

Closing a Treatment Gap in Ontario: Pilot of a Tutorial Workbook for Women Gamblers

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Abstract

Past research has shown that treatment services for problem gambling are being under-utilized in Ontario, especially by women. Our pilot study involves the development of a Tutorial Workbook (TW) designed specifically to address the special issues and treatment needs of women who gamble and develop consequent problems. Investigators tested the effectiveness of the intervention and reviewed comments from women gamblers on the contents and layout of the workbook. The TW study involved 12 modules and required progress update and feedback forms for each. A mixed method analysis was used to evaluate the intervention, with quantitative and qualitative feedbacks indicating that it was well received by participants. The majority reported that the program helped them modify gambling behaviours through increased understanding and awareness of their triggers. They reported feeling better about themselves, improved mood and anxiety levels, feeling less isolated, positive changes in their relationships and hope for the future. Their input provided suggestions for changes to the TW. The TW will serve women seeking self-help materials, including on-line or paper-based support. As such, it expands services to reach a sub-group of women who might not otherwise seek or accept treatment because of a variety of barriers.

Keywords: Women and gambling, problem gambling, treatment, self-help work book

Résumé

Dans des recherches faites précédemment, on a montré que les services de traitement de problèmes liés au jeu compulsif sont sous-utilisés en Ontario, surtout par les femmes. Notre étude pilote a porté sur la conception d'un cahier didactique conçu spécialement pour répondre aux problèmes particuliers et aux besoins de traitement des femmes qui s'adonnent au jeu et développent des problèmes connexes. Les chercheurs ont testé l'efficacité de l'intervention et analysé les commentaires faits par

des joueuses pathologiques sur le contenu et la mise en page du cahier. L'étude sur le cahier didactique comprenait douze modules et des formulaires de bilan/retour des progrès à remplir obligatoirement pour chaque module. On a utilisé une méthodologie mixte pour évaluer l'intervention, avec commentaires quantitatifs et qualitatifs indiquant un accueil favorable par les participantes. La plupart ont indiqué que le programme les a aidées à modifier leurs comportements de jeu, car il leur a permis d'acquérir une meilleure compréhension de leurs déclencheurs et d'en prendre conscience. Les participantes ont déclaré se sentir mieux à propos d'elles-mêmes, avoir noté une amélioration de l'humeur et une baisse de l'anxiété, s'être senties moins isolées, avoir observé des changements positifs dans leurs relations et avoir regagné espoir pour l'avenir. Dans leurs commentaires, elles ont fourni des suggestions pour modifier le cahier de travail. Ce cahier sera utile aux femmes qui recherchent des documents d'initiative personnelle, en ligne ou sur papier. Comme tel, cet outil apporte donc un complément aux services déjà offerts afin d'atteindre un sous-groupe de femmes qui autrement pourraient ne pas chercher ou accepter un traitement en raison de diverses barrières.

Introduction

A minority of problem gamblers seek formal treatment, with only one in ten gamblers ever obtaining any type of service (Cunningham, 2005). Rates for this phenomenon vary across the world. In Australia, 15.7% of female and 6.8% of male problem gamblers enter treatment (Slutske, Blaszczynski, & Martin, 2009). Data from Ontario, however, indicate that only 3% of problem gamblers have ever sought professional treatment for gambling (Suurvali, Hodgins, Toneatto, & Cunningham, 2008). The treatment program in Ontario attracts more male than female gamblers. In 2012-13 there was a higher proportion of men over women in treatment populations (63% vs. 39%) (Ontario Drug and Alcohol Treatment Information System – DATIS).

A study by Boughton and Brewster (2002) involved 365 Ontario women who gambled at problematic levels but were not in treatment. It identified a number of barriers for women to on-site treatment programs—practical, psychological and emotional. Prominent practical concerns were time constraints (work and caretaking demands), need for childcare, financial limitations, and travel obstacles (Boughton & Brewster, 2002; Gainsbury, Hing, & Suhonen, 2014; Suurvali, Cordingley, Hodgins, & Cunningham, 2009). These barriers are especially applicable in small communities. Boughton and Brewster (2002) also found internal barriers; psychological issues such as social stigma; and a fear of recognition, judgment or exposure. In addition, comorbid mental health issues of depression and anxiety served to impede access to treatment. And key among the findings were considerable ambivalence, a fear that treatment would demand total abstinence, and a belief on the part of the women

gamblers that they should be able to make changes on their own. The study also considered women's identified treatment needs.

A criticism leveled at gambling treatment (Crisp et al., 2000; Mark & Lesieur, 1992) is that it generally employs information and strategies based on the interests and needs of male gamblers. This parallels concerns in the field of substance abuse that treatment methods have been developed primarily based on research with men (Bepko, 1991).

Suurvali et al. (2008) report that gamblers who had gained access to help were more likely to have chosen self-help, either through the web or printed materials. They conclude that "the relatively frequent use of self-help resources underscores the value of providing a range of treatment options. There is a growing body of literature supporting the effectiveness of brief interventions for gambling problems offered by telephone or the Internet or in the form of self-help workbooks" (p. 1345).

This paper reports a pragmatic clinical trial (see Tse et al., 2013) describing a pilot treatment study that builds on the findings of the Boughton and Brewster (2002) earlier study, addresses the limitations of treatments based on male interests and needs, and incorporates the findings of Suurvali et al. (2008) on the need for an expansion of treatment options for women.

Barriers to Treatment for Women

Boughton and Brewster (2002) highlight the many barriers to treatment for women, practical, psychological and emotional. Time constraints were the most commonly reported practical barriers (34%), specifically work demands (21%) and responsibilities at home (18%). Money issues were reported by many of the women (33%): treatment costs (26%), transportation costs (16%) and lost work income (11%). Almost half (49%) of those with children under the age of 13 (23% of the sample, n=87) reported childcare obstacles to treatment, such as babysitting costs (37%) or having no one trustworthy to care for the child (20%).

Consistent with research on women's substance abuse, which identifies internal barriers to treatment of stigma and psychological distress such as depression (Jaffe 2012), Boughton and Brewster (2002) report mental health issues as hindering access to services (24%) for women who gamble. Depression (18%) and anxiety (16%) were endorsed most often. Safety issues were common: Almost half of the women (49%) indicated that they would not feel comfortable or safe attending a treatment program. Safety concerns tended to be more emotional (14%) than physical (3%). Women worried about confidentiality (29%) and recognition (17%). They feared that family members or other important figures in their lives might learn of the gambling (22%). Embarrassment and shame (33%) and fear of being criticized or judged (34%) were common barriers. The high levels of shame reported are consistent with other addictions. Mason (1991) describes shame in women struggling with eating disorders and alcoholism, noting that shame is more common in women than men, arguing

that the impacts of patriarchy, objectification and abuse both instill and ensure women's shame. Ashely, Marsden, and Brady (2003) report that social stigma, labelling and guilt serve as significant barriers to women's seeking treatment (see also Forth-Finegan, 1991; Lisansky Gomberg, 1987). Poole (2005), writing for the Canadian Centre on Substance Abuse, identifies stigma and negative stereotypes about women's substance use as barriers to treatment.

