

Treatments for PTSD and Pathological Gambling: What Do Patients Want?

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Abstract This study explored the treatment preferences of 106 people with posttraumatic stress disorder (PTSD), pathological gambling (PG), or both. It is the first known study of its type for this comorbidity. Sixteen different treatment types were rated, with a broad array of modalities including manualized psychotherapies, medication, self-help, alternative therapies, coaching, and self-guided treatments (use of books and computerized therapy). A consistent finding was that PTSD treatments were rated more highly than PG treatments, even among those with both disorders. Further, of the sixteen treatment types, the sample expressed numerous preferences for some over others. For example, among PG treatments, self-help was the highest-rated. Among PTSD treatments, psychotherapies were the highest-rated; and individual therapy was rated higher than group therapy. For both PG and PTSD, medications were rated lower than other treatment types. Non-standard treatments (i.e., computerized treatment, books, coaching, family therapy, alternative therapies) were generally rated lower than other types. Discussion includes implications for the design of treatments, as well as methodological limitations.

Keywords PTSD · Posttraumatic stress disorder · Pathological gambling · Problem gambling · Therapy

Pathological gamblers (PG) have high rates of co-occurring disorders, including substance use disorder, mood disorders, and personality disorders (Petry et al. 2005). In recent years, there is also growing attention to PTSD as an important comorbidity with PG. For example, in a study of US military veterans entering treatment for PTSD (Biddle et al. 2005), 17% met DSM-IV criteria for PG. In a study of 843 elderly adults, 11% were identified as at-risk gamblers, with current PTSD symptoms one of the strongest predictors (Levens et al. 2005). Finally, among treatment-seeking pathological gamblers, 34% had a high level of PTSD symptoms, with the latter assessed by self-report checklist (Ledgerwood and Petry 2006).

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Overall, estimates of PTSD among problem gamblers are estimated at 12.5–29% (Ledgerwood and Petry 2006).

Of particular clinical importance is the fact that PTSD is known to be underdiagnosed and undertreated relative to the more commonly diagnosed mood, anxiety and addictive disorders that so commonly co-occur with it and/or are misdiagnosed instead of it (Dansky et al. 1997; Davidson 2001). Yet PTSD is a prevalent disorder (7% lifetime rate in the general population) (Kessler et al. 2005); is typically chronic for many years; incurs high health care utilization and cost; and is associated with a numerous life problems (including poor health, homelessness, poverty, and numerous co-occurring Axis I and Axis II disorders) (Foa et al. 2008; Jones et al. 2001; Ouimette and Brown 2002; Walker et al. 2003). The addition of PG to the diagnostic picture adds the burden of yet another disorder with serious psychosocial impact (Erickson et al. 2005; Petry et al. 2005). Rates of problem and pathological are also notable, with estimates of up to 3.5% in adult-based epidemiological research (Kessler et al. 2008; Pulford et al. 2008).

One area that has not yet received any prior study is what treatments might be appealing to people with PG/PTSD. The goal of the current study was thus to explore help-seeking preferences by conducting a comparative study of three groups: people with PTSD, PG, or both PTSD and PG. This area is not only novel, but also has direct clinical implications for the design of treatments, for outreach efforts to engage people in treatment, and for treatment retention. Indeed, prior studies of PG samples indicate that they have quite low treatment utilization. For example, in the National Comorbidity Study Replication none of the sample who met criteria for problem or pathological gamblers had ever been treated for it (Kessler et al. 2008). In a recent community-based study of over 4,200 adults in Ontario only 18% of those who met criteria for problem gambling or PG had ever accessed treatment for it in their lifetime (including Gamblers Anonymous) (Suurvali et al. 2008). In the US, an analysis of data from the National Epidemiological Survey on Alcohol and Related Conditions found that only 10% with PG during their lives had accessed treatment for it; and in the Gambling Impact and Behavior Study, only 7% had (Suurvali et al. 2008). One study (Pulford et al. 2008) explored barriers to help-seeking in a comparative study of 125 callers to a national gambling helpline (help seekers) versus 102 non-help-seeking gamblers from the general population. In both groups, pride, shame, and denial were the most common barriers, and both groups also endorsed multiple additional barriers (a mean of 7 in the help-seeking group and 12 in the non-help-seeking group). Finally, in a study of particular relevance to the current paper (and using the same sample), community-based participants with current PTSD or comorbid PTSD/PG reported higher treatment utilization than those with PG alone (Najavits in press). The problems with help-seeking among those with PG is particularly poignant given that psychosocial treatments for it show favorable outcomes in both the short- and long-term (Leung and Cottler 2008; Pallesen et al. 2005).

