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Double Jeopardy: Older Women and Problem Gambling

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The growth in legal gambling in North America, indeed worldwide, has been dramatic in the last three decades. Increased availability of gambling opportunities, as well as social acceptability, has led to a huge growth in the number of older adults who are gambling. Between 1975 and 1998, a large study by the University of Chicago found that the number of older adults (65+) gambling had more than doubled (National Opinion Research Center [NORC], 1999). Research on older adults who gamble or who have gambling problems is just starting to emerge and little is known specifically about older women who gamble, why they gamble or how many are at risk for developing problems. In this article, the existing literature on older women, here defined as including women 55 years and older, and problem gambling will be reviewed. Risk factors associated with age and gender, as well as gambling industry marketing strategies and electronic game machine factors, may place older women at heightened risk for developing gambling problems, especially related to electronic gaming machines (EGMs)[1]. Problem gambling is a "very, very hidden issue" (McNeilly, 2000, as cited in Berns, 1998) amongst the older adult population and research suggests that older women are even less likely to seek help. More research is necessary to inform public awareness campaigns, treatment interventions and social policies regarding older women and gambling.

Keywords: Problem gambling; Older women; Elderly; Gender; Canadian Community Health Survey; CPGI; SOGS-R.

Introduction

The legalization of commercial gambling in many parts of the world, particularly during the 1990s and on, has led to massive growth in both the size of the gambling industry and gambling expenditures globally (Reith, 2003). According to Campbell and Lowman (1988, as cited in Kelly, Skinner, Wiebe, Turner, Noonan, & Falkowski-Ham, 2002), legal gambling in Canada was limited to occasional charity bingos and raffles, mid-way games of chance, pari-mutuel wagering on horse races and betting on cards between individuals prior to the 1970s (Kelly et al., 2002). Over the last three decades, gambling has become more accessible with a huge growth in casinos, bingo games, lotteries, video lottery terminal sites, sports betting and Internet gambling (Wiebe, 2000).

Older adults, particularly older women, are participating in gambling activities in increasing numbers. Many older adults find gambling fun and exciting. A survey of activity directors from 81 residential facilities, seniors and retirement centers in the United States, found that gambling activities, such as bingo and casino gambling, were the most popular recreational activities for older adults (McNeilly & Burke, 2001).

Older adults represent a large and growing segment of the adult population—a fact that has not been lost on casino operators (Shaffer, LaBrie, LaPlante, & Kidman, 2002). The gambling industry has recognized that older adults, particularly older women, are a growing demographic, and have been successful at attracting older adults to casinos and *racinos* (facilities that com-

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[1] EGMs include reel and video slots, video lottery terminals (VLTs) and are called "fruit" machines in Britain and "pokies" in Australasia.

bine horse-racing and EGMs). The gambling industry employs marketing strategies that specifically target this demographic with "golden oldie" entertainment, cheap meals, discounts on medication, and special promotions that often coincide with the receipt of pension cheques (McNeilly, 2000). Bus trips to casinos, often organized by retirement homes or seniors' centers, are affordable, easy to attend alone or with others, and help for those with mobility or health problems is provided (Neufeld & Burke, 1999). In Ottawa, older adults also report supplementing their income by acting as "shepherds" for bus companies providing transportation to the racino and earn a dollar (CAD) for every person that takes the bus (Smith, Leach, Fierheller, & Fourdraine, 2003, p. 16). Other older adults report trying to cash-in on gambling industry incentives; for example, many casinos and racinos in Ontario offer a package of transportation, food and tokens that can be exchanged for cash and people with low incomes, such as students and older adults, try to make $10 (CAD) a day tax-free. These promotions make casino gambling attractive to the older population (McNeilly & Burke, 2001).

Older women, in particular, are targeted by the gambling industry and have been identified as a niche market colloquially called "the blue hairs" (Schull, 2002, p. 3). In a New York Times Magazine article ("*The Tug of the Newfangled Slot Machines*"), Rivlin (2004) reports that EGMs are primarily designed for women over 55 with lots of time and disposable income. In another newspaper article ("*Golden Age Gambling*"), Landon (2000) interviews Lyall Thompson, the marketing manager at the Rideau Carleton Racetrack Slots in Ottawa. Thompson reports that over half of the 4,300 patrons each day are older adults and that most gamble on the slots. According to Mr. Thompson: "The slots have a tendency to be designed for seniors and women. They have a tendency to like them better, anyway" (Landon, 2000). The gambling industry has been very successful in attracting older adults, especially older women, and casinos have been called "daycare for the elderly" (Rivlin, 2004).

Existing prevalence studies on gambling in the older adult population generally indicate that gambling activity declines in the 65+ population, with the exception of gambling on EGMs which remains constant across age groups (Kelly et al., 2001). However, research findings regarding whether gambling activity declines with age are inconclusive, as McNeilly and Burke (2000) suggest that gambling activity may not decline with age, as previously reported by Mok and Hraba (1991).

While the prevalence of problem gambling in the older adult population appears to be lower than in the general adult population at this time, gambling problems in this age group will likely increase for a number of reasons: (a) estimates suggest that the number of older adults in Canada will almost double by 2021 (Health Canada, 2003a); (b) the availability of gambling opportunities, including Internet gambling, continues to rapidly expand; (c) the consequences of problem gambling may be more significant for older adults as there is little time or earnings potential to recoup gambling losses (Borrell, 2003; Gosker, 2000; Hirsch, 2000); and (d) older adults, especially those 65+, are less likely than younger adults to seek formal treatment for gambling-related problems (Borrell, 2003; Hirsch, 2000; McNeilly & Burke, 2000).

Shaffer et al. (2002) noted that there may be specific populations that develop gambling problems and have distinct treatment needs due to the influence of culture, gender, age or socio-economic status alone or in combination. Other researchers contend that age and gender, as well as income, health, and ethnicity, all constitute risk factors for problem gambling and that problem gambling is an emerging, yet largely unrecognized, public health issue (Korn, 2002; Korn & Shaffer, 2000; McNeilly & Burke, 2000; Petry, 2002; Volberg, 2003a).

