A Qualitative Study of the Development and Maintenance of Pathological Gambling in Females: And Making the Choice to Recover

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Dedication

To all females who have ever experienced maltreatment at the hands of someone they love. May you find peace.

Abstract

Much of the gambling research has been done on males, and differences in female problem gamblers are less understood. This research is a phenomenological study designed to explore the process of the development, maintenance and making the choice to recover from pathological gambling in women. A semi-structured one-hour interview was conducted with each of eight female participants who were in recovery from gambling problems. Elements of Consensual, Qualitative Research (Hill, Thompson, and Williams (1997) were used to guide the data analysis. The results indicate that the participants' early family history was characterized by unpredictability and lack of stability due to psychiatric illness in the family, often a parent, substance abuse and dependency in the family, and the participants reported a history of maltreatment in the form of sexual, physical, emotional abuse or neglect within the family. Disordered gambling progressed rapidly after a difficult emotional event and loss was experienced. The participants reported that gambling allowed them to enter a trancelike state to manage negative emotions and to avoid problems, which helped maintain disordered gambling. Significant family disruptions, loss of job, debt, loss of housing, emotional distress and legal problems for some occurred prior to seeking treatment and choosing recovery. Participants reported that processing emotions related to maltreatment, finding compassion for themselves, experiencing a sense of belonging, learning to establish boundaries and to accept responsibility for themselves facilitated recovery. Implications for treatment are discussed.

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Chapter 1

Introduction

Gambling is a popular recreational activity enjoyed without problem by many people. However, some individuals become problem or pathological gamblers and enter into destructive gambling behavior. Pathological gambling, now identified as Gambling Disorder in the Diagnostic and Statistical Manual 5 (DSM-5; American Psychiatric Association, 2013), is the most problematic form of gambling and is associated with a wide range of psychosocial disturbances. Gambling Disorder is categorized as a Substance Related and Addictive Disorder in the DSM-5 (2013), and is characterized by persistent and maladaptive gambling behavior. Thus, it is conceptualized as a psychological problem that may result in significant negative consequences before a person seeks help. The personal costs may involve risking or losing important relationships, debt and lying to pay for or hide gambling debt, and negative effects on work or career preparation. Additionally, preoccupation with gambling can decrease work and academic performance. Problem gamblers may have poor health and rely on medical care at high rates (DSM-5, 2013). Individual lives' and their family members' can be destroyed by the behavior. Consequently, pathological gambling is a public health issue.

Society has chosen to allow recreational gambling, in part, due to the revenue it receives. Revenue derived from gambling contributes to the functioning of the government and reduces the need for increased taxes (Walker, 2013). For example, in 2006, five billion dollars in taxes were paid to U.S. states and local governments by

casinos the same year (American Gambling Association, 2007). The costs of gambling are less clear, but they are reflected in police, social services and health care costs that result from gambling problems (Wynne, & Schaffer, 2003). Therefore, while society benefits from gambling behavior, it also has a stake in, and responsibility for, helping those individuals who succumb to gambling problems.

The fifth edition of the Diagnostic and Statistical Manual (DSM-5; American Psychiatric Association, 2013) reports a past year prevalence rate of gambling disorder in the range of 0.2 - 0.3% and a lifetime prevalence rate of 0.4 - 1.0% in the general adult population based on community studies. A North American meta-analysis of prevalence studies found a 1.14% rate of past year pathological gambling and a 1.6% lifetime prevalence rate in adults (Potenza, Koston, & Rounsaville, 2001). The lifetime prevalence rate for females is 0.2% and for males it is 0.6% (APA; DSM-5 2013). Although these reported past year and lifetime prevalence rates are somewhat different, taken together they indicate that gambling problems affect millions of people in the U.S. each year.

Certain populations, such as adolescents and adults being treated for mental health and substance abuse problems have higher prevalence rates of problem gambling, and are considered at risk for developing gambling problems (DSM-5, 2013). Adolescents have been found to have prevalence rates of 5.8% for pathological gambling and 14.8% for problem gambling according to the meta-analysis done by Shaffer, Hall and Bilt (1997). Studies suggest that this higher prevalence rate for adolescents does not remain stable as these young people enter adulthood. Instead, maturing out of the problem behavior as

youngsters enter adulthood with its increased responsibility may be common (Winters, Stinchfield, Botzet, and Anderson, 2002; Slutske, Jackson, & Sher, 2003). Those in substance abuse treatment are 4-10 times more likely to have gambling problems (Potenza et al, 2001) than the general population.

People who develop gambling problems commonly have other vulnerabilities, including mood disorders, anxiety and personality disorders (DSM-5, 2013), and may be socially disadvantaged. African Americans and Native Americans have higher prevalence rates than European Americans and Hispanics (DSM-5, 2013) suggesting that cultural beliefs and socio-economic status, racism and oppression may affect prevalence rates.

Gender has also been considered a risk-factor for the development of gambling problems with females at lower risk to develop problems than males. Males have consistently been found to have higher prevalence rates of gambling problem prevalence rates than females (DSM-5, 2013; Blanco, Hasin, and Petry, 2006; Potenza et al., 2001; DSM-IV-TR, 2000; Cunningham et al., 1998; Shaffer, Hall, & Vanderbilt, 1997). However, recent research suggests that females have a different trajectory in the development of gambling problems, choice of gambling venue and in seeking treatment.

Women problem gamblers tend to be older at the onset of gambling, and develop problems more rapidly than males (SAMHSA, 2009; Blanco et al., 2006; Nower & Blaszczynski, 2006; Grant & Kim, 2002; Tavares et al., 2001). The more rapid emergence of problem gambling among females has been called the "telescoping effect,"

and is similar to the more rapid development of alcohol dependence among females as compared to males (Piazza, Vrbka, & Yeager, 1989; Potenza et al., 2001; Tarvares et al., 2003). Because of the more rapid emergence of problem gambling among women, they also experience the negative effects of their gambling addictions, such as loss of financial stability and marital problems, more rapidly. Additionally, researchers suggest that gender effects (i.e., the sociological basis of gender in which women are in a less prestigious and powerful position than men in society) places some women at greater risk for developing addiction problems (Tavares et al., 2001). Cultural factors, such as the cultural disempowerment experienced by ethnic minority communities, may also place women at risk for pathological gambling (DSM-5, 2013).

Female gamblers prefer games of chance rather than games of skill, suggesting a less authoritative approach to gambling (Griffiths, 1995). Tavares et al. (2003) found that in Brazil, electronic gaming, such as electronic bingo and video lottery terminals (VLTs), were preferred by female gamblers and were "strongly related to the 'telescoping effect." The authors speculated that the expansion of electronic gaming and the decreased time between placing a bet and reinforcement may be factors that increase addiction to gambling itself, and that women may be more affected by this than males because they often choose this type of gambling activity. Addictions can be thought of as a strategy to manage problems, and disadvantaged groups may see themselves as having fewer options to solve problems than the majority. This may increase the attractiveness of gambling and distort the negative aspects of it.

Women choose the activity of gambling for reasons that are different from men. Grant and Kim (2002) found that women gamble to distract themselves from negative emotions, such as depression and anxiety, while men gamble to gain a reward or for sensory stimulation. Lesieur (1993) reported that gambling in women becomes an escape from problems and has a numbing or dissociative quality to it. Hing and Breen (2001) found that women are likely to choose games that cost less per bet than males, and that they are likely to maximize their playing times. Women are taking an emotional vacation from their troubles rather than trying to overtly achieve a win. Gambling offers women a "time out" from their lives, (Lesieur, 1991).

Women who have gambling problems also tend to have higher rates of affective disorders than women in the general population (Petry & Steinberg, 2005). The etiology of problem gambling in women appears to be similar to the etiology of such psychiatric diagnoses as nicotine dependence, major depression, dysthymia, panic disorder, generalized anxiety disorder and social phobia (SAMHSA, 2009). Women are more likely to have experienced childhood maltreatment (Petry & Steinberg), including physical abuse, and neglect, sexual abuse, and emotional neglect (Wegman & Stetler, 2009). Females with gambling problems may have entered adulthood with histories that leave them vulnerable to developing or continuing to use inadequate coping strategies for emotional pain, and to already have low expectations about their ability to resolve problems. This suggests that counseling psychologists who provide treatment for women gamblers would benefit from taking a history of childhood maltreatment in their clients.

The outcomes of problem gambling behaviors also appear to be different among women than among men. Women gamblers were found to attempt suicide more often than men and to have sought mental health care at some point. Women were more likely than men to be anxious about gambling and to have made suicide attempts associated with gambling itself (Potenza, Steinberg, McLaughlin, Wu, Rounsaville, & O'Malley, 2001). Females reported more illegal activities and greater credit card debt than males. Males were more likely to be in debt to bookies or loan sharks. Females tended to stay within the legal limit and therefore may not have been as subject to legally enforced interventions, although women are now seen in treatment at the same rate as males (Petry, 2005), and women who have gambling problems tend to receive greater social sanction than men who have gambling problems (Volberg & Wray, 2007).

Purpose of Present Study

According to the DSM-5, males have higher prevalence rates of gambling addictions than do females. Much of the research reflects a male process, and while there are similarities, there are also differences that, when illuminated, may add to the effectiveness of treatment for females. Problem gambling treatment is predominantly based on research conducted with male problem gamblers, although the etiology, development and outcomes of female problem gambling appear to be different for females than for males. The process of developing gambling problems, choosing to enter recovery, and receiving treatments that prove to be effective may be different for females. Further investigations are needed to examine the following: 1) is there a process of developing gambling problems and seeking treatment that is common to women; 2) what

family and life problems contribute to developing gambling problems; 3) what is the purpose of gambling in participants' lives; 4) what motivates participants to seek treatment to stop gambling; and, 5) what aspects of treatment are effective for females?

Accordingly, the purpose of this qualitative study is to investigate the process of the development and maintenance of gambling problems and the decision to seek treatment by women who are self-identified as having a gambling problem. Consensual Qualitative Research (CQR; Hill, Thompson and Williams, 1997) methods were utilized to explore common themes in the development and maintenance of gambling problems and the decision to seek treatment. Hill et al., (2005) suggested that between 8 and 15 participants are ideal for CQR with fewer participants producing the most in-depth information. Thus, recruiting ceased after eight participants were identified both based on the suggestion of Hill et al., and because the data were saturated (i.e., when the information that is being shared with the researcher becomes repetitive and contains no new ideas, so the researcher can be reasonably confident that the inclusion of additional participants is unlikely to generate any new ideas; Encyclo.co.uk, 2014). Participants from the greater Minneapolis/St. Paul metropolitan area were recruited to participate in one semi-structured interview about their thoughts, feelings, behaviors, and experiences with gambling.

Chapter2

Literature Review

The Diagnostic and Statistical Manual IV Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) categorized Pathological Gambling as an Impulse Control Disorder characterized by persistent and maladaptive gambling behavior. The DSM IV-TR included symptoms of physiological and psychological dependence demonstrated by the diagnostic criteria of withdrawal, tolerance, craving and preoccupation (Westphal, 2008), which are symptoms shared with substance abuse and dependence.

The DSM-5 (APA, 2013), which is a revision of the DSM IV-TR, now categorizes Gambling Disorder within the category of Substance-Related and Addictive Disorders, but the criteria for diagnosis are unchanged. Diagnosis requires meeting both Criterion A and Criterion B. From Criterion A, an individual must engage in persistent and recurrent problematic gambling behavior with clinically significant impairment indicated by meeting 5 (or more) of 10 criteria experienced in a 12-month period. These 9 criteria (paraphrased) include (1) an individual's preoccupation with gambling, (2) the need to gamble with increasing amounts of money in order maintain the excitement one seeks, (3) repeated attempts to control or stop gambling", (4) irritation and restlessness when attempting to disengage from gambling, (5) use of gambling as an escape mechanism in order to relieve a dysphoric mood, (6) being motivated to gamble in order to recoup one's losses (also known as chasing losses), (7) lying to others about the extent of gambling, (8) engaging in illegal acts in order to get money to continue gambling, (9) losing significant relationships or opportunities because of gambling, and (10) depending

on other's for support because the gambler has lost her money by gambling. Criterion B states: "The gambling behavior is not better accounted for by a Manic Episode (p. 585).

The discussion about how to categorize gambling problems that has resulted in their inclusion in Addictive Disorders in the DSM-5 (APA, 2013) reveals that there are different motivations and goals for gambling behavior. All problem gamblers are not the same (Derevensky, 2007). Blaszczynski and Nower (2002) proposed the Pathway Model indicating that there are three distinct subgroups of gamblers that demonstrate impaired control over gambling. These are: 1) behaviorally conditioned problem gamblers, 2) emotionally vulnerable problem gamblers, and 3) antisocial, impulsive problem gamblers.

Nower, Martins, Lin, and Blanco (2012) used data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), to empirically support the subtypes in the Pathway Model that are based on etiological and clinical characteristics of problem gamblers. Nower et al., (2012) found support for three subtypes of disordered gamblers roughly corresponding to those from the Pathway model. The authors suggested that effective treatment can be enhanced by considering these subtypes, and also suggest that perhaps the subtypes provide information about gender differences.

Prevalence Rates

DSM-5 (APA, 2013) prevalence rates for the diagnosis of Gambling Disorder differ for males and females. The past one-year prevalence rate is 1.0%. The lifetime prevalence rate of disordered gambling in males is 0.6% and in females it is 0.2%.

Higher lifetime prevalence rates are seen in African Americans (0.9%) and lower lifetime prevalence rates are seen in Hispanics (0.3%). The lifetime prevalence rate for European Americans is 0.4% (DSM-5, 2013). The differing rates across different populations suggest that cultural and socioeconomic factors, such as lower education, lower income, race, and oppression, may affect the prevalence of disordered gambling in these groups.

