Research Report

Examination of the associations between problem gambling and various demographic variables among women in Ontario

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Prepared for the Ontario Problem Gambling Research Centre and ECHO, August, 2011
**Purpose:** In this study, we examine the between and within gender differences in problem gambling. Specifically, we investigate the ways in which the predictors of women’s problem gambling differ from those of men’s problem gambling. More importantly, we attempt to discern how many different “types” of female gamblers there are, as well as what their distinctive needs might be.

**Methods:** In order to answer these research questions, we take a mixed methods approach. As such, our study contains four parts: (1) a literature review; (2) a content analysis of online and print biographies, examining what ordinary women are saying about their gambling problems in their own words; (3) a secondary analysis of survey data; and (4) an analysis of policy initiatives undertaken in various jurisdictions.

**Results:** Demographic indicators of problem gambling among women that are present in more than one of our data sources include being middle aged (30-59), being widowed or divorced, having less than a secondary school education, being unemployed, being part of a minority population, and having a low personal income (below $40,000). Gambling behaviours that are associated with female problem gambling in more than one source of data include preferring chance-based games and gambling as a means of escape. More than one section of our report acknowledges certain psychosocial variables that predict problem gambling among women, including having had an unstable childhood, experiencing a mood or anxiety disorder, and having a stressful adult life.

**Conclusions:** Our literature review, content analysis and policy analysis reveal that treatment for problem gambling women should make use of help lines and internet services. The literature review suggests that treatment for problem gambling among women should also address comorbidity with depression and anxiety. We conclude from our policy analysis that treatment should involve women-only groups which are accessible, culturally specific and situated in pre-existing community agencies. Further, treatment should focus on resources that are appealing to these gamblers, namely family counselling, supportive therapy, personal enrichment, stress management, coping skills and conflict management. In terms of addressing age-specific issues, programs for older women should use peer mentorship initiatives, in-home treatment and help lines, while programs for younger women should employ school-based initiatives, family programming and Internet counselling.
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1) **INTRODUCTION**

The goals of this research are to identify the key factors that predict and influence women’s gambling, as distinct from men’s gambling, and to identify key variations among women gamblers.

This analysis is important because there can be no success in the fight against problem gambling and its effects – for the gamblers, their families, and their communities – unless we understand the types and extent of variation among problem gamblers. Intervention that may work for men may not work for women. Equally important, an intervention that may work for highly educated, single, young urban women may not work for less-educated, married, middle-aged rural women or suburban elderly widows. What may work for socially embedded Canadian-born women may not work for women who have immigrated only recently. Therefore, our goal is to identify an empirically and theoretically useful typology of female gamblers using both quantitative statistical analysis and qualitative content analysis.

We have taken a mixed-methods approach in this project. Accordingly, the study contains four main segments or aspects: (1) a review of existing literature; (2) analyses of online and print biographies; (3) a secondary analysis of survey data; and (4) an analysis of policy initiatives undertaken in other jurisdictions. The examination of previously existing literature on problem gambling (Part 1) will allow us to recommend policy and treatment initiatives that take into consideration the specific needs of female gamblers that have already been identified by other researchers. Part 2, our analysis of female gambling narratives, gives us a sense of the problems women gamblers struggle with, and the kinds of treatment they feel would be most effective, all expressed in their own words. The secondary analysis of survey data conducted in Part 3 contributes to an understanding of the various factors that typically characterize female gamblers, including demographic characteristics and gambling behaviours. These attributes are important to note because they indicate which types of women are particularly at risk for developing gambling addictions, and accordingly, they denote which women should be targeted for prevention and treatment, as well as the types of treatment they should receive. Finally, the fourth section of our report, in which we have analyzed various policies on gambling, provides some insight into the many approaches that have been taken around the world to help problem gamblers overcome their addictions.

Thus our four-fold approach to the issue of female problem gambling has resulted in a broad, thorough investigation of various types of information on the topic, allowing us to make well-informed recommendations for female-specific treatment initiatives. Because we have drawn on such a diverse range of sources, we are able to suggest improvements for prevention and intervention strategies that will make treatment approaches far more helpful for high-risk female gamblers.
2) RESULTS OF THE LITERATURE REVIEW

INTRODUCTION

Over the past two decades, Canada’s legalized gambling industry has grown substantially. Decriminalization and the expansion of gambling-related products and technologies have vastly changed the gambling landscape from the time when gambling outside of horse tracks or at midway fairs was illegal (Stevens 2005). In 1969, the Canadian Criminal Code amended its ban on gambling, making provincial- and federal-run lotteries and licensed charitable casino gambling permissible. In 1985, an additional amendment made gambling exclusively controlled and regulated at the provincial level, as it is today (Stevens 2005). This shift toward legalization and government ownership was a strategy to promote economic development in Canadian entertainment and leisure sectors by increasing revenues without increasing taxation (Korn 2000). This tactic was certainly successful: a 2005 Statistics Canada release reported that from 1991 through 2004, the net revenue generated from legalized gambling rose from 2.7 billion to 12.4 billion dollars.

Gambling in Canada is now promoted and organized as a local, typical and convenient leisure activity. Most communities, urban or rural, offer various gambling opportunities for their inhabitants, including corner stores that sell lottery tickets, churches and service organizations running bingo and raffles, electronic gaming machines (EGM) and video lottery terminals (VLT) placed strategically in local bars and restaurants, and licensed community casinos (MacDonald, McMullan and Perrier 2004). The expansion of legalized gambling activities and institutions represents an important public health concern for Canadians, as research supports the link between increasing legalized opportunities to gamble with higher prevalence rates of problem gambling (Volberg 2004).

The recent expansion of legalized gambling is particularly problematic for women. In the past, legal constraints and social norms deterred women from gambling because gambling activities typically took place in the illegal and/or male-dominated terrains of dog and horseracing, cards, and sports betting (Li 2007). However, legalization and the proliferation of gambling activities have meant that gambling has become widely accessible and socially acceptable for women. While estimates suggest that at least one third of gamblers are now female, an increasing proportion of women have been reporting their own gambling addictions (Ibanez et al. 2003; Lesieur and Blume 1991; Volberg 1994). Despite this evidence that women’s gambling has become widespread and problematic, female problem gamblers remain poorly understood and under-represented in research, literature, and treatment (ibid.)

RATIONALE

Our understanding of male problem gamblers is far more extensive than our knowledge of the issues surrounding female gambling. One estimate suggests that up to 95% of the literature on problem gambling is based on sample populations that are made up of 98% men (Boughton 1999). Even those researchers who intend to investigate gender differences in problem gambling contribute to the bias simply because male
problem gamblers are more accessible. In the past, researchers most frequently obtained their samples from male-dominated gambling venues and outpatient treatment programs like Gambler’s Anonymous (GA), in which females are extremely under-represented, composing only 2-6% of the group’s population (Mark and Lesieur 1992). Research into problem gambling has typically considered the male experience as the benchmark, assuming that what is true for a male problem gambler is also true for a female problem gambler (ibid.).

While problem gambling has typically been understood as largely male-dominated terrain, recent literature acknowledges that there is a shortage of gender-specific research in problem gambling. In addition, further investigation into the differences between male and female gambling has been advocated with the hopes that we will be able to better our understanding of female gamblers (Boughton and Falenchuk 2007; Lesieur and Blume 1991; Mark and Lesieur 1992). These gendered differences that distinguish male from female problem gamblers exist within a broader framework of gendered health experiences and outcomes. For example, it is widely understood that males and females experience and show their symptoms of stress differently, and that consequently, they may differ in their course and treatment response. Essentially, “women experience gambling and gambling problems differently than men,” and they will therefore need different kinds of treatment than men do in order to overcome their gambling addiction (Brown and Coventry 1997, p.25).

Variations across a number of gambling characteristics suggest that gender-related differences do exist among problem gamblers. These characteristics include the age of onset of gambling, speed of progression to disordered gambling, time spent gambling before seeking treatment, type of gambling activities, motivation to gamble, associated mental health issues, and treatment response (Barry, Steinberg and Potenza 2009; Blanco et al. 2006; Boughton and Falenchuk 2007; Echeburua et al. 2010; Ladd and Petry 2002; Potenza et al. 2001). Both within- and between-gender research into problem gambling will contribute to our understanding of the associations between problem gambling and various socio-demographic and health correlates among women.

METHODOLOGY

Objectives

This section of our report provides a systematic review of the existing literature and interprets findings in a way that adds to the current knowledge base regarding between and within gender differences in the predictors and characteristics of problem gambling. Understanding gender differences in problem gambling is a necessary step toward developing more effective prevention and treatment policies. The final objective, then, is to identify and explain these variations in a way that can be translated into improved health for Canadians.

Identification of Literature

To locate relevant literature, we conducted a systematic search of the University of Toronto’s library catalogues, articles archived at OPGRC and the Alberta Gaming
Research Institute, and journal article databases including PubMed, PsycInfo, Google Scholar, JSTOR and The Sociological Abstracts. All sources published in English from 1990 to 2011 were searched using both keywords (gambling, pathological gambling, problem gambling, disordered gambling, compulsive gambling, gambling issues) and subject headings (sex differences, sex characteristics, sex factors, gender, gender differences, females, women). Based on the information provided in the title, abstract, and keywords, sources that met selection criteria were retrieved and analysed in full. Reference lists of relevant literature were also manually searched using the above search terms. For each source, methodological quality was assessed (i.e. sample size, proportion of female gamblers, recruitment strategy, assessment instruments), and our key findings were documented.

Selection Criteria

Only peer-reviewed literature meeting the following five criteria was included in the analysis: (1) the work was published between 1990 and 2011; (2) adults (individuals over the age of 18) made up the entire sample; (3) the sample was at least one third female; (4) problem or pathological gambling was analyzed within the article; (5) clinical aspects of gambling were addressed.

A key issue in current literature drove us to create the requirement for a sample that was at least one third female. Specifically, if and when females are included in the sample, their proportion is so low that the male influence overrides the female’s (Mark and Lesieur 1992). By only examining literature based on these more equally proportioned samples, we are reducing the possibility that the results are skewed due to a gender imbalance.

The fourth criteria, problem gambling, was defined as meeting a minimum of three positive SOGS criteria, three CGPI criteria or three DSM-IV criteria. Similarly, pathological gambling was defined by a minimum of five positive SOGS criteria, eight CGPI criteria or five DSM-IV criteria.

All three measures have been found reliable (α=.84) and correlation among these assessment instruments is high (r=.81) (Ferris and Wynne 2001). Individuals seeking treatment or self-exclusion due to gambling problems were also included on a case-by-case basis in order to broaden the spectrum of qualitative literature included in the analysis. Including literature that uses DSM-IV criteria as well as SOGS and CGPI criteria allows us to investigate the findings from both clinical and population health perspectives. Clinical aspects of gambling refer to socio-demographic variables, gambling patterns and behaviours, type of gambling activity, motivation for gambling, vulnerability, comorbidity and gambling-related problems, and treatment outcomes. With one exception that allows us to contextualize findings (Perez de Castro et al. 1997), this review does not include literature that discusses genetics, neurophysiology, or pharmacology in relation to problem gambling.

RESULTS

Literature Search and Selection
The search of library catalogues, journal article databases and reference lists using the search terms outlined above yielded 394 abstracts. Applying the selection criteria reduced this number to 62. After a preliminary review for relevance and methodological quality, the total and final number of sources used our analysis was further reduced to 40.

Prevalence

Estimates for the prevalence of male and female problem or pathological gambling vary widely across studies depending on the sample population and assessment instrument(s) used in each study. Small sample sizes and recruitment biases are common problems that make comparisons between studies unreliable. In addition, many different forms of gambling are considered across these different studies, making extrapolation to other forms of gambling, and disordered gambling in general, difficult and undependable.

The rate of pathological gambling in the general population is typically reported as being between 1 and 2% (SE 0.2%). When problem or subclinical gambling is considered, this statistic rises to anywhere from 2.5 to 7% (Afifi et al. 2010a; Blanco et al. 2006; Marshall and Marshall and Wynne 2004). For example, a series of recent studies by Afifi and colleagues (2010) obtained a nationally representative and gender-stratified sample of Canadians via the Canadian Community Health Survey (CCHS 1.2 2003, n=10056 females) and assessed the combined prevalence rate of problem and pathological gambling over the past 12 months, as defined by a score of at least three on the CGPI. The researchers found that 2.7% of women who gambled in the past 12 months were problem gamblers. Marshall and Wynne (2004) reported that in 2002, 5% of Canadian adults were at-risk or already problem gamblers according to the CGPI, and Volberg (1994), a leading researcher in the field of gambling, asserts that those scoring as probable problem gamblers in the general population are most likely to be women and minorities. Welte and colleagues (2002) reported similar findings, asserting that in their representative sample of American adults (n=2630), the combined prevalence rate of problem and pathological gambling is 2.9% for females and 4.2% for males. When the sample was limited to only pathological gamblers however, the male to female ratio decreased to near equivalence (1.3% for males; 1.4% for females).

In contrast to studies using the CGPI, a recent study using a nationally representative sample of Americans obtained from the National Epidemiological Survey of Alcoholism and Related Conditions (NESARC, n=43093) and DSM-IV diagnostic criteria reported combined problem or pathological gambling rates of 0.7% in males and 0.4% in females (Desai and Potenza 2008). This prevalence rate is lower than the majority of other estimates. The discrepancy is likely due to the fact that the individual and clinical focus of DSM criteria often yield lower estimates than community screening instruments like SOGS or CGPI, which prefer to define problem gambling by the negative impact it has on the individual, as well as his or her social network and community (Desai and Potenza 2008; Ferris and Wynne 2001).

Blanco and colleagues (2006) also used the same NESARC sample as Desai and Potenza (2008), but they distinguished between subclinical and pathological gambling, with scores of 1-4 DSM-IV criteria indicating subclinical, and scores five and above being considered pathological gambling. The authors reported that the lifetime
prevalence of pathological gambling was 0.23% for women and 0.46% for men, but when subclinical gambling was included, these rates jumped substantially to 3.26% for women and 6.79% among men. Moreover, when the sample was restricted to those who gamble more than five times per year, the gender ratio decreases to less than two to one.

It is important to acknowledge such high rates of problem and subclinical gambling in the general population, as these individuals also experience negative consequences due to their gambling, even though their problem is less severe than that of clinically pathological gamblers. Despite the wide variability, the male to female prevalence ratio tends to remain slightly under two to one. This is consistent with estimates from the earlier nineties that claimed although GA members were 94-98% male, females still represent one third of problem and pathological gamblers (Lesieur and Blume 1991; Volberg 1994).

Demographics

Rates of problem or pathological gambling vary by demographic characteristics like income, ethnicity and age. In a representative sample of American adults (n=2630, 56% female) Welte et al. (2002) found that 82% of the population had engaged in at least one type of gambling in the past year. Importantly, participation rates in most gambling activities tended to increase with socioeconomic status (SES), yet higher SES gamblers had significantly lower rates of problem or pathological gambling and were involved in gambling to a lesser extent. The variation in prevalence rates is most likely the result of both genuine socio-demographic disparities, as well as differences in how and among whom gambling is defined and measured.

(a) Socioeconomic status

Socioeconomic status refers to an individual’s personal and/or household income, education, and occupational status. Overall, associations between gambling problems, education and occupation are largely similar across gender. However, a gender difference emerges clearly for annual income levels. Where differences in employment status did occur, results were only mildly significant (p<0.1). Crisp et al. (2004) found that, compared to males, a greater proportion of female problem gamblers are not in the labour force (44.4% vs. 33.5%). This result was nearly replicated by Desai and Potenza (2008) (43.24% vs. 28.19%). Nower and Blaszczynski (2006) and Walker, Hinch and Weighill (2005) all reported that female gamblers were significantly less likely to be employed full time. Gender differences in education appear to be negligible, with most problem gamblers having attained a high school diploma and some college education. Compared to the general population however, problem gamblers as a group are considerably less educated (Afifi et al. 2010b; Ibanez et al. 2003; Ladd and Petry 2002; Martins 2004; Nower and Blaszczynski 2006; Petry & Steinberg 2005; Tavares et al. 2001; Walker et al. 2005).

Much of the literature on SES and health status demonstrates that the risk for poor health - in this case, for developing gambling problems - tends to increase proportionally with decreasing SES. Afifi et al. (2010b) found that as income brackets decreased, the odds of problem gambling increased significantly among women relative to men in the
general Canadian population. Their findings showed that women with an income from $50,000-79,999 faced an odds ratio of 2.4, compared with an odds ratio of 5.0 among incomes of $15,000-30,000, and a staggering odds ratio of 9.4 when income is less than $15,000. Similarly, Blanco et al. (2006) reported that female problem gamblers were nearly twice as likely as male problem gamblers to have an income of less than $20,000 (60.94% vs. 34.1%). Finally, Potenza et al. (2001) report that females were greatly overrepresented in the lowest income decile (less than $15,000).

Likewise, Nower and Blaszczynski (2006) confirm this pattern using a large sample of American self-excluders (n=2670, 48.4% female). These “self-exclusion” programs allow gamblers to voluntarily “exclude” or ban themselves from gaming venues as an attempt to control gambling behaviours. Nower and Blaszczynski reported that a disproportionate number of female gamblers were in the lowest two personal income brackets, whereas significantly more males were found to have personal incomes in the two highest brackets. This pattern stands outside of North America as well: in an outpatient sample of Spanish gamblers (n=103), Echeburua and colleagues (2010) found that female problem gamblers were nearly three times as likely to report a low to medium-low socioeconomic level (42% vs. 15.4%).

For women, the risk that they may develop a gambling problem increases as their SES decreases. In an ethnographic study of seven Ontario female gamblers, Li (2007) noted that even though most demographics varied wildly, including employment status and education, all of the participants lived in a low-income household. Afifi et al. (2010b) stratified their Canadian sample and found that there were no gender differences in risk for problem gambling across education levels. However, when problem-gambling women were compared to non-problem gambling women, a clear increased risk emerged among those who had attained less than a high school education. This is particularly interesting since problem-gambling men were no different from non-problem gambling men in terms of income or education. The authors further confirmed that females in the lowest income bracket (less than $15,000) face increased odds (OR=2.8) of problem gambling when compared to other women. While the odds ratio is not as high within gender as it is across genders, these results suggest that low SES women are most vulnerable to gambling problems. In comparison with women who have a higher SES, low-status women are more likely to experience a range of related life stressors. These women may think of gambling as a way to escape their low SES. This thought process makes these women more likely to continue gambling, even if they experience severe losses. Women of low SES therefore represent an especially vulnerable group, as it takes fewer and/or less severe losses to cause adverse financial consequences for them.

(b) Marital status

Largely due to methodological inconsistencies, the studies we examined came to contrasting conclusions regarding gender differences in marital status. However, most of these studies tend to agree that as a group, about half of gamblers tend to be married or in a relationship. Studies suggest that there is an increased risk for problem gambling among women who have never married (Afifi et al. 2010b; Boughton and Brewster 2002). Echeburua et al. (2010) found that female pathological gamblers are significantly more likely than their male counterpart to be divorced or widowed (37.2% vs. 9.6%), but the
study did not report on the likelihood of people who have never been married. Similarly, multiple studies concluded that female problem gamblers were more likely to be living alone, while males with a gambling problem were more likely to be married (Blanco et al. 2006; Nower and Blaszczynski 2006; Tavares et al. 2001, 2003).

Desai and Potenza (2008) reported that compared to male gamblers, female gamblers are less likely to be currently married (59.06% vs. 64.41%) but more likely to have been married in the past (22.66% vs. 11.8%). The higher rates of separation/divorce make sense when we consider Ibanez et al.’s (2003) finding that women were considerably more likely than males to report fair or poor marital relations before the onset of problem gambling (36.85% vs. 10%). Another thing to consider is that the high rates of separation/divorce/singlehood among female gamblers may be a reflection of the significantly older average age of female gamblers compared to males (which will be discussed below in the section on Age).

In contrast to the findings above, Crisp et al. (2000) reported that female gamblers who sought treatment were more likely than their male counterparts to be married or living with a current partner (42.8% vs. 35.7%). Conversely, Grant and Kim (2002), Ladd and Petry (2002) and Petry and Steinberg (2005) all conclude that there are no significant gender differences in marital status.

(c) Race/ethnicity

While a few studies maintain that there are no significant gender differences in the racial/ethnic background of problem gamblers (Ladd and Petry 2002; Petry and Steinberg 2005; Tavares et al. 2001), most report that in comparison with the general population, a disproportionate number of minorities are problem or pathological gamblers. Particularly, these studies showed that African Americans are over-represented among female gamblers. For example, Blanco et al. (2006) found that African American women were more than twice as likely as their male counterparts to report problem gambling, even when various other socio-demographic characteristics were the same across both genders. Similarly, Potenza and colleagues (2001) report that female problem gamblers were more likely to be African American than male problem gamblers (11.7% vs. 6.6%), and Nower and Blaszczynksi (2006) further confirmed this finding.

Little information linking immigrant status to risk for problem gambling turned up in the literature we reviewed, but this is a factor that warrants more attention. Gambling has many unique features that would appeal particularly to recent immigrants trying to establish themselves in a new country. Immigrants often gamble together, for instance, because this offers an opportunity for social interaction and support (Fong 2005). Gambling also offers the possibility of making money quickly, and thus the potential to improve one’s social status; with the vast array of gambling activities available, particularly EGMs and VLTs, neither citizenship nor the ability to speak English is necessary in order to make this money. These factors that potentially motivate immigrants to gamble make them a particularly vulnerable group in terms of becoming problem gamblers, which suggests that this area of problem gambling needs to be addressed more thoroughly.
(d) Age

A very clear gendered pattern exists in the literature in terms of age. The vast majority of studies in this area conclude that female problem gamblers are typically middle-aged (30-49 years), meaning they are generally older than their male counterparts, who tend to be in their twenties and thirties (Crisp et al. 2000; Crisp et al. 2004; Desai and Potenza 2008; Echeburua et al. 2010; Ladd and Petry 2002; Nower and Blaszczynski 2006; Potenza et al. 2001; Tavares et al. 2003; Walker et al. 2005). In general, older age appears to be a risk factor for female gambling, as suggested by Blanco et al. (2006), who found that women aged 65+ are significantly more likely than their male counterparts to report problem gambling. Similarly, Afifi et al. (2010b) found that the risk for problem gambling increases among females relative to males in people who are between 40-49 (OR=3.1) and 50-59 (OR=2.9) years old, further confirming this trend.

Many of the studies we analyzed used samples containing gamblers who were seeking treatment. The mean age of male and female gamblers in these studies tended to be significantly closer than in studies that used samples drawn from the general population (see Crisp et al. 2000, 2004; Ibanez et al. 2003; Potenza et al. 2001). This may be because most gamblers seeking treatment are doing so for the first time (Tavares et al. 2003). Although female gamblers tend to be older, they usually progress to disordered gambling more quickly (which we will discuss further in Progression to disordered gambling). This means that women typically reach the treatment-seeking stage when they are roughly the same age as males, so these particular samples taken from gamblers receiving treatment tend to be composed primarily of men and women who are similar in age.

Gambling characteristics

(a) Progression to disordered gambling

Of the forty studies we reviewed, thirteen commented on the gender differences in the progression of gambling behaviours. All of these studies came to the same conclusions: first, women begin gambling significantly later in life, usually in their mid-thirties, compared to males, who typically begin in their early twenties. Second, women’s progression toward disordered gambling is significantly faster than that of males. This accelerated progression is frequently referred to as a “telescoping” effect and is very similar to the progression of female alcoholism (Blanco et al. 2006; Echeburua et al. 2010; Ladd and Petry 2002; Nower and Blaszczynski 2006; Potenza et al. 2001; Tavares et al. 2001). A study by Echeburua et al. (2010) exemplifies such findings, reporting that the average age of onset of gambling behaviours was 34.8 years for women and 23.4 years for men. Moreover, women in this sample took an average of 5.9 years to meet the criteria for problem gambling, whereas the average male time span to reach this point was 9.7 years. Ibanez et al. (2003) report similar statistics: women in their sample were older at the time they made their first bet, at an average age of 32.7 years in comparison to the average male age of 23.8 years. Their study also revealed that the interval between their first bet and the point at which their gambling developed into a problem was nearly three times shorter than it was for men, with women averaging 4.2 years, while men typically took 11 years. Ladd and Petry’s study (2002) put forward the most substantial age
differences in gambling progression among treatment-seeking pathological gamblers as diagnosed by SOGS. Females in this sample (n=115) began gambling when they were twice as old as the newly gambling males (32 years vs. 16 years). They also began gambling regularly at an older age, typically starting at the average age of 40.1 years, while the men in the study started gambling with regularity when they were an average of 26.4 years old. Finally, the women within the sample spent fewer years as problem gamblers – only an average of 4.4 years in comparison with the 14.6 years of men - before they sought treatment.

One particular study we reviewed, by Tavares and colleagues (2001, 2003), specifically sought to investigate the factors that caused female problem gambling to progress faster than male problem gambling. The researchers obtained a sample (n=77, 56% female) of treatment-seeking Brazilians who met DSM-IV criteria for pathological gambling and who were screened by SOGS in order to assess the severity of their problem. In these studies, gambling is divided into three stages, each of which represent a certain stage in the progression to problem and pathological gambling: following the age of initial gambling onset, gambling is divided into the intervals of social gambling, intense gambling, and problem gambling before the gambler seeks treatment.

After a series of semi-structured interviews and multivariate analyses, the authors concluded that female gamblers reach all of these intervals later in life and that they also move through each stage more quickly. First, women began gambling later in life, at the average age of 34.2, in comparison with the younger start for males at age 20.4 (p<0.001). Next, they took only an average of 7.7 years to meet DSM-IV criteria for problem gambling, compared to the 12.3 years it took males to reach this point. This “telescoping” effect is further confirmed by a comparison of the time that men and women spent in each stage, which highlights the fact that the gender difference is greater when the level of severity of gambling is higher. For example, women spend an average of 5 years in the social gambling stage, whereas men tend to be in this stage for only 8 years. This difference increases when comparing the years that men and women spend in the intense gambling phase, in which women typically spend 0.8 years on average, and men, 4.3. Finally, the different amounts of time men and women usually spend problem gambling before they seek treatment is the factor that sets the two genders apart the most distinctly, with women only taking 1.9 years, and men taking an average of 6.7.

It is important to note that the authors of this particular study accounted for variables of gambling progression, preference for particular types of gambling, maximum abstinence length, and certain demographic variables, including marital and socioeconomic status. After a stepwise regression model, only the gambling progression variables remained significant in the model. This allowed the authors to conclude that the differences between men and women in terms of how they move through the stages of gambling progression are independent of demographics and gambling behaviours.

Although women are no more or less likely to seek treatment than males, those who do try to get help for their problem tend to do so at an earlier stage in the progression of gambling behaviours (Blanco et al. 2006; Grant and Kim 2002; Tavares et al. 2001). Some of the literature suggested that this might be because people of each gender perceive the severity of their gambling problems differently, and that men and women
will therefore choose to seek treatment at different stages in their progression. However, research also assures that there are no significant gender differences in overall gambling participation or severity of gambling by SOGS, CGPI or DSM-IV scores (Echeburua et al. 2010; Grant and Kim 2002; Hing and Breen 2001; Ibanez et al. 2003; Ladd and Petry 2002; Nower and Blaszczynski 2006).

(b) Gambling activities

The faster progression through these various stages that occurs among female gamblers may be due to biological vulnerabilities specific to women. However, it is also likely that socio-cultural context plays a substantial role in this rapid progression by restricting the gambling activities and behaviours available to females to those that are the most addictive. In support of this theory is work by Tavares et al. (2003) and Petry (2003), both claiming that the prominent use of EGMs was the most important factor contributing to an accelerated progression among females. Another interesting finding comes from Volberg (2003), who analysed data from several American states. Her findings revealed that in states in which access to EGMs was limited, rates of problem or pathological gambling were higher among males, whereas gender rates were equal in those states with more accessible EGMs.

Twenty-two studies in this body of literature comment on the differences between men and women in terms of the types of gambling activities that they each prefer. All of these studies reached the conclusion that female problem gamblers participate in a considerably more narrow range of activities, tending to prefer continuous-play, non-strategic and chance-based forms of gambling like slot machines/EGMs/VLTs, and bingo (Blanco et al. 2006; Crisp et al. 2000; Hing and Breen 2001; Nower and Blaszczynski 2006; Petry 2003). One of these studies, by Nower and Blaszczynski (2006), reports that 54.2% of male gamblers participate in mixed (strategic and non-strategic) forms of gambling, compared to only 27.1% of female gamblers. Another study found that 61.4% of males preferred strategic and skill-based games like blackjack and sports betting, while 81.8% of females participated exclusively in non-strategic games like slots, bingo and the lottery (Toneatto and Wang 2009). Finally, Crisp et al. (2000) reported that 91.1% of the females from their sample indicated a preference for EGMs, while only 61.4% of men did. These statistics become significant within the context of Affifi et al.’s (2010) study, which compared gambling women to non-gambling women within an entirely female sample. They found that with the exception of games of skill, all non-strategic forms of gambling were associated with significantly higher odds of problem gambling, whereas the association was non-significant with strategic gambling forms. VLTs both inside and outside the casino were associated with the largest odds of problem gambling among women who gamble; compared to women who never gamble on VLTs, those who did so at least weekly were 53.73 times more likely to become problem gamblers. These findings are significant because they imply that women’s preference for these kinds of non-strategic forms of gambling puts them at a higher risk for developing a gambling problem than men.

Further, these studies revealed that female gamblers are more likely than males to play lower denomination machines, wager less per bet, and spend less money gambling overall (Hing and Breen 2001; Nower and Blaszczynski 2006; Petry 2003; Welte et al. 2006; Welte et al. 2007).
Hing and Breen (2001) found that females were significantly more likely than males to play 2-cent and 5-cent denominations, whereas males were more likely than females to bet every other denomination higher than 5 cents. Their study also revealed that men have a higher expenditure per gambling session and per week than women do.