Method

The sample consisted of 106 adults from Toronto and Boston: 36 with current PTSD (21 and 15 in the respective cities); 35 with current PG (24 and 11, respectively), and 35 with current PTSD and PG (15 and 20, respectively). Recruitment was conducted primarily in the community through local advertising, online postings, and fliers; also some recruitment occurred at local treatment centers. Inclusion criteria were current PTSD, PG, or both; and age 18 or older. Exclusion criteria were: current uncontrolled bipolar I disorder; current

psychotic disorder; and/or inability to read or write. The inclusion/exclusion criteria were minimal to capture a broad sample.

An initial telephone screen included the two-item Lie/Bet problem gambling screen (Gotestam et al. 2004; Johnson et al. 1988) and four-item PTSD screen (Kimerling et al. 2006). Following the phone screen, participants attended an in-person assessment that included a diagnostic interview to ascertain the presence of the inclusion/exclusion criteria. The Diagnostic Interview for Gambling Severity—Revised (DIGS-R) (Winters et al. 2002) was used to determine PG. The Mini-International Neuropsychiatric Interview (MINI; Sheehan et al. 1998) was used to diagnose PTSD and the absence of the exclusionary diagnoses. Participants who met eligibility criteria completed a battery of measures addressing various areas related to PTSD/PG; other reports provide data beyond what is covered here (Najavits in press; Najavits et al. under review). For the current study, sociodemographic characteristics were obtained from the Addiction Severity Index (McLellan et al. 1992) and the Canadian Problem Gambling Index (Ferris and Wynne 2001). Treatment utilization data were obtained from the Treatment Summary Questionnaire for PG and PTSD (TSQ; Najavits 2007a, b). The TSQ is a 52-item interview that assesses participants' self-reported lifetime and current treatment history. This measure was based on an earlier version on substance use disorder and PTSD (Najavits and Weiss 1996). For the current paper, we used just two items: attendance at any current or lifetime treatment. The current treatment utilization variable was coded as yes or no based on participants' self-report across nine possible current treatments (individual psychotherapy, medication, day treatment, professionally-led group treatment, alcohol or drug counseling, family therapy, gambling counseling, inpatient psychiatric hospitalization, or other treatment). The lifetime treatment utilization variable was coded across seven types (adding in halfway-house, and omitting family therapy and medication). A previous paper reports detailed results on this measure (Najavits in press). Ratings of treatments were obtained from the Interest in Treatment Scale (ITS; Najavits 2007a, b). The ITS is a self-report questionnaire that lists 21 different types of therapy, each with a brief description and scale, in which respondents rate the perceived helpfulness of each therapy type from 0% (not at all) to 100% (extremely), rated separately for PTSD and gambling. Examples of therapy descriptions include the following.

Cognitive-Behavioral Therapy. The therapist helps you change your thoughts and your actions. For example, you might learn new ways to rethink situations, fill out worksheets to identify thinking errors, experiment with new behaviors, etc.

Self-Help Groups. You meet with others who share similar problems, but there is no professional therapist. The goal is mutual aid, sometimes using 12-step approaches. Groups include Alcoholics Anonymous, Gamblers Anonymous, Al-Anon, Survivors of Incest Anonymous, Codependents Anonymous, etc.

Body Therapies. For example, yoga, therapeutic massage, bodywork, pressure-point work, etc.

Coaching. This might be telephone or email check-ins and advice to help improve your life in target areas that you choose.

Medication. There are various medications that may help. These can include antidepressants, anti-anxiety medication, sleep aids, and others.

