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Issue 8, May 2003
Guest editorial

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The same criticisms made 20 years ago about the literature on alcoholism are now being made about the problem gambling literature. Gender comparisons are rare, and most of the existing research is based on studies of men. As Mark and Lesieur (1992) pointed out 10 years ago, too few women are included in many samples to determine whether there are differences between men and women. In many cases as well, researchers assume that what holds true for males will also hold true for females. Given recent changes in women's gambling and rapid growth in the number of women seeking help, an entire issue (*EJGI*, Issue 8) devoted to the topic of women and gambling is timely and, we hope, will help create a "critical mass" of knowledge in this area.

As Bunkle points out in this issue, if women are going to drink, smoke and gamble as much and as often as men, we should expect to see the same "negative externalities" associated with these behaviors — alcohol abuse and dependence, tobacco-related morbidity and mortality, and gambling disorders — achieve parity between the genders. The research presented in this issue strongly suggests that, in fact, gender may be only one of several important dimensions that must be considered when seeking to understand differences and changes in gambling involvement over time. Borsoi and Toneatto suggest that gender

may have less to do with gambling problems than deficits in self-confidence and problem-solving skills. While Thomas and Moore identify significant differences between male and female gamblers, their data point to an excessive reliance on particular coping styles by both male and female problem gamblers.

Much of the work presented here has implications for the treatment of women with gambling problems. Boughton, Martin and the anonymous author of the first person account clearly show that women in problem gambling treatment bring with them gender-specific issues that must be addressed, including experiences of abuse and caregiving demands. Women entering treatment are also more likely than male problem gamblers to have emotional issues with autonomy and rebellion that will color the therapeutic relationship. However, it also seems clear that fostering self-confidence, teaching problem-solving skills and enhancing positive coping strategies are important elements of a problem gambling treatment program, regardless of the gender of the problem gambler seeking help.

It may be, as Griffiths speculates, that different factors lead men and women to gamble. Based on research presented in this issue, it appears that similar factors lead men and women to continue to gamble despite adverse consequences. Recent research clearly shows, however, that women seeking help for gambling problems start gambling later in life and that the progression of the disorder appears to be more rapid among women than among men (Ladd & Petry, 2002; Potenza, et al., 2001; Tavares, Zilberman, Beites & Gentil, 2001).

What stands out as this issue goes to bed is that women remain less involved in gambling than men. Women are still far less likely than men to begin gambling at a young age. And yet, the number of women accessing gambling helplines has grown substantially as has the number of women seeking help for a gambling problem of their own.

What are the factors that keep women away from gambling up to a certain point but then facilitate quicker, deeper involvement? How have the types of gambling as well as social attitudes toward gambling changed to normalize such behavior? What has happened to the stigma that was once attached to women gambling? Are deficits in problem-solving skills and coping strategies a symptom or a precursor to gambling problems? What are the factors that explain why women (and men) begin gambling, and how are these different from factors that explain why women and men continue to gamble in spite of adverse consequences?

These are questions that we do not have answers to yet. As with so many of our questions, they require more and better research to answer. But at least we have identified some of the key

questions — and that is an important step forward.

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The *Electronic Journal of Gambling Issues: eGambling (EJGI)* offers an Internet-based forum for developments in gambling-related research, policy and treatment as well as personal accounts about gambling and gambling behaviour. Through publishing peer-reviewed articles about gambling as a social phenomenon and the prevention and treatment of gambling problems, it is our aim is to help make sense of how gambling affects us all.

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Has there been a "feminization" of gambling and problem gambling in the United States?

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Abstract

This paper examines the question of whether there has been a "feminization" of gambling and problem gambling in the United States. Feminization refers to the idea that more women are gambling, developing problems and seeking help for problems related to gambling than in the past. Data from a theoretically derived sample of four states are examined to identify patterns in the distribution of gambling participation and the prevalence of problem gambling in the general population. Despite widespread acceptance of the notion of the feminization of gambling and problem gambling, men remain significantly more likely than women to participate regularly in most types of gambling. Most gambling activities remain highly gendered; however, in the United States, the widespread introduction of gaming machines is associated with increases in gambling and problem gambling among women. The present analysis highlights the importance of taking socio-demographic characteristics besides gender into account when considering the distribution of gambling and problem gambling in the general population.

Introduction

The final quarter of the 20th century saw a rapid expansion in the availability of legal, commercial gambling throughout the world, and particularly, in the affluent Western societies of Australia, Europe and North America. In the United States, the availability of legal gambling grew tenfold between 1975 and 1999. In the same period, annual revenues from legal gambling in the United States grew eighteen-fold from $3 billion to $58 billion (National Gambling Impact Study Commission, 1999). Casinos and lotteries joined more mature forms of gambling, such as horserace wagering and bingo, which have been joined in their turn by even newer forms of gambling, including widely distributed non-casino gaming machines and Internet gambling (Gerstein et al., 1999).

The recent rapid growth in the availability of legal gambling has raised concerns about the potential impact of such legalization on the overall rate of gambling problems in the general population and, more significantly, on specific at-risk groups in the population, including youth (Gupta & Derevensky, 2000), older adults (Korn & Shaffer, 1999; Petry, 2002), minorities (Wardman, el-Guebaly & Hodgins, 2001) and women (Ladd & Petry, 2002; Lesieur & Blume, 1991).

Gambling participation and gambling problems are not distributed evenly throughout the general population (Abbott & Volberg, 2000; Gerstein et al., 1999; Volberg & Abbott, 1997; Volberg, Abbott, Rönnberg & Munck, 2001). With regard to gender and gambling, a particular concern has been with what Australia's Productivity Commission (1999) called the "feminization" of problem gambling. "Feminization" refers to the notion that more women are gambling, developing gambling problems and seeking help for such problems than in the past. Like their counterparts in Australia, problem gambling service providers in Canada and the United States have also observed that growing numbers of women are seeking help for gambling problems (Potenza et al., 2001; Toneatto & Skinner, 2000).

The feminization of gambling and problem gambling appears to be linked particularly to increased availability of gaming machines. Several researchers have noted the distinct preference that women problem gamblers have for gaming machines (Hing & Breen, 2001b; Lesieur & Blume, 1991; Tavares, Zilberman, Beites & Gentil, 2001). While epidemiological studies have found that, commonly, about one-third of problem gamblers in the general population are female (Shaffer, Hall & Vander Bilt, 1999), prevalence rates for men and women are nearly identical in jurisdictions where gaming machines operate in venues frequented by women, such as restaurants, convenience stores, social clubs and hotels (Polzin et al., 1998; Productivity Commission, 1999; Volberg & Moore, 1999a). In Australia, the Productivity Commission (1999) noted that the

proportion of women problem gamblers in the general population grew from 14% to 41% between 1991 and 1999, a period during which the number of gaming machines per capita increased rapidly in that country.

This paper examines the question of whether there has been a feminization of gambling and problem gambling in the United States. The importance of this question lies in the growing availability of non-casino gaming machines in many American communities as well as the increasing dominance of gaming machines within the American casino environment (Connor, Kelly & Parets, 1996; National Gambling Impact Study Commission, 1999). The paper begins by reviewing the literature on gender, gambling and problem gambling. Data from a theoretically derived sample of states that vary along the dimensions of gaming machine availability and problem gambling prevalence are then examined. Finally, the results of this analysis are considered in relation to the question of whether there has been a feminization of gambling and problem gambling in America.

Literature review

Gender and gambling

Historically, many forms of gambling have been class based. Reith (1999) and Rosecrance (1988) have both observed that gambling among the upper classes, whether on horses, cards, casino games, real estate or stocks, has long been condoned in Western societies. While broadly tolerated, similar activities among the working and lower classes have been widely condemned, and until the middle of the 20th century, gambling among the middle classes was thoroughly discouraged.

Historically, many forms of gambling have also been highly gendered. In general, men are more likely than women to gamble on the stock market, on sports, at the racetrack and at off-track betting facilities; men are much more likely than women to engage in certain other types of gambling, including cockfights and dogfights (Evans, Gauthier & Forsyth, 1998; Geertz, 1973). Hing and Breen (2001a) recently noted that the broad range of gambling activities deemed suitable for men coexists with widely accepted views of men as risk-takers, innovators and speculators. In contrast, women in Western cultures are generally viewed as caretakers and nurturers, social roles that are not easily reconciled with many types of gambling. In a separate article, these same researchers suggested that gambling preferences are culturally based and influenced by the availability and social acceptance of different types of gambling for both males and females (Hing & Breen, 2001b).

One possible key to understanding changes in gambling participation by women is the attractiveness, including the perceived safety, of gambling venues. For example, a study of bingo players in England

in the 1980s identified several factors that influenced working-class women to participate, including flexible hours, local availability, the low price of playing and the safety of the venues (Dixey, 1996). Similarly, researchers today argue that the growing proportion of women at modern gambling venues stems from the provision of clean, attractive locations where patrons are treated with respect and experience a feeling of physical safety (Hing & Breen, 2001b; Trevorrow & Moore, 1999). The availability of childcare likely contributes to women's willingness and ability to gamble at many casinos in the United States (Connor, 1996) while the availability of lottery products and gaming machines in growing numbers of grocery stores, convenience stores and restaurants as well as the low price of participation makes it easier for women to engage in these activities as well.

Gender and problem gambling

Much of what is known about problem gambling comes from studies of male pathological gamblers to the exclusion of women. Criticisms similar to those of the literature on alcoholism have been made of the literature on pathological gambling — too few females are included in samples to determine whether there are differences between males and females and researchers often make the assumption that what holds true for males will also hold true for females (Mark & Lesieur, 1992).

In the earliest studies of women problem gamblers, researchers found that women in Gamblers Anonymous were less likely to be married than their male counterparts. These women were more likely than male problem gamblers to have gambled alone and to have hidden the extent of their gambling from friends and family (Lesieur & Blume, 1991; Strachan & Custer, 1993).

More recent studies of problem gamblers who call helplines or enter treatment have found that women with gambling problems started gambling later in life than the men. However, there are few differences in the age at which men and women seek help for gambling problems, suggesting that the progression of the disorder may be more rapid among women than men (Tavares et al., 2001). Across the board, women seeking help for gambling problems are much more likely to have experienced difficulties with gaming machines than with any other type of gambling (Ladd & Petry, 2002; Lesieur & Blume, 1991; Potenza et al., 2001; Productivity Commission, 1999; Strachan & Custer, 1993; Tavares et al., 2001).

In a study of gender of problem gamblers in the community, Hraba and Lee (1996) examined differences between male and female problem gamblers using a telephone survey of Iowa adults. They found that education level, religion, childhood exposure to gambling, number of marriages, frequent changes of residence and alcohol consumption were all significant predictors of problem gambling for women. The only significant predictor of problem gambling for men

was their level of education.

A more recent survey examined participation in gambling, gaming machine play and problem gambling among both female and male members of social clubs in Sydney, Australia (Hing & Breen, 2001a, 2001b). The women were more likely than their male counterparts to engage in patterns of gaming machine play that maximized playing time. They experienced gambling problems at levels comparable to men who gambled at the same intensity.

A methodological note

Observers have commented on the dearth of coherent theories and models in the field of gambling studies (Abbott & Volberg, 1999; National Research Council, 1999; Shaffer, Hall & Vander Bilt, 1997; Wildman, 1998). Given the lack of theoretical integration in the field, an exploratory approach seems likely to yield valuable insights for future investigation.

My approach in this paper rests, to a significant degree, on the "grounded theory" method developed by Glaser and Strauss (1967). Grounded theory refers to the systematic discovery of theory from data, rather than the other way around. Grounded theory stands in contrast to more conventional scientific approaches of theory testing and verification. As with other qualitative approaches, the evidentiary rules of grounded theory are rather different from those associated with quantitative data, such as accuracy and validity. As Glaser and Strauss caution, "when theory is the purpose… the representativeness of the sample is not an issue" (1967, p.189).

One important element of the grounded theory approach is theoretical sampling (Glaser & Strauss, 1967). In contrast to random sampling, which is designed to equalize the chance of every permutation turning up, theoretical sampling aims to identify cases that are likely to upset our thinking. Theoretical sampling rests on the notion that general ideas are a reflection of the selection of a small number of cases from a larger universe of cases. The "trick" in theoretical sampling is to select cases that maximize the chances of something unusual turning up that will challenge our taken-for-granted views or open new directions in our thinking (Becker, 1998).

While the data considered in this paper were obtained using traditional population research methods, the selection of jurisdictions for inclusion in the analysis was driven by theoretical sampling concerns. The strength of this approach lies in the unexpected patterns and new insights that emerge when a sample is developed according to a theoretical framework rather than based on availability or convenience. The limits of this approach lie in its unconventionality — researchers trained in quantitative methods are unlikely to appreciate the results of such an exercise.

The feminization of gambling and problem gambling has been linked to the availability of gaming machines. As a consequence, the sampling framework was driven by the desire to select jurisdictions where the availability of gaming machines and the prevalence of problem gambling varied from low to high. In selecting "cases" for this exercise, I was further constrained by the need to select from studies where I had access to the original data. This is because I wanted to analyze them in ways that were not part of the original reports on these studies. The jurisdictions selected for this exercise include the following states: Washington (machines: low; prevalence: low), New York (machines: low; prevalence: high), Oregon (machines: high; prevalence: low) and Montana (machines: high; prevalence: high). (Note: In this paper, Washington and New York refer to the states, unless otherwise specified.)

Characteristics of the theoretical sample

In this section, I review features of the four jurisdictions selected to represent extremes on the two dimensions of gaming machine availability and problem gambling prevalence. First, I consider the differences in population demographics in each of these jurisdictions and the availability of legal, commercial gambling, and then address features of the surveys conducted in each state.

Table 1: Characteristics of the jurisdictions and surveys

	Washington	New York	Oregon	Montana
Machines/1,000 adults	>1	(not legal)	3	26
Problem gambling prevalence	2.3%	3.6%	2.3%	3.6%
Geographic region	West Pacific	Northeast Mid-Atlantic	West Pacific	West Mountain
Population 18 years+*	4,380,278	14,286,350	2,574,873	672,133
Urban population**	76.4%	84.3%	70.5%	52.5%
White	83.9%	64.4%	86.6%	92.3%
Year completed Baseline	1992	1986	1997	1992
Replication	1998	1996	2000	1998

Sample size				
Baseline	1,502	1,000	1,502	1,020
Replication	1,501	1,829	1,500	1,227
Response rate				
Baseline	60%	65%	51%	63%
Replication	59%	45%	48%	83%

*Population figures from Census 2000.
**Urban and rural population percentages for 1990 are available at www.census.gov/population/censusdata/urpop0090.txt

The four jurisdictions in question are characterized by notable differences in their resident populations. New York, the only northeastern state, has the largest and most urban population, while Montana has the smallest and most rural population. The four states also differ in terms of ethnic and racial diversity. The population of New York is the most diverse with 14% of the population described as "Black," another 14% described as "Hispanic," and 6% described as "Asian." In contrast, the population of Montana is the least diverse, with Native Americans (6% of the adult population) as the only significant minority group. Both Oregon and Washington represent middle points on this spectrum with significant minority populations of Hispanic people (6% in both states), Asian people (3% and 5%, respectively), African American people (1% and 3%, respectively) and Native Americans (just over 1% in both states) (U.S. Census Bureau, 2000).

Availability of gambling

Washington was selected because of its low availability of gaming machines and low prevalence of problem gambling. Although legal, few electronic gaming machines are in operation. However, substantial opportunities exist to gambling legally in Washington. The Washington State Lottery offers a full range of games, including several large jackpot games, daily games and instant scratch tickets; charitable gambling is legal and on-track and off-track wagering is permitted on horse and dog races. In the wake of the Indian Gaming Regulatory Act of 1988, 17 Native American tribes in Washington State established compacts to operate casino gambling, and at least 28 tribal gaming facilities are currently operating. In response to the expansion of the tribal gaming industry, the Washington State Legislature permitted commercial cardrooms to expand their operations, and by 1998, many had grown large enough to be labeled "mini-casinos" (Volberg & Moore, 1999b).

New York was selected because of its low availability of gaming machines and high prevalence of problem gambling. In 1986, when the first survey of gambling and problem gambling was carried out in New York, legal gambling included charitable bingo, on- and off-track

wagering on horseraces and a well-established state lottery. New York residents also had relatively easy access to casino gambling in New Jersey (Volberg & Steadman, 1988). By 1996, legal gambling in New had grown to include simulcasts of horseraces as well as off-track betting (OTB) theaters where patrons could watch and wager on races while dining in a restaurant-like setting. New York residents also had easy access to casino gambling in the central region of the state as well as in Montreal, southeastern Connecticut and Atlantic City. Although the lottery had expanded to include instant scratch tickets, there were no legal gaming machines operating in New York in 1996 (Volberg, 1996).

Oregon was selected because it has high availability of gaming machines and a low problem gambling rate. Legal gambling opportunities in Oregon include a state lottery that offers a full range of lottery products and the nation's only sports lottery. In 1992, the Oregon Lottery received approval to operate video poker at establishments where alcohol is served. There are now nearly 9,000 video poker machines operating in Oregon, or approximately 3 per 1,000 adults in the state. On- and off-track wagering on horseraces, commercial cardrooms and charitable gambling, including bingo, are all legal and operational in Oregon as well as eight tribal-run casinos, which are permitted to operate video lottery games, blackjack, keno, off-track wagering and card and dice games (Volberg, 2001a).

Finally, Montana was selected because it has high availability of gaming machines and a high prevalence rate of problem gambling. Gambling in Montana has evolved from a long tradition rooted in the freewheeling atmosphere of the mining and logging camps of the 19th century. In 1985, Montana became the first state to permit video gaming machines in bars. Establishments that are licensed to serve alcohol are also permitted to operate live bingo or keno games and non-banked card games. Montana gaming establishments differ from full-service casinos — they do not offer traditional slot machines or table games such as blackjack, roulette or craps (Polzin et al., 1998). Montana has one of the highest concentrations of gaming machines in the United States with 26 machines per 1,000 adults — a ratio as high as that of Australia, widely regarded as the most saturated gaming machine market in the world (Productivity Commission, 1999). In addition to video gaming machines, gambling in Montana includes a state-operated lottery and pari-mutuel wagering on horse and dog races.

Surveying the population

The data were collected in surveys of gambling and problem gambling carried out in the general population. Two surveys were carried out in each state, although the interval between baseline and replication varies from 10 years in New York to three years in Oregon (Polzin et al., 1998; Volberg, 1992, 1993, 1996, 1997, 2001a; Volberg & Moore, 1999b; Volberg & Steadman, 1988). To provide a basis for comparison, it is important to examine how these

data were collected in some detail. While the author directed all of the surveys, the responsibility for data collection was contracted to a different survey research organization in each state.

The questionnaires for all of these surveys included sections on gambling involvement, problem gambling and demographics. Different gambling activities were assessed in each state; however, in each case it was possible to isolate casino gambling, lottery play, private wagering, and wagering on gaming machines. Similar demographic questions were included in each survey. Finally, the revised South Oaks Gambling Screen (SOGS-R), used in most of the problem gambling surveys conducted internationally, was included in all of the questionnaires, with the exception of the baseline survey in New York. The baseline survey in New York was further limited in terms of the data collected about respondent's gambling participation.

The original SOGS is composed of 20 weighted items that include questions about hiding evidence of gambling, spending more time or money gambling than intended, arguing with family members over gambling and borrowing money from a variety of sources to gamble or to pay gambling debts (Lesieur & Blume, 1987). The SOGS-R is composed of 20 lifetime and 20 past-year questions and is designed to provide both lifetime and current measures of problem and pathological gambling (Abbott & Volberg, 1996). Individuals who score 3 or 4 on the lifetime or current items are classified as "problem" gamblers, while those who score 5 or more are classified as "probable pathological" gamblers.

In all of the surveys, the respondents were contacted, recruited and interviewed by telephone. Respondents were randomly recruited within households that were selected from banks of randomly generated telephone numbers. One respondent per household was interviewed and a minimum of five and maximum of 10 callbacks were made to complete an interview with an eligible respondent. All of the achieved samples were representative in terms of gender, age and ethnicity, with one exception. The data from the New York replication survey were weighted to adjust for the low number of respondents recruited from the New York City region.

Table 1 presents information on the sample sizes and response rates for all of the surveys. It shows that, with the exception of New York, the sample sizes for the surveys changed very little between baseline and replication. The largest sample was achieved in the New York replication survey, while the smallest samples were achieved in the New York and Montana baseline surveys. Table 1 also shows that response rates for the surveys changed very little in Oregon and Washington, where the same organization collected data at baseline and replication. In New York, the response rate was substantially lower at replication than at baseline, while in Montana, the opposite was true. Given falling response rates for telephone surveys in general, the response rate from the Montana replication

survey is somewhat surprising but may have been due to the much larger budget for the replication survey than for the baseline survey in that state.

Even the best telephone surveys are limited because some groups are excluded from the sampling frame. Excluded groups included people who reside in non-residential dwellings, such as hospitals, nursing homes and prisons, residents in households without telephones and some demographic groups whose members are more likely to gamble regularly, such as older African-American men and unemployed people (Abbott & Volberg, 1999; Gerstein et al., 1999).

There is great uncertainty about the characteristics of individuals who choose not to participate in gambling surveys. It has generally been assumed that people who are not contacted or who decline to be interviewed in gambling surveys include disproportionate numbers of problem gamblers (Lesieur, 1994). Another possibility is that both problem gamblers and people who do not gamble may be underrepresented in surveys with low to medium response rates. If this is the case, the effects of their omission may partially or totally cancel each other out (Abbott, Volberg & Rönnberg, 2001).

Comparison of the results of recent national surveys in Australia and New Zealand suggests that low response rates may be less of a concern in gambling surveys than previously hypothesized. Abbott (2001) compared the results of the most recent New Zealand survey with the results of a recent Australian national survey that also used the current SOGS (Productivity Commission, 1999). In contrast to the high response rate achieved in the New Zealand survey, the Australian study achieved a relatively low response rate, comparable to response rates attained in recent U.S. gambling surveys. The analysis showed that the New Zealand prevalence estimate was very similar to prevalence estimates obtained for the two Australian states that had per capita gambling expenditures and numbers of gaming machines closest to those in New Zealand and was markedly lower than estimates for the Australian states with higher per capita gambling expenditures and numbers of machines.

In the present context, however, the question of whether the original survey data is accurate is not a salient one. Indeed, though some basic statistical tests of significance have been included here, the strongest associations are actually less interesting than several of the weaker associations that appear more theoretically relevant (Glaser & Strauss, 1967).

Results

Recent changes in gambling participation

Two national studies of gambling carried out in the United States provide top-line information about changes in gambling participation.

The first survey was completed in 1975; the second survey in 1998 (Kallick, Suits, Dielman & Hybels, 1976; Gerstein et al., 1999). Although the 1975 and 1998 surveys used somewhat different methodologies, they were sufficiently similar to enable some comparisons to be made.

In 1975, the first national survey of gambling in the United States showed that 68% of adults had ever gambled; the second national survey in 1998 found that 86% of adults had ever gambled. In contrast, rates of past-year gambling participation changed little between since 1975 and 1998. The proportion of respondents indicating that they had gambled in the past year barely changed, rising from 61% to 63%. The small increase in past-year gambling participation in 1998 is at least partly explained by the fact that Americans are now much more likely to participate in casino and lottery gambling and less likely to participate in older types of gambling, such as bingo and horserace wagering. In 1998, the percentage of people who reported playing the lottery in the past year was two times higher than in 1975, while the percentage increase in respondents who reported gambling in a casino in the past year was even greater. In contrast, past-year participation in bingo and horserace wagering both decreased by two-thirds between 1975 and 1998 (Gerstein et al., 1999).

All of the "cases" in our theoretical sample provide information about changes in gambling participation over time. In contrast to the other three states, the baseline survey in New York was carried out in 1986, before the recent expansion of casino gambling in the United States. As in the United States in general, lifetime participation in gambling rose significantly in New York between 1986 and 1996. The greatest increases were for lottery play and wagering at casinos; pari-mutuel wagering remained steady and wagering on bingo declined.

In the three states where both surveys were conducted in the 1990s — Washington, Oregon and Montana — substantial declines were identified in the proportion of the population that gambled weekly (Polzin et al., 1998; Volberg, 2001a; Volberg & Moore, 1999b). In these three states, there were statistically significant declines in weekly gambling on lotteries and stability in weekly bingo and private wagering. In Montana, where gaming machines have been legal for more than a decade, there was a significant decline in weekly gambling of this type. A significant decline in weekly gambling on machines was also detected in Oregon. In contrast, in Washington there were significant increases in weekly participation in several recently introduced types of gambling, such as cardrooms and casinos. In Oregon, a significant increase in gambling on the Internet was identified between 1997 and 2000.

An important question in the present context is whether more women are gambling in spite of recent overall declines in gambling participation. Two national surveys showed that the proportion of

women who reported ever having gambled rose substantially from 61% in 1975 to 83% in 1998. While the proportion of men who had ever gambled also rose, the increase from 75% to 88% was much smaller. Changes in past-year gambling were much smaller, with the proportion of women who had gambled in the past year rising from 55% to 60% and the proportion of men remaining unchanged (Gerstein et al., 1999).