Grant and Kim (2002) and Petry (2003) both report extensively on gendered preferences for certain types of gambling. Among a sample of DSM-IV pathological gamblers, Grant and Kim (2002) found that even though the severity of gambling across genders was not significant, women were considerably more likely to participate in bingo (15.4% vs. 1.9%) and slots (82.1% vs. 45.3%), whereas men were more likely to engage in sports betting (22.6% vs. 3.8%), strategic card games (56.6% vs. 16.7%) and track racing (17% vs. 2.6%). In a fair-sized sample of treatment-seekers in Connecticut (n=347, 40.6% female), Petry (2003) distinguishes between 5 types of DSM-IV pathological gamblers: sports gamblers, horse/dog-race gamblers, card players, slot machine gamblers, and lottery/scratch ticket gamblers. Further, this study notes that sports and horse/dog-race gamblers were the youngest in the sample (34.1 years), and almost exclusively male (96-100%). Slot machine players were considerably older (47.9 years) than all of the other groups, and were most likely to be female (67%).

Machine gambling is now the most common form of gambling for which female problem gamblers seek treatment (Petry 2003). The characteristics of these forms of non-strategic gambling make them particularly addictive. Gambling machines like slots, EGMs and VLTs offer a quick betting turnover, minimizing the time between the bet and outcome, and thereby allowing for faster play and immediate results. Although the variable outcomes are virtually randomized, results are presented in the form of near-misses and frequent minimum pay-outs. The repeated payouts, regardless of their amount, encourage players to believe that they are winning more often than they are losing. Electronic monitoring of EGMs in New Zealand, for example, shows that these EGMs return approximately 54% of what is put in (Bunkle 2009). By creating the impression that players have a good chance of winning, and by suggesting that they almost won this time, these kinds of gambling machines encourage continuous and compulsive play (Potenza et al. 2001; Welte et al. 2007). As we mentioned above, women’s preference for these non-strategic forms of gambling means that they are more likely than men to develop the compulsive gambling habits that these types of gambling encourage.

Gambling machines and other non-strategic forms of gambling, like scratch/lottery tickets, are also easily accessible at non-casino venues, and require little concentration and minimal skill. These characteristics may be particularly appealing to disadvantaged groups like low-SES women and non-English speaking minorities, putting these groups at an especially high risk of developing the gambling addictions that are fostered by these forms of gambling.

It is clear that gambling activities are qualitatively different, and thus appeal to qualitatively different types of gamblers. As such, it is clear that male and female problem gamblers differ substantially in their gambling patterns and consequent psychosocial outcomes. We must therefore understand the characteristics of each form of gambling, as well as what appeal they hold and for whom, in order to address female
problem gambling effectively.

Psychiatric history and concurrent mental health problems

As with many mental disorders, comorbidity rates are high among problem gamblers. Generally, psychiatric comorbidity and increasing gambling severity are related for both males and females (Desai and Potenza 2008), but this association appears to be stronger in females (Echeburua et al. 2010; Ibanez et al. 2003). Nineteen studies from the literature we reviewed comment on gender differences in associated mental health issues, and they all tended to agree that gender differences in comorbidity are marked.

(a) Internalizing vs. externalizing disorders

The most obvious trend we observed in the literature was the higher concurrent rates of internalizing or affective disorders among female problem gamblers when compared to both male problem gamblers and other non-gambling females. Research consistently finds significantly higher levels of both depressive and anxiety disorders among female problem gamblers. This pattern among females stands in contrast to the high levels of externalizing disorders among male gamblers, namely substance use and dependence disorders (Afifi et al. 2010a; Blanco et al. 2006; Desai and Potenza 2008; Getty, Watson and Frisch 2000; Ibanez et al. 2003; Potenza et al. 2001; Specker et al. 1996; Tavares et al. 2003; Toneatto and Wang 2009). A study by Desai and Potenza (2008) revealed this trend: within their NESARC sample (n=43093), the male and female depression rates differ by less than 5%. Among problem gamblers however, there was a sharp increase in the co-occurrence of depression among female gamblers, making the gender gap in depression rates differ by nearly 25%. The authors also found significantly higher rates of other DSM-IV Axis I disorders, including panic disorder, social phobia and general anxiety disorder among female problem gamblers in comparison with the much lower rates they found for males (p<0.0001). In contrast, the authors found non-significant gender variability in the otherwise strong associations between Axis II disorders and problem gambling.

In a sample of GA members compared to non-gambling controls matched on demographics (n=60, 33.3% female), Getty et al. (2000) found significantly higher depression scores on the Beck Depression Inventory (BDI) among female GA members than they did among males (19.25 vs. 10.28). Ibanez et al. (2003) conclude that although the overall comorbidity rate is similar for both genders (68.25% of females vs. 59.6% of males), female gamblers are significantly more likely than males to have a concurrent major depressive disorder (MDD) diagnosis (40.9% vs. 4.3%). On the other hand, male gamblers are more likely to have a concurrent alcohol abuse or dependence diagnosis (46.8% vs. 9.1%, p<0.001). Tavares et al. (2003) confirm this trend with their findings that the female gamblers within their sample (n=140, 50% female) were more likely to have depressive disorders (80% vs. 63%), while males more often reported alcohol dependence (27% vs. 6%, p<0.001). Specker et al. (1996) also report substantially higher rates of anxiety disorders among female problem gamblers (73%) versus male gamblers (16%). Further, they note that social anxiety and avoidant personality disorder were the most frequently diagnosed disorders among females, but that these disorders were
virtually absent in males.

Some of the researchers attempted to explain female problem gamblers’ preference for non-strategic, individual activities like slot machines by contextualizing this preference within the findings that women were more likely than men to struggle with an internalizing disorder. Unlike card games or other kinds of gambling activities preferred by males, these forms of non-strategic gambling usually require minimal social interaction, which might be preferred by people who experience some of the internalizing disorders discussed above. Such gendered comorbidities also make sense in the context of findings from symptom scales that show female gamblers to be considerably more affected by depressive symptoms than men. These scales also show women to be more anxious than men, and have lower self-esteem than their male counterparts. In contrast, male gamblers score significantly higher on impulsivity and sensation seeking scales, which corresponds to their tendency to place higher wagers per bet, and to participate in more exhilarating gambling activities like horse/dog-race or sports betting. (Echeburua et al. 2003; Ibanez et al. 2003).

In a very recent and novel study looking to explain the role of gender in the relationship between environment, mood, and problem gambling, Tschibelu and Elman (2011) used the Daily Stress Inventory (DSI) and Profile of Mood States (POMS) to assess non-treatment-seeking DSM-IV diagnosed pathological gamblers (n=22, 41% female) matched on demographics. The DSI provides an “impact” score that expresses the perceived severity of stressful events. While male and female gamblers reported experiencing an equal number of daily stressful events, the researchers found significantly higher impact scores among females both overall (145.7 vs. 84) and for individual events (4.3 vs. 3.4). These findings suggest that the average impact of a stressful event is significantly higher for a female gambler than it is for a male gambler.

Not surprisingly, the authors also found female gamblers scored significantly higher on most POMS dimensions, including overall mood disturbance (96.1 vs. 57.5), tension-anxiety (37.8 vs. 9.4), depression-dejection (29.2 vs. 17.2), and anger-hostility (21.2 vs. 10.0), in which the greatest gender difference exists. Moreover, gambling urges correlated with both stress and anger-hostility scores in women only (r=0.93 vs. r=0.03), which supports the idea that mood states are considerably more likely to precipitate gambling in women than they are in men.

(b) Family history and childhood maltreatment

In their book profiling the lives of female gamblers, Lesieur and Blume (1991) discuss how the lives of female gamblers are often plagued by instability from their childhood onwards in comparison to those of males. Physical and/or sexual abuse, family psychiatric histories, physically and emotionally abusive romantic relationships, and spousal addiction to substances or gambling were common sources of anxiety and distress for these women. Not surprisingly, the experience of extreme stress or trauma, especially from a young age, often leads to learned development of ineffective emotion-focused coping strategies that include self-blame, withdrawal, escapism or avoidance. These coping styles aggravate depressive symptoms and are highly associated with both affective disorders and problem gambling (Scannell et al. 2000).
Although rates of mental health issues in family histories are higher among problem gamblers than they are for the general population, gender differences in family psychiatric history are minimal. Grant and Kim (2002) report that male and female gamblers tend to have similar family histories in terms of gambling and substance use: approximately 25% of both male and female gamblers reported a parent with problematic gambling behaviour, and 30% reported the same of their siblings. Moreover, half of both men and women reported having a father with an alcohol abuse or dependence diagnosis. Boughton and Falenchuk (2007) also report a high incidence of addiction and mental health issues in the families of a sample of 365 non-treatment-seeking females in Ontario who responded to a mail-in survey and met SOGS criteria for problem gambling. In this group of female gamblers, 52% reported a psychiatric disorder in their immediate family, most often in their mother or sibling; 50% reported having an immediate family member with problematic gambling behaviours; and an astounding 89% reported drug and/or alcohol problems in their immediate family.

In 1996, Specker and colleagues reported that 32.5% of their sample (n=40, 37.5% female) acknowledged being physically or sexually abused during their childhood, which was startlingly higher than the rate of abuse found in national samples (1-2%). However, more up to date literature is lacking with regards to the influence of childhood maltreatment on the development of gambling problems, and particularly on how this factor impacts gambling behaviour in people of each gender differently. Apart from Specker et al. (1996), we were only able to find three studies that included measures of childhood maltreatment (Boughton and Falenchuk 2007; Hodgins et al. 2010; Petry and Steinberg 2005). At the time, Petry and Steinberg’s 2005 investigation was the largest study to date to explore the role of childhood maltreatment. The researchers used the Childhood Trauma Questionnaire (CTQ), a validated multidimensional measure of childhood maltreatment to assess both male and female DSM-IV pathological gamblers (n=149). They found that overall, the people within their sample experienced a more remarkable history of moderate to severe abuse compared to general population norms, as well as a point-of-comparison sample of substance abusers.

Significant gender differences emerged in the results of this study, with female gamblers reporting significantly higher overall scores on the CTQ (56.2 vs. 45.8, p<0.001), as well as more severe physical neglect, emotional abuse, and sexual abuse than male gamblers (p<0.05). In a series of multivariate analyses, the authors included all four subscales of abuse and controlled for history of drug and/or alcohol problems, antisocial personality disorder, age, and depression scores. Only gender was a significant predictor of trauma scores. Furthermore, CTQ scores were independent and significant predictors for an earlier age of gambling onset, higher SOGS scores, and a higher frequency of gambling. This is reflected in the average age of onset for both the men (15.6 years) and women (24.6 years) in this sample when compared to the majority of literature, which estimates the average age of onset for men to be early twenties, and for women, early to mid-thirties (as we discussed in our section on Age).

In 2007, Boughton and Falenchuk investigated childhood maltreatment histories in their sample of female problem gamblers. The authors note that these women experienced considerable histories of emotional and physical abuse both as children and
as adults. Whereas the Ontario Health Supplement (1994) reports rates of childhood physical abuse to be 21% and childhood sexual abuse to be 13% for the general Ontarian population, Boughton and Falenchuk report much higher rates within their sample: 41% of female problem gamblers reported physical abuse, 38% reported sexual abuse, and 63% reported emotional abuse.

Most recently, Hodgins et al. (2010) add to the literature using a large community sample of Canadians (n=1372). They report that greater degrees of maltreatment were significantly associated with an increased frequency of gambling and higher odds of developing a gambling problem. However, even though the authors found significant cross-gender variations for emotional and sexual abuse as females experienced higher rates, the interaction between gender and gambling was reported as being non-significant. This may be a result of using a community sample, which contrasts with Specker et al.’s (1996) and Petry and Steinberg’s (2005) treatment-seeking populations; given that maltreatment is associated with gambling severity, female problem gamblers with more significant maltreatment histories might be more likely to seek treatment, which would introduce a selection bias to treatment-seeking populations. Regardless, it is likely that the development of problem gambling is strongly influenced by a complex interplay of factors that often stem from people’s childhoods.

(c) Current relationships

In comparison with those of males, the intimate relationships held by female problem gamblers are stressful, violent and chaotic, frequently marked by addiction, mental illness and abuse. Whereas troubled and abusive marriages seem to be common among female gamblers, these kinds of relationships are considerably less prominent among males. Ladd and Petry (2002) note that compared to males, females are more than twice as likely to live with someone with a current alcohol problem (15.6% vs. 7.1%), and over four times more likely to live with someone with a current gambling problem (13.3% vs. 2.9%). Another study by Lesieur and Blume (1991) discusses the troubled marriages of their sample of female problem gamblers, explaining that 62% of female gamblers were married to problem gamblers, alcoholics, and/or drug abusers, or who were physically and emotionally abusive, and chronically absent from the home. Boughton and Brewster (2002) report similar statistics, with 22% of female problem gamblers having problem gambling spouses and 32% reporting spousal drug addiction.

These relationships are also frequently plagued by financial abuse and frequent conflicts over how finances are handled. Up to 60% of female gamblers in Lesieur and Blume’s sample reported that their relationships were strained by severe financial stress. Boughton and Falenchuk (2007) also report substantial rates of adulthood physical abuse (46%), sexual abuse (28%), and emotional abuse (69%) among their sample of female problem gamblers, further noting that 39% are currently in an abusive relationship.

These troubled relationships create a home environment for female gamblers that is extremely stressful, unstable and unsupportive. Gambling may then be conceptualized as a coping method that helps women deal with the negative emotional states they experience because of the wide variety of stressors in their lives.
Motivations for gambling

In order to prevent and treat female problem gambling as effectively as possible, perhaps the most important distinction between male and female gamblers that must be understood is the underlying motivations that drive people of each gender to gamble. The literature points toward stark gender differences in terms of these motivations to gamble that can also be applied to explain why women differ from men in the types of gambling activities they choose to participate in and the concurrent issues they face as a result of those preferences.

(a) Escape

Female problem gamblers report significantly more specific motivations for gambling than do males. The division between the “action” of gambling and the “escape” it allows appears to be central to the distinction between male and female motivations; “‘action’ is an aroused euphoric state comparable to a drug-induced high. ‘Action’ means excitement, thrill and tension.” (Lesieur and Blume 1991, p. 185). As discussed earlier, male gamblers score considerably higher on measures of impulsivity and sensation seeking (Echeburua et al. 2010; Ibanez et al. 2003). It is not surprising then that males are primarily motivated to gamble by the thrill of the game itself, as certain aspects including chasing wins and losses, thoughts of potential profits, and also peer pressure and sensory stimuli can provide the exhilarating experience they are looking for (Echeburua et al. 2010; Blanco et al. 2006; Crisp et al. 2000; Grant and Kim 2002; Ibanez et al. 2003). In contrast, this “action” serves as an escape mechanism for women by giving them something to focus on other than their (typically poor) mood and life conditions. Gambling therefore provides an anaesthetic or dissociative effect that is highly valued by female gamblers seeking refuge from the stresses, dissatisfactions, and frustrations of their everyday lives, both past and present. As we have seen in our discussion on Internalizing vs. externalizing disorders, high comorbidity rates with depression and anxiety are common among female gamblers. With this in mind, it is evident that female gamblers’ motivations are strongly tied to their affective state.

Noting the distinction between “action” and “escape”, it is not surprising to find an unequivocal consensus in the literature suggesting that women gamble almost exclusively to escape problems, relieve negative moods and cope with loneliness and boredom (Afifi et al. 2010b; Blanco et al. 2006; Crisp et al. 2000; Echeburua et al. 2010; Grant and Kim 2002; Ladd and Petry 2003; Lesieur and Blume 1991; Li 2007; Toneatto and Wang 2009). Findings by Crisp et al. (2000) support this hypothesis, as they reported that females in their sample were 1.5 times more likely than males to gamble as a way of escaping from other problems. Similarly, Blanco et al. (2006) reported that 82.7% of women in their nationally representative American NESARC sample (n=43093) reported gambling to relieve depressed mood, and likewise, Afifi and colleagues (2010b) reported that 43.4% of females in their nationally representative Canadian CCHS sample (n=10056) gambled to forget about problems or depressed feelings (p<0.001). The female gamblers in Boughton and Falenchuk’s (2007) sample claimed that gambling served a variety of coping functions for them, including helping to manage negative or depressed moods (44%), allowing them to “cheer myself up” (61%), to relieve their stress (53%)
Two studies sought to identify gender differences in “triggers” for gambling. Grant and Kim (2002) found that female gamblers were most often triggered by feeling sad or lonely (19.2%) or by boredom (26.9%), and Ibanez et al. (2003) found female gamblers were significantly more likely to have negative emotional feelings trigger their gambling behaviour than males were (54.5% vs. 23.4%). Although female gamblers frequently cite loneliness and boredom as reasons for gambling, it is important to note that ‘gambling as a social activity’ does not appear to be a dominant theme for female gamblers. Semi-structured interviews revealed that 55% of female gamblers in one sample always or almost always play alone, and that women prefer slot machines because it allows them to be present in a social scenario without feeling any pressure to interact (Boughton and Falenchuk 2007; Boughton and Brewster 2002; Grant and Kim 2002).

Sacco and colleagues (2010) present an interesting finding in a recent paper with the use of differential item functioning (DIF), a statistical technique that allows the researcher to isolate how probabilities of a particular item endorsement differ across demographics (namely gender) while accounting for equal levels of gambling severity. The authors use a sample of DSM-IV pathological gamblers derived from the NESARC (n=10899, 41.35% female) and find that overall, women are more likely to endorse gambling as a means of escape. Further, factor analysis showed that the criterion of endorsing escapism does not load significantly on a single gambling factor, which indicates that the motivation to gamble as a means of escape is more strongly associated with the female gender than it is with pathological gambling.

This finding is particularly interesting within the context of a report from Perez de Castro and colleagues (1997), which found a significant genetic association between problem gambling and the D4 receptor gene that was only found among female gamblers. The report revealed that D4 has repeatedly been implicated in a range of affective disorders and primarily, depression. Similarly, Desai and Potenza (2008) highlight a stronger relationship between depressed mood and gambling pathology in women when compared to men, suggesting that gambling is first and foremost a coping mechanism for female gamblers. The findings from both of these studies suggest that women are more likely than men to develop a strong emotional involvement with gambling, which quickens the pace of addiction and causes more severe emotional reactions and distress. This idea is further supported by Petry’s (2003) analysis of gambling types that we discussed previously, in which she finds significantly higher rates of anxiety in slot machine and lottery gamblers, who were generally older, almost entirely female, and more likely to experience psychiatric problems along multiple dimensions.

It is apparent that escapism is the primary motivation that drives females to gamble. In general, going to the casino allows women to physically escape their typically stressful home life. But more specifically, this motivator explains why women prefer the forms of gambling they do: female patterns of play – i.e. spending less in total, choosing low denomination machines, wagering the minimum bet – all appear to be strategies that extend playing sessions, allowing women to spend more time outside of the home. Also, the mindlessness of continuous-play, non-strategic, chance-based games like slot machines and EGMs allow women to become absorbed in the fast-paced action of the
machines, taking their attention away from their various stressors.

(b) Equality

Another theme that may be conceptualized as a form of escapism is that of social justice, or gambling to gain equality. This idea was put forward in the qualitative pieces that focus on conducting in-depth interviews with small groups of female gamblers. Female gamblers generally hold a lower social status compared to the general population. Some forms of gambling, especially those preferred by women, are termed “equal chance”, in that there are very few restrictions on who can participate because “the machines don’t care … whatever you look like, however old you are … the machine does not judge you, and does not discriminate. Where else can you participate on such equal terms?” (Bunkle 2009, p.41). The non-strategic, chance-based forms of gambling preferred by women are exactly that: chance-based, meaning that their chances of winning big are just as good as the person next to them, regardless of social status or demographic characteristics. Bunkle (2009, p.42) explains,

After all, a random chance is just that – random. Every chance is as good as every other. I observed that women tend to like the sorts of gambling where that is true. It’s not that they avoid games of skill; it’s that they like games where they have an equal chance. You have to be ‘in to win’, but if you are ‘in' then your chance is as good as the next person, and for these women that’s as good as it is ever going to get. At least they aren’t disadvantaged relative to everybody else. And in the rest of their lives they certainly are.

Random chance games, particularly the lottery, promote wins as life changing. Consider Lotto 649 ads in Ontario for example, which depict ordinary couples on private yachts or enjoying a private dinner atop a mountain. These depictions promote a fantasy of immediate relief for those women who are struggling, suggesting that winning the lottery can ‘transform one’s life’ and that ‘anyone can be a winner.’ These ideas translate to machine gambling as well, meaning that the forms of gambling preferred by females tend to promote the idea that every participator has an equal chance at winning.

Along the same lines, a report by Casey (2008) discusses working class women in the UK who participate in the National Lottery with hopes of winning a better life in which they gain some status and power. For these women, the lottery allows them to believe that they have a chance to improve their difficult financial situations. Similarly, Li (2007) interviewed a small group (n=7) of problem gambling women whose disadvantaged SES and lack of control over their life situations drove them to gamble. All seven women who participated in this study approached games of chance out of curiosity and were slowly drawn in to habitual gambling, which came to be sustained by their hopefulness that winning big would positively change their lives.

These women also felt that gambling temporarily bridged the gap between the haves and the have-nots; instead of the inequality and disadvantages these women face in their everyday lives, they felt like they were all simply gamblers when they were in the casino. This sense of equality and empowerment that gambling provided for these women was another factor that motivated them to continue to gamble. For these women,
gambling is invariably related to their disadvantaged status within in society, and the dissatisfaction they feel with their lives; “they found no comfort in their lives, either in the past or present, so they took pleasure in betting on something unknown in the hope of a better future” (Li 2007, p. 633). Gambling becomes a solution for these problems, and because it eases the pain these issues cause, women become emotionally attached to and reliant on it, further reinforcing their addiction.

CONCLUSIONS

Summary

Overall, our examination of the literature has revealed that female problem gamblers tend to be characterized by certain demographic features. They are less likely to be employed full time, and as a result, they tend to have incomes below $20,000. These women are more likely to be middle aged (ranging from 30-49 years old), they typically have less than a high school education, and more often than not, they are part of a minority population. Their final distinguishing demographic characteristic is that of marital status, as females problem gamblers were usually single, divorced or widowed.

Female problem gamblers are also typified by certain gambling behaviours. These women tend to begin gambling later in life and progress toward disordered gambling quickly. They prefer a narrow range of games that are non-strategic and chance based, such as slot machines and bingo. Finally, women problem gamblers are characterized by having similar reasons for gambling: they generally resort to gambling in an attempt to escape from the stresses of their everyday lives.

Lastly, we may conclude that female problem gamblers tend to have higher concurrent rates of internalizing and/or affective disorders. Often, these women experience instability and/or trauma during their childhood, as well as abusive or troublesome relationships in adulthood. As a result, female problem gamblers tend to turn to gambling because it allows them to feel a temporary sense of empowerment.

Treatment outcomes

It is clear that female problem gambling is inseparable from both the disadvantaged position women have in society, and their usually dire affective state. Until recently, female gamblers have faced social stigmas that have limited their inclusion in both research and treatment practices. Currently, telephone help lines are the most advertised treatment option for females, as well as the most used (Afifi et al. 2010a). This popularity is likely due to the fear women have of being stigmatized for their problem; telephone help lines allow them to keep their identities hidden, and thus reduce the sense of being judged that some women may have felt with other forms of treatment. However, as it stands, telephone help lines and other treatment options seem unable to adequately address the roots of female problem gambling behaviour. This was emphasized in a study by Toneatto and Wang (2009), which revealed that women are not as successful in treatment programs as their male counterparts. This study assessed sex differences in community treatment outcomes among a mixed-gender group of treatment-seeking problem gamblers after seven sessions of cognitive-behavioural therapy (CBT).
Standard CBT for gambling focuses on therapeutic tasks that are considered central to changing gambling behaviour, including identifying high-risk situations, discussing gambling-related cognitive distortions, and developing appropriate coping responses (Toneatto and Wang 2009). The authors found that in comparison with women in the program, men reported significantly more positive treatment outcomes and reduced severity of their gambling problem; males showed an average reduction of four DSM-IV symptoms for pathological gambling, while women showed an average reduction of only one symptom. Moreover, the women rated the therapeutic tasks involved in the program as being less helpful than the men in the program rated them.

Six months after receiving treatment, participants had follow-ups which revealed that at that point, men had a higher abstinence rate, at 82.4%, than women did, at only 41.7%. Further, the women who had received treatment continued to rate their gambling problem as being more severe than the post-treatment men did. Unsurprisingly, and in accordance with some of the findings we discussed previously (Desai and Potenza 2008; Perez de Castro et al. 1997; Petry 2003), DSM-IV symptom patterns at these follow-ups indicated that there was a stronger functional relationship between gambling and negative affect among women. Females were more likely to use gambling as a coping mechanism for gambling-related withdrawal symptoms, including the regulation of negative affect. The researchers conclude by emphasizing the need to integrate CBT with pharmacological management in order to effectively treat women dealing with both problem gambling and affective disorders.

**Recommendations for prevention and treatment**

The findings in the literature we reviewed suggest that more efficient treatment interventions are needed. In order to make these treatments more effective, they need to be tailored to the particular patterns and characteristics of female gambling. Women tend to gamble compulsively as a result of an intricate mix of stressors, mental health issues, and poor coping skills, all of which often find their roots in the early lives of these women. Given the strong link between female problem gambling and affective state, the treatment these women receive should involve training them in how to regulate their emotions. Further, these women should be taught productive, positive coping skills that they can use to manage their stress, so they will not feel the need to use gambling as a coping mechanism. Finally, treatment should address comorbidity with depression and anxiety; the affective states that result from these concurrent conditions appear to be a primary factor in driving women to gamble, so treatment that aims to relieve these emotional states should be effective for many problem gambling women.

Prevention efforts should target women who are particularly susceptible to problem gambling. This means that those women who are not employed full time, who are middle aged (30-49), who have incomes below $20,000, who have less than high school education, who are part of a minority population, and who are single, divorced or widowed should be targeted.

In terms of the preventative measures that should be applied to these women, screenings for comorbid mental issues should be performed by general practitioners. Additionally, gambling should be made less accessible for low-SES females by removing
gaming machines from community venues, and by relocating gambling venues from disadvantaged urban areas. These practical preventative efforts would likely curb the tendency women have of resorting to gambling in order to cope with the stress in their lives.

These recommendations for prevention and treatment flow from our examination of previous studies on problem gambling. This literature review has allowed us to synthesize the most relevant findings from studies that other researchers have conducted in their efforts to investigate the needs of problem gamblers. In the next section, we will supplement this existing knowledge base through our analysis of female gambling narratives. These narratives introduce valuable information on the ways women experience gambling and different types of treatment, in the words of female gambling addicts themselves. Our literature review and our biographical content analysis thus work together to enhance our understanding of female gambling, with the former acknowledging statistical findings as expressed by researchers, and the latter providing insight into the struggles of female gambling addiction from the vantage point of women gamblers themselves.
3) RESULTS OF THE BIOGRAPHICAL CONTENT ANALYSIS

INTRODUCTION

This portion of our report explores (1) whether there is variation among female problem gamblers based on demographic characteristics; (2) how female gambling behaviour progresses; (3) the role of distress in various life stages in the development of problem gambling; (4) the forms of treatment that are most often sought by female gamblers and; (5) which treatment methods are the most effective in curbing compulsive gambling and preventing relapse.

We will begin with a discussion of the study methodology, as well as the process we took to analyze the cases. This will be followed by the findings of our analyses, and finally, the implications and significance of those findings for the sociological study of problem gambling, for individual female problem gamblers, and for the community at large. This section aims to highlight the perspectives of the women who have written about their gambling behaviours by including selections from their published narratives. Our content analysis report uses the voices of female problem gamblers throughout to provide insight into the factors influencing women's gambling.

METHODOLOGY

We began by obtaining a list of print and online sources containing stories of problem gambling from a previous study by the principle investigators on the inter-generational transmission of problem gambling. The original list was compiled using an online search of websites such as Google, Amazon, and online bookstores. Key words used in the search included, but were not limited to, 'personal stories gambling', 'gambling problem', and 'gambling biographies and memoirs'. Each source on this list was checked for basic relevance, and all sources that were not written by and/or about female problem gamblers were eliminated. The same method of online searching was then conducted for additional print and web-based sources that may have been published since the time of the previous study. In addition to the websites listed above, the search encompassed the Toronto Public Library catalogue, Toronto Reference Library, and the local university library systems (both the University of Toronto and Ryerson University).

Potentially relevant titles, both print and online, were added to the master sources list. All instructional, self-help, and fictional texts were excluded from the master list, as they were not relevant to this portion of the study. For both print and online cases, only those containing non-fiction first and third person accounts of female gambling behaviour published in English were included. Our original intent was to gather as many cases as possible, with the hope of identifying the size of the genre of female gambling narratives. However, a couple of factors prohibited achieving this goal. Instead, selection criteria were implemented (which are discussed below). The first round of searches, in combination with the list provided from the previous study, yielded 144 potentially relevant cases. All available print sources were obtained through library catalogues and mail-order bookstores.

We also wanted to provide some additional cultural context to draw a comparison
between the North American and Australian cases we had collected. As will be discussed below, measures for ethnicity could not be obtained for a large number of cases. However, we were able to record the location of publication for all of the cases we analyzed, which allows us to see how the availability and type of gambling establishments, as well as the level of cultural acceptance of gambling behaviour, varies between different locations.