Males have also sought treatment for problem gambling in greater numbers than females, although this difference is diminishing (Petry, 2005). Stinchfield and Winters (2001) found that 0.59% of gamblers requesting treatment in Minnesota were male. Studies in Canada (Wiebe & Cox, 2001), Brazil (Travers et al., 2001), Australia (Jackson, Thomas, Ross, & Kearney, 2000) and New Zealand (Paton-Simpson, Gruys, & Hannifin, 2002) reported consistent gender differences in problem gamblers seeking treatment. The research reports that males seek treatment in greater numbers than females, although this is changing (Petry, 2005).

Developmental Course

Wenzel and Dahl (2009) reviewed 28 papers published between 1970 and 2007 that provided clinical information on female problem gamblers. The papers were separated into higher and lower quality studies. The Nelson, LaPlante, and LaBrie (2006), and the Nower and Blaszcynski (2006) studies were evaluated as higher quality. ~~During~~ In these studies, the researchers found that women start gambling at a significantly older age (30.0-37.5) than men (21.9-28.3). Two lower quality studies (Ibanez, Blanco, & Moreryra, 2003; Potenza et al., 2001) supported this finding. Grant

and Kim (2002) studied 131 subjects with pathological gambling and found a similar and significant difference of age of onset between males and females. The mean age of onset for male gamblers was 26.2 (*n=53*) and 33.4 (*n=78*) for females.

Blanco et al., (2006) reviewed gender differences in age of onset of people with subclinical and pathological gambling from a National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The NESARC survey was given to a nationally representative sample of the adult U.S. population (*N* = 43,093). The results indicated significant differences in mean age of onset between males and females that are consistent with the findings reviewed by Wenzel and Dahl (2009) in which they found that the mean age of onset for males was 25.6 years and for females was 34.9 years. These differences in age of onset suggest that the motivation for gambling may be different between males and females.

Telescoping Effect

The telescoping effect in female problem gambling was first identified in addictions studies. Piazza, Vrbka, and Yeager (1989) observed this result after studying female alcoholics on age of onset, number of years between landmark intervals, and number of symptoms within each interval between the landmarks. The results indicated that, compared to males, female alcoholics were found to have a faster progression from initiation of the behavior, development of problems, and seeking treatment. Similar patterns for age of onset, number of years between landmark intervals and number of symptoms within each interval between landmarks have been identified in female gamblers by other researchers. Potenza, Steinberg, McLaughlin, Wu, Rounsaville and

O'Malley (2001) examined characteristics of female (*n* = 213) and male (*n* = 349) callers into a gambling helpline in New England between 1998 and 1999. A questionnaire was given to the male and female gamblers who were calling because of concerns about their own gambling behavior. The researchers found a significant difference in the duration of gambling between the genders, with females reporting shorter times between problem gambling and seeking treatment than males. Analogous to the findings in the Piazza et al. (1989) study, the authors interpreted this to mean that females develop gambling problems at a faster rate than males.

Grant and Kim (2002) evaluated the demographic and phenomenological differences between males (*n* = 53; 40% of the sample) and females (*n* = 78; 60% of the sample) who were diagnosed as pathological gamblers according to the DSM-IV-TR (2000) criteria. Participants were assessed on demographic characteristics, clinical features, and treatment history. The authors found evidence to support the faster progression to gambling problems in women (5.7 years) when compared to men (7.1 years), although this result was not significant.

Tavares et al. (2001) compared females (*n* = 39) and males (*n* = 38) seeking outpatient treatment for pathological gambling in Brazil, and found that the progression to problem gambling was significantly more than two times faster in the women than in the men. There was no significant difference between the genders in age of first seeking treatment. It has been suggested that the telescoping effect in women may indicate a biological vulnerability to addictions that may exist in females more than in males, and

that gender should be taken into account when considering treatments that would be effective (Tavares, et. al.).

The telescoping effect in women was further explored by Slutske, Piasecki, Deutsch, Stratum, and Martin (2014) in a community-based sample in Australia. Previous evidence had been derived from treatment-seeking populations (Slutske et al, 2014). The authors conducted structured diagnostic telephone interviews with 2,001 males and 2,662 females. The researchers found no evidence that female gamblers progressed more rapidly to disordered gambling behavior when compared to males in a general population. These results are consistent with substance use disorder research when telescoping in treatment-seeking female populations is compared with telescoping in a community sample. The results suggest that other factors may be important to examine in understanding what supports the telescoping effect in females in treatment-seeking sample.

Female gamblers may have different motivations for gambling than do male gamblers. Gamblers are categorized into two types: action gamblers and escape gamblers (Lesieur & Blume, 1991). Action gamblers are motivated by a desire for excitement, stimulation and a chemical high from the activity. Escape gamblers are characterized by a desire to numb negative feelings, such as anxiety, and to escape life problems (Lesieur & Blume, 1991). Action gamblers are more likely to be male and believe they can develop a strategy to beat the odds (Arizona Council on Compulsive Gambling, 1999). Escape gamblers tend to be nurturing and responsible people who begin their gambling later in life and seek escape from stress. Escape gamblers are more often women

(Arizona Council on Compulsive Gambling, 1999). Escape gamblers are more likely to seek help and to recover (Arizona Council on Compulsive Gambling, 1999). Thus, women gamblers are more likely to progress more rapidly into pathological gambling behavior and they are also more likely to gamble because they are seeking to escape psychologically.

Gender Differences in Problem Gambling

Hing and Breen (2001) researched gender differences in gambling behavior by conducting telephone interviews on randomly selected members of six of the largest clubs in Sydney, Australia. The clubs are registered with the government. They are not for profit, require membership to participate in club activities, and are formed by people with a common interest. The clubs studied were the largest providers of gaming machines in Sydney. The researchers interviewed 1,257 females and 1,743 male respondents. The authors found that females encounter problem gambling at the about the same rate as males, but engage in different types of gambling games. Females preferred bingo, lotto, lotteries, pools and gaming machines when compared to males.

The findings of Hing and Breen (2001) were consistent with other research results. Wiebe, Single, and Falkowski-Ham, (2001) conducted telephone interviews with randomly selected people 18 years or older in Ontario, Canada. Five thousand people were contacted, with a 37% respondent rate. The researchers found that females tend to engage in gambling by using scratch tickets, bingo and casino slots.

Scannell, Quirk, Smith, Madden, and Dickerson (2000) recruited and interviewed 163 women machine poker players about their gambling behavior. The participants were

recruited from gambling venues in metro areas in Australia. The researchers found that instead of solving problems, female gamblers tended to use emotional management strategies in order to decrease their negative emotions. The authors hypothesized that female problem gamblers use gambling to avoid emotions associated with other life stressors. This may suggest that female gamblers feel less empowered to manage problems and their negative emotions, and instead choose to escape from them for a time.

Crisp et al. (2004) analyzed social and demographic differences between male and female gamblers. The female (n = 694) and male (n = 826) participants were people who sought help for gambling problems over 12 months from BreakEven counseling services in the state of Victoria, Australia. BreakEven is composed of 18 publicly funded counseling centers across Victoria. Crisp et al. analyzed data from the de-identified data that these centers are required to keep. The authors found that females were more inclined to use electronic gaming machines (91.1 vs. 61.4; odds ratio 2.68, CI 95, 1.83-3.94). Females were more likely to be older than males (39.6 years vs. 36.1 years; $F(1,1435) = 39.31$, $p < .001$). Females were more likely to be married than males (79.4 vs. 74.7; X^2 (5) = 99.68, $p < .001$), and were more likely to have dependent children than males (48.4 vs. 35.7; X^2 (1) = 24.27, $p < .001$). Females reported less than half of the gambling debt ($7,342) of males ($19,091). Logistic regression *demonstrated* that females were more likely to gamble as a way to escape from problems. Nearly half of both males and females relied partly or completely on social welfare payments for income (X^2 (4) = 130.84, $p < .001$). Females were more likely to receive money for single parenthood while males were likely to receive benefits for unemployment. The

researchers found that female gamblers were more likely to be escape gamblers, and that equal amounts of males and females were dependent on social welfare payments for income. The author's findings suggested that female gamblers may have less income and more financial pressure than males. Limitations of the study were that the data was self-report, and some data were missing. The sample was composed of treatment-seeking gamblers, which limits generalizability to a wider population (Crisp et al., 2004).

Nower and Blaszczynski (2006) analyzed data from gamblers in the Missouri state self-exclusion program between 2001 and 2003 to identify their characteristics and gender differences. Self-excluders are gamblers who voluntarily identify themselves to the casino as having problems. They can agree to be denied access to the casino, and will be physically removed if encountered on the grounds of the casino. The presence at the casino of a self-excluder may or may not result in additional sanctions beyond removal. Self-selected bans may range between six-months to a life-time exclusion. The self-exclusion policy was adopted in Missouri in 1996. Other states followed suit. Self-exclusion is a way for the gaming industry to help patrons limit negative consequences associated with problem gambling behavior (Nower & Blaszczynski, 2006).

The authors looked at the de-identified data set that is maintained by the Missouri Gaming Commission composed of a required application for self-exclusion and demographic information. The researchers evaluated records from 2,670 self-excluders (females n = 1,298, males n = 1,372) who applied for self-exclusion between January of 2001 and March of 2003. There were no significant differences in education between the genders. The majority of the sample had high school degrees and some college. Females

were significantly less likely to be employed full-time when compared to males (X^2 = 67.30, df = 4, p < .0001). Females were more likely to report being in the lowest two of six income brackets (X^2 = 112.16, df = 5, p < .0001) while males were significantly more likely to report being in the top two brackets of income. There were no significant differences in overall household income between males and females. Married males made significantly more income than those who were single, divorced/separated or widowed (X^2 = 79.94, df = 15, p< .0001). Married self-excluders had significantly higher household incomes than other groups. Logistic regression revealed that female self-excluders were more likely than males to be older, African-American, and to have jobs or income sources outside the mainstream workforce (X^2 =85.33, df = 3, p < .0001).

Nower and Blaszczynski found that the age of gambling onset was significantly different between the genders, with females starting later in life (Mean = 33.85, SD = 12.03) than males (Mean =27.39, SD = 10.92). Females applied for self-exclusion after an average of 9 years gambling. Males gambled on average for 13 years prior to applying for self-exclusion (F(1, 1736) 134.67, p = < .0001). There was no significant difference between genders on amount of days gambling in the past month. Females on average gambled 10 days in the previous month while males gambled 11 days on average. Females lost between $15 and $45,000 (Mean = $1091) on any one day in the previous year and males lost between $5 and $60,000, (Mean = $1673) ($F$(1,2642) = 20.05, p < .0001). There was no significant difference between the genders in amount of money won on any one day in the previous year. Females were more likely to choose nonstrategic gambling activities, such as slot machines, video poker, and lottery (X^2 =

94.97, df = 1, $p < .0001$). Males were more likely to engage in strategic games, such as black jack, craps, and sports betting, ($X^2 = 311.94$, df = 1, $p < .0001$). Logistic regression analysis found that older age and preference for non-strategic games were predictors of female self-excluders. These differences are consistent with previous findings (Crisp et al., 2004) and raise questions about which factors contribute to the choices female gamblers make about gambling behavior.

The researchers found that 54.5% of the female gamblers reported that their primary motivations for requesting self-exclusion were to gain control over their gambling. Other motivations included recognizing that they needed help (32.3%), believing they had hit rock bottom (21.2%), because they were advised to by others (15.6%), in order to save their marriage (14.7%), because they were afraid that if they continued they would end up committing suicide (6.5%), and because they were referred to the program by a therapist (4.2%). Males reported that their primary motivations for seeking self-exclusion were a desire to gain control over their gambling (48.5%), recognizing that they needed help (27.2%), in order to preserve their marriage (23.0%), because they had hit rock bottom (20.3%), because they were advised to by others (17.0%), in order to save their job (9.3%), and because they were afraid that if they continued, they would end up committing suicide (4.7%).

The results of the study by Nower and Blaszczynski (2006) supported previous findings about a telescoping effect in female gambling progression in self-excluders (Tavares et al., 2003). Females were more likely to be older than males at the onset of gambling behavior, and to move more rapidly to problem gambling. Females were more

likely to choose non-strategic forms of gambling than males, although both females and males endorsed slot machines as the more common gambling activity in which they were engaged. The authors suggested that self-excluders' gambling problems may be enhanced by machine play that has an addictive reinforcement schedule despite limited return (Nower & Blaszczynski, 2006). The study also found that females had lower incomes than males, and this may contribute to the choice of self-exclusion rather than seeking psychological help. Limitations to the study were the inclusion of questions devised by Commission staff rather than gambling researchers, gambling levels that were undefined, unknown psychiatric comorbidity and un-assessed use/abuse of substances. Thus, the results of this study may not be generalizable to other groups of self-excluders, since Missouri offers the possibility of a lifetime ban that may not be revoked, and this may discourage some problem gamblers from using this strategy to manage gambling behavior.

Blanco, Hasin, Petry, Stinson, and Grant (2006) analyzed data from a large epidemiological study on a nationally representative sample in the United States using the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) data. The survey was conducted by the National Institute on Alcohol Abuse and Alcoholism and the Bureau of the Census. The data were based on DSM-IV-TR (2000) diagnostic criteria for pathological gambling and other psychiatric disorders. The authors analyzed data on clinical (5 or more DSM-IV-TR, 2000 diagnostic criteria endorsed), and subclinical (1-4 DSM-IV-TR, 2000 diagnostic criteria endorsed) gambling behavior, and characteristics in both sexes. The survey was given to 43,093 adults, 18 or older living in

non-institutionalized settings. The researchers used the data from the survey to evaluate whether participants met full criteria for DSM-IV-TR pathological gambling (5 criteria endorsed), demonstrated subclinical symptoms for the disorder (1-4 criteria endorsed), or met criteria for substance use disorders or for a range of mood and anxiety disorders.