In contrast to the national data, evidence from the replication surveys in our theoretical sample suggests that, over the 1990s, women were less likely to gamble and particularly less likely to gamble on a regular basis. In Montana, Oregon and Washington, past-year gambling among women declined substantially, with the steepest declines reported among women from minority groups in all three states (Polzin et al., 1998; Volberg, 2001a; Volberg & Moore, 1999b). At the end of the 1990s, only Native American men in Montana showed an increased likelihood of having gambled in the past year. In the 1990s, weekly gambling also declined overall among women, with two exceptions: weekly gambling rose from 17% to 23% among women from minorities in Washington (between 1992 and 1998), and from 16% to 26% among women from minorities in Oregon (between 1997 and 2000).

Differences in gambling participation

We now consider the differences in gambling participation across the four states at the most recent point in time. Table 2 presents information about the size of the groups of males and females who are white and those from other minority groups in each state. This allows readers to assess for themselves the magnitude of differences in gambling participation presented in the tables that follow.

Table 2: Cell sizes across four jurisdictions

	Washington	New York	Oregon	Montana
White				
Male	605	640	665	543
Female	673	695	692	563
Other				
Male	119	202	78	60
Female	83	249	65	60

Table 3 presents information from the replication surveys on the rates of lifetime, past-year and weekly gambling among white and non-white men and women in the four states. New York stands out with the highest rates of gambling participation and Oregon clearly

has the lowest rates of gambling participation.

Table 3: Gambling participation by gender and ethnicity in four jurisdictions

	Washington	New York	Oregon	Montana
	%	%	%	%
Lifetime gambling	**88.9**	**90.4**	**79.5**	**89.7**
White			***	**
Male	90.2	95.6	84.2	92.1
Female	88.7	94.0	75.6	87.9
Other		*		
Male	88.2	82.7	80.8	91.7
Female	85.5	75.9	72.3	83.3
Past-year gambling	**74.4**	**80.5**	**60.6**	**77.5**
White			***	***
Male	76.7	85.8	64.8	80.5
Female	73.1	85.2	55.8	73.7
Other				
Male	73.9	71.3	69.2	86.7
Female	71.1	64.5	58.5	76.7
Weekly gambling	**20.1**	**35.2**	**13.5**	**18.9**
White	***	*	***	*
Male	24.0	39.8	15.9	20.8
Female	14.9	34.9	9.7	16.5
Other		*		**
Male	27.7	34.7	15.4	31.7
Female	22.9	26.9	26.2	11.7

Pearson Chi-Square: * $p<0.05$, ** $p<0.01$, *** $p<0.001$
Level of significance indicated above each group.

In addition to differences in overall gambling participation, there were differences in the rates of gambling participation by men and women in the four states. Across all four jurisdictions, weekly gambling participation was much lower among women than among men. In contrast to the consistency of the differences between men's and women's gambling overall, the differences in gambling rates between white people and people from "other" population groups vary substantially.

In all four states, lifetime gambling rates were higher among white people than among people of other groups. In New York, past-year and weekly gambling rates were all higher among white people than people of other groups. Past-year gambling rates were also highest among white people in Washington. In contrast, past-year gambling rates in Montana and Oregon were higher among people from minorities than among white people in those states, and in Washington and Montana, weekly gambling rates were highest among people from minorities.

The weekly gambling rates in Oregon and Montana show variations between rates for both white and minority groups and for gender within those groups. In Montana, men from minority groups were more likely than white men to gamble weekly, but in Oregon, the data for men in both groups was similar, with white men reporting a slightly higher rate of weekly gambling. For women, the reverse appeared to be true: in Montana, women from minorities reported a lower rate of weekly gambling participation than white women, but in Oregon, women from minorities reported a much higher rate of weekly gambling (26.2%) to that of white women (9.7%) in the state.

Table 3 shows that, in all four states, white men were significantly more likely to gamble regularly than white women. While the small size of the minority groups sample, particularly in Oregon and Montana, suggests caution in interpreting these results (see Table 2 for actual cell sizes), it is interesting that men from minorities in Montana, Washington and New York were more likely to gamble than women from minorities in these states, whereas the opposite appeared to be true in Oregon.

Specific gambling activities

Next, we examine differences in participation rates for specific gambling activities. As noted above, there are substantial legal gambling opportunities available to residents of all four states. All of these states operate lotteries and permit bingo as well as pari-mutuel wagering on horseraces. Access to gaming machines is relatively high in Oregon and extremely high in Montana, in contrast to New York and Washington (see Table 1). Access to casino gambling also varies across these four jurisdictions: high in Washington and Oregon, much lower in New York and Montana.

Table 4 shows rates of past-year lottery play among male and female white and minority respondents in the four states. Past-year lottery play was highest in New York and lowest in Oregon. New York also stands out as the only jurisdiction where past-year lottery play was higher among white people than among minority respondents. In Washington and Oregon, past-year lottery play was higher among both men and women from minorities than among white people, but in Montana women from minorities reported the lowest rates for past-year lottery play.

Table 4: Past-year participation in specific gambling activities in four jurisdictions

	Washington	New York	Oregon	Montana
	%	%	%	%
Lottery (total)	**57.1**	**66.1**	**40.7**	**46.5**
White	*		**	*
Male	58.8	69.4	43.6	49.3
Female	53.9	70.5	36.0	43.7
Other				
Male	65.5	56.4	50.0	54.1
Female	59.0	56.2	49.2	40.0
Private (total)	**23.1**	**31.0**	**19.7**	**33.6**
White	***	***	***	***
Male	31.1	44.2	27.5	43.1
Female	14.9	27.1	11.4	24.0
Other	**	***		*
Male	34.5	27.2	24.4	45.9
Female	15.7	13.3	23.1	26.7
Machines (total)	**10.4**	**18.0**	**21.7**	**38.6**
White		*	***	**

Male	10.1	22.2	27.1	42.9
Female	10.1	17.4	14.9	34.8
Other				*
Male	14.3	15.8	30.8	47.5
Female	10.8	12.1	29.2	26.7

Pearson Chi-Square: * p<0.05, ** p<0.01, *** p<0.001
Level of significance indicated above each group.

Table 4 also presents information about past-year private wagering across the four states. Private wagering includes wagering on sports, games of skill and card games with family, friends or acquaintances. Table 4 shows that, across the board, and regardless of ethnicity, men were much nearly two times more likely than women to have wagered privately in the past year. The one exception is in Oregon, where women from minority groups (23.1%) were just as likely as men from minority groups (24.4%) to have wagered privately in the past year.

Finally, Table 4 presents information about past-year gaming machine play in the four states. Given our theoretical sampling procedure, it is hardly surprising that past-year gaming machine play was lowest in Washington and highest in Montana. In spite of widespread notions about the relationship between the "feminization" of gambling and the availability of gaming machines, Table 4 shows that men were substantially more likely than women to have played gaming machines in the past year. The only exceptions are in Washington, where there was little variation in past-year gaming machine play by either gender or ethnicity, and in Oregon, where minority men and women were equally likely to have played gaming machines in the past year.

Given differences in availability and access, it is difficult to compare past-year casino gambling rates across the four states. In New York in 1996, just under one-quarter (23%) of the respondents acknowledged gambling at a casino in the past year, with white men most likely to have done so (25%) and minority women least likely to have done so (21%). In Oregon in 2000, 28% of all respondents had gambled at a casino in the past year, with white men the most likely (31%) and white women the least likely to have done so (25%). The picture is quite different in Washington, where card games are widely available at both tribal-run casinos and commercial cardrooms. In Washington in 1998, 13% of the respondents had wagered on card games at a casino or commercial cardroom in the past year. Past-year participation in this form of gambling was highest among men from minorities (27%) and lowest among women (9%), whether white or minority (both 9%).

Turning to bingo and horserace wagering, we find substantial gender differences in spite of very low past-year participation rates for these

mature gambling activities. Overall, women were more likely to have played bingo in the past year, with minority women more likely than white women to have played in the past year in Montana, Oregon and Washington but not in New York. Past-year wagering on horseraces was even lower than past-year participation in bingo. Overall, men were more likely to have wagered on horseraces in the past year than women, regardless of ethnicity. The one exception was, again, New York, where white men and women were more likely than minority men and women to have wagered on horseraces in the past year.

One reason to look at past-year gambling participation rates is that weekly gamblers represent only a small proportion of the entire sample in each state. There are a few noteworthy differences between men and women who gamble once a week or more often.] In Washington, female weekly gamblers were more likely than male weekly gamblers to play bingo regularly. In contrast, male weekly gamblers in Washington were more likely to wager privately on a regular basis. In New York, male weekly gamblers were more likely than female weekly gamblers to play the lottery, wager privately and gamble on horseraces regularly. As in Washington, women weekly gamblers in New York were more likely than male weekly gamblers to play bingo regularly. In both Oregon and Montana, the major difference in weekly gambling was that men were more likely than women to wager privately.

When it comes to gaming machines, the patterns of weekly gambling participation across the four states suggest that the question of availability suddenly becomes much more salient. In Washington, only 1% of women who gambled weekly and 2% of men who gambled weekly played gaming machines regularly. In New York, 10% of women who gambled weekly and 8% of men who gambled weekly played gaming machines regularly. In Oregon, 19% of women who gambled weekly and 17% of men who gambled weekly played gaming machines once a week or more often. Finally, in Montana, 45% of women who gambled weekly and 48% of men who gambled weekly played gaming machines regularly.

Are more women gambling?

In considering changes in gambling over time, a more complicated picture emerges. Past-year gambling on gaming machines declined across the board in Montana, with the steepest decline among women in minority groups. In Oregon, past-year gambling on gaming machines declined among white women but went up among women in minority groups. In Washington, where gaming machines were introduced in the period between the two surveys, past-year participation rose from a baseline of zero to about 10% across all gender and ethnic groups.

Private wagering, the most "masculine" gambling activity, again presents a varied picture. Past-year private wagering increased

among men, whether white or minority, in Montana but decreased among women. In contrast, past-year private wagering declined across all groups in Oregon, with the exception of minority women. Past-year private wagering in Washington declined across the board, but with the largest decline among men in minority groups. Looking at bingo, we find declines across the board in past-year participation; the one exception being minority women in Montana, Oregon and Washington who were more likely to have played bingo in the past year.

Problem gambling prevalence rates

Next, we turn to examine the prevalence of problem gambling in these four states. We noted above that Oregon and Washington were selected because of their low rates of problem gambling while Montana and New York were selected because of their high rates. Table 5 presents problem gambling prevalence rates for the four states. Problem gambling is defined here as the proportion of the entire sample from each state that scored 3 or more points on the current (past year) items of the SOGS-R .

Table 5: Problem gambling prevalence rates

	Washington	**New York**	**Oregon**	**Montana**
	%	%	%	%
Total	**2.3**	**3.6**	**2.3**	**3.6**
White	*			
Male	2.3	3.4	1.8	3.1
Female	0.9	2.6	1.9	3.2
Other	**			
Male	11.8	5.0	5.1	6.6
Female	1.2	6.0	7.7	8.3

Pearson Chi-Square: * p<0.05, ** p<0.01, *** p<0.001
Level of significance indicated above each group.

The first observation is that, overall, the current prevalence of problem gambling is quite low in the general population. The next observation is that, with the exception of Washington, there are no significant differences in current prevalence rates of problem gambling among men and women. This is interesting in view of the far lower gambling participation rates that we observed among women (see Table 3). In contrast to the lack of gender differences, there are substantial and significant differences in prevalence rates of problem gambling between the two groups identified: white people and "other," minority groups in all four states. The differences in

prevalence rates between these groups are greatest in Washington and smallest in New York.

To elucidate the relationship between gender, problem gambling and gaming machines more clearly, it is helpful to examine problem gambling prevalence rates among participants in specific types of gambling. To do so, it was necessary to combine data from the four surveys to achieve samples of past-year players that were large enough to provide useful information. Table 6 presents current prevalence rates of problem gambling in the combined samples of people who reported past-year gambling on lottery games, gaming machines, private wagers, bingo and horseracing.

Table 6: Problem gambling prevalence among past-year players

	Lottery	**Machines**	**Private**	**Bingo**	**Pari-mutuel**
	%	%	%	%	%
Total	**4.9**	**7.8**	**7.0**	**10.1**	**8.1**
White	(n=2810)	(n=1175)	(n=1468)	(n=432)	(n=344)
Male	4.1	6.2	6.0	9.7	7.7
Female	3.7	7.0	5.2	6.2	6.3
Other	(n=561)	(n=204)	(n=253)	(n=114)	(n=41)
Male	10.6	15.7	16.1	34.2	16.0
Female	9.8	16.2	13.0	12.5	20.0

Table 6 shows, first, that prevalence rates for problem gambling among past-year players are substantially higher for specific games than in the general population, with the highest rates among past-year bingo players and the lowest among past-year lottery players. Table 6 also shows that, across the board, problem gambling prevalence rates are higher among past-year participants from minority groups in specific gambling activities than among participants who are white. The differences in problem gambling rates between white people and people from minority groups are far greater than the differences between male and female gamblers.

Changes in prevalence over time

Data from the replication surveys are, again, helpful in understanding that the characteristics of problem gamblers may change over time and in relation to changes in the availability of specific types of gambling. Let us consider Washington, where the availability of card games at cardrooms and casinos expanded dramatically between 1992 and 1998. This is the only jurisdiction in our theoretical sample where the overall prevalence of problem gambling is significantly higher among men than among women. Between 1992 and 1998 in

Washington, the proportion of problem gamblers who were male increased from 63% to 75% (Volberg & Moore, 1999b).

Washington forms an interesting contrast to Montana and Oregon, where the availability of gaming machines has been high throughout the 1990s. In Montana, the proportion of problem gamblers who were female remained stable at about 50% between 1992 and 1998. In Oregon, the proportion of problem gamblers who were female increased from 36% to 45% between 1997 and 2000 (Volberg, 2001a). It is interesting that the proportion of problem gamblers in Oregon who were Native American increased in the same period from 3% to 7% — a possible response to an increase in the number of tribal-run casinos in that state.

Discussion

Gender and gambling

What do the data presented here suggest about the relationship between gender, gambling and problem gambling? It is worth beginning by considering the differences between New York and the other three states selected for this exercise. As Table 1 demonstrates, New York is the only state in the theoretical sample located in the northeastern United States. Furthermore, New York's population is more than three times larger and far more ethnically diverse than any of the other three states. Another difference is that a larger proportion of the New York population lives in urban areas. Finally, the problem gambling surveys in New York were completed somewhat earlier than the surveys carried out in the other states. The nature of the exercise attempted here means that the differences between New York and the other states are less a threat to validity than an opportunity to explore whether differences in geography, ethnicity and population size and density affect the relationships between gender, gambling and problem gambling.

Over the final quarter of the 20th century, national surveys of gambling in the United States found substantial increases in lottery and casino gambling at the expense of more mature forms of gambling, such as bingo and horserace wagering (Gerstein et al., 1999). The data from New York, where gambling participation rose substantially between 1986 and 1996, with increases most evident for lottery play and casino gambling, echo these larger, national trends and suggest that these trends continued at least through the mid-1990s.

However, it has been suggested that the market for legal gambling in the United States matured rapidly in the 1990s, and that, with few exceptions, the U.S. gambling market is now fully supplied (Christiansen & Sinclair, 2001). The more recent data from Montana, Oregon and Washington support this contention and suggest that gambling participation rates began to decline in the late 1990s — perhaps as people who had experimented with new gambling

activities stabilized their involvement to balance it with other, important parts of their lives (Volberg, 2001b).

Gender and specific gambling activities

The role that gender plays in gambling participation is clarified when we turn from gambling in general to look at specific gambling activities. In general, we have seen that women are less likely to gamble than men and, in particular, less apt to gamble regularly. The data presented here support the notion of a strong relationship between gender and some types of gambling. Conventional casino gambling showed relatively little variation with between 20% and 30% of the adult population having gambled at a casino in the past year, regardless of gender or ethnicity. When it comes to other gambling activities, there are clear and substantial gender differences. Across the board, women were more likely to play bingo than men. In contrast, men were far more likely than women to wager privately and on horseraces.

There is greater variability in the regular gambling of men and women when we take ethnicity into consideration. Weekly gambling rates were higher among white people than among people from minorities in New York. In Montana and Oregon, people from minorities were more likely to gamble regularly than white people. Within the minority population, men were more likely to gamble than women in Montana and New York; the opposite was true in Oregon. This finding suggests the importance of examining differences in gender roles within ethnic groups that may affect gambling participation.

Again, New York stands out in relation to the other states in our theoretical sample. New York had higher rates of lottery play among white people than among people from minorities. New York also had higher rates of bingo participation among white women than women from minorities. Finally, horserace wagering in New York was higher among white people than people from minorities, regardless of gender. It is possible that these differences in gambling patterns are due to geography, population density or ethnic diversity. Another possibility is that these differences are a historical artefact — the result of the fact that the surveys in New York were completed somewhat earlier than the surveys carried out in the other states. A third possibility is that these differences are due to the existence of a substantial white working-class population in New York with gambling "habits" similar to those in other working-class communities (Dixey, 1996). However, all of these are hypotheses that remain to be tested.

Another interesting difference emerges with regard to women from minority groups in Oregon. They present an exception to the more general finding that private wagering is much more common among men; their past-year rate for participation in private wagering was quite similar to that for men from minority groups in Oregon. Women

from minorities in Oregon were also more likely than their counterparts in New York and Washington, but not Montana, to have played gaming machines in the past year. This difference may be due to the small sample of respondents from minorities interviewed in Oregon. Another possibility is that a real difference exists in the gambling involvement of minority women in Oregon compared with other states. A third possibility is that the availability of gaming machines affects the gambling of women from minority groups more significantly than the gambling of white women. Again, these questions can only be answered with further research.

A third interesting question relates to casino gambling in Washington. The tribal-run casinos in Washington are unique in offering primarily table games and very few slot machines. Washington is also unique in the number of large commercial cardrooms (or "mini-casinos") that operate throughout the state. Private wagering in Washington State declined across the board between 1992 and 1998, with the largest decline among men from minorities. It is possible that this change reflects a shift among this group of men from private wagering to gambling at tribal-run casinos and commercial cardrooms. As noted above (see subsection Specific gambling activities under Results), Washington was the only jurisdiction where casino participation rates were substantially lower among women compared with men — perhaps another consequence of the unique characteristics of "casinos" in that state.

Finally, consideration of the data from people who gamble regularly suggests that gender roles may become even more pronounced at the far end of a continuum of participation in some types of gambling but not others. Male weekly gamblers were far more likely than female weekly gamblers to wager privately on a regular basis while female weekly gamblers were much more likely than their male counterparts to play bingo on a regular basis. In contrast, regular gaming machine play appears to be more closely related to the number of machines in a jurisdiction than to gender roles. Unlike most other types of gambling, nearly equal proportions of regular gaming machine players were male and female.

Are women more likely to have gambling problems?

In general, the data considered here show that women are far less likely to gamble regularly than men. In spite of substantially lower rates of regular gambling among women, rates of current problem gambling were quite similar for men and women. The one exception is Washington, where both white and minority women were far less likely than men to score as current problem gamblers.

The picture becomes clearer when we consider weekly gambling among different groups of respondents separately. Among white men, the prevalence of current problem gambling varies as expected, with the lowest prevalence rate in Oregon where white men are least likely to gamble regularly, and the highest prevalence

rate in New York, where white men are most likely to gamble regularly. The relationship between weekly gambling and problem gambling rates is not as strong among white women but still varies in the expected direction.

The relationship between weekly gambling and problem gambling is far less predictable among men and women from minorities. Among minority men, the prevalence of current problem gambling was substantially higher in Washington in spite of the fact that men from minorities in other states were just as likely to gamble weekly. Among minority women, the prevalence of current problem gambling was substantially lower in Washington in spite of the fact that women from minorities in Washington were just as likely to gamble weekly as minority women in other states. The question is whether this difference is due to unique characteristics of the minority population group surveyed in Washington, something unique about the available types of gambling or to another factor altogether.

The picture is further clarified when we consider gaming machine participation separately. Predictably, Table 4 shows that past-year gaming machine play increases with the number of machines in a jurisdiction. Table 5 shows that, while prevalence rates for problem gambling among white men vary independently of the availability of gaming machines, prevalence rates among white women vary almost entirely as expected. Among men from minorities, problem gambling prevalence rates appear to drop in relation to the availability of gaming machines, while the opposite is true of women from minority groups. Indeed, prevalence rates for problem gambling were actually higher among women from minorities in Oregon and Montana than among white people (male or female) or men from the minority population. These data suggest that the relationship between gaming machines and problem gambling among women is stronger than this relationship among men and, further, that this relationship is particularly strong among minority women.

Hing and Breen (2001b) argue that social norms influence women's gambling preferences and frequency more than the characteristics of specific types of gambling. They argue further that problem gambling prevalence rates will be similar among male and female players who gamble at equal intensity. The data presented here support the argument that men and women who gamble at equal frequency experience gambling problems at about the same rate. In contrast to the lack of differences between men and women, there appear to be substantial differences in the prevalence of problem gambling among majority and minority ethnic groups. As Table 6 shows, the prevalence of problem gambling is two or more times higher among minority men and women than among white men and women, regardless of whether we are looking at past-year lottery play, gaming machine play, private wagering, bingo or pari-mutuel wagering. A question for future research is how variability between different ethnic groups in attitudes towards women and gambling may influence gambling behavior.

It is interesting, in this regard, to consider another curious intersection of gambling, gender and ethnicity. Among past-year bingo players, the prevalence of problem gambling was lowest among white women and highest among men from minorities. Although this difference may result from the small size of the group of past year bingo players surveyed, there is a possibility that male players of a traditionally "female" gambling pastime are particularly troubled individuals (Wood, 2002).

What lies ahead?

In the wake of rapid growth in the availability of legal gambling opportunities, and particularly, casino and non-casino gaming machines, service providers have observed growing numbers of women seeking help for gambling problems in the United States and internationally. The majority of these women attribute their gambling problems to recent involvement with gaming machines as opposed to other types of gambling. The question is whether these growing numbers of women seeking help reflect a broader "feminization" of gambling and problem gambling in the general population.

The exercise undertaken here suggests that, in fact, little has changed when it comes to gender and gambling. Men are still the social actors predominantly engaged in "strategic," skill-based and competitive forms of gambling while women remain predominantly engaged in "non-strategic," luck-based forms of gambling (Potenza et al., 2001; Volberg & Banks, 2002). The major historical change has been the growing involvement of women in non-strategic gambling activities at venues outside the home that provide a sense of physical and emotional safety. Gaming machines are increasingly available at venues frequented by women — restaurants, hotels and bars, but also grocery stores, convenience stores, gas stations and even laundromats. As gambling becomes more available at venues frequented by women, the data we have examined suggest that women from minority groups are especially likely to begin gambling and may be particularly vulnerable to developing difficulties related to their gambling.

One of the most interesting findings to emerge from the analysis presented here is the relationship between the availability of specific types of gambling and the socio-demographic characteristics of problem gamblers. It appears likely that the characteristics of problem gamblers in a given jurisdiction are a reflection of differences in the availability and acceptability of different types of gambling among different groups in the population. Gender and ethnicity and, perhaps, also age and social class may play a role in what type of gambling people choose and, for those who gamble regularly, who gets into difficulties with their gambling.

Another intriguing question that emerges from this exercise is the issue of why women are just as likely as men to score as problem

gamblers when their overall gambling participation remains lower? Are women in fact more vulnerable to developing gambling problems? Or are women simply more likely than men to seek help for a gambling problem, just as they are more likely to seek help for other physical and psychological ailments? Another possibility is that methods for identifying problem gambling may not work equally well in different subgroups in the population. There may be something about the problem gambling screens we use that elicits more positive responses from women and people from minorities.

Finally, we must consider the emergence of new forms of gambling and ask what will be the impacts of the implosion of this means of consumption into the home (Ritzer, 1999). As Cividino (2002) notes, women represent a rapidly expanding segment of the on-line gambling population and there is a growing number of specialized Web sites for women gamblers. On-line gambling offers excitement and escape but also local availability, flexible hours, a low price of participation and physical and emotional safety — features especially appealing to women. It would be wise to give careful consideration to measures to prevent gambling problems in this new and very private gaming venue.

Qualitative research is viewed with skepticism by most gambling researchers, and there is little appreciation of its value in generating testable hypotheses. The exercise undertaken here has raised numerous issues that deserve further exploration. While not yet a single, coherent "theory" of gambling or problem gambling, testing the hypotheses generated here is likely to move us significantly forward in our efforts to understand the role of gambling in postmodern society.

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The interactive effects of avoidance coping and dysphoric mood on problem gambling for female and male gamblers

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Abstract

A study involving 83 female and 72 male gamblers tested the direct and interactional effects of avoidance coping and five dysphoric moods on problem gambling via regression analysis. Important differences were found between female and male gamblers. For female gamblers, loneliness, boredom, anxiety, depression and avoidance coping were all positively related to problem gambling.

Additionally, interactions between these mood states and avoidance coping significantly predicted problem gambling; female gamblers with high dysphoria and high avoidance coping showed substantially more symptoms of problem gambling than those scoring high on only one variable. In contrast, loneliness and stress were the only significant predictors of problem gambling for males — neither avoidance coping nor any of the interactional relationships between mood and coping predicted problem gambling. These results support previous qualitative studies and suggest that female problem gamblers gamble as an escape from dysphoric moods. Even though male problem gamblers expressed more negative affect than male non-problem gamblers, there was no evidence to suggest that negative mood was a precursor rather than an outcome of gambling behaviour.