Once the search was complete, each source was read and either chosen for analysis, or deemed ineligible for the study. A case was chosen for the analysis if it was a non-fiction account; written in English; about female gambling behaviour; and if it provided basic information about compulsive gambling behaviour, motivation, and/or gambling treatment. From the master list of 460 stories, 144 were deemed potentially relevant and, of those, 88 were chosen for analysis (16 print and 72 online). Online cases will be referenced as 'OC', and print cases as 'PC' throughout the report. Although some cases are incomplete in the sense that they do not provide information for each variable, they were included in the analysis because they offer a different perspective on gambling, interesting gambling behaviour or motivations, or add particular insight to a certain trend of interest.

In analyzing all of these autobiographies, we were not attempting to come to any kind of conclusive statements about female problem gamblers. Rather, we were hoping to uncover some insight into the everyday experiences of female problem gamblers, as expressed in their own words. By using a broad set of criteria to determine which cases we would use, we were able to uncover a much wider range of texts, providing lots of rich, unique data, than we would have been able to using another method.

(a) Definition of Variables

We framed an initial reading of these cases with some insight from a previous study, as well as from the literature review above. Variables of particular interest at the outset of our analysis therefore somewhat reflect certain aspects discussed in the literature review, including demographic information (age, location, ethnicity, and income) and measures of childhood and adulthood stressors. In particular, some of the demographic variables we wanted to examine included the age of the author at time they were writing the narrative, how old they were at the time of their gambling onset, their employment and marital status, and if they had any dependents (children, grandchildren, and/or elderly parents). We were also interested in measuring other demographic variables like income and ethnicity, but this information was not disclosed in the majority of the cases we collected, and therefore could not be accurately measured.

All of the gamblers we analyzed were female. In our sample, 53% of women were over age 30 at the time of gambling onset, with 34 women being at least 40 years old at that time. The age of gambling onset was unknown for 21 of the cases. This is consistent with the results of the literature review, in which we found that most female problem gamblers are middle aged.

Similarly, with the exception of two cases, all of the authors were over the age of 30 when they wrote about their gambling experiences. Just over 50% of these women
were aged 50 or older. In terms of marital status, 63% were married or in a committed relationship, while 34% were single. This finding is in contrast to the literature review results, where we found that most female problem gamblers are single, divorced or widowed. Regardless of their marital status, 74% of stories mentioned that the author had responsibilities for children, grandchildren, and/or elderly parents. These figures on relationship status and dependents are particularly relevant with regards to the role of stress in inducing gambling activities, as discussed in the previous literature review.

With time, and through our exposure to a larger number of cases, it became evident that a clear typology of female problem gamblers would not emerge from the narratives we were examining. Even though a large number of variables was measured for each story, there were a few challenges inherent to content analysis that prevented the construction of a complete template in each case. First of all, as is the case with secondary data analysis, we could only analyze the information we were given in each narrative, which may not have been as broad in its coverage or as specific in its particulars as we would have liked. Secondly, there were some cases for which certain variables were unknown, as they weren’t addressed in the author’s narrative. Ethnicity and income are good examples of such variables; as we discussed above, these two factors were immeasurable for most of these cases, and therefore have not been included in the findings below.

These demographic variables were supplemented significantly by our examination of some additional variables, which we felt could have an impact on the type, severity, and outcomes of a woman's gambling habits. We included these second level variables in order to consider the influence that proximity to a gambling outlet, history of addiction, and/or mental and physical conditions had on female gamblers. We also analyzed the addictions and gambling behaviour of these women’s close friends and family members, as well as the age and personal response they had to their first notable experience of gambling.

Key second level variables incorporated into the analysis template included childhood distress, adulthood stressors, the types of games these women played, and the motivations that drove them to gamble. We considered a number of factors that could cause childhood distress, including parentification, abuse (physical, emotional, and sexual), familial instability (such as parental conflict and/or divorce, or constantly moving), and financial strain (including poverty and/or parent/guardian unemployment). We also considered childhood distress to be any kind of traumatic experience, ranging from a parent's addiction, to the death of a friend or family member.

Similarly, the adulthood stressors variable was intended to measure a range of factors that could affect a woman's life satisfaction and lead her to seek out new coping mechanisms – in these cases, gambling – in an attempt to manage the difficulties of daily life. Our template included a range of factors to measure this variable, including family-related stress (such as role strain), work-related stress (high levels of responsibility, for example), psychological stressors (such as boredom), relationship trouble (either romantic or friendship), physical pain, and financial trouble. We reserved a separate space for 'other' stressors that we felt to be relevant, such as adjusting to a new culture or learning to cope with a close friend's illness. Because these adulthood stressors were so
prevalent in our analysis, a discussion of this variable is integrated throughout the report, rather than standing alone in the Findings section.

We differentiated the types of games that these women played by determining whether they were social or solitary activities. In order for a game to be deemed 'social,' there must have been explicit mention in the narrative of an opportunity to socialize or interact with others while participating in it. The fact that the activity took place in a social environment, such as a casino, was not sufficient to warrant the experience as being social. Conversely, the author would describe keeping to herself and avoiding unnecessary interactions with others if she was engaged in what we defined as a solitary game; whether or not others were in the same room was irrelevant. We further differentiated the types of game played by whether they require skill, such as poker, blackjack, and sports betting. In games of luck on the other hand, the gambler has no control over the outcome of any given hand or bet, despite the common reference to perceived skill. Such games of luck could include bingo, roulette, lottery tickets, or slot machines.

Finally, we incorporated the motivations that drove these women to gamble in order to explore the way each woman defined her gambling behaviour. Specifically, we wanted to understand what characteristics of gambling draw a woman back repeatedly, despite the potentially dangerous consequences. Our template included the following motivations: seeking a rush; winning (which becomes even more attractive when women believe they can use these winnings to alleviate financial problems); relieve boredom; to feel in control (as habitual gambling can provide a predictable, routine, experience, relieving women from the chaotic stresses of their daily lives); seeking company or public attention; and finally, seeking “escape,” which could be anything from trying to avoid a negative emotion or experience, to a desire to achieve anonymity, to attempts to attain a state of emotional numbness.

(b) Process of Analysis

We began our analysis by examining a small sample of online sources. We did so in order to ensure that our template would suit variations in the structure and progression of each narrative. A number of meetings took place so that we could develop our analysis template, adding to it, reworking its organization, and introducing sub-sections to measure all of the desired variables. The template was then uploaded to an online drop-box, where we could add our cases and view the entire template. This template, along with a sample of the cases we examined, is presented in the appendices to demonstrate the extent of our analysis.

We also wanted to assess the potential differences between each of our different approaches to the material (inter-rater reliability). Although we shared a sense of agreement as we developed the template, we wanted to conduct a formal measure of inter-rater reliability in order to make our analysis even more consistent. In imitation of a previous study, we used the following websites to obtain an appropriate method by which to measure inter-rater reliability: http://pareonline.net/getvn.asp?v=9&n=4 and http://www.socialresearchmethods.net/kb/reltypes.php.
To conduct this measure, each of us read a sample of five randomly selected cases from the online sources list. We then analyzed each case according to the template we had created, determining the appropriate measure for each variable. Next, we compared both sets of cases, sub-section by sub-section. This method of inter-rater reliability resulted in an 80% accuracy rating between us – a very satisfactory level of accuracy for research purposes.

Satisfied with the level of consistency between our different approaches, we proceeded to analyze all of the online life stories, splitting the number of cases between us. The print sources were collected from the Toronto Public Library system, as well as through Amazon.com. Each of these print sources was read through and analyzed once obtained, but since their availability varied, most were examined following the analysis of the online cases. As we filled out the template for each case, we sometimes found that either a particular life story did not have sufficient detail for analysis, or it was not relevant to our study. These cases were not given a column in the final template.

Once all of the online cases and almost all of the print cases were analyzed, we began to create a new spreadsheet to further organize relevant information and compare variables of interest. Creating this spreadsheet allowed us to organize each case into one row and compare key variables such as age of gambling onset, motivation to gamble, childhood distress, and so on. We found this to be a particularly efficient method for drawing out themes from all of the cases and grouping them based on patterns we found. A sample of the themes template can be found in the appendices.

Finally, we wanted to include as much of a sense of voice from the cases as possible. Obviously, making use of direct quotations from the women's stories was the most effective way to accomplish this. We could have sufficiently analyzed each case by marking the appropriate box in our template with an 'X'. However, throughout the analysis, we would substitute a notable quotation for this 'X' to make sure the true meaning of the narrative was captured. This was also helpful during the writing process, as we could use the analysis template as a starting point that would direct us towards some particularly useful quotations. Taking the time to review some cases a second time allowed us to delve deeper into the true words and experiences of the authors of these narratives.

The following discussion will not only serve to communicate the stories of these female problem gamblers through their own words; we will also present a number of themes and patterns that we believe are important to developing an understanding of some of the factors that both predict and influence the gambling behaviours of women, using these particular narratives as models.

**FINDINGS**

**Narrative Structure and Use of Language**

It is useful to preface the following findings with a brief discussion of the structure and language that typically characterized the life stories in our sample. The 88 cases we analyzed can be divided into three distinctive groups, each distinguished by the
type of language used, and by the structure of the narrative.

First, 20 stories were embedded with language of guilt, shame, and hopelessness. The women who wrote these narratives evidently felt lost, out of control, and helpless as a result of their gambling addiction. Most often, they were in the midst of seeking treatment and other assistance in an attempt to stop their problem gambling. However, these narratives remain distinct from the other two types because their authors were either still gambling compulsively, or were caught in a cycle of brief abstinence that would be followed by a relapse to gambling.

Carmen’s writing is exemplary of this first type of narrative, as she repeatedly describes her feelings of guilt and shame. A 52-year old woman from California, Carmen posted her story to a gambling forum on the same day that she called the Gambler's Anonymous hotline after struggling with a gambling addiction for 5 years. Lacking a positive vision for her future, Carmen's writing clearly expresses that she doubts she will ever be able to recover. She says,

*I hate gambling out of desperation. I gamble now to try to make money to pay all of what I owe and each time I increase my jail time because of course, I lose all the money and am back to square one in a desperate scramble to find money to pay what is of necessity to live day by day.* (OC 86)

Often, the authors of our second type of narrative write reflectively on a time when they had similar feelings to those Carmen expressed. These 37 stories were differentiated from the category to which Carmen’s narrative belonged by their inclusion of language that signified hope for the future. Even though these stories described a period of hopelessness, their authors were beginning to rebuild their lives following the devastation and damage that had resulted from their gambling addictions and they were either currently in treatment or pursuing abstinence from gambling as a step toward recovery. Adriana from Mexico catches the essence of this narrative pattern: “Not everything has been solved, but...I am trying to go ahead...I am working on my addiction to put things in order again.” (OC 90)

The final group of narratives are those written by compulsive gamblers who have been clean for an extended period of time, having abstained from their gambling habits through continued attendance at support groups, with the help of a counsellor, and/or through the support of family and friends. Although these women have, essentially, recovered from their gambling addictions, the life stories that fit into this category all seem to emphasize the notion that a relapse is only one bet away. One such narrative was written by Lorraine, who has been clean for more than five years, and is now a facilitator at her local Gamblers Anonymous organization. However, she acknowledges that she could potentially return to compulsive gambling.

*Can I say I will never gamble again? The true answer to that question is “NO”. I have an addiction, but my desire is too great to continue the life I lead than to be lured by one coin followed by despair.* (OC 30)

Despite having faced continued challenges, the women whose life stories belong to this
third category demonstrate appreciation for having been given a second chance. These women who have been recovering from their addiction for a long period of time also express commitment to their continued success, as well as renewed hope for the future.

**Psychosocial State and Crises of Identity**

As we mentioned earlier, childhood distress was one of the second level variables in our template analysis. Many of the women whose gambling stories we analyzed had taken on significant responsibilities early in life. One of these women was Ginny (PC 134), who told her story through Mary Sojourner in *She Bets Her Life*. Both of Ginny’s parents were compulsive gamblers, so she was forced to spend most of her time at home in their one-bedroom apartment taking care of her four younger siblings. Like Ginny, five other women mentioned taking care of siblings or incapable parents during their childhood and adolescent years. Other narratives did not specifically identify parentification, but other childhood stressors that were described, such as having an alcoholic father, suggest that these women may have had to take on greater responsibilities in their early years. These findings mirror the literature review results, which report that female problem gamblers are plagued by traumatic childhoods.

Other large responsibilities that some of these women took on early in their lives were those relating to marriage and/or having children. Seven of the women were married in their teens, while a few others were married before their 24th birthday. Further, six of these authors became mothers before their 24th birthday. Mary (OC 39) was one of these women who took on marital- and children-related responsibilities at an early age, having had two children and being divorced twice by the age of 24. Taking on the role of wife and/or mother at such a young age appears to have been a huge source of stress for these women – so much so that it potentially compromised their psychosocial state. This stress likely contributes to the early onset of compulsive gambling, as was the case with Jane, who moved to London with her husband for his job when she was only 21.

*I was unemployed, trying to find work and felt very secluded with a lot of time on my hands. My friends were gambling online so I thought I'd give it a try, but I quickly realized my gambling was out of control.* (OC 52)

For others, the roles of both wife and mother dominated their life, so that when they acquired new roles, the strain was more than they could bear. One former stay at home mother, Michelle, started gambling at the age of 25 after entering the workforce.

*I am an introverted person; I was an only child who married at nineteen and was a stay-at- home mom for seven years. Then I began an outside career that forced me to come face-to- face with the public everyday. I found it so intimidating that I could not wait to get off work, so I could go "hide" at the casino 50 miles away; there no one would know me.* (OC 65)

Marital issues were obviously also stressful when they occurred later in life. Another woman, Michele, lost her marriage and custody of her four children when she was 35, after having been married 15 years. She then found herself in a seven year long abusive relationship, which shattered her self-esteem. Michele turned to gambling in an
attempt to escape from the feelings of anxiety and insignificance these relationships had made her suffer through. This narrative is echoed in the literature review, in which we found that problem gambling women often have abusive adult relationships.

...In my mind I had just become a worthless human being, existing in a world with no real love or happiness. And that was just how it was going to be for me. With no sense of self, I isolated myself from everyone except for this man who had complete control of me... I felt that I was not worthy of my children, a happy life, or a relationship with family or friends. As the abuse became more and more physical, I needed a safe place where I could go; but I didn’t want any relationships, just a place to be away from the chaos. (OC 54)

Michele had not developed a sense of self independent from the roles of wife and mother, such that when she could no longer fulfill these roles, she was catapulted into a poisonous relationship that led to her attempting to escape through gambling. For many others, however, this experience of no longer being able to fulfill certain roles contributed directly to their gambling compulsion. For some, this role loss was due to divorce, while for others, it was due to “empty nest syndrome” (caused by their children moving away), job loss, or deteriorating health. Many of these roles were lost by Jane S., whose descent into gambling can partly be explained by the boredom she felt after the her responsibilities as a mother, daughter and wife were reduced.

*My teenage daughter got an after school job, my mother, who had been diagnosed with Alzheimer’s in 1990, had to be placed in a nursing home and my husband was working his second shift job. I had no reason to go home after work. (OC 8)*

Another female gambler, Meg, attributed her gambling habit to the boredom she experienced as a result of losing her job. She speculates that had she been able to continue fulfilling the role she played at work, she would have been able to avoid her gambling addiction.

*If I hadn’t been retrenched five years ago, I’d probably still be working. If I was working, I probably wouldn’t be bored. If I wasn’t bored, I probably wouldn’t want to play the poker machines. (OC 15)*

For Jane S., Meg and many others, this loss of the role of mother, daughter, wife, and/or working woman contributed to their development of problematic gambling behaviours. Despite having experienced differing kinds of role strain and loss, the women described above all turned to gambling as a means of coping with the their uncertainties that had resulted from their changing or shifting identities.

**Childhood distress**

We expected to find a correlation between childhood distress and compulsive gambling behaviour. Specifically, we expected to see a high proportion of our cases draw attention to incidences of child abuse, traumatic experiences, and so on, and potentially relate these experiences to their gambling addiction. Yet despite our expectations, this variable was absent in a large number of the narratives we analyzed, and a handful of these female narrators even fondly reflected on their upbringings. This finding is
inconsistent with our literature review, in which we discussed the traumatic childhoods that many female gamblers experience. Regardless of their upbringing, these women still reported developing a gambling addiction, as is demonstrated by Sandy’s narrative; despite having had a “great childhood”, this 56-year old elementary school teacher found herself losing control of what had once been a social pastime.

I started going...everyday. I would have breakfast, get dressed and the excitement in my heart would begin. Would I win today? Could this be the day?...I went from gambling just $40.00 to sometimes $300.00. I went through my savings, sold coins and jewellery, took out a small loan to pay off my cards and spent that money and then began to use a pin number to take money out on my Discover card. (OC 18)

Of the 19 cases in which some form of childhood distress was discussed, the first notable gambling experience was described positively. For example, two anonymous narratives based in the United States describe their childhood distress as having been manifested in frequent relocations of the family home. Both authors first experienced gambling in childhood, citing it as a positive past-time, and both progressed to compulsive gambling in adulthood. Even though information on first notable experience was not available for two of the narratives that described distressing childhood experiences, the remaining 17 cases demonstrate a pattern similar to the cases described above; the authors were fascinated and intrigued with gambling from the beginning.

Gambling Behaviour

 Regardless of the nature of their first notable gambling experience, be it positive or negative, social or solitary, many (46) of the women in our analysis demonstrated solitary problem gambling behaviour. While only eight women began as solitary gamblers, the remainder had originally gambled socially, and became solitary gamblers as their compulsion progressed. This development in gambling behaviour is exemplified by Sandy, a 56-year old elementary school teacher.

I started playing for fun, a chance to relax, visit with new people who had similar interests. We discussed wins and losses, family, travel, our health. Everything! It was so much fun. But soon I was out of control. (OC 18)

Similarly, a 50-year old lecturer named Carol, pinpoints this pattern in her story:

The whole thing about gambling and gamblers is that it's a solitary occupation – all of us are in our own little world. (OC 24)

This quotation reveals one of the motivations that drove many women to gamble; using gambling as a means of escape was also discussed in our literature review. Nearly three quarters of these narratives cited gambling as a means of escaping reality, whether this “reality” referred to a negative emotional experience, role strain, or early life stressors. This kind of mentality is reflected in Jo’s writing, as she recalls escaping to the casino to avoid difficult daily experiences.
You can close out the world when you're sitting in front of the damn thing...All of your problems go away. (OC 9)

Another author, Pam, also wrote about her escape gambling. A self-described 'busy bee' with two children in college and an elderly mother to care for, Pam claimed to use gambling as an escape from her performance as a perfect mother, wife and daughter.

What gambling offered me was a beautiful escape into nothingness. No need to think, no need to worry, no need for stress. I was one with the machine and absolutely nothing else. (OC17)

For these women, gambling provided an opportunity to relax or escape from their stress-inducing responsibilities. Yet some of the other women found that the atmosphere of the venue was what brought them back repeatedly, like Judy, who described the casino itself as being the thing that drove her to gamble.

The atmosphere in the casino appealed to me too – dark, soft neon lights flashing here and there, beckoning “come, play me.” No sense of time; no windows. The tinkling of ice cubes in glasses, people laughing in the background. It was party time! (OC 50)

The atmosphere created within the casino or bingo hall helped motivate some women to gamble for different reasons. Some women found the atmosphere to be soothing, in that is was a place that always provided what they expected. For these women, gambling could provide relief from otherwise chaotic daily lives, providing a place where they felt they could (re)gain control. Their regular slot machine always waited in the same corner, the smells and sounds were always the same, and it was up to them whether to bet high or low – for them, it was all about control. Developing gambling routines contributed to these women's sense of stability and control and, more often than not, contributed to their development of false perceptions regarding the odds of winning. One author, , exemplified this mentality, as she was unwilling to alter her strict gambling routine out of fear that it was these customs and rituals that brought her good luck.

My rituals for my weekend at the casino were to wear my lucky shirt, my lucky jewellery, and to follow the same path around the casino floor each weekend. I thought any changes would spoil my luck...I believed I could win all of my losses back if I just tried harder...I had to gamble until I hit the big jackpot. (OC 25)

Another author, who chose to remain anonymous, also felt as though the odds were stacked in her favour; she described having feelings that contradicted her rational knowledge about the likelihood of coming out a winner.

I know that casinos are in business to make money, and the odds are always in their favour. But I have this weird mental twist and totally wrong idea that somehow I am different and I can beat them. (OC 68)

Many of the women whose writing we analyzed convinced themselves that a false perception they had of their chosen game was actually true; some, for example, had
persuaded themselves that it was only a matter of time before a machine paid out, or that games that appeared to be of luck could be won with skill. Others started to think that if a higher bet were placed, the chances of winning would increase. In a similar manner, many women would compare themselves to other gamblers who were in greater financial trouble, or who were otherwise in a worse state than themselves. These tactics allowed many women to feel justified in their compulsive gambling, if only for long enough to get back to the table and place another bet.

*I rationalized constantly, everyone gambles...what's the big deal? I hadn't lost my home...yet. I still had my car...of course I hadn't made an actual payment for a few months but as soon as I hit it big again I would make it all right once more. Problem was I was living the same pattern, day after day after day. (OC 105)*

Lying to themselves and to others was a pattern we saw in every case that we analyzed. These common mentalities endorsing rituals and skewed perceptions of the odds of winning contributed to the construction of complicated webs of manipulation, which compromised both the financial and psychological well-being of the women involved. The following excerpt is characteristic of the majority of the cases we analyzed in that it reveals the lengths that these women were willing to go to in order to maintain their gambling behaviour.

*I started taking money from our joint account and changing the details of our electronic money accounting system. My view changed from just enjoying the social event and spending some money to wanting to win more money, which meant it also changed the way I gambled. I started gambling multiple lines with multiple credits and the more I gambled the worse I felt because I was losing money that wasn't mine and lying about it. (OC 5)*

**Proximity to Gambling Establishments**

Of the 88 cases analyzed, 68 of the women primarily gambled in establishments close by, usually in the same city or town. Even with regards to online gambling, four of the eight women who primarily gambled online also gambled concurrently in nearby venues. Though most of the women went to casinos, a few frequented a variety of other gambling establishments including bingo halls, racetracks with slot machines, arcades, clubs, etc. The proximity of a gambling establishment, in combination with an atmosphere designed to shut out the outside world, created a breeding ground for habitual gamblers seeking an escape. At least eighteen of the women whose writing we analyzed cited the proximity of gambling establishments as part of the reason why they began gambling, or used this factor to explain how their occasional gambling progressed into an addiction.

Frances was one of these women; originally from a small town in Arizona, she used to take trips occasionally to Las Vegas or Phoenix, where she would gamble. However, with the emergence of casinos in her town, her gambling quickly became habitual.

*Then for some ungodly reason they had to build Casinos in our town. Next thing I*
know, I'm stopping to gamble so I could drink their coffee, so I won't sleep on my only day off, then it's the quick lunch breaks. Before I knew what happened I'm finding any kind of excuse to go to the Casino. (OC 81)

In a slightly different scenario, Martha was already a problem gambler when she discovered online gambling. Yet this discovery introduced her to a form of gambling that was continuously available, which only served to intensify her problem.

I then found Internet gambling and that felt really great. I could now spend hours locked into my own little world without even having to get dressed! (OC 105)

While many others did not explicitly cite the proximity of the gambling establishment as one of the reasons behind their compulsive gambling, they did frequently refer to its closeness when describing their gambling. For example, Marcia (OC 27) worked across the road from a casino, and would “go play on [her] lunches and not come back for a couple of hours.” Other women would write about the multiple casinos that were within a short drive of their home or place of work. For example, one author, who used the pseudonym “1goodspin” for her online post, wrote that there were five casinos within a 30-minute drive from her home (OC 113), while another woman, Bonnie, lived “between two casinos... each 45 minutes away” (OC 55).

Those compulsive gamblers who lived such short distances from gambling venues were faced with a particularly difficult challenge when they were attempting to quit their habit. Often, these women would develop strategies to help them avoid the temptation to relapse when casinos were nearby. Katkanpur (OC 44) created such a strategy: while she was quitting gambling, she forced herself to drive in the middle or right lanes so that it would be difficult for her to take one of the exits off the main road towards the nine possible gambling establishments between her work and home. The ease by which Katkanpur could access so many gambling venues evidently contributed to her development of a compulsive gambling habit. It is therefore perfectly fitting that the strategy she used in her attempt to quit was to try to physically distance herself from those establishments that had pulled her in to begin with.

We do not mean to suggest that the proximity of gambling establishments is the main reason for the addictions that these women struggle with. Many of the narratives we analyzed described women who had developed a gambling problem despite having lived far away from gambling sites. Karen, for example, gambled compulsively for years before she moved to Las Vegas in order to be in closer proximity to gambling venues; the distance she had to travel in order to gamble before she moved had not deterred her from feeding her addiction.

Although it took three more years to actually move to Las Vegas, I knew that I was home. Bingo and slots available 24/7, 365 days a year and now, I could get my fix whenever I needed to kill a little time. (OC 58)

While Karen wanted to enhance her gambling experiences by getting closer to gambling establishments, another woman named Helen wanted to adjust her proximity in relation to venues in an attempt to start a new life after five destructive years of gambling.
She moved to Darwin from Adelaide, 3200 kilometres away, but soon discovered a casino there and began gambling more than ever.

Again, the convenience of having a casino right around the corner was not the sole factor that drove these women to gamble; some felt their addiction to be so strong that the distance did not matter. One anonymous author writes that it does not “matter how far or close they are because I would crawl on glass to get to them” (OC 56). Other women described the distances they would travel in order to feed their addiction: Terri (OC 85) would drive two hours across the border to Kansas to gamble, while for seven years, Marilyn (PC 25) made weekly nine-hour round trips to gamble. Evidently, these women were completely unconcerned with the amount of time and energy they had to put towards fulfilling their gambling addiction; proximity to gambling venues only influenced some women’s gambling habits.

Treatment

Many of the women whose narratives we analyzed experienced gambling addictions so crippling that they took over their lives. Some acknowledged their gambling as a poisonous addiction, but others felt that their gambling was not a big deal, despite the obvious effects it was having on their family, friends, and their own personal well-being. Most women needed either to hit rock bottom, or at least see the bottom approaching, before they decided to get help. Others, however, persisted with their gambling until legal or family intervention forced them into treatment.

How rock bottom is defined varies from one gambler to another. For some, rock bottom means the prospect of losing their dearest possessions, while for others, it is the legal system catching on to their gambling addiction. Some women just became tired of all the lying and deception that had been necessary in order to maintain their habit. One woman in particular, Jo, emphasizes the importance of an individual's definition of rock bottom to her attempts to get help:

I suppose I have not hit rock bottom yet but I would say I am pretty close...If it's not rock bottom, I need to MAKE it rock bottom, because I refuse to go any lower than I can. (OC 114)

For many of the women in our study, resorting to illegal means such as embezzlement and theft were considered necessary to acquire the resources they needed to continue gambling. It was only a matter of time, then, until these behaviours were discovered and ramifications were set in place. In an extreme case, Karen sat in her car, wearing all-black, including a ski-cap and face paint, contemplating possible victims that she could rob for money, which she would put towards her gambling addiction. Days later, Karen’s ex-husband helped to show her that she had reached rock-bottom:

Although he was unaware of how bad my gambling had progressed, he suspected that I was thinking about committing a crime and wanted to give me a scared straight experience. I remember the day that I arrived at the prison and how fitting that it was sleeting, grey, and cold. I was there for a tour of the new medium-security male prison in Southern Nevada, but for me it was the slap
upside the head that was needed for me to finally seek help. (OC 58)

While Karen defined rock bottom as being imprisoned for the illegal actions she would have taken in order to fund her gambling problem, other women considered hitting rock bottom to be losing their most valued possessions. Denise originally thought her ultimate downfall was this sort of material loss, and she believed she had hit rock bottom after selling a prized possession.

The shock of having to sell one of my two cars, a Chrysler LeBaron Coupe, to pay my bills helped me begin to realize that I had a problem. I had been so proud of that car; it was completely paid for, yet I sold it for about $4,000 and lost all the money in one week. After that, I attended my first 12-Step meeting for compulsive gamblers. (OC 41)

Despite the obvious shame and guilt Denise felt after having lost one of her most cherished possessions, she still had further to fall. Like many of the other female authors whose narratives we analyzed, she relapsed after having sought treatment due to feelings of having hit rock bottom. For Denise, it was not until her failed suicide attempt that she returned to 12-step meetings. Her story is similar to those of some of the other more fortunate women; their thoughts of suicide led them to seek the treatment for their gambling problems that they needed.

Yet another definition of rock bottom existed among these narratives; these women did not need to court suicide, or await possible jail time to realize that they had reached a low point of desperation below which they were not willing to fall. One such woman, Suzi, discussed her realization that she did not want to continue living with her gambling problem.

Two years ago I decided enough, I had personally hit my emotional rock bottom. I was done - through with the lies and deceit and so I confessed everything to my husband. I also decided to attend Gamblers Anonymous. This was the hardest decision I had to make. I admitted finally that gambling had me beat. (OC 68)

Unlike Suzi, who had clearly identified that her gambling habit had grown into something highly problematic, some women do not seek help or do not perceive themselves to have a gambling problem until the law or their family intervene. The writings of an anonymous author revealed that she did not believe she could quit her addiction of her own accord. Her addiction had spiralled so far out of control that she knew she would not be able to stop without some sort of intervention. This woman expressed her relief at having been caught embezzling from the convenience store where she worked.