Ambivalence about gambling is also an obstacle. Boughton and Brewster (2002) note that women's reluctance to engage in gambling treatment included a fear that treatment would demand a commitment to total abstinence (57%). Many women believed that they could control the gambling because they had sometimes been able to limit their play (48%). Thirty percent (30%) believed that they could stop any time they want. Many participants believed that treatment services are only for women having very serious problems (46%). The primary obstacle, however, was the belief that they should be able to make changes on their own (73%).

Recent studies have confirmed these findings and extended the scope to elaborate on additional demographic barriers such as age and cultural concerns. Suurvali et al. (2009) reviewed 19 empirical studies that explored barriers to treatment, two of them women specific (including Boughton & Brewster, 2002). A similarity of findings is noted across the studies. Gainsbury et al. (2014) further note that in culturally and linguistically diverse (CALD) gambling populations, individuals "may be reluctant to seek professional help because of the stigma associated with public disclosure, fear of losing respect and cultural resistance to discussing problem in support groups or in front of an unknown counsellor" (p. 514). They suggest that this may reflect a preference for CALD gamblers to avoid psychologically-based interventions and address more practical issues related to the negative consequences of gambling, such as relationship or health concerns, rather than the gambling itself.

Importance of Treatment Tailored to Women

A treatment concern identified in the field of substance abuse treatment (Ashley et al. 2003; Wilke, 1994) is a male as norm bias and a paucity of specialized services for women to meet their distinctive needs. A similar criticism leveled at gambling treatment (Crisp et al., 2000; Mark & Lesieur, 1992) is that it generally employs information and strategies based on the interests and needs of male gamblers. While treatment is typically based on male models, evidence does exist that treatment needs and approaches for women differ from those of men (Albanese et al., 2011; Grant & Kim, 2002; Ibáñez, Blanco, Moreryra, & Sáiz-Ruiz, 2003; Thomas & Moore, 2003; Toneatto & Wang, 2009). Potenza et al. (2001) note gender differences in both motivations to gamble and problems, suggesting that different strategies may be necessary to maximize treatment efficacy.

Women are often referred to as "escape gamblers," a reflection of gambling as typically triggered by emotional stressors, avoidance coping and significantly higher levels of psychiatric disorders (Boughton, 2003; Boughton & Falenchuk, 2007;

Thomas & Moore, 2003; Trevorrow & Moore, 1998; Westphal & Johnson, 2003), As with other addictions, histories of women problem gamblers reveal high levels of abuse and trauma as children and adults (Boughton, 2003; Boughton & Falenchuk, 2007; Kausch, Rugle & Rowland, 2005; Ledgerwood & Petry, 2006). And as with substance abuse treatment, women need treatment tailored to their unique needs and life experiences (Ashley et al., 2003; Poole, 2005). Ibáñez et al. (2003) propose that “female gamblers may respond better to treatment strategies that take into account their more specific emotional needs” (p. 300). Grant and Kim (2002) argue gender specific implications for treatment:

Men and women seem to have their urges to gamble triggered by distinct and perhaps gender-specific stimuli—mood state for women and sensory stimuli for men. Therefore an appropriate treatment for women should target what may be affective symptoms Because men appear to gamble more often in response to sensory stimuli (advertisement, billboards, etc.), they may benefit preferentially from a cognitive-behavioral approach. (p. 60)

Cognitive behavioral treatment (CBT), a best practice treatment of pathological gambling, has been empirically demonstrated as effective with male gamblers (Ladouceur et al. 2003). Dowling, Smith, and Thomas (2007), in what was a first CBT based study of female problem gamblers, report that 89% no longer met the criteria for pathological gambling at a six-month follow up, concluding that CBT is also effective for women. This would suggest that women specific treatment embrace CBT, but with qualitatively different emphasis tailored to address the specific needs and emotional triggers underlying women’s escape into gambling as a coping strategy.

Women’s Treatment Needs and Self Help Workbooks

Boughton and Brewster (2002) explored diverse approaches that might be helpful to women who gamble. Of direct relevance to this pilot, many women endorsed self-help materials as very or extremely helpful. Specific to indirect services, over half of the women (52%) expressed an interest in information and reading materials on women and gambling, and would look for written materials (75%) or a self-help manual (43%).

In a review of the status and future direction of self-help treatments for problem gamblers, Raylu, Oei, and Loo (2008) describe self-help treatments as serving to remove barriers to treatment, improve access and limit social costs of problem gambling. They note that studies are “significantly lacking,” with only four published studies evaluating the efficacy of self-help treatments, all focused on self-help manuals and workbooks. Existing research does confirm the effectiveness of self-help workbooks (Blaszczynski, 1998; Byrne, 1999; Dickerson, Hinchy, & Legg England, 1990; Hodgins & Marachuk, 1997; O’Connor & Fergusson-Stewart, 1989). Hodgins (2000) argues that self-help workbooks are particularly advantageous with gamblers who are not seeking formal treatment.

In some studies, the use of self-help workbooks is combined with minimal therapeutic intervention. Hodgins, S. R. Currie, G. Currie, and Fick (2009) used a mailed workbook in a treatment study with pathological gamblers. Contrary to their hypothesis, the workbook only participants were as likely as participants who also received a brief motivational phone interview to have reduced their losses over a year and no longer meet criteria for pathological gambling (see also Hodgins, Currie, & el-Guebaly, 2001). Of great interest, over half of the participants (55%, n=314) were women, providing evidence that self-help material may be beneficial to female problem gamblers.

In Sweden, Carlbring and Smit (2008) report on a trial of an Internet-delivered CBT. The program consisted of 8 modules, minimal therapist contact via e-mail, and weekly telephone calls of less than 15 minutes. They report favorable changes in pathological gambling, anxiety, depression, and quality of life compared with the wait-list control group. In another Swedish study, Carlbring et al. (2005) evaluated a treatment of panic disorder: comparing 10 live therapy sessions with a 10 module CBT self-help program on the Internet. They conclude that Internet-administered self-help plus minimal therapist contact via e-mail can be as effective as traditional individual cognitive behaviour therapy.

Although a number of self-help materials have been developed (e.g., O'Connor, 2004; Problem Gambling Institute of Ontario, 2012), no specific self-help manuals designed for women who gamble appear to exist. There was reason to believe that self-help workbook options may be particularly helpful for women. Research in the field of alcohol treatment found that women showed more success in reducing drinking using a self-help workbook than did men (Sanchez-Craig, Leigh, Spivak, & Lei, 1989). Consistent with the findings of Boughton and Brewster (2002), women appear to be especially drawn to options that provide anonymity and can be wrapped around the demands of busy lives. It is also arguable that the effective use of self-help material is empowering, dovetailing neatly with the women's desire to deal with problems on their own. The development of the self-help workbook for women used in this study is described below.