One of the purposes of the study was to gather data on gender differences in the clinical course and treatment seeking patterns of DSM-IV-TR pathological gamblers. The demographic data revealed that there was no significant difference between percentages of female and male Caucasians in subclinical pathological gambling (females = 68.68 %, males = 69.92 %) and pathological gambling (females = 53.69 %, males 63.67 %). There were significant differences between female and male African-Americans (with 17.84% of females and 11.36% of males meeting criteria for subclinical pathological gambling). African-American genders differed significantly in meeting full criteria for pathological gambling with more females (34.31%) than males (17.48%) meeting criteria. Hispanic men (10.46%) were significantly more likely than Hispanic females (6.07%) to display subclinical pathological gambling symptoms. In this ethnic group, females meeting criteria for subclinical pathological gambling were significantly more likely to be 65 years old or older. Males with subclinical pathological gambling were significantly more likely to be in the 18 - 29 age range.

Females of all ethnic groups with subclinical gambling addictions were significantly more likely to fall in the lowest income ranges ($ 0 – 19,999, and $ 20,000 – 34,999) than were males. Males with subclinical pathological gambling symptoms were significantly more likely to make $35,000 or more than were female. More males than

females with subclinical gambling behaviors had never been married while more women with subclinical and full criteria pathological gambling addictions were separated, widowed or divorced.

Women with subclinical and pathological gambling addictions were more likely than men to have anxiety and mood disorders. Males with subclinical gambling symptoms were more likely to drink heavily, to use drugs, and to have a history of alcohol and drug use disorders. Females with both subclinical symptoms of pathological gambling and clinical Pathological Gambling Disorder endorsed using gambling to escape problems or manage depression significantly more than males. Males with subclinical gambling symptoms were more likely than women to report preoccupation with gambling and chasing losses/winnings.

Onset of symptoms of subclinical and clinical pathological gambling was significantly later for females (34.9 years) than for males (25.6 years). Women were significantly more likely to seek treatment (72 %) for mood or anxiety disorders than males (54%). Females meeting criteria for pathological gambling were significantly more likely to gamble in casinos and to prefer slot machines, video games, bingo and keno. Males were more likely to play roulette sporting events and the stock market. There was no difference between the genders in intensity of gambling or in seeking treatment for gambling. Rates of treatment seeking for gambling problems were low for both males and females.

Limitations of this study identified by the researchers are the data was self-report, which may introduce bias, and sample was composed of non-institutionalized adults only

and cannot be easily generalized to institutionalized populations. The information on the progression and course of pathological gambling was collected, but the information for subclinical gambling was not. Consequently, differences between the two categories in the beginning of symptoms, preferred type of gambling activity, and details about pursuing treatment could not be compared. No data were collected about the transition between subclinical pathological gambling and pathological gambling.

The results of the epidemiologic survey conducted by Blanco et al. (2006) are consistent with previous studies that found that females tend to begin problem gambling later in life than males but are similar in severity of symptoms when seeking assessment for gambling problems (Tavares et al., 2001; Grant & Kim, 2002). Also, females are more likely to gamble to manage negative emotions or to avoid stress from life problems (Grant & Kim). The Blanco et al. (2006) study results found that females with subclinical gambling problems were more likely to fall into the oldest age group(65 or older) while males with subclinical problem gambling were more likely to fall into the youngest age group (18 – 29). Additionally, females were found to have higher levels of anxiety and mood disorders than men, which is consistent with the finding that females used subclinical pathological gambling to manage emotions. Males in the survey meeting criteria for subclinical pathological and pathological gambling were more likely than females to use substances, and to have substance use disorders. The authors determined this difference may possibly be explained by biological and cultural influences affecting the two genders. Both substance use disorders and anxiety and mood

disorders suggest vulnerability that is expressed and managed in ways that may avoid whatever is causing stress rather than finding an effective solution to reduce the stress.

Comorbidity and Vulnerability in Females

Specker, Carlson, Edmondson, Johnson and Marcotte (1996) conducted psychiatric interviews with 15 females and 25 male pathological gamblers to determine the severity of Axis I and Axis II diagnoses in the participants. The participants had been in outpatient treatment for pathological gambling for a minimum of two weeks. The researchers found that participants in their sample had feelings of social discomfort, sensitivity to criticism and the tendency to isolate socially. Depression and anxiety were the most usual comorbid diagnoses in the females, and more often occurred in women who gambled using slot machines or video poker that required little need to engage socially with others. The authors found that the incidence of childhood and sexual abuse among female problem gamblers was greater than the incidence among national samples of women (32.5% among female problems gamblers vs. 1% to 2% in the general population). These research findings suggest that female problem gamblers have family and personal histories that may contribute to vulnerability for developing gambling problems. These findings also suggest that specific treatment programs should be prepared to address problem gambling among women because gambling problems may be related to these other problems.

Westphal and Johnson (2003) researched the level of comorbid psychiatric diagnoses in problem gamblers, and the effect of the comorbid illness on gambling behavior by giving 38 females and 40 males. The authors reported that women with

problem gambling had two to three clusters of behaviors that were comorbid with gambling. Eleven percent had an anorexia or bulimia, 55% had overeating behavior, and 39% engaged in compulsive shopping. Women problem gamblers tended to use alcohol and illegal drugs less than males problem gamblers. However, females were more likely than males to report having used psychotropic medication, to abuse medication and to be using medication at the time of assessment for gambling disorder.

Boughton and Falenchuk (2007) conducted a study on 365 Ontario, Canada women concerned about their gambling behavior. The authors used a self-administered survey to collect information on demographics, gambling behavior, personal and family history and questions about treatment. The participants were women worried about their gambling behavior, but not currently in treatment. The women were a representative sample of females in Ontario, Canada, except that they had less than average income for their geographical area. The participants engaged in a variety of gambling activities, and represented a range of ages, cultures, and sexual orientations. The participants were predominantly of European descent. Forty-three percent were from the greater Toronto, Ontario metro area. The mean age was 45. Fifty-six percent were employed. Thirty-four percent had achieved a high school degree. Nearly half of the women were married or in a live-in relationship. Eighty-nine percent identified as heterosexual, and 8 identified as lesbian or bisexual.

The measure used in this study to assess gambling behavior was the South Oaks Gambling Screen (SOGS, Lesieur & Blume, 1987). The SOGS is used to identify people with problem and pathological gambling behavior over the past 12 months, and

also over their lifetimes. The SOGS lifetime score excluded the previous 12 months gambling behavior. Seventy-six met criteria for probable pathological gambling, which is defined on the SOGS as comprising 1-4 endorsed symptoms in the past year. Sixty-six percent met criteria for probable problem gambling over their lifetime. The 10% difference between the past 12-month score and the lifetime score suggested that there had been a recent increase in gambling behavior among participants.

The researchers found that most of the females in the sample played 3 or 4 types of games on a monthly basis. Eighty-seven percent bought lottery tickets, 83% bought scratch tickets, 71% played casino slots, and 64% played bingo. Seventy percent reported that their motivations for gambling were to win money and for fun, excitement and entertainment. Other motivations for gambling behavior in percentages were: to manage negative mood (44%), to cheer themselves up (61%), to relieve stress (53%), and to escape (49%). Forty-six percent reported gambling to "get time for myself," and "to take a break from responsibilities."

The authors found that percentages of drug or alcohol use problems were reported to be high among the fathers (38%), siblings (28%), and relatives (43%) of the women in the sample. Percentages of those who had psychiatric problems among family members were also high (e.g., mothers (20%), siblings (24%), fathers (8%), grandparent (6%) and relatives (19%) were reported by participants to have psychiatric problems). Gambling problems were reported in mothers (16%), fathers (16%), siblings (18%), grandparent (6%) and other relatives (18%) of the women of the sample. This data suggests that the

family environments of these women were troubled and characterized by escape/distraction management of problems rather than finding an effective solution.

Boughton and Falenchuk found that women in their sample often reported having experienced physical or sexual abuse as children and/or adults. For those who were physically abused, 41% were abused as children, and 46% were abused as adults. A significant female in their lives was engaged in the physical abuse with a male partner 45% of the time, and was the perpetrator 15% of the time. Thirty-eight percent reported a history of childhood sexual abuse, and 28% had experienced sexual abuse as an adult. Sixty-three percent reported experiencing emotional abuse as a child, and 69% experienced emotional abuse as an adult.

The authors reported that 32% of the participants' current partners abused drugs or alcohol and 64% had had previous partners who had abused drugs or alcohol. Fifteen percent reported mental health problems in their current partners and 35% reported mental health problems in past partners. Twenty-two percent reported that both their current and past partners had gambling problems. Seventy-seven percent reported that their current partner had emotional problems, and 94% reported that past partners had had emotional problems. Fifty percent reported that their current partners had financial problems, and 65% reported that their previous partners had had financial problems. Additionally, binge eating (27%) and compulsive shopping (24%) were endorsed by the participants. Alcohol (9%) and drug problems (8%) occurred at lower levels than other problem behaviors. The women in the sample reported problem behaviors at higher rates than in the general population, and, consequently, experienced large amounts of stress in

relationships that are, ideally, supportive. These results suggest that the women in the sample experienced high amounts of stress and had limited support or protective factors in their lives.

Trauma Experienced in Female Gamblers

Lesieur and Blume (1991) suggested that gambling was a way to cope with trauma and abuse. Petry and Steinberg (2005) conducted a study of 149 problem gamblers (77 females and 72 males) who were seeking treatment for gambling problems at seven treatment centers in the United States and Canada. Petry and Steinberg evaluated data concerning-participants' histories of childhood maltreatment. The authors used the Childhood Trauma Questionnaire (CTQ) developed by Bernstein, Fink, Handlesman Foote, Lovejoy, and Wenzel (1994) to quantify the effect of emotional abuse, emotional neglect, physical neglect, physical abuse, and sexual abuse on those who had experienced maltreatment. The CTQ has been validated in 2,200 people in community and treatment seeking samples. Higher scores indicate more severe abuse or neglect. Internal consistency of the scales ranges between $\alpha = .66$ and $\alpha = .92$ (Bernstein, Ahluvalia, Pogge & Handelsman, 1997; Bernstein & Fink, 1998). Scores showed adequate test-retest reliability and demonstrated convergent and discriminant validity with other assessments of trauma (Bernstein et al., 1994). The SOGS (Lesieur & Blume, 1987) was used to evaluate gambling behavior.

The data from the CTQ revealed differences between males and females. The women gamblers had higher overall CTQ scores and higher scores on the Physical Neglect, Emotional Abuse and Sexual Abuse subscales than did the men gamblers.

Differences were revealed in overall severity and types of maltreatment experienced between the male and female gamblers. Severe maltreatment in childhood predicted age of onset of gambling behavior ($F(5, 143) = 18.67$, $p < .05$), frequency of gambling behavior ($F(5, 143) = 2.98$, $p < .05$) and level of gambling problems ($F(5, 143) = 2.64$, $p < .05$) in women. The severity of maltreatment in childhood was significantly associated with these factors even after holding constant for depression, antisocial personality, and substance use problems.

This study is limited by the reliance on memory and self-report in a treatment seeking population. Strengths of the study were that there were an approximately equal number of men and women who participated in the study, and that participants were recruited from seven gambling treatment centers located in the United States and Canada rather than from only one in one country, which enhanced generalizability.

Regarding the relationship between trauma and pathological gambling, the results support the idea that experiences of early trauma are present in female and male problem gamblers, and that females are more likely to have higher overall scores on the CTQ, suggesting that females experienced a wider range of abuse and neglect (Petry & Steinberg, 2005). The researchers also found that maltreatment in childhood predicted age of onset of gambling problems, severity of gambling problems and the frequency of gambling activity. However, the authors did not seek data to research whether childhood maltreatment leads to gambling problems. The data suggests that childhood maltreatment is a risk factor for females in the development of pathological gambling, and that effective treatment for gambling may be enhanced by alertness to this relationship.

Summary of Chapter 2

The literature review in Chapter two suggests that females may have different goals, motivation, and developmental course for gambling problems when compared to males. Female problem gamblers are more likely to use gambling to escape life stressors and to cope with negative emotional states (Blanco et al., 2006). Female problem gamblers commonly have comorbid diagnoses that accompany gambling, such as anxiety and depression (Blanco et al.). Female problem gamblers may have a history of maltreatment (Specker et al., 1996; Petry & Steinberg, 2005) all of which may suggest vulnerabilities to developing gambling problems. Additionally, the families of female problem gamblers are characterized by high rates of mental illness and alcohol or drug use abuse in family members (Boughton & Falenchuk, 2007).

The vulnerabilities found in female problem gamblers may provide some explanation of why female problem gamblers commonly develop gambling problems at a later age and more rapidly progress to problem gambling than males. Female problem gamblers often have had difficult family and life experiences. Problem gambling may emerge for females when normal coping mechanisms for stress or negative emotions are overwhelmed by challenging life circumstances.

Chapter Three

Methodology

Participants

Eight women in recovery from pathological gambling were interviewed. These women ranged in age between 33 and 64. Two were adopted and six were biological offspring of their parents. Regarding ethnicity, one women identified as Asian, one as Native American, one as African-American, and five as Caucasian. Regarding partner/no partner relationships, three of the women were single-never married, four were single-divorced, and one was married. Regarding offspring, three had one or more children, and five had no children. Regarding educational attainment, one woman had less than a high school degree, four had high school degrees (with one graduating at 16 years old), one had finished three years of college, and two had four-year college degrees. All of the women were living in the metropolitan area of Minneapolis/St. Paul.