Key words: women, gambling, avoidance, coping, depression, anxiety, loneliness, boredom

Gambling today is far from being a secret vice undertaken by a deviant few. In Australia, and indeed in most Western countries, gambling has been transformed into a respectable and popular leisure activity (Trevorrow & Moore, 1998). A recent inquiry into Australia's gambling industries found that 82% of Australian adults had participated in at least one gambling activity in the 12 months preceding April 1999. It also found that women were just as likely to gamble as men (Productivity Commission, 1999). In addition, the Productivity Commission (1999) report estimated that one per cent of the Australian adult population were experiencing severe gambling problems, and another one per cent had moderate but significant problems. Problem gambling amongst women appears to be increasing, and female and male problem gamblers are now evenly represented at counselling services in Australia. Similarly, other Western studies estimate that females represent one-third to one-half of the problem gamblers in the general population (Getty, Watson & Frisch, 2000; Hraba & Lee, 1996; Mark & Lesieur, 1992; Productivity Commission, 1999). However, few studies have investigated this change in what has historically been seen as a male issue.

There have been many theories to explain problem gambling — ranging from a focus on individual pathology to a focus on social factors. However, it is probable that most of these theories were developed with male problem gamblers in mind, and certainly the vast majority of past research about problem gambling has concentrated on males, with samples of gamblers consisting of all or almost all male participants. Other studies that included female and male problem gamblers failed to systematically assess gender differences (e.g., Blaszczynski, McConaghy & Frankova, 1990; Delfabbro, 2000; Mark & Lesieur, 1992; McCormick, 1994). This is somewhat understandable because historically the majority of problem gamblers receiving counselling were male (Blaszczynski et al., 1990; Mark & Lesieur, 1992). Today, however, the widely held assumptions that problem gambling is a male problem and that what is true for males is also true

for females needs to be challenged.

On the basis of case material, Lesieur and Blume (1991) implied that women's gambling may be differently motivated from men's gambling. They concluded that women use gambling to escape personal and family problems, whereas men are more likely to gamble for excitement and financial gain. Similarly, two other studies which investigated the motivations of male and female problem gamblers found that female problem gamblers were significantly more likely to say they were gambling to escape isolation, depression, anxiety and worry compared to male problem gamblers. On the other hand, male problem gamblers were more likely to say they were gambling to win or to improve their self-worth (Loughnan, Pierce & Sagris, 1996; Pierce, Wentzel & Loughnan, 1997). These studies suggest that gambling motivations may not be homogeneous across gender and that women may be gambling to temporarily escape negative moods and situations, rather than for excitement or to win money.

Qualitative research by Brown and Coventry (1997) also sheds light on the motivational processes involved for a sample of women who defined themselves as problem gamblers. Through telephone interviews, most of these women reported that they gambled initially for social reasons rather than as a means of increasing stimulation. However, as time went on gambling became a method of distraction from everyday problems, a way of avoiding dysphoric states, such as loneliness, boredom, anxiety, depression and stress. As more problems arose from gambling, dysphoric moods increased, leading to a cycle of "escaping" through gambling, with resulting financial loss and family problems, dysphoric mood, etc.

A review of quantitative research into problem gambling interestingly revealed evidence of elevated dysphoric states, such as loneliness, depression, boredom and anxiety in both male and female problem gamblers (e.g., Blaszczynski & McConaghy, 1988; Blaszczynski et al., 1990; Coman, Burrows & Evans, 1997; McCormick, Russo, Ramirez & Taber, 1984; Trevorrow & Moore, 1998). Indeed, the few studies that compared male and female problem gamblers dysphoric emotions showed mixed results. Some found that female problem gamblers had significantly higher levels of dysphoria compared to male problem gamblers (Specker, Carlson, Edmonson, Johnson & Marcotte, 1996; Steel & Blaszczynski, 1996). In contrast, others have found no differences (Becoña, Lorenzo & Fuentes, 1996; Ohtsuka, Bruton, DeLuca & Borg, 1997). Therefore, these quantitative studies suggest that it is possible for both male and female problem gamblers to have elevated levels of dysphoria. However, the studies mentioned earlier suggest that female problem gamblers are more likely to gamble to escape these feelings (Brown & Coventry, 1997; Lesieur & Blume, 1991; Loughnan et al., 1996; Pierce et al., 1997).

If female problem gamblers, in particular, are deliberately choosing to gamble to escape dysphoric emotions their gambling could fundamentally be seen as a form of coping, albeit a maladaptive form.

The Folkman and Lazarus (1988) model of stress proposes that individuals appraise potential stressors and search for a coping strategy to reduce the threat. These strategies can range from active attempts to "solve the problem," through to emotional responses, help-seeking or attempts to escape from the situation, either physically or mentally. Therefore, coping resources are theorised to mediate the impact of stressors (Billings & Moos, 1984), although it is clear that some strategies will be more effective than others. Avoidance or escapist coping refers to activities or cognitions used by people to divert attention away from a source of distress (Folkman & Lazarus, 1988). This method of coping is very common and can range from culturally acceptable activities such as jogging to destructive behaviours such as taking drugs or alcohol (Folkman & Lazarus, 1988). It is possible that gambling could be used in a similar same way to divert attention away from a distressing issue.

In fact, there is some evidence of excessive reliance on avoidance coping in both male and female problem gamblers. For example, a study by Scannell, Quirk, Smith, Maddern and Dickerson (2000) found that female gamblers with low control over their gambling behaviours used avoidance coping significantly more than females with high control over their gambling. Similarly, McCormick (1994) found that male substance abusers with gambling problems used avoidance coping strategies significantly more than those without gambling problems. In addition, one study that directly compared male and female problem gamblers found that they were very similar in their use of avoidance coping (Getty, Watson & Frisch, 2000).

In sum, prior research suggests that both coping style and dysphoric emotions may be important factors in explaining problem gambling; however, it is less certain that they are equally important for males and females. Recent qualitative data can be interpreted to suggest that it may not be negative mood that leads to problem gambling per se — but the use of gambling as an escape from dysphoric mood (Brown & Coventry, 1997). In other words, the effect of emotional stressors on problem gambling may be moderated by coping tendencies. This complex relationship requires an assessment of the combined effects of high dysphoric mood and high avoidance coping (as opposed to assessing only the simple or direct effects of high scores on either of these variables). To the authors' knowledge, no prior research has directly tested the extent to which the interaction between dysphoric mood and coping style predicts problem gambling.

Therefore, an initial aim of this study was to partially replicate prior research by investigating the differences between males and females and between problem gamblers and non-problem gamblers on dysphoric mood and avoidance coping. In line with prior research (e.g., Blaszczynski, et al, 1990; McCormick, 1994; Scannell, Quirk, Smith, Maddern & Dickerson, 2000; Trevorrow & Moore, 1998), it was expected that problem gamblers would score higher on avoidance coping and all measures of dysphoric mood than non-problem gamblers. Due to the mixed results of prior studies (Becoña et al.,

1996; Getty et al., 2000; Steel & Blaszczynski, 1996), an exploration was undertaken to determine whether there would be significant differences between male and female gamblers or male and female problem gamblers on avoidance coping or dysphoric mood.

The main aim of this study was to test the interactional model discussed above by assessing the emotion-moderating effects of coping for both male and female gamblers, using more sophisticated analyses than those used in prior research. Three steps were taken in testing this model. Firstly, it was hypothesised that female and male gamblers with higher levels of dysphoric emotion (depression, anxiety, loneliness, stress or anxiety) would show more symptoms of problem gambling than those with lower levels of dysphoric emotion. Secondly, it was hypothesised that both male and female gamblers who had a high tendency to use avoidance coping would exhibit more problems with their gambling. Finally, it was hypothesised that these avoidant styles of coping would become very maladaptive when paired with dysphoric emotions. When placed together these factors were expected to interact to predict problem gambling more effectively than either dysphoric mood or avoidant coping alone. Whether or not these effects would differ for male and female gamblers was explored because past research did not allow for a clear hypothesis of either difference or similarity in process.

Methods

Participants

Current gamblers (who had gambled for money at least once in the past 12 months) 18 and older were recruited for this study. The sample comprised 155 participants: 83 females (M=28.4 years, SD=13.5 years) and 72 males (M=30.1 years, SD=12.9 years). Ninety-five participants were first-year psychology students at a university in Melbourne, Australia, 13 were recruited via a gambling counselling organisation in a suburb of Melbourne and 47 were accessed via broader community contacts. Unfortunately, the anonymous method of data collection did not allow for demographics to be collated on specific sub-samples.

Materials

Participants completed a questionnaire that included questions about gambling behaviour and demographics as well as measures of coping, problem gambling and several measures of dysphoric mood (loneliness, anxiety, depression, stress and boredom). All of these mood states were included because they had been implicated in prior gambling research, but not all had been tested on both male and female gamblers or in conjunction with coping strategies.

Loneliness measurement

The UCLA Loneliness Scale (Russell, Peplau & Cutrona, 1980) rates feelings of loneliness the participant may have experienced in relation to other people. Twenty items are rated on a four-point scale, where 1 = *never* and 4 = *often*. The measure has 10 positively scored items (e.g., *I feel isolated from others*) and 10 negatively scored items (e.g., *I do not feel alone*); overall loneliness scores are calculated by summing all items. Higher scores indicate higher levels of loneliness. The measure has shown excellent internal consistency (a =.94). That it showed positive correlations with several other loneliness scales and a lack of relationship with conceptually distinct emotions indicate that the measure has construct validity (Russell, 1982).

Depression, anxiety and stress measurement

The Depression, Anxiety, Stress Scale (DASS21) (Lovibond & Lovibond, 1995) is a shortened version of the full DASS, consisting of 21 items querying the participant's feelings over the past week. All items are rated on a four-point scale, where 0 = *did not apply to me* and 3 = *applied to me very much, or most of the time*. The measure has three sub-scales that have questions (seven in each) relating to depression (e.g., *I felt down-hearted and blue*), anxiety (e.g., *I felt I was close to panic*) and stress (e.g., *I found it hard to wind down*). Scores are summed and multiplied by two so that they can be directly compared to Australian normative samples based on the full-scale DASS. Higher scores relate to higher levels of depression, anxiety and stress. The measure has shown high internal consistency (depression a = .81; anxiety a = .73; stress a = .81) and good evidence of test-retest reliability and construct validity (Lovibond & Lovibond, 1995).

Boredom measurement

The Boredom Proneness Scale (Farmer & Sundberg, 1986) is a 28-item true-false scale designed to capture the participant's tendency to become bored. The measure particularly relates to feelings of emptiness and loneliness associated with boredom. It also measures the ability of individuals to access adaptive resources and their level of connectedness to environments or situations. The measure has 18 positively scored items (e.g., *Time always seems to be passing slowly*) and 10 negatively scored items (e.g., *I am good at waiting patiently*). Items are summed and high scores indicate higher boredom proneness. The measure has good reliability (a = .73-.79; test-retest reliability at one week =.83) and has shown validity via moderate to strong positive relationships with other boredom scales and self-reports of boredom (Farmer & Sundberg, 1986).

Coping measurement

Billings and Moos' (1984) coping scale was used to assess avoidance coping. This measure involves asking respondents to think of a

stressful event that occurred in the last three months. It then asks them to indicate the frequency of use of 28 different coping strategies to resolve the event. The use of each strategy is rated on a four-point scale, where 1 = *never used* and 4 = *often used*. The measure has three subscales, two of which contain two individual factors. Scores for each factor are obtained by calculating the mean response of all items contained in the factor. However, as the focus of this study was on avoidance/escapist coping, only the avoidance factor (labelled emotional discharge) has been fully described here. Emotional discharge (avoidance coping) has six items and relates to attempts made by the individual to reduce tension by refocusing on potentially distracting behaviours, such as smoking or eating (e.g., *Tried to reduce tension by drinking more*). The fairly low alpha for this factor (a = .41) was argued by Billings and Moos (1984) to be due to the likelihood that only one or two distracting strategies would be utilised by an individual, thereby reducing the use of alternative responses and setting an upper limit on the reliability coefficients. For the purposes of this study, this level of internal consistency was considered sufficient.

Problem gambling measurement

The South Oaks Gambling Screen (SOGS) is a 23-item instrument with 20 scored items designed to indicate the severity of problem gambling (Lesieur & Blume, 1987). The screen is based on the Diagnostic and Statistical Manual of Mental Disorders' (DSM-III) (American Psychiatric Association, 1980) problem gambling criteria and is consistent with later versions of the DSM. Questions cover problem gambling indicators such as chasing losses, gambling more than intended, feeling guilty about gambling, borrowing money to gamble and reactions of others to the individual's gambling. Scores range from 0 to 20. A score of 5 or more indicates problem gambling, and a score of 10 or more indicates severe problem gambling. The SOGS is a widely used measure of problem gambling and has shown high internal consistency and test-retest reliability as well as correlating highly with the DSM-III-R criteria for problem gambling (Lesieur & Blume, 1987).

Procedure

The authors employed several methods to recruit participants for this study. From a Melbourne university, 95 first-year psychology students were recruited as part of their class requirement. From the wider community, 47 participants were recruited as a convenience sample and 13 problem gamblers were recruited through a Melbourne problem gambling counselling centre. Questionnaires were distributed either in classes, through a sample of gamblers available to the researchers or through counsellors at the gambling counselling centre. All questionnaires were completed voluntarily and anonymously on the participants' own time and returned in a postage-paid return envelope to the researchers.

Results

Descriptive statistics

All participants were current gamblers. Scores on the SOGS ranged from 0 to 18 and had a mean score of 2.97 (SD=3.88). Thirty-two participants were designated as problem gamblers (a SOGS score of five or more): 21 were male and 11 female. The average SOGS score was significantly higher for male gamblers (Mean males = 3.65; Mean females = 2.39, $F(1,153)=4.20$, $p<.05$).

Alpha reliabilities of scales used in this study were as follows: Loneliness (.93), Boredom (.82), Depression (.91), Anxiety (.88), Stress (.87), Avoidance Coping (.49), Problem Gambling (.86). All reliabilities were considered adequate for research purposes while acknowledging that the low reliability for avoidance coping was related to the nature of this activity as previously discussed.

Gambling behaviours

In order to gain an overall picture of their favoured forms of gambling, participants were asked to list the types of gambling they participated in most often. Percentages were calculated and are shown in Table 1.

Table 1
Percentage of female and male gamblers by their most frequent form of gambling

	Females	Males
Gambling type	**%**	**%**
Poker machines	41	33
Lotto/scratch-it	31	21
Bet on horses/dogs	4	17
Play cards	11	10
Bet on sports	1	4
Table games at casino	4	7
Bingo	5	1
Other	4	6

Note: Percentages will not sum to exactly 100% due to rounding.

As the table illustrates, poker-machine gambling was by far the most

popular form of gambling for both males and females, and lotto and scratch-it tickets were also popular for both genders. However, betting on horse or dog races appeared to be popular only with male gamblers. Table 2 highlights the favoured forms of gambling for problem gamblers.

Table 2
Number of female and male problem gamblers by their most frequent form of gambling

Gambling type	Females	Males	n^a
Poker machines	6	8	56
Lotto/scratch-it	4	2	40
Bet on horses/dogs	0	8	15
Play cards	1	0	16
Bet on sports	0	0	4
Table games at casino	0	1	8
Bingo	0	1	5
Other	0	1	7

Note: Problem gambler= SOGS score of 5+
n^a = Total number of participants who designated this as their favourite form of gambling.

This pattern of popularity is similar to other gamblers, albeit with more sharply defined gender preferences. As illustrated, a substantial proportion of men and women who prefer to play poker machines displayed problematic gambling behaviours. Male problem gamblers also showed a strong preference for horse or dog races, while female problem gamblers showed a preference for lotto or scratch-it tickets.

Initial analysis of measures

In order to partially replicate prior research, a series of initial analyses were conducted. A two-way multivariate analysis of variance (MANOVA) was performed on participants' levels of dysphoric mood. The independent variables were gender (male, female) and gambler type (problem gambler, non-problem gambler). A two-way analysis of variance with the same independent variables was performed on avoidance coping scores. Table 3 shows the means of the dependant variables.

Table 3
Mean scores for male and female problem and non-problem gamblers on dysphoric mood and avoidance coping

	Non-problem gamblers (n ranges from 119-123)			Problem gamblers (n ranges from 31-32)		
	Females	Males	Total	Females	Males	Total
Variables	M	M	M	M	M	M
Anxiety	6.39	8.12	7.11	13.45	12.29	12.69
Depression	8.13	9.76	8.80	17.45	14.86	15.75
Stress	14.42	12.75	13.72	20.55	17.24	18.38
Boredom	8.92	11.27	9.89	12.91	14.33	13.84
Loneliness	34.24	37.10	35.43	46.50	45.10	45.55
Avoidance	2.04	2.02	2.04	2.45	2.23	2.31

Note. SOGS scores 0–4 = non-problem gamblers, SOGS scores 5+ = problem gamblers

Results indicated that problem gamblers differed significantly from non-problem gamblers on dysphoric mood (Pillai's Trace = .130, $F(5,145)=4.35$, $p<.01$, $R^2=.13$). Univariate analyses revealed that problem gamblers were significantly more anxious ($F(1,149)=10.38$, $p<.01$, $R^2=.07$), depressed ($F(1,149)=16.14$, $p<.001$, $R^2=.10$), stressed ($F(1,149)=8.71$, $p<.01$, $R^2=.06$), bored ($F(1,149)=12.42$, $p<.01$, $R^2=.08$) and lonely ($F(1,149)=20.23$, $p<.001$, $R^2=.12$) than non-problem gamblers. Problem gamblers also used significantly more avoidance coping ($F(1,147)=8.80$, $p<.01$, $R^2=.06$) than non-problem gamblers.

There were no significant differences between the genders on dysphoric mood or avoidance coping, nor any significant interactions between gender and gambler type on these variables. A power analysis indicated that the study had sufficient power to detect a moderate interaction effect.

Regression analyses

A series of hierarchical multiple regressions were used to test the hypothesised model that the relationship between dysphoric mood and problem gambling would be moderated by avoidance coping. It was expected that participants who scored high on a measure of dysphoric mood and high on the use of avoidance coping would exhibit substantially more problems than those who scored high on only one of the predictors. These regressions also assessed predicted relationships between problem gambling and (a) dysphoric mood and (b) avoidance coping. Separate regressions were performed for each mood state and all independent variables were centred to prevent problems with multicollinearity (Tabachnick & Fidell, 2001). For each

regression, mood state and avoidance coping were entered at stage one and the interaction between mood state and avoidance coping were entered at stage two (Cooper, Russell, Skinner, Frone & Mudar, 1992). All analyses were performed separately for males and females in order to examine the relationships between mood, coping and problem gambling for each gender.

To facilitate interpretation, one of the significant interactions has been presented graphically, using the regression equation to generate a predicted score on problem gambling for each group, which represents all possible combinations of low and high (Cohen & Cohen, 1983). Low and high scores were operationalised using one standard deviation below and one standard deviation above the mean, respectively, giving two regression lines.

Hierarchical regression analyses for females

Table 4
Summary of hierarchical regression analyses showing main and interactive effects of dysphoric mood and avoidance coping on problem gambling for females

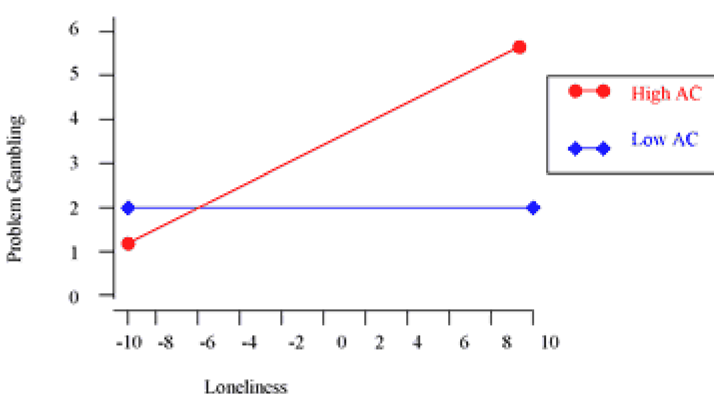
Predictor variables	Loneliness		Anxiety		Depression		Boredom		Stress	
	$R^2\Delta$	ß	$R^2\Delta$	ß	$R^2\Delta$	ß	$R^2\Delta$	ß	$R^2\Delta$	ß
Stage 1	.31***		.23***		.25***		.19***		.17**	
Mood		41***		.34**		.37**		.30*		.21+
AC		.28*		.27*		.22*		.21+		.30**
Stage 2	.10**		.10**		.04*		.06*		.03+	
Mood		.31**		.34**		.32**		.22+		.20+
AC		.28**		.18+		.18+		.20+		.26*
Mood x AC		.33**		.32**		.21*		.26*		.18+
Total R2	.41**		.33***		.28***		.25***		.20**	

Note. N=83, $R^2\Delta$=R^2 change, β=Beta, AC=Avoidance Coping, $p<.10^+$, p<.05*, p<.01**, p<.001***

A summary of the regression results for female gamblers is shown in Table 4. In the first regression, loneliness and avoidance coping at stage one accounted for 31% of the variation in problem gambling,

and as expected, both factors significantly predicted problem gambling. Lonely women and women who had a tendency to use avoidance coping tended to experience more gambling problems. At stage two, the interaction between loneliness and avoidance coping was entered. It accounted for an additional 10% of the variation in problem gambling, over and above what was explained by loneliness and avoidance coping directly. Together the model was able to explain 41% of the variance in problem gambling. The interaction (shown in Figure 1) is now the strongest predictor of problem gambling. As illustrated, female gamblers who scored high on both avoidance coping and loneliness showed substantially more symptoms of problem gambling than female gamblers showing high scores for either variable.

Figure 1
Interaction between avoidance coping (AC) and loneliness for female gamblers



Click diagram for larger image.

An examination of the other regressions showed a similar pattern of results. Avoidance coping and all mood states, except stress, significantly predicted problem gambling. In all cases, women who scored high in negative mood or who had a tendency to cope by avoiding were more likely to show more symptoms of problem gambling than those who scored low in those variables. The introduction of the mood by avoidance coping interaction enabled an additional 3% to 10% of the variation in problem gambling to be accounted for, over and above what was accounted for by the mood or avoidance coping directly (see Table 4). All interactions between mood and avoidance coping were significant with the exception of the interaction involving stress. An examination of the significant interactions revealed that, as was the case with loneliness, women who scored high in negative mood and who showed a strong tendency to cope by avoiding showed substantially more symptoms of problem gambling than women who scored high in just one variable.

It should be noted that the addition of the interaction term did not substantially increase the predictive ability of the model for the regressions involving depression and boredom. However, the pattern of relationships was consistent for all regressions, and in each case, the total model accounted for a substantial percentage of the variance.

Hierarchical regression analyses for males

Table 5
Summary of hierarchical regression analyses showing main and interactive effects of dysphoric mood and avoidance coping on problem gambling for males

Predictor variables	Loneliness $R^2\Delta$	ß	Anxiety $R^2\Delta$	ß	Depression $R^2\Delta$	ß	Boredom $R^2\Delta$	ß	Stress $R^2\Delta$	ß
Stage 1	.10*		.04		.06		.07+		.07+	
Mood		.31*		.18		.24+		.25*		.26+
AC		.02		.03		.03		.02		.02
Stage 2	.02		.02		.01		.03+		.01	
Mood		.34*		.27+		.26+		.23+		.27*
AC		.00		.03		.02		.00		.02
Mood x AC		-.16		-.17		-.08		-.17		-.08
Total R^2	.12*		.06		.07		.10+		.08	

Note. N=72, $R^2\Delta=R^2$ change, β=Beta, AC=Avoidance Coping,
$p<.10^+$, $p<.05^*$

A summary of regression results for male gamblers is shown in Table 5. The picture is quite different for males compared to females. None of the mood by avoidance coping interactions were predictive of problem gambling. Also, contrary to expectations, avoidance coping failed to predict problem gambling in any of the regressions. A power analysis indicated that the study had a 73% chance of detecting even weak correlations in the population.

Loneliness and stress were the only mood states able to significantly predict problem gambling, although the relationship between problem gambling and the predictors of depression, boredom and anxiety approached significance. Men who scored high on these negative emotions tended to show more symptoms of problem gambling than those who scored low.

Discussion

This study provides important insights about the gambling processes of males and females; however, this data needs to be viewed in the

light of several limitations. The sample was drawn from disparate sources, so it may not accurately represent the general population. Of particular concern is the over-representation of university students who may differ from the general population in terms of age, gender or education. It is possible that the inclusion of so many university students has biased the results of the study. The rationale for the broad recruiting strategy was (a) to over-represent the number of problem or potential problem gamblers in the sample (those scoring five or more on the SOGS) through targeting a source of known problem gamblers; and (b) to target a wide range of adults who gamble, using both student and community recruitment. A second limitation was the cross-sectional nature of the study. Cause-effect relationships cannot be assumed between the key variables of coping, mood and problem gambling. Findings of the current study should be seen as supporting other work that suggests cause and effect. A third limitation of the study concerned the measure of avoidance coping. This measure was less than optimal as it questioned coping on a single occasion, targeted only a few of the many possible avoidant coping behaviours and was not a highly reliable measure. Replication of this study with a range of more developed scales would be of value. Finally, given the practical difficulties of sampling, this study did not focus on any particular gambling type, and factors predicting problem gambling may vary across gambling types. Nevertheless, it was clear that poker-machine gambling was the most favoured form of gambling in the sample and by problem gamblers. It is within the context of these limitations that the following discussion and conclusions must be viewed.

