CHAPTER 14

POST-TRAUMATIC STRESS DISORDER AND THE PROBLEM GAMBLER

Mary Anne Cooke

Introduction

A considerable body of research has examined the relationship between substance abuse and Post-Traumatic Stress Disorder (PTSD), with findings that have advanced our understanding and intervention approaches for addressing these ailments. Since an increasing number of clients with gambling problems present with co-morbid PTSD features, research examining the associated properties between PTSD and pathological gambling offers significant advances for client treatment. As no studies have specifically investigated the relationship between problem gambling and PTSD, this chapter is based on anecdotal evidence and the application of associated research examining the relationships between PTSD and substance-type addictions.

Since problem gambling received recognition within the mental health field, our perception of this disorder has evolved from the original paradigm. It is this change in perception which has led to a strengthening of the interconnection between pathological gambling and PTSD. In many respects the two disorders have experienced a parallel process of development, and they share many symptoms and risk factors in common, as well as similar intervention approaches.

Changing paradigms

In common with PTSD, problem gambling received recognition by the American Psychiatric Association in the 1980 *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-III (American Psychiatric Association, 1980). Classified as an impulse-control disorder, pathological gambling behaviour was viewed as a robust phenomenon comprising ten

diagnostic criteria. It had earlier been recognised by the World Health Organization (1977) in its *International Classification of Mental and Behavioural Disorders.*

Originally, the perception of a problem gambler was of someone who was driven to gamble primarily to gain prize money. Support for this was derived from the fact that many problem gamblers never forget their feelings about their first win. The belief was that adrenalin surges and excitement remains unusually high throughout the gambling experience and that the decision to gamble is mostly an impulsive one (Sullivan, 1994b). Interestingly, Sullivan (1994b) points out that even though pathological gambling is classified as an impulse disorder, terms used to identify addiction (e.g. tolerance, lack of control, preoccupation, and withdrawal), are also applied to understanding problem gambling behaviour.

The original perception of a problem gambler, especially within the past decade, has increasingly become a paradigm limited in value as significant inconsistencies have arisen. Through treatment outcomes it has been found that pathological gamblers are not deterred by consistent losses. In fact, in counselling problem gamblers report an expectation of money loss. Many pathological gamblers describe reduced excitement during gambling, and they often plan for their next gambling episode rather than it being an impulsive decision.

In order to understand this paradigm shift, it is helpful to review some of the changes in the profile of pathological gamblers over the last decade. In 1992, approximately 80% of pathological gamblers were male, but by 2002 problem gamblers presenting for help were almost evenly divided between men and women. During this same period modes of gambling changed significantly with the social proliferation of electronic gambling machines, or 'pokies.' Gambling turnover has increased by 700% in the last decade, with approximately 85% of those adults seeking treatment doing so due to problems developed from playing pokie machines (Paton-Simpson et al, 2002). Recent research suggests that there is a significant relationship between machine availability and problem development (Australian Productivity Commission, 1999).

One significant finding regarding gambling machines is that people who primarily play the pokies tend to be more depressed (Paton-Simpson et al, 2002). Individuals who are depressed can appear to be sociable in casinos or pubs, but in reality gambling feeds their need for isolation and

escape (i.e. they only interact with the machines). Women with gambling problems tend to play the pokies. Since pokie numbers have increased in recent years, this helps to explain why women have had a raised problem gambling profile in the past decade (Paton-Simpson et al, 2002).

Evidence such as this suggests that pathological gamblers are driven by negative reinforcers to escape pre-existing conditions or the effects of gambling. In many cases, money or winning may be somewhat irrelevant, while stress avoidance is a priority. It is within this complex and multi-dimensional paradigm for understanding a problem gambler that an association with PTSD can be made.

