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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

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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.

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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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