After each such therapy description, the following questions were listed, with the instruction, "Rate each from 0% (not at all) to 100% (extremely). You can use any number from 0 to 100":

How helpful would it be for your PTSD? ____

How helpful would it be for your gambling? ____

Participants were assessed only at one time (a cross-sectional study design), and they received up to \$70 (Canadian dollars) in cash or gift cards for full completion of the assessments. All ethical safeguards for informed consent and confidentiality of records were followed, and the study was approved by the New England Internal Review Board (Boston) and the University of Toronto Internal Review Board (Toronto). All interview-based measures used for this report were conducted by trained interviewers (an advanced doctoral student in clinical psychology for Toronto and a licensed clinical social worker in Boston), supervised by the author based on audiotapes of the interviews. Data analysis was conducted to address the key study questions. First, descriptive statistics were used to characterize the study sample on sociodemographic variables. This was followed by a comparison of the three groups (PG, PTSD, BOTH) on those variables, using one-way ANOVAs for continuous variables (with post hoc comparisons using the least-significant differences, LSD), and chi-square tests for categorical variables (with post hoc chi-square tests comparing each group to the others to identify which were significantly different). To evaluate possible site differences (Boston versus Toronto) independent-samples *t*-tests and chi-squares were used. Second, a key study question was a comparison of the three groups on each of the 16 types of treatment, as well as overall for the domains of PTSD treatments and PG treatments. ANOVAs were conducted for each treatment type (with LSD post hoc tests). Next, independent-samples *t*-tests were used to compare PG versus PTSD on their respective domains within each treatment type (e.g., self-help groups for PG rated by the PG sample versus self-help groups for PTSD rated by the PTSD sample). Also, paired-samples *t*-tests were used within the BOTH sample to compare the two domains (PG versus PTSD treatments). Third, an analysis was conducted to compare how much different treatment types were valued relative to each other. For this, profile analysis were conducted based on the general linear model. The fourth and final analysis was a comparison of participants who had been exposed to treatment versus those who had not. First, participants were classified into “current treatment utilization” (yes or no), based on the TSQ. They were then compared on the ITS on their overall mean for PTSD treatments (selecting for this analysis those with PTSD), overall mean for gambling treatments (selecting those with PG), and overall mean for all treatments (selecting those with BOTH). This same analysis was then conducted on the “lifetime treatment utilization” question on the TSQ. All results reported were significant at .05 or below unless noted otherwise.

Results

Participant Characteristics

Among the 106 participants, most were female ($n = 63$, 59.4%), and the average age was 43 ($sd = 14.06$). Most were never married ($n = 46$; 43.4%); after which there were equal numbers of married and divorced (each $n = 18$; 17%); and the rest were living with someone ($n = 11$, 10.4%); separated ($n = 8$, 7.5%), or widowed ($n = 5$, 4.7%). Most had no children ($n = 56$, 52.8% without children; $n = 50$, 47.2% with children). In education level, most had some college ($n = 60$, 56.6% either graduated or had attended college); the rest were equal amounts with high school or less or some graduate/professional school (each $n = 23$, 21.7%). Median annual income was \$10,000–\$25,000. By race/ethnicity,

most of the sample was Caucasian ($n = 73$, 68.9%), then Black ($n = 14$, 13.2%), Asian ($n = 9$, 8.5%), Hispanic ($n = 6$, 5.7%), and more than one ($n = 4$, 3.8%).

Comparison of the three groups (PTSD, PG, BOTH) revealed no differences on age, marital status, education level, or income. However, on gender, PTSD was higher than PG ($n = 27$ female versus $n = 15$; chi-square = 7.59, $p < .01$, $df = 1$). On race/ethnicity, PTSD was more likely to be Caucasian than minority compared to PG ($n = 33$ Caucasian versus $n = 20$, chi-square = 11.18, $df = 1$, $p = .001$) and also compared to BOTH ($n = 33$ Caucasian versus $n = 20$, chi-square = 11.18, $df = 1$, $p = .001$). On number of children, there was a trend for BOTH to have more children ($M = 1.31$, $SD = 1.34$) than PTSD ($M = .78$, $SD = 1.22$, chi-square =) or PG ($M = .66$, $SD = .91$) ($F = 3.04$, $df = 2$, 103, $p = .052$). A prior report documents rates of all major Axis I and Axis II comorbid psychiatric disorders in this sample, as well as comparisons on numerous other descriptive variables (Najavits et al. under review). It was found, for example, that the PG group had significantly fewer Axis I and II disorders than the other two groups.

In an analysis of demographics by site (Toronto versus Boston), no differences were found on marital status, number of children, income, education level, race/ethnicity, gender, family history of gambling problems or SUD, or age.

