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Counselling Mary about her gambling problems: A self-reliant person

Introduction

This is a case review with a slight difference. Mary M. is not a real person. She represents a composite of the "average" woman with gambling problems based on research conducted by Roberta Boughton, Problem Gambling Services, Centre for Addiction and Mental Health, (Toronto, Canada).

Like many people with a gambling problem, Mary brings a complex interplay of family genetics, personal history, precipitating life events and environmental influences to therapy. This challenges the clinician to carefully consider which element of the individual's narrative to respond to and when.

Through anecdotal data and epidemiological studies we know that problem gamblers are reluctant to seek help. A recent Ontario study found that of the estimated 318,000 people in the province with gambling problems, only 1,425 had sought help from the formal treatment system. Of those, only 975 were

problem gamblers —the rest were family members (Rush, Shaw Moxam & Urbanoski, 2002). We also know that problem gamblers often approach treatment after all other avenues have been exhausted, yet we do not really understand why. It may be the stigma associated with getting help for a mental health problem, lack of knowledge that help is available, denial of the extent of the problem, or uncertainty about what happens during the therapeutic process.

Many differing treatment models exist to explain problem gambling and guide clinicians in their delivery of care. Some models borrow from our understanding of the treatment of other addictive disorders; others are unique conceptualizations, which build on newly emerging understanding of the diverse needs of problem gamblers. Communicating the value of treatment and the hope for recovery is essential to enhance greater use of the treatment system.

This case study provides an opportunity to compare and contrast how the understanding and treatment of clients varies depending on the theoretical filter applied by the therapist. Most clients who seek professional care do not know the differences between cognitive therapy, psychotherapy, narrative therapy and the role of psychopharmacology in getting well. They only know things feel out of control. Successful treatment requires a "good fit" with the therapist and a shared belief in the efficacy of treatment, the treatment process and how it will help.

We invite clinicians to participate in this case study, to make transparent the therapeutic model that you would select based on your conceptualization of Mary's situation. Clinicians are also challenged to include a brief explanation of the therapeutic process in language that Mary and her family could understand to engage them in a therapeutic contract. Please consider your priorities of care, the therapist's role in family therapy and any additional information or assessments that would be advantageous to understand Mary's situation. Also consider what additional community supports and resources could or should be brought into play to aid her recovery and why.

Recent research is beginning to document the correlation between the availability of gambling opportunities, the various modalities of play and the rise in problem gambling prevalence rates. With the active involvement of government in both the proliferation and management of gambling activities, this presents some interesting ethical issues that challenge the traditional client-centered focus of clinical care. Mary's gambling decisions may also provoke your consideration of what role, if any, therapists have in personal and systemic advocacy with the gaming industry and government. Mary

clearly blames herself for her gambling problems, but are there issues to consider beyond personal responsibility? If so, how should these issues be handled within the therapeutic alliance and within the community?

Case study

The Ontario Problem Gambling Help-Line referred Mary to therapy. She made the initial appointment from the parking lot of the casino following what she reports as "another brutal beating at the slots." Her presenting complaint was:

"I can't control my gambling anymore, it's invading my life. I hate what has happened to me and what gambling is doing to my family and my life. Everything is a lie. I want control of my life back!"

Presentation

Mary is 46-year-old female of Anglo-Irish decent. She presented as an attractive middle-aged woman. She arrived on time and was neatly dressed and well groomed. Her thoughts were normal in form and flow. She displayed a wide range of affect throughout the assessment interview appropriate to content of conversation.

Mary reported episodes of forgetfulness and distraction. She complained of decreased appetite, of weight loss and nighttime waking, with an inability to return to sleep. She complained of increasing feelings of irritability and dread, and a loss of interest in normal activities. Although she has no active plan, she reports increasing preoccupation with thoughts of suicide: "I would never do anything but I wish that my life would just end."

Mary reported long-standing difficulty with anxiety dating back to her teens, which is currently treated by her family physician with medication. He is unaware of the presence of a gambling problem and has provided increasing doses of an anti-anxiety medication to help her "cope with my fathers' death." Mary reports a growing dependency on the medication and admits to taking more than the prescribed amount. She expressed feeling ashamed of her deception.

Mary feels that gambling has "stolen my self-esteem." Mary described the development of a gambling problem as a "complete shock…I am an intelligent, responsible person…I can't believe that I've lost control…it is a nightmare…I have to accept that I have become a compulsive gambler." Mary has always prided herself on her ability to competently manage the household finances, over which she has control. She expressed pride in her ability to

save significant amounts of money in RRSPs (registered retirement savings plans) through careful money management. Fortunately, these were placed in her husband's name to take advantage of tax savings. In retrospect, she sees this as a "saving grace," for she is certain that she would have used the money to try to win back her losses.

Gambling history

The family has a combined annual income of approximately $32,000. Mary reported being over $6,500 in debt, accumulated by credit card use, bank overdrafts and borrowing from family and friends. At this point, she reports having trouble meeting even the minimum charges on her debt and is behind in paying household bills. Creditors call frequently and are increasingly aggressive in their demands.

Mary reluctantly admits that if she had money she would probably be at the casino "trying to make things right." She is angry with herself that she can't control her gambling. Mary's husband is unaware of the extent of her problem with gambling or the amount of debt incurred. She is fearful of him finding out; this makes her "a nervous wreck." Mary reports feeling tired of maintaining the deception that everything is fine when she feels totally overwhelmed and out of control. Although her husband, Steve, is conscious that things are not quite right, he ascribes Mary's sadness and anxiety to her father's death.

In an effort to stop gambling, Mary registered herself with the self-exclusion program at the local casino. It did not take long for Mary to "test the system" and return to play. Although she is frustrated that the staff have never asked her to leave, she feels her losses are her own fault and a sign of her weakness of character.

Mary reported that gambling has always been a part of her life. She recalls going to the community bingo hall with her mom and a time when the family bought a weekly lottery ticket. Fantasizing about winning a million dollars in the lottery was a frequent game with her family. Mary's problem with gambling began with the introduction of the casino into her community three years ago. Mary and her friends and neighbours all saw it as an exciting opportunity to create needed jobs and bring tourist dollars into their community. Mary occasionally visited the casino with her girlfriends as part of a "girls' night out." The bright lights and excitement dazzled her. Initially she set a spending limit and had no difficult keeping to it, but things rapidly changed following the death of her father. At the same time, her husband began a job as a long-distance trucker and was away from home more often.

Mary reports that she plays approximately $25 each week in break-open

lottery tickets and experiences an average loss of $250 per visit to the casino to play the slots. At first, Mary went once a month with friends, but lately she has gone two or three times a week on her own. She says that while playing on the machines her mind completely empties and she feels vaguely soothed by the rhythmic quality of play. "When I sit down at a video lottery terminal, I don't see anything else around me. I feel nothing…nothing matters but playing the game." But Mary notes that when play stops and she appreciates the reality of her losses "…life crashes down upon me…I go to bed and pull up the covers, hoping that when I wake up, it will all just be a bad dream. But it's not, and even though I don't want to, I go back to the casino and try again."