Since its original classification in the DSM-III, PTSD has also experienced some evolution in the features originally used to define this disorder. Complex PTSD now includes chronic life traumas, such as childhood sexual abuse and domestic violence (Friedman, 2000). Many clients of treatment providers for gambling problems describe untreated early sexual abuse, which is also a common presentation in substance abuse programmes. An additional similarities is that sub-types of PTSD have been hypothesised, which is also the case for problem gamblers (Blaszczynski, 2000).

Symptoms in common

Many symptoms of PTSD parallel the symptoms of pathological gambling (e.g. increased arousal, persistent and recurrent behaviour, self-destructive and impulsive acts). These features are highlighted by the co-morbid problems found in both disorders. Associated disorders are common, including depression, anxiety and related phobias, obsessive-compulsive behaviour, suicidal ideation and substance abuse. For example, some research suggests that women sufferers on average meet the criteria for three of the DSM-IV disorders co-morbid with PTSD (Cloitre, 1997).

Dissociation is common for both problem gambling and PTSD clients, but clearly for different reasons. For pathological gamblers dissociation allows for escape from problems and the suspension of time, whereas for PTSD dissociation includes a sense of reliving the trauma (Friedman, 2000). Another different yet common feature for the two disorders is the way in which death is perceived. For gamblers death may be perceived as a solution rather than as a traumatic threat (see chapter 12).

Feelings of shame, despair and hopelessness are strong elements of concern, along with somatic complaints. Typically, gamblers will admit

to associated health difficulties, rather than acknowledging a gambling problem (Sullivan, 1994a, 2000b).

Emotional numbing is a symptom for both disorders, possibly acting as a coping mechanism. In relation to PTSD, emotional numbing self-manages the long-lasting effects of the trigger event. In the short term it is helpful in reducing the impact level of the stressor to something bearable, but in the long-term it reinforces the harmful symptoms of the disorder. For pathological gamblers, emotional numbing prolongs the inevitable crisis of having to face devastating gambling losses. The emotional detachment allows the gambler to continue gambling in an attempt at solving their indebtedness by a big win (Sullivan, 2000b). Unfortunately for the problem gambler their selected solution contributes to their problem.

The impact of gambling on the family can be devastating. Research suggests that for every problem gambler seven other people are negatively influenced (Australian Productivity Commission, 1999). Similarly, family members of someone with PTSD are also adversely affected. Depression, guilt, shame, substance abuse, sleep disruption, and other health problems are commonly found in family members related to sufferers of both disorders (Carlson & Ruzek, 2002).

Although the emphasis so far has been on the similarities between the two disorders, it is important to mention a few distinguishing characteristics. For one, re-experiences of gambling behaviour are not dysphoric. Conversely, experiences that may relate to a traumatic event would understandably cause feelings of being ill at ease, and any stimuli that may act as a trigger would be avoided. For gamblers, stimuli that trigger gambling are not avoided, except in attempts at recovery. Lastly, gambling participation is usually not a traumatic event. How PTSD and problem gambling could potentially impact on one another will now be explored.

Risk factors in common

Post-Traumatic Stress Disorder cannot be diagnosed unless an individual has had exposure to some form of trauma, and conversely trauma alone does not predispose a PTSD diagnosis. What mediates these two concepts is the way in which an individual cognitively and emotionally processes the event. Different trauma thresholds help to determine who may become more vulnerable to developing clinical symptoms (Friedman, 2000).

To understand the trauma threshold further, research has examined predisposing risk factors and their synergy with traumatic events. For example, an epidemiological study conducted in the United States on the readjustment of Vietnam veterans found that risk factors such as a family history of substance abuse, physical abuse and deviant behaviour as a child, negative relationships with immediate family and lower educational attainment increased the likelihood of developing war zone-related PTSD (Friedman, 2000). This same study also found that cultural minorities were at greater risk of developing PTSD. Similarly, cultural minorities in New Zealand run a greater risk of developing problem gambling behaviour: Māori are three times and Pacific people are six times more likely to be problem gamblers (Abbott & Volberg, 1999). An affiliated study examining the readjustment of women veterans returning from Vietnam also found that access to high levels of social support helped to reduce the risk of developing PTSD symptoms (King & King, 1998). As highlighted earlier, there is consensus that problem gambling may be better viewed as an addiction rather than as an impulse disorder (Sullivan, 2000b). Therefore it is useful to search within the addiction framework for theories of predisposition. The general theory of addictions can be applied to understanding substance-related disorders and problem gambling (Jacobs, 1989). This theory suggests that addiction, as a way of self-medicating, may be the result of individual predisposing factors, such as anxiety associated with a self-identity of inadequacy/rejection that may have formed in childhood. Consequently, addictive responses can follow trauma as a dysfunctional adaptive strategy.

