Working with CEP
including
Personality Disorders & Mania

ABACUS Counselling Training & Supervision Ltd

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Working with PG and Mania

- If excessive gambling only occurs during a diagnosed Manic Episode then may be attributed to that
- Can have both if excessive gambling also occurs outside of the Manic Episode
- Some gambling may appear to be manic during a gambling binge – e.g. chasing losses – but difference is that these symptoms of Mania decrease as gambling stops

Manic Episode – DSM4

- Elevated, or irritable mood lasting one week or more
- 3 of following (4 if just irritable):
    - Inflated self-esteem or grandiosity
    - Little sleep
    - Talkative
    - Racing thoughts/ideas
    - Easily distracted
    - Increased activity
- Excessive involvement in risky pleasurable activities
- Marked impairment in relationships with others
- Not due to a substance or medical condition

Exercise

Jodie (21) lives with her parents and presents with her father for her gambling problems. Her father says she is spending all of her money earned as a receptionist at a youth work programme. He says she 'talks rubbish' and he can hardly keep up with her. She plays a video game for hours on end and keeps them all awake with her loud yelling. Lately she has also started playing on-line Poker and has maxed out her card. Jodie distractedly agrees – she's been watching the fish in your fishtank and only partly followed the conversation.

What would you ask and who?

Would you diagnose Pathological Gambling?

Can you help?

Personality Disorders

'A Personality Disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'

DSM4

Personality Disorders – general criteria

- Enduring inner experience/behaviour deviating markedly from their culture in at least 2 of:
    1. Cognition (perceiving/interpreting)
    2. Emotional response (appropriate, intensity)
    3. Inter-personal functioning
    4. Impulse control
- Inflexible and usual
- Significant distress/impairment in functioning
- Long term and started at least by adolescence
- Not caused or explained by another mental disorder
- Not due to use of drugs or a medical condition

Personality Disorders – DSM4

Currently there are 10 Personality Disorders (PD):

- Paranoid PD
- Schizoid PD
- Schizotypal PD
- Antisocial PD
- Borderline PD
- Histrionic PD
- Narcissistic PD
- Avoidant PD
- Dependent PD
- Obsessive-Compulsive PD
- and Personality Disorder Not Otherwise Specified

Cluster A – 'odd or eccentric'

Cluster B – 'dramatic, emotional, erratic'

Cluster C – 'anxious, fearful'

Prevalence of Personality Disorders

PD	General prevalence	Prevalence in PG Steel & Blaszczynski 1998
Paranoid PD	0.5-2.5%*	**40%**
Schizoid PD	'uncommon'	**21%**
Schizotypal PD	Approx 3%	**38%**
Antisocial PD	3% males; 1% females	**29%**
Borderline PD	2%	**70%**
Histrionic PD	2-3%	**66%**
Narcissistic PD	Less than 1%	**57%**
Avoidant PD	0.5-1%	**37%**
Dependent PD	Common in MH clinics	**49%**
Obsessive-Compulsive PD	1%	**32%**

Narcissistic PD

Pervasive grandiosity, need for admiration, lack empathy, all beginning by early adulthood, indicated by at least 5 of:

- Grandiose self-importance
- Preoccupation fantasies of success, power, brilliance, ideal love
- Belief they special, and only associate with similar
- Requires admiration
- Sense of entitlement
- Exploits others
- Lacks empathy
- Envious of others – also that others envy them
- Arrogant

Exercise: role play Robert

Robert is referred to your service by his probation officer following a conviction for attempted theft (by false pretences) and a sentence of intensive supervision following gambling in the casino. When he called for an appointment he complained that your service didn't open before 9am as he had more important things to do. You meet him and he asks you what your experience and qualifications are and what experience you have of 'the more intelligent client'. You invite him to join a group that regularly meets in addition to one-to-one therapy and he offers to assist you to facilitate it because of his experience. He brings you a nice bottle of wine and offers to have a glass of it with you at the end of the session. He shows emotion when you ask him what effect the prosecution has had on him and angrily tells you the person lied and he was entitled to it because of advice he'd given them – then described his sadness at the unfairness of it all. You ask about his gambling and he says he has no problems, and that he has exceptional skills at poker. He then, smiling, asks if you have any knowledge whatsoever about the finer points of Poker.

What is an outcome measure?

Two definitions

- Determination and evaluation of the results of an activity, plan, process, or program and their comparison with the intended or projected results.
- A measure of the quality of medical care, the standard against which the end result of the intervention is assessed.

