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Group therapy for women problem gamblers: A space of their own

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Abstract

This report presents the results of a grounded theory analysis produced from in-depth interviews with 14 women participating in group counselling for problem gambling. Themes emerged from this analysis that provided insights into effective counselling practices for women problem gamblers. The results explore the impact of a group therapy approach in addressing the needs of these women. Participants indicated that perceived effectiveness of counselling groups was situated in accessibility, gender-specific clusters, and following specific treatment formats in group meetings designed for gamblers. This paper outlines implications for improving problem gambling treatment within the context of the experiences of the women in this study.

Keywords: gambling addiction, women's gambling treatment, grounded theory research, feminist paradigm research, effectiveness of counselling groups, gambling treatment barriers

Group therapy for women problem gamblers: A space of their own

This research focuses on the perceived effectiveness of an all-female therapy group for problem gamblers. Gender-responsive treatments for women experiencing addictions are a critical component of treatment (Currie, 2001). There is a lack of research exploring the benefits of gender-specific treatments for gambling addiction (Grant & Potenza, 2004). Previous research demonstrates that female problem gamblers are very different from their male counterparts. According to Ladd and Petry (2002), women are more likely to participate in gaming activities as a means of escaping negative affective states and stressful life situations, whereas men are more likely to participate in gambling activities for the thrill of the game. With expanded gambling and easy access to venues and credit, it has been predicted that the number of women who gamble and experience problems with their gambling will increase (Potenza et al., 2001). Problem gambling counselling programs need to take into account the needs and issues of women (Crisp et al., 2000).

Many definitions of problem gambling fall into categories related to medical disorders or mental health problems, economic problems, and harm to oneself and partners through the act of gambling, or are considered as a social construct. A national or international definition for problem gambling that meets the needs of all stakeholders, researchers, and therapists has yet to be achieved. The term *problem gambling* is utilized in this article to denote the continuum of difficulties for an individual involved in gambling activities. Numerous researchers categorize problem gambling as a level of difficulty that does not meet the standards for pathological gambling (e.g., Shaffer, Hall, & Vander Bilt, 1997). This contrasts with the established term *pathological gambling*, which describes a disorder characterized by persistent and recurrent maladaptive patterns of gambling behaviour (Grant & Kim, 2002).

The context of women gamblers

The American Psychological Association (APA) approved the "Principles Concerning the Counseling and Psychotherapy of Women" in 1978, and updated them in 2007, as a means of recognizing and acknowledging the need for increased attention to women's needs (APA, 2007). The domain of problem gambling has started to focus on the unique needs of women, but as a research field, it is still in its infancy. Volberg (2003) and Boughton and Falenchuk (2007) highlight a major criticism of the literature on problem gambling: the paucity of information on women since most of the existing research is based on studies of men. "The limited available literature, however, indicates that females presenting to counseling services for gambling-related problems have significantly different demographic characteristics from males" (Dowling, Smith, & Thomas, 2006, p. 358). Several authors have described the gender bias that continues to pervade traditional, male-oriented approaches to therapeutic assessment, diagnosis, and intervention (APA, 2007; Caplan & Cosgrove, 2004; Worell & Remer, 2003).

The May 2003 issue of the *Journal of Gambling Issues* was devoted to the topic of women and gambling. The editor cites the rapid growth in the number of women seeking help. In this issue, gender differences are discussed that relate to the experience and, therefore, the treatment of problem gambling. These include women's deficits in self-confidence and problem-solving skills and female gamblers' excessive reliance on particular coping styles. Potenza et al. (2001) point out the need for additional effort in engaging problem gamblers and advocate for gender-specific gambling research because, with expanded gambling and easy access to venues and credit, they predict the number of women who gamble and experience problems with their gambling will increase. Treatment programs need to take into account the needs and issues of women (Crisp et al., 2000).

Mark and Lesieur (1992) advocated for women-only counselling groups in the treatment of problem gambling. Crisp et al. (2000) noted that gambling treatment programs

designed for men may be detrimental to women. Additionally, Crisp et al. stressed that the stigma women feel about being identified as problem gamblers needs to be understood, and agencies need to provide supportive counselling and psychotherapy for this population. Tavares, Zilberman, Beites, and Gentil (2001) stressed that the treatments for women gamblers need to include the implications of gender roles and social structures.

