ADDRESSING CO-OCCURRING DISORDERS IN PATHOLOGICAL GAMBLING TREATMENT

Project Turnabout/Vanguard Residential Treatment Programs
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Co-Occurring Disorders

• Many individuals suffering from addiction often simultaneously suffer from a serious mental health disorder.

• Addiction and medical professionals call this condition co-occurring disorders, formerly known as dual diagnosis.
Diagnosis

An accurate diagnosis for co-occurring disorders may be difficult because clinicians need to be able to establish at least one addiction disorder and one mental health disorder independently of each other.
Psychiatric Symptoms or Major Psychiatric Disorder?

• It is common for people in active addiction to present with symptoms of mental health disorders, including depression, anxiety, panic, mania, psychosis, impulse-control problems, and personality disorders.

• As a person achieves and maintains recovery from addiction, the majority of psychiatric symptoms will often dissipate unless the person has a pre-existing condition.
Does One Cause the Other?

• Addiction and chemical abuse may induce mental illnesses such as mood, anxiety, and personality disorders, as well as dementia, cognitive impairment, and psychosis.

• Many people with mental health disorders are drawn to psychoactive drugs and other high-inducing behaviors as a means of alleviating symptoms. This is referred to as self-medicating.
It's Complicated

THE AGE OLD DEBATE OF WHICH CAME FIRST: THE CHICKEN OR THE EGG?
Chicken or Egg?

• Whether or not gambling addiction leads to co-occurring disorders or vice versa, they both exist and evidence suggests all disorders need to be simultaneously addressed to achieve best outcomes.

• One disorder will exacerbate symptoms of the other(s), causing symptoms to increase in number and intensity.

• If one disorder is treated while the other remains unaddressed, treatment and sustained recovery will be nearly impossible.
Why the Need to Address Co-Occurring Disorders in Gambling Addiction Treatment?

"Assessment by a mental health professional is very important to be sure that all co-occurring disorders are being treated. It is said that if we are not treating them all, we are not effectively treating any. This a very important part of treatment to be sure no undiagnosed or untreated disorder remains and threatens the recovery from the identified disorder."

--Joanna Franklin, MS NCGC II
Co-Occurring Disorders Commonly Associated with Pathological Gambling

- Substance Use Disorders
- Mood Disorders (Depression and Bipolar)
- Anxiety Disorders
- Personality Disorders
Substance Use Disorders

Percentage of pathological gamblers who also have co-occurring:

Alcohol Use Disorders: 73.2%

Drug Use Disorders: 38.1%

(www.samhsa.gov/co-occurring)
Mood Disorders

- 49.6% of pathological gamblers also have a co-occurring mood disorder:
  - Major Depressive Disorder: 37%
  - Bipolar Disorder: 22.8%

(www.samsha.gov)
Anxiety Disorders

- 41.3% of pathological gamblers suffer from an anxiety disorder.
- Generalized Anxiety
- Panic Disorder
- Social Phobia
- Post-traumatic Stress

(www.samsha.gov)
Personality Disorders

- 60.8% of pathological gamblers have a co-occurring personality disorder:
  - Borderline
  - Narcissistic
  - Antisocial
  - Histrionic
Diagnosed Psychological Problems

- 65% No
- 35% Yes
Emergency Room Trips

Directly Relate to Compulsive Gambling

- Yes: 12%
- No: 88%
Neglect of Health Issues
Directly Related to Compulsive Gambling

- Yes: 15%
- No: 85%
Not Taking Prescribed Meds

Directly Related to Compulsive Gambling

88% 12%

Yes No
Suicide Thoughts

Directly Related to Compulsive Gambling

[Diagram showing a pie chart with 82% labeled as 'Yes' and 18% labeled as 'No']
Suicide Attempts

