambling in many regions of a country. The sizeable, representative sample and high response rate achieved by Statistics Canada in empirical data referred to above provides a valuable foundation of information concerning the extent of gambling problems across different provinces in Canada, the United States, and Australia.²⁵⁹ Similar studies have been undertaken in other jurisdictions including Singapore, China, South Africa, and certain European States.²⁶⁰ These findings offer important information for policy-makers and public health planners. Notably, the availability of gambling within a community corresponded with an increased rate of problem gambling.²⁶¹ The studies do not, however, represent with accuracy an account and comparable ratio of problem gambling to pathological gambling using identical control methods.²⁶² Such studies would be equally central to highlighting discrepancies or overlap with gambling classifications, and advancing an argument (from a broader socio-economic and science perspective) to classify pathological gambling as a disability. Nevertheless, the interprovincial diversity in the availability of legalized gambling and in rates of gambling problems sanction a detailed examination of this public health issue.

256. *Id.*; see also AUSTL. PRODUCTIVITY COMM’N, *supra* note 49 (providing results of a meta-analysis of existing state and territory prevalence survey results from the previous decade).

257. *Database on Australia’s Gambling, supra* note 232.

258. *Id.*

259. *See supra* Part III.

260. *See* Nat’l Council on Problem Gambling, *Report of Survey on Participation in Gambling Activities Among Singapore Residents, 2011*, MINISTRY OF SOCIAL & FAMILY DEVELOPMENT (Feb. 23, 2012), <http://app.msf.gov.sg/Research-Room/Research-Statistics/Survey-on-Gambling-Participation-Among-Spore-2011>; Jasmine M. Y. Loo, Tian Po Oei, & Namrata Raylu, *Problem Gambling, Gambling Correlates, and Help-Seeking Attitudes in a Chinese Sample: An Empirical Evaluation*, 2 PSYCHOL. 342 (2011); Harold Kincaid et al., *A Taxometric Analysis of Problem Gambling Data from a South African National Urban Sample*, 29 J. GAMBLING STUD. 277 (2013).

261. Brian J. Cox et al., *A National Survey of Gambling Problems in Canada*, 50 CANADA J. PSYCHIATRY 213, 216 (2005).

262. *See supra* Part I.

V. PATHOLOGICAL GAMBLING AND GAMBLING AS A DISABILITY?

A. “Disability”

This paper acknowledges that disability may be referred to in different ways. Two categories of disability models are commonly labeled medical and social.²⁶³ Medical models tend to view disability as a problem of an individual to perform activities as a result of impairment.²⁶⁴ Rehabilitation, on the other hand, aims at correcting the shortcomings of the individual.²⁶⁵ The political response, generally speaking, is often that of modifying or reforming healthcare policy.²⁶⁶ On the contrary, social models depict disability as a socially created problem that results in minimal integration of individuals with impairments into society.²⁶⁷ Rehabilitation aims at rectifying the deficiencies of the environment—whether tangible, social, or attitudinal.²⁶⁸

Disability is not undoubtedly perceived as an attribute of an individual, but rather, as a matter of social-policy or politics, as well as a question of human rights. Scholars, including Borg, have criticized the medical and social models for what has been described as a “narrow construct.”²⁶⁹ The World Health Organization (WHO) has adapted its medically oriented model to align better with both medical and social models.²⁷⁰ This, it is observed, is in response to the WHO’s aim to furnish a lucid view of health (particularly in its International Classification of Functioning, Disability, and Health (ICF)) “from a biological, individual and social perspective.”²⁷¹ Characterized as the result of a manifold relationship between inherent matters such as an individual’s health condition and personal factors, and of external factors, disability is used as an umbrella term for a number of facets—for example, impairments, activity limitations, and participation restrictions.²⁷² At the same time, the term functioning is used as an umbrella term for functional and structural integrity of the body, activities, and participation.²⁷³

Although the CRPD does not define “disability,” it does state in Article 1 that

263. See Janet Read, *Conductive Education and the Politics of Disablement*, 13 *DISABILITY & SOC’Y*, 279, 282–283 (1998).

264. See *id.*

265. *Id.* at 6.

266. *Id.*

267. *Id.* at 283; See also MICHAEL OLIVER, *THE POLITICS OF DISABLEMENT* (1990) (discussing impaired individuals in relation to society); ROHER INSTITUTE, *DISABILITY IS NOT MEASLES: NEW RESEARCH PARADIGMS IN DISABILITY* (Marcia H. Rioux & Michael Bach eds., 1994); Helen Liggett, *Stars Are Not Born: An Interpretive Approach to the Politics of Disability*, 3 *DISABILITY, HANDICAP & SOC’Y* 263, 263–76 (1988).

268. See OLIVER, *supra* note 267 (discussing impaired individuals in relation to society); ROHER INSTITUTE, *supra* note 267, at 275.

269. JOHAN BORG, *ASSISTIVE TECHNOLOGY, HUMAN RIGHTS AND POVERTY* 12 (2011). See generally, Tom Shakespeare & Nicolas Watson, *Defending the Social Model*, 12 *DISABILITY & SOC’Y* 293, 293–300 (1997) (discussing the shortcomings of social models in regards to disabled people).

270. BORG, *supra* note 269, at 12.

271. *Id.*; see also WORLD HEALTH ORGANIZATION, *TOWARDS A COMMON LANGUAGE FOR FUNCTIONING, DISABILITY AND HEALTH: ICF (2002)* (Geneva), available at <http://www.who.int/classifications/icf/en/>.