Mary reported playing 18 hours straight at the same slot machine without interruption. Her son Terry was concerned when she failed to return home that night. The next day, Mary broke down in tears, told him about her gambling and swore him to secrecy about her problem. Mary recognizes that this is causing increased tension within the family and weighs heavily on her son. Mary has noticed that Terry is becoming more withdrawn and sullen and she fears this is related to her gambling problem. She reports this fear as a major motivator for her seeking help. Mary's friends are unaware of the degree of her gambling problem and this secret leaves her feeling isolated from both family and friends.

Mary described with great enthusiasm a "big win early on in her play. Playing her "lucky machine" she won over $10,000, which she spent on a family holiday and shared amongst her family and friends. Mary enjoyed the attention she received and loved being able to treat her family to a "luxurious vacation with all the trimmings."

Approximately two years ago, Mary's father developed lung cancer. She cut down her hours working as a cashier to help her mom care for him at home. Although he was drinking less by then, he was still a difficult man to care for. When he died, Mary described an overwhelming sense of relief.

Personal history

Mary reports being happily married to Steve for the past 26 years. They live together in their own three-bedroom home in the same small town where they were born. Mary and Steve started dating in high school and married two years after graduation. They have three grown children, ages 25, 23 and 18. Their youngest son lives with them while he completes school. Her two daughters moved away before their grandfather became ill. Both appear to be happy and well adjusted.

Mary is the eldest and only daughter of four children. She described her father

as a "hard drinking, hardworking man" who was prone to aggressive flare-ups when drunk. Although violent with her brothers, Mary reports her dad never hit her or her mom. Her mother was a stay-at-home mom, with whom Mary reports having a close, loving relationship. Although her mother was never treated for depression, Mary suspects that there were periods of illness throughout her life. At times her mother became irritable and withdrawn and would take to her bed for what seemed to Mary like months on end. Her periods of depression were never discussed inside or outside the home. When her mom was well they would go out together to the local bingo hall. At these times, her mom was friendly and outgoing, and appeared to be well liked in the community.

Mary expressed pride in her ability to support the family when her mother "was not herself." As a teenager, she cooked meals and cared for her younger brothers. She wanted to make things seem as "normal as possible" and keep her brothers out of "the line of fire." During this time, she took a job as a cashier at the local grocery store. Again, Mary expressed pride at her ability to responsibly hold a job, care for her family and save money.

During high school, Mary described periods where she felt highly anxious "but nobody would ever know." Mary was a good student, worked hard and achieved good grades. She participated in school activities and had a number of friends but never felt she could trust anyone enough to let them know what was going on at home. It was at this time she started to date Steve who was her one and only boyfriend. Mary was attracted to Steve because he was "steady, hardworking, and had a friendly, kind nature."

Mary reports that two of her brothers have adjusted well; they are working and married, with families of their own. They do not live in the same town and Mary sees them only on special occasions. She reports that one brother is a heavy drinker, unable to hold a steady job and has had two "failed" marriages.

Mary describes herself as a sociable and outgoing person with a number of female friends. But Mary reports that she currently has no interest in seeing her friends because of her "shameful problem." Being with others feels like a chore. Mary does not participate in any of her previous interests.

For the first time in her marriage, Mary feels cut off from her husband. Probing revealed a deep-seated fear that her husband would leave her if he knew the extent of her problem. He has always spoken contemptuously of people, like her brother, who were "too weak to stop drinking" and believes they should "just pull up their socks" to overcome their problems. From his perspective, discipline, hard work and family are all that a person needs to live a good life. Without Steve, Mary feels there would be no purpose in living. Her shame at

being "weak" and her fear of Steve leaving her have contributed to both the secrecy of her addiction and (unsuccessful) attempts to "win back" her losses.

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case study

[This Responses portion of the case study conference prints out to about 14 pages.]

Case study conference —Responses by clinicians

Counselling Mary about her gambling problems: A self-reliant person

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Addressing medical aspects, targeting the gambling behaviour, managing urges, preventing relapses and developing new coping skills

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Addressing medical aspects

Comorbidity with mood disorders is more common in females than males seeking treatment for pathological gambling. In the present case, Mary clearly is undergoing a major depressive episode. Her symptoms include loss of interest in usual activities, irritability, decreased appetite with consequent weight loss, terminal insomnia, reduced concentration and memory, and suicidal thoughts.

It is not clear if the depression antedated the onset of problem gambling three years ago, as no information is provided regarding the progression of depressive symptoms. Even acknowledging that the gambling problem and its consequences (debts and fear of disclosure, among others) might have had an impact on triggering this depressive episode, at this point, it has probably acquired an autonomous course and requires specific treatment. It could also be that depressive symptomatology (linked to her father's death) would render her more vulnerable to the development of a gambling addiction. Either way, adequate management of depression is crucial to the outcome of the gambling treatment, as Mary's depressive symptoms may directly (loss of interest, for instance) or indirectly (cognitive difficulties, such as reduced concentration and memory) make it difficult for her to participate in and benefit integrally from gambling treatment.

Antidepressants, such as a selective serotonin reuptake inhibitor (SSRI) would be appropriate pharmacological treatment. An assessment of her history of anxiety symptoms since adolescence is warranted, and communication with her family doctor is essential to obtain details regarding the medication Mary takes for anxiety. That Mary takes more medication than prescribed indicates she may already have developed a dependency problem with the medication. Individuals with an addiction problem should not be prescribed potentially addictive medications, such as benzodiazepines (BZD).

Also, no indication supports the long-term prescription of BZD in any condition. Unfortunately, female clients are more at risk than male clients of being prescribed benzodiazepines. In addition to having increased the risk of developing another addiction problem, long-term use of BZD may have worsened Mary's depressive symptomatology (particularly cognitive features).

Also, if the anxiety symptoms are intense enough to warrant specific treatment, given the duration of the symptoms, a non-habit forming medication such as an SSRI is more appropriate. Among SSRIs, no clear evidence suggests specific medications that would be more effective. In addition to the effect on the depression, preliminary evidence shows that some SSRIs may be useful in the treatment of pathological gambling, particularly in the short-term (e.g., fluvoxamine and citalopram).

Mary's mood assessment should also include her menstrual history, noting mood fluctuations within the menstrual cycle and hormone levels (e.g., estrogen and progesterone) as well as checking thyroid functioning. These steps are best accomplished by working closely with physicians with addiction expertise in the community. Clinicians and physicians should communicate regularly regarding shared cases in treatment to ensure continuity of care.

Targeting the gambling behaviour

The gambling behaviour needs to be addressed, and at the same time, the first medical steps must be taken as described above. The approach has to take into account that Mary does not begin treatment at the full capacity of all her psychological resources. Hence, a supportive feature will prevail in the initial phase of the therapeutic intervention. This is precisely where problems arise. To have further support, Mary has to disclose her gambling behaviour.

The secrecy over gambling may have a double meaning. It may be the result of negative consequences brought about by gambling, but it may also reveal an ambivalent motivation towards gambling abstinence. Moreover, the secret enables the gambling. Motivational sessions are needed until the client agrees to share her problems with her husband or another close relative. Pros and cons of keeping the secret must be addressed in a non-judgmental fashion.