Although little research exists on gambling addictions and women, there is a substantial amount of research exploring substance abuse and women. This area of addiction research demonstrates that women have unique cultural and gender characteristics that can best be addressed in gender-sensitive or gender-specific treatment (United Nations, 2004; Currie, 2001). *Best practices: Treatment and rehabilitation for women with substance use problems* (Currie, 2001) highlights meta-analyses of 20 studies of co-ed group treatment; the results of these analyses indicate that women show decreased levels of discussion and participation in treatment when treated with men (Currie, 2001). However, no such best practice guide exists for gamblers or, more specifically, female problem gamblers. With a record number of women reporting gambling addictions and more and more gaming facilities being built throughout Canada, it is clear that evidence-based treatment protocols need to be developed to best treat women who develop gambling addictions.

Gender differences in gambling

Multiple theories exist as to why women gamble. Women often gamble to win money in the hopes of improving their financial situation. Schull (2002) proposed that women gamble to escape from the excessive demands that society places on them to care for others. Gambling becomes a method of self-abandonment, as the woman can isolate herself and focus on the machine while she forgets her troubles. Grant and Kim (2002) found that feelings of loneliness and dysphoria trigger the need to gamble for women. Feminist theorists argue that women gamble to escape unresolved anxieties and tensions surrounding a women's role as caregiver (Schull, 2002). Grant and Kim (2002) report that for women loneliness is a major trigger to gambling, while men tend to gamble for the sensory stimulation. For women, gambling may serve as a way to control mood states such as depression and anxiety. Beaudoin and Cox (1999) report that women gamble to feel detached from their surroundings. Gambling then becomes a method of escapism for women and a type of psychic anaesthetizer (Boughton, 2003). Some theorists have proposed that there may be a connection between a history of trauma or abuse and a predisposition to developing a gambling addiction (Grant Kalischuk & Cardwell, 2004; Specker, Carlson, Edmonson, Johnson, & Marcotte, 1996).

Although pathological gambling is not gender specific, a review of the literature on pathological gambling shows that much research has focused on the situation of the American male gambler. There has been a tendency to generalize the findings of this

male-focused research to the female population of gamblers. Research indicates that women and men gamble differently. Women tend to start gambling later in life and progress more quickly from the leisure gambler to the addicted gambler than do men (Grant & Kim, 2002). This quick pathway to pathological gambling indicates the importance of early intervention for female gamblers who may be at risk of addiction.

Women and men tend to favour different types of gambling. Researchers have found that women tend to prefer non-strategic and less interpersonally interactive games such as bingo and slot machines (Boughton, 2003; Grant & Kim, 2002; Potenza et al., 2001). Men tend to favour action gambling and are drawn to games of strategy such as cards and horse racing (Potenza et al., 2001). Boughton (2003) notes that middle class career women tend to be more competitive than younger women and prefer action gambling that requires skill.

Women gamblers are more likely to report that they have received mental health services for nongambling issues and are more likely than men to report anxiety and suicide attempts attributed to gambling (Potenza et al., 2001). Shaffer, Hall, and Vander Bilt (1997) discovered that there was a significantly greater rate of pathological gambling among persons with psychiatric or substance dependence disorders than there was in the nongambling population. For women gamblers, common comorbid disorders are depression, anxiety, and alcohol and prescription drug abuse (Westphal & Johnson, 2003). Gambling is a coping or survival strategy to deal with psychological, physical, and emotional pain (Boughton, 2003). Gamblers who present for treatment of comorbid conditions are often not screened for gambling addictions (MacCallum & Blaszczynski, 2002).