Not an ***output*** measure

What is the purpose of outcome measures?

Some purposes

- To prove the value and benefits of the service
- To prove the effectiveness of the treatment
- To improve the quality of the service and to establish desired patterns of treatment service
- To provide a quality control measure
- To provide information for accrediting bodies
- To assess client satisfaction with the service by helping us to understand deficits as well as satisfaction with the treatment plan

Some outcome examples with gambling treatment

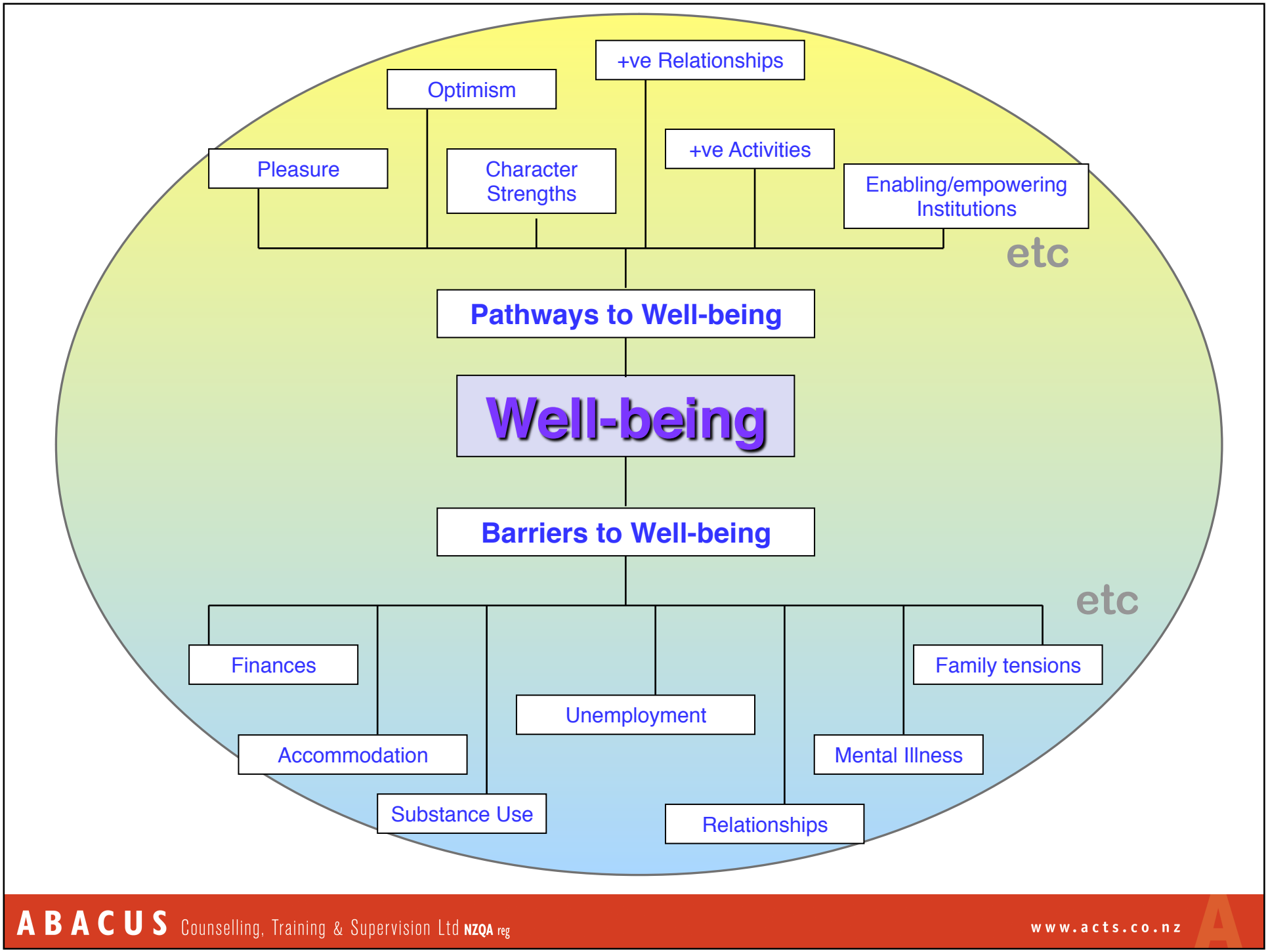
MoH in NZ	Current; Follow-up 1,3,6 and 12 mths from last session	Gambler harm screen (PGSI repeated with 'Since we last talked..'; Control over gambling in last month; Dollars lost in last month (+ approx household income); **optional** – asking last 12 mths: AUDIT-C, drug use, depression, suicidality, family concern; **If family** – repeat Family Harm screen 'Do you still..', Gambling Frequency of gambler, and Coping Ability
Sth Australia Research: Smith et al.	2011; 1,3,6 and 12 mths. Aim: drop out	**Baseline**: demographic + Social support (MSPSS 12 item), Trait anxiety (TAI 20 item), Sensation Seeking (AISS 20 item) **Outcome**: VGS 21 item, GRCS 23 item, GUS, DASS 21 item, AUDIT 10 item, WSAS 5 item