272. BORG, *supra* note 269, at 13.

273. *Id.*

[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.²⁷⁴

As discussed, there is an absence of general consensus as to the precise definition of "pathological gambling," "gambling disorder," "compulsive gambling," and "problem gambling."²⁷⁵ It is acknowledged, however, that while pathological gamblers and persons with gambling disorder may be problem gamblers, the classification does not apply universally in reverse.²⁷⁶ One common factor with both pathological and problem gambling (compulsive gambling) is that it can be described as an impulse-control disorder.²⁷⁷ It is this finite point that may present a hurdle to include pathological gambling, as opposed to a gambling disorder, within the ambit of disability discrimination legislation.²⁷⁸

Caution should be exercised in assuming that accessibility is associated with a single disability. All are in fact equally important, and provision for catering to and for all needs should be addressed.²⁷⁹ Pathological gamblers, for example, are frequently faced with barriers to access—those barriers being exploitation of a venue's position as, for example, enticing a pathological gambler.²⁸⁰ Both access and barriers remain analytical constants, and overcoming barriers remains problematic.²⁸¹

This paper argues that barriers to access can include an inverted form of barrier, to function otherwise in substance as facilitating, through exploitation of, a person's classification as a pathological gambler (and within the definition of person with disability); for example, by being allowed access to a casino or physical gambling venue. One limitation of such a classification is policing, as knowledge of an individual's disability, *per se*, would be required.²⁸² Such a classification only works through self-exclusion. Unlike the latter, however, a disability would place a significant onus on a gambling provider—likely resulting in a higher standard of care.²⁸³

Importantly, synergy exists between impairments and obstacles, which is distinct from between entities and the broader environment. Participation is seen to

274. United Nations Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, U.N. Doc. A/RES/61/106 (Jan. 24, 2007), available at <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>. [hereinafter CRPD].

275. See *supra* Part III.B.

276. INSERM COLLECTIVE EXPERTISE CENTRE, GAMBLING: CONTEXTS AND ADDICTIONS 28 (2008).

277. *Contra* DSM-V, *supra* note 2, at 585 (outlining criteria to determine "gambling disorder").

278. See *id.*

279. Neil Witt & David Sloan, *Access as the Norm*, TIMES HIGHER EDUC. (April 30, 2004), available at <http://www.timeshighereducation.co.uk/News-and-Analysis/Access-as-the-norm/188593.article>.

280. See generally AMANDA V. MCCORMICK & IRWIN M. COHEN, BARRIERS TO ACCESSING TREATMENT FOR PROBLEM GAMBLING 1–3 (2006) (discussing various barriers to treatment for problem gamblers).

281. See *id.*

282. See THOMAS R. TRENKNER, AMERICANS WITH DISABILITIES: PRACTICE & COMPLIANCE MANUAL § 2:94 (1999).

283. See *infra* section V.B–C (assuming that a duty of care is owed in the first place).

be fundamentally frustrated by impairments.²⁸⁴ This is contrasted with the preamble of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which states that “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society.”²⁸⁵

It would appear logical, at least at face value, to consider the disability perspective of the CRPD as comprising a greater social element as opposed to medical classification.²⁸⁶ While a detailed discussion is beyond the scope of this article, it is noted that by directing measures towards changes dually towards the body and environment, the CRPD endorses the presence of impairments *and* barriers.²⁸⁷ This, in turn, would appear to indicate that the CRPD regards disability (in a general sense) in much the same way as the ICF.²⁸⁸

A number of countries have already attempted to remove these barriers to access via legislative measures.²⁸⁹ These are outlined in more detail below. A brief consideration of some of those measures illustrates the trends both favorable and negative. It may provide some indication as to what developing countries should consider when implementing similar types of solutions. But, it may also provide some factual basis for the belief that an international arrangement is needed to standardize these matters. Without it, pressing issues are resolved nationally while others are created at the international level, to the detriment of pathological gamblers.

B. International Framework—WIPO, CRPD

It has become popular to pronounce the desire to end discrimination against people with disabilities—whether direct or indirect forms of discrimination.²⁹⁰ It has become increasingly apparent that significant progress has been made in terms of reducing or eliminating the most obvious and overt expressions of discrimination, *vis-à-vis*, in the context of the exploitation by gambling venues of persons classified as pathological gamblers.²⁹¹

The fundamental human rights of people with disabilities are set out in the CRPD, and in that the human rights framework that is based in that Convention, as well as in international covenants and related human rights instruments.²⁹² In

284. See BORG, *supra* note 269, at 15.

285. CRPD, *supra* note 274, at Preamble ¶(e).

286. BORG, *supra* note 269, at 15.

287. *Id.*

288. *Id.*

289. See UNICEF INNOCENTI RESEARCH CENTRE, PROMOTING THE RIGHTS OF CHILDREN WITH DISABILITIES, v. 32 (2007), available at <http://www.unicefirc.org/publications/pdf/digest13-disability.pdf>.

290. See CRPD, *supra* note 274, at art. 4(1)(e).

291. See Richard Thompson Ford, *Rethinking Rights After the Second Reconstruction*, 123 YALE L.J. 2942, 2944 (2014).

292. CRPD, *supra* note 274, at Preamble ¶¶(b)–(c) (recognition that people with disabilities benefit and enrich societies is made, and equality is stated as a right that should be based in normative standards and, while they may culturally differ, that all states without exemption incorporate human rights standards into their legislation).

addition to adopting a broad categorization of persons with disabilities, the CRPD reiterates that persons with disabilities must enjoy all human rights and fundamental freedoms.²⁹³ The Convention also clarifies and qualifies how categories of rights apply to persons with disabilities.²⁹⁴ In addition, it identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights, areas where their rights have been violated and where protection of rights must be reinforced.²⁹⁵

Notably, for many years, the United Nations’ treaties addressing human rights did not address the rights of people with disabilities.²⁹⁶ As mentioned above, disabilities may either be seen as a medical or a social phenomenon, and so long as disabilities were viewed as a medical issue, the solution was perceived to be medical treatment rather than the protection of rights.²⁹⁷ The social approach focuses instead on disabilities as social phenomena.²⁹⁸ The observation here is that disability is viewed as a consequence of the interaction of persons with impairments with certain barriers (including societal, and environmental) that obstructs complete and effective participation in society on par with others.²⁹⁹ This understanding led to a rights-based paradigm, focusing on human rights and human dignity.³⁰⁰

Understanding the role of society in protecting the rights of people with disabilities empowers people with disabilities to transfer what was traditionally viewed as a medical need into claimable rights.³⁰¹ Recently, the notion of protecting the rights of people with disabilities started to impact international organizations, such as the United Nations.³⁰²

The adoption of the Convention in 2006 may be viewed as central to the promotion and protection of the full and equal enjoyment of all human rights by persons with disabilities—including striking a balance between accessibility to facilities under Article 9 and safeguarding the integrity of a person under Article 17.³⁰³ The degree to which such articles can strike a harmonious balance to achieve requisite international and national objectives remains questionable.