Currently, there is no consensus on the elements to include in efficacy research on pathological gambling treatment (Hodgins, 2005). The traditional treatment goal is abstinence, which is typically the sole measure of success (Stinchfield & Winters, 2001). Stinchfield and Winters assert that a reduction in gambling should not be ignored or interpreted as a treatment failure. Significant reductions in gambling frequency and gambling problem severity as well as improvements in social functioning and financial responsibilities can be considered important clinical changes (Stinchfield & Winters, 2001). Ladouceur (as cited in González-Ibáñez, Rosel, & Moreno, 2005) pointed out that the reason for high dropout rates in problem gambling treatment programs may be due to abstinence being the only treatment goal. There is currently no research on the treatment efficacy of controlled gambling.

Women problem gamblers

The current study

The purpose of this study was to examine the perceived benefits of gender-specific group treatment for female problem gamblers. The term *problem gambler* was selected in order to capture the essence of the gambling issue rather than to classify the participants into

the somewhat contentious categories of problem gambling, gambling addiction, and pathological gambling. The participants and their therapist used this term to refer to the behaviours and issues surrounding their common concern. This study explored the opinions and perceptions of female problem gamblers participating in group counselling. The purpose of the group was twofold. It was a form of treatment for the women because the facilitator was a counsellor working exclusively in a problem gambling treatment clinic, and it was a self-help group for the women. The findings present a number of themes that arose from the women's expressions of what contributed to the effectiveness of the group treatment. Categories are strengthened and supported throughout this report by the inclusion of women's direct quotations. This study is congruent with the feminist paradigm of research, which gives women a voice to express personal experience and honours each participant's subjectivity. These categories may contribute to effective counselling practices for women problem gamblers by presenting the women's perspectives on what works for them.

Procedure

A qualitative approach, in particular a grounded theory, was employed in this study. This is a general methodology for constructing a theory that is grounded in the process of systematically gathering and analyzing data (Strauss & Corbin, 1998) in order to uncover patterns of behaviour and interaction between different types of social units (Dey, 2004). Theory conceptualization is about discovering the process and how the explored patterns change under different conditions that are both internal and external to the process. Generating theory is interpretative work that involves the inclusion of voices and perspectives of the research participants being studied (Strauss & Corbin, 1998) to allow the researcher to understand and synthesize the actions of these individuals (Glaser & Strauss, 1998). Coding procedures employed in grounded theory ensure that researchers do not conceptualize data according to their personal biases or preconceived notions (Strauss & Corbin, 1998), but the procedures do include the integration of the researcher's theoretical sensitivity (Glaser, 1992).

In order to include the voices and perspectives of the participants, data were first collected from the women using audiotaped individual interviews. Each woman was interviewed three times over a 6-month period — at the beginning of the study, 3 months later, and at the end of the study. The interviews, averaging about an hour, were semistructured and included questions such as "What made you go to the group?" "Why do you continue to attend the group?" "What do you find helpful about the group?" "What makes the group effective for you?" "Would you encourage other women to join the group?" "What recommendations do you have for the group?" The constant comparison method (Glaser & Strauss, 1998) was employed in order to organize and code the transcribed interviews through four distinct stages. Stage one involved comparing incidents applicable to each category through coding the transcribed text, looking for similar categories to emerge, and comparing these categories to generate theoretical properties. Stage two involved integrating the categories and their properties into a unified concept. Stage three, delimiting the theory, involved reducing the original

number of categories to a smaller set of higher-level concepts. The theory becomes solidified through theoretical saturation, dismissal of nonrelevant properties, clarification, and reduction. The fourth stage is the actual writing process of the theory. Coded data are processed into a series of memos and a theory. Memos provide the content encompassed in the categories and, in turn, these categories become the themes to be presented.

Each interview was separately coded for themes by two researchers and then the themes were compared. Open or axial coding, a preliminary process of breaking down the raw data and categorizing them, was utilized in this study. Codes that captured the meaning of the data were created through close examination and comparison between different parts of the interview transcripts. Ideas were generated through this detailed comparison of sentence-by-sentence, paragraph-by-paragraph coding. Themes were coded by exploring common words in all of the women's answers to each of the interview questions. From this response search, common quotations were arranged and the themes took shape, as the data themselves dictated the types of categories that emerged.

To further enhance the credibility and validity of the themes, the researchers then shared the themes with the women, who were then able to offer clarification of, insight into, and support for themes found by the researchers. This allowed the participants to verify whether the themes and categories extracted from the interviews accurately portrayed their shared experiences and words. This is also known as checking the goodness of fit (Osborne, 1990).