Although gambling is a popular activity for older women, little is known about the impact of both age and gender on problem gambling. While researchers in the problem gambling field have studied older adult problem gamblers (Fraser, 2003; Gosker, 2000; McNeilly & Burke, 2000, 2001; Mok & Hraba, 1991; Munro et al., 2003; Petry, 2002), female problem gamblers (Borrell, 2004; Boughton & Brewster, 2002; Brown & Coventry, 1997; Crisp et al., 2000; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Potenza et al., 2001; Schull, 2002; Surgey & Seibert, 2000), as well as income, age and problem gambling (Borrell, 2003), very little research has specifically addressed older women and problem gambling.

A literature search on female problem gambling reveals very little on age differences (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Potenza et al., 2001; Tavares, Zilberman, Beites, & Gentil, 2001; Volberg, 2004), while the literature on older gamblers, on the whole, neglects gender differences and similarities (Fraser, 2003; McNeilly & Burke, 2000, 2001; Mok & Hraba, 1991). Older women may experience a double jeopardy with regards to problem gambling due to gender and age factors that reflects both historic and current societal discrimination against women. Only Petry (2002) and Boughton (2004) specifically address the influence of combined age and gender factors in relation to older women and problem gambling. Researchers in Canada, to the best of my knowledge, have not yet explored gambling and problem gambling in the older female demographic with specific reference to factors such as race, culture and the challenges related to immigration.

Research in problem gambling is just starting to address older women and problem gambling—how many are gambling, why they gamble, how many are at risk for developing problems, and treatment considerations. This article will focus on problem gambling, particularly on EGMs, in the older adult female population. The existing research, when possible from an international focus but primarily studies from Canada and the United States, will be reviewed and treatment considerations will be described. Finally, gaps in knowledge and directions for future research will be outlined.

Definition of Gambling and Problem Gambling

Many definitions of gambling and problem gambling exist. One definition of gambling is the risking of something of value when there is an element of chance associated with the outcome (Centre for Addiction & Mental Health [CAMH], 2002). For the purpose of this paper, problem gambling refers "to the situation when a person's gambling activity gives rise to harm to the individual players, and/or his or her family, and may extend into the community" (Dickerson, McMillen, Hallebone, Volberg, & Woolley, 1997). In a November 24, 2003 "*On Line Opinion*" interview with W. Barrett, Mark Dickerson states that anyone who gambles regularly is at risk of becoming a problem gambler; in fact, he argues that the term "at risk" is preferable to "problem gambler" because all regular gamblers are faced with the difficulty of avoiding gambling problems as "it is quite difficult to gamble regularly on continuous forms of gambling (EGMs) without losing control."

The determinants of problem gambling, according to Korn and Shaffer (2000), reflect a complex interaction between a number of variables including individual factors (biological, behavioural, and psychological); the characteristics of the games themselves, especially electronic gambling machine factors, such as design and pay-out schedules (Dekker, 1997; Dickerson, 1990; Griffiths, 1999, 2004; Griffiths & Parke, 2003); and the gambling setting, local environment, and social acceptability. Gambling is a multi-faceted rather than unitary phenomenon and is best viewed from a biopsychosocial perspective (Griffiths & Delfabbro, 2001).

Older Women and Gambling in Canada

Older women are the fastest growing segment of the population in Canada. In the coming decades, the population of older adults (defined by Health Canada as 65 years of age or older) will almost double with a projected increase from 3.5 million people in 1996 to an estimated 6.9 million by 2021 (Health Canada, 2003a). Women are over-represented in the older adult population—approximately 58% of people over 65 are women. This means that there are about 138 women for every 100 men over age 65, and 273 women for every 100 men age 90 and over (Canadian Centre for Justice, 2001). The older population in Canada is not a homogenous group: approximately, six percent belong to visible minority groups (Health Canada, 2002). Only one out of every 25 Aboriginal persons in Canada is an older adult (Health Canada, 2002). Like the population in general, older women in Canada come from a diverse range of backgrounds. Factors that influence their quality of life are: health, income, housing, family and social support, culture, race, class, sexual orientation and immigration status. Older women are also impacted by social and economic conditions that reflect ageism, sexism and racism.

Older women in Canada have experienced great social changes during their lifetimes. Many were children during the Depression and young women during World War II (WWII), some being employed in nontraditional female job categories like factory work or the military. After WWII, many women left the paid work force to raise children. The majority of women who worked outside the home, if only before they raised children, were employed in underpaid and undervalued jobs, such as housekeeping, clerical work, nursing, and teaching, that offered no pension benefits. As a consequence of employment and pension gender-based discrimination, as well as other factors, a disproportionate number of older women in Canada have low annual incomes and often live in poverty. In 1996, more than one-half of women 65 and older had incomes below $15,000 (CAD). The average income for Canadian women aged 65 to 69 in constant 1995 dollars in 1996 was $16,157 (CAD) compared to $28,540 (CAD) for men in the same age group (Health Canada, 2003b). Aboriginal women, immigrant women, visible minority women, and women with disabilities are more likely to be poor than other women in Canada (Canadian Feminist Alliance For International Action [FAFIA], 1999).

Older women in Canada have also seen great changes in gambling practices over their lifetimes. Although gambling activity, in its numerous forms, has existed throughout human history and across cultures (Gabriel, 1996), legal gambling in Canada was largely limited to small raffles, charitable bingos, and horseracing until 1969. Prior to WWII, gambling activity was largely condemned as a pastime of the lower classes but tolerated, even condoned, amongst the upper classes (Reith, 2003; Volberg, 2003b). Until the 1980s, public gambling was considered socially unacceptable for

women, with the exception of playing bingo, often in church basements to support charitable causes.

Bingo became popular in many parts of North America, as well as Britain, during the 1930s. For many women playing bingo was an inexpensive night out with their friends and provided a sense of belonging and community (Dixey, 1987). Over time, bingo has become increasingly commercialized and is not as inexpensive as it once was. Fraser (2003) reports that the average bingo player spends $27 (CAD) per game and stays for a minimum of two games. An individual who plays only 2 games per month will spend approximately $648 (CAD) a year or about 10% of a low income older adult's annual funds (Fraser, 2003). While many older women may have played bingo socially without problems throughout their adult lives as they age they may start playing more frequently for a number of reasons such as retirement, physical health limitations, a break from care-giving responsibilities, and a lack of safe and accessible leisure alternatives. Due to the expenses involved, older women may experience financial hardship due to frequent bingo playing.

