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The Clinical Profile of Gambling Disorder: Implications for Prevention and Treatment
SUMMARY OF THE DOCTORAL THESIS

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Synthesis of the Main Ideas

The fundamental problem and the timeliness of the topic

The doctoral thesis starts from the observation that gambling can no longer be understood merely as a recreational activity or as an individual moral problem, but as a clinical and public-health phenomenon amplified by digitalization, permanent accessibility, diversification of gambling products, and the integration of gambling into online and sports environments. In contemporary literature, gambling disorder is the first behavioral addiction included in the main DSM-5 section on substance-related and addictive disorders, marking the transition from the impulse-control paradigm to a multidimensional, biopsychosocial, addiction-based understanding [1-4].

The topic is particularly relevant for Romania, where data on the adult population with pathological gambling remain limited, while the available national studies have mainly addressed adolescents or restricted clinical samples [5]. In this context, the doctoral research aims to describe the clinical profile of adults with pathological gambling, going beyond the mere inventory of DSM criteria and integrating symptom severity, personality, cognitive-emotional coping strategies, quality of life, and socio-relational factors.

The fundamental problem investigated is that the severity of pathological gambling cannot be sufficiently explained by gambling frequency or financial losses alone. In psychiatric practice, patients often present with negative affectivity, impulsivity, cognitive distortions, personality vulnerabilities, deteriorated relationships, reduced social support, and deeply impaired quality of life. Therefore, the thesis proposes an integrated clinical assessment, useful both for prevention and for individualized therapeutic formulation.

Hypothesis, objectives, and logic of the research

The general hypothesis of the research states that the severity of pathological gambling symptomatology is associated with maladaptive personality organization, cognitive-emotional coping strategies, quality of life, and relevant socio-relational factors. More specifically, higher scores for psychopathological tendencies, maladaptive personality dimensions and traits, dysfunction indicators, and maladaptive cognitive strategies were expected to correlate with greater severity, whereas adaptive cognitive strategies and perceived social support were expected to be associated with a lower symptom burden.

The general objective was the multidimensional, clinical, and psychometric characterization of adults with pathological gambling. The specific objectives were: to analyze correlations between Personality Clinical Form scores and severity; to investigate the relationship between cognitive-emotional coping assessed with the CERQ and severity; to examine the relationship between personality, coping, and quality of life measured by the QOLI; and to analyze differences in severity according to sociodemographic variables, family history, and perceived social support.

Through this organization, the thesis does not treat gambling disorder as a homogeneous entity, but as a clinical expression resulting from the interaction between individual vulnerabilities, cognitive and emotional processes, gambling behavior, and social context. This orientation is consistent with recent literature on behavioral addictions and with etiological models that integrate reward, inhibitory control, emotion regulation, cognitive distortions, and personality traits [7-10].

Research methodology

The research had a quantitative, clinical, psychometric, observational, and cross-sectional design. The study was conducted at the "Prof. Dr. Alexandru Obregia" Clinical Hospital of Psychiatry in Bucharest and included 122 adults with a psychiatrist-confirmed diagnosis of pathological gambling/gambling disorder. The clinical diagnosis was correlated with DSM criteria for severity assessment, and the structured clinical interview allowed the calculation of a dimensional indicator of symptom burden.

The instruments used were the Personality Clinical Form (PCF) for personality assessment, the Cognitive Emotion Regulation Questionnaire (CERQ) for cognitive-emotional coping strategies, and the Quality of Life Inventory (QOLI) for quality of life. Of the 122 participants, 109 had valid PCF profiles; 13 profiles were excluded only from PCF analyses, without excluding the participants from analyses based on DSM, CERQ, QOLI, or sociodemographic variables. This decision respected the psychometric logic of the instrument and allowed the preservation of as many valid observations as possible.

The statistical analysis included descriptive statistics, Shapiro-Wilk normality tests, Spearman correlations, the Mann-Whitney U test for comparisons between two groups, and the Kruskal-Wallis H test for comparisons among three or more groups. Because the distributions of the variables showed significant deviations from normality, the use of nonparametric methods was justified. The Benjamini-Hochberg procedure was used to

control for multiple testing, with the purpose of reducing the risk of type I error in the context of a large number of comparisons.