All of the women had been in some sort of treatment for their addiction or were members of and had received support from Gamblers Anonymous. Two relied on Gamblers Anonymous alone. One sought help from Gamblers Anonymous and had also received inpatient treatment. One sought help from Gamblers Anonymous and had also received outpatient treatment. Two had been in both inpatient and outpatient treatment. Two participants had been in inpatient and outpatient treatment and were also members of Gamblers Anonymous. Participants had been in recovery from 150 days to five years (model 3.5 to 4 years). Five participants did not gamble as part of their recovery, two

continued to gamble, but did not believe that their gambling behavior was compulsive, and one gambled only after her bills were paid with the help of a representative payee.

Table 1. Descriptive Demographics.

	Mean (SD) or % (n)
Age (Mean/SD)	45.8 (11.37)
Race	
African American	12.5% (1)
European American	62.5% (5)
Native American	12.5% (1)
Number of Children	0.75 (1.16)
Education	
H.S. or less	50.0% (4)
College or less	50.0% (4)
Marital Status	
Single, never married	37.5% (3)
Married	12.5% (1)
Divorced	50.0% (4)

Design

This is a qualitative phenomenological study that focused on the individual experience of the participants. Data were collected through a semi-structured interview with women who had developed gambling problems and were in recovery. Interviews were one hour in length, and consisted of open-ended questions that were elaborated on for greater depth, with additional probing questions determined by the answers provided. Interview data were transcribed and analyzed to identify emerging common themes that describe the process of developing gambling problems in women and in making the choice to recover. Inclusion criteria for participating in the study were that participants must: (1) identify as a woman, (2) identify as having a gambling compulsion, having a gambling addiction, or a being problem gambler, (3) be 18 to 64 years old, and (4) be in recovery for gambling addiction and have received some type of formal assistance to help them in that recovery, such as being members of Gamblers Anonymous or receiving treatment from a therapist or treatment facility (with recovery being conceptualized as a lifelong process rather than a final stage; Gamblers Anonymous, 2015).

Procedures

Participants were solicited via a recruitment flier electronically distributed to gambling treatment centers and Gamblers Anonymous groups in the Minneapolis/St. Paul metropolitan area. Participants were additionally solicited through the distribution of the flier to psychiatric clinics/mental health clinics, and individual, licensed mental health professionals identified by the state of Minnesota department of Human Services as qualified to work with clients who have gambling problems. Eight women responded to

the flier and a brief telephone contact determined if the participants met inclusion criteria, and understood the nature of the study and possible risks. Explanation of the study purpose and expectations of the participants were provided prior to the consent form being signed at the beginning of the 60-minute, semi-structured, audio-taped interview. Each interviewee received a twenty-five dollar Target gift card in compensation for participation in the interview at its conclusion.

Data collection

The principal investigator conducted the face-to-face, semi-structured, audio-taped interview with each participant for 60 minutes. Questions were developed based on the data in the literature. Question topic areas included, family history of psychiatric illness, chemical use and attitude toward gambling, and the participants' history of trauma in the family environment, the participants' gambling behavior and purpose, the consequences of gambling, and recovery (please refer to appendix A for a complete list of initial questions). One pilot interview was conducted with a confederate to evaluate the ability of the questions to produce useful data. Questions that provided limited relevant information about the process (such as greetings between the interviewer and the participants) were discarded as the interviews accumulated.

Data analysis

Transcription procedures: All of the interviews were audio recorded and later professionally transcribed by confidential transcriptionists in a mental health clinic setting. The tapes were erased after transcribing and the individual interviews were then

identified by the numerical order in which they had been interviewed thus protecting the anonymity of the participants.

Coding: Elements of Consensual Qualitative Research (CQR; Hill et al., 1997) were used to guide the coding of the data. CQR was chosen because it assumes that reality is predominantly constructivist in that it asserts that people construct their own reality, and there are multiple valid and equal constructed versions of the truth (Hill et al., 1997). Truth is considered to be of social construction and one individual's experience will reflect some shared reality with the experiences of other participants. Therefore, when using the CQR method, the researcher looks for common features in individual experience that suggests a shared phenomenon.

The CQR method of qualitative research was chosen because of its respect for individual experience and its relationship to socially constructed reality, which suggests that people make reasonable choices about their behavior based on their experiences, even when the choices create problems for them. CQR is constructionist in that it assumes that researcher and participant influence each other and because of its emphasis on consensus and collaboration (Hill et al, 2005). The researcher's role is to reveal the participant's experience rather than to construct or interpret meaning, and to deepen the participant's understanding of what has occurred.

The purpose of the present study is to explore the process of developing and recovering from pathological gambling. Knox, Hess, Williams and Hill, (2003) used CQR to explore the process and interactions between psychotherapists and clients when the client gives a gift to the psychotherapist, which reflects both an individual and shared

experience between the two people. It was chosen in this study to help determine if there is an individual process in women as they develop gambling problems and choose recovery.

The research team was comprised of the principal investigator and two mental health professionals. All of the team members are female. One is a PhD. Level counseling psychologist experienced in qualitative research. One is a master's level counselor licensed to evaluate substance use problems and counseling. The third is the principal investigator, a master's level licensed mental health provider with 25 years of experience in the counseling field. The team members had from five to 25 years' experience in interviewing clients. The team was trained by reading how the method (Hill et al., 2005) was supported theoretically, developed and utilized for qualitative research. The team then discussed their understanding of the method guided by the member who had previously utilized it. All members reported understanding the method and how to implement it before analysis began.

The principal investigator reviewed the transcribed interviews to eliminate extraneous material and establish core ideas, which are intended to emphasize the essence of what was said with increased clarity without interpretation of the data (Hill et al., 1997). Domains, which are topics used to group the data into topic areas, and themes emerged from the data and were determined by the use of the consensus process among the team members. Differing opinions about the domains and themes were discussed with all team members until consensus was achieved. Conflicting opinions focused on how to determine domains and themes because the data flowed together and they were

related to each other in a manner that made it challenging to establish clear domains. Four domains and twelve themes were identified in the data analysis. One hundred thirty-nine pages of data were generated from eight interviews.

Chapter 4

Results

Introduction

The domains and themes derived from the interviews are presented in this chapter. Four domains and 12 themes emerged from the semi-structured interviews. Domains are the major areas of the data presented by the participants describing their individual processes in the development of problem gambling behavior, and choosing recovery. Domains were developed as the data taken from the interviews was grouped into major topic areas. The domains are: early family environment, purpose of gambling, consequences of problem gambling, and recovery. A number of themes within each domain are presented and selected quotes are cited as "raw data." Hill, Thompson, and Williams (1997) suggested that variations within samples are designated as follows: Concepts that apply to all participants ($N = 8$) are designated as general, concepts that apply to half or greater participants ($n \geq 4$) are designated as typical. Concepts applying to fewer than half of the participants ($n < 4$) designated as variant. Additionally, results of qualitative studies are often presented in the order of the most commonly occurring themes, and then more variant themes, which is the process I used to present themes in this study. The domains in this study are presented according to the chronological process of developing gambling problems and making the choice to be in recovery.

In this study, the participants began their lives in family environments that modeled poor boundaries, ineffective emotional management and limited problem solving skills. Additionally, their families of origin were described as usually under

significant stress from various factors that overwhelmed them. In this chapter the interviewees are referred to as "participants." The emergent domains and themes are presented below. The study data, includes 4 domains and 12 themes. The domains were Early Family Environment, the Purpose of Gambling, Negative Consequences that Preceded Initial Recovery, and Recovery. Five themes composed Domain 1 (Early Family Environment): Psychiatric Illness in the Family, Chemical Use in the Family, Family Gambling Behavior, Family Dynamics, and Trauma History. Three themes composed Domain 2 (the Purpose of Gambling): Triggering Events, the Experience of the Casino, and Escaping Problems and Managing Emotions. Only one theme composed Domain 3 (Negative Consequences that Preceded Initial Recovery): Negative Consequences. Finally, three themes composed Domain 4 (Recovery): Acceptance of the Problem, What is Aiding Recovery, and New Coping Mechanisms. Participants' responses to the semi-structured interviews are depicted in the following sections.

Domain 1: Early Family Environment

Theme 1: Psychiatric Illness in the Family. All participants reported psychiatric illness in their families of origin. All participants reported having a mother with psychiatric illness that made home life difficult for them. Life was often unpredictable, and sometimes dangerous because of parental psychiatric illness. All participants reported that treatment of the illness was either absent or ineffective. All the participants also reported having and having been treated for a psychiatric illness themselves, which suggests family heritability, either because of genetic vulnerability or environment. Example responses for this theme are:

> "My dad, sister, and brother all have depression. Dad has post-traumatic stress (PTSD) from war. My sister has PTSD from a rape. Medication is not taken by most of them." My mother was sexually abused when she was young.
>
> "Mom is bipolar, depressed and wouldn't take medication. She terrorized the family. We never knew what to expect. Dad was depressed. I have PTSD and bipolar."
>
> "Mom was explosively angry. She was good one day and bad the next. One family member committed suicide."
>
> "Mom had bad depression. Her side of the family has a lot of depression. She argued about everything. She took medication, but it didn't help enough. Her mother ignored depression (in herself)."
>
> "Mom had two week bouts of depression. She stopped caring for us when she was depressed and we had to do it ourselves. Dad would help. She had no treatment. I just thought that was the way she was. I have anxiety and depression."

Theme 2: Chemical Use in the Family. According to the participants, chemical use was present in all of the families, which negatively affected family functioning. Chemical use was generally multigenerational, and not treated. All of the participants reported viewing substance use as normal in the family. Three participants abused alcohol and drugs briefly, but stopped chemical abuse. One participant had treatment to stop abusing chemicals and the others stopped without professional help. One of the participants was using drugs while compulsively gambling. Generally, the participants were not abusing alcohol or drugs during their problem gambling period. Example responses for this theme are:

> **"**My mother, father, grandparents, and cousins abused alcohol and drugs. Mom got treatment and stopped after her drinking threatened her life. Dad drank to cover depression. He stopped after going to the workhouse two years before he died. My adolescent sister and her friends got me drunk when I was learning to walk. They laughed while I wobbled around the circle. I have forgiven her. She didn't know better. I was alcoholic until I was in my early twenties. I quit without treatment because I didn't want to repeat what happened in my family."
>
> "Dad was a sneak drinker. He would invite me to go on an errand with him and we would stop at the bar. He drank two beers in 5 minutes while I had a soda. Mom would ask me if we had stopped and I would lie because I didn't want him to get into trouble. My younger brother is a severe alcoholic.
>
> "Mom is an alcoholic. She still drinks, but not as much. Dad got drunk and was a fun drunk. He could still function. One sibling didn't get treatment, but decreased her drinking. One sibling is in recovery. Two of my siblings are still using drugs and alcohol. One sibling got treatment for alcohol abuse twice."
>
> "My mother was alcoholic. My siblings used drugs and alcohol. One stopped and one is still using."

Theme 3: Family Gambling Behavior. All participants had family environments that approved of and engaged in gambling activities as a family and as part of their social interactions with others. Parents taught their children how to gamble when they were young. Gambling was viewed as a fun social, exciting time in an otherwise distressed environment, even if gambling itself was a problem. Sacrificing family needs in order to gamble was accepted. It was a positive family activity where problems were forgotten for a time.

> "I gambled with my family before I finished elementary school. Dad taught us as kids. My siblings and parents gambled. I thought gambling was normal even if it was a problem. We socialized with other families by gambling. The cousins played with the cousins. All of the adults were smoking, drinking and gambling. All my immediate family members have trouble with gambling. I'm the only one in recovery. All the others are in denial."
>
> "Everyone in the family gambled. My grandfather went to Las Vegas to gamble, but I don't know if he had a problem. My parents left the kids at home with my brother in charge when I was in elementary school and he was 11-12 to go out of state to gamble. I gambled with my brother and his friends at home. It was fun and exciting. No other family members have problems."
>
> "My family approved of and engaged in gambling. Dad would wait until others had bought most of the pull-tab box, and then buy and win. He made fun of those that lost control of gambling. My uncle by marriage had a slot machine at home that we played on when I was between five and seven. We got to keep our winnings if we used our own nickels. We had to give them back if they were his.
>
> "My parents played cards while the kids sat on their laps once a week. The family played together. It gave me a passion for gambling. I first played poker at while in early elementary school. My brother had a gambling problem. My ex-husband had a gambling problem."

Theme 4: Family Dynamics. All participants reported family dynamics that did not provide appropriate boundaries, effective management of emotional distress, or problem solving for which modeling was ineffective, including blaming of others for individual emotional distress and taking of sides in conflicts. The participants were required to accept a different reality than the one they lived. They all had to find a way to survive the family rather than be supported by the family environment. The participants reported learning to take care of others emotionally and not themselves. Boundaries of responsibility were unclear or unreasonable. Conflicts and problems found resolution only with time. Example responses included:

> "My grandparents lived in a war zone. Mom is a difficult person. Her depression broke the family. Her family fought a lot. She and her sisters would hold grudges. They went for years fighting, and not talking. I had to agree that I did something I didn't to avoid the price. Mom had to be right. Her family focused on appearances and you had to be perfect. They tried to raise me differently. I was close to my dad growing up. I was a tomboy and he was my coach. He used to make homophobic jokes until he knew I was gay. He says he loves me but he became very religious after being told."
>
> "I was adopted from an orphanage when I was four or five. I was told I was special. I didn't feel special. I felt entitled. I didn't look like my parents. I had a drive to be special. Mom ruled. Everything was all right with dad as long as it didn't make mom mad. I went back to visit the orphanage with my mom shortly before gambling became a problem. Mom rescued the kids financially. My parents are enablers."
>
> "My parents were kids themselves. My parents had no parents. My mom was alone by 17. I learned to care for others not myself. There was no food or lights at times. I was neglected. The family was chaos with poor boundaries and no discipline. I was never told, I love you. There was no strong male figure. No one was in charge. My parents were angry and I thought that was normal family life."