The results of this study revealed that problem gamblers, both male and female, were significantly more likely to be depressed, anxious, stressed, bored or lonely than non-problem gamblers and were more likely to use an avoidance coping style to deal with stressful events or feelings. This initial analysis supported prior research findings (e.g., Becoña et al., 1996; Getty et al., 2000; Ohtsuka et al., 1997), suggesting that avoidance coping and dysphoria are important variables associated with problem gambling for both males and females. Such a conclusion, however, does not tell the whole story, and should not be used to justify the application of a "male model" of problem gambling to female gamblers. Further investigation with more sensitive methods of analysis revealed substantial differences in the way avoidance coping and dysphoria predicted problem gambling for males compared to females. It is to a discussion of these analyses that we now turn.

An interactional model of dysphoric mood and avoidance coping

An interactional model of problem gambling predicts that the effects of dysphoric mood on problem gambling will be moderated by avoidance coping. From such a model it would be expected that gamblers who scored high on both dysphoric mood and avoidance coping would show substantially more symptoms of problem gambling than

gamblers who scored high on only one of these variables. These predictions were strongly supported for female but not for male gamblers.

As expected, female gamblers with high levels of dysphoria tended to experience more symptoms of problem gambling than those with low dysphoria. This prediction was supported for all mood states, except stress, giving strong support to prior research that found that women with gambling problems experience higher levels of negative mood (Brown & Coventry, 1997; Trevorrow & Moore, 1998). Secondly, as expected, female gamblers who scored high on avoidance coping tended to exhibit more problems with their gambling. Again, these results were consistent with prior research (Getty et al., 2000; Scannell et al., 2000).

Thirdly, the hypothesis that there would be a significant interaction between avoidant coping and dysphoria, such that female gamblers with high dysphoria and high avoidance coping would tend to show more symptoms of problem gambling than those high in just one variable, was supported. The introduction of a variable representing the mood by avoidance coping interaction significantly improved prediction of problem gambling for women. Again, this was true for all mood states except stress. Overall, these results gave strong support to the interactional model of avoidance coping and dysphoric mood for female gamblers. They suggest that while avoidance coping and dysphoric mood are both important factors in problem gambling, female gamblers who score high on both variables may be particularly vulnerable to problem gambling. These results are in tune with prior qualitative research that found that female problem gamblers reported gambling specifically as a means of escaping emotional problems (Brown & Coventry, 1997; Loughnan et al., 1996; Pierce et al., 1997).

The results of regressions involving male gamblers were markedly different to those involving female gamblers. Male gamblers who experienced loneliness or stress tended to have more symptoms of problem gambling. However, none of the other mood states were significantly correlated with problem gambling. Therefore, these results show very little support for prior research that found evidence of elevated loneliness, boredom, depression and anxiety in male problem gamblers (McCormick et al., 1984; Ohtsuka et al., 1997). These inconsistent findings cast some doubt on the applicability of negative mood in explaining male problem gambling.

Secondly, contrary to expectations, there was no relationship between avoidance coping and problem gambling for the male gamblers. These results appear to be contrary to prior research that found that male problem gamblers use significantly more avoidance coping than male non-problem gamblers (Getty et al., 2000; McCormick, 1994). One explanation for these apparently contradictory findings may be the use of more sophisticated methods of analysis in the current study. The regression analyses used in this study scrutinised the relationships between avoidance coping and problem gambling separately for male

and female gamblers rather than simply comparing the average level of avoidance coping. Possibly, avoidance coping is high (on average) in male problem gamblers but is not predictive of problem gambling.

Thirdly, the hypothesis that there would be a significant interaction between avoidance coping and dysphoria, such that male gamblers with high dysphoria and high avoidance coping would tend to show more symptoms of problem gambling than those high in just one variable, was not supported. None of the regressions were able to significantly predict the dependent variable via an interaction between mood and avoidance coping. These results cast considerable doubt on the applicability of this interactional model for male gamblers.

Gendered avoidance strategies?

The tendency for female gamblers to see gambling as a form of distraction rather than a source of excitement or money may, in part, be due to social restrictions on gambling access for females. There is some evidence that female gamblers tend to gamble on a narrower range of activities compared to male gamblers; many showing a strong preference for poker machines over other forms of gambling (Hraba & Lee, 1996; Productivity Commission, 1999; Slowo, 1997). The tendency for female gamblers, particularly regular gamblers, to play poker machines rather than other forms of gambling may be because these venues are seen as more socially acceptable for females. Local hotels and clubs have made considerable efforts to ensure that their poker-machine venues are attractive and comfortable for women, even for women who are alone (Blaszczynski, Walker, Sagris & Dickerson, 1999). In contrast, it doesn't appear that other betting venues such as horse racing outlets have made the same sort of efforts to encourage female gamblers.

Different forms of gambling may satisfy different psychological needs. People who play poker machines often cite "escape" as their reason for gambling while racing and casino gamblers report gambling for "excitement" (Hraba & Lee, 1996; Slowo, 1997). If women are regularly exposed to a form of gambling that lends itself to escapism rather than excitement, it is possible that women who are searching for a socially acceptable means of escape find it in gambling — or in other words, poker-machine gambling. Indeed, a study investigating gambling in Australia (Productivity Commission, 1999) found that the vast majority of female problem gamblers seeking help had problems with poker machines. The Commission even went so far as to say that the "feminisation" of problem gambling appears strongly associated with the spread of gaming machines in Australia.

In contrast, male gamblers who relied heavily on avoidance coping did not show any particular tendency to display more problems with their gambling than those who showed less reliance on avoidance coping. Prior research has found that male gamblers tend to see their gambling as a source of excitement or money rather than as a means of escape (Pierce et al., 1997; Slowo, 1997), although this information

is controversial (Blaszczynski, Wilson & McConaghy, 1986). Perhaps males who rely on avoidance strategies have a tendency to turn to other forms of avoidance.

It is widely accepted that many people drink alcohol to regulate negative emotions and that those who do so tend to drink more often and may be at greater risk of developing drinking problems than purely social drinkers. However, although this stressor-drinking model is quite popular, Cooper et al. (1992) found that the effect of negative life events on drinking behaviour was moderated by coping in a manner similar to what is discussed in this study. They found that negative life events only predicted alcohol use and drinking problems in men who relied heavily on avoidance coping. In contrast, men who scored low in avoidance coping did not display additional drinking problems when faced with more stressors.

It is possible, therefore, that socialisation encourages men and women to choose different methods of avoidance coping. Drinking and particularly drinking to excess are generally more socially acceptable for men than women (Broom, 1994; Cooper et al., 1992). Similarly, gambling and gambling on poker machines have become acceptable forms of entertainment for women (Blaszczynski et al., 1999). Societal values that play a big part in determining which behaviours are acceptable for men and women may also be indirectly influencing which behaviours are more likely to become maladaptive forms of coping for each gender.

Counselling implications

The results of this study have implications for the counselling methods used with women. In terms of female problem gamblers, ongoing battles with gambling and other maladaptive behaviours may be an indication that some therapies focus too narrowly on overt gambling behaviours or cognitions and too little on underlying factors, such as poor coping strategies or dysphoria. If, for instance, a woman is gambling to escape loneliness, then counselling strategies that focus entirely on her gambling behaviour are unlikely to be successful in the long term. Even if problem gambling is successfully halted, it is possible that she may simply turn to another form of avoidance, such as excessive drinking or eating to cope with her ongoing loneliness.

The results of this study have also shown that effective counselling for female problem gamblers should include an active search for underlying factors such as dysphoric mood or maladaptive coping strategies. Female problem gamblers who display a lack of sophistication in their use of coping strategies may find that counselling that integrates an element of coping enhancement provides long-term assistance. This may involve expanding a limited coping repertoire or simply increasing understanding around the appropriate use of various coping strategies. Counselling of female problem gamblers may also need to include an active search for underlying emotional problems. If women are gambling because of

dysphoric emotions then the overt behaviours should be seen as symptoms rather than the cause of problems.

McCorriston (1999) argues that if counsellors can identify the "needs" that are satisfied by gambling, they can then work with clients to find alternate methods of satisfying these needs. In this way, they can help clients make problematic gambling behavior redundant.

Conclusion

The results and conclusions of this research are starkly different from previous research that investigated the relationship between avoidance coping and problem gambling for male gamblers (Getty et al., 2000; McCormick, 1994). It is possible that these contrasting results are an aberration of the current sample. However, the sample size was quite large and the results of the initial analysis supported those of prior research, which suggested that male and female problem gamblers had elevated levels in avoidance coping. This implies that the current sample was not substantially different to past samples. It seems that the deviation of the results and conclusions of this research stemmed directly from the differing methods of analysis used. It is therefore important for future studies to replicate the research methodology with other samples of male and female gamblers.

Future research replicating the current study's interactional model may also find that controlling gambling type (perhaps restricting participation to current poker machine gamblers) would ensure that gender differences observed are not confounded by gambling preference (Delfabbro, 2000). Additionally, where possible, coping tendencies should be assessed on several occasions rather than the single episode measured in the present study, ensuring a more accurate assessment of stable coping tendencies (Folkman, Lazarus, Gruen & DeLongis, 1986). Of course, there are likely to be many different causal paths to problem gambling; this study has attempted to isolate one potentially causal relationship between mood, coping skills and problem gambling.

In summary, this study indicates that the motivations of female problem gamblers may differ from those of male problem gamblers. Female gamblers who were high in both avoidance coping and dysphoric mood showed substantially more symptoms of problem gambling than those high in just avoidance or dysphoria. These results supported prior qualitative research and suggest that some female gamblers may be gambling to escape dysphoric mood, and that these females may be particularly susceptible to problem gambling (Brown & Coventry, 1997). In contrast, there was no evidence that this combination of high avoidance coping and high dysphoric mood substantially increased the risk of problem gambling for males suggesting this model may not be applicable to male gamblers.

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Problem-solving skills in male and female problem gamblers

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Abstract

The current study was designed to compare the self-reported problem-solving skills of male and female gamblers. In total, 148 females and 112 males (mean age = 43.6 years, SD = 12.0), responding to an advertisement for people concerned about their gambling, completed the Problem Solving Inventory (Heppner, 1988). The PSI consists of three factors related to self-perception of problem-solving: confidence, personal control and approach-avoidance style. Gamblers were categorized into three subgroups according to their DSM-IV scores: Asymptomatic, Problem, and Pathological. Results from a series of analyses of co-variance (co-varying for the confounding effects of current emotional distress) revealed that gender had no significant effect, but problem severity on appraisal of problem-solving confidence and sense of personal control had a significant effect. Pathological gamblers were less confident and felt less in control than the other subgroups while engaging in problem-solving activities. Problem gamblers tended to have more negative appraisals of control than Asymptomatic gamblers. Problem-solving skills were also a significant predictor of DSM-IV scores for pathological gambling (i.e., negative appraisals were associated with higher DSM-IV scores). The results suggest that problem-solving skills are deficient in pathological gamblers and problem gamblers, but are not related to gender.

Introduction

In a meta-analytic study of gambling disorders in Canada and the United States, Shaffer, Hall and Vander Bilt (1997) estimated that the lifetime prevalence rate of pathological gambling for women in the general population is approximately 1%. Another 3% of women experience a variety of adverse consequences from their gambling activities, despite not meeting diagnostic criteria for pathological gambling. Their analyses, which included studies spanning 20 years of empirical research, suggested that up to a third of pathological and problem gamblers in the general population were women.

The vast majority of empirical studies on gambling have either included only male gamblers or an insufficient number of women to permit meaningful comparisons. Mark and Lesieur (1992), in reviewing this literature, found very few studies that addressed pathological gambling in women. Furthermore, where sizeable numbers of female gamblers have been studied, differences in sampling, methodology, representativeness (e.g., GA membership) and assessment have made comparisons with other studies including women difficult. The available data suggest that women when compared to men generally experience a later onset of gambling (Lesieur & Rosenthal, 1991), report a shorter duration between non-problem and problem gambling (Rosenthal, 1992; Lesieur, 1988), tend to gamble within a social context, focus on games that are not considered to require skill (e.g., bingo, slot machines) or intended to enhance social functioning or self-esteem (Lorenz, 1990; Rosenthal, 1992), tend to wager smaller amounts and adopt gambling as a means to cope with dysphoric emotions (Rosenthal, 1992). This suggests that there may be important gender differences in problem-solving behaviours that may produce different patterns and characteristics of gambling behaviour. The purpose of the current study is to compare the problem-solving skills of male and female gamblers.

Cognitive behaviour therapy (CBT) is among the most validated treatment approaches to addictive behaviours (e.g., Walters, 2000). CBT interventions tend to be goal-oriented, practical and problem-focused. Commonly, distortions in thinking and perception and/or behavioural deficiencies or excesses are targeted. Motivational interventions intended to reduce ambivalence are also routinely used. Cognitive-behavioural treatment of alcohol problems often target deficits in problem-solving skills (Heather, 1995). While the evidence to date is not yet strong, a recent review of randomized control studies found CBT to be the most effective therapeutic modality for problem gambling (Toneatto & Ladouceur, in press). Since CBT can be viewed as a form of problem-solving therapy, a greater understanding of the problem-solving characteristics of problem gamblers might be important in informing CBT approaches for problem gambling and may guide the development of gambling-specific CBT interventions. Unfortunately, little is known about the problem-solving behaviours of problem gamblers. After a CBT intervention that included a specific problem-solving training

component, Ladouceur and Sylvain (1999) found that treatment outcomes improved in pathological gamblers compared to a wait-list control group. Clearly, more research is needed to directly examine problem-solving skills in gamblers.

Method

Participants

In total, 148 female and 112 male gamblers, age 18 or older, volunteered to participate in a confidential survey about gambling. Participants were recruited primarily from advertisements placed in major urban newspapers seeking people concerned about their gambling.

Procedure

Individuals interested in the study contacted the research coordinator by telephone. The coordinator described the study, answered any questions and screened individuals to see if they met the primary study criteria: Are they concerned about their gambling behaviour? Those consenting to participate were mailed a self-administered questionnaire booklet. Participants who returned completed booklets received $40 in gift certificates.

Measures

Gambling severity

The Diagnostic and Statistical Manual (American Psychiatric Association, 1994) criteria for pathological gambling was used to assess gambling severity. Participants answered 10 questions related to symptoms experienced within the past 12 months. Scores ranged from zero to10, and individuals scoring five or higher met criteria for pathological gambling. For the current study, gamblers were categorized into one of three levels of gambling-problem severity based on their DSM-IV gambling scores: asymptomatic (score of 0), problem (1 to 4) and pathological (5 or higher).

Problem-solving skills

The Problem Solving Inventory (PSI) (Heppner, 1988) was administered as the key measuring device of problem-solving skill. The PSI is a 35-item instrument measuring how individuals believe they react to personal problems encountered in their daily lives. The instrument consists of three sub-scales: Problem-Solving Confidence (scores range from 11 to 66), Approach-Avoidance Style related to problem-solving activities (scores range from 16 to 96) and degree of Personal Control of emotions and behaviours while engaging in problem-solving activities (scores range from 5 to 30). Low scores are associated with a positive

view of problem-solving skills. This instrument possesses good internal consistency (alphas range from .72 to .85 on the sub-scales and .90 on the entire test) and there is good test-retest reliability. The validity of the PSI has been evaluated in various populations including adolescents, psychiatric populations and university students. For example, validity studies have shown that the PSI is linked to psychological well-being (e.g., Heppner & Anderson, 1985); symptoms of generalized anxiety disorder (Ladouceur, Blais, Freeston, & Dugas, 1998); hopelessness, depression severity and dysfunctional attitudes in depressed outpatients (Cannon et al., 1999; Otto et al., 1997)' depression, hopelessness, and psychosocial impairment in patients with chronic low back pain (Witty, Heppner, Bernard, & Thoreson, 2001).

Current psychiatric distress

The Brief Symptom Inventory (BSI) (Derogatis, 1993; Derogatis & Melisaratos, 1983) consists of 53 symptoms designed to measure nine dimensions of psychopathology experienced by individuals within the past week. The Global Severity Index (GSI), based on the mean rating for all 53 items, is scored on a five-point scale, ranging from zero, meaning "not at all," to four, meaning "extremely," and provides an overall index of current emotional distress. Internal consistency coefficients for the nine sub-scales cluster around .80 with test-retest correlations ranging from .68 to .91 over a two-week period (Derogatis & Melisaratos, 1983). The GSI has a stability coefficient of .90 over a two-week period.

Data analysis

A series of 2x3 analyses of covariance (ANCOVAs) were conducted to explore the effects of gender and gambling severity on each of the measures of problem-solving skills while controlling for current psychiatric distress (measured by the GSI on the BSI) that may confound coping activities (Stanton, Danoff-Burg, Cameron, & Ellis, 1994). The alpha level was set at .05 for main effects and interaction effects. Observations that were two or more standard deviations away from the mean were considered outliers, and were excluded from the analyses of covariance. A regression analysis using the STEPWISE method (SPSS 10.0) was also conducted to determine whether self-perception of problem-solving skills predicted DSM-IV scores when other demographic variables, psychiatric variables and gambling frequency were included in the regression equation.

Results

Demographic characteristics of the sample are found in Table 1. There were significantly more unmarried men (68.8%) than women (54.1%) in the sample (χ^2 , p = .016).

Table 1. Demographic characteristics by gender

	N	Males	Females	Total sample
Age (M years [SD])	260	42.9 (11.4)	44.2 (12.4)	43.6 (12.0)
Marital status:[1] n (%)	260			
Married/partnered		35 (31.3%)	68 (45.9%)	103 (39.6%)
Not married/partnered		77 (68.8%)	80 (54.1%)	157 (60.4%)
Education level: [2] n (%)	260			
Secondary or less		50 (44.6%)	79 (53.4%)	129 (49.6%)
Post-secondary		62 (55.4%)	69 (46.6%)	131 (50.4%)
Employment status: [3] n (%)	258			
Employed		59 (53.6%)	76 (51.4%)	135 (52.3%)
Not employed		51 (46.4%)	72 (48.6%)	123 (47.7%)
Gross annual income ($); n (%)	258			
< 20 000		44 (39.6%)	78 (53.1%)	122 (47.3%)
20 000 — 39 000		32 (28.8%)	44 (29.9%)	76 (29.5%)
40 000 — 59000		23 (20.7%)	19 (12.9%)	42 (16.3%)
60 000 +		12 (10.8%)	6 (4.1%)	18 (7.0%)
Gambling categories n (%)	260			
Asymptomatic		16 (14.3%)	18 (12.2%)	34 (13.1%)
Problem		44 (39.3%)	57 (38.5%)	101 (38.8%)
Pathological		52 (46.4%)	73 (49.3%)	125 (48.1%)

[1] χ^2, p = .016

[2] χ^2, p = .163

[3] χ^2, p = .716

Otherwise, there were no other gender differences. About half of the sample was employed, reported some post-secondary education and earned more than $20,000 per year. The proportion of men and women whose gambling severity was asymptomatic, problem and pathological is also reported in Table 1. Within each severity category, there were comparable proportions of men and women. Almost half of the sample consisted of gamblers whose problem severity was pathological while approximately 13% were asymptomatic.

Table 2 shows the frequency of gambling behaviours for the male and female participants. Lottery, scratch tickets, casino slot machines and bingo were popular gambling activities.

Table 2. Description of gambling behaviour by gender

	Number of times per year Mean (SD)			
Gambling activity	**N**	**Males**	**N**	**Females**
Lottery	97	97.6 (69.4)	129	126.3 (131.4)
Scratch tickets	64	104.2 (108.8)	101	130.6 (147.3)
Pull tabs	25	106.5 (129.2)	50	76.6 (116.0)
Card games (private)	34	54.9 (62.7)	28	45.0 (72.7)
Casino card games	37	56.9 (87.3)	22	31.1 (48.6)
Casino table games	19	58.2 (74.5)	8	40.3 (69.1)
Casino slot machines	42	54.6 (77.6)	79	61.7 (89.4)
Casino video gambling	11	55.3 (112.0)	16	37.2 (53.1)
Stock market	10	45.3 (33.8)	11	23.5 (53.1)
Race track	39	50.7 (84.8)	29	59.8 (123.0)
Real estate	2	3.0 (1.4)	2	53.0 (72.1)
Sports lotteries	53	148.4 (125.0)	16	91.4 (123.0)
Sports betting	25	92.6 (116.3)	5	56.1 (61.3)
VLTs	9	129.7 (145.1)	12	44.0 (50.2)
Bingo	25	41.2 (64.3)	98	96.3 (85.2) [1]
Charity	15	76.4 (99.5)	15	47.7 (99.5)
Internet gambling	1	4 (--)	3	160.3 (183.1)

[1] excludes one extreme outlier

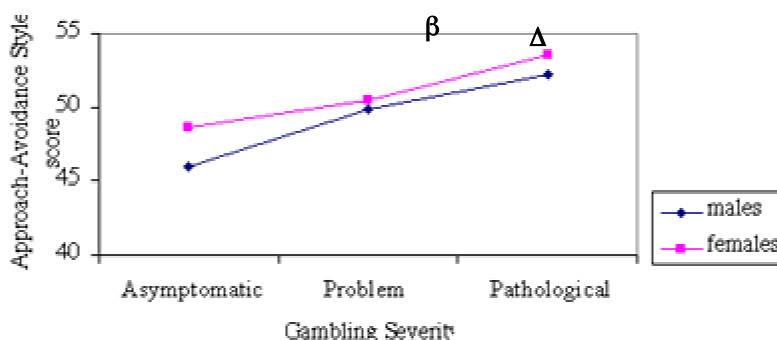
Male and female participants playing lottery, scratch tickets or pull tabs were playing on average between 1.5 and 2.5 times per week. Participants also reported playing a variety of casino games between 30 and 60 times per year. About twice as many women reported playing bingo than men. Few participants engaged in real estate or Internet gambling. The gambling activities that were identified as causing the biggest concern for men were casino card games (23.2%), lotteries/scratch tickets (13.7%), sports lotteries (13.7%) and race track betting (12.6%). For women, the gambling activities that caused the most concern were bingo (34.1%), casino card games (27.8%) and lotteries/scratch tickets (15.0%).

Treatment by a psychiatrist was reported by 40.2% of the sample while 45.6% reported receiving treatment by a psychologist or other mental

health professional. Almost one-third had been prescribed anti-anxiety medication, 42.9% prescribed anti-depressants and 7.7% prescribed anti-psychotic medication or mood regulators. Almost one-fifth (18%) of the sample reported having been hospitalized for a mental health problem. No gender differences were found on any of these variables.

Figure 1 displays the mean scores for problem-solving confidence, personal control and approach-avoidance sub-scales of the PSI by gender and gambling severity. Results of the ANCOVA on the Problem-Solving Confidence sub-scale revealed that there was a significant main effect of gambling severity ($F_{2,250} = 5.02$, $p = .007$) and no significant gender or interaction effects. Simple contrasts of the severity subgroups revealed that the pathological gamblers rated themselves as significantly less confident in their problem-solving skills than both the asymptomatic subgroup (mean difference = 4.41; 95%CI = 1.52 to 7.30; p=.003) and the problem gambler subgroup (mean difference = 2.20, 95%CI = 0.16 to 4.23; p=.035). The difference in confidence scores between the asymptomatic and problem groups was not significant ($p > .10$).

Figure 1. PSI problem-solving confidence, personal control and approach-avoidance style sub-scale scores by gender and gambling severity.



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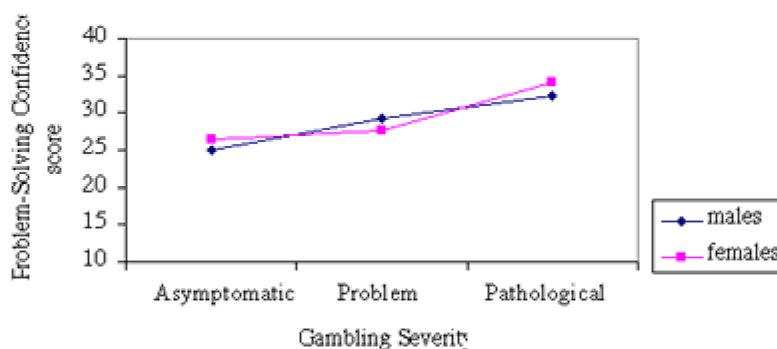

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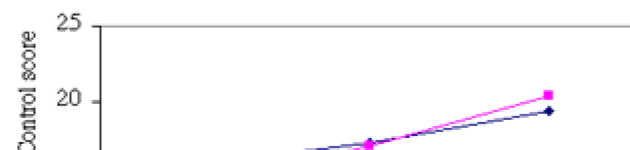

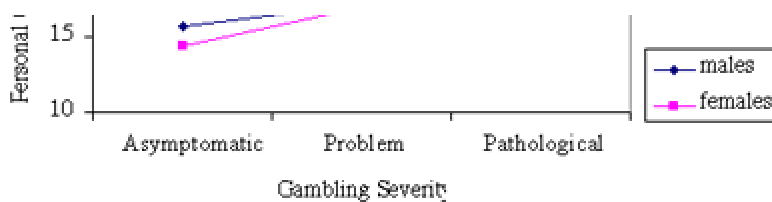

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On the Personal Control sub-scale, there was also a significant effect of gambling severity ($F_{2,247}$ = 13.09, p<.001), but no significant gender or interaction effects. Simple contrasts revealed that pathological gamblers felt significantly less personal control during problem-solving than the problem gamblers (mean difference = 1.66; 95%CI= 0.67 to 2.65; p=.001), and the problem subgroup, in turn, reported less control than the asymptomatic subgroup (mean difference = 1.83, 95%CI = 0.49 to 3.18; p=.008).