Interest in Treatment: Comparison of the Three Samples

See Table 1 for means of each of the three groups (PG, PTSD, BOTH) on each treatment type. It is notable that the comparison of PG versus PTSD on their respective treatments indicates that of 17 comparisons 11 were significant and one was a trend, and all were in the direction of PTSD treatments being rated more highly than PG treatments with just one exception: PG self-help groups were rated more highly than PTSD self-help groups. The same pattern held when looking at the BOTH sample: of 17 comparisons, 8 were significant and two were trends, all in the direction of PTSD treatments being more highly rated than PG treatments. Note that one analysis is not on Table 1: ANOVAs comparing the three samples (PG, PTSD, BOTH). On that analysis, we did not find any significant results for the comparison of BOTH versus PG, or BOTH versus PTSD on their respective treatment domains. Thus, the comorbid sample did not value treatments at a higher level than either of the single-diagnosis samples.

Comparison of Specific Treatments to Each Other

The next key study question was the comparison of specific treatments to each other, within PG and PTSD, respectively. Figure 1 displays which gambling and PTSD treatments were most desired by the relevant participants. Note that BOTH was combined with each single diagnosis sample as the earlier comparison of BOTH versus each single diagnosis found no significant differences, and thus we had greater power by using the aggregated samples. Figure 1 indicates a substantial number of significant differences, which may have important implications for designing treatments for these populations. The large number of analyses (each of 16 treatments compared to all others) raises the issue of Type I error, but the number of significant findings vastly exceeds the 5% rate that would be expected by chance, and thus all results are reported “as is.”

Several patterns are notable. For example, among PG treatments the most highly rated treatment was self-help (higher than six other types) and the lowest rated was medication (lower than seven other types). Interestingly, most of the professionally-led psychotherapies were not significantly different from each other (individual therapy, Seeking Safety,

Table 1 Interest in treatment (all questions are, "How helpful would this be for your PTSD/gambling?")

Treatment	PG		PTSD		<i>t</i> -Test: PG versus PTSD	Both		<i>t</i> -Test within BOTH
	Mean	SD	Mean	SD		Mean	SD	
Professionally-led								
General group therapy								
PTSD			48.24	36.50	-.38	48.63	40.52	1.32
Gambling	46.42	36.79				42.09	38.39	
General individual therapy								
PTSD			64.19	33.30	-2.02*	70.69	32.23	3.56**
Gambling	47.44	36.75				51.29	34.44	
CBT								
PTSD			72.24	30.16	-3.76***	60.51	36.01	1.19
Gambling	42.09	37.24				55.14	35.86	
Psychodynamic therapy								
PTSD			60.26	34.55	-2.96**	57.74	35.33	2.00
Gambling	34.61	37.43				48.03	36.34	+
Exposure therapy								
PTSD			65.53	36.49	-3.32**	61.74	37.74	4.19***
Gambling	35.67	38.77				44.74	37.98	
Contingency management								
PTSD			43.54	39.92	.20	53.00	39.35	-.46
Gambling	45.29	35.67				55.60	40.37	
Seeking Safety therapy								
PTSD			71.05	30.82	-4.05***	65.26	31.40	2.48*
Gambling	38.24	37.41				53.60	33.66	

Table 1 continued

Treatment	PG		PTSD		t-Test: PG versus PTSD	Both		t-Test within BOTH
	Mean	SD	Mean	SD		Mean	SD	
Medication								
PTSD			49.23	39.75	-3.84***	39.86	39.08	3.47**
Gambling	17.44	29.69				24.71	34.32	
Self-guided								
Self-help groups			42.31	36.78	2.04*	46.26	39.78	-1.01
PTSD						53.29	40.47	
Gambling	59.47	33.73						
A course (like school)			51.49	38.00	-1.51	58.97	37.83	2.91**
PTSD						45.46	38.01	
Gambling	37.79	38.12						
Family or couples therapy			51.36	41.33	-2.17**	39.31	37.82	1.28
PTSD						32.29	37.59	
Gambling	30.32	39.74						
Books			54.32	35.10	-1.69	43.54	37.59	1.77
PTSD						36.34	36.30	+
Gambling	39.27	39.81						
Computer-based self-help			44.85	38.92	-0.97	41.74	37.24	1.58
PTSD						34.00	36.92	
Gambling	35.91	38.98						
Alternative methods								
Alternative healing								