"My parents are a different race from me. They adopted me after they took me in for foster care. Mom was explosively angry and dad lost most of his hearing in the war. There was no direct communication between them. I lied to Mom about Dad's drinking, because he would say, "don't tell." Mom would ask and I would lie to protect him, but I worried that she would find out. My mom took care of my alcoholic brother until she died four years ago. She asked me to do it after she died. I told him to stay away until he stopped drinking. Mom used to ask me to talk to him and I'd refuse if he had been drinking. I was able to set boundaries with him. I don't know how to set boundaries and that has been a problem all my life."

Theme 5: Trauma History. All participants reported a history of sexual or physical abuse, or significant loss. The participants were generally abused by family members or friends of the family. None of the participants told anyone what was happening because they thought that is what life was like. The abusers were siblings, grandparents, family friends or professionals and there seemed no option but to tolerate it. The participants then went on to have had abusive relationships in adulthood. Example responses included:

> "I was sexually abused by my adoptive brother who was two years older but adopted into the family after I was. I was eight and he was 11. It lasted for a year. The family found out after my younger sister saw something sexual on TV and said that is what (brother) does to me. Our parents took us to therapy and after it was done told us not to talk about it again, because we "took care of it." It affected my relationships with men. The first one was abusive. Then I decided, I'll use them before they used me."
>
> "I was sexually abused by my family member's boyfriend after I claimed abuse in kindergarten to live with her in foster care and get regular food. We were neglected at home. I shared the abuse with my sister. We alternated and I would turn him away if it was my sister's turn."
>
> "Mom tried to kill me several times beginning at age 4. Once I played dead when she was trying to smother me. She let go but I don't know why I didn't die. She tried to kill dad. She was physically abusive to the other kids but didn't try to kill them. Other members of the family saw it happen but no one intervened. Dad was physically abusive. He wouldn't let me eat in the house when I was thirteen. I got a paper saying I could work underage, so I could buy food. I left the family at 14 to live in a group home.
>
> "I was sexually abused by my grandfather when I was young. I suspect my mother had been abused by him, too. I went to a physician at 12 to get a physical to go into the convent, and he sexually assaulted me. I didn't go into the convent. I knew I didn't want to get married. I impulsively overdosed one to three months later just before ninth grade. I wanted to die but I didn't know why. The third person was another physician who was inappropriate. I filed charges that were dropped and then sued him

and he surrendered his license. My ex-husband was a sex addict. He would wake me up several times at night for sex. I slept in the bathtub at night to get away from him."

Domain 2: The Purpose of Gambling

Theme 1: Triggering Events. All participants reported that problems with gambling were triggered by a difficult event that was experienced as a significant loss when they were already vulnerable. Consequently, emotions and problems they had been able to manage somewhat became overwhelming. Gambling was an escape, a way to manage feelings, something to do when they couldn't sleep at night, and a way to be around others with no social demands or responsibilities. Gambling was a way to provide boundaries for themselves. Gambling was fun, soothing and distracting. The participants agreed that gambling was never about the money, but rather about a way to enter into a trancelike state. Example responses included:

> "I was pregnant with my first child. I was depressed and couldn't drink or take medication. I had to have something to do, so I turned to gambling because I thought it was safer. My mom and I went back to visit the orphanage I was in when I was 20, but I hadn't thought about it as a trigger. The gambling became a problem shortly after the visit.
>
> "My brother was in a gang and was murdered. Everyone was afraid of the gang members that came to the funeral. My dad left to go gamble. No one was in charge, so I stepped in. Then mom had a heart attack and dad got cancer. He died and gambling got out of control. My daughter was out of town with a relative and I had the time."
>
> "My father died and I started gambling the next year. I was dejected at home in my marriage. I had been trying to tell him (husband) that I wasn't happy for years. I want attention and I need someone as thoughtful as I am. I've been depressed since I was a teenager. I still wonder if life is worth it. The last time I hadn't gambled for seven years when my husband and I went on a vacation and he paid attention to me. He returned to the same behavior when we got back and I went back to gambling after seven years of abstinence."

"I was devastated by a divorce that I didn't see coming after several years of marriage. I first turned to God, but that didn't last. I then turned to gambling. I couldn't sleep and would go to the casino when I couldn't sleep. I started on the slots and started to gamble heavily. I started when I was very vulnerable and didn't have people in my life. Now I have people in my life and I still gamble."

Theme 2: the Experience of the Casino. All participants reported experiencing the casino as comforting, welcoming and providing a sense of recognition that was important for them. Half of the women reported getting a big win early on that reinforced gambling behavior and contributed to feeling lucky. The casino seemed provide what they had been missing in their lives, such as having a community that recognized and valued them. For example, at the casino, they received recognition and tangible rewards when they did something well (e.g., they were given free rooms and food). They felt a sense of belonging they had not felt in their families. Example responses included:

> "The casino was welcoming, special, and social without talking."

> "The casino made you feel special until you were hooked. They asked how I was. They asked how my kids were. They made offers of free hotel room and food. They didn't offer a room if you were down (losing). I was encouraged to feel I was special, not one of eight like my family. After I was hooked, the welcoming behavior stopped. People knew me because I was a high stakes gambler. People wanted to be around me because I was lucky. You get to meet and talk to new people."

> "I loved just being in the casino in hope of getting rich. I felt numb while gambling and anxious afterward. I wasn't completely comfortable in the casino because of the anxiety. I would light a cigarette when I already had one burning. I once walked around the casino trying to demonstrate self-control but I was very anxious not gambling."

> "I felt welcomed and accepted. I got a big win early on. I won a few thousand dollars on the slots. I'd go and win a similar amount at a time. I made a lot of money. The casino was a place to be social, around other without being present. It started as fun and profitable until the addiction set in."

Theme 3: Escaping Problems and Managing Emotions. The participants all reported that gambling served the purpose of escaping from problems and managing emotions that emerged after the triggering event of loss. They all said gambling was not about the money. They often gambled away winnings and knew they were investing more than they were gaining financially. The participants generally experienced telescoping of problem gambling behavior.

> "I gambled for numbing, excitement, safety, problem solving, escape, manage feelings of loneliness, avoid reality, avoid bill collectors. I don't know how to make myself feel better and be responsible. It was a combination of too much responsibility and not knowing how to handle it. I used it for stress relief, distraction and to manage my mood. I liked the adrenaline rush, planning for and getting money. I was excited to gamble. I do everything excessively. I lacked balance. I went to socialize but not speak to others."
>
> "It was the adrenaline of winning. People knew me because I was a high stakes gambler and thought to be lucky. I felt special when I was winning. Others acknowledged me. I gambled to make money to pay bills, to avoid life, to avoid chaos, escape problems, escape responsibility and real life. I only cared about getting the high, feeling special, and recognized. It gave me structure. It gave me a trancelike state. I felt great when winning."
>
> "I gambled to take me out of the uncomfortableness. Gambling took me out of my feelings. I would get depressed and want to die and then find a way to avoid the feelings. I was avoiding the abuse. The machines or watching the numbers, hearing numbers, flipping chips. I step away from whatever. I lost time a couple of times. I was almost separate from my body experience. In nothingness type of thing. It was being separate, something I could do for myself. I was lonely. I was with others. I could talk to them if I wanted or shut it down. I didn't have that alone feeling I'd probably had my whole life."
>
> "Gambling kept me in the moment and I didn't have to think about my problems. I didn't have to worry about work or school or disappointing people. Or, how the drug problem was getting out of control. It was another world. Safe. It wasn't fun losing but it was kind of safe in that I knew what was happening. It was familiar. I used gambling to manage stress and avoid problems."

Domain 3: Consequences of Problem Gambling

Theme 1: Negative Consequences. All participants reported experiencing significant negative consequences before they were able to consider stopping gambling. They all acted against their values by stealing and lying to get money for gambling. They lost their jobs, friends and future possibilities, such as buying a home or having a family. All had to pay back significant debt. Legal consequences were not common. Example responses included:

> "I got fired because I was using the corporate card purchasing gift cards for myself. I had no legal consequences. My company allowed me to pay restitution and leave with a good recommendation. I felt guilt for not being with my child. I got divorced. I lost shared custody with my kids. I lost access to my kids. I nearly died after starting to hemorrhage at the table because I didn't want to leave. The doctor said I could have died. They wanted to hospitalize me. I asked to leave the clinic to pack but was going to gamble. They wouldn't let me leave. I was angry that I was having a baby."
>
> "I was conservator for my aunt and had taken funds from her. I have a felony for embezzling her money. She was a vulnerable adult. Her bills weren't getting paid. My aunt was nearly evicted from assisted living. The state took the proceeds from the sale of her home because of a lien on me. I didn't show up on time for the hearing and I spent the night in jail. I was mandated to pay restitution. I was demoted at work. I took a 20 - year probation to avoid losing my job and to pay back money. I can't get promoted until I'm off probation. I spent time in the workhouse. I realized I was neglecting my child. I probably didn't have money for food. We were eating peanut butter and jelly on pancakes. My child asked what we were going to do, and I decided to go to treatment.
>
> "I lost my inheritance because of gambling. I went back to gambling to make money. I couldn't sleep at night because I was worried about my husband leaving if he knew. He threatened to leave me the last time. I was in trouble after six months that time. I spiraled fast and hit rock bottom. I was very anxious about the negative consequences when I was away from the casino. I was thousands of dollars in debt. We don't have children, partly due to gambling. I thought about killing myself but didn't

want to leave my husband with the debt. He considered not marrying me after I lost the inheritance. I told him first this time and he is struggling with it."

"The debt was the problem. I maxed out my credit cards. I saw the destruction of debt. I had good credit and lost it. I'm at the mercy of whatever (happens). I could have had a house by now. I went to inpatient and it helped because I was away from it for 30 days. You could gamble four times in outpatient before being kicked out. I gambled three times. I lost recovery when I let a homeless guy into my home and he talked me into gambling again."

Domain 4: Recovery

Theme: 1: Acceptance. All participants reported that the accumulated negative consequences, and feedback from family members allowed acceptance that gambling was a problem. The participants reported regret about having had trouble with gambling. All reported that their lives were better in recovery than they had been before gambling began. Example responses included:

> "I walked into GA when my son was two to get people off my back, not because I thought I had a problem. I would gamble after meetings. I wasn't hurting anyone or myself. It was socially acceptable and people can't see it on you like alcohol. I was into body image and didn't want to drink. I found something better. I gambled for 18 years. I began to see it as a problem in when my parents called from out-of-state and expressed concern. I'd already gone through a divorce, lost joint custody of my kids. I had gone to GA and two outpatient treatments but wouldn't go to inpatient. I went to inpatient after my parent's intervention."
>
> " Gambling had been a problem for 7 years. I had an interaction with my dad after legal problems that helped me see how bad it was. I accepted my behavior in treatment. I surrendered to not being able to beat gambling.
>
> "I accepted the uncomfortable feelings about abuse that I'd had much of my life and faced them. I got knocked off my high horse. I can't gamble because it is an addiction. The disease model helped."
>
> "Depression and finances got me into treatment, more depression than finances. I stay in recovery to avoid negative consequences. I remember how hard it was in the past. I accepted that gambling was the problem, not me."

Theme 2: What is Helping Recovery? All participants reported that social support and viewing the behavior as an addiction rather than a failure is helping recovery. They found compassion for themselves and could see they weren't alone in the behavior. They learned to establish boundaries and take care of themselves. Example responses included:

> "Facing negative emotions was effective. They learned to believe they could accept responsibility and take care of themselves. And, family support was important "I found social support in treatment. I felt understood. I found out who I was, and it helped establish boundaries." I tell the truth without judgment. I learned to care to for myself, not others. I learned chaos was a trigger."
>
> "I love everyone I've met. I've been taught (by program) to be more open. I learned to trust myself. I'm stronger."
>
> "Treatment taught me to evaluate risk more carefully and that it was a lie that I would win."
>
> "Facing the abuse. I take care of uncomfortable feelings (more effectively). I (learned to) trust my gut instinct. Social support was helpful."
>
> "GA meetings let me see I wasn't the only one. The disease model and the literature helped. I can't gamble because it is an addiction. Talking about it helps. I'm honest."
>
> "Social support. I remember the pain of gambling, remember how hard it has been. I've learned to see things from a new perspective and be more open. I remind myself that gambling was the problem, not me. And, I see depression as an illness."

Theme 3: New Coping Mechanisms. All participants reported learning significant new ways to cope with their realities in ways that helped them feel better about themselves, and that helped them manage their gambling urges**.** The process was difficult**,** but they appreciated what they were learning from the journey and they were happier than they had been before they began the process of recovery. The participants found strength in themselves they had not been able to see previous. Learning to establish boundaries and believing in themselves were important lessons.