Participants

The 14 participants in this study were drawn from those attending a counselling group offered through a health agency in a Canadian city. The ages of the women who volunteered to participate ranged from 26 years to 70–80 years. The average age of the women was 46.5 years, with a median age of 50 years, and the most common age (the mode) was also 50 years. The women's marital status was divided: four women reported being divorced, three women were single, six women were married, and one woman reported living common-law. The majority of the women had obtained postsecondary education; three women did not report their educational level and three women obtained grade 12. The majority of the women (seven) had children. All of the women fit the diagnosis of a problem gambler using the South Oaks Gambling Screen. Participants were not asked to elaborate on comorbid conditions other than addictions; there were no additional addictions noted. They were offered individual counselling, but many women chose to participate in the group after participating in individual sessions. The participants in group treatment were advised of confidentiality issues and were informed of the therapeutic goals: abstinence, support and structure for the reduction and elimination of gambling behaviours, self-regulation strategies, motivational techniques, goal-setting, and accomplishment celebration.

Results

What makes a counselling group effective?

How can the needs of women who have developed problems with gambling best be met (Berry et al., 2004)? Services must be responsive to these women's needs. This study starts with the women's perspectives on what they found effective about their all-female treatment group. The exploration of the participant's experiences and beliefs related to effective group therapy resulted in five conceptualized categories. The core category, or emergent theory, that evolved from this study was availability of a women's-only treatment option. It was selected as the core category because the other categories — accessibility, a safe space, mixed ages, therapy format, and barriers — were all characterized by the implicit need to have a women's-only therapy group for problem gambling issues. The categories that emerged from this study are outlined with descriptions, including the relevance to how women problem gamblers could be increasingly encouraged and supported. Direct quotations from participants are incorporated in order to accurately provide their experiences and vividly portray their voices.

Category 1: Accessibility and nourishment

A common theme that developed among all of the participants was that they wanted to attend a group that was sensitive to their own busy lives as employees, mothers, wives, and friends, as well as their other roles. The women were asked if elements such as time, location, and nourishment (e.g., tea and coffee service) had an impact on their participation. The women reported that accessibility was a key element in group success. The majority of the participants identified that an evening group was most beneficial because it made the group accessible to women who work in the daytime. In regards to length of time of the group sessions, the women were split. Half of the participants reported that they appreciated a specific start and end time and the other half reported that a more flexible format where the group could be extended in time could be helpful for group process. In regards to nourishment, the majority of the participants indicated that this was a useful element and it was indicated that it helped create a comfortable environment to share information.

Having coffee and cookies makes me feel that we are relaxed and can talk about things. Sometimes I don't want any but others enjoy it and they can fuss around the table, getting their food and talking about how their week went.

... when there is food it feels like we belong together.

Category 2: A safe space that provides acceptance

This category is underscored by the fact that all of the participants indicated that the most critical aspect to making the group counselling experience effective was to create a safe space for discussing personal issues. This safe space is a physical one, in which the women cannot be viewed or heard by nonparticipants, but it must also be an emotionally safe place. This environment is established by ensuring that the women are in a closed room and that there are ongoing discussions related to confidentiality or nondisclosure of shared information. The safe space provides an opportunity for the women to share their stories, to gain insight about their behaviour, and to receive feedback. Most importantly, it is a place where they feel accepted:

It is very, very helpful being accepted.

This week I needed to talk and it just seems like when I really need to talk I am able to because ... people just kept talking to me and I could get it out. It just seems like when I really need to talk everyone is there and they listen.

The fact that there are so many different ages and different situations and different women and they have all ended up at the same place for various reasons. And they are so welcoming. It is a place where I can talk about my problems without being judged; it is supportive people who understand.

Openness as I had the ability to cry out no matter what. Nobody judged me or got upset with me if I did cry.

Group and you have helped me to realize that I am an okay person.