Figure 1 shows that the pathological gambling subgroup had a higher mean score on the Approach-Avoidance Style sub-scale (higher scores signify a more avoidant style to problem-solving activities) than the other gambling subgroups; however, the ANCOVA revealed no significant effects of gambling severity (p=.13), gender, and gender by severity interaction effects.

To examine whether problem-solving skills predicted DSM-IV scores for pathological gambling, the following variables were entered into a stepwise regression: age, gender, employment status, GSI from the BSI, history of treatment by psychiatrist (yes/no), gambling frequency (frequency of the gambling activity with the highest level of participation within the past year) and total score on the PSI. The PSI total score measures perception of general problem-solving abilities and was included instead of the individual PSI sub-scale scores to avoid problems of multicollinearity. (Pearson correlation coefficients ranged from .51 to .69 among the various sub-scales in this sample.) The Global Severity Index, gambling frequency and total PSI score were the only variables retained in the final regression model (Table 3). Higher psychiatric distress, higher gambling frequency and more negative views of

Table 3. Predictors of DSM-IV pathological gambling scores

		Stepwise multiple regression[2]				
Predictors[1]	**Step**	**β**	**Δ R^2**	***df***	**Total R^2**	**Adjusted R^2**
BSI — Global Severity Index	1	.370	-	1,251	.227	.224
Gambling frequency measure	2	.223	.062	1,250	.288	.283
PSI total score	3	.183	.026	1,249	.315	.306

[1] Variables entered into the stepwise regression but excluded from the final regression equation include: age, gender, employment status, psychiatric treatment.

[2] β denotes standardized beta coefficients of the final regression equation.

problem-solving ability predicted higher DSM-IV scores. The final regression model explained 31.5% (adjusted R^2 = 30.6%) of the variance in DSM-IV gambling scores, with PSI scores contributing to a small (ΔR^2 = 2.6%) but significant increase in explained variance. If instead the three sub-scales scores (in place of the PSI total score) are allowed to compete for entry into the regression, the Personal Control sub-scale enters as the third step in the model following the BSI global index severity and gambling frequency, and predicts 4.4% of the total (33.2%) explained variance.

Discussion

This study revealed that there were differences in perceived problem-solving skills among gamblers with different levels of problem severity. However, there were no significant gender differences. Both male and female pathological gamblers reported being less self-assured while trying to solve problems they encountered in their lives and felt less in control over their emotions and behaviours during problem-solving activities than either the asymptomatic or problem gamblers. The problem gamblers perceived themselves to have less control over their emotions and behaviours during problem-solving compared to the asymptomatic gamblers.

A comparison of PSI scores observed in the pathological gamblers, and to some extent the problem gamblers, were quite similar to those reported in other clinical populations (e.g., inpatient males with alcohol problems, Larson & Heppner, 1989; generalized anxiety disorders, Ladouceur, et al., 1998). These clinical populations tended to have more negative appraisals of problem-solving skills than undergraduate student populations or adult populations. This suggests that pathological gamblers and patients with substance use disorders or psychiatric disorders might benefit from interventions addressing these deficits. Both male and female gamblers in this study appear to require some problem-solving skills training.

The absence of significant gender differences in various aspects of problem-solving skills also suggests that CBT gambling-treatment interventions for men and women do not need to be drastically different with respect to problem-solving skills training. CBT interventions for problem gamblers and especially pathological gamblers may also benefit from targeting problem-solving skills that need attention (e.g., enhancing emotional and behavioural control when handling high-risk gambling situations). The relatively high avoidance scores observed in the pathological gamblers also seem to indicate that CBT interventions

may be a good treatment approach in teaching gamblers a more effective style of dealing with problems.

A limitation of the study is that the PSI measures perceived and not actual problem-solving skills; however, there is some evidence that they are related (Heppner, Hibel, Neal, Weinstein & Rabinowitz, 1982). Furthermore, there does seem to be a pattern among clinical populations to report negative appraisals of problem-solving skills, suggesting that these problem-solving skills warrant attention. While Dixon, Heppner, Burnett, Anderson and Wood (1993) found that PSI scores were both an antecedent and predictor of a depressed mood, it not possible in this study to determine whether deficits in problem-solving appraisal was a symptom of or precursor to gambling problems. Deficits in problem-solving skills may contribute to vulnerability in the development of gambling problems, or conversely, having a gambling problem may, over time, negatively influence problem-solving skills. The current study was correlational in nature, and additional controlled research is needed to further explore problem-solving abilities in problem gamblers.

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Gender differences in psychiatric comorbidity and treatment-seeking among gamblers in treatment

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Abstract

Objectives: To assess the effects of gender on comorbid problems and treatment-seeking among gamblers in treatment and the effects of comorbid problems on participants' gambling

Method: Participants completed a survey on comorbid problems and the effects of comorbid problems on their gambling

Sample: Seventy-eight adults (40 males, 38 females) enrolled in state-supported outpatient programs or Gamblers Anonymous

Results: The majority of participants (53%) had multiple comorbid problems and 38.5% said they had a comorbid problem related to their gambling. Eleven different types of comorbid problems were reported. Females had significantly more comorbid problems than males; females reported problem drinking and both genders reported that depression increased the severity of their gambling problems.

Conclusion: Patterns of comorbid problems and treatment-seeking are consistent with well-known gender

differences in health behaviors. Clinicians involved in gambling treatment may wish to assess for depressive syndromes and problem drinking and investigate their interaction with their patient's gambling.

Keywords: comorbidity, alcohol, gamblers, gender, treatment, career length, depression

Introduction

Gender has been a determinant of many health-related behaviors, such as treatment utilization, substance use, and psychiatric symptoms and diagnoses (Robins & Regier, 1991; Verbrugge, 1985). Males tend to have earlier and higher mortality rates(Verbrugge, 1985) and use substances (alcohol, tobacco and street drugs)more than females (Robins & Regier, 1991). Females tend to use physical and mental health services more (Verbrugge, 1985) and use more prescribed drugs than males (Verbrugge, 1985). Gender is also important in psychiatric disorders, where males tend to have higher rates of disordered substance use, with the exception of prescription drug use (Robins & Regier, 1991) and females tend to have more psychiatric disorders, especially in the anxiety and mood disorder cluster(Robins & Regier, 1991).

Historically, in studies of the prevalence of gambling disorders, males have significantly outnumbered females. Volberg (1994), in a paper summarizing prevalence studies from five states in the United States, estimated males to be 76% of pathological gamblers in the community. The most current diagnostic manual states that females comprise only 33% of pathological gamblers (American Psychiatric Association, 2000). However, the expansion of legalized gambling in the United States has changed this ratio. The most recent U.S. national survey of gambling behavior, completed in 1999, shows gambling disorders more equally distributed by gender. Although the National Opinion Research Center (1999) found higher prevalence rates of problem and pathological gambling among men than women — male lifetime rates: problem 1.6%, pathological 0.9%; female lifetime rates: problem 1.0%, pathological 0.7% — in their initial (RDD) survey, the differences were not statistically significant.

Studying the patterns of comorbid disorders can lead to better treatment and understanding of the causal factors in the disorder. Additional disorders of all types have implications for treatment. The presence of comorbid diagnoses makes it more likely that the patient will seek treatment (Andrews, Slade & Issakidis, 2002; Noyes, 2001). The presence of comorbid diagnoses also increases the likelihood of treatment failure in many psychiatric disorders: depression (Bagby, Ryder & Cristi, 2002), bipolar disorder (Frangou, 2002), obsessive-compulsive disorder (Ruppert, Zaudig, Hauke, Thora & Reinecker, 2001), generalized anxiety disorder (Noyes, 2001), post-traumatic stress disorder (Breslau, 1999) and panic disorder

(Mennin & Heimberg, 2000). The presence of comorbid diagnoses affects cognitive-behavioral therapies (Mennin & Heimberg, 2000), inpatient treatment (Haettenschwiler, Rueesch & Modestin, 2001) and pharmacotherapy (Bagby et al., 2002).

The National Comorbidity Survey (Kessler et al., 1994) was the first survey to administer a structured psychiatric interview to a national probability sample of non-institutionalized people in the United States. The study found that psychiatric morbidity was highly concentrated in one-sixth, or approximately 16% of the adult population with a lifetime history of three or more comorbid disorders.

The most well-studied comorbid relationships among psychiatric disorders are the (misnamed) dual disorders, or the association between substance use disorders and psychotic, anxiety and mood disorders. The interactions can be very complex. To generalize: 1) the two disorders may occur by chance, 2) substance use may cause or exacerbate the psychiatric disorder, 3) the psychiatric disorder may cause or increase the severity of the substance use, 4) both disorders may be caused by a third condition, and 5) substance use or withdrawal may mimic the psychiatric disorder.

Studies of dual disorders often attempt to determine the temporal relationship of the onset of the different disorders to clarify causation. However, the comorbidity pattern can differ by the substance used and the specific other psychiatric disorder or disorders as well as by the population studied. For example, the National Comorbidity Study found that alcohol use problems and dependence consistently occurred after the onset of the psychiatric disorder (Kessler et al., 1997). However, nationwide studies of psychiatric comorbidity and both alcohol and drug use disorders in six countries found that only anxiety disorders consistently preceded substance use disorders; mood disorders and substance use disorders had no consistent temporal pattern (Merikangas et al., 1998). Despite the theoretical complexity, the temporal relationship among comorbid disorders can be useful clinically, in deciding which of several disorders is primary, which have implications for treatment priorities and plans.

The study of other psychiatric diagnoses occurring with gambling disorders is early in its development. The Harvard Division of Addictions gambling disorder prevalence meta-analysis (Shaffer, Hall & VanderBilt, 1997) established psychiatric comorbidity as a risk factor for gambling disorders. Their analysis established significantly higher prevalence rates for gambling disorders among samples of adults with psychiatric or substance dependence disorders and those in prison than among community samples of adults. The relative risk varies from four to seven, depending on the population studied (Shaffer et al., 1997).

Comorbidity patterns change based on the population studied and site of assessment (Berkson, 1946). Clinical studies of patients in treatment with gambling disorders have found that other psychiatric disorders occur consistently. Ibañez et al. (2001) found comorbidity in 43% of

gamblers seeking treatment. There have been more studies of treatment populations than community populations in the study of comorbid disorders in gambling. However, the number of subjects studied is usually small, especially in studies of anxiety and personality disorders. Clinically useful information, such as the nature and relevance of the specific comorbidity associations, is limited. See Table 1 for a summary of the relevant studies.

Table 1

Summary table of research on comorbid diagnoses in community and treatment samples

Disorder	Total number of studies	Community studies		Treatment studies	
		Number	Total subjects	Number	Total subjects
Mood disorders	20	3	9,100	17	3,200
Anxiety disorders	5	1	7,200	4	250
Antisocial personality disorder	2	1	7,200	1	109
Substance use disorders	12	2	9,200	10	3,200

Substance dependency has been relatively well established as a significant comorbidity with pathological gambling (Crockford & el-Guebaly, 1998; Ibañez et al., 2001; National Research Council, 1999; Shaffer et al., 1997). Approximately 50% of pathological gamblers will have a substance use or dependency diagnosis. Affective symptoms have also been found to be associated with pathological gambling (Crockford & el-Guebaly, 1998; Maccallum & Blaszczynski, 2002; National Research Council, 1999; Shaffer et al., 1997); however, the results have been inconsistent. One analysis proposed that affective disorders were a significant comorbidity in only a subgroup of problem gamblers (Crockford & el-Guebaly, 1998). Personality disorder comorbidity has also been studied, with antisocial personality disorder being the strongest association (Crockford & el-Guebaly, 1998; Ibañez et al., 2001). However, the strong association between substance use disorders and antisocial personality disorder confounds the association between gambling disorders and antisocial personality disorder (National

Research Council, 1999).

There are many unanswered questions about the influence of comorbid psychiatric disorders in problem gamblers. Because of the historical predominance of males in populations with gambling disorders, the effect of gender on comorbidity patterns in gambling disorders is unstudied. In addition, since treatment populations for any psychiatric disorder are more likely to have other psychiatric disorders (Berkson, 1946), the clinical relevance of comorbid disorders in problem gambling has been minimally studied. Only one study has determined that comorbid disorders increase the severity of the gambling disorder (Ibañez et al., 2001). But do the comorbid disorders only add to disease burden and make it more likely for the patient to seek treatment or do they directly affect the gambling behavior and need to be considered in the formulation of treatment plans for problem gamblers?

The objectives of this study were to assess (1) the effect of gender on comorbid problems and (2) treatment-seeking behavior of gamblers in treatment and (3) the interactive effects of the comorbid problems on the participants' gambling.

Method

Participants

An anonymous, voluntary questionnaire was distributed to all state gambling disorder treatment sites and Gamblers Anonymous meeting sites in the state of Louisiana in January of 1999 as part of a study on the social cost of gambling (Ryan et al., 1999). Seventy-eight questionnaires were returned in time for statistical analysis.

Materials

Participants completed a survey that included a screen for gambling disorders, demographic questions, and questions about types and frequency of gaming activities, quantifiable consequences of gambling disorders, comorbid conditions, illicit substance use, gambling career and treatment-seeking history. Questions covered gambling behavior and work and legal and other consequences of disordered gambling based on Lesieur's model (Lesieur, 1998). Gender differences in these behaviors are under study. The questionnaire inquired about the types of other mental health and substance use problems that the participants had experienced. The questionnaire specifically asked, "Did any of these problems ever make your gambling problems worse?" Each participant's history of gambling, substance use disorder and psychiatric treatment was also reported.

Design and procedure

Chi-square analyses were performed on the types of comorbid problems, total number of comorbid problems, types of mental health or

substance use treatment sought and the response to whether or not gambling had been worsened by comorbid problems. A one-way ANOVA was performed on total number of comorbid problems by gender. The chi-square on each comorbid condition was analyzed separately by gender and by the dichotomous variable that reflected their worsening of the gambling problem.

Results

Previous treatment

Males reported larger treatment costs for gambling treatment and more substance abuse treatments. Females reported significantly more outpatient mental health treatment ($\chi^2(1, N = 78) = 5.198, p < .05$).

Comorbid problems

Sixty-one of the 78 respondents (78%) reported other substance use or mental health problems. A total of 168 comorbid problems in 11 categories were reported by the sample. Twice as many males (30.7% of the total sample) as females (16.7%) had one or no other comorbid problems. See Table 2 for the distribution of the number of comorbid problems by gender. More females (32%) than males (20.6%) had two or more comorbid problems. A one-way ANOVA on total number of comorbid problems by gender showed that females (mean 2.42) had more comorbid problems than did males (mean 1.6) ($F (1,76) = 3.948$, $p < .05$).

Table 2

Total number of comorbid problems by gender with percentages of total sample

Number of comorbid problems Count/per cent of total	Males		Females	
0	14	17.9%	7	9.0%
1	10	12.8%	6	7.7%
2	7	9.0%	10	12.8%
3	2	2.6%	3	3.8%
4	3	3.8%	6	7.7%
5	2	2.6%	3	3.8%
6	2	2.6%	3	3.8%

Table 3 presents the percentages of males and females reporting

specific problems. Males reported significantly more alcohol problems (χ^2 (1, N = 78) = 5.641, $p < .05$) and problem use of other drugs ($\chi2$ (1,N = 24) = 4.8, $p < .05$) than females and showed tendencies to greater marijuana use ($\chi2$ (1, N = 78) = 3.486, $p = .062$). Females reported significantly higher problems with overeating ($\chi2$ (1, N = 78) = 7.453, $p < .01$), eating disorders (χ 2 (1, N = 78) = 4.438, $p < .05$), compulsive shopping ($\chi2$ (1, N = 77) = 16.896, $p < .001$) and tranquilizer use ($\chi2$ (1, N = 24) = 10.667, $p < .001$).

Table 3

Per cent of sample reporting comorbid problems by gender

	Per cent of total sample	
Disorder	**Males**	**Females**
Alcohol use	20.5**	7.7
Overeating	12.8	26.9**
Eating disorder	0	5.1*
Compulsive shopping	1.3	19.5***
Depression	28.2	30.8
Any drug use	14.1	14.1
	Per cent of drug users	
Substance	**Males**	**Females**
Marijuana	39.1	17.4
Tranquilizers	8.3	41.7***
Stimulants, "uppers"	8.3	8.3
LSD	4.2	0
Narcotics	8.3*	4.2
Other drugs	16.7	0

Note: * $p < .05$; ** $p < .01$; *** $p < .001$

Effect of comorbid problem on gambling

Forty-nine per cent of those reporting comorbid problems (38.5% of the total sample) indicated that a comorbid problem had increased the severity of their gambling behavior. Eleven different types of comorbid problems were reported. Only two, depression and problem drinking, were identified as exacerbating gambling behavior. Females were significantly more likely than males to report that problem drinking ($\chi2$ (1, N = 34) = 5.13, $p < .05$) had increased the severity of their gambling.

About the same percentage of males and females reported depression had increased the severity of their gambling. Chi-square analyses on depression by gender and by the variable that measured a worsening of gambling problems found that depression exacerbated gambling problems independent of gender. Both males ($\chi 2$ (1, N = 38) = 5.546, $p < .01$) and females ($\chi 2$ (1, N = 34) = 5.903, $p < .01$) reported that depression significantly worsened their gambling problems.

Discussion

Many of the comorbid and treatment-seeking behaviors reported by this sample are consistent with well-known and studied gender differences in health behaviors. Males reported more alcohol and drug use problems and females reported more psychiatric problems, tranquilizer use and outpatient psychiatric treatment, which is consistent with previous reports (Kessler et al., 1994; Robins & Regier, 1991; Verbrugge, 1985).

The majority of the gamblers in this treatment sample from Louisiana had other psychiatric or substance use problems in addition to their gambling disorder. Comorbid problems were the rule rather than the exception in this population of gamblers in treatment. However, only a minority of patients with comorbid disorders answered positively to the question that the comorbid disorder had ever increased the severity of their gambling. This study partially supports the findings of Ibañez et al. (2001) that comorbid disorders increase the severity of gambling problems.

One finding of this study is that, from the participants' viewpoint, only two of the multiple comorbid problems reported had ever affected the severity of their gambling. Unfortunately, the effects were inconsistent: only about half of the patients with comorbid problems identified that depression or problem drinking had increased their gambling behavior. Most of the males with comorbid problem drinking and some of the participants with depression did not identify these problems as ever negatively affecting their gambling.

Although preliminary, this study provides more evidence of the need for careful attention to diagnosing and investigating the interactions of comorbid alcohol (Maccallum & Blaszczynski, 2002) and affective disorders. Clinicians should further investigate the interaction of the comorbid disorder with gambling behavior and the order of onset of the disorders. For example, a patient who developed depressive symptoms after the onset of pathological gambling in response to financial, legal or marital problems should be treated differently than a patient who developed depressive symptoms, and later, found that gambling temporarily relieved the symptoms of depression. In this example, the clinical approach should be different, even if both patients reported that their depressive symptoms increased their desire to gamble or their gambling behavior.

In addition, this study provides some perspective on the inconsistent results of pharmacological treatments for gambling disorders.

Inconsistent and possibly gender-related effects of comorbid disorders may be confounding the results of these trials. Several agents that affect mood and alcohol use behavior have shown inconsistent, mixed results in treatment trials. It may be necessary to sub-type gambling populations in treatment trials by both the presence and type of comorbid disorders as well as the effect of the comorbid disorder on the gambling behavior.

This study needs to be replicated with larger numbers and independent confirmation of comorbid diagnoses, rather than self-report alone. Family or other collateral information on the interaction of the comorbid disorders and the gambling would also be useful to supplement the patient's perceptions of the interactions. In addition, information on the onset of the comorbid disorders in relation to the gambling disorder would be crucial to determine causality. Further, more targeted studies are needed to clarify the clinical relevance of comorbid disorders for gamblers in treatment programs and to determine the role of these disorders in the development of gambling disorders.

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Fruit machine addiction in an adolescent female: A case study

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Gambling is perceived as an "adult" activity primarily because of the legal restrictions placed on it. However, fruit machine gambling (a kind of slot machine playing) is one activity that is legally available to adolescents in the United Kingdom. Adolescent fruit machine playing is a widespread phenomenon, yet we still know so little about it in comparison with other potentially addictive behaviours. In the most recent U.K. study by Fisher and Balding (1998), 75% per cent of close to 10,000 adolescent participants stated that fruit machines were their favourite form of gambling.

A more thorough examination of the literature (Griffiths, 1995; Fisher, 1992; Fisher & Balding, 1998) indicates that in the U.K.:

- At least two-thirds of adolescents play fruit machines at some point during adolescence.
- One-third of adolescents have played fruit machines in the last month.
- 10% — 20% of adolescents are regular fruit machine players (playing at least once a week).

- Up to 6% of adolescents are probable pathological gamblers and/or have severe gambling-related difficulties.

Published studies report that males play fruit machines more often than females and that as fruit machine playing becomes more regular it is more likely to be a predominantly male activity. Researchers have identified few female adolescent fruit machine addicts.

Why do adolescents play fruit machines? There is no easy answer. However, research suggests that irregular ("social") gamblers play for different reasons than excessive ("pathological") gamblers (Griffiths, 1995). Social gamblers usually play for fun and entertainment, their friends or parents do (i.e., it is a social activity), for the chance of winning money, because it’s challenging and easy to access or for the excitement (the "buzz") and because there is little else to do. It appears that pathological gamblers play to change the way they feel, for mood modification and to escape reality. As noted, young males seem to be particularly susceptible to fruit machine addiction. Using an adapted version of the American Psychiatric Association criteria (Fisher, 1993; Griffiths, 1995), with up to 6% of adolescents in the U.K. experiencing problems with their fruit machine playing at any given time. Not everyone who plays fruit machines will develop an addiction, just as not everyone who drinks alcohol will become an alcoholic. What it does mean is that given a cluster of factors (genetic and/or biological predisposition, social upbringing, psychological constitution, situational and structural characteristics) a small proportion of people will unfortunately experience severe problems.

Like other potentially addictive behaviours, an addiction to playing fruit machines causes negative behaviours such as truancy (Griffiths, 1990a, 1990b, 1995; Fisher & Balding, 1998), stealing money to play (Griffiths, 1990a, 1993; Yeoman & Griffiths, 1996; Fisher & Balding, 1998), having trouble with teachers and/or parents because of machine playing (Griffiths, 1990a, 1993, 1995), borrowing or using lunch money to play (Griffiths, 1990a, 1995; Fisher & Balding, 1998), doing poorly at school (Griffiths, 1990a, 1995), and in some cases, aggressive behaviours (Griffiths, 1990a, 1995). These behaviours are similar to other types of adolescent problem gambling. Furthermore, adolescents addicted to fruit machine playing also display bona fide signs of addiction including withdrawal effects, tolerance, salience, mood modification, conflict and relapse.

As already noted, researchers have identified few adolescent females addicted to playing fruit machines. Fisher (1993) and Griffiths (1991), through their observational studies, have published the only findings relating to females who play fruit machines. Fisher reports that some female teenagers have no playing skills and little interest in acquiring them. They also

gamble on fruit machines primarily to gain access to the arcade venue where they can socialize with friends (Fisher calls them "rent-a-spacers"); they prefer the role of spectators. Griffiths (1991) observed that arcades are social meeting places dominated by male activities and that female adolescents often play a "cheerleading" role in these activities. With so little known about excessive fruit-machine playing by female adolescents, this study reports the rare case of a female teenager who has a fruit-machine addiction.

Method

The participant — an adolescent problem fruit-machine gambler — contacted the author after hearing a lecture he had given on problem gambling at the college where she studied. During a nine-month period, the author interviewed the participant three times formally and stayed in regular contact with her on an informal basis. The DSM-IV criteria for pathological gambling (American Psychiatric Association, 1994) were utilised, confirming that the participant was a former pathological gambler. At the time of the study, the participant was 22 years old.

This account tells the participant's story of how she acquired, developed and maintained her fruit-machine gambling problem. The account is presented chronologically; however, the original interviews were unstructured and allowed the participant to talk freely about whatever came to mind. A critical interpretation of the account follows in the discussion, although some initial observations are made where appropriate. Since the account is highly personal, the participant has been given the pseudonym "Jo."

Results: The case study

Background

Jo was brought up as an only child in a seaside town in the South West of England. She described her parents as "comfortable, middle class and loving" but added that they made her follow reasonably strict rules. Her father was an insurance salesman and her mother a schoolteacher. She went to a mixed school, boys and girls, and up until the age of 13, received good report cards, performing in the top 10% of her class. She was also very good in sports, an active member of the school's athletic club, and described herself as "physically stronger" than most of her peers. Jo claims she couldn't really relate to the other girls in her school and often got into playground fights with them. During her early adolescence, she made a few good friends, mostly with boys her own age or a little older. She described herself as a "tomboy." When she was nearly 15, she had her "first serious boyfriend" whom she described as the "leader of the gang."

She left school when she was 16 and got an office job working as an administrative assistant. After recovering from her gambling problem, she is now back at school completing a vocational paramedical course.

Acquisition of fruit-machine gambling

Jo started playing fruit machines at a young age because they were easy to access in her town, like "being part of the wallpaper." To some extent, her parents encouraged her to gamble. Like a lot of "seaside parents," they often took Jo to the amusement arcades as a child for a weekend treat. Jo's parents, like many, didn't see anything wrong with this type of gambling — "it was harmless fun and didn't cost much." However, these early experiences coupled with fruit-machine playing in her peer group were instrumental factors in Jo's acquisition of fruit-machine playing. The seaside town where Jo lived was a popular tourist attraction. It had four to five arcades, providing a popular meeting place for her friends and easy access to the machines. She was part of a gang that hung around the arcades for one of the few activities they could engage in. At 13, she regularly just watched her male friends play fruit machines and video games. However, within a year, she was playing fruit machines just as much as they were. "I'd go down to the arcade almost every day after school and be there most of the day during weekends. It was somewhere for us all to meet and have fun."