Table 1 continued

Treatment	PG		PTSD		<i>t</i> -Test: PG versus PTSD	Both		<i>t</i> -Test within BOTH
	Mean	SD	Mean	SD		Mean	SD	
PTSD			55.00	37.40	-3.78***	46.20	40.25	2.24*
Gambling	22.79	34.05				37.06	39.02	
Coaching ^a			46.44	35.37	-1.15	42.37	35.36	.47
PTSD						38.91	36.08	
Gambling	36.16	39.21						
Body therapies ^b			65.11	34.14	-3.70***	57.06	40.07	3.51**
PTSD						37.20	38.36	
Gambling	32.94	39.14						
Overall			55.34	22.12	-2.92***	52.05	23.67	2.81**
Overall mean—PTSD treatments ^c						43.03	25.77	
Overall mean—gambling treatments ^d	38.57	26.48				47.58	22.84	
Overall mean—all treatments ^e								

Significance levels:

$p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$

^a “This might be telephone or email check-ins and advice to help you improve life in target areas that you choose”

^b “For example, yoga, therapeutic massage, bodywork, pressure-point work, etc.”

^c This was a calculation across all of the treatments labeled “PTSD” in this table

^d This was a calculation across all of the treatments labeled “gambling” in this table

^e This was a calculation across all of the treatments in this table

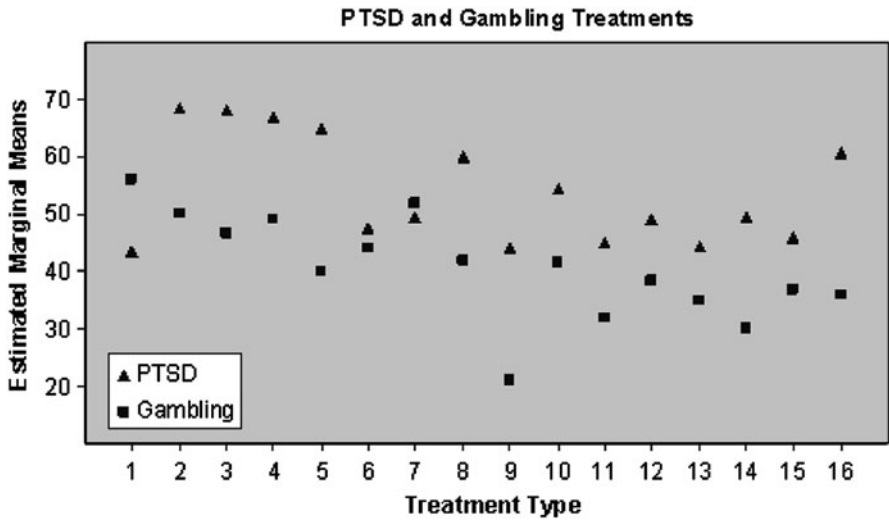


Fig. 1 Interest in Treatments for PTSD and Gambling. *Figure notes:* treatments are as follows, with abbreviations in parentheses. 1 Self-help groups (SH), 2 General individual therapy (INDIV), 3 Seeking Safety therapy (SAFE), 4 CBT (CBT), 5 Exposure therapy (EXP), 6 General group therapy (GROUP), 7 Contingency management (CM), 8 Psychodynamic therapy (PD), 9 Medication (MED), 10 A course, like school (COURSE), 11 Family or couples therapy (FAMI), 12 Books (BOOK), 13 Computer-based self-help (COMP), 14 Alternative healing (ALT), 15 Coaching (COACH), 16 Body therapies (BODY). For gambling treatments, $n = 66$ (those with PG or BOTH). Overall $F = 6.78$ ($p < .0001$). All treatment types refer to gambling treatments only. Significant differences between treatments (all at $p < .05$) were as follows: SH preferred more than MED, FAM, BOOK, COMP, COACH, BODY; INDIV preferred more than MED, and ALT; SAFE preferred more than MED; CBT preferred more than MED; EXP: no differences; GROUP preferred more than MED; CM preferred more than MED; PD preferred more than MED; MED preferred less than SH, INDIV, SAFE, CBT, GROUP, CM, PD; COURSE: no differences; FAM preferred less than SH; BOOK preferred less than SH; COMP preferred less than SH; ALT preferred less than SH, INDIV; COACH preferred less than SH; BODY preferred less than SH. For PTSD treatments, $n = 69$ (those with PTSD or BOTH). Overall $F = 6.97$ ($p < .0001$). All treatment types refer to PTSD treatments only. Significant differences between treatments (all at $p < .05$) were as follows: SH preferred less than INDIV, SAFE, CBT, EXP; INDIV preferred more than SH, GROUP, MED, FAM, BOOK, COMP, ALT, COACH; SAFE preferred more than SH, GROUP, CM, MED, FAM, BOOK, COMP, COACH; CBT preferred more than SH, GROUP, MED, FAM, COMP, COACH; EXP preferred more than SH, GROUP, COMP, COACH; GROUP preferred less than INDIV, SAFE, CBT, EXP; CM preferred less than SAFE; PD: no differences; MED preferred less than INDIV, SAFE, CBT; COURSE: no differences; FAM preferred less than INDIV, SAFE, CBT; BOOK preferred less than INDIV, SAFE; COMP preferred less than INDIV, SAFE, CBT, EXP; ALT preferred less than INDIV; COACH preferred less than INDIV, SAFE, CBT, EXP; BODY: no differences