Being with other women who have had similar experiences helps the women accept themselves:

When I go to group ... I realize there are other people that have just as large problem[s] as I did and that is helpful to me because I realize that I am not alone. There are other people out there that have it just as bad as I do and that is effective to me.

Well one thing that is a definite benefit is that somebody else is there; other people there have failed. When I failed before, I spiralled into a severe depression ... it gives me permission to be human and make a mistake without thinking I have to die for it. So it helps to hear other women say, "I screwed up once and went and gambled so huge." It is normalizing that you are not the only one who is struggling with addiction and has been able to come back.

And accepting who they are helps them accept others:

We are here in the group to let...that other people see the light at the end of the tunnel.

Each session begins with "circle check," when the women take turns sharing what has been going on in their lives during the past week. The women reported that this was a very important component of the group and contributed to its effectiveness:

I really like the check in, you know knowing how your week went. I think that is really important and it is a good way to break it up getting to know what your week was like and special topics because you can be more focused on the special topics. Just hearing everybody talk and how their week went is really good. It kind of lets you relax and refocus because sometimes circle check can be sort of emotional.

Being able to share experiences in a safe space helped the women understand their behaviour and develop skills for relapse prevention:

I was not gambling because of the need to gamble, I was gambling because I needed to change something in my life. So talking about different areas, when somebody says, "That fits for me," maybe that is why I would gamble. You can see how, when someone says, "Well my mother was an alcoholic," or "mine was this." You can see when we get on these subjects that it all relates back to gambling. I think it is a good idea to talk about other subjects other than gambling because it opens people's minds maybe to the reasons why.

When people call you on stuff — that is good because then you got to stop and think about it. Maybe just that time somebody calls you on something — maybe that will do it, you never ever know. But I like the honesty and the peers and the laughter.

How do you get refocused? How do you reach out to your security line? What do you have in place for alternatives to sinking so you do not gamble? I have got A, B, C, D so if plan A, B do not work plan C or D is going to. Hopefully you do not have to go beyond plan A. I guess it is to know that you can get discussion and you can go home and think it through.

I still get a lot of urges and it seems that if I continue to come to the meetings like I am able to talk about the urge or listen to someone else who has given in to the urge it is beneficial because if they have given in to the urge I get a lot out of it because they say what they have done. And you will ask what you could do to change that.

The women reported that acceptance was their main motivation for their continued participation in the group. The understanding and support they received in group, as well as the opportunity to listen to other women's stories, kept them coming back:

I think I continue to keep coming because first, everyone has had, to some degree, the same experience so there is people that you know can understand what you are talking about...

And I think the stories scare me. And I realize that without help and without keeping myself in check that I could maybe be one of those people.

The women also mentioned that the group's facilitator and her actions help create a safe space. It was indicated that a knowledgeable, sometimes directive, counsellor who listens and provides feedback contributes to making the group effective:

I myself appreciate it that my counsellor actually listens to me. She makes eye contact with me; she asks a question or two throughout the process. Whatever it is that I am saying is thrown out on the table for the rest of the ladies to intervene and perhaps give a little bit of advice. To me that is very important because I can tell that the counsellor has actually listened to me.

Category 3: All women of various ages

This category focuses on descriptions of the participants' beliefs that the group therapy should be simultaneously exclusive and nonexclusive. They viewed the exclusive elements of a gender-specific group and the openness of an all-ages group as advantageous. All of the women reported that they were most comfortable in an all-female environment and that they would prefer to participate in a women's group rather than a mixed group. Therefore, gender-specific services were seen as a critical element of the group's success:

[With men] I do not feel as comfortable; I am not so sure I could talk about problems. I think women understand women better than men.

I would not be able to say what I wanted to say [with men in the group] ... that is why I go to the all-women group — it helps.

Older male gamblers seemed to monopolize time and want to ask women for numbers. I would say it is probably better that it is just women.

We are looking at it [problem gambling] from a woman's point of view. Sometimes we can see a common thread that follows through women's lives that may have a bearing on addiction.

I trust women more than I trust men.

I do feel a lot more comfortable among a group of women because we can talk about anything — even menopause, having a hot flash — whereas I do not know if I would be comfortable saying that when there is men in the room.