Older Adults and Problem Gambling in Canada: Prevalence Studies

Prevalence studies on gambling and problem gambling in Canada and the United States indicate that despite the increase in the numbers of older people gambling, the rates of both pathological and problem gambling in the older population are lower than in the general adult population (Hirsch, 2000; Kelly et al., 2001; Mok & Hraba, 1991; National Opinion Research Center [NORC], 1999; Schellinck, Shrans, Walsh, & Grace, 2002; Shaffer, Hall, & Vanderbilt, 1997; Shaffer et al., 2002; Volberg, 2003b; Wiebe, 2000; Wynne, 2002). These studies, primarily random telephone surveys, must be interpreted with caution for the following reasons: (a) older adults are often under-represented in studies measuring the prevalence of gambling and problem gambling in the "general" adult population (Borrell, 2003; McNeilly & Burke, 2002; Petry, 2002); (b) self-reports of gambling problems generally yield gross underestimates (Borrell, 2003); (c) a self-selection bias regarding participation in surveys (Productivity Commission, 1999); and (d) older adults may lack telephones or live in rooming houses or retirement residences that lack personal telephones.

Another consideration raised by Wiebe (2000) is that the *South Oaks Gambling Screen—Revised* (*SOGS-R*; Abbott & Volberg, 1991; Lesieur & Blume, 1987), a standardized problem gambling screening tool used to identify problem gambling in the general adult population in earlier prevalence studies, may not accurately reflect problem gambling in the older adult population as none of the older adults who participated in the Manitoba prevalence study responded to the question of missing work due to gambling as most of the study participants were retired. Although the *SOGS-R* has been used in prevalence studies of gambling and problem gambling throughout the world, it may be limited as a problem gambling screening tool for sub-groups of gamblers such as women and older adults (Volberg, 2003a). Consequently, estimates of problem gambling in the older adult population may be conservative. Frisch, Fraser, and Govoni (2003) have developed the *Windsor Problem Gambling Screen for Older Adults* that may increase the identification of gambling problems in the older adult population.

While many surveys of gambling in the older adult population in Canada find similarities in the prevalence rates of problem gambling in the older adult population between provinces, it is impossible to directly compare findings as each province governs gambling legislation within its jurisdiction, with the exception of federal Canadian Criminal Code statutes; consequently, the expansion of gambling has taken place at different rates provincially and this may affect the maturation of gambling problems within the population studied (Borrell, 2003). As well, the availability of gambling, especially VLTs, is different in each province. Each survey also employs different methodologies and there is no clear consensus regarding what age constitutes being an "older adult" (55, 60 or 65 years old) making comparisons difficult, especially if one wants to compare with data from treatment-seeking older adults. The majority of age-specific addictions treatment programs in Canada use 55 years and over as the age of admission.

In Canada, the first national study to include questions about gambling and problem gambling was the 2002 Canadian Community Health Survey (CCHS) on Mental Health and Well-Being (Marshall & Wynne, 2004).[2] This random telephone survey employed the *Canadian Problem Gambling Index* (*CPGI*), a problem gambling screening instrument designed to measure gambling involvement, level of risk, and associated problems.[3] Based on the survey's results, it was estimated that approximately 18.9 million Canadians gamble, with the majority (17.7 million) considered to be non-problem gamblers. Although the percentage of those at-risk or currently exhibiting gambling problems

[2] This sample included more than 30,000 Canadians (aged 15 or over) but excluded those living in the three territories and individuals living on reserves or crown land, residents of institutions, and members of the Armed Services.

[3] See *CPGI* questions at http://www.agingincanada.ca/canadian_problem_gambling_index.htm.

seems relatively small (5%), this amounts to 1.2 million Canadians (Marshall & Wynne, 2004). Gender differences in gambling behaviour were found to be similar to previous prevalence studies, with men being at an overall greater risk than women (8% vs. 5%). In the older adult population (65+), the percentage of the population found to be "at risk" of gambling problems was 2.2% (with women having slightly higher rates; Statistics Canada, 2003). In comparison, the CCHS found that those "at risk" of alcohol dependence in the older adult population was lower than those "at risk" of problem gambling (1.2% vs. 2.2%; Statistics Canada, 2003).

Researchers have also conducted prevalence studies on gambling and problem gambling in most provinces. One of the first studies in Canada to examine problem gambling in the adult population was the Social Gaming Survey that was conducted in British Columbia in 1993 (Neufeld & Burke, 1999). This study revealed the following regarding gambling in the older adult population in British Columbia: nearly 28% of all gamblers were 65+, casino games account for the largest share of the gambling expenditures and reflect large sums spent by a small segment of the population; the 55+ population were the second biggest spenders on gambling activities at $2,055 CAD annually (Neufeld & Burke, 1999).

Researchers in Ontario (Wiebe, Single, & Falkowski-Ham, 2001) and Saskatchewan (Wynne, 2002) have also examined rates of gambling and problem gambling in the adult population, while researchers in Manitoba (Wiebe, 2000), Alberta (Hirsch, 2000), and New Brunswick (Schellinck et al., 2002) have conducted studies specifically on gambling and problem gambling in the older adult population (see data for these studies in Appendix A, B, and C). These prevalence studies of problem gambling in the older adult population suggest that 2% to 4% of the 3.5 million older adults in Canada (Statistics Canada, 2001) exhibit gambling problems (or approximately 70,000 to 140,000 individuals).

These surveys found that older adults were less likely than younger adults to exhibit signs of problem gambling, with older men more likely to be problem gamblers. The Manitoba study found that older men were more likely than older females to be gambling at problematic levels (Wiebe, 2000). The Alberta study reported that more older males than older females participate in some form of gambling activity. However, older females are more likely to play bingo than older men (Hirsch, 2000).