> "I learned to appreciate self and set boundaries with others. I learned to care for myself, not others. I stay out of family chaos and drama. I limit contact with my family. I learned to accept I feel chaos but acknowledge I don't like it and it is temporary. Gambling was my way to reward myself for taking care of others and get away from the chaos. I accepted I can't beat gambling. I have to finish things and I can't finish gambling, so I don't play. I have no urges. I accept I don't have my family with me on this journey. "

> "I trust myself more. I feel like I'm growing up or the first time. I have a job I like and I enjoy going to it. It's fun and I get praised. I need to be rewarded for my work. I recently asked for a raise, and I got it. I use therapy, meditation, projects and crafts, jigsaw puzzles (to soothe myself)."

> " I found empathy and compassion for myself (GA). I avoid gambling friends, bars, lotteries, casinos and racetrack. I don't drink or use drugs. When I have thoughts about gambling, I play the tape in my head to the end when I'm homeless, broke and disappointing people again.

> "I manage the depression. I keep it under control. I see my doctor for medication. I seek social support. I stay in recovery to avoid the negative consequences. I remember that the pain of gambling is more than temporary. I remember how it has gone in the past, how hard it has been. I feel satisfaction that I may help someone else in their recovery. I've learned to look at things from a new perspective. I'm more open. I let go

of hurts from the past. I let go of guilt that I could have done things differently. I see depression as an illness. I remember that gambling was the problem, not me."

Summary of Chapter 4

The women who participated in this study report common experiences that may have contributed to the development of their pathological gambling. Their early family environments were difficult due to mental illness, substance abuse, and poorly defined emotional boundaries. The participants were not safe in their environments and that lack of safety contributed to additional physical and/or sexual abuse or neglect. All of the participants' families engaged in gambling behavior, which was experienced as a happy time in an otherwise chaotic family environment. All of the women experienced an event, usually one of a loss, that preceded the problem gambling. Gambling in the casino provided a sense of belonging and a sense of escape from problems. Early "big" wins added to the positive atmosphere of the casino. The negative consequences were severe before they considered stopping gambling. The women all valued being in recovery from pathological gambling. They were helped by social support, viewing gambling as addiction and a disease, and learning to set boundaries for themselves. They learned how to care for themselves in ways they hadn't before problem gambling began, and were pleased with where they were now along the difficult pathway toward recovery.

Chapter Five

Discussion

Five research questions were posed that guided this qualitative study on gambling addictions among women. These questions were used to guide the exploration of the process of the development of gambling problems in females, and of making the choice to recover. The questions were: 1) Is there a process of developing gambling problems and seeking recovery that was common to the women in the study, 2) What family problems contributed to developing gambling problems, 3) What was the purpose of gambling in the participants' lives, 4) What motivated seeking treatment, 5) What aspects of treatment were effective. Results of the data analysis detected domains and themes that provides response to these questions, and provides evidence that there are commonalities in the process that underlay the development, and recovery of compulsive gambling among participants. The discussion will include analyses in relation to the questions, comparisons with extant literature, the limitations of the current study, and suggestions for future practice.

Responses to the Research Questions

Research Question 1): Is there a process of developing gambling problems and seeking recovery that was common to the women in the sample?

A process of developing gambling problems and seeking recovery that was common to the participants was detected in the data. The process was ascertained by examining data across all four domains. This analysis ascertained that the development of gambling problems was characterized by overarching family problems, including

negative and unstable family environments that allowed significant and painful abuse and childhood trauma. The development of gambling problems was also encouraged by the role modeling of significant family members who used gambling as a way to manage emotions and cope with the negative factors in their own lives. Participants typically learned how to gamble for fun. Then, when a stressful life event occurred, they modeled the behavior of their significant others, and began to also gamble as a way to cope. Their gambling became addictive as they more and more found the comfort, solace, and appreciation that they were denied in other aspects of their lives through the gambling itself, and in the environments in which they were gambling and with the people with whom they were gambling. A triggering event in each case was the point at which a potential problem behavior became a compulsive behavior over which participants had little control.

Likewise the process of seeking recovery that was common to participants was detected in the data. All participants experienced significant negative consequences before entering into recovery. These included damage to relationships and loss of jobs, loss of homes, violating their own personal values, and increasingly negative mood states and cognitions. Interventions from family members or the self-realization of how bad things had become contributed to their final acceptance that they had a gambling addiction. Through social support and continuing to learn about and view their gambling behavior as an addiction were the primary mechanisms that were assisting them in their process of recovery. Also, they learned new coping mechanisms to counter the pain and confusion that they previously escaped from ~~by~~ through compulsively gambling.

Research Question 2): What family and life problems contributed to developing gambling problems?

Domain 1 included participants' descriptions of their family environments that contributed to their gambling problems. These family environments were characterized by unpredictability, and a lack of stability related to the psychiatric illnesses of family members and of the participants themselves. These dynamics limited family members' abilities to manage their emotions effectively, and contributed to alcohol and drug problems in the family. Physical and/or sexual abuse of the participants commonly emerged from these environments, which is analogous to previous studies which found that affect regulation difficulties are part of many psychiatric conditions and are associated with interpersonal trauma and post-traumatic stress (Dvir, Ford, Hill, and Frazier, 2014). Abuse is also analogous to studies that show that female problem gamblers have been shown to have a high rate of childhood maltreatment (Specker et. al, 1996), and that maltreatment in childhood predicts age of onset of gambling problems, severity of gambling problems, and frequency of gambling activity (Petry & Steinberg, 2005).

All the participants grew up in families that were stressed by psychiatric illness, alcohol and drug use, and trauma. Five of the eight participants reported significant mental illness in their primary caregivers that negatively affected the safety of the environments. The remaining three family environments were affected by depression in more than one member. Thus all the families were stressed by mental illness. This is

consistent with the findings of Black, Coryell, Crowe, McCormick, and Shaw (2014) who found significantly higher rates of major depression, bipolar disorder, social anxiety disorder and antisocial personality disorder in relatives of pathological gamblers.

In regard to the variable of early family history, solutions for the mental illnesses were limited and sometimes ineffective. Choices made about managing mental illness suggests that families viewed mental illness as part of life that had to be endured rather than resolved to make the environment better for everyone. A common solution was for the mentally ill person to blame someone for his or her plight. Often the person being blamed was one of the participants in the study. The families were also unable to teach the ability to identify feelings, give them voice, and find a solution to what was distressing, or tolerate the feelings until they decreased. Instead, the participants learned that the only option was to blame others or avoid and deny problems and feelings. The women found a powerful way to avoid problems and manage feelings, at least while they were gambling. This is consistent with the findings of Lesieur and Blume (1991) who asserted that women with gambling problems and a history of trauma used gambling to manage feelings associated with abuse.

Chemical use occurred in all participants' families. Alcohol abuse and dependency problems and drug use occurred in all but one of the families, and drug use or abuse occurred in all but two of the participants' families. Moreover, a third of the participants had siblings with drug or alcohol abuse or dependency. This finding is consistent with that of Ramirez, McCormick, Russo, and Taber (1983) who found that drug or alcohol problems occurred in relatives of 50% of male pathological gamblers

interviewed. The wide use of alcohol and drug abuse and dependency in participants' families is consistent with the idea that these families demonstrated limited ability to solve problems directly and rather relied on distraction or avoidant activities that enhanced the problems rather than solved them.

The data in this current study reveal that participants' families were unable to protect participants from physical or sexual abuse or both, or from physical neglect and emotional deprivation. For example, five of the participants were sexually abused by close relatives, which sometimes led to sexual trauma outside of the family or in later relationships. One participant's life was threatened by her mother on several occasions while other family members observed and did not intervene. Other participants were traumatized emotionally, such as when one participant who relied almost exclusively on her father for emotional and safety needs, lost him when she was 24.

Moreover, seven of the eight participants found limited safety or predictability in their homes. Instead, chaos was common, and they were sometimes emotionally, physically or sexually abused. Yet, a positive child environment relies on regularity, consistency predictability and controllability (Bronfenbrenner & Evans, 2000). Participants' responses suggest that the pathological gambling in which they engaged could have provided the type of stimulus that was familiar to them given the chaotic environments in which they were raised. Research suggests that gambling itself alters the dopamine, serotonin and norepinephrine levels of pathological gamblers, which may influence individual responses to reward, impulsivity, learning and self-control,

(Goudriaan, Oosterlaan, deBuurs, and Van den Brink, 2004), which are all problems associated with pathological gambling.

Within the atmosphere of unpredictability, the families of the participants approved of and engaged in gambling, often as a family or social activity. Additionally, gambling was experienced as a fun, exciting and comforting activity. Black et al. (2014) reported that first-degree relatives of pathological gamblers had more than an 8-fold higher lifetime prevalence of definite/probable pathological gambling than relatives of the control group of non-pathological gambling relatives. The current study may reflect the mechanisms regarding how pathological gambling is passed from generation to generation. For example, four of the participants described gambling as a youngster with their families, including sitting on their parent's laps while their parents gambled, and gambling with extended family members or other families as a social mechanism. These behaviors started for some as early as five years old. One participant learned to gamble with her young adolescent brother while in his care because the parents had gone to Las Vegas to gamble. One participant described gambling with extended family members or other families for socializing. One participant described gambling with her parents who had ignored her gambling problems. Five of the participants reported other family members with gambling problems. Three of the participants reported family members who gambled but remained in control of the behavior. For 7 of the 8 participants, gambling was cited as a common activity in their families. Early gambling was seen as fun, exciting and a positive time for the participants in families that often were otherwise distressed.

Dvir et al. (2014) reported that emotional dysregulation, and lack of appropriate boundaries are associated with an unpredictable and unstable family environment. The family environments described were not equipped to provide a predictable and safe environment for the participants to grow up. Boundaries within the families were not clearly defined and participants were being held accountable for other family members' emotions even though they had no control over others' emotions. The participants learned to cope with the difficulties in their families' environments any way they could even though they did not have adequate direction, modeling or teaching. For example, they learned to blame themselves for problems rather than change the behavior that was causing the problem. The participants did not learn to establish boundaries or good self-care in their family environments. Instead, they learned to take care of others rather than themselves and to have little regard for their individual value. Gambling provided a way for participants to establish individual boundaries, a temporary positive sense of self, and a social community without excessive interpersonal demands, especially when they were winning at gambling.

The emotional stress of the family environments and maltreatment reported by seven of the eight participants suggest that healthy emotional management, and effective problem solving were skills the families were unable to provide. Putnam, (1992) asserted that the core sense of self is to a great degree is defined by the capacity to regulate internal states. The participants all reported that gambling helped them to manage emotions and provided some with a positive sense of self associated with being seen as lucky, as a high roller, and as a winner. Six of the participants' families were reported by

the participants to be challenged by psychiatric illness, chemical abuse and childhood maltreatment of some form. Two described enmeshed relationships with their parents. This suggests that effective problem solving may not have been available to learn, and the participants' sense of self was impaired by enmeshment and devaluation of family interpersonal relationships (Ford, Courtois, Steele, and van der Hart, 2005).

The participant's described family distress and problems that were not managed well. In these environments, all of the families of the participants approved of and engaged in gambling for entertainment and as a means of socializing. In fact, gambling activities were often positive times in the families of the participants. "I learned a passion for gambling" in childhood with the family; "the adults played cards (gambling) while the kids sat on their laps;" "we socialized as family in gambling activities; "it was exciting" to play on family member's slot machine. "I gambled with my brother and his friends (while parents were out of state to gamble) at home. It was fun and exciting."

Research Question 3): What was the purpose of gambling in the participants' lives?

The second domain described the participants' purpose for engaging in gambling activities. All the participants experienced a triggering event that set off an emotional crisis prior to gambling behavior that became compulsive. The casinos where they gambled became a haven for safety and comfort that provided them with something essential that they had been missing, such as a sense of belonging, and being treated as special and important rather as invisible. The casino environment allowed them to distract themselves from emotional pain and forget about their responsibilities. Four of

the participants got a big win early on that contributed to difficulty assessing the real odds of winning vs. losing.

All of the participants reported a crisis event that overwhelmed their equilibrium triggering their pathological gambling behavior. The casino was an inviting environment and seemed to provide them with well-being that was missing, a positive sense of self as a winner and known to others, a sense of belonging, emotional management, boundaries and a community that was present but not close. All of the participants described using gambling to manage/avoid emotions.

Participants further reported that they used gambling to induce a trancelike state so they could escape problems and avoid negative mood states. The trancelike state while gambling was powerful enough to over-ride physical needs, such as eating, sleeping or going to the bathroom, which suggests an explanation for telescoping behavior in female problem gamblers. Gambling moved beyond entertainment to a method of managing seemingly insurmountable emotional distress. As one participant reported, "it took me out of the uncomfortableness" associated with sexual abuse that otherwise led her to consider dying. In this context, it is understandable that a compulsive behavior became the solution. This supports the findings in the literature indicating that females are more likely to be escape gamblers who utilize gambling activities to manage negative feelings (Ledgerwood & Petry, 2006; Crisp et al., 2004).

Various events served as triggers to the participants in this study. For example, depression occurred during pregnancy without the option of taking antidepressants because of the pregnancy. In this case, gambling seemed like a safe way to deal with the

depression without taking dangerous chemicals. Experiencing feelings of being powerful and in control and of being wealthy counteracted depression. Additionally, the death of important family members, and the feelings of loneliness, emptiness and thoughts of suicide following divorce served as triggers as well.

The course of the gambling behavior went from experiencing a triggering event, to experiencing almost immediate gratification for gambling. For example, one participant stated that she won a few thousand dollars on slots "early on in the process." Is the exact amount an identifier???She stated that she had not won much for four years but was still hopeful. Immediate gratification was also accompanied by compulsive behavior based on cognitive distortions about the relative safety of gambling compared to drinking, the beliefs that winning made one important, and money that was lost could be won again.