People feel very dominated by men, which might make it difficult.

With just the women's group it is more intimate — there is nothing really that cannot be said. With the men it is more reserved. The honesty is there about the gambling but there is more than that in this group.

I think I am just more comfortable with women, because I think women understand women better.

The majority of the women talked about the benefits of having group members who vary in age:

I think that it is better to have the age range. Just say even a "young person group" they would not see that it is affecting others. I think it helps to see that there are people from every age in life and every walk in life. And we all have a commonality — we are all women.

I think the age range is good; the spectrum helps you to realize that it is affecting older people and younger people.

Category 4: Therapy format

The emergence of this category makes clear the importance to the women of an all-women's problem gambling therapy group, evidenced by statements such as, "more women should be given the opportunity to be in a group like this." Through their stories they described their negative experiences in alternative therapy settings and suggested ways to continue and improve their own group format and/or process. When asked, the majority of the women reported that they had suggestions for format changes to increase the effectiveness of the group. One suggestion was for guest speakers:

I think it would be helpful. Once there was a man who spoke about AA. It was so powerful to learn about another addiction. It is so powerful for people to tell their stories.

Psycho-educational presentations were also suggested:

We also did some sessions in the day program on assertiveness — that would be helpful.

Other suggestions were based on watching videos prior to a focused discussion, and *topic nights*:

I like it when there is a topic, when something comes out of it — sort of like an end result — through the comments of how the week has gone.

I like the circle check. I would not mind, and I do not know if others would be willing, preparing a statement for each week that could be a topic for discussion.

The participants in this study were asked to keep a journal as a means of additional data collection beyond the three interviews. In the last interview, these women were asked whether they found the journalizing therapeutic. The majority of the women reported that journalizing helped them by reinforcing what they learned in the group:

It has been good because you ask some very poignant questions and they make me think about things that I have not really thought about or reflected on in depth.

It is weekly homework that forces one to document feelings, behaviours, and accountability.

I have journaled in the past and I find it hard to start but once I start I do it for myself. When I first quit [gambling] it [journalizing] helped me release anger....With the journaling for this I was in such a blah state I did not want to do it, but I released a lot of anger. It was all built up in me — it was a lot more than I realized.

Category 5: Barriers to participation and increasing accessibility to services

Coming to terms with their own problem gambling and then seeking assistance was identified as a complex struggle within this category. Indeed, the most challenging task appeared to be accessing counselling treatment that ensured that the participants felt heard and valued. The women in this study identified a range of complex issues that they perceived as preventing women from accessing service. These included personal barriers related to women's internal processes (e.g., shame and guilt): "People feel ashamed of themselves when they come to group. They are so sceptical when they come to group because they think they are a bad person"; interpersonal barriers (e.g., partner): "coming up with excuses as to where you are going"; structural barriers (e.g., travel, distance): "Maybe it is travelling." The personal and interpersonal variables emerged as the most significant barriers to accessing services: their partners' influences, their own stage of recovery (e.g., precontemplation and contemplation), feelings of shame and guilt, lack of awareness, and other personal issues.

In response to these barriers, the women felt the issue of problem gambling needs increased visibility, along with more treatment facilities and counsellors who specialize in the area of problem gambling:

We need more counsellors. I wish they [the government] would spend more of their money on getting more counsellors because this is not going to stop on its own. I do not know how they expect to work with all of the gambling addictions with the few counsellors that we have.

I think we need a counsellor in a casino for one thing. I think we need to have some people to just suggest where to go. They have it on the machines but that is not enough. We need some people there.

... more access to the day program — everybody says good things about the day program; everyone in group just praises it so much.

They have no educated people out here who know what is going on — and more treatment centres.

Theory: Availability of a women's-only therapy group

Taken together, the categories of accessibility, a safe space, all women/all ages, therapy format, and barriers represent the major common themes among the interviews in this study. The core category that unites and describes each of these categories is the availability of women's-only treatment options for problem gamblers. The element of availability is central to the perceived effectiveness of working through the myriad of issues present when addressing problem gambling. It can be stated that these women felt safe and felt that they were heard, that they were supported, and that they were assisting each other because they were in a therapeutic setting with only females. Recall that the therapist who facilitated and led the group was also female, so the entire group had three common elements: they were women, they were involved in problem gambling, and they desired positive changes in their gambling behaviours and/or beliefs.