Directly Related to Compulsive Gambling

- 68% No
- 32% Yes
Hospitalized For Suicide Attempt

Directly Related to Compulsive Gambling

- 85%
- 15%
Suicide Risk

• 3x more likely for pathological gamblers than for those with other addictions--even greater risk for those with co-occurring personality disorders (Nauert, 2010)
• Pathological gamblers make up 5% of those who complete suicide (WHO).
• Three lethal elements:
  • depression
  • addiction
  • personality disorders
Pre-Admission Assessment

• Facility medical staff retrieves collateral information from:
  • Patient and relatives
  • Primary Physicians
  • Psychiatrists
  • Psychologists
  • Pharmacists
  • Hospital Social Workers
Pre-Assessment Considerations

<table>
<thead>
<tr>
<th>Patients with Pathological Gambling diagnosis often have multiple...</th>
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<tbody>
<tr>
<td>Diagnoses</td>
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<tr>
<td>Prescribed Medications</td>
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<tr>
<td>Medical and Other Health Issues</td>
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<td>Physicians</td>
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<td>Psychiatrists and Therapists</td>
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<table>
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<tr>
<th>Patients with Substance Use Disorder may not have...</th>
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<tr>
<td>Prescribed Medications</td>
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<td>A Primary Physician</td>
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<td>A Primary Medical Facility</td>
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Addressing Co-Occurring Disorders

Upon intake, each Vanguard patient receives a holistic assessment from a multidisciplinary team that includes mental health, addiction, medical, and health & fitness professionals.

Holistic Multidisciplinary Assessment

• Dimensions
  • Intoxication/Withdrawal
  • Biomedical
  • Emotional, Behavioral, Cognitive
  • Readiness for Change
  • Relapse, Continued Use Potential
  • Recovery Environment
Strengths-Based Assessment

Considers patient strengths, values and beliefs, goals, abilities, personal and environmental assets, and cultural/personal treatment preferences.
## Biomedical Assessment

- Done by medical staff
- Detoxification needs
- Quick drug screen
- Medical history
- Gambling history
- Substance use history/chemicals of choice
- Release of medical records
- Intake physical
- Medication recommendations
Dimensions I & II

- **Dimension I: Acute Intoxication/Withdrawal Potential**
  - **Treatment Goal:** To display a minimum amount of signs and symptoms of withdrawal from gambling

- **Dimension II: Biomedical Conditions and Complications**
  - **Treatment Goals:** To tolerate and cope with physical discomfort and to be able to get needed services. Also, to learn strategies to manage chronic health condition(s) while maintaining abstinence and recovery from addiction.
Assessing Patients with Mood Disorders

• Have patient meet with staff psychologist
• Ensure patient is medication compliant
• Structured Atmosphere
  • Balanced diet/nutrition
  • Relaxation
  • Exercise
  • Group
  • Recreation

• Stability—Is patient stable and appropriate for treatment?
• Consistency of programming and staff (rules and expectations)
• Individualized treatment planning
Assessing Patients with Substance Use Disorders

- Psychological evaluation
- Obtain collateral information
- Conduct a chemical use assessment (prior to or during treatment)
- If necessary, refer patient to chemical dependency treatment
- Assign patient to attend AA/NA
Out of 116 Vanguard Patients

Average diagnosis per person: 1.5
Average Mental health meds per person: 1.9
Mental Health Diagnosis

104 Mental Health diagnoses

- Depression: 58%
- Anxiety: 20%
- Bipolar: 9%
- ADHD: 6%
- PTSD: 2%
- Schizoaffective: 2%
- Borderline: 1%
- Mood Disorder: 2%
Mental Health Diagnosis Besides Gambling

- 61%
Mental Health Diagnosis and Medications

*There were 8 different mental health diagnosis categories
Psychological Assessment

1. Emotional, Behavioral, and Cognitive Evaluation within first 24 hours of treatment

2. Substance Use Status and History

3. DSM IV TR Multiaxial Diagnosis

4. Assessment of Suicidality

5. Beck Depression Inventory

6. Quality of Life Index

7. MMPI II

8. Off-campus Medical/Mental Health Evaluations and Services
Dimension III: Emotional, Behavioral, Cognitive Conditions and Complications