293. *Id.* at art. 1.

294. *Id.* at Preamble ¶(e).

295. *Id.*

296. *Backgrounder: Disability Treaty Closes a Gap in Protecting Human Rights*, UNITED NATIONS ENABLE, <http://www.un.org/disabilities/default.asp?id=199> (last visited March 2, 2015).

297. BORG, *supra* note 269, at 12.

298. *Id.*

299. CRPD, *supra* note 274, at Preamble ¶(e)

300. *Id.* at art. 1.

301. Aaron A. Dhir, *Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, 41 STAN. J. INT’L L. 181, 196 (2005).

302. *See generally* CRPD, *supra* note 274.

303. *See id.* at art. 9, 17.

C. Domestic Legislation

The following section outlines the scope of disability under legislation in the United States, United Kingdom, and Australia. This section focuses on the rationale behind certain exclusions regarding compulsive gambling, and an examination of whether other categories of gambling not otherwise expressly excluded—in particular pathological gambling and now gambling disorder—would qualify as a disability under domestic legislation.

1. United States

On July 26, 1990, the Americans with Disabilities Act (ADA)³⁰⁴ was signed into law and represents what one commentator has called “the same bundle of protections for the disabled” that were provided for persons of color by the Civil Rights Acts of the 1960s.³⁰⁵

The objective of the ADA is to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring those individuals into the economic and social mainstream of American life.³⁰⁶ It provides enforceable standards addressing discrimination against individuals with disabilities and ensures that the Federal Government plays a central role in enforcing these standards on behalf of individuals with disabilities.³⁰⁷

The ADA covers both physical and mental disabilities (including psychiatric illnesses), and provides its own definition of what constitutes a disability.³⁰⁸ Although it does not delineate what disabilities are covered, it does exclude specific disabilities from coverage, among them is “compulsive gambling.”³⁰⁹ In their original forms, neither House Bill 2273, nor Senate Bill 933, would have explicitly excluded compulsive gambling as a disability.³¹⁰ However, potential problems with the Senate Bill’s definition of “disability,” which was essentially a carryover from the Rehabilitation Act of 1973, were identified.³¹¹ It is noted that

304. 42 U.S.C. § 12101 (2009).

305. Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes be Undone?*, 8 J. L. & HEALTH 15, 15–16 (1994).

306. H.R. REP. NO. 101-485(III), at 23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 446.

307. H.R. REP. NO. 101-485(III), at 23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 446; *see also* 29 C.F.R. § 1630.1(a) (2013) (“The purpose of [the ADA] and these regulations, are intended to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . .”).

308. Paul F. Mickey, Jr. & Maryelena Pardo, *Dealing with Mental Disabilities Under the ADA*, 9 LAB. LAW. 531, 534–36 (1993).

309. *See* 42 U.S.C. § 12102(A)–(C) (2009) (Under the ADA, “the term ‘disability’ means, with respect to an individual—(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.” The Americans with Disabilities Act began its life as H.R. 2273, but what was eventually signed into law by President Bush was S. 933, the Senate bill, which contained much of the language of the House version. 42 U.S.C. § 12211(b)(2) (2012)); *see also* 42 U.S.C. § 12211(b)(2) (2012) (The other excluded disabilities are *transvestism* [sic], transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments (or other sexual behavior disorders), kleptomania, pyromania, and psychoactive substance use disorders resulting from the current use of illegal drugs.)

310. H.R. REP. NO. 101-596, at 88 (1990), *reprinted in* 1990 U.S.C.C.A.N. 565, 597.

311. H.R. REP. NO. 101-485(III), at 75 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 498.

the ADA would cover any and all mental impairments that substantially limit a claimant’s major life activities.³¹² However, the Senate and the Committee denied listing the mental impairments that are covered by the Act.³¹³ With that said, neither the Senate nor the Committee portrayed doubt about the Act’s intention to cover “any mental or psychological disorder.”³¹⁴ It has been noted, in this regard, that “[a] statute that protects all mental impairments that substantially limit a major life activity will potentially have the most far-reaching, disruptive effects on private decision-makers.”³¹⁵

The introduction of Amendment 722 in 1973 specifically excluded certain mental impairments as disabilities.³¹⁶ The stated goal of the Amendment was to prevent the private employment sector from being “swamped” with certain types of mental disability litigation that had already plagued employers who took federal financial assistance and were being sued under the Rehabilitation Act of 1973.³¹⁷

Despite the fear of flooding the system with litigation concerning compulsive gambling, only one case has ever been brought in which a compulsive gambler claimed disability status under the Rehabilitation Act of 1973.³¹⁸ *Rezza v. United States Department of Justice* involved an agent of the Federal Bureau of Investigation, Anthony Rezza, who had a career with the agency spanning twenty-two years, from 1964 until his termination in 1986.³¹⁹ In July of 1985, Rezza took an FBI vehicle to Atlantic City, New Jersey, and gambled with (and lost) \$2,000 he had been given by the agency as part of an undercover assignment.³²⁰

On August 15, 1986, he was dismissed from the FBI even after (as his complaint alleged) being assured “that if he made a full confession regarding his compulsive gambling, replaced the government’s money, and sought treatment, he would not be dismissed.”³²¹ Rezza appealed to the Merit System Protection Board,³²² which eventually affirmed the dismissal.³²³ Rezza appealed this decision to the United States District Court for the Eastern District of Pennsylvania,³²⁴ and it was that court’s analysis of Rezza’s claim of disability under the Rehabilitation Act of 1973 that concerned the legislatures proposing the Amendment.³²⁵