Synthesis of the general part

The general part of the thesis examines the nosological transformation of pathological gambling, from its inclusion among impulse-control disorders to its conceptualization as a behavioral addiction. The differences between recreational gambling, at-risk gambling, problem gambling, pathological gambling, and gambling disorder are discussed, emphasizing that population screening instruments are not equivalent to psychiatric diagnosis. This delimitation is important for Romanian practice, where the term “pathological gambling” remains commonly used in the ICD-10 context, whereas “gambling disorder” reflects DSM-5 terminology.

The thesis synthesizes international and national epidemiological data, highlighting the variability of prevalence, the financial and social burden of gambling, and the low proportion of individuals who seek treatment. It also analyzes frequent psychiatric comorbidities - substance use disorders, depression, anxiety, ADHD, suicidality, and personality disorders - as well as the role of early onset, online access, sports betting, slot machines, and cognitive distortions.

The second chapter of the general part develops the role of pathological personality, cognitive and emotional regulation, and psychosocial functioning. Personality is approached transdiagnostically, as a dimension that may influence vulnerability, severity, the therapeutic relationship, and the risk of relapse. Emotion regulation is discussed through adaptive and maladaptive strategies, while quality of life is treated as an indicator of functional burden, not merely as a secondary outcome of symptoms.

Synthesis of the personal contributions and results

The research sample consisted of 122 participants, with a male predominance (87.7%) and a majority representation of young and middle-aged adults. The largest age categories were 25-34 years and 35-44 years, together accounting for 64.7% of the sample. Most participants had an early onset of gambling: 67.2% before the age of 18 and 94.2% before the age of 25. The most frequent forms of gambling were sports betting, online card games/online poker, and slot machines, while the frequency and duration of sessions indicated a high level of behavioral involvement.

The severity analysis showed a clinical sample with a substantial symptom burden. Most participants presented moderate or severe forms, and the binary index of DSM

criteria showed a ceiling effect, indicating that, in a psychiatric sample, the simple number of criteria may insufficiently differentiate the true degree of impairment. This result supports the need to complement DSM assessment with dimensional, functional, and psychometric measures.

The PCF results revealed consistent associations between symptom severity and maladaptive personality. General psychopathological tendencies - emotional, behavioral, and cognitive problems - correlated positively with severity. Among the maladaptive dimensions, negative emotionality and psychoticism showed moderate correlations, around $\rho = .49$, while antagonism and disinhibition had significant but lower associations. Social and affective detachment did not remain significant after correction for multiple testing.

At the level of specific PCF traits, most scales were associated with severity, with the most important results observed for emotional lability, perceptual dysfunctions, separation anxiety, and depression. At the categorical level, 9 of the 10 personality-disorder scales were significantly associated with severity, with the highest correlations for borderline, schizotypal, and dependent traits. All indicators of personality dysfunction - diffuse identity, problematic goals, deficient empathy, problematic intimacy, problematic self, and problematic relationships - showed positive associations with severity.

The CERQ strategies showed a coherent pattern, although of lower intensity than personality. Blaming others, catastrophizing, and rumination correlated positively with severity, whereas positive reappraisal, putting into perspective, and positive refocusing correlated negatively. Self-blame, acceptance, and refocusing on planning did not show the same statistical behavior in relation to severity, indicating that the adaptive/maladaptive label must be interpreted clinically and in relation to the concrete content of cognitions.

Quality of life, assessed with the QOLI, was low or very low in most participants. The mean T score was 35.99, and 73.8% of participants had low or very low quality of life. However, DSM severity did not correlate directly and significantly with QOLI, suggesting that deterioration in quality of life is probably influenced by personality, coping, social support, relational conflict, comorbidity, and functional consequences more than by the isolated number of diagnostic criteria.

Comparative analyses indicated that relational and social variables had greater relevance than structural factors. No significant differences in severity were found according to sex, age, educational level, income, residence environment, or family history. By contrast, marital status, occupational status, and especially perceived social support differentiated severity. Participants with low social support had the highest scores, whereas

those with high social support had the lowest scores, supporting the systematic inclusion of the support network in assessment and treatment.

Conclusions and personal contributions

The research confirms that personality represents the central axis of vulnerability in the clinical sample analyzed. The objective regarding the relationship between PCF and severity was fully achieved, while the objectives concerning coping, quality of life, and sociodemographic differences were partially achieved. Overall, the results support a model in which the severity of pathological gambling is embedded in a network of associations with negative affectivity, psychoticism as a personality dimension, emotional instability, self dysfunction, maladaptive cognitive strategies, and social support.