Jo felt "safe and protected" at the arcade. She liked it that everyone who worked there knew who she was — she was a "somebody" rather than a "nobody." In essence, being at the arcade boosted Jo's self-esteem.

Motivations to gamble

Jo gave a number of insightful reasons why she played fruit machines. Skill did not appear to be a motivating factor for continued play. She played to win money, so she could continue to play rather than fuel fantasies of winning a lot of money. Jo thought that playing fruit machines didn't require much skill; however, most of Jo's male friends claimed that fruit-machine playing required a lot of skill to be good at it. However, Jo always believed that to "win big" at fruit machines, unlike video games, you needed a lot of luck. Knowing how to use fruit machines didn't make her feel particularly skilful except when novices played next to her. Women older than her playing fruit machines wanted to socialize with her but not with boys her age — this made Jo feel wanted and needed.

When Jo was between 15 and 17, her fruit-machine playing became all-encompassing:

There was a period in my life between the ages of 15 and 17 where the machines became the most important thing in my life. I didn't

worry about money. I just believed I would win it back or that money would come from somewhere, because it always had. I was forever chasing my losses.

I would always tell myself that after a bad loss, the arcade was only "borrowing" my money and that they would have to "pay it back" next time I was in there. Of course, that rarely happened, but once I was playing again, money worries and losses went out of the window. Gambling became my primary means of escape. On the positive side, at least it helped me to give up smoking and drinking. I simply couldn't afford to buy nicotine or alcohol — or anything else for that matter. I never believed that gambling would make me rich — I just thought it would help me clear my debts.

I used to love the anticipation of going to play on the machines. The feeling after just being paid was almost intoxicating. Knowing I could afford to gamble because I had the cash in my purse was a wonderful feeling. Losing it all wasn't though. I remember blowing all my wages in a few hours one Friday night. I got really upset and depressed. It's like drugs, you tell yourself "never again" but deep down you know that as soon as the next pay cheque comes in, you'll be down at the arcade.

Development of problem gambling

Jo didn't acknowledge that she had a problem — even when she was going to the arcade alone and using all of her disposable income to play the fruit machines. However, in retrospect, she realized a problem was developing.

Over time I saw less and less of my parents. Straight after school, I would go to one of two arcades and play on the [fruit] machines for half an hour or so. Originally, I would go to the arcade to meet up with my friends. As time went on, I didn't care if they were there or not. I used to spend hours in there and only leave if I lost all my money, or it was time for the arcade to close. I simply wanted to play the machines. I became totally obsessed with them to the point where I couldn't get to sleep because I would be going over moves in my head. Looking back, I cannot believe I spent so much mental energy thinking about gambling.

… I used to spend every penny I had on the machines. It was a good job I wasn't into clothes like the other girls at school. I couldn't have afforded to buy anything, as I lost everything I had in the long run. I used to wear the same pair of jeans for months. I don't even think I washed them.

… My parents are lovely people but at the height of my playing, I didn't care about anyone — not even my boyfriend. We had loads of arguments about my gambling. He said it was OK for him to play on them but not for me. He called me an "embarrassment to be with." He was quite well off, which is one of the reasons I went out with

him. I would always be borrowing money off him. I would tell him I needed to get cigarettes or something, but all of it went into the machines. He eventually realized my gambling was a problem. Initially he tried to help but just got pissed off and left me. At the time, I didn't give a shit as the machines were more important than anyone living.

Hiding the problem

When Jo was 15 years old, her mother received a phone call from the headmaster at Jo's school explaining that Jo had missed a lot of school in the last three months, had stopped attending athletics practice and might be having some problems in her life. When Jo was confronted, she admitted that she wasn't attending school. But the reason she gave was that all the girls in her class hated her. To some extent this was true (she didn't get on with any of the girls at her school) but it wasn't the reason she was truanting. Instead of going to school, she was spending her time in the local arcades. For a few weeks she tried to stop gambling — now that her parents knew she had a problem, she thought it would be the ideal time to give it up. However, after 17 days without gambling, her boyfriend split up with her and she relapsed and started gambling again. She played for almost two years after that.

Jo's parents were understanding and looked for ways to help their daughter. They considered switching Jo's classes so she would be with new classmates and changing schools. Jo simply said she would try to integrate more. Even after Jo received a less than favourable year-end report card, her parents viewed her situation sympathetically surmising that her decline in academic performance was caused by circumstances beyond her control. Jo's parents never suspected that her erratic behaviour was linked to anything other than problems with adolescent socializing. Jo successfully managed to keep her secret for another two years before everything came out into the open.

As an only child it was difficult for her parents to know whether their experience was typical. They hardly saw Jo. At 16, Jo left school and then moved out of home. Her parents were upset but there was little they could do about it. When Jo left home, she assumed that all her problems would disappear; however, she got into more trouble. She was unable to make ends meet and ended up living hand to mouth. She began to steal from friends, people at work and from anyone she met. Twice she met men, went back to their houses and then stole their money and/or valuables.

At the time it seemed the only answer. I was in debt, running up my overdraft. Having just started a job with a reasonable salary for someone of my age, I opened up a few bank accounts and abused them all. I couldn't believe how easy it was for me to get credit.

During this period of nearly two years, Jo became more and more

withdrawn, lost her friends and resorted to stealing from her place of work. Eventually she was sacked for taking the petty cash. Her employers were unaware of her gambling problem; they assumed she wanted more money to supplement her modest wages. Although she lost her job, the company did not press charges.

Confronting the problems and recovery

The first major turning point for Jo was being fired from her first job for theft. She had nowhere else to go but back home. Although Jo's parents were surprised that fruit-machine playing was at the heart of their daughter's problems, they were tremendously supportive. Jo claimed her mother didn't believe her at first. Her parents wondered how someone could become addicted to a machine. Jo thought it would have been easier for her mother to accept that she had a drug or alcohol problem, rather than a gambling problem.

The cessation of her gambling began when Jo, with her parents' help, got another job in a remote village in Cornwall (South West England). There was no arcade, no fruit machines in the local pub and no fruit machines within a four-mile radius. She did not drive a car, and it was too far to walk to the nearest town. Essentially, the lack of access to fruit machines forced her to stop playing. She still had cravings but she couldn't do anything about them. She also reported a number of serious withdrawal symptoms. At work she was short-tempered, irritable with colleagues and constantly moody. She had trouble sleeping, occasionally experienced stomach cramps and felt nauseous.

When Jo lived on her own, there was little overt family distress (although she claims her parents worried about her living on her own). Even when her parents discovered she was skipping school, they were supportive rather than punitive. It wasn't until she was sacked from her job and came home penniless and deep in debt did they realize how many problems Jo had. Even then, they stuck by her. They realized she wanted to live independently, so they got her an apartment about half an hour away. As Jo says, it was "near enough for (her parents) to come over in an emergency but far enough away that they didn't pop over all the time."

Jo eventually joined a local Gamblers Anonymous (GA) group, which her parents drove her to every week. She attended a few sessions but stopped because she was the only female, the only fruit-machine player and also the youngest. Despite the opportunity to share her experiences with eleven or twelve people in a similar situation, she felt psychologically isolated. Being able to talk about her problems with people she trusted (i.e., her parents) was a great help. Because she wanted to stop gambling and had no access to fruit machines, Jo managed to curtail her gambling. She claims she "wasted four years of her adolescence" because of fruit-machine playing — and she doesn't want to waste any more of her life. However, there is no certainty that Jo is "cured" — she feels a

number of incidents could trigger her fruit-machine playing again, like being rejected by someone close to her. Talking to people has been what Jo calls her "salvation." She always thought that fruit-machine playing couldn't be a problem; therefore, she found it hard to believe that people accepted it as an "addiction." Because people accepted her addiction as something akin to alcoholism or drug addiction she was able to recover.

Discussion

As in most case studies, it is hard to make generalizations about people affected by similar phenomena. However, this study highlights a number of findings that have yet to be reported in the general literature about adolescent gambling. Similar to previous survey research, this case study confirmed that gambling acquisition was the result of sociological factors, rather than psychological or biological factors (Griffiths, 1995). More specifically, these factors included widespread legal accessibility of fruit machines and parental encouragement and acceptance of fruit-machine gambling. Fruit machine-playing is also a major peer-group activity. Another acquisitional factor is what Griffiths (1995) described as "choice limitation" (i.e., there is not much else for this particular age group to do). All these factors appear to play a part in behaviour acquisition. It's highly unusual for a young female to be addicted to fruit-machine playing, and as far as the author knows, there no accounts of female fruit machine addiction in the gambling literature. The participant in this study described herself as a "tomboy" — her male friends may have felt more comfortable with her because of this.

As with previous male case studies of fruit-machine addiction (Griffiths, 1995), the participant's gambling pathology only seemed to affect a few people. Her boyfriend and, to some extent, her parents were directly affected by her problematic gambling behaviour. The number of people affected is significantly less than the commonly quoted figure of 10 to 15 people cited by Lesieur and Custer (1984).

The development and maintenance of the participant's gambling habits appear to be because of psychological and physiological factors. Feelings of self-worth and a way of escape appear to be the primary motivations for continuing to gamble. Winning money allowed the participant to keep gambling, rather than providing financial stability — playing with money rather than for it. One interesting point to note was that at the beginning of her gambling career, the participant conformed to the female arcade stereotype as "cheerleader" (Griffiths, 1991) and "rent-a-spacer" (Fisher, 1993). However, within a short period, the participant's behaviour was similar to males who gambled excessively. This implies that further observational research needs to take account of how people can change over time rather than being in the fixed and static category of player.

In previous studies, gamblers report skill as being one of the possible critical factors in fruit-machine gambling (Griffiths, 1994). However, this case study is markedly different. The participant believed that to play fruit machines, you didn't need to be particularly skilful. She also had a balanced view of chance and winning. Because males are generally more competitive, they may define "skill" differently than females. This is one area where further research could prove useful. The participant's motivation to gamble appeared to come from a number of desires. In the arcade, she felt that she was a "somebody" rather than a "nobody" because everyone knew her. Women older than her playing fruit machines also sought her views. Her popularity at the arcade seemed to raise her self-esteem. The arcade and machines also provided a means of escape in her life. This is a common feature of most addictions and appears to be no different in this case.

From this author's research experience, the account presented here is fairly typical of people addicted to fruit-machine playing. This individual began playing fruit machines socially. Steadily, she gambled more and more over time, spent every last penny, borrowed money and then finally stole money to fund her gambling habit. Criminal proceedings may have proceeded against her but fortunately for her, she was only punished by losing her job. The one major difference between this account and other accounts is that this participant is female. By examining the participant's gambling behaviour in detail, there is little doubt that she was addicted to playing fruit machines. In addition to fulfilling the DSM-IV classification as a pathological gambler, the participant displayed the classical features of addiction:

- **Salience:** The participant became totally preoccupied with gambling and thought about it all the time. She also claimed she had become "obsessed" with fruit machines and that they were the most important and all encompassing thing in her life.
- **Tolerance:** Over time the participant went from watching others gamble to gambling for short periods to gambling all the time.
- **Mood modification:** The participant used gambling as a means of escape and to forget about everything. She also found some of the anticipatory feelings "intoxicating."
- **Withdrawal:** The participant experienced both psychological and physiological effects when prevented from gambling. These included moodiness, irritability, nausea, stomach cramps and insomnia.
- **Conflict:** The participant experienced a lot of conflict in her life because of gambling. It happened at an interpersonal level with her boyfriend. Her behaviours were adversely affected — she didn't go to school or have many friends. Gambling

caused intra-psychic conflict.

- **Relapse:** After a period of non-gambling a key personal relationship disintegrated and the participant returned to full-time gambling.

In addition, she constantly chased her losses and exhibited other classic signs of adolescent problematic gambling behaviours, such as having cravings, borrowing and stealing money, truanting from school, etc.

The participant eventually curtailed her gambling behaviours without formal treatment, although she did attend GA for a handful of sessions. However, she perceived GA as a negative experience particularly because of the psychological isolation she felt. Not only was she the only fruit-machine player in the self-help group, but she was the only female and the youngest. All these factors led to her eventual dropout, and raise important issues for treatment. Other vulnerable individuals may require help but drop out of programs such as GA because they cannot identify with people in the particular self-help group. The good thing in this case was that despite the lack of treatment, the participant managed to overcome her problems. As with previous case studies (Griffiths, 1995), one of the most salient themes in preventing bad gambling behaviours is family communication and support.

The major limitation of a study such as this is that it relies totally on retrospective self-report. Not only does the author have to take the participant's account as true, but the report is also subject to the fallibility of human memory. Because this study is based on one person's account, generalizations about the findings are limited. However, further research made with larger samples may help confirm these observations and speculations.

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A feminist slant on counselling the female gambler: Key issues and tasks

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This article explores key issues and tasks involved in counselling women who are gambling at a problematic level. It draws upon feminist literature, gendered studies and research specific to the female problem gambler — including findings of a recent study, *Voices of Women Who Gamble in Ontario: A Survey of Women's Gambling, Barriers to Treatment* (Boughton & Brewster, 2002). The study, referred to here as *Voices*, involved 365 female gamblers from across the province of Ontario.

A social context for understanding women's gambling and related problems

"No one has the luxury of a gender-free view of the world, and there is plenty of evidence that the genders see the world differently" (Chambliss, cited by Grant, 2002, p.7). A gendered analysis is not simply about sex (physical, biochemical or genetic differences between men and women) but about "different roles, responsibilities and activities prescribed for women and men, based on cultural conventions and expectation. These differences relate primarily to power — the relative possession or absence of it" (Grant, 2002, p.4).

Gambling also reflects gender differences. "Women experience gambling and gambling problems differently than men" (Brown & Coventry, 1997, p.25). These differences emerge in "underlying motivations to gamble and in problems generated by excessive gambling" (Potenza et al., 2001; see also Crisp et al., 2000; Delfabbro, 2000; Martins, Lobo, Tavares & Gentil, 2002). To

appreciate this, consider male and female orientations to the world. Tannen (1990, p.25) writes that men engage the world as "individuals in a hierarchical social order" in which one is either one up or one down. It is a "world of status where independence is key." Women approach the world as "individuals in a network of connections. Life is community, a struggle to preserve intimacy and avoid isolation. Though there are hierarchies in this world too, they are hierarchies more of friendship than of power and accomplishment."

Although Tannen notes that these differences are a matter of relative focus and degree, it is a helpful paradigm for understanding the typical gambling choices of men and women. Men tend to prefer fast action and competitive games based on some degree of strategic skill. Male tendencies to promote themselves in a hierarchy by beating other players or showing a superiority of skill are facilitated in card games, sports betting and handicapping. Thus, Fischer (cited by Walker, 1992, p.80) discovered that for male adolescent fruit-machine players the "acquisition of self-esteem and recognition among peers for the prowess shown was more important than monetary gains. Fruit machines become an arena of contests through which social hierarchies are worked out." Males score significantly higher on competitiveness and mastery than do females, "placing more value on outperforming others and winning in competitive situations" (Martin & Kirkcaldy, 1998, p.4).

Female priorities of connection and intimacy are better met in games where winning is not at the direct expense of others. Women generally prefer games that are less directly combative: for instance, games of chance such as bingo, slot machines and scratch tickets (Wiebe, Single & Falkowski-Ham, 2001). They often gamble in a social context in which relationships are nurtured. Dixey (1987, p.207) notes that bingo winnings are usually shared: "Sharing is a way of sustaining special networks." Women are more concerned about being liked than jockeying for status: "Having information, expertise or skill at manipulating objects is not the primary measure of power for most women. Rather they feel their power enhanced if they can be of help" (Tannen, 1990, p.68). Indeed, Brownlow, Whitener and Rupert (1998, p.283) hypothesize that women "may also misrepresent their levels of capability in order to be more likeable… Women are perceived as unlikeable, unfeminine and unfriendly when they show competence and dominance."

In keeping with this women are prone to minimize differences and be modest and self-effacing rather than boastful (Tannen, 1990). This may partially explain why King (1990) found that bingo players tend to make excuses and deny responsibility for winning, interpreting wins as luck. She hypothesizes that the women struggle with a moral conflict about playing for self-interest (greed) rather than for charity. They may also be concerned with

symmetry in relationships, sensitivity to the feelings of others and a socialization process that encourages modesty and eschews competition. But not all women avoid competition; some female gamblers, particularly middle-class career women "become empowered through competition in a male-dominated world" (Lesieur & Blume, 1991, p.191).

Problem gambling and women

Whether or not they seek treatment, most women with gambling-related problems experience difficulties related to playing scratch tickets, bingo and casino slots (Potenza et al., 2001; Rush & Shaw Moxam, 2001; Wiebe, Single & Falkowski-Ham, 2001). The most common gambling activities of the women in the *Voices* study were lottery tickets (87%), instant win or scratch tickets (83%), casino slots (71%) and bingo (64%). On average, the women played 4.2 different games each month, the majority selecting casino slots or bingo as their first choice or favourite game.

Many (74%) of the women in the *Voices* study scored as probable pathological gamblers on the South Oaks Gambling Screen (>4) and 20% scored as having some gambling problems (1–4). The women described an escalation in play and an increase in risk tolerance related to their gambling. They increased the time spent gambling (47%), the number of games played (51%) and the amount of money per hand or game (58%). While 56% tend to increase play when they win, playing until the money is gone, only 36% report cutting back on gambling after losing. The women gamble during the day (78%), the evening (85%), and sometimes, through the night (43%).

Access to money is a factor: 60% of the women gamble *whenever I have or can get the money to do so* and 41% *play more at certain times of the month because of the availability of money*. Many (55%) have become immune to the losses. Another 43% find that *the game loses interest if I try to cut back on the amount of money played*.

The women surveyed identified multiple drawbacks to gambling. Financial concerns — *losing money I can't afford* — was the most frequent response (59%), followed by *stress over money loss* (53%) and *financial worries about the future* (54%). Another concern was *secrecy over time* or *money spent gambling* (57%). While only 33% named gambling-related debts as a drawback, some women focused on financial concerns directly related to the gambling; for instance, *diverting money from other things* (41%), *spending savings or inheritance* (28%), *interest charges on credit cards* (25%), *confrontations about spending* (24%), *borrowing* (19%) and *spending the whole paycheque on gambling* (19%).

The significant differences between the women gambling at a

pathological level who have never attended treatment or Gamblers Anonymous (GA) and those who have are interesting. Although the demographic and gambling profiles are the same, the latter group reported risking much larger amounts of money at one time and having much higher gambling-related debts ($18,366 compared to $4,000). It would seem that increasing financial distress is a factor in propelling women to seek treatment.

A second cluster of drawbacks describes psychological or emotional distress. A large percentage of the women identified guilt (46%), anger (45%), depression related to gambling (43%), worry (37%), fear and anxiety related to gambling (31%) and loss of self-esteem (28%). Ten percent. indicated both suicidal thoughts and/or attempts related to the gambling and increased use of medications for anxiety and/or depression.

A third group of drawbacks concerns the negative impact on relationships: *losing the trust and respect of others* (43%), *breaking promises to oneself or others* (34%), *increased tensions and arguments* (24%) and *lying and manipulations* (19%).

Despite the considerable drawbacks to gambling identified by these women in *Voices* many were resistant to treatment. Almost 90% had thought about making changes in the 12 months prior to the study, 25% said they think about it all the time. Most (80%) had tried to stop or cut down on gambling; however, the majority had never sought gambling-specific counselling (89%) or attended GA (91%). Although a number of barriers exist, including lack of awareness of services, a significant number of women identified fears that treatment would *require me to give up all gambling when I don't want to* (57%). Consistent with this they supported a harm reduction approach to change that included moderation (51%) over total abstinence (29%).

Although other motivations affect women's reluctance to cease gambling, one clear barrier is the "eternal spring of hope." Many women hope for a big win to *resolve problems* (59%) and *improve their life situation* (41%). Intermittent experiences of winning, exposure to other people's wins and promotions by the gaming industry may reinforce this hope and strengthen resistance to abstinence. This element of hope distinguishes women problem gamblers from women with substance use disorders: although both groups may seek escape and relief from stress, the gambler actively believes that the outcome of the behaviour will be positive, improving her life in the long run. This belief influences women's preference to set controlled gambling as the goal of treatment. While it is a legitimate treatment goal, it can complicate treatment. Significant wins may lead to a shift in motivation and the return to problematic gambling.

Summing up, female problem gamblers are involved

predominantly in the continuous-play forms of gambling. They report increasing involvement and preoccupation as gambling progresses. The multiple negative consequences often involve financial pressures and intra-psychic issues of guilt and shame, compounded by emotional distress and relationship problems. Despite the consequences of gambling and thoughts about making changes, many women are unwilling to cease gambling entirely.

Relationship concerns

Feminist therapists direct us to the centrality of relationship and connection in the lives of women (Claremont de Castillejo, 1973; Gilligan, 1993; Greenspan, 1983; Miller, 1986; Tannen, 1990). Relationship issues are also important in the treatment of both women with gambling problems (Mark & Lesieur, 1992) and those struggling with drug and alcohol dependence (Currie, 2001; Wilke, 1994).

Married female problem gamblers often have poor relationships. Their marriages are often chaotic, marked by spousal addiction to drugs or alcohol, mental illness, infidelity or absences, anger and abuse (Boughton & Brewster, 2002; Lesieur & Blume, 1991). Many women in the *Voices* sample reported having spouses with gambling (22%) or drug (32%) problems. This resembles the relationships of women struggling with chemical addictions, of whom Gordon (2002) reports that an estimated one-third to one-half are living with a person who also has a drug or alcohol addiction. Often women have difficulties with anger, assertiveness and setting relational boundaries; thus, it is no surprise that 45% to 50% of respondents identified assertiveness, setting healthy boundaries, dealing with anger and conflict and meeting personal needs in relationships as very or extremely helpful topics to address in treatment. There were no significant differences between the married, single, divorced or widowed women in this; however, women who indicated abuse in their current relationships (n=84) selected these interpersonal issues as helpful more frequently and showed less interest in the topic of sexuality (28%).

Curiously, although important to almost half of the women in the *Voices* study, topics related to relationships were selected less frequently than topics related to personal enrichment, finances and leisure. This challenges the emphasis on relationships in the feminist literature. Perhaps the average age (45) of the women in *Voices* helps explain this in that many of the women may have resolved relationship tensions, accepted or resigned themselves to the status quo or separated from unhappy partnerships. It may also be relevant to consider other social pressures and stresses in women's lives.

Women are society's caregivers, constituting 80% of people

providing care, whether or not that care is paid for or provided in institutions or at home (Grant, 2002). Even when employed outside the home, women are still "largely responsible for looking after their homes and families" (Statistics Canada, 2000). The "demand to be Superwomen, juggling family and career, has created a whole new set of problems for women who feel that they should, but do not, measure up" (Greenspan, 1983, p.287). Stress is increasing for women at a rate that places stress levels above those of men (Grant, 2002) and the "greater burden on women to provide care… affects the health of women rather than men" (Morris, 2002, p.2).

It is not surprising then that dealing with stress was the issue most often identified as problematic (72%). Gambling counsellors also identified stress most frequently (98%) as an issue for female gamblers (Brewster & Boughton, 2002); it pre-empted relationship concerns. This might reflect some exhaustion and frustration with caretaking demands and the "sex-class" expectation to perform the "labour of relatedness" (Greenspan, 1983, p.228). Dow Schull (2002, p.2) argues this, proposing that for many women gambling is a highly addictive mechanism of "escape from what they experience as an excess of demands and responsibilities to care for others."

The *Voices* women confirm the role of gambling in escaping stress and overwhelming responsibilities. Between 40% and 60% cited items related to stress relief as very or extremely important gambling motivations: *relief from stress* (53%), *a break from reality* (49%), *escape from problems or worries* (48%), a *break from responsibilities or work* (46%). Reasons of autonomy were also common: to be *free to do what I want* (56%), to *treat myself* (48%) and to *have time for myself* (46%).

Women demonstrate a greater sense of responsibility for the well-being of others and experience more life-stress than men as a result. Lerner (1985, p.20) notes women are socialized to be over-responsible in relationships, "prone to de-self, putting the needs of others first, allowing too much of herself to be negotiable under pressure from the relationship." Women may also be poor at self-care, feeling guilty and selfish about taking time for themselves (Lesieur & Blume, 1991). Many lack a healthy balance between caring of their own needs and caring for others. Perhaps the women in *Voices* illustrate a shift in relational interests, a shift, sometimes defiant, away from caretaking and into self-care. Their responses emphasized the critical importance in treatment of addressing issues of personal enrichment: *dealing with stress* (72%), *self-esteem* (63%), *empowerment* (57%), *spiritual well-being* (53%) and *dealing with burn-out* (41%). Dow Schull (2002, p.11) notes that, paradoxically, gambling involves more loss of self: "Although the women who spoke with me frequently remarked on the way in which their caretaking behaviour disappears when they gamble, surprisingly they did not talk about

gambling as a means of asserting a coherent, independent self. Instead, they described both caretaking and gambling as activities that can bring about a loss of self."

Dealing with relationship issues is valuable in the treatment of female gamblers; however, in counselling women, we must be careful not to collude with societal and internalized expectations and pressure women to engage in yet more caretaking to fix problematic relationships. While skill training in areas such as assertiveness may benefit the client, it may be more essential to attend to and explore more effective means of self-care. Counsellors need to validate a woman's right and need to "escape" but encourage her to find healthier ways than gambling to nurture and reward herself.