Gender Differences in Gambling

Historically, gambling activities have been gendered with women and men tending to engage in different types of gambling, in keeping with (and reinforcing) their socially constructed gender roles. In general, males have preferred to gamble on games of "skill", such as poker or other card games, craps or other dice games, horse racing, sports, and the stock-market, and have been categorized as "action" gamblers. Women, on the other hand, are generally categorized as "escape" gamblers and often prefer to gamble on "luck" or "chance" based games, such as bingo, lotteries or slots (Boughton & Brewster, 2002; Hing & Breen, 2001; Lesieur & Blume, 1991; Potenza et al., 2001). These gender differences in gambling preferences persist (Potenza et al., 2001) but with the widespread introduction of EGMs, men are increasingly participating in this type of "escape" gambling. Cultural representations of problem gambling also reflect this "male-as-norm" bias (Wilke, 1994); gambling is portrayed in film, for example, as being an almost exclusively male problem rendering female problem gamblers of all ages invisible.

Until recently, problem gambling was thought to be a male affliction, and the research on problem gambling reflects this bias (Lesieur & Blume, 1991; Mark & Lesieur, 1992; Volberg, 2003b). Until the 1990s, most problem gambling studies were conducted on male problem gamblers, largely Gamblers Anonymous (GA) members; thus, much of the problem gambling literature considers the (white) male "action" gambler to be the norm (Mark & Lesieur, 1992; Volberg, 2003a). While prevalence studies of problem gambling generally indicate that more males than females exhibit gambling problems, with the widespread availability of EGMs gambling has become increasingly "feminized" (Darbyshire, Oster, & Carrig, 2001); especially amongst women from ethnic minorities (Volberg, 2003a). Clearly there is a need in problem gambling research for gender-based analysis (Grant, 2002), which also focuses on age, class and race differences and similarities.

Research is starting to emerge on gambling and problem gambling in both the older adult and female populations. Compared to men, women largely gamble for escape (Boughton & Brewster, 2002; Potenza et al., 2001); start later in life (Borrell, 2003; Rosenthal, 1992; Shaffer et al., 2002; Tavares et al., 2001); and prefer a more solitary game at less competitive levels where luck, rather than skill, is involved. Evidence also suggests that women's gambling problems tend to progress more rapidly (McNeilly, 2000; Tavares et al., 2001); and that women seek help faster compared to men (Petry, 2002; Rosenthal, 1992; Tavares et al., 2001). Shaffer et al. (2002) found that 73% of the female problem gamblers in their study preferred slots and that they gambled to reduce boredom, escape from responsibility and relieve loneliness rather than for excitement, financial gain or pleasure. In a study that ex-

amined differences between male and female problem gamblers, Potenza et al. (2001) found that: (a) women were more likely to report gambling as a means of escape from distressing problems, while men tend to gamble for the thrill of competitive risk-taking for large stakes; (b) females were more likely to report problems with slot machines or bingo, whereas men report problems with blackjack or poker; and (c) that men were more likely to have a drug problem or to report an arrest for gambling, while women were more likely to report receiving mental health treatment unrelated to gambling. Boughton and Brewster (2002), in a large study of female gamblers in Ontario, found that the majority of women gambled for "escape" and preferred continuous play forms of gambling (EGMs).

Types of Problem Gambling in the Older Adult Population

Gambling, like alcohol consumption, exists along a continuum of involvement from not gambling at all, to social gambling, to problem gambling. A typology has been developed by the Florida Council on Compulsive Gambling (2000, as cited in CAMH, 2002) to describe the patterns of problem gambling found amongst the older adult population:

1. *Life-long Senior Problem Gambler*: Long-term problems associated with gambling; started gambling early in life but has never sought help. Gambling may accelerate and become more problematic after retirement;
2. *Social Senior Problem Gambler*: Has gambled socially throughout their life with no difficulties but after retirement gambling behaviour intensifies and problems occur;
3. *Late-Onset Senior Problem Gambler*: Never gambled or gambled infrequently prior to retirement. Gambling problems can occur over a relatively short period of time;
4. *Inactive Senior Problem Gambler*: Older adults who are socially isolated due to physical restrictions or lack of social activities. These older adults usually become involved with gambling via the mail, telephone, or Internet on sweepstakes or scams (CAMH, 2002).

Late-onset problem gambling is associated with "escape" gambling and the majority of escape gamblers are women. It has been hypothesized that older adults may also be at risk for late-onset problem gambling due to the stresses that are associated with aging (Frisch et al., 2003). Older women, in particular, may be vulnerable to late-onset problem gambling as many only started gambling regularly when commercial gambling expanded during the 1990s (Borrell, 2003). Tarras, Singh, and Moufakkir (2000) surveyed a small random sample of older women in Michigan about their gambling practices in a study providing advice to the gambling industry and found that 37.3% had only started gambling in casinos in 1991 with the majority (25.4%) starting to gamble in casinos sometime between 1994 and 1995.

The "inactive" problem gambler who plays sweepstakes excessively has not been investigated in the problem gambling literature and some problem gambling researchers and clinicians argue that this activity is not gambling. Many service providers for older adults, especially those dealing with elder abuse such as the police, describe clients who are "hooked" on sweepstakes. Sweepstakes, as well as scams, are a growing consumer problem, particularly in the older adult population. A recent Federal Trade Commission (2004) survey of fraud in the United States indicates that nearly 25 million adults (or 11.2 percent of the adult population) were victims of fraud in the past year.

Reasons Why Older Women Gamble

With the expansion of commercial gambling, women are gambling on EGMs in increasing numbers at casinos or non-casino settings, such as restaurants and hotels. For many women, especially older women, casino gambling is a new social activity that has emerged with the expansion of commercial gambling during the 1990s (Borrell, 2003). Gambling provides fun, excitement, a way to pass the time and forget worries, as well as the opportunity of winning money. Casinos appeal to women, and older women in particular, because they offer friendly service and a safe environment where one feels comfortable going alone (Brown & Coventry, 1997).

Women prefer to gamble in local venues where they feel safe and have a sense of belonging (Brown & Coventry, 1997; Dixey, 1987). Safety is particularly important for older women who gamble as they may have physical limitations and often play alone. Many gamble during the day, ensuring they get home before dark. In Australia, where EGMs are widely available, older women prefer gambling on the "pokies" at hotels or restaurants, rather than in a casino (Borrell, 2003).

The most common reasons that women reported for gambling in the Boughton and Brewster (2002) study were: relief from stress, a break from reality, escape from problems or worries, and a break from responsibilities or work. Conversely, asserting one's autonomy from the needs of others, especially controlling partners, was also cited as a reason to gamble.