Treatment must challenge misperceptions about breaking even as well as hopeless strategies to predict outcomes on games that are random by nature. Building a log of the last gambling episodes could help Mary realize that the sum of her gambling winnings did not cover the sum of her losses. This is called a negative rate of return. The therapist should stress that gambling machines are programmed to operate this way; therefore, losing money is not the result of a lack of skill. The logical conclusion most likely to come out of this process is the knowledge that her gambling activity will be uncovered sooner or later by the mounting debts, but the sooner it stops, the lesser the harm. At this point, the patient should be willing to accept the following suggestions:

- a conjoint session with her husband or a close relative of her choice

- the temporary avoidance of gambling cues, such as handling chequebooks, credit cards and other means of access to money.

Managing urges, preventing relapses and developing new coping skills

No matter how hard disclosing the secret may be, patients usually experience a strong feeling of relief after it is done. Yet, the abstinence prompted by these initial steps has to be regarded only as a window of opportunity, not as the magical cure some patients and families fantasize about. Internal and external triggers for gambling urges have to be investigated and addressed; a debt management strategy has to be put in place; and high-risk situations need to be identified and preventative strategies established. Therapist and client may want to rehearse some of these strategies. Clients must explore alternatives for leisure. Getting acquainted with relaxation techniques and developing stress coping skills are warranted, particularly among female gamblers since they report a greater proneness to anxiety and depression. The family has to be further educated on the nature of pathological gambling and how to support recovery.

A treatment program for gambling should be able to provide these interventions; nonetheless, if Mary's community lacks such a program, she should seek out alternatives. Self-help groups such as Gamblers Anonymous (GA) and Gam-Anon cover most of the needs described above. Female clients have reported difficulties fitting in at GA; however, the profile of gamblers is rapidly changing, with more women gambling nowadays. Consequently, a greater proportion of women now attend GA meetings. Clients should try different meetings before rejecting self-help groups. If difficulties persist, Mary still has the option of women-only groups such as Women for Sobriety. Searching for complementary support from community resources is a must-do, as recovery usually takes years, and treatment programs, even where available, are unlikely to last that long.

Submitted: April 25, 2002

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..Mary appears to be typical of the women I have seen

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I am interested to learn from others in the field who work with female gamblers. I apologize that, unfortunately, my response is to be short and to the point. Presently I am busy writing my final project to complete master's degree requirements; this area has been my focus for the last several months, and continues to be so.

I have worked with over 300 female pathological gamblers to date and Mary appears to be "typical" of the women I have seen. My first priority with Mary would be to encourage her to "fess up" to her family physician. Many women are embarrassed and ashamed to admit to their family doctor that they have been gambling excessively. If Mary refused, I would encourage her to be assessed by one of the psychiatrists at the clinic where I work to rule out depression. I would be concerned as Mary is displaying many of the symptoms of a clinical depression. I would also be very concerned about the medications she is prescribed.

My second priority would be for Mary to have her spouse, Steve, accompany her to an appointment with me. I find that most women resist their husband's knowing, and yet, once the gambling problem has been revealed, their stress level decreases. I would want to explain to her husband in plain language,

without jargon, how, initially, gambling may be fun and exciting but can become stressful and lead to financial loss and escapism. Most spouses I have worked with were unaware of their wife's dilemma and are understanding when they find out. I would also stress the importance of communication and refer them for marital counselling as well as family counselling, since their son has been triangulated into the "problem" by having to pick sides and keep secrets. I would also encourage their son to come for counselling at the next session and encourage the family to talk with each other.

I would also address the importance of limiting access to money and accountability for the money Mary does access as well as for her time. Most women are hesitant when it comes to this topic and are resistant to have their spouses "control their lives." I would encourage Mary to attend my all-female gamblers group or Gamblers Anonymous (GA).

The non-GA group that I conduct has several members in long-term recovery. It appears that most women who enter the group will take direction from a peer rather than from myself (an authority figure). The group that I facilitate is not a 12-step program but an opportunity for the women to discuss issues that are of importance to them in a group setting. We work on self-esteem, confidence building, ways to deal with urges to gamble, conflict resolution and healthy coping methods. The issues discussed are important to the women themselves and they have a choice in what we discuss.

I would also discuss self-banning from the casino for Mary. Unfortunately, she has experienced the lack of enforcement that so many others have also encountered with self-exclusion programs. I would also encourage Mary to take responsibility and to avoid driving or walking by the venues where she likes to gamble. I would encourage Mary to replace the gambling activity with other activities. Like many others, Mary has learned to use gambling as a quick fix to her problems and must now learn to incorporate healthy activities and stress-reducing tactics.

From my experience, eliminating gambling from one's life takes time and patience. The more support Mary has from family and friends the easier this daunting task will be. Initially, I would see Mary on a regular basis and then reduce individual appointments to a less frequent basis as long as she attended groups. Mary has many issues she needs to discuss and work through, which will take time.

In short (very short), this is how I would initially work with Mary. I would appreciate feedback or suggestions from others. Thanks for the opportunity to participate.

Submitted: May 13, 2002

Evelyn McCaslin is a problem gambling counsellor with the Regina Qu'Appelle Health Region in Saskatchewan. She has counseled pathological gamblers since 1997, working with individuals and family members. Evelyn facilitates an all-female gambling support group and co-facilitates a dual diagnosis group. She is a registered social worker and recently completed a masters degree in educational psychology.

Using Wilber's developmental approach in working with Mary

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Wilber's Spectrum of Development Model

Wilber's (1977, 1986, 1990, 1995, 1997, 2000) spectrum of consciousness model mapped out nine stages, or levels, in a developmental, structural, holarchical, systems-oriented format. Wilber synthesized the initial six stages from the cognitive, ego, moral and object relations lines of development of conventional psychology, represented by such theorists as Piaget (1977), Loevinger (1976), and Kohlberg (1981), and the final three stages from Eastern and Western sources of contemplative development. Wilber's model is unique in that not only is it a developmental spectrum of pre-personal, personal and transpersonal consciousness but also a spectrum of possible pathologies, as there are developmental issues at each stage. It is a model that allows us to integrate many of the Western psychologies and interventions. Originally used for mental health issues (Wilber, 1986), it has now been applied to substance use issues (Nixon, 2001), and this case study looks at the application of this model to gambling issues. Here is an outline of

the first six stages of the developmental model as they apply to working with Mary on her gambling issues.

Pre-personal stages

The first three stages of development, all pre-personal stages, are sensoriphysical, phantasmic-emotional and rep-mind (Wilber, 1986). The first stage, sensoriphysical, consists of matter, sensation and perception. Pathologies at this level need to be treated with equally basic physiological interventions, as the whole point is to stabilize the person. In addictions treatment, this typically means detox programs; for gamblers, some form of physical exclusion from the casinos.

The second stage, phantasmic-emotional, is represented by the development of emotional boundaries to self (Wilber, 1986). Problems at this stage show up as a lack of cohesive self. The self treats the world as an extension of the self (narcissistic) or is constantly invaded by the world (borderline). Typical interventions focus on ego- and structure-building techniques, such as object relations and psychoanalytic therapy. In addictions treatment, 12-step programs can provide a structured format and focus on the selfishness of the person's lifestyle. Chronic cocaine users can regress to this core narcissistic level; an interesting issue is whether pathological gamblers regress to this level as well.

The third developmental stage is rep-mind (Wilber, 1986). This stage represents the birth of the representational self. This is typified by the development of the id, ego and superego and intrapsychic structures. Problems at this level are experienced through psyche splits, such as issues of inhibition, anxiety, obsession, guilt and depression. Interventions focus on intrapsychic resolution through awareness of cognitive distortions, stress management, assertiveness training and feeling awareness.