Risk Score 0: Good impulse control and coping skills and presents no risk of harm to self or others. Functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

Risk Score 1: Has impulse control and coping skills. Presents a mild to moderate risk of harm to self or others without means or displays symptoms of emotional, behavioral, or cognitive problems. Has a mental health diagnosis and is stable. Functions adequately in significant life areas.
Dimension III: Emotional, Behavioral, Cognitive Conditions and Complications

Risk Score 2: Difficulty with impulse control and lacks coping skills. Thoughts of suicide or harm to others without plan or means; however, the thoughts may interfere with participation in some Tx activities. Difficulty functioning in significant life areas. Moderate symptoms of emotional, behavioral, or cognitive problems. Able to participate in most treatment activities.

Risk Score 3: Severe lack of impulse control and coping skills. Frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. Severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.

Risk Score 4: Severe emotional or behavioral symptoms that place the client or others at acute risk of harm. Intrusive thoughts of harming self or others. Unable to participate in treatment activities.
Guiding Principles for Clinical Interventions

- Intake/Assessment
- Treatment Planning
- Pharmacotherapy
- Behavioral Therapy & Counseling
- Substance Use Monitoring
- Self Help & Peer Support
- Clinical & Case Management
- Continuing Care
Treatment Planning

Addresses Six Dimensions:
- Intox/Withdrawal
- Biomedical
- Emotional, Behavioral, Cognitive
- Readiness for Change
- Relapse Potential
- Recovery Environment

- Individualized planning to treat pathological gambling and to address co-occurring disorders that impair participation in addiction treatment
- May call for off campus medical evaluation and introduction and monitoring of psychopharmaceuticals
- May include immediate or subsequent need for substance use disorder treatment
- May include additional therapy sessions with facility mental health therapists to address and monitor signs and symptoms of depression, anxiety, and other mental health disorders
Treatment Plan Master Problems that Specifically Address Co-Occurring Disorders

- Lacks Coping Skills
- Co-Occurring Mental Health Disorder(s)
- Co-Occurring Substance Use Disorder(s)
- Unresolved Grief and Loss, Prolonged or Complicated Grief
- Anger and Resentments
- History of Trauma/Abuse
"The extent to which an individual is able, on the one hand, to change and cope with their environment and, on the other hand, to satisfy needs and realize aspirations"
Patient Treatment Goals

- To understand the reciprocal relationship between gambling addiction and their co-occurring disorder(s)

- To think and behave in new, reality-based ways to meet needs and self-actualize

- To effectively manage strong emotions, distress, and urges through the use of coping strategies (affect tolerance and regulation)

- To maintain treatment gains/recovery long-term
• Addictive disorders and mental health disorders are fundamentally intertwined.

• The tendency for patients to carry dual diagnoses indicates a "biological predisposition to overreact to stress in combination with a high-risk, nonprotective, stressful environment."

• Stress responses are impaired in those with early life trauma and chronically stressful environments.

• Changes in stress responses alter neurotransmitter levels (dopamine, serotonin), increasing susceptibility to stress, mental illness, and addictive disease.

• Decreased levels of neurotransmitters linked to "intoxicating states, depression, anxiety, poor impulse control, aggressiveness, and suicidal behavior."
Neuronal Growth
Brain Plasticity and Recovery

- Simultaneous alleviation of addiction and mood disorder symptoms related to degree of neuronal growth and integration

- Neuronal networks involved include sensations (brainstem), affect (limbic system), cognition (cortex), and behavior

- Interventions based on brain plasticity and its ability to re-wire and repair neuronal damage

(Applegate & Shapiro, 2005, Neurobiology for Clinical Social Work, W. W. Norton & Co.)
Clinical Approach for Promoting Neurobiological Resiliency and Recovery

• Provide patient with a safe treatment "holding environment" that includes nurturing, trusting relationships.

• Help patient acquire new information and experiences through education and treatment programming.