More

Canada; D Hodgins	2004	NODS screen (DSM based) as an outcome measure – 1 yr after brief treatment
Walker et al: A Framework for reporting outcomes in problem gambling treatment research	2006	Concluded minimum for outcome: net expenditure each month, frequency gambling (days per month), time spent gambling or thinking about gambling each month, measures of problems caused by gambling (especially personal health, relationships, financial, legal) – optional are quality of life measures, and measuring what change processes have occurred
ORS & SRS	2000	General (not gambling specific) client self-assessment of last week (wellbeing, close inter-personal, social, overall for last week (Outcome Rating Scale) and today's session (relationship with counsellor, whether worked on goals/wanted, approach fit, overall (Session Rating Scale)

More

Riley et al; Exposure therapy for problem gamblers in rural communities: a program model and early outcomes	2011	South Australia – outcome measure were SOGS, Kessler K10, Work and Social Adjustment Scale, and hours gambled the previous month


+ve Relationships
Optimism
Pleasure
Character Strengths
+ve Activities
Enabling/empowering Institutions
etc
Pathways to Well-being
Well-being
Barriers to Well-being
etc
Finances
Family tensions
Unemployment
Accommodation
Mental Illness
Substance Use
Relationships

KESSLER K10	None of the time (0)	A little of the time (1)	Some of the time (2)	Most of the time (3)	All of the time (4)
1. In the past 4 weeks about how often did you feel tired out for no good reason?					
2. In the past 4 weeks, about how often did you feel nervous?					
3. In the past 4 weeks about how often did you feel so nervous that nothing could calm you down?					
4. In the past 4 weeks about how often did you feel hopeless?					
5. In the past 4 weeks about how often did you feel restless or fidgety?					
6. In the past 4 weeks about how often did you feel so restless you could not sit still?					
7. In the past 4 weeks about how often did you feel depressed?					
8. In the past 4 weeks about how often did you feel that everything was an effort?					
9. In the past 4 weeks about how often did you feel so sad that nothing could cheer you up?					
10. In the past 4 weeks about how often did you feel worthless?					

What measures?

- Demographics - Who aren't we accessing?
- Baseline measures
  - Screens? – Best practice? Funder required? Validated?
  - Assessments? Or refer? Who to?
- Formulate treatment plan – what will achieve client wellbeing? Work with client to formulate
- Re-assess baseline measures (using modified baseline or other measures)
- Outcome: Review if achieved – make changes to programme, processes