The next day I was called to the main office. When I pulled up there was the chief of police’s truck. I took a deep sigh of relief. “Now I can quit.” I confessed to playing lottery without paying for the tickets and false writings in the daybook. (OC 71)
This woman felt that she was not capable of searching out treatment herself, even though she clearly expressed a desire to quit. Yet some of the other women who couldn’t bring themselves to seek help claimed that the shame and stigma attached to being a compulsive gambler discouraged them from doing anything that would make their addiction known. One author, Jo, was particularly troubled with this problem, as she lived in a small town. She writes:

*If your car is seen at a place...you definitely are more exposed, recognized...Seeking help, that's very difficult as well because people are known. People in the health services work in the community...There's still a lot of shame in saying you have a problem out loud.* (OC 9)

This theme is reflected in our literature review, where we discussed that women problem gamblers often face stigma in terms of research and treatment.

In cases where women did decide to seek help, some appealed to their family and friends, while others found information online. At least nine others called their local, toll-free gambler’s helpline, where they were directed to possible treatment options and support services. As we discussed in our section on treatment in the literature review, these preferences for certain types of treatment seem to reflect women’s desire to keep their problem out of the public eye. Friends and particularly family members would likely be willing to keep their relation’s gambling addiction private, should the problem gambler ask them to. Technologically mediated help, such as online and telephone resources, offer problem gamblers the opportunity to remain anonymous, thus lowering the likelihood that they would experience the stigmatization and shame that they dreaded. So while there was variation in the types of help that these women selected, each form of help seems to allow them to protect their privacy, giving them the option of keeping their habit as confidential as they want.

In terms of how successful women found each of these forms of treatment to be, most attributed their ability to refrain from gambling to the 24-hour support they had from their family or support groups. One writer, Jane, clearly believed that such support networks were what helped her abstain from gambling. This mother of two from Ontario attributed her success to the help of her family, and to the availability of her fellow GA members, who were always there for her when she needed their support.

*Anybody on a dime would be there for you. I could call someone at two in the morning and they'll be here... I've had to do it for other people too. I've had to go to their doorsteps; I've had to stay on the phone.* (OC 49)

Jane clearly felt that her participation in Gamblers Anonymous contributed significantly to her successful abstinence. 42 other women had similar hopes, as they all mentioned in their narratives that they had tried GA at some point during their attempt at recovery. However, this support system is just one of many that aim to assist recovering compulsive gamblers, and while it worked for some of these women, it did not work for others. Many either turned to, or concurrently depended on online support. For example, 39 women took their narratives from their own online forum postings, or from their own emails which had been posted by moderators of the site they frequented. This
incorporation of online material into these women’s narratives indicates that they had been receiving some form of online support.

Other women seeking different forms of treatment from support groups frequently appealed to counsellors or psychiatrists, in in-patient, residential, and out-patient settings. Mary (OC 32), for example, had initially tried self-help groups, but she eventually found that she preferred seeing a “trained individual.” Another author, Carol, also sought this kind of treatment; though she initially had face-to-face meetings with a counsellor, the difficulties she had with scheduling appointments prompted her to look for counselling online.

*I'm where I am because of my counsellor there who runs the gambling section of the site. I have weekly counselling sessions with her in a secure cyber room with live chat.*

*That's one part of it. The other part has been her availability in terms of e-mails.*

*In the first few weeks when I was 'coming off the web', I would send emails saying, 'Help, I can't cope.' (OC 24)*

Despite the many examples of treatment success in the narratives we analyzed, more than 30% of the women from our sample relapsed at least once. After the relapse, some gambled more intensely, for a long period of time, while others went on a gambling binge after which they immediately sought help. These women did not adopt any clear pattern in terms of their gambling behaviour after they relapsed. However, the majority of these authors did attribute their relapse to either the lack of sufficient support they had had during treatment (as noted above), or to their not having been personally invested in the treatment itself. In some cases, certain women stopped participating in their treatment because they either had no time, or felt that they had recovered. This behaviour frequently resulted in a relapse into gambling, as one woman named Gail experienced:

*I went for counselling for five months and I did not gamble in that time. Then I became too confident and thought I didn’t need counselling any more and so I stopped going. Eventually I found myself back at the poker machines. (OC 6)*

Many women like Gail wrote about how they stopped going to Gamblers Anonymous meetings - and relapsed as a result - mainly because they had nobody to hold them accountable for attending these meetings. However, successful experiences with GA were frequently characterized by a friend or family member who would either encourage or force the problem gambling author to attend their meetings. Such was the case with the success story of an anonymous author (OC 42), whose friend would give her a place to live only if she went to GA every day.

Despite having the best intentions to quit, these women would fail to abstain from gambling because they struggled to continue getting the treatment they needed. For others, however, the treatment they were receiving failed because they did not have any intention to quit gambling. This type of failed treatment occurred most often in the cases
where women would refrain from gambling not as a personal choice, but due to family or legal intervention. Helen’s narrative described this type of unsuccessful treatment; despite having been jailed for 8 months following an embezzlement scam with a partner, Helen did not view her gambling as problematic.

*I blamed her and never actually looked at it as being my crime and so never admitted that I had the problem. I left prison still with the attitude that I could control my gambling and would just gamble within my means.* (OC 37)

Women like Helen were different from others, who did recognize that their gambling was out of control, but who simply did not want to stop. One such woman, another named Helen, was sent to a treatment program following an intervention by her family and a gambling treatment counselor. Though she completed the program, she “got out of there with no intention of quitting” (PC 129; p161).

Other women still had strong convictions to stop, but they could not resist the urges to gamble. Kat was one of the 12 women who had attempted to go through treatment, but who still could not resist the pull of gambling.

*Sometime later in 1997 or early ‘98, I sought help with a gambling counselling service. I kept my appointments, and even managed to ‘kick it’ for a while, almost two months. But then it hit again, and continued to do so for approximately the next two years.* (OC 44)

A few of these women were pulled back to gambling establishments out of frustration; the financial problems and stigma associated with being a recovering compulsive gambler were too intense for them to cope with in any other way. This kind of relapse was described by Barb (PC 133), who, despite having worked hard to pay back the money, had embezzled from her church. Because of this “unfortunate” history, neither her credit card company nor her bank would allow her to get a loan, or pay back money in smaller payments. Frustrated and angry, Barb drove to the casino to gamble, attempting to relieve these emotions by engaging in the very activity that had indirectly caused them.

Participation in support groups such as Gamblers’ Anonymous was evidently highly effective for some of these women attempting to quit their gambling addiction, but for others, these groups simply did not work. The success of GA for each woman seems to depend on both the make-up of the group, as well as on the individual herself in terms of the characteristics mentioned above, such as intention to quit and recognition of having a problem. Janet was one of those individuals whose personal characteristics were not suited to this form of treatment; attending GA gave her such a rush that she dived right back into gambling.

*I went to Gamblers Anonymous. At the first meeting, one guy started rhapsodizing about hitting the 777s; the point was to let us in on the moment when he knew he had to quit. But I got an incredible rush. After leaving the meeting, I drove straight across the bridge from Nebraska to Iowa, where casinos are legal.* (OC 35)
The other factor we mentioned, the make-up of the GA group, was also crucial to the experiences women had with this kind of treatment. Some women, such as Donna, had trouble relating to their male-dominated group.

*I walked in to a room filled with 15 men. No one could relate to my compulsion. Everything was different on how we gambled and our behavior triggers. Everyone was really supportive but I didn’t feel any connection. (OC 75)*

Donna’s experience with GA fits perfectly with the findings we discussed in the treatment section of our literature review. As we mentioned, women were much less successful than men were in abstaining from gambling as a result of participating in these kinds of support groups. Cases like Donna’s offer a potential explanation for this discrepancy, as her feelings of alienation from the male members of her group prevented her from benefitting from her treatment as much as possible. We will discuss this issue of mixed-gendered support groups, particularly those used by GA, in our Group Therapy section in the Policy Analysis portion of our report.

As such, women-only support groups seem to be more common. Women within such groups would likely feel more comfortable, as they would be able to relate more easily to those they view are similar to them. Mary (PC 126) wrote about one such group called Scheherazade’s Sisters, located in California.

Other women felt GA to be an ineffective form of treatment for still other reasons. Terri, for example, specifically found the GA group created in her area to be unproductive. The newness of this particular group meant that there were few members who had abstained from gambling for any extended period of time, meaning that Terri had virtually no success stories to inspire her.

*I began attending GA meetings but because gambling was new to our area, the program was new and there were only one or two members with any clean time. I found the meetings would trigger my gambling urges and I recognized this wasn’t what a healthy Gamblers Anonymous program looked like so I began looking for other alternatives. (OC 85)*

One such “alternative” that nine of the gamblers attempted or were going to attempt was to self-ban from casinos. However, all the gamblers who used this form of “treatment” eventually returned to gambling. Many authors questioned the effectiveness of this self-banning system, as it is easy for a compulsive gambler to relapse, at which point they will simply disregard the good intentions they had of avoiding gambling establishments.

A number of women were able to gamble despite having banned themselves from a number of locations. Pat (OC 89), for example, intended to put herself on the self-ban list in Jefferson City, Missouri, despite gambling mostly in Oklahoma. She wrote that in order to self-ban in Oklahoma, she would have had to travel to each individual casino to have her picture taken, making this kind of “treatment” far too time- and energy-consuming. Another woman, Terri (OC 85), simply drove to another state to gamble, while Donna (OC 75) turned to the endless possibilities that Internet gambling could
offer. One writer, Marcia *(OC 27)*, found herself back at a casino once her self-imposed ban had expired. One extremely pressing issue was revealed in two of the narratives written by women from Ontario; the women had put themselves on the self-ban list, but they were still able to gamble without confrontation or any disciplinary action from casino staff. Kelly was one of these women who tried this self-mediated form of treatment.

*I have tried to stop...last year I banned myself from all casino's in Ontario...but I still go. I have five casinos within an hour of my house. Despite being banned I still go and get in...* *(OC 76)*

Similarly, Jane had banned herself from the Windsor casino, but returned after one week.

*That didn't work for me. There's an arrogance...The way I looked at it was, it was just one more joke; it was only a piece of paper and no one really cared. (OC 49)*

Despite the good intentions that Kelly and Jane may have had in imposing a ban on their own gambling habits, the individuals that were responsible for keeping them away from the casino failed to fulfill their duties, allowing these women to continue gambling compulsively. Thus while formal support groups such as GA may not work for some women, and may cause them to look for other forms of treatment, this kind of self-help can also be highly ineffective.

**DISCUSSION**

As the above findings indicate, there are a number of factors that affect the likelihood of a woman becoming involved in gambling, as well as the nature of her gambling behaviour. While the proximity of gambling institutions creates opportunities for some women to begin gambling, it also creates a constant lure for current problem gamblers, as well as for those attempting to stop gambling. Similar problems have resulted from the increased availability of online gambling, and a corresponding sense of panic has developed regarding this convenient and private venue through which gambling addictions can now develop. Further, it is important to note that for many gamblers, once hooked, distance and the hardship of accessing gambling venues are nothing compared to the need these people feel to gamble.

In this respect, we were highly concerned that the widespread availability of gambling institutions, including those accessed through the Internet, seemed to provide an opportunity for women to retreat from everyday life. Rather than developing the coping skills necessary for a healthy mental and physical well-being, the women whose writing we analyzed used gambling to remove themselves from reality. In many of these narratives, there was the possibility that the author was in an unstable psychosocial state before they began to exhibit compulsive gambling behaviour. While the gambling patterns of the women in our analysis could not necessarily be differentiated by such variables as age and ethnicity, it was evident that almost all cases referred to underlying sources of personal strain or stress that had remained unaddressed before the onset of problem gambling.
These issues could manifest themselves as lingering pain from childhood distress, as described above, or in the form of current adulthood stressors, such as low self esteem, depression, role strain from competing responsibilities, or the diagnosis of an illness and its associated symptoms. In many cases, the women in our sample were able to name which of these triggers or factors that led to their dependency on gambling when they wrote about their addiction after having received treatment. It would therefore be to the benefit of treatment programs and problem gamblers alike if future research addressed this aspect of the addiction and looked for ways to intervene before gambling became a vice used to suppress other personal issues. By providing a window into the lived experiences of female problem gamblers, our analysis of female gamblers’ autobiographies has provided support for the findings discussed in our literature review, as many of the results we mentioned in that section suggested a correlation between the increasing availability of gambling outlets and high prevalence of problem gambling (Volberg 2004).

Because of these varied motivations that drive women to gamble, varied forms of treatment are necessary in order to successfully treat different types of female gamblers. Certain female authors who have abstained from gambling for longer periods of time seem to agree that each individual may react differently to treatment, and our analysis of the above cases supports this assertion. Further, as we previously discussed, the cases we examined express a consensus that compulsive gamblers can never be truly recovered from their gambling addiction; none of these women will ever be able to gamble casually again. This notion is concurrent with the Gamblers Anonymous philosophy, which almost half of the women in our analysis tried to commit to. Yet, as was evident from the number of women whose attempts at GA failed, what works for each woman on the road towards recovery is highly variable, and, based on our content analysis, it cannot be concluded that a given type of gambling addiction will respond well to a set treatment. However, having the conviction to stop, and developing a strong support system once that decision has been made, both seem to be crucial to the successful abstinence of all of the female problem gamblers within our sample.

This philosophy cannot be better illustrated than through Bonnie, who has celebrated 9 months in recovery after spending the previous two and a half years, in seven different attempts, in and out of inpatient treatment. In addition to the support she received from her gambling counsellor, her GA group, and her family and friends, she credits her recovery to the dedication she felt towards putting and keeping gambling in her past.

_I am committed to my recovery from gambling in a way I never was before ...I had the tools before, yet I was willing to use only a few. Part of my struggle was that I was not willing to go to any lengths to maintain abstinence from gambling. Today I am willing, and as a result, my life is better in so many ways. (OC 101)_

Another key finding in the literature for which our analysis provided further support is the high level of stigma that women who gamble are faced with (Fong 2005). This stigma discourages women from seeking the help they need to successfully overcome their gambling addiction. From our analysis of these 88 cases, one can see that women often feel ashamed to seek treatment, and will not seek treatment until they feel
that they feel they have hit “rock bottom.” Such feelings of shame and disgrace are no surprise, considering how frequently friends and family distance themselves from the supposedly appalling behaviour of a compulsive gambler. Further, some women experience such intense feelings of guilt for their gambling problem that they contemplate suicide before they consider seeking help. Because of these feelings that so many women experience, it is imperative that different forms of help, whether they are hotlines, family, support groups, or structured treatment programs, are made available and visible to female problem gamblers.

CONCLUSION

While our content analysis of the collected cases did not produce a clear typology of female gamblers, it did provide a wealth of information surrounding the factors motivating gambling behaviour, and the life situations that often lead to the onset of problem gambling. Further, we gained significant insight into both the barriers and successes of different methods of treatment, as well as into the ways women are searching for assistance with their problem gambling behaviour, revealing that a large proportion of female gamblers are turning to Gambler’s Anonymous and the Internet for help. In addition, we discovered that the majority of women in our study hide their addiction entirely from their friends and family members, and it is likely that they intend to address and seek treatment for their gambling problem in an equally discreet manner.

While some women attempted to self-treat their addiction through web forums and other online resources partially in order to maintain secrecy from their families, others used the Internet as a tool to gain access to communities of support and connect to further assistance, after which they would disclose their problem to friends and family. This pattern of seeking assistance has important implications for the advertisement of treatment options and deserves further research attention to determine the most effective means of reaching out to female problem gamblers.

As discussed at the beginning of this report, we suspect that ethnicity and culture could play a significant role in influencing the type of games a woman plays, as well as how her gambling behaviour progresses. Particularly in Canada, where multiculturalism fosters a wide range of cultural experiences, it is important to further examine the impact these factors will have on both gambling behaviour and treatment options. While ethnicity could not be measured with the limited information provided in each of the cases we analyzed, this variable could reveal differences in gambling patterns based on cultural norms and practices, and therefore, as we mentioned in the literature review, it deserves further attention.

There are a number of practical implications for the findings of our autobiographical content analysis. First, considering the prevalence of stress in almost all of the cases we examined, it is recommended that casinos and online gambling outlets take proactive measures to regulate excessive gambling. In addition, communities can assist problem gamblers through the implementation of gender-specific services. For example, our extensive discussion of female gamblers and their treatment attempts reveals the importance of readily available, female-only support groups. Ideally, these gendered services would also be available to monitor gambling venues in an attempt to
intercept the path of a problem gambler before the behaviour escalates. Further, women centered treatment and prevention programs should target women who are middle aged (30-40 years), are married or in a committed relationship, who took on responsibilities early in life, who have recently suffered a role loss, who exhibit solitary gambling behaviour, and who gamble as a means of escape. The treatment programs in which such women participate should focus on teaching new, healthier coping strategies and on providing consistent support. Moreover, these services should encourage the participant to be personally invested in treatment, and, finally, they should aim to remove the stigma that surrounds female gambling.

Finally, it is important to draw attention to the representativeness of the cases examined in our content analysis. The cases included in this study provide a wealth of information surrounding female problem gambling, with candid perspectives of those who know the depth of problem gambling better than anyone else. It is possible that the reason a typology of female gamblers did not emerge from our analysis is that, in collecting published life stories of problem gambling, we inadvertently selected narratives written by a certain type of female gambler. What this means is that women who choose to write about their experiences with gambling are differentiated from other female problem gamblers by their age, previous life experiences, income, or other variables.

Given our time restraints, a more thorough collection of cases could not be conducted. One remaining question, then, is if the analysis of unpublished stories, such as those shared at support group meetings, would illuminate a different type of female gambler. Despite these limitations, we are confident that our report has provided considerable insight into the lives of female problem gamblers, the factors affecting their gambling behaviour, and the impact this behaviour has on the likelihood of these women to seek treatment. We encourage future researchers to expand on the knowledge acquired through this study, and to focus particularly on the collection of more detailed demographic information.

Through conducting our content analysis, we were fortunate enough to engage with a large number of narratives, and we have gained an appreciation for the courage and confidence of those women who chose to publish their stories. By providing the opportunity to hear the experiences of female problem gamblers as expressed in their own words, these narratives have added significant depth to our broader study, and should be utilized in future research to gain further insight into the variations among female gamblers.

Because these narratives are so essential to developing an understanding of female problem gambling, we will continue to reference some of these biographies throughout the next two sections of our report. We feel that these narratives have the potential to explain (in part) some of the statistical findings in both the survey and policy analyses that follow; since many of the female authors whose works we analyzed wrote about the factors that motivated them to gamble, or the ways in which they responded to treatment, we have been able to use these narratives to explain certain research outcomes. The popularity of certain kinds of treatment among women, for example, can be largely explained by the reasoning our female authors provided in their writing, as was the case
with the low female success rates in other forms of treatment programs. Thus the narratives that have been examined in our content analysis help to explain some of the findings from the other sections of our report, contributing to our overall ability to understand why certain trends in female gambling behaviours exist.
4) RESULTS OF THE SURVEY ANALYSIS

RATIONALE AND METHODOLOGY

In order to compliment and expand on the literature review and autobiographical content analysis results, we conducted a secondary quantitative analysis of three datasets: the 2005 Ontario Prevalence Survey, the 2007 Canadian Community Health Survey (CCHS) and the 2009 Ontario Student Drug Use and Health Survey (OSDUHS). We selected these datasets because they offer the most recent data on gambling in Ontario and Canada. Further, each survey highlights slightly different populations, which allows us to cross-validate our results. Finally, these datasets present the most comprehensive data for our purposes, as they contain detailed questions on gambling, demographics, and other predictors of interest (stress, mental health, substances use, etc). Detailed descriptions of each dataset can be found in the appendices.

Each dataset was analyzed with standard statistical routines available in the Statistical Package for the Social Sciences (SPSS). Our multivariate technique of choice was logistic multiple regression, which is useful for finding the unique contribution of specific variables under conditions of non-normality or non-linearity.

In order to answer our first research question regarding the gender differences in problem gambling, we will 1) examine the gender differences in gambling behaviours, gambling problems and psychosocial variables using cross tabular analyses and analyses of variance, and 2) identify explanatory variables for the gender differences in problem gambling using regression analyses.

In our attempt to answer our second research question concerning female variations in problem gambling, we will 1) use frequency tables to explore how the different demographic, gambling behaviour, and psychosocial variables combine with problem gambling among women; 2) identify clusters of women based on socio-demographic, psychosocial and gambling characteristics; and 3) examine how the clusters of women are related to problem gambling using regression analyses. Cluster analysis is a data reduction tool that creates subgroups that are more manageable (and meaningful, in scientific senses) than individual data. In addition, we intended to use multilevel regression analysis to identify contextual (census tract level) factors that shape the gambling practices and gambling problems of individual women in the 2005 Ontario Prevalence Survey. However, skill and data analysis limitations prevented us from completing this last portion of the analysis. Further details with regards to our data analysis strategy can be found in the appendices.

RESULTS FROM THE 2005 ONTARIO PREVALENCE SURVEY

The 2005 Ontario Prevalence Survey has a total sample size of 3,604 adults, composed of individuals who are 18 years and older, and are residing in Ontario. Respondents were asked about their gambling activities, including the type of game they played, the frequency at which they played it, the percent of their income they wagered, the time they spent gambling, and the amount they wagered. They were asked further questions about their gambling problems (CPGI), and the strategies they used for
managing their gambling activities. Finally, the respondents were asked questions regarding demographics, including their age, gender, marital status, income, education, employment status, and ethnicity. Complete results for the 2005 Ontario Prevalence Survey can be found in the appendices.

Gambling Behaviours and Problem Gambling by Gender

Of the 18 types of gambling that we studied within our analysis, 14 games showed significant relationships to gender. The four gambling games that did not differ according to gender were raffle/fundraising tickets, Ontario slot machines at casinos, Ontario slot machines at racetracks, and slot machines outside of Ontario. We found that men were most likely to play cards or board games (13%), table games at Ontario casinos (11%), and to purchase lottery tickets (56.6%). In contrast, women were most likely to play instant win or scratch tickets (26.3%) and bingo (6.5%).

It was also revealed that the frequency at which people gamble is related to gender. Gambling games played more frequently by men include the lottery, card or board games, raffle tickets, horse racing, casino table games, sports betting, games of skill, arcade gambling, internet gambling and speculative investments. In contrast, the games that were played more often by women included instant win tickets and bingo. These results are similar to those presented in the literature review and our content analysis, where we discussed the tendency of males to play games of skill, while women usually play games of chance. However, no significant gender differences were evident in gambling frequency for sports betting with a bookie and slot machine play in Ontario casinos, at racetracks and in out of province casinos.

There were also no significant differences in the amount of time men and women spent in a typical month on gambling. Further, gender was not related to the amount of money spent on gambling in a typical month. Bingo, however, was an exception, as men spend over twice as much money as women do on the activity. This finding is somewhat consistent with the literature review, in which we mentioned that men spend more money on gambling overall.

A clear connection between gender and gambling related problems was evident. Overall, men experienced twice as many gambling related problems as women. Specifically, four of the 9 CPGI items are significantly related to gender, as males are more likely to report 1) feeling the need to gamble with larger amounts of money in order to get the same feeling of excitement; 2) going back another day to try and win back money lost; 3) borrowing or selling something in order to get money with which to gamble; and 4) being criticized for their gambling behaviour.

Similarly, problem gambling status was also found to vary by gender. Women were found to be more likely to be non-problem gamblers than men, as 89% of women maintained this status versus the 82% of men who did. Conversely, men are more likely to be classified as at risk gamblers, with 11.4% of men defined as such, compared to 6.6% of women. Finally, it was revealed that men were also more likely to be problem gamblers who were experiencing severe issues, as 1.8% of men were within this category, versus the 0.8% of women who were. This result is mirrored in the literature
review, where we discussed how men are just under twice as likely to be problem
gamblers as women.

Overall, the 2005 Ontario Prevalence Survey revealed that men play more games
than women, spend more money on Bingo, experience more gambling related problems
and are more likely to be problem gamblers.

Regression Analysis: Gender and the CPGI

In order to determine how gender is related to problem gambling, and to identify
any explanatory variables, we ran a series of binary logistic regressions with the CPGI
dichotomy as the dependent variable (non-problem and low risk versus moderate risk and
problem).

In the first run, we included the independent variables of age, gender, personal
income, education, ethnicity, marital status, and employment status. This model is
significant, and the demographics explain between 1.5 and 4.4% of the variance in the
CPGI dichotomy. The only variables that were significant are gender and the age
categories of 18-24 and 25-34 years. Males, particularly those between 18-24 and 25-34
years of age, were more likely to be problem gamblers, compared to those 60 years of age
and older. Specifically, the odds of experiencing moderate or severe gambling problems
decreased by a factor of .644 if the gambler was female. These findings produced by the
first model were consistent with those of the literature review.

In the second model, we added type of gambling activities to the regression. With
this addition, the model now explains between 5.6 and 16% of the variance in the CPGI
dichotomy. The addition of this variable to the model rendered gender and the two age
categories non-significant. As such, the type of gambling activity explains the association
between gender and the CPGI dichotomy. Again, the literature review supports this
finding, as it suggested that male and female gamblers play different games. The
gambling games that were positively associated with the CPGI dichotomy were slots at
Ontario racetracks and card or board games played with family or friends.

In the third model, we added the variable of number of different gambling games
played over the past year. With this addition, the model now explains between 6.4 and
18% of the variance in the CPGI dichotomy. The inclusion of this factor rendered
gambling on card and board games non-significant, but it caused buying raffle or
fundraising tickets to become significant. Buying raffle or fundraising tickets is
negatively associated with the CPGI dichotomy, while number of gambling games played
is positively associated with the CPGI dichotomy.

Finally, in the fourth model, we added the percent of income spent on gambling.
This final model explains between 7.1 and 20.5% of the variance in the CPGI dichotomy.
Only the four variables of buying raffle or fundraising tickets, playing slot machines at
Ontario racetracks, number of gambling activities, and percent of income spent on
gambling were significantly related to the CPGI dichotomy in this model. Specifically,
respondents who bought a raffle or fundraising ticket in the past year were .439 times less
likely to develop gambling problems than those who did not. Conversely, respondents
who played slots at an Ontario racetrack were found to be 2.607 times more likely to experience gambling problems. Further, it was revealed that with every additional gambling activity engaged in, the likelihood of developing a gambling problem increases by a ratio of 1.778. Similarly, with every extra percent of income spent on gambling, the likelihood of experiencing gambling problems increased by 3.215.

In sum, the variations in problem gambling that were discovered in this sample can be explained by buying raffle or fundraiser tickets (protective factor), playing slot machines at Ontario racetracks, the percent of income spent on gambling, and the number of gambling activities participated in. As is consistent with the descriptive results reported above, gender was found to be related to problem gambling, with males being more likely to be problem gamblers. This association between gender and problem gambling is explained by the type of gambling activities played.

Table: Regression Output for Model 4: Binary Logistic Regression for All Gamblers and CPGI Dichotomy – 2005 Ontario Prevalence Survey

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
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<tr>
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<td>Age: 25-34</td>
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</tr>
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<td>Age: 35-49</td>
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<td>Age: 50-59</td>
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</tr>
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<td>Personal Income: Less than $20,000</td>
<td>.586</td>
<td>.487</td>
<td>1.450</td>
<td>1</td>
<td>.229</td>
<td>1.797</td>
</tr>
<tr>
<td>Personal Income: $20,000 TO $39,999</td>
<td>.520</td>
<td>.429</td>
<td>1.467</td>
<td>1</td>
<td>.226</td>
<td>1.681</td>
</tr>
<tr>
<td>Personal Income: $40,000 TO $59,999</td>
<td>.316</td>
<td>.430</td>
<td>.543</td>
<td>1</td>
<td>.461</td>
<td>1.372</td>
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<tr>
<td>Personal Income: $60,000 TO $79,999</td>
<td>-.377</td>
<td>.536</td>
<td>.495</td>
<td>1</td>
<td>.482</td>
<td>.686</td>
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<td>Lottery tickets</td>
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<td>.327</td>
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<td>1</td>
<td>.058</td>
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<tr>
<td>Scratch tickets</td>
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<td>.278</td>
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<td>.787</td>
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<tr>
<td>Raffle tickets</td>
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<td>.271</td>
<td>9.232</td>
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<tr>
<td>Horse races</td>
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<td>.380</td>
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<td>1</td>
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<td>.666</td>
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<td>Bingo</td>
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<td>.352</td>
<td>.005</td>
<td>1</td>
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<td>Slot machines in Ontario casinos</td>
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<td>.739</td>
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<tr>
<td>Table games at Ontario casinos</td>
<td>.047</td>
<td>.327</td>
<td>.021</td>
<td>1</td>
<td>.886</td>
<td>1.048</td>
</tr>
</tbody>
</table>
In order to explore the differences between women gamblers, and to potentially define different types, we examined how the demographics and gambling behaviours of women gamblers are distributed across the CPGI levels.

In terms of demographics, we found that the majority of women gamblers are between 35 and 59 years of age, and that most are married or single. Almost half of these women have completed post-secondary education, and 22% have completed high school. One third have personal incomes of less than $20,000, while another 31% have incomes between $20,000 and $39,999. The majority of these women had higher household incomes, with 29% reporting incomes between $60,000 and $99,999 and 21% reporting incomes of more than $100,000. However, we did not find any significant relationship between age, marital status, education or income and CPGI level.

Of all the demographic variables we examined, only employment status and ethnicity were related to CPGI level. Women gamblers who are employed full time or retired were more likely to be classified as non-problem gamblers. In contrast, the unemployed were the least likely to be classified as non-problem gamblers, and employed students were the most likely to be deemed moderate risk or problem gamblers. This finding was somewhat consistent with the results of the literature review, in which we found that female problem gamblers were more likely to be unemployed than male problem gamblers. In terms of ethnicity, women who identified themselves as South Asian were the most likely to be labelled as non-problem gamblers, while those who identify themselves as Southeast Asian were more likely to be classified as moderate risk gamblers. While this is consistent with the literature review, where we discussed that minority women, particularly Native Americans, have higher levels of problem gambling, it is in contrast to the content analysis, which suggested that most problem gambling women are Caucasian.