The follow-up interview and group meeting in which the researcher shared her interpretations found participant congruence between their shared stories and the resulting categories. The experience of talking about their own experiences within the treatment group and involvement in this research study was described as informative and reflective, and each participant found that it promoted self-discovery. The women stressed that every geographical setting that has access to gambling venues should also have access to treatment venues, and specifically, women's-only groups.

Implications for clinical practice

It is important to note that the findings from this study can only be directly applied to the group of women with whom the research was conducted and cannot be generalized to all counselling groups for women problem gamblers. However, this research is a starting point of inquiry that other researchers and practitioners may find helpful in their own practice by asking their clients if they have similar perceptions.

The results of this study were congruent with suggestions for women-responsive treatment strategies outlined by the *Best practices: Treatment and rehabilitation for women with substance use problems* (Currie, 2001), the United Nations (2004) publication *Substance abuse treatment and care for women: Case studies and lessons learned*, and an Australian government report outlining the importance of gender-responsive groups for women addicted to electronic gaming machines (Surgey & Seibert, 2000). Women-responsive treatment practices include "a safe, supportive and women-nurturing environment that encourages trust, bonding and connection" (United Nations, 2004, p. 58), where women can learn skills, have access to female role models, and discuss women-specific health issues (e.g., pregnancy, menopause).

The traditional gambling treatment goal of abstinence was what all women were working toward, and the women had different lengths of time during which they abstained before a relapse. But this was not the sole measure of the effectiveness of the group, as demonstrated by the other benefits they reported. The women spoke of the need for more counsellors with training in pathological gambling. They felt that the facilitator of their group was an expert in the field but that she was rare. Some described negative experiences they had in the past with counsellors who did not understand that gambling addiction was different from substance addictions and as a result used treatment approaches typically employed with substance abusers. The women also raised the issue of difficulty accessing treatment services. Most felt that there was a paucity of information available to the general public on where to seek help as well as a lack of treatment options, particularly for women living in rural areas. It is important to note that the women in this study chose this group treatment approach, which may help explain their motivation for attending, but does not explain the barriers or the treatment goals for women who chose not to attend the group.

The women reported that they liked having the group at the clinic because it is a safe and accessible space and that they would like to continue to have coffee and cookies as it makes the group welcoming. The women also reported that an emotionally safe space was critical because having this place to share their feelings, stories, and emotions was the most effective ingredient in the treatment. "Circle checks," which included the opportunity to receive feedback, were described as an effective part of the group sessions. However, it is important to note that while the majority of the women reported that they enjoyed receiving feedback, they said they were not comfortable giving feedback. This

indicates that the women in this study would benefit from psycho-educational sessions on how to give feedback.

Effectiveness was also explored in terms of what continues to motivate the women to participate in the group. The theme that emerged from this exploration is that the group provides a feeling of acceptance. Therefore, fostering a feeling of being accepted and belonging in the group is critical to group effectiveness.

In regards to the composition of the group, the importance and the effect of age and gender were explored in this study. Almost all of the women reported that they liked that the group members varied in age and that it was even helpful to them. All of the women reported that they preferred the all-female counselling group. Gender-specific services enabled the women to talk more freely about personal issues that affected their gambling. This finding is congruent with other investigations of women's gender preferences in group, which indicated that mixed-gender groups are less effective for women than all-female groups (Currie, 2001). Hence, an all-women's group responsive to women's needs can be considered *best practice* for problem gambling treatment groups as identified by these participants.

In addition to men being identified as a potential barrier that would impede female group members' full participation in the group, the women identified a range of other barriers that would prevent them from accessing service. These included personal barriers relating to the women's internal processes (e.g., shame and guilt), interpersonal barriers (e.g., partners), and structural barriers (e.g., travel distance). Personal and interpersonal variables stood out as the most significant barriers to accessing services. The women in this study identified a range of complex issues that appear to prevent women from accessing service. This included the distance they had to travel to the group, their partners' influences, and their own stage of recovery (e.g., precontemplation and contemplation), feelings of shame and guilt, lack of awareness, and other personal issues.