All of the participants reported engaging in behaviors that violated their morals, such as stealing, embezzling and borrowing money that was not paid back in order to maintain gambling. All the participants reported shoplifting and returning shoplifted merchandise in exchange for gift cards they could sell for cash. One participant reported not going to the bathroom for a number of hours, not eating for the same period, and going to work with no sleep after gambling all night. One participant lost a significant amount of blood that threatened her life because she didn't want to leave the table at the casino.

The participants reported that the primary purpose of gambling was to avoid negative feelings and problems. It was not to make money, although, making money was

sometimes a justification for gambling. These findings are consistent with the literature, which has found that female gamblers use gambling to escape from feelings and life problems and that female problem gamblers have higher rates of mood disorders and anxiety, and higher rates of maltreatment. Hodgins, Schopflocher, el-Guebaly, Casey, Smith, Williams, and Wood (2010) found female pathological gambler had significantly higher rates of emotional and sexual abuse than male pathological gamblers. Childhood maltreatment was associated with higher frequency of gambling and higher probability of having gambling problems.

One participant returned to visit the orphanage from which she had been adopted with her mother when she was four or five. She reported feeling nothing, but gambling became a problem shortly afterwards when she became pregnant. She was already depressed, decided to stop drinking and couldn't take medication for the depression, and she was having relationship conflicts. Gambling seemed a safe alternative to drinking.

All but one participant reported telescoping of gambling behavior after the triggering event even if they had been gambling for years. One participant loved getting the winning ticket when she bought an entire box of pull-tabs, and she did this despite knowing she was losing more than she was winning. "It was never about the money. It was the big shot attitude." She began to engage in illegal activities to get money to gamble. And, eventually she nearly lost her life because of gambling, and didn't lose her life only because others took over control.

Four of the participants got a big win early in their gambling experience. One participant got a big win at 21 and thought that was part of getting hooked. She would

get her paycheck and stay at the casino for two-three days. She chased her losses because she felt important when she won big. She loved the adrenaline of winning big. "I'm a winner at everything I do. I succeed. I can beat the table. I stay until I win." She wouldn't go to the bathroom for 12-13 hours at a time while gambling. She couldn't stop when losing, even though she couldn't pay her bills and thought it was killing her. She would sleep in her car if she was not given a room at the casino.

Another participant won three $2500 jackpots in six months. She started going with her cousin after her father's death, and then started going alone. She thought gambling was safer than drugs or alcohol. She was afraid she would kill herself if she was under the influence of a substance and lost control. She chain-smoked and didn't eat while there. She always thought she could win her losses back.

One participant won a few thousand dollars on slots early on in the process. She hasn't won much for four years, but is still hopeful. "I would always go there hopeful and get down when I lost. It was like my mom who was nice at one point and terrible the next. I would gamble for hours and not go to the bathroom. I never keep my winnings. I gamble until it is gone."

One participant loved the distraction of the casino. She gambled without problems until 2009. The casino sent her a coupon for a once per week free stay at the hotel. She initially went and gambled $20. She got more comfortable going to the casino, and it got toxic quickly after her marriage ended.

One participant felt lonely, empty and wanted to die. Gambling took her out of those feelings. "I gambled all night one night and didn't realize I had been there. I lost time a couple of times. I would gamble ten hours at a time. I don't remember if I ate or went to the bathroom. It was never about the money."

One participant started before she was 20 and hit a big jackpot right away. "I had spent most of my money, bought a fifty-cent pull tab and won a few thousand dollars. I took my friends out and paid for everything to celebrate. I liked the appearance of being wealthy. It meant others would want to date me or be my friend. I kept hoping it would happen again. I was the boss when I was winning. It was a chemically induced high. I would be there for days and wouldn't sleep or go home. The extremes were attractive. I went from regular to high stakes gambling."

Participants reported that they experienced an emotionally difficult event involving loss that overwhelmed their current coping mechanisms for negative emotions. The faster progression (telescoping) of problem gambling found in women (Wenzel & Dahl, 2008) may be due to the women using gambling to manage negative mood states as found in previous research (Ledgerwood & Petry, 200; Crisp et al. 2004).

Research Question 4): What motivated seeking treatment?

The third domain describes the negative consequences that occurred because of gambling. All incurred significant debt and engaged in behaviors, such as shoplifting, stealing from family and friends, and lying that violated their usual values. Significant relationships were damaged or lost, as were jobs and homes. Two encountered legal consequences. The outcomes increased negative thoughts and moods that gambling had

initially been utilized to manage, and increased problems that the participants already felt unable to face. Participants also described interventions from significant others that may have been motivating. Participants began to recognize gambling as a problem rather than a solution.

The participants reported that losses associated with gambling had to become significant enough to overcome the emotional benefit of the activity. All participants described social and emotional losses that were deemed extraordinary before deciding to stop gambling. Social, emotional, financial and legal problems are associated with pathological gambling. Pathological gambling can trigger or worsen depression, generalized anxiety, obsessions and personality disorders, and an increased rate of suicidal ideation and attempts (Fong, 2005). The National Gambling Impact Study (1999) reports that five billion dollars are lost each year due to money losses, legal expenses and lost productivity. Many of the participants described engaging in behaviors that violated their values, such as not performing their job, lying and stealing, not repaying loans to people who had tried to help, and neglecting children and pets. One participant lost her work, her children, her marriage and nearly died before deciding to recover, and she made the decision after her parents intervened. One participant was embezzling funds from her aunt who was a vulnerable adult and for whom she was conservator. Her aunt was nearly evicted from assisted living. She and her daughter were nearly evicted from their home due to unpaid rent. She recalled "probably not having money for food" and, her daughter's questioning what they were going to do, before she decided to seek treatment. One was into gambling trouble three times before

her most recent recovery. She had lost the inheritance left by her father, didn't have children, and nearly lost her marriage due to gambling. One participant valued good credit, and lost it after maxing out her credit cards. She believes that she would have a secure financial life closer to what she desires had it not been for gambling. One participant accepted she could not control gambling after her mother bailed her out twice and then said, "enough is enough." The participant was warned not to come back if she gambled again. She had maxed out her credits cards and was neglecting her pet. Her mother's warning drew her into recovery. One participant reported that it was the debt and how rapidly she got into it that helped her decide to stop gambling. One participant "hit rock bottom" after her family was done with her. She was stealing from people for gambling and drug money, and she lost all her friends. She had no one else to borrow from and lost her living environment. She was arrested for drug possession, court ordered to treatment and requested gambling treatment as well. One participant described debt, shame, guilt, depression and remorse that contributed to choosing recovery. "I lost my morals. You lose your whole being. Spiritually, physically, emotionally, I lost it all." All the participants reported losses so significant due to gambling that they were able to choose recovery over the important perceived benefits of gambling. Gambling itself became more dangerous than everything else they had been avoiding.

The research indicates that legal social and health costs are associated with pathological gambling (Wynne & Schaffer, 2003). Significant emotional costs are also associated with pathological gambling in women. Potenza et al. (2001) found that female

problem gamblers report higher rates of anxiety disorders, are more likely to attempt suicide, and to have sought treatment for mental concerns than male pathological gamblers. The women in this study reported that social, emotional and financial losses had to be significant to override the benefit of gambling.

Research Question 5): What aspects of treatment were effective for women?

The fourth domain describes what allowed the participants to enter into recovery rather than to continue gambling to regain losses (chase their losses) or try to solve problems with gambling as they had been doing. All of the participants valued recovery and six intended to remain abstinent. One reported engaging in controlled gambling. Only one participant continued to gamble without problems, and she was the one who "faced emotions related to sexual abuse" with the help of psychotherapy. One described understanding what drove the behavior and accepting she was unable to achieve her goal with gambling. She is abstinent and reported that she has no urges to gamble. Two described the development of gambling problems and recovering from them as a spiritual journey that was difficult, but also allowed them to accept themselves in a positive way.

All participants reported an accumulation of loss and problems before entering recovery. The recovery process involved acknowledging the negative consequences of gambling, and accepting that gambling behavior could not be controlled. Seven participants reported responding well to the disease model and they attributed gambling behavior to addiction. This approach seemed to reduce shame about the behavior. One participant reported that she learned to identify gambling as the problem, not her.

Family involvement was a component of recovery. One participant responded to her parent's opinion and willingness to escort her to treatment. One participant reported that an interaction with her father after encountering legal problems helped her make the decision for treatment. One was clear she would lose her marriage if she didn't stop gambling and decided the marriage was more important. Other participants responded to the possibility of losing family contact. One participant's mother threatened to cut her off if she didn't stop gambling. One participant's partner left because the participant continually threatened to leave in order to be begged to stay until the partner decided to leave.

Social support was identified as an important aspect of recovery. One participant said she felt understood in treatment. "I could see I wasn't the only one. I found out who I was." Most of the participants reported an improved relationship with themselves due to family and/or social support provided in treatment and with GA. One reported that she found empathy and compassion for herself. They reported a sense of belonging and increased self-trust in their ability to assess risk about gambling and to take care of themselves. They found their own ability to accept responsibility for themselves. Their ability to identify realistic risks for gambling behavior may have been part of this change.

Changes in choices to manage feelings include social support, using sponsors and GA phone list, and taking one day at a time. "The program taught me to trust myself and be more open." Medication and psychotherapy were tools to manage emotions. They learned to establish boundaries and to care for themselves rather than others. Some

reported a change of perspective and learning to see gambling and depression as an illness rather than failure.

Six of eight participants planned to remain abstinent from gambling and two continued to gamble. One paid her bills before gambling and was managing to stay in control of gambling by limiting her access to her money. She arranged to have a payee for her bills, and this structure was working for her at the time. This participant did not utilize the social support available in GA because other's vulnerability was a trigger for gambling.

In contrast, one participant was able to gamble for entertainment purposes only. She believed that gambling was a method to avoid the feelings associated with sexual abuse. "I faced the abuse," and then did not have urges to gamble to extremes. She was no longer using gambling for emotional management, and instead was using it for entertainment alone, as do others who do not encounter problems.

Many of the participants learned to identify triggers for gambling and to manage or avoid them instead. "I limit contact with my family to stay out of the chaos and drama." She identified chaos as a powerful trigger for gambling. Another one reported that she avoided her ex-husband. One participant avoided gambling friends and gambling places where she had gambled. One came to understand that depression, anxiety, sadness, and feeling devastation for others and not caring for herself were triggers for gambling. Two of the participants played out the entire process of gambling in their minds when urges to gamble arose, including all the negative consequences at the

end. One learned to "let go of old hurts and the guilt of thinking I could have done things differently."

All of the participants reported being happier in recovery than they were before. They increased social support, self-value based on their own achievements, and were able to assume responsibility for themselves. They learned to establish boundaries for themselves and to care for themselves rather than others. Many of the women interviewed described the process as a spiritual journey during which they learned things about themselves they were unlikely to have known if gambling had not forced the exploration.

Conclusion

One study question before gathering data was, "what makes gambling so compelling that the negative consequences of the behavior can be denied or ignored?" This question was answered in the interviews. All the participants started life in difficult circumstances with distressed families influenced by untreated or partially treated mental illness that affected the functioning of the family and the woman interviewed. Effective emotional management was not demonstrated in the family. The women learned to deny or ignore or accept the reality in front of them in order to survive. Physical and emotional safety was absent. Participants learned not to trust in others. They learned that emotions were to be avoided not resolved. The women did not learn about appropriate boundaries or to value themselves. Rather, they learned that it was best to take care of others and not themselves or participate in the chaos.

Five of the women were sexually abused, and two were physically or emotionally abused. One was not abused but grew into adulthood without having a sense of how to care for herself without her father, and he died when she was 24. Boundaries within the participant's families seem to have encouraged dependence on someone else to take care of their feelings and needs. She had a history of limited social support and her father helped her when she was depressed about having few friends. Another participant grew up in a family that valued appearances and being perfect, and she is gay. Her mother required her to accept responsibility for things she had not done because the cost of the truth was too high when compared to accepting responsibility that wasn't hers.

Sexual abuse is associated with problem gambling behavior in women. Specker, Carlson, Edmonson, Johnson and Marcotte (1996) found that rates of childhood sexual/physical abuse are higher in pathological gamblers than in national samples (32.5% vs. 1-2%). The fact that sexual abuse has occurred is difficult enough. Disassociation is a known coping mechanism for tolerating abuse. The women in the study described entering into a trancelike state through gambling when avoidance of problems seemed most effective.

Gambling problems followed a difficult event for all the women. All the families of the women socialized by engaging in gambling activities, and the women had memories of belonging, safety and comfort when engaged in gambling. Gambling provided a sense of socializing without having to engage with others. The casino was there when they couldn't sleep or tolerate their feelings. A big win early on for four

participants and the welcoming environment of the casino added to the power of the experience. In the absence of a wider array of choices, gambling solved problems for the women when other solutions seemed impossible.

The women in this study responded to treatment. They reported processing feelings about maltreatment in therapy, finding compassion for themselves, developing the ability to set boundaries and learning to take responsibility for themselves. This is consistent with the focus of Gamblers Anonymous, which provides peer support and structure. Cognitive behavioral therapy can address the cognitive distortions that help maintain problem gambling. Psychodynamic psychotherapy explores deeper motivations for gambling, and family therapy can help solve problems in the family that were created by the gambling, or one of the concerns the gambler was trying to escape (Fong, 2005).