In contrast with our findings from the literature review and content analysis, both of which suggested that women prefer games of chance, female problem gamblers in this survey were more likely to bet on sports select, sports pools, games of skill, and slots in Ontario racetracks. In terms of the frequency of their gambling activities, they were more likely to bet on the lottery, scratch tickets and Ontario casino slot machines daily. It was also found that women problem gamblers spend considerable time and money on their

| **Slot machines at an Ontario racetrack** | .958 | .324 | 8.732 | 1 | .003 | 2.607 |
| **Slot machines or VLTs outside of Ontario** | -.385 | .486 | .628 | 1 | .428 | .680 |
| **Sport select like Pro line etc.** | -.114 | .385 | .088 | 1 | .767 | .892 |
| **Sports pools or outcome of sporting events** | -.153 | .390 | .153 | 1 | .695 | .858 |
| **Cards or board games played with family or friends** | .116 | .317 | .133 | 1 | .716 | 1.122 |
| **Games of skill** | -.016 | .373 | .002 | 1 | .965 | .984 |
| **Casinos out of province** | .074 | .409 | .033 | 1 | .856 | 1.077 |
| **Number of gambling activities (recoded)** | .575 | .161 | 12.747 | 1 | .000 | 1.778 |
| **Percent of income spent on gambling** | 1.168 | .357 | 10.711 | 1 | .001 | 3.215 |
| **Constant** | -4.374 | .669 | 42.718 | 1 | .000 | .013 |

**Descriptives: Women Gamblers**

In terms of demographics, we found that the majority of women gamblers are between 35 and 59 years of age, and that most are married or single. Almost half of these women have completed post-secondary education, and 22% have completed high school. One third have personal incomes of less than $20,000, while another 31% have incomes between $20,000 and $39,999. The majority of these women had higher household incomes, with 29% reporting incomes between $60,000 and $99,999 and 21% reporting incomes of more than $100,000. However, we did not find any significant relationship between age, marital status, education or income and CPGI level.

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gambling activities.

Overall, women problem gamblers tended to be unemployed or employed students of Southeast Asian decent. Typically, they would bet on sports select, sports pools, games of skill and slots in Ontario racetracks, play the lottery, scratch tickets and slots in Ontario casinos daily. Finally, we found that female problem gamblers usually spend considerable time and money on gambling.

**Cluster Analysis: Indentifying Types of Women Gamblers**

In our attempt to identify different types of women gamblers, we also conducted a two-step cluster analysis. This analysis groups women based on their socio-demographic characteristics and their gambling behaviours. While we had hoped to identify types of women problem gamblers, unfortunately, our sample size was too small – only 115 of our female respondents had experienced one or more gambling problems over the past year. Because of this restriction, we have opted to identify different types of women gamblers instead.

The sample for our cluster analysis consists of 1222 women who had gambled at least once over the past 12 months. Variables included in our analysis are demographics such as age, marital status, education, income and employment status, as well as gambling behaviours including type of game played and the percent of income spent on gambling.

Our two-step cluster analysis yielded three clusters, across which all of the individuals in our sample were somewhat evenly distributed. The first cluster is the largest, containing 37.4% of the sample. The second largest, Cluster 2, captured 25.9% of the sample, while Cluster 3 was the smallest, with only 18.2% of the sample. Based on the clustering of variables, we identified the first cluster as containing Casual Gamblers, the second as Regular Gamblers, and the third, Involved Gamblers.

The Casual Gamblers were grouped in Cluster 1. The women within this cluster play the least number of gambling games, with a mean of 1.96 games. These casual gamblers were spread evenly throughout the variable of the percent of personal income spent on gambling; evidently, this variable is not significant in this cluster. In terms of the age variable, these women were mostly between the ages of 25-34 and 35-49. They were with partners, had received post-secondary education, were employed, and made between $60,000 and $79,999 a year. When they do gamble, these women prefer to play slots or gamble at casinos outside of the province, while they were the least likely to bet on horse races, play bingo, slots in Ontario, and casino table games.

The Regular Gamblers, contained in Cluster 2, were characterized by their tendency to play a moderate number of gambling games, with a mean of 2.03. Similarly, these women also spend a moderate percent of their income on gambling. Mostly between the ages of 18-24 or over 60 years of age, these Regular Gamblers were equally likely to be with or without partner. They had attained less than secondary school education, were unemployed, and made less than $20,000 a year. These women were most likely to play slot machines in Ontario, while they were least likely to bet on raffle
Involved Gamblers are found in Cluster 3. These women play the highest number of gambling games, with a mean of 4.84, and they spend the largest percent of their personal income on gambling. This cluster spanned all age groups and levels of education, making these variables insignificant in this cluster. However, the majority of these women did have partners. But yet again, the employment variable was not significant for this cluster, as the women who fell within this group were equally likely to be employed or unemployed. These Involved Gamblers were the least likely to have low incomes, and were slightly more likely to make $80,000 or more a year. They were the most frequent players of several games, including the lottery, scratch tickets, raffle tickets, horse races, bingo, slots in Ontario, casino table games, slots at racetracks, slots outside of Ontario, sports betting, games of skill, card or board games and casinos out of province.

The gambling behaviours that characterized each of these kinds of gamblers are important in distinguishing between the three clusters. As the cluster number increases, so does the percent of personal income spent on gambling, number of gambling activities and type of gambling activities, much like our descriptive results reported above. Also consistent with the descriptive findings we discussed previously is our finding that demographics play a smaller role in distinguishing these cluster. The women in Cluster 1 are clearly successful and stable individuals, while those in Clusters 2 and 3 are less so, with Cluster 2 containing the women of the lowest socioeconomic status. However, this apparent pattern disappears with Cluster 3, in which several demographic variables are not significant, namely age, education and employment status, making demographic characteristics less effective in their ability to distinguish between these three clusters than gambling behaviours.

Table: Breakdown of Variables by Cluster for Women Gamblers – 2005 Ontario Prevalence Survey

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cluster 1</th>
<th>Cluster 2</th>
<th>Cluster 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of personal income spent on gambling</td>
<td>Not significant</td>
<td>Middle ground</td>
<td>Spends the greatest % of income on gambling</td>
</tr>
<tr>
<td>Number of gambling activities</td>
<td>Least number of gambling activities (mean=1.96)</td>
<td>Middle ground in number of gambling activities (mean=2.03)</td>
<td>Participates in the highest number of gambling activities (mean =4.84)</td>
</tr>
<tr>
<td>Age</td>
<td>Most likely to be between the ages of 25-34 or 35-49</td>
<td>Most likely to be 18-24 or 60+</td>
<td>Evenly distributed across all age categories (not significant)</td>
</tr>
<tr>
<td>With/out partner</td>
<td>Most likely to be with partner</td>
<td>Split almost evenly between with/out partner</td>
<td>With partner</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Education</td>
<td>Most likely to have post-secondary education, and least likely to have less than secondary education</td>
<td>Most likely to have less than secondary school</td>
<td>Spread evenly (not significant), but somewhat more likely to have graduated from secondary school or to have attained some post secondary education</td>
</tr>
<tr>
<td>Employment</td>
<td>Most likely to be employed</td>
<td>Least likely to be employed</td>
<td>Not significant</td>
</tr>
<tr>
<td>Personal income</td>
<td>Most likely to have an income of $60,000 to $79,999</td>
<td>Most likely to have an income of less than $20,000</td>
<td>Least likely to be in the lowest income categories, with somewhat greater numbers making $80,000 or more</td>
</tr>
<tr>
<td>Lottery tickets</td>
<td>Not significant</td>
<td>N/A</td>
<td>Most likely to engage in this form of gambling</td>
</tr>
<tr>
<td>Scratch tickets</td>
<td>N/A</td>
<td>N/A</td>
<td>Most frequent participants in this form of gambling</td>
</tr>
<tr>
<td>Raffle tickets</td>
<td>Not significant</td>
<td>Least likely players</td>
<td>Most likely players</td>
</tr>
<tr>
<td>Horse races</td>
<td>Least likely to play</td>
<td>Not significant</td>
<td>Most likely to play</td>
</tr>
<tr>
<td>Bingo</td>
<td>Least likely participants</td>
<td>Not significant</td>
<td>Most likely participants</td>
</tr>
<tr>
<td>Slots in Ontario casinos</td>
<td>Least likely players</td>
<td>Somewhat likely players</td>
<td>Most likely players (creating an overwhelming majority)</td>
</tr>
<tr>
<td>Casino table games</td>
<td>Least likely to participate</td>
<td>Not significant</td>
<td>Most likely to participate</td>
</tr>
<tr>
<td>Slots at racetracks</td>
<td>N/A</td>
<td>N/A</td>
<td>Most likely players (overwhelmingly)</td>
</tr>
<tr>
<td>Slots/VLTs outside Ontario</td>
<td>Small numbers would participate</td>
<td>Least likely to play</td>
<td>Most likely to play</td>
</tr>
<tr>
<td>Sport select</td>
<td>Not significant</td>
<td>Not significant</td>
<td>Highly likely to participate</td>
</tr>
<tr>
<td>Sport pools</td>
<td>Not significant</td>
<td>Not significant</td>
<td>Not significant</td>
</tr>
<tr>
<td>Games of skill</td>
<td>None participate in these types of games</td>
<td>Not significant</td>
<td>The majority play</td>
</tr>
<tr>
<td>Card/board games played with friends or family</td>
<td>Not significant</td>
<td>Not significant</td>
<td>Somewhat more likely to participate</td>
</tr>
<tr>
<td>Casinos out of province</td>
<td>Second highest number of participants</td>
<td>Least likely to play</td>
<td>Most likely to play</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------</td>
<td>---------------------</td>
<td>--------------------</td>
</tr>
</tbody>
</table>

Regression Analysis: Types of Women Gamblers and the CPGI

In our efforts to address our gender-specific research question, the next step was to use a regression analysis to determine whether our clusters of women gamblers are related to problem gambling as measured by the CPGI.

We first conducted a logistic regression, where the dependent variable was a dichotomy between problem and non-problem CPGI scores. This model was very unstable, and the clusters were not related to problem gambling. We then ran multinomial logistic regressions, using CPGI level and CPGI score as dependent variables. Again, the clusters were not related to problem gambling. The complications we experienced with these models were mainly due to sample size.

Supplemental Regression Analysis: Women Gamblers and the CPGI

Because these regressions including our clusters were unstable, we ran a binary logistic regression including only women gamblers in order to identify explanatory factors for problem gambling among women.

In this analysis, a CPGI dichotomy between non-problem/low risk gambling and moderate risk/problem gambling was used as the dependent variable. In the first model, several demographic variables were included as independent variables, such as age, personal income, education, ethnicity, marital status, and employment status. This model was not significant, as only the single variable of secondary education was found to be related to problem gambling. It was revealed that those whose highest level of schooling is secondary school education are more likely to be problem gamblers than those who had obtained post-secondary degrees. However, this finding was inconsistent with the results of our literature review, where we found that problem gambling women typically have less than a high school education.

In the second model, we added the variable of type of gambling activities. This model is significant, and explains between 7 and 23% of the variance in the problem gambling dichotomy. Only two games were revealed to be significantly related to problem gambling: playing slots at an Ontario racetrack and betting on card/board games with family or friends, which were both positively associated with problem gambling.

In the third model, we included the variable describing the number of different gambling games played within the analysis. This model was also significant, but does not increase the explanatory power of the previous model, as the number of different gambling games was not related to the problem gambling dichotomy. However, the addition of this variable rendered betting on card/board games with family or friends non-significant.

In the last model, we added the variable regarding the percent of income spent on gambling. This model is significant, explaining between 10 and 33.5% of the variance in the problem gambling dichotomy, and consequently revealing that the percent of income
spent on gambling is significantly related to problem gambling. Further, the addition of this variable changed some other relationships: while playing slots at an Ontario racetrack was rendered non-significant, several other variables (namely lottery tickets, buy scratch tickets, raffle tickets and the number of gambling activities an individual participated in) became significant.

Specifically, the likelihood of experiencing gambling problems increases by a dramatic ratio of 833.162 with every single percent increase in the income an individual spent on gambling. Similarly, with every additional type of game played, the likelihood of experiencing gambling problems increased by a ratio of 2.544. The three significant types of games are all protective: women who play the lottery, scratch tickets or raffle tickets are .278, .287 and .309 times less likely to develop gambling problems.

In sum, variations in problem gambling behaviour among women are explained by the percent of income they spend on gambling, the number of games they play, and the type of game, where the lottery, scratch tickets, and raffle/fundraising tickets are protective. The only demographic variable that was found to be significant at any point in this analysis was education, which is rendered non-significant by the type of gambling activities participated in.

Table: Regression Output for Model 4: Binary Logistic Regression for Women Gamblers and CPGI Dichotomy – 2005 Ontario Prevalence Data

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>4.245</td>
<td>4</td>
<td>.374</td>
<td></td>
</tr>
<tr>
<td>Age: 25-34</td>
<td>.892</td>
<td>.946</td>
<td>.889</td>
<td>1</td>
<td>.346</td>
<td>2.440</td>
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<tr>
<td>Age: 35-49</td>
<td>1.558</td>
<td>.853</td>
<td>3.336</td>
<td>1</td>
<td>.068</td>
<td>4.748</td>
</tr>
<tr>
<td>Age: 50-59</td>
<td>1.015</td>
<td>.884</td>
<td>1.321</td>
<td>1</td>
<td>.250</td>
<td>2.760</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td>.400</td>
<td>.013</td>
<td>1</td>
<td>.909</td>
<td>1.047</td>
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<tr>
<td>Marital Status</td>
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<td>Employment Status</td>
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<td>.498</td>
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<td>.842</td>
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<tr>
<td>Education</td>
<td></td>
<td></td>
<td>5.254</td>
<td>3</td>
<td>.154</td>
<td></td>
</tr>
<tr>
<td>Education: Less than secondary school graduation</td>
<td>-1.498</td>
<td>1.149</td>
<td>1.699</td>
<td>1</td>
<td>.192</td>
<td>.224</td>
</tr>
<tr>
<td>Education: Secondary school grad</td>
<td>.583</td>
<td>.453</td>
<td>1.652</td>
<td>1</td>
<td>.199</td>
<td>1.791</td>
</tr>
<tr>
<td>Education: Some post-secondary</td>
<td>-.511</td>
<td>.732</td>
<td>.487</td>
<td>1</td>
<td>.485</td>
<td>.600</td>
</tr>
<tr>
<td>Personal income</td>
<td></td>
<td></td>
<td>5.422</td>
<td>4</td>
<td>.247</td>
<td></td>
</tr>
<tr>
<td>Personal Income: Less than $20,000</td>
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<td>.784</td>
<td>.285</td>
<td>1</td>
<td>.593</td>
<td>.658</td>
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<td>.779</td>
<td>.820</td>
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### Summary

Through our examination of both between-gender and within-gender differences in gambling behaviour using the 2005 Ontario Prevalence Survey, we found that men are overall more involved with gambling than women. Men are more likely to be problem gamblers, which can be explained by the types of games that most men tend to play. Throughout our gendered analysis, only one other demographic variable was significant, which was age. However, this variable was also explained by type of game played. Overall, the variations in problem gambling that were observed in this sample are explained by buying raffle or fundraiser tickets, which had a protective factor; playing slot machines at Ontario racetracks; the percent of income spent on gambling; and the number of gambling activities an individual participated in. We conclude that in this sample, gambling behaviours play a greater role in explaining gender differences in problem gamblers than demographic characteristics.

In our analysis of women, we found that women problem gamblers are also more involved with their gambling than non-problem gamblers. As with our non-gendered sample, gambling behaviours were better factors by which to distinguish between three different types of women gamblers. Demographics on the other hand played a smaller role, as three of five demographic variables were not significant for Cluster 3, which could arguably contain the problem gamblers. The importance of gambling behaviours is supported by our supplemental binary logistic regression of women gamblers, in which variations in problem gambling among women are explained by the percent of income spent on gambling, number of games played, and type of game played, where the lottery, scratch tickets and raffle/fundraising tickets are protective. The only demographic variable that we found to be significant at any point in this analysis was education, which was rendered non-significant by type of gambling activities. In conclusion, gambling behaviours in this sample play a greater role in explaining differences among women gamblers than demographic characteristics, much the same as with our gendered analysis.

Despite our conviction that gambling behaviours were particularly influential in differentiating certain kinds of gamblers, we do believe that certain demographic variables may be important in identifying women problem gamblers. Our descriptive results suggest that women who are unemployed, employed students or of Southeast...
Asian decent are more likely to be problem gamblers. Further, the first run in our binary logistic regression suggests that those with secondary school education are more likely to be problem gamblers than those with post-secondary degrees. Thus while we found an examination of gambling behaviours to be particularly useful in differentiating different types of gamblers, certain demographic characteristics were also telling.

We now move on to examine the 2007 Canadian Community Health Survey (CCHS 2007), in hopes of confirming and expanding on the results found here in the 2005 Ontario Prevalence Survey.

RESULTS FROM THE 2007 CANADIAN COMMUNITY HEALTH SURVEY

In our analysis of the CCHS 2007, we focused on the Ontario sample (N=28,288) who completed the problem gambling component of the survey. Respondents were asked about their gambling problems (CPGI); their gambling behaviours in terms of the type of game they preferred to play; psychosocial variables such as alcohol use, general health status, mental health, and stress; and demographics including their age, sex, marital status, education, immigrant status, employment, and income. One important modification made in the CCHS 2007 is that respondents who voluntarily stated in response to the second CPGI question that ‘I am not a gambler’ were classified as ‘Not a Gambler,’ and were not asked the CPGI questions. This kind of self-reporting poses a potential problem with the accuracy of some of the results of this survey, because, as we have discussed in the preceding literature review and autobiographical content analysis, many individuals fear that they will be stigmatized for their gambling problem. As a result of this fear, some possibly problematic gamblers may have denied their gambling addiction in an attempt to avoid being negatively judged. Complete results for the CCHS 2007 can be found in the appendices.

Gambling Behaviours, Problem Gambling and Psychosocial Variables by Gender

The CCHS revealed that gambling participation varies by gender, with men being more likely to have gambled in the past year than women (75% versus 70%). It was also found that men participate in a larger variety of games, with men playing 2.29 different games and women playing 2.10 games. Finally, men were found to be more likely to say that they are not gamblers, despite having participated in at least one gambling activity in the past year.

A clear connection between gender and gambling problems was also exposed, as women score lower than men on the CPGI with an average .16 in comparison to men, who display an average of .22 symptoms. Similarly, women were more likely to be classified as non-problem gamblers, while men were more likely to be deemed low risk, moderate, or problem gamblers. These results were consistent with our literature review, in which we discussed similar findings.

A subset of the Ontario sample was questioned about the degree to which their gambling activities interfere with the social aspects of their lives, such as home responsibilities, social life, ability to attend school or to work, and ability to form and maintain close relationships with other people. Of the 449 respondents, the average
interference score was .631, and this level of interference did not differ by gender.

In contrast, men and women differed significantly in terms of their views on certain aspects of their health. First, men were more likely to view the quality and availability of health care as excellent or good, while women usually rated it as being merely fair or poor. Secondly, even though overall health did not seem to vary by gender, men were more likely to assess their health as being the same as it was one year ago, while women were more likely to feel they should do something to improve their health and to believe they are overweight. The final distinction between genders was that women were more likely to cite disease, illness or ageing as the source of their health problems, while men tended to indicate injury or work conditions.

Another health related factor about which respondents were questioned was that of stress. Men were more likely to report experiencing no stress in their life, while women reported having either a small amount, or quite a bit of stress. Similarly, men were more likely to report that their work is not very or not at all stressful, while women felt that their work caused quite a bit or an extreme level of stress. Further, it was common for men to feel that their mental health was excellent, while women more often reported that it was fair or poor. This finding is obviously consistent with the stress levels that both genders reported, as was the observation that women were more likely than men to state they had an anxiety or mood disorder, and to admit to having considered suicide. Further, women were twice as likely to have consulted a professional about their mental health, which also corresponds to the higher levels of stress they reported experiencing.

Other health related issues examined in the CCHS were those related to substance use. It was found that men were more likely to have consumed alcohol in the past year, and to have done so more frequently. Consistently, men were more likely to be classified as regular drinkers, while women were more often occasional or non-drinkers. And finally, in a similar vein, men were more likely to be smoke on a daily or occasional basis, whereas women were more likely to have never smoked.

One final result that the CCHS revealed was that men and women felt a similar level of satisfaction with their lives. However, gendered differences were revealed in terms of the stronger sense of belonging to their community that the majority of women felt.

In sum, men were found to be more likely to gamble, play more gambling games, experience more gambling problems and be problem gamblers. Women experienced more stress, had poor mental health in comparison to men, and were more likely to suffer from an anxiety or mood disorder. All of these findings were consistent with the results we discussed in our literature review. Women also felt a stronger sense of belonging to their community, but men reported consuming more substances such as alcohol and cigarettes.

Regression Analysis: Gender and the CPGI

In order to examine the relationship between gender and problem gambling, and to identify any variables that might explain this relationship, we ran a series of binary
logistic regressions with the CPGI dichotomy as the dependent variable (non-problem and low risk versus moderate risk and problem).

In the first run, the independent variables of age, gender, personal income, marital status, and education were included. This model is significant, but the demographic variables only explain 0.5-2.7% of the variance in the CPGI dependent variable. Several variables were significant in this model, but the relationship between gender and the CPGI dichotomy is of particular interest. First of all, and consistently with the information presented in our literature review, we found that the odds of experiencing moderate or severe gambling problems decreased by a factor of .702 if the gambler was female. Secondly, respondents in the 18-24 year age category were less likely than those over the age of 60 to experience moderate or severe gambling problems. Further, those who are married were less likely to experience gambling problems compared to those who are single. Finally, those with less than secondary school education, or who had attained only some post-secondary education, were considerably more likely to experience gambling problems than those with post secondary degrees.

In our second model, we added several health variables, including self-perceived general health, self-perceived mental health, mood disorders and anxiety disorders. This model is significant, explaining between 1 and 4.9% of the variance in the problem gambling dichotomy. The addition of these variables renders the age category non-significant, but gender and the other demographic variables remained significant. This means that these four health variables do not explain the gender difference in problem gambling; self-perceived health is related to gambling problems, but the individual categories were not significant. For self-perceived mental health, the odds of experiencing gambling problems were lower for those who rated their mental health as being excellent compared to those who rated it as poor.

In the third model, we added the variable regarding satisfaction with life in general. This model is significant and explains between 1.2 and 5.8% of the variance in problem gambling. The addition of this variable rendered perceived mental health non-significant, while gender, however, remains significant. The variable of life satisfaction therefore fails to explain gender differences in problem gambling. Similarly, variables such as marital status, education and self-perceived health were still significant. While the overall effect of the variable of satisfaction with life is significant, the individual categories are not.

In our fourth model, we added the variables of perceived life stress and perceived work stress. This step was not significant and thus did not substantially increase the explanatory power of the model. Neither source of stress was found to be related to problem gambling, but gender, marital status, education, self-perceived health, and satisfaction with life remain significant. Therefore, these two sources of stress do not explain gender differences in problem gambling.

In model 5, we included the sense of belonging to the community. As with our fourth model, this step was insignificant, and the explanatory power was not markedly increased as a result. The variables from the previous model remained significant.
We added the variable of being a self-identified immigrant to our sixth model. This model was significant and explained between 1.3 and 6.6% of the variance in problem gambling. Model 6 revealed that being a self-identified immigrant was positively associated with problem gambling, while the variables from the previous models remained significant.

In model 7, we included the type of drinker to the analysis, but this step was not significant and did not markedly increase the explanatory power of the model. This variable is therefore not associated with problem gambling, but all of the variables from the previous models remained significant.

In our final model, which was significant, we added the number of gambling activities. This model explains between 3.8 and 18.8% of the variance in problem gambling. With the addition of this variable, gender was rendered non-significant, meaning that the number of gambling activities explains the gender difference in problem gambling. Other variables rendered non-significant with the addition of this variable included marital status and self-perceived health, but two age categories and the variable of type of drinker also became significant. Education, satisfaction with life and self-identified immigrant remained significant. Finally, this final model revealed that the number of gambling activities people participate in is positively associated with problem gambling.

More specifically, we discovered that the odds of experiencing moderate or severe gambling problems fluctuated as follows:

- The odds decreased by a factor of .395 for gamblers 18-24 years of age and by a factor of .560 for those 25-34 years of age compared to those 60 years of age or more
- They increased by a factor of 2.603 for gamblers with less than secondary school education, while they increased by factor of 1.631 for those with other post-secondary education compared to those with post secondary degrees
- As satisfaction with life increased, the odds decreased
- The odds increased by a factor of 2.064 for gamblers who self-identified as being immigrants
- They also increased with the frequency of alcohol consumption
- Finally, the odds increased by a factor of 1.741 with every unit increase in number of gambling activities.

In sum, the variations in problem gambling that we detected within this sample are explained by age (18-24 years and 25-34 years), education (less than secondary, other post-secondary), life satisfaction, immigrant status, alcohol consumption, and the number of gambling activities participated in. Gender is also related to problem gambling, with males being more likely to be problem gamblers than females, as is consistent with the descriptive results reported above. Further, we found that the association between gender
and problem gambling can be explained by the number of gambling activities played. The results from the 2005 Ontario Prevalence Survey support this finding, as these results also suggested that gender differences in problem gambling could be explained by the type of game played. However, these findings also diverge from those of the 2005 Ontario Prevalence Survey analysis, as several demographic variables remained significant in the final model, including age, education and immigrant status. In addition, the two psychosocial variables of life satisfaction and type of drinker were significant here.

<table>
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Table: Regression Output for Model 7: Binary Logistic Regression for All Gamblers and CPGI Dichotomy – CCHS 2007

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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>-.339</td>
<td>.214</td>
<td>2.514</td>
<td>1</td>
<td>.113</td>
<td>.713</td>
</tr>
<tr>
<td>Occasional</td>
<td>.110</td>
<td>.240</td>
<td>.210</td>
<td>1</td>
<td>.647</td>
<td>1.116</td>
</tr>
<tr>
<td>Number of Gambling Activities</td>
<td>.554</td>
<td>.031</td>
<td>312.417</td>
<td>1</td>
<td>.000</td>
<td>1.741</td>
</tr>
<tr>
<td>Constant</td>
<td>-.422</td>
<td>1.182</td>
<td>13.999</td>
<td>1</td>
<td>.000</td>
<td>.012</td>
</tr>
</tbody>
</table>

**Descriptives: Women Gamblers**

In our early attempts to form an idea of the types of women gamblers, we examined how the demographics and psychosocial variables of women gamblers are
distributed across CPGI levels.

We found that most frequently, women who are classified as problem gamblers are between 35-49 or 50-59 years of age, are in common-law relationships, have secondary or lower education, have personal incomes below $40,000 or above $80,000, and have immigrated to Canada. Women with or without a job were equally likely to be moderate risk or problem gamblers. However, differences emerged in our examination of the variable of race, with respondents coded as “white” being more likely to be non-problem gamblers, while those coded as “visible minority” were more likely to be low risk gamblers.

These findings for age, education, immigrant status and ethnicity are all consistent with those from our literature review. On the other hand, the problem gambling women in this sample are older and are more often part of a visible minority than those in our content analysis, but both samples of women tend to have similar marital status, as the majority of women were with partners. This variable did not correspond with the results in our literature review, however, as the problem gambling women in this sample are more likely to be in a relationship. Finally, these problem gambling women frequently had higher incomes than those we discussed in our literature review.

Our analysis also revealed that women problem gamblers were more likely to rate the availability of health care as poor. They also rated their own health as being fair or poor more often, and typically reported having quite a bit of stress in their life. In terms of mental health, many women with gambling problems stated that they had a mood or anxiety disorder, and many also reported being dissatisfied with their life. These female gamblers were also usually substance users, with the majority having consumed 5 or more drinks more than once a week over the past year. Similarly, they consumed alcohol less than once a month, and they smoked cigarettes daily. The frequency with which these women experience mood and anxiety disorders is consistent with our discussion of these variables in our literature review, while the presence of stress within this sample of women echoes the findings from our content analysis.

**Cluster Analysis: Identifying Types of Women Gamblers**

The next step we took in our attempt to identify different types of women gamblers was to conduct a two-step cluster analysis. This analysis groups women based on their socio-demographic characteristics, psychosocial variables and gambling behaviours. In terms of this final variable, the CCHS 2007 only provides information on the number of gambling activities, meaning that it lacks the information that the 2005 Ontario Prevalence Survey provides on the type of gambling activities. As such, we used this variable of the number of gambling activities to generate our clusters.

As with the 2005 Ontario Prevalence Survey, we created clusters of female gamblers, rather than just female problem gamblers. The sample for this cluster analysis contained 14,860 women who had gambled at least once over the past 12 months. Variables included in this analysis were also similar to those incorporated in the previous one; as such, we examined various demographic variables such as age, marital status, education, income and immigrant status, as well as a number of psychosocial variables.
like satisfaction with life, stress, health, mental health, mood or anxiety disorder, sense of belonging and alcohol use. The final variable we analyzed was that of gambling behaviours, which, as we explained above, we had to limit to the number of gambling activities participated in.

Our two-step cluster analysis yielded three clusters, the first of which is the largest, containing 23.6% of the sample. The second largest is Cluster 3, with 18.3% of the sample, while Cluster 2 is the smallest, capturing 12.0% of the sample.
Based on the clustering of variables, we identified these three clusters as containing Very Healthy Gamblers, Healthy Gamblers, and Unhealthy Gamblers.