Many older women play bingo on occasion in their seniors' residence or local church basement, or they go to casinos once a month (or less) on day-trips from their apartment buildings, retirement homes or senior centres. However, some older women, who may initially start gambling for fun with friends or family, may be unaware of the risks involved in gambling fre-

quently, especially on EGMs. EGMs, according to Griffiths (1999), incorporate machine factors that may contribute to the development of "technological addictions." While the majority of older women are not problem gamblers, many are unaware of the risk factors associated with regular and/or frequent gambling.

Risk Factors for Problem Gambling in the Older Female Population

Factors that influence the development of gambling problems in older women include biological (e.g., health status), psychological (e.g., depression and anxiety associated with poor health; a history of loss, abandonment, trauma or abuse; concurrent disorders such as alcohol abuse) and socio-economic (e.g., poverty, concurrent stresses associated with age and gender, including gender role expectations; a lack of safe leisure alternatives; and gambling industry strategies that target the older female population, including EGM design). While it is unclear which factors contribute more to the development of problem gambling in the adult population, Breen and Zimmerman (2002) found that machine factors had more to do with the rapid onset of problem gambling than intrapersonal factors such as gender and comorbid disorders.

A number of different age-related factors may also increase the risk of older adults developing gambling problems. McNeilly (2000) identifies some of the changes that many older adults experience as a part of aging, factors which can contribute to problem gambling such as loneliness (loss of partner, family members or special friends); retirement (loss of self-esteem/self-worth, financial security concerns, isolation); dislocation (a move from familiar surroundings); and anxiety over changes in health of self or loved one.

McNeilly (2000) also highlights the importance of identifying cognitive losses that may contribute to problem gambling such as undetected/undiagnosed age-related damage to the prefrontal cortex (or frontal lobe dementia) that can cause poor decision-making in otherwise healthy older adults or other subtle cognitive impairments that may occur early in such conditions as Alzheimer's Disease. Research also suggests that there is a risk of problem gambling associated with drug treatment (levodopa and dopamine agonists) for Parkinson's Disease, which most often develops after the age of 65 (Bhattacharya, 2003).

Neufeld and Burke (1999) identified the following risk factors that older adults experienced who had gambling problems in the British Columbia: chronic pain; difficult and/or controlling relationships with one's partner or family member(s); a lack of alternative meaningful leisure activities; dislocation stress from relocation; and a lack of awareness of potential financial problems associated with sweepstakes by mail.

Other factors that may contribute to problem gambling in the older population include: isolation, boredom and a previous mental health diagnosis (Cousins, Moodie, & Witcher, 2002; Wiebe, 2000); living on a fixed income and coping with multiple losses (Wiebe, 2000); gambling frequently alone or with friends and family; drug and/or alcohol use while gambling, gambling as a means of escaping or fixing problems (Burke, 2001); historical or current physical, sexual or emotional abuse (Lesieur & Blume, 1991); and gambling in response to experiences of alienation and marginalization (ageism), particularly acute for older women (combined effects of ageism and sexism). Cultural factors and ethnicity as well as the stresses related to immigration also appear to play a role in the development of gambling problems in women (Tran, 1999; Volberg, 2003a).

Many women who develop gambling problems have experienced traumatic or difficult life challenges in the past (Rich, 1998). Common stories involve loss of a parent at an early age, alcoholism and/or emotional neglect from one or both parents. Their childhoods have often been traumatic and marked by parental alcohol abuse, gambling problems, mental illness, or war (Lesieur & Blume, 1991). Women with gambling problems often have a family or personal history of trauma and abuse. According to Jacobs (1988) and Specker, Carlson, Edmonson, Johnson, and Marcotte (1996), physical or sexual abuse in childhood is a precipitating factor in the development of problem gambling. High rates of childhood physical and sexual abuse were found in the female problem gamblers in the Boughton and Brewster (2002) study. Older women seeking treatment for gambling problems in Manitoba also reported a much higher rate of historical sexual abuse than male problem gamblers (Kostyk & McKay, 2002). Younger women (44.8%) and older women (23.1%) were more likely to report sexual abuse than younger men (13.5%) and older men (8.7%). Generally, older women have not told anyone about these problems because they fear being judged, do not want to burden family or friends, experience emotional discomfort recalling painful memories, and are uncertain about the value of sharing the information.

Married or attached female problem gamblers are frequently in difficult relationships and their marriages are complicated by spousal addiction to drugs or alcohol, mental illness, infidelity or absences, anger and abuse (Boughton & Brewster, 2002; Lesieur & Blume, 1991). In the Boughton and Brewster (2002) study, a large proportion of the spouses of female problem gamblers had gambling problems (22%) or drug problems (32%). The same pattern is found in the relationships of women struggling with chemical dependency

(Boughton, 2003) as estimates suggest that one-third to one-half are living with a partner that has a drug or alcohol addiction (Gordon, 2002). Many female problem gamblers also experience abuse in their relationships. Lesieur and Blume (1991) found that 29% of the married female problem gamblers in their study had physically abusive husbands while 30% of the women in the Boughton and Brewster (2002) study had abusive partners. Other partners of female problem gamblers are often absent, either womanizers or workaholics (Lesieur & Blume, 1991). Older female problem gamblers who sought treatment in Manitoba also reported being in marriages where the spouse was often absent due to working out of town, alcoholism, or poor health, or the spouse was controlling and abusive (Kostyk & McKay, 2002).

Schull (2002) linked the development of female problem gambling on EGMs with societal gender-role and care giving expectations. It is estimated that 80% of the people providing care are women, whether or not that care is paid for or provided in institutions or at home (Grant, 2002). Older women may experience a heightened need for escape from care-giving burdens as many provide care for grandchildren, adult children, spouses, and parents. They may also be overly involved in community work. Gambling allows these older women to escape from endless requests for their help without having to assert themselves in a direct way. Schull (2002) argues that the desire for such an escape is symptomatic of the unresolved anxieties and tensions surrounding the place of care in our increasingly individualistic society.