Implications for Treatment

The variables associated with treatment and recovery for the participants of this study included, family support if available, social support, identifying pathological gambling as an illness rather than personal failure, use of medication to manage mood problems, learning new coping mechanisms for negative emotions, learning to establish boundaries for themselves rather than relying on an external source to do it, and accepting responsibility for their lives. Childhood maltreatment characterized all but one of the families in which the participants grew up. The data in this study suggests that female pathological gamblers should be assessed for a history of maltreatment, and females with a history of maltreatment should be assessed for gambling problems. The disease model of gambling seems to allow the women to develop a more positive

relationship with themselves, and to accept social support offered in Gamblers Anonymous and inpatient/outpatient treatment. Only one participant was able to gamble without problems after recovery. She reported avoiding the emotions associated with sexual abuse for several years despite several psychotherapists suggesting it to her. She additionally reported that "facing the abuse" was the reason she is able to maintain recovery and gamble for entertainment only. The common experience of maltreatment in the participants' histories suggest that women may be better suited to single gender treatment.

Limitations

This study relied on recruiting women who were in the process of recovery. Thus, by design, the sample in this study does not represent all women who suffer from gambling addictions. A natural limitation of phenomenological research is the emphasis on depth rather than breadth. The phenomenological method provides richness in understanding of the subjective experience of the participants. Because of this, and because inferential statistical analyses are not used in qualitative research, generalizability is not available.

References

American Gaming Association (2007). *The 2007 state of the states: The AGA survey of casino entertainment.* Retrieved from www.americangaming.org/assets/files/aga_2007_sos.pdf.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders, 3rd. ed., Revised (DSM-IIIR-R).* Washington DC: Author.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, 4th ed., Text Revision (DSM-IV-TR).* Washington DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders,* 5th ed. (DSM-5). Washington DC: Author.

Arizona Counsel on Compulsive Gambling (1999). The Arizona council on compulsive gambling. Retrieved from website. http//www.azccg.org.

Black, D. W., Coryell, W., Crowe McCormick, B., Shaw, M., & Allen, J. (2015). *Suicide ideation, suicide attempts and completed suicides in persons with pathological gambling, and their first-degree relatives.* Suicide and Life Threatening Behavior. Doi:10, 1111/sltb. 12162. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/sltb.12162/abstract

Blanco, C., Hasin. D. S., Petry, N., Stinson, F. S., and Grant, B. F. (2006). Sex differences in subclinical and DSM-IV-TR pathological gambling: Results from the national epidemiologic survey on alcohol and related conditions. *Psychological Medicine, 36,* 943-953.

Blasczcynski, A., & Nower, L. (2002). A pathways model of problem and pathological gambling. *Addictions, 5,* 487-499.

Boughton, R., & Falenchuk, O. (2007). Vulnerability and comorbidity factors of female problem gambling. *Journal of Gambling Studies, 23,* 323-334.

Bronfenbrenner, U. & Evans, G. W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development, 9,* 115-125.

Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology, 60,* 174-184.

Crisp, B. R., Thomas, S. A., Jackson Smith, S., Borrell, J., Ho, W. Y., & Thomason, N. (2004). Not the same: A comparison of female and male clients seeking treatment from problem gambling counseling services. *Journal of Gambling Studies, 20,* 28-299.

Cunningham-Williams, R. M., Cottler, L. B., Compton, W. M. III, Spitznagel, E. L. T. (1998). Taking chances: Problem gambling and mental health disorders. *American Journal of Public Health, 88,* 1093-1096.

Derevensky, J. L. & Gupta, R. (2007). Internet gambling amongst adolescents: A growing concern. *International Journal of Mental Health and Addictions, 5,* 93-101.

Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2014). Childhood maltreatment, emotional dysregulation and psychiatric comorbidities. *Harvard Review of Psychiatry, 22,* 149-161.

Encyclo.co.uk (2014). *Saturation.* Retrieved from http://www.encyclo.co.uk/meaning-of-Data%20saturation

Fong, T. W. (2005). The vulnerable faces of pathological gambling. *Psychiatry (Edgmont), 2,* 34-42.

Ford, J. D., Coustois, C. A., Steele, K., & van der Hart, O. (2005). Treatment of comlex sequelae of psychological trauma. *Journal of Traumatic stress 18,* 437-447.

GamblersAnonymous.org (2013). Steps of recovery program. Gamblers Anonymous International Service Office, Los Angeles, CA, 90017. Retrieved from http://www.gamblersanonymous.org/ga/content/recovery-program

Goudriaan, A. E., Oosterlaan, J., de Beurs, E., & Van den Brink, W. (2004). Pathological gambling: A comprehensive review of biobehavioral findings. *Neuroscience and Biobehavioral Review, 28,* 123-141.

Grant, J. E., and Kim, S. W. (2002). Gender differences in pathological gamblers seeking medication treatment. *Comprehensive Psychiatry, 43,* 56-62.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to consensual qualitative research. *Counseling Psychologist, 25,* 517-572.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52,* 196-205.

Hing, N., & Breen, H. (2001). Profiling lady luck: An empirical study of gambling and problem gambling amongst female club members. *Journal of Gambling Studies, 17,* 47-69.

Hogins, D. C., Schopflocher, D. P., el-Guebaly, N., Casey, D. M., Smith, G. J., Williams, R. J., Word, R. T. (2010). *Psychology of addictive behavior, 24,* 548-554.

Ibanez, A. Blanco, C., & Moreryra, P. (2003). Gender differences in pathological gambling. *The Journal of Clinical Psychiatry, 64,* 295-301.

Jackson, A., Thomas, S. A., Ross, C., & Kearney, E., (July 1999-June 2000). Analysis of clients presenting to gambling counseling services. *Clients Services Analysis, Report No. 6,* Department of Human Services, Melbourne.

Knox, S, Hess, S. A., Williams, E. N., & Hill, C. E. (2003). Here is a little something for you. How therapists respond to client's gifts. *Journal of Counseling Psychology, 50,* 199-210.

Ledgerwood, D. M. & Petry, N. M. (2006). Psychological experience of gambling and subtypes of pathological gamblers. *Psychiatry Research, 144,* 17-27.

Lesieur, H. R., & Blume, S. B., (1987). The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American Journal of Psychiatry, 144,* 1184-1188.

Lesieur, H., & Blume, S. (1991). When lady luck loses: Women and compulsive gambling. In Nan Van Den Bergh (Ed.) *Feminist perspectives on addiction* (pp. 181-197), New York, NY: Springer Publishing Company.

Lesieur, H. (1993). Female pathological gamblers and crime. In W. Eadington & Cornelius (Eds.) *Gambling behavior and problem gambling* (pp. 495-515). Las Vegas, NV: University of Las Vegas Press.

Nelson, S. E., LaPlante, D. A., LaBrie, R. A., and Shaffer, H. J. (2006). The proxy effect: gender and gambling problems trajectories of Iowa gambling treatment program participants. *Journal of Gambling Studies, 22,* 221-240.

Nower, L. & Blasczynski, A. (2006). Characteristics and gender differences among elf-excluded casino problem gamblers: Missouri data. *Journal of Gambling Studies, 22,* 81-99.

Paton-Simpson, G. R., Gruys, M. A., & Hannifin, J. B. (2002). Problem gambling counseling in New Zealand. *2001 National Statistics,* Palmerton North, New Zealand: Problem Gambling Purchasing Agency.

Petry, N. M. (2005). Pathological gambling: Etiology, comorbidity and treatment. Washington DC: American Psychological Association.

Piazza, N. J., Vrbka, J. L., and Yeager, R. D., (1989). Telescoping of alcoholism in women alcoholics. *International Journal of Addiction, 24,* 19-28.

Potenza, M. N., Steinberg, M. A., McLaughlin, S. D., Wu, R., Rounsaville, B. J., & O'Malley, S. S. (2001). Gender related differences in the characteristics of problem gamblers using a gambling helpline. *American Journal of Psychiatry, 158,* 1500-1505.

Ramirez, L .F., McCormick, R. A., Russo, A. M., & Taber (1983). Patterns of substance abuse in pathological gamblers undergoing treatment. *Addictive Behavior, 8,* 425-428.

Shaffer, H. J., Hall, M. N., & Bilt, J. V. (1997). *Estimating the prevalence of disordered gambling behavior in the United States and Canada: A meta-analysis*. Boston, MA: Harvard Medical School.

Shaffer, H., Hall, M. N., & Bilt, V. J. (1999). Estimating the prevalence of disordered gambling behavior in the United States and Canada: A research synthesis. *American Journal of Public Health, 89*, 1369-1376.

Slutske, W. S., Jackson, K. M., & Sher, K. J. (2003). The natural history of problem gambling from age 18 to 29. *Journal of Abnormal Psychology*, *112*, 263-274.

Slutzke, W., Piasecki, T. M. Deutch, A. R., Statman, D. J., Martin, N. G. (2014). *Addiction, 110,* 144-151.

Specker, S. M., Carlson, G. A., Edmonson, K. M., Johnson, P. E., & Marcotte, M. (1996). Psychopathology in pathological gamblers seeking treatment. *Journal of Gambling Studies, 12,* 67-81.

Stinchfield, R., & Winters, K. (2001). Outcome of Minnesota's gambling programs. *Journal of Gambling Studies, 17,* 217-245.

Substance Abuse and Mental Health Services Administration (2010). *Results from the 2009 national survey on drug use and health* (vol. 1). Rockville, MD: Summary of National Findings.

Tavares, H., Zilberman, M., Beites, F., Gentil, V. (2001) Brief communications: gender differences in gambling progression. *Journal of Gambling Studies, 17,* 151-159.

Tavares, H., Martins, S. S., Lobo, D. S., Silveira, C. M., Gentil, V. & Hodgkins, D. C. (2003). Factors at play in faster progression for female pathological gamblers: An exploratory analysis. *Journal of Clinical Psychiatry, 64,* 433-438.

Voberg, R. A. & Wray, M. (2007). Legal gambling problem gambling as mechanisms of social domination: Some considerations for future research. *American Behavioral Scientist, 51,* 56-85.

Wegman, H. L., & Stetler, C. (2009). A meta-analytic review of effects of childhood abuse on medical outcomes in adulthood. *Psychosomatic Medicine, 71,* 805-812.

Welte, J. W., Barnes, G. M., Wieczorek, W. F., Tidwell, M. C., & Parker, J. (2002). Gambling participation in U.S. adults: Prevalence, demographic patterns and co-morbidity. *Journal of Gambling Studies, 18,* 313-337.

Wenzel, H. G. & Dahl, A. A. (2009). Female pathological gamblers: A critical review of the clinical findings. *International Journal of Mental Health and Addiction, 7,* 190-202.

Westphal, J. R., (2008). Pathological gambling: Psychiatric models. *International Journal of Mental Health Addiction, 6,* 602-618.

Wiebe, J. M., & Cox, (2001). A profile of Canadian adults seeking treatment for gambling: Problems and comparisons with adults entering an alcohol treatment program. *Canadian Journal of Psychiatry 46,* 418-421.

Winters, K. C., Stinchfield, R. D., Botzet, A., & Anderson, N. (2002). A prospective study of youth gambling behaviors. *Psychology of Addictive Behaviors, 16*, 3-9.

Wynne, H. J. & Shaffer, H. J. (2003). The socioeconomics of gambling: The whistler symposium. *Journal of Gambling Studies*, *19,* 111-121.

Appendix A

Interview Questions

Demographics:

Interview #:

Ethnicity: Relationship Status: Children:

Age: Current At Onset At Recovery

Gender:

Education:

Employment History:

Family History:

- Family attitudes about gambling
    a) Approve/disapprove/engage
- Others with gambling problems in family
    a) Immediate and extended family
    b) If problems, active or in recovery? Method of treatment.
    c) How did gambling problems affect the family?
- Family history of alcohol abuse, drug abuse, impulse control problems
    a) Who in immediate and extended family?
    b) What behaviors or substance use?

c) In treatment or not? Level of success in treatment.

- Family history of mood disorders

a) Immediate and extended family.

b) What disorder?

c) Treated or not?

d) How affected family?

1. What contributed to you developing gambling problems?

a) Psychiatric, alcohol, drug use, age at onset, history of trauma?

b) Family?

c) Environment situations: work, financial stress, relationship conflict, limited social support, trauma?

e) Other?

2. What were your emotional, physical and thinking experiences when you gambled?

a) Mood changes?

b) Physical changes, heart rate, breathing, perspiration, sense of exhilaration?

c) Gambling behavior as problem solving tool, reduce stress?

d) Beliefs about winning vs. losing in gambling?

e) How did you feel about yourself before, during and after gambling?

3. How did your mood, physical experience and thinking process change over time?

a) Each time: winning/losing streak, luck/ability, happy/irritable/excited?

b) Over time between initiation and recovery?

4. What did you enjoy about gambling?

a) How skilled are you?

b) Competitiveness?

c) Mood change?

5. What did you dislike about gambling?

a) Need higher and higher stakes, increased reward, defend losing streaks?

6. Do you think your age at onset contributed to gambling problems? If so, how?

a) How risky did you think gambling was initially?

b) How risky do you think gambling behavior is now?

7. What experiences led you to believe you had a problem?

a) Legal?

b) Social, family, friends?

c) Who first labeled the behavior?

d) Academic/employment/financial/debt?

e) Other?

8. What made you decide to enter treatment? If mandated, how did you come to accept gambling as a problem?

9. What aspects of treatment have been most useful to help you with recovery? Least

helpful?

10. How much are you in recovery now?

a) Do you intend to maintain abstinence?

b) Have you identify triggers for gambling behavior?

c) What new coping mechanisms have you developed for the triggers?

b) How will you accomplish abstinence?

11. What makes recovery compelling enough to overcome problem gambling behavior?

12. What challenges to your recovery do you experience?

13. How do you feel about yourself now versus when you were gambling?

14. Why do you think others can gamble socially without problem while for you it is problematic?

Is there anything else you would like to comment on?