Very Healthy Gamblers are found in Cluster 1. The mean number of gambling activities for this group is 2.13, which is the lowest of the three clusters. These women were typically married, and had generally attained a post-secondary education. Very Healthy Gamblers were also characterized by incomes greater than $80,000, and they also tended to be somewhat older than women in the other clusters. In terms of the self identified immigrant variable, these women were generally Canadian born. These Very Healthy Gamblers were very satisfied with their lives, and felt a very strong sense of belonging to their community. Accordingly, they claimed that they experienced no or very little life and work related stress, and rated their general and mental health as excellent. They also did not report having mood or anxiety disorders, which corresponds to their low levels of stress and high levels of life satisfaction. Finally, Very Healthy Gamblers were regular drinkers, consuming alcohol once a month or more.

Cluster 2 contained those women that we deemed Healthy Gamblers. The mean number of gambling activities for this group is 2.46, making it the highest of the three clusters. In direct contrast to the women belonging to Cluster 1, those in Cluster 2 were single, younger (18-34), and had incomes of less than $20,000. However, the variable regarding immigrant status yielded consistent results across both the first and second clusters, as Healthy Gamblers were also Canadian born. Women in this group were equally dispersed across education levels, in contrast with the uniform levels of education we saw in Cluster 1. Healthy Gamblers, similar to Very Healthy Gamblers, were generally satisfied with their life, but they experienced a bit more life stress than the women in Cluster 1. They also rated their general and mental health as being very good, though not “excellent,” like the women in Cluster 1. Healthy Gambling women experienced varied levels of perceived work stress, as well as a range of different senses of belonging to the community. Similarly, they differed in terms of having a mood disorder, and they only occasionally experienced anxiety disorders. Finally, as they tended to consume alcohol less than once a month, they were also labelled occasional drinkers.

Unhealthy Gamblers were grouped in Cluster 3. The mean number of gambling activities for this group is 2.17, which is not significantly different from the mean number of the other clusters. The marital status of these women differentiated them from the gamblers in Clusters 1 and 2, as they were widowed or divorced. While they were similar in age to those women in Cluster 1, they differed from Healthy Gamblers in that they had less than secondary school education, and had lower incomes, ranging between $20,000 and $39,999. Unhealthy Gamblers broke the pattern we saw in Clusters 1 and 2 with regards to immigrant status, as these women had immigrated to Canada. Also in contrast to the women of the other two clusters, Unhealthy Gamblers were dissatisfied with their lives, felt a weak sense of belonging to their community, and felt extremely stressed by their life and work. Further, they rated their physical and mental health as being poor, and many experienced mood and anxiety disorders. The final factor differentiating these women from Very Healthy and Healthy Gamblers was that they had not had a drink in the last year.

In terms of demographics, the first clusters created from the CCHS and from the 2005 Ontario Prevalence Survey seem to match relatively well; Very Healthy gamblers and Casual
Gamblers were both with partners, had attained some form of post-secondary education, were middle aged (25-49), and had moderate incomes, at $60,000 and above. Interestingly, the women in both of these clusters were found to play the lowest number of gambling games of the three clusters from the respective samples. The second clusters created from the CCHS and the Ontario Prevalence Survey, containing Healthy Gamblers and Regular Gamblers respectively, do not match as well. While both contain women who made less than $20,000 a year, and who were in a younger age bracket (18-24), the two clusters differ in terms of marital status, education and number of games played. Finally, the third clusters created from each sample, containing Unhealthy Gamblers and Involved Gamblers, do not share any demographic variables and do not have similar levels of number of games played.

While we found that gambling behaviours were very useful in distinguishing between the three clusters created from the 2005 Ontario Prevalence Survey, this factor was much less important in distinguishing between the three clusters from the CCHS. This was primarily because the only gambling behaviour mentioned for this second set of clusters is the number of gambling activities, and this variable is not even significant for Cluster 3. Demographics play a larger role for the clusters created from the CCHS, as all five demographic variables were significant in each of the three clusters. In addition, all nine psychosocial variables were influential in these clusters, further demonstrating that demographics played a larger role in distinguishing between these clusters than gambling behaviour.

**Table: Breakdown of Variables by Cluster for Women Gamblers – CCHS 2007**

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>CLUSTER 1</th>
<th>CLUSTER 2</th>
<th>CLUSTER 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Gambling Activities</td>
<td>Mean = 2.13</td>
<td>Mean =2.46</td>
<td>Mean = 2.17 (not sig.)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married</td>
<td>Single</td>
<td>Most were widowed/divorced, but there were also many married people</td>
</tr>
<tr>
<td>Age</td>
<td>Somewhat older than those in cluster 3</td>
<td>Youngest group, typically in the age brackets of 18-24 or 25-34</td>
<td>Roughly the same age as cluster 1</td>
</tr>
<tr>
<td>Respondents’ Education Level</td>
<td>Post secondary graduate</td>
<td>Equally dispersed across education levels</td>
<td>Less than secondary school (these women seem to be the least educated)</td>
</tr>
<tr>
<td>Personal Income</td>
<td>Greater than $20,000 (most people had an income of $80,000 or more)</td>
<td>Less than $20,000</td>
<td>Between 20,000 and 39,999</td>
</tr>
<tr>
<td>Satisfaction with life</td>
<td>Very satisfied</td>
<td>Satisfied</td>
<td>More likely to be very dissatisfied or dissatisfied</td>
</tr>
<tr>
<td>Perceived Life Stress</td>
<td>None at all or not very much</td>
<td>A bit</td>
<td>Extremely or quite a bit</td>
</tr>
</tbody>
</table>
Regression Analysis: Types of Women Gamblers and the CPGI

The next step we took in our attempt to address our gender-specific research question was to use a regression analysis to determine whether our clusters of women gamblers are related to problem gambling as measured by the CPGI. We began by running a binary logistic regression, using the CPGI problem gambling dichotomy (non-problem and low risk versus moderate risk and problem). Next, we ran a multinomial logistic regression using all four CPGI levels as the dependent variable. These two regressions yielded similar results.

For the binary logistic regression, the model is significant and explains between 0.8 and 4.3% of the variance in the problem gambling dichotomy. The clusters were significant predictors of problem gambling, as the odds of experiencing moderate or severe gambling problems decreased by a factor of .436 for the women in Cluster 2 compared to those in Cluster 3. Similarly, the odds of problem gambling decreased by a factor of .227 for women in Cluster 1 compared to those in Cluster 3.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cluster 1</th>
<th>Cluster 2</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>-1.482</td>
<td>-0.831</td>
<td>-3.257</td>
</tr>
<tr>
<td>S.E.</td>
<td>.241</td>
<td>.237</td>
<td>.118</td>
</tr>
<tr>
<td>Wald</td>
<td>37.955</td>
<td>12.239</td>
<td>755.663</td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sig.</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Exp(B)</td>
<td>.227</td>
<td>.436</td>
<td>.039</td>
</tr>
</tbody>
</table>

For the multinomial logistic regression, the model is significant, explaining between 1.2 and 3.1% of the variance in CPGI level. Consistent with the binary logistic regression results, women in Cluster 1 and Cluster 2 were more likely to be classified as non-problem or low risk gamblers than the women in Cluster 3. Women in Cluster 1 were more likely to be classified as
moderate risk gamblers than those in Cluster 3.

Table: Multinomial Logistic Regression Results for Women Gambler Clusters and CPGI Levels – CCHS 2007

<table>
<thead>
<tr>
<th>CPGI Level</th>
<th>B</th>
<th>Std. Error</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% Confidence Interval for Exp(B)</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NON-PROBLEM GAMBLER</td>
<td>Intercept</td>
<td>4.381</td>
<td>.210</td>
<td>435.975</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cluster 1</td>
<td>3.470</td>
<td>1.022</td>
<td>11.529</td>
<td>1</td>
<td>.001</td>
<td>32.135</td>
<td>4.336</td>
<td>238.164</td>
</tr>
<tr>
<td></td>
<td>Cluster 2</td>
<td>1.742</td>
<td>.615</td>
<td>8.022</td>
<td>1</td>
<td>.005</td>
<td>5.706</td>
<td>1.710</td>
<td>19.043</td>
</tr>
<tr>
<td></td>
<td>Cluster 3</td>
<td>0$^a$</td>
<td>.</td>
<td>.</td>
<td>0</td>
<td>.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOW RISK GAMBLER</td>
<td>Intercept</td>
<td>1.283</td>
<td>.236</td>
<td>29.661</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cluster 1</td>
<td>2.828</td>
<td>1.035</td>
<td>7.458</td>
<td>1</td>
<td>.006</td>
<td>16.904</td>
<td>2.222</td>
<td>128.605</td>
</tr>
<tr>
<td></td>
<td>Cluster 2</td>
<td>1.745</td>
<td>.636</td>
<td>7.520</td>
<td>1</td>
<td>.006</td>
<td>5.727</td>
<td>1.645</td>
<td>19.935</td>
</tr>
<tr>
<td></td>
<td>Cluster 3</td>
<td>0$^a$</td>
<td>.</td>
<td>.</td>
<td>0</td>
<td>.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MODERATE RISK GAMBLER</td>
<td>Intercept</td>
<td>.796</td>
<td>.251</td>
<td>10.052</td>
<td>1</td>
<td>.002</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cluster 1</td>
<td>2.295</td>
<td>1.053</td>
<td>4.750</td>
<td>1</td>
<td>.029</td>
<td>9.922</td>
<td>1.260</td>
<td>78.124</td>
</tr>
<tr>
<td></td>
<td>Cluster 2</td>
<td>1.150</td>
<td>.666</td>
<td>2.976</td>
<td>1</td>
<td>.084</td>
<td>3.157</td>
<td>.855</td>
<td>11.654</td>
</tr>
<tr>
<td></td>
<td>Cluster 3</td>
<td>0$^a$</td>
<td>.</td>
<td>.</td>
<td>0</td>
<td>.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These results indicate that women who are classified as Very Healthy and Healthy Gamblers are less likely to be problem gamblers than those who fall into the Unhealthy cluster. According to our cluster analysis, this means that the women in this sample who were most likely to be deemed problem gamblers were usually widowed or divorced, middle aged, made between $20,000 and $39,999 a year, and had less than secondary school education. These women would gamble on 2.17 gambling games on average, and they were also characterized by being immigrants to Canada. In terms of their health, these women tended to be dissatisfied with their lives, feel a weak sense of belonging to their community, feel extremely stressed by their life and work, rate their physical and mental health as poor, experience mood and anxiety disorders, and, finally, the majority of them had not had a drink in the last year. These results are largely consistent with the literature review in terms of marital status, age, education, immigrant status, level of stress and mental health disorders. However, the women problem gamblers in this sample have slightly higher incomes.

As we discussed earlier, the single gambling behaviour indicator is not significant for Cluster 3. Because this is the cluster to which the majority of problem gambling women belonged, it seems as though demographic characteristics and psychosocial variables are more important predictors of problem gambling among women than gambling behaviours.
Summary

In order to expand on and confirm the results from the 2005 Ontario Prevalence Survey, we examined both between-gender and within-gender differences in the CCHS 2007.

We found that, as with the 2005 Ontario Prevalence data, men are overall more involved in gambling than women, and they consume more substances, such as alcohol and cigarettes. The poor mental health that the majority of the women in the sample reported experiencing set them apart from the men. As with the 2005 data, male respondents to the CCHS were more likely to be problem gamblers, and this gender difference is explained by number of gambling games played. Overall, variations in problem gambling in this sample are explained by age (18-24 years and 25-34 years), education (less than secondary, other post-secondary), life satisfaction, immigrant status, alcohol consumption and number of gambling activities. In terms of the gender differences that were evident in this sample, we concluded that these differences were better explained by gambling behaviours than demographic characteristics and psychosocial variables. However, these latter variables remained important for explaining overall variation in problem gambling.

In our analysis of women, we found that demographics and psychosocial variables are important in distinguishing between the three types of women gamblers that composed our three clusters. All five demographic characteristics and all nine psychosocial variables were important for each cluster, while in contrast, the only gambling behaviour variable – number of games played – was not significant for Cluster 3. This finding diverges from the results for the 2005 Ontario Prevalence Survey, for which gambling behaviours were more influential in distinguishing the clusters. When we compared the clusters from each dataset, we found that the clusters containing the more stable or successful individuals (both Cluster 1s) were fairly uniform, while those clusters to which the more unstable individuals belonged (each Cluster 2 and 3) were not so similar. Though the datasets seem to offer a consensus on who could be classified as non-gamblers, we had more difficulty determining who would be considered a problem gambler.

The ability of demographic and psychosocial variables to more effectively distinguish between the three clusters of female gamblers was confirmed by our regression analysis that examined the relationship between our clusters and the CPGI. Here, we found that belonging to Cluster 3 – the Unhealthy Gamblers – predicted a woman’s development of problem gambling. In conclusion, demographic characteristics and psychosocial variables were more important for predicting problem gambling among the women in this sample than gambling behaviours, since the one gambling behaviour indicator was not significant in the cluster that is related to problem gambling.

Because of the diverging findings from our descriptive results and our cluster analysis, we have come to the conclusion that women problem gamblers are not typified by certain demographic variables. First, our descriptive results suggested that women problem gamblers are most often between 35-49 or 50-59 years of age, are in common-law relationships, have secondary or lower education, have personal incomes below $40,000 or above $80,000, and are immigrants to Canada. Secondly, our cluster analysis implied that these women problem
gamblers are most often widowed or divorced, middle aged, have incomes between $20,000 and $39,999, have less than secondary school education and are immigrants to Canada. So even though the age categories and level of education suggested by these two sources are similar, the other demographics are inconsistent. Further, these results are not consistent with those provided by the 2005 Ontario Prevalence Survey, suggesting that there are not specific demographic characteristics that all, or even the majority of women gamblers fulfill.

We will now move on to examine the 2009 Ontario Student Drug Use and Health Survey, (OSDUHS), in hopes of expanding on the results found here for the CCHS 2007.

RESULTS FROM THE 2009 ONTARIO STUDENT DRUG USE AND HEALTH SURVEY

Though the 2009 OSDUHS had a sample size consisting of 9,112 students, we only examined the smaller sample of 4,851 students who completed Form A, which contains questions pertaining to gambling. These students answered questions about their demographic characteristics, including age, gender, and Canadian citizenship (by birth). Further questions in terms of their demographics were asked concerning the hours they worked, the language they primarily spoke, and the education their parents had received. These students were also questioned with regards to their gambling behaviours, in particular, the frequency at which they gambled, the type of game they played, and the largest amount of money they had gambled. They were then asked six questions from the South Oaks Gambling Screen Revised for Adolescents, which pertained to gambling problems. Finally, this form contained questions about psychosocial variables such as the safety of the school they attended, their sense of belonging within their school community, the relationships they had with parents, their substance use, general physical and mental health, symptoms of anxiety and depression, and bullying.

Gambling Behaviours, Problem Gambling and Psychosocial Variables by Gender

Through our analysis of the 2009 OSDUHS, we found that male students are more likely to participate in every type of gambling game. Further, the male students from this sample tended to play a larger variety of games, and to spend more money on their gambling activities. In terms of game preference, it was revealed that female students play bingo and the lottery more often, while male students preferred games involving cards, dice and the internet. These findings for the variables of game preference and amount of money spent correspond to the data we presented in our literature review.

Corresponding to the findings of our literature review was our observation that male students tended to experience more problems as a result of their gambling behaviour than were females. Primarily, male students were twice as likely to be classified as problem gamblers, while female students were more likely to score 0 on the modified SOGS scale. Male students were also more likely to report that betting had caused them problems in general, but more specifically, they also said that they had experienced interpersonal conflicts as a result of their gambling. They tended to lose control over their gambling activities, which was revealed by their common confessions that they had gambled more than they had planned to in the past. This kind of problematic gambling behaviour was further supported by their claims that they had been
absent from work or school because they had been gambling instead, and that they had borrowed or stolen something in their attempts to cover their gambling debts. Likely as a result of these kinds of gambling behaviours, male students reported that they had been criticized for their gambling, and that they got into arguments over it.

In response to the questions concerning school safety, female students admitted more frequently that they were worried about being harmed by someone at school.

The questioning regarding the kinds of relationships respondents had with their parents revealed that male students had better relationships with both their mothers and fathers than female students. However, female students were more likely to reach out to their mothers to discuss important problems, and the majority claimed that they would always let their parents know where they are.

Next were the questions pertaining to personal health. It was found that male students were more likely to rate their physical and mental health as being excellent. In contrast, female students showed more symptoms of emotional distress and lower levels of self-esteem. Consistently with this finding, the female students in this sample struggled with depression more often, and they were more likely to have considered and/or attempted suicide. In terms of mental health and self-esteem, these findings are consistent with those of our literature review.

Finally, we found that male and female students behaved in generally similar ways where substance use was concerned. Male students consumed alcohol more often, drank more alcohol per occasion, and tended to binge drink more frequently, while female students experienced more symptoms of harmful drinking. Both genders therefore tended to drink irresponsibly. Gender differences were also absent in terms of drug use, drug use problems and cannabis dependence. However, the one gendered element within this category was that female students typically engaged in less risk taking than male students.

To sum up our findings from the OSDUHS, we discovered that the male students within this sample were more likely to gamble, to play a larger variety of games and to spend more money on gambling than female students. Their preferred games were those involving cards, dice and the internet. Male students were also found to be more likely to be classified as problem gamblers and to experience more problems in general as a result of their gambling. Even though male students tended to have better relationships with their parents, female students were more likely to communicate with them, and approach them to talk, or for advice. Finally, while female students were found to have poorer mental health and to experience more symptoms of harmful drinking than male students, male students exhibited better physical health, consumed more alcohol, and engaged in more risk taking.

Regression Analysis: Gender and the SOGS

In order to examine the relationship between gender and problem gambling, and to identify any variables that might potentially explain this relationship, we ran a series of binary logistic regressions with a SOGS dichotomy as the dependent variable. The SOGS scores were dichotomized into “having experienced two or more gambling related problems” and “having experienced less than two gambling problems.”
The first model had gender as the only independent variable, and is significant, with gender explaining between .8 and 2% of the variance in the SOGS dichotomy. As the results from the other two datasets and the literature review revealed, male student gamblers were more likely to experience two or more gambling problems than female student gamblers.

In our second model, we added all of the additional variables of interest. Because of the sampling technique for this dataset however, we were not able to use stepwise entry. This model is significant and explains between 15.7 and 47.4% of the variance in the SOGS dichotomy. The variables that we included in the model were age, school marks, fear of school harm, physical health, mental health, medication, self-esteem, psychological distress, depression, cannabis dependency, drug use problem, alcohol use problem, and type of gambling activities participated in. The addition of these variables rendered gender non-significant, meaning that one or more of the variables in this model explains the gender difference in problem gambling. Contributing to this explanation were the variables of self-esteem, psychological distress, and type of game played, as these were the variables that remained significant in this model; two indicators of self-esteem (‘Sometimes I feel I can’t do anything right’ and ‘I feel that I’m a person of worth’), elevated psychological distress, and three types of gambling (cards, slot machines and other gambling) were significant. The importance of the type of game played that we see here is consistent with the results of the other two datasets, but the effects of the psychosocial variables are not.

From our examination of the results of the OSDUHS, we were able to deduce that self-esteem is a protective factor for problem gambling, at least within this sample. This was revealed through our finding that the odds of experiencing two or more gambling problems increased by a factor of 1.401 if the gambler ‘seldom’ feels s/he can’t do anything right in comparison to the odds they face if they never feel this way. However, even though we found that feeling a sense of self-worth was significant in the regression model, the differences between how the categories are related to gambling problems remain unclear.

Our analysis also revealed that experiencing psychological distress puts people at a higher risk of becoming problem gamblers. We were able to come to this conclusion through our observation that the odds of experiencing two or more gambling problems decreased by a factor of .364 if the respondent experiences a low rather than a high level of distress, as indicated by scoring less than 3 on the psychological distress scale.

Finally, we were able to conclude that all three types of gambling are risk factors, as the odds of experiencing two or more gambling problems decreased by a factor of .319, .456 and .486 if the respondent does not bet on cards, slot machines or other types of gambling, respectively.

In sum, problem gambling behaviours among the individuals in this sample are explained by low self-esteem, high psychological distress and three types of gambling: cards, slot machines and other gambling. The importance we place here on the type of game played is consistent with the results we found from the other two datasets. The significance of psychosocial factors, namely self-esteem and distress, is consistent with the results from the CCHS 2007, but it does not correspond with the results of the 2005 Ontario Prevalence Survey. Another difference
between the datasets was that no demographic variables were significant in the final model for the OSDUHS, while they were significant for the CCHS 2007.

**Pseudo R Squares**

<table>
<thead>
<tr>
<th></th>
<th>Cox and Snell</th>
<th>Nagelkerke</th>
<th>McFadden</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.157</td>
<td>.474</td>
<td>.424</td>
</tr>
</tbody>
</table>

**Table: Regression Output for Model 2: Binary Logistic Regression for All Gamblers and SOGS Dichotomy – 2009 OSDHUS**

<table>
<thead>
<tr>
<th>Source</th>
<th>Adjusted Wald Chi-Square</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Corrected Model)</td>
<td>76.519</td>
<td>.000</td>
</tr>
<tr>
<td>(Intercept)</td>
<td>.472</td>
<td>.492</td>
</tr>
<tr>
<td>Gender</td>
<td>1.673</td>
<td>.196</td>
</tr>
<tr>
<td>School marks</td>
<td>2.506</td>
<td>.461</td>
</tr>
<tr>
<td>Response to: &quot;At school, how worried are you that someone will harm, threaten or take something from you?&quot;</td>
<td>2.740</td>
<td>.395</td>
</tr>
<tr>
<td>Response to: &quot;How would you rate your physical health?&quot;</td>
<td>2.910</td>
<td>.531</td>
</tr>
<tr>
<td>Been prescribed medicine to treat anxiety or depression (yes/no)</td>
<td>3.542</td>
<td>.060</td>
</tr>
<tr>
<td>Depression: Felt Sad</td>
<td>4.968</td>
<td>.161</td>
</tr>
<tr>
<td>Depression: Felt Lonely</td>
<td>3.650</td>
<td>.244</td>
</tr>
<tr>
<td>Depression: Felt Depressed</td>
<td>.318</td>
<td>.951</td>
</tr>
<tr>
<td>Depression: Felt like crying</td>
<td>5.913</td>
<td>.101</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;sometimes I feel can't do anything right&quot;</td>
<td>9.390</td>
<td>.039</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;I feel good about myself&quot;</td>
<td>4.529</td>
<td>.323</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;I feel I don't have much to be proud of&quot;</td>
<td>7.151</td>
<td>.111</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;I feel that i'm a person of worth&quot;</td>
<td>11.235</td>
<td>.022</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;sometimes i think i am no good at all&quot;</td>
<td>2.512</td>
<td>.583</td>
</tr>
<tr>
<td>Low Self Esteem: agreement to statement: &quot;I am able to do most things as well as other people can&quot;</td>
<td>7.949</td>
<td>.083</td>
</tr>
<tr>
<td>Elevated Psychological distress GHQ binary score</td>
<td>4.983</td>
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</tr>
<tr>
<td>Cannabis SDS score (binary)</td>
<td>.835</td>
<td>.361</td>
</tr>
<tr>
<td>CRAFFT Score (binary)</td>
<td>.028</td>
<td>.867</td>
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<tr>
<td>AUDIT Score (binary)</td>
<td>.260</td>
<td>.610</td>
</tr>
<tr>
<td>Played cards for money</td>
<td>6.478</td>
<td>.011</td>
</tr>
<tr>
<td>Played bingo for money</td>
<td>.209</td>
<td>.647</td>
</tr>
<tr>
<td>Bet money in sports pools</td>
<td>.872</td>
<td>.350</td>
</tr>
<tr>
<td>Bought sports lottery tickets</td>
<td>.198</td>
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</tr>
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<td>Bought any other lottery tickets</td>
<td>2.574</td>
<td>.109</td>
</tr>
<tr>
<td>Bet money on video gambling machines, slot machines</td>
<td>5.980</td>
<td>.014</td>
</tr>
<tr>
<td>Bet money at a casino in ontario</td>
<td>2.266</td>
<td>.132</td>
</tr>
<tr>
<td>Bet money over the internet</td>
<td>1.665</td>
<td>.197</td>
</tr>
<tr>
<td>Bet money on poker over the internet</td>
<td>3.292</td>
<td>.070</td>
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</table>
Descriptives: Female Gamblers

In our attempt to form an idea of the types of female gamblers that composed this sample, we examined how the demographic characteristics, psychosocial variables and gambling behaviours of the female respondents were distributed across SOGS levels.

This analysis resulted in our finding that female students who experienced two or more gambling problems typically split their time between two or more households. If we consider splitting time between two households to be a stressful circumstance, than this finding is consistent with the literature review and content analysis, which both suggest that childhood distress is related to problem gambling among women. Next, we found that female students also usually earned lower marks in school, and were more likely to be francophones or unilingual. Despite the overarching similarities characterizing these variables, we did not find any significant relationship between age, grade level or employment status and the SOGS levels. This lack of relationship between age or employment status and problem gambling is inconsistent with the findings we presented in our literature review.

Our study also revealed that the female problem gamblers within this sample tended to have negative school experiences, and viewed their schools pessimistically as a result. First of all, these women were less likely to feel safe when they were at school, and they also rarely felt close to people at school. They also typically lacked a sense of belonging within their school community, and they seldom reported that they thought their teachers were excellent. Potentially because of these negative feelings they harboured for their schools and the people within them, the majority of these female problem gamblers frequently skipped classes.

In the same way that they experienced unhealthy interactions within their school environments, the female problem gamblers within this sample tended to have poor relationships with their parents. These women were less likely to get along with their parents, and, potentially as a result of having such adverse parental connections, they were also less likely to talk to their parents about their problems, or to inform their parents about their whereabouts.

In terms of their health, these women appeared to be typified by their generally substandard levels of wellbeing, which is consistent with our findings in both the literature review and content analysis. Those women who experienced two or more gambling problems were found to report worse self-perceived physical and mental health, higher levels of psychological distress, lower levels of self-esteem and more depressive symptoms. Correspondingly, these female students were more likely to have contemplated and/or attempted suicide. Further, female problem gamblers tended to exhibit unhealthy substance use behaviours; they consumed higher than average amounts of alcohol, drank more frequently than was usual or healthy, and commonly consumed a harmful level of alcohol. These women also tended to abuse drugs, as many had drug use problems, and/or were dependent on cannabis. Finally, female problem gamblers were differentiated from the other types of women students in our gendered analysis.
because they tended to engage in risk taking activities.

Finally, we examined the gambling behaviours of these women, and found that they tended to participate in a larger variety of gambling games, being more likely to play all games, with the exception of lottery tickets. Another aspect of gambling behaviour was the amount of money these women spent on their gambling activities; female problem gamblers were characterized by a tendency to spend more on their gambling, typically spending over $50.

**Cluster and Regression Analysis: Types of Female Gamblers**

Unfortunately, we were unable to examine the types of female gamblers in the 2009 OSDUHS by grouping them into clusters or performing a regression analysis of those clusters, as we did for the 2005 Ontario Prevalence Survey and the CCHS 2007. Our inability to conduct these analyses was due to there being only 26 female problem gamblers in this sample. For the 2009 OSDUHS, we must therefore rely on the results presented thus far for this dataset to inform our understanding of women gamblers generally and women problem gamblers specifically.

**Summary**

In order to expand on and confirm the results from the 2005 Ontario Prevalence Survey and the 2007 CCHS, we examined both between-gender and within-gender differences in the 2009 OSDUHS.

Consistent with the results from the other two datasets, our examination of the 2009 OSDUHS revealed that male students were more involved in gambling than female students. We also discovered that the male and female students within this sample experienced different health issues; female students had poorer mental health and displayed more symptoms of harmful drinking, while male students consumed more alcohol and engaged in more risk taking. More similarities emerged between the 2009 OSDUHS and the 2005 and 2007 data as we found that the male students within this sample were more likely to be problem gamblers, and that this relationship is (partially) explained by the type of game they played. Overall, our analysis suggests that variations in the problem gamblers from this sample are explained by self-esteem, psychological distress and three types of games played (cards, slots and other gambling). Finally, while we are unable to conclude what factor is most influential in explaining gender differences in problem gambling, we do believe that gambling behaviours play a large role, as they did with the previous two datasets we analyzed.

While we were able to address our first research question using the same format as we had for the other two datasets, our analysis of female gamblers from the 2009 OSDUHS was severely limited. The small sample size of this survey prevented us from being able to conduct any cluster or regression analysis, making us unable to examine this data in the same ways that we had for the 2005 Ontario Prevalence Survey and the 2007 CCHS. As such, we relied on the descriptive statistics for female gamblers to inform our conclusions on the types of female gamblers within this sample. Based on the crosstabs of several variables and the SOGS dichotomy for women gamblers, we were still able to identify demographic variables that may be important in identifying female problem gamblers. Namely, female students who have a gambling problem most often split their time between two households, earned lower marks in
school, and were more likely to be francophone or unilingual.

CONCLUSIONS

Our analyses of these datasets have led us to conclude that we are unable to identify different types of women problem gamblers using survey data, as the sample size for each dataset is too small to conduct cluster analyses. As such, we chose instead to identify types of women gamblers with the hopes of determining the factors that cause women to become problem gamblers.

In the 2005 Ontario Prevalence Survey, we identified factors that explained problem gambling among women using a series of binary logistic regressions for women gamblers. In the CCHS 2007, this was accomplished with binary and multinominal logistic regressions for our three clusters of women gamblers. As we have discussed, the small sample size of the women gamblers in the 2009 OSDUHS rendered us unable to conduct such analyses of this dataset.

Our findings from the 2005 Ontario Prevalence Survey revealed that variations in problem gambling among the women in this sample are explained by percent of income spent on gambling, number of games played, and type of game, where the lottery, scratch tickets and raffle/fundraising tickets are protective. Notably absent from these variables are the direct effects of demographic factors.