• Foster patient's movement from dissociation and denial to thought and emotional awareness and expression.

• Provide patient with opportunities to experience and tolerate strong emotional states and "safe emergencies," followed by times of processing, reflection, and ascribing new meaning.

(Applegate & Shapiro, 2005, Neurobiology for Clinical Social Work, W.W. Norton & Company)
Clinical Interventions

Provide patient with a safe treatment "holding environment" that includes nurturing, trusting relationships

- 12-Step Facilitation
- Patient/Counselor therapeutic alliance established in individual counseling sessions
- Supportive Peer/12-Step Fellowship
- Group-based therapy
- Structured daily activities
- Clear guidelines and expectations
- Relationship skills development
- Group skills development
Clinical Interventions

Help patient acquire new information and experiences through education and treatment programming

- Educational lectures and presentations on addiction and co-occurring disorders
- Daily 12-Step meetings and groups, including GA and AA
- Daily fitness and recreation activities
- Educational videos and books
- Discussion on neurobiology of addiction, depression and anxiety
- Financial Management counseling
- Relapse Prevention
- Daily instruction and practice of coping strategies
Primary Coping Strategies

- 4-7-8 Breath
- Mindful Breathing
- Emotional Freedom Technique (Tapping)
- Mindfulness/Acceptance
- Meditation & Prayer
- Relaxation
- Guided Imagery
- Journaling
- Dealing with Urges and Triggers
- Tolerating Strong Emotions
Clinical Interventions

Foster patient's movement from dissociation and denial to thought and emotional awareness and expression

- Daily feelings journaling
- 12-Step patient writing assignments and presentations
- Patient gambling history presentations
- Family education and therapy
- Therapeutic process comments
- Motivational Interviewing and Enhancement
- Solution-focused writing assignments (Miracle Question)
- Cognitive Restructuring
Clinical Interventions

Provide patient with opportunities to experience and tolerate strong emotional states and "safe emergencies," followed by times of processing, reflection, and ascribing new meaning.

- Empathic, nonjudgmental, helping counselor stance
- 12-Step writing assignments and patient presentations
- Externalizing the problem
- Exercises in tolerating strong emotions
- Mindfulness/Acceptance meditations
- Urge Surfing and craving management
- Cognitive Restructuring
- Grief Facilitation
- Tapping (EFT)
Continuing Care

- Continuing Care Plans are created by patients in the last week of treatment with the guidance of their counselor.

- Clinical recommendations include:
  - 2-3 GA meetings per week
  - Find a GA sponsor and have daily contact for 6 months
  - Vanguard Growth Group 2x/month for 4 months
  - Continued outpatient gambling counseling
Continuing Care

- Clinical recommendations frequently include:
  - AA, Alanon, and/or NA meetings
  - Inpatient or outpatient CD treatment
  - Residential (1/2 or 3/4 way) housing
  - Mental health services
Continuing Care

- Care plans include patient plans for addressing triggers associated with:
  - Physiology (i.e. hunger, fatigue, medical condition)
  - Psychology (i.e. anxiety, depression, guilt/shame)
  - Relationships and Environment
  - Change

- Care plans also account for:
  - Spiritual growth
  - Employment and schooling
  - Living environment
  - Improving relationships
  - Recreational needs
  - Legal requirements
Patient Treatment Difficulties

- Low frustration tolerance
- Difficulty working persistently for a goal
- Lie to avoid punishment
- Feeling hostile about their addiction
- Test limits

- Feelings expressed as behaviors
- Shallowness of mood
- Fear of rejection
- No hope for future
- Denial
- Feeling “Either you’re for me or against me.”
Stigma

• People with co-occurring disorders are 3x less likely to have consulted with a mental health professional in that year due to guilt, shame and stigma.

• In addition, people with gambling addiction often times don’t consult with professionals because they believe the problem will solve itself, believing that financial or alcohol/drug problems are ONLY the result of gambling.
Questions
Thank You