Another common theme for older women who receive help for gambling problems in Manitoba is the sense of over-responsibility (Kostyk & McKay, 2002). Over-responsibility is also noted in younger female problem gamblers (Boughton & Brewster, 2002; Lesieur & Blume, 1991). Over-responsibility in women has been linked to female socialization (Krestan & Bepko, 1985; Lerner, 1985). Many women with gambling problems neglect their own needs and feel guilty about taking time to care for themselves (Lesieur & Blume, 1991). Many of the older female problem gamblers seeking treatment in Manitoba experienced anxiety about at least one adult child; worrying a lot about that individual's well being. The adult children were typically struggling with addiction, failed relationships, unstable employment, or mental health problems. Over-responsibility also occurs when women have managed home, family and finances on their own as single parents or with an absent or irresponsible spouse. Gambling, for some older women, becomes a way to find relief from exhaustion, distress and free of responsibility to others (Kostyk & McKay, 2002). For other older women, gambling begins as a way to reduce social isolation but as problem gambling progresses most women gamble alone and become more isolated. Paradoxically, gambling may begin as a way to assert needs for autonomy but eventually involves more loss of self (Schull, 2002).

Women who exhibit gambling problems may also suffer from depression and anxiety although it is not always clear in studies whether symptoms of depression and anxiety precede or are a consequence of problem gambling. Of the female problem gamblers in the Boughton and Brewster (2002) study, 63% had seen a professional for depression, while 53% had seen a professional for anxiety. Specker et al. (1996) found that female problem gamblers have significantly higher rates of anxiety disorders than male gamblers (73% vs. 16%). Women with gambling problems are also dealing with other mental health issues such as anorexia or bulimia, over-eating and compulsive shopping (Boughton & Brewster, 2002; Lesieur & Blume, 1991). Women with gambling problems are less likely than men to have alcohol problems or use illicit drugs (Potentza et al., 2001; Toneatto & Skinner, 2000) but female gamblers report more lifetime use of psychiatric medications than male gamblers. Older women are prescribed the most sedatives, such as tranquillizers, in Canada (Currie, 2003; Harding, 1986) and whether such prescription drug use or abuse may be a risk factor for developing gambling problems is an under-researched area in the problem gambling field.

Many women describe EGM gambling as an "escape" from unpleasant emotional states. EGMs, like alcohol and drugs, can be used for mood management. While some female gamblers are hooked by the high of gambling action, EGM gambling is most often described as an "anesthetic" that "hypnotizes" (Lesieur & Blume, 1991, p. 186) and creates a "dissociative state" (Jacobs, 1988). Many women with gambling problems are seeking a way to numb emotions, shut out the world and orchestrate a time-out (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Schull, 2002; Surgey & Seibert, 2000) that is perceived to be a socially acceptable (Surgey & Seibert, 2000). Gambling provides women with an escape (Schull, 2002) from situational stresses in a safe and friendly environment. Borrell (2004) links gambling in women to being a form of resistance that arises from the contradictions in life circumstances and that for some women gambling is a form of "acting out" against socially proscribed roles.

Consequences of Problem Gambling for Older Women

Many older women with gambling problems experience significant financial hardship and emotional distress. In the Boughton and Brewster (2002) study, the average amount of debt for female gamblers was $7000

while women 60 years and older had an average debt of $5400 (Boughton, 2004). The most common financial concerns of younger female gamblers included: diverting money from other things, spending savings or inheritance, and interest charges on credit cards (Boughton & Brewster, 2002).

Problem gambling can have serious long-term financial consequences for older adults, especially older women, as incomes tend to decrease in retirement while the time available to recover from gambling-related debt is much shorter (Gosker, 2000; Wiebe, 2000). Many older women, particularly those that never married, live on fixed incomes and are poor. They may spend the same amount of money on gambling as older men but this will be a proportionately greater amount of their annual incomes. A widowed or single older woman may have difficulty getting a bank loan to pay off gambling debt because she is perceived to be a poor risk by financial institutions. While some older women may be able to find employment, many older women experience both age and gender discrimination in their attempts to find work. Paying off debt on a fixed, limited income often with no way to add to their income by getting another job adds to a sense of hopelessness. Some older women may be forced to turn to credit companies who charge very high rates of interest in order to pay off their gambling-related debts. Older women may also experience additional anxiety about paying off their gambling debt before they die, fearful that their remaining family members will have to pay for their financial mistakes.

Most women who develop gambling problems gamble alone and keep it a secret from their partners, friends and family members. As problem gambling progresses, many women become more and more isolated. This exacerbates the feelings of loneliness, shame and guilt that women with gambling problems experience. Older women are particularly vulnerable to loneliness and slowly lose opportunities for intimacy with others as spouses, friends, siblings move away, die, or become ill. Many older women with gambling problems are grieving losses and find it difficult to make new friends.

Older people also think they should know better than to lose control over their gambling (Focus on Geriatric Care and Rehabilitation, 2000). Many older women in treatment for gambling problems in Manitoba refer to themselves as stupid for allowing their gambling to cause financial hardship (Kostyk & McKay, 2002). Many older women experience a great deal of shame for over their lose of control over their gambling and behaving in ways that contradict their self-identity, particularly older women that have committed crimes of theft or fraud for the first time in their lives, borrowed money from their children, or accumulated debt.

Older women may also experience psychological or emotional distress due to the negative impact of gambling on their relationships. The younger women with gambling problems in the Boughton and Brewster (2002) study cited the following concerns: the loss of trust and respect of others; breaking promises to oneself or others, increased tensions and arguments, lying and manipulation. They also identified multiple negative consequences related to problem gambling that included financial pressures or crisis, issues of guilt and shame arising from deceit and deception, and emotional distress and relationship problems. When they do seek help for their gambling problems they are likely in financial distress, depressed, and even suicidal (Shaffer et al., 2002). Some women may turn to illegal activity after exhausting financial resources (Lesieur & Blume, 1991).

Treatment Considerations for Older Women with Gambling Problems

Individuals with gambling problems are reluctant to seek treatment. Only about 3% of people with gambling or similar problems, such as alcohol abuse, seek formal assistance (Victorian Local Governance Association Gambling Research Newsletter, volume 2, issue 5, as cited in Borrell, 2003, p. 6). There is evidence to suggest that older adults, especially older women, are even less likely to seek help than either younger or older men (Borrell, 2003; Hirsch, 2000; Kostyk & McKay, 2002; McNeilly & Burke, 2002). For example, prevalence studies suggest that there are 12,348 older women (65+) with gambling problems in Ontario but less than 100 called the Ontario Problem Gambling Helpline in 2003 for assistance (Boughton, 2004).