Personal stages

The pre-personal stages are followed by rule/role, formal-reflexive and vision-logic stages of development and represent the mature ego developmental phase. The rule/role phase, Wilber's fourth stage of development and first personal stage, is highlighted by individual development of rules and roles to belong. A person's stance is becoming less narcissistic and more sociocentric (Wilber, 1986). Because problems at this level are experienced as a fear of losing face, losing one's role or breaking the rules, typical interventions center on script pathology, such as transactional analysis, family therapy, cognitive therapy and narrative therapy. At this level, a person with gambling issues may have developed a whole set of unique roles and rules to support an

addictive lifestyle.

The next personal stage and fifth overall, formal-reflexive, represents the development of the mature ego (Wilber, 1986). A person at this level has a highly differentiated, reflexive self-structure. At this stage, identity issues need to be explored and the processes of philosophical contemplation and introspection need to take place. At this stage, the underlying identity of a person with an addiction can be challenged. The next stage of development, the final personal stage and sixth overall, is the vision-logic or existential stage. Here, the integrated body-mind confronts the reality of existence (Wilber, 1986). Thus, we see a concern for the overall meaning of life, a grappling with personal mortality and an effort to find the courage to be. At this level, a person may be forced to deal with the emptiness of their addictive lifestyle.

The first six stages culminating in the vision-logic or existential stage represent conventional Western psychology. To this conventional scheme of development, Wilber (1986, 2000) also added psychic, subtle and causal contemplative levels that represent psycho-spiritual levels of development.

Counselling Mary using a developmental model

Wilber (1986) makes the point that counselors using the developmental model must start with the basic levels first to avoid an elevationalist stance. It is evident that Mary is out of control with her gambling. So, at a basic sensoriphysical level, it is important for Mary to have strategies to avoid gambling in the casino. Self-exclusion appears not to have worked for Mary. A referral to Gamblers Anonymous may be helpful in giving Mary a place to turn to other than the casinos. A financial management program in co-operation with her husband may be the best option, but Mary may need a few counselling sessions before she feels she can disclose her gambling problems to him.

The big win can be a moment in time that any gambler constantly tries to recreate. At the time of winning her $10,000, Mary felt she had the answer. In our counselling session, we would recreate the glory of that moment so Mary could recognize her thoughts and feelings about that "big win," which she has been trying to recreate ever since. Mary could be challenged to view this as a counterfeit way to being a success, just as Grof (1993) observed that substance abuse can be a counterfeit quest for wholeness.

The real clinical work with Mary, however, would begin with the intrapsychic work of the representational mind (level three). At this level, Mary could begin to examine the thought processes that keep her preoccupied with gambling. A

cognitive therapy approach could be used to teach Mary about the cognitive distortions she embraces when she is gambling, such as chasing losses and other distortions she uses to convince herself her luck is about to change. Mary could be asked to log her distortions.

In addition, Mary is having thoughts of suicide. A split in the psyche can represent conflict at this level; Mary's super-ego is overfunctioning with strong critical messages. An empty chair technique from Gestalt therapy could be used with Mary in which her normal self and her critical self are split off into two chairs. Therefore, Mary could see how huge and negative her critical voice is. This awareness of her critical self could be expanded to deal with the theme of anxiety that has haunted Mary her whole life. Mary could learn just how much her critical voice has shut her down in life and begin to reframe her anxiety as energy when she begins to become more aware of her split off judging part. We could also work on recognizing that gambling has served as a sanctuary to escape all of this psychic tension, including, perhaps, the recent grief of her father dying and her anxiety.

As the counselling work progressed, the process could now look at the rules and roles Mary has embraced in life (Wilber's fourth level). As Feinstein and Krippner (1988) asked, what has Mary's mythic journey been like? Mary could be asked to talk about the family myths she grew up with. She might describe learning to be a harmonizer to deal with her dad's drinking. She might have learned to take care of everybody and adopt the martyr role in her family. Taking care of others and putting others needs ahead of hers is a myth she might have carried into her adulthood. We can process what it means to be the mother and how she has always been there for other people. At this point, it might be important to consider the feminist perspective in that she has served as a nurturer and a mother her whole life, yet at a societal level, this role can be devalued. Mary could be asked if she has ever had any time for herself; she could be encouraged to start exploring personal passions and interests.

At this point in time, it may be important to involve Mary's husband in the counselling process. Hopefully, she would now have the strength to disclose her gambling history and be able to process any shock and anger her husband might feel about the lost money as well as the strength to get him on board in both her recovery plan and money management issues.

While the family therapy work could take up a number of sessions, it would be important for Mary to continue her individual counselling work. She would need to continue to monitor her work so far, including the cognitive therapy work around her distortions and watching her critical voice. Mary might be ready to do the introspective work of level five: asking who she really is. She

has been a wife and mother, a good money saver all her life, and recently, she has fallen into the gambling track. Who does she really want to be? The pull of gambling can be about so many unmet needs in Mary's life. Can she have the courage to look at those unmet needs of her own journey? Mary could be encouraged to look at herself beyond the mother and nurturer archetype.

This would naturally lead to the existential level (level six) in which Mary could look at what gives meaning in her life. It is clear that she loves her husband, and her family gives her tremendous meaning in life. But using a Frankl logotherapy approach (Frankl, 1985), maybe Mary could look at what steps she can take to increase the meaning in her life beyond these roles. She may have passions, hobbies or career interests that she has put on hold for a long time. She may have psycho-spiritual needs that she wants to investigate. Obviously, this would be a time to look at terminating the counselling process, as Mary would now be into her life journey herself and doing much exploring beyond the counselling process.

A concluding note

This clinical case study response is designed to show how using a developmental approach allows for an integration of multiple perspectives, in that one technique or approach does not work for all issues of the client. In this response, cognitive, gestalt, family, Jungian and logotherapy perspectives are combined to deal with a person with a multitude of gambling-related issues.

Submitted: May 15, 2002

Gary Nixon followed a brief legal career by pursuing master's and doctoral degrees in counselling psychology. Initially attracted to the humanistic traditions of Rogers and Maslow, in the late 1980s he became excited about Wilber's transpersonal developmental approach as a tool for integrating schools of psychotherapy. Since completing his doctorate in 1993, Gary has worked in addictions and mental health settings and joined the faculty of the Addictions Counselling Program at the University of Lethbridge in 1998. He currently researches quantum change in recovery and gambling mythic structures and

archetypes and explores clinical applications of Wilber's developmental approach. Gary also maintains a private practice.

Mary is at a crisis point…

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Mary appears to be a high-functioning woman who, up until three years ago, had strong relationships with family and friends and has always had steady employment. She was responsible and took good care of herself, her family and her finances. However, her family of origin was not so positive; it included alcoholism and depression in her two parents, which left her in a position as eldest of having to care for her family at an early age without getting the support she needed herself. Mary developed an anxiety disorder around this time. Positive times with her mother were associated with gambling.

Mary's increased gambling appears to have been precipitated by the introduction of a gambling venue near her home, her father's illness and death, and perhaps fewer demands for her at home: her children were growing up and moving out and her husband was around less due to changed hours. An early big win probably helped tip her into problem levels of gambling.