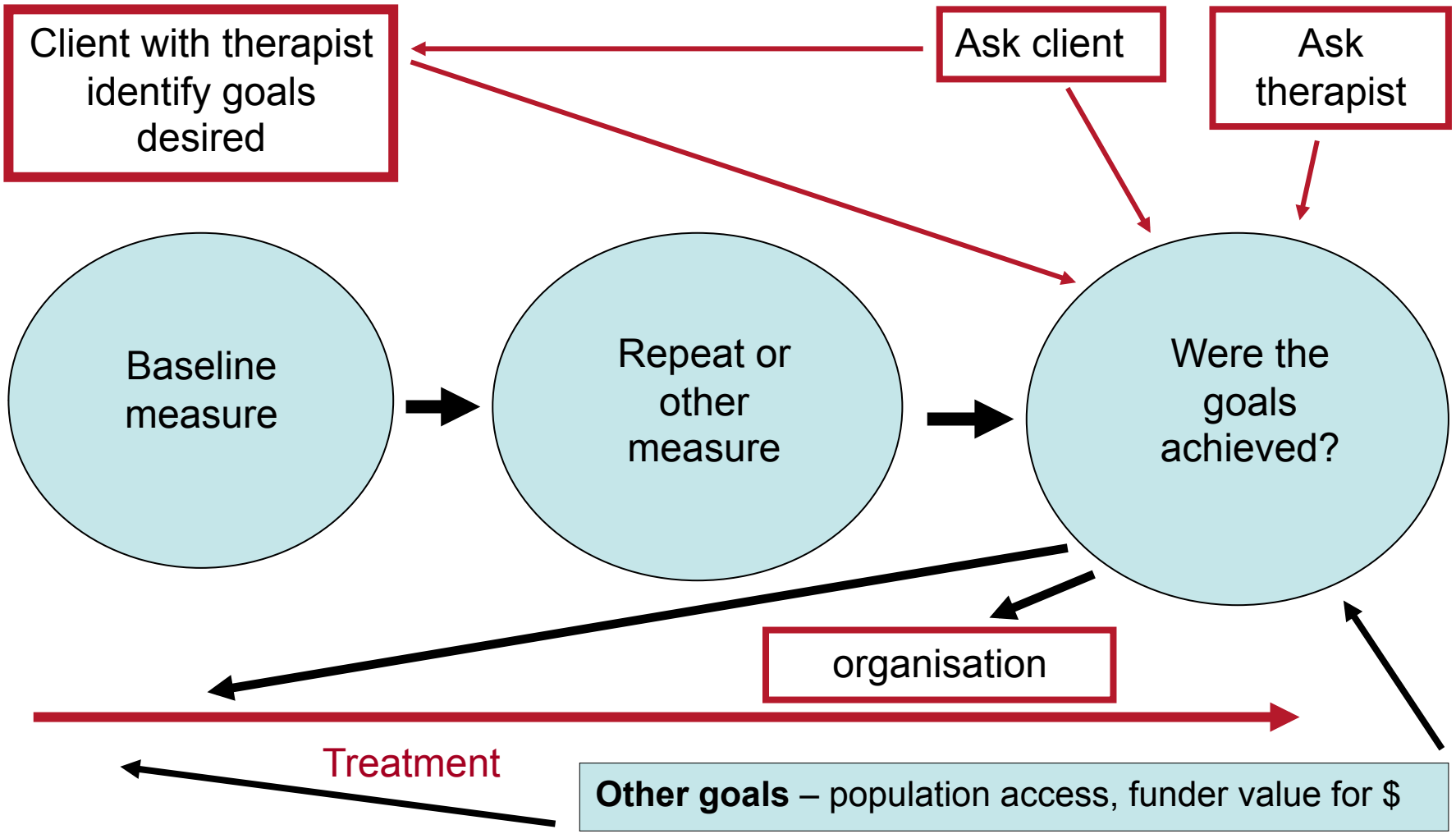
Exercise

- List the important information you would obtain in order to:
  - Know the needs of your client
  - Be able to confirm to yourself and others that your intervention has worked
  - Know what in your intervention works, and what doesn't
  - What you would require from your organisation to ensure this information was available with every client

Co-existing Problems expands the perspective

- Some CEP considerations
- Expanding the way we consider problem gambling requires a wider approach and therefore wider outcome considerations
- Outcomes are therefore wider than treatment outcomes
- Also goals may be what the client has decided as sufficient – ‘wellbeing’

Treatment Outcome



Possible screens & data

- MoH screens – plus all optional screens to all?
- What other conditions? Anxiety? Depression? K10 may achieve both and can be used for retest
- What demographic data? See wellbeing overhead – also, where would we expect our clients to be sourced? Are they? (need demographic data to understand)
- What wellbeing information (as well as screens) should we ask clients to self-assess? Client satisfaction questionnaire?
- What do we do with this information – how do we systematically use it to improve (use the outcome measures)?

Treatment

Well-being

- Instead of the aim being to reduce gambling harm (and CEP issues) alone, a well-being perspective includes the aim of strengthening and enhancing positive aspects in the client's life

- Positive aspects of client's life?

Engagement

- Engagement early in treatment important in outcomes, especially with CEP
- Engagement with the clinician (therapeutic alliance), the service, and the plan
- Continue with engagement throughout the plan – not just the beginning
- Connect and engage the CEP client to the organisation, the therapist, and the plan

Motivation

- Motivation to change and readiness for treatment important
- Zuckoff: some CEP clients may wish to attend treatment but not wish to change because of the negative effects of not gambling
- Motivation can be external or internal (or non-existent)
- Identify clients' goals

Assessment

- Aim of assessment is to engage client, increase motivation to increase well-being, gain information to form expert opinion on their problems so as to enhance well-being

- Comprehensive assessment = form understanding of all significant problems of client, whanau, in their socio-cultural context (screens, assessment tools, conversations)