312. H.R. REP. NO. 101-485(III), at 27 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 450.
 313. H.R. REP. NO. 101-485(III), at 28 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 451.
 314. H.R. REP. NO. 101-485(III), at 28 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 450. *See* 135 CONG. REC. S11, 173-01 (1989).
 315. 135 CONG. REC. S11, 173-201 (1989).
 316. *See id.* (The Senate adopted Amendment 722, and its provisions were codified in 42 U.S.C. § 12211(b) (2012)).
 317. *Id.*
 318. *See Rezza v. U.S. Dep’t of Justice*, CIV. A. No. 87-6732, 1988 WL 48541, at *1 (E.D. Pa. May 16, 1988); *see also* 29 U.S.C. § 706 (8)(F)(ii) (1992) (In 1994, the Rehabilitation Act of 1973 was amended to exclude compulsive gambling as a disability).
 319. *Rezza*, 1988 WL 48541, at *1.
 320. *Id.* (noting that the day after this incident, Rezza entered a twenty-two day treatment program for compulsive gamblers, and approximately one month later, he returned to active duty with the FBI and “performed his duties satisfactorily.” Thereafter, Rezza attended Gamblers Anonymous twice a week and quit gambling.).
 321. *Id.* at *5.
 322. *Id.* at *1.
 323. *Id.*
 324. *Id.*
 325. *Rezza*, 1988 WL 48541, at *1.

The court reviewed the criteria for stating a claim under the Rehabilitation Act, citing four specific averments a plaintiff must make.³²⁶ The first, and the only one of concern, is the requirement that the plaintiff be an individual with a handicap.³²⁷ The Act itself defines such a person as one who: “(i) has a physical or mental impairment which substantially limits one or more of such person’s major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment.”³²⁸

Courts use the regulations promulgated to aid in the enforcement of the Act to interpret the specific provisions thereof.³²⁹ Here, the “regulations define ‘physical or mental impairment’ to mean ‘any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.’”³³⁰ In order to qualify as a disability under the Act, the mental impairment must substantially limit a “major life activity” of the claimant, and one of the major life activities specifically delineated by the regulations is the activity of “working.”³³¹

The court in *Rezza* considered three sources other than the Act and regulations in assessing the facts underlying his claim of disability.³³² First, the affidavit of a medical doctor characterized by the court as “a leading expert in the field;”³³³ second, the plaintiff’s affidavit; and third, the criteria for “pathological gambling” offered in the *DSM-III*.³³⁴

Notwithstanding pathological gambling or compulsive gambling falling within the abstract definitional realm of “psychological impairment,” the court highlighted the importance of assessing whether there is “actual impairment.”³³⁵ The facts of the present case indicated that “major life activities” (i.e., that the plaintiff’s state required residential treatment) were affected.³³⁶ The case of *School Board of Nassau Company v. Arline* considered hospitalization as “[a] fact more than

326. *Id.* (highlighting that the plaintiff is required to establish that: (a) s/he is an individual with a disability; (b) s/he is otherwise certified for and capable of undertaking the particular position; (c) s/he was excluded from that position purely because of his/her disability; and (d) the activity on the facts receives federal financial assistance).

327. *Id.*

328. *Id.* (quoting 29 U.S.C. § 706(8)(B)(1973)).

329. *Id.* at *2.

330. *Id.* (quoting 29 C.F.R. § 1613.702(a) (1987)).

331. *Rezza*, 1988 WL 48541, at *2 (citing 29 C.F.R. § 1613.702(c) (1987)).

332. *Id.*

333. *Id.* (Presumably, the court meant that this physician was an expert in the psychology of compulsive gambling.).

334. *Id.* at *2–3 (quoting AMERICAN PSYCHIATRIC ASSOCIATION, *DSM-III: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3d ed. 1987)) (“[C]hronic and progressive failure to resist impulses to gamble, and gambling behavior that compromises, disrupts, or damages personal, family or vocational pursuits. The gambling preoccupation, urge, and activity increase during periods of stress. Problems that arise as a result of the gambling lead to an intensification of the gambling behavior. Characteristic problems include extensive indebtedness and consequent default on debts and other financial responsibilities, disrupted family relationships, inattention to work, and financially motivated illegal activities to pay for gambling.” The court ultimately deferred ruling on *Rezza*’s impairment because of the issue of whether he was “otherwise qualified” to continue as an FBI agent.).

335. *Id.* at 3.

336. *Id.*

sufficient to establish that one or more . . . life activities were substantially limited by . . . impairment.”³³⁷

Thus, it appears the court was on the verge of declaring compulsive gambling—at least in this case—to be a disability under the Rehabilitation Act of 1973.³³⁸ The matter was settled out of court because the Justice Department “could see the handwriting on the wall.”³³⁹ “In *Rezza*, the largest law firm in the world (the Department of Justice) . . . had to settle a case rather than carry on a dispute over whether compulsive gambling was a covered disability.”³⁴⁰

Although never expressly verbalized, the inference to be drawn from the above is that the elementary goal of Amendment 722 was to mitigate private-sector employers of the financial encumbrance of having to litigate potentially costly cases involving mental disability claims under the ADA.³⁴¹ As already noted, Congress has recognized that if not for the statutory exclusion, compulsive gambling would be included as a mental impairment under the ADA and, therefore, a potential covered disability.³⁴² The word “potential” is crucial because not every legitimate mental or physical impairment is a covered disability under the ADA.³⁴³ The impairment in question must “substantially limit” one or more of the claimant’s major life activities before it rises to the level of a disability under the ADA.³⁴⁴

What constitutes a disability is never decided in the abstract.³⁴⁵ Every claim of disability under the ADA must be decided on a case-by-case basis, and the criteria set forth in the ADA must be utilized in each and every case.³⁴⁶ Dispositive is: (1) whether the claimant has a physical or mental impairment as set forth under the ADA; and (2) if so, whether that impairment substantially limits one or more major

337. *Rezza*, 1988 WL 48541, at *3 (quoting *School Bd. of Nassau Co. v. Arline*, 480 U.S. 273, 280–81 (1987)).

338. *See id.* at *4 (Procedurally, the Department of Justice had filed a cross-motion for summary judgment as to count one, the count alleging violation of the Rehabilitation Act of 1973, which the district court denied. The court, while not ruling on *Rezza*’s status as disabled, said there were genuine issues of material fact to be decided at trial on this issue. The Department of Justice moved for reconsideration of their summary judgment motion as to count one (and count three, a due process claim), and their motion was denied.).