The Development of the Tutorial Workbook (TW)

The TW was developed as a woman-sensitive, trauma-informed approach created specifically for women who are struggling with gambling-related issues. Poole and Greaves (2012) write of trauma as pervasive in women's lives and of the compelling evidence that mental health and substance use are connected to the experience of violence, abuse and trauma. So too with women caught up in process addictions such as compulsive shopping and gambling. The workbook has a focus on the sequelae of trauma, dealing with emotions and emotion regulation skills, mindfulness and compassion. The contents drew in part from the input of the women in the Boughton and Brewster (2002) study, which investigated key treatment issues for women (Table 1): Changing gambling behaviours, finances, personal enrichment, relationships, and

Table 1
Key Treatment Issues

Key Treatment Issues	Details	Response Rate
Changing gambling behaviours	Coping with urges to gamble	71%
	Learning strategies to limit gambling	68%
	Learning strategies to stop outright	64%
	Self-awareness and learning about triggers	67%
	False beliefs about how to win	50%
	Getting support from family and friends	46%
	Mathematical odds in gambling	43%
	Understanding social pressures to gamble	29%
Finances	Increasing income	69%
	Managing money	66%
	Resolving debts	60%
Personal enrichment	Dealing with stress	72%
	Handling self-esteem issues	63%
	Managing depression	59%
	Empowering self	57%
	Dealing with anxiety	56%
	Dealing with guilt and shame	53%
	Improving spiritual well-being	53%
	Coping with burnout	63%
Relationship issues	Becoming more assertive	50%
	Setting healthy boundaries	49%
	Dealing with anger	46%
	Managing conflict in relationships	45%
	Meeting my needs in relationships	47%
	Understanding trauma	49%
	Understanding grief	54%
	Excessive Drinking	23%
	Excessive drug use	20%
	Leisure and social needs	Making meaningful use of my free time
Having fun		69%
Dealing with isolation and loneliness		54%
Food and body	Food and my moods	59%
	Nutritional well-being	57%
	Healthy weight management	55%

leisure and social needs predominated. Also important to many respondents were topics related to food and body.

Background of the TW: Best Practices and Research Sources

In addition the TW materials were sourced from both general best practice CBT materials (Ladouceur & Walker, 1996; O'Connor et al., 2000; Toneatto, Blitz-Miller, Calderwood, Dragonetti, & Tsanos, 1997; Toneatto & Wang, 2009) and clinically

validated women's treatment resources, including, the Seeking Safety program for dealing with trauma (Najavits, 2002), the work of Linehan (1993) on emotion regulation, and the materials from the Sensorimotor Psychotherapy Institute on trauma (Fisher, 2011). Mindfulness resources were also adapted (Maté, 2009; Roberts, 2009; Williams, Teasdale, Segal, & Kabat-Zinn, 2007), with an emphasis on self-compassion (Gilbert, 2009) as well as literature specific to treatment considerations with women (Crisp et al., 2000; Thomas & Moore, 2003; Trevorrow & Moore, 1998; Underhill, 1986). The material was modified and adapted for use with women with gambling problem. Developed within a cognitive behavioural framework, and drawing from the work of highly respected clinicians and researchers, the materials are thus consistent with evidence based research on women's addiction and recovery needs and are shaped by the 25 year clinical expertise of the co-investigator.

Contents of TW Modules

The 12 Modules of the TW address both gambling-specific issues and those commonly underlying problematic gambling for women. The first few modules explore whether gambling is a problem, establish gambling-related goals, and address relapse prevention strategies. They include topics such as supporting the change process and dealing with urges to gamble, with lapses, or with both. The remaining modules shift to a focus on issues often lurking below the surface of the gambling urges. The modules include exploration of mindfulness, stress management, relationships and regulating emotions. Skill training is incorporated into the contents.

Gainsbury and Blaszczynski (2011) note that participants using self-help literature preferred a combination of different formats. Consistent with this, the modules are a mixture of didactic information, quotations, and worksheets presented in a colorful layout with graphics and text boxes rather than in a strictly narrative script. They range in size and are structured to build on each other. Certain themes are repeated for improved comprehension; the general thrust of the modules can best be described as an emphasis on awareness, self-compassion, and healthy choices. In addition to the TW, participants were mailed a CD with a series of 16 Mindfulness meditations recorded by the clinical researcher (RB), in collaboration with Kimberly Murdoch, Stress Management Therapist of Centre for Addiction and Mental Health. Content and literature sources for the modules are summarized below.

Module I: Introduction, Treatment: What's it all about? Is my gambling causing me problems? Setting goals. This module reviews a Choice Theory CBT model of total behaviour as an interaction of thinking, actions, feelings and physiology (Montagnes, 2006). A car analogy is used: the front wheels, thinking and doing, steer the car and give it direction while the two rear wheels, feelings and physiology, provide energy and drive. While the front wheels can be controlled directly the rear wheels can only be changed indirectly, by changing what we think and do. Treatment is described as a process that addresses all four wheels to create balance. Clients use a needs profile to consider whether the gambling is effectively meeting their needs.

They also complete the Canadian Problem Gambling Index (Ferris & Wynne, 2001) and identify their gambling goals.

Module II: Stages of change. The stages of change outlined by Prochaska, Norcross, and Diclemente (1994) are reviewed, exploring tasks and obstacles at each stage. The module includes a Decisional Balance exercise worksheet, and one geared to identifying alternative ways to create the benefits of gambling.

Module III: Lining up your ducks to support change. Four areas important in early recovery to support change are covered: (1) Stop the Bleeding: Limiting Access to Money or Credit; (2) Reduce Temptation; (3) Increase Social Networks; and (4) Bringing Our Wisdom Into Play: Change Related Goals. All aim to build on strengths and call on innate wisdom to implement activities that will nurture and support recovery. A final section, Coping With Symptoms and Side-Effects of Medications That Trigger Urges (O’Grady & Skinner, 2007) is also included as of special interest to some clients. It identifies common symptoms of mental illness as triggers for gambling and provides coping tips. The module provides examples of relevant strategies in each area and clients are asked to complete personal worksheets.

Module IV: Gambling hooks and traps—the head, the heart, the hype. This module highlights key areas that can trap gamblers into excessive play: the head (ways of thinking beliefs about gambling, misunderstanding of odds and probabilities), the heart (the emotional payoff and lure of gambling), and the hype (manipulation by the gaming industry through promotional advertising, the venue atmosphere and the mechanics of the slot machines).

Materials on head traps draw from Toneatto, Kosky, and Leo (2003) who provide information and worksheets to deal with gambling related thoughts and beliefs. Magical, wishful or superstitious thinking and behaviours are also explored. Heart traps materials explore the emotional valence of gambling and the high jacking of the intellect by the emotions. It highlights how gambling can relate to emotions (i.e., coping and self-soothing, distraction from emotional pain, efforts to change our emotions and attempts to maintain good feelings) and offers coping strategies and materials on increasing positive emotions from Dialectical Behaviour Therapy (Linehan, 1993).