Support issues in recovery

Many female gamblers are separated, divorced or single; about half of female problem gamblers are married (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Rush & Shaw Moxam, 2001). As noted, some have partners with drug, alcohol or gambling problems. Gordon (2002, p.14) observes that partners may resist treatment for themselves or their mates and "because women are heavily influenced by their partners' attitudes towards treatment, these women often fail to seek treatment."

A lack of spousal support may be a treatment issue. Many women fear their spouse's anger or rejection if they disclose the extent of the gambling. The literature suggests that husbands of women with gambling or alcohol use problems are more likely than the wives of men with gambling or alcohol use problems to leave the marriage (Custer & Milt, 1985; Gordon, 2002; Lesieur & Blume, 1991). This is compounded by the strong shame and guilt many women feel, which leads them to cloak the gambling in secrecy, not only from partners but also from friends and family members who might be willing to help.

Some of the women in *Voices* indicated that they don't have anyone to support and encourage them in making changes (18%) and many identified *fear of being recognized* (17%), *fear of having others learn of the gambling* (22%), *fear of being criticized or judged* (34%) and *embarrassment or shame* (33%) as barriers to seeking treatment. Furthermore, many of the women (73%) believe *I should be able to make changes on my own*, which also prevented them from reaching out for support. Such self-reliance is commonly identified as a barrier for women to seek support and help (Gordon, 2002; Hodgins, 2000).

In short, support systems for women wanting to change their gambling behaviour are often non-existent or limited, increasing their isolation. Developing these supports can be key to recovery. Women's groups can be vital. Mark and Lesieur (1992, p.556)

suggested 10 years ago that "treatment is currently meeting the needs of only the male segment of the population" arguing that women-only groups are advisable in early recovery. Mixed gender groups can be less effective for some women because of what they refer to as a "masculine tilt." Other researchers also note that different gambling styles, preferences and issues between men and women make it difficult for women to seek help in co-ed groups. The dropout rate from Gamblers Anonymous is high for women; they have difficulty gaining credibility and empathic acceptance as a gambler (McGurrin, 1992). Hulen and Burns (1998, p.12) note that women often feel uncomfortable: "Most men whom I know cannot relate to female gamblers, nor can most women relate to male action gamblers. Many male, egotistical, controlling action gamblers, like myself, looked down on female gamblers…. Women were hit on in male-dominated meetings. Swearing was commonplace. Women were made to feel unwanted." One woman, notes Wildman (1997), had difficulty getting admittance to GA because she had trouble convincing them that she was a gambler.

Second, co-ed treatment can impede successful outcomes because of women's common histories of harmful or painful relationships with men (Underhill, 1986; Wilke, 1994), and focusing on gender dynamics may be counterproductive in early recovery, when women are vulnerable and need a safe, supportive environment.

Third, socially conditioned gender roles and power dynamics are active in mixed groups. Males tend to dominate, speaking more often and interrupting others. They "use manipulative techniques to silence women or direct the discussion" (Wilke, 1994, p.32). Women use more language that connotes uncertainty when men are present than when in a group of women. In short, the tendencies of women to nurture others, to "de-self" and underfunction in relationships with men is recreated in the group context. It becomes problematic in meeting women's recovery needs. As Deborah Smith, executive director of the California Women's Commission on Alcoholism quips: "In mixed groups, men talk about their problems. The women support the men. The men get better, the women don't" (cited by Underhill, 1986, p.47).

These factors combine to make women-only groups preferable to meet the recovery needs of many women. *The Hidden Majority* (Addiction Research Foundation, 1996), a guidebook for counsellors who work with women, notes that such groups offer freedom and increased comfort to talk about issues such as sexuality or intimacy, body image, the impact of factors such as PMS, pregnancy and menopause, and their experience of violence. Women learn to value themselves and other women. They understand and share similar experiences. This process of normalizing, sharing and supporting is a critical therapeutic factor in change It brings hope and energy to recovery (Yalom, 1985).

Evidence shows that a women-only treatment group "produces positive results for women in terms of increased self-esteem and sense of personal power" (Wilke, 1994, p.32). Moreover, women may benefit socially; group members often form bonds of friendship, offering both extended support and recreational networks. This helps to address issues of isolation, boredom and loneliness.

The women in the *Voices* study frequently endorsed the option of a women's group as a very helpful or extremely helpful treatment service and showed a significant difference, almost two to one, between the perceived value of a *women's group* (59%) and a *co-ed group* (33%).

Social and leisure issues for female gamblers

Women's needs for relationship, connection, social comfort and safety help mould their choices of gambling venues, in particular, their attraction to bingo halls and casinos. Brown and Coventry (1997, p.14) write that "fear of sexual harassment and violence still make many public spaces out of bounds for women. Gaming venues are one of the few places where women feel safe enough to attend alone." Dixey (1987, p.206) also notes "the absence of male domination in these venues allows women to relax and to be in control of any sexual innuendo."

Brown and Coventry (1997, p.14) also suggest that women prefer "local venues where they feel safe and a sense of belonging. Gambling provides a cheap means of entertainment, a social outlet by which the women can escape their home and be with other women." While this is true, gambling often ceases to be a social activity for women who develop problems. More than half (55%) of the women in *Voices* gamble mostly alone or always alone, and the social activity aspect of gambling, *to spend time with friends*, was the least frequently identified incentive (16%). While many women indicated that gambling helps them *feel less lonely* (34%) and *less isolated* (30%), fewer women saw gambling as a *way to spend time with friends* (28%) or their *partner* (9%) or *look for romance* (4%). They were more likely to indicate that gambling allows them to *be around people without the pressure to talk* (41%) and *to be alone* (33%).

These findings are consistent with the observation by Specker, Carlson, Edmonson, Johnson and Marcotte (1996) that many female problem gamblers tend toward isolative gambling behaviour. Though social reasons may help account for their initial involvement in gambling, it becomes asocial as problems develop. As Griffiths (1999) notes, most problem gamblers report that gambling becomes a solitary activity. Ultimately, many female problem gamblers suffer the same fate as many of their alcoholic counterparts. What may begin as a way to reduce isolation and meet social needs ends up creating more isolation as a result of

the increasing preoccupation with gambling and the internal shame it generates.

Reconnecting socially and replacing gambling with satisfying, meaningful social and leisure alternatives are critical for many women, but finding these alternatives is often a challenge. This was underscored in the *Voices* study. Over two-thirds of the women identified *meaningful use of my free time* (70%) and *having fun* (69%) as very or extremely helpful topics to be addressed in treatment. Sixty-five per cent recommended accessible, affordable and safe alternative leisure activities as key prevention measures. Furthermore, over half (54%) considered *dealing with isolation and loneliness* an extremely helpful treatment topic. Unmarried women, women with a psychiatric history and bingo players were significantly more likely to identify this as helpful. Concurrent issues can complicate the already difficult and challenging task of filling the leisure vacuum created by abstinence.

Concurrent issues of female problem gamblers

Many women struggling with gambling are also dealing with mental health issues, depression and anxiety being the most common. Although Greenspan (1983) notes that depression is endemic to women as a group, the rates among women who gamble are higher than for women in the general population (Specker et al., 1996; Westphal & Johnson, 2000a). In Ontario, the prevalence of depression in the general population of women is 10% and anxiety, 28% (Zoutris, 1999). But even higher percentages of the *Voices* respondents reported having seen a professional for *depression* (63%) or *anxiety* (53%).

Specker et al. (1996, p.78) found that female problem gamblers have significantly higher rates of anxiety disorders than male gamblers (73% vs. 16%); and the most frequently diagnosed personality disorder was avoidant, diagnosed in 13% of the females but none of the males. They refer to women with isolative gambling behaviour described earlier as "avoidant gamblers."

Concomitant problematic behaviours are common. Westphal and Johnson (2000a) found two to three comorbid disorders in addition to gambling. Women were dealing with anorexia or bulimia (11%), overeating (55%) and compulsive shopping (39%) significantly more often than men (also Black & Moyer, 1998; Lesieur & Blume, 1991). Likewise the *Voices* women reported considerable levels of current or past problematic behaviours. The most common current problems were *smoking* (48%), *binge eating* (27%) and *compulsive shopping* (24%). The rates of problematic behaviours were higher than the rates reported in studies of the general population (Adlaf & Ialomiteanu, 2001; Christenson et al., 1994; Woodside et al., 2001).

Studies of problem gamblers report varying rates of substance use problems (Black & Moyer, 1998; Lesieur & Blume, 1991; Specker et al., 1996; Westphal & Johnson, 2000b). Generally, women are less likely than men to have alcohol problems or use illicit drugs (Potenza et al., 2001; Toneatto & Skinner, 2000; Westphal & Johnson, 2000b). However, more female than male gamblers report lifetime use of psychiatric medications, inappropriate use of medications and medication use at the time of seeking treatment (Toneatto & Skinner, 2000).

Issues of abuse and trauma

Women who are vulnerable to developing gambling-related problems often have a family or personal history of trauma and abuse. Their childhoods were often traumatic, impacted by parental alcohol abuse, gambling problems or mental illness (Custer & Milt, 1985; Jacobs, 1986, 1993; Lesieur & Blume, 1991). Similarly, the *Voices* women report high rates of family problems: including fathers (38%), siblings (28%) and relatives (28%) with alcohol-related problems, and mothers (20%) and siblings (24%) treated for psychiatric issues. Gambling problems within the family were ascribed to mothers and fathers at the same rate (16%).

In the general population, a history of physical and/or sexual abuse is significantly more common in females than males (MacMillan et al., 1997; Specker et al., 1996). Specker et al. (1996, p.79) suggest "physical/sexual abuse is a precipitating factor in pathological gambling"; female gamblers in this study had high rates of physical or sexual abuse, "considerably higher than child abuse rates of 1% to 2% found in a national sample." The *Voices* women also report high incidents of childhood physical abuse (41%) and sexual abuse (38%). These childhood rates are higher than in the general population of women in Ontario (21%; 13%) (MacMillan et al., 1997).

Almost half (46%) of the *Voices* women also report experiencing physical abuse as adults and 28% report experiencing sexual abuse as adults. Although alarming, these rates are on a par with a Statistics Canada (1993) finding that half of Canadian women (51%) have been victims of at least one act of physical or sexual violence since the age of 16. Turning to domestic relationships, Lesieur and Blume (1991) report that 29% of the married female problem gamblers had physically abusive husbands. Thirty per cent of the *Voices* respondents report physical abuse in current relationships; which is a much higher rate than partner violence towards women (8%) reported by Statistics Canada (1999). More than half (51%) of the *Voices* sample also report physical abuse in past relationships.

Given the endemic nature of violence towards women, and the

concurrent issues and life stress many women face, not surprisingly, women are often described as "escape gamblers" (Blaszcznyski, 2000; Blaszczynski, Walker, Sagris & Dickerson, 1999; Brown & Coventry, 1997; Custer & Milt, 1985; Hulen & Burns, 1998; Jacobs, 1986, 1993; Lesieur, 1989; Lesieur & Blume, 1991). Gambling, like substance use, serves as a means of changing mood states. For some women, the psycho-physiological mechanism of escape is mediated through the action of the game: "Action is an aroused euphoric state comparable to the high derived from cocaine or other drugs. Action means excitement, thrill and tension…. Being in action pushes out other concerns for women" (Lesieur & Blume, 1991, p.186). For others, the mechanism may induce dissociative experiences (Jacobs, 1986, 1989, 1993). Many female gamblers (like many women in treatment for chemical dependence, many of whom are addicted to tranquilizers) are seeking a way to numb emotions, shut out the world and orchestrate a time-out. "Gambling is a psychic anesthetizer with tension-relieving and anti-depressant (analgesic) effects. It provides relief from psychic distress, including anxiety, depression, anger, loneliness, emptiness, boredom, worry, hopelessness. Relief and escape gamblers differ in seeking the analgesic rather than the euphoriant effects of gambling" (Custer & Milt, 1985, p.29).

The motif of escape was apparent among the reasons for gambling. Among *Voices* respondents, between 40% and 60% indicate their gambling is related to mood management: used to *cheer myself up* (61%), *deal with boredom* (52%), *feel less depressed* (44%), *feel hope* (51%), *feel charged and energized* (43%), *soothe myself* (40%) or *get a break from reality* (49%).

Summing up, counsellors working with female problem gamblers must be conscious of the layers of the addictive gambling behaviours and possible co-mingling with mental health issues, which are often accompanied by a history of abuse and trauma. Working with women means attending to the whole person and often involves addressing more than a specific focus on the gambling behaviours. Many fall into the emotionally vulnerable subgroup described by Blaszczynski (2000). To the extent that gambling is a coping or survival strategy to deal with psychological, physical and emotional pain, changes to behaviour will not occur without attention to underlying issues, either in treatment sessions or through appropriate referrals.

Financial issues of female gamblers

When gambling reaches problematic levels, gamblers are often in or bordering on financial crisis. On average, the *Voices* women spent the equivalent of 80% of their personal net income on gambling. The average gambling-related debt was almost $7000. Consistent with this financial stress, they frequently identified topics related to finances as very or extremely helpful to address

in treatment: *ways to increase income* (69%), *money management* (66%), *money values* (60%) and *resolving debts* (60%).

Financial counsellors tell us that money conflicts are a chief factor in marital discord (Barbanel, 1996; Blumstein & Schwartz, 1983; Collins & Brown, 1997; Dowling, 1998; Mellan, 1994). Thus, it is not surprising that almost half (49%) of the women in partnered relationships selected *couples and money* as an extremely helpful issue to address in treatment. Finances are a potential source of conflict by the time gambling has reached problematic proportions. Forty percent of the *Voices* sample indicated that money arguments have centred on their gambling. Money conflicts, however, may also precede and even contribute to the development of problem gambling. Money tensions are like depression, which can serve as both a cause and consequence of gambling. Many *Voices* women indicated that *how money is spent* (55%) and *lack of money* (43%) were also sources of conflict in their relationships.

Money is often central to the power dynamics of relationships (Barbanel, 1996; Blumstein & Schwartz, 1983; Collins & Brown, 1997; Dowling, 1998; Mellan, 1994; Zuo, 1997). In addition to representing security, autonomy and love, it can serve as a weapon of power and revenge. Collins and Brown (1997, p.58) suggest there may be "paybacks" when financial power is hoarded: "A payback is a sting — an overt or camouflaged retaliation for a partner's behaviour. It conveys everything from frustration to fury, without the need to exchange one word." Revenge spending and skimming are two common payback strategies. Gambling may also serve as a defiant protest of anger or autonomy. It is striking that 28% of the *Voices* women in relationships reported financial abuse in their relationships and 24% admitted *setting aside money my partner doesn't know about*. Half (50%) indicated being able *to do what I want with my money* as a reason for gambling.

In sum, financial concerns are important to address in helping women rebuild and recover from gambling problems. Credit counselling services can help with consolidation, budgeting and debt repayment. Employment or retraining programs will work with clients to plan more hopeful financial futures. Equally important is the therapeutic task of exploring the meaning, history, values and relational power dynamics attached to money for the female problem gambler.

Summary

We've considered women's gambling and problem gambling issues from a woman-centred perspective to highlight the social context in which women's gambling can be better understood. Important issues of gender stratification, patriarchy, disempowerment, bias and oppression shape the lives of women

(Dixey, 1987; Greenspan, 1983; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Wilke, 1994). No therapy is complete, suggests Greenspan (1983), unless it includes helping the woman understand herself in relation to her society.

Women's gambling behaviours and vulnerability to develop gambling problems are shaped by a number of factors. Women's orientation to the world, with an emphasis on connection rather than hierarchy, often influences her choice of gaming venues. Socio-economic forces, such as lower income and limited access to financing, shape gambling behaviour and contribute to the more rapid development of problems. Social constraints may affect many women who have limited alternative leisure options.

Many women who develop gambling-related problems struggle with issues of psychiatric comorbidity, of which depression and anxiety are the most common. Some women with gambling problems reveal a painful history of family problems, childhood and adult experiences of abuse, violence and trauma. Many struggle with other problematic behaviours, most commonly smoking, compulsive eating and compulsive shopping. The lives of women are often stressful, managing demands of caretaking and employment pressures. Many female problem gamblers are isolated and may be in relationships disturbed by spousal problems, including addiction. Gambling provides an escape for many female problem gamblers.

Counselling female gamblers requires a feminist sensitivity to the reality of women's lives. While not all women who develop gambling problems will present with the issues described above, many will have some of the concerns we've explored. Others will fall into the pathway of the "normal" problem gambler described by Blaszczynski (2000), in which problematic gambling is not related to a pre-morbid psychopathology but "occurs as a result of poor judgment or poor decision-making strategies." Supporting women through a process of making changes to their gambling can involve a variety of tasks in addition to relapse prevention: developing support systems, addressing relationship and leisure needs, working with financial issues, dealing with psychiatric concerns or the aftermath of violence and trauma.

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Case study conference — Introduction

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.]

Introduction: Counselling Mary about her gambling problems

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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*.

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Amethyst Women's Addiction Centre

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Program description

Amethyst works with women, individually and in groups, who are concerned about their substance use and/or problem gambling. We provide structured community based day treatment and educational services which promote healthy lifestyles. Treatment programs are structured and include individual and group therapy. Through education and social action, we help prevent women and children at high risk from developing an addiction. At a community level, we provide training and consultation to improve understanding of women's addiction issues.

The Problem Gambling Program works with women to develop their goals of reducing or stopping gambling. Services are free and are available in both French and English.

Here is an outline of the Problem Gambling Program:

Intake: To see a counselor for an assessment, clients must call Amethyst and complete a brief intake interview over the phone. An appointment for the client will usually be made for one week later.

Assessment: During the first meeting, the counselor will assess the client's gambling problem and decide if Amethyst is the right place for the client to seek treatment.

Individual counseling: Provision of counseling using a variety of therapeutic approaches including: cognitive behavioral, feminist, empowerment, humanistic counseling.

Group support: Therapeutic groups are facilitated by a problem gambling counselor.

Twelve-week treatment program (available in English only)**:** The program consists of 12 psycho-educational groups and is held two hours per week for 12 weeks. The following topics are covered in the group discussions:

- Problem gambling
- Women and gambling
- Finances and the emotional meaning of money
- Assertiveness
- Stress
- Body image and self-esteem
- Relationships
- Relapse prevention
- Women and violence
- Anger
- Women and depression
- Priorities and goals

Two-year follow-up support: Individual counselling and support groups are available for up to two years after cessation of treatment.

Other services available to Amethyst clients (available in English only)**:**

- Sexual Abuse Program: A 12-week support group for Amethyst clients confronting painful memories of childhood sexual abuse.

- Childcare: Available two half days per week for women attending appointments.

- Children's programming: Children who have parents in either the gambling program or the substance abuse program can participate. There are two programs available for children at Amethyst: a play-therapy group for four- to seven-year-olds

and a drug abuse prevention program group for eight- to 12-year-olds.

- Parenting course for women in recovery
- Other services: Amethyst often offers courses on a variety of topics, such as dealing with anger, stress or building self-esteem. Other courses include Art Therapy and Structured Relapse Prevention.

Philosophy of service

Amethyst is grounded in the feminist belief that women's experience with problem gambling, alcohol or other drugs cannot be separated from our experiences and status as women. We address the direct links between gambling and/or substance use with the unequal position of women in society and the many forms of violence against women. A central task for Amethyst is to help women take charge of their lives by changing or ending their gambling habits and by making changes that enhance their strengths, their freedom and their choices. We help link women to other services that are available in the community for issues such as abuse, mental health and housing.

Staff background

Amethyst staff come from a variety of different educational backgrounds, including social work, psychology and counselling.

Description of our clients

Amethyst is mandated to work with women 18 and over. Couple counselling is available as requested and services for children are available. Our primary clients are adult women. The majority of the women we work with have experienced physical and/or sexual abuse.

Program evaluation and research involvement

Amethyst has been involved in several research initiatives since the inception of our Problem Gambling Program in 2000. We were a part of the advisory board for a research project on women and gambling with the University of Toronto. Students working toward their master of social work degree at Carleton University conducted research that evaluated problem gambling treatment services for women; this evaluation tool has been administered to Amethyst service users. We look forward to contributing to and benefiting from further research on gender specific issues with problem gambling.

This service profile was not peer-reviewed.

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First person account

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Reflections on problem gambling therapy with female clients

Name withheld by request

I am an addiction therapist who works full-time with problem gamblers. In the course of my brief career, I have seen hundreds of clients, with a little more than one-third being female. When the e-journal editor asked me to write about my therapeutic experiences with women clients, I necessarily had to reflect on the many challenges this work holds for me. Some of these musings concerned what impacts me emotionally; what female clients bring to therapy that is unique; how their therapy unravels; how female clients mark success in treatment; and what they demand of me as their therapist.

It is abundantly clear to me that working with women poses some very distinct challenges compared to working with men. In describing overall experiences working with women and problem gambling in general, there is always the risk of stereotyping. So, I shall qualify my biases right up front. First, let me say that I really enjoy gambling. In my personal life, I am often up for a good outing at the casino. What I cannot abide is exploitation of people with gambling problems. I should also say that I am a feminist, female and I think women are fabulous. Still, when I work with them, the issues of transference and counter-transference can be overwhelming. The work can leave me infuriated and deflated, or revved up and rejuvenated. I find that women possess multilayered abilities to endure and survive all kinds of adversity. Their strength inspires me, while their wounds inflict pain.

Some of the unique emotional issues I see women bring to problem gambling therapy concern rebellion and autonomy. Almost every female client I have seen states that gambling is in some manner a

way of her "letting go of her obligations"; "rebelling"; "doing what I want, finally, after taking care of everyone else all my life." Many of my clients have experienced abusive relationships and lasting loneliness. Several are grandmothers, many are divorced, and a few are young and with partners. The crux of this rebellion seems to be the end result of feeling emotionally and physically responsible to others first and themselves last. When the pressure cap finally blows, and the woman says, "Screw you, world, watch me do what I want!" she finds herself "asserting" her autonomy in a casino or bingo game, etc.

My typical therapeutic challenge is to ask the woman to make sense of this for me: how is losing her money and her time liberating? I tell her I am confused as to how this anger is solved by an activity so filled with loss and regret. All the while, as I explore this thread, I know that as women, in our society, their real and imagined alternatives for expressing rebellion are very limited. This is a real issue that cannot be minimized or ignored in therapy.

It is always strange and disheartening for me to hear women say that gambling is the only activity they have that allows them to "enjoy a social outing alone" without being judged, scrutinized, approached sexually or harassed. One can only wonder what is occurring in a culture where casinos, bingo halls or racetrack or slot venues are the only places some women experience as safe and acceptable to go by themselves. How did it happen that games of chance, with their built in losses, became synonymous with "a nice outing for grandma"? I wonder about our cultural values. When my clients are urged to uncover alternative activities that meet the same criteria — safety, anonymity and social approval — they are hard-pressed to come up with any.

In sessions with clients, I have a difficult time not sharing my disappointment in our culture's values when I encounter this issue. I find myself having some "wicked" counter-transference, wanting to say: "But this is not right. Every social environment should offer you these possibilities, without costing your life savings." Men can go almost anywhere for social activity and it is accepted. Except for maybe attending figure skating or something like that, but you catch my drift. It is still a man's world, and when women seek some autonomy, it seems strange that it comes at such a cost and in such a form. I have asked every female problem gambler if she feels she received the value of what she purchased by gambling. Each one has given an unqualified *No*: she paid for much more than she received in terms of a dollar value assigned for entertainment, escape or rebellion.

It is easy to see why women clients say that they need a socially acceptable outlet where they feel safe and anonymous in their activities. I have heard more stories of women feeling neglected, alone, abused, rejected and enslaved than I could possibly count. Usually, when I hear these tales, I find myself wondering how this

person "escaped" these experiences with "only" a gambling problem. Of course, on exploration, it is obvious that many have more issues to deal with than gambling. When I hear these stories, I always marvel at women's resilience. Usually, women recount the same terrible tales that men tell of loss, loss, loss: financial devastation; shattered values and self-respect; lost jobs and homes. Women also speak clearly about losing their ability to connect with others emotionally and about losing their sense of connectedness, period.

And when women tell these stories, they further relate their mental health diagnoses and struggles with violence from the past. They speak to me about how these issues are connected. A female client told me how, with scratch tickets, "I felt like I was scratching the abuse away, and all thoughts of the abuse. If only I could keep scratching… ." When I explore what the material concerns are in their daily lives, I often discover that they are working, taking care of practically every household detail, dealing with children and in-laws and, additionally, dealing with ghosts of the past. Invariably, male clients do not deal with all of these issues; they just gamble and work. It seems so easy for the men that I wonder how all of them can't suddenly experience full recovery in a hurry. And many do, as a matter of fact. But the women: they have so damn much to do in a day that even the all-consuming nature of problem gambling does not allow them to avoid.

This is why I may be called biased. I think women deal better with both the daily and emotional tasks of life. The men get off easily compared to the women. The men usually have the goal of getting their finances in order first, their relationships second, which, alone, they often consider treatment success. On the other hand, many women clients not only have gambling-related and financially related goals but also real, current and explicit concerns about dealing with underlying issues. The men rarely want to deal with those: with abuse, feelings invoked by encounters with their fathers, and the like. Women often tell me they need to deal with these issues, as their unresolved emotions are triggers to gamble. Women see the connections between all of their difficulties, while men more easily compartmentalize their problems — this is gambling over here, that is my relationship over there. The lines of demarcation are rarely so black and white for the women.