Mary is at a crisis point with regard to her gambling for several reasons: her son is showing the effects of holding this secret for her; her debts are becoming too pressing to conceal; she is afraid her husband will reject her if he finds out about her problem; her self-esteem is suffering severely; and she feels out of control of her life. However, she has not yet reached the point of deciding to change her gambling behaviour.

If I were seeing Mary, I would be addressing this decision point. This is a time for motivational interviewing. I would encourage her to explain her concerns about her gambling and the effects it was having on her life and those around her. I would ask her about the consequences of either continuing to gamble or quitting. We might do a decision matrix. Although I would gather information

on the anxiety disorder and family history, I would not spend a lot of time on them initially. As a gambling counsellor my role would be to explore the immediate gambling problem first, and try to move toward getting it under control before tackling other issues. With someone as articulate and high functioning as this, the other problems are unlikely to be so disabling as to block practical strategies for change.

Assuming that Mary did move from contemplation into preparation, we would contract for some period of abstinence at the beginning, and then, plan together the best means of avoiding gambling. Barriers would be discussed. It might be helpful to find some way to reinforce self-exclusion so that the casino could be counted on to recognize and bar Mary in the future. During this time, I would encourage her to spend time with at least one friend, despite her discomfort. I would also engage Mary in looking at non-harmful ways to escape her troubles for a brief time.

I would suggest bringing in her family, and would try to help her through the decision-making process around "if" and "when" to tell her husband. This might take some time, but concern for her son would be a good lever. If her father and/or her children came in, my role would probably include education around problem gambling and help in processing their anger, hurt, disappointment, grief and loss of trust. Since the relationships have been positive, I would support the family in returning to previous good levels of communication.

The issue of Mary's medication would need to be addressed; I would refer her back to her doctor, or to a specialist in anxiety. I would address other issues arising out of her family of origin as they emerged; I suspect that over-responsibility would be an important issue. Mary might have difficulties accepting any weakness in herself and might be reluctant to allow others to support her because of parentification early on.

Submitted: June 19, 2002

Nina Littman-Sharp, MSW, CGC is the manager of the Problem Gambling Service of the Centre for Addiction and Mental Health. She has worked in addictions for 16 years and with gamblers for eight. Nina is involved in a wide variety of clinical, research, training, outreach and public education efforts. She has made presentations and written on many gambling topics, including strategies for change and relapse prevention, gambling and attention deficit

disorder. She is a co-developer of the Inventory of Gambling Situations, an instrument that assesses areas of risk for relapse. Nina moderates a 330-member international listserv for problem gambling professionals.

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[This Response to clinicians' comments prints out to about 15 pages.]

Introduction: Counselling Mary about her gambling problems

Responses by clinicians

Case study conference —Summary and Reference

Response to clinicians' comments on Introduction: Counselling Mary about her gambling problems

By Neasa Martin
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What makes Mary unique? Certainly not the profile of problems she presents in treatment; Mary reflects the "average" female gambler. Mary is unique because she has actually sought out treatment, something the "average" female problem gambler is not doing in droves!

Like many before her, Mary is at an important crossroads of intersecting problems. Her unique biology, family history of abuse, altered life roles and changed environment have all contributed to developing problems that have

tipped the balance in her capacity to cope. The therapist's challenge is to consider which avenue to pursue and when.

Mary does not know how to gain control of her gambling or how to make sense of her unravelling life. She is surprised to find herself in difficulty. Successful therapy is a dynamic partnership that hinges on a shared understanding and agreement between the therapist and client in defining the problem and how to move forward. Through this case study I hope to gather some current insights and ideas from treatment experts on how therapy can help Mary.

However, the current low rate of access to treatment provokes my interest in extending our thinking beyond the walls of existing treatment programs to consider how therapists can reach people with gambling problems through the development of self-directed resources, involvement within the community to promote public awareness and at a systemic level, to reduce the potential for harm.

I would like to thank Nina Littman-Sharp, Evelyn McCaslin, Gary Nixon, Hermano Tavares and Monica Zilberman for sharing their wisdom in treating Mary. While there are many similarities in the approaches recommended, there are also marked differences in the contributors' recommendations.

An overview

Nina Littman-Sharp notes in her response that Mary's gambling is at a crisis point; her son is showing negative effects from withholding her secret, her debts are becoming too pressing to conceal, she is afraid her husband will reject her, her self-esteem is suffering severely and she feels that her life is out of control.

Littman-Sharp also recognizes that Mary brings many strengths and capacities to therapy, which can be supported, reinforced and built upon through treatment. To quote her: "Mary appears to be a high functioning women who, up until three years ago, had strong relationships with family and friends and has always had steady employment. She was responsible and took good care of herself, her family and her finances."

Beginning therapy by sharing with Mary a vision of her wholeness as a competent person who is struggling with difficult problems, but within a context of great strength, will help to lay a balanced, empathic approach to moving forward as partners in therapy. It will instill a sense of hopefulness in Mary that her active participation in treatment will restore her sense of well-

being. Understanding that therapy is not something that is done to her, or over which she has no influence, will also help instill a sense of personal ownership of and responsibility for managing her gambling problem, but with support and resources available to help with this task. "You alone can do it, but you can't do it alone," is an important message for people with gambling problems who seek magical solutions for life's problems while, simultaneously, they fear the dependency of a therapeutic alliance.

Biological aspects

Let us start by considering Mary at a biological level. Given her family history she may well be burdened by a major depressive disorder that both renders her vulnerable to and can keep her stuck in problem gambling behaviour. The changes she reports in thinking (forgetfulness, distractibility), feeling (anxiety, irritability, dread, hopelessness, shame, suicidal urges) and physical changes (sleep disturbances, weight loss, decreased interest in previously enjoyed activities) all point to a major depressive episode. Her family history of depression, substance abuse and her personal history of emotional trauma place Mary at high risk for depression. Unfortunately, it can be easy to overlook the presence of a major depressive disorder as readily explainable events could account for Mary's presenting depressed and anxious moods. When left untreated, depression compromises the efficacy and responsiveness to treatment, and in combination with substance abuse and dependence, seriously increases the risk for suicide. Depression worsens problem gambling, problem gambling worsens depression, and prolonged problem substance use worsens both.

Research suggests a positive correlation between problem gambling and the presence of mental illness in the client's family. In U.S. studies, problem gamblers were found to have two times the rate of major depression compared to recreational gamblers, and other studies revealed pathological gamblers in inpatient settings have rates of depression as high as 50% to 75% (Linden, Pope & Jonas, 1986; McCormick, Russo, Ramirez & Taber, 1984). In comparison, depression in the general population is estimated at 10% to 25% (Parikh & Lam, 2001). Family histories of mood disorders are frequent, with one-third of pathological gamblers reporting a biological parent or sibling with a major mood disorder (Roy et al., 1988; Linden et al., 1986).

Monica Zilberman and Hermano Tavares in their response note that "it is not clear if the depression antedated the onset of problem gambling three years ago… Even acknowledging that the gambling problem and its consequences (debts and fear of disclosure, among others) might have had an impact on triggering this depressive episode, at this point, it has probably acquired an autonomous course and requires specific treatment."

