Screening & First Stage Trauma Treatment for Problem Gambling Clients

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Trauma and Problem Gambling
## Trauma & Problem Gambling Prevalence Rates

<table>
<thead>
<tr>
<th></th>
<th>Childhood Experiences</th>
<th>Adult Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>41%</td>
<td>46%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>63%</td>
<td>69%</td>
</tr>
<tr>
<td>Religious Abuse</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>Traumatic Incidents</td>
<td>39%</td>
<td>46%</td>
</tr>
<tr>
<td>Financial Abuse</td>
<td>N/A</td>
<td>45%</td>
</tr>
</tbody>
</table>

Boughton & Brewster, 2002
## Trauma & Problem Gambling
### Prevalence Rates

<table>
<thead>
<tr>
<th>Type</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any trauma</td>
<td>61%</td>
<td>100%</td>
</tr>
<tr>
<td>Emotional</td>
<td>53%</td>
<td>100%</td>
</tr>
<tr>
<td>Physical</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td>Sexual</td>
<td>22%</td>
<td>56%</td>
</tr>
<tr>
<td>Multiple*</td>
<td>39%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Kausch et al. 2006
PTSD and Problem Gambling Studies

• PTSD amgst PG: 12.5%-29% vs Gen Pop: 3%-4%  
  (Ledgerwood & Petry, 2006)

• 843 older adults, 11% at risk for PG, PTSD symptoms one of the strongest predictors  
  (Levens et al., 2005)

• 34% of treatment seeking PG had a high level of PTSD symptoms  
  (Ledgerwood & Petry, 2006)

• 17% of military vets in treatment for PTSD met the DMS-IV criteria for PG  
  (Biddle et al., 2005)
Prevalence of Traumatic Events

- Percentage of the population who have experienced a severe traumatic event:

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Males</td>
<td>81%</td>
</tr>
<tr>
<td>Females</td>
<td>74%</td>
</tr>
</tbody>
</table>
Gender Differences: Types of Trauma

• Males experience higher rates of physical assault, combat and life-threatening accidents.

• Females experience higher rates of childhood abuse and sexual assaults.
Traumatic Event

It is not the event that determines whether something is traumatic to someone, but the individual’s experience of the event.
Understanding Trauma
Type I Trauma

• A one time event

For example:
  – Motor vehicle accident
  – Natural disaster
  – Industrial accident
  – Rape
Type II Trauma

• Traumatic events that occurred over an extended period of time or happened repeatedly

For example:
– Childhood sexual abuse
– Domestic violence
– Combat
– Torture
Acute Stress Disorder

• Trauma reaction developed within first few days or weeks after the traumatic event
  – Minimum 2 days
  – Maximum 4 weeks
  – Within 4 weeks of trauma
Post-Traumatic Stress Disorder

• Trauma reaction persist or occurs at least six months after the event occurred.

  – Minimum 1 month
  – Acute: Less than 3 months
  – Chronic: More than 3 months
  – With Delayed Onset: If 6 months after trauma
Post-Traumatic Stress Disorder (PTSD) is NOT the common response to traumatic events
PTSD Responses

• Re-experiencing Phenomena
• Avoiding and Numbing Responses
• Hyperarousal Responses
Factors that influence the development of PTSD

• Deliberate acts vs. Accidents
• Perception of life threat & Physical injury
• Multiple vs Single incidents
• Preexisting psychiatric disorders
• Gender
• Witnessing death
• Loss of loved one
• Sexual vs non-sexual
Factors that influence the development of PTSD (continued)

• Individual strengths & resources
• Social and systemic resources
• Age
• Race
• Lower socio-economic status
• Family dysfunction
• Genetic predisposition
Complex PTSD (PTSD with prominent dissociative symptoms)

Traumatic event is over a prolonged period, involves a form of physical or emotional captivity and the person is under the control of another without the ability to easily escape
Dimensions of Complex PTSD

Alterations in:

• affect regulation
• consciousness
• self-perception
• perception of the perpetrator
• relations with others
• systems of meaning
Activity Trauma Reactions
Best Practices

- Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. SAMHSA Best Practices for Co-occurring disorders

For post-traumatic stress syndrome an integrated treatment approach that deals with both the post-traumatic stress syndrome and substance abuse at the same time is recommended. Health Canada’s Best Practices for Concurrent Disorders
Screening for Trauma
Why Screen?

• High prevalence rates of trauma among PG

• Failure to identify has adverse effects on a person’s physical and mental health

• Untreated trauma can impair recovery
How to Screen?

• Focus on symptoms or adaptations
• Do not ask about details
• Use screening tools
Primary Care Screen

• Designed for use in primary care and other medical settings

• Brief (4 questions)

• Focus on symptoms (adaptations)
Stressful Life Experiences Screen

• 19 stressful life events presented
• Screening for stressfulness of events (then & now)
• No scoring
More on Screening

• Normalize the process
• React appropriately
• Be respectful
• Don’t probe/explore
• Assess for safety
• Don’t cut-off if disclosure happens
• Don’t make sweeping statements about trauma
More on Screening  (continued)

• Don’t disclose personal experiences
• Be prepared for client’s responses
• Discuss results with client
• Make appropriate referrals
• Proceed with Stage One Trauma Treatment
• Gambling Connection
• Follow-up
Language and Trauma

• Responses vs Disorders
• Adaptations vs Symptoms
• Clients vs Patients
• Survivors vs Victims
Cultural Considerations

• Misdiagnosed:
  – Schizophrenia
  – Bipolar Disorder
  – Paranoid Type
  – Borderline Personality Disorder*

• PTSD behavioural and cognitive reactions may be different from culture to culture
Stage Trauma Treatment
Stage-Oriented Trauma Treatment

• Stage One:
  - Stabilization and managing trauma responses.