Women, on the other hand, come to therapy with much less concrete goals and are much harder on themselves in evaluating success than men. This makes working with women much more challenging for me. The treatment goals are more elusive and the client's measure of success harder to pin down. Her goal will rarely be "to stop gambling" in and of itself, and she will usually be much harder on herself than her male counterpart if she has a setback. For female clients, measures of success are typically so large that, clinically, it is one of my greatest challenges to help the client make treatment goals that are measurable and humanly achievable.

Emotionally, I have many experiences that are exclusive to working with female clients. Counter-transference for me looks like this: I expect a lot from women, more than I expect from men. Referring to the fact that women seem to contend with all that men contend with on a daily basis plus a hearty dose more, I have the distinct feeling women need to be tougher to survive in the world, period. When I see a female client become so trapped in a cycle of victimization that she has no hope or willpower left, sometimes I feel angry at the woman herself. This troubles me. I was taught early that girls had a lot to deal with and they had to be twice as good as boys to be given close to the same respect. So, when I have this feeling of "Come on, lady, toughen up or the world will eat you alive," I am actually confronting my own past. My own childhood awareness of discrimination and victimization suddenly stares me right in the face.

Men do not evoke this response but I cannot avoid encountering it when I work with women. I observe this feeling in myself in most sessions with women who are really struggling. It takes great vigilance, and presence with the client, to ensure I do not recreate for her an experience of "failure," wherein she does not measure up to some "superwoman" standard for me, her therapist.

Female clients also seem to have pretty high expectations of me. I have yet to feel any woman wanted me to "mother" her, as I often find with male clients. I do feel, though, that female clients expect me to join them in a way that men do not. This can be painful and it is certainly rigorous. It involves me being open to their experiences and reflecting them with absolute presence. With men, you can often get the job done quite nicely by offering cerebral interpretations of events and some good, pragmatic behavioural assignments. Not so with women; at least, not usually.

I feel I am called upon to help women clients sort through so many competing issues, real and current, that all of my great CBT* techniques are not enough. The women want good strategies from me, but this is not what I feel they demand most. They seem to want to know that I am there with them, to acknowledge that I see their pain and I am not afraid of them; that I can bear their stories and carry them, and that I will attend to them when they feel unworthy. I feel I am asked to testify to their survival; to help them see what I see: a person, deeply injured, and with great, unbelievable resilience.

*cognitive behavioural therapy

This First person account was not peer-reviewed.

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review

[This article prints out to about five pages.]

Net-working the steps: Web-based support for women in recovery from problem gambling

Reviewed by Virginia M. McGowan, PhD
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Computer-mediated communication, echoing other quantum leaps in technology, is transforming social lives on a global scale as networks formed in cyberspace reach across group boundaries, space, and time itself. In some instances, people's on- and off-line lives intersect as they develop multi-dimensional, intentional communities (Rheingold, 2000; Wellman, 2001). Increasingly, professional counsellors and psychotherapists are creatively exploring use of the Internet to augment standard interventions or to reach individuals who are reluctant or unable to use existing in-person or real-time services (Cunningham, Humphreys & Koski-Jannes, 2000; Galanter & Brook, 2001; Hsuing, 2000). Paralleling the boom in the reliance on self-help resources and mutual aid to complement or replace the help of a treatment professional, electronic support groups are forming to help people struggling with illness, disability, loss, addiction and other problems.

Women Helping Women (*WHW*), www.femalegamblers.org, is a popular Gamblers Anonymous (GA)-based Web site designed to support women's recovery from problem gambling. Marilyn L. and

Betty C., two GA members residing in Phoenix, Arizona, began to edit and publish *WHW* as a way to respond to requests for their newsletter, which has been published on-line monthly since July 1999. *WHW* serves both advocacy and information functions, providing a virtual space where women dealing with problem gambling can cultivate an on-line dimension to the self-help resources and mutual help they receive through real-time GA step groups. Moreover, *WHW* responds to the need for gender-specific support expressed by many women in recovery who struggle with the male-dominated dynamics of many GA groups (Arizona Council on Compulsive Gambling Inc., 2002).

The Web site is self-described accurately as "informal but informative." At the centre of the homepage is a menu that changes monthly to highlight the core article appearing in the current issue, or the most recent article in a multi-part series. Consistent with the GA approach to recovery, the central message to homepage readers is that mutual support is critical for recovery. Similar messages provide succinct points for action, and reinforce the existential experience of being a problem gambler (Makela et al., 1996, p.124). As one might expect to see on the walls where a GA or other 12-step group meeting is taking place, slogans, mottos and proverbs such as "You can't do it for me, but I can't do it without you" and "We may not have it all together, but together we have it all" have been hung on most of the *WHW* homepages published on-line since 1999.

The *WHW* homepage is accessed easily through a variety of search engines such as Google using search terms such as "women and gambling" or "female and gambling" on AltaVista. Alternatively, hypertext links are available from a variety of other websites such as the Arizona Council on Compulsive Gambling (www.azccg.org). All past issues of the monthly newsletter can be accessed from the *WHW* homepage, which, in turn, provides hypertext links to a selection of other resources as well. A clear purpose statement appears on the *WHW* homepage: To support and educate women in recovery for a gambling addiction. There is no explicit mention of the orientation of *WHW* as GA-based, but this perspective is readily apparent from the content of the newsletters. The source of the newsletter is obvious, with the editor and publisher providing no less than three places on the somewhat busy *WHW* homepage where the reader can click to contact them by e-mail.

A private sector Internet service provider, Infinet, is clearly identified as the corporate sponsor, and donates Web server and hosting functions in return for a hypertext link from the *WHW* website. Nine other active links provide quick access to a variety of reliable sources of information, such as an essay on women and gambling from a site hosted by the Substance Abuse Network of Ontario, the text of a lecture on women and problem gambling delivered in 1998 by an Australian gambling expert, and the Web sites published by Women for Sobriety, the Responsible Gambling Council of Ontario,

and the Arizona Council on Compulsive Gambling Inc., which provide further links to a wide range of information and other resources.

Raising concerns about the distinction between promoting products or services and providing objective, unbiased information or perspectives (Alexander & Tate, 1996, pp. 26–27), the two remaining links blend advertising and information. Hazelden Books is a well-known publisher of 12-step- and co-dependency-based recovery literature and Viva Consulting is a private Quebec-based company offering a range of counselling, education and other services.

The newsletter is the core of *WHW* Web-based support, replicating the oral tradition of GA on-line in print form. The newsletter is generally brief, comprising narratives provided by readers with occasional submissions from professional therapists. Brief contributions are solicited from the readers, but the newsletter does not function as an electronic bulletin board. Postings to the newsletter must be sent to either the publisher or editor, who choose the contributions to post in the next issue. The newsletter has a limited "snail-mail" distribution also, which included 100 women around the U.S.A. in February, 2001.

In accordance with the philosophy of support groups modelled on Alcoholics Anonymous, the editor, publisher and other contributors to the *WHW* newsletters take their authority on problem gambling and recovery largely from their individual life experiences and existential identity of being in recovery (Makela et al., 1996). Both the editor and publisher are active GA members, a fact that can be confirmed by reading their personal stories in past issues of the newsletter, such as Marilyn L.'s contribution to mark her 10-year GA anniversary.

As with many Web-based sources of information, the reader must take it as a matter of faith that the person contributing to the newsletter is neither misrepresenting her identity nor attempting to deceive the readers in other ways about her personal story. Fortunately, the personal accounts ring true. Personal stories presented as testimonials and moral tales are a central motif in GA-based recovery; they provide compelling narratives of downward spiralling chaos, culminating in restitution and recovery. Many stories focus on the role of GA in an individual woman's recovery; others provide pointers for "doing GA"; that is, how the GA-based recovery process unfolds and how to "do the steps." Occasionally, a brief article discusses a particular Unity or Recovery step in detail. Other stories provide a motivational or inspirational message, reinforcing the "yes, you can" message, and poetry or prayers appear occasionally. From time to time, particularly in recent issues, articles written by professional therapists are included on the role of counselling and other topics. Clinical Corner was a section that appeared in earlier newsletters published in 2000, but

was dropped in favour of an ad hoc approach to contributions by professionals, such as a four-part series on empowered recovery in 2001.

Lest the contributors commit the sin of pride in extolling their successes in recovery, humorous anecdotes and jokes bring the reader down to earth by poking fun at common perceptions, habits, cognitive distortions and other characteristics of active problem gamblers.

WHW is an important resource for women who seek to resolve problem gambling through GA-based recovery processes. In the virtual community created by *WHW*, women will find the more expressive and responsive interactions that many women say is lacking in male-dominated GA groups. Women will read personal narratives that resonate with their own experiences and needs and address life problems that reflect women's socialization and gendered roles. In addition to advice and support for working the GA steps, women will also find other features, such as discussions of professional help and issues that are not often addressed in face-to-face GA groups, such as unhealthy messages about female identity and opportunities that many women absorb growing up.

Simply put, *WHW* places value on women's experiences with problem gambling, recovery and life. For those women who are seeking support in their recovery, but are unable to find a local gender-specific support group or have access to support in the right way, time or place, *WHW* will become a regular stop on the information highway.

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Virginia McGowan, who has a PhD in anthropology, University of Toronto, researches the socio-cultural context of addictive behaviours and community-based approaches for dealing with addiction through field research in Aotearoa/New Zealand, Australia and Canada. Formerly a research scientist at the Addiction Research Foundation, Virginia was the founding co-ordinator of the Addictions Counselling Program in the school of health sciences, University of Lethbridge, where she is an associate professor. She currently researches indigenous women's narratives of addiction and recovery, cultural perspectives on how people think about gambling, cultural competence in prevention and education program design and implementation, and the application of indigenous knowledge to address addictions and related problems. She is also interested in the shape and form of Web-based social support networks.

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[This article prints out to about 10 pages. Colloquial words and acronyms are in italics at their first use and are explained in a glossary at the end of the article.]

The changing participation of women in gambling in New Zealand

From an address given by Phillida Bunkle to the Centre for Gambling Studies, University of Auckland, and the Problem Gambling Foundation of New Zealand, April 2002. At the time, Phillida Bunkle was a member of Parliament, Wellington, New Zealand.

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In order to understand the rapid change in women's participation in gambling, it is helpful to develop a sense of the cultural politics within which this change has occurred.

Some time ago I was in Foxton, a rundown, low-income community — probably the poorest part of the area where I live. That day I saw a sight which gave me a great deal of hope; I thought there must be some cultural or community revival going on. There was a long line of women outside the local pub at 9:30 in the morning. I thought they must be coming together for something exciting. They began to jostle a bit and at 10 o'clock, when the pub opened, I went over to see what they were doing — what they were doing was fighting to get near the *pokie* machines.

This event summed up for me a major change in this society, which needs investigation. When I arrived in New Zealand 30 years ago, I found an extremely gender-segregated society. A woman's place was quite clearly in the home. The liquor licensing and gambling laws were a legacy of the suffrage movement, which, having failed to achieve prohibition, had sought to segregate women from participation in any aspect of the culture of drinking and gambling. Drinking and gambling were successfully corralled into the male-only preserves of the pub and the *TAB* (Bunkle, 1980).

By the 1970s, this meant that on Friday nights the boys all went

drinking after work and it was quite clear that women weren't welcome. This activity was somewhat hidden, the law demanded that the bar could not be seen by passersby, so that you couldn't see what was going on unless you went inside. They were were unpleasant and thoroughly unwelcoming, at least to women. The TAB was associated with this activity and it too was also extremely discrete — women didn't really get to see it — it was clearly a male preserve. The only forms of gambling that women had any involvement with were the occasional on-course flutter and *housie*, or its Maori equivalent called *batons-up*.

Well, of course, I was enthusiastic about changing the world, so with a group of other women, I went to war against the *wowsers* of society and sex segregation. We began with the university club — we got some women together and formed the Academic Women's Association and set forth to normalise the presence of women in the university tearoom. This took quite a lot of effort. We decided we would always go to the club at the same time so no one was ever exposed to being the only woman there. We were sitting together on one of these occasions and a senior professor came up and said, "What are you witches brewing up?" And I replied, "We're learning from you, professor. We're doing what you've been doing for years." Which made him turn pale.

In return for all of this, Geoffrey Palmer had me removed from the tearooms for a whole term. The occasion of my removal wasn't for my insistence on "drinking with the boys," it was actually that I laughed at sex segregation in the judiciary. The law faculty was there one evening, so I asked, "Well, why are all the judges men?" And Sir Geoffrey (he was just Geoffrey then) answered that it was because the profession selected the best available people. I laughed and said that just showed how prejudiced the law profession really was. He gravely explained that only a distorted mind could call this process prejudiced; the guarantee that judges were disinterested was that their appointment processes were in-house: the profession consulted all the best people and they made confidential recommendations to the minister. I absolutely howled with mirth and said it sounded like an old boys club to me. So he gave me the boot and I had a whole term to learn why one should take the old boys club seriously and shouldn't laugh at Sir Geoffrey. I am still learning — I obviously didn't get the message clearly enough or I wouldn't be where I am today.

So it was rather surprising that I found myself some 20 years later designated as the new *wowser* and leading the parliamentary charge for the sort of wowser-ism that seemed to be such an evil in the '70s.

I think several dramatic changes occurred in the '90s, as more of a market approach and ideas of individual choice as sovereign took hold, embedding the changes initiated in the '80s. Those women going into the bar at 10 in the morning embody three of these changes that have impinged quite drastically on the health

of women.

Firstly, we have a dramatic increase in the consumption of alcohol by women; and we haven't yet come to grips with the health implications of that. I am one of the people who have been supportive of trying to get health warnings about fetal alcohol effects on alcohol labels. I believe we are building in disadvantage to the bodies and brains of a whole generation of children because we refuse to actively recognise the impact of alcohol during pregnancy.

If you had said that to me 30 years ago, I would have been outraged at the very idea that women should be judged as ambulant uteri. And, indeed, at that time I opposed the idea that the Ministry of Health should even have a separate concern about women because it was called "maternal health" and reinforced the idea that gender segregation was based on biological destiny. I called New Zealand "the land of the free positive-pregnancy test" because if you went along to the doctor and had a pregnancy test and it was positive, it was part of your "maternity services" and was free, but if it was negative, you paid. That demonstrated the official policy towards women's role in society. New Zealand had a thoroughly pro-natal health policy. Enlightened women used to try to obtain permission to leave the maternity hospital earlier than the two weeks designated in statute. (In fact, one corner of my hospital card said "independent mother" and they whisked me out as quickly as they could. But my secretary was allowed to finish knitting her baby jacket before she was allowed to leave the maternity hospital.)

At the time, if you had said to me that women shouldn't drink during pregnancy, I would have said you were thoroughly paternalistic; that women were perfectly capable of making up their own mature minds. But a rapacious liquor industry has somehow managed to muddle liberation and liberalism, and there are some serious consequences of young women's increased alcohol consumption, which we haven't sorted out.

The second change is — and I am sure Sir Geoffrey would approve of my attitude here — the dramatic increase in women smoking. Now, I don't smoke, but if you look at who is taking up this activity, it is young women, and it is young Maori women. Now, at least we acknowledge that this has had a dramatic impact on our public health and some effort is going into trying to reduce this consumption.

The third change is, of course, the dramatic change in women's behaviour around gambling. At this stage it is difficult to give you actual figures — and we desperately need them — but women certainly appear to be the fastest-growing segment of the population taking up gambling. Abbott and Volberg's prevalence studies in 1991 and 1999 do not comment on changes in women's

level of gambling (Abbott & Volberg, 1991, 2000). But a re-analysis of their data shows that between 1991 and 1999 the number of regular women gamblers rose by 5.1% per year. At the same time, that of men fell by 2.2% per annum. In 1991, 1.86 men for every woman gambled regularly, but in 1999, it was 1.05 man for every woman. In other words, the gender figures have converged to the point that women's gambling activity was almost the same as men's.

Now that women gamble more, they lose more money. In 1999, treatment providers found that in the four weeks prior to seeking treatment, men lost on average $2,849, and women, $1,542. But only one year later, the gap between men and women was almost non-existent: men were losing $2,703 but women were losing $2,619 (Clifford, 2002). Given women's much lower average income, such losses could have terrible implications for the women and their families.

Since women are gambling more they are also experiencing more problems. In 1997, when I first became patron of the Compulsive Gambling Society, just over 12% of all new referrals to problem gambling services were women. Two years ago, it was over 30% and now more than 50% of the people receiving counselling are women. And if we select particular segments of the population of women — young women, Maori women and women from Pacific Islands women — we find a particularly rapid growth. Of women presenting for treatment now, up to 70% are Maori and Pacific Islands women (Paton-Simpson, Gruys & Hannifin, 2001).

Since the chance of winning has nothing to do with skill, machine gambling is equally available to all players; the machines do not discriminate between people. A woman can choose to be a player without qualifying as "attractive." Since no skill is required participation does not depend on physical, mental or linguistic capabilities or gender. Nor are there class barriers to access. It may be that the appeal of the machines in communities like Foxton is that they are "equal opportunity" facilities, which include people who are otherwise socially excluded.

When women are asked why they like playing the machines, they respond that they feel safe. Their presence in the pub is not interpreted as trying to attract male attention. While playing the machines they are observers rather than the observed; they are not objects of sexual evaluation; they are players and subjects not objects; they are consumers not the consumed. They can claim a space in the pub without challenging men's space or exposing themselves to the sexual marketplace. They also enjoy the fact that they can be part of a crowd without having to risk rejection (Kaita, 2002).

Today gender segregation feels like a social anachronism. Sir Geoffrey now works alongside women in their capacities as chief

justice, attorney general, seniour partners in his law firm, not to mention prime minister and governor general. But while the change has no doubt been good for the privileged women who were well positioned to take advantage of this change, the new behaviours have had serious health consequences for the rest.

I want to look briefly at the shift in cultural attitudes that underlie women's changed participation in gambling, because I think we've got to understand that as well as researching the statistics.

Firstly, I think that this behavioural change has everything to do with the normalisation of gambling. The fact that gambling has become so accessible gives a false message about safety. And the more we open up access to a variety of forms of gambling, the more we normalise it.

Gambling on Lotto, *scratchies* and daily Keno has spread to the suburbs and is integrated with your grocery outlet, your post office, your dairy, your bowling alley and even your local mall. This reinforces the message that it is safe. So we have seen an integration of this activity into daily suburban life and a complete change from the segregation of this hidden activity 30 years ago that I described earlier. The message that goes with it is that there is no danger; it is just part of shopping.

The massive advertising around Lotto, for example, is all about the activity being innocuous fun, all about happy families. Lotto is the second biggest product advertised on television, and an integral, normal part of most families' Saturday night in front of the tele. We know that the poorer you are the more likely you are to see gambling as an investment, so much so that buying your Lotto ticket is so important that you actually feel deprived if you can't play. Budgeting agencies try to leave enough in the pockets of the poor to buy their ticket. It is their ticket to hope; their one "real" chance for something that might change their lives.

Along with advertising and normalisation, we have what I call a "driver" that clearly links gambling with poverty — I call it "addicted to hope." I think it is vital to start the research to unravel this connection. If we have a third of our children living in poverty and if female-headed households are the poorest group in this society, then you don't have to look very hard to find out why the budget advice services want to give people enough left over to buy their "lucky dip." And in a society that has closed off virtually every other possibility of hope, this is not an unrealistic view.

It is really worrying that now pokies are following down the same path as lotto shops, with "convenience" gambling located in suburban high streets and shopping malls. Communities like Taradale and Gisborne sensed the danger but found themselves powerless to stop them from creeping out of the segregated confines prescribed by our suffragette foremothers and

penetrating everyday domestic life.

Recently, I have been on the Select Committee considering new gambling legislation. One pokie operator proudly came before the committee to show us a video of his mini-casino premises. He emphasized that it was in a mall; not at all like traditional pub outlets, but alongside shops. It had a bar license but was more like a coffee bar serving café food. It was marketed to couples going to the movies or women having lunch or just a coffee break. You could play the pokies or pop into the dress shop next door. He was proud of the fact that his outlet had moved away from the segregated world of the pub into "respectable company."

We have to give communities and individuals the tools to make choices. But the legislation as proposed only pays lip service to empowering local government or individuals. What we need to do is to make sure that we change the context of these "tickets to hope" in such a way that we control the supply side, while giving the demand side realistic guides to behaviour and real information about the risks, and to direct this message to the people who are drawn to these risks.

I think people who become addicted to gambling are more difficult to help than those addicted to cigarettes or alcohol. If you're stuck on cigarettes, you have a physical addiction problem and there are some services to help you (although perhaps not as many as you might like). If you've got an alcohol problem and you get off it and you get on the wagon and dry out, you're off it. But with gambling, you've always got the debt issue driving you back into the behaviour. Once you're into debt it's the only way out, so you drive right back into that behaviour of hope. So once you've helped the person stop the behaviour, you've then got to deal with the debt issue — and then break the association with hope and with normality, and I think those are powerful issues.

In terms of government response, it is important that we begin to get wider government input into the legislation that is coming up and the implementation of it. I believe that it is important that Maori Affairs and Women's Affairs start to give policy advice in this area and it is disappointing to me that so far they haven't. We do have to get a much stronger sense of social responsibility into the flow of policy advice; but the truth is, it is not going to be effective until we have some real research to back it up, research that looks at the outputs of the market economy in a way which is not merely anecdotal. What I am asking you to consider is the cultural change backing up the behavioural change that underlies what has emerged as a serious public health issue.

Glossary

batons-up

A community-oriented, relatively informal, indigenous version of housie, previously popular in Maori communities and usually played for donated items rather than money. An important fundraising form for communities, as the players make a small donation for each baton. The first person to put all their "batons up" wins the prize.

housie
A version of bingo; the first person to match all the numbers on their card with those called wins a prize. Housie can be relatively informal or a regular "house" can be established in a neighbourhood and licensed by police. Proceeds are usually for community, charity or political fundraising.

pokies
Electronic gambling machines with a game on screen and an attached mechanism allowing the player to bet on the outcome. The game requires no skill to play as the result is pre-programmed and ensures that the machine is always the net winner. Profits are supposed to benefit community or club activities.

scratchies
Tickets covered with a metallic surface layer which can be scratched off to show if the purchaser has a winning combination of numbers or other icons.

TAB
Totalisator Agency Board, the government-owned agency with a monopoly on all betting on horse and dog racing and sports betting, with the exception of limited on-course betting at local race days. The agency pays substantial taxes but profits support the thoroughbred industry or the various sports organisations.

wowser
A supporter of prohibition of smoking, drinking alcohol and gambling. Wowsers were closely associated with Protestant fundamentalist churches and women's suffrage and were politically well organised and important from the 1890s to 1930s. Their activities resulted in strict regulations limiting these activities, especially in Maori-dominated areas that were supposedly "dry." For the purported Australian origins of this word: www.cyberbondi.com.au/reception/bondi/history/people/wowser.html

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Phillida Bunkle studied in Britain and the United States. In the 1970s, she helped introduce women's studies into New Zealand universities and was the first patron of the Compulsive Gambling Society of New Zealand. From 1996 to 2002, she was a member

of the New Zealand Parliament. Her bill to give a local option on casinos prompted the government to introduce its own (unpassed) responsible gambling bill. From 1999 to 2002, she developed the policy that gambling should be regulated as a public health issue along with alcohol and tobacco smoking. As Minister of Consumer Affairs 1999-2001, she initiated consumer protection measures supporting an informed choice to "purchase" gambling.

Bunkle did not stand in the 2002 election, which saw her former party wiped out in the Parliament. She is now visiting professor at the Centre of Gender Studies, Foreign Languages College, Dalian University, China.

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http://www.cmhask.com/programs/gambling/index.html

Public education and community development components of the province of Saskatchewan's Problem Gambling Program

http://www.gamb-ling.com

A multilingual gambling information Web site in 11 languages (Arabic, Chinese, English, Farsi, Hindi, Italian, Portuguese, Russian, Somali, Spanish and Urdu). Information in audio formats and through these click-on topics: "What's problem gambling?," "Do I have a problem?," "Get help," "Ethno-cultural resources," "Library" and a help-line number.

http://www.youthbet.net

The TeenNet Youth Gambling Web site (University of Toronto) has an interactive neighbourhood (community centre, library, corner store, casino, schoolyard, and back alley) with access to youth gambling information and help resources, diagnostics, and activities related to risk assessment, time management, money management and balanced decision making.

http://www.ncpgambling.org

National Council on Problem Gambling : to increase public awareness of pathological gambling, ensure the availability of treatment for problem gamblers and their families, and to encourage research and programs for prevention and education.

http://www.gov.ab.ca/aadac/addictions/subject_gambling.htm

Alberta Alcohol and Drug Abuse Commission: information,

brochures and survey results

http://www.responsiblegambling.org

Responsible Gambling Council (Ontario): information, publications and calendar of international gambling-related events

http://www.unr.edu/unr/colleges/coba/game

Institute for the Study of Gambling and Commercial Gaming: an academically oriented program on gambling and the commercial gaming industries

http://www.ncrg.org

National Centre for Responsible Gaming: funding for scientific research on problem and underage gambling

http://www.problemgambling.ca

Problem Gambling: A Canadian Perspective Website (Gerry Cooper): annotated international links

http://www.youthgambling.org

Youth Gambling Research & Treatment Clinic (McGill University, Montreal, QC, Canada): information, self-quiz and FAQ's

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Ontario Ministry of Health. Schedule of Benefits, Ontario Health Insurance Plan. Kingston, Ontario: Ontario Ministry of Health; April 1987.

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