PTSD and substance abuse co-morbidity has been recognised in many clinical studies, especially those testing self-medication theories. Meisler (1996) refers to one study by McFall and colleagues (1992) in which certain PTSD patterns could predict substance use patterns. For example, alcohol problems were often associated with elevated arousal symptoms and drug abuse was often associated with heightened avoidance/numbing features.

Given that no studies have specifically investigated the relationship between problem gambling and PTSD, problem gambling counsellors may apply the findings from studies examining PTSD and addiction to their clients. Bearing this in mind, anecdotal evidence suggests that pathological gambling may lead to trauma. According to the DSM-IV, 20% of pathological gamblers attempt suicide and the potential to commit illegal acts is one of the diagnostic criteria. Within the prison system,

25% of male and 33% of female inmates are problem gamblers (Abbott & McKenna, 2000; Abbott, McKenna, & Giles, 2000). Domestic violence and homicide cases are increasingly associated with problem gambling (see Chapter 13). Many gamblers who rely on loan-sharks live in fear and/or experience brutal retaliation when not able to pay back debts. In one study addressing the prevalence of trauma and PTSD in substance abuse patients, it was found that opiate and cocaine users reported the greatest prevalence of trauma and that women who were presenting with cocaine/opiate addictions were at risk of developing PTSD symptoms independent of trauma exposure (Cottler, Compton, Mager, Spitznagel, & Janca, 1992). These types of drug use can dramatically change a person's life. Pathological gambling can also cause lifestyle devastation and it is hoped that future research will examine the associations between PTSD and problem gambling.

Intervention

Clinical best practice suggests a concomitant approach for addressing features of both PTSD and problem gambling. If only one disorder is receiving intervention, symptoms of the other disorder run the risk of becoming increasingly unmanageable. Also, substitution is a common maladjustment to addiction recovery, and relapse prevention should deal with the risk of turning to other addictive behaviours or substances.

PTSD and problem gambling share counselling interventions in common. Providing a safe and supportive environment is crucial for building trust. Rogerian acceptance rather than elements of confrontation allow the client to grieve for losses, and to develop coping skills. Such cognitive-behavioural therapies as exposure, desensitization and cognitive restructuring have been highly successful, along with selective serotonin re-uptake inhibitor medications (Friedman, 2000). Group therapy at later stages of recovery is also highly effective for keeping clients focused on recovery.

Conclusion

To be convinced that the compulsion to gamble is due to a desire for money and winning is a limited perception. For many, pathological gambling may be best understood as a dysfunctional adaptive behaviour to stress. Driven by negative reinforcers, gambling offers escape from pre-existing trauma as a form of self-medication. Much like the high stressors associated with pre-existing trauma, the effects of problem

gambling may also lead to trauma. For many pathological gamblers, their social supports and emotional capacities are significantly disadvantaged by this entrenched dysfunction, which places them more at risk of developing PTSD clinical features. For problem gamblers, determining PTSD features at assessment and proceeding with interventions that address both issues simultaneously will offer healthier opportunities for change. Creating a safe therapeutic environment will attend to the hypervigilant nature that is shared by both disorders. Future research will significantly advance our knowledge regarding the relationship between PTSD and pathological gambling, and will enable the design of more effective interventions.