339. 135 CONG. REC. S11, 173–201 (1989).

340. *Id.* (Thus, he theorizes the impetus for the Department of Justice settling the suit was financial. “Although a final ruling on [*Rezza*’s] impairment was deferred, the Department of Justice could see which way the judge was headed and, because litigation is costly and time consuming, the U.S. Government settled the *Rezza* case after first losing its motion for summary judgment and then losing a motion for reconsideration.”).

341. H.R. REP. NO. 101-485(III), at 76 (1990) (Conf. Rep.); *reprinted in* 1990 U.S.C.C.A.N. 445, 499.

342. *Id.*

343. *See* Michael A. Stein, Sarah Hinchliffe, & Jonathan Lazar, *A Comparative Analysis of Digital Copyright Law in the Context of E-books for People with Disabilities—Perspectives from the United States, United Kingdom, and Australia*, in DEVELOPING HUMAN RIGHTS APPROACHES TO INTELLECTUAL PROPERTY 14 (Molly Land & Peter K. Yu eds., Cambridge University Press, 2015).

344. *Ennis v. Nat’l Ass’n Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 60 (4th Cir. 1995); *see Chandler v. Dallas*, 2 F.3d 1385, 1396 (5th Cir. 1993) (pointing out the need for case-by-case inquiry because “the effect of a given type of impairment... can vary widely from individual to individual”); *Greenburg v. New York*, 919 F. Supp. 637, 642 (E.D.N.Y. 1996); *see also* 135 CONG. REC. S11, 173–201 (1989) (where Sen. Armstrong points out that this is also the case under the Rehabilitation Act).

345. *See Chandler*, 2 F.3d at 1396.

346. *Id.*

life activities.³⁴⁷ Once these two criteria are met, a claim has been made under the ADA.³⁴⁸

Given the exclusion of compulsive gambling, any claim of disability based on it will automatically fail the first of the two criteria.³⁴⁹ However, if compulsive gambling was not excluded under any given set of facts, it is likely that it could rise to the level of an ADA-covered disability.³⁵⁰ As one court has pointed out: “The legislative history of the ADA indicates that ‘Congress intended that the relevant case law developed under the Rehabilitation Act be generally applicable to the term “disability” as used in the ADA.’”³⁵¹

Although, as an unpublished district court opinion, *Rezza* would have little or no precedential value, it is interesting that at least one district court, in deciding an ADA claim, found the rationale of an unpublished Rehabilitation Act case “sensible and persuasive.”³⁵² Because the court was not faced with a statutory omission of the plaintiff’s mental impairment, the opinion in *Rezza* centered on determining whether his compulsive gambling limited at least one major life activity.³⁵³ The plaintiff’s alleged “residential treatment” for his compulsive gambling strongly indicated that his major life activities were affected.³⁵⁴ Therefore, it is likely that in the absence of other case law dealing with compulsive gambling under the Rehabilitation Act, courts would look to *Rezza* in an effort to determine whether a specific claim of compulsive gambling could be a disability under the ADA.

2. Reasonable Accommodation?

Of course, as with any other physical or mental impairment, employers themselves can establish an impairment as a disability under the ADA by treating or regarding the employee as if he or she has a disability that substantially limits one or more major life activities.³⁵⁵ Because one of those activities delineated by the regulations is working,³⁵⁶ compulsive gambling could rise to the level of a qualified disability if the employer were to make allowances in the workplace to

347. *Overton v. Tar Heel Farm Credit*, 942 F. Supp. 1066, 1069 (E.D.N.C. 1996).

348. *Id.*

349. See H.R. REP. NO. 101-485(III), at 75 (1990) (Conf. Rep.); reprinted in 1990 U.S.C.A.N. 445, 498.

350. *Id.*

351. *Dutcher v. Ingalls Shipbuilding*, 53 F.3d 723, 726 (5th Cir. 1995) (quoting 29 C.F.R. § 1630, App., § 1630.2(g) (citing legislative history)).

352. *Overton*, 942 F. Supp. at 1068 n.2.

353. See *Rezza*, 1988 WL 48541, at *3.

354. See *id.* (This case was cited by the court in support of “residential treatment” being prima facie evidence of major life activities being affected. This case has recently been cited to support the same proposition by a court deciding an ADA claim.)

355. 42 U.S.C. § 12102(2) (2009).

356. *Dutcher v. Ingalls Shipbuilding*, 53 F.3d 723, 726 (5th Cir. 1995) (quoting 29 C.F.R. § 1630.2(i)) (“Major Life Activities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”).

accommodate an employee with compulsive gambling.³⁵⁷ A claimant may still have a feasible case under the ADA notwithstanding the employer’s failure to recognize the employee having an impairment that limits major life activities.³⁵⁸ It is, however, necessary for the claimant to establish a history of major life activities that are substantially circumscribed by compulsive gambling.³⁵⁹ In light of the statutory exclusion, it would be a long shot to establish that compulsive gambling is a disability, pursuant to Rule 12(b)(6), under the ADA.³⁶⁰ However, at least one method to circumvent the exclusion is worthy of further inquiry.

As already noted, in lieu of the Senate’s adoption of Amendment 722 to Senate Bill 933, compulsive gambling would not have been excluded under the ADA.³⁶¹ Yet, the exclusion of compulsive gambling under the ADA does not expressly prevent the application of the ADA in the case of pathological gambling.³⁶² For instance, Senator Armstrong, the author of Amendment 722, relied almost wholly on the *DSM* to amass his list of excluded mental impairments.³⁶³ Thus, mental disorders excluded by the amendment such as pyromania and kleptomania are listed as legitimate mental impairments in the *DSM*.³⁶⁴ However, the term compulsive gambling was not listed as a mental impairment in *DSM-III*, which was current at the time of Amendment 722; the *DSM* term for an impulse-control disorder involving gambling was pathological gambling.³⁶⁵ And yet, because of the vocabulary of Amendment 722, the mental impairment involving gambling excluded by the ADA is compulsive gambling, not pathological gambling.³⁶⁶

Therefore, by implicative insinuation, the ADA could cover pathological gambling—a higher threshold than problem or compulsive gambling. At this stage, however, one may only notionally theorize about whether a plaintiff who had a clinically verifiable case of pathological gambling, and who could satisfy the other indispensable criteria, to preserve a claim under the ADA. The viability of such a claim would depend largely on how strict a construction the court would be willing to give the actual language of the ADA. On a narrow view, legislative construction of the ADA may indeed exclude an impulse-control disorder involving gambling—which (at present) problem gambling, compulsive gambling, and pathological

357. See, e.g., *Rezza*, 1988 WL 48541 at *3 (this case provides a clear example of an employer ‘regarding’ an employee as having a mental impairment that substantially limits the major life activity of working. In that case, the FBI gave Rezza time off for residential treatment for his compulsive gambling problem.).