The hype portion reflects on the shame and devastation women often feel as a result of the loss of control, their tendency to judge themselves as weak, the resultant anger and depression. It speaks of the addictive habit as shaped by external forces such as commercial strategies and psychological traps (intermittent reinforcement schedule, near misses, illusion of control and “ambience management”) (Dow Schüll, 2012) that women may not even be aware of, identifying player manipulation to maximize “time on device.”

Module V: Avoiding lapses. The Gambling Lapse Cycle is described by King (1999) as gambling-remorse-abstinence-triggers and urges-gambling. The importance of learning from lapses and compassionate curiosity (rather than self-criticism) are

emphasized and clients are introduced to the COAL acronym of Mate (2009): curiosity, openness, acceptance, and love. The module includes a relapse worksheet to prepare for risk situations.

Module VI: Relationships. The module explores the duality of the how relationships can both trigger and be affected by gambling. The role, for many women, of gambling as an escape from excessive caretaking is flagged (Dow Schüll, 2002). Gambling triggered by a lack of relationships, by loneliness and isolation (Boughton & Brewster, 2002; S. Brown & Coventry, 1997), is also explored, and it also includes a recommendation to read Copeland (2000) as a way of dealing with loneliness. Relationship skill building utilizes worksheet materials on setting healthy boundaries (Katherine, 2002; Najavits, 2002), assertiveness (Linehan, 1993) and connecting and disconnecting behaviours (Montagnes, 2006; Shelley, 2010).

Module VII: The addicted brain: Why do I keep on gambling even when I don't want to? Addiction is described as an overlearned habit, automatic and mostly unconscious. The module explores the brain's role in perpetuating gambling urges and behaviours. It provides education about the evolution of three brain layers, the importance of the mid-brain (mammalian brain) as the matrix of emotions, of the reward system and of addiction, and the role of dopamine and endorphins in creating gambling urges. Withdrawal symptoms and the danger of euphoric recall are explored, and neuroplasticity is introduced to instill hope that recovery is possible. Sources for this information include Doidge (2007), Goleman (1995), Mate (2009), and Toneatto, Vettese, and Nguyen (2007).

Module VIII: Thinking and well-being. This module incorporates key concepts of CBT in exploring the role of thoughts in creating feelings. Materials are adapted from *The Feeling Good Handbook* (Burns, 1999) to exemplify gambling-related distorted and unreasonable beliefs. Burns's techniques on countering thoughts, such as examining the evidence and thinking in shades of grey, are included, along with worksheets to employ the three-column technique of constructing rational responses. A final section explores shame, guilt and self-criticism as barriers to healing. Quotes from *The Compassionate Mind* (Gilbert, 2009a) on the importance of self-compassion are included, as are materials on practices to nurture self-compassion (see also Hanson & Mendius, 2009).

Module IX: Mindfulness. As a self-awareness tool and introduction to the practice of mindful awareness, the module includes the MAAS, a 15-item validated scale designed to assess a core state of mindfulness (K. W. Brown & Ryan, 2003; Carlson & Brown, 2005). Participants are taught that mindfulness involves a turning towards experience with awareness, developing an ability to detach and observe without judgment. A number of practical applications are offered: surfing urges, relapse prevention (Bowen, Chawla, & Marlatt, 2011; Maté, 2009; Roberts, 2009), compassion (Gilbert, 2009a & B; Hanson & Mendius, 2009), commuting suffering to honest pain, radical acceptance (Linehan, 1993), and using mindful strategies to deal with depression and anxiety (Williams et al., 2007). Mindfulness meditations are

included both in the written materials and recorded on a CD which accompanies the TW.

Module X: Our emotions. The module describes primary emotions, the more complex emotions resulting from a combination of thoughts and feelings, and reactive secondary emotions (Linehan, 1993). The role of both nature and nurture in shaping emotional expression is explored, looking at examples of display rules of family systems and cultures. The benefits of emotions are articulated (Goleman, 1995; Linehan, 1993).

The module also addresses troublesome emotions for women, providing strategies to identify and more effectively manage them. Primary attention is paid to anger, anxiety, depression and shame as these are typically associated with women's gambling. Physical and psychological tools for regulating emotions such as grounding, containment and visualization (Haskell, 2003; Najavits, 2002), radical acceptance, willingness and building positive emotions (Linehan, 1993) are covered. A client handout on food and mood was also included.

Module XI: The stress connection. The stress module has a number of components. The first identifies stressors in the lives of many women such as power imbalances, caretaking roles and limited income. It also looks specifically at trauma and abuse as common antecedents to problematic gambling. The signs and symptoms of PTSD are touched on with brief descriptions of the cluster of symptoms (intrusion, hypervigilance, numbing) that can occur. Stress symptoms are explored using a Stress Awareness Checklist. It offers education on the stress response (Sympathetic) and restorative calm response (Parasympathetic) of the Autonomic Nervous System, and stress management practices to help maintain an optimal level of stimulation (Fisher, 2011). Included are both top-down and bottom-up (mind and body): approaches to maintaining a healthy balance: mindfulness, psycho education, cognitive appraisal, food, exercise, muscle release skills, yoga, self-care (food, water and sleep), music, setting limits and social support. Sources for the materials in the module include Benson (1975), Boughton and Brewster (2002), Charlesworth and Nathan (1991), Fehmi and Robbins (2007), Fisher (2011), Jacobs (1993), Kabat-Zinn (1990), Maté (2009), Peterson (2001), Stroebel (1985), and Wallace (2006).

Module XII: Soaring with the eagles. This final module includes a quick review of past modules and resources for recovery (books, on-line web resources, crisis lines and women specific sites). Supplemental tools to support recovery are introduced such as the 10% Solution Worksheet (Fisher, 2011), and the importance of creating a Survival Kit to buffer against high stress periods. Finally, the women are invited to think about how to support next steps in recovery.

The foregoing has provided a review of a selection of the current literature related to women's treatment needs as distinct from men and noted the benefit women may derive from the use of self-help materials. It has described the sources and content of a self-help workbook developed as a treatment protocol for women who are

gambling at a problematic level. We will now consider the findings of a small pilot study testing the effectiveness of the materials in helping women make positive changes.

Research on the Effectiveness of the TW

This study aimed to test the effectiveness of the Tutorial Workbook for women gamblers. This pilot aimed to be responsive to concerns about the limited engagement of women in treatment and circumvent barriers by offering women access to resources and support using a mailed self-help or Tutorial Workbook (TW) designed to address the special issues and treatment needs of women who gamble at a problematic level but may not be able to access traditional treatment. The method chosen was to run it as a pragmatic clinical trial (see Tse et al., 2013). Pragmatic clinical trials investigate how effective an intervention is in everyday practice (MacPherson, 2004). For the pilot, we invited feedback from women gamblers on the content and format of the TW.