In contrast, our analysis of the 2007 CCHS suggested that women problem gamblers were characterized by a number of demographic features. In particular, these women tended to be widowed or divorced, middle aged, and immigrants to Canada. They were also typified by their incomes, typically making between $20,000 and $39,000 a year. Further, the women problem gamblers in this sample tended to gamble on an average 2.17 games. Other distinguishing characteristics included being dissatisfied with their lives, feeling a weak sense of belonging to their community, and feeling extremely stressed by their life and work. These women generally rated their physical and mental health as poor, and correspondingly, they frequently experienced mood and anxiety disorders. The final distinctive demographic feature that these women exhibited was that of their substance use habits; these problem gamblers had not had a drink in the last year. From examining all of these characteristics, we may conclude that demographics play a much larger role in understanding problem gambling among the women in this dataset. Specifically, four of the factors explaining female problem gambling are demographic characteristics, while 9 are psychosocial variables; on the other hand, only one is a gambling behaviour, and this variable does not significantly distinguish the problem gambling cluster from the others.

These contrasting results may be explained by the regression results for between-gender and within-gender differences that we discussed above, as the impact of demographic variations among women may work indirectly through gambling behaviours. This was the case for gender differences in problem gambling, which were explained by the type and number of gambling games played by the respondents in the 2005 and 2007 data respectively. This was also the case for educational differences among women gamblers in the 2005 Ontario Prevalence Survey, as the first model of the binary logistic regression analysis revealed that those who had graduated
from secondary school were more likely to be problem gamblers than those with post-secondary degrees. However, this finding was later explained by the type of gambling game these women played.

Based on the data presented in the 2005 Ontario Prevalence Survey, we believe that in order to provide the most effective treatment for women gamblers of all demographic characteristics, the gambling behaviours of these women need to be addressed. In particular, the percentage of income a woman spends on gambling, the number of games she plays, and the type of game she plays are important gambling behaviours that should be taken into consideration when she receives treatment. However, if a certain woman prefers the lottery, scratch tickets or raffle/fundraiser tickets, this variable may not need to be addressed, since these are protective forms of gambling.

Similarly, the results from the 2007 CCHS suggested that women who exhibit certain psychosocial characteristics may be more likely to become problem gamblers. As a result, particular attention should be paid to women who display these features. Specifically, women who are dissatisfied with their life, feel a weak sense of belonging to their community, feel extremely stressed by their life and work, rate their physical and mental health as poor, experience mood and anxiety disorders, and have not had a drink in the last year are at a high risk for developing a gambling problem, and should therefore be targeted for problem gambling treatment.

The results from the 2009 OSDUHS revealed psychosocial variables that are of particular importance for younger female gamblers. Our descriptive results suggested that warning signs of problem gambling among younger women may include a sense of detachment from school, poor parental relationships, low self-perceived physical and mental health, high levels of psychological distress, low self-esteem, symptoms of depression, and other addictions such as alcoholism, drug use, and/or cannabis dependence. Consequently, young women who display these characteristics should be paid additional attention when receiving treatment, as they are at a higher risk for having become problem gamblers.

Though the datasets we analyzed provided mixed results for the demographic indicators of problem gambling among women, we were still able to identify certain groups of women that should be targeted for problem gambling treatment. In particular, women who are middle aged (35-59), in common-law relationships, widowed or divorced, have secondary or lower education, are unemployed, have incomes below $40,000 or above $80,000, are immigrants to Canada, and/or are of Southeast Asian descent should be targeted for treatment.

The analysis we have conducted here of the most recent, up to date data on gambling in Ontario and Canada adds significantly to the statistical information we gathered in our literature review. By conducting our own rigorous examination of this data, we have been able to confirm and expand upon the findings of previous studies investigating female problem gambling, of which the most relevant were discussed in our literature review. In the following analysis of existing gambling treatment policies, we will be exploring the most effective ways to integrate the findings from the previous three sections of our report into effective, efficient treatment and prevention programs for female problem gamblers.
5) RESULTS OF THE POLICY ANALYSIS

INTRODUCTION

Official gambling policies are typically under the jurisdiction of the province or state, as they are in Canada, Australia, and the United States, but these policies may also be national, as is the case in Britain, Sweden, and New Zealand. Government policies tend to encompass awareness campaigns, hotlines, and funding for counselling services, and are supplemented by local and international organizations, including community health centres, Gamblers’ Anonymous, and internet-based supports. Yet while this may make it seem as though there are a variety of treatment programs available, these programs vary in their ability to reach women problem gamblers, making government-lead or supported gambling policies a concerning issue.

For the most part government policies fail to consider the different ways in which men and women experience gambling and addiction. While evaluations of government policies may be broken down by gender, these policies appear to be developed without any consideration of gender differences. Furthermore, there is a dearth of policies that acknowledge and address the fact that women’s needs vary across age groups, social classes, and/or culture. And while some programs may address issues of culture (New Zealand, for instance, targets Maori and Asian gamblers), these programs rarely consider the different ways that people of each gender within the culture respond to treatment.

The results of our literature review, content analysis, and secondary data analysis suggest that women gamblers differ from men in terms of their experiences of gambling, their motivations, and their demographic traits. We have included the following review of international policies to demonstrate the variety of ways in which the needs of women gamblers are–or are not–currently being met by different policy approaches. Our goal in this section is to identify existing initiatives across policy jurisdictions in comparable political contexts, in order to inform, motivate, and direct policy-makers towards a more effective course of action in Ontario. Ultimately, however, our analysis of international policies has revealed many areas for further study, but few conclusive paths to follow.

METHODOLOGY

Social context inevitably influences the effectiveness of social policy; therefore, the countries we have included in this analysis have some degree of cultural similarity with Canada. By choosing to examine policies from these countries, we feel we have made the international policies studied in this section more relevant to our Canadian context. Initially, we focused on collecting data on the policies of English-speaking Western countries, as well as welfare state Scandinavian countries, owing to the political similarities these countries share with Canada. Selection criteria also included the existence of policies which have been evaluated in terms of their effectiveness for women, or which (more rarely) actually target women gamblers. We searched for policies that fit these criteria in the following manners: internet searches of country names along with “policy” or “treatment,” “gambling,” and “women”; database searches of the same; and searches of “women” and “gambling” on various government websites. The policies of five countries, along with Canada, were eventually selected for inclusion within this review: New Zealand, Sweden, England, Australia, and the United States. States within Australia and the United States were also selected based on the availability of gender-specific data.
The countries selected represent a range of levels of government engagement in gambling policy. The national gambling policy of New Zealand is, as will be discussed, coherent and well-developed; Sweden’s gambling policy is in its early stages of development, but the issue is considered high-priority; and Britain’s national gambling policies are less developed and largely supplemented by non-governmental organizations. Australia provides a model of comprehensive state-based policies, while in the United States, there is less consistency across states. In the event that government services are substantially supplemented by outside organizations, we have also taken into consideration the programs offered by these organizations. Additionally, we have paid close attention to services that aim to meet the diverse needs of certain cultural communities, since, as we discussed in our literature review, these needs may be particularly relevant to women.

Only policies with direct implications for treatment, including treatment programs, help lines, and awareness campaigns, were considered within this policy review. Information was sourced from internal and external evaluations of programs, annual reports, and program websites. Evaluations and reports were found by searching the websites of relevant government departments, which varied by country but generally included ministries of health and social services. Databases were also searched for relevant studies, using as a search term the country or state name, “gambling policy” or “gambling treatment,” and “woman,” “gender,” or “female.”

Overall, we found some recognition that women gamblers constitute a separate group with separate needs. However, there is little agreement about what should be done to meet these female-specific needs. While gender data is tracked in the examples included, the differential outcomes for men and women gamblers are rarely explored in depth by the reporting organizations. For example, a help line may report predominantly male clients, but there is little or no information available about the women gamblers who do—or do not—call. Nonetheless, from gender breakdowns alone, it is evident that certain programs and policies have a greater degree of success in reaching woman gamblers. And yet even though these more successful programs suggest avenues to pursue, it is also clear that an ideal policy model has yet to be identified. We see this lacuna as an opportunity for Ontario to take the lead in developing innovative policy initiatives that aim to meet the needs of female problem gamblers.

Below, we examine the policies of New Zealand, Britain, Sweden, Australia, and the United States before turning to Canada and the existing recommendations that have been made for Ontario’s policies. We also discuss recommendations made for clinicians and the implications of these recommendations for policy-makers.

ANALYSIS OF POLICIES

(a) New Zealand

New Zealand has a coherent and relatively comprehensive national gambling program, in which the Ministry of Health funds and oversees gambling prevention campaigns, telephone hotlines, screening, treatment services, and research. Evaluations of most of these policies include gender data. Each service is offered in both a “general population” format, and through services specifically dedicated to Maori, Pacific Island, and Asian people. The people who actually use these services are only somewhat differentiated by gender; while roughly equal numbers of men and women contact the help lines, around 60% of face-to-face counselling
clients are male (Bellringer et al, 2007). However, success rates were not gendered, as those women who do partake in counselling experience equal rates of success (ibid).

In terms of the targeted services we mentioned, Maori and Pacific people are actually under-represented in treatment, despite having these services specifically dedicated to them. Interestingly, a number of these organizations provided for Maori serve more women than men (Bellringer & Coombes, 2009). On the other hand, 70% of the clients of the Asian hotline are male, which may reflect the cultural norms and stigma regarding women and gambling that we discussed throughout our literature report and autobiographical content analysis (ibid). Unfortunately, gender statistics reflecting the outcomes and success rates are not available for the culturally targeted services. Nonetheless, New Zealand’s coexisting services reflect a strong effort to meet diverse needs, and an acknowledgement that needs do indeed differ amongst different demographics.

(b) Sweden

Like New Zealand, Sweden has designed a national strategy to address and treat problem gambling. In fact, reducing harm from gambling, as well as from tobacco, alcohol, and other drugs, is the final item on Sweden’s eleven-point public health priority list. Sweden is unique in its recognition of gambling as a public health problem, as well as in the emphasis it has placed on this issue. However, Sweden’s gambling policies are much less developed than those of New Zealand. This is probably not unrelated to the fact that Swedish public health policies only began to address gambling in 2003 (Hansen, 2006). As a result of this recent inclusion of gambling into health policies, the key focus is currently on research, with a major longitudinal study in progress. The government also funds a helpline and treatment centres, with evaluations currently under way; these evaluations include gender data (Swedish National Institute of Public Health, 2010).

However, this newly developing policy does not appear to be serving women very effectively; despite comprising 28% of problem gamblers, women represent just 17% of callers to the helpline (Swedish National Institute of Public Health, 2010). In all Nordic countries, including Sweden, more men than women use government treatment services (Hansen, 2006), which at least partially reflects the fact that overall, men are more likely to gamble (Swedish National Institute of Public Health, 2010). In addition to these gendered differences, certain women are more likely to use these services than others; despite there being no age difference in gambling rates (Swedish National Institute of Public Health, 2010), older women are more likely to use gambling treatment services than younger women (Hansen, 2006). This is consistent with findings in other jurisdictions (for instance Boreham et al., 2006). Perhaps the abundance of older women in treatment services can be explained by the later onset and quicker progression of problem gambling among female gamblers, as we discussed in our literature review.

Unlike the culturally targeted treatment services offered in New Zealand, Swedish policies do not seem to take into account the different treatment needs that people of different ethnicities and cultures may have. In spite of the noted high prevalence rates of problem gambling in immigrant communities, there are no specialized programs serving these groups (Hansen, 2006). Furthermore, therapists report that immigrants from non-Western communities are more likely to drop out of treatment programs (ibid). These statistics indicate a strong need for treatment services targeted at immigrants, which Swedish gambling policies appear to ignore.
However, we must bear in mind that these policies are relatively new; it remains to be seen whether women and diverse groups will be taken into account as Sweden’s gambling policy develops.

(c) Britain

Britain’s National Health Service has also only recently begun to develop a problem gambling policy. A pilot clinic called the Central North West London Problem Gambling Clinic has been created in London with the goal of establishing efficient, successful practices. The clinic currently offers group, individual, and family counselling. A consultation study found that practitioners felt that the clinic is limited in its impact due to geographic barriers to access and limited knowledge of how best to support diverse groups (Gambling Commission, 2008). Service providers specifically expressed a need for more research and funding directed towards serving women gamblers (ibid).

Despite the creation of this clinic, most gambling programming in the United Kingdom is not government-implemented. GamCare, an organization funded primarily by voluntary industry donations, provides a telephone and online helpline, and face-to-face counselling services, while also conducting research. Women make up 39% of GamCare’s online clients, 28% of helpline callers, and just 9% of face-to-face counselling clients (Kalsy, 2009). Since women represent approximately one-sixth of Britain’s problem gamblers (ibid), they are over-represented among online and helpline clients, but under-represented in traditional treatment. This is consistent with our discussion throughout both the literature review and autobiographical content analysis regarding women’s preference for anonymity when they seek treatment; the fear most women have of being stigmatized for their gambling likely leads them to seek help online or through the telephone, as these forms of treatment allow them to keep their identity private, and consequently avoid the feeling of being judged. Interestingly, GamCare directly targets women by offering woman-only groups, which were established in response to demand in 2005 (Kalsy, 2009). Desire for this kind of treatment was expressed in one of the narratives we examined in the autobiographical content analysis: Donna revealed that she did not feel as though she could relate to the experiences of the male gamblers who dominated her GA group, and as a result, she did not find the program helpful. Because many women problem gamblers likely share Donna’s sentiments, these woman-only groups offered by GamCare should be highly effective. However, almost half of the participants in these groups are single mothers, and more than two-thirds are unemployed (ibid), suggesting that this initiative is generally only successful in reaching out to a select group of marginalized women. As a result, the impact of these woman-only groups is limited in that only certain types of women are likely to find this form of treatment helpful. Further, only three women-only groups exist at present; since space is limited within these programs, and since these groups are in such high demand, they have become available only to a relatively small number of geographically concentrated women. Ultimately, this high-demand, limited space scenario has barred access to these women-only groups for some female gamblers who may have benefitted from them immensely (ibid).

As with Swedish gambling policies, the novelty of these British initiatives means that with time, services may be implemented that more effectively address the various needs of different groups of female gamblers. Currently, however, availability and access remain problematic.
(d) Australia

Australia’s gambling policy is relatively comprehensive, and combines both national- and state-level initiatives. The national government, via the Select Council on Gambling Reform, oversees a helpline and website as well as a research program, while state governments carry out awareness campaigns and fund counselling and treatment programs. Adopted in 2008, the Public Health Association of Australia’s Gambling and Health policy describes a framework for collaboration between the state and the national government and recommends that each state takes a public health approach to problem gambling (Public Health Association of Australia, 2008). While Australia does not have gender-specific policies, various states do offer programs targeted towards diverse cultural communities.

Despite these good intentions, needs assessments generally reveal that state treatment programs do not meet the needs of diverse cultural communities. An assessment of services in Canberra, for example, found that members of cultural or linguistic minority groups are more likely to seek help from family or friends, rather than turning to professional services (McMillen, et al, 2006). Culture also mediates the effect of gender, as was seen with Aboriginal Australian women who were frequently unwilling to meet with male counsellors (ibid). Indeed, women from minority communities often expressed a desire for services that were women-only and culturally-specific (ibid). McMillen, Marshall, et al’s report recommended the implementation of these services, but these recommendations have yet to be incorporated into Australia’s gambling policy.

New South Wales attempts to address cultural issues by offering a Multicultural Gambling Service, which provides culturally-specific, multilingual support and media campaigns, and matches clients with counsellors on the basis of language, cultural community, and, when possible and appropriate, gender (Cultural and Indigenous Research Centre Australia, 2008). However, evaluations have found this approach to be problematic, particularly because clients may be unwilling to meet with counsellors from their own cultural community out of fear of losing their anonymity (ibid). Again, this finding becomes significant when framed within our previous discussions of the stigmatization that women in particular face as a result of gambling problems, and the consequent desire they have to remain anonymous when they seek treatment. These fears of being judged were likely heightened for those individuals belonging to minority groups, as certain cultures potentially disapprove of gambling more than others.

The same report that suggested this issue with anonymity also found that cultural differences in family dynamics could influence the effectiveness and appropriateness of certain forms of therapy (Cultural and Indigenous Research Centre Australia, 2008). Involving the entire family in counselling can, in some cases, make treatment more successful, but it may also present an obstacle in cultures where gamblers are likely to feel that they have failed to fulfill their prescribed family roles (ibid). This issue corresponds to the results of our literature review and autobiographical content analysis, both of which touch upon the significance of loss of role or identity when treating female gamblers.

Thus while New South Wales’ policy attempted to address the specific treatment needs of minority groups, modifications need to be made to certain services, taking into account the anonymity that these individuals want to maintain, as well as their conceptions of familial roles and duties.
The Queensland Government strongly emphasizes public awareness campaigns. One campaign it supported involved posters and cards displayed in gambling establishments near ATMs and gambling machines, as well as in washrooms. This has been evaluated as having a greater impact on female gamblers than male: while 38% of surveyed men and just 20% of surveyed women reported having set time limits on their gambling prior to the campaign, 45% set limits after the campaign (Queensland Government Office of Liquor and Gaming Regulations, 2010). The government also attempted to create a curriculum to teach responsible gambling in schools, but this effort was less successful (ibid). Meanwhile, plans for campaigns targeting Aboriginal and other cultural groups are underway (ibid).

We also tracked age data concerning problem gambling service users in Queensland, and found that there are disparities in the ages of women accessing services. There is evidence of success in reaching older female gamblers, as 60% of clients above the age of 60 are female (Boreham et al, 2006). However, just 18% of service users aged 18-34 are female (Queensland Government Office of Liquor and Gaming Regulations, 2010). Recommendations have been made to create youth-focused awareness campaigns to address this, and a study of young adults’ gambling is also in progress (ibid).

The Australian province of Victoria has been notably successful in reaching female gamblers. In 2000, Crisp et al conducted a study that examined gender differences in the outcomes of the province’s gambling service, which was then known as BreakEven, but is currently called Gambler’s Help. Nearly half of the service’s clients are women, suggesting that female gamblers have been made aware of the program, and that access to treatment within the program is readily available (Crisp et al, 2000). Within this program, women’s cases are less likely than men’s to be formally closed; that is, the client and therapist are less likely to mutually agree to end therapy. However, the female cases that are closed are more likely to be deemed a success (ibid).

In their study, Crisp et al identify several characteristics of BreakEven/Gambler’s Help that are woman-friendly. First, their gambling services are housed in pre-existing community agencies, and since many women may already have a relationship with these agencies, the barriers discouraging them from accessing these services are reduced (Crisp et al, 2000). In addition, the program offers a range of services in order to meet a range of needs, making it attractive to a more varied population of women (ibid). This varied approach was evidently successful, as men and women tend to access different services within the program: while male clients often received cognitive treatments, legal aid, and assessments, female clients were more likely to opt for family counselling or supportive therapy (ibid). The success of the BreakEven/Gambler’s Help model demonstrates that diverse treatment options are needed to meet diverse treatment needs.

(e) United States

Like Australia, problem gambling programs in the United States are provided on a state-by-state basis. However, the US’s approach differs from the Australian model in that there is no national strategy or overseeing body. As a result, there is a great deal of variation in the extent, funding structure, and nature of these programs. The following analyses focus on states which track gender data.
The Connecticut Council on Problem Gambling, for instance, manages a helpline and runs awareness campaigns, but does not provide counselling or treatment services. Forty-four percent of helpline callers are female, and since these clients are more likely than male clients to be low-income (CCPG, 2008), the Council’s 2008 report calls for awareness campaigns targeting low-income women and families (ibid). These campaigns have not, however, been carried out.

Similarly, the Massachusetts Council on Compulsive Gambling also offers a helpline and awareness campaigns, but its strong focus on advocacy distinguishes it from the Connecticut Council on Problem Gambling. A statement of policy recommendations, released in 2009, calls for more state funding to enable a wider range of treatment options, including inpatient, correctional facility based, youth-specific, and multilingual programs. In 2004, the Council published treatment guidelines in which there is a section on “Special Populations;” this part of the document recommends female-only settings, and urges clinicians to remain aware of the greater likelihood of trauma in female patients (Korn & Shaffer, 2004). This section also notes the importance of cultural sensitivity and suggests using interpreters to address cultural as well as linguistic barriers (ibid).

The Massachusetts Council on Compulsive Gambling is also notable for its efforts to raise awareness of problem gambling in diverse populations. Through a program called Congregation Assistance Program, the Council works with churches to establish early intervention and prevention strategies (MCCG). The Congregation Assistance Program has been adapted specifically for working with Latino and African American congregations (ibid). The Council has also made efforts to address different age groups; to reach older adults, the Council has created a peer mentorship initiative, while youth are targeted with school-based presentations (ibid). Finally, the Council also offers a helpline and website targeting the Asian community (ibid). Unfortunately, evaluations of these programs are not available, rendering us incapable of judging how successful they actually are.

Oregon offers one of the more comprehensive state programs. Funded by the Department of Human Services, programs include outpatient, inpatient, home-based, and prison-based counselling services. Notably, women more frequently enrol in family or residential programs, and are more likely than men to successfully complete these programs (ibid). More women than men are also enrolled in a program called GEAR (Gambling Evaluation and Reduction), which offers telephone counselling in an attempt to reduce barriers to access imposed by geography, disability, or other transportation needs (ibid). Gender-specific outcome data were not available for the GEAR program, so, again, we could not assess how men and women responded differently to its services.

Oregon’s policy seems to attempt to address gendered differences in gambling behaviour, as gambling programs are offered in two different correctional facilities: one serving men and the other, women. This program aims to change attitudes towards gambling amongst incarcerated problem gamblers (Moore, 2008). The program in the women’s correctional facility has achieved a more positive response than its newer and less established counterpart (ibid).

Despite this attempt to specifically address female gambler’s needs, not all women seem to be finding Oregon’s framework useful: women enrolled in programs in Oregon are older on average than male clients are, and are also less likely to be Asian or Hispanic (Moore, 2008). Furthermore, female clients were less likely than males to be married, and more likely to be
divorced (ibid). These programs are therefore more appealing to women with certain demographic characteristics. However, women represent half of service users, and experience treatment outcomes equal to male clients (Moore, 2008), suggesting that those women who participate in these programs do find them helpful. As with BreakEven/Gambler’s Help in the Australian province of Victoria, these positive outcomes for women may be attributable to the wide variety of treatment options that Oregon’s programs offer.

(f) Canada

Like the United States, Canada lacks a national strategy on gambling. Instead, establishing a gambling policy is a task that has been left to the provinces.

Alberta offers a helpline, outpatient therapy, and awareness campaigns through the Alberta Alcohol and Drug Abuse Commission (James, 2003). The AADAC offers women’s mental health programming through its Enhanced Services for Women initiative, but this initiative appears to be limited to alcohol and substance abuse despite the inclusion of gambling in the AADAC’s mandate (James, 2003).

A policy recommendation report addressing problem gambling in Alberta highlighted the need to include greater outreach to seniors and cultural minority groups (James, 2003). As well, the report notes that Aboriginal people living on reserves may have difficulty accessing services. This is due to geographic barriers preventing access to mainstream services, compounded by the fact that federal health services for Aboriginal people, administered by the First Nations and Inuit Health Branch, do not address problem gambling (ibid). It seems likely that this has implications for First Nations people in all provinces.

Nova Scotia offers counselling and a helpline as part of its gambling policy. A report of recommendations focused on the need for interventions and campaigns targeting youth and older adults (Roberts et al, 2008). The report also suggested the need to train family physicians in order to provide one-time counselling on problem gambling (ibid), which may help to reach problem gamblers who are reluctant to seek treatment. The report also notes the higher prevalence rates of gambling among young males, and accordingly suggests increasing programming in order to reach this demographic (ibid). Unfortunately, data is not available on whether women access services at a rate proportional to their gambling prevalence.

In Ontario, gambling policies fall under the purview of the Ministry of Health and Long-Term Care, as well as the Ministry of Economic Development and Trade (Sadinsky, 2005). Treatment is administered by 47 funded agencies, nine of which provide specialized services for different populations, including women, seniors, and various cultural groups (ibid). A 24-hour telephone helpline is also available. Finally, awareness campaigns are managed by the Responsible Gambling Council Ontario, an industry group (ibid).

In terms of Ontario’s gendered approach, services specially designed for women are provided by two agencies in the province: Amythest Women’s Addiction Centre in Ottawa, and the Centre for Addiction and Mental Health (CAMH) in Toronto. CAMH describes the format of its women’s groups as combining cognitive-behavioural therapy with skills training (Centre for Addiction and Mental Health, no date cited). The Centre also states that emotional empowerment is a key issue to address within the groups (ibid).
Boughton and Brewster’s needs assessment for the Ministry of Health and Long-Term Care (2000) revealed that women desire a variety of different types of treatment. Focusing on women problem gamblers, they surveyed a sample of 365 women gamblers who were not currently in treatment. Fifty-five percent of these women thought female-only group counselling would be helpful, while 33% thought mixed-gender groups would be (Boughton & Brewster, 2000). This finding seems consistent with the feelings Donna expressed in our autobiographical content analysis; in a group dominated by men, she (and likely other women) could not relate to the experiences and needs of her other group members, and in turn, felt that other group members did not understand her problems and needs. Yet a significant number of respondents (33%) still believed mixed-gender groups would be useful, which could potentially reflect the needs of a different age or cultural group. Within the same sample, 67% of women expressed support for the hotline, and 64% believed individual counselling would be valuable (ibid).

This survey also revealed that aboriginal and younger women were more likely to support family programming, and that younger women were more likely to endorse Internet counselling (ibid). In terms of access issues, 68% wanted weekend hours and 64% wanted evenings; 41% of mothers felt childcare services would be helpful (ibid). Validating CAMH’s group focus on empowerment, two thirds of women wanted treatment to enable “personal enrichment” through improved self-esteem and stress management training (ibid). Around half wanted to address issues of conflict management and healthy relationships (ibid). Finally, the report also indicated a need for an expansion of awareness campaigns (ibid).

There is no evidence that the needs of female gamblers that Boughton and Brewster identified have been addressed. Five years after their assessment was conducted, a review of Ontario’s gambling strategy called for further research into diverse populations including women, and for increased funding to expand treatment options for these populations (Sadinsky, 2005). The report found that treatment services are significantly under-utilized, and suggests increasing outreach activities, especially to diverse populations (ibid). Ironically, Sadinsky’s report advises a needs assessment for groups including women, evidently in ignorance of Boughton and Brewster’s work (2005).

**Treatment types**

Women problem gamblers do not necessarily benefit from the same types of treatment as male gambling addicts. Therefore, in order to develop the best, most efficient and successful practices, treatment programs and policies must be gender-specific. It is imperative that policy makers are aware of the different ways people of either gender respond to treatment, so that programs may be implemented and funded which meet the needs of women gamblers as well as their male counterparts. We have outlined several types of treatment below, in addition to exploring the implications these treatment types have for woman gamblers.

(a) Cognitive-behavioural therapy

Cognitive-behavioural therapy is widely considered to be one of the most effective methods for treating problem gamblers (Dowling et al, 2006). However, this evaluation may be more relevant to men; a study carried out at CAMH’s Problem Gambling Service found that women who receive cognitive-behavioural therapy are less likely than men to experience positive outcomes (Tonneatto & Jing Wang, 2009). Just 17.6% of men continued to meet
diagnostic criteria for problem gambling following cognitive-behavioural treatment, while 58.3% of women still met these criteria (ibid). Further, the study revealed that many women continued to rely on gambling as a coping mechanism after they had received cognitive-behavioural treatment, using their game of choice in their attempts to handle emotional challenges. This suggests that counsellors working with women need to address their patients’ coping skills, and try to implement healthier, more productive strategies in order to make this kind of treatment more effective for women.

Tonneatto and Jing Wang’s study also revealed that women do not find gambling-specific elements of treatment, such as discussing distorted beliefs, to be very helpful (2009). This finding is supported by one of the narratives we analyzed in our autobiographical content analysis, in which Janet felt even more compelled to gamble after hearing a fellow group member describe his former gambling activities. Rather than discouraging her from gambling, as was the intention, this kind of treatment appears to have worsened Janet’s addiction, if only momentarily. Thus while cognitive-behavioural therapy may be one of the most effective practices for men, several aspects of this form of treatment do not appear to work very well for women.

However, in contrast to these findings, an earlier Australian study found that only 11% of women who received cognitive-behavioural therapy continued to meet diagnostic criteria for problem gambling (Dowling et al, 2006). It is worth noting though, that the treatment employed in Dowling et al’s study had a slightly different emphasis from that described in Tonneatto and Jing Wang’s; Tonneatto and Jing Wang state that CAMH’s treatment approach focused on triggers for gambling behaviour, while in Dowling’s study, therapy included sessions devoted solely to communication skills, problem solving, alternative leisure, and general (non-gambling-related) cognitive correction. This model therefore seems to fix the elements of CAMH’s approach that were not serving women well, which explains (to some extent) the discrepancy in female success rates for each treatment program.

While the validity of these studies is limited by small sample sizes (16 women in Tonneatto and Jing Wang’s study, and 19 in Dowling et al’s), it seems evident that female gamblers benefit from therapy that considers their emotional needs. Particularly, the various stressors that we discussed throughout our literature review and autobiographical content analysis should be recognized as having a significant effect on women’s emotional state. Consequently, such factors as employment stressors, financial difficulties, strained relationships, and the other problems we discussed in our literature review and content analysis should be taken into consideration when treating female problem gamblers. Further, the strategies that women use to cope with these stresses, and the generally poor affective conditions these stresses contribute to, need to be addressed. Overall, clinicians working with female gamblers should be aware that women might not respond in the same way as men to cognitive-behavioural therapy. Specifically, policy makers should consider the need for gender-specific practices in cognitive-behavioural therapy, so that the training, funding, and resources required for such practices can be established.