358. See *Thomas ex rel. Thomas v. Davidson Acad.*, 846 F. Supp. 611, 617–18 (M.D. Tenn. 1994) (where the court pointed to the claimant’s “hospitalization on three occasions over the past two and one-half months” as “sufficient to establish . . . a record of impairment of one or more . . . major life activities”).

359. *Id.*

360. See H.R. REP. NO. 101-485(III), at 75 (1990) (Conf. Rep.); *reprinted in* 1990 U.S.C.C.A.N. 445, 498.

361. *Id.*

362. See 135 CONG. REC. S11, 173–201 (1989).

363. *Id.*

364. *Id.*

365. *Id.* The term “pathological gambling” is likewise found in *DSM-IV*.

366. See, e.g., *Disability Discrimination Act 1992* s 15 (Austl.), available at http://www5.austlii.edu.au/au/legis/cth/consol_act/dda1992264/s15.html (in Australia, any form of discrimination on the grounds of disability is illegal. This section is one example that promotes equal rights, access and opportunity. The scope of protected rights and grounds of discrimination, as will be seen, are much narrower in Australia than under international human rights law.).

gambling appear to be classified.³⁶⁷ The ADA currently falls short, in many respects, of preventing such discrimination against those with addictions.³⁶⁸ When inequitable discriminatory practices hinder employment of otherwise qualified, though stigmatized, individuals any benefit afforded to an addicted persons, as well as to the larger society, is struck.³⁶⁹

Following the introduction of the *DSM-V* in 2013, however, it seems plausible for persons diagnosed with “gambling disorder” to fall justly within the ambit of the ADA.³⁷⁰ As previously outlined, the *DSM-V* no longer classifies gambling disorder as an impulse-control disorder, but rather as an addiction.³⁷¹ Until recently, the construct of “addictions” referred commonly to the use of alcohol or illegal drugs.³⁷² While persons diagnosed with alcohol dependence are protected by the ADA, those who have drug dependence are only afforded protection if their treatment targets the addiction, or they are not currently using any illegal drugs and have completed a treatment program.³⁷³ The scope of “currently” under the ADA is inconclusive—subsequent guidance is available only from the United States Equal Employment Opportunity Commission (EEOC).³⁷⁴ For example, persons addicted to drugs or alcohol are excluded from the ambit of the ADA if their condition poses a direct threat of harm to others, or to themselves.³⁷⁵ As with all ADA claims, the addicted person must be otherwise qualified to complete the necessary tasks, with or without accommodations, and the accommodations must not cause “undue hardship” to the employer.³⁷⁶ The definitions of current drug use, direct threat, and undue hardship have, however, been the subjects of vigorous litigation—a detailed analysis that is beyond the scope of this paper.³⁷⁷

367. See 135 CONG. REC. S11,173-01 (1989).

368. Laurence M. Westreich, *Addiction and the Americans with Disabilities Act*, 30 J. AM. ACAD. PSYCHIATRY & L. 355, 355 (2002).

369. *Id.*

370. Kathleen V. Wade, *Challenging the Exclusion of Gambling Disorder as a Disability Under the Americans with Disabilities Act*, 64 DUKE L.J. 947, 987 (2015).

371. See *DSM-V*, *supra* note 2.

372. 42 U.S.C. § 12114 (2012); 29 C.F.R. § 1630, App. (2014). Under the ADA, addiction coverage is divided according to use of alcohol or illegal drugs. Illegal drugs are defined as street-purchased or manufactured substances, and prescription medications used without the supervision of a health care professional. *Id.*

373. See 42 U.S.C. § 12114 (2012).

374. See 29 C.F.R. § 1630.2(r); see also Letter from the Equal Emp’t Opportunity Comm’n, to the Public (Aug. 23, 2007), available at http://www.eeoc.gov/eeoc/foia/letters/2007/ada_confidentiality_medical_information_aug_23_2007.html (last visited May 16, 2014) (outlining that although the original ADA provided for exclusions based only on threats to the well-being of others, subsequent EEOC interpretation provided for exclusion of ADA coverage based on “a significant risk of substantial harm to the health or safety of the individual or others . . .”); *Mendez v. Gearan*, 956 F. Supp. 1520, 1527 (N.D. Cal. 1997) (outlining that although courts have generally ruled against the EEOC’s apparent expansion of the ADA’s meaning to include danger to self as an exclusionary criterion, the federal court ruled that the ADA did not protect an individual who presented a significant danger to her own well-being. Given the high correlation of addiction with suicide and suicide-related behavior, the potential denial of ADA protection to persons potentially harmful to themselves remains a contentious issue for the addicted person.).

375. See Letter from the Equal Emp’t Opportunity Comm’n, to the Public (Aug. 23, 2007), available at http://www.eeoc.gov/eeoc/foia/letters/2007/ada_confidentiality_medical_information_aug_23_2007.html (last accessed May 16, 2014).