The original contributions of the thesis are: the description of a Romanian adult clinical sample with pathological gambling; the integrated use of DSM criteria, PCF, CERQ, and QOLI; the highlighting of the role of personality in severity; the demonstration of the selective relationship between coping and severity; the finding that QOLI is closer to personality and coping than to isolated DSM severity; the characterization of invalid PCF profiles; and the formulation of practical directions for the multidimensional assessment of patients with pathological gambling.

From a clinical perspective, the thesis supports the need for an assessment that includes not only diagnostic criteria, but also gambling onset, types of gambling, frequency, session duration, chasing losses, cognitive distortions, emotion regulation, personality, comorbidities, suicidality, social support, and quality of life. For prevention, the data emphasize the importance of early onset and young people's exposure to rapid or online forms of gambling. For therapy, the results indicate the need to integrate interventions targeting personality, emotion regulation, cognitive restructuring, family support, and reconstruction of quality of life.

Synthesis of the thesis chapters

Chapter 1 describes gambling disorder as a behavioral addiction and clarifies the paradigm shift introduced by DSM-5. The analysis centers on the transition from the impulsivity model to the addiction model, in which loss of control, craving, behavioral reinforcement, chasing losses, and continuation of gambling despite negative consequences form the clinical core of the disorder. The chapter emphasizes that differentiating between recreational gambling, problem gambling, and psychiatric diagnosis is essential for research, prevention, and communication with the patient.

The same chapter integrates the epidemiological and public-health perspective. International data show that prevalence depends on instruments, thresholds, and legislative contexts, while Romanian data remain insufficient for the adult population. Nevertheless, the early onset of gambling behavior, the high proportion of men in clinical samples, and the need for repeated national studies differentiated for adults and adolescents are highlighted. The thesis argues that gambling must be understood in relation to commercial and social determinants, not only to individual decision-making.

Chapter 2 develops the argument that personality, cognitive-emotional regulation, and psychosocial functioning are indispensable components of the clinical profile. Pathological personality is treated as a transdiagnostic dimension, relevant to vulnerability, comorbidity, severity, and the therapeutic relationship. Cognitive-emotional regulation is discussed through the strategies of rumination, catastrophizing, self-blame, blaming others, acceptance, positive reappraisal, and putting into perspective, while quality of life is described as an indicator of the global functional burden.

Chapter 3 formulates the rationale for the personal contribution. The research starts from the premise that a DSM score, although necessary, cannot sufficiently capture the complexity of the patient with pathological gambling. The general hypothesis and working hypotheses are constructed to test the relationships between severity, personality, coping, quality of life, and contextual variables. Through this structure, the thesis creates a coherent analytical framework in which results can be interpreted both statistically and clinically.

Chapter 4 presents the general methodology. The study is cross-sectional, clinical, and exploratory, with a sample recruited from a specialized psychiatric service. The inclusion and exclusion criteria delimit an adult sample with a confirmed diagnosis, while the separation between the full sample and the valid PCF subsample allows psychometrically appropriate analyses. The instruments used cover several levels: diagnosis and severity, personality profile, cognitive-emotional coping, and life satisfaction.

Chapter 5 characterizes the sample and gambling behavior. Participants are predominantly men, mostly young and middle-aged adults, with frequent onset before the age of 18. The dominant gambling types - sports betting, online poker, and slot machines - are important for prevention because they combine accessibility, rapid pace, intermittent reward, and social exposure. The long duration of sessions and the high frequency of

gambling indicate a clinical sample in which the behavior is already stabilized and associated with functional impairment.

Chapter 6 describes the personality profile assessed with the PCF. The scores indicate high levels of emotional, behavioral, and cognitive problems, as well as a significant load on maladaptive dimensions. The chapter has additional methodological value because it discusses invalid PCF profiles and shows that profile invalidity should not automatically be interpreted as bad faith, but may reflect distress, fatigue, difficulties in understanding, or an inconsistent response style.

Chapter 7 analyzes CERQ strategies and quality of life. The results show that participants simultaneously use strategies considered adaptive and maladaptive, which requires qualitative interpretation. In the context of gambling, positive reappraisal may have protective value, but it may become problematic when it justifies chasing losses or expecting a compensatory win. The QOLI shows predominantly low quality of life, confirming that the burden of the disorder goes beyond the gambling symptom and affects personal projects, relationships, self-esteem, and global functioning.