Although many barriers were identified, many solutions to the barriers were offered. More treatment programs and raising awareness were identified as potential factors that could increase women's access to problem gambling services. The women reported that more counsellors are needed in the province, as well as increased access to gambling treatment centres. The women also reported that more advertising of services would be helpful (e.g., antismoking ads are much more visible) by making problem gambling more visible to the public.

It was clearly evident from the transcribed interviews and subsequent discussions with the participants that they had numerous suggestions for therapists who work with problem gamblers. All of the women provided specific ideas for creating an environment that would support the counselling process for individuals identified as problem gamblers. Although the participants' points were not elaborated on in this article due to space limitations, the researchers felt that it was important to provide a space for the

participants' recommendations, as each is based on personal experience. The suggestions put forth by the women participants create valuable implications for clinical practice. Table 1 summarizes the recommendations that were derived from the collection of interviews.

Table 1.

Participant Summary of Recommendations for Clinical Practice

- use a physically safe and accessible space for group
- provide a cookie and coffee service
- acknowledge the women's unique experiences as women
- create a safe, accepting, understanding space where women can explore their problem gambling
- create space for women to have a voice
- take into account each group member's stage of change (e.g., precontemplation, contemplation, preparing for action, action, maintenance)
- address women's unique roles in relationships with men
- provide opportunity for women to discuss women's health issues such as pregnancy, menopause, and premenstrual syndrome in relation to addiction
- be gender responsive and versed in women's issues and addiction
- provide opportunity for women to receive feedback from their peers
- teach appropriate strategies for giving feedback, as some women feel uncomfortable with this
- include a psycho-educational component
- discuss skills for relapse prevention and assertiveness
- include journal exercises where women have a safe, uncensored space to process the group
- help women to normalize the experience of a gambling addiction
- provide a variety of ways of communicating material (e.g., guest speakers, videos, and discussion)
- guide the process of the group
- be age inclusive
- foster a feeling of being accepted and belonging in the group

Future research

All women reported personal satisfaction from participating in the research; they reported gaining a sense of contributing to a greater purpose and wanting to help others in similar situations. The reasons cited for this positive impact included: the study increasing their responsibility, accountability, and honesty, and helping the women to feel heard:

I started at the same time as the research study started. I do not know if it affected the ones attending prior to that but for me it gave a feeling of responsibility of forging a path in a treatment area.

Being part of the study made me feel like I counted.

I mentioned to a few people that I am involved in a gambling research study and it helped me to see that maybe my problems would help someone else.

The women's satisfaction from their participation is an important consideration for future research, as the women in this study are interested in participating in future research.

Yes as often as possible as long as I live.

Absolutely I would do anything to participate in research that would help to stop this pathological gambling.

The women were asked about what ideas they would like to see explored in future studies. Ideas generated by the participants included the following:

I would like to see more on the effect on the family and young children. It seems to me that the age group is getting younger and younger. I still go out to bars; I used to see a lot of seniors, now I see a lot of kids 19 to 20. I notice a lot of younger people and that scares me. My own son was starting to have a gambling problem 6 months ago and I think when you have a gambler in the family it is seen as an alright thing to do. If you see your mother going into the bar drunk — but the mother coming home happy and elated when she is usually grumpy — it is just simply the reaction to the gambling....

You introduced to us the changes with menopause ... I think there is something to do with the hormones and the cycles. You do not see a whole bunch of young people [problem gamblers] — the majority, from what I see, are women with grey hair, between 40 and beyond.

The research I want an answer to before I die is whether it is genetic, which I feel it is. I have always said "genes and machines." I have said that from day one and I will continue to say it.

One profoundly moving sentiment was articulated by a participant, but echoed in different phrases and at different times by all of the female problem gamblers in this study, and it basically captured the essence of their group treatment outcome. This woman stated, "I lost my voice somewhere but I am regaining my voice by coming to group." We hope that this research helps other women regain their voices as well.

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