A number of factors keep older women from seeking formal assistance for problem gambling. Many older adults do not identify their gambling as a problem either out of a lack or awareness, or perhaps denial (Cousins et al., 2002; Frisch, Govoni, & Johnson, 2001; Hirsch, 2000). Older adults, like other age groups, are more likely to seek help for other related problems before disclosing a gambling problem (Nolte, 1997). Many older women view problem gambling as a health issue and seek help from their doctor. Others tend to view the results of problem gambling as a financial problem, rather than a gambling problem, and seek help through consumer credit hotlines (McNeilly & Burke, 2002).

Many of the current generation of older women grew up during the Depression, when money was tight and gambling was frowned upon, especially for women. Older women with gambling problems experience an increased sense of shame and stigma because they are more likely to view problem gambling in terms of moral weakness or vice due to their social conditioning and

values. Older women also view seeking help for problems as a sign of personal weakness and most think that they should be able to help themselves and do not need support. This self-reliance has been identified as a barrier that keeps younger women with gambling problems from seeking help (Boughton & Brewster, 2002). However, many older women likely do stop or limit their gambling without formal assistance; unfortunately, very little research exists in the problem gambling field that addresses the rate of "natural recovery" from problem gambling in the older female population.

Problem gambling counsellors need to be very sensitive to age-related differences as well as the difficult economic realities many older women face. For example, often problem gambling counsellors recommend participation in voluntary self-exclusion programs offered by the casino industry. Many older women may be too embarrassed and ashamed to do so. This refusal may be incorrectly interpreted by the problem gambling counsellor as "denial" or a lack of compliance with treatment recommendations.

Problem gambling counsellors also need to be aware of the meaning of gambling in various cultures. Problem gambling may be particularly stigmatized in some cultures and religious beliefs may create an additional layer of shame for an older woman who develops a gambling problem. Newcomers who have experienced the dislocation of immigration also may have additional concerns.

Another factor that may discourage older women from seeking help is that many traditional addictions treatment programs have been designed to meet the needs of male "action" gamblers. Since men and women gamble for different reasons, women with gambling problems benefit from different treatment approaches than men (Manzer, 2001). Many female problem gamblers prefer women-specific treatment settings and programming, for example, women-only group formats for counselling (Petry, 2002; Schaffer et al., 2002). Women with gambling problems in the Boughton and Brewster (2002) study preferred women-only groups where they felt free to discuss issues of intimacy and sexuality, body image, their experience of violence, and care-giving demands.

Traditional addictions treatment programs may also not suit the needs of older adults (Weibe, 2000), particularly older women. Age-specific addictions treatment programs exist throughout Canada (e.g., Spencer, n.d.), and have been developed to address barriers to treatment in the older adult population such as transportation issues, psychological health, physiological health, culture, comfort, and a lack of independent living (Lemay, 2002). Age-specific addictions treatment programs frequently offer individual counselling through home-visits (Lemay, 2002; McKee, 2000) or telephone counselling as well as gender-specific support groups for older women and men.

Many older adults entering addictions treatment find it difficult to set a goal of abstinence initially, even though this is often the long-term goal (CAMH, 1998). Generally, older adults seek help for problem gambling when in crisis and their first priority is to stabilize finances, health, food and lodging (Lemay, 2002). Emotional and physical health, as well as safety, needs to be assessed, as many female problem gamblers are depressed and anxious, even suicidal. Safety planning, as well as referrals to domestic violence or elder abuse services, may be necessary if the woman is living with an abusive or violent family member.

Many older women are also ambivalent about gambling especially initially in treatment. Despite all the emotional and physical hardships that gambling has created in their lives, they still like playing, meeting people, anticipating a win, getting out of the house to do something different, and forgetting about their problems (Kostyk & McKay, 2002). Gambling allows them a sense of freedom from the current constraints on their behaviour such as controlling family members, limited income, health concerns. The pros and cons of gambling, as well as the functions that gambling served, need to be explored.

For many older women attempting to reduce the harm related to gambling may be a more realistic initial goal in treatment. For example, many older female clients choose the goal of reducing gambling to once every month and only spend $20-30 each time or make arrangements to pay all their bills and purchase necessities before gambling each month. They may also choose to continue to buy one or two lottery tickets per week. The risks associated with these goals are discussed and the need for ongoing monitoring is encouraged. Some older women choose abstinence from all forms of gambling as a goal and may want to attend GA, a co-ed, self-help group that provides support for problem gamblers, especially if a women's GA group is available. However, many women with gambling problems find Gamblers Anonymous too male-dominated and drop out (Stearns, 2002).

Older women with gambling problems may also have other mental health issues that need to be addressed, including depression, anxiety, concomitant disorders such as alcohol or drug abuse, or a history of abuse and trauma. To the extent that gambling is a coping or survival strategy to deal with psychological, physical and emotional pain, problem gambling counsellors need to explore and attend to these underlying issues as well as refer on to specialist services to deal with comorbid issues, as appropriate.

Problem gambling counsellors also need to be sensitive to the difficult economic and emotional realities that many older women face. Often problem gambling

counsellors recommend participation in voluntary self-exclusion programs offered by the casino industry but many older women may be too embarrassed and ashamed to do so.

To curtail the impulse to gamble, problem gambling counsellors often recommend participation in voluntary self-exclusion programs offered by the casino industry but many older women may be too embarrassed and ashamed to do so. Another recommendation is to limit access to money. Older women with gambling problems face unique challenges. Limiting access to money is commonly perceived as giving up freedom and independence, something that older women worked many years to achieve. Some older female problem gamblers possess a firm conviction that willpower alone can extinguish problems so that changing access to finances is not necessary. As Boughton (2003) noted, it may also be necessary to explore the relationship between gambling and the meaning, history, values and relational power dynamics attached to money.