They comment further: "It could also be that depressive symptomatology (linked to her father's death) would render her more vulnerable to the development of a gambling addiction. …Either way, adequate management of depression is crucial to the outcome of her gambling treatment, as Mary's depressive symptoms may directly (loss of interest, for example) or indirectly (cognitive difficulties, such as reduced concentration and memory) make it difficult for her to participate in …treatment. Antidepressants such as selective serotonin reuptake inhibitors (SSRI) would be appropriate."

Zilberman and Tavares also note that "individuals with an addiction problem should not be prescribed potentially addictive medications, such as benzodiazepines (BZD) " and that "no indication supports the long-term prescription of BZD in any condition. Unfortunately, female clients are more at risk than male clients of being prescribed BZD."

Zilberman and Tavares recommend the use of SSRIs because they may have the additional advantages of alleviating Mary's depression and addressing her longstanding anxiety, they are non-addictive and preliminary evidence suggests they may also prove useful in treating pathological gambling, particularly in the short-term (e.g., fluvoxamine and citalopram).

However, they also recognize that other physiological processes can alter mood, including hormonal changes associated with menopause and thyroid function, which should be assessed by her physician.

A shared care approach

The family physician remains the single most important point of contact for people with mental health and addictions problems. Problem gambling therapists are well advised to work within a "shared care" model and build upon this primary element of support, which Mary has relied on over many years.

In her response, Evelyn McCaslin notes that Mary is typical of the women she sees in therapy. McCaslin's first priority would be to "encourage her to 'fess up' to her family physician." Like Mary, McCaslin says "many women are embarrassed and ashamed to admit to their family doctor that they have been gambling excessively." McCaslin would want Mary to be assessed to rule out depression and expressed that she "would also be very concerned about the medications she is prescribed." A psychiatric assessment performed by a mood and anxiety disorders specialist would be highly desirable.

If Mary's gambling activity temporarily alleviates her depression and contains

her anxiety, then she may be less willing to stop gambling or give up the use of BZD and risk suffering the psychic pain of untreated illness. Helping Mary understand the link between mood and gambling and her familial vulnerability to depression as well as providing her with reassurance that relief will be forthcoming may also make her more receptive to changing her gambling behaviour. That said, addressing the medical issues does not preclude targeting the problematic gambling. Instead, it provides Mary with empathic support and helps bring her full psychological resources into play to address her gambling behaviour.

Theoretical approaches provide a road map

Mary's case is complex. Various theoretical models were proposed by participants, which provide a useful road map in deciding suitable approaches.

Gary Nixon in his case response proposes using Wilber's developmental approach in working with Mary. Originally used for mental health issues it is now applied to managing disordered substance abuse. He sees its potential value in treating gambling issues. Nixon's sophisticated model is distilled here into the core elements that apply to Mary's care.

According to Nixon, Mary's problems are addressed within the Wilber model in a sequential fashion that mirrors developmental phases of cognitive, ego, moral and object relations lines of development as well as higher order contemplative development. In this way, Nixon believes that many Western psychologies can be successfully integrated into care in a rational and coherent fashion.

Nixon advises that Mary's care starts with physiological interventions to introduce stability; they include physical exclusion from gambling facilities, moves towards ego- and structure-building techniques, which could involve the use of 12-step programs to give Mary a place to turn other than the casino. Additional structure is introduced through a financial management program in cooperation with her husband.

At the third stage within Wilber's framework, after addressing Mary's physiological needs, a therapist can help her develop healthy intrapsychic structures (i.e., ego, and super ego), addressing her anxiety, depression, obsessions and guilt related to gambling through building self-awareness, challenging cognitive distortions, assertiveness training, and teaching stress management and feeling awareness. "In our counselling sessions, we would recreate the glory of that moment so Mary could recognize her thoughts and feelings about that 'big win,' which she has been trying to recreate ever

since."

Building on this strong foundation shifts Mary's focus outward in the next phase of therapy by addressing individual rules and roles for belonging. At this point, the therapist can draw upon transactional analysis, family therapy, cognitive therapy and narrative therapies. The goals are to restore lost roles and develop a new, healthy lifestyle to replace the emptiness of the lifestyle being left behind. Nixon proposes addressing Mary's suicidal thinking by exploring her strongly critical, over functioning super-ego. This will help her to see how huge and negative her critical voice is so she can then begin to monitor and tame it.

The final existential level is to help Mary explore issues of self identity, uncovering unexplored passions and undeveloped roles beyond her love of family, which will help Mary identify and become the person she wishes to be. Beginning the dialogue of finding meaning in life and responding to psycho-spiritual needs launches Mary into her own life journey beyond the bounds of the counselling process.

The pathways model of problem gambling described by Alex Blaszczynski (1998) provides a useful approach. It uses a developmental approach to allow for the integration of multiple perspectives and suggests that all people do not develop gambling problems by the same route. Some gamblers have distorted concepts and ideas about gambling, predict erroneous outcomes and place themselves at risk (Pathway 1). Others have personal and emotional vulnerabilities that play a contributing role (Pathway 2). Yet others have impulse and personality disorders that increase their risk for addiction (Pathway 3).

Within this framework, I believe Mary would be considered a Pathway 2 gambler, whose pre-existing psychological factors, inadequate role models, past trauma and depression or anxiety leave her vulnerable to developing gambling problems. Gambling has helped her relieve anxiety, find an escape from interpersonal and intrapsychic problems and instill a sense of hope in coping with difficult events (i.e., her father's death, an absent husband). Cognitive therapy would be used to manage her gambling and psychotherapy to deal with past trauma and loss, in either an individual or group setting.

The stages of change model (Prochaska, DiClemente & Norcross, 1992) proposes that clients move through predictable stages in resolving their addictive behaviour. The client will move back and forth through the pre-contemplative stage, where they are unaware, under-aware or unwilling to do anything about their problem, to the contemplative stage, where change is considered and planned for, towards the preparation, and finally, the action

stage, where they work to maintain new healthy behaviours. The client does not always come to therapy ready to change their behaviour. The task for the therapist is to accurately gauge where a client is and to match interventions appropriately.

As Littman-Sharp notes, "Assuming that Mary did move from contemplation [of reducing her gambling] into preparation, we would contract for some period of abstinence at the beginning, and then, plan together the best means of avoiding gambling. Barriers would be discussed. …During this time, I would encourage her to spend time with at least one friend, despite her discomfort. I would also engage Mary in looking at non-harmful ways to escape her troubles for a brief time."

Motivational interviewing

Ambivalence is a characteristic of the problem gambler. The drive to win and the thrill and relief felt during play can overwhelm the desire to avoid the negative consequences of gambling. The motivational interview helps clients recognize the problem behaviours and strategize ways to manage them.

While Mary actively sought out treatment, her willingness to give up gambling remains unclear. Littman-Sharp recommends using this current crisis as a time for motivational interviewing as defined by Miller and Rollnick (1991). "I would encourage her to explain her concerns about her gambling and the effects it was having on her life and those around her. I would ask her about the consequences of either continuing to gamble or quitting." She suggests the possibility of using a decision matrix (Soden & Murray, 1993).

Secrecy "enables the gambling," note Zilberman and Tavares, and it can often indicate an ambivalence to quit. Mary is keeping secrets from her doctor, her husband and her friends; a willingness to give up the "secret" becomes an important indicator of motivation to change.