The Tutorial Workbook was mailed to a sample of Ontario women. The interest was twofold: to obtain input on the actual workbook contents and to assess the effectiveness of the TW in helping the women make gambling related changes. The Research Ethics Board of the Centre for Addiction and Mental Health (CAMH) approved the pilot study as protocol # 153/2012. Participant information security was in accordance with CAMH protocols.

We had three hypotheses. First, that women in the program would make positive progress on their stated gambling goals when comparing their pre-program scores to their post-program scores. Second, participants would report positive experiences of personal growth and learning in their quantitative feedback to the program. Third, participants would report positive experience of personal growth and learning in their qualitative feedback to the program.

Method

Participants

Ontario women over age 19, with self-identified gambling concerns, were recruited in communities across Ontario through community newspaper advertisements and flyers. Investigators employed a telephone script to screen for respondent eligibility. Inclusion criteria included women who identified gambling concerns but were not currently in formal gambling specific treatment, English proficiency (reading, writing, and verbal), ability to commit to time demands of weekly participation, and interest in the pilot treatment. Exclusion criteria included mental health concerns of sufficient severity to compromise weekly involvement (i.e., active psychosis, unstable mood disorders), cognitive challenges in reading, materials or completing written assignments, suicidal behaviours, and drugs or alcohol abuse, all of which would interfere with participation. Women not eligible were offered information on

Table 2
Participant Demographics (n = 33)

Ethnicity	White European descent	65%
	First Nation	19%
Average Age (in years)		51.5 (7.3)
Age range (in years)		32-67
Relationship	Married or common-law	62.5%
Children	At least one child	55%
Education	High school or less	39%
	Community College	36%
	Some University or Professional Degree	24%
Work	Full or part-time	33%
	Disability	36%
	Retired	21%

appropriate services when possible. Participants received compensation after completing the first six modules, after completing the last six modules, and upon the return of the post study package, for a total of \$120.

There were 44 initial enquiries from potential participants. Of these, 33 completed and returned the pre-study package and consents to treatment, 25 took part in the first group, and 19 completed the post-test evaluation. The completion rate was 59% of those who completed the pre-test questions, and 76% of those who completed the first group. Demographics are outlined in Table 2.

Measures

Both quantitative and qualitative data were gathered in the study. The pre-study package mailed to potential participants included standardized gambling, mental health, and quality of life and well-being measures. Level of problem gambling was measured using the Diagnostic and Statistical Manual of disordered gambling (DSM IV) (Slutske, Zhu, Meier, & Martin, 2011) and the Canadian Problem Gambling Index (CPGI) (Ferris & Wynne, 2001). Participants were asked for demographic information (see Table 2), family history, and background such as drug or alcohol use, struggles with other behaviours (i.e., eating, shopping), mental health status, trauma history, and gambling behaviours (triggers, patterns, type). Indicators of well-being included the Multidimensional Scale of Perceived Social Support (MSPSS) (G. D. Zimet, Dahlem, S. G. Zimet, & Farley, 1988), the UCLA Revised Loneliness Scale (Russell, 1996) and the Index of Self Esteem (ISE) (Hudson, 1992).

Participants provided feedback of each module through the course of completing the study. Post-study feedback was also gathered: a questionnaire explored goals, changes in gambling patterns and impressions of success; the women documented whether and how participation in the study made a difference to beliefs and attitudes about their gambling and gambling behaviours. Two additional screening measures

evaluated the pre- and post-treatment impact of the TW: the Perceived Stress Scale (PSS) (Cohen, Kamarck, & Mermelstein, 1983) measured the degree to which situations in the participant's life are appraised as stressful, while three subscales of the DASS-21 (Lovibond & Lovibond, 1995) were used to measure levels of depression, anxiety, and stress. Seventeen women completed both screening measures.

Procedure

Distribution of the TW modules and feedback forms. Participants were mailed the 12 modules in groups of three. Included in each mailing was a self-addressed, pre-stamped envelope to return the enclosed feedback forms. Subsequent modules were not mailed until the feedbacks forms from the previous package had been returned.

Participants rated the strength of gambling urges over the course of the week and progress towards gambling goals. If they had gambled they were asked to report how often and how much they spent. A second page asked for reflections on what they have learned from the module, what changes they feel good about, and coping strategies they used. A Likert scale on a third page tracked opinions about the contents and format of the module, i.e., ease of comprehension, length, relevance, and whether they would recommend it to a friend. The last page asked for written comments and suggestions for improvement. Every module had exactly the same questions to allow for comparisons.

Data analysis

The quantitative data (demographic, history and background) provided by the participants is reported in terms of frequency. For the PSS and DASS-21 the data are reported using repeated measures t-tests. A qualitative analysis was utilized to provide an understanding of women's perspective of the workbook. Participant responses in the weekly Progress Updates and feedback forms for each module were coded using NVIVO10 software. Participant's responses were first read as they progressed through each module and then all participant responses were examined as an entire group. Braun and Clarke (2012) outline a series of phases through which researchers conduct thematic analysis. The initial coding phase involved coding each question of the survey across all the modules. This resulted in the emergence of 530 codes from the collected data. Various themes were revealed through analysis of these codes. A full coding pass allowed for the emergence of themes.

Perspectives related to gambling behaviours and triggers, emotions, mood and relationship issues were identified. On the basis of this analysis, a thematic framework was developed. The raw data were again examined using Nvivo10 software to ensure the robustness of the analytical process and to confirm that all data were indeed reflected in the coding. A refined coding scheme was developed and used to

explore the data, increase understanding of the data, test-coding rigour, and to develop and understand thematic relationships of participant responses.

Following the extensive coding process, the original 530 codes were further categorized and thematized. During this phase, relevant quotes that illustrated major categories were identified. Four major dimensions resulted: workbook effectiveness in relation to dealing with gambling, positive psychological impact, improved coping, and decreased isolation. Corresponding data were examined to understand the interplay of each dimension.

Results

Family History and Background Behaviours

The women reported high levels of addiction and mental health problems in the family systems, considerably higher than in the general population. Mothers (24%) and siblings (30%) were more likely to be reported as having psychiatric problems than were fathers (12%). In contrast, fathers were more likely to have gambling problems (27%, compared with 12% of mothers). Both mothers and fathers were reported to have issues with drugs or alcohol (33%).

Trauma and abuse. Over 60% reported experiences of emotional abuse, both as children (67%) and adults (64%), while more than 40% reported experiences of physical abuse, both as children (42%) and adults (52%). Sexual abuse was more common as children (33%) than as adults (21%): the Ontario Health Supplement (MacMillan et al., 1997) reports rates of childhood physical abuse in the general population at 21% and child sexual abuse at 13%. In addition the women reported high levels of loss as both children (58%) and adults (88%), and high levels of trauma as children (52%) and adults (58%).

Relationship issues. More than half of the group (n=20, 61%) reported being in a current relationship. These ranged from 7 years to 43 years in length, with an average of 24 years. The most common spousal issue reported in current relationships is anger at 19%. The predominant form of abuse they report is emotional abuse at 19%. This stands in stark contrast to the reports about spouses from past relationships (n=17, 51%) where drug and alcohol abuse were reported at 65%, anger at 67%, mental health at 59%, and gambling at 40%. Emotional abuse in past relationships was reported at 77%.