CBT, exposure, group therapy, contingency management, psychodynamic); also these were not significantly different than self-help. However, in the several significant differences among psychosocial treatments, it appears that non-standard types of treatment were relatively lower rated (e.g., self-help and/or individual therapy were rated higher than computer therapy, books, coaching, body therapy, alternative therapies, and family therapy).

For PTSD treatments, results were quite different. Here, self-help was one of the lowest-rated modalities (less than four professionally-led psychotherapies), in contrast to PG treatments where self-help was the highest-rated. Next, it is notable that, among PTSD treatments, professionally-led psychotherapies generally more highly rated than many non-

standard types of treatment. That is, individual therapy, Seeking Safety, CBT, exposure therapy, and group therapy were significantly higher than books, computer therapy, coaching, alternative therapies, and/or family therapy. Note that in PG treatments, the psychotherapies were not generally found different than other types of treatment. Further, in looking at the PTSD treatments in Fig. 1, it is clear that some professionally-led psychotherapies were more highly rated than other treatment types: individual therapy and Seeking Safety were especially highly rated (more than eight other treatment types), followed by CBT (higher than six others), followed by exposure therapy and group therapy (higher than four others). Another observation is that among PTSD treatments, individual therapy was more highly rated than group therapy; this did not occur for PG treatments. Finally, medications were rated lower than three other PTSD treatment types; per Fig. 1, medications were rated lower than seven PG treatment types; thus medications were rated as one of the lowest among both PTSD and PG treatments (but lowest among the latter).

Comparison Based on Treatment Utilization (Current and Lifetime)

First, current treatment utilization was analyzed within each study group. PG participants were classified on current treatment utilization (yes = 13, 37.14%; no = 22, 13.83%) and were found significantly different in their overall rating of PG treatments on the ITS ($x = 51.96$, $sd = 27.93$ versus $x = 30.66$, $sd = 22.65$, $t = -2.47$, $p < .02$). PTSD participants were classified on current treatment utilization (yes = 25, 69.44%; no = 11, 30.56%) and were not found significantly different in their overall rating of PTSD treatments on the ITS. BOTH participants were classified on current treatment utilization (yes = 18, 51.43%; no = 17, 48.57%) and were not found significantly different on their overall rating of all treatments on the ITS. This same set of analyses were then conducted on the lifetime treatment utilization and none were significant. For PG, lifetime treatment utilization was $n = 16$, yes (45.71%), $n = 19$, no (54.29%); for PTSD it was $n = 34$, yes (94.44%), $n = 2$, no (5.55%); for BOTH, it was $n = 27$, yes (77.14%), $n = 8$, no (22.86%).

Discussion

This is the first study to compare people with current PG, PTSD, or both disorders on their views of different types of treatment. Strengths of this study include rigorous diagnoses for inclusion into the study; a large sample ($n = 106$); minimal exclusion criteria (thus obtaining broad representation); and ratings of sixteen different types of treatments (including various manualized models; alternative models such as coaching, body therapies, books, and computer-based therapy; and both professionally- and non-professionally-led models). Moreover, because the study recruited primarily a community-based sample rather than a treatment sample, findings of this study provide relevant information for attempts to engage people in the community who have these disorders. This is particularly important for PG, where it is now well-documented that they tend not to engage in therapeutic treatments (Pulford et al. 2008; Suurvali et al. 2008).