Helping Mary to consider the risks and rewards of giving up her secret must be done within a non-judgmental and supportive environment. Mary is clearly concerned about the negative impacts that her gambling and associated secrets are having on her son, which could provide a valuable lever for change. But she is also concerned at the risk of disclosure to her marriage. This fear is best addressed by exploring the risks and rewards of moving forward.

Gambling is a family problem

Bringing the family into therapy can accomplish a number of ends, as pointed out by all respondents, including education around problem gambling and support in processing the anger, which can accompany disclosure of the financial consequences, as well as feelings of hurt, grief and loss of trust. Building on Mary's previously close relationship with her husband and restoring open communication between family members will help to recruit the support Mary will need in managing her finances and gambling addiction.

As McCaslin notes, "I find that most women resist their husband's knowing, and yet, once the gambling problem has been revealed, their stress level decreases. I would explain in plain language …how, initially, gambling may be fun and exciting but can become stressful and lead to financial loss and escapism. …Their son has been triangulated into the 'problem' by having to pick sides and keep secrets."

Sharing the gambling secret can bring immediate relief and open up a window of opportunity for change, but rarely does it bring the "magical cure some patients and families fantasize about," say Zilberman and Tavares. Learning to manage urges and developing strategies to prevent relapse and new coping mechanisms become important next steps in therapy.

"You are not alone"

Sharing the gambling secret does not come easily and many people benefit from practicing disclosure within self-help groups such as Gamblers Anonymous or Women for Sobriety. In a safe, supportive environment, gamblers share their experience without fear of judgment, gain comfort in knowing they are not alone, learn coping strategies, build confidence, give and provide support to others who are struggling and they are challenged by their peers when denial or minimization of their problem places them at risk. This positive experience can empower people to share their experiences and concerns more openly with others. The Internet is also opening up opportunities for sharing and peer support and affords people a level of autonomy and privacy that is highly valued.

In addition, groups also provide a wider base of long-term support to draw on. As Zilberman and Tavares point out, "Searching for complementary support from community resources is a must-do, as recovery usually takes years, and treatment programs, even when available, are unlikely to last that long."

Teach a man to fish…

Most gamblers have misperceptions about the nature of gambling and the

likelihood of their success in winning. Many harbour fantasies that their system of play will ultimately pay off. Gamblers stay, bound to play, long after their losses have mounted, falsely assuming they are "due to win," or chasing their losses through continued play. These cognitive distortions and fallacies about winning help to keep gambling levels high. For women gamblers, for whom hope may be scarce and problems many, the "big win" can remain a beacon of light to solve life's problems. This hope contributes to their unwillingness to give up gambling, even as they head for the rocky shores of financial, emotional and social ruin. Learning more about negative rate of return, understanding odds and probabilities and house advantage and gaining a realistic understanding of gambling risk can help clients manage impulses more effectively, particularly Pathway 1 gamblers.

Reducing harm

If Boughton and Brewster's (2002) research on women problem gamblers is broadly reflective of that group, treatment that takes a harm reduction approach over total abstinence may be more attractive to them. In fact, 51% of the survey's respondents reported they were reluctant to seek professional gambling counselling for fear that they would be pushed into quitting. Some problem gamblers, either through therapy or independently, learn to adjust their gambling behaviours to minimize risk and continue with the more enjoyable elements of play. Others find the allure of gambling too hard to resist and abstinence is their only solution.

Avoiding such gambling cues as handling chequebooks, credit cards and other means of accessing money and having a spouse or family member take short-term control of finances can help to buffer clients in the early stages of change. However, learning over time to manage personal finances is an important goal to restore previous areas of competence. Staying away from gambling venues is also important. It is unfortunate that the casino's self-exclusion program was not effective in keeping Mary out because it can serve as a deterrent some people. One option is for Mary to contact the casino to discuss how to improve recognition so she will be barred from entry in the future should she relapse. However, given the plethora of gambling opportunities available within the community, the responsibility to avoid gambling triggers will ultimately rest with Mary.

Mary can also work with the therapist to identify triggers such as loneliness and boredom and plan appropriate alternatives. Mary will also need to consider new routines to replace the functions gambling previously served. Her high levels of anxiety can be addressed through supporting her to learn new stress-reducing techniques, such as yoga, meditation and relaxation therapies. This has the added advantage of providing important activities to

replace gambling and will help restore her social network. McCaslin notes, "Like many others, Mary has learned to use gambling as a quick fix to her problems and must now learn to incorporate healthy activities and stress-reducing activities."

Mary's changing roles

Mary is struggling with changes in her life roles, as her children grow up and leave home and her husband is away more frequently. People with gambling problems like Mary frequently lose touch with friends and previously enjoyed leisure pursuits. But we also know from Mary's history that she was placed prematurely in a caregiving role and missed out on important opportunities to explore her own interests and needs.

All respondents recognized the importance of helping Mary understand that the roles she assumed within her primary family (harmonizer, martyr, caregiver) have been carried into her adult life with negative effect. Littman-Sharp writes, "I suspect that over-responsibility would be an important issue. Mary might have difficulties accepting any weakness in herself and might be reluctant to allow others to support her because of parentification early on."

Nixon notes, "She has been a wife and mother, a good money saver all her life… Who does she really want to be?" In many ways the pull of gambling can be about so many unmet needs in a person's life. Can Mary find the courage to look at the unmet needs of her own journey?

Replacing the focus of "care of others" with "care of self" will be a challenging and potentially invigorating process. In therapy, Mary can be encouraged to place herself and her own needs in the center of her life and take time to explore her own passions and interests to create new ways of defining herself. What are the roads Mary has not taken in her life? Should they be explored further?

The drive for self-realization is universal. Mary's willingness to explore her own needs will serve as a powerful benchmark of progress. Learning that it is only through caring for oneself we are able to care for others is part of the journey of self-actualization. As Mary learns to master her urges, monitor her feelings, assert her rights and discover her true identity, she will define a life of purpose and meaning where gambling holds no power.

This journey of self-discovery will not be easy for Mary. In Boughton and Brewster's (2002) research with female problem gamblers disturbing trends emerged. These women have experienced significantly higher rates of emotional (60%) and physical abuse (40%) as children and adults than the

general population as well as higher rates of childhood sexual abuse (38% vs. 13%). They have higher rates of personal struggles with other problematic behaviours, including smoking, eating disorders, shopping addictions and substance use problems with alcohol, prescription and non-prescription drugs. These factors will have a profound effect on their levels of trust, self-identity, sense of personal entitlement and self-esteem. Creating a connection between these hurts and violations and the escape into gambling is essential to move forward avoiding further need sublimation with a different addiction.

Yet Boughton and Brewster (2002) also found that this was a group of women who were highly motivated to make positive changes: 89% were thinking of making changes and 80% had tried to stop or cut down, but the majority had the goal of moderation rather than abstinence in mind. These women were highly self-reliant and strongly believed that they should and could control their gambling without help. However, they reported wanting written materials to understand their gambling problem and self-directed strategies for change. They would like others to talk to who understand what they are going through. The fear of being judged and criticized leads to embarrassment and shame and a reluctance to seek out professional help.