Chapter 8 brings together the inferential analyses. Spearman correlations and nonparametric tests indicate a network of associations in which personality has a central role. Severity is associated with psychopathological tendencies, maladaptive traits, and personality dysfunction; coping contributes through catastrophizing, rumination, and blaming others; quality of life is selectively associated with personality and coping; and perceived social support clearly differentiates severity levels. The chapter supports the hypothesis of a multidimensional clinical profile rather than a single explanatory factor.

Chapter 9 interprets the results from a clinical perspective. It proposes interpretative profiles useful in case formulation: affective-negative, impulsive-disinhibited, relational-borderline, cognitive-distortive, and socially isolated profiles. These profiles are not autonomous diagnostic categories, but orientative clinical models derived from the integration of the results. The chapter also proposes a multidimensional assessment algorithm that may guide history-taking, selection of instruments, risk identification, and intervention planning.

Chapter 10 synthesizes the conclusions and personal contributions. The thesis shows that all conclusions must be interpreted within the limits of the cross-sectional design and the clinical sample, without causal inferences and without uncritical generalization to the general population. At the same time, the work offers an original contribution to Romanian psychiatry by characterizing an adult sample with pathological gambling, by using clinical

and psychometric instruments in an integrated manner, and by formulating directions applicable to prevention and therapy.

Implications for prevention and therapy

For prevention, the results of the thesis support early interventions oriented toward adolescents and young adults, especially in the context of the early onset observed in the sample. Education regarding probability, chance, chasing losses, and the illusion of control should be combined with limiting minors' exposure to marketing and with the early identification of people who use gambling as a strategy for emotion regulation. Effective prevention cannot be reduced to the generic message of individual responsibility; it must also include the family, school, digital environment, and regulatory policies.

For treatment, the research indicates the need for a clinical formulation that includes personality and self-functioning. The patient with pronounced negative affectivity may need interventions targeting distress tolerance, shame, and depression; the patient with impulsivity and disinhibition needs behavioral barriers and stimulus control; the patient with borderline vulnerabilities requires stabilization of the therapeutic relationship and assessment of suicidal risk; and the socially isolated patient needs reconstruction of support and daily life routines.

An important practical consequence is that therapeutic success should not be evaluated only through abstinence or reduced gambling frequency. Quality of life, social support, occupational functioning, debt reduction, the ability to tolerate negative emotions, and return to meaningful activities are equally relevant indicators. In this respect, the thesis proposes an approach in which psychiatric, psychotherapeutic, family, and social interventions are complementary.

Degree to which the research objectives were achieved

The first objective, concerning the relationship between personality profile and symptom severity, was fully achieved. The analyses showed that the general psychopathological tendencies assessed by the PCF - emotional, behavioral, and cognitive problems - are positively associated with the severity of pathological gambling. At the same time, most maladaptive dimensions and clinical traits remained significant after Benjamini-Hochberg correction. This result supports the idea that personality is not merely a secondary variable, but a framework organizing clinical vulnerability.

Within the same objective, the hypothesis regarding personality disorders was supported at both dimensional and categorical levels. The most robust associations were

observed for borderline and schizotypal traits, followed by dependent traits. Clinical interpretation must nevertheless remain cautious: PCF scales indicate areas of vulnerability and do not replace the categorical diagnosis of a personality disorder, which requires longitudinal clinical evaluation, stability, pervasiveness, and functional impact.

The objective concerning cognitive-emotional coping was partially achieved. The maladaptive strategies of blaming others, catastrophizing, and rumination were associated with severity, whereas self-blame did not remain significant after adjustment for multiple testing. Among the strategies considered adaptive, positive reappraisal, putting into perspective, and positive refocusing were negatively associated with severity. Acceptance and refocusing on planning did not show significant relationships. This nuance is important because it shows that the usefulness of a strategy depends on the concrete psychological context in which it is used.

The objective concerning the relationship between personality, coping, and quality of life was partially achieved. Quality of life was not directly and significantly associated with the DSM severity score, but it was associated with emotional and cognitive problems, negative emotionality, traits in the sphere of submissiveness, depression, shyness, and eccentricity, as well as with indicators of self-functioning. From the perspective of coping, catastrophizing was negatively associated with QOLI, whereas acceptance, positive reappraisal, and refocusing on planning were positively associated. This pattern suggests that functional burden is filtered by personality and by the cognitive processing of negative events.