376. See *Aka v. Washington Hosp. Ctr.*, 156 F.3d 1284, 1300 (D.C. Cir. 1998).

377. See, e.g., *Mararri v. WCI Steel, Inc.*, 130 F.3d 1180, 1184–85 (6th Cir. 1997); *Schmidt v. Safeway Inc.*, 864 F. Supp. 991, 999 (D. Or. 1994); *Judice v. Hosp. Serv. Dist.*, 919 F. Supp. 978, 982 (E.D. La. 1996); *Leary v.*

3. Negligence

Any determination of casino liability to problem gamblers is traditionally approached in the realm of tort law, and applying the law of negligence.³⁷⁸ It is proposed that notwithstanding being classified as a disability for the purposes of the ADA, there would likely be little impact, however, on a case brought under the tort of negligence against a casino operator.³⁷⁹ Problem gamblers, in grounding a successful cause of action in negligence against casinos, must establish that:

1. The gambler’s loss is a legally recognizable loss;
2. The casino owed a duty of care to the gambler;
3. The casino breached a reasonable standard of care;
4. The casino caused the loss suffered by the gambler; and
5. There was a sufficient nexus between the casino and the loss suffered by the gambler.³⁸⁰

It is therefore necessary, in assessing pure economic loss experienced by problem and also pathological gamblers, to draw a causal connection to the underlying condition.³⁸¹ It is necessary for that condition to be caused *by* the gambling facility.³⁸² Yet, such an action would unlikely be prohibitive—it would cease to preserve or prevent the underlying condition of problem gambling or pathological gambling.³⁸³ It has been recognized that it would, instead:

[M]ark a radical extension of the neighbor principle, with significant consequences for theories of responsibility This type of extension would create a duty to an indeterminate group of individuals and create an unlimited liability for casinos to all *possible* problem gamblers. Such an extension would defeat the cardinal purpose of finding a duty of care, which is “to take all due

Dalton, 58 F.3d 748, 752 (1st Cir. 1995); Flynn v. Raytheon Co., 868 F. Supp. 383 (D. Mass. 1994); Ham v. Nevada, 788 F. Supp. 455 (D. Nev. 1992); Collings v. Longview Fibre Co., 63 F.3d 828, 832–33 (9th Cir. 1995); Wormley v. Arkla, Inc., 871 F. Supp. 1079 (E.D. Ark. 1994); McDaniel v. Mississippi Baptist Med. Ctr., 877 F. Supp. 321, 326–27 (S.D. Miss. 1994); Shaffer v. Preston Mem’l Hosp. Corp., 107 F.3d. 274, 280 (4th Cir. 1996); Albertson’s, Inc. v. Kirkingburg, 527 U.S. 555 (1999).

378. See Crowne-Mohammed & Harper, *supra* note 97, at 102–03.

379. *Id.*

380. See Crowne-Mohammed & Harper, *supra* note 97, at 102–10; see also Donoghue v. Stevenson, [1932] A.C. 562, 580 (H.L. 1932) (referencing Lord Atkin’s famous formulation of the neighbor principle).

381. Crowne-Mohammed & Harper, *supra* note 97, at 103. This can be described as a loss suffered by an individual that is not accompanied by a physical injury or property damage. Notably, purely economic losses are usually not recoverable under the common law due to problems with compensating an indeterminate number of defendants, for an indeterminate amount of time. See also Norsk Pacific S.S. Co. v. Canadian Nat’l Ry. Co., [1992] 1 S.C.R. 1021, 1049 (Can.) (recognizing five different categories of negligence claims for which a duty of care has been found with respect to purely economic losses).

382. See Crowne-Mohammed & Harper, *supra* note 97, at 103.

383. *Id.* at 104.

care and to carry safely as far as *reasonable* care and forethought can attain that end.³⁸⁴

It is also recognized that gaming facilities have the ability to monitor their patrons for problem behavior.³⁸⁵ Therein, the standard of care for that alleged duty is one of “reasonable surveillance,” and in doing so, one should be mindful of privacy implications.³⁸⁶ Monitoring casino patrons for all possible signs of problem gambling that it has observed “[w]ould require a physician, psychologist, nurse, or social worker to analyze such patterns of behavior and provide the casino with a preliminary diagnosis of *all suspected* problem gamblers.”³⁸⁷

To establish causation, there must be probable cause, not merely a possible cause.³⁸⁸ Concluding that the acts or omissions of gaming facilities are the probable cause of a serious impulse control disorder would be wrought with challenge. Specifically, that under present scientific and medical research already discussed, such a “disorder” has numerous known causes and risk factors.³⁸⁹

It cannot be afforded with certainty, therefore, that a casino’s failure to monitor patrons for signs of pathological gambling³⁹⁰ or its failure to expel self-identified problem gamblers (on a balance of probabilities) *causes* problem gambling.³⁹¹ The same conclusion could apply notwithstanding a finding of pathological gambling, where classified as a disability. Since gamblers may still develop problem gambling behaviors (or “risks”), this could withal be the case where casinos were to monitor patrons utilizing clinical psychiatrists and psychologists, and/or preclude problem gamblers employing the absolute standard of surveillance. Classification as a disability, however, could deem pathological gambling as a reasonable psychological harm and therefore reasonably foreseeable by casinos or gambling providers, which could potentially impact the standard of care applicable.

In the case of pathological gamblers, in particular those who self-exclude, identifying themselves as suffering from a clinical inability to control their gambling impulses³⁹² at the time of self-exclusion may also support foreseeability of the harm from a tort perspective.³⁹³ It could be said, therefore, that the role of classifying pathological gambling is unlikely to greatly impact the possibility of a pathological gambler establishing a claim in negligence under tort law.

384. *Id.* (citing *Kauffman v. Toronto Transit Comm’n*, [1960] S.C.R. 251, 255 (Can.) (emphasis added)).

385. *See* William Sasso & Jasminka Kalajdzic, *Do Ontario and Its Gaming Venues Owe a Duty of Care to Problem Gamblers?* 10 GAMING L. REV. 552, 555 (2006); *see also* Crowne-Mohammed & Harper, *supra* note 97, at 105.

386. Crowne-Mohammed & Harper, *supra* note 97, at 105–06.

387. *Id.* at 105.

388. *Id.* at 107.

389. *Id.*

390. Sasso & Kalajdzic, *supra* note 385, at 563.

391. Crowne-Mohammed & Harper, *supra* note 97, at 107.

392. *Id.* at 110.