To reduce secrecy and isolation with money management, a method of financial monitoring is often established. This often means getting someone else to keep credit cards, changing financial accounts over to another person's name, assigning a power of attorney, or reporting spending to another person. Because many older women live alone, are widowed, or have adult children who live long distances away, or have mental health/addiction concerns, there may not be another person to share this task with. Because older women were often extremely responsible for household management and children's well being, asking their adult children to help them manage their money is perceived as relinquishing their role as parent and adding burden to their children's lives. Older women with gambling problems may be at increased risk for emotional or financial abuse if they give up financial control to an already controlling spouse or adult child. Sometimes older adults in general may feel more comfortable having a trusted friend assist them in monitoring their money or the Office of the Public Guardian and Trustee. Non-profit credit counselling services can also help with organizing a budget, debt consolidation and repayment in many instances.

Conclusion

Since the expansion of commercial gambling during the 1990s, older women are gambling more than ever before. While the majority of older women who gamble do not develop gambling problems, increases in problem gambling appear to be associated with expanded gambling availability, particularly EGMs (Volberg, 2004). Despite the increases of gambling and problem gambling in the older female population, there is very little research that specifically addresses older women and problem gambling. Another gap in the problem gambling literature in Canada, and elsewhere, is the influence of race, culture and immigration status in tandem with the variables of age and gender.

Prior to the expansion of gambling during the 1990s, most research regarding problem gambling was based on male problem gamblers. This "male-as-norm" bias in addictions treatment (Wilke, 1994) influences the current lack of knowledge on problem gambling in women. Estimates suggest that problem gambling affects 1% of the female population, putting the prevalence on par with psychiatric illnesses such as schizophrenia or bipolar disorder (Manzer, 2001). In comparison to these conditions, which have been well studied, problem gambling in women is very under-researched despite the increasing "feminization" of gambling. What is known at present is that middle-aged and older women tend to seek help for problem gambling faster than men (Petry, 2002) and are the fastest growing group presenting with gambling problems in cities with casinos or VLTs (R. Gupta, as cited in McTavish, 2000).

The majority of information regarding problem gambling in the older adult population is derived from prevalence studies on gambling and problem gambling in the older adult population which suggest that older adults have lower rates of problem gambling than the general adult population. However, concerns have been raised by a number of problem gambling researchers that prevalence studies on problem gambling may not accurately reflect the magnitude of problem gambling in the general adult population, especially in specific populations such as women and older adults (Volberg, 2004). Existing studies that examine prevalence rates of problem gambling in the older adult population may also be conservative due to a number of factors that have previously been identified. McNeilly and Burke (2000), for example, found much higher rates of problem gambling in a non-random sample of older adults from both gambling venues and community settings. Rates of problem gambling in the gambling venue sample were 11% compared to 3% in the community sample.

Wildman (1998) notes that most of the empirical studies in the problem gambling field have been predominantly quantitative and outcome-oriented. This is true as well with regards to older adults and there is a need for qualitative studies that examine problem gambling in the older adult population (Munro et al., 2003). While there has been one qualitative study by Langewisch (2003) that focused on what led older adults to start gambling, possible precursors to gambling, and why they found it difficult to stop gambling, there are no qualitative studies to date that examine problem gambling in the older female population.

Very little research focuses on older women specifically. What research exists suggests that older women may be a vulnerable subgroup of problem gamblers due to a complex interaction of individual and social factors, including the characteristics of the games and the gambling setting. Individual factors that have been found to increase the risk of problem gambling and are associated with age and gender include: gender socialization around care-giving; poverty; multiple losses; social isolation; physical health problems, including cognitive deficits; a lack of leisure alternatives; and historical and/or current abuse issues. Social factors that may increase the risk of problem gambling are gambling industry marketing strategies, including advertising and EGM design, which target older women as gambling consumers. It is unclear which factors may place older women at greater risk for gambling problems but gambling industry marketing strategies, including EGM design factors, are implicated (Dekker, 1997; Griffiths, 2004; Schull, 2002). It is also not clear which factors may protect older women from developing gambling problems.

The emotional and physical stress related to problem gambling may exacerbate existing health problems in older adults and contribute to a loss of independence. The costs associated with problem gambling in the older adult population are also borne by Canadian society in terms of increased medical expenses and possibly hospitalizations. It has been estimated that the overall cost to taxpayers in Canada for each person that develops a significant gambling problem is $56,000 (CAD), including the cost of treatment, health-related costs, and time spent in courts (National Council on Welfare, 1996). These societal costs may be even higher when an older adult develops a gambling problem as generally the older gambler exhausts their retirement savings and this may increase demands on publicly funded pension plans as well as subsidized housing.

Problem gambling has been identified as an emerging, yet unrecognized, public health issue in the older adult population (McNeilly & Burke, 2000). Much more research on older adults, particularly older women, who gamble and may be at risk or exhibit problem gambling behaviour is necessary to inform early identification, outreach, treatment, and prevention strategies as many questions remain unanswered. It is likely that there will be an increase in gambling problems in the older female population as the demographic of older women rapidly expands globally and opportunities for gambling become increasingly accessible in casino and non-casino settings, as well as in the home on the Internet.

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Appendix A

Prevalence of Gambling and Problem Gambling in the Older Adult Population in Manitoba and Alberta (2000)

Location and Age Group	Non-Gambling	Non-Problem Gambling	Problem Gambling	Probable Pathological
Manitoba (2000), 60+	0.8%	88.0%	2.4%	1.9%
Alberta (2000), 65+	12.6%	82.6%	2.8%	2.0%

Instrument: SOGS-R
Sources: Hirsh (2000) and Wiebe (2000).

Appendix B

Prevalence of Gambling and Problem in Ontario (2001)

Age Group	Non-Gambling	Non-Problem Gambling	At Risk for Problem Gambling	Moderate Problem Gambling	Severe Problem Gambling
50-59	15.7%	73.5%	6.6%	3.5%	0.8%
60+	26.6%	67.0%	4.3%	2.0%	0.1%

Instrument: CPGI (2001)
Source: Wiebe, Single, & Falkowski-Ham (2001).

Appendix C

Prevalence of Gambling and Problem Gambling in Saskatchewan (2002)

Age Group	Non-Gambling	Non-Problem Gambling	Problem Gambling	Probable Pathological
50-59	87.2%	7.8%	3.5%	0.6%
60-69	88.9%	7.1%	3.5%	0.5%
70+	87.6%	10.1%	2.3%	0.0%

Instrument: PGSI (part of CPGI)
Source: Wynne (2002).

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