The objective regarding differences in severity according to sociodemographic and contextual variables was partially achieved. Sex, age, educational level, income, residence environment, and family history did not significantly differentiate severity within the sample. By contrast, marital status, occupational status, and perceived social support had statistical and clinical relevance. The clearest difference emerged for perceived social support, indicating that relational support may have protective value or may buffer severity.

Overall, of the 11 working hypotheses formulated, some were fully supported, some were partially supported, and one was not supported. This distribution is important because it shows that the results do not mechanically confirm all theoretical expectations, but describe a selective clinical profile. Personality produced the most stable associations, coping had a differentiated role, and quality of life proved to be closer to psychological and social vulnerabilities than to isolated DSM severity.

Original value of the research

The original value of the thesis rests on the clinical character of the sample and on the integration of several instruments within a single interpretative framework. In Romania, most data regarding pathological gambling in adults come from surveys, studies on adolescents, or fragmented clinical observations. This thesis provides data from an adult sample recruited from a psychiatric service, with high severity and multidimensional assessment.

A distinct contribution is the use of the PCF in research on behavioral addiction. The instrument allowed the simultaneous analysis of psychopathological tendencies, maladaptive dimensions, specific traits, self and relational functioning, and categorical scales of personality disorder. This approach provided a much finer picture than would have been possible with a simple impulsivity scale or a single global personality score.

The thesis also contributes by integrating cognitive-emotional coping into the interpretation of severity. The results show that cognitive strategies are not merely descriptive variables, but may indicate mechanisms through which the patient maintains gambling, justifies losses, manages shame, or protects against negative affect. This contribution has therapeutic value, because it supports interventions that explore not only gambling behavior, but also the way the patient explains losses, failures, and the hope of recovery.

Another contribution is the inclusion of quality of life as a major indicator of clinical burden. In a disorder often measured through criteria, money lost, or frequency, QOLI brings to the foreground satisfaction with life domains and deterioration of global functioning. The finding that QOLI does not correlate directly with DSM severity, but is associated with personality and coping, is clinically important: treatment should aim at reconstructing the patient's life, not only reducing criteria.

Finally, the thesis proposes a bridge between research and practice. The multidimensional assessment algorithm, interpretative clinical profiles, and the recommendation to integrate social support, family, and quality of life provide concrete directions for clinical psychiatry. These elements are not presented as definitive protocols, but as starting points for interventions adapted to the Romanian patient with pathological gambling.

Methodological limitations and perspectives

The main limitation of the research is its cross-sectional design, which allows the identification of associations but does not allow causality to be established. A correlation between personality and severity does not demonstrate that the trait produces pathological gambling; it may represent a vulnerability factor, a consequence of distress, a marker of comorbidity, or the expression of a common psychopathological substrate. For this reason, the interpretation of the results constantly preserves the distinction between statistical association and etiological explanation.

Another limitation is the male predominance of the sample, compatible with the clinical profile of patients who seek treatment, but restrictive for generalization to women. Moreover, the clinical sample does not represent the general population of individuals who gamble, but a category with high severity that has come to the attention of psychiatric services. This limitation reduces population applicability, but increases relevance for psychiatric practice.

Future directions include longitudinal studies, larger and more gender-balanced samples, control groups, analyses differentiated by types of gambling, comparison of online and offline gambling, assessment of comorbidities through complete structured interviews, and monitoring of response to interventions. In addition, it would be useful to develop a standardized clinical sheet for the assessment of patients with pathological gambling, including DSM severity, personality functioning, coping, quality of life, suicidality, debts, and social support.

Clinical model derived from the research results

Based on the results, the thesis proposes a clinical assessment model in which DSM diagnosis represents only the starting point. The first level of assessment is behavioral and includes age at onset, dominant gambling type, frequency, session duration, chasing losses, gambling as a response to stress, hiding the behavior, and relational or occupational impairment. This level allows the clinician to understand the concrete pattern of the behavior and the stimuli that maintain it.

The second level is psychopathological and personality-based. The results suggest that negative affectivity, emotional instability, separation anxiety, depression, perceptual dysfunctions, and borderline or schizotypal traits should be explored systematically. These variables may indicate not only severity, but also difficulties in the therapeutic alliance,

risk of dropout, reactivity to conflict, vulnerability to shame, and suicidal risk. In this sense, personality becomes a map for case formulation, not a static label.

The third level concerns cognitive and emotional regulation. The strategies of rumination, catastrophizing, and blaming others may maintain the vicious cycle of gambling by intensifying negative affect and transferring responsibility. Apparently adaptive strategies must be interpreted carefully: positive reappraisal is useful when it helps the patient learn from experience, but may become maladaptive if it supports the belief that losses prepare a future win. Therefore, the clinical interview must explore concrete examples, not only scores.

The fourth level is functional. Quality of life, relationships, professional activity, debts, daily routine, and meaningful activities provide data that cannot be inferred automatically from the number of DSM criteria. In a severe sample, almost all patients may meet diagnostic criteria, yet differ greatly in resources, support, shame, isolation, and ability to initiate change. The QOLI offers precisely this perspective on life satisfaction and affected domains.

The fifth level is social and relational. Perceived social support proved to be one of the variables with the greatest clinical relevance. The patient who feels isolated or insufficiently supported may use gambling for activation, belonging, avoidance, or compensation. At the same time, gambling behavior erodes family trust, generates conflicts, and may further reduce available support. Therefore, intervention should include the family or the support network whenever possible and ethical.

The proposed model has a practical role: it helps the clinician move from formal diagnosis to individualized case formulation. Instead of asking only whether the patient meets DSM criteria, the assessment should clarify why the patient gambles, what emotions precede gambling, what type of reward is sought, what beliefs maintain the behavior, what resources are available, what risks are present, and what life goals can be rebuilt. This transition from diagnosis to formulation represents one of the clinical stakes of the thesis.

Transferability and cautions regarding generalization

The results are primarily transferable to similar adult clinical populations, with moderate or high severity and access to psychiatric services. They should not be used to estimate prevalence in the general population and do not describe the full variety of people who gamble. Individuals with recreational gambling, low-risk gambling, or incipient problems may have a profile different from that observed in a hospital-based sample.

International transferability is supported by the use of constructs comparable in the literature: DSM severity, emotion regulation, coping, quality of life, and personality functioning. At the same time, the PCF instrument has Romanian specificity, which represents both an advantage, through cultural adaptation, and a limitation, through the need for replication in other contexts and with equivalent international instruments.

An important caution concerns the interpretation of the ceiling effect of DSM criteria. In severe clinical samples, the number of criteria met may have reduced variability, limiting the ability to capture fine differences. For this reason, severity should be complemented by frequency, duration, consequences, functioning, comorbidity, and quality of life. The thesis provides an empirical argument for this extended assessment.

Another caution concerns the relationship between correlations and intervention. The fact that a score is associated with severity does not mean that modifying that score will automatically reduce gambling. Nevertheless, the associations indicate clinical areas worth exploring and can guide therapeutic hypotheses. In this respect, the results are best used as support for clinical formulation, not as a rigid algorithm or as an instrument for individual prediction.

Selective bibliography

1. Abbott MW. The epidemiology and impact of gambling disorder and other gambling-related harm: discussion paper developed for the WHO Forum on Alcohol, Drugs and Addictive Behaviours, 26-28 June 2017. Geneva: World Health Organization; 2017.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed., text rev. Washington (DC): American Psychiatric Association Publishing; 2022.
3. Petry NM, Blanco C, Auriacombe M, Borges G, Bucholz K, Crowley TJ, et al. An overview of and rationale for changes proposed for pathological gambling in DSM-5. J Gambl Stud. 2014;30(2):493-502.
4. Wardle H, Degenhardt L, Marionneau V, Reith G, Livingstone C, Sparrow M, et al. The Lancet Public Health Commission on gambling. Lancet Public Health. 2024;9(11):e950-e994.
5. Lupu V, Lupu IR. Romanian National Prevalence Study: problem and pathological gambling in children and adolescents. Clujul Med. 2018;91(4):435-440.
6. Lorains FK, Cowlishaw S, Thomas SA. Prevalence of comorbid disorders in problem and pathological gambling: systematic review and meta-analysis of population surveys. Addiction. 2011;106(3):490-498.
7. Moreira D, Azeredo A, Dias P. Risk factors for gambling disorder: a systematic review. J Gambl Stud. 2023;39(2):483-511.
8. Blaszczynski A, Nower L. A pathways model of problem and pathological gambling. Addiction. 2002;97(5):487-499.
9. Garnefski N, Kraaij V, Spinhoven P. Negative life events, cognitive emotion regulation and emotional problems. Pers Individ Dif. 2001;30(8):1311-1327.
10. Frisch MB, Cornell J, Villanueva M, Retzlaff PJ. Clinical validation of the Quality of Life Inventory: a measure of life satisfaction for use in treatment planning and outcome assessment. Psychol Assess. 1992;4(1):92-101.
11. Bonfils NA, Aubin HJ, Benyamina A, Limosin F, Luquiens A. Quality of life instruments used in problem gambling studies: a systematic review and a meta-analysis. Neurosci Biobehav Rev. 2019;104:58-72.
12. Currie SR, Hodgins DC, Casey DM. Validity of the Problem Gambling Severity Index interpretive categories. J Gambl Stud. 2013;29(2):311-327.

13. Stinchfield R, Govoni R, Frisch GR. DSM-IV diagnostic criteria for pathological gambling: reliability, validity, and classification accuracy. Am J Addict. 2005;14(1):73-82.
14. Ioannidis K, Hook R, Wickham K, Grant JE, Chamberlain SR. Impulsivity in gambling disorder and problem gambling: a meta-analysis. Neuropsychopharmacology. 2019;44:1354-1361.
15. Cowlishaw S, Merkouris SS, Dowling NA, Rodda S, Suomi A, Thomas SL. Locating gambling problems across a continuum of severity: Rasch analysis of the Quinte Longitudinal Study. Addict Behav. 2019;92:32-37.
16. Browne M, Greer N, Rawat V, Rockloff M. A population-level metric for gambling-related harm. Int Gambl Stud. 2017;17(2):163-175.
17. **Ioniță I**, Mușat MI, Cătălin B, Ciobanu CA, Ciobanu AM. A systematic review of personality disorders in patients with gambling disorder. Clin Pract. 2026;16(1):15. doi:10.3390/clinpract16010015.
18. **Ioniță I**, Mușat MI, Cătălin B, Ciobanu AM. Assessment of cognitive emotion regulation in gambling disorder: a systematic review of the literature. Clin Pract. 2026;16(3):56. doi:10.3390/clinpract16030056.
19. **Ioniță I**, Mușat MI, Cătălin B, Lutescu DA, Ciobanu CA, Ciobanu AM. Exploratory associations of personality traits, cognitive emotion regulation, and quality of life with DSM-related symptom burden in gambling disorder. Clin Pract. 2026;16(7):122. doi:10.3390/clinpract16070122.
20. Williams RJ, Volberg RA, Stevens RMG. The population prevalence of problem gambling: methodological influences, standardized rates, jurisdictional differences, and worldwide trends. Guelph (ON): Ontario Problem Gambling Research Centre; 2012.

LIST OF SCIENTIFIC PAPERS PUBLISHED

Full-text articles published as a result of the doctoral research

1. **Ioniță I**, Mușat MI, Cătălin B, Ciobanu CA, Ciobanu AM, A systematic review of personality disorders in patients with gambling disorder, Clinics and Practice, 2026, 16(1), 15, p. 1-16, FI - 2.8/2025, Q1.

   This study is included in Chapter 1, pp. 5-12; Chapter 2, pp. 16-24.
   https://doi.org/10.3390/clinpract16010015,

   https://www.mdpi.com/2039-7283/16/1/15

2. **Ioniță I**, Mușat MI, Cătălin B, Ciobanu AM, Assessment of cognitive emotion regulation in gambling disorder: a systematic review of the literature, Clinics and Practice, 2026, 16(3), 56, p. 1-19, FI - 2.8/2025, Q1.

   This study is included in Chapter 1, pp. 5-12; Chapter 2, pp. 16-24.
   https://doi.org/10.3390/clinpract16030056,

   https://www.mdpi.com/2039-7283/16/3/56

3. **Ioniță I**, Mușat MI, Cătălin B, Lutescu DA, Ciobanu CA, Ciobanu AM, Exploratory associations of personality traits, cognitive emotion regulation, and quality of life with DSM-related symptom burden in gambling disorder, Clinics and Practice, 2026, 16(7), 122, p. 1-20, FI - 2.8/2025, Q1.

   This study is included in Chapters 3-10, pp. 26-109.
   https://doi.org/10.3390/clinpract16070122,

   https://www.mdpi.com/2039-7283/16/7/122