Comorbid issues. The gambling literature reports high levels of mental health issues and concurrent struggles with other problematic behaviours among female problem gamblers. Findings in this study confirm this. A majority of respondents (70%) had sought professional help for depression, anxiety (58%), panic (27%), manic-depression (9%), schizophrenia (12%), and anger (30%); 58% had been prescribed medications for emotional issues, and a third (36%) were currently taking medications. Many acknowledged serious thoughts of suicide (42%) or attempts

Table 3
History of Substance Abuse and other Problematic Behaviours (n = 33)

Problematic Behaviour	Past Problem %	Current Issue %
Alcohol	36	3
Prescription drugs	36	12
Non-prescription drugs	33	6
Smoking	73	46
Shoplifting	15	6
Compulsive shopping	36	21
Sexual behavior	30	3
Eating disturbances		
Binge eating	33	24
Starving self	24	9
Aggressive behavior	33	18
Criminal behaviour	27	6

(39%). One third (36%) had been hospitalized for mental health issues. Comorbidities include drug and alcohol use, smoking, eating disorders (bulimia or anorexia), compulsive spending, shoplifting, compulsive sexual activity and anger issues (see Table 3).

Gambling behaviours, problems and drawbacks. Scratch tickets (73%), slot machines (67%), and bingo (21%) were the games played by most of the women. On average the women played 3.9 different games each month, with a range from 2 to 7 games. They spent considerably more on slot play than other games. The monthly expenditure on slots ranged from \$100 to \$7,500 with an average of \$1,133 month (*SD*: \$1,936). On Bingo the range was from \$20 to \$600 with an average of \$84 a month (*SD*: \$174). The range of spending on scratch tickets was from \$10 to \$600 with an average of \$115 a month (*SD*: \$154). Women spent, on average, forty eight percent (48%) of their net personal income on gambling every month. Fifty four percent (54%) had accumulated debts related to gambling through credit cards (39%), bank loans (12%), unpaid bills (39%), and borrowing from family (27%). A number also pawned or sold personal property (30%); two (6%) declared bankruptcy.

Problem Gambling Screens

DSM-IV. The DSM-IV diagnostic criteria for pathological gambling was also included, however, given the recent publication of DSM 5 we used the DSM-5 scoring rather than the DSM-IV scoring, using the scoring suggestions of Turner, Stinchfield, McCready, McAvoy, and Ferentzy (2016). The women ranged in scores on the DSM 5 from 0 to 9 with an average of 4.7 (*SD*: 2.5). More than half (70%) of the women scored as disordered gamblers and another 24% scored in the subclinical range.

Table 4
Drawbacks to Gambling as Reported by the Women

Drawbacks to Gambling	Often or always an issue (%)
Stress over money loss	58
Losing money I can't afford	58
Guilt	55
Taking money from other things	47
Anger at myself or others	45
Secrecy about the time or money spent	43
Worry about my financial future	42
Worry	42
Depression as a result of gambling	39
Fear/anxiety related to gambling	39
Difficulty sleeping	36
Breaking promises to self or others	36
Debts as a result of gambling	33
Feeling out of control	30
Loss of self-esteem	30
Interest charges on credit cards	30
Gambled whole check	27
Spending savings or inheritance	24
Confrontations about money spent on gambling	22
Losing the trust and respect of others	21
Time away from friends or family	21
Not taking care of myself	19
Lying or manipulating	15
Borrowing money	15
Tensions or arguments with others	24

CPGI. The Canadian Problem Gambling Inventory (CPGI) is an assessment measure developed by Ferris and Wynne (2001). The Problem Gambling Severity Index (CPI), which focuses on the harms associated with problem gambling, is composed of nine items from the longer CPGI. Based on the CPI many TW participants were identified as gambling at a moderate (42%, score 3–7) or problematic (48%, score 8 or 9) level. Only 6% had no problems or low level gambling (score 0–2).

Drawbacks to gambling. Participants indicated drawbacks to their gambling from a list of 60 items. Table 4 lists the top 25 items endorsed. “Stress over money loss” (58%) was the most frequent response, along with “losing money I can’t afford” (58%) and “worries about my financial future” (42%). A large percentage of the women identified emotional reactions: guilt (55%), anger (45%), and depression over gambling (39%). Also endorsed were items related to the negative impact of gambling on relationships such as tensions and arguments (24%) and losing the trust and respect of others (21%).

Table 5
Pre (T1) and post treatment (T2) scores for the PSS and DASS including subscale scores

Variable	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>T</i>	<i>P</i>	<i>D</i>
PSS Total T1	17	17.4	9	0.88	0.19	0.21
PSS Total T2	17	15.2	7.9			
DASS Depression T1	19	5.5	5.4	0.98	0.17	0.22
DASS Depression T2	19	4.3	4.2			
DASS Anxiety T1	18	5.2	5.9	1.4	0.09	0.33
DASS Anxiety T2	18	3.8	4.9			
DASS Stress T1	18	4.8	5.2	1.38	0.09	0.33
DASS Stress T2	18	3.6	4			
DASS Total	19	15.4	15.3	1.26	0.11	0.29
DASS Total	19	11.9	12.7			

Note: *t* the t-test value, *p* the probability estimate for the t-test, *d* = the estimated effect size. For values of *d*, *d* = .2 = small; *d* = .5 = medium; *d* = .8 = large. *P* values are based on one-tailed tests.

Evaluation Data

Four scales evaluated the pre- and post-treatment impact of the program on participants (see Table 5): the Perceived Stress Scale (PSS, and three subscales—depression, anxiety, and stress—of the DASS-21). Seventeen (17) women completed both screens. In the PSS, scores around 13 are considered average, scores of 20 or higher are considered high stress. The average score was in the pre-study measures was 17.4 (*SD*: 9.0). The post-study scores show an average of 15.2 (*SD*: 7.9; *n*=17). SPSS results of a Paired Samples Test comparing the pre and post scores indicates that the mean PSS initial score was not significantly different from the PSS final score.

The analyses were conducted on the raw scores for the DASS 21 scales (see Table 5). For all three subscales the results indicate some reduction in scores however, again the results did not reach significance. This lack of significance in the reduction in depression, anxiety and stress is surprising and inconsistent with the qualitative feedback from participants, and is likely because of the small sample size. Further research is warranted.

Quantitative Feedback on the TW

As noted, each of the 12 modules included identical 4-page feedback forms that participants mailed in.