Main findings were as follows. First, it is clear from Table 1 that PTSD treatments were rated consistently more highly rated than PG treatments. This held true for the comparison of the PTSD versus PG samples, but also notably within the BOTH sample (i.e., even those with both disorders gave higher ratings to PTSD treatments). This pattern would suggest that “all comorbidities are not equivalent”—i.e., here, PTSD appears to be more

distressing and in need of care than PG, at least as rated by those who have these disorders. The same pattern was found in a prior study of PTSD and substance use disorder (SUD) comorbidity (Najavits et al. 2004), where those with both disorders rated their desire for PTSD treatment higher than for SUD treatment. This pattern is especially important from a public health perspective in that people with addictions (whether PG or SUD) routinely tend to get routed to addiction treatment prior to or instead of PTSD treatment—yet people with these disorders value exactly the opposite.

Also worth mentioning is that those with comorbid PG and PTSD (named “BOTH”), did not want treatment more than those with the single diagnoses (PG or PTSD). It might have been expected that those with both disorders were perceive significantly higher need for treatments of all types, but in fact across the sixteen different treatment types, not one was significantly higher-rated by those with the comorbidity. Thus, it appears that it simply the presence of PTSD, whether comorbid or not, that drives the desire for treatment.

The next major area addressed in this study was ratings of different types compared to each other. In other words, among the 16 treatment types, which specific ones were valued more than others? There were many significant findings in this area, and notably, findings for PG treatments had a different pattern than those for PTSD treatments. For example, self-help was the highest-rated of all sixteen PG treatments, but among PTSD treatments, was rated lower than psychotherapies. Among PG treatments, psychotherapies were generally perceived alike (no significant differences among them, and not different from self-help), whereas among PTSD treatments, various psychotherapies were rated more highly than others, and they were rated higher than self-help. This could imply that for outreach purposes, it may be useful to provide the types of treatments that these specific potential clientele prefer over others. Similarly, group versus individual modalities were an important consideration for PTSD treatments (individual rated more highly than group), but this did not hold for PG treatments. As one participant noted, “With regard to groups, I wouldn’t like to be talking to others about my PTSD, but I would consider getting input from others about their gambling problems.”

One area of commonality among both PG and PTSD treatment ratings was a relatively low rating for medications compared to other treatment types. Here too, this may have implications for the design of services, as medications are often a first approach but likely need to at least be combined with psychosocial treatments, at least based on the results from this study. Another area of commonality was the relatively lower rating for non-standard types of therapy (coaching, books, computer-based care, family therapy). This was more prominent for PTSD treatments, but occurred to some extent for both PTSD and PG treatment ratings. However, several respondents wrote in types of alternative therapies they engaged in or wanted including hypnosis, meditation, art therapy, music therapy, animal-assisted therapy, herbal remedies, energy therapies, rituals, martial arts, bodywork, pressure-point work, and acupuncture. One respondent wrote, “I would like to learn how others handle gambling.”

It was also interesting that treatment utilization (exposure to current and lifetime treatment) largely did not show a relationship to treatment ratings. The only significant result was that for the PG group, those in current treatment of any kind rated PG treatments higher than those not in current treatment. However, this did not hold for PTSD or BOTH, nor, on the lifetime treatment utilization variable, for any of the three groups (PG, PTSD, BOTH). Thus, treatment preferences appear to be largely independent of exposure to treatments. This may have important implications for clinical practice, suggesting that prior treatment experiences may not “bias” people, either positively or negatively, in their interest in potential new treatments.

Despite the strengths of this project, several limitations also need to be noted. The large number of variables studied made Type I error more likely, although as mentioned, the rate of significant findings in this study vastly exceeded the 5% rate that would have been expected by chance. Another limitation was the cross-sectional design (one time-point), which did not offer the opportunity to determine change over time on the measures nor to assess test–retest reliability of responses. There also was no ability to explore treatment ratings in relation to actual treatment outcomes; i.e., the appeal versus effect of a treatment are different constructs. In the future, exploring these areas empirically could be informative. A further limitation was that the primary measure in this study was “home-grown” and not as yet validated, which thus needs cautious interpretation. There is no validated instrument for this topic, but in future research with a larger sample, validation of this instrument would be useful. Also, in this study, we assessed only for current diagnoses; lifetime diagnoses would be helpful to document as well. Finally, subsample issues could not be explored without a larger sample size (differences within group by gender, type of trauma, type of gambling problem, age, ethnicity/race, severity of PTSD and PG, and other factors). Despite these limitations, this is the first study in an area of work that has direct implications for clinical practice, outreach, and the design of treatments. All treatments are not the same from the perspective of those with these disorders. Sensitivity to their preferences and greater exploration for why they prefer some over others may be important areas to help build their engagement in treatment services.

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