(b) Group therapy

As we mentioned in our discussion of Boughton and Brewster’s needs assessment, mixed-gender groups are recognized as being less effective for women than for men (Piquette-
Tomei et al, 2008). In our autobiographical content analysis, we examined the experiences that certain women had in mixed-gender groups within Gambler’s Anonymous (GA). One female gambler, Donna, did not find this kind of treatment helpful, and she claimed that the inability of male group members to relate to her problems was what made the program unsuccessful for her. The majority of GA members are male, validating Donna’s feelings of isolation from other members of her group. But in addition to making them feel alienated, these meetings may also be less effective for women because they are potentially organized around the needs of male problem gamblers (Ferentzy & Skinner, 2003). For instance, women tend to prefer opportunities to discuss emotional and health issues relating to their gambling, while men usually want to focus on legal and financial issues (ibid). In addition, women may feel less comfortable sharing personal information in mixed-gender settings (Piquette-Tomei et al, 2008). For these reasons, women like Donna might not find GA very helpful because they do not feel like they can adequately address their personal problems within their mixed-gender group sessions.

Because of these factors that make mixed-gender group therapy ineffective for many women, many female gamblers express a desire for single-gender groups. Another study by Boughton and Brewster (their 2002 “Voices of Women” study) revealed similar findings to their earlier needs assessment, with 59% of women suggesting that single-gender group therapy would be helpful for them. This was nearly double the 33% who believed that mixed-gender groups would be effective.

However, findings suggest that even women-only group therapy may not be as beneficial as individual counselling. 60% of women enrolled in a female-only treatment group in Australia no longer met diagnostic criteria for problem gambling after a six-month follow-up period, but the same was true for 92% of those who received individual treatment (Dowling et al, 2007).

Nonetheless, women-only groups can provide a space for empowerment and acceptance (Piquette-Tomei et al, 2008). Women involved in Piquette-Tomei et al’s qualitative study describe the emotional safety and trust that a single-gender environment creates. Furthermore, participants called attention specifically to the benefits of a group format, pointing out the reassuring aspect of meeting others who were in similar situations to their own.

At the policy level, single-gender groups may be an important area of further study. As with gender-sensitive cognitive behavioural therapy, the implementation of single-gender groups may require additional resources which can be made available through policies including those relating to funding.

(c) Online therapy

Online support, unlike traditional face-to-face services, attracts more female than male clients (Wood & Wood, 2009). Most gamblers using online supports also access other services: Wood and Wood found 30% of members of two UK gambling forums had been members of support groups in the past, 27% had contacted a helpline, and 17% had received individual counselling, with a total of 58% of members having sought help elsewhere (2009). Still, the forums provided an opportunity for catharsis and a sense of community (ibid). For the remaining 42% who were not receiving additional services, online support served as an especially important resource. As we have mentioned throughout our report so far, gamblers turning to Internet forums avoid the social stigma of seeking face-to-face treatment. Because female compulsive
gamblers are typically judged more frequently and more harshly than men for their gambling problems, this desire to remain anonymous can explain why more females than males seek help online. Internet forums also allow people to bypass geographical barriers that might otherwise have prevented them from accessing treatment. Further, they allow treatment seekers to avoid the financial costs of transportation and childcare (ibid). These issues may be especially pertinent to women, further explaining the gendered use of online services.

While Wood and Wood examined two fairly unstructured forums, the Internet can also be used to recreate more traditional clinical settings. GamCare in the United Kingdom, for example, offers weekly web-based counselling, with the option of using a webcam to establish a “face-to-face” relationship (Kalsy, 2010). Consistently with Wood and Wood’s results, GamCare’s online service has a much higher proportion of female clients than the organization’s in-person counselling service. It is especially popular with younger gamblers, mothers, and people living in geographically isolated areas (ibid), which reinforces the statements we made above, suggesting that an online format alleviates barriers often experienced by these groups, including those related to transportation and childcare.

Women using GamCare’s online service tend to require more hours of counselling than their male peers, often due to their need to work through trauma (Kalsy, 2009). Some women may be more comfortable discussing trauma online than they would be in the intimate setting of face-to-face therapy (ibid). Despite the greater prevalence of trauma among female clients, the proportion of men and women who successfully complete online treatment is roughly equal at around 50% (ibid).

The establishment of a Canadian or Ontario-based online treatment service could prove beneficial to women gamblers. Collaboration between treatment organizations and governments would bolster efforts to create such a service, and allow it to reach more of the women who need it.

**Diverse groups and diverse needs**

Women are not a homogenous group, and neither are women gamblers. There is currently a paucity of both policy and research addressing and examining the different needs of different groups of women gamblers. Ontario presently funds gambling services for a small set of “special populations,” which include women, as well as ethnocultural communities, older people, and youth (Sadinsky, 2002). However, gender differences within these latter groups are not necessarily recognized, as evidenced by the lack of gendered programs for people from different cultural communities. Moreover, little is known about diversity outside of these communities.

Diverse needs must be taken into account to maximize the effectiveness of gambling policies and treatment programs. The following subsection addresses different groups of women whose needs may not be met within currently existing service models. As well, this subsection highlights areas in which further research is needed in order to inform effective policy design.

(a) **Diverse cultural communities**

Different cultures endorse different norms surrounding gambling and the participation of women in gambling activities. Despite the greater stigma for gambling that women of many cultures face, women actually have higher rates of problem gambling than men in some
communities within Ontario, such as the Iranian community (Ontario Resource Group on Gambling, Ethnicity and Culture, 2010). What makes these high rates even more problematic is the fact that women gamblers may be subject to greater stigma in some of these cultures because of their failure to fulfill traditional roles (ibid). Further problematizing the issue is the lack of gendered treatment for these minorities; while there are currently several culturally-specific gambling treatment services in Ontario, these programs do not appear to have programming directed at women.

Women from diverse communities may face additional barriers preventing them from accessing problem gambling treatment. The stigma that certain cultures place on women who gamble contributes to women keeping their gambling a secret (ibid). In sharp contrast, the men within these cultures are not usually faced with the same problem. Another factor that might limit women’s access to treatment is the traditional gender roles that some cultures maintain; these roles may also give decision-making power solely to the men within a family (ibid), meaning that the choice of whether or not to seek treatment may be completely out of a woman’s hands. Further, these gender norms influence the type of treatment that women of particular cultures may deem appropriate, as they may be uncomfortable meeting with a male counsellor, or taking part in a mixed-gender therapy group (Cultural and Indigenous Research Centre Australia, 2008).

Members of varying cultural communities may seek help for problem gambling from religious leaders, cultural organizations, and friends or family before turning to mainstream mental health services (Ontario Resource Group on Gambling, Ethnicity and Culture, 2010). Depending on the community, this tendency may be more prevalent among women: a study found that while South Asian males in Toronto and Windsor would primarily seek mainstream treatment, women would prefer to seek help within their own community (Wynne et al, 2004a). However, this pattern does not hold across all cultures; in the Somali community, while both men and women prefer to seek guidance from their mosque, women also mentioned community health centres as a place to turn for help with their problem gambling (ibid).

In order to help address some of the issues faced by members of different cultural communities, Wynne et al (2004) produced a series of reports on gambling in ethnocultural communities in Toronto and Windsor-Essex. The reports conclude with a series of “action plans” for various communities. For example, within the South Asian community, the study found a need for an awareness campaign targeting women. However, this campaign would be aimed at the spouses of problem gamblers, rather than female gamblers themselves (Wynne et al, 2004b). None of the other communities involved, including Afghan, Filipino, Greek, Indo-Caribbean, Iraqi, Jewish, and Somali groups, had gender-specific plans. This in large part reflects the fact that these communities did not include single-gender focus groups in their research process, where such concerns and suggestions would likely be raised. As such, the voices of gambling women from different cultural communities are largely absent from the literature, making it difficult to assess their needs.

(b) Older women

Gambling prevalence rates among older women are increasing (McKay, 2005), while problem gambling rates among this age group are likely to increase as well. However, while gambling in general, and gambling by women in particular, is becoming increasingly accepted in
society, older women grew up in a time when such behaviour was frowned upon (McKay, 2005). As a result, older women with gambling problems are likely to feel intense shame, which may prevent them from seeking the treatment they need in order to overcome their addictions (ibid).

Despite this hypothesis, there is evidence showing that older women are more likely than older men to seek treatment (Boreham et al., 2006). For instance, studies in Australia have suggested that as many as 67% of gambling service clients over the age of 60 are women. However, those who do enter treatment may not feel that their needs are met. Many of the options that therapists traditionally suggest to reduce gambling, including self-exclusion or limiting access to money, may be perceived as an affront to an older woman’s already diminished sense of independence (McKay, 2005). Further, abstinence may be an unrealistic treatment goal for older women, as many tend to rely on gambling for social interaction (ibid). Another factor making strict moderation difficult for women in this age group is their use of gambling as a coping mechanism; as we have discussed in other parts of this report, women in general are more likely to gamble for emotional escape rather than financial gain (Boreham et al, 2006). But this use of gambling as a coping strategy is exacerbated by the isolation that all too often accompanies old age.

In terms of making treatment more effective for older women, a study of older gamblers in Queensland found that half would prefer to receive treatment in their home (33%) or by telephone (20%) instead of travelling to a service agency (Boreham et al., 2006). These types of services should therefore be provided in order to adequately address gambling problems among older women. Specific policy recommendations made in the report include implementing targeted gambling prevention campaigns and interventions that focus on building social networks and alternative leisure (ibid). These would be particularly helpful, considering our discussion above regarding the tendency of older women to use gambling as a social activity. The report was less successful in offering a gendered approach to treatment; despite noting gender differences in gambling motivations and style, it does not make gender-specific treatment recommendations. Further research is therefore needed in order to understand how older women problem gamblers respond to treatment, so that the adequacy of existing programs may be assessed.

(c) Youth

Youth-focused gambling campaigns often revolve around websites, like Ontario’s youthbet.net or New Zealand’s www.inyaface.co.nz. Ontario’s problem gambling services also include youth-specific treatment programs at St. Joseph’s Health Centre in Thunder Bay, Lake of the Woods Addiction Services in Kenora, and Options for Change in Kingston (Sadinsky, 2002).

For women, but not for men, prevalence rates of gambling increase with age (Welte et al., 2011). Perhaps because young women are less likely than young men to gamble (ibid), youth-focused programs do not tend to exhibit a gendered approach to treatment, or emphasize the needs of young women as being different from those of young men. There is evidence, though, that different needs may exist: in their study of teenage gamblers in Ontario and Quebec, Ellenbogen et al. (2007) found that young women were more likely to experience social and academic problems as a result of gambling, and, much like adult women, these younger females tended to use gambling as an emotional escape. These findings suggest that young women gamblers may benefit more from interventions focusing on emotional coping and social skills.
Another important distinction between male and female youth gamblers is that young males are more likely than their female counterparts to identify themselves as having a problem (Ellenbogen et al., 2007). This means that young women are likely under-represented in problem gambling treatment, and could consequently benefit from gender-specific awareness messages.

(d) Aboriginal women

In New Zealand, Maori women are six times more likely than non-Maori women to gamble (Morrison, 2004). This finding can be explained by the financial problems that many of these women face; the potential to win a life-changing amount of money has an enormous appeal to Maori women, who are likely to be impoverished and to feel powerless within society (ibid). Another factor motivating these women to gamble is that the activity provides an opportunity for companionship and social interaction, which is important because Maori women frequently experience social isolation (ibid). Accordingly, Morison calls for treatment options that consider these social and emotional needs.

Canadian Aboriginal women experience conditions similar to those faced by Maori women. Like Maori women, Aboriginal women in Canada often live in poverty, and in the wake of the disempowering legacy of colonialism. Aboriginal women see gambling as a chance for recreation and socializing (Oakes et al, 2004), in much the same manner as Maori women. Aboriginal women also differ from the general population in that they are as likely, or more likely than men to gamble (Wyne et al, 2005). There is a need for more research to be done in order to understand why this disparity exists, and to learn what must be done to address it.

Oakes et al (2004) conducted a study of Aboriginal communities located close to gambling facilities, finding that respondents from within this sample often emphasized the importance of traditional activities, including games of chance that do not involve money, as an alternative to gambling. Respondents also mentioned a return to traditional roles as an issue of particular importance to women, who would customarily be responsible for harmony within the community (ibid). Further, this study found that members of Aboriginal communities tend to want local, culturally-specific gambling treatment services, and this finding was supported by a study by Wynne et al (Oakes et al, 2004; Wynne et al, 2005). However, apparently without regard for these findings, Aboriginal gambling services are funded by neither the Ontario Ministry of Health and Long Term Care (Sadinsky, 2002), nor the federal First Nations and Inuit Health Branch (James, 2003).

Thus the needs of Aboriginal women gamblers have neither been studied in adequate detail, nor have they been satisfactorily addressed by policy. Ontario therefore has the chance to take the lead in implementing treatment programs that consider the needs and desires of Aboriginal female problem gamblers.

(e) Other groups

Many groups are virtually absent from the literature. For example, more research is needed to understand how women with disabilities or women with low-incomes are affected by problem gambling, and how they respond to certain types of treatment.

Research suggests that people with disabilities may be more likely to gamble: an American study found that people receiving disability support payments were much more likely
to be problem or pathological gamblers, as 26% of participants receiving disability support met criteria for disordered gambling (Morasco & Petry, 2005). While this finding has significant treatment implications, Morasco’s paper does not include gender information, and therefore does not address how the gambling behaviour of disabled men and women may differ. This lack of research is maintained outside of this paper, as the issue of problem gambling among women with disabilities has not been investigated.

Income level is also under-researched and poorly understood as a problem-gambling risk factor. Despite evidence that lower incomes play a role in problem gambling risk (for instance CCPG, 2008) the particular treatment needs of low-income problem gamblers are rarely addressed. Income level is especially pertinent to women, who in Canada and elsewhere earn less than men (Boughton & Brewster, 2002). As a result, women are at a higher risk of developing problem gambling behaviour, meaning that treatment and prevention strategies targeting female gamblers need to be informed by a more thorough investigation of income levels.

Along these lines, the Connecticut Council on Problem Gambling uniquely identified low-income women as a target population for future awareness campaigns, as we previously mentioned (ibid). However, despite these campaigns, gambling policies rarely attend to this group.

Finally research must also be conducted to determine if income or socioeconomic status plays a role in women’s help-seeking behaviour and treatment preferences. The literature suggests that these women are at a greater risk for becoming problem gamblers, but effective treatment and prevention strategies for these groups remain to be investigated.

While low income and disabled women may be disproportionately affected by problem gambling, they are largely ignored by policy. As we discussed in our secondary data analysis, there are a variety of other demographic variables that may be relevant to women’s problem gambling risk, such as marital status, level of education or immigrant status. What is clear is that much work remains to be done in order to better understand what policies and programs are required to address the needs of these specific types of women gamblers, as well as to determine the best ways in which to implement these services.

CONCLUSION

Our systematic and detailed search for national and international policies and programs specifically targeting women problem gamblers resulted in the revelation that there is precious little policy activity on this issue. We found some recognition that women gamblers constitute a separate group from male gambling addicts, with correspondingly distinct needs. However there is no general agreement about what should be done to address these female specific needs. That said, our findings in this and other sections of our report indicate that women problem gamblers are a heterogenous group with diverse challenges and needs. We therefore recommend an action plan that follows up on these findings in an effort to clarify and expand upon them, through consultation with other researchers, therapists, women's organizations, and diverse cultural community organizations willing to consider a gender dimension and diversity. Such follow-up would aim to confirm and elaborate on our findings, but also to help devise policies and practices
that are functional within the Ontario context, given the province’s population mix, available resources, and gambling industry.

To conclude, we have outlined below a brief summary of our findings from this section, as well as a suggested plan of action. Our analysis of the various gambling policies that have been implemented in various countries around the world has led us to conclude that certain forms of treatment need to be made available to women in order to effectively address female problem gambling. First, treatment for problem gambling should be offered in the form of women-only groups, in order to satisfy requests from women who feel that they would benefit more from these single gender groups. Research finds that the women who are most likely to participate in such groups are often divorced, unemployed, and/or single mothers, all of which are important risk factors for problem gambling. Finally, these women-only groups should be located in pre-existing community agencies, as women report that their pre-existing relationships with these agencies make access easier for them.

According to our analysis, treatment in these groups should involve family counselling, supportive therapy, trauma therapy, and cognitive-behavioural therapy. Also, because of the tendency of female problem gamblers to use gambling as a coping mechanism, treatment should involve skills training, emotional empowerment, personal enrichment, stress management, conflict management, and the teaching of healthier coping skills.

These women-only groups should also be tailored to the culture-specific needs of women from minority communities. Some of the counsellors in such groups should be taken from outside of the community to satisfy the desires of women seeking to preserve their anonymity and protect their identity within their respective communities. For Aboriginal women, treatment should be local, culturally specific, and should involve family programming.

In addition to these kinds of support groups, individual counselling should also be made available, as many women have expressed a desire for this kind of treatment. Also, as we have seen throughout this report, help lines and online support are particularly attractive to women, and should therefore be used to their full advantage. Such forums allow women to avoid the social stigma, geographical barriers and financial costs associated with seeking treatment. They also allow mothers of young children the opportunity to better manage their time and child care needs, since seeking help would not require them to leave their homes or work around fixed meeting schedules.

Finally, treatment for female problem gamblers must be made more age specific. Older women should be targeted using a peer mentorship initiative, in-home treatment and help lines. Such treatment should focus on building social networks and alternative leisure, considering the tendency of older female gamblers to use gambling as a social activity. Young women should be targeted with school-based programs, family programming and Internet counselling, and their treatment should focus on emotional coping and social skills. Lastly, physicians should be trained to offer one-time counselling on problem gambling in order to address the needs of problem gamblers who would not otherwise seek treatment.

The systematic search we conducted for national and international policy initiatives
clearly shows that there is no ideal, “ready-to-go” plan of action supported by evidence of successful implementation in other jurisdictions that could be easily transplanted into the Ontario context. Although what flows from our research does not constitute an action plan, it points to the need for flexible, diverse programming, and for further consultation by policy-makers with various stake-holders, including women from diverse demographic and cultural backgrounds.
6) Conclusions and Recommendations

The research we have conducted for this study has produced useful findings that may be translated into new and innovative programming ideas. First, the results of previous studies have shown that women gamblers differ from men, in important ways. This finding is confirmed in our own research, though we have not focused on that issue. Rather, we have concentrated on what we believe to be the more important finding that women gamblers feel their problems are different from men’s gambling problems. Further, we have found that female gamblers would like to receive treatment that is sensitive to, and aware of, this gender difference.

Second, while our results do not confirm the existence of different “types” of women problem gamblers, we have found differences in types of women gamblers. According to the 2005 Ontario Prevalence Survey, variations in problem gambling among women are explained by percent of income spent on gambling, number of games played and type of game, where the lottery, scratch tickets and raffle/fundraising tickets are protective. Notably absent are direct effects for demographic factors.

In contrast, analysis of the 2007 CCHS finds that women problem gamblers: gamble on 2.17 gambling games on average, are typically widowed or divorced, middle aged, and make between $20,000 and $39,999 a year. Further, these women are often immigrants to Canada, dissatisfied with their life, feel a weak sense of belonging to their community, feel extremely stressed by their life and work, rate their health and mental health as poor, experience mood and anxiety disorders, and have not had a drink in the last year. In this dataset, we see that demographics play a much larger role in understanding problem gambling among women. Specifically, four of the explanatory factors are demographic characteristics, while 9 are psychosocial variables and one is a gambling behaviour (which does not significantly distinguish this cluster from the others).

Our content analysis also revealed that while the gambling patterns of the authors of these autobiographies could not necessarily be differentiated by such variables as age and ethnicity, it was evident that almost all cases referred to underlying sources of personal strain or stress that were unaddressed before the onset of problem gambling. These issues could manifest as lingering pain from childhood distress, as described above, or in the form of current adulthood stressors, such as low self esteem, depression, role strain from competing responsibilities, or the diagnosis of an illness and its associated symptoms. Women who speak about their gambling after treatment are often able to name the triggers or factors that led to their dependant relationship with gambling. It would be to the benefit of treatment programs and problem gamblers alike if future research and policy addressed these aspects of the addiction and looked for ways to intervene before these women began to use gambling as a means to suppress other personal problems.

Third, our examination of the policy data confirms that some jurisdictions have gone farther than others in their treatment of gamblers, including in their efforts to offer services specifically tailored to women gamblers. However, none of these policies go very far at all in identifying different types of women gamblers and tailoring policy, programming, or treatment to the needs of these different groups. This means that Ontario has an excellent opportunity to take the lead on this issue and develop innovative strategies.
To capitalize on this opportunity, we would like to propose various “next steps” to be carried out simultaneously, or in stages yet to be determined.

First, we recommend that OPGRC organize a research conference in Toronto, designed to bring together gambling and other addiction researchers to discuss the findings of this project. Doing so might reveal important research refinements that could yield an even richer range of program insights.

Second, to further validate the findings of this study, we recommend sending this report to all stakeholder organizations in Ontario that are concerned with gambling in general and female problem gambling in particular. The recipients would be encouraged to send ECHO their views about the report and its implications, which would help both OPGRC and ECHO decide on the next steps to be taken towards implementing the findings of this report.

Third, we recommend that OPGRC and ECHO consider funding new research on cognate addictions in order to determine the similarity between the types of women addicts discussed here, and types found in other addiction domains. This would include the study of alcoholics, drug addicts and people with various property-related compulsions, such as shopping addiction, kleptomania, and hoarding for example. Such research might be carried out through a literature review, at little cost.

Fourth, we recommend that OPGRC fund an internet-based (non-random) survey of women gamblers to further validate the findings of this study. This would allow the collection of new survey date that would address the “types of women” question more directly than we have been able to do with survey data collected for other purposes.

Fifth, we recommend that OPGRC fund and ECHO organize a set of focus groups for therapists who deal mainly with women’s issues, especially those pertaining to gambling. These groups would brainstorm to come up with treatment options that are gender-sensitive and likely to work with women problem gamblers. The treatment options proposed in this way would be evaluated in the next recommended step, below.

Sixth, we recommend that OPGRC provide three or four small grants (<$10,000) to design, field-test, and evaluate new treatment programs for some of the different “types” of women gamblers described in this report. This would provide the strongest possible test of the value of this present report, and may move the planning process toward larger program changes.

SPECIFIC RECOMMENDATIONS FOR CONSIDERATION

A broader spectrum of services

Our examination of BreakEven/Gambler’s Help in Australia and the Oregon Problem Gambling Services in the United States suggests that offering a broad menu of services is the best way to meet a broad spectrum of needs. Including approaches such as family counselling, residential services, and telephone or Internet-based treatment options would diversify the options available to problem gamblers.

Therapeutic approaches
Studies on cognitive-behavioural therapy for women gamblers suggest that offering a diversity of approaches, even within traditional counselling, is of value. As we discussed in both our autobiographical content analysis and policy analysis, women appear to benefit more from therapy focused on emotional resources and empowerment, rather than counselling that directly addresses gambling behaviour. Issues identified as pertinent to women gamblers include conflict management, relationship health, self-esteem building, and handling stress (Boughton & Brewster, 2002).

**Single gender groups**

Currently, only CAMH in Toronto and Amethyst Women’s Addiction Centre in Ottawa receive government funding to provide women-specific gambling services in Ontario (Sadinsky, 2000). However, because women tend to prefer single-gender treatment settings (eg. Boughton & Brewster, 2007), treatment centres outside of these two urban areas should be given the resources to establish women-only groups.

**Integrating services into community organizations**

Currently, most problem gambling services are provided through addiction or mental health organizations. This can pose a barrier to access because of the stigma associated with these agencies. A notable feature of Victoria’s successful BreakEven/Gambler’s Help program is the location of services within community organizations, as women may simply be more comfortable approaching a familiar agency for help. Integrating problem gambling services into community health centres could therefore enhance access by limiting the stigmatization women gamblers would face.

**Online and distance services**

Online therapy offers a novel way of reaching women who may be geographically isolated or facing significant barriers to transportation and travel. It also appeals to younger women, who tend to be less likely than older women to seek treatment. Because of the various factors that make online treatment attractive to female gamblers, Ontario should begin to develop such services; potentially, GamCare’s online services could serve as a model for the development of an online counselling service in Ontario.

Oregon’s GEAR program, a telephone counselling service, has a high proportion of female clients. Like Internet services, this could benefit women who have difficulty accessing services because of geography, health problems, or disabilities. It also may appeal to older women who are unfamiliar with the technology involved in an Internet service. It is important to note the difference between telephone counselling and a helpline: telephone counselling involves scheduled calls between a client and a therapist, while helplines are intended to direct callers towards services. Thus despite the usefulness of helplines, Ontario should be more focused on developing effective telephone counselling services.

**Enhancing accessibility**

Childcare can pose a significant barrier to treatment seeking. Agencies that provide gambling treatment could benefit from receiving funding in order to offer childcare services to clients. As well, offering treatment on weekends or evenings could be beneficial to women who
are in the labour force. Finally, gamblers for whom transportation poses a significant barrier could benefit from receiving bus tickets or transit vouchers.

**Awareness campaigns**

A study by the Queensland Government Office of Liquor and Gaming Regulations in 2010 found that women are more responsive than men are to awareness posters displayed in gambling establishments. Women who live in Ontario are therefore at an advantage, as all of Ontario’s gambling venues and lottery products display responsible gambling messages and advertise the province’s gambling helpline (Sadinsky, 2002).

However, according to research, these current efforts may not be sufficient: women in Boughton and Brewster’s 2002 study expressed a desire for expanded awareness campaigns. Given that women gamblers have different motivations for, and experiences of, problem gambling, women may not identify with current awareness messages. For instance, women tend to gamble to escape stress or emotional issues, rather than strictly for financial gain (see Crisp et al, 2002); as a result, these women may be less responsive to messages about the slim chances of winning. Future campaigns must take the experiences of women gamblers into account.

**Outreach to diverse cultural communities**

CAMH and COSTI are both engaged in working with cultural organizations to expand the number of languages in which problem gambling treatment is offered (Ontario Resource Group on Gambling, Ethnicity, and Culture, 2010). However, problem gamblers from diverse cultural communities may seek help from religious or cultural organizations rather than mental health service agencies (Ontario Resource Group on Gambling, Ethnicity, and Culture, 2010). The Massachusetts Council on Compulsive Gambling provides an interesting model for addressing this issue: through its Congregation Assistance Program, leaders of faith-based organizations are trained to provide early intervention in problem gambling (Massachusetts Council on Compulsive Gambling, no date cited). A similar program of partnerships between Ontario’s mental health agencies and cultural organizations could ease barriers to access for gamblers from diverse communities.

This may be especially important for women gamblers, who in many communities face greater stigma than their male counterparts (Ontario Resource Group on Gambling, Ethnicity, and Culture, 2010). While women from minority communities often prefer programs that are both culture- and gender-specific (McMillen et al, 2006), some may fear a loss of anonymity when seeking help within the community (Cultural and Indigenous Research Centre Australia, 2008).

Counselors in mainstream services therefore need to be aware of cultural factors that may influence a client’s treatment needs. For instance, family therapy may be inappropriate for clients who feel that they have failed to fulfill their family role as defined within their own culture. Further, as recommended by Korn and Shaffer (2004), interpreters could be involved in treatment not only to reduce not only linguistic barriers, but also cultural ones.

**Older women**

Older women are more likely than younger women— or older men— to seek treatment for
problem gambling (Boreham et al., 2006). However, it is unclear how older women fare once they have sought and received treatment, as they are particularly troubled by issues of independence, shame, and stigma. Massachusetts Council on Compulsive Gambling addresses these challenges through a peer mentorship program. This type of program may be of particular value to older women, who may have grown up believing that gambling was a male activity, and who therefore feel isolated.

In addition, older women gamblers could also benefit from interventions that help them to find other means of recreation and socialization, as they tend to use gambling as a social activity.

Younger women

Because younger women are less likely to self-identify as problem gamblers (Ellenbogen et al., 2007), awareness campaigns targeting youth should be cognizant of this discrepancy. Moreover, young women gamblers also experience problem gambling differently from their male peers, being less likely to be preoccupied with gambling, but more likely to incur negative social consequences (ibid). Therefore, youth-focused campaigns should attend to these outcomes of problem gambling that young women gamblers are likely to identify with.

As well, Internet-based treatment appeals more to younger gamblers (Boughton & Brewster, 2000), and should therefore be explored as a means to reach out to this demographic.

Aboriginal women

Treatment programs for Aboriginal women need to take into account the role that gambling may play in the lives of these problem gamblers. Aboriginal women are more likely to live in poverty, meaning that gambling offers them a dream of escape. It also offers them an opportunity for recreation and socialization, of which they are usually deprived. Aboriginal problem gambling programs could therefore emphasize traditional games as alternatives to gambling in order to fulfill these social and recreation needs.

While more research is required to understand the needs of these Aboriginal women gamblers, offering culturally sensitive services would likely benefit all Aboriginal problem gamblers. Funding is needed to establish such services, especially in remote communities where access to mainstream services may not be practical or possible.

AREAS FOR FUTURE RESEARCH

Boughton and Brewster’s 2002 report, which we discussed in our policy analysis, represents a significant step towards elucidating the needs of female problem gamblers. Further research, however, must be undertaken in order to understand the challenges facing women gamblers from different backgrounds (including women from diverse cultural communities and Aboriginal women); women living in rural or remote areas; younger and older women; women with high incomes and low incomes; women who are with and without partner; educated and uneducated women, employed and unemployed women; and women with disabilities and health problems. Until such research is carried out, it will remain unclear how the needs of specific groups of women differ, and whether or not these needs are being met by current treatment services.
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