Module feedback. The content and format of each module was evaluated from a variety of perspectives: ease and clarity of the module, amount of information, impressions of the graphics and layout, relevance, helpfulness, whether they would recommend it to a friend in their situation, and finally, disappointment in the module. The women were asked to circle the answer that best describes their

Table 6
Percentages of Participants who Agree or Strongly Agree with Feedback Items

Module #	1	2	3	4	5	6	7	8	9	10	11	12
<i>N</i>	25	25	25	25	25	21	21	20	18	20	20	21
I found this module easy to understand clear	84	71	80	92	80	84	67	90	72	80	75	90
This module had too much information	4	4	0	4	4	12	15	10	11	10	30	5
I liked the graphics and layout	56	46	48	48	24	60	50	55	67	37	60	50
I found this information relevant to me	80	83	80	92	80	80	95	90	94	90	85	95
Overall I found this module helpful	76	91	92	92	88	88	81	100	94	95	90	100
I would recommend this module to a female friend in my situation	80	83	88	96	96	96	86	100	88	95	90	100
I was very disappointed with this module	4	0	0	4	4	0	15	5	0	0	5	0

thoughts using the following scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. As shown in Table 6 all positively keyed feedback items were endorsed by a majority of the participants, whereas the negatively keyed feedback items were endorsed by no more than 15%. For the sake of simplicity, we have reported percentages only of the number of women who agreed or strongly agreed with each of the evaluation statements. Overall, the positive items were strong endorsed and the negative items were infrequently endorsed. For example, between 67% to 90% agree that the modules were “easy to understand”, but hardly anyone agreed they were “disappointed” with the module. The highest score for disappointed was 15% for module 7 (The Addicted Brain). However, item 3 about the graphics and layout ranged from 24% to 67% suggesting that there is some room for improvement in terms of the graphics.

Goals. Information was gathered on the women’s initial goals specific to gambling and their goal progress. One third of the women (35%) had wanted to stop all gambling but the majority wanted to limit amount played (25%), limit the frequency (20%) or stop certain games (10%).

Changes in urges. Changes in strength of urges over the course of treatment were addressed: Most (85%) reported still having urges but being better at not acting on them while 15% reported a large reduction in urges. The urges rating after the first session was 5.7 out of 10 ($SD = 2.7$), but by the 12th module had dropped to 3.0 ($SD = 2.3$). This difference is significant $t(9) = 2.5$, $p = .025$ (one-tailed), and was a large effect size decrease in urges, $d = 1.1$.

Gambling behaviours. Gambling shifts during the study were explored—patterns of frequency, time or money spent and types of gambling. Seventy percent (70%) reported a decrease in frequency of play, and 20% indicated no change. Similarly, seventy percent (70%) reported a decrease in the amount of time they gamble while 20% indicated no change. Sixty percent (60%) report spending less money while 15% report no change. Over half (53%) have stopped certain forms of gambling, while 21% report no change.

Table 7
Benefits of the Treatment

TW Participants (n=20)	Agree %	Strongly Agree %
I think I have a better understanding of my gambling triggers and issues	55	45
I have more tools of awareness and choices as a result of what I have learned	55	40
I am feeling better about myself	40	40
I think it has helped my moods and anxiety levels	45	30
I feel less isolated and alone with this issue	30	35
I have been able to improve my relationships with what I have learned	40	30
I am more hopeful about the future	45	40

Change progress. The women were asked about changes and provided with a list of positive and negative selections. A quarter (25%) indicated that they have been successful in making the changes they wanted. The rest (75%) indicated, “Overall, I feel I’m making positive progress”.

Impacts of TW involvement. Participants reflected on the overall impact of being involved in the pilot, looking at key areas of self-esteem, moods, isolation, increased understanding and awareness of gambling triggers and behaviours. They were asked to circle the answer that best describes their thoughts about the benefits using the following scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree. The results are indicated in Table 6. A majority positively endorsed each statement. Almost all (90%–100%) felt they had gained a better understanding of gambling triggers and urges and had increased awareness. A majority (80%–90%) felt more hopeful, reporting improved moods and anxiety levels and feeling better. A reduction in isolation and improved relationships were endorsed by fewer of the women (65% and 70%) which may be understood in part by the nature of the TW protocol in that the women worked on the self-help modules on their own and without the benefit of contact with and support from other women or the therapist.

Qualitative Feedback on the TW

A purposive data analysis technique with the coding scheme described earlier was used to provide a qualitative analysis. Women conceived that participation in the TW was related to changes that extended across four primary dimensions: (1) dealing with gambling, (2) improved coping, (3) positive psychological impact, (4) decreased isolation. These dimensions include themes and sub-themes. Relevant quotes that illustrated major categories were identified.

Dealing with Gambling. Feedback identifying the usefulness of the TW in relation to gambling was consistently positive. It was a robust theme, evident in feedback for all modules, and stated by all participants. Sub-themes were identified, such as finances, the nature of addiction and the brain, and mental health and

gambling-related behaviours. Participants reported that the workbook was beneficial in presenting gambling-specific information and assisted them in reducing gambling behaviours:

Gambling has consumed me for so long that having information presented and being given facts about what the gambling is and what it's doing/has done to me is a wake-up call. The weekly packages were an incentive not to gamble because I wanted to give a good report. I also had weeks when I worked on the next module as a deterrent to gambling. (Participant #52)

Improved Coping. The women reported that the TW helped with triggers and urges as they discovered new ways of coping: One participant volunteered, "I still have thoughts/urges although minimal. I have not attempted to gamble. This is different. I found it interesting that if I wait for a half hour without giving in to the urge, it often subsides or goes away entirely. I feel more able to cope with the urges." (Participant #79). Reports of new coping strategies included themes of stress management, self-care, and such strategies as utilization of prayer. The payoffs for the changes were improved moods and empowerment. Another participant described the psychological benefits of self-care: "I am spending more time on my own de-stressing. I am relaxing and not feeling guilty when I make choices that are good or bad." (Participant #77). Participants identified the helpfulness of the TW materials in the development of more adaptive coping mechanisms such as social alternatives to gambling:

I review these modules when I'm feeling anxious sometimes. It is also good to remember what I'm working on. I found it helpful when the examples of the benefits of gambling were listed but instead of seeing the whole gambling thing as a negative, we can take the positive benefits of gambling (like socializing as a good thing) and keep that same feeling while not gambling and replace the action and venue of gambling with something more beneficial such as socializing with others or by joining a pottery class. It's fun and yet at the same time, I am learning a new hobby. (Participant #71)

Positive Psychological impact. The psychological impact of study involvement includes sub-themes of increased self-compassion, self-esteem and emotional awareness. Women expressed feeling more comfortable with themselves as a result of the increases in knowledge and awareness of how they had become trapped in gambling. Self-acceptance allowed for less judgment for past behaviours, less guilt, more confidence, and a stronger sense of self: "I feel much stronger and more confident in myself. This is related to self-acceptance. In the past, my generosity was attracting the wrong people." (Participant #67)

The setting of boundaries was related to having more self-compassion and caring for one's own needs: "A big issue for me that was related to gambling was being self-critical. I often think I am not worthy of my existence. I need to see the good in myself first, then, I will be more positive to others. I find that I am trying to learn to be more accepting of situations" (Participant #57). Forgiveness was identified as part

of the journey of recovery, while insight into gambling-related triggers such as a low sense of self worth, self-blame, depression, and shame were important components of the women's growth in awareness. One woman captured this well:

For me, I realize that the reason I was gambling was because of shame and feeling like I wasn't good enough. I recognized that my depression has links to my gambling and I now need to consider options to meet my needs. I can't blame myself for everything. When bad things happen, it is not always my fault and instead of gambling I need to cheer myself up, get back to reality and enjoy it. I used to feel that by gambling, I was free. But then after a while, I began to feel a prisoner to gambling so really I am not free at all. (Participant #54)

Decreased isolation. A decrease in the sense of isolation was a key theme among the women. Related sub-themes included an understanding of loneliness as a gambling trigger, self-acceptance, increased social support and improved communications, and emotional transparency with significant others. Women expressed that the content of the Tutorial Workbook itself led to feeling less alone. Some participants would turn to the material for support when they required it:

The tremendous amount of supportive material made me feel less isolated. This study and the workbooks have become almost like a friend I can turn to, to remind me where I was and what I have done to cope with my feelings and actions when I feel I might slip or become "overly" confident. This material has opened up another side of me that has been dormant for a long time. (Participant #59)

Engaging in the study served to further reduce a sense of isolation as it normalized the problem gambling; the women recognized that other females also gambled and ran into similar problems and emotional reactions. Thus participation in the study validated their struggles:

Being part of this study, I now know that there are lots of people with gambling problems. Doing this study has made me realize that there is a big need for help for women like me and that makes me feel less alone. I feel less alone and therefore not isolated. I know that many others have the same issues. (Participant #81)

In another dimension of the theme of reduced isolation, the women wrote of the importance of relationships in their lives, and of rebuilding and strengthening connections:

I am spending more time reconnecting with family members. I talk to them and my friends about how I am feeling. (Participant #73)

Discussion

This project was the realization of the need noted by Boughton and Brewster (2002) for treatment options specifically designed and geared towards women facing practical or emotional barriers to treatment services for gambling problems.

We aimed to test the effectiveness of an intervention to meet the unique treatment needs of women gamblers through the use of a self-help Tutorial Workbook (TW). It capitalized on existing gambling literature that validates the treatment effectiveness of self-help materials. The TW was developed at CAMH and drawn from best practice resources in mental health and gambling treatment.

Treatment research participants effectively served as pseudo focus group to provide experiential and practical feedback from women gamblers on the content and structure of the TW. In terms of clinical outcomes, the researchers anticipated positive progress on the stated gambling goals of participants, positive personal growth and learning, improvement in terms of the perceived stress (PSS) and depression, anxiety, and stress (DASS-21). It was also anticipated that the women who receive the workbook would report satisfaction with the treatment outcomes as evidenced in both the quantitative and qualitative analysis of the feedback. As reported in the foregoing, there is strong evidence that the TW did meet these expectations. In addition we found a significant reduction in urges.

The quantitative feedback was uniformly positive. Participants found all 12 modules of the workbook very helpful. The lowest score was for the visual layout and graphics, nevertheless, a majority gave positive responses. Of the four scales (The Perceived Stress Scale or PSS, and the DASS-21 depression, anxiety, and stress subscales) evaluating the impact of the TW by comparing pre and post treatment scores, all four showed somewhat lower means (indicating an improvement) at time two, but these results were not statistically significant. The trend is encouraging, but requires replication with a larger sample.

Qualitative data also added to our understanding. Analysis revealed that a participant's involvement in the TW study resulted in beneficial changes that extended across four primary dimensions: dealing with gambling, improved coping, positive psychological impact and decreased isolation. Improved coping was the most frequently cited theme. They wrote of developing new awareness regarding their gambling triggers and urges, of implementing new coping strategies, changes in gambling-related behaviours, and diminished urges. The women also conveyed that the mindful awareness, stress inoculation and new ways to cope (i.e., meditation, etc.) nurtured greater hope, and a reduction in unresolved negative emotions and isolation. They helped women create calm, deal with triggers, and learn to live in the present moment even when urges to gamble arose.

Participants also shared that they felt decreased isolation and loneliness. Learning that other females also gambled and had similar issues validated their feelings. Given the degree of loneliness identified by the women, and their generally low sense of having support, it is noteworthy that a large proportion (65%) of the women indicated that a benefit of using the workbook was "feeling less isolated and alone with this issue." The findings are additionally interesting in that the TW participants did not generally have more than the initial intake contact with the researcher. One can only speculate the extent to which being involved in the study and reading

materials about women and gambling may have normalized their experience of gambling and reduced a sense of being a misfit. Certain participants also reported that relationships improved over the course of the study.

Limitations

There are several limitations to this study. The sample size was small. The attrition rate was 41% from pre-test to post-test, and 24% from the first session to the post test. More than half of the attrition occurring prior to the first session. Of those 25 who actually engaged in the study, 19 completed the study (76%). No statistically significant differences were found between those who completed the study and those who did not. In addition, because not all participants completed all of the questionnaires there were some missing values in the data set. In addition, there was no formal diagnostic screening process. The intake screening was carried out over the phone and information was provided by self-report. These factors add additional uncontrolled variance to the study's results. Although pragmatic research is thought to monitor effectiveness, the efficacy of the results cannot be ascertained, as this was not a controlled study using random assignment to a control or treatment group. In addition the quantitative results were encouraging, but not significant. Thus, despite the overall preliminary positive findings of this pilot treatment study, more research would further evaluate the impact of the workbook.

Further Considerations, Next Steps and Conclusions

The TW pilot was a preliminary effort to gather feedback from women gamblers on a self-help workbook. The results of this small study are promising. From a pragmatic standpoint the intervention proved to be effective. The feedback from the women suggests some changes that can be implemented in the actual workbook materials.

The high attrition rate was a concern in the study. This may have been avoidable: The women were required to mail in the feedback form for the module before the next was sent out. Mailing delays (women forgot to mail) and not completing the module in a timely fashion extended the study length considerably, slowing progress on completion of the study and likely contributing to attrition. One woman withdrew because she went blind, another, because of illness. Other reasons for dropping out included scheduling conflicts and health problems (family, personal). In future studies, sending the full workbook at the beginning may prevent delays.

Women-specific resources for addictions treatment, in general, are only now becoming more mainstream. The results argue for the addition of the TW as a women's resource to further this movement. Whether available in hard copy or on-line, it will augment existing support options and enhance treatments. Further refinement of the workbook and a more extensive evaluation is needed to determine the efficacy of these materials. Such research would benefit from the addition of a control group. In order to increase sample sizes recruitment efforts would need to be expanded, with

more varied Internet social networking and more extensive advertising than was possible in this small study. Future studies on the enhanced effectiveness of a combination of phone support and the TW may also have merit. Nevertheless the current results suggest that the TW is a positive first step towards closing the treatment gap for many for female problem gamblers. They warrant making the TW available to women of Ontario facing multiple barriers to accessing treatment.

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