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case study

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

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Case study conference — Responses by clinicians

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

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

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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

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