393. *Id.*

VI. SUMMARY AND CONCLUDING COMMENTS

Reference to “pathological gambling” was first apparent in the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 under “disorders of impulse control” as a mental health diagnosis.³⁹⁴ The condition was described as one that is both chronic and progressive, comprising a failure of a person to control their need to gamble and defined by unpleasant outcomes, spanning from seeking financial assistance from relative or friends, to criminal offenses committed to fund gambling.³⁹⁵

The purpose of this article has not been to determine if compulsive gambling should be excluded as a disability under the ADA, but rather to look at the explicit and implicit reasons it was excluded and, beyond that, to examine the possibility of pathological gambling qualifying as a disability. The rationale for the exclusion was to prevent private sector employers from being inundated with mental health litigation under the ADA based on claims concerning certain mental disorders listed in the *DSM* that were permitted as disabilities under the Rehabilitation Act of 1973.³⁹⁶ This was even in light of the single case dealing with compulsive gambling as a disability under the Rehabilitation Act at that time.³⁹⁷

A large portion of literature concerning pathological gambling echoes the conceptualization of pathological gambling by the American Psychiatric Association, namely as a disorder characterized by a preoccupation with gambling and with obtaining money with which to gamble, irrational thinking, periodic or continuous loss of control as a result of their gambling behavior.³⁹⁸ Present research focuses on probing variables that extricate pathological gamblers from social gamblers, rather than the reason for the existence of relationships among these factors.³⁹⁹ As enumerated in this paper, classifying both problem and pathological gambling as an impulse-compulsive disorder, as opposed to an addiction under *DSM-V*, carries weight in deeming (or otherwise) pathological gambling as a disability under anti-discrimination legislation, including the ADA. There is therefore a need to conclusively determine whether a direct link between impulsivity and within-session gambling behavior exists, and therein clarify the role of impulsivity to gambling while controlling for potential confounding factors. The substance of terms could indeed impact the application of certain legislation including the ADA, which specifically excludes compulsive gambling.⁴⁰⁰ As already mentioned, however, such reference is to be distinguished from pathological gambling, which is not expressly excluded under the ADA *per se*.⁴⁰¹

394. NAT'L RESEARCH COUNCIL, *PATHOLOGICAL GAMBLING: A CRITICAL REVIEW 2* (National Academy Press, eds. 1999).

395. See NEAL, DELFABBRO & O'NEIL, *supra* note 49, at 10.

396. See H.R. REP. NO. 101-485(III), at 76 (1990) (Conf. Rep.); *reprinted in* 1990 U.S.C.C.A.N. 445, 498.

397. See *Rezza*, 1988 WL 48541, at *3.

398. NAT'L RESEARCH COUNCIL, *supra* note 236.

399. See Blaszczyński & Nower, *supra* note 116, at 489.

400. See H.R. REP. NO. 101-485(III), at 76 (1990) (Conf. Rep.); *reprinted in* 1990 U.S.C.C.A.N. 445, 498.

401. See Stein, Hinchliffe & Lazar, *supra* note 343.

Because the statutory exclusion of compulsive gambling as a disability under the ADA still stands, it is doubtful that any claim brought on the basis of compulsive gambling would succeed. If, however, a strict construction were given to the exclusion, a court might be willing to distinguish compulsive gambling (i.e., the impairment excluded by the language of the ADA) from pathological gambling (i.e., the impulse-control disorder listed in the current edition of the *DSM*). On the contrary, there exists a stronger case for persons diagnosed with gambling disorder pursuant to the *DSM-V*. Further, while there may be reluctance in establishing liability in tort law for claims by either a compulsive or pathological gambler against a casino, grounds do exist which may be strengthened where pathological gambling is classified as a disability. One must of course be mindful, in novel cases, of allowing the bounds of basic negligence principles to be extensively stretched.

On the other hand, it could be argued that the legislative history of the ADA shows an intent to exclude any impulse-control disorder involving gambling. This article has highlighted some deficiencies in the methods of classification—in particular, whether there is scope to classify pathological gambling as something other than an impulse disorder. Such a classification, it is expected, would continue to limit the application of disability discrimination legislation with respect to compulsive and problem gambling, but exclude pathological gambling. The method of achieving this, and purported lateral impact, was discussed and it was proposed that further scientific studies should be undertaken to conclusively determine this scope.

Indeed, an accurate examination of the costs of pathological gambling requires an assessment of the costs and benefits of gambling. Gambling appears to have net economic benefits for economically depressed communities, but the available data is insufficient to determine with accuracy the overall costs and benefits of gambling.⁴⁰² To understand vicissitudes in gambling and pathological gambling over time, as well as the nature and origins of pathological gambling, both cross-sectional and longitudinal studies of gambling will be paramount.

There is no doubt that studies have hypothesized that impulsivity may be connected to the initial decision to gamble as opposed to within-session gambling decisions.⁴⁰³ Although most support the relationship between sensation seeking and gambling, there are a number of issues that arise.⁴⁰⁴ For instance, these studies often rely on retrospective self-reported gambling behavior, which may be susceptible to recall error or other reporting biases.⁴⁰⁵ They tend to focus solely on exploring the variables that differentiate pathological gamblers from social or non-gamblers, as opposed to *how* and *why* these relationships among factors exist.⁴⁰⁶ It should, therefore, be conclusively determined whether a direct link between

402. NAT'L RESEARCH COUNCIL, *supra* note 236, at 4.

403. *See, e.g.*, Brevers & Noël, *supra* note 90, at 1.

404. *See* Blaszczyński et al, *supra* note 91, at 75–76.

405. *See* Breen & Zuckerman, *supra* note 83.

406. *See* Blaszczyński & Nower, *supra* note 116, at 489.

impulsivity and within-session gambling behavior exists, and therein clarify the role of impulsivity to gambling while controlling for potential confounding factors.

Policing problem gamblers and pathological gamblers presents a quite complex policy issue that requires the wisdom, utmost consideration, and appropriate intervention by legislatures. Further, whether courts should intervene in matters of public policy, as they tend to do—whether reluctantly, implicitly, or in the interests of expediency—should be tread upon carefully with full appreciation of all competing considerations. When it comes to pathological gamblers, and persons with gambling disorder, the goal should be treatment and appropriate responsibility. This still remains to be seen!