A broader context

We also need to consider Mary within the context of her community. The opening of the casino brought with it much needed jobs and economic revitalization which have benefited many people. There is no question that the opening of a casino in Mary's community also made gambling more attractive and accessible; however, it is obvious that Mary's problems with gambling have far more complex origins than accessibility alone can explain. Gambling represents just one of many opportunities for addictive behaviour available to Mary.

Canadians have entered a period of unprecedented growth in the proliferation of gambling opportunities. Games of chance are promoted as a solution for funding hospitals, charities, stimulating regional economic growth and development and a way to sell all kinds of products. But social, economic and public health costs of this growth are yet to be fully understood. A recent Canada West Foundation study (Azmier, 2001) noted that the public's level of current acceptance for and tolerance of gambling is tied to their belief that government, which in Canada both manages and regulates gambling, will ensure a balance in public and individual interests.

In Ontario, the use of problem gambling treatment remains disappointingly low, with only .004 per cent of the estimated 318,000 problem gamblers in 2000 seeking help (Rush, Shaw Moxam & Urbanoski, 2002). A recent public

awareness survey, Project Weathervane (Kelly, Skinner, Wiebe, Turner & Noonan, 2001), documented that the level of awareness of problem gambling and what constitutes responsible gaming and the availability of treatment resources amongst the public is spotty at best. Clearly there is a lot of work to be done to raise awareness and educate the public of the potential risks associated with gambling activities.

Research and treatment providers are learning important information about risk factors through working with problem gamblers: who is particularly vulnerable, how to minimize harm and what helps people recognize and overcome their addiction. This information can also help to inform larger public policy.

Mary's road to treatment started with the toll-free helpline number posted on casino machines. Because the gambling environment remains an important point of contact with problem gamblers, it is strategic for treatment providers to work with the gambling industry to develop "point of sale" customer information. This will include teaching gaming industry staff to understand risk and help customers assess harm, appreciate when gambling is a problem and determine where to go for assistance. To help mitigate harm, it is necessary to evaluate and strengthen the effectiveness of self-exclusion programs and train gaming staff and lottery retailers to identify potential concerns and direct customers to assistance. Policies and programs that enhance informed consent and promote duty of care by gaming staff will be best informed by the knowledge acquired through clinical practice and research.

Awareness, prevention and treatment effectiveness are most likely to be achieved through a shared commitment by government, the gaming industry, treatment providers and problem gambling advocates. Each has a unique but complementary role to play. The larger questions regarding what is an acceptable level of gambling availability, responsible gambling promotion and when the potential for harm exceeds the public good require the active participation of all stakeholders, including treatment providers as well as an informed public.

Hopefully, through sharing the stories of problem gamblers like Mary and identifying successful intervention strategies, we can encourage others to come forward for help and put a personal face on a growing public health issue, and thereby, mobilize a community of shared concern.

Acknowledgement: *I have drawn heavily upon the Centre of Addiction and Mental Health's publication* Helping the Problem Gambler *(2001) edited by Robert Murray, as a*

comprehensive reference guide.

References

Azmier, J.J. (2001).
Gambling in Canada 2001: An Overview. Report prepared for the Canada West Foundation. Calgary, AB: Canada West Foundation.

Blaszczynski, A (1998).
Overcoming Compulsive Gambling: A Self-Help Guide Using Cognitive Behavioural Techniques. London: Robinson.

Boughton, R. & Brewster, J.M. (2002).
Voices of Women Who Gamble in Ontario: A Survey of Women's Gambling, Barriers to Treatment and Treatment Service Needs. Toronto, ON: Ministry of Health and Long-Term Care. Available: www.gamblingresearch.org/downloads/documents/pdf/voicesofwomen.pdf

Feinstein, D. & Krippner, S. (1988).
Personal Mythology: The Psychology of Your Evolving Self. Los Angeles: Jeremy P. Tarcher.

Frankl, V. (1985).
Man's Search for Meaning. New York: Washington Square.

Grof, C. (1993).
The Thirst for Wholeness. New York: Harper Collins.

Kelly, J., Skinner, W., Wiebe, J., Turner, N. & Noonan, G. (2001).
Project Weathervane: Measuring Gambling Behaviours, Knowledge and Attitudes in Ontario. Guelph, ON: Ontario Problem Gambling Research Centre. Available: www.gamblingresearch.org/downloads/documents/pdf/weathervane.pdf

Kohlberg, L. (1981).
Essays on Moral Development, Volume One. San Francisco, CA: Harper & Row.

Linden, M.D., Pope Jr., H.G. & Jonas, J.M., (1986).

Pathological gambling and major affective disorder: Preliminary findings. *Journal of Clinical Psychiatry, 47*, 201–202.

Loevinger, T. (1976).
Ego Development. San Francisco, CA: Jossey-Bass.

McCormick, R.A., Russo, A.M., Ramirez, L.F. & Taber, L.F. (1984).
Affective disorders among pathological gamblers seeking treatment. *American Journal of Psychiatry*, *141,* 215–218.

Miller, W. & Rollnick, S. (1991).
Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: The Guilford Press.

Murray, R. (Ed.) (2001).
Helping the Problem Gambler. Toronto, ON: Centre for Addiction and Mental Health.

Nixon, G. (2001).
Using Wilber's transpersonal model of psychological and spiritual growth in alcoholism treatment. *Alcoholism Treatment Quarterly, 19* (1), 79–95.

Parikh S.V. & Lam R.W. (2001).
Clinical guidelines for the treatment of depressive disorders, I. Definitions, prevalence, and health burden. *Canadian Journal of Psychiatry, 46 (Suppl. 1)*, 13S–20S.

Piaget, J. (1977).
The Essential Piaget. New York: Basic Books.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992).
In search of how people change: Applications to addictive behaviors. *American Psychologist, 47 (9)*, 1102–1114.

Roy, A., Ardinoff, B., Roehrich, L., Lamparski, D., Custer, R., Lorenz, V., et al. (1988).
Pathological gambling: A psychobiological study. *Archives of General Psychiatry, 45*, 369–373.

Rush, B., Shaw Moxam, R. & Urbanoski, K. (2002, February).
Characteristics of people seeking help from specialized programs for the treatment of problem gambling in Ontario [30 paragraphs]. *Electronic Journal of Gambling Issues: eGambling, 6*. [On-line serial]. Available: www.camh.net/egambling/issue6/research/index.html

Soden, T. & Murray, R. (1993).
Motivational interviewing techniques. In B. Howard (Ed.), *Alcohol and Drug Problem: A Practical Guide for Counsellors* (pp. 47–85). Toronto, ON: Addiction Research Foundation.

Wilber, K. (1977).
The Spectrum of Consciousness. Wheaton, Ill.: Quest.

Wilber, K. (1986).
The spectrum of development. In K. Wilber, J. Engler & D. Brown (Eds.), *Transformations of Consciousness* (pp. 65–105). Boston: Shambhala Publications.

Wilber, K. (1990).
Eye to Eye: The Quest for the New Paradigm. (Rev. ed.). Boston: Shambhala Publications.

Wilber, K. (1995).
Sex, Ecology, and Spirituality: The Spirit of Evolution. Boston: Shambhala Publications.

Wilber, K. (1997).
The Eye of Spirit: An Integral Version for a World Gone Slightly Mad. Boston: Shambhala Publications.

Wilber, K. (2000).
Integral Psychology. Boston: Shambhala Publications.

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