• Stage Two:
  - Processing and grieving traumatic memories.

• Stage Three:
  - Reconnecting with the world.
Stage One Trauma Treatment

Essential Components

- Client safety
- Therapeutic alliance
- Normalizing and Validating
- Emphasize client strengths
- Educating about trauma
- Teaching coping skills
First Stage Trauma Treatment

Client Safety

• Trauma is about vulnerability therefore safety is a critical issue for survivors.

• Outside of therapy

• In therapy:
  – Physical Safety
  – Psychological Safety

• Perceived Safety
First Stage Trauma Treatment
Therapeutic Alliance

• Too much care leads to dependency
• Supportive neutrality
• Establishing effective therapeutic stance
• Set clear expectations and boundaries
First Stage Trauma Treatment
Normalizing & Validating Experiences

• Validate emotional responses and reactions.
• Normalize the creative adaptations they have developed to survive the trauma.
First Stage Trauma Treatment
Emphasizing Client Strengths

• Highlight strengths and supports

• Reframing statements and normalizing comments
First Stage Trauma Treatment
Collaborating on Treatment Goals

• Set mutual goals
• Provide information on the therapeutic process
• Guide and help in establishing the pace of therapy
First Stage Trauma Treatment
Educating About Trauma

• Goal:
  ▪ Understand the range and complexity of trauma
  ▪ Understand how trauma has shaped their life
  ▪ Learn to reinterpret their life
First Stage Trauma Treatment
Educating About Trauma (continued)

• Explaining trauma
  – “a traumatic experience is an event that can continue to exert negative effects on thinking (cognition), feeling (affect) and behaviour, long after the event is in the past”

• Explaining ways of surviving trauma
First Stage Trauma Treatment
Teaching Coping Skills

• Goal is not to stop symptoms
• Suit techniques and exercise to each client
• Determine what is most painful and debilitating
• Develop “Toolbox”
First Stage Trauma Treatment
Teaching Coping Skills (continued)

• Trigger Awareness
• Grounding Techniques
• Developing a Container
• Developing a Safe Place
• Cognitive Restructuring
• Soothing Techniques
• Body Awareness
• Alternatives to Self-Harm
Stage Two Trauma Treatment
Stage Two Trauma Treatment

• Cognitive Behavioural Therapy
• Eye Movement Desensitization Reprocessing
• Body-Psychotherapy
• Medication
Cognitive Behavioural Therapy
CBT Model of Anxiety

Trigger

Interpretation

Neutral

Anxiety

Escape/Avoid

Relief
CBT – Treatment Rational

Trigger

Interpretation

Neutral

Anxiety

Escape/Avoid

Relief
Cognitive Behavioural Therapy
Goal of Exposure Therapy

• Reminder of trauma does not equal danger
• Remembering trauma is not the same as being traumatized
• Anxiety will be reduced if you get through the feared situation
• Experiencing anxiety/PTSD does not equal loss of control
Self Care
Vicarious Trauma

Experiencing the affects of trauma events due to indirect exposure to the trauma
Signs of Vicarious Trauma

They show up in the form of:
• Feelings
• Cognitions
• Behaviours
Signs of Vicarious Trauma

• Feelings
  – Overwhelmed, emotionally exhausted, anger, rage and sadness
  – Apathetic, depressed, loss of pleasure, overly involved emotionally
  – Isolated, alienated, distant, detached, rejected by colleagues
  – Heightened sense of vulnerability and personal threats
Signs of Vicarious Trauma

• Cognitions
  – Preoccupied thoughts outside of work
  – Over-identification, loss of hope, pessimism, cynicism
  – Questioning competence and self worth, low job satisfaction
Signs of Vicarious Trauma

• Behaviour
  – Distancing, numbing, detachment
  – Experiencing trauma responses (intrusive imagery, somatic symptoms)
  – Impact on personal relationships
  – High general distress level
  – Difficulty maintaining professional boundaries
Self care: The ABC Model

• **Awareness:** attunement to one’s needs, limits, emotions and resources

• **Balance:** balancing the multiple aspects of self & one’s activities

• **Connection:** to oneself, to others and to something larger

» Pearlman and Saakvitne
Enhance Self care

- Set clear boundaries
- Keep a manageable caseload
- Don’t work in isolation
- Develop and use support network
- Get clinical supervision
- Plan time for self care activities
- Keep professional and personal time separate

Research shows that the most effective resource is a group of peers
Cognitive strategies to counter vicarious trauma

• Recognize that you are not alone
• Validate and normalize your reactions
• Listen to the narratives you tell yourself and others
• Set realistic expectation
• Remind yourself that you cannot take responsibility for someone else’s healing
Professional Quality